8–3–10
Vol. 75 No. 148
Book 1 of 3 Books
Pages 45475–45698

Tuesday
August 3, 2010

Federal Register

The **FEDERAL REGISTER** (ISSN 0097–6326) is published daily, Monday through Friday, except official holidays, by the Office of the Federal Register, National Archives and Records Administration, Washington, DC 20408, under the Federal Register Act (44 U.S.C. Ch. 15) and the regulations of the Administrative Committee of the Federal Register (1 CFR Ch. I). The Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402 is the exclusive distributor of the official edition. Periodicals postage is paid at Washington, DC.

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Conference Room, Suite 700
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Washington, DC 20002

RESERVATIONS: (202) 741–6008

Printed on recycled paper.

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DEPARTMENT OF STATE

22 CFR Parts 40 and 42

[Public Notice: 7085]

Visas: Documentation of Immigrants Under the Immigration and Nationality Act, as Amended

AGENCY: State Department.

ACTION: Final rule.

SUMMARY: This final rule amends the Department of State's regulations related to the application for an immigrant visa and alien registration, to offer a completely electronic application procedure as an alternative to submission of Form DS–230, the Application for Immigrant Visa and Alien Registration.

DATES: This rule is effective August 3, 2010.

FOR FURTHER INFORMATION CONTACT: Andrea Lage, Legislative and Regulations Division, Visa Services, 2401 E Street, NW., Department of State, Washington, DC 20520–0106, (202) 663–1399.

SUPPLEMENTARY INFORMATION:

Why is the Department promulgating this rule?

The Government Paperwork Elimination Act (GPEA) requires that, when possible, Federal agencies use electronic forms, electronic filing, and electronic signatures to conduct business with the public. For this reason, the Department of State developed and introduced an electronic application process for immigrant visa applicants to eventually replace the current paper-based application process, which consists of Parts 1 and 2 of Form DS–230, Application for Immigrant Visa and Alien Registration. While the Department will continue to accept the DS–230 when necessary, it proposes to eventually eliminate the DS–230 entirely and replace it with the DS–260, the Electronic Application for Immigrant Visa and Alien Registration, an electronic form designed to be completed and signed electronically.

What effect does the electronic application process have on the immigrant visa applicant?

The procedure is the same for the immigrant visa applicant except that he or she will not be required to print a form to take to the visa interview. All information entered into the DS–260 will be available to the National Visa Center and to the consular officer at the time of application processing and interviewing, thus simplifying the process for the applicant. The applicant is required to sign the DS–260 electronically at the time of submission by clicking a "Sign and Submit Application" box contained within the application. The applicant will also be required to swear under oath at the time of the interview that the information provided on the DS–260 is true and correct to the best of the individual's knowledge and provide a biometric signature in connection with the oath.

How does the applicant sign the form electronically?

The applicant will be required to click on the box designated "Sign and Submit Application" found within the certification section of the application.

How does the consular officer confirm the identity of an applicant who has submitted an electronic application (DS–260)?

Photos, passports, and fingerscans collected as part of the application process will identify the applicant.

How does the applicant certify that the information on the DS–260 is correct?

By signing the DS–260 electronically (*i.e.,* clicking on the "Sign and Submit Application" button), the applicant certifies that the information provided is correct. The applicant will also be required to swear under oath to statements contained on the DS–260 at the time of the interview and to provide a biometric signature in connection with the oath.

Is the electronic signature binding on an immigrant visa applicant?

Yes. The electronic signature indicates that the applicant is familiar with and intends to be bound by the statements contained in the application and has answered all questions truthfully, under penalty of perjury.

Can a third party prepare the DS–260?

A third party may assist the applicant in preparing the DS–260, however the applicant must electronically sign the application himself or herself. The applicant must identify in the application any third party who has assisted in the preparation of the DS–260.

Regulatory Findings

Administrative Procedure Act

This regulation involves a foreign affairs function of the United States and, therefore, in accordance with 5 U.S.C. 553(a)(1), is not subject to the rule making procedures set forth at 5 U.S.C. 553.

Regulatory Flexibility Act

Because this final rule is exempt from notice and comment rulemaking under 5 U.S.C. 553, it is exempt from the regulatory flexibility analysis requirements set forth at sections 603 and 604 of the Regulatory Flexibility Act (5 U.S.C. 603 and 604). Nonetheless, consistent with section 605(b) of the Regulatory Flexibility Act (5 U.S.C. 605(b)), the Department certifies that this rule will not have a substantial economic impact on a substantial number of small entities. This regulates individual aliens who seek consideration for immigrant visas and does not affect any small entities, as defined in 5 U.S.C. 601(6).

Unfunded Mandates Act of 1995

Section 202 of the Unfunded Mandates Reform Act of 1995, Public Law 104–4, 109 Stat. 48, 2 U.S.C. 1532, generally requires agencies to prepare a statement before proposing any rule that may result in an annual expenditure of $100 million or more by State, local, or tribal governments, or by the private sector. This rule will not result in any such expenditure, nor will it significantly or uniquely affect small governments.

Small Business Regulatory Enforcement Fairness Act of 1996

This rule is not a major rule as defined by 5 U.S.C. 804, for purposes of congressional review of agency

rulemaking under the Small Business Regulatory Enforcement Fairness Act of 1996, Public Law 104–121. The rule will not result in an annual effect on the economy of $100 million or more; a major increase in costs or prices; or significant adverse effects on competition, employment, investment, productivity, innovation, or the ability of United States-based companies to compete with foreign-based companies in domestic or import markets.

Executive Order 12866

The Department of State has reviewed this rule to ensure its consistency with the regulatory philosophy and principals set forth in Executive Order 12866 and had determined that the benefits of the proposed regulation justify the costs. The Department does not consider the rule to be an economically significant action within the scope of section 3(f)(1) of the Executive Order since it is not likely to have an annual effect on the economy of $100 million or more or to adversely affect in a material way the economy, a sector of the economy, competition, jobs, the environment, public health or safety, or state, local, or tribal governments or communities.

Executive Order 12372 and 13132: Federalism

This regulation will not have substantial direct effects on the States, on the relationship between the national government and the States, or the distribution of power and responsibilities among the various levels of government. Nor will the rule have federalism implications warranting the application of Executive Orders No. 12372 and No. 13132.

Executive Order 12988: Civil Justice Reform

The Department has reviewed this regulation in light of sections 3(a) and 3(b)(2) of Executive Order 12988 to eliminate ambiguity, minimize litigation, establish clear legal standards, and reduce burden.

Paperwork Reduction Act

This rule does not impose any new reporting or record-keeping requirements subject to the Paperwork Reduction Act, 44 U.S.C. Chapter 35.

List of Subjects in 22 CFR Parts 40 and 42

Aliens, Foreign Officials, Immigration, Nonimmigrants, Passports and Visas.

■ Accordingly, for the reasons set forth in the preamble, the Department of State amends 22 CFR Part 40 and 41 as follows:

PART 40—[AMENDED]

■ 1. The authority citation for Part 40 continues to read as follows:

Authority: 8 U.S.C. 1104.

■ 2. Section 40.1 is amended by revising paragraph (l)(2) to read as follows:

§ 40.1 Definitions.

* * * * *

(l) * * *

(2) For an immigrant visa applicant, personally appearing before a consular officer and verifying by oath or affirmation the statements contained on Form DS–230 or Form DS–260 and in all supporting documents, having previously submitted all forms and documents required in advance of the appearance and paid the visa application processing fee.

* * * * *

PART 42—[AMENDED]

■ 3. The authority citation for part 42 continues to read as follows:

Authority: 8 U.S.C. 1104; Pub. L. 107–56, sec. 421.

■ 4. Section 42.63 is revised to read as follows:

§ 42.63 Definitions.

(a) *Application Forms.* (1) *Application on Form DS–230 or Form DS–260 Required.*—Every alien applying for an immigrant visa must make application, as directed by the consular officer, on Form DS–230, Application for Immigrant Visa and Alien Registration, or on Form DS–260, Electronic Application for Immigrant Visa and Alien Registration. This requirement may not be waived. Form DS–230 consists of parts I and II which, together, are meant in any reference to this Form.

(2) *Application of alien under 14 or physically incapable.* The application on Form DS–230 or on Form DS–260 for an alien under 14 years of age or one physically incapable of completing an application may be executed by the alien's parent or guardian, or, if the alien has no parent or guardian, by any person having legal custody of, or a legitimate interest in, the alien.

(b) *Preparation of forms.* The consular officer shall ensure that Form DS–230 or Form DS–260 and all other forms an alien is required to submit are fully and properly completed in accordance with the applicable regulations and instructions.

(c) *Additional information as part of application.* The officer may require the submission of additional information or question the alien on any relevant matter whenever the officer believes that the information provided in Form DS–230 or Form DS–260 is inadequate to determine the alien's eligibility to receive an immigrant visa. Additional statements made by the alien become a part of the visa application. All documents required under the authority of § 42.62 are considered papers submitted with the alien's application within the meaning of INA 221(g)(1).

■ 5. Section 42.67 is revised to read as follows:

§ 42.67 Execution of application, registration, and fingerprinting.

(a) *Execution of visa application:* (1) *Application fee.*—A fee is prescribed for each application for an immigrant visa. It shall be collected prior to the execution of the application and a receipt shall be issued.

(2) *Oath and signature on Form DS–230.* The applicant shall be required to read the Form DS–230, Application for Immigrant Visa and Alien Registration, when it is completed, or it shall be read to the applicant in the applicant's language, or the applicant shall otherwise be informed of its full contents. Applicants shall be asked whether they are willing to subscribe thereto. If the applicant is not willing to subscribe to the application unless changes are made in the information stated therein, the required changes shall be made. The application shall then be sworn to or affirmed and signed by or on behalf of the applicant before a consular officer, or a designated officer of the American Institute of Taiwan, who shall then sign the application over the officer's title.

(3) *Oath and signature on Form DS–260.* The applicant shall be required to read the Form DS–260, Electronic Application for Immigrant Visa and Alien Registration, when it has been completed, or it shall be read to the applicant in the applicant's language, or the applicant shall otherwise be informed of its full contents, before the applicant electronically signs and submits the application to the Department. At the time of the applicant's interview the applicant shall be asked whether they are willing to subscribe thereto to the information provided on Form DS–260. If the alien is not willing to subscribe to the application unless changes are made in the information stated therein, the required changes shall be made. The application shall then be sworn to or affirmed and signed, biometrically, by or on behalf of the applicant before a consular officer, or a designated officer

of the American Institute of Taiwan, who shall then electronically sign the application.

(b) *Registration.* The alien shall be considered to be registered for the purposes of INA 221(b) and 203(g) upon the filing of Form DS–230 or Form DS–260, when duly executed, or the transmission by the Department to the alien of a notification of the availability of an immigrant visa, whichever occurs first.

(c) *Fingerprinting.* Every applicant for an immigrant visa must furnish fingerprints prior to the execution of Form DS–230 or Form DS–260.

■ 6. Section 42.81 is amended by revising paragraph (b) to read as follows:

§ 42.81 Procedure in refusing individual visas.

* * * * *

(b) *Refusal procedure.* A consular officer may not refuse an immigrant visa until either Form DS–230, Application for Immigrant Visa and Alien Registration, or Form DS–260, Electronic Application for Immigrant Visa and Alien Registration, has been executed by the applicant. When an immigrant visa is refused, an appropriate record shall be made in duplicate on a form prescribed by the Department. The form shall be signed and dated by the consular officer. The consular officer shall inform the applicant of the provision of law or implementing regulation on which the refusal is based and of any statutory provision of law or implementing regulation under which administrative relief is available. Each document related to the refusal shall then be attached to Form DS–230 for retention in the refusal files. Alternatively, each document related to the refusal shall be electronically scanned and electronically attached to Form DS–260 for retention in the electronic refusal files. Any documents not related to the refusal shall be returned to the applicant. The original copy of a document that was scanned and attached to the DS–260 for the refusal file shall be returned to the applicant. If the ground of ineligibility may be overcome by the presentation of additional evidence and the applicant indicates an intention to submit such evidence, all documents may, with the consent of the alien, be retained in the consular files for a period not to exceed one year. If the refusal as not been overcome within one year, any documents not relating to the refusal shall be removed from the file and returned to the alien.

* * * * *

Dated: July 22, 2010.

Janice L. Jacobs,

Assistant Secretary, Bureau of Consular Affairs, Department of State.

[FR Doc. 2010–19046 Filed 8–2–10; 8:45 am]

BILLING CODE 4710–06–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 117

[Docket No. USCG–2010–0687]

Drawbridge Operation Regulation; Company Canal, Bourg, LA

AGENCY: Coast Guard, DHS.

ACTION: Notice of temporary deviation from regulations.

SUMMARY: The Commander, Eighth Coast Guard District, has issued a temporary deviation from the regulation governing the operation of the LA 24 vertical lift span bridge across Company Canal, mile 8.1, at Bourg, Terrebonne Parish, Louisiana. The deviation is necessary to perform electrical rehabilitation work on the bridge. This deviation allows the bridge to remain closed to navigation for twelve consecutive days.

DATES: This deviation is effective from 6 a.m. on Monday, October 25 through 10 p.m. on Friday, November 5, 2010.

ADDRESSES: Documents mentioned in this preamble as being available in the docket are part of docket USCG–2010–0687 and are available online by going to *http://www.regulations.gov*, inserting USCG–2010–0687 in the "Keyword" box and then clicking "Search." They are also available for inspection or copying at the Docket Management Facility (M–30), U.S. Department of Transportation, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue, SE., Washington, DC 20590, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

FOR FURTHER INFORMATION CONTACT: If you have questions on this rule, call or e-mail Kay Wade, Bridge Administration Branch, Coast Guard; telephone 504–671–2128, e-mail *Kay.B.Wade@uscg.mil.* If you have questions on viewing the docket, call Renee V. Wright, Program Manager, Docket Operations, telephone 202–366–9826.

SUPPLEMENTARY INFORMATION: The Louisiana Department of Transportation and Development has requested a temporary deviation from the operating schedule of the vertical lift span bridge across Company Canal at mile 8.1 in Bourg, Terrebonne Parish, Louisiana. The vertical clearance of the bridge in the closed-to-navigation position is 5.17 feet above Mean High Water Elevation 3.0 feet Mean Sea Level.

In accordance with 33 CFR 117.438(b), the vertical lift span of the bridge currently opens on signal except that, from 10 p.m. to 6 a.m. the draw opens on signal if at least 4 hours notice is given. This deviation allows the vertical lift span of the bridge to remain closed to navigation for twelve consecutive days from 6 a.m. Monday, October 25 through 10 p.m. Friday, November 5, 2010.

The closure is necessary in order to replace electrical conductors and conduit throughout the bridge structure, including the removal and replacement of all navigation lights on the span and fender system. This maintenance is essential for the continued operation of the bridge. Temporary navigational lighting will be provided during the closure and power outage period. Notices will be published in the Eighth Coast Guard District Local Notice to Mariners and will be broadcast via the Coast Guard Broadcast Notice to Mariners System.

Navigation on the waterway consists of commercial and recreational fishing vessels, small to medium crew boats, and small tugs with and without tows. There are no commercial docks or marine type facilities within one mile of the bridge along Company Canal or Bayou Terrebonne. The bridge opens for the passage of navigation an average of 53 times per month. There are two alternate waterway routes available via the Gulf Intracoastal Waterway east to Bayou Lafourche and west to Navigation Canal. Small vessels may pass under the bridge while in the closed-to-navigation position provided caution is exercised. In an emergency, the bridge can be returned to operation with a 36 hour notice.

Due to prior experience and coordination with waterway users, it has been determined that this closure will not have a significant effect on vessels that use the waterway.

In accordance with 33 CFR 117.35(e), the drawbridge must return to its regular operating schedule immediately at the end of the designated time period. This deviation from the operating regulations is authorized under 33 CFR 117.35.

Dated: July 23, 2010.

David M. Frank,

Bridge Administrator.

[FR Doc. 2010–18961 Filed 8–2–10; 8:45 am]

BILLING CODE 9110–04–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 165

[Docket No. USCG–2010–0706]

RIN 1625–AA00

Safety Zone; Transformers 3 Movie Filming, Chicago River, Chicago, IL

AGENCY: Coast Guard, DHS.

ACTION: Temporary final rule.

SUMMARY: The Coast Guard is establishing two separate temporary safety zones on the Chicago River near Chicago, Illinois. These zones are intended to restrict vessels from a portion of the Chicago River due to the filming of a major motion picture, Transformers 3. These temporary safety zones are necessary to protect the surrounding public and vessels from the hazards associated with the different types of stunts that will be performed during the filming of this movie.

DATES: Effective Date: this rule is effective in the CFR from August 3, 2010 until 9 p.m. on August 8, 2010. This rule is effective with actual notice for purposes of enforcement beginning 7 a.m. on July 27, 2010.

ADDRESSES: Documents indicated in this preamble as being available in the docket are part of docket USCG–2010–0706 and are available online by going to *http://www.regulations.gov,* inserting USCG–2010–0706 in the "Keyword" box, and then clicking "search." They are also available for inspection or copying at the Docket Management Facility (M–30), U.S. Department of Transportation, West Building Ground floor, Room W12–140, 1200 New Jersey Avenue SE., Washington DC 20590, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

FOR FURTHER INFORMATION CONTACT: If you have questions on this temporary rule, contact or email BM1 Adam Kraft, U.S. Coast Guard Sector Lake Michigan, at 414–747–7154 or *Adam.D.Kraft@uscg.mil.* If you have questions on viewing the docket, call Renee V. Wright, Program Manager, Docket Operations, telephone 202–366–9826.

SUPPLEMENTARY INFORMATION:

Regulatory Information

The Coast Guard is issuing this temporary final rule without prior notice and opportunity to comment pursuant to authority under section 4(a) of the Administrative Procedure Act (APA) (5 U.S.C. 553(b)). This provision authorizes an agency to issue a rule without prior notice and opportunity to comment when an agency for good cause finds that those procedures are "impracticable, unnecessary, or contrary to the public interest." Under U.S.C. 553 (b)(B), the Coast Guard finds that good cause exists for not publishing a notice of proposed rulemaking (NPRM) with respect to this rule because the final details for these events were not submitted to the Coast Guard until July 20, 2010. Based on the hazards associated with the filming of this major motion picture, delaying the enactment of this rule to provide for a comment would be against the public interest. Therefore, there was not enough time to solicit the public for comments concerning this temporary final rule.

Under 5 U.S.C. 553(d)(3), the Coast Guard finds that good cause exists for making this rule effective less than 30 days after publication in the **Federal Register**. Delaying the effective date of this rule would be contrary to the public interest as immediate action is needed to protect the public from the hazards associated with the filming of this major motion picture.

Basis and Purpose

These temporary safety zones are necessary to protect vessels from the hazards associated with the stunts that will be occurring during this filming of the major motion picture, Transformers 3. The Captain of the Port, Sector Lake Michigan, has determined that the stunts associated with the filming of this motion picture do pose significant risks to public safety and property. The likely combination of congested waterways and the stunts that will be performed during the filming of a major motion picture could easily result in serious injuries or fatalities.

Discussion of Rule

The Coast Guard is establishing two temporary safety zones. The first safety zone will be enforced between 7 a.m. and 9 p.m. on July 27, 2010 and encompasses all U.S. navigable waters of the Chicago River between the Lakeshore Drive Bridge, 41°53′19″ N, 087°36′51″ W and the Wabash Street Bridge, 41°53′17″ N, 087°37′36″ W. The second safety zone will be enforced between 7 a.m. and 9 p.m. on August 8, 2010 and encompasses all U.S. navigable waters of the Chicago River between the Dearborn Street Bridge, 41°53′14″ N, 087°37′46″ W and the Wabash Street Bridge, 41°53′17″ N, 087°37′36″ W. [DATUM: NAD 83].

All persons and vessels shall comply with the instructions of the Coast Guard Captain of the Port, Sector Lake Michigan, or his or her on-scene representative. Entry into, transiting, or anchoring within the safety zone is prohibited unless authorized by the Captain of the Port, Sector Lake Michigan, or his or her on-scene representative. The Captain of the Port, Sector Lake Michigan, or his or her on-scene representative may be contacted via VHF Channel 16.

Regulatory Analyses

We developed this rule after considering numerous statutes and executive orders related to rulemaking. Below we summarize our analyses based on 13 of these statutes or executive orders.

Regulatory Planning and Review

This rule is not a significant regulatory action under section 3(f) of Executive Order 12866, Regulatory Planning and Review, and does not require an assessment of potential costs and benefits under section 6(a)(3) of that Order. The Office of Management and Budget has not reviewed it under that Order.

Although this regulation will restrict access to the area, the effect of the rule will not be significant because: The minimal time that vessels will be restricted from the zone and the zone is an area where the Coast Guard expects insignificant adverse impact to mariners from the zones' ten minute or less activation periods.

Small Entities

Under the Regulatory Flexibility Act (5 U.S.C. 601–612), we have considered whether this rule will have a significant economic impact on a substantial number of small entities. The term "small entities" comprises small businesses, not-for-profit organizations that are independently owned and operated and are not dominant in their fields, and governmental jurisdictions with populations of less than 50,000.

The Coast Guard certifies under 5 U. S. C. 605(b) that this rule will not have a significant economic impact on a substantial number of small entities.

This rule will affect the following entities, some of which might be small entities: The owners or operators of vessels intending to transit or anchor in a portion of the Chicago River between 7 a.m. and 9 p.m. on July 27, 2010 and August 8, 2010.

The safety zones will not have a significant economic impact on a substantial number of small entities for the following reasons: This rule will only be enforced while unsafe conditions exist. Traffic will only be prohibited from passing through the

zones when actual filming is being conducted. Traffic will only be stopped for a short duration not to exceed ten minutes during any one closure. In the event that these temporary safety zones affect shipping, commercial vessels may request permission from the Captain of The Port, Sector Lake Michigan, or his or her on scene representative to transit through the safety zone. The Coast Guard will give notice to the public via a Broadcast to Mariners that the regulation is in effect.

Assistance for Small Entities

Under section 213(a) of the Small Business Regulatory Enforcement Fairness Act of 1996 (Pub. L. 104–121), we offer to assist small entities in understanding the rule so that they could better evaluate its effects on them and participate in the rulemaking process.

Small businesses may send comments on the actions of Federal employees who enforce, or otherwise determine compliance with, Federal regulations to the Small Business and Agriculture Regulatory Enforcement Ombudsman and the Regional Small Business Regulatory Fairness Boards. The Ombudsman evaluates these actions annually and rates each agency's responsiveness to small business. If you wish to comment on actions by employees of the Coast Guard, call 1–888–REG–FAIR (1–888–734–3247). The Coast Guard will not retaliate against small entities that question or complain about this rule or any policy or action of the Coast Guard.

Collection of Information

This rule calls for no new collection of information under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3520).

Federalism

A rule has implications for federalism under Executive Order 13132, Federalism, if it has a substantial direct effect on State or local governments and would either preempt State law or impose a substantial direct cost of compliance on them. We have analyzed this rule under that Order and have determined that it does not have implications for federalism.

Unfunded Mandates Reform Act

The Unfunded Mandates Reform Act of 1995 (2 U.S.C. 1531–1538) requires Federal agencies to assess the effects of their discretionary regulatory actions. In particular, the Act addresses actions that may result in the expenditure by a State, local, or tribal government, in the aggregate, or by the private sector of $100,000,000 or more in any one year. Though this rule will not result in such expenditure, we do discuss the effects of this rule elsewhere in this preamble.

Taking of Private Property

This rule will not affect a taking of private property or otherwise have taking implications under Executive Order 12630, Governmental Actions and Interference with Constitutionally Protected Property Rights.

Civil Justice Reform

This rule meets applicable standards in sections 3(a) and 3(b)(2) of Executive Order 12988, Civil Justice Reform, to minimize litigation, eliminate ambiguity, and reduce burden.

Protection of Children

We have analyzed this rule under Executive Order 13045, Protection of Children from Environmental Health Risks and Safety Risks. This rule is not an economically significant rule and does not concern an environmental risk to health or risk to safety that may disproportionately affect children.

Indian Tribal Governments

This rule does not have tribal implications under Executive Order 13175, Consultation and Coordination with Indian Tribal Governments, because it does not have a substantial direct effect on one or more Indian tribes, on the relationship between the Federal Government and Indian tribes, or on the distribution of power and responsibilities between the Federal Government and Indian tribes.

Energy Effects

We have analyzed this temporary rule under Executive Order 13211, Actions Concerning Regulations That Significantly Affect Energy Supply, Distribution, or Use. We have determined that it is not a "significant energy action" under that order because it is not a "significant regulatory action" under Executive Order 12866 and is not likely to have a significant adverse effect on the supply, distribution, or use of energy. The Administrator of the Office of Information and Regulatory Affairs has not designated it as a significant energy action. Therefore, it does not require a Statement of Energy Effects under Executive Order 13211.

Technical Standards

The National Technology Transfer and Advancement Act (NTTAA) (15 U.S.C. 272 note) directs agencies to use voluntary consensus standards in their regulatory activities unless the agency provides Congress, through the Office of Management and Budget, with an explanation of why using these standards would be inconsistent with applicable law or otherwise impractical. Voluntary consensus standards are technical standards (*e.g.,* specifications of materials, performance, design, or operation; test methods; sampling procedures; and related management systems practices) that are developed or adopted by voluntary consensus standards bodies. This rule does not use technical standards. Therefore, we did not consider the use of voluntary consensus standards.

Environment

We have analyzed this rule under Department of Homeland Security Management Directive 023–01 and Commandant Instruction M16475.lD, which guide the Coast Guard in complying with the National Environmental Policy Act of 1969 (NEPA) (42 U.S.C. 4321–4370f), and have concluded this action is one of a category of actions which do not individually or cumulatively have a significant effect on the human environment. This rule is categorically excluded, under figure 2–1, paragraph (34)(g), of the Instruction. This rule involves the establishment of two safety zones and is therefore categorically excluded under paragraph 34(g) of the Instruction.

A final environmental analysis check list and categorical exclusion determination are available in the docket where indicated under **ADDRESSES**.

List of Subjects in 33 CFR Part 165

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

■ For the reasons discussed in the preamble, the Coast Guard amends 33 CFR Part 165 as follows:

PART 165—REGULATED NAVIGATION AREAS AND LIMITED ACCESS AREAS

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

Authority: 33 U.S.C. 1226, 1231; 46 U.S.C. Chapter 701; 50 U.S.C. 191, 195; 33 CFR 1.05–1(g), 6.04–1, 6.04–6, and 160.5; Pub. L. 107–295, 116 Stat. 2064; Department of Homeland Security Delegation No. 0170.1.

■ 2. Add § 165.T09–0706 to read as follows

§ 165.T09–0706 Safety Zone; Transformers 3 Movie Filming, Chicago River, Chicago, IL

(a) *Safety Zones.* (1) The first safety zone encompasses all U.S. navigable waters of the Chicago River between the

Lakeshore Drive Bridge, 41°53′19″ N, 087°36′51″ W and the Wabash Street Bridge, 41°53′17″ N, 087°37′36″ W.

(i) *Date.* July 27, 2010.

(2) The second safety zone encompasses all U.S. navigable waters of the Chicago River between the Dearborn Street Bridge, 41°53′14″ N, 087°37′46″ W and the Wabash Street Bridge, 41°53′17″ N, 087°37′36″W. [DATUM: NAD 83].

(i) *Date.* August 8, 2010.

(b) *Enforcement period.* The first safety zone will be enforced between 7 a.m. to 9 p.m. on July 27, 2010. The second safety zone will be enforced between 7 a.m. to 9 p.m. on August 8, 2010. The Captain of the Port, Sector Lake Michigan, or the on-scene representative may suspend and restart the enforcement of the safety zone at anytime within the stated enforcement times.

(c) *Regulations.* (1) In accordance with the general regulations in section 165.23 of this part, entry into, transiting, or anchoring within this safety zone is prohibited unless authorized by the Captain of the Port, Sector Lake Michigan, or his or her on-scene representative.

(2) This safety zone is closed to all vessel traffic, except as may be permitted by the Captain of the Port, Sector Lake Michigan, or his or her on-scene representative.

(3) The "on-scene representative" of the Captain of the Port, Sector Lake Michigan, is any Coast Guard commissioned, warrant or petty officer who has been designated by the Captain of the Port, Sector Lake Michigan, to act on his or her behalf. The on-scene representative of the Captain of the Port, Sector Lake Michigan, will be on land in the vicinity of the safety zone and will have constant communications with the Chicago Marine Unit vessels that will be on-scene as the enforcement vessels.

(4) Vessel operators desiring to enter or operate within the safety zone shall contact the Captain of the Port, Sector Lake Michigan, or his or her on-scene representative to obtain permission to do so. The Captain of the Port, Sector Lake Michigan, or his or her on-scene representative may be contacted via VHF Channel 16. Vessel operators given permission to enter or operate in the safety zone must comply with all directions given to them by the Captain of the Port, Sector Lake Michigan, or his or her on-scene representative.

Dated: July 21, 2010.

L. Barndt,

Captain, U.S. Coast Guard, Captain of the Port, Sector Lake Michigan.

[FR Doc. 2010–18960 Filed 8–2–10; 8:45 am]

BILLING CODE 9110–04–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[EPA–R05–OAR–2010–0450; FRL–9182–2]

Approval and Promulgation of Air Quality Implementation Plans; Minnesota

AGENCY: Environmental Protection Agency (EPA).

ACTION: Direct final rule.

SUMMARY: EPA is approving a request submitted by the Minnesota Pollution Control Agency (MPCA) on May 7, 2010, to revise the Minnesota State Implementation Plan (SIP) for sulfur dioxide (SO_2). The approval revises the Minnesota SIP by updating information regarding the heat and steam distributor facility of United Defense, LP, Inc, located in Fridley, Minnesota. The source has changed its name from United Defense, LP, Inc to ELT Minneapolis, LLC, as a consequence of a change in ownership. The revision replaces the joint Title I/Title V document currently approved in the SIP for the facility to reflect the change in ownership. These revisions do not change any of the SO_2 control requirements and will not result in an increase in SO_2 emissions at the facility because no emission limits were increased.

DATES: This direct final rule will be effective October 4, 2010, unless EPA receives adverse comments by September 2, 2010. If adverse comments are received, EPA will publish a timely withdrawal of the direct final rule in the **Federal Register** informing the public that the rule will not take effect.

ADDRESSES: Submit your comments, identified by Docket ID No. EPA–R05–OAR–2010–0450, by one of the following methods:

1. *http://www.regulations.gov:* Follow the on-line instructions for submitting comments.
2. *E-mail: bortzer.jay@epa.gov.*
3. *Fax:* (312)629–2054.
4. *Mail:* Jay Bortzer, Chief, Air Programs Branch (AR–18J), U.S. Environmental Protection Agency, 77 West Jackson Boulevard, Chicago, Illinois 60604.
5. *Hand Delivery:* Jay Bortzer, Chief, Air Programs Branch (AR–18J), U.S. Environmental Protection Agency, 77 West Jackson Boulevard, Chicago, Illinois 60604. Such deliveries are only accepted during the Regional Office normal hours of operation, and special arrangements should be made for deliveries of boxed information. The Regional Office official hours of business are Monday through Friday, 8:30 a.m. to 4:30 p.m. excluding Federal holidays.

Instructions: Direct your comments to Docket ID No. EPA–R05–OAR–2010–0450. EPA's policy is that all comments received will be included in the public docket without change and may be made available online at *http://www.regulations.gov,* including any personal information provided, unless the comment includes information claimed to be Confidential Business Information (CBI) or other information whose disclosure is restricted by statute. Do not submit information that you consider to be CBI or otherwise protected through *http://www.regulations.gov* or e-mail. The *http://www.regulations.gov* Web site is an "anonymous access" system, which means EPA will not know your identity or contact information unless you provide it in the body of your comment. If you send an e-mail comment directly to EPA without going through *http://www.regulations.gov* your e-mail address will be automatically captured and included as part of the comment that is placed in the public docket and made available on the Internet. If you submit an electronic comment, EPA recommends that you include your name and other contact information in the body of your comment and with any disk or CD–ROM you submit. If EPA cannot read your comment due to technical difficulties and cannot contact you for clarification, EPA may not be able to consider your comment. Electronic files should avoid the use of special characters, any form of encryption, and be free of any defects or viruses.

Docket: All documents in the docket are listed in the *http://www.regulations.gov* index. Although listed in the index, some information is not publicly available, *e.g.,* CBI or other information whose disclosure is restricted by statute. Certain other material, such as copyrighted material, will be publicly available only in hard copy. Publicly available docket materials are available either electronically in *http://www.regulations.gov* or in hard copy at the Environmental Protection Agency, Region 5, Air and Radiation Division, 77 West Jackson Boulevard, Chicago, Illinois 60604. This facility is open from

8:30 a.m. to 4:30 p.m., Monday through Friday, excluding Federal holidays. We recommend that you telephone Charles Hatten, Environmental Engineer, at (312) 886–6031 before visiting the Region 5 office.

FOR FURTHER INFORMATION CONTACT: Charles Hatten, Environmental Engineer, Control Strategies Section, Air Programs Branch (AR–18J), U.S. Environmental Protection Agency, Region 5, 77 West Jackson Boulevard, Chicago, Illinois 60604, (312) 886–6031, *hatten.charles@epa.gov.*

SUPPLEMENTARY INFORMATION: Throughout this document whenever "we," "us," or "our" is used, we mean EPA. This supplementary information section is arranged as follows:

I. General Information
II. What revision did the State request be incorporated into the SIP?
III. What is EPA's analysis of the State submission?
IV. What action is EPA taking?
V. Statutory and Executive Order Reviews.

I. General Information

A. Does this action apply to me?

This action applies only to the ELT Minneapolis, LLC, (ELT) for its River Road Industrial facility located at 4800 East River Road, Fridley, Minnesota (Anoka County).

B. Has public notice been provided?

Minnesota published a public notice of the revisions to the SIP on February 17, 2010. The comment period began on February 26, 2010, and ended on March 29, 2010. In the public notice, Minnesota stated it would hold a public hearing if one were requested during the comment period. This follows the alternative public participation process EPA approved on June 5, 2006 (71 FR 32274). For limited types of SIP revisions that the public has shown little interest in, a public hearing is not automatically required. Because no one requested a public hearing, Minnesota did not hold a public hearing.

C. What is the background to this action?

ELT owns and operates boilers and emergency generators in the city of Fridley, formerly owned and operated by United Defense, LP, Inc. The facility is used as a heat and steam distributor. The facility is located in the Anoka area's non-attainment plan for the SO_2 National Ambient Air Quality Standard (NAAQS). However, the area currently meets the NAAQS for SO_2, and was officially redesignated as attainment on July 31, 1995.

The primary emission units at the facility are three fossil fuel-fired boilers (Nos. 1, 2, and 3), and four emergency generators. Each boiler burns natural gas as fuel with distillate oil as a backup fuel. The generators only burn low sulfur diesel fuel.

II. What revision did the State request be incorporated into the SIP?

To reflect the change in ownership the State has requested that EPA replace the joint Title I/Title V document currently in the Minnesota SIP for United Defense, LP, Inc, with a new joint document for ELT Minneapolis, LLC.

A. What prior SIP actions are pertinent to this action?

The facility has been subject to a federally enforceable permit incorporated into Minnesota's SIP as a joint Title I/Title V document, containing requirements for ensuring the attainment of the NAAQS for SO_2. As a result, the facility is subject to fuel usage limitations to restrict the total facility SO_2 emissions.

B. What are Title I conditions and joint Title I/Title V documents?

SIP control measures were contained in permits issued to culpable sources in Minnesota until 1990 when EPA determined that limits in state-issued permits are not federally enforceable because the permits expire. Minnesota then issued permanent Administrative Orders to culpable sources in nonattainment areas from 1991 to February of 1996.

Minnesota's consolidated permitting regulations, approved into its SIP on May 2, 1995 (60 FR 21447), include the term "Title I condition" which was written, in part, to satisfy EPA requirements that SIP control measures remain permanent. A "Title I condition" is defined as "any condition based on source-specific determination of ambient impacts imposed for the purposes of achieving or maintaining attainment with the national ambient air quality standard and which was part of the state implementation plan approved by EPA or submitted to the EPA pending approval under section 110 of the act * * *." The rule also states that "Title I conditions and the permittee's obligation to comply with them, shall not expire, regardless of the expiration of the other conditions of the permit." Further, "any title I condition shall remain in effect without regard to permit expiration or reissuance, and shall be restated in the reissued permit."

Minnesota has initiated using joint Title I/Title V documents as the enforceable document for imposing emission limitations and compliance requirements in SIPs. The SIP requirements in joint Title I/Title V documents submitted by MPCA are cited as "Title I conditions," therefore ensuring that SIP requirements remain permanent and enforceable. EPA reviewed the State's procedure for using joint Title I/Title V documents to implement site-specific SIP requirements and found it to be acceptable under both Titles I and V of the Clean Air Act (July 3, 1997 letter from David Kee, EPA, to Michael J. Sandusky, MPCA). Further, a June 15, 2006, letter from EPA to MPCA clarifies procedures to transfer requirements from Administrative Orders to joint Title I/Title V documents.

III. What is EPA's analysis of the State submission?

The revision to the Minnesota SIP is solely an administrative change to reference the new name of the facility from United Defense, LP, Inc, to ELT Minneapolis, LLC. On November 22, 2005, the heat and steam distributor facility formerly owned and operated by United Defense, LP, Inc, was purchased by ELT. ELT operates the facility in an area that currently meets the NAAQS for SO_2.

This SIP revision replaces the joint Title I/Title V document, Air Permit No. 00300020–001, currently approved into the SIP for United Defense, LP, Inc with a new joint Title I/Title V document, Air Permit No. 00300245–001, for ELT Minneapolis, LLC. This revision does not involve any substantive changes to the SIP conditions. All fuel restrictions and SO_2 emission limits that apply to the boilers and emergency generators remain the same as those currently approved into the SIP.

IV. What action is EPA taking?

EPA is approving a revision to Minnesota's SIP to replace the joint Title I/Title V document currently approved into the SIP for United Defense, LP, Inc, with a new joint Title I/Title V document, Air Permit No. 00300245–001, for ELT Minneapolis, LLC. These revisions do not change any of the SO_2 control requirements and will not result in an increase in SO_2 emissions because no emission limits were increased.

We are publishing this action without prior proposal because we view this as a noncontroversial amendment and anticipate no adverse comments. However, in the proposed rules section of this **Federal Register** publication, we are publishing a separate document that will serve as the proposal to approve the state plan if relevant adverse written comments are filed. This rule will be

effective October 4, 2010 without further notice unless we receive relevant adverse written comments by September 2, 2010. If we receive such comments, we will withdraw this action before the effective date by publishing a subsequent document that will withdraw the final action. All public comments received will then be addressed in a subsequent final rule based on the proposed action. The EPA will not institute a second comment period. Any parties interested in commenting on this action should do so at this time. If we do not receive any comments, this action will be effective October 4, 2010.

V. Statutory and Executive Order Reviews

Under the Clean Air Act, the Administrator is required to approve a SIP submission that complies with the provisions of the Act and applicable Federal regulations. 42 U.S.C. 7410(k); 40 CFR 52.02(a). Thus, in reviewing SIP submissions, EPA's role is to approve state choices, provided that they meet the criteria of the Clean Air Act. Accordingly, this action merely approves state law as meeting Federal requirements and does not impose additional requirements beyond those imposed by state law. For that reason, this action:

- Is not a "significant regulatory action" subject to review by the Office of Management and Budget under Executive Order 12866 (58 FR 51735, October 4, 1993);
- Does not impose an information collection burden under the provisions of the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*);
- Is certified as not having a significant economic impact on a substantial number of small entities under the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*);
- Does not contain any unfunded mandate or significantly or uniquely affect small governments, as described in the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4);
- Does not have Federalism implications as specified in Executive Order 13132 (64 FR 43255, August 10, 1999);
- Is not an economically significant regulatory action based on health or safety risks subject to Executive Order 13045 (62 FR 19885, April 23, 1997);
- Is not a significant regulatory action subject to Executive Order 13211 (66 FR 28355, May 22, 2001);
- Is not subject to requirements of Section 12(d) of the National Technology Transfer and Advancement Act of 1995 (15 U.S.C. 272 note) because application of those requirements would be inconsistent with the Clean Air Act; and
- Does not provide EPA with the discretionary authority to address, as appropriate, disproportionate human health or environmental effects, using practicable and legally permissible methods, under Executive Order 12898 (59 FR 7629, February 16, 1994).

In addition, this rule does not have tribal implications as specified by Executive Order 13175 (65 FR 67249, November 9, 2000), because the SIP is not approved to apply in Indian country located in the state, and EPA notes that it will not impose substantial direct costs on tribal governments or preempt tribal law.

The Congressional Review Act, 5 U.S.C. 801 *et seq.,* as added by the Small Business Regulatory Enforcement Fairness Act of 1996, generally provides that before a rule may take effect, the agency promulgating the rule must submit a rule report, which includes a copy of the rule, to each House of the Congress and to the Comptroller General of the United States. EPA will submit a report containing this action and other required information to the U.S. Senate, the U.S. House of Representatives, and the Comptroller General of the United States prior to publication of the rule in the **Federal Register**. A major rule cannot take effect until 60 days after it is published in the **Federal Register**. This action is not a "major rule" as defined by 5 U.S.C. 804(2).

Under section 307(b)(1) of the Clean Air Act, petitions for judicial review of this action must be filed in the United States Court of Appeals for the appropriate circuit by October 4, 2010. Filing a petition for reconsideration by the Administrator of this final rule does not affect the finality of this action for the purposes of judicial review nor does it extend the time within which a petition for judicial review may be filed, and shall not postpone the effectiveness of such rule or action. This action may not be challenged later in proceedings to enforce its requirements. (*See* section 307(b)(2).)

List of Subjects in 40 CFR Part 52

Environmental protection, Air pollution control, Incorporation by reference, Intergovernmental relations, Reporting and recordkeeping requirements, Sulfur dioxide.

Dated: July 19, 2010.

Susan Hedman,

Regional Administrator, Region 5.

■ 40 CFR part 52 is amended as follows:

PART 52—[AMENDED]

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

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

Subpart Y—Minnesota

■ 2. In § 52.1220, the table in paragraph (d) is amended by removing the entry for "United Defense, LP (formerly FMC/U.S. Navy)" and adding in alphabetical order an entry for "ELT Minneapolis, LLC" to read as follows:

§ 52.1220 Identification of plan.

* * * * *

(d) * * *

EPA-APPROVED MINNESOTA SOURCE-SPECIFIC PERMITS

Name of source	Permit No.	State effective date	EPA approval date	Comments
*	*	*	*	*	*	*
ELT Minneapolis, LLC	003000245–001	09/10/08	August 3, 2010, [Insert page number where the document begins].	Only conditions cited as "Title I condition: SIP for SO_2 NAAQS."
*	*	*	*	*	*	*

* * * * *

[FR Doc. 2010–18563 Filed 8–2–10; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[EPA–R02–OAR–2010–0161; FRL–9175–7]

Approval and Promulgation of Implementation Plans; Implementation Plan Revision; State of New Jersey

AGENCY: Environmental Protection Agency (EPA).

ACTION: Final rule.

SUMMARY: The Environmental Protection Agency (EPA) is approvinga request from the State of New Jersey to revise its State Implementation Plan (SIP) to incorporate amendments to Subchapter 4 "Control and Prohibition of Particles from Combustion of Fuel," Subchapter 10 "Sulfur in Solid Fuels," Subchapter 16 "Control and Prohibition of Air Pollution by Volatile Organic Compounds," Subchapter 19 "Control and Prohibition of Air Pollution from Oxides of Nitrogen," and related amendments to Subchapter 21 "Emission Statements." The amendments relate to the control of oxides of nitrogen (NO_x), sulfur dioxide (SO_2), particles and volatile organic compounds (VOCs) from stationary sources.

This SIP revision consists of control measures needed to meet the State's commitment to adopt additional reasonably available control technology (RACT) rules that address RACT requirements for the 1997 national ambient air quality standards for ozone. Additionally, the SIP revision includes control measures that will help the State meet the national ambient air quality standards for fine particles.

The intended effect of this action is to approve the State control strategy, which will result in emission reductions that will help achieve attainment of the national ambient air quality standards for ozone and fine particles required by the Clean Air Act (the Act).

DATES: *Effective Date:* This rule is effective on *September 2, 2010.*

ADDRESSES: EPA has established a docket for this action under Docket ID No. EPA–R02–OAR–2010–0161. All documents in the docket are listed on the *http://www.regulations.gov* Web site. Although listed in the index, some information is not publicly available, *e.g.,* CBI or other information whose disclosure is restricted by statute. Certain other material, such as copyrighted material, is not placed on the Internet and will be publicly available only in hard copy form. Publicly available docket materials are available either electronically through *http://www.regulations.gov* or in hard copy at the Environmental Protection Agency, Region II Office, Air Programs Branch, 290 Broadway, 25th Floor, New York, New York 10007–1866. This Docket Facility is open from 8:30 a.m. to 4:30 p.m., Monday through Friday, excluding legal holidays. The Docket telephone number is 212–637–4249.

FOR FURTHER INFORMATION CONTACT: Paul Truchan (*truchan.paul@epa.gov*) concerning Subchapters 16 and 21, Anthony (Ted) Gardella (*gardella.anthony@epa.gov*) concerning Subchapter 19, and Kenneth Fradkin (*fradkin.kenneth@epa.gov*) concerning Subchapters 4 and 10, at the Air Programs Branch, Environmental Protection Agency, 290 Broadway, 25th Floor, New York, New York 10007–1866, (212) 637–4249.

SUPPLEMENTARY INFORMATION:

Table of Contents

I. What action is EPA taking?
II. What supplemental SIP information did New Jersey submit?
III. What comments did EPA receive in response to its proposal?
IV. What are EPA's conclusions?
V. Statutory and Executive Order Reviews

I. What action is EPA taking?

On April 21, 2009, as supplemented on May 7, 2010, New Jersey submitted a proposed revision to the State Implementation Plan (SIP) that includes amendments to New Jersey Administrative Code, Title 7: Chapter 27 (NJAC 7:27) Subchapter 4 "Control and Prohibition of Particles from Combustion of Fuel;" Subchapter 8 "Permits and Certificates for Minor Facilities (and Major Facilities Without an Operating Permit);" Subchapter 10 "Sulfur in Solid Fuels;" Subchapter 16 "Control and Prohibition of Air Pollution by Volatile Organic Compounds;" Subchapter 19 "Control and Prohibition of Air Pollution from Oxides of Nitrogen;" and Subchapter 21 "Emission Statements."

EPA is approving the State amendments to Subchapter 4 and Subchapter 10 as revisions to the SIP. These amendments relate to the control of particle and sulfur dioxide emissions and will help the State make advances towards reducing regional haze and meeting the national ambient air quality standards (NAAQS) for fine particles.

EPA will review Subchapter 8 and will address the approvability of all Subchapter 8 amendments in a future action.

EPA is approving, as revisions to the New Jersey ozone SIP, the State-adopted amendments to Subchapter 16 and Subchapter 19, and related amendments to Subchapter 21, each adopted by New Jersey on March 20, 2009, and submitted to EPA on April 21, 2009 and as supplemented on May 7, 2010. New Jersey amended Subchapter 16 and Subchapter 19 to meet the State's commitment to adopt additional RACT rules for 12 of 13 source categories (see 74 FR 2945, January 16, 2009), which will result in additional emission reductions of NO_x and VOCs. New Jersey's State-adopted Subchapters 16 and 19, and the related amendments to Subchapter 21, are fully approvable as SIP-strengthening measures for New Jersey's ozone SIP. The amendments to Subchapters 16, 19 and 21 in New Jersey's submittal meet the State's commitment to adopt additional RACT control measures for 12 of 13 source categories to achieve additional emission reductions of NO_x and VOCs to attain the 8-hour ozone standard. The one remaining source category, adhesives and sealants, will be addressed in a separate rulemaking.

For additional details on EPA's analysis and findings the reader is referred to the proposal published in the April 23, 2010 **Federal Register** (75 FR 21197) and a more detailed discussion as contained in the Technical Support Document which is available on line at *http://www.regulations.gov*, Docket number EPA–R02–OAR–2010–0161.

II. What supplemental SIP information did New Jersey submit?

On May 7, 2010, New Jersey submitted to EPA a supplement to the State's proposed SIP revision dated April 21, 2009. The supplement consists of two administrative changes to Subchapter 19 and includes a copy of the changes as published in the New Jersey Register (NJR) and the updated version of Subchapter 19. The specific administrative changes to Subchapter 19 are as follows: (1) At section 7:27–19.1, the definition of "interim period" is changed to correct an erroneous date and now correctly limits the end date of the "interim period" for phased compliance for reasons of practicability pursuant to section 19.22 to no later than May 19, 2010 (41 NJR 2648(c), dated July 6, 2009); and (2) at section 7:27–19.29(b)2, the deadline for owners/operators of High Electric Demand Day (HEDD) units to submit the 2009 HEDD Emission Reduction Compliance Demonstration Protocol ("2009 Protocol") is corrected and shortened to the rule operative date of May 19, 2009 (41 NJR 2470(a), dated June 15, 2009).

The first administrative change regarding the definition of "interim period" addresses EPA's comment in the

April 23, 2010 proposal (see section I.I.5) regarding an inconsistency between two provisions. The second administrative change clarifies when the 2009 Protocol is required to be submitted by owners/operators of HEDD units regulated under section 19.29 of Subchapter 19. EPA agrees with these changes.

This supplement to the SIP is included in the Docket and may be viewed by the reader at *http://www.regulations.gov.*

III. What comments did EPA receive in response to its proposal?

No comments were received on EPA's April 23, 2010 proposal.

IV. What are EPA's conclusions?

EPA has evaluated New Jersey's submittal for consistency with the Act, EPA regulations, and EPA policy. The new control measures will strengthen the SIP by providing additional NO_x, SO_2, fine particulate, and VOC emission reductions that the State committed to achieve. Accordingly, EPA is approving the revisions to Subchapters 4, 10, 16, 19, and related revisions to Subchapter 21, as adopted on March 20, 2009 and July 6, 2009, except that EPA is continuing to not act on the phased compliance plans by repowering and innovative control in sections 19.21 and 19.23, respectively. In addition, EPA has determined that New Jersey has met the requirement to adopt NO_x RACT and EPA is removing 40 CFR 52.1576, relating to a prior finding that NO_x RACT was not included in the New Jersey SIP. At a later date, EPA will act on Subchapter 8, as adopted by New Jersey on March 20, 2009.

With the adoption of Subchapters 16, 19 and 21, New Jersey has fulfilled its commitment to adopt additional RACT control measures for 12 of 13 source categories to achieve additional emission reductions of NO_x and VOCs to attain the 8-hour ozone standard. The one remaining source category, adhesives and sealants, will be addressed in a separate rulemaking.

V. Statutory and Executive Order Reviews

Under the Clean Air Act, the Administrator is required to approve a SIP submission that complies with the provisions of the Act and applicable Federal regulations. 42 U.S.C. 7410(k); 40 CFR 52.02(a). Thus, in reviewing SIP submissions, EPA's role is to approve state choices, provided that they meet the criteria of the Clean Air Act. Accordingly, this action merely approves state law as meeting Federal requirements and does not impose additional requirements beyond those imposed by state law. For that reason, this action:

- Is not a "significant regulatory action" subject to review by the Office of Management and Budget under Executive Order 12866 (58 FR 51735, October 4, 1993);
- Does not impose an information collection burden under the provisions of the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*);
- Is certified as not having a significant economic impact on a substantial number of small entities under the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*);
- Does not contain any unfunded mandate or significantly or uniquely affect small governments, as described in the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4);
- Does not have Federalism implications as specified in Executive Order 13132 (64 FR 43255, August 10, 1999);
- Is not an economically significant regulatory action based on health or safety risks subject to Executive Order 13045 (62 FR 19885, April 23, 1997);
- Is not a significant regulatory action subject to Executive Order 13211 (66 FR 28355, May 22, 2001);
- Is not subject to requirements of Section 12(d) of the National Technology Transfer and Advancement Act of 1995 (15 U.S.C. 272 note) because application of those requirements would be inconsistent with the Clean Air Act; and
- Does not provide EPA with the discretionary authority to address, as appropriate, disproportionate human health or environmental effects, using practicable and legally permissible methods, under Executive Order 12898 (59 FR 7629, February 16, 1994).

In addition, this rule does not have tribal implications as specified by Executive Order 13175 (65 FR 67249, November 9, 2000), because the SIP is not approved to apply in Indian country located in the state, and EPA notes that it will not impose substantial direct costs on tribal governments or preempt tribal law.

The Congressional Review Act, 5 U.S.C. 801 *et seq.,* as added by the Small Business Regulatory Enforcement Fairness Act of 1996, generally provides that before a rule may take effect, the agency promulgating the rule must submit a rule report, which includes a copy of the rule, to each House of the Congress and to the Comptroller General of the United States. EPA will submit a report containing this action and other required information to the U.S. Senate, the U.S. House of Representatives, and the Comptroller General of the United States prior to publication of the rule in the **Federal Register**. A major rule cannot take effect until 60 days after it is published in the **Federal Register**. This action is not a "major rule" as defined by 5 U.S.C. 804(2).

Under section 307(b)(1) of the Clean Air Act, petitions for judicial review of this action must be filed in the United States Court of Appeals for the appropriate circuit by October 4, 2010. Filing a petition for reconsideration by the Administrator of this final rule does not affect the finality of this action for the purposes of judicial review nor does it extend the time within which a petition for judicial review may be filed, and shall not postpone the effectiveness of such rule or action. This action may not be challenged later in proceedings to enforce its requirements. (*See* section 307(b)(2)).

List of Subjects in 40 CFR Part 52

Environmental protection, Air pollution control, Incorporation by reference, Nitrogen dioxide, Ozone, Particulate matter, Reporting and recordkeeping requirements, Sulfur oxides, Volatile organic compounds.

Dated: July 2, 2010.

Judith A. Enck,

Regional Administrator, Region 2.

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

PART 52—[AMENDED]

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

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

Subpart FF—New Jersey

■ 2. Section 52.1570 is amended by adding new paragraph (c)(88) to read as follows:

§ 52.1570 Identification of plan.

* * * * *

(c) * * *

(88) A revision submitted on April 21, 2009, as supplemented on May 7, 2010, by the New Jersey Department of Environmental Protection (NJDEP) that establishes revised control measures for achieving additional reductions of NOx, SO_2, fine particulate, and VOC emissions from stationary sources that will help achieve attainment of the national ambient air quality standard for ozone and fine particles, as well as help to reduce regional haze.

(i) Incorporation by reference:

(A) New Jersey Administrative Code, Title 7, Chapter 27 (NJAC 7:27): Subchapter 4 "Control and Prohibition

of Particles from Combustion of Fuel" with an effective date of April 20, 2009; Subchapter 10 "Sulfur in Solid Fuels" with an effective date of April 20, 2009; Subchapter 16 "Control and Prohibition of Air Pollution by Volatile Organic Compounds" with an effective date of April 20, 2009; Subchapter 19 "Control and Prohibition of Air Pollution from Oxides of Nitrogen" with an effective date of July 6, 2009 (including two Administrative Corrections published in the New Jersey Register on June 15, 2009 and July 6, 2009); and Subchapter 21 "Emission Statements" with an effective date of April 20, 2009.

(ii) Additional information:

(A) Letter dated April 21, 2009 from Acting Commissioner Mark N. Mauriello, NJDEP, to George Pavlou, Acting Regional Administrator, EPA Region 2, submitting the SIP revision for Subchapters 4, 8, 10, 16, 19 and 21.

(B) Letter dated May 7, 2010 from Director William O'Sullivan, NJDEP, to Barbara Finazzo, Director, Division of Environmental Planning and Protection, EPA Region 2, submitting supplemental SIP information for Subchapter 19.

■ 3. Section 52.1605 is amended by revising the table entries, under Title 7, Chapter 27: for Subchapters 4, 10, 16, 19, and 21, to read as follows:

§ 52.1605 EPA-approved New Jersey regulations.

State regulation	State effective date	EPA approved date	Comments
*	*	*	* * * *
Title 7, Chapter 27:			
*	*	*	* * * *
Subchapter 4, "Control and Prohibition of Particles from Combustion of Fuel."	April 20, 2009	August 3, 2010 [Insert Federal Register page citation].	
*	*	*	* * * *
Subchapter 10, "Sulfur in Solid Fuels."	April 20, 2009	August 3, 2010, 2009 [Insert Federal Register page citation].	Notification of "large zone 3 coal conversions" must be provided to EPA (40 CFR 52.1601(b)).
*	*	*	* * * *
Subchapter 16, "Control and Prohibition of Air Pollution by Volatile Organic Compounds."	April 20, 2009	August 3, 2010 [Insert Federal Register page citation].	
*	*	*	* * * *
Subchapter 19, "Control and Prohibition of Air Pollution from Oxides of Nitrogen."	July 6, 2009, as corrected on June 15, 2009 and July 6, 2009.	August 3, 2010 [Insert Federal Register page citation].	Subchapter 19 is approved into the SIP except for the following provisions: (1) phased compliance plan through repowering in §§19.21 that allows for implementation beyond May 1, 1999; and (2) phased compliance plan through the use of innovative control technology in §§19.23 that allows for implementation beyond May 1, 1999.
*	*	*	* * * *
Subchapter 21, "Emission Statements."	April 20, 2009	August 3, 2010 [Insert Federal Register page citation].	Section 7:27–21.3(b)(1) and 7:27–21.3(b)(2) of New Jersey's Emission Statement rule requires facilities to report on the following pollutants to assist the State in air quality planning needs: hydrochloric acid, hydrazine, methylene chloride, tetrachlorethylene, 1, 1, 1 trichloroethane, carbon dioxide and methane. EPA will not take SIP-related enforcement action on these pollutants.
*	*	*	* * * *

§ 52.1576 [Reserved]

■ 4. Section 52.1576 is removed and reserved.

[FR Doc. 2010–18887 Filed 8–2–10; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 81

[EPA–R09–OAR–2010–0590; FRL–9184–6]

Determination of Attainment for PM_{10} for the Las Vegas Valley Nonattainment Area, NV

AGENCY: Environmental Protection Agency (EPA).

ACTION: Direct final rule.

SUMMARY: EPA has determined that the Las Vegas Valley nonattainment area in Nevada attained the National Ambient Air Quality Standard (NAAQS) for particulate matter with an aerodynamic diameter of less than or equal to a nominal ten micrometers (PM_{10}) by the applicable attainment date (December 31, 2006), and that the Las Vegas Valley nonattainment area is currently attaining the standard.

DATES: This action is effective on *October 4, 2010* without further notice,

unless EPA receives adverse comment by *September 2, 2010.* If EPA receives adverse comment, we will publish a timely withdrawal in the **Federal Register** informing the public that the rule will not take effect.

ADDRESSES: Submit comments, identified by docket number EPA–R09–OAR–2010–0590, by one of the following methods:

1. *Federal eRulemaking Portal: http://www.regulations.gov.* Follow the on-line instructions.

2. *E-mail: tax.wienke@epa.gov.*

3. *Mail or Deliver:* Wienke Tax, Air Planning Office, EPA Region IX, 75 Hawthorne Street, San Francisco, CA 94105–3901.

Instructions: All comments will be included in the public docket without change and may be made available online at *http://www.regulations.gov,* including any personal information provided, unless the comment includes Confidential Business Information (CBI) or other information whose disclosure is restricted by statute. Information that you consider CBI or otherwise protected should be clearly identified as such and should not be submitted through *http://www.regulations.gov* or e-mail. *http://www.regulations.gov* is an "anonymous access" system, and EPA will not know your identity or contact information unless you provide it in the body of your comment. If you send an e-mail directly to EPA, your e-mail address will be automatically captured and included as part of the public comment. If you submit an electronic comment, EPA recommends that you include your name and other contact information in the body of your comment and with any disk or CD–ROM you submit. If EPA cannot read your comment due to technical difficulties and cannot contact you for clarification, EPA may not be able to consider your comment. Electronic files should avoid the use of special characters, any form of encryption, and be free of any defects or viruses.

Docket: The index to the docket for this action is available electronically at *http://www.regulations.gov* and in hard copy at EPA Region IX, 75 Hawthorne Street, San Francisco, California. While all documents in the docket are listed in the index, some information may be publicly available only at the hard copy location (*e.g.,* copyrighted material), and some may not be publicly available in either location (*e.g.,* CBI). To inspect the hard copy materials, please schedule an appointment during normal business hours with the contact listed in the **FOR FURTHER INFORMATION CONTACT** section.

FOR FURTHER INFORMATION CONTACT: Wienke Tax at telephone number: (415) 947–4192, e-mail address: *tax.wienke@epa.gov,* or the above EPA, Region IX address.

SUPPLEMENTARY INFORMATION: Throughout this document, wherever "we", "us" or "our" are used, we mean EPA. Information is organized as follows:

Table of Contents

I. Background
A. PM_{10} NAAQS
B. Designation and Classification of PM_{10} Nonattainment Areas
C. How does EPA make attainment determinations?
D. What is the attainment date for the Las Vegas Valley PM_{10} nonattainment area?
E. What PM_{10} planning has occurred for the Las Vegas Valley PM_{10} nonattainment area?
II. EPA's Analysis
A. What does the air quality data show as of the December 31, 2006 attainment date?
B. Does more recent air quality data also show attainment?
III. EPA's Final Action
IV. Statutory and Executive Order Reviews

I. Background

A. PM_{10} NAAQS

The NAAQS are levels for certain ambient air pollutants set by EPA to protect public health and welfare. PM_{10}, or particulate matter with an aerodynamic diameter less than or equal to a nominal 10 micrometers, is among the ambient air pollutants for which EPA has established health-based standards. On July 1, 1987 (52 FR 24634), EPA promulgated two primary standards for PM_{10}: A 24-hour standard of 150 micrograms per cubic meter (μg/m^3) and an annual PM_{10} standard of 50 μg/m^3. EPA also promulgated secondary PM_{10} standards that were identical to the primary standards.

Effective December 18, 2006, EPA revoked the annual PM_{10} standard but retained the 24-hour PM_{10} standard. 71 FR 61144 (October 17, 2006). The 24-hour PM_{10} standard is attained when the expected number of days per calendar year with a 24-hour concentration in excess of the standard (referred to herein as "exceedance"), as determined in accordance with 40 CFR part 50, appendix K, is equal to or less than one.[1] 40 CFR 50.6 and 40 CFR part 50, appendix K.

B. Designation and Classification of PM_{10} Nonattainment Areas

Areas meeting the requirements of section 107(d)(4)(B) of the Clean Air Act (CAA or the Act) were designated nonattainment for PM_{10} by operation of law and classified "moderate" upon enactment of the 1990 Clean Air Act Amendments. *See generally* 42 U.S.C. 7407(d)(4)(B). These areas included all former Group I PM_{10} planning areas identified in 52 FR 29383 (August 7, 1987), as further clarified in 55 FR 45799 (October 31, 1990), and any other areas violating the NAAQS for PM_{10} prior to January 1, 1989. A **Federal Register** notice announcing the areas designated nonattainment for PM_{10} upon enactment of the 1990 Amendments, known as "initial" PM_{10} nonattainment areas, was published on March 15, 1991 (56 FR 11101) and a subsequent **Federal Register** document correcting the description of some of these areas was published on August 8, 1991 (56 FR 37654). The Las Vegas Valley[2] was one of these initial moderate PM_{10} nonattainment areas.

All initial moderate PM_{10} nonattainment areas had the same applicable attainment date of December 31, 1994. States containing initial moderate PM_{10} nonattainment areas were required to develop and submit to EPA by November 15, 1991, a state implementation plan (SIP) revision providing for implementation of reasonably available control measures (RACM) for the control of PM_{10}, and either a demonstration that the plan would provide for attainment by the applicable attainment date (December 31, 1994) or a demonstration that attainment by such date was impracticable. See CAA section 189(a).

A moderate PM_{10} area could subsequently be reclassified as "serious" either before the applicable moderate area attainment date if EPA determines the area cannot "practicably" attain the PM_{10} NAAQS by this attainment date, or

[1] An exceedance is defined as a daily value that is above the level of the 24-hour standard (150 μg/m^3) after rounding to the nearest 10 μg/m^3 (*i.e.,* values ending in 5 or greater are to be rounded up). Thus, a recorded value of 154 μg/m^3 would not be an exceedance since it would be rounded to 150 μg/m^3 whereas a recorded value of 155 μg/m^3 would be an exceedance since it would be rounded to 160 μg/m^3. See 40 CFR part 50, appendix K, section 1.0.

[2] Specifically, the Las Vegas Valley PM_{10} nonattainment area is defined by reference to State hydrographic area #212. See 40 CFR 81.329. The Las Vegas Valley encompasses roughly 1,500 square miles within Clark County and includes the cities of Las Vegas, North Las Vegas, and Henderson. Roughly two million people reside in Clark County, mostly within Las Vegas Valley. NDEP is the state agency under state law that is responsible for SIP matters for the State of Nevada. Within Clark County, the Clark County Board of Commissioners, acting through the Department of Air Quality and Environmental Management (DAQEM), is empowered under state law to develop air quality plans and to regulate stationary sources within the county with the exception of certain types of power plants, which lie exclusively within the jurisdiction of NDEP.

following the passage of the applicable moderate area attainment date if EPA determines that the area has failed to attain the standard. Effective February 8, 1993, EPA determined that Las Vegas Valley could not "practicably" attain the PM_{10} NAAQS by December 31, 1994 (*i.e.,* the applicable attainment date for initial moderate PM_{10} nonattainment areas), and reclassified the area as "serious." *See* 58 FR 3334 (January 8, 1993). Reclassification of Las Vegas Valley to "serious" triggered deadlines for additional SIP revisions and established a new applicable attainment date of (no later than) December 31, 2001. See CAA section 188(c)(2).

Section 188(e) of the Act authorizes EPA to extend the applicable attainment date for serious PM_{10} nonattainment areas under certain circumstances. In 2004, EPA approved the PM_{10} attainment plan for Las Vegas Valley and granted the State of Nevada's request to extend the applicable attainment date from December 31, 2001 to December 31, 2006. See 69 FR 32273 (June 9, 2004).

C. How does EPA make attainment determinations?

Section 188(b)(2) of the Act requires EPA to determine within six months of the applicable attainment date whether, based on air quality data, PM_{10} nonattainment areas attained the PM_{10} NAAQS by that date. Generally, EPA determines whether an area's air quality is meeting the PM_{10} NAAQS based upon complete (minimum of 75 percent of scheduled PM_{10} samples recorded), quality-assured data gathered at established state and local air monitoring stations (SLAMS) and national air monitoring stations (NAMS) in the nonattainment area and entered into the EPA Air Quality System (AQS) database. Data from air monitors operated by State/local/tribal agencies in compliance with EPA monitoring requirements must be submitted to AQS. EPA relies primarily on data in AQS when determining the attainment status of an area. *See* 40 CFR 50.6; 40 CFR part 50, appendix J; 40 CFR part 53; 40 CFR part 58, appendix A. EPA will also consider air quality data from other air monitoring stations in the nonattainment area provided that the stations meet the Federal monitoring requirements for SLAMS, including the quality assurance and quality control criteria in 40 CFR part 58, appendix A. 40 CFR 58.14 (2006) and 58.20 (2007); [3] 71 FR 61236, 61242 (October 17, 2006). All valid data are reviewed to determine the area's air quality status in accordance with 40 CFR part 50, appendix K.

Attainment of the 24-hour PM_{10} standard is determined by calculating the expected number of exceedances of the standard in a year. The 24-hour standard is attained when the expected number of exceedances averaged over a three-year period is less than or equal to one at each monitoring site within the nonattainment area. Generally, three consecutive years of air quality data are required to show attainment of the 24-hour PM_{10} standard. See 40 CFR part 50 and appendix K.[4]

D. What is the attainment date for the Las Vegas Valley PM_{10} nonattainment area?

As noted above, the original attainment date for the Las Vegas Valley PM_{10} nonattainment area was December 31, 1994, but was later extended, first to December 31, 2001, and later, to December 31, 2006. *See* 58 FR 3334 (January 8, 1993) and 69 FR 32273 (June 9, 2004).

E. What PM_{10} planning has occurred for the Las Vegas Valley PM_{10} nonattainment area?

After Las Vegas Valley was designated nonattainment for PM_{10}, Clark County and NDEP began in the early 1990s to prepare the technical elements needed to bring the area into attainment and meet the planning requirements of title I of the CAA. NDEP submitted a moderate area PM_{10} plan for the Las Vegas Valley on December 6, 1991. Based on this submittal, EPA determined on January 8, 1993, that the Las Vegas Valley could not practicably attain the PM_{10} NAAQS by the applicable attainment deadline for moderate areas (December 31, 1994, per section 188(c)(1) of the Act), and reclassified the Las Vegas Valley as serious (58 FR 3334).

In response to the area's reclassification as a "serious" PM_{10} nonattainment area, Clark County prepared and, and NDEP submitted, a serious area PM_{10} plan in 1997 that EPA subsequently proposed to disapprove, along with the previously submitted plan. See 65 FR 37324 (June 14, 2000). However, NDEP submitted a revised serious area PM_{10} plan in July 2001, which EPA later approved. 69 FR 32273 (June 9, 2004). Among the various serious area SIP elements approved by EPA in 2004 are the best available control measures (BACM) demonstration under CAA section 189(b)(1)(B), the most stringent measures (MSM) demonstration under CAA section 188(e), and various Clark County air pollution control rules regulating such fugitive dust sources as open areas, unpaved roads, and construction activities.

II. EPA's Analysis

A. What does the air quality data show as of the December 31, 2006 attainment date?

Clark County DAQEM is responsible for monitoring ambient air quality within Clark County. DAQEM submits monitoring network plan reports to EPA on an annual basis. These reports discuss the status of the air monitoring network, as required under 40 CFR part 58. Beginning in 2007, EPA reviews these annual plans for compliance with the applicable reporting requirements in 40 CFR 58.10. With respect to PM_{10}, we have found DAQEM's annual network plans to meet the applicable requirements under 40 CFR part 58. See EPA letters to DAQEM concerning DAQEM's annual network plan reports for years 2007, 2008, and 2009. Furthermore, we concluded in our *Technical System Audit Report* (February 2010) that Clark County DAQEM's ambient air monitoring network currently meets or exceeds the requirements for the minimum number of monitoring sites designated as SLAMS for all of the criteria pollutants, and that all of the monitoring sites are properly located with respect to monitoring objectives, spatial scales and other site criteria.

Clark County DAQEM currently operates nine PM_{10} SLAMS monitoring sites within Las Vegas Valley: Craig Road (North Las Vegas), Green Valley (Henderson), J.D. Smith School (North Las Vegas), Joe Neal (northwest Las Vegas), Lone Mountain (northwest Las Vegas), Orr School (central-southeast Las Vegas), Paul Meyer Park (southwest Las Vegas), Palo Verde School (west Las Vegas), Sunrise Acres School (central Las Vegas), and Walter Johnson (west Las Vegas). All nine sites monitor PM_{10} concentrations on a continuous basis using Beta Attenuation Monitors (BAMs). *See* Clark County DAQEM's *Annual Network Plan Report* (June 2010). Most of the sites are sited to provide PM_{10} concentration data at a

[3] EPA promulgated amendments to the ambient air monitoring regulations in 40 CFR parts 53 and 58 on October 17, 2006. See 71 FR 61236. The requirements for Special Purpose Monitors were revised and moved from 40 CFR 58.14 to 40 CFR 58.20.

[4] Because the annual PM_{10} standard was revoked effective December 18, 2006, see 71 FR 61144 (October 17, 2006), this document discusses only attainment of the 24-hour PM_{10} standard.

neighborhood scale [5] for the purpose of determining population exposure. The Craig Road site, however, is intended to capture the highest PM_{10} concentrations in Las Vegas Valley (*i.e.,* at the neighborhood scale), and Green Valley and Palo Verde are intended to represent middle scale [6] conditions.

In Table 1, below, we present a summary of AQS data collected at the nine PM_{10} sites currently in operation, as well as two sites (City Center in Las Vegas and Southeast Valley in Henderson), which have closed since 2006, and two sites (East Sahara in central Las Vegas and Walter Johnson in west Las Vegas), which no longer monitor PM_{10}. As shown in Table 1, only one PM_{10} exceedance was measured at any of the monitoring sites over the 2004–2006 period.

TABLE 1—SUMMARY OF LAS VEGAS VALLEY PM_{10} MONITORING DATA, 2004–2006

Monitoring site	Highest 24-hour PM_{10} concentration (μg/m^3)			Expected exceedances per year
	2004	2005	2006	2004–2006
City Center *	84	70	95	0.0
Craig Road	151	149	**157**	0.4
East Sahara *	89	99	93	0.0
Green Valley	84	79	97	0.0
J.D. Smith	122	144	136	0.0
Joe Neal	135	124	122	0.0
Lone Mountain	58	55	82	0.0
Orr	88	75	94	0.0
Paul Meyer	86	70	100	0.0
Palo Verde	65	46	69	0.0
Southeast Valley *	119	84	77	0.0
Sunrise Acres	72	120	113	0.0
Walter Johnson *	64	56	106	0.0

PM_{10}NAAQS = 150 μg/m^3. Exceedances shown in **bold** type.
* Site is no longer in operation or is no longer monitoring PM_{10}

Based on a review of air quality data during the three-year period ending with the December 31, 2006 attainment date (and summarized above in table 1), we find that the expected number of exceedances per year for Las Vegas Valley for 2004–2006 is 0.4 days per year (based on the Craig Road monitoring site, the only one measuring an exceedance). This is less than an annual expected exceedance rate for the 24-hour PM_{10} NAAQS of 1.0 and represents attainment of the standard. EPA has therefore determined that the Las Vegas Valley PM_{10} nonattainment area attained the PM_{10} NAAQS by the applicable attainment date of December 31, 2006.

B. Does more recent air quality data also show attainment?

Although the attainment date for the Las Vegas Valley PM_{10} nonattainment area is December 31, 2006, EPA has also reviewed the air quality data collected at Clark County DAQEM's PM_{10} monitoring sites in Las Vegas Valley from January 2007 through the first quarter of 2010. During this period, the only exceedances of the 150 μg/m^3 24-hour standard occurred at the Craig Road site, which monitored 24-hour concentrations of 203 and 168 μg/m^3 in 2008, but given the continuous nature of PM_{10} monitoring at the site, the annual expected exceedance rate, averaged over three years, has not exceeded 1.0. Thus, the data continue to show attainment of the 24-hour PM_{10} NAAQS in Las Vegas Valley since the end of 2006.

III. EPA's Final Action

Under section 188(b)(2) of the Clean Air Act, and based on complete, quality-assured data, we find that the Las Vegas Valley PM_{10} nonattainment area attained the 24-hour PM_{10} NAAQS by the applicable attainment date (December 31, 2006). We also find that the Las Vegas Valley nonattainment area is currently attaining the PM_{10} standard. This action is not a redesignation to attainment under CAA section 107(d)(3) because we have not yet approved a maintenance plan as meeting the requirements of section 175A of the CAA or determined that the area has met the other CAA requirements for redesignation. The PM_{10} classification and designation status in 40 CFR part 81 will remain serious nonattainment for Las Vegas Valley until such time as the State of Nevada meets the CAA requirements for redesignation of the valley to attainment.

We are publishing this rule without prior proposal because the Agency views this as a noncontroversial action and anticipates no adverse comments. However, in the proposed rules section of this **Federal Register** publication, EPA is publishing a separate document that will serve as the proposal should adverse comments be filed. This action will be effective *October 4, 2010,* without further notice unless the EPA receives relevant adverse comments by *September 2, 2010.*

If we receive such comments, then we will publish a document withdrawing the final rule and informing the public that the rule will not take effect. All public comments received will then be addressed in a subsequent final rule based on the proposed rule. We will not institute a second comment period. Parties interested in commenting should so at this time. If no such comments are received, the public is advised that this rule will be effective on *October 4, 2010* and no further action will be taken on the proposed rule.

IV. Statutory and Executive Order Reviews

This action merely makes a determination based on air quality data and does not impose any additional

[5] In this context, "neighborhood scale" refers to conditions throughout some reasonably homogeneous urban sub-region with dimensions of a few kilometers. See 40 CFR part 58, appendix D, section 4.6.

[6] In this context, "middle scale" refers to conditions characteristic of areas from 100 meters to several kilometers.

Federal requirements. For that reason, this action:

- Is not a "significant regulatory action" subject to review by the Office of Management and Budget under Executive Order 12866 (58 FR 51735, October 4, 1993);
- Does not impose an information collection burden under the provisions of the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*);
- Is certified as not having a significant economic impact on a substantial number of small entities under the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*);
- Does not contain any unfunded mandate or significantly or uniquely affect small governments, as described in the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4);
- Does not have Federalism implications as specified in Executive Order 13132 (64 FR 43255, August 10, 1999);
- Is not an economically significant regulatory action based on health or safety risks subject to Executive Order 13045 (62 FR 19885, April 23, 1997); is not a significant regulatory action subject to Executive Order 13211 (66 FR 28355, May 22, 2001);
- Is not subject to requirements of Section 12(d) of the National Technology Transfer and Advancement Act of 1995 (15 U.S.C. 272 note) because application of those requirements would be inconsistent with the CAA; and
- Does not provide EPA with the discretionary authority to address, as appropriate, disproportionate human health or environmental effects, using practicable and legally permissible methods, under Executive Order 12898 (59 FR 7629, February 16, 1994).

In addition, this rule does not have tribal implications as specified by Executive Order 13175 (65 FR 67249, November 9, 2000), because it will not impose substantial direct costs on tribal governments or preempt tribal law.

The Congressional Review Act, 5 U.S.C. 801 *et seq.,* as added by the Small Business Regulatory Enforcement Fairness Act of 1996, generally provides that before a rule may take effect, the agency promulgating the rule must submit a rule report, which includes a copy of the rule, to each House of the Congress and to the Comptroller General of the United States. EPA will submit a report containing this action and other required information to the U.S. Senate, the U.S. House of Representatives, and the Comptroller General of the United States prior to publication of the rule in the **Federal Register**. A major rule cannot take effect until 60 days after it is published in the **Federal Register**. This action is not a "major rule" as defined by 5 U.S.C. 804(2).

Under section 307(b)(1) of the Clean Air Act, petitions for judicial review of this action must be filed in the United States Court of Appeals for the appropriate circuit by *October 4, 2010.* Filing a petition for reconsideration by the Administrator of this final rule does not affect the finality of this action for the purposes of judicial review nor does it extend the time within which a petition for judicial review may be filed, and shall not postpone the effectiveness of such rule or action. Parties with objections to this direct final rule are encouraged to file a comment in response to the parallel notice of proposed rulemaking for this action published in the proposed rules section of today's **Federal Register**, rather than file an immediate petition for judicial review of this direct final rule, so that EPA can withdraw this direct final rule and address the comment in the proposed rulemaking. This action may not be challenged later in proceedings to enforce its requirements. (*See* section 307(b)(2)).

List of Subjects in 40 CFR Part 81

Environmental protection, Air pollution control, National parks, Particulate matter, Wilderness areas.

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

Dated: July 21, 2010.

Keith Takata,

Acting Regional Administrator, EPA Region IX.

[FR Doc. 2010–19061 Filed 8–2–10; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 272

[EPA–R02–RCRA–2010–0249; FRL–9178–8]

New York: Incorporation by Reference of State Hazardous Waste Management Program

AGENCY: Environmental Protection Agency (EPA).

ACTION: Direct final rule.

SUMMARY: The Solid Waste Disposal Act, as amended, commonly referred to as the Resource Conservation and Recovery Act (RCRA), allows the Environmental Protection Agency (EPA) to authorize States to operate their hazardous waste management programs in lieu of the Federal program. EPA uses the regulations entitled "Approved State Hazardous Waste Management Programs" to provide notice of the authorization status of State programs and to incorporate by reference those provisions of the State regulations that will be subject to EPA's inspection and enforcement. This rule does not incorporate by reference the New York hazardous waste statutes. The rule codifies in the regulations the prior approval of New York's hazardous waste management program and incorporates by reference authorized provisions of the State's regulations.

DATES: This regulation is effective October 4, 2010, unless EPA receives adverse written comment on this regulation by the close of business September 2, 2010. If EPA receives such comments, it will publish a timely withdrawal of this direct final rule in the **Federal Register** informing the public that this rule will not take effect. The Director of the Federal Register approves this incorporation by reference as of October 4, 2010 in accordance with 5 U.S.C. 552(a) and 1 CFR part 51.

ADDRESSES: Submit your comments, identified by Docket ID No. EPA–R02–RCRA–2010–0249, by one of the following methods:

- *Federal eRulemaking Portal: http://www.regulations.gov.* Follow the on-line instructions for submitting comments.
- *E-mail: infurna.michael@epa.gov.*
- *Fax:* (212) 637–4437.
- *Mail:* Send written comments to Michael Infurna, Division of Environmental Planning and Protection, EPA, Region 2, 290 Broadway, 22nd Floor, New York, NY 10007.
- *Hand Delivery or Courier:* Deliver your comments to Michael Infurna, Division of Environmental Planning and Protection, EPA, Region 2, 290 Broadway, 22nd Floor, New York, NY 10007. Such deliveries are only accepted during the Regional Office's normal hours of operation. The public is advised to call in advance to verify the business hours. Special arrangements should be made for deliveries of boxed information.

Instructions: Direct your comments to Docket ID. No. EPA–R02–RCRA–2010–0249. EPA's policy is that all comments received will be included in the public docket without change, including any personal information provided, unless the comment includes information claimed to be Confidential Business Information (CBI) or other information whose disclosure is restricted by statute. Do not submit information that you consider to be CBI or otherwise protected through *http://www.regulations.gov,* or e-mail. The Federal *http://www.regulations.gov* Web site is an "anonymous access" system, which means EPA will not know your

identity or contact information unless you provide it in the body of your comment. If you send an e-mail comment directly to EPA without going through *http://www.regulations.gov,* your e-mail address will be automatically captured and included as part of the comment that is placed in the public docket and made available on the Internet. If you submit an electronic comment, EPA recommends that you include your name and other contact information in the body of your comment and with any disk or CD–ROM you submit. If EPA cannot read your comment due to technical difficulties, and cannot contact you for clarification, EPA may not be able to consider your comment. Electronic files should avoid the use of special characters or any form of encryption, and be free of any defects or viruses. (For additional information about EPA's public docket, visit the EPA Docket Center homepage at *http://www.epa.gov/dockets/*).

Docket: All documents in the docket are listed in the *http://www.regulations.gov* index. Although listed in the index, some information is not publicly available, *e.g.,* CBI or other information whose disclosure is restricted by statute. Certain other material, such as copyrighted material, will be publicly available only in hard copy. Publicly available docket materials are available either electronically in *http://www.regulations.gov* or in hard copy. You can inspect the records related to this codification effort in the EPA Region 2 Library by appointment only. To make an appointment please call (212) 637–3185.

FOR FURTHER INFORMATION CONTACT: Michael Infurna, Division of Environmental Planning and Protection, EPA Region 2, 290 Broadway, 22nd Floor, New York, NY 10007; *telephone number:* (212) 637–4177; *fax number:* (212) 637–4377; *e-mail address: infurna.michael@epa.gov.*

SUPPLEMENTARY INFORMATION:

I. Incorporation By Reference

A. What is codification?

Codification is the process of including the statutes and regulations that comprise the State's authorized hazardous waste management program into the CFR. Section 3006(b) of RCRA, as amended, allows the Environmental Protection Agency (EPA) to authorize State hazardous waste management programs. The State regulations authorized by EPA supplant the federal regulations concerning the same matter with the result that after authorization EPA enforces the authorized regulations. Infrequently, State statutory language which acts to regulate a matter is also authorized by EPA with the consequence that EPA enforces the authorized statutory provision. EPA does not authorize State enforcement authorities and does not authorize State procedural requirements. EPA codifies the authorized State program in 40 CFR part 272 and incorporates by reference State statutes and regulations that make up the approved program which is federally enforceable. EPA retains the authority to exercise its inspection and enforcement authorities in accordance with sections 3007, 3008, 3013 and 7003 of RCRA, 42 U.S.C. 6927, 6928, 6934 and 6973, and any other applicable statutory and regulatory provisions.

B. What is the history of the authorization and codification of New York's hazardous waste management program?

New York initially received final authorization for its hazardous waste management program, effective on May 29, 1986 (51 FR 17737) to implement its base hazardous waste management program. Subsequently, EPA authorized revisions to the State's program effective July 3, 1989 (54 FR 19184), May 7, 1990 (55 FR 7896), October 29, 1991 (56 FR 42944), May 22, 1992 (57 FR 9978), August 28, 1995 (60 FR 33753), October 14, 1997 (62 FR 43111), January 15, 2002 (66 FR 57679), March 14, 2005 (70 FR 1825, as corrected on April 5, 2005 (70 FR 17286)) and August 31, 2009 (74 FR 31380). EPA codified New York's authorized hazardous waste program effective September 30, 2002 (67 FR 49864) and May 25, 2007 (72 FR 14044). In this action, EPA is revising Subpart HH of 40 CFR part 272 to include the recent authorization revision actions effective August 31, 2009. (Note: Both the Federal and State requirements for the NY State Public Utilities Project XL, which were authorized effective August 31, 2009, will, unless extended, expire on May 24, 2011.)

C. What decisions have we made in this action?

This action codifies EPA's authorization of revisions to New York's hazardous waste management program. This codification reflects the State program in effect at the time EPA authorized revisions to the New York hazardous waste program in a final rule dated July 1, 2009 (74 FR 31380). The rule incorporates by reference the most recent version of the State's authorized hazardous waste management regulations. This action does not reopen any decision EPA previously made concerning the authorization of the State's hazardous waste management program. EPA is not requesting comments on its decisions published in the **Federal Register** notices referenced in section B of this document concerning revisions to the authorized program in New York.

EPA is incorporating by reference the authorized revisions to the New York hazardous waste program by revising Subpart HH to 40 CFR part 272. 40 CFR 272.1651 previously incorporated by reference New York's authorized hazardous waste regulations, as amended effective September 5, 2006, as well as selected provisions as found in the New York regulations dated January 31, 1992. Section 272.1651 also references the demonstration of adequate enforcement authority, including procedural and enforcement provisions, which provide the legal basis for the State's implementation of the hazardous waste management program. In addition, § 272.1651 references the Memorandum of Agreement, the Attorney General's Statements and the Program Description, which were evaluated as part of the approval process of the hazardous waste management program under Subtitle C of RCRA.

D. What is the effect of New York's codification on enforcement?

EPA retains the authority under statutory provisions, including but not limited to, RCRA sections 3007, 3008, 3013 and 7003, and other applicable statutory and regulatory provisions to undertake inspections and enforcement actions and to issue orders in all authorized States. With respect to enforcement actions, EPA will rely on Federal sanctions, Federal inspection authorities, and Federal procedures rather than the State analogs to these provisions. Therefore, the EPA is not incorporating by reference New York's inspection and enforcement authorities nor are those authorities part of New York's approved State program which operates in lieu of the Federal program. 40 CFR 272.1651(c)(2) lists these authorities for informational purposes, and because EPA also considered them in determining the adequacy of New York's procedural and enforcement authorities. New York's authority to inspect and enforce the State's hazardous waste management program requirements continues to operate independently under State law.

E. What State provisions are not part of the codification?

The public is reminded that some provisions of New York's hazardous waste management program are not part

of the federally authorized State program. These non-authorized provisions include:

(1) Provisions that are not part of the RCRA subtitle C program because they are "broader in scope" than RCRA subtitle C (see 40 CFR 271.1(i));

(2) Unauthorized amendments to authorized State provisions;

(3) New unauthorized State requirements; and

(4) State procedural and enforcement authorities which are necessary to establish the ability of the State's program to enforce compliance but which do not supplant the Federal statutory enforcement and procedural authorities.

State provisions that are "broader in scope" than the Federal program are not incorporated by reference in 40 CFR part 272. For reference and clarity, 40 CFR 272.1651(c)(3) lists the New York statutory and regulatory provisions which are "broader in scope" than the Federal program and which are not part of the authorized program being incorporated by reference. This action updates that list of "broader in scope" provisions. While "broader in scope" provisions are not part of the authorized program and cannot be enforced by EPA; the State may enforce such provisions under State law.

Additionally, New York's hazardous waste regulations include amendments which have not been authorized by EPA. Since EPA cannot enforce a State's requirements which have not been reviewed and authorized in accordance with RCRA section 3006 and 40 CFR part 271, it is important to be precise in delineating the scope of a State's authorized hazardous waste program. Regulatory provisions that have not been authorized by EPA include amendments to previously authorized State regulations as well as new State requirements.

State regulations that are not incorporated by reference in this rule at 40 CFR 272.1651(c)(1), or that are not listed in 40 CFR 272.1651(c)(3) ("broader in scope") or 40 CFR 272.1651(c)(2) ("procedural and enforcement authorities"), are considered new unauthorized State requirements. These requirements are not Federally enforceable.

F. What will be the effect of Federal HSWA requirements on the codification?

With respect to any requirement(s) pursuant to the Hazardous and Solid Waste Amendments of 1984 (HSWA) for which the State has not yet been authorized and which EPA has identified as taking effect immediately in States with authorized hazardous waste management programs, EPA will enforce those Federal HSWA standards until the State is authorized for those provisions.

The codification does not affect Federal HSWA requirements for which the State is not authorized. EPA has authority to implement HSWA requirements in all States, including States with authorized hazardous waste management programs, until the States become authorized for such requirements or prohibitions, unless EPA has identified the HSWA requirement(s) as an optional or as a less stringent requirement of the Federal program. A HSWA requirement or prohibition, unless identified by EPA as optional or as less stringent, supersedes any less stringent or inconsistent State provision which may have been previously authorized by EPA (50 FR 28702, July 15, 1985).

Some existing State requirements may be similar to the HSWA requirement implemented by EPA. However, until EPA authorizes those State requirements, EPA enforces the HSWA requirements and not the State analogs.

II. Statutory and Executive Order Reviews

This rule codifies EPA-authorized hazardous waste requirements pursuant to RCRA 3006 and imposes no requirements other than those imposed by State law. Therefore, this rule complies with applicable executive orders and statutory provisions as follows.

1. *Executive Order 12866: Regulatory Planning Review*—The Office of Management and Budget (OMB) has exempted this rule from its review under Executive Order 12866 (58 FR 51735, October 4, 1993).

2. *Paperwork Reduction Act*—This rule does not impose an information collection burden under the provisions of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

3. *Regulatory Flexibility Act*—This rule codifies New York's authorized hazardous waste management regulations in the CFR and does not impose new burdens on small entities. Accordingly, I certify that this action will not have a significant economic impact on a substantial number of small entities under the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*).

4. *Unfunded Mandates Reform Act*—Because this rule codifies pre-existing State hazardous waste management program requirements which EPA already approved under 40 CFR part 271, and with which regulated entities must already comply, it does not contain any unfunded mandate or significantly or uniquely affect small governments, as described in the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4).

5. *Executive Order 13132: Federalism*—Executive Order 13132 (64 FR 43255, August 10, 1999) does not apply to this rule because it will not have federalism implications (*i.e.,* substantial direct effects on the States, on the relationship between the Federal government and the States, or on the distribution of power and responsibilities among the various levels of government). This action codifies existing authorized State hazardous waste management program requirements without altering the relationship or the distribution of power and responsibilities established by RCRA.

6. *Executive Order 13175: Consultation and Coordination with Indian Tribal Governments*—Executive Order 13175 (65 FR 67249, November 6, 2000) does not apply to this rule because it will not have tribal implications (*i.e.,* substantial direct effects on one or more Indian tribes, or on the relationship between the Federal government and Indian tribes, or on the distribution of power and responsibilities between the Federal government and Indian tribes).

7. *Executive Order 13045: Protection of Children from Environmental Health & Safety Risks*—This rule is not subject to Executive Order 13045 (62 FR 19885, April 23, 1997), because it is not economically significant and it is not based on environmental health or safety risks.

8. *Executive Order 13211: Actions that Significantly Affect Energy Supply, Distribution, or Use*—This rule is not subject to Executive Order 13211 (66 FR 28355, May 22, 2001) because it is not a significant regulatory action under Executive Order 12866.

9. *National Technology Transfer Advancement Act*—The requirements being codified are the result of New York's voluntary participation in EPA's State program authorization process under RCRA Subtitle C. Thus, the requirements of section 12(d) of the National Technology Transfer and Advancement Act of 1995 (15 U.S.C. 272 note) do not apply.

10. *Executive Order 12988*—As required by section 3 of Executive Order 12988 (61 FR 4729, February 7, 1996), EPA has taken the necessary steps in this action to eliminate drafting errors and ambiguity, minimize potential litigation, and provide a clear legal standard for affected conduct.

11. *Congressional Review Act*—EPA will submit a report containing this rule and other information required by the Congressional Review Act (5 U.S.C. 801 *et seq.,* as amended) to the U.S. Senate, the U.S. House of Representatives, and the Comptroller General of the United States prior to publication in the **Federal Register**. A major rule cannot take effect until 60 days after it is published in the **Federal Register**. This action is not a "major rule" as defined by 5 U.S.C. 804(2). This action will be effective October 4, 2010.

List of Subjects in 40 CFR Part 272

Environmental Protection, Administrative practice and procedure, Confidential business information, Hazardous waste, Hazardous waste transportation, Incorporation by reference, Indian lands, Intergovernmental relations, Penalties, Reporting and recordkeeping requirements, Water pollution control, Water supply.

Authority: This action is issued under the authority of Sections 2002(a), 3006 and 7004(b) of the Solid Waste Disposal Act as amended, 42 U.S.C. 6912(a), 6926, 6974(b).

Dated: April 27, 2010.

Judith A. Enck,

Regional Administrator, EPA Region 2.

■ For the reasons set forth in the preamble, 40 CFR part 272 is amended as follows:

PART 272—APPROVED STATE HAZARDOUS WASTE MANAGEMENT PROGRAMS

■ 1. The authority citation for part 272 continues to read as follows:

Authority: Secs. 2002(a), 3006, and 7004(b) of the Solid Waste Disposal Act, as amended by the Resource Conservation and Recovery Act, as amended, 42 U.S.C. 6912(a), 6926, and 6974(b).

■ 2. Revise § 272.1651 to read as follows:

§ 272.1651 New York State-Administered Program: final authorization.

(a) Pursuant to section 3006(b) of RCRA, 42 U.S.C. 6926(b), New York has final authorization for the following elements as submitted to EPA in New York's base program application for final authorization which was approved by EPA effective on May 29, 1986. Subsequent program revision applications were approved effective on July 3, 1989, May 7, 1990, October 29, 1991, May 22, 1992, August 28, 1995, October 14, 1997, January 15, 2002, March 14, 2005, and August 31, 2009. (**Note:** Both the Federal and State requirements for the NY State Public Utilities Project XL, which were authorized effective August 31, 2009, will, unless extended, expire on May 24, 2011.)

(b) The State of New York has primary responsibility for enforcing its hazardous waste management program. However, EPA retains the authority to exercise its inspection and enforcement authorities in accordance with sections 3007, 3008, 3013, 7003 of RCRA, 42 U.S.C. 6927, 6928, 6934, 6973, and any other applicable statutory and regulatory provisions, regardless of whether the State has taken its own actions, as well as in accordance with other statutory and regulatory provisions.

(c) *State Statutes and Regulations.*

(1) The New York regulations cited in paragraph (c)(1)(i) of this section are incorporated by reference as part of the hazardous waste management program under subtitle C of RCRA, 42 U.S.C. 6921 *et seq.* The Director of Federal Register approves this incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain copies of the New York regulations that are incorporated by reference in this paragraph from West Group, 610 Opperman Drive, Eagan, MN 55123, *Attention:* D3–10 (*Phone #:* 1–800–328–9352). You may inspect a copy at EPA Region 2 Library, 290 Broadway, 16th Floor, New York, NY 10007 (Phone number: (212) 637–3185), or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: *http://www.archives.gov/federal-register/cfr/ibr-locations.html.*

(i) The Binder entitled "EPA Approved New York Regulatory Requirements Applicable to the Hazardous Waste Management Program", dated July 2009.

(ii) [Reserved]

(2) EPA considered the following statutes and regulations in evaluating the State program but is not incorporating them herein for enforcement purposes:

(i) Environmental Conservation Laws (ECL), 1997 Replacement Volume, as revised by the 2004 Cumulative Pocket Part: sections 1–0303(18), 3–0301(1) (introductory paragraph); 3–0301(1)(a) and (b); 3–0301(1)(m); 3–0301(1)(o); 3–0301(1)(w); 3–0301(1)(x); 3–0301(1)(cc); 3–0301(2) introductory paragraph; 3–0301(2)(a), (b), (d) through (j), (l), (m) and (q); 3–0301(2)(z); 3–0301(4); 19–0301(1) (except 19–0301(c), (e) and (f)); 19–0303(1) through (3); 19–0304; 27–0105; 27–0701; 27–0703; 27–0705; 27–0707 (except 27–0707(2–c)); 27–0711; 27–0900 through 27–0908; 27–0909 (except 27–0909(5)); 27–0910 through 27–0922; 27–1105; 70–0101; 70–0103; 70–0105 (except 70–0105(3) and 70–0105(6)); 70–0107(1) and (2); 70–0107(3) introductory paragraph; 70–0107(3)(l); 70–0109; 70–0113; 70–0115 (except (2)(c) and (d)); 70–0117 (except 70–0117(5)–(7); 70–0119; 70–0121; 71–0301; 71–1719; 71–2705; 71–2707; 71–2709 through 71–2715; 71–2717; 71–2720; and 71–2727.

(iii) McKinney's Consolidated Laws of New York, Book 1, Executive Law (EL), Article 6: Section 102.

(iv) McKinney's Consolidated Laws of New York, Book 46, Public Officers Law (POL), as amended through 2004: Sections 87 and 89.

(v) McKinney's Consolidated Laws of New York, Book 7B, Civil Practice Law and Rules (CPLR), as amended through 2004: Sections 1013, 6301; 6311; and 6313.

(vi) Title 6, New York Codes, Rules and Regulations (6 NYCRR), Volume A–2A, Hazardous Waste Management System, as amended through September 5, 2006: Sections 372.1(f); 373–1.1(f) and (g); 373–1.4(b); 373–1.4(d) through (f); 373–1.6(c); 621.1 through 621.4; 621.5 (except (d)(5), (d)(6)(i), (d)(7)(i)(a), (d)(7)(i)(c) and (d)(9)); 621.6 (except (b), (d)(4) and (d)(5)); 621.7; 621.8; 621.9 (except (a)(5), (c)(2) and (e)(2)); 621.10; 621.11 (except (d)); 621.12 through 621.15; and 621.16 (except (b), (d) and (e)).

(3) The following statutory and regulatory provisions are broader in scope than the Federal program, are not part of the authorized program, are not incorporated by reference and are not federally enforceable:

(i) Environmental Conservation Laws (ECL), 1997 Replacement Volume, as revised by the 2004 Cumulative Pocket Part: Sections 27–0301; 27–0303; 27–0305; 27–0307; 27–0909(5); 27–0923; 27–0925 and 27–0926.

(ii) Environmental Conservation Laws (ECL), 1997 Replacement Volume, as revised by the 2006 Cumulative Pocket Part: Section 27–1109(6).

(iii) Title 6, New York Codes, Rules and Regulations (6 NYCRR), Volume A–2A, Hazardous Waste Management System, as amended through September 5, 2006: Sections 370.2(b)(92) "Household hazardous waste"; 370.2(b)(93) "Household collection facility"; 371.4(e); 372.1(e)(9); 372.2(b)(5)(ii); 372.3(a)(1); 372.3(a)(4); 372.3(b)(6)(iv); 372.3(d)(3); 373–1.1(d)(1)(x); 373–1.4(c); 373–2.5(b)(3)(ii)(d); 373–2.5(b)(3)(ii)(e); 373–2.15(a)(2); 373–3.5(b)(3)(ii)(d); 373–3.5(b)(3)(ii)(e); 374–3.4(a)(2); and 376.4(f).

(iv) At 371.4(c), New York retains K064, K065, K066, K090 and K091 as

hazardous wastes while EPA has removed them from the table at 40 CFR 261.32 and no longer regulates them as hazardous wastes (64 FR 56469; October 20, 1999).

(v) Throughout New York's hazardous waste regulations, the State cross-references Part 364, which sets forth additional transporter requirements including permit and liability requirements (for examples, see 6 NYCRR sections 372.2(b)(8), 373–1.7(h)(3), 374–3.3(i)(1) and (2), 374–3.4(a), 374–3.6(a)(1) and Appendix 30 Instructions for Generators/Item 8). The transporter permit and liability requirements are broader in scope than the Federal program.

(vi) New York did not adopt an analog to 40 CFR 261.4(g) that excludes certain dredged materials from the State definition of hazardous waste. Instead, the State subjects these materials to full regulation as hazardous wastes.

(vii) New York State regulations do not incorporate the Mineral Processing Secondary Materials Exclusion at 40 CFR 261.4(a)(17) and the related changes affecting 40 CFR 261.2(c)(3) and (c)(4)/Table, and 40 CFR 261.2(e)(1)(iii). Since New York did not adopt the exclusion at 40 CFR 261.4(a)(17) the State has a broader in scope program because the effect is to include materials that are not considered solid waste by EPA.

(viii) At 373–4, New York implements a Household Hazardous Waste program, whereas the Federal program excludes household waste from regulation as hazardous waste at 261.4(b)(1).

(ix) The following New York provisions are broader in scope because they include requirements associated with the regulation of PCB waste as a state-only hazardous waste: 372.1(e)(9) and 376.1(g)(1)(i), 376.4(f). PCB wastes are regulated under the Federal Toxic Substances Control Act (TSCA) at 40 CFR part 761 rather than under the Federal RCRA program.

(4) *Memorandum of Agreement.* The Memorandum of Agreement between EPA Region 2 and the State of New York, signed by the Commissioner of the State of New York Department of Environmental Conservation on July 20, 2001, and by the EPA Regional Administrator on January 16, 2002, although not incorporated by reference, is referenced as part of the authorized hazardous waste management program under subtitle C of RCRA, 42 U.S.C. 6921 *et seq.*

(5) *Statement of Legal Authority.* "Attorney General's Statement for Final Authorization", signed by the Attorney General of New York in 1985 and revisions, supplements and addenda to that Statement dated August 18, 1988, July 26, 1989, August 15, 1991, October 11, 1991, July 28, 1994, May 30, 1997, February 5, 2001, April 2, 2004 and June 13, 2008 (including three certifications), although not incorporated by reference, are referenced as part of the authorized hazardous waste management program under subtitle C of RCRA, 42 U.S.C. 6921 *et seq.*

(6) *Program Description.* The Program Description and any other materials submitted as supplements thereto, although not incorporated by reference, are referenced as part of the authorized hazardous waste management program under subtitle C of RCRA, 42 U.S.C. 6921 *et seq.*

■ 3. Appendix A to part 272, State Requirements, is amended by revising the listing for "New York" to read as follows:

Appendix A to Part 272—State Requirements

* * * * *

New York

The regulatory provisions include:

Title 6, New York Codes, Rules and Regulations (6 NYCRR), Volume A–2A, Hazardous Waste Management System, as amended through September 5, 2006.

Please Note: For a few regulations, the authorized regulation is an earlier version of the New York State regulation. For these regulations, EPA authorized the version of the regulations that appear in the Official Compilation of Code, Rules and Regulations dated January 31, 1992. New York State made later changes to these regulations but these changes have not been authorized by EPA. The regulations where the authorized regulation is an earlier version of the regulation are noted below by inclusion in parentheses of January 31, 1992 after the regulatory citations.

Part 370—Hazardous Waste Management System—General: Sections 370.1(a) (except (a)(3)); 370.1(b) through (d); 370.1(e) (except (e)(9)); 370.1(f); 370.2(a); 370.2(b)(1) through (b)(15) "battery"; 370.2(b)(15) "bedrock" (January 31, 1992); 370.2(b)(17) through (b)(91); 370.2(b)(94) through (b)(125); 370.2(b)(127) through (b)(137); 370.2(b)(139) through (b)(213); 370.2(b)(215); 370.2(B)(216); 370.2(b)(217) (except the last sentence); 370.2(b)(218) through (b)(221); 370.3 (except 370.3(c)); 370.4; 370.5 (except (b)).

Part 371—Identification and Listing of Hazardous Waste: Sections 371.1(a) through (c); 371.1(d) (except (d)(1)(ii)(c) and (d)(1)(ii)(e)); 371.1(e) (except 371.1(e)(2)(vi)(b)(21); 371.1(f)(1) through (7); 371.1(f)(8) (except the phrase "or such mixing occurs at a facility regulated under Subpart 373–4 or permitted under Part 373 of this Title"); 371.1(f)(9) and (f)(10); 371.1(g)(1)(i); 371.1(g)(1)(ii) (except (g)(1)(ii)(c)); 371.1(g)(1)(iii); 371.1(g)(2) through (4); 371.1(h) through (j); 371.2; 371.3; 371.4(a) and (b); 371.4(c) (except K064, K065, K066, K090 and K091 entries); 371.4(d), (f) and (i).

Part 372—Hazardous Waste Manifest System and Related Standards for Generators, Transporters and Facilities: Sections 372.1(a) through (d); 372.1(e)(2)(ii)(c) (January 31, 1992); 372.1(e)(2)(iii)(c) (January 31, 1992); 372.1(e)(3) through (e)(8); 372.1(g) and (h); 372.2 introductory paragraph through (b)(4); 372.2(b)(5) (except (b)(5)(ii)); 372.2(b)(6) through (b)(8); 372.2(b)(10); 372.2(c); 372.2(d) [1]; 372.3 (except (a)(1), (a)(4), (a)(7)(i), (a)(8), (b)(3), (b)(5)(ii), (b)(6)(iv), (b)(7)(i)(d), (c)(4) and (d)(3)); 372.5 (except (h) and (i); 372.6; 372.7(a) and (b); 372.7(c) (except (c)(1)(ii)); and 372.7(d).

Part 373, Subpart 373–1—Hazardous Waste Treatment, Storage and Disposal Facility Permitting Requirements: Sections 373–1.1(a) through (c), 373–1.1(d) introductory paragraph through (d)(1)(xx) (except reserved paragraphs, (d)(1)(x) and (d)(1)(xviii); 373–1.1(d)(1)(xxi) [1]; 373–1.1(d)(2); 373–1.1(e); 373–1.1(h) and (i); 373–1.2; 373–1.3; 373–1.4(a); 373–1.4(g) and (h); 373–1.5(a)(1); 373–1.5(a)(2) (except (a)(2)(xviii)); 373–1.5(a)(3) and (4); 373–1.5(b) and (c); 373–1.5(d) through (p) (except reserved paragraphs); 373–1.6 (except (c)); 373–1.7 through 373–1.11.

Part 373, Subpart 373–2—Final Status Standards for Owners and Operators of Hazardous Waste Treatment, Storage and Disposal Facilities: Sections 373–2.1 through 373–2.4; 373–2.5(a); 373–2.5(b) (except (b)(1)(i)(c), (b)(3)(ii)(d) and (b)(3)(ii)(e)); 373–2.5(c) through (g); 373–2.6 through 373–2.11; 373–2.12 (except 373–2.12(a)(1) and (d)); 373–2.12(a)(1) (January 31, 1992); 373–2.13; 373–2.14; 373–2.15 (except (a)(2)); 373–2.19 (except (e)(1)(ii)); 373–2.23; 373–2.24; 373–2.27; 373–2.28; 373–2.29; 373–2.30; and 373–2.31.

Part 373, Subpart 373–3—Interim Status Standards Regulations for Owners and Operators of Hazardous Waste Facilities: Sections 373–3.1 (except 373–3.1(a)(4) and the phrase "or Subpart 374–2 of this Title" in 373–3.1(a)(6)); 373–3.2 through 373–3.4; 373–3.5 (except 373–3.5(b)(1)(i)(c), (b)(3)(ii)(d) and (b)(3)(ii)(e)); 373–3.6 through 373–3.18; 373–3.23; and 373–3.27 through 373–3.31.

Part 374, Subpart 374–1—Standards for the Management of Specific Hazardous Wastes and Specific Types of Hazardous Waste Management Facilities: Sections 374–1.1; 374–1.3; 374–1.6 (except (a)(2)(iii)); 374–1.7; 374–1.8(a)(1); 374–1.8(a)(2) (except the second sentence "Such used oil * * * of this Title" in (a)(2)(i)); 374–1.8(a)(3) through (a)(6); 374–1.8(b) through (m) (except reserved paragraphs); 374–1.9; and 374–1.13.

Part 374, Subpart 374–3—Standards for Universal Waste: Sections 374–3.1 (except (f) and (g)); 374–3.2; 374–3.3; 374–3.4 (except (a)(2)); 374–3.5; 374–3.6; and 374–3.7.

Part 376—Land Disposal Restrictions: Sections 376.1 (except (a)(5), (a)(9), (e), (f), and (g)(1)(ii)(b)); 376.2; 376.3 (except (b)(4) and (d)(2)); 376.4 (except (c)(2), (e)(1)–(7) and (f)); and 376.5.

Appendices: Appendices 19 through 25; Appendices 27 through 30; Appendix 33; Appendix 37; Appendix 38; Appendices 40 through 49 and Appendices 51 through 55.

Copies of the New York regulations that are incorporated by reference are available from West Group, 610 Opperman Drive, Eagan, MN 55123, ATTENTION: D3–10 (Phone #: 1–800–328–9352).

Note: Both the Federal and State requirements for the NY State Public Utilities Project XL, which were authorized effective August 31, 2009 (74 FR 31380), will, unless extended, expire on May 24, 2011.

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[FR Doc. 2010–18927 Filed 8–2–10; 8:45 am]

BILLING CODE 6560–50–P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 1

[WC Docket No. 07–245; GN Docket No. 09–51; FCC No. 10–84]

Implementation of Section 224 of the Act; a National Broadband Plan for Our Future

AGENCY: Federal Communications Commission.

ACTION: Declaratory ruling.

SUMMARY: In this Declaratory Ruling, the Commission clarifies that communications providers have a statutory right to use space- and cost-saving techniques that are consistent with pole owners' use of those techniques. The Commission also establishes that providers have a statutory right to timely access to poles.

DATES: Effective September 2, 2010.

FOR FURTHER INFORMATION CONTACT: Jonathan Reel, Wireline Competition Bureau, Competition Policy Division, 202–418–1580.

SUPPLEMENTARY INFORMATION: This is a synopsis of the Commission's Declaratory Ruling in WC Docket No. 07–245, GN Docket No. 09–51, adopted May 20, 2010, and released May 20, 2010. This Declaratory Ruling rules on issues raised in Implementation of Section 224 of the Act; Amendment of the Commission's Rules and Policies Governing Pole Attachments, Notice of Proposed Rulemaking 73 FR 6879, February 6, 2008.

Synopsis of the Declaratory Ruling

1. In this Order, the Commission takes steps to clarify the statute to lower the costs of telecommunications, cable, and broadband deployment and to promote competition, as recommended in the National Broadband Plan. The Commission clarifies that communications providers have a statutory right to use space- and cost-saving techniques that are consistent with pole owners' use of those techniques. The Commission also establishes that providers have a statutory right to timely access to poles.

Background

2. In 1978, Congress first directed the Commission to ensure that the rates, terms, and conditions for pole attachments by cable television systems are just and reasonable when it added section 224 to the Act. The Telecommunications Act of 1996 (1996 Act) expanded the definition of pole attachments to include attachments by providers of telecommunications service, and granted both cable systems and telecommunications carriers an affirmative right of nondiscriminatory access to any pole, duct, conduit, or right-of-way owned or controlled by a utility. However, the 1996 Act permits utilities to deny access where there is insufficient capacity and for reasons of safety, reliability or generally applicable engineering purposes. Besides establishing a right of access, the 1996 Act mandates a rate formula for telecommunications carriers that differs from the rate formula for attachments used solely to provide cable service.

3. The Commission implemented the new section 224 access requirements in the *Local Competition Order.* At that time, the Commission concluded that it would determine the reasonableness of a particular condition of access on a case-by-case basis. Finding that no single set of rules could take into account all attachment issues, the Commission specifically declined to adopt the National Electric Safety Code (NESC) in lieu of access rules. The Commission also recognized that utilities typically develop individual standards and incorporate them into pole attachment agreements, and that, in some cases, federal, state, or local laws also impose relevant restrictions. The *Local Competition Order* acknowledged concerns that utilities might deny access unreasonably, but rather than adopt a set of substantive engineering standards, the Commission decided that procedures for requiring utilities to justify the conditions they placed on access would best safeguard attachers' rights. The Commission did adopt five rules of general applicability and several broad policy guidelines in the *Local Competition Order.* The Commission also stated that it would monitor the effect of the case-specific approach, and would propose specific rules at a later date if conditions warranted.

4. In the *1998 Implementation Order,* the Commission adopted rules implementing the 1996 Act's new pole attachment rate formula for telecommunications carriers. The Commission also concluded that cable television systems offering both cable and Internet access service should continue to pay the cable rate. The Commission further held that the statutory right of nondiscriminatory access includes attachments by wireless carriers. The latter two determinations were challenged but ultimately upheld by the Supreme Court. In particular, the Court held that section 224 gives the Commission broad authority to adopt just and reasonable rates. The Court also deferred to the Commission's conclusion that wireless carriers are entitled by section 224 to attach facilities to poles.

5. On November 20, 2007, the Commission issued the *Pole Attachment Notice* 73 FR 6879, February 6, 2008 in recognition of the importance of pole attachments to the deployment of communications networks, in part in response to petitions for rulemaking from USTelecom and Fibertech Networks. USTelecom argued that incumbent LECs, as providers of telecommunications service, are entitled to just and reasonable pole attachment rates, terms, and conditions of attachment even though, under section 224, they do not count as "telecommunications carriers" and have no statutory right of access. Fibertech petitioned the Commission to initiate a rulemaking to set access standards for pole attachments, including standards for timely performance of make-ready work, use of boxing and extension arms, and use of qualified third-party contract workers, among other concerns. The *Pole Attachment Notice* focused on the effect of disparate pole-attachment rates on broadband competition and arrived at two tentative conclusions: first, that all attachers should pay the same pole attachment rate for all attachments used to provide broadband Internet access service and second, that the rate should be higher than the current cable rate, yet no greater than the telecommunications rate. In addition to the concerns raised by USTelecom and Fibertech, the *Pole Attachment Notice* inquired about application of the telecommunications rate to wireless pole attachments and other pole access concerns.

6. The American Recovery and Reinvestment Act of 2009 included a requirement that the Commission develop a national broadband plan to ensure that every American has access to broadband capability. On March 16, 2010, the National Broadband Plan was released, and identified access to rights-of-way—including access to poles—as having a significant impact on the deployment of broadband networks.

Accordingly, the Plan included several recommendations regarding pole attachment policies to further advance broadband deployment. Among other things, the Plan recommended that:

- The FCC implements rules that will lower the cost of the pole attachment "make-ready" process. For example, the FCC should authorize attachers to use space- and cost-saving techniques, such as boxing or extension arms, where practical and in a way that is consistent with pole owners' use of those techniques; and
- The FCC establish a comprehensive timeline for each step of the section 224 access process and reform the process for resolving disputes regarding infrastructure access.

Discussion

7. The National Broadband Plan recommended a number of actions intended to lower the cost and improve the speed of access to utility poles. The Commission finds that it is in the public interest to implement some of these recommendations immediately to clarify the statutory provisions governing pole attachments and to streamline the pole attachment process. In particular, the Commission clarifies that the statutory nondiscriminatory access requirement allows communications providers to use space- and cost-saving attachment techniques where practical and consistent with pole owners' use of those techniques. The Commission also concludes that the statutory right to just and reasonable access to poles includes the right of timely access.

Nondiscriminatory Use of Attachment Techniques

8. The Commission concludes that the nondiscriminatory access obligation established by section 224(f)(1) of the Act requires a utility to allow cable operators and telecommunications carriers to use the same pole attachment techniques that the utility itself uses. For example, in the 2007 *Pole Attachment Notice,* the Commission sought comment on the use of techniques such as boxing and bracketing. As attachers have explained, boxing and bracketing can help avoid the cost and delay of pole replacement or make-ready work involving electrical facilities, and could be appropriate when practical—for example, when the facilities on the pole can be safely reached by a ladder or bucket truck—and when such techniques previously have been allowed by the pole owner. Similarly, the National Broadband Plan recommends that the Commission give attachers the right to use these techniques "where practical and in a way that is consistent with pole owners' use of [them]."

9. The Commission now clarifies that utilities must allow attachers to use the same attachment techniques that the utility itself uses in similar circumstances, although utilities retain the right to limit their use when necessary to ensure safety, reliability, and sound engineering. Its conclusion here is consistent with the interpretation of the Act in prior bureau orders.

10. Clarifying this application of a utility's nondiscriminatory access obligation provides certainty that will spur competition and promote the deployment of a variety of technologies. As observed in the National Broadband Plan and by commenters, allowing attachers equal use of techniques like boxing and bracketing will encourage competition and advance the deployment of telecommunications, cable, and both wireless and wireline broadband services. Accordingly, any attachment technique that a utility uses or allows to be used will henceforth be presumed appropriate for use by attachers on that utility's poles under comparable circumstances. The Commission believes that this action will promote the deployment of and competition for telecommunications, cable, and broadband services.

11. The Commission's holding is carefully tailored to reflect the legitimate needs of pole owners, as well. Some pole owners contend that the use of boxing and bracketing complicates pole maintenance and replacement, can compromise safety, and may not be consistent with sound engineering practices. Commenters also assert that utilities should be free to prohibit their use or, at the very least, to consider the appropriateness of such techniques on a case-by-case basis. The Commission agrees and emphasizes that its commitment to ensuring this form of nondiscriminatory access is limited by the utility's existing practices. If a utility believes that boxing and bracketing are fundamentally unsafe or otherwise incompatible with proper attachment practice, it can choose not to use or allow them at all. Moreover, even once the presumption that such techniques are appropriate has been triggered, a utility may rebut it with respect to any single pole or class of poles for reasons of safety, reliability and generally applicable engineering purposes.

12. The Commission recognizes that some pole owners employ these techniques sparingly and may be concerned that this clarification will allow attachers to use boxing and attachment arms in situations where the pole owner itself would not. The Commission believes, however, that this framework will allow utilities to limit the use of these techniques whenever appropriate and, thereby, prevent attachers from employing the techniques inappropriately. The Commission's present holding is not designed to broaden the range of circumstances in which these techniques are used. Rather, it is to prevent utilities from denying attachers the benefits of these techniques in situations where the utility itself would, or has, used them.

13. If a utility chooses to allow boxing and bracketing in some circumstances but not others, the limiting circumstances must be clear, objective, and applied equally to the utility and attaching entity. They should also be publicly available—on a website, for instance—with the utility providing examples where helpful. Such *ex ante* guidance will help attachers make informed decisions and should facilitate the attachment process. If a utility denies an attachment technique that it uses for reasons not included in those made publicly available, it must explain its decision in writing to the requesting entity. In an accompanying Further Notice of Proposed Rulemaking (Further NPRM), FR Doc. 2010–17048, the Commission seeks comment on additional considerations regarding boxing and bracketing, including the ability of utilities to prohibit boxing and bracketing going forward, and whether utilities' decisions regarding the use of boxing and bracketing should also be made publicly available.

14. The Commission rejects the argument that its conclusion is inconsistent with section 224(f)(2) of the Act, which allows electric utilities to deny access where there is "insufficient capacity." Although the Commission recognizes that the Eleventh Circuit held in *Southern Co.* v. *FCC* that utilities are not obligated to provide access to a pole when it is agreed that the pole's capacity is insufficient to accommodate a proposed attachment, the Commission does not find that to be the case when boxing and bracketing are able to be used. The Eleventh Circuit held that the term "insufficient capacity" in section 224(f)(2) is ambiguous, and that the Commission has discretion in filling that "gap in the statutory scheme." The court upheld the Commission's finding that "insufficient capacity" means the absence of usable physical space on a pole. Applying that definition here, the Commission finds that a pole does not have "insufficient capacity" if it could accommodate an additional attachment using

conventional methods of attachment that a utility uses in its own operations, such as boxing and bracketing. Unlike requiring a pole owner to replace a pole with a taller pole, these techniques take advantage of usable physical space on the existing pole.

15. The Eleventh Circuit acknowledged in *Southern* that its decision was driven by the need to "construe statutes in such a way to 'give effect, if possible, to every clause and word of a statute.' " By virtue of that decision, however, the statutory language of section 224(f)(2) *is* given effect, in that utilities may deny access for "insufficient capacity" when "it is agreed that capacity on a given pole or other facility is insufficient." Thus, no particular interpretation of section 224(f)(2) is required in the context of boxing and bracketing simply to "give effect" to that statutory language.

16. The Commission finds that its reading of the ambiguous term "insufficient capacity" is a reasonable middle ground. Some utilities have argued that a pole has insufficient capacity—and thus access may be denied under section 224(f)(2)—if *any* make-ready work is needed. At the other extreme, the statute might be read to require a utility to completely replace a pole—an interpretation that some commenters oppose. The Commission sees no reason to adopt either of those extreme positions. Within those extremes is a range of practices, such as line rearrangement, overlashing, boxing, and bracketing that exploit the capacity of existing infrastructure in some way. Although commenters are divided regarding whether a pole has insufficient capacity if techniques such as boxing and bracketing are necessary to accommodate a new attachment, the Commission finds more persuasive the position that a pole does not have insufficient capacity if a new attachment can be added to the existing pole using conventional attachment techniques. Utilization of existing infrastructure, rather than replacing it, is a fundamental principal underlying the Act. As discussed above, the Commission finds that the Commission's interpretation still ensures that "insufficient capacity" is given some meaning, while also, to the greatest extent possible, helping spur competition and promoting the deployment of communications technologies, consistent with the broad "pro competitive" purposes of the 1996 Act, as well as the more specific direction of section 706 of the 1996 Act that the Commission promote the deployment of advanced services "by utilizing, in a manner consistent with the public interest, convenience, and necessity, * * * measures that promote competition in the local telecommunications market, or other regulating methods that remove barriers to infrastructure investment." Accordingly, the Commission concludes that, where a pole can accommodate new attachments through boxing, bracketing, or similar attachment techniques, there is not "insufficient capacity" within the meaning of section 224(f)(2)

Timely Access to Pole Attachments

17. The Commission also holds that access to poles, including the preparation of poles for attachment, commonly termed "make-ready," must be timely in order to constitute just and reasonable access. Section 224 of the Act requires utilities to provide cable television systems and any telecommunications carrier with nondiscriminatory access to any poles, ducts, conduits, and rights-of-way owned or controlled by it, and instructs the Commission to ensure that the terms and conditions for pole attachments are just and reasonable. The Commission previously has recognized the importance of timeliness in the context of specific aspects of the pole attachment process. The National Broadband Plan likewise recognized the importance of timely access to poles. The Commission thus holds that, pursuant to section 224 of the Act, the duty to proceed in a timely manner applies to the entirety of the pole attachment process. Make-ready or other pole access delays not warranted by the circumstances thus are unjust and unreasonable under section 224.

18. Section 224 also provides for the adoption of rules to carry out its provisions, and the Commission seeks comment in the Further NPRM regarding a proposed comprehensive timeline for each step of the pole access process. The Commission clarifies, however, that utilities must perform make-ready promptly and efficiently, consistent with evaluation of capacity, safety, reliability, and generally applicable engineering practices, whether or not a specific rule applies to an aspect of the make-ready process.

Procedural Matters

Paperwork Reduction Act

19. This document does not contain new information collection requirements subject to the Paperwork Reduction Act of 1995, Public Law 104–13. In addition, therefore, it does not contain any proposed information collection burden for small business concerns with fewer than 25 employees, pursuant to the Small Business Paperwork Relief Act of 2002, Public Law 107–198, see 44 U.S.C. 3506(c)(4).

Ex Parte Procedures

20. This proceeding shall be treated as a "permit-but-disclose" proceeding in accordance with the Commission's *ex parte* rules. Persons making oral *ex parte* presentations are reminded that memoranda summarizing the presentations must contain summaries of the substance of the presentations and not merely a listing of the subjects discussed. More than a one or two sentence description of the views and arguments presented is generally required. Other requirements pertaining to oral and written presentations are set forth in § 1.1206(b) of the Commission's rules.

Ordering Clauses

21. Accordingly, *it is ordered* that pursuant to sections 1, 4(i), 4(j), 224, 251(b)(4), and 303 of the Communications Act of 1934, as amended, 47 U.S.C. 151, 154(i)–(j), 224, 251(b)(4), 303, this Order in WC Docket No. 07–245 *is adopted.*

22. *It is further ordered* that, pursuant to §§ 1.4(b)(1) and 1.103(a) of the Commission's rules, 47 CFR 1.4(b)(1), 1.103(a), this Order *shall be effective* September 2, 2010.

Federal Communications Commission.

Bulah P. Wheeler,

Deputy Manager.

[FR Doc. 2010–18904 Filed 8–2–10; 8:45 am]

BILLING CODE 6712–01–P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 101

[WT Docket No. 09–114; RM–11417; FCC 10–109]

Amendment of the Commission's Rules to Accommodate 30 Megahertz Channels in the 6525-6875 MHz Band; and to Provide for Conditional Authorization on Additional Channels in the 21.8-22.0 GHz and 23.0-23.2 GHz Band

Correction

In rule document 2010–17205 beginning on page 41767 in the issue of Monday, July 19, 2010, make the following corrections:

§101.147 [Corrected]

On page 41771, in §101.147, in the third column, the tables are corrected to read as set forth below:

* * * * *

(s) * * *

Transmit (receive) (MHz)	Receive (transmit) (MHz)
(3) 10 MHz bandwidth channels:	
* * * * *	
22025 [2]	23225 [2]
* * * * *	
22075 [2]	23275 [2]
* * * * *	

* * * * *

Transmit (receive) (MHz)	Receive (transmit) (MHz)
(7) 50 MHz bandwidth channels:	
* * * * *	
22025 [2]	23225 [2]
22075 [2]	23275 [2]
* * * * *	

[2] These frequencies may be assigned to low power systems, as defined in paragraph (8) of this section.

* * * * *

[FR Doc. C1–2010–17205 Filed 8–2–10; 8:45 am]

BILLING CODE 1505–01–D

DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

50 CFR Part 17

[Docket No. FWS-R9-IA-2008-0118]
[MO 92210-0-0010-B6]

RIN 1018–AW40

Endangered and Threatened Wildlife and Plants; Determination of Threatened Status for Five Penguin Species

AGENCY: Fish and Wildlife Service, Interior.

ACTION: Final rule.

SUMMARY: We, the U.S. Fish and Wildlife Service (Service), determine threatened status for five penguins: The yellow-eyed penguin (*Megadyptes antipodes*), white-flippered penguin (*Eudyptula minor albosignata*), Fiordland crested penguin (*Eudyptes pachyrhynchus*), Humboldt penguin (*Spheniscus humboldti*), and erect-crested penguin (*Eudyptes sclateri*) under the Endangered Species Act of 1973, as amended (Act).

DATES: This rule becomes effective September 2, 2010.

ADDRESSES: This final rule is available on the Internet at *http://www.regulations.gov. Comments and materials received, as well as supporting* documentation used in the preparation of this rule, will be available for public inspection, by appointment, during normal business hours at the U.S. Fish and Wildlife Service, 4401 N. Fairfax Drive, Suite 420, Arlington, VA 22203.

FOR FURTHER INFORMATION CONTACT: Janine Van Norman, Chief, Branch of Foreign Species, Endangered Species Program, U.S. Fish and Wildlife Service, 4401 North Fairfax Drive, Room 420, Arlington, VA 22203; telephone 703-358-2171; facsimile 703-358-1735. If you use a telecommunications device for the deaf (TDD), call the Federal Information Relay Service (FIRS) at 800-877-8339.

SUPPLEMENTARY INFORMATION:

Background

On December 18, 2008, we published a proposed rule (73 FR 77303) to list the yellow-eyed penguin (*Megadyptes antipodes*), white-flippered penguin (*Eudyptula minor albosignata*), Fiordland crested penguin (*Eudyptes pachyrhynchus*), Humboldt penguin (*Spheniscus humboldti*), and erect-crested penguin (*Eudyptes sclateri*) under the Endangered Species Act of 1973, as amended (Act; 16 U.S.C. 1531 *et seq.*). That document also served as the 12–month finding on a petition to list these species, which are 5 of 12 penguin species included in the petition. We opened the public comment period on the proposed rule for 60 days, ending February 17, 2009, to allow all interested parties an opportunity to comment on the proposed rule. On March 9, 2010, the Center for Biological Diversity (CBD) filed a complaint (CV-10-992, N.D. Cal) for failure to issue a final listing determination within 12 months of the proposal to list the species. In a court-approved settlement agreement, the Service agreed to submit a final rule to the **Federal Register** by July 30, 2010.

Previous Federal Action

For a detailed history of previous Federal actions involving these five penguin species, please see the Service's proposed listing rule, which published in the **Federal Register** on December 18, 2008 (73 FR 77303).

Summary of Comments and Recommendations

In the proposed rule published on December 18, 2008 (73 FR 77303), we requested that all interested parties submit information that might contribute to development of a final rule. We also contacted appropriate scientific experts and organizations and invited them to comment on the proposed listings. We received 13 comments: 4 from members of the public, and 9 from peer reviewers.

We reviewed all comments received from the public and peer reviewers for substantive issues and new information regarding the proposed listing of these five species, and we have addressed those comments below. Overall, the commenters and peer reviewers supported the proposed listings. One comment from the public included substantive information; other comments simply supported the proposed listing without providing scientific or commercial data.

Peer Review

In accordance with our policy published on July 1, 1994 (59 FR 34270), we requested expert opinions from 14 knowledgeable peer reviewers with scientific expertise that included familiarity with the species, the geographic region in which the species occur, and conservation biology principles. We received responses from nine of the peer reviewers. They generally agreed that the description of the biology and habitat for each species was accurate and based on the best available information. They provided some new or additional information on the biology and habitat of some of these penguin species and their threats, and we incorporated that information into the rulemaking as appropriate. In some cases, it has been indicated in the citations by "personal communication," which could indicate either an email or telephone conversation, while in other cases the research citation is provided.

Peer Reviewer Comments

(1) Comment: Several peer reviewers provided new data and information regarding the biology, ecology, life history, population estimates, and threat factors affecting these penguin species, and requested that we incorporate the new data and information into this final rule and consider it in making our listing determination. With respect to potential threats, one peer reviewer raised the issue of flipper banding of the yellow-eyed penguin. Several peer reviewers provided clarifying information on predation with respect

to the Humboldt and white-flippered penguins. Additionally, some of the peer reviewers provided technical corrections and brought to our attention recent papers discussing taxonomy and genetics.

Our Response: In addition to the critical review provided by species experts, we considered scientific and commercial information regarding these penguin species contained in technical documents, published journal articles, and other general literature documents, including over 30 documents we reviewed since the publication of the proposed rule to list these 5 penguin species. We have incorporated the new information and technical corrections into this final rule. In addition, we address flipper banding of the yellow-eyed penguin, and information on predation of the Humboldt and white-flippered penguins in the threats analyses for those species in this final rule.

(2) Comment: One peer reviewer suggested that the mainland and sub-Antarctic populations of yellow-eyed penguins should be considered separate management units, stating that there was negligible genetic interchange between populations. The peer reviewer cited information from 1989, and indicated that more recent work was in review, although no researcher or paper was cited.

Our Response: We reviewed the best available information, including two papers on the genetics of yellow-eyed penguin published in 2008 and 2009, and found no basis to amend our initial finding. The 2008 and 2009 papers support our finding that the species should be listed as threatened throughout its range. Additional discussion is found later in this document under yellow-eyed penguin.

(3) Comment: One peer reviewer raised the issue that the taxonomy of the white-flippered penguin has long been in debate.

Our Response: We reviewed the best available information regarding the taxonomy of white-flippered penguin (*Eudyptula minor albosignata*), and we found no basis to amend our taxonomic treatment of the species. See the background section below on white-flippered penguin for additional discussion.

Public Comments

(4) Comment: One commenter provided additional information regarding potential threat factors affecting these five species, and requested that we consider the information and incorporate it into the listing determinations. Specifically, the commenter indicated that the Service failed to address anthropogenic climate change and how it will affect penguins, particularly the Humboldt penguin. The commenter also requested that we address the issue of accelerated ocean warming and ocean acidification. The commenter suggested that the pH (acidity) of the ocean is rapidly changing, and may lower by 0.3 to 0.4 units by the year 2100, which would mean the acidity would increase by 100 to 150 percent. The commenter cited Orr *et al.* 2005 and Meehl *et al.* 2007.

Our Response: We thank the commenter who provided this information for our consideration in making this final listing determination. We will first respond to the comment that greenhouse gas emissions will accelerate ocean warming and increase sea level rise. Gille (2002, p. 1276) found that while ocean warming occurred in the 1950s and 1960s, it leveled off in the 1980s and 1990s; overall, there was an increase in ocean water temperature in the Southern Hemisphere over the past 50 years. Looking forward to years 2090-2099, precipitation is predicted to increase across the sub-Antarctic and Antarctic region, with a greater than 20 percent increase predicted for the Antarctic continent (IPCC 2007, p. 10). We acknowledge that ocean warming and sea level rise may occur. Warming of the climate system is unequivocal, as is now evident from observations of increases in global average air and ocean temperatures, widespread melting of snow and ice, and rising global average sea level ((IPCC 2007, p. 30). During the status review, we carefully evaluated threats facing these species. We considered the various threats in part based on their severity. In some cases, the effects of climate change are unpredictable and understudied, and the best available information does not indicate how increased sea level rise and ocean warming may affect these five penguin species. However, we determined what major stressors are affecting the status of the species, and evaluated those stressors based on the best available scientific and commercial information

Secondly, we acknowledge that the issue of ocean acidification was not directly addressed in the proposed rule. Again, with respect to penguins, the best available information does not address how ocean acidity would impact the physiology and food web associated with these five penguin species. We acknowledge that ocean acidification may be a concern, but at this time, any conclusion would be purely speculative regarding how much the oceanic pH may change in the penguins' habitat and how the other changes in the species' environments would interact with other known threats. The manner in which a change in ocean pH may affect penguins is currently unpredictable.

(5) Comment: The same commenter requested that the Service consider listing these five species as endangered instead of threatened based on the two issues noted above.

Our Response: Section 4(b)(1)(A) of the Act requires us to make listing decisions based solely on the best scientific and commercial data available. We have thoroughly reviewed all available scientific and commercial data for these species in preparing this final listing determination. We reviewed historical and recent publications, as well as unpublished reports, concerning these species. In addition, we used peer review to provide a more focused, independent examination of the available scientific information and its application to the current status of the species. As part of our evaluation, we carefully considered the quality and reliability of all data to decide which constitutes the best available data for our consideration in making our final determination. We analyzed the threats in making our determination, and our review of the threat factors indicate that listing these five species as threatened is warranted. After reviewing the peer review and public comments we received, we have no reason to alter our assessment. Based on our analysis, we determined that none of these five penguin species is currently in danger of extinction throughout its entire range, and therefore none of them meet the definition of endangered under the Act (16 U.S.C. 1532(6)).

Summary of Changes from Proposed Rule

We fully considered comments from the public and peer reviewers on the proposed rule to develop this final listing of five foreign penguin species. This final rule incorporates changes to our proposed listing based on the comments that we received that are discussed above and newly available scientific and commercial information. Reviewers generally commented that the proposed rule was very thorough and comprehensive. We made some technical corrections based on new, although limited, information. None of the information, however, changed our determination that listing these five species as threatened is warranted.

Species Information and Factors Affecting the Species

Section 4 of the Act (16 U.S.C. 1533), and its implementing regulations at 50 CFR 424, set forth the procedures for adding species to the Federal Lists of Endangered and Threatened Wildlife and Plants. A species may be determined to be an endangered or threatened species due to one or more of the five factors described in section 4(a)(1) of the Act. The five factors are: (A) The present or threatened destruction, modification, or curtailment of its habitat or range; (B) overutilization for commercial, recreational, scientific, or educational purposes; (C) disease or predation; (D) the inadequacy of existing regulatory mechanisms; and (E) other natural or manmade factors affecting its continued existence.

Below is a species-by-species threats analysis of these five factors. The species are considered in the following order: Yellow-eyed penguin, white-flippered penguin, Fiordland crested penguin, Humboldt penguin, and erect-crested penguin.

Yellow-eyed Penguin (*Megadyptes antipodes*)

Background

The yellow-eyed penguin, also known by its Maori name, hoiho, is the third largest of all penguin species, averaging around 18 pounds (lb) (8 kilograms (kg)) in weight, the males averaging 1 kg more than females at 8.5 kg. It is the only species in the monotypic genus *Megadyptes* (Boessenkool *et al.* 2009, p. 819). Yellow-eyed penguins breed on the southeast coast of New Zealand's South Island, from Banks Peninsula to Bluff at the southern tip; in Fouveaux Strait, and on Stewart and adjacent islands just 18.75 mi (30 km) from the southern tip of the New Zealand mainland; and at the sub-Antarctic Auckland and Campbell Islands, 300 mi (480 km) and 380 mi (608 km), respectively, south of the southern tip of the South Island. The distribution is thought to have moved north since the 1950s (McKinlay 2001, p. 8). The species is confined to the seas of the New Zealand region and forages over the continental shelf (Taylor 2000, p. 93).

Unlike more strongly colonial breeding penguin species, yellow-eyed penguins nest in relative seclusion, out of sight of humans and one another (Ratz and Thompson 1999, p. 205; Seddon and Davis 1989, pp. 653-659; Wright 1998, pp. 9–10). Current terrestrial habitats range from native forest to grazed pasture (McKinlay 2001, p. 10). In some places, they nest in restored areas, and in other places, they nest in areas where livestock are still present (McKinlay 2001, p. 10). Prior to land clearing for agriculture by European settlers, the historic habitat was in coastal forests and shrub margins (Marchant and Higgins 1990, p. 237).

In 2001, the New Zealand Department of Conservation (NZDOC) published the Hoiho (*Megadyptes antipodes)* Recovery Plan (2000–2025) to state the NZDOC's intentions for the conservation of this species, to guide the NZDOC in its allocation of resources, and to promote discussion among the interested public (McKinlay 2001, p. 20). The goal of the Recovery Plan, which updates a 1985–1997 plan previously in place, is to increase yellow-eyed penguin numbers and have active community involvement in their conservation. The primary emphasis over the 25–year period is to "retain, manage and create terrestrial habitat" and to "investigate the mortality of hoiho at sea" (McKinlay 2001, p. 2).

In 2007, the total population estimate was 1,600 breeding pairs (3,200 breeding adults in the population) (Houston 2007, p. 3). As of 2009, the total estimate for this species is 7,000 individuals (Boessenkool *et al.* 2009, p. 815), which is not substantially different from the 2007 estimate.

In the recent past, the number of breeding pairs has undergone dramatic periods of decline and fluctuation in parts of its range on the mainland of the South Island. Records suggest that the mainland populations declined by at least 75 percent from the 1940s to 1988. In 1988, there were 380 to 400 breeding pairs (Darby and Seddon 1990, p. 59). There have been large fluctuations since a low of about 100 breeding pairs in the 1989–90 breeding season to over 600 in the 1995–96 breeding season (McKinlay 2001, p. 10). Current mainland counts indicate 450 breeding pairs on the southeast coast of the mainland of the South Island (Houston 2007, p. 3). As recently as the 1940s, there were reported to be individual breeding areas where penguin numbers were estimated in the hundreds; in 1988, only 3 breeding areas on the whole of the South Island had more than 30 breeding pairs (Darby and Seddon 1990, p. 59).

Just across the Fouveaux Strait at the southern tip of the South Island, at Stewart Island and nearby Codfish Island, yellow-eyed penguin populations numbered a combined estimate of 178 breeding pairs in the early 2000s (Massaro and Blair 2003, p. 110). While these populations are essentially contiguous with the mainland range, this is the first population estimate for this area based on a comprehensive count. This estimate, while lower than previous estimates, may be lower because when the population estimates were done in the 1980s and 1990s, they were partial surveys rather than full surveys. It is unclear whether numbers have declined in the past two decades or whether previous estimates, which extrapolated from partial surveys, were overestimates (Massaro and Blair 2003, p. 110), but evidence points to the latter. For example, Darby and Seddon (1990, p. 58) provided 1988 estimates of 470 to 600 breeding pairs at Stewart Island and nearby Codfish Island, which the researchers extrapolated from density estimates. In the Hoiho Recovery Plan, which reported these 1988 numbers, it is noted that, "In the case of Stewart Island, these figures should be treated with a great deal of skepticism. Only a partial survey was completed in the early 1990s" (McKinlay 2001, p. 8). Darby (2003, p. 148), one of the authors of the 1988 estimate, subsequently reviewed survey data from the decade between 1984 and 1994 and revised the estimates for this region down to 220 to 400 pairs. Houston (2008, p. 1) reported numbers are stable in all areas of Stewart and Codfish Islands, except in the northeast region of Stewart Island where disease and starvation are impacting colonies, as discussed in detail below. While it is reported that the numbers of birds at Stewart and Codfish Islands have declined historically (Darby and Seddon 1990, p. 57), it is unclear to what extent declines are currently under way.

As of 2007, in the sub-Antarctic island range of the yellow-eyed penguin, there were an estimated 400 pairs on Campbell Island (down from 490 to 600 pairs in 1997), and 570 pairs on the Auckland Islands (Houston, 2007, p. 3).

The yellow-eyed penguin is classified as "Endangered" by the International Union for Conservation of Nature (IUCN) criteria (BirdLife International 2007, p. 1). When the New Zealand Action Plan for Seabird Conservation was completed in 2000, the species' IUCN Status was 'Vulnerable,' and it was listed as Category B (second priority) on the Molloy and Davis threat categories employed by the New Zealand Department of Conservation (NZDOC) (Taylor 2000, p. 33). On this basis, the species was placed in the second tier of New Zealand's Action Plan for Seabird Conservation. The species is listed as "acutely threatened—nationally vulnerable" on the New Zealand Threat Classification System

List (Hitchmough *et al.* 2007, p. 45; Molloy *et al.* 2002, p. 20).

Summary of Factors Affecting the Yellow-eyed Penguin

Factor A. The Present or Threatened Destruction, Modification, or Curtailment of the Yellow-eyed Penguin's Habitat or Range

Deforestation and the presence of grazing animals and agricultural activities have destroyed or degraded yellow-eyed penguin habitat throughout the species' range on the mainland South Island of New Zealand. Much of the decline in breeding numbers can be attributed to loss of habitat (Darby and Seddon 1990, p. 60; Taylor 2000, p. 94). The primary historic habitat of the reclusive yellow-eyed penguin on the southeast coast of the South Island of New Zealand was the podocarp hardwood forest. During the period of European settlement of New Zealand, almost all of this forest was cleared for agriculture, with forest clearing activities continuing into at least the 1970s (Sutherland 1999, p. 18). This has eliminated the bulk of the historic mainland breeding vegetation type for this species (Marchant and Higgins 1990, p. 237). With dense hardwood forest unavailable, the breeding range of yellow-eyed penguins has now spread into previously unoccupied habitats of scrubland, open woodland, and pasture (Marchant and Higgins 1990, p. 237). Here the breeding birds are exposed to new threats. In agricultural areas, breeding birds are exposed to the trampling of nests by domestic cattle. For example, on the mainland Otago Peninsula in 1985, cattle destroyed 25 out of 41 nests (60 percent) (Marchant and Higgins 1990, p. 238).

Yellow-eyed penguins are also more frequently exposed to fire in these new scrubland and agricultural habitat, such as a devastating fire in 1995 at the Te Rere Yellow-eyed Penguin Reserve in the southern portion of the mainland of the South Island, which killed more than 60 adult penguins out of a population of 100 adults at the reserve, as well as fledgling chicks on shore (Sutherland 1999, p. 2; Taylor 2000, p. 94). Five years after the fire, there was little evidence of recovery of bird numbers at this reserve (Sutherland 1999, p. 3), although there had been considerable efforts to restore the land habitat through plantings, creation of firebreaks, and predator control.

Habitat recovery efforts, dating as far back as the late 1970s and set out in the 1985–1997 Hoiho Species Conservation Plan (McKinlay 2001, p. 12), have focused on protecting and improving breeding habitats. Habitat has been purchased or reserved for penguins at the mainland Otago Peninsula, North Otago, and Catlins sites, with 20 mainland breeding locations (out of an estimated 32 to 42) reported to be under "statutory" protection against further habitat loss (Ellis 1998, p. 91). New, currently unoccupied areas have been acquired to provide the potential to support increased populations in the future (McKinlay 2001, p. 12). Fencing and re-vegetation projects have been implemented to restore nesting habitat and to exclude grazing animals from breeding habitats (McKinlay 2001, p. 12). In some cases, efforts to fence penguin reserves to reduce trampling by cattle have created more favorable conditions for attack by introduced predators (see Factor C) (Alterio *et al.* 1998, p. 187). In addition, the Yellow-eyed Penguin Trust has been active in the conservation of this species, and has purchased land specifically for the protection of the species (*http://yellow-eyedpenguin.org.nz*). Despite these efforts, yellow-eyed penguin numbers on the mainland have not increased and have continued to fluctuate dramatically at low levels, with no sustained increases over the last 27 years (McKinlay 2001, p. 10). Although we did not rely on future conservation efforts by New Zealand in our analysis of threats, we note that efforts in the second phase of the Hoiho Recovery Plan continue to focus on managing, protecting, and restoring the terrestrial habitat of the yellow-eyed penguin (McKinlay 2001, p. 15).

On the offshore and sub-Antarctic islands of its range, feral cattle and sheep destroyed yellow-eyed penguin nests on Enderby and Campbell Islands (Taylor 2000, p. 94). All feral animals were removed from Enderby Island in 1993, and from Campbell Island in 1984 (cattle) and 1991 (sheep) (Taylor 2000, p. 95). Reports indicate very little change in the quality of terrestrial habitat of the yellow-eyed penguin habitat on these islands (McKinlay 2001, p. 7).

Although individual locations remain susceptible to fire or other localized events, the threat of manmade habitat destruction has been reduced over the dispersed range of the species on the mainland South Island. In our analysis of other threat factors, in particular Factor C, we will further examine why the recovery goals for mainland populations have not been achieved. Specifically, the goal in the 1985–1997 recovery plan of maintaining two managed mainland populations, each with a minimum of 500 pairs, was not achieved (McKinlay 2001, p. 13). Eight years into the 2000–2025 recovery plan, the long-term goal to increase yellow-eyed penguin populations remains elusive. However, significant public and private efforts have been undertaken in New Zealand over past decades to protect and restore yellow-eyed penguin breeding habitat on the mainland South Island. Further, the species' island breeding habitats have either not been impacted or, if historically impacted, the causes of disturbance have been removed. In addition, the Yellow-eyed Penguin Trust has been active in the conservation of this species, and has purchased land specifically for the protection of the species. Because these conservation efforts have been implemented, we find that the present or threatened destruction, modification, or curtailment of its terrestrial habitat or range is not a threat to the species.

In the marine environment, yellow-eyed penguins forage locally around colony sites during the breeding season. Unlike most penguin species, yellow-eyed penguins tend to be benthic (bottom of ocean) rather than pelagic (surface of ocean) feeders (Mattern 2007, p. 295). They are known to feed on a variety of fish and squid species, including opal fish (*Hemerocoetes monopterygius*), blue cod (*Parapercis colias*), sprat (*Sprattus antipodum*), silverside (*Argentina elongata*), red cod (*Pseudophycis bachus*), and arrow squid (*Nototodarus sloani*) (van Heezik 1990b, pp. 209-210). Yellow-eyed penguins that were tracked from breeding areas on the Otago Peninsula on the mainland of the South Island foraged over the continental shelf in waters from 131 to 262 feet (ft) (40 to 80 meters (m)) deep. In foraging trips lasting on average 14 hours, they ranged a median of 8 mi (13 km) from the breeding area (Moore 1999, p. 49). Foraging ranges utilized by birds at the offshore Stewart Island were quite small (ca. 7.9 mi^2 (20.4 km^2)) compared to the areas used by birds at the adjacent Codfish Islands (ca. 208 mi^2 (540 km^2)) (Mattern *et al.* 2007, p. 115).

There is evidence that modification of the marine environment by human activities may reduce the viability of foraging areas for yellow-eyed penguins on a local scale. Mainland population declines in 1986–1987 have been attributed to "changes in the marine environment and failure of quality food" (McKinlay 2001 p. 9), but we have not found evidence attributing recent population changes at either mainland colonies or the more distant Campbell and Auckland Islands' colonies to changes in the marine environment.

Mattern *et al.* (2007, p. 115) concluded that degradation of benthic

habitat by commercial oyster dredging is limiting viable foraging habitat and increasing competition for food for a small portion of Stewart Island penguins breeding in areas on the northeast coast of that island, resulting in chick starvation (King 2007, p. 106). Chick starvation and disease are the two most prevalent causes of chick death at the northeast Stewart Island study colonies (King 2007, p. 106). Poor chick survival and, presumably, poor recruitment of new breeding pairs, is reported to be the main cause of a decline in the number of breeding pairs (King 2007, p. 106). At the adjacent Codfish Island, where food is more abundant and diverse (Browne *et al.* 2007, p. 81), chicks have been found to flourish even in the presence of disease. Browne *et al.* (2007, p. 81) found dietary differences between the two islands. Stewart Island chicks received meals comprised of fewer species and less energetic value than those at Codfish Island. The foraging grounds of these two groups do not overlap, suggesting that local-scale influences in the marine environment (Mattern *et al.* 2007, p. 115) are impacting the Stewart Island penguins. These authors concluded that at Stewart Island, degradation of benthic habitat by commercial oyster dredging is limiting foraging habitat for yellow-eyed penguins. The 178 pairs on Stewart Island and adjacent islands make up 11 percent of the total current population, and only a portion of this number are affected by the reported degradation of benthic habitat by fisheries activities. Therefore, while the present or threatened destruction, modification, or curtailment of its marine habitat or range by commercial oyster dredging is a threat to chick survival for some colonies at Stewart Island, we find that the present or threatened destruction, modification, or curtailment of its marine habitat is not a threat to the species overall.

Factor B. Overutilization for Commercial, Recreational, Scientific, or Educational Purposes

The yellow-eyed penguin has become an important part of the ecotourism industry on the mainland South Island of New Zealand, particularly around the Otago Peninsula and the Southland areas. Tourism is the primary commercial, recreational, or educational use of the yellow-eyed penguin. Approximately 126,000 tourists viewed penguins in New Zealand in 2006 and 2007 (NZ Ministry of Tourism, 2007).

When the proposed rule was published, we were not aware of tourism activities in the island portions of the range of the yellow-eyed penguin. However, since then, we have learned that tourists are viewing yellow-eyed penguins on Enderby Island, which is the northernmost island of a Subantarctic group known as the Auckland Islands approximately 320 km (199 mi) south of New Zealand. Yellow-eyed penguins are extremely wary of human presence and will not land on the beach if humans are in sight (McClung *et al.* 2004, p. 279). Yellow-eyed penguins select nest sites with dense vegetative cover and a high degree of concealment (Marchant and Higgins 1990, p. 240), and prefer to be shaded from the sun and concealed from their neighbors (Seddon and Davis 1989, p. 653). Given these secretive habits, research has focused on how the potential of increasing tourism impacts yellow-eyed penguins (Seddon and Ellenberg, 2008). In one study, yellow-eyed penguins showed lower breeding success in areas of unregulated tourism than in those areas visited infrequently for monitoring purposes only (McClung *et al.* 2004, p. 279).

In an older study, no obvious impacts of tourist presence were found (Ratz and Thompson 1999, p. 208). Breeding success appeared to be equivalent in both the colony visited by tourists and the colony not visited by tourists; however, the penguins were habituated to a particular noninvasive level of tourism. In newer studies, disturbance was associated with increased heart rate, stress level, energy use, and corticosterone levels (associated with stress) in parents and lower fledgling weights of chicks (Ellenberg *et al.* 2006, p. 95). Yellow-eyed penguins exhibited a stronger initial stress response than other penguin species at a breeding site exposed to unregulated tourism compared to an undisturbed area (Seddon and Ellenberg, 2008p. 171.) These studies have provided information, some of which is being used in the design of visitor management and control procedures at yellow-eyed penguin viewing areas to minimize disturbance to breeding pairs. A key impact from human disturbance described in the Recovery Plan is that yellow-eyed penguins may not come ashore or may leave the shore prematurely after landing. The Hoiho Recovery Plan identified 14 mainland areas where current practices of viewing yellow-eyed penguins already minimize tourism impacts on yellow-eyed penguins and recommends that practices in these areas remain unchanged. Eight additional areas were identified as suitable for development as tourist destinations to observe yellow-eyed penguins where minimization of tourism impacts can be achieved (McKinlay 2001, p. 21). NZDOC is using these existing lists to guide the approval of tourism. Overall, under the plan, tourism is being directed to those sites where impacts of tourism can be minimized. However, unregulated tourism still occurs (McKinlay 2001, p. 8; PenguinSpirit 2009, p. 2, BLI 2010b, p. 2) and affects penguins.

With respect to the impact of research on yellow-eyed penguins, flipper banding for scientific research was identified as having a negative effect on some penguin species. At a 2005 penguin symposium, van Heezik presented findings (pp. 265-266) that flipper banded penguins had a lower survival rate than nonbanded penguins for age class 2 to 11. Another review of scientific research regarding flipper banding found the survival rate of flipper banded penguins compared with nonbanded penguins to be 21 percent less (Froget *et al.* 1998, pp. 409-413). Dugger found a 10 percent reduced survival rate in stainless steel–banded penguins compared with nonbanded penguins (Petersen *et al.* 2006, p. 76). Petersen's review of the effects of flipper banding indicated that there may be negative effects of flipper banding.

Different types of banding have been used, and species appear to be affected differently by them. In addition, there may be coping mechanisms to compensate for any drag that penguins experience when swimming with flipper bands. Other evidence of negative effects of flipper banding include the finding that unbanded King penguin adults were more likely to successfully breed, possibly because they arrived earlier at the colony for courtship. They produced almost twice as many young over four breeding seasons (Gauthier-Clerc *et al.* 2004, p. 424). Researchers hypothesize that the unbanded penguins have a competitive advantage over the banded penguins, which appears to be a reasonable conclusion. This research identified flipper banding as a problem, and the penguin scientific community subsequently modified banding techniques. The detrimental tagging methods were abandoned or modified. Therefore, after evaluating this factor, we find that flipper banding, while it should continue to be monitored, does not constitute a threat to this species. We have found no other reports of impacts on this species from scientific research or any other commercial, recreational, scientific, or educational purposes.

Nature-based tourism has increased in recent decades. The New Zealand DOC, in cooperation with conservation,

tourism, and industry stakeholders, has put measures in place to understand and minimize the impacts of tourism activities on the yellow-eyed penguin through the Hoiho Recovery Plan. A study by Seddon and Ellenberg in 2008 indicates that yellow-eyed penguins are particularly sensitive to human disturbance such as tourism (pp. 169-170). Although yellow-eyed penguins do not always exhibit an obvious alarm reaction, other penguin species have exhibited increased heart rates when humans were within 1 m (3 ft) of nesting penguins (Seddon and Ellenberg, 2008, pp. 167, 170). Yellow-eyed penguins needed more recovery time than other penguins after exposure to a stressor (p. 170), and this stress response carries with it an associated expenditure of energy. Based on this information, we find that overutilization for commercial, recreational, scientific, or educational purposes, particularly unregulated tourism, is a threat to the yellow-eyed penguin.

Factor C. Disease or Predation

Disease has been identified as a factor influencing both adult and chick mortality in yellow-eyed penguins. We have identified reports of one major disease outbreak involving adult penguins and ongoing reports of disease in yellow-eyed penguin chicks.

Initial investigation of a major die-off of adult yellow-eyed penguins at Otago Peninsula in 1990 failed to identify the etiology of the deaths (Gill and Darby 1993, p. 39). This involved mortality of 150 adult birds or 31 percent of a mainland population estimated at the time to include 240 breeding pairs. Subsequent investigation of avian malaria seroprevalence among yellow-eyed penguins found that the mortality features, climatological data, and pathological and serological findings at the time conformed to those known for avian malaria outbreaks (Graczyck *et al.* 1995, p. 404), leading the authors to conclude that avian malaria was responsible for the die-off. These authors associated the outbreak with a period of warmer than usual sea and land temperatures. More recently, Sturrock and Tompkins (2007, pp. 158–160) looked for DNA from malarial parasites in yellow-eyed penguins and found that all samples were negative. This suggests that earlier serological tests were overestimating the prevalence of infection or that infection was transient or occurred in age classes not sampled in their current study. While this raises questions as to the role of avian malaria in the 1990 mortality event, the authors noted, given the spread of avian malaria throughout New Zealand and previous results indicating infection and mortality in yellow-eyed penguins, that continued monitoring of malarial parasites in this species should be considered an essential part of their management until the issue of their susceptibility is resolved. There have been no subsequent disease-related die-offs of adult yellow-eyed penguins at mainland colonies since the 1990s (Houston 2007, p. 3).

The haemoparasite *Leucocytozoon*, a blood parasite spread by blackflies, was first identified in yellow-eyed penguins at the offshore Stewart and Codfish Islands in 2004 (Hill *et al.* 2007, p. 96) and was one contributor to high chick mortality at Stewart Islands in 2006–2007, which involved loss of all 32 chicks at the northeast Anglem Coast monitoring area of the Yellow-eyed Penguin Trust. This parasite may have spread from Fiordland crested penguins, which are known to house this parasite (Taylor 2000, p. 59). Chick mortality was also reported at this area in 2007–2008 (Houston 2008, pers. comm.). It is not clear if the *Leucocytozoon* predisposes animals to succumb from other factors, such as starvation or concurrent infection with other pathogens (such as diphtheritic stomatitis), or if it is the factor that ultimately kills them, but over 40 percent of chick mortality over three breeding seasons at Stewart Island study colonies was attributed to disease (King 2007, p. 106). The survival of infected chicks at nearby Codfish Island, where food is more abundant, indicates that nutrition can make a difference in whether mortality occurs in diseased chicks (Browne *et al.* 2007, p. 81; King 2007, p. 106). Healthy adults who are infected, but not compromised, by this endemic disease provide a reservoir for infection of new chicks through the vector of blackflies. No viable method of treatment for active infections in either chicks or adults has been identified.

At the mainland Otago Peninsula in the 2004–2005 breeding season, an outbreak of *Corynebacterium amycolatum* infection (diptheritic stomatitis) caused high mortality in yellow-eyed penguin chicks (Houston 2005, p. 267) at many colonies there and on Stewart Island (where it may have been a contributing factor to the mortalities discussed above from *Leucocytozoon*). Mortality was not recorded at Codfish Island or at the sub-Antarctic islands (Auckland and Campbell Islands). The disease produced lesions in the chicks' mouths and upper respiratory tract and made it difficult for the chicks to swallow. All chicks at Otago displayed the symptoms, but survival was better in older, larger chicks. Treatment with broad spectrum antibiotics was reported to have achieved "varying results," and it is not known how this disease is triggered (Houston 2005, p. 267).

In summary, disease has seriously impacted both mainland and Stewart Island populations of yellow-eyed penguins over the past two decades. A mainland mortality event in 1990, attributed to avian malaria, killed 31 percent of the mainland adult population of yellow-eyed penguin. While there is lack of scientific certainty over the impact of malaria on yellow-eyed penguins, the overall spread of this disease, the small population size of yellow-eyed penguins, and evidence of its presence in their populations lead us to conclude that this is an ongoing threat. Disease events contributed to or caused mortality of at least 20 percent of chicks at Stewart Island in 2006–2007 and complete mortality in local colonies. The continuing contribution to yellow-eyed penguin chick mortality from *Leucocytozoon* and diptheritic stomatitus at Stewart Island and the recent high mortalities of mainland chicks from diptheritic stomatitis indicate the potential for future emergence or intensified outbreaks of these or new diseases. The emergence of disease at both mainland and Stewart Island populations in similar time periods and the likelihood that Leucocytozoon was spread to the yellow-eyed penguin from the Fiordland crested penguin point out the significant possibility of future transmission of known diseases between colonies or between species, and the possibility of emergence of new diseases at any of the four identified breeding locations of the yellow-eyed penguin.

Predation of chicks and sometimes adults by introduced stoats (*Mustela erminea*) (which are good swimmers), ferrets (*M. furo*), cats (*Felis catus*), and dogs (*Canis domesticus*) is the principal cause of yellow-eyed penguin chick mortality on the South Island with up to 88.5 percent of chicks in any given habitat being killed by predators (Alterio *et al.* 1998, p. 187; Clapperton 2001, p. 187, 195; Darby and Seddon 1990, p. 45; Marchant and Higgins 1990, p. 237; McKinlay *et al.* 1997, p. 31; Ratz *et al.* 1999, p. 151; Taylor 2000, pp. 93–94). In a 6–year study of breeding success of yellow-eyed penguins in mainland breeding areas, predation accounted for 20 percent of chick mortality overall, and was as high as 63 percent overall in one breeding season (Darby and Seddon 1990, p. 53). Proximity to farmland and grazed pastures was found to be a factor accounting for high predator densities

with 88 percent predation at one breeding area adjacent to farmland (Darby and Seddon 1990, p. 57). Of 114 yellow-eyed penguin carcasses found on the South Island mainland between 1996 and 2003, one-quarter of deaths were attributed to predation. Dogs and mustelids were found to be the most common predators (Hocken 2005, p. 4).

In light of this threat, protection of chicks from predators is a primary objective under the 2000–2025 Hoiho Recovery Plan. Approaches to predator control are being established and refined at breeding sites on the mainland (McKinlay *et al.* 1997, pp. 31–35), targeting ferrets, stoats, and cats. The New Zealand DOC has concluded that predation is a threat that may be managed through trapping or other cost-effective methods to protect chicks in nests (McKinlay 2001, p. 18). The recovery plan indicates that a minimum protection of 43 percent of nests would be needed to ensure population growth (McKinlay 2001, p. 18). The recovery plan establishes a goal of protecting 50 percent of all South Island nests from predators between 2000 and 2025. Where intensive predator control regimes have been put in place, they are effective (McKinlay *et al.* 1997, p. 31), capturing 69 to 82 percent of predators present. In a long-term analysis of three closely monitored study colonies, which make up roughly half the nests at the Otago Peninsula and about 10 to 20 percent of the nests on the mainland, Lalas *et al.* (2007, p. 237) found that the threat of predation on chicks by introduced terrestrial mammals had been mitigated by trapping and shooting, and no substantial predation events had occurred between 1984 and 2005. We do not have information on the extent to which anti-predator measures are in place for the remaining 80 to 90 percent of yellow-eyed penguin nests on the mainland of the South Island of New Zealand. Other efforts to remove or discourage predation have not been as successful. A widely applied approach of establishing "vegetation buffers" around yellow-eyed penguin nest sites to act as barriers between predators and their prey was found to actually increase predation rates. Predators preferred the buffer areas and used penguin paths within them to gain easy access to penguin nests (Alterio *et al.* 1998, p. 189). Given these conflicting reports, we cannot evaluate to what extent management efforts are moving toward the goal of protection of 50 percent of all yellow-eyed penguin nests on the mainland.

Offshore, at Stewart and Codfish Islands, there are a number of introduced predators, but mustelids are absent. Research indicated that the presence of feral cats could be depressing the population of yellow-eyed penguins at Stewart Island. (Harper 2004, p. 26; Massaro and Blair 2003, p. 107). Weka (*Gallirallus australis*) have been eradicated from Codfish Island, but may prey on eggs and small chicks in the Fouveaux Strait and some breeding islands in the Stewart Island region at the southern tip of New Zealand (Darby 2003, p. 152; Massaro and Blair 2003, p. 111).

Some islands, including the Codfish and Bravo group, have Norway rats (*Rattus norvegicus,* Pacific rats (*R. exulans),* and ship rats (*R. rattus*), which are thought to prey on small chicks (Massaro and Blair 2003, p. 107). Even though Norway rats are present on Campbell Island, evidence of egg or chick predation by terrestrial mammalian predators was not observed during two breeding seasons (Taylor 2000, pp. 93–94).

At Auckland Island, it is reported that feral pigs (*Sus scrofa*) probably kill adults and chicks (Taylor 2000, pp. 93).

At Otago Peninsula, even as objectives are set to attempt to bring terrestrial predators under more effective control, an emerging threat is predation by the New Zealand sea lion (*Phocarctos hookeri*). Since 1985, sea lions have recolonized the area and predation of yellow-eyed penguins has increased. Penguin remains have been more frequently found in sea lion scat samples. Two penguin breeding sites in close proximity to the founding nursery area of female sea lions have been particularly impacted. The number of nests at these two colonies has declined sharply since predation was first observed and when colonization by female sea lions first took place. As discussed above, these two sites are among those that have been intensively and successfully protected from introduced terrestrial predators between 1984 and 2005 (Lalas *et al.* 2007, p. 237), so declines can be directly attributed to sea lion predation. The predation has been attributed to one female, the daughter of the founding animal. Population modeling of the effect of continued annual kills by sea lions predicts the collapse of small populations (fewer than 100 nests) subject to targeted predation by one individual sea lion. At the current time, none of the 14 breeding sites at Otago Peninsula exceeds 100 nests. No action has been taken to control this predation, although removal of predatory individuals has been suggested (Lalas *et al.* 2007, pp. 235–246). Similar predation by New Zealand sea lions was observed at Campbell Island in 1988 and was considered a probable cause for local declines there (Moore and Moffat 1992, p. 68). Some authors have speculated that New Zealand sea lion may take yellow-eyed penguins at Stewart Island, but there are no documented reports (Darby 2003, p. 152). Because of its continued role in suppressing the recovery of yellow-eyed penguin populations and because of the continued impact of introduced terrestrial and avian predators and native marine predators, we find that predation is a threat to the yellow-eyed penguin.

In summary, on the basis of the best available scientific information, we find that disease and predation, which have impacted both mainland and island populations, threaten the yellow-eyed penguin. New or recurrent disease outbreaks are reasonably likely to occur in the future and may result in further declines throughout the species' range. Although some predator eradication efforts within breeding areas of the yellow-eyed penguin have been successful, predation continues to affect the species, and we do not expect that regulatory mechanisms will be sufficient to address or ameliorate the threats to the species in the foreseeable future. Furthermore, the threat of predation by endemic sea lions is impacting populations on the mainland and at the Campbell Islands, and we have no reason to believe this threat will not continue to reduce population numbers of the yellow-eyed penguin in those areas. We find that disease and predation are threats to this species.

Factor D. Inadequacy of Existing Regulatory Mechanisms

The yellow-eyed penguin is protected under New Zealand's Wildlife Act of 1953, which gives absolute protection to wildlife throughout New Zealand and its surrounding marine economic zone. No one may kill or have in their possession any living or dead protected wildlife unless they have appropriate authority.

The species inhabits areas within Rakiura National Park, which encompasses Stewart and Codfish Islands (Whenua Hou). Under section 4 of New Zealand's National Parks Act of 1980 and Park bylaws, "the native plants and animals of the parks shall as far as possible be preserved and the introduced plants and animals shall as far as possible be eradicated." In addition to national protection, all New Zealand sub-Antarctic islands, including Auckland and Campbell Islands, are inscribed on the World Heritage List (2008, p. 16), although no additional protections are afforded by

this designation. We do not have information to evaluate whether and to what extent these National Park bylaws reduce threats to the yellow-eyed penguin in these areas.

The yellow-eyed penguin is considered a "threatened" species, and measures for its protection are outlined under the New Zealand DOC's Action Plan for Seabird Conservation in New Zealand (Taylor 2000, pp. 93–94) (see discussion of Factor D for Fiordland crested penguin). Ellis *et al.* (1998, p. 91) reported that habitat has been purchased or reserved for penguins at the mainland Otago Peninsula, North Otago and Catlins sites. Twenty mainland breeding locations (out of an estimated 32 to 42 sites) are reported to be under "statutory protection" against further habitat loss. However, we have not found a complete breakdown of the types of legal protection in place for these areas, of the percent of the total mainland population encompassed under such areas, or of the effectiveness, where they are in place, of such regulatory mechanisms in reducing the identified threats to the yellow-eyed penguin.

As a consequence of its threatened designation, a 2000–2025 Recovery Plan for this species was developed. This plan builds on the first phase (1985–1997) of Hoiho Recovery efforts (McKinlay 2001, pp. 12–13). This plan lays out future objectives and actions to meet the long-term goal of increasing yellow-eyed penguin populations and achieving active community engagement in their conservation (McKinlay 2001, pp. 1–24). The Recovery Plan outlines proposed measures to address chronic factors historically affecting individual colonies, such as destruction or damage to colonies due to fire, livestock grazing, and other manmade disturbance; predation by introduced predators; disease; and the impact of human disturbance (especially through tourism activities) (McKinlay 2001, pp. 15–22). Another objective of the plan is to provide enduring legal guarantees of protections for breeding habitat through reservation or covenant (McKinlay 2001, p. 12). The best available information does not allow us to evaluate in detail the progress that has been made in meeting the eight objectives of the 2000–2025 recovery plan, but as discussed elsewhere, the population recovery goals of the original earlier plan continue to be hard to reach for all but the Auckland Islands, and the development of anti-predator measures is an ongoing challenge. We are aware, as discussed in analysis of other threat factors, that concerted public and private efforts on these objectives continue. However, in the absence of concrete information on implementation of the plan and reports on its efficacy, we did not rely on future measures proposed in the Hoiho Recovery Plan in our threats analysis.

New Zealand has in place the New Zealand Marine Oil Spill Response Strategy, which provides the overall framework to mount a response to marine oil spills that occur within New Zealand's area of responsibility. The aim of the strategy is to minimize the effects of oil on the environment and human safety and health. The National Oil Spill Contingency Plan promotes a planned and nationally coordinated response to any marine oil spill that is beyond the capability of a local regional council or outside the region of any local council (Maritime New Zealand 2007, p. 1). As discussed below under Factor E, rapid containment of spills in remote areas and effective triage response under this plan have shown these to be effective regulatory mechanisms (New Zealand Wildlife Health Center 2007, p. 2; Taylor 2000, p. 94).

A review of the best available information indicates that there are general, or in some cases specific, protective or regulatory measures to address threats to the yellow-eyed penguin. The best available information indicates that despite the existence of these protective or regulatory measures to address the threats to the yellow-eyed penguin, local marine habitat modification through oyster dredging in some areas (Factor A), disease and predation pressure (Factor C), and gillnet fisheries bycatch (Factor E), continue to act as threats to the yellow-eyed penguin. We therefore find that the existing regulatory mechanisms are currently inadequate to protect the yellow-eyed penguin.

Factor E. Other Natural or Manmade Factors Affecting the Continued Existence of the Species

The Action Plan for Seabird Conservation in New Zealand (Taylor 2000, p. 94) reported that there is no evidence that commercial or recreational fishing is impacting prey availability for the yellow-eyed penguin.

Offshore Fisheries Bycatch

Long-line fisheries were indicated as potentially having an effect on yellow-eyed penguins (BLI 2010b, p 2). Long-line fishing uses a long line with baited hooks attached to hanging fishing lines at various intervals. These lines are sometimes set using an anchor, or they can be left to drift. Thousands of hooks can be attached and the lines can be miles long and can alternatively be dragged along the seafloor or the surface of the ocean. Seabirds, particularly petrels, are especially vulnerable to long-line fishing because they take baited hooks. In certain conditions, birds can get hooked and tangled in the line and drown. This type of fishing impacts a number of New Zealand seabird species; however, the Action Plan for Seabird Conservation indicates it is unlikely that yellow-eyed penguins are caught in long-lines. The National Plan of Action to Reduce the Incidental Catch of Seabirds in New Zealand Fisheries does not identify this as a threat to yellow-eyed penguins (Ministry of Fisheries and New Zealand DOC (MOF and NZDOC) 2004, p. 57)).

Coastal Fishing Bycatch

Otago Peninsula

New Zealand's National Plan of Action to Reduce the Incidental Catch of Seabirds in New Zealand Fisheries, prepared by the MOF and NZDOC (2004, p. 57), indicated that yellow-eyed penguins are being incidentally caught in inshore set fishing nets (also known as gill nets). Gill nets are mesh nets, and they can at times be thousands of meters long. A study of bycatch of yellow-eyed penguins along the southeast coast of South Island of New Zealand during the period 1979–1997 identified gill-net entanglement as a significant threat to the species (Darby and Dawson 2000, p. 327). Fishing nets are used in various ways. They may be set as anchored nets in long rows at or near the bottom of the ocean, or sometimes drift with a fishing vessel. Mortality was highest in areas adjacent to the Otago Peninsula (on the east coast of South Island, below Banks Peninsula) breeding grounds. Approximately 55 of 72 gill-netted penguins were found in this particular area (Darby and Dawson 2000, p. 329) as bycatch. An analysis of 185 carcasses collected between 1975 and 1997 found that 42 (23 percent) showed features consistent with mortality from gill-net entanglement. In that period, a further 30 entanglements were reported to officials (Darby and Dawson 2000, p. 327). While these numbers may appear small for the timeframe under study, the authors consider them to be underestimates of actual bycatch mortality (Darby and Dawson 2000, p. 331) because not all fishermen report bycatch.

Most gill-net entanglements reported by Darby and Dawson (2000, p. 331) are from a small geographic area at or near the Otago Peninsula, near the small concentrations of yellow-eyed penguins.

In 1996, for example, there were approximately 350 breeding pairs of yellow-eyed penguin on the Otago Peninsula. Given these small numbers, the authors report that gill-net bycatch may be severe at a local scale. One small colony inside the entrance to Otago harbor suffered seven bycatch mortalities and was subsequently abandoned. The death of 32 birds along the north Otago coast over the period of the study is significant in light of the reported breeding population of only 39 pairs in this region, and, at Banks Peninsula, 7 reported mortalities occurred where there were only 8–10 breeding pairs (Darby and Dawson 2000, p. 331). Given the small sizes of local yellow-eyed penguin concentrations, this mortality rate is significant to the maintenance of breeding colonies and the survival of adults in the population.

Banks Peninsula

In response to bycatch of various species, set net bans have been implemented in the vicinity of the Banks Peninsula on the east coast of South Island, which has been designated as a marine reserve. A 4–month set net ban was primarily designed to reduce entanglements of Hector's dolphin (*Cephalorhynchus hectori*), as well as yellow-eyed penguins and white-flippered penguins (NZ DOC 2007, p. 1). Early reports were that this ban had been widely disregarded (Taylor 2000, p. 70). Based on the best available information, we are unable to conclude that these measures at the Banks Peninsula had been effective in reducing bycatch of yellow-eyed penguins. The Hoiho Recovery Plan states that bycatch is likely the largest source of mortality at sea; the Plan outlines the need for research and liaison with fisheries managers to inform implementation of further measures to reduce the impact of fishing operations on yellow-eyed penguins (McKinlay 2001, p. 19). We do not have information on whether these proposed measures have been implemented. Therefore, for purposes of this analysis, we did not rely on these proposed measures to evaluate incidental take from gill-net entanglement.

Based on the significant gill-net bycatch mortality of yellow-eyed penguins along the southeast coast of the South Island of New Zealand, which has the potential to impact over a quarter of the population, we find that fisheries bycatch is a threat to the yellow-eyed penguin. In spite of efforts to regulate this activity, bycatch in coastal gill net fisheries is a threat to yellow-eyed penguins foraging from mainland breeding areas; therefore, we expect this threat to continue into the foreseeable future.

Under Factor A, we concluded that habitat modification by commercial oyster dredging is a threat to local yellow-eyed penguin colonies at Stewart Island, but we have not found evidence of direct competition for prey between yellow-eyed penguins and human fisheries activities. While following penguins from mainland colonies fitted with Global Positioning System (GPS) dive loggers, Mattern *et al.* (2005, p. 270) noted that foraging tracks of adult penguins were remarkably straight. They hypothesized that individuals were following dredge marks from bottom trawls, but there is no information to indicate that fishery interaction has any impact on the penguins. Therefore, we find that commercial or recreational fishing is not a threat to this species. However, local marine habitat modification through oyster dredging (commercial oyster dredging is a threat to chick survival for some colonies at Stewart Island), and fisheries bycatch from coastal or inshore set net or gillnet fishing, continue to act as threats to the yellow-eyed penguin in some areas of their range.

Oil and chemical spills

We examined the possibility that oil and chemical spills may impact yellow-eyed penguins. Such spills, should they occur and not be effectively managed, can have direct effects on marine seabirds such as the yellow-eyed penguin. In the range of the yellow-eyed penguin, the sub-Antarctic Campbell and Auckland Islands are remote from shipping activity and the consequent risk of oil or chemical spills is low. The Stewart Islands populations at the southern end of New Zealand and the southeast mainland coast populations are in closer proximity to vessel traffic and human industrial activities which may increase the possibility of oil or chemical spill impacts. Much of the range of the yellow-eyed penguin on mainland New Zealand lies near Dunedin, a South Island port city, and a few individuals breed at Banks Peninsula just to the south of Christchurch, another major South Island port. While yellow-eyed penguins do not breed in large colonies, their locally distributed breeding groups are found in a few critical areas on the coast of the South Island and its offshore islands. A spill event near the mainland South Island city of Dunedin and the adjacent Otago Peninsula could have a major impact on the 14 breeding sites documented there. Nonbreeding season distribution along the same coastlines provides the potential for significant numbers of birds to encounter spills at that time as well. Two spills have been recorded in this overall region. In March 2000, the fishing vessel *Seafresh 1*sank in Hanson Bay on the east coast of Chatham Island and released 66 U.S. tons (T) (60 tonnes (t)) of diesel fuel. Rapid containment of the oil at this remote location prevented any wildlife casualties (New Zealand Wildlife Health Center 2007, p. 2). The same source reported that in 1998 the fishing vessel *Don Wong 529*ran aground at Breaksea Islets off Stewart Island. Approximately 331 T (300 t) of marine diesel were spilled along with smaller amounts of lubricating and waste oils.

With favorable weather conditions and establishment of triage response, no casualties of the *Don Wong 529*pollution event were discovered (Taylor 2000, p. 94). There is no doubt that an oil spill near a breeding colony could have a major effect on this species (Taylor 2000, p. 94). However, based on the wide distribution of yellow-eyed penguins around the mainland South Island, offshore, and on sub-Antarctic islands, the low number of previous incidents around New Zealand, and the fact that each was effectively contained under the New Zealand Marine Oil Spill Response Strategy and resulted in no mortality or evidence of impacts on the population, we find that oil and chemical spills are not threats to the yellow-eyed penguin.

Yellow-eyed Penguin Finding

Yellow-eyed penguin populations number approximately 1,600 breeding pairs. After severe declines from the 1940s, mainland yellow-eyed penguin populations have fluctuated at low numbers since the late 1980s. The total mainland population (on the east coast of South Island) of 450 breeding pairs (Houston 2007, p. 3) is well below single-year levels recorded in 1985 and 1997 (600 to 650 pairs) and well below historical estimates of abundance (Darby and Seddon 1990, p. 59). At Stewart Island and its adjacent islands, there are an estimated 180 breeding pairs. There are an estimated 400 pairs at Campbell Island where numbers have declined since 1997, and 570 pairs at the Auckland Islands.

Some of the documented factors affecting yellow-eyed penguin populations are tourism and predation. Predation occurs by introduced (and to a lesser extent native) predators within the species' breeding range. The impact of predators is inferred from the decline of this species during the period of introduced predator invasion and from documentation of continuing predator

presence and predation. New Zealand laws including the bylaws of New Zealand's national parks, which encompass some of the range of the yellow-eyed penguin, provide some protection for this species. New Zealand also has programs for eradication of nonnative invasive species, which includes nonnative predators. However, while complete eradication of predators in isolated island habitats may be possible, permanent removal of the introduced mammalian predators on the mainland has not been achieved, and the ongoing threat of predation remains. Both intensive trapping and physical protection of significant breeding groups through fencing have proven successful for yellow-eyed penguins at local scales in terms of reducing predation, but existing efforts require ongoing commitment, and not all breeding areas have been protected. More recently, local-scale predation by New Zealand sea lions reestablishing a breeding presence at the mainland Otago Peninsula has become a threat to yellow-eyed penguin populations as this rare and endemic Otariid species recovers. This threat has also been documented for Campbell Island. We conclude that predation is still a significant threat to yellow-eyed penguins.

Disease is an ongoing factor negatively influencing yellow-eyed penguin populations. Disease has seriously impacted both mainland and Stewart Island colonies of yellow-eyed penguins in the last two decades. In mainland populations, avian malaria is thought to have led to mortality of 31 percent of the adult population on the mainland of New Zealand in the early 1990s, and an outbreak of *Cornybacterium* infection caused high chick mortality in 2004–2005 and contributed to disease mortality at Stewart Island. Entire cohorts of penguin chicks at one breeding location at Stewart Island have been lost to the pathogen *Leucocytozoon*, especially at times when other diseases and other stress factors, such as food shortages, were present. Given the ongoing history of disease outbreaks at both the island and mainland locations, it is highly likely that new or renewed disease outbreaks will impact this species in the foreseeable future with possible large-scale mortality of adults and chicks and consequent breeding failures and population reductions. Emergence or recurrence of such outbreaks on the mainland, where there are currently 450 breeding pairs, or at island breeding areas could result in severe reductions for a species which totals only 1,600 breeding pairs rangewide.

The yellow-eyed penguin is also impacted by ongoing activities in the marine environment. Local marine habitat modification of the sea floor through oyster dredging has been implicated in food shortages at penguin colonies at Stewart Island, which combined with disease, has led to years of 100 percent mortality of chicks at local breeding sites there. Bycatch in coastal gillnet fisheries is a threat to yellow-eyed penguins foraging around mainland breeding areas despite efforts to regulate this activity. In this case, regulatory mechanisms are currently inadequate and we do not have any information that would lead us to anticipate that this would change in the foreseeable future.

We considered whether pollution from oil or chemicals is a threat to the yellow-eyed penguin. Documented oil spill events have occurred within the range of this species in the last decade, but there have been no documented direct or indirect impacts on this species. Such events are rare and New Zealand oil spill response and contingency plans have been shown to be in place and effective in previous events; therefore, we do not find this to be a threat to the yellow-eyed penguin.

In considering the foreseeable future as it relates to the status of the yellow-eyed penguin, we considered the threats acting on the yellow-eyed penguin, as well as population trends. We considered the historical data to identify any relevant existing trends that might allow for reliable prediction of the future (in the form of extrapolating the trends). The available data indicate that historical declines, which were the result of habitat loss and predation, continue in the face of the current threats of predation from introduced predators, disease, gillnet fisheries bycatch, and the inadequacy of regulatory mechanisms throughout the species' range. Based on our analysis of the best available information, we have no reason to believe that population trends will change in the future, or that the effects of current threats acting on the species will be ameliorated in the foreseeable future.

The yellow-eyed penguin has experienced consistent widespread declines in the past, and declines and low population numbers persist. This species has a relatively high reproductive rate (compared to other penguins) and substantial longevity. Despite these life history traits, which should provide the species with the ability to rebound, and despite public and private efforts undertaken in New Zealand to address the threats to its survival, the species has not recovered. Historical declines resulting from habitat loss and predation are exacerbated by the impacts of predators, disease, and the inadequacy of regulatory mechanisms throughout the species' range. The threat of predation by endemic sea lions is impacting populations on the mainland and at the Campbell Islands. New or recurrent disease outbreaks are likely to cause further declines throughout the range in the foreseeable future. Just offshore of the southern tip of the South Island, local breeding groups at Stewart Island have been impacted by disease in concert with food shortages brought on by alteration of their marine habitat. At the Auckland Islands, the population has remained stable but exists at low numbers and, like all yellow-eyed penguin populations, is susceptible to the emergence of disease and impacts of predation. Increased tourism is taxing the species based on the penguins' increased energy usage due to human presence. Because of the species' low population size (estimated to be approximately 1,600 breeding pairs); its continued decline in three out of four areas, the threats of predation by primarily introduced species, disease, fisheries bycatch, tourism, and the inadequacy of regulatory mechanisms, we find that the yellow-eyed penguin is likely to become in danger of extinction within the foreseeable future throughout all of its range.

Significant Portion of the Range Analysis

To determine whether any portion of the range of the yellow-eyed penguin warrants further consideration as endangered, we evaluated the geographic concentration of threats and the significance of portions of the range to the conservation of the species. Our evaluation was in the context of whether any potential threats are concentrated in one or more areas of the projected range, such that if there were concentrated impacts, those populations might be threatened, and whether any such population or complex might constitute a significant portion of the range. The word "range" is used here to refer to the range in which the species currently exists, and the word "significant" refers to the value of that portion of the range being considered to the conservation of the species. We also considered factors used to determine biological significance of a population, including: the quality, quantity, and distribution of habitat relative to the biological requirements of the species; the historical value of the habitat to the

species; the frequency of use of the habitat; the uniqueness or importance of the habitat for other reasons such as breeding, feeding, or suitability for population expansion; and its genetic diversity (the loss of genetically based diversity may substantially reduce the ability of the species to respond and adapt to future environmental changes). We do not find that any one population is more biologically significant than the other three; however, we did find that the occurrence of certain threats is uneven across the range of the yellow-eyed penguin. On this basis, we determined that some portions of the yellow-eyed penguin's range might warrant further consideration as possibly endangered significant portions of its range.

The yellow-eyed penguin's range can be divided into four areas. The first area consists of the mainland colonies distributed along the southeast coast of the South Island of New Zealand. This mainland area is separated from the three island groups to the south. Just to the south is the Stewart-Codfish Islands group, which lies 18.75 mi (30 km) below the mainland South Island across the Fouveaux Strait. Stewart Island is a large island of 1,091 square mi (mi^2) (1,746 square km (km^2)), and Codfish Island is a small island of 8.75 mi^2 (14 km^2) located 6.25 mi (10 km) west of Stewart Island. The third and fourth areas of yellow-eyed penguin habitat are the sub-Antarctic Auckland Islands and Campbell Island, which lie 300 mi (480 km) and 380 mi (608 km), respectively, south of the southern tip of the South Island. These four groups are clearly isolated from each other and from other portions of the yellow-eyed penguin's range.

We evaluated these four areas of the entire range of the yellow-eyed penguin to determine which areas may warrant further consideration. Under the five-factor analysis, we determined that predation, disease, and inadequacy of regulatory mechanisms are threats to the yellow-eyed penguin throughout all of its range. In addition, we determined that fisheries bycatch and marine habitat modification from oyster dredging are threats to the species in only some portions of its range.

For the first two areas, two unique threats were identified. Fisheries bycatch was identified as a unique threat for the mainland South Island population; and marine habitat modification due to oyster dredging was identified as a unique threat for the Stewart-Codfish Island population. Therefore, we determined that yellow-eyed penguins on the mainland and on the Stewart-Codfish Islands may face a greater level of threat than populations at the Auckland and Campbell Islands. In addition, the mainland population of 450 pairs represents more than a quarter of the overall reported population of 1,600 pairs, indicating that this may be a significant portion of the range. Having met these two initial tests, we analyzed whether this portion of the range is both significant and endangered. There have been large fluctuations in the mainland population of yellow-eyed penguins since at least 1980, with cyclical periods of population decline, followed by some recovery. As described in our threat factor analysis, these larger fluctuations have been tied to changes in the marine environment and the quality of food, as well as to periodic outbreaks of disease. The species is described as inherently robust, but recovery from these fluctuations is hampered by chronic predation threats as well as by the ongoing impact of fisheries bycatch. The combination of these cyclical and chronic factors has kept the mainland population fluctuating within the range of a few hundred to about 600 pairs over the last three decades. We have no evidence that the single factor of fisheries bycatch is driving the species toward extinction. Because the current population trend for the mainland populations is one of decline and fluctuation around low numbers, rather than precipitous decline, and because reproduction and recruitment are still occurring, we have determined the population is not currently in danger of extinction, but is likely to become so within the foreseeable future.

The Stewart-Codfish Islands population represents only 11 percent of the overall population of yellow-eyed penguins and its habitat is small in terms of geographical area. It is only 18.75 mi (30 km) away from the mainland of New Zealand, where the majority of this species resides. Marine habitat modification due to oyster dredging was identified as a unique threat for the Stewart-Codfish Island population. However, due to the proximity of this small population to the more numerous mainland population portion of the range, and because the population is adjacent to colonies at the southern tip of the South Island, we do not find that this portion of the range is significant relative to the conservation of this species. Therefore, we have determined the population is not currently in danger of extinction but is likely to become so within the foreseeable future.

With respect to the Auckland Islands and Campbell Islands populations, there were no additional threats found to be acting on these populations nor did we determine that either of these populations have any unique biological significance to the species as a whole. Therefore, we have determined that the Auckland Islands and Campbell Islands portions of the species population is not currently in danger of extinction, but is likely to become so within the foreseeable future.

In conclusion, we did not find that any one portion of the species' population contributes more substantially than others to the representation, resiliency, or redundancy of the species. At this time, although the different populations face different threats, there is no evidence to suggest that threats affect portions of the range disproportionately, or will in the foreseeable future. Therefore, we are listing the yellow-eyed penguin as threatened throughout all of its range under the Act.

White-flippered Penguin *(Eudyptula minor albosignata)*

Background

Among those researchers who have considered the phylogeny of the *Eudyptula* penguins (little penguins) in detail, Banks *et al.* (2002, p. 35), supported by Peucker *et al.* (2007, p. 126), make a strong case that the white-flippered penguin is part of one of two distinct lineages, or clades, of *Eudyptula* species (the Australian-Otago clade and the New Zealand clade, which includes the white-flippered penguin), each descended from one common ancestor.

Limited evidence for subspeciation within the New Zealand clade is found in some genetic differences, but the taxonomic status of the white-flippered penguin remains somewhat unclear (Peucker *et al.* 2007, p. 126). The New Zealand DOC considers the white-flippered penguin, with its distinct life history and morphological traits, as the southern end of a clinal variation of the little penguin (Houston 2007, p. 3). Consistent with the findings of Banks *et al.* (2002, p. 35), the New Zealand DOC recognizes the white-flippered penguin as an endemic sub-species in its Action Plan for Seabird Conservation in New Zealand (Taylor 2000, p. 69). We recognize the findings of Banks *et al.* (2002, p. 35), and the determination of the New Zealand Department of Conservation, and consider the white-flippered penguin (*Eudyptula minor albosignata*) as one of six recognized subspecies of the little penguin (*Eudyptula minor*). We accept the white-flippered penguin as a subspecies, *Eudyptula minor albosignata*, which follows the

Integrated Taxonomic Information System (ITIS 2010).

The overall population of little penguins, which are found around Australia and New Zealand, numbers 350,000 to 600,000 birds. The total breeding population of the white-flippered subspecies, which is only found in New Zealand, is about 10,460 birds (Challies and Burleigh 2004, p. 1).

It is estimated that the Peninsula-wide population was tens of thousands of pairs at the time of European settlement. White-flippered penguins were "very common" on the Banks Peninsula in the late 1800s (Challies and Burleigh 2004, p. 4). Distribution of colonies was more widespread on the shores of the Banks Peninsula during the 1950s, with penguins nesting from the seaward headlands around to the inshore heads of bays.

At Motunau Island there are an estimated 1,650 breeding pairs or about 4,590 birds (Ellis *et al.* 1998, p. 87). This population is reported to have increased slightly since the 1960s (Taylor 2000, p. 69). On Banks Peninsula, exhaustive counts of all colonies in 2000–2001 and 2001–2002 found 68 colonies with a total of 2,112 nests or about 5,870 birds (Challies and Burleigh 2004, p. 5). This detailed survey increased the previously reported minimum estimates of 550 pairs published in 1998 (Ellis *et al.* 1998, p. 87), which were derived from partial surveys of only easily accessible colonies (Challies and Burleigh 2004, p. 1). While baseline information is lacking, Challies and Burleigh (2004, p. 5) have estimated that the present population is less than 10 percent of the population that was occupied on the Peninsula prior to European settlement. Detailed monitoring of four individual colonies indicated that severe declines continue, with an overall loss of 83 percent of 489 nests monitored over the period from 1981–2000 (Challies and Burleigh 2004, p. 4).

The white-flippered penguin breeds on Motunau Island and the Banks Peninsula of the South Island of New Zealand. Birds disperse locally around the eastern South Island. Breeding adults appear to remain close to nesting colonies in the nonbreeding season (Taylor 2000, p. 69; Challies and Burleigh 2004, p. 5; Brager and Stanley 1999, p. 370). White-flippered penguins feed on small shoaling fish such as pilchards (*Sardinops neopilchardus*) and anchovies (*Engraulis australis*) (Brager and Stanley 1999, p. 370).

The little penguin is classified as a species of "Least Concern" in the IUCN Red List (BirdLife International 2007, p. 1); there is no separate status for the white-flippered subspecies. On New Zealand's Threat Classification system list, the white-flippered subspecies is listed as "acutely threatened—nationally vulnerable," indicating small to moderate population and moderate recent or predicted decline (Hitchmough *et al.* 2007, p. 45; Molloy *et al.* 2002, p. 20). This species was addressed in the Action Plan for Seabird Conservation in New Zealand, and it was ranked as Category B (second priority) on the Molloy and Davis threat categories employed by the New Zealand DOC (Taylor 2000, p. 33).

Summary of Factors Affecting the White-flippered Penguin

Factor A. The Present or Threatened Destruction, Modification, or Curtailment of White-flippered Penguin's Habitat or Range

The terrestrial breeding habitat of the white-flippered penguin comprises the shores of the Banks Peninsula south of Christchurch, New Zealand, and of Motunau Island about 62 mi (100 km) north. Banks Peninsula has a convoluted coastline of approximately 186 mi (300 km), made up of outer coast and deep embayments (Challies and Burleigh 2004, p. 1). Motunau is a small island of less than 0.3 mi (0.5 km) in length. While cattle or sheep sometimes trample nests at Banks Peninsula, white-flippered penguin nest sites are usually in rocky areas or among tree roots where they are inaccessible to such damage (Taylor 2000, p. 69). Fire has also been identified as a factor that could threaten white-flippered penguin habitat, but we are not aware of documented fire incidents (Taylor 2000, p. 69).

On the basis of this information, we find that the present or threatened destruction, modification, or curtailment of its habitat or range is not a threat to the white-flippered penguin.

Factor B. Overutilization for Commercial, Recreational, Scientific, or Educational Purposes

White-flippered penguins are the object of privately managed local tourism activities at the Banks Peninsula (Taylor 2000, p. 70). Neither the New Zealand Action Plan for Seabird Conservation nor the IUCN Conservation Assessment and Management Plan provides any evidence that tourism is a factor affecting white-flippered penguin populations (Taylor 2000, p. 69; Ellis *et al.* 1998, p. 87). There is no evidence of use of the species for other commercial, recreational, scientific or educational purposes.

On the basis of this information, we find that overutilization for commercial, recreational, scientific, or educational purposes is not a threat to the white-flippered penguin.

Factor C. Disease or Predation

There is no evidence of disease as a threat to the white-flippered penguin.

The most significant factor impacting white-flippered penguins is predation at Banks Peninsula by introduced mammalian predators. Populations are reported to have declined drastically since 1980 due to predation (Williamson and Wilson 2001, pp. 434–435). Challies and Burleigh reported that predation on white-flippered penguins is mainly by ferrets, feral cats, and possibly stoats (2004, p. 1). We know that introduced predators such as these as well as rats prey on penguins. They have been known to take chicks, eggs, and adults. On one occasion, 50 dead penguins were found with mustelid bite marks on their necks (Challies 2009, pers. comm.). Dogs have also been cited as a potential predator (Taylor 2000, p. 69). In the past 25 years, predators have overrun colonies at the accessible heads and sides of bays at Banks Peninsula, reducing colony distribution to less accessible and more remote headlands and outer coasts (Challies and Burleigh 2004, p. 4). Thirty-four colonies (50 percent) surveyed in 2000 to 2002, containing 1,345 nests (69 percent of the nests at Banks Peninsula), were considered to be vulnerable to predation. Seven of the 12 largest colonies (each containing more than 20 nests) contained either the remains of penguins that had been preyed on or other evidence predators had been there (Challies and Burleigh 2004, p. 4). The five large colonies not considered vulnerable to predation were either protected by bluffs or, in one case, located on an island.

The encroachment of predators destroyed the most accessible colonies first, in a progression from preferred habitat at the heads of bays towards the coast along a gradient of increasing coastal erosion. In the 1950s, penguins were still nesting around the heads of bays. These colonies disappeared soon thereafter (Challies and Burleigh 2004, p. 4). Of four colonies of greater than 50 nests on the sides of bays, one was destroyed between 1981 and 2000, and nest numbers in the other three colonies were reduced by 72 to 77 percent. In these four colonies, the total number of nests decreased 83 percent between 1981 and 2000, from 489 nests down to 85 nests. The surviving colonies are almost all inside the bays close to the headlands or on the peripheral coast (Challies and Burleigh 2004, p. 4), with white-flippered penguins breeding

primarily on rocky sites backed by bluffs. Challies and Burleigh (2004, p. 4) concluded, given the subspecies' historical habitat and the difficulties of landing at these exposed breeding sites, that predation has forced white-flippered penguins into marginal, non-preferred habitat.

At the present time, colonies are largest either on inshore predator-free islands or in places on the mainland where predators are being controlled or which are less accessible to predators. The historic decline in penguin numbers is clearly continuing based on the current evidence of predation in existing recently surveyed colonies and we expect this to continue into the foreseeable future (Challies and Burleigh 2004, p. 5). In addition to documenting direct overland access to colonies by predators, Challies and Burleigh (2004, p. 5) documented predation at colonies thought not to be accessible over land. For example, there is evidence that stoats, which are good swimmers, are reaching colonies at otherwise inaccessible parts of the shoreline, indicating that the spread of predation continues.

The potential for dispersal and establishment of new colonies, which might allow for expansion of white-flippered penguin numbers, is also severely limited by predation. Fifty percent or more of adults attempt to nest away from their natal colony. Historically, such movements led to interchange between colonies and maintenance of colony size even as dispersal took place. With the presence of predators, this dispersal now leads breeding birds to settle in areas accessible to predators where the penguins are eventually killed (Challies and Burleigh 2004, p. 5). One consequence of this pattern of dispersal and predation is that colonies suffer a net loss of breeding adults.

Predator trapping started in 1981 on Godley Head near Christchurch and is carried out by a network of volunteers and private landowners around the Banks Peninsula. Some small, predator-proof fences were erected to protect vulnerable colonies (Taylor 2000, p. 70; Williamson and Wilson 2001, p. 435). It is not clear how widespread such efforts are over the large geographical area of the Banks Peninsula or how successful they are. Williamson and Wilson (2001, p. 435) reported on two predator trapping programs that occurred in 1988 and 1991 at two relic colonies at the heads of Flea and Stony Bays. Predator trapping programs continue today (Challies 2009, pers. comm.). Preliminary results indicated white-flippered penguins numbers were stable at Flea Bay, but Stony Bay populations of white-flippered penguins were in decline. Even though such trapping efforts began in 1981, Challies and Burleigh (2004, p. 5) concluded on the basis of data collected in the 2000–2001 and 2001–2002 breeding seasons that the historic decline in white-flippered penguin numbers was continuing. However, although the numbers are still less than 10 percent of what existed at the time of European settlement, since 2000, most of the penguin colonies have grown by approximately 50 percent (Challies 2009, pers. comm.).

At Motunau Island, the only other breeding area for this subspecies, there are no introduced predators. Rabbits, which could have impacted breeding habitat, were eradicated in 1963 (Taylor 2000, p. 70). The Action Plan for Seabird Conservation in New Zealand lists pest quarantine measures to prevent new animal and plant pest species reaching Motunau Island as a needed future management action (Taylor 2000, p. 70), but we have no reports on whether such measures are now in place, and we cannot discount the current or future risk of predator introduction to Motunau Island.

Predators are present at the larger Banks Peninsula colony (56 percent of the nests for the subspecies), but not currently at the smaller colony at Motunau Island (46 percent of the nests), although the risk of future predator introduction to Motunau Island exists. On the basis of information on the impact of predators, the failure of existing programs to eliminate them, and the possibility of dispersal of predators to current predator-free areas such as Motunau Island, we conclude that predation by introduced mammals is a threat to the white-flippered penguin.

Factor D. Inadequacy of Existing Regulatory Mechanisms

The white-flippered penguin is protected under New Zealand's Wildlife Act of 1953, which gives absolute protection to wildlife throughout New Zealand and its surrounding marine economic zone. No one may kill or have in their possession any living or dead protected wildlife unless they have appropriate authority.

In 1998, the IUCN Conservation Assessment and Management Plan (CAMP) data sheet for white-flippered penguin (Ellis *et al.* 1998, p. 87) concluded that the deteriorating status of this subspecies was not a high priority for the New Zealand DOC due to budgetary constraints. The CAMP noted that activities to date had not been government funded, but self funded by investigators or by grants from non-governmental organizations. Since then, the New Zealand DOC has adopted the Action Plan for Seabird Conservation, which includes recommendations on management of terrestrial threats to the white-flippered penguin as well as threats within the marine environment. We did not rely on these measures in our analysis because we do not have reports on which measures, if any, have been implemented and how they relate, in particular, to efforts to reduce the threat of predation on white-flippered penguins at Banks Peninsula.

The Banks Peninsula marine waters have special protective status as a marine sanctuary, which was established in 1988 and primarily directed at protection of the Hector's dolphin (*Cephelorhynchus hectori*) from bycatch in set nets. The 4–month set net ban, from November to the end of February, which also includes Motunau Island, is designed to reduce entanglements of these dolphins and to reduce the risk of entanglement of white-flippered penguins and yellow-eyed penguins (NZ DOC 2007, p. 1). Ten years ago, in the Action Plan for Seabird Conservation, this ban was reported to have been widely disregarded (Taylor 2000, p. 70). That Action Plan states that restriction on the use of set nets near key white-flippered penguin colonies may be necessary to protect the subspecies and recommends an advocacy program to encourage set net users to adopt practices that will minimize seabird bycatch. We have information indicating that white-flippered penguins are frequently caught in set nets, and no current information to indicate whether, or to what extent, set net restrictions have reduced take at either Banks Peninsula or Motunau Island.

New Zealand has in place The New Zealand Marine Oil Spill Response Strategy, which provides the overall framework to mount a response to marine oil spills that occur within New Zealand's area of responsibility. The aim of the strategy is to minimize the effects of oil on the environment and on human safety and health. The National Oil Spill Contingency Plan promotes a planned and nationally coordinated response to any marine oil spill that is beyond the capability of a local regional council or outside the region of any local council (Maritime New Zealand 2007, p. 1). As discussed below under Factor E, rapid containment of spills in remote areas and effective triage response under this plan have shown these to be effective regulatory mechanisms (New Zealand Wildlife

Health Center 2007, p. 2; Taylor 2000, p. 94). However, because the two major concentrations of white-flippered penguins are near a major South Island port, we conclude under Factor E that oil spills are a threat to this subspecies.

Given that existing programs have failed to eliminate introduced predators and that these predators appear to be spreading, we believe their impact on the white-flippered penguin will continue in the future. There is no information to suggest that the current effects of bycatch will be reduced in the foreseeable future, nor that regulatory mechanisms will become sufficient to address or ameliorate this threat to the subspecies. Based on the occurrence of previous oil spills around New Zealand and the location of the only two breeding populations of white-flippered penguins adjacent to Christchurch, a major South Island port, we find that oil spills will likely occur in the future. Furthermore, because of the low overall numbers of white-flippered penguins, there is a high likelihood that oil spill events, should they occur in this area, will impact white-flippered penguins. On the basis of a review of available information and on the basis of the continued threats of predation, fisheries bycatch (including the use of set nets), and oil spills to this subspecies, we find that inadequacy of existing regulatory mechanisms is a threat to the white-flippered penguin.

Factor E. Other Natural or Manmade Factors Affecting the Continued Existence of the Species

In 2000, Taylor reported that New Zealand's Action Plan notes that white-flippered penguins were frequently caught in nearshore set nets, especially around Motunau Island (p. 69). The number of birds currently caught is not known, but there is a history of "multiple net catches" of penguins around Motunau Island (Ellis *et al*, 1998, p. 87). Restrictions on the use of set nets in the areas of Banks Peninsula and Motunau Island were instituted in 1988 (see discussion under Factor D above), but bans on leaving nets set inshore overnight were reported to be widely disregarded a decade ago (Ellis *et al*. 1998, p. 87). Such impacts interact with the more severe threat of predation at Banks Island, exacerbating declines there. Reports indicate bycatch impacts are most severe at Motunau Island, which is currently predator-free. Although enforcement of all fisheries regulations has increased within the past few years (Challies 2009, pers. comm.), based on the best available information we do not have a basis to conclude that rates of bycatch have in fact declined or will decline in the foreseeable future. We have found no documented information to indicate that net restrictions have reduced take. Therefore, we find that bycatch of the white-flippered penguin by fishing activities is a threat to this subspecies of penguin.

We have examined the possibility that oil and chemical spills may impact white-flippered penguins. Such spills, should they occur and not be effectively managed, can have direct effects on marine seabirds such as the white-flippered penguin. The entire subspecies nests in areas of moderate shipping volume coming to Port Lyttelton at Christchurch, New Zealand. This port lies adjacent to, and just north of, the Banks Peninsula and just south of Motunau Island. On this basis, the Action Plan for Seabird Conservation in New Zealand specifically identifies a large oil spill as a key potential threat to this species (Taylor 2000, pp. 69–70) and recommends that penguin colonies be identified as sensitive areas in oil spill contingency plans (Taylor 2000, pp. 70–71).

Two spills have been recorded in the overall region of the South Island of New Zealand and its offshore islands. These spills did not impact the white-flippered penguin. In March 2000, the fishing vessel *Seafresh 1*sank in Hanson Bay on the east coast of Chatham Island and released 66 T (60 t) of diesel fuel. Rapid containment of the oil at this remote location prevented any wildlife casualties (New Zealand Wildlife Health Center 2007, p. 2). The same source reported that, in 1998, the fishing vessel *Don Wong 529*ran aground at Breaksea Islets, off Stewart Island. Approximately 331 T (300 t) of marine diesel was spilled along with smaller amounts of lubricating and waste oils. With favorable weather conditions and establishment of triage response, no casualties from this oil spill event were discovered (Taylor 2000, p. 94).

While New Zealand has a good record of oil spill response, an oil spill in the vicinity of one of the two breeding colonies of the white-flippered penguin, which lie closely adjacent to the industrial port of Port Lyttelton, could impact a large portion of the individuals of this subspecies if not immediately contained. Previous spills have been in more remote locations, with more leeway for longer term response before oil impacted wildlife. Based on the occurrence of previous spills around New Zealand, the low overall numbers of white-flippered penguins, and the location of their only two breeding populations adjacent to Christchurch, a major South Island port, there is a high likelihood that oil spill events, should they occur in this area, will impact white-flippered penguins. Therefore, we find that oil spills are a threat to the white-flippered penguin.

Based on the analysis above, we find that both fisheries bycatch and the potential for oil spills are threats to the white-flippered penguin now and in the foreseeable future.

White-flippered Penguin Finding

Predation by introduced mammalian predators is the most significant factor threatening white-flippered penguin within the subspecies' breeding range. Predation by introduced species has contributed to the historical decline of this subspecies since the late 1800s and is reducing numbers at the current time. In addition to reducing numbers in existing colonies, the presence of predators has been documented as a barrier to the dispersal of breeding birds and the establishment of new colonies, perhaps indicating larger declines are to be expected. New Zealand laws require protection of this native subspecies. Anti-predator efforts have not stopped declines of white-flippered penguins at Banks Peninsula, although eradication of predators has been achieved at Motunau Island. Removal of introduced mammalian predators on the mainland Banks Peninsula is an extremely difficult, if not impossible, task. Trapping and physical protection of a few local breeding groups through fencing have proven locally successful, but these efforts are not widespread. The Banks Peninsula, with 186 mi (300 km) of coastline and approximately 70 white-flippered penguin colonies, is a very large area to control, and predation impacts will continue. The threat of reinvasion remains, both at Motunau Island and in areas of the Banks Peninsula where predator control has been implemented (Taylor 2000, p. 70; Challies and Burleigh 2004, p. 5). Therefore, we find that predation is a threat to the white-flippered penguin.

The white-flippered penguin is also impacted by threats in the marine environment. While set-net bans have been in place since the 1980s to reduce take of white-flippered penguins and other species, bycatch in coastal gill-net fisheries is known to result in mortality to white-flippered penguins foraging from breeding areas. Although we do not have quantitative data on the extent of bycatch, the best available information indicates that take by set nets is exacerbating the more severe threat of predation at Banks Island, while such impacts are the primary threat at Motunau Island. Based on the best available scientific and commercial

information, we conclude that bycatch is a threat to the white-flippered penguin.

Documented oil spills have occurred in the vicinity of the South Island of New Zealand in the last decade. While such events are rare, future events have the potential to impact white-flippered penguins. If a spill event were to occur near the city of Christchurch and the adjacent Banks Peninsula, and not be immediately contained, it would be very likely to impact either, or both, of the two breeding sites of the white-flippered penguin in a very short time, affecting up to 65 percent of the population at one time. While New Zealand oil spill response and contingency plans have been shown to be effective in previous events, the location of the only two breeding areas of this subspecies near industrial areas and marine transport routes increase the likelihood that spill events will impact the white-flippered penguin.

Major reductions in the numbers of nests in individual colonies and the loss of colonies indicate the population of white-flippered penguin at Banks Peninsula is declining as the threat of predation impacts this subspecies. The subspecies has a low population size (10,460 individuals), with breeding populations concentrated solely in two highly localized breeding areas. Bycatch from fisheries activities is an ongoing threat to members of this subspecies breeding at both Motunau Island and the Banks Peninsula. For both breeding areas, which are close to an industrial port and shipping lanes, oil spills are a threat to the white-flippered penguin in the foreseeable future.

In considering the foreseeable future as it relates to the status of the white-flippered penguin, we considered the threats acting on the subspecies, as well as population trends. We considered the historical data to identify any relevant existing trends that might allow for reliable prediction of the future (in the form of extrapolating the trends).

The available data indicate that the historic decline in penguin numbers is clearly continuing based on the current evidence of predation by introduced species in existing recently surveyed colonies at Banks Island. Based on our analysis of the best available information, we have no reason to believe that population trends will change in the future, nor that the effects of current threats acting on this subspecies will be ameliorated in the foreseeable future. Therefore, we find that the white-flippered penguin is likely to become in danger of extinction within the foreseeable future throughout all of its range.

Significant Portion of the Range Analysis

Having determined that the white-flippered penguin is likely to become in danger of extinction within the foreseeable future throughout all of its range, we also considered whether there are any significant portions of its range where the subspecies is currently in danger of extinction.

White-flippered penguins breed in two areas; one area is on the shores of the Banks Peninsula south of Christchurch on the mainland of New Zealand, and the other area is Motunau Island about 62 mi (100 km) north. Colonization of any possible intermediate breeding range appears to be precluded by predation (Challies and Burleigh 2004, p. 5). The Banks Peninsula colony is larger, consisting of about 2,110 breeding pairs; Motunau Island has about 1,635 breeding pairs. During our analysis, we did not find that there were any significant differences in the quality, quantity, or distribution of habitat relative to the biological requirements of the species. Nor did we find that there was uniqueness of either habitat for reasons such as breeding, feeding, or suitability for population expansion. No genetic differences were found between the populations such that one or the other was found to be significant.

Threats in the marine environment, particularly fisheries bycatch, have similar impacts on the two areas. Given the proximity of each colony to the port of Christchurch, we conclude that oil spills are also an equal threat in both areas. Predation by introduced predators is documented at Banks Peninsula, and introduction of predators is a potential future threat at Motunau Island, where population numbers are stable. Because predation is a current threat in the Banks Peninsula portion of the range, we considered whether the Banks Peninsula portion of the range, where population declines are ongoing, may be currently in danger of extinction. Although the threat of introduced predators is greater at the Banks Peninsula, two other factors offset this: a combination of local management protection of some colonies and the existence of inaccessible refugia from predators for some small colonies on the outer coast and offshore rocks and islands. The threat of predation is somewhat greater at the Banks Peninsula relative to Motunau Island, but as discussed in our analysis under Factor D, the best available scientific and commercial data suggest that this threat is not so disproportionately severe as to place the species in danger of extinction at the Banks Peninsula portion of its range at present. As a result, we have determined that there are no significant portions of the range in which the subspecies is currently in danger of extinction. Therefore, we are listing the white-flippered penguin as threatened throughout all of its range under the Act.

Fiordland Crested Penguin *(Eudyptes pachyrhynchus)*

Background

The Fiordland crested penguin, also known by its Maori name, tawaki, is endemic to the South Island of New Zealand and adjacent offshore islands southwards from Bruce Bay. The species also nests on Solander Island (0.3 mi^2 (0.7 km^2), Codfish Island (5 mi^2 (14 km^2)), and islands off Stewart Island at the south end of the South Island (Taylor 2000, p. 58). Major portions of the range are in Fiordland National Park (4,825 mi^2 (12,500 km^2)) and Rakiura National Park (63 mi^2 (163 km^2)) on Stewart Island and on adjacent islands. Historically, there are reports of breeding north to the Cook Straits and perhaps on the southernmost part of the North Island (Ellis *et al.* 1998, p. 69). The Fiordland crested penguin breeds in colonies situated in inaccessible, dense, temperate rainforest along shores and rocky coastlines, and sometimes in sandy bays. It feeds on fish, squid, octopus, and krill (van Heezik 1989, pp. 151-156).

Outside of the breeding season, the birds have been sighted around the North and South Islands and south to the sub-Antarctic islands, and the species is a regular vagrant to southeastern Australia (Simpson 2007, p. 2; Taylor 2000, p. 58). Houston (2007a, p. 2) of the New Zealand DOC comments that the appearance of vagrants in other locations is not necessarily indicative of the normal foraging range of Fiordland crested penguins; however, he also states that the non-breeding range of this species is unknown.

A five-stage survey effort, conducted during 1990–1995, documented all the major nesting areas of Fiordland crested penguin throughout its known current range (McLean and Russ 1991, pp. 183–190; Russ *et al.* 1992, pp. 113–118; McLean *et al.* 1993, pp. 85–94; Studholme *et al.* 1994, pp. 133–143; McLean *et al.* 1997, pp. 37–47). In these studies, researchers systematically surveyed the entire length of the range of this species, working their way along the coast on foot to identify and count individual nests, and conducting small boat surveys from a few meters offshore

to identify areas to survey on foot. The coastline was also scanned from a support ship, to identify areas to survey (McLean *et al.* 1993, p. 87). A final count of nests for the species resulted in an estimate of between 2,500 and 3,000 nests annually (McLean *et al.* 1997, p. 45) and a corresponding number of 2,500 to 3,000 breeding pairs. The staging of this survey effort reflects the dispersed distribution of small colonies of this species along the convoluted and inaccessible mainland and island coastlines of the southwest portion of the South Island of New Zealand.

Long-term and current data on overall changes in abundance are lacking. The June 2007 Fiordland National Park Management Plan (New Zealand Department of Conservation (NZ DOC) 2007, p. 53) observed that Fiordland crested penguin numbers appear to be stable, and reported on the nesting success of breeding pairs at island (88 percent) versus mainland (50 percent) sites. The Management Plan raises uncertainty as to whether 50 percent nesting success will be sufficient to maintain the mainland population long term. Populations on Open Bay Island decreased by 33 percent between 1988 and 1995 (Ellis *et al.* 1998, p. 70), and a long-term decline may have occurred on Solander Island (Cooper *et al.* 1986, p. 89). Historical data report thousands of individuals in locations where numbers in current colonies are 100 or fewer (Ellis *et al.* 1998, p. 69). The species account in the New Zealand Action Plan for Seabird Conservation states that "the population status of the species throughout its breeding range is still unknown and will require long-term monitoring to assess changes" (Taylor 2000, p. 58).

The IUCN Red List (BirdLife International 2010, p. 1) classifies this species as "Vulnerable" because it has a small population assumed to have been undergoing a rapid reduction of at least 30 percent over the last 29 years. This classification is based on trend data from a few sites. For example, at Open Bay Island there was a 33 percent decrease for the time period 1988–1995. The Fiordland crested penguin is listed as Category B (second priority) on the Molloy and Davis threat categories employed by the New Zealand DOC (Taylor 2000, p. 33) and placed in the second tier in New Zealand's Action Plan for Seabird Conservation. The species is listed as "acutely threatened—nationally endangered" on the New Zealand Threat Classification System list (Hitchmough *et al.* 2007, p. 38; Molloy *et al.* 2003, pp. 13–23). Under this classification system, which is nonregulatory, species experts assess the placement of species into threat categories according to both status criteria and threat criteria. Relevant to the Fiordland crested penguin evaluation are its low population size and reported declines of greater than or equal to 60 percent of the total population in the last 100 years (Molloy *et al.* 2003, p. 20).

Summary of Factors Affecting the Fiordland Crested Penguin

Factor A. The Present or Threatened Destruction, Modification, or Curtailment of the Fiordland Crested Penguin's Habitat or Range

The Fiordland crested penguin has a patchy breeding distribution from Jackson Bay on the west coast of the South Island of New Zealand southward to the southwest tip of South Island and southern offshore islands, including Stewart Island. A major portion of this range is encompassed by the Fiordland National Park on South Island and Solander Island and Rakiura National Park on Stewart Island and on adjacent islands at the southern tip of New Zealand. The majority of the breeding range of the Fiordland crested penguin lies within national parks and is currently protected from destruction and modification. The only reported instance of terrestrial habitat modification comes from the presence of deer (no species name provided) in some colonies that may trample nests or open up habitat for predators (Taylor 2000, p. 58). Therefore, we find that the present destruction, modification, or curtailment of the terrestrial habitat or range of the Fiordland crested penguin is not a threat to the species.

The marine foraging range of the Fiordland crested penguin is poorly documented. Recent observations on the foraging behavior of the species around Stewart and Codfish Islands found birds foraging very close to shore and in shallow water (Houston 2007a, p. 2), indicating the species may not be a pelagic (open ocean) feeder. The species is a vagrant to more northerly areas of New Zealand and to southeastern Australia, but that is not considered indicative of its normal foraging range (Houston 2007a, p. 2).

"Prey shortage due to sea temperature change" while foraging at sea has been cited as a threat to Fiordland crested penguins because of possible changes in prey distribution as a result of warming sea temperatures. ((Ellis *et al.* 2007, p. 6; Taylor 2000, p. 59). However, the Action Plan for Seabird Conservation in New Zealand concluded that the effects of oceanic changes or marine perturbations such as El Nino events on this species are unknown (Taylor 2000, p. 59). The plan identified the need for future research on distribution and movements of this species in the marine environment (Taylor 2000, p. 61).

Based on this analysis, we find that the present or future destruction, modification, or curtailment of the terrestrial and marine habitat or range is not a threat to the Fiordland crested penguin.

Factor B. Overutilization for Commercial, Recreational, Scientific, or Educational Purposes

Although human disturbance of colonies is rare because the birds generally nest in inaccessible sites, this species exhibits high nest fidelity, and their ability to reproduce may be significantly impacted by a small amount of human disturbance (St. Clair 1999, pp. 37-41). In more accessible areas, such as the northern portion of the range at South Westland, large concentrations of nests occur in areas accessible to people. In addition, tourism may disturb breeding (McLean *et al.* 1997, p. 46; Taylor 2000, p. 58). The 2000 Action Plan for Seabird Conservation in New Zealand stated that guidelines are needed to control visitor access to mainland penguin colonies and accessible sites should be protected as wildlife refuges (Taylor 2000, p. 60). It is unclear whether such measures have been implemented based on the information available. Research activities, particularly handling penguins for purposes such as insertion of transponders and weighing, may also disturb breeding birds. Houston (2007a, p. 1) reported that monitoring of breeding success at Jackson's Head has been abandoned due to concerns of adverse effects of the research on breeding success and recruitment. There is no evidence of use of the species for other commercial, recreational, scientific, or educational purposes.

The threat of human disturbance could increase as tourism activities become more widespread in the region, and we have no information that indicates this threat will be alleviated for the Fiordland crested penguin in the foreseeable future. Because this species is so sensitive to human disturbance and exhibits high nest fidelity, we find that the present overutilization for commercial, recreational, scientific, or educational purposes, particularly human disturbance from tourism, is a threat to the survival of the Fiordland crested penguin.

Factor C. Disease or Predation

Reports from 1976 documented that Fiordland crested penguin chicks have

been infected by the sandfly-borne protozoan blood parasite (*Leucocytozoon tawaki)* (Taylor 2000, p. 59) (see discussion under Factor C for the yellow-eyed penguin). Diseases such as avian cholera, which has caused the deaths of southern rockhopper penguin adults and chicks at the Campbell Islands, are inferred to be a potential problem in Fiordland crested penguin colonies (Taylor 2000, p. 59). However, with no significant disease outbreaks reported, the best available information leads us to conclude that disease is not a threat to this species.

Predation from introduced mammals and birds is a threat to the Fiordland crested penguin (Taylor 2000, p. 58; Ellis *et al.* 1998, p. 70). Comments received from the New Zealand DOC link historical declines of Fiordland crested penguins to the time of arrival of mammalian predators, particularly stoats, to the area (Houston 2007a, p. 1). Only Codfish Island, where 144 nests have been observed, is fully protected from introduced mammalian and avian predators (Studholme *et al.* 1994, p. 142). This island lies closely adjacent to Stewart Island, so the future possibility of predator reintroduction is possible. Mustelids, especially stoats, are reported to take eggs and chicks in mainland colonies and may occasionally attack adult penguins (Taylor 2000, p. 58). The Norway rat, ship rat, and Pacific rat are also likely predators, but there is no direct evidence of rat predation of Fiordland crested penguins. Feral cats and pigs are also potential predators, but they are not common in nesting areas. Recent observations since the development of the Action Plan (Taylor 2000, p. 58), which originally discounted the impact of the introduced possum (*Trichosurus vulpecula*), indicate that this species has now colonized the mainland range of the Fiordland crested penguin in South Westland and Fiordland. Initially thought to be vegetarians, it is now documented that possums eat birds, eggs, and chicks and also compete for burrows with native species. It is not yet known if they compete for burrows or eat the eggs of Fiordland crested penguins, as they do other native species, but it is likely (Houston 2007b, p. 1). Domestic dogs are also known to kill adult penguins and disturb colonies near human habitation (Taylor 2000, p. 58).

Weka, which are omnivorous, flightless rails about the size of chickens and native to other regions of New Zealand, have been widely introduced onto offshore islands of New Zealand. At Open Bay Islands and Solander Islands, this species has been observed destroying the eggs and killing the chicks of Fiordland crested penguins. At Open Bay Island colonies, weka caused 38 percent of egg mortality observed and 20 percent of chick mortality (St. Clair and St. Clair 1992, p. 61). The decline in numbers of Fiordland crested penguin on the Solander Islands from "plentiful" to a few dozen since 1948 has also been attributed to egg predation by weka (Cooper *et al.* 1986, p. 89). Among the future management actions identified as needed in New Zealand's Action Plan for Seabird Conservation are eradicating weka from Solander Island and addressing the problem of weka predation at Open Bay Islands (Taylor 2000, p. 60).

The available data indicate that historical declines have been linked to introduced predators on the South Island of New Zealand, and recently documented declines have been attributed to introduced predators. Given the remote and widely dispersed range of the Fiordland crested penguin, especially on the mainland of the South Island, significant anti-predator efforts are largely impractical for this species. We are unaware of any time-bound plan to implement anti-predator protection for Fiordland crested penguins or of any significant efforts to stem ongoing rates of predation. Therefore, we find that predation by introduced species is reasonably likely to continue in the foreseeable future. Predator control programs have been undertaken on only a few islands in a limited portion of the Fiordland crested penguin's range and are not practicable in the inaccessible mainland South Island strongholds of the species (Taylor 2000, p. 59).

Predation by introduced mammalian species is the primary threat facing the Fiordland crested penguin on the mainland South Island of New Zealand. On breeding islands free of mammalian predators, for example, on Open Bay Islands and Solander Island, an introduced bird, the weka, is a predator of Fiordland penguin eggs and chicks. Only Codfish Island is fully protected from introduced mammalian and avian predators. Therefore, we find that although predation by introduced species is not a threat to the Fiordland crested penguin on Codfish Island, it is a threat to this species in other portions of its range.

Factor D. Inadequacy of Existing Regulatory Mechanisms

The Fiordland crested penguin is protected under New Zealand's Wildlife Act of 1953, which gives absolute protection to wildlife throughout New Zealand and its surrounding marine economic zone. No one may kill or have in their possession any living or dead wildlife unless they have appropriate authority.

The majority of the range of the Fiordland crested penguin is within the Fiordland National Park (which includes Solander Island) and adjacent parks, including Rakiura National Park on Stewart Island. Fiordland National Park covers 15 percent of public conservation land in New Zealand. Under section 4 of New Zealand's National Parks Act of 1980 and Park bylaws, "the native plants and animals of the parks shall as far as possible be preserved and the introduced plants and animals shall as far as possible be eradicated" (NZ DOC 2007, p. 24). The June 2007 Fiordland National Park Management Plan (NZ DOC 2007, pp. 1–4) contains, in its section on Preservation of Indigenous Species and Habitats, a variety of objectives aimed at maintaining biodiversity by preventing the further loss of indigenous species from areas where they were previously known to exist. The Fiordland crested penguin is specifically referenced in the audit of biodiversity values to be preserved in the Park (NZ DOC 2007, p. 53). In addition, the Fiordland Marine Management Act of 2005 establishes the Fiordland Marine area and 8 marine reserves within that area, which encompass more than 2.18 million ac (882,000 ha) extending from the northern boundary of the Park to the southern boundary (excluding Solander Island) (NZ DOC 2007, p. 29). The species also inhabits Rakiura National Park on Stewart Island and Whenua Hou (Codfish Island) and is protected by New Zealand's National Parks Act of 1980 and Park bylaws.

The Fiordland National Park is encompassed in the Te Wahipounamu—South West New Zealand World Heritage Area. World Heritage areas are designated under the World Heritage Convention because of their outstanding universal value (NZ DOC 2007, p. 44). Such designation does not confer additional protection beyond that provided by national laws.

Despite these designations and the possibility of future efforts, we have no information to indicate that measures have been implemented that reduce the threats to the Fiordland crested penguin.

The Fiordland crested penguin has been placed in the group of birds ranked as second tier threat status in New Zealand's Action Plan for Seabird Conservation on the basis of its being listed as 'Vulnerable' by IUCN Red List Criteria and as Category B (second priority) on the Molloy and Davis threat categories employed by the New

Zealand DOC (Taylor 2000, p. 33). The Action Plan, while not a legally binding document, outlines actions and priorities intended to define the future direction of seabird management in New Zealand. High-priority future management actions identified are eradication of weka from Big Solander Island and development of a management plan for the Open Bay Islands to address the problem of weka predation on Fiordland crested penguins and other species. We do not have information to allow us to evaluate whether any of these proposed actions and priorities have been carried out and, therefore, have not relied on this information in our threat analysis.

New Zealand has in place the New Zealand Marine Oil Spill Response Strategy, which provides the overall framework to mount a response to marine oil spills that occur within New Zealand's area of responsibility. The aim of the strategy is to minimize the effects of oil on the environment and on human safety and health. The National Oil Spill Contingency Plan promotes a planned and nationally coordinated response to any marine oil spill that is beyond the capability of a local regional council or outside the region of any local council (Maritime New Zealand 2007, p. 1). As discussed below under Factor E, rapid containment of spills in remote areas and effective triage response under this plan have shown these to be effective regulatory mechanisms (New Zealand Wildlife Health Center 2007, p. 2; Taylor 2000, p. 94).

Major portions of the coastal and marine habitat of the Fiordland crested penguin are protected under a series of laws, and the species itself is covered under the New Zealand Wildlife Act. New Zealand's National Parks Act specifically calls for controlling and eradicating introduced species. While there has been limited success in controlling some predators of Fiordland crested penguins at isolated island habitats comprising small portions of the overall range, the comprehensive legal protection of this species has not surmounted the logistical and resource constraints that stand in the way of limiting or eradicating predators on larger islands and in inaccessible mainland South Island habitats. Furthermore, we are not able to evaluate whether efforts to reduce the threats of human disturbance discussed in Factor B have been implemented or achieved results.

On the basis of this information, we find that inadequacy of existing regulatory mechanisms is a threat to the Fiordland crested penguin.

Factor E. Other Natural or Manmade Factors Affecting the Continued Existence of the Species

Commercial fishing in much of the species' range is a comparatively recent development and is considered unlikely to have played a significant role in historic declines (Houston 2007a, p. 1). New Zealand's Seabird Action Plan noted that Fiordland crested penguins could potentially be caught in set nets near breeding colonies and that trawl nets are also a potential risk. Competition with squid fisheries is also noted as a potential threat (Taylor 2000, p. 59; Ellis *et al.* 1998, p. 70; Ellis *et al.* 2007, p. 7). The 1998 CAMP recommended research on foraging ecology to identify potential competition with commercial fisheries and effects of climatic variation (Ellis *et al.* 1998, pp. 70–71), but we are not aware of the results of any such studies. The New Zealand DOC (Houston 2007a, p. 1), in its comments on our 90–day petition finding (73 FR 77303), noted that the "assessment of threats overstates the threat from fisheries" to the Fiordland crested penguin. The distribution and behavior of this species may reduce the potential impact of bycatch. The Fiordland crested penguin is distributed widely along the highly convoluted, sparsely populated, and legally protected South Island coastline for a linear distance of over 155 mi (250 km), as well as along the coasts of several offshore islands. These marine reserves are granted protection under the Marine Reserves Act of 1971 (NZ DOC 2010, pp. 1-3). The Act, in part, states that the reserves shall be preserved as far as possible in their natural state, marine life of the reserves shall as far as possible be protected and preserved, the public shall have freedom of access and entry to the reserves, and no person shall fish in a marine reserve [unless specifically authorized]. Significant feeding concentrations of the species, which might be susceptible to bycatch, have not been described. Given the absence of documentation of actual impacts of fisheries bycatch on the Fiordland crested penguin, we conclude that this is a not threat to the species.

We have examined the possibility that oil and chemical spills may impact Fiordland crested penguins. Such spills, should they occur and not be effectively managed, can have direct effects on marine seabirds such as the Fiordland crested penguin. The range of the Fiordland crested penguin on the southwest coast of the South Island of New Zealand is remote, far from shipping activity and away from any major human population centers. Thus the consequent risk of oil or chemical spills is low. The Stewart Islands populations at the southern end of New Zealand are in closer proximity to vessel traffic and human industrial activities, which may increase the possibility of oil or chemical spill impacts. Two spills have been recorded in this overall region. In March 2000, the fishing vessel *Seafresh 1*sank in Hanson Bay on the east coast of Chatham Island and released 66 T (60 t) of diesel fuel. Rapid containment of the oil at this remote location prevented any wildlife casualties (New Zealand Wildlife Health Center 2007, p. 2). The same source reports that, in 1998, the fishing vessel *Don Wong 529*ran aground at Breaksea Islets off Stewart Island. Approximately 331 T (300 t) of marine diesel was spilled along with smaller amounts of lubricating and waste oils. With favorable weather conditions and establishment of triage response, no casualties from this pollution event were discovered (Taylor 2000, p. 94). There is no doubt that an oil spill near a breeding colony could have a major effect on this species (Taylor 2000, p. 94). However, based on the remote distribution of Fiordland penguins around the mainland South Island, and on offshore islands at the southern tip of the South Island, the low number of previous incidents around New Zealand, and the fact that each was effectively contained under the New Zealand Marine Oil Spill Response Strategy and resulted in no mortality or evidence of impacts on the population, we find that oil and chemical spills are not a threat to the Fiordland crested penguin.

In summary, while fisheries bycatch has been suggested as a potential source of mortality to the Fiordland crested penguin, the best available information leads us to conclude that this is not a threat to this species. There is a low-level potential for oil spill events to impact this species, but the wide dispersal of this species along inaccessible and protected coastlines leads us to conclude that potential oil spills are not a threat to the Fiordland crested penguin. Therefore, we find that other natural or manmade factors are not a threat to the species.

Fiordland Crested Penguin Finding

The primary documented threat to the Fiordland crested penguin is predation by introduced mammalian and avian predators within the species' breeding range. We are only aware of one small breeding location that is known to be free of predators. The impact of predators is evidenced by the major

historical decline of the Fiordland crested penguin during the period of invasion by these predators of the South Island of New Zealand. Historical data from about 1890 cites thousands of Fiordland crested penguins in areas where current surveys find colonies of only 100 or fewer. Even though this species is poorly known, an exhaustive multi-year survey effort documented current low population numbers. Recent declines at Open Bay and Solander Islands have been documented as resulting from weka predation. The Fiordland crested penguin is a remote and hard-to-study species. However, in observing the impact of predators on other similar naïve, New Zealand penguins, such as the yellow-eyed (Darby and Seddon 1990, p. 45) and the white-flippered penguin (Challies and Burleigh 2004, p. 4), one can assume that predators would have a similar impact on Fiordland crested penguins.

In considering the foreseeable future as it relates to the status of the Fiordland crested penguin, we considered the threats acting on the species, as well as population trends. We considered the historical data to identify any relevant existing trends that might allow for reliable prediction of the future (in the form of extrapolating the trends).

New Zealand laws and the bylaws of its national parks, which encompass the majority of the range of the Fiordland crested penguin, institute provisions to "as far as possible" protect this species and to seek eradication of nonnative invasive species. Unfortunately, while complete eradication of predators, such as weka, in isolated island habitats (e.g., Solander Island), may be possible, removal of the introduced mammalian predators now known to be widespread in mainland Fiordland National Park is an extremely difficult, if not impossible, task. Similarly, physical protection of some breeding groups from predation, as has been done for species such as the yellow-eyed and white-flippered penguins, is impractical for the Fiordland crested penguin. For other penguin species located in more accessible and more restricted ranges, the task of predator control has been undertaken at levels of effort meaningful to the protection of those species. For this remote and widely dispersed species, predator control has only been undertaken on a limited basis, and we have no reason to believe this threat to the Fiordland crested penguin will be ameliorated in the foreseeable future.

The threat of human disturbance is present in those areas of the range most accessible to human habitation, but could increase as tourism activities become more widespread in the region. While efforts to control this threat have been undertaken, we have no information that allows us to conclude this threat will be alleviated for the Fiordland crested penguin in the foreseeable future.

The overall population of the Fiordland crested penguin is small (2,500–3,000 pairs) and reported to be declining (Ellis *et al.* 2007, p. 6). The ongoing pressure of predation by introduced mammalian and avian species on this endemic species over the next few decades, with little possibility of significant anti-predator intervention, and the potential for human disturbance to impact breeding populations, leads us to find that the Fiordland crested penguin is likely to become in danger of extinction within the foreseeable future throughout all of its range.

Significant Portion of the Range Analysis

Having determined that the Fiordland crested penguin is likely to become in danger of extinction within the foreseeable future throughout all of its range, we must consider whether there are any significant portions of its range where the species is in danger of extinction now.

Fiordland crested penguins breed in widely dispersed small colonies along the convoluted and inaccessible southwest coast of the western side of South Island, New Zealand, and adjacent offshore islands southwards from Bruce Bay, including Stewart Island, Solander Island, and Codfish Island. There are a total of 2,500 to 3,000 breeding pairs throughout its range. In our previous five-factor analyses, we found that threats from human disturbance and inadequacy of regulatory mechanisms have similar impacts on both island and mainland portions of the range. We also found that a primary threat to the Fiordland crested penguin is predation by introduced birds on islands and introduced mammals on the mainland. Major portions of this species' range are in Fiordland National Park and Rakiura National Park, and on Stewart Island and adjacent islands. The Fiordland National Park Management Plan reported that nesting success of breeding pairs at island sites was greater than at mainland sites (88 and 55 percent, respectively). This led us to consider whether the threats in the mainland portion of the range may cause this portion of the range to be in danger of extinction now. While the eradication of predators, such as weka, in isolated island habitats may be possible, removal of the widespread introduced mammalian predators on the mainland may be extremely difficult, if not impossible. However, on the mainland, the nests are widely distributed, and we believe therefore are somewhat buffered from predators. Although the predation rate is greater than that of other species (Gustafson 2005, p. 2), the mainland population has been able to persist and is not currently in danger of extinction. While the threat of introduced predators is greater on the mainland, the population is being managed to some extent, and the threats do not rise to the level that the mainland population is in imminent danger of extinction. Due to the ability of the mainland population to persist, we find that there is not substantial information to conclude that the species in the mainland portion of its range may currently be in danger of extinction.

As a result, while the best scientific and commercial data available allows us to make a determination as to the rangewide status of the Fiordland crested penguin, we have determined that there are no significant portions of the range in which the species is currently in danger of extinction. The species is widely distributed throughout its range and current threats do not put the species in immediate danger of extinction. In conclusion, we have determined that there are no significant portions of the range in which the species is currently in danger of extinction. Therefore, we are listing the Fiordland crested penguin as threatened throughout all of its range under the Act.

Humboldt Penguin *(Spheniscus humboldti)*

Background

The Humboldt penguin is endemic to the west coast of South America from Foca Island (5°12'0"S) in northern Peru to the Puñihuil Islands near Chiloe, Chile (42 °S) (Araya *et al.* 2000, p. 1). It breeds on islands off the coasts of both Peru and Chile. It is a congener (within the same genus) of the African penguin and has similar life history and ecological traits.

Humboldt penguins historically bred on guano islands off the coast of Peru and Chile (Araya *et al.* 2000, p. 1). Prior to human mining of guano for fertilizer, the Humboldt penguin's primary nesting habitat was in burrows tunneled into the deep guano substrate on offshore islands. While the guano is produced primarily by three other species (the Guanay cormorant (*Phalacrocorax bouganvillii*), the Peruvian booby (*Sula variegate*), and Peruvian pelican (*Pelecanus thagus*)),

Humboldt penguins depend on these burrows for shelter from the heat and from predators. With the intensive harvest of guano over the last century and a half in both countries, Humboldt penguins have been forced to nest out in the open or seek shelter in caves or under vegetation (Paredes and Zavalga 2001, pp. 199–205).

The distribution of the Humboldt penguin is very closely associated with the Humboldt (Peruvian) current. The upwelling of cold, highly productive waters off the coast of Peru provides a continuous food source to vast schools of fish and large seabird populations (Hays 1986, p. 170). In the Chilean system to the south, upwelling is lighter and occurs more seasonally than in the Peruvian system (Simeone *et al.* 2002, p. 44). In all regions, Humboldt penguins feed primarily on schooling fish such as the anchovy (*Engraulis ringens*), Auracanian herring (*Strangomera bentincki*), silversides (*Odontesthes regia*), garfish (*Scomberesox saurus)* (Herling *et al.* 2005, p. 21), and Pacific sardine (*Sardinops sagax*) (Simeone *et al.* 2002, p. 47). Depending on the location and the year, the proportion of each of these species in the diet varies.

Periodic failure of the upwelling and its impact on schooling fish and fisheries off Peru and Ecuador were the first recorded and signature phenomena of El Niño Southern Oscillation events (ENSO). El Niño events occur irregularly every 2–7 years (National Oceanic and Atmospheric Administration (NOAA) 2007, p. 4). This periodic warming of sea surface temperatures and consequent upwelling failure affects primary productivity and the entire food web of the coastal ecosystem. Anchovy and sardine populations are especially impacted, and these are the major diet of Humboldt penguins. During El Niño events, seabirds, fish, and marine mammals experience reduced survival and reproductive success, as well as population crashes (Hays 1986, p. 170).

Given the north-south distribution of the Humboldt penguin along the Peruvian and Chilean coasts, researchers have looked for variation in breeding and foraging along this climatic gradient (Simeone *et al.* 2002, pp. 43–50). In dry Peruvian breeding areas, where upwelling provides a constant food source, penguins nest throughout the year with two well-defined peaks in breeding in the autumn and spring. Adults remain near the colony all year. Further south, in northern and north-central Chile, the birds follow the same pattern, despite stronger seasonal differences in weather (Simeone *et al.* 2002, pp. 48–49). They also attempt to breed twice a year, but the autumn breeding event is regularly disrupted by rains more typical at that latitude, and there is high reproductive failure. Adults in the southern extent of the range (south-central Chile) leave the colonies in winter, presumably after abandoning nesting efforts (Simeone *et al.* 2002, p. 47). Peruvian and northern Chilean colonies are only impacted by rains and flooding during El Niño years, and during those years, nesting attempts are reduced as food supplies shift and adults forage farther away from nesting sites (Culik *et al.* 2000, p. 2317).

The distribution of colonies within the breeding range of the Humboldt penguin in Peru has shifted south in recent years. This shift may be in response to a number of factors:

(1) El Niño events in which prey distribution has been shown to move to the south (Culik *et al.* 2000, p. 2311);

(2) Increasing human pressure in central coastal areas;

(3) Long-term changes in prey distribution (Paredes *et al.* 2003, p. 135); or

(4) Overall increases in sea surface temperature.

Modinger (1998, p. 67) estimated that historically there may have been a million Humboldt penguins in the Humboldt Current. By 1936, there was already evidence of major population declines and of breeding colonies made precarious by the harvest of guano from over 100 Peruvian islands (Araya *et al.* 2000, p. 1, Modinger *et al.* 1998, p. 1; Ellis *et al.* 2007, p. 7).

Estimates of the population in Peru have fluctuated in recent history. They were estimated to be between 3,500 and 7,000 in 1981, with a subsequent reported decrease to 2,100 to 3,000 individuals after the 1982–1983 El Niño event. In 1996, there were reported to be 5,500 individuals, and after the strong 1997–1998 El Niño event, fewer than 5,000. In Peru, population surveys in the southern portion of the range in 2006 found 41 percent more penguins than in 2004, increasing estimates for that area from 3,100 individuals to 4,390 and supporting an overall population estimate for Peru of 5,000 individuals (Instituto Nacional de Recursos Naturales (INRENA) 2007, p. 1; IMARPE 2007, p. 1).

In Chile, researchers estimated there were 7,500 breeding Humboldt penguins in Chile in 1995–1996 (Ellis *et al.* 1998, p. 99; Luna-Jorguera *et al.* 2000, p. 508). This estimate for Chile was significantly revised following surveys conducted in 2002 and 2003 at Isla Chanaral, one of the most important breeding islands for the Humboldt penguin (Mattern *et al.* 2004, p. 373). Mattern *et al.* counted 22,000 adult penguins, 3,600 chicks, and 117 juveniles at that island in 2003 (2004, p. 373). While 6,000 breeding birds had been recorded in the 1980s, counts after 1985 had never exceeded 2,500 breeding birds (Ellis *et al.* 1998, p. 99). The authors indicated that rather than representing a sudden population increase, the discrepancy may be a result of systematic underestimates in eight previous counts at Isla Chanaral, which were all conducted using a uniform methodology, but may not have considered the absence of penguins due to breeding versus nonbreeding season in conducting the population estimate. Just to the south of this study area in the Coquimbo region, Luna-Jorguera *et al.* counted a total of 10,300 penguins in on-land and at-sea counts conducted in 1999 (2000, p. 506). They found numbers higher than the most recent previous census, which had estimated only 1,050 individuals in the Coquimbo region (Luna-Jorguera *et al.* 2000, p. 508). In 2007, Ellis *et al.* (2007, p. 7), estimated that there were approximately 30,000 to 35,000 individuals in the Chilean population. Other than the overall rangewide figures for the species presented by Ellis *et al.* (2007, p. 7), no current comprehensive estimate of the total number of penguins in Chile exists.

There are varied total population estimates for this species. As recently as 2007, Ellis *et al.* (p. 7) reported a total population of 41,000 to 47,000 individuals. However, BirdLife International currently indicates that there is an estimated total population of 3,000 to 12,000 (2009, p. 2). BLI is the official IUCN Red List Authority for birds. BLI supplies information for all of the world's birds to the IUCN Red List each year. The 2007 IUCN Red List (BirdLife International 2007, p. 1) categorizes the Humboldt penguin as "Vulnerable" on the basis of 30 to 49 percent declines over the past three generations and predicted over three generations into the future. Thus, because BLI is the accepted authority for IUCN's Red List for birds, we accept the estimate of the total population to be between 3,000 and 12,000 birds.

Summary of Factors Affecting the Humboldt Penguin

Factor A. The Present or Threatened Destruction, Modification, or Curtailment of Humboldt Penguin's Habitat or Range

The habitat of the Humboldt penguin consists of terrestrial breeding and molting sites and the marine environment, which serves as a foraging range year-round.

Terrestrial Habitat

Modification of their terrestrial breeding habitat is a continuing threat to Humboldt penguins. Humboldt penguin breeding islands were, and continue to be, a source of guano for the fertilizer industry and have been exploited since 1840 in both Peru and Chile. Between 1840 and 1880, Peru exported an estimated 12.7 million T (11.5 t) of guano from its islands (Cushman 2007, p. 1). Throughout the past century, Peru has managed the industry through a variety of political and ecological conflicts, including the devastating impacts of El Niño on populations of guano-producing birds and the competition between the fishing industry and the seabird populations that are so valuable to guano production. After 1915, caretakers of the islands routinely hunted penguins for food even as their guano nesting substrate was removed, which resulted in penguins being virtually eliminated from the guano islands (Cushman 2007, p. 11). Harvest of guano continues on a small scale today and is managed by Proyecto Especial de Promocion del Aprovechamiento de Abonos Provenientes de Aves (PROABONOS), a small government company that produces fertilizer for organic farming (Cushman 2007, p. 24).

Reports from 1936 described completely denuded guano islands and indicated that by 1936, Humboldt penguin populations had undergone a vast decline throughout the range (Ellis *et al.* 1998, p. 97). Guano, which was historically many meters deep, was initially harvested down to the substrate level. Then, once the primary guano-producing birds had produced another ankle-deep layer, it was harvested again. The Humboldt penguins, which formerly burrowed into the abundant guano, were deprived of their primary nesting substrate and forced to nest in the open, where they are more susceptible to heat stress. In addition, their eggs and chicks are more vulnerable to predators. Alternatively, they can be forced to resort to more precarious nesting sites (Ellis *et al.* 1998, p. 97).

Paredes and Zavalga (2001, pp. 199–205) investigated the importance of guano as a nesting substrate and found that Humboldt penguins at Punta San Juan, Peru, where guano harvest has ceased, preferred to nest in high-elevation sites where there was adequate guano available for burrow excavation. As guano depth increased in the absence of harvest, the number of penguins nesting in burrows increased. Penguins using burrows on cliff tops had higher breeding success than penguins breeding in the open, illustrating the impact of loss of guano substrate on the survival of Humboldt penguin populations.

Guano harvesting continues on Peruvian points and islands under government control. The fisheries agency, Instituto del Mar del Peru (IMARPE), is working with the parastatal (government-owned) guano extraction company, PROABONOS, to limit the impacts of guano extraction on penguins at certain colonies to ensure that harvest is conducted outside the breeding season and that workers are restricted from disturbing penguins (IMARPE 2007, p. 2). In 1998, the Wildlife Conservation Society and PROABONOS fenced off penguin rookeries, which successfully prevented guano harvesters from harming wildlife (Paredes *et al.* p. 136).

Two major penguin colonies at Punta San Juan and Pachacamac Island are in guano bird reserves. They are under the management and protection of the guano extraction agency, which has built walls to keep out people and predators (UNEP World Conservation Monitoring Center (UNEP WCMC) 2003, p. 9). However, guano extraction is still listed as a moderate threat to some island populations within the Reserva Nacional de Paracas (Lleellish *et al.* 2006, p. 4), and illegal guano extraction is listed by the Peruvian natural resource agency, Instituto Nacional de Recursos Naturales (INRENA), as one of three primary threats to the Humboldt penguin in Peru (INRENA 2007, p. 2). The penguin Conservation Assessment and Management Plan (CAMP) (Ellis *et al.* 1998, p. 101) recommended that the harvest of guano in Peru be regulated in order to preserve nesting habitat and reduce disturbance during the nesting seasons. Although guano harvest is still a concern in Peru, guano harvest is reported to have ceased in Chile (UNEP WCMC 2003, p. 6).

Historical declines have resulted from the destruction of Humboldt penguin's nesting substrate by guano collection, and this loss of nesting habitat continues to impact the breeding success of the species in Peru. Although guano harvest is being managed to some extent, we have no reason to believe the level of guano collection will change in the foreseeable future. We conclude, on the basis of the extent and severity of habitat modification and exploitation throughout the range of the Humboldt penguin in both countries over the past 170 years, and on the basis of ongoing guano extraction in Peru, that modification of the terrestrial breeding habitat is a threat to the survival of the Humboldt penguin.

Marine Habitat

With respect to modification of the marine habitat of the Humboldt penguin, periodic El Niño events have been shown to have significant effects on the marine environment on which Humboldt penguins depend, because they reduce the available food sources for this species. These El Niño events are considered to be the main marine perturbation for the Humboldt penguin impacting penguin colonies in Peru (Hays 1986, pp. 169–180; Ellis *et al.* 1998, p. 101; INRENA 2007, p. 1) and Chile (Simeone *et al.* 2002, p. 43). The strength and duration of El Nino events has increased since the 1970s. The 1997–1998 event was the most extreme on record (Trenberth *et al.* 2007, p. 288). The Humboldt Penguin Population and Habitat Viability Assessment (Araya *et al.* 2000, pp. 7–8) concluded that, even without El Nino and other impacts, documented rates of reproductive success and survival would cause declines in the Chilean populations. In the absence of other human impacts, El Nino events in Chile alone were projected to lead to 2.3 to 4.4 percent annual population declines. Peruvian population data for this species found an overall population decline of 65 percent during the 1982–83 El Niño event (Hays 1986, p. 169).

While we have not found comparable documentation of the impact of the 1997–1998 event in Peru, few birds were recorded breeding at guano bird reserves in 1998. At one colony, Punta San Juan, the number of breeding individuals appears to have declined by as much as 75 percent between 1996 and 1999 before a subsequent rebound (Paredes *et al.* 2003, p. 135). This suggests that a similar level of impact from a single El Niño event in the future could reduce current Peruvian populations from 5,000 birds to 1,250 - 1,750 birds. Cyclical El Nino events cause high mortality among seabirds, but there is also high selection pressure on Humboldt Current seabird populations such as the Humboldt penguin to increase rapidly in numbers after each event (Ellis *et al.* 1998, p. 101). Nonetheless, with strengthening El Nino events, reduced Humboldt penguin population numbers, and the compounding influence of other threat factors, such as ongoing competition with commercial fisheries for food sources which are discussed below under Factor E, the resiliency of Humboldt penguins to recover from cyclical El Nino events is highly likely

to be reduced from historical times (Ellis *et al.* 1998, p. 101).

On the basis of this analysis, we find that the present and threatened destruction, modification, or curtailment of both its terrestrial and marine habitats, primarily due to El Niño events and guano extraction, are threats to the Humboldt penguin.

Factor B. Overutilization for Commercial, Recreational, Scientific, or Educational Purposes

While hunting of Humboldt penguins for food and bait and harvesting of their eggs have been long established on the coasts of Chile and Peru, it is not clear how much hunting persists today. At Pajaros Island in Chile, Humboldt penguins are sometimes hunted for human consumption or for use as bait in the crab fishery. At the Puñihuil Islands farther south, they have also been hunted on occasion for use as crab bait (Simeone *et al.* 2003, p. 328; Simeone and Schlatter 1998, p. 420). Paredes *et al.* reported that as fishing occurs more frequently in the proximity of penguin rookeries, fishermen have begun to take penguins for food in Peru (2003, p. 136). Cheney (UNEP WCMC 2003, p. 6) reported an observation of a fisherman taking 150 penguins to feed a party. In 1995, egg harvest was listed as the primary threat to Chilean populations (UNEP WCMC 2003, p. 6), but recent information does not indicate whether that practice continues today. Paredes *et al.* (2003, p. 136) also reported that guano harvesters supplement their meager incomes and diets through the collection of eggs and chicks, although the fisheries agency, IMARPE, is working with PROABONOS to restrict workers from disturbing penguins (IMARPE 2007, p. 2). On the basis of this information, we conclude that localized intentional harvest may be ongoing. We have no basis to evaluate the effectiveness of reported efforts to control this harvest.

In 1981, the Humboldt penguin was listed on Appendix I of the Convention on International Trade in Endangered Species of Wild Fauna and Flora (CITES). CITES regulates international trade in order to ensure that trade of the species is compatible with the species' survival. International trade in specimens of Appendix-I species is authorized through permits or certificates under certain circumstances, including verification that trade will not be detrimental to the survival of the species in the wild. It also must be determined that the specimen (live animal, part, or product) was legally acquired, and that the activity is not for primarily commercial purposes. (UNEP-WCMC 2010, p. 1). Prior to 1985, it was estimated that 9,264 Humboldt penguins had been exported to several zoos around the world within a period of 32 years. Between the time the species was listed under CITES in 1981 and 2008, there were 937 live CITES-permitted Humboldt penguin international shipments (UNEP-WCMC 2010, p. 1). Only one of these live shipments (from Peru to Venezuela) indicated that its origin was from the wild; the other shipments all indicated that they were of captive origin. Chile and Peru's exports are included in these numbers. Peru exported 48 live animals for educational and zoological purposes; Chile exported 10 live animals in 1981 and none since then. We believe that this limited amount of international trade, controlled via valid CITES permits, is not a threat to the species. Because commercial exportation of Humboldt penguins from Peru or Chile is now prohibited (Ellis *et al.* 1998, p. 101, UNEP 2003, p. 8), export is no longer a threat to the species.

Tourism has been identified as a potential threat to the Humboldt penguin. Since the 1990 designation of the Humboldt National Reserve, which includes the islands of Damas, Choros, and Chanaral in Chile, tourism has increased rapidly but with little regulation (Ellenberg *et al.* 2006, p. 97). Ellenberg *et al.* (2006, p. 99) found that Humboldt penguin breeding success varied with levels of tourism on these three islands. Breeding success was very low at Damas Island, the most tourist accessible island, which saw over 10,000 visitors in 2003. Better breeding success was observed at Choros Island, a less accessible island which saw fewer than 1,000 visitors. The highest breeding success was observed at the remote and largest Chanaral Island colony, where tourist access was negligible. Unlike their congener (species within the same genus) the Magellanic penguin (*Spheniscus magellanicus*), Humboldt penguins reacted to human presence and displayed little habituation potential. Their reactions indicate that there is a strong need for tourism guidelines for this species (Ellenberg *et al.* 2006, p. 103). Researchers described nest destruction by tourists at Puñihuil Island, a popular unregulated tourist destination in southern Chile (Simeone and Schlatter 1998, p. 420). Both the attractiveness of the penguins for tourism and the potential for increased impacts from human disturbance stem from the coincidence of the prime tourist season with the Humboldt penguin's spring and summer breeding season.

Tourism has increased rapidly and with little regulation in the Humboldt National Reserve and has caused nest destruction at Puñihuil Island in Chile. In Peru, tourism is reported to be a minimal to mid-level threat at Reserva Nacional de Paracas (Lleellish *et al.* 2006, p. 4). Because Humboldt penguins are extremely sensitive to the presence of humans, the species' breeding success is impacted by increased levels of tourism. Since the prime tourist season coincides with the species' spring and summer breeding season, we conclude that insufficiently regulated tourism is a threat to the species.

Other human activities may disturb penguins. For example, fishermen hunting European rabbits (*Oryctolagus cuniculus*) disturbed penguins at Choros Island (Simeone *et al.* 2003, p. 328), but we do not conclude that this activity has occurred at a scale that represents a threat to the Humboldt penguin.

We have identified intentional take (hunting of Humboldt penguins for food and bait and harvesting of their eggs) and unregulated tourism as threats to Humboldt penguins. Therefore, we find that overutilization for commercial, recreational, scientific, or educational purposes is a threat to the Humboldt penguin.

Factor C. Disease or Predation

There is no information to indicate that disease is a threat to the Humboldt penguin.

Various types of predation on Humboldt penguins have been documented. Simeone *et al.* (2003, p. 331) reported that the presence of rats, rabbits, goats, and cats have been documented on islands along the Chilean coast, but their actual impacts on the Humboldt penguin population are unknown. In Chile, "rats were observed at Pájaros, Cachagua, and Pájaros Niño [Islands]. At Pájaros Island, rats were present in large numbers and were observed to prey on penguin eggs and chicks" (Simeone *et al.* 2003, p. 328). Rats and cats are a significant threat because they eat eggs and chicks. Luna-Jorquera *et al.* observed vampire bats preying upon juvenile Humboldt penguins (1995, p. 471); however, there have been no other similar reports since 1995. Foxes were reported to prey on Humboldt penguins at Pan de Azucar National Park in Chile (Culik 2009 pers. comm.). Limited conclusive data are available for the Humboldt penguin; however, based on studies of other species, it is very likely that predation is a significant threat to the species. Simeone and Schlatter found that the

threat of predation has been shown to result in rapid population declines in the past and that this threat is likely to continue in the foreseeable future due to the lack of control efforts to eradicate these predators (UNEP 2003, p. 7). Therefore, on the basis of the best available information, we conclude that predation is a threat to the Humboldt penguin.

Factor D. Inadequacy of Existing Regulatory Mechanisms

The Humboldt penguin is listed as "endangered" in Peru, the highest threat category under Peruvian legislation. Take, capture, transport, trade, and export are prohibited except for scientific or cultural purposes (IMARPE 2007, p. 1; UNEP WCMC 2003, p. 8). Most breeding sites are protected by designated areas. The principal breeding colonies are legally protected by PROABONOS, the institute which manages guano extraction. The Reserva Nacional de Paracas protects an area of 1,293 mi^2 (3,350 km^2) of the coastal marine ecosystem. In 2006, 1,375 penguins were observed in this reserve (Lleellish *et al.* 2006, pp. 5–6). However, patrols of this area are inadequate to police illegal activities such as dynamite fishing (Lleellish *et al.* 2006, p. 4).

In 2008, the Chilean National Commission for the Environment (CONAMA) listed this species as vulnerable. Other protections include a 30–year moratorium on hunting and capture of Humboldt penguins; and at least four major colonies are protected by Federal law. In fact, most terrestrial sites where the species occurs are within the national system of protected areas (UNEP WCMC 2003, p. 8).

The species is listed in Appendix I of CITES and in Appendix I of the Convention on Migratory Species. Refer to the discussion of the application of CITES under Factor B with respect to international trade. Because commercial exportation of Humboldt penguins from Peru or Chile is not only prohibited (Ellis *et al.* 1998, p. 101, UNEP 2003, p. 8), but also regulated under CITES, export is not a threat to the species.

While legal protections are in place for the Humboldt penguin in both Chile and Peru, in general it is reported that enforcement of such laws is limited due to inadequate resources and the remote location of penguin colonies (UNEP WCMC 2003, p. 8). The UNEP WCMC Report on the Status of Humboldt Penguins concluded that little has been done to establish fishing-free zones and that there has been slow progress in preventing penguins from being caught in fishing nets. Majluf *et al.* (2002, p. 1342) stated, "There is currently no management of artesanal [sic] gill-net fisheries in Peru, except for restrictions on retaining cetaceans and penguins. Even these regulations are difficult to enforce in remote and isolated ports such as San Juan." Therefore, regulation is still inadequate with respect to fisheries bycatch.

Both countries have national authorities and national contingency plans for oil spill responses. Chile has the capability to respond to Tier One (small spills with no outside intervention) and Tier Two oil spill events (larger spills requiring additional outside resources and manpower) (International Tankers Owners Pollution Federation Limited (ITOPF) 2003, p. 2). Although Peru responded well to an oil spill in 2008 near Paracas National Reserve, as of 2009, Peru was not listed as having significant capability to respond to oil spill events (ITOPF 2009, p. 1). Based on the ability of Chile to respond to threats, Peru's successful response in 2008, and the location of Humboldt penguins in an area where they are not likely to be exposed to many oil spills, we find that oil spills are not a threat to the Humboldt penguin.

As indicated under factor B, tourism has been identified as a threat to the Humboldt penguin. Since the 1990 designation of the Humboldt National Reserve in Chile, tourism has increased rapidly with little regulation (Ellenberg *et al.* 2006, p. 97). Humboldt penguin breeding success varied based on levels of tourism on these three islands. Breeding success was very low at Damas Island, the most tourist accessible island, which saw over 10,000 visitors in 2003. Better breeding success was observed at Choros Island, a less accessible island which saw fewer than 1,000 visitors. The highest breeding success was observed at the remote and largest Chanaral Island colony, where tourist access was negligible. Humboldt penguins reacted to human presence and displayed little habituation potential. Their reactions indicate that there is a strong need for tourism guidelines for this species (Ellenberg *et al.* 2006, p. 103). Researchers described nest destruction by tourists at Puñihuil Island, a popular unregulated tourist destination in southern Chile (Simeone and Schlatter 1998, p. 420). Both the attractiveness of the penguins for tourism and the potential for increased impacts from human disturbance stem from the coincidence of the prime tourist season with the Humboldt penguin's spring and summer breeding season.

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We find that inadequacy of existing regulatory mechanisms, particularly due to the lack of enforcement of existing prohibitions related to fishing methods and management of fisheries bycatch, and to insufficiently regulated tourism, is a threat to the Humboldt penguin.

Factor E. Other Natural or Manmade Factors Affecting Its Continued Existence

Both large-scale commercial fisheries and small local fisheries compete for the primary food of the Humboldt penguin throughout its range (BirdLife International 2007, p. 4; Ellis *et al.* 1998, p. 100; Herling *et al.* 2005, p. 23; Hennicke and Culik 2005, p. 178). While El Niño events (see Factor A) cause severe fluctuations in Humboldt penguin numbers, overfishing and entanglement (see Factor E) are identified as steady contributors to underlying long-term declines (BirdLife International 2007, p. 4). Anchovies are a primary component of Humboldt penguins' diet. The anchovy fishery in Peru collapsed in the 1970s due to a high number of catches and the overcapacity of fishing fleets, factors that were exacerbated by the effects of the 1972–1973 El Niño event. Twenty years passed before it became clear that this fishery had recovered (Food and Agriculture Organization (FAO) 2007, p. 2). These recovered stocks continue to be significantly impacted by major El Niño events, but have rebounded more quickly recently. Peru reported anchovy catches of 8.64 million T (9.6 million t) in 2000, and 5.76 million T (6.4 million t) in 2001 (FAO 2007, p. 2). El Niño events have caused periodic crashes of the food supply of Humboldt penguins in Peru and Chile in both the historic and recent past. El Niño events, which occur irregularly every 2–7 years, have increased in frequency and intensity in recent years. Commercial fishing in combination with El Niño events has contributed to the historic declines of Humboldt penguins, and the identified threat of El Niño will interact with fisheries during future El Niño episodes. These events in combination with

competition for prey from fisheries are likely to impact Humboldt penguins more frequently and more severely in the foreseeable future. Chile reported fish catches of 1.25 million T (1.4 million t) in 2004 (FAO 2006, p. 4). In Chile, local-level commercial extraction of specific fish species has reduced those species in the diet of penguins, and fisheries' extraction has the potential to harm Humboldt penguins if overfishing occurs (Herling *et al.* 2005, p. 23). Researchers tracking the foraging effort of penguins in northern Chile concluded that even small variations in food supply, related to small changes in sea-surface temperature, led to increased foraging time (Culik and Luna-Jorquera (1997, p. 555) and Hennicke and Culik (2005, p. 178). They concluded that Humboldt penguins have high energetic costs to obtain food even in non-El Niño years. The synergistic actions of these fisheries with El Niño events can be devastating to the Humboldt penguin, since anchovies are one of the primary food sources for the species. The establishment of no-fishing zones encompassing the foraging range around the breeding area at Pan de Azucar Island has been recommended to buffer the species from possible catastrophic effects of future El Niño events. Competition between local fishermen (both for commercial and noncommercial consumption) and penguins for local pelagic fish, particularly anchovies (Herling *et al.* 2005, p. 21) exists. The farther penguins have to travel for food, the more energy they expend (Davis 2001, p. 9) which leads to a reduced ability to survive. Herling *et al.* calculated that 1,400 T (1,272 t) of fish are required in a breeding season for 40,000 penguins. If fish are unavailable due to competition from fisheries, this could lead to decreased reproductive capabilities and starvation. (Herling *et al.* 2005, p. 21). Chile is monitoring the fisheries in relation to El Niño episodes and Humboldt penguins. However, on the basis of the best available information we conclude that competition for prey from commercial or local fisheries is currently a threat to the Humboldt penguin.

We find that the synergistic effects of El Niño combined with competition for prey from commercial or local fisheries is likely to be a threat to the Humboldt penguin within the foreseeable future by causing a reduction in food availability for the penguins and an increase in energy expenditure.

Incidental take by fishing operations has been identified to be one of the most significant threat to Humboldt penguins (BLI 2010, p. 1). The Government of Peru lists incidental take by fisheries in fishing nets as one of the major sources of penguin mortality (IMARPE 2007, p. 2). Paredes *et al.* (2003, p. 135) attribute increased human disturbance to the changes in distribution of penguin colonies southward in Peru. There are now fewer penguins on the central coastal area and more to the south. Reports from Chile indicated a similar level of impact on the species (Majluf *et al.* 2002, pp. 1338–1343). In Peru, the expansion of local-scale fisheries and the switching to new areas and fish species is occurring. Local fisheries are unable to compete with larger commercial operations, bringing humans and penguins into increasing contact, and subsequently increasing penguin mortality due to entanglement in fishing nets (Paredes *et al.* 2003, p. 135). Between 1991 and 1998, Majluf *et al.* (2002, pp. 1338–1343) recorded 922 deaths in fishing nets out of a population of approximately 4,000 breeding Humboldt penguins at Punta San Juan, Peru. Take was highly variable between years, with the greatest incidental mortality occurring when surface set drift gill nets were being used to catch cojinovas (*Seriolella violace),* a species that declined during the course of the study. A subsequent study found that the risk of entanglement is highest when surface nets are set at night (Taylor *et al.* 2002, p. 706). This level of incidental take was found to be unsustainable even without factoring in periodic El Niño impacts.

In Chile, Simeone *et al.* (1999, pp. 157–161) recorded that 605 Humboldt penguins drowned in drift gill nets set for corvina (*Cilus gilberti*) in the Valparaiso region of central Chile between 1991 and 1996. Birds pursuing anchovies and sardines were apparently unable to see the transparent nets in their path and were entangled and drowned. These mortalities occurred outside of the breeding season when penguins forage in large aggregations and probably involved birds originating from beyond small, local colonies. The deaths recorded represent underestimates of rangewide mortality—the authors only studied one of four major regions where corvina fishing occurred. Incidental mortality from such fishing operations is thought to affect Humboldt penguins throughout the species' range (Wallace *et al.* 1999, p. 442). Therefore, we conclude that fisheries bycatch is a threat to the Humboldt penguin.

Fishing with explosives, such as dynamite, is listed by INRENA as one of three major threats to Humboldt penguins in Peru (INRENA 2007, p. 2). The use of explosives is recurrent in the marine area around Reserva Nacional de Paracas, the primary center of population for penguins in Peru. Explosives use is especially prevalent in the southern zone, an area that contains more than 73 percent of the population, but does not receive as thorough patrolling as the north (Lleellish *et al.* 2006, p. 4).

Oil and chemical spills can have direct effects on the Humboldt penguin. The range of the species encompasses major industrial ports along the coast of both Chile and Peru. Approximately 100,000 barrels per day of crude oil pass through the coastal waters from the tip of South America to Panama (ITOPF 2003, p. 1), with over 1,000 tankers calling annually at ports in the entire region. Major spill events in Chile have been limited to the area from the Straits of Magellan to the south of the range of the Humboldt penguin, and no major events have been recorded for Peru (ITOPF 2000a, p. 2; ITOPF 2000b, p. 2). On May 25, 2007, about 92,400 gallons (350,000 liters) of crude oil leaked into San Vicente Bay in Talcuhuano, near Concepcion, Chile, during offloading of fuel by the vessel *New Constellation*, with impacts on sea lions and seabirds, including Humboldt penguins (Equipo Ciudano 2007, p. 1). A similar spill of 2,206 T (2,000 t) of crude oil occurred at an oil terminal off Lima in 1984, severely polluting beaches there (ITOPF 2000b, p. 3). As noted in Factor D, Chile and Peru have limited ability to handle spill cleanup.

While there is a possibility of oil spill impacts as a result of incidents along the Peruvian or Chilean coast, we find a number of factors mitigate against a finding that oil spills are a threat to the species. There is little history of spill events in the region, and the breeding colonies of Humboldt penguin are widely dispersed along a very long coastline. In addition, the Humboldt penguin's distribution does not encompass the southern tip of South America where the risk of oil spill is greatest. On this basis, we conclude that oil spill impacts are not a threat to the survival of the Humboldt penguin in any portion of its range.

Other than El Niño events, which were identified as a threat factor and discussed under factor A, the best available information does not indicate that climate change is likely to cause this species to become in danger of extinction now or in the foreseeable future. We rely primarily on synthesis documents (e.g., IPCC 2007) that present the consensus view of a very large number of experts on climate change from around the world. We have found

that these synthesis reports, as well as the scientific papers used in those reports or resulting from those reports, represent the best available scientific information we can use to inform our decision. Gille (2002, p. 1276) found that ocean warming did occur in the 1950s and 1960s, but that it leveled off in the 1980s and 1990s. Climate-change scenarios estimate that the mean air temperature could increase by more than 3 °C (5.4 °F) by 2100 (IPCC 2007, p. 46). Overall, there was an increase in ocean water temperature in the Southern Hemisphere over the past 50 years. Additionally, during 2090-2099, precipitation is predicted to increase across the sub-Antarctic and Antarctic region, with a greater than 20 percent increase predicted for the Antarctic continent. Ocean warming and sea level rise may occur based on increases in global average air and ocean temperatures, widespread melting of snow and ice, and rising global average sea level ((IPCC 2007, p. 30). However, although the models above make general predictions at a large scale, we know of no climate change models currently available that make meaningful predictions of climate change at a smaller scale that includes the range of the Humboldt penguin. Given this lack of information, we are unable to conclude that climate change, sea level rise, or ocean warming other than El Nino events, are a threat to the species.

The Humboldt penguin is vulnerable to various threats under Factor E. In summary, we find that the synergistic effects of El Niño combined with competition for prey from commercial or local fisheries (competition with fishermen in times of reduced food availability), fisheries bycatch (catch in gillnets), and fishing with explosives are threats to the survival of the Humboldt penguin.

Humboldt Penguin Finding

The Humboldt penguin has decreased historically from what was believed by some to be more than a million birds in the 19th century to 41,000 to 47,000 birds today (Ellis *et al.* 1997, pp. 96-97; Ellis *et al.* 2007, p. 7.). Since 1981, the Peruvian population has fluctuated between 3,500 and 7,000 individuals, with the most recent estimate at 5,000 individuals. Estimates of the population in Chile (30,000 to 35,000 individuals) have been recently updated with improved documentation of a colony at Isla Chanaral. The increase in the population estimate is believed to be a correction of systematic undercounting that occurred for 20 years; we cannot conclude that it signifies recent population increases in Chile.

Under Factor A, we find that the present or threatened destruction, modification, or curtailment of the Humboldt penguin's habitat or range is occurring. Historical threats to terrestrial habitat, in particular the destruction of Humboldt penguin nesting substrate by guano collection, have in part been responsible for the massive historical decline of the species, and this loss of nesting habitat continues to impact the breeding success of the species. Effects of guano extraction on the current populations appear to have been reduced by designation of protected areas and management of the limited guano harvesting that still occurs. However, at guano islands the availability and quality of nesting habitat is still impacted by ongoing harvest.

The impact of El Niño events, which have caused periodic crashes of the food sources of Humboldt penguins in Peru and Chile in the historic and recent past, is a threat factor leading to declines of this species. Given reduced population sizes and the existence of other significant threats, the resiliency of the Humboldt penguin to respond to these cyclical El Nino events is greatly reduced. Such events, which occur irregularly every 2–7 years, have increased in frequency and intensity in recent years and are likely to impact Humboldt penguins more severely in the foreseeable future.

Under Factor B, we find that the species is being overutilized for commercial, recreational, scientific, or educational purposes. Harvest of Humboldt penguins for food, eggs and bait is a threat to the survival of the Humboldt penguin throughout its range. We have no reason to believe this threat will be ameliorated in the future. Tourism, if not properly managed or regulated, has the potential to impact individual colonies; therefore, we conclude that inadequately managed tourism is currently a threat to the species.

Under Factor C, on the basis of the best available information, we conclude that predation is a threat to the Humboldt penguin.

Under Factor D, there is evidence of lack of enforcement and lack of significant measures to reduce the impacts of bycatch and inadequately regulated tourism. Therefore, we find that inadequacy of existing regulatory mechanisms, particularly due to the lack of enforcement of existing prohibitions related to fishing methods and management of fisheries bycatch, along with insufficiently regulated tourism, is a threat to the Humboldt penguin.

Under Factor E, we find that other natural or manmade factors are affecting the continued existence of this species. First, the range of the Humboldt penguin along the coast of Chile and Peru does not have the same history of major spills or the same level of shipping traffic as ranges of other penguin species. Therefore, we conclude that oil spill impacts are not a threat to the survival of the Humboldt penguin. Industrial fisheries' extraction, which in conjunction with El Niño caused collapse of anchovy stocks in the 1970s, has had a historical influence on the species and contributed to its long-term decline. The recovery of fish stocks since the 1970s, however, has improved the food base of this species. Large-scale commercial fisheries and local-scale fisheries' extraction are targeting the same prey as the Humboldt penguin, which is a current threat to the species. More importantly, incidental take by fisheries operations has emerged as the most significant human-induced threat to Humboldt penguins in both Chile and Peru. Entanglement in gill nets caused significant documented mortality of Humboldt penguins in both countries in the 1990s. We have no reason to believe this will be ameliorated in the foreseeable future. Therefore, we find that ongoing threat of incidental take from fisheries bycatch and fishing with explosives are threats to the Humboldt penguin.

In summary, we find that the Humboldt penguin is likely to become in danger of extinction within the foreseeable future due to : (1) Destruction of its habitat by guano extraction; (2) high likelihood of El Niño events impacting the prey of Humboldt penguins in cyclical 2- to 7–year timeframes; (3) intentional harvest of this species for meat, eggs, and bait, and improperly managed tourism; (4) inadequacy of existing regulatory mechanisms, particularly in the area of enforcement of existing prohibitions related to fishing methods and management of fisheries bycatch and inadequately regulated tourism; (5) predation by rats and cats; and (6) incidental take from fisheries bycatch and fishing with explosives.

Distinct Population Segment (DPS)

Section 3(15) of the Act defines "species" to include "any distinct population segment of any species of vertebrate fish or wildlife which interbreeds when mature." To interpret and implement the DPS provisions of the Act, the Service and National Marine Fisheries Service published a Policy Regarding the Recognition of Distinct Vertebrate Population Segments

in the **Federal Register** (DPS Policy) on February 7, 1996 (61 FR 4722). Under the DPS policy, three factors are considered in a decision concerning the establishment and classification of a possible DPS. These are applied similarly to both endangered and threatened wildlife.

We determine: (1) The discreteness of a population in relation to the remainder of the taxon to which it belongs; (2) the significance of the population segment to the taxon to which it belongs; and (3) the population segment's conservation status in relation to the Act's standards for listing (addition to the list), delisting (removal from the list), or reclassification (i.e., whether the population segment is endangered or threatened).

The policy first requires the Service to determine that a vertebrate population is discrete in relation to the remainder of the taxon to which it belongs. Discreteness refers to the ability to delineate a population segment from other members of a taxon based on either (1) physical, physiological, ecological, or behavioral factors, or (2) international governmental boundaries that result in significant differences in control of exploitation, management, or habitat conservation status, or regulatory mechanisms that are significant in light of section 4(a)(1)(D) of the Act—the inadequacy of existing regulatory mechanisms.

Second, if we determine that the population is discrete under one or more of the discreteness conditions, then a determination is made as to whether the population is significant to the larger taxon to which it belongs. In carrying out this examination, we consider available scientific evidence of the population's importance to the taxon to which it belongs. This consideration may include, but is not limited to the following: (1) The persistence of the population segment in an ecological setting that is unique or unusual for the taxon; (2) evidence that loss of the population segment would result in a significant gap in the range of the taxon; (3) evidence that the population segment represents the only surviving natural occurrence of a taxon that may be more abundant elsewhere as an introduced population outside of its historic range; and (4) evidence that the discrete population segment differs markedly from other populations of the species in its genetic characteristics from other populations of the species. A population segment needs to satisfy only one of these conditions to be considered significant.

Lastly, if we determine that the population is both discrete and significant, then the policy requires an analysis of the population segment's conservation status in relation to the Act's standards for listing (addition to the list), delisting (removal from the list), or reclassification (i.e., whether the population segment is endangered or threatened).

Humboldt penguins have a continuous range from northern Peru to mid-southern Chile. We analyzed this species to determine if a DPS existed because its range spans two countries.

Discreteness Analysis

Under the DPS policy, a population segment of a vertebrate taxon may be considered discrete if it satisfies either of the following conditions: (1) It is markedly separated from other populations of the same taxon as a consequence of physical, physiological, ecological, or behavioral factors, or (2) it is delimited by international boundaries within which differences in control of exploitation, management of habitat, conservation status, or regulatory mechanisms exist that are significant in light of section 4(a)(1)(D) of the Act.

With respect to discreteness criterion 1, we did not identify any marked biological boundaries between populations within that range or any differences in physical, physiological, ecological, or behavioral factors among any groups within that range. We found no reports of genetic or morphological discontinuity between any discrete segments of the population.

The range of the Humboldt penguin crosses the international boundary between Peru and Chile, which leads to evaluation of the second discreteness factor. However, in our analysis of differences between Peru and Chile in conservation status, habitat management, and regulatory mechanisms, we have found no significant differences between the two countries. In both countries, intentional take of penguins is prohibited, but some illegal take occurs. Measures to address fisheries bycatch are similar, but fisheries bycatch remains widespread. Both countries provide protection to major breeding colonies of the species. The Chilean population is more numerous, but the extent of their range is greater. Given the fact that problems in census data have only recently been corrected, we cannot conclude that Chilean Humboldt penguin population trends are different from the Peruvian trends or that conservation concerns are different. In fact, the impacts of habitat loss, the effects of El Niño, intentional take, inadequacy of regulatory mechanisms, and fisheries bycatch are concerns throughout the species' range in both countries.

Based on our analysis, we do not find that differences in conservation status or management for Humboldt penguins across the range countries are sufficient to justify the use of international boundaries to satisfy the discreteness criterion of the DPS Policy. Therefore, we have concluded that there are no population segments that satisfy the discreteness criterion of the DPS Policy. As a consequence, we could not identify any geographic areas or populations that would qualify as a DPS under our 1996 DPS Policy (61 FR 4722).

Significant Portion of the Range Analysis

Given the continuous linear range of the Humboldt penguin, which breeds from northern Peru to south-central Chile, and the distribution of colonies along that coast, no specific geographic portions of concern were immediately apparent. Recent research found that long-term gene flow is occurring between populations in Peru and Chile, but, as would be expected, it is affected by geographic distance (Schlosser *et al.* 2009, p. 839). The researchers further suggest that this species should be managed as a metapopulation rather than as separate populations.

Overall, for each factor identified as a threat, we found that threats occurred throughout the range. Terrestrial and marine habitat loss, which included the impacts of guano extraction and the effects of El Niño, intentional harvest, insufficiently regulated tourism, the inadequacy of regulatory mechanisms, and fisheries bycatch were determined to be threats throughout the Humboldt penguin's range.

In reviewing our findings, one difference within threat Factor A relates to the ongoing limited harvest of guano in Peru, while such harvest has stopped in Chile. In our finding, we indicated that both the historic and present impacts of guano extraction were a threat to the Humboldt penguin. On the basis of this difference, we considered whether the Peruvian population of Humboldt penguin may be in danger of extinction in a significant portion of its range. The information available on local harvest patterns or population trends in specific areas where guano harvest is documented does not allow us to divide the range further. The most recent 2006 estimate of the Peruvian population of the Humboldt penguin is approximately 5,000 individuals. This count includes an increase of 41 percent since 2004 in the southern portion of the range, where 80 percent of the birds are found. The overall population has

fluctuated between 2,100 and 7,000 individuals since 1981, with fluctuations attributed to response to El Niño events. While the population of Humboldt penguins in Peru has fluctuated at low numbers for many years, current evidence of increases over the last few years reflects continued reproduction and resiliency of this population. Therefore, we find that the Humboldt penguin is not currently in danger of extinction in the Peruvian portion of the range.

As a result, while the best available scientific and commercial data allow us to make a determination as to the rangewide status of the Humboldt penguin, we have determined that there are no significant portions of the range in which the species is currently in danger of extinction. Therefore, we are listing the Humboldt penguin as a threatened species throughout its range under the Act.

Erect-Crested Penguin (*Eudyptes sclateri*)

Background

The erect-crested penguin, a New Zealand endemic, breeds on the Bounty Islands and Antipodes Islands, located approximately 437 mi (700 km) and 543 mi (870 km), respectively, southeast of the South Island of New Zealand (NZ DOC 2006, pp. 27, 30). Its habitat consists of 8 of the 20 Bounty islands, with a total area of 0.5 mi^2 (1.3 km^2). The Antipodes Islands consist of two main islands and some minor islands. The largest is Antipodes Island, consisting of 2,025 hectares (ha) (5,004 acres (ac)), and the second island, Bollons, consists of 50 ha (124 ac). Erect-crested penguins nest in large, dense, conspicuous colonies, numbering thousands of pairs, on rocky terrain (BirdLife International 2007, p. 3). Winter distribution at sea is largely unknown.

The Action Plan for Seabird Conservation of New Zealand lists the total world breeding population of erect-crested penguin at 81,000 pairs +/- 4,000 pairs (Taylor 2000, p. 65). In 1978, counts of erect-crested penguins at Bounty Islands estimated 115,000 breeding pairs (Robertson and van Tets 1982, p. 315), but these counts are considered overestimations (Houston 2007, p. 3). While the data were not directly comparable, 1997 counts found 27,956 pairs (Taylor 2000, p. 65), suggesting that a large decline in numbers may have occurred at the Bounty Islands (BirdLife International 2007, p. 2). There have been no complete surveys of the species since 1997–1998; however, a 2004 survey found numbers on Proclamation Island (2,788 breeding pairs) (De Roy and Amey 2005) to be similar to the numbers found in 1998, suggesting a stable population, at least at that breeding site.

In 1978, the population on the Antipodes was thought to be similar in size to that of the Bounty Islands (about 115,000 breeding pairs). Surveys in 1995 indicated a population of 49,000 to 57,000 pairs in the Antipodes (Taylor 2000, p. 65). Tennyson (2002) estimated a population of 52,000 pairs in 1995. Comparisons of photographs of nesting areas from the Antipodes show a constriction of colonies at some sites during the period 1978–1995. There have been no subsequent formal counts of erect-crested penguins at either the Bounty Islands or the Antipodes, and visits to the islands are rare. Both observations and photographs taken by researchers visiting these islands for other purposes have provided anecdotal information that erect-crested penguin colony sizes continue to decrease (Davis 2001, p. 8; Houston 2008, pers. comm.).

A few hundred birds formerly bred at Campbell Island farther to the southwest in the 1940s (Bailey and Sorensen 1962); in 1986–1987, a small number of birds (20 to 30 pairs) were observed there, but no breeding was seen (Taylor 2000, p. 65). Breeding on the Auckland Islands, also to the southwest, was considered a possibility, with one pair found breeding there in 1976 (Taylor 2000, p. 65). The most recent penguin conservation assessment (Ellis *et al.* 2007, p. 6) reported erect-crested penguins are no longer present at Campbell or Auckland Islands. There is one record of breeding on the mainland of the South Island of New Zealand at Otago Peninsula, but it is unlikely there was ever widespread breeding there (Richdale 1950, pp. 152-166; Houston 2007, p. 3). Based on this information, we do not consider these areas to be part of the erect-crested penguin's current range, and have not included them in our analysis of the status of this species.

On the basis of declines of at least 50 percent in the past 45 years and a breeding range constricted to two locations, the IUCN has listed the species as "Endangered" on the IUCN Red List (BirdLife International 2007, p. 1). It is ranked as Category B (second priority) on the Molloy and Davis threat categories used by the New Zealand DOC (Taylor 2000, p. 33). On that basis, it was placed in the second category of highest priority in the New Zealand Action Plan for Seabird Conservation (Taylor 2000, p. 33). The species is listed as "acutely threatened—nationally endangered" on the New Zealand Threat Classification System list (Hitchmough *et al.* 2007, p. 38; Molloy *et al.* 2002, pp. 13–23). Under this classification system, which is nonregulatory, species experts assess the placement of species into threat categories according to both status criteria and threat criteria.

Summary of Factors Affecting the Erect-Crested Penguin

Factor A. The Present or Threatened Destruction, Modification, or Curtailment of Erect-crested Penguin Habitat or Range

There is little evidence of destruction, modification, or curtailment of erect-crested penguin breeding habitat on land at the Bounty and Antipodes Islands. Feral animals such as sheep and cattle, which could trample nesting habitat, are absent. Competition for breeding habitat with fur seals is reported to be minimal (Houston 2007, p. 1).

The New Zealand sub-Antarctic islands have been inscribed on the World Heritage List (World Heritage List 2008, p. 16). All islands are protected as National Nature Reserves and are State-owned (World Heritage Committee Report 1998, p. 21). We find that the present or threatened destruction, modification, or curtailment of the terrestrial habitat or range of the erect-crested penguin is not a threat to the species.

Given the lack of terrestrial predators at the majority of erect-crested penguin colony sites, the absence of direct competition with other species, and the lack of physical habitat destruction at these sites, recent declines in erect-crested populations have been attributed to changes in the marine habitat. Penguins are susceptible to local ecosystem perturbations because they are constrained by how far they can swim from the terrestrial habitat in search of food (Davis 2001, p. 9). It has been hypothesized that slight warming of sea temperatures, which is attributed to El Niño events, coupled with change in distribution of prey species due to a change in the ocean environment, is having an impact on erect-crested penguin colonies (Taylor 2000, p. 66; Ellis *et al.* 2007, p. 6). With respect to modification of the marine habitat of this species, periodic El Niño events have been shown to have significant effects on the marine environment on which species such as the erect crested penguins depend. El Niño events are known to reduce the available food sources such as fish species on which penguins rely heavily. These El Niño events are considered to be the main marine perturbation for the erect-crested

penguins. The primary basis for this inference comes from studies of a closely related species, the southern rockhopper penguin at Campbell Island (Cunningham and Moors 1994, p. 27), where the population declined by 94 percent between the early 1940s and 1985, from an estimated 800,000 breeding pairs to 51,500 (Cunningham and Moors 1994, p. 34). The majority of this decline appears to have coincided with a period of warmed sea surface temperatures between 1946 and 1956. It is widely inferred that warmer waters most likely affected southern rockhopper penguins through changes in the abundance, availability, and distribution of their food supply (Cunningham and Moors 1994, p. 34). Recent research suggests they may have had to work harder to find the same food (Thompson and Sagar 2002, p. 11).

The suggestion that erect-crested penguins may have been similarly impacted by changes in the marine habitat during this time period is strengthened by the fact that erect-crested penguin breeding colonies are now absent from Campbell Island (Ellis *et al.* 2007, p. 6); they disappeared from the island during the same time period (1940s to 1987) as the southern rockhopper's decline. In the 1940s, a few hundred erect-crested penguins bred on the island (Taylor 2000, p. 65). The latest IUCN assessment of the erect-crested penguin found that oceanic warming is a continuing threat, resulting in a "very rapid decline" in more than 90 percent of the population, and thus is a threat of high impact to this species (BirdLife International 2007, p. 2 of "additional data"). Therefore, based on the best available information, we find that the present or threatened destruction, modification, or curtailment of the erect-crested penguin's marine habitat is a threat to the species.

Factor B. Overutilization for Commercial, Recreational, Scientific, or Educational Purposes

Aside from periodic surveys and the possibility of a future research program focused on the diet and foraging of the species, we are unaware of any purpose for which the erect-crested penguin is currently being utilized. Therefore, we conclude that overutilization for commercial, recreational, scientific, or educational purposes is not a threat to this species.

Factor C. Disease or Predation

Avian disease has not been recorded in erect-crested penguins, although disease vectors of ticks and bird fleas are found in colonies (Taylor 2000, p. 66).

The only known mammalian predators within the current range of the erect-crested penguin are mice, which are present only on the main Antipodes Island. Although their eradication from this island is recommended as a future management action in the Action Plan for Seabird Conservation in New Zealand, we have found no reference to these mice impacting the erect-crested penguins on this one island in their range (Taylor 2000, p. 67). At the other islands in the Antipodes group (Bollons, Archway, and Disappointment) and at the Bounty Islands, mammalian predators are not present. Feral cats, sheep, and cattle are also no longer present (Taylor 2000, p. 66). The threat of future introduction of invasive species is being managed by the New Zealand DOC, which has measures in place for quarantine of researchers working on sub-Antarctic islands (West 2005, p. 36). These quarantine measures are an important step toward controlling the introduction of invasive species. At this time, however, we have no means to measure their effectiveness.

On the basis of this information, we find that neither disease nor predation is a threat to the erect-crested penguin.

Factor D. Inadequacy of Existing Regulatory Mechanisms

All breeding islands of the erect-crested penguin are protected by New Zealand as National Nature Reserves. The marine areas are managed under fisheries legislation (World Heritage Committee Report 1998, p. 21).

The Action Plan for Seabird Conservation in New Zealand is in place and outlines previous conservation actions, future management actions needed, future survey and monitoring needs, and research priorities. Among the most relevant recommendations are pest quarantine measures to keep new animal and plant pest species from reaching offshore islands and eradication of mice from the main Antipodes Island (Taylor 2000, p. 67). At least one of these recommendations has been put into place; as mentioned under Factor C, strict required quarantine measures are now in place for researchers and expeditions to all New Zealand sub-Antarctic islands to prevent the introduction or re-introduction of animal and plant pest species (West 2005, p. 36). At this time, we have no means to measure the effectiveness of these quarantine measures.

In addition to national protection, all of New Zealand sub-Antarctic islands are inscribed on the World Heritage List (World Heritage List 2008, p. 16). World Heritage designation places an obligation on New Zealand to "take appropriate legal, scientific, technical, administrative and financial measures necessary for the identification, protection, conservation, presentation and rehabilitation of this heritage" (World Heritage Convention 1972, p. 3). At the time of inscription of this site onto the World Heritage List in 1998, human impacts were described as "limited to the effects of introduced species at Auckland and Campbell Islands" (World Heritage Convention Nomination Documentation 1998, p. 1).

New Zealand has in place the New Zealand Marine Oil Spill Response Strategy, which provides the overall framework to mount a response to marine oil spills that occur within New Zealand's area of responsibility. The aim of the strategy is to minimize the effects of oil on the environment and human safety and health. The National Oil Spill Contingency Plan promotes a planned and nationally coordinated response to any marine oil spill that is beyond the capability of a local regional council or outside the region of any local council (Maritime New Zealand 2007, p. 1). As discussed below under Factor E, rapid containment of spills in remote areas and effective triage response under this plan have shown these to be effective regulatory mechanisms (New Zealand Wildlife Health Center 2007, p. 2; Taylor 2000, p. 94).

On the basis of national and international protections in place, we find that inadequacy of existing regulatory mechanisms is not a threat to the erect-crested penguin.

Factor E. Other Natural or Manmade Factors Affecting the Continued Existence of the Species

New Zealand's Action Plan for Conservation of Seabirds notes that, while there is a possibility that erect-crested penguins could be caught in trawl nets or by other fishing activity, there are no records of such (Taylor 2000, p. 66). The IUCN noted that the New Zealand DOC has limited legal powers to control commercial harvesting in waters around the sub-Antarctic islands and recommended that the New Zealand Ministry of Fisheries should be encouraged to address fisheries bycatch and squid fishery impacts (World Heritage Nomination—IUCN Technical Evaluation 1998, p. 25). As noted in the discussion under Factor A, the Action Plan for Conservation of New Zealand Seabirds outlines research efforts that would provide more data on the diet

and activities and distribution of erect-crested penguins at sea. Such research will assist in evaluating whether competition for prey with fisheries or bycatch from fisheries' activities is a factor in declines of the erect-crested penguin. However, in the absence of such research results, we have found no evidence that erect-crested penguins are subject to fisheries bycatch.

We have examined the possibility that oil and chemical spills may impact erect-crested penguins. Such spills, should they occur and not be effectively managed, can have direct effects on marine seabirds. A large proportion of erect-crested penguin populations are found on two isolated, but widely separated, island archipelagos during the breeding season. While the 138-mi (221-km) distance between the two primary breeding areas reduces the likelihood of impacts affecting the entire population, the limited number of breeding areas is a concern relative to the potential of oil spills or other catastrophic events. As a gregarious, colonial nesting species, erect-crested penguins are potentially susceptible to mortality from local oil spill events during the breeding season. A significant spill at either the Antipodes or Bounty Islands could jeopardize more than one-third of the population of this species. The nonbreeding season distribution of erect-crested penguins is not well-documented, but there is the potential for birds to encounter spills within the immediate region of colonies or, if they disperse more widely, elsewhere in the marine environment.

Based on previous incidents of oil and chemical spills around New Zealand, we might have concluded that this is a threat to this species, were it not for New Zealand's successful Oil Spill Response and Contingency Plan. For example, in March 2000, the fishing vessel *Seafresh 1*sank in Hanson Bay on the east coast of Chatham Island and released 66 T (60 t) of diesel fuel. Rapid containment of the oil at this very remote location prevented any wildlife casualties (New Zealand Wildlife Health Center 2007, p. 2). The same source reported that, in 1998, the fishing vessel *Don Wong 529*ran aground at Breaksea Islets, off Stewart Island, outside the range of the erect-crested penguin. Approximately 331 T (300 t) of marine diesel was spilled along with smaller amounts of lubricating and waste oils. With favorable weather conditions and establishment of triage response, no casualties from this pollution event were discovered (Taylor 2000, p. 94). The potential threat of oil or chemical spills to the erect-crested penguin is mitigated by New Zealand's oil spill response and contingency plans, which have been shown to be effective in previous events even at remote locations. The remoteness of Antipodes and Bounty Islands and their extreme distance from major shipping routes or shipping activity further lessen the chance that oil and chemical spills would affect this species. On the basis of the best available information, we find that oil and chemical spills are not a threat to the erect-crested penguin.

Erect-crested Penguin Finding

Significant declines in numbers have been documented for the erect-crested penguin between 1978 and 1997 at their two primary breeding grounds on the Bounty and Antipodes Islands. The latest population estimates from the late 1990s indicated there were approximately 81,000 pairs of erect-crested penguins in these two primary breeding grounds. The declines are reported to be largest at Bounty Island, although the extent of the decline is uncertain due to the differing methodologies between the surveys conducted there in 1978 and those conducted in 1997–1998. At the Antipodes Islands, declines of 50 to 58 percent have been estimated between 1978 and 1995, with photographic evidence from those 2 years showing obvious contraction in colony areas at some sites (Taylor 2000, p. 65). Formal surveys have not been conducted since the 1995 and 1997–1998 surveys referenced above for the Antipodes and Bounty Islands, respectively. The only further information for this primary portion of the range is qualitative photographic evidence and observations suggesting that declines continue.

The most recent detailed information, from a decade ago, indicated populations were in decline, with more recent qualitative information suggesting declines continue. We have no recent population assessments for the erect-crested penguin. Although this qualitative data is currently the best information available, its use in establishing a reliable population trend is limited. Despite the relatively high population numbers of this species estimated in 1998, the population numbers at the time showed a very high rate of decline.

The weight of evidence of available information suggests that the changes in the marine environment due to El Niño events may be the most likely cause of this species' decline. This species' breeding colonies have been reduced to only two breeding island groups, separated from one another by 138 mi (221 km). Lower population numbers, combined with the limited number of breeding areas, make this species even more vulnerable to the threats from changes in the marine habitat. El Niño events can have an effect on the marine environment by causing changes in ocean currents. Warmer waters will not contain the fish species normally preyed upon by penguins. Ocean areas used by penguins to forage for fish species may be warmer during El Niño years, which decreases food availability for the penguins. Because the normal prey base is unavailable for the erect crested penguins, they have to travel farther and expend more energy to obtain food.

We are unsure the exact mechanism causing the decline of the erect-crested penguin populations, however data indicate that the population is in a declining trend. Although changes in the marine environment (Factor A) have been hypothesized to be responsible for the species' decline, the cause of the decline are not definitively known. It is not necessary to identify the causes of the decline with certainty to warrant listing of a species under the Act. At this time, NZDOW can monitor any threats to the species, but they currently have no management tools to reduce any suspected threats. Therefore, it is reasonably likely that these threats will continue in the future. We have no reason to believe that population trends will change in the future, nor that the effects of current threats acting on the species will be ameliorated in the foreseeable future. Therefore, on the basis of our analysis of the best available scientific and commercial information, we conclude that, due to changes in the marine environment, the erect-crested is likely to become in danger of extinction within the foreseeable future throughout all of its range.

Significant Portion of the Range Analysis

Erect-crested penguins breed on two primary island groups, Bounty and Antipodes Islands, which lie about 138 mi (221 km) from one another in the South Pacific Ocean to the southwest of the South Island of New Zealand. The erect-crested penguin is documented as in decline at these two islands. Our rangewide threats analysis found that changes in the marine habitat—slight warming of sea surface temperatures and their possible impact on prey availability—have the same impact on the two areas. No information is available that suggests this threat is disproportionate between these two areas. The overall population number of the erect-crested penguins is not low—27,956 pairs at Bounty Island and 49,000 to 57,000 pairs at the Antipodes Islands. Although the population

numbers have declined at a very high rate and appear to be continuing to decline, the most recent population estimates indicate that the populations of both island groups are not currently in danger of extinction.

As a result, while the best scientific and commercial data allow us to make a determination as to the rangewide status of the erect-crested penguin, we have determined that there are no significant portions of the range in which the species is currently in danger of extinction. Because we find that the erect-crested penguin is not currently in danger of extinction in these two portions of its range, we need not address the question of significance for these populations.

Therefore, we are listing the erect-crested penguin as a threatened species throughout all of its range under the Act.

Available Conservation Measures

Conservation measures provided to species listed as endangered or threatened under the Act include recognition, requirements for Federal protection, and prohibitions against certain practices. Recognition through listing results in public awareness, and encourages and results in conservation actions by Federal governments, private agencies and groups, and individuals.

Section 7(a) of the Act, as amended, and as implemented by regulations at 50 CFR part 402, requires Federal agencies to evaluate their actions within the United States or on the high seas with respect to any species that is proposed or listed as endangered or threatened, and with respect to its critical habitat, if any is being designated. However, given that the yellow-eyed penguin, white-flippered penguin, Fiordland crested penguin, Humboldt penguin, and erect-crested penguin are not native to the United States, critical habitat is not being designated for these species under section 4 of the Act.

Section 8(a) of the Act authorizes financial assistance for the development and management of programs that the Secretary of the Interior determines to be necessary or useful for the conservation of endangered and threatened species in foreign countries. Sections 8(b) and 8(c) of the Act authorize the Secretary to encourage conservation programs for foreign endangered species and to provide assistance for such programs in the form of personnel and the training of personnel.

The Act and its implementing regulations set forth a series of general prohibitions and exceptions that apply to all endangered and threatened wildlife. As such, these prohibitions would be applicable to yellow-eyed penguin, white-flippered penguin, Fiordland crested penguin, Humboldt penguin, and erect-crested penguin. Regulations governing permits are codified at 50 CFR 17.22 for endangered species, and at 17.32 for threatened species. The prohibitions for threatened species state that most of the prohibitions for endangered species also apply to threatened species. The prohibitions under 50 CFR 17.21 make it illegal for any person subject to the jurisdiction of the United States to "take" (take includes to harass, harm, pursue, hunt, shoot, wound, kill, trap, capture, collect, or to attempt any of these) within the United States or upon the high seas, import or export, deliver, receive, carry, transport, or ship in interstate or foreign commerce in the course of a commercial activity, or to sell or offer for sale in interstate or foreign commerce, any endangered wildlife species. It also is illegal to possess, sell, deliver, carry, transport, or ship any such wildlife that has been taken in violation of the Act.

We may issue permits to carry out otherwise prohibited activities involving endangered and threatened wildlife species under certain circumstances. A permit must be issued for the following purposes: for scientific purposes, to enhance the propagation or survival of the species, and for incidental take in connection with otherwise lawful activities.

Required Determinations

National Environmental Policy Act (NEPA)

We have determined that environmental assessments and environmental impact statements, as defined under the authority of the National Environmental Policy Act of 1969 (42 U.S.C. 4321 *et seq.*), need not be prepared in connection with regulations adopted under section 4(a) of the Act. We published a notice outlining our reasons for this determination in the **Federal Register** on October 25, 1983 (48 FR 49244).

References Cited

A complete list of all references cited in this rule is available on the Internet at *http://www.regulations.gov or upon request from the Endangered Species Program, U.S. Fish* and Wildlife Service (see the **FOR FURTHER INFORMATION CONTACT** section).

Authors

The primary authors of this final rule are the staff members of the Branch of Foreign Species, Endangered Species Program, U.S. Fish and Wildlife Service, 4401 N. Fairfax Drive, Arlington, VA 22203.

List of Subjects in 50 CFR Part 17

Endangered and threatened species, Exports, Imports, Reporting and recordkeeping requirements, Transportation.

Regulation Promulgation

■ Accordingly, we amend part 17, subchapter B of chapter I, title 50 of the Code of Federal Regulations, as set forth below:

PART 17—[AMENDED]

■ 1. The authority citation for part 17 continues to read as follows:

Authority: 16 U.S.C. 1361-1407; 16 U.S.C. 1531-1544; 16 U.S.C. 4201-4245; Pub. L. 99-625, 100 Stat. 3500; unless otherwise noted.

■ 2. Amend § 17.11(h) by adding new entries for "Penguin, erect-crested," "Penguin, Fiordland Crested," "Penguin, Humboldt," "Penguin, white-flippered," and "Penguin, yellow-eyed" in alphabetical order under BIRDS to the List of Endangered and Threatened Wildlife as follows:

§ 17.11 Endangered and threatened wildlife.

* * * * *

(h) * * *

Species		Historic range	Vertebrate population where endangered or threatened	Status	When listed	Critical habitat	Special rules
Common name	Scientific name						
*	*	*	*	*	*		*
BIRDS							

Species		Historic range	Vertebrate population where endangered or threatened	Status	When listed	Critical habitat	Special rules
Common name	Scientific name						
*	*	*	*	*	*		*
Penguin, erect-crested	*Eudyptes sclateri*	New Zealand, Bounty Islands and Antipodes Islands	Entire	T	771	NA	NA
Penguin, Fiordland crested	*Eudyptes pachyrhynchus*	New Zealand, South Island and offshore islands	Entire	T	771	NA	NA
*	*	*	*	*	*		*
Penguin, Humboldt	*Spheniscus humboldti*	Eastern Pacific Ocean—Chile, Peru	Entire	T	771	NA	NA
Penguin, white-flippered	*Eudyptula minor albosignata*	New Zealand, South Island	Entire	T	771	NA	NA
Penguin, yellow-eyed	*Megadyptes antipodes*	New Zealand, South Island and offshore islands	Entire	T	771	NA	NA
*	*	*	*	*	*		*

* * * * *

Dated: July 12, 2010

Wendi Weber,

Acting Director, U.S. Fish and Wildlife Service.

[FR Doc. 2010–18884 Filed 8–2–10; 8:45 am]

BILLING CODE 4310–55–S

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 218

[Docket No. 0907281180–0269–02]

RIN 0648–AX90

Taking and Importing Marine Mammals; Military Training Activities and Research, Development, Testing and Evaluation Conducted Within the Mariana Islands Range Complex

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

ACTION: Final rule.

SUMMARY: NMFS, upon application from the U.S. Navy (Navy) on behalf of the Department of Defense (including the Navy, the U.S. Air Force (USAF), and the U.S. Marine Corps (USMC)), is issuing regulations to govern the unintentional taking of marine mammals incidental to activities conducted in the Mariana Islands Range Complex (MIRC) study area for the period of July 2010 through July 2015. The Navy's activities are considered military readiness activities pursuant to the Marine Mammal Protection Act (MMPA), as amended by the National Defense Authorization Act for Fiscal Year 2004 (NDAA). These regulations, which allow for the issuance of "Letters of Authorization" (LOAs) for the incidental take of marine mammals during the described activities and specified timeframes, prescribe the permissible methods of taking and other means of effecting the least practicable adverse impact on marine mammal species or stocks and their habitat, as well as requirements pertaining to the monitoring and reporting of such taking.

DATES: Effective August 3, 2010 through August 3, 2015.

ADDRESSES: A copy of the Navy's application (which contains a list of the references used in this document), NMFS' Record of Decision (ROD), and other documents cited herein may be obtained by writing to Michael Payne, Chief, Permits, Conservation and Education Division, Office of Protected Resources, National Marine Fisheries Service, 1315 East-West Highway, Silver Spring, MD 20910–3225 or by telephone via the contact listed here (*see* **FOR FURTHER INFORMATION CONTACT**).

FOR FURTHER INFORMATION CONTACT: Jolie Harrison, Office of Protected Resources, NMFS, (301) 713–2289, ext. 166.

SUPPLEMENTARY INFORMATION:

Availability of Supporting Information

Extensive Supplementary Information was provided in the proposed rule for this activity, which was published in the **Federal Register** on October 20, 2009 (74 FR 53796). This information will not be reprinted here in its entirety; rather, all sections from the proposed rule will be represented herein and will contain either a summary of the material presented in the proposed rule or a note referencing the page(s) in the proposed rule where the information may be found. Any information that has changed since the proposed rule was published will be addressed herein. Additionally, this final rule responds to the comments received during the public comment period.

Background

Sections 101(a)(5)(A) and (D) of the MMPA (16 U.S.C. 1361 *et seq.*) direct the Secretary of Commerce (Secretary) to allow, upon request, the incidental, but not intentional taking of marine

mammals by U.S. citizens who engage in a specified activity (other than commercial fishing) during periods of not more than five consecutive years each if certain findings are made and regulations are issued or, if the taking is limited to harassment, notice of a proposed authorization is provided to the public for review.

Authorization shall be granted if NMFS finds that the taking will have a negligible impact on the species or stock(s), will not have an unmitigable adverse impact on the availability of the species or stock(s) for subsistence uses, and if the permissible methods of taking and requirements pertaining to the mitigation, monitoring and reporting of such taking are set forth. NMFS has defined "negligible impact" in 50 CFR 216.103 as:

> An impact resulting from the specified activity that cannot be reasonably expected to, and is not reasonably likely to, adversely affect the species or stock through effects on annual rates of recruitment or survival.

The National Defense Authorization Act of 2004 (NDAA) (Pub. L. 108–136) modified the MMPA by removing the "small numbers" and "specified geographical region" limitations and amended the definition of "harassment" as it applies to a "military readiness activity" to read as follows (Section 3(18)(B) of the MMPA):

> (i) Any act that injures or has the significant potential to injure a marine mammal or marine mammal stock in the wild [Level A Harassment]; or
>
> (ii) Any act that disturbs or is likely to disturb a marine mammal or marine mammal stock in the wild by causing disruption of natural behavioral patterns, including, but not limited to, migration, surfacing, nursing, breeding, feeding, or sheltering, to a point where such behavioral patterns are abandoned or significantly altered [Level B Harassment].

Summary of Request

In August 2008, NMFS received an application from the Navy requesting authorization for the take of individuals of 26 species of marine mammals incidental to upcoming Department of Defense (including Navy, USMC, and USAF) training and research, development, testing, and evaluation (RDT&E) activities to be conducted from June 2010 through June 2015 within the MIRC study area, which encompasses a 501,873-square-nautical mile (nm^2) area around the islands, including Guam, Tinian, Saipan, Rota, Farallon de Medinilla, and also includes ocean areas in both the Pacific Ocean and the Philippine Sea. These training activities are military readiness activities under the provisions of the NDAA. The Navy states, and NMFS concurs, that these military readiness activities may incidentally take marine mammals present within the MIRC study area by exposing them to sound from mid-frequency or high frequency active sonar (MFAS/HFAS) or underwater detonations. After submitting supplemental applications, the Navy requested authorization to take individuals of 26 species of marine mammals by Level B Harassment, 2 individuals of 2 species by Level A Harassment annually, and 10 individual beaked whales by mortality over the course of the 5-year regulations. The Navy's model, which did not factor in any potential benefits of mitigation measures, predicted that 2 individual marine mammals would be exposed to levels of sound or pressure that would result in injury; thus, NMFS is authorizing the take, by Level A Harassment of 2 individuals per year. However, NMFS and the Navy have determined that injury can most likely be avoided through the implementation of the Navy's proposed mitigation measures. Further, although it does not anticipate that it will occur, the Navy requested, and NMFS is authorizing the take, by injury or mortality, up to 10 beaked whales over the course of the 5-year regulations.

Background of Request

The proposed rule contains a description of the Navy's mission, their responsibilities pursuant to Title 10 of the United States Code, and the specific purpose and need for the activities for which they requested incidental take authorization. The description contained in the proposed rule has not changed (74 FR 53795, pages 53796–53797).

Overview of the MIRC Study Area

The proposed rule contains a description of the MIRC study area. It also includes a discussion of the Marianas Trench Marine National Monument (MTMNM), where the MTMNM overlaps with the MIRC study area, and protected resources within the MTMNM. These descriptions have not changed (74 FR 53795, pages 53797–53798).

Description of Specified Activities

The proposed rule contains a complete description of the Navy's specified activities that are covered by these final regulations, and for which the associated incidental take of marine mammals will be authorized in the related LOAs. The proposed rule describes the nature and number of anti-submarine warfare (ASW) training exercises and RDT&E activities, involving both mid- and high-frequency active sonar (MFAS and HFAS), explosive detonations, and vessel movement. It also describes the sound sources and explosive types used (74 FR 53795, pages 53798–53807). It also briefly describes the limited use of low frequency active (LFA) sonar in conjunction with the MIRC training, which has also been analyzed in a separate MMPA rule and EIS. The narrative description of the action contained in the proposed rule has not changed, with the exception of a few clarifications, which have been indicated in italics in tables 1 and 2, which list the types of sonar sources and the estimated yearly use and summarize the characteristics of the exercise types. Of note, the Navy indicated in the proposed rule that they will conduct one multi-strike group type exercise in the summer each calendar year. This fact remains true, however, if NMFS' annual LOAs for this action are issued in July (as currently planned), it is possible that 2 multi-strike group exercises could occur within the coverage period of one LOA (for example if a multi-strike group exercise occurred in early August one year and late June the next). The Navy would still not conduct more than 5 of these multi-strike group exercises within the life of the 5-year regulations, however, and this clerical issue does not impact our analyses of the effects on marine mammals.

The Navy has carefully characterized the training activities planned for the MIRC over the 5 years covered by these regulations; however, evolving real-world needs necessitate flexibility in annual activities. NMFS has attempted to bound this flexibility with updated language in the regulatory text (see § 218.100(d) and § 218.102(c)). This language allows for flexibility in activities, as long as the resulting impacts to marine mammals do not vary beyond those contemplated in the effects analysis, which has been also been updated accordingly in this document.

BILLING CODE 3510–22–P

Sonar Sources	Frequency (kHz)	Source Level (dB) re 1 µPa @ 1 m	Emission Spacing (m)*	Vertical Directivity	Horizontal Directivity	Associated Platform	System Description	Annual Amount	Unit
AN/SQS-53	3.5	235	154	Omni	240° forward-looking	Cruiser (CG) and Destroyer (DDG) hull mounted sonar	ASW search, detection, & localization (approximately 120 pings per hour)	1989-summer / 184-winter**	Hours
AN/SQS-56	7.5	225	129	13°	30°	Frigate (FFG) hullmounted sonar	ASW search, detection, & localization (approximately 120 pings per hour)	109-summer / 32-winter	Hours
AN/AQS-22	Classifed (MF)	Classified				Helicopter Dipping sonar	ASW search, detection, & localization (10 pings/dip, 30 seconds between pings), also used to represent AN/AQS-13	440-summer / 152-winter	*Dips*
AN/BQQ-10	Classifed (MF)	Classified				Submarine hull-mounted sonar	ASW search and attack (approximately *two pings per hour* when in use)	6-summer / 6-winter	Hours
AN/SSQ-62 DICASS (sonobuoy, tonal)	8	201	450	Omni	Omni	Helicopter and maritime patrol aircraft (P3 and P8 MPA) dropped sonobuoy	Remotely commanded expendable sonar-equipped buoy (approximately 12 pings per use, 30 secs between pings, 8 buoys per hour)	1568-summer / 86-winter	Buoys
MK-48 torpedo sonar	Classified (>10)	Classified	144	Omni	Omni	Submarine (SSN) launched torpedo (used during TORPEX)	Recoverable and non-explosive exercise torpedo; sonar is active approximately 15 min per torpedo run	20-summer / 20-winter	Torpedoes
AN/SSQ-110A (IEER)	Classified (impulsive, broadband)	Classified	n/a	Omni	Omni	MPA deployed	ASW system consists of explosive acoustic source buoy (contains two 4.1 lb charges) and expendable passive receiver sonobuoy	102-summer / 4-winter	Buoys
AN/SSQ-125 (AEER)	1	Classified	n/a	Omni	Omni	MPA deployed	ASW system consists of active sonobuoy and expendable passive receiver sonobuoy	102-summer / 4-winter	Buoys
MK-84 Range Pingers	12.9 or 37 (rare)	194	Ping dur. 15 msec / ping every 2 sec	90°		Ships, submarines, weapons, targets, and UUV (8-10 knot platform)	4 pingers max used during a PUTR TORPEX or TRACKEX exercise. Surface ship pingers are at 7 m depth / target or sub pingers at 100 m depth. 8 hours total event duration each during PUTR operational days.	280	Hours
PUTR Transponder	8.8 or 40	186 or 190	n/a		180 upward looking	Portable Undersea Tracking Range, deployed on ocean floor	*System is a 7 transponder field used in an 8hr event. When a pinger heard, transponder produces transponder report. Pinger rate is variable depends: # pingers, ping rates, platform speed, depth and orientation. Each report lasts 15 ms.*	280	Hours

Table 1. Active sonar sources in the MIRC and parameters used for modeling them. Many of the actual parameters and capabilities of these sonars are classified. Parameters used for modeling were derived to be as representative as possible. When, however, there were a wide range of potential modeling values, a nominal parameter likely to result in the most impact was used so that the model would err towards overestimation.

*Spacing means distance between pings at the nominal speed

CG – Guided Missile Cruiser; DDG – Guided Missile Destroyer; DICASS – Directional Command-Activated Sonobuoy System; FFG – Fast Frigate; HF – High-Frequency; MF – Mid-Frequency.

** As modeled, summer is mid-May through mid-November, winter is mid-November through mid-May

EXERCISE TYPE	SINKEX	EER/EER	DEMO	BOMBEX [A-S]	GUNEX [S–S]	MSSILEX [A-S]	ASW TRACKEX /TORPEX/ OTHER	(Major Ex.) Joint Expedit.	(Major Ex.) MAGTF	MULTI-STRIKE GROUP
Sources/Weapons/ Rounds	See SINKEX Ordnance Table	SSQ-110A (4.1 pound [lb] NEW)	10 lb NEW	MK 82/83/84 Series General Purpose Bombs -GBU 38/32/31 JDAM	5 in gun 76 mm gun	HELLFIRE	AN/SQS-53 MFA Sonar AN/SQS-56 MFA Sonar BQQ-10 Submarine Sonar AN/SSQ-62 DICASS Sonobuoy AN/SSQ-125 AEER Sonobuoy AN/ASQ-22Track Mode (Dipping Sonar) MK-48 Torpedo HFA Sonar PUTR: transponders and MK-84 tracking pinger	AN/SQS-53 MFA Sonar AN/SQS-56 MFA Sonar BQQ-10 Submarine Sonar AN/SSQ-62 DICASS Sonobuoy AN/SSQ-125 AEER Sonobuoy AN/ASQ-22Track Mode (Dipping Sonar) MK-48 Torpedo HFA Sonar	AN/SQS-53 MFA Sonar AN/SQS-56 MFA Sonar BQQ-10 Submarine Sonar AN/SSQ-62 DICASS Sonobuoy AN/SSQ-125 AEER Sonobuoy AN/ASQ-22 Track Mode (Dipping Sonar) MK-48 Torpedo HFA Sonar
Explosion in or on water	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes
Length of Exercise	4-8 hrs over 1-2 days	6 hours	Variable	Variable	1 to 2 hours	2 – 4 hours	8 hours	10 days	10 days	10 days
Detonations/hours/ rounds/sonobuoy or torpedo deployments, or helicopter sonar dips per exercise or year	See SINKEX Ordnance Table	106 deploy/yr (non SINKEX)	50/yr (10 lb)	Delivery of up to (1) bomb/ quarter; up to 4 bombs/ year	5" - 320 Rounds 76mm – 120 Rounds	2 HELLFIRE Missiles	SQS-53 (Search) = 368 hrs/yr SQS-53 (Kingfisher) = 0 hrs/yr SQS-56 = 64 hrs/yr BQQ-10 = 12 hrs/yr SSQ-62 DICASS = 172 Sonobuoys/yr AN/SSQ-125 AEER = 8 ASQ-22 Track Mode = 304 Dips/yr MK-48 Torpedo = 40 torpedoes/yr PUTR: 8 hours/exercise	*Joint Expeditionary and MAGTF exercises are separate events supported by amphibious ships and surface and subsurface combatants with Marine Corps expeditionary elements. These exercises may occur year around, but will not affect the total estimated projected sonar use in table 1 (including winter/summer ratio)*		SQS-53 (Search) = 1,705 hrs/exercise SQS-53 Kingfisher = 0hrs/exercise SQS -56 = 77 hrs/exercise BQQ-10 = 0 hrs/exercise SSQ-62 DICASS* = 1,282 Sonobuoys/exercise AN/SSQ-125 AEER = 98 ASQ-22Track Mode = 288 Dips/exercise MK-48 Torpedo* 0/exercise
Number Exercises per Year	2	N/A	N/A	4	5" – 8/yr 76mm– 4/yr	2	ASW TRACKEX: 66 ASW TORPEX: 17 PUTR: 35	1	4	1*
Area Used	W-517; maritime areas >50 nm from land, ATCAAs	General	Piti Floating Mine Neutralization Site, Outer Apra Harbor Deep Agat Bay Mine Neutralization	W-517, maritime areas > 12 nm from land	W-517, maritime areas > 12nm from land, > 3 nm for small arms	W-517 > 12 nm from land,	Maritime areas > 3 nm from land, W-517	General MIRC	General MIRC	General MIRC
Months of Yr	Year Round	Year	Year Round	Year Round	Year Round	Year Round	Year round	*Year Round*		Summer

Table 2. Summary of exercises in MIRC Study Area

* Note that one multi-strike group exercise may occur once per summer in every calendar year. Due to potential summer issuance of LOAs, though, two multi-strike group exercises could occur under the coverage of one LOA, though no more than 5 would occur over the course of the rule.

Description of Marine Mammals in the Area of the Specified Activities

Thirty-two marine mammal species or populations/stocks have confirmed or possible occurrence within the MIRC, including seven species of baleen whales (mysticetes), 22 species of toothed whales (odontocetes), two species of seals and sea lions (pinnipeds), and the dugong (sirenian). Table 3 summarizes their abundance, Endangered Species Act (ESA) status, population trends, and occurrence in the area. Eight of the species are ESA-listed and considered depleted under

the MMPA: Blue whale; fin whale; humpback whale; sei whale; sperm whale; North Pacific right whale; Hawaiian monk seal; and dugong. The dugong is managed by the U.S. Fish and Wildlife Service and will not be addressed further here. The proposed rule contains a discussion of five species that are not considered further in the analysis because of their rarity in the MIRC (North Pacific right whale, Hawaiian monk seal, Hubb's beaked whale, Indo-Pacific bottlenose dolphin, and northern elephant seal). The proposed rule also contains a discussion of important spinner dolphin resting areas. The proposed rule also includes a discussion of marine mammal vocalizations. Last, the proposed rule includes a discussion of the methods used to estimate marine mammal density in the MIRC. The Description of Marine Mammals in the Area of the Specified Activities section has not changed from what was in the proposed rule (74 FR 53795, pages 53807–53813).

Common Name	Species Name	IUCN/ ESA/ MMPA Status	Occurrence		Density
			Summer July-Nov	Winter Dec-June	
Mysticetes					
Blue whale	*Balaenoptera musculus*	E, D, S	Rare	Rare	0.0001***
Fin whale	*Balaenoptera physalus*	E, D, S	Rare	Regular	0.0003***
Sei whale	*Balaenoptera borealis*	E, D, S	Rare	Regular	.00029*
Bryde's whale	*Balaenoptera edeni*		Regular	Regular	.00041*
Minke whale	*Balaenoptera acutorostrata*		Rare	Regular	.0003***
Humpback whale	*Megaptera novaeangliae*	E, D, S	Rare	Regular	.0069***
North Pacific right whale	*Eubalaena japonica*	E, D, S	Rare	Rare	n/a
Odontocetes					
Sperm whale	*Physeter macrocephalus*	E, D, S	Regular	Regular	.00123*
Blainville's beaked whale	*Mesoplodon densirostris*		Regular	Regular	.00117**
Bottlenose dolphin	*Tursiops truncatus*		Regular	Regular	.00021*
Cuvier's beaked whale	*Ziphius cavirostris*		Regular	Regular	.00621**
Dwarf sperm whale	*Kogia sima*		Regular	Regular	.00714**
False killer whale	*Pseudorca crassidens*		Regular	Regular	.00111*
Fraser's dolphin	*Lagenodelphis hosei*		Regular	Regular	.00417**
Ginkgo-tooth beaked whale	*Mesoplodon ginkgodens*		Rare	Rare	.0005***
Hubbs beaked whale	*Mesoplodon carlhubbsi*		Extra-limital	Extra-limital	n/a
Indo-Pacific bottlenose dolphin	*Tursiops aduncus*		Extra-limital	Extra-limital	n/a
Killer whale offshore	*Orcinus orca*		Regular	Regular	.00014**
Longman's beaked whale	*Indopacetus pacificus*		Regular	Rare	.00041**
Melon-headed whale	*Peponocephala electra*		Regular	Regular	.00428*
Pantropical spotted dolphin	*Stenella attenuata*		Regular	Regular	.0226*
Pygmy killer whale	*Feresa attenuata*		Regular	Regular	.00014*
Pygmy sperm whale	*Kogia breviceps*		Regular	Regular	.00291**
Risso's dolphin	*Grampus griseus*		Regular	Regular	.00097**
Rough-toothed dolphin	*Steno bredanensis*		Regular	Regular	.00029*
Short-beaked common dolphin	*Delphinus delphis*		Rare	Rare	.0021***
Short-finned pilot whale	*Globicephala macrorhynchus*		Regular	Regular	.00159*
Spinner dolphin	*Stenella longirostris*		Regular	Regular	.00314*
Striped dolphin	*Stenella coeruleoalba*		Regular	Regular	.00616*
Pinniped					
Northern elephant seal	*Mirounga angustirostris*		Extra-limital	Extra-limital	n/a
Hawaiian Monk Seal	*Monachus schauinslandi*	T, D, S	Extra-limital	Extra-limital	n/a
Sirenia					
Dugong	*Dugong dugon*	E, V	Extra-limital	Extra-limital	n/a

Table 3. Marine Mammals of known or possible occurrence in MIRC. Table includes status, ocurrence, and density.

* Density derived from 2007 Mariana Islands Survey (MISTCS Report - DoN 2007)

**Density derived from Hawaii Offshore Report (Barlow 2006)

*** Density derived from Eastern Tropical Pacific (Ferguson and Barlow 2001, 2003)

E = Endangered under the ESA; T = Threatened under the ESA; D = Depleted under the MMPA; S = Strategic Stock under the MMPA;

V = Vulnerable under the International Union for the Conservation of Nature (ICUN) Red List (Reeves et al. 2003)

Extralimital: Species that has occurred rarely in the past, may be only one or several documented sightings or may occur based on genera distribution patterns.

BILLING CODE 3510–22–C

Brief Background on Sound

The proposed rule contains a section that provides a brief background on the principles of sound that are frequently referred to in this rulemaking (74 FR 53795, pages 53813–53814). This section also includes a discussion of the functional hearing ranges of the different groups of marine mammals (by frequency) as well as a discussion of the two main sound metrics used in NMFS analysis (sound pressure level (SPL) and sound energy level (SEL)). The information contained in the proposed rule has not changed.

Potential Effects of Specified Activities on Marine Mammals

With respect to the MMPA, NMFS' effects assessment serves four primary purposes: (1) To prescribe the permissible methods of taking (*i.e.,* Level B Harassment (behavioral harassment), Level A Harassment (injury), or mortality, including an identification of the number and types of take that could occur by Level A or B harassment or mortality) and to prescribe other means of effecting the least practicable adverse impact on such species or stock and its habitat (*i.e.,* mitigation); (2) to determine whether the specified activity will have a negligible impact on the affected species or stocks of marine mammals (based on the likelihood that the activity will adversely affect the species or stock through effects on annual rates of recruitment or survival); (3) to determine whether the specified activity will have an unmitigable adverse impact on the availability of the species or stock(s) for subsistence uses (however, there are no subsistence communities that would be affected in the MIRC, so this determination is inapplicable for this rulemaking); and (4) to prescribe requirements pertaining to monitoring and reporting.

In the Potential Effects of Specified Activities on Marine Mammals section of the proposed rule NMFS included a qualitative discussion of the different ways that MFAS/HFAS and underwater explosive detonations may potentially affect marine mammals (some of which NMFS would not classify as harassment), as well as a discussion of the potential effects of vessel movement and collision. It also briefly describes the anticipated impacts of limited use of low frequency active (LFA) sonar in conjunction with the MIRC training, which has also been analyzed in a separate MMPA rule and EIS. Marine mammals may experience direct physiological effects (such as threshold shift), acoustic masking, impaired communications, stress responses, and behavioral disturbance. This section also included a discussion of some of the suggested explanations for the association between the use of MFAS and marine mammal strandings (such as behaviorally-mediated bubble growth) that have been observed a limited number of times in certain circumstances (the specific events are also described). The information contained in Potential Effects of Specified Activities on Marine Mammals section from the proposed rule has not changed. *See* 74 FR 53795, pages 53814–53831.

Later, in the Estimated Take of Marine Mammals Section of this final rule, NMFS relates and quantifies the potential effects to marine mammals from MFAS/HFAS and underwater detonation of explosives discussed here to the MMPA definition of take, which includes Level A and Level B Harassment, as well as mortality.

Mitigation

In order to issue an incidental take authorization (ITA) under Section 101(a)(5)(A) of the MMPA, NMFS must set forth the "permissible methods of taking pursuant to such activity, and other means of effecting the least practicable adverse impact on such species or stock and its habitat, paying particular attention to rookeries, mating grounds, and areas of similar significance." The NDAA of 2004 amended the MMPA as it relates to military-readiness activities and the ITA process such that "least practicable adverse impact" shall include consideration of personnel safety, practicality of implementation, and impact on the effectiveness of the "military readiness activity." The training activities described in the MIRC application are considered military readiness activities.

NMFS reviewed the proposed MIRC activities and the proposed MIRC mitigation measures as described in the Navy's LOA application to determine if they would result in the least practicable adverse effect on marine mammals, which includes a careful balancing of the likely benefit of any particular measure to the marine mammals with the likely effect of that measure on personnel safety, practicality of implementation, and impact on the effectiveness of the "military-readiness activity." NMFS determined that further discussion was necessary regarding the potential relationship between the operation of MFAS/HFAS and marine mammal strandings.

NMFS worked with the Navy to identify potential additional practicable and effective mitigation measures, which included a careful balancing of the likely benefit of any particular measure to the marine mammals with the likely effect of that measure on personnel safety, practicality of implementation, and impact on the "military-readiness activity." NMFS and the Navy developed a Stranding Response Plan to address the concern listed above.

NMFS' proposed rule includes a list of the Navy's proposed mitigation measures (74 FR 53795, pages 53831–53836), which have been included in the regulatory text of this document. Some of the measures have been refined for increased clarity, but without a change in substance. Additionally, in the interest of further minimizing the likelihood of vessel collision, the following mitigation measure has been added since the publication of the proposed rule:

> Naval vessels will maneuver to keep at least 1,500 ft (500 yds) away from any observed whale in the vessel's path and avoid approaching whales head-on. These requirements do not apply if a vessel's safety is threatened, such as when change of course will create an imminent and serious threat to a person, vessel, or aircraft, and to the extent vessels are restricted in their ability to maneuver. Restricted maneuverability includes, but is not limited to, situations when vessels are engaged in dredging, submerged activities, launching and recovering aircraft or landing craft, minesweeping activities, replenishment while underway and towing activities that severely restrict a vessel's ability to deviate course. Vessels will take reasonable steps to alert other vessels in the vicinity of the whale. Given rapid swimming speeds and maneuverability of many dolphin species, naval vessels would maintain normal course and speed on sighting dolphins unless some condition indicated a need for the vessel to maneuver.

Based on our evaluation of the proposed measures and other measures considered by NMFS or recommended by the public, NMFS has determined that the Navy's proposed mitigation measures, including the Adaptive Management component (see Adaptive Management below), are adequate means of effecting the least practicable adverse impacts on marine mammals species or stocks and their habitat, paying particular attention to rookeries, mating grounds, and areas of similar significance, while also considering personnel safety, practicality of implementation, and impact on the effectiveness of the military readiness activity. The proposed rule contains further support for this finding in the

Mitigation Conclusion section (74 FR 53795, pages 53836–53837). During the public comment period, a few mitigation measures not previously considered were recommended and NMFS' analysis of these measures is included in the Response to Public Comment section.

Research

The Navy provides a significant amount of funding and support to marine research. In the past five years the agency funded over $100 million ($26 million in FY08 alone) to universities, research institutions, federal laboratories, private companies, and independent researchers around the world to study marine mammals. The U.S. Navy sponsors 70 percent of all U.S. research concerning the effects of human-generated sound on marine mammals and 50 percent of such research conducted worldwide. Major topics of Navy-supported research include the following:

- Better understanding of marine species distribution and important habitat areas,
- Developing methods to detect and monitor marine species before and during training,
- Understanding the effects of sound on marine mammals, sea turtles, fish, and birds, and
- Developing tools to model and estimate potential effects of sound.

This research is directly applicable to Fleet training activities, particularly with respect to the investigations of the potential effects of underwater noise sources on marine mammals and other protected species. Proposed training activities employ active sonar and underwater explosives, which introduce sound into the marine environment.

The Marine Life Sciences Division of the Office of Naval Research currently coordinates six programs that examine the marine environment and are devoted solely to studying the effects of noise and/or the implementation of technology tools that will assist the Navy in studying and tracking marine mammals. The six programs are as follows:

- Environmental Consequences of Underwater Sound,
- Non-Auditory Biological Effects of Sound on Marine Mammals,
- Effects of Sound on the Marine Environment,
- Sensors and Models for Marine Environmental Monitoring,
- Effects of Sound on Hearing of Marine Animals, and
- Passive Acoustic Detection, Classification, and Tracking of Marine Mammals.

The Navy has also developed the technical reports referenced within this document, which include the Marine Resource Assessments and the Mariana Islands Sea Turtle and Cetacean Survey density report. Furthermore, research cruises by NMFS and by academic institutions have received funding from the U.S. Navy.

The Navy has sponsored several workshops to evaluate the current state of knowledge and potential for future acoustic monitoring of marine mammals. The workshops brought together acoustic experts and marine biologists from the Navy and other research organizations to present data and information on current acoustic monitoring research efforts and to evaluate the potential for incorporating similar technology and methods on instrumented ranges. However, acoustic detection, identification, localization, and tracking of individual animals still requires a significant amount of research effort to be considered a reliable method for marine mammal monitoring. The Navy supports research efforts on acoustic monitoring and will continue to investigate the feasibility of passive acoustics as a potential mitigation and monitoring tool.

Overall, the Navy will continue to request funding for ongoing marine mammal research, and is implementing long term monitoring/studies of marine mammals on various established ranges and operating areas. The Navy will continue to request funding for research and contribute to university/external research to improve the state of the science regarding marine species biology and acoustic effects. These efforts include mitigation and monitoring programs; data sharing with NMFS and via the literature for research and development efforts; and future research as described previously.

Memorandum of Agreement (MOA) for Navy Assistance With Stranding Investigations

The Navy and NMFS are currently developing a nationwide Memorandum of Understanding (MOU) (or other mechanism consistent with Federal fiscal law requirements and all other applicable laws), that will establish a framework whereby the Navy can assist NMFS with stranding investigations in certain circumstances.

Long-Term Prospective Study

Apart from this final rule, NMFS, with input and assistance from the Navy and several other agencies and entities, will perform a longitudinal observational study of marine mammal strandings to systematically observe for and record the types of pathologies and diseases and investigate the relationship with potential causal factors (*e.g.,* active sonar, seismic, weather). The study will not be a true "cohort" study, because NMFS will be unable to quantify or estimate specific active sonar or other sound exposures for individual animals that strand. However, a cross-sectional or correlational analyses, a method of descriptive rather than analytical epidemiology, can be conducted to compare population characteristics, *e.g.,* frequency of strandings and types of specific pathologies between general periods of various anthropogenic activities and non-activities within a prescribed geographic space. In the long-term study, NMFS will more fully and consistently collect and analyze data on the demographics of strandings in specific locations and consider anthropogenic activities and physical, chemical, and biological environmental parameters. This approach in conjunction with true cohort studies (tagging animals, measuring received sounds, and evaluating behavior or injuries) in the presence of activities and non-activities will provide critical information needed to further define the impacts of major training exercises (MTEs) and other anthropogenic and non-anthropogenic stressors. In coordination with the Navy and other Federal and non-Federal partners, the comparative study will be designed and conducted for specific sites during intervals of the presence of anthropogenic activities such as active sonar transmission or other sound exposures and absence to evaluate demographics of morbidity and mortality, lesions found, and cause of death or stranding. Additional data that will be collected and analyzed in an effort to control potential confounding factors include factors such as average sea temperature (or just season), meteorological or other environmental variables (*e.g.,* seismic activity), fishing activities, etc. All efforts will be made to include appropriate controls (*i.e.,* no active sonar or seismic sounds); environmental variables may complicate the interpretation of "control" measurements. The Navy and NMFS along with other partners are evaluating mechanisms for funding this study.

Monitoring

In order to issue an ITA for an activity, Section 101(a)(5)(A) of the MMPA states that NMFS must set forth "requirements pertaining to the monitoring and reporting of such taking." The MMPA implementing regulations at 50 CFR 216.104 (a)(13) indicate that requests for LOAs must

include the suggested means of accomplishing the necessary monitoring and reporting that will result in increased knowledge of the species and of the level of taking or impacts on populations of marine mammals that are expected to be present.

Proposed Monitoring Plan for the MIRC

The Navy's final Monitoring Plan for the MIRC may be viewed at NMFS' Web site: *http://www.nmfs.noaa.gov/pr/permits/incidental.htm#applications.* Based on input received during the public comment period, the Navy has refined the goals of the monitoring plan to include more effort put towards obtaining better density and distribution information for the marine mammals present in the MIRC study area. Primarily, the Navy plans to conduct summer and winter visual surveys using a small boat and/or plane with Marine Mammal Observers (MMOs) around Guam, Tinian, and Saipan in cooperation with NMFS' Pacific Islands Fisheries Science Center or Guam's Division of Aquatic Wildlife and Resources (DAWR). Visual surveys would integrate methods such as photographic ID to provide additional data to be used for distribution and abundance estimates.

The research elements in the modified plan include:

—Passive acoustic monitoring (PAM) including both the deployment of 4 new PAM devices as well as the analysis of an existing dataset that was collected during the 2007 MISTCS survey.

—Visual monitoring utilizing marine mammal observers (MMOs) in small boats and/or planes.

Table 5 contains a general summary of the Monitoring effort planned for each year and has been refined since the draft Monitoring Plan. The amount of each type of monitoring may vary from the summary table or Monitoring Plan based on annual discussions between NMFS and the Navy regarding previous monitoring results and effectiveness and in accordance with the Adaptive Management component of this rule, but, the overall effort over the 5-year period will remain approximately equal to that laid out in the table and monitoring plan.

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	FY10	FY11	FY12	FY13	FY14	FY15
		ADAPTIVE MANAGEMENT REVIEW (AMR)				
Passive Acoustic Monitoring		Deploy four passive acoustic monitoring devices around the Mariana Islands that are capable of gathering data throughout the year.	Continue recording from PAM devices and begin data analysis.	Continue recording from PAM devices and conduct data analysis.	Continue recording from PAM devices and conduct data analysis.	Continue recording from PAM devices and conduct data analysis.
Acoustic Data Analysis		Analyze existing acoustic data set which was collected during Navy's 2007 MISTCS survey.	AMR	AMR	AMR	AMR
Visual Surveys	- Small boat surveys around Guam, Tinian and Saipan. - Visual observations using marine species observers aboard NMFS/PIFSC oceanographic survey in the Region, as well as during transits between Hawaii and Guam.	Conduct summer and winter visual surveys using a small boat and/or airplane around Guam, Tinian, Rota and Saipan in cooperation with NMFS and/or DAWR. Visual surveys would integrate methods such as photo ID that provide data that can be used for distribution and abundance. 45 days total.	Conduct summer and winter visual surveys using a small boat and/or airplane around Guam, Tinian, Rota and Saipan in cooperation with NMFS and/or DAWR. Visual surveys would integrate methods such as photo ID that provide data that can be used for distribution and abundance. 45 days total.	Conduct summer and winter visual surveys using a small boat and/or airplane around Guam, Tinian, Rota and Saipan in cooperation with NMFS and/or DAWR. Visual surveys would integrate methods such as photo ID that provide data that can be used for distribution and abundance. 45 days total.	Conduct summer and winter visual surveys using a small boat and/or airplane around Guam, Tinian, Rota and Saipan in cooperation with NMFS and/or DAWR. Visual surveys would integrate methods such as photo ID that provide data that can be used for distribution and abundance. 45 days total.	Conduct summer and winter visual surveys using a small boat and/or airplane around Guam, Tinian, Rota and Saipan in cooperation with NMFS and/or DAWR. Visual surveys would integrate methods such as photo ID that provide data that can be used for distribution and abundance. 45 days total.

Table 4. Planned monitoring effort in MIRC

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In addition to the Monitoring Plan for MIRC, the Navy has completed an Integrated Comprehensive Monitoring Program (ICMP) Plan.

The ICMP will be used both as: (1) A planning tool to focus Navy monitoring priorities (pursuant to ESA/MMPA requirements) across Navy Range Complexes and Exercises; and (2) an adaptive management tool, through the consolidation and analysis of the Navy's monitoring and watchstander data, as well as new information from other Navy programs (*e.g.,* R&D), and other appropriate newly published information. The Navy finalized a 2009 ICMP Plan outlining the program on December 22, 2009, as required by the 2009 LOAs for the Hawaii Range Complex, the Southern California

Range, and Atlantic Fleet Active Sonar Training. The ICMP may be viewed at: *http://www.nmfs.noaa.gov/pr/permits/incidental.htm.*

The ICMP is a developing program that will be in place for the length of this rule, and beyond, and NMFS and Navy will evaluate it annually to determine if it needs to be updated in order to keep pace with advances in science and technology and the collection of new data. In the 2009 ICMP Plan, the Navy outlines three areas of targeted development for 2010, including:

- Identifying more specific monitoring sub-goals under the major goals that have been identified.
- Characterizing Navy Range Complexes and Study Areas within the context of the prioritization guidelines described here.
- Continuing to Develop Data Management, Organization and Access Procedures.

The Navy shall comply with the 2009 ICMP Plan and continue to improve the program in consultation with NMFS. Changes and improvements to the program made during 2010 (as prescribed in the 2009 ICMP and otherwise deemed appropriate by the Navy and NMFS) will be described in an updated 2010 ICMP and submitted to NMFS by October 31, 2010, for review. An updated 2010 ICMP will be finalized by December 31, 2010.

Monitoring Workshop

The Navy, with guidance and support from NMFS, will convene a Monitoring Workshop, including marine mammal and acoustic experts as well as other interested parties, in 2011. The Monitoring Workshop participants will review the monitoring results from previous monitoring pursuant to the MIRC rule as well as monitoring results from other Navy rules and LOAs (*e.g.,* the Southern California Range Complex (SOCAL), Hawaii Range Complex (HRC), etc.). The Monitoring Workshop participants will provide their individual recommendations to the Navy and NMFS on the monitoring plan(s) after also considering the current science (including Navy research and development) and working within the framework of available resources and feasibility of implementation. NMFS and the Navy will then analyze the input from the Monitoring Workshop participants and determine the best way forward from a national perspective. Subsequent to the Monitoring Workshop, modifications would be applied to monitoring plans as appropriate.

Adaptive Management

Our understanding of the effects of MFAS/HFAS and explosives on marine mammals is still in its relative infancy, and yet the science in this field is evolving fairly quickly. These circumstances make the inclusion of an adaptive management component both valuable and necessary within the context of 5-year regulations for activities that have been associated with marine mammal mortality in certain circumstances and locations (though not the MIRC in the Navy's over 60 years of use of the area for testing and training). NMFS has included an adaptive management component in the regulations, which will allow NMFS to consider new data from different sources to determine (in coordination with the Navy) on an annual basis if mitigation or monitoring measures should be modified or added (or deleted) if new data suggest that such modifications are appropriate (or are not appropriate) for subsequent annual LOAs.

Following are some of the possible sources of new data:

- Results from the Navy's monitoring from the previous year (either from MIRC or other locations).
- Findings of the Workshop that the Navy will convene in 2011 to analyze monitoring results to date, review current science, and recommend modifications, as appropriate to the monitoring protocols to increase monitoring effectiveness.
- Compiled results of Navy funded research and development (R&D) studies (presented pursuant to the ICMP, which is discussed elsewhere in this document).
- Results from specific stranding investigations (either from MIRC or other locations, and involving coincident MFAS/HFAS of explosives training or not involving coincident use).
- Results from the Long Term Prospective Study described above.
- Results from general marine mammal and sound research (funded by the Navy (described above) or otherwise).
- Any information which reveals that marine mammals may have been taken in a manner, extent or number not anticipated by these regulations or subsequent Letters of Authorization.

Mitigation measures could be modified or added (or deleted) if new data suggest that such measures would have (or do not have) a reasonable likelihood of accomplishing the goals of mitigation laid out in this final rule and if the measures are practicable. NMFS would also coordinate with the Navy to modify or add to (or delete) the existing monitoring requirements if the new data suggest that the addition of (or deletion of) a particular measure would more effectively accomplish the goals of monitoring laid out in this final rule. The reporting requirements associated with this final rule are designed to provide NMFS with monitoring data from the previous year to allow NMFS to consider the data and issue annual LOAs. NMFS and the Navy will meet annually, prior to LOA issuance, to discuss the monitoring reports, Navy R&D developments, and current science and whether mitigation or monitoring modifications are appropriate.

Reporting

In order to issue an ITA for an activity, Section 101(a)(5)(A) of the MMPA states that NMFS must set forth "requirements pertaining to the monitoring and reporting of such taking." Effective reporting is critical both to compliance as well as ensuring that the most value is obtained from the required monitoring. The proposed rule contains the reporting requirements for the Navy (74 FR 53795, pages 53843–53845), and these requirements remain unchanged with the following exception. The requirements as written in the proposed rule include specific due dates for each of the reports. NMFS and the Navy are coordinating a workload plan to determine the best times during every year to submit all of the reports that Navy is responsible for under multiple final rules for multiple Range Complexes and training exercises. Although the reports described will always be submitted every year at a time that allows for adequate analysis by NMFS prior to the issuance of the subsequent LOA, we want to allow flexibility to change those dates yearly. Therefore, the regulatory text below will not specify the specific dates that the reports are due, but each annual LOA will.

Comments and Responses

On October 20, 2009 (74 FR 53795), NMFS published a proposed rule in response to the Navy's request to take marine mammals incidental to military readiness training, maintenance, and RDT&E activities in the MIRC and requested comments, information and suggestions concerning the request. During the 30-day public comment period, NMFS received comments from 4 private individuals, the Marine Mammal Commission (MMC) and the Natural Resources Defense Council (NRDC). NMFS has responded to those comments below.

Comment 1: The MMC recommended that the MIRC final rule and any Letter of Authorization issued under that rule include all marine mammal species that may be taken as a result of the proposed activities. Specifically, the MMC suggested that NMFS and/or the Navy should consult with the U.S. Fish and Wildlife Service (USFWS) to determine if authorization also is needed to take dugongs, which, according to the proposed rule, could occur within the Mariana Islands Range Complex.

Response: The Navy has consulted on the MIRC action under Section 7 of the ESA with the USFWS, which has jurisdiction over dugongs. The Navy and the USFWS coordinated regarding the list of species, and dugongs were not included. Dugongs have not been observed in the action area since 1985. Palau, over 1000 miles away, is the closest location that they have been seen recently.

Comment 2: The MMC notes that the Navy, in its applications and related documents, generally has done a commendable job of reviewing the existing literature on marine mammal density, distribution, behavior, and habitat use for the areas under consideration, but expressed concern that the manner in which the Navy is using that information to form conclusions about density, distribution, behavior, and habitat use has not been subjected to the normal scientific review process. The MMC recommends that NMFS require the Navy to conduct an external peer review of its marine mammal density estimates, the data upon which those estimates are based, and the manner in which those data are being used.

Response: Both NMFS and the Navy use peer-reviewed science whenever it is available and applicable, and NMFS has encouraged the Navy to get the models they use and data they gather peer-reviewed. However, neither the NEPA, the MMPA, nor the ESA require that data or calculations used in the analyses pursuant to these statutes be peer-reviewed prior to making a decision. Rather, NMFS and the Navy are required to use the best available science to inform our analyses.

The Navy proactively funded a baseline survey for the Mariana Islands in 2007 (the "Mariana Islands Sea Turtle and Cetacean Survey" or MISTCS) to gather data on the distribution and density of marine mammals and sea turtles. This survey is the first and only systematic survey to be conducted in the region and not only generated density estimates but added sei whales to the confirmed species in the area. Because it is the only data of this kind collected specifically around the Mariana Islands, it is considered the best available science. The Navy primarily used that data to derive their density estimates, and laid out a systematic approach for using other existing Pacific data when there was not enough MISTCS data to calculate a density for a particular species. Most of the densities estimated in the MIRC are not notably different than those estimated in Hawaii or the Eastern Tropical Pacific.

Also, while it is not the same as a peer review, both the NEPA and MMPA processes include a comment period in which the public can specifically recommend better ways to use the data to estimate density, and which the Navy and NMFS would need to address.

While it will not be published until after this final rule is complete, the Navy is preparing for publication an article presenting the MISTCS data that was used to inform their density estimates, and it will be peer-reviewed. Additionally, the Navy is developing a new systematic framework (that includes a hierarchy of preferred methodologies based on the data available in an area) to estimate density in the analyses for the rule renewals that will follow the expiration of the rules issued in 2009, 2010, and 2011 (*i.e.,* rules that would, if appropriate, be issued in 2014 and later). The Navy has indicated that they may pursue a peer review of this framework and NMFS has encouraged them to do so.

Comment 3: The MMC recommends that NMFS require that a sufficient level of monitoring be conducted during all training activities to ensure that marine mammals are not being taken in unanticipated ways and numbers. They further note that, according to the Navy's monitoring plan, "major exercises may undergo significant schedule changes in reaction to higher-priority commitments and such changes may limit monitoring opportunities * * * [or] extreme weather precludes effective sampling." The plan further states that, in case of such monitoring delay(s), "monitoring will be re-scheduled to the next available opportunity * * * [and] * * * may have to be made up in the subsequent year." The MMC further states that they assume that, although it is not clear in either the monitoring plan or the proposed rule, if monitoring associated with the focused studies cannot take place during a major training exercise, other standard types of monitoring will be conducted for mitigation and documentation purposes.

Response: The Commission's assumption is correct. There are two different types of monitoring required pursuant to the MIRC training exercises. One type is the monitoring outlined in the Monitoring Plan (which has been modified since the proposed rule, see Comment 10 below), which consists of different study methods designed to collect density and distribution data and is conducted by MMOs. This monitoring includes systematic sampling conducted at a different time and place than the training exercises. The Navy feels this monitoring may need to be rescheduled as appropriate. This is the monitoring that the Navy may need to reschedule.

Separately, monitoring is routinely conducted by watchstanders on surface vessels (and opportunistically by personnel on other platforms). This monitoring is used to detect animals so the necessary mitigation can be implemented. Behavioral data which allow for a general assessment of impacts are collected with other information (such as the status of sonar sources) that help verify the Navy's mitigation implementation. This data-gathering requirement is described in § 218.105 Requirements for monitoring and reporting.

Comment 4: The MMC requested that NMFS require that, upon its completion, the plan for the Navy's Integrated Comprehensive Monitoring Program (ICMP) be made available for Commission review and comment.

Response: The 2009 ICMP was completed and is posted on NMFS' Web site at: *http://www.nmfs.noaa.gov/pr/permits/incidental.htm#applications.* The ICMP is an iterative outline of an ongoing program, and NMFS and the Navy will evaluate the potential need to update it annually. NMFS made some specific recommendations on how to improve the 2009 ICMP, which are outlined in Section 6 of that document. Pursuant to the AFAST, HRC and SOCAL 2010 LOAs, the Navy will submit an updated version addressing those recommended improvements and any others, as appropriate, to NMFS at the end of 2010. NMFS has provided the MMC with a copy of the 2009 ICMP and notified them that NMFS and the Navy will consider any comments provided by August 15, 2010 in the development of the 2010 ICMP.

Comment 5: The MMC recommends that NMFS advise the Navy and specify in the final rule and Letter of Authorization that any and all data that the Navy collects as part of monitoring and reporting requirements are essential for documenting compliance with the requirements of the Marine Mammal Protection Act, the incidental take regulations, and the terms and conditions of the Letter of Authorization

and, unless subject to national security restrictions, should be considered as public information. The MMC further notes that the draft Monitoring Plan indicated that "[a]ll data will be considered "pre-decisional" and proprietary and will be shared among the Navy and NMFS (at a minimum) during the five-year period of the LOA."

Response: NMFS concurs with the MMC and clarified this point with the Navy. The language the MMC cited has been removed in the Final Monitoring Plan. As specified in the final regulations (and in the LOAs), the Navy includes all of the information specified as part of the monitoring and reporting requirements in their annual reports (which are posted on NMFS Web site) unless the information is classified or the analysis has not been completed (*i.e.,* passive acoustic data).

Comment 6: The MMC recommends that NMFS require that, in the event of the death or serious injury of a marine mammal during activities associated with any of the training exercises or other activities covered by this authorization, those activities be suspended, pending an investigation and determination that further serious injuries or deaths are unlikely or until authorization for such taking has been obtained. The MMC specifically notes that there is no shutdown measure in place for non-major sonar activities. The MMC further recommends that NMFS require that the Navy, in conjunction with the NMFS, investigate any injury or death of a marine mammal to determine the cause, assess the full impact of the activity or activities (*e.g.,* the total number of animals involved), and determine how activities should be modified to avoid future injuries or deaths. If the death or serious injury involves a marine mammal not included in the authorization for such takes, NMFS should allow the activity to proceed only if it has reviewed the circumstances and determined that additional serious injuries or deaths are unlikely or the Navy has obtained authorization for such taking. Lastly, the MMC recommends that prior to issuing the final regulations, NMFS ensure that it can provide oversight of and response to an uncommon stranding event in the Mariana Islands Range Complex Study Area sufficient to meet in full the monitoring and reporting requirements of the Marine Mammal Protection Act.

Response: NMFS and the Navy have developed a detailed Stranding Response Plan for MIRC that outlines protocols for, and describes the underlying rationale for, shutdown (in very specific circumstances) and investigation in the event that dead or stranded animals are found in the vicinity of major sonar exercises. The regulations also include a provision for "General notification of injured or dead marine mammals," under which Navy personnel shall ensure that NMFS is notified immediately (or as soon as clearance procedures allow) if an injured, stranded, or dead marine mammal is found during or shortly after, and in the vicinity of, any Navy training exercise (including non-major ones) utilizing MFAS, HFAS, or underwater explosive detonations. The provision further requires the Navy to provide NMFS with species or description of the animal(s), the condition of the animal(s) (including carcass condition if the animal is dead), location, time of first discovery, observed behaviors (if alive), and photo or video of the animals (if available).

All but one of the small number of strandings that have been associated with MFAS exercises occurred concurrent to exercises that would be considered "major", which typically involve multiple surface vessels and last for a much longer duration than non-major exercises. It can take months to years to complete the necessary tests and analyses required to determine, with a reasonable amount of certainty, the cause of a marine mammal death—and sometimes it is not possible to determine it. In consideration of these facts, NMFS (with input from the Navy) determined that it was beneficial and practicable to preemptively outline an explicit plan (that includes a shutdown requirement in certain circumstances) for how to deal with a stranding that occurs during a major exercise. Alternatively, for non-major exercises, the general stranding provisions apply, which means that the Navy would contact NMFS as soon as clearance procedures allow and we would determine how best to proceed then. In light of the fact that so few strandings have been definitively associated with MFAS training in the 60+ years that the U.S. and other countries that share information have been conducting MFAS training, it is not reasonable or practicable to require the Navy to shut down pending the results of an investigation that could take years to conduct.

However, NMFS and the Navy will implement the Stranding Response Plan as written and, as in the past, will work together on a case-by-case basis within the constraints of our available resources to investigate the causes should a stranding or death occur during a non-major exercise. Once investigations are completed and determinations made (as feasible), NMFS would use the available information to help reduce the likelihood that a similar event would recur and would work with the Navy on the necessary steps to ensure compliance by the Navy with the MMPA. NMFS and the Navy are near finalizing an MOU that will streamline and improve the way that the Navy is able to assist NMFS during a stranding investigation. Lastly, the Stranding Response Plan includes a provision for stranding debriefs/lessons learned meetings between NMFS and the Navy following a stranding response, and the MIRC rule includes an adaptive management provision that allows for the modification of mitigation or monitoring measures based on new information (like that which might be gathered during a stranding response/investigation), as appropriate.

Comment 7: The MMC recommended that NMFS work with the Navy to analyze the cumulative effects of adding LFA sonar to the other activities planned for the Mariana Islands Range Complex before using LFA sonar as a component of the proposed training exercises and, if appropriate, add authorization for the use of LFA to the final rule and Letter of Authorization. The NRDC had similar concerns, including the fact that the mitigation used with LFA sonar was not discussed.

Response: As noted, the impacts of LFA sonar (alone) have been analyzed in the Navy's SURTASS LFA Sonar EISs and take of marine mammals incidental to that activity has been authorized in LOAs pursuant to NMFS' Final Rule for LFA Sonar, both of which include required mitigation measures. As described in the proposed rule, the military intends to conduct three exercises (multi-strike group exercises) during the five-year duration of the rule that may include both SURTASS LFA and MFA sonar sources. The expected duration of these combined exercises is approximately 14 days. Based on an exercise of this length, an LFA sonar system would be active (*i.e.,* actually transmitting) for no more than approximately 25 hours. Tactical and technical considerations dictate that the LFA sonar ship would typically be tens of miles from the MFA sonar ship when using active sonar. It is unlikely, but possible, that both LFA and MFA sonar would be active at exactly the same time during a major exercise. In the unlikely event that both systems were operating simultaneously, the likelihood of more than a relatively small number of individual marine mammals being physically present at a time, location, and depth to be able to receive both LFA and MFA sonar signals at levels of

concern at the same time is even smaller as the sound from both signals would have attenuated when they reached the marine mammal in question, so even a simultaneous exposure would not be at the full signal of either system. Additionally, few species have maximum sensitivity to both the low and middle frequencies.

That said, pursuant to this rule, NMFS worked with the Navy to more specifically analyze impacts that might result from animals being exposed to both the LFAS and the MFAS at the same time. The Navy developed a model to evaluate the likelihood of an animal being exposed to both sources based on the operational parameters of the two systems and the propagation characteristics of the two sound sources. Assuming an LFA and MFA sonar source transmitting at the same time over a 25-hour period and based on the fact that the two sources transmit at very different duty cycles, the overlap of the actual signals would be approximately 3.2%, or 0.8 hours (assuming that there is only one MFA sonar ship transmitting). But the possibility of even that overlap must consider the other factors discussed above.

Based on the fact that an LFA sonar ship would be tens of miles away from an MFA ship when using active sonar and that the overlap of the signals would only be about 50 minutes at attenuated levels, as well as the other information discussed above, the exposure of marine mammals simultaneously to both MFA and LFA sonars would be limited, and the impacts would not be expected to result in a detectable increase in the number or severity of the takes already analyzed and estimated in this rule.

Comment 8: The MMC recommended that NMFS limit the authorization to avoid Navy operations within the Marianas Trench Marine National Monument (MTMNM) to the extent possible. Further, if the Navy must conduct activities within the Monument, the Service should include in the final rule and Letter of Authorization a description of the measures that the Navy will adopt to minimize adverse impacts and to comply with the intent of the presidential proclamation establishing the Monument.

Response: The MTMNM was established to protect the submerged lands and waters of the Mariana Archipelago and was designated with the purpose of protecting the submerged volcanic areas of the Mariana Ridge (which include chemosynthetic features and hydrothermal vents), the coral reef ecosystem of the waters of surrounding islands, and the Marianas Trench. The Monument includes the submerged lands of the "Volcano Unit" and the water column and submerged lands within the "Island Unit". The MTMNM contains no areas specifically designated as important to marine mammal protection in the MTMNM. The presidential proclamation establishing the Monument indicates that the prohibitions required by the proclamation shall not apply to activities and exercises of the Armed Forces, but also indicates the Armed Forces shall ensure, by the adoption of appropriate measures not impairing operations or operational capabilities, that its vessels and aircraft act in a manner consistent, so far as is reasonable and practicable, with the proclamation.

Pursuant to the MMPA, NMFS makes decisions regarding required mitigation based on biological information pertaining to the potential impacts of an activity on marine mammals and their habitat (and the practicability of the measure), not management designations intended for the broad protection of various other marine resources. A portion of the MTMNM overlaps with the MIRC Study Area; however, there are no areas within this area of special importance to marine mammals for which restricting sonar use would afford a notable benefit. If training or exercises occur in this area, the Navy would be required to follow the general mitigation protocols established in the final rule and LOA. For example, powering or shutting down sonar when marine mammals are detected within ranges where the received sound level is likely to result in temporary threshold shift (TTS) or injury and using exclusion zones that avoid exposing marine mammals to levels of explosives likely to result in injury or death of marine mammals. NMFS expects the mitigation measures employed in the MTMNM will reduce the number of marine mammals exposed to levels of sound expected to result in TTS or more severe behavioral responses in these areas.

Comment 9: The NRDC suggests that NMFS should not issue an MMPA authorization because the information on species densities and distributions of marine mammals in the Marianas region is inadequate for NMFS to be able to effectively analyze the environmental impacts, and that the Navy should have obtained the information before requesting an MMPA authorization. They further suggest that because of this lack of information, the NEPA analysis is inadequate both for the Navy and for NMFS to adopt. They note that there has only been one comprehensive survey conducted in the area (during one single season) and that the sea states were high during this survey (making detection difficult), which, combined with the detection probabilities used, likely resulted in an underestimate of the density of animals in the area. They further noted that off-shore data were used to estimate density across both the inshore and offshore areas, even though there are often density differences across inshore and offshore areas (some species are more dense inshore).

Response: Both NMFS and the Navy have a responsibility to use the best available science to support our analysis and decisions under both NEPA and the MMPA. In 2007, the Navy funded a baseline survey for the Mariana Islands (the "Mariana Islands Sea Turtle and Cetacean Survey" or MISTCS) to gather data on the distribution and density of marine mammals and sea turtles. This survey is the first and only systematic survey to be conducted in the region and not only generated density estimates, but also added sei whales to the confirmed species in the area. In this case, the Navy has generated the best available science and both NMFS and the Navy are using it. The limitations of the data were acknowledged by the Navy in the MISTCS report, and the Navy plans to improve upon this information moving forward as more data are gathered. The sea states in the MIRC are comparatively higher than in other areas, so scientists will continue to deal with this challenge. As more surveys are conducted, data will be collected across more seasons and areas (inshore and offshore), which will allow for the calculation of more spatially and temporally explicit density estimates. The collection of additional data will allow scientists to determine whether the development of MIRC-specific detection probabilities is appropriate. In the meantime, the density estimates from the MISTCS surveys are not unexpected and are similar to those for the Hawaii offshore areas and the eastern tropical Pacific and will allow NMFS to make reasonable predictions regarding the number of marine mammals that might be exposed to particular levels of sound.

Regarding the comment that take estimates are likely underestimates, for comparison we use data collected in Hawaii, where surveys are more robust. For naval exercises in Hawaii, there are more survey data, across different seasons, incorporating both inshore and offshore data, and using specific detection probability factors. The Navy estimated approximately 28,000 Level B harassment takes for a total of about 1670 hours of hull-mounted MFAS (the

most powerful source, which accounts for the vast majority of takes). In MIRC, the Navy estimated approximately 80,000 Level B harassment takes to result from the operation of approximately 2320 hours of hull-mounted MFAS. At a broad level, these estimates (the ratio of the two) do not suggest the Navy is likely underestimating take in MIRC. Similarly, below is an overview of the watchstander data collected during major exercises in Hawaii and MIRC, which, while not a systematic comparison, broadly suggests the number of animals encountered in the vicinity of an exercise in MIRC is not much different than the numbers encountered in Hawaii.

Location	hours sonar	# sightings	# animals sighted
MIRC (August, 2007)	1208	25	235
Hawaii (RIMPAC, July 2006)	472	26	70 individuals + 8 pods
Hawaii (April, 2007)	265	0	0
Hawaii (April, 2007)	50	1	1
Hawaii (November, 2007)	77	0	0
Hawaii (January, 2009)	918	24	135

Table 5. Marine mammal sightings by watchstanders during major exercises in MIRC and Hawaii since 2006.

Lastly, the animals that watchstanders have detected during exercises have not exhibited any observable behavioral effects. In summary, using the density estimates generated from the Navy's survey and the take estimates modeled by the Navy, NMFS has considered the best available science. Additionally, taking into consideration other data/literature related to the likely impacts of MFAS exposure on marine mammals (see proposed rule) combined with data from the Navy regarding the number of marine mammal detections and observed behaviors that have been recorded during other Navy exercises, NMFS has sufficient information to make the findings required under the MMPA.

Comment 10: The NRDC recommends that to meet its responsibilities under the MMPA and NEPA, NMFS should require the Navy, as a condition of any future permit, to sponsor a multiyear survey effort within the Marianas Islands Range Complex that can serve as a reasonable basis of both geographic mitigation and improved environmental assessment. NRDC recommends (1) that NOAA scientists participate in the survey design, including the design of tracklines and the determination of detection probabilities; (2) that surveys are conducted consistently and across multiple seasons, given the presence of migratory species, and for more than 1 year, given the potential for interannual variability and the typically high sea states around the Marianas; and (3) that surveys are designed, at least in part, to aid in identifying areas of importance to marine mammals (*e.g.,* gathering oceanographic data relevant to marine mammal distribution). Finally, (4) the survey results should be integrated into habitat suitability models available for other regions, such as Hawaii or the Eastern Tropical Pacific (NMFS interprets this to mean that habitat suitability models from these other areas should be used in conjunction with MIRC data to predict density in the MIRC).

Response: NMFS agrees with NRDC regarding the importance of gathering more density, distribution, and abundance data in the MIRC and has recommended the Navy refocus their Monitoring Plan. In response to this recommendation, the Navy has modified their draft Monitoring Plan to focus completely on gathering density and distribution data that can be used to better inform our analyses of the impacts of the action as well as to inform decisions regarding the development of areas of special protection and, further, the Navy has increased the amount of survey effort that they had committed to in the draft Monitoring Plan. The Navy has now committed to conduct 45 days of visual surveys annually (over the 5 years of the rule) using a small boat and/or airplane around Guam, Tinian, Rota and Saipan. These surveys will be conducted over both summer and winter and will be developed in coordination with NMFS scientists and conducted in cooperation with NMFS and/or DAWR. Visual surveys will integrate methods such as photo ID which provide data that can be used for estimating distribution and abundance. Additionally, as already discussed in the proposed rule, the Navy will deploy four passive acoustic devices to collect data throughout the years. Lastly, the Navy has also committed to additional analysis of acoustic data gathered during the 2007 MISTCS survey that have not yet been analyzed.

Earlier this year, NMFS's Pacific Islands Fisheries Science Center (PIFSC) and the Navy collaborated to conduct cetacean observations in conjunction with an oceanographic survey aboard NOAA Research Vessel Oscar Elton Sette. Coverage was between Honolulu and Guam and within the Exclusive Economic Zones (EEZs) of Guam and the Commonwealth of the Northern Marianas between January and May 2010. The goal was to monitor the presence and distribution of cetaceans on the high seas and within the Guam/Commonwealth of the Northern Mariana Islands EEZs. PIFSC performed four data collection projects during the outward bound and early arrival portion of the survey:

(1) Cetacean visual and acoustic observations during daylight hours on the high seas survey between Honolulu and Guam, 20 January–4 February.

(2) Cetacean visual and acoustic observations conducted from small boats chartered in Guam, Rota, Tinian, and/or Saipan, 10 February–4 March.

(3) Cetacean visual observations during daylight hours during an oceanography survey around Guam and southern CNMI, 18 March–14 April.

(4) Cetacean visual and acoustic observations during daylight hours on the high seas survey between Guam and Honolulu, 18 April–4 May.

The goal of the vessel-based visual surveys was to monitor cetacean presence, distribution and diversity in Hawaii, Marianas and the high seas. These surveys were conducted by experienced marine mammal observers aboard a capable vessel using established NMFS PIFSC protocols for conducting and recording sighting data. The observers recorded marine mammal sightings as well as environmental data (Beaufort Sea sea state, wind speed/direction, swell height/direction, visibility, etc.). Digital photographs were taken to assist in species

identification. In addition to visual sightings, a towed acoustic array was used to detect animal calls. Using both visual and acoustic methods provides a more complete assessment for the presence of marine mammals in the survey area.

The MIRC rule has an adaptive management provision that requires the Navy and NMFS to review new information (such as monitoring results) on an annual basis and allows that mitigation or monitoring measures could be modified, if appropriate. NMFS and the Navy will consider the results of any required monitoring, as well as the voluntary 2010 monitoring, in our annual assessment of mitigation and monitoring measures. Additionally, NOAA has committed to convene a workshop of marine mammal experts in 2010/2011 to identify cetacean hotspots (areas of specifically important use or high density) using both field data and habitat modeling, as appropriate. The data that the Navy gathers this year in MIRC pursuant to their modified monitoring plan (see above) will inform the cetacean hotspot workshop. The workshop results, in turn, could potentially support the need to designate protected areas in which Navy activities could potentially be limited, depending on NMFS' analysis of the benefit to the species of limiting activities in the area, the likely effectiveness of the measure, and the practicability of implementation. The adaptive management provisions would allow for the application of these protected areas, if appropriate.

With respect to using habitat suitability models from other regions in conjunction with the MIRC data to inform density estimates, while habitat suitability models can be helpful in predicting marine mammal presence/density in an area, the less actual information that is available to inform a model, the less robust the model is likely to be—especially if one extrapolates from one region to another where there is not necessarily a basic understanding of the regional ecological processes in play (*e.g.,* sea surface temperature or salinity can mean completely different things in different areas). Additionally, it is very difficult to validate a model in areas with little information. In short, a model would not necessarily increase the accuracy of the density estimates in the MIRC area, given the amount of data that is currently available in the MIRC. That said, the Navy is exploring (and NMFS supports this exploration) incorporating habitat modeling into their density estimates, as appropriate, as they develop the environmental analysis for their training actions moving forward.

Comment 11: NRDC states that within the scientific community, there is general consensus that protecting important habitat represents the most effective means currently available to reduce the impacts of mid-frequency sonar on marine mammals. They further state that "Nonetheless, no portion of this vast 501,000 nm^2 range was excluded by the Pacific Fleet from sonar training, and neither the Navy's DEIS nor its take application—nor NMFS' Proposed Rule—considers establishing any protection areas in which sonar training would be limited or excluded." NRDC then recommends that certain protection areas, in which sonar training should not be conducted, should be established. Those areas include:

(1) Waters surrounding Saipan and Tinian Islands to the 1000m isobath (particularly but not exclusively the northwest coast of Saipan)—for humpback whales.

NRDC notes that the Navy's MISTCS identified waters around Saipan and Tinian Islands as "probable" humpback whale breeding grounds, based on both acoustic and sighting data. Singing males were detected acoustically, and social interactions between individuals were detected visually. Concentrations were especially high around the northwest coast of Saipan.

They further note that the MISTCS report indicates that whaling data from the 1700s and 1800s indicate concentrations of humpback whales around the Northern Mariana Islands and it is likely that the area around Saipan and Tinian represents a formerly important breeding ground now being recolonized as the population slowly recovers from whaling.

(2) West Mariana Ridge—for False killer whale; Short-finned pilot whales; Mesoplodon spp.; Bryde's whale.

NRDC notes that a chain of conical seamounts (extinct volcanoes) comprises the West Mariana Ridge, on the far side of the Mariana Basin. Some seamounts (including the Pathfinder, Arakane, and Suruga Seamounts between 142°–143°E) rise to summits less than 50m below sea level (Miller *et al.* 2008). These seamounts support a rich diversity of coral reef and continental slope species, and previous surveys have shown dense concentrations of biological productivity (high planktonic production, large schools of small and predatory fishes including skipjack and other species of tuna) (Miller *et al.* 2008; Tsukomoto 2006). Consistent with this, multiple sightings of several cetacean species known to prefer high bathymetric relief were made by the MISTCS on or near the West Mariana Ridge, including two of the survey's three beaked whale sightings.

(3) Western edge of the Mariana Trench with high bathymetric relief (roughly 4000–8000m)—for Sei and Bryde's whale; minke whale, and

(4) Western side of the main Mariana Islands to 5000m—for Sperm whales.

NRDC indicates that the potential for concentrations of species exists in these areas (3 and 4), but also that systematic analysis is needed.

Response: NMFS acknowledges protecting important habitat (i.e., areas where there is robust evidence animals are predictably gathering in higher densities, or are known to display important behaviors such as breeding and calving and could potentially be disrupted by the proximity of MFAS activities), can be one of the more effective ways to minimize impacts (both in number and severity) to marine mammals.

The first paragraph of NRDC's comment seems to express surprise that, despite the importance of habitat protection, no protective areas have been established in MIRC. Before discussing the specific areas that NRDC has recommended, NMFS must explain that we do not begin with the assumption that any particular area contains areas that warrant special protection for marine mammals. Rather, we analyze the existing data to determine whether there is suitable evidence indicating that conditions exist in which the limitation of activity in an area would afford a notable reduction (either in quantity or potential severity) in the take of marine mammals. If there is suitable evidence indicating that a protective measure of this nature is, in fact, warranted, then we must review the measure in the context of personnel safety, practicality of implementation, and impact on the effectiveness of the "military readiness activity" to determine whether it would result in the "least practicable adverse impact."

Unfortunately, the supporting data do not support the recommendations that NRDC proposes, specifically:

(1) Waters surrounding Saipan and Tinian Islands to the 1000m isobaths—During the MISTCS survey, over the course of approximately 2 months, the survey had 11 acoustic detections of singing humpback whales (primarily to the north and west of Saipan) and sighted one group of approximately 8 animals. The acoustic detections were of singing males and the visually detected group was exhibiting behaviors consistent with a group of males

competing for females. Although the detected behaviors were consistent with breeding behaviors, the number of animals observed is too small to draw a robust conclusion, and also does not seem indicative of the high density of humpbacks seen in other known breeding/calving areas. By contrast, in Hawaii (where a protective area was designated for the Navy), humpback whales and calves concentrate in densities up to 3.6 animals/mile^2.

(2) West Mariana Ridge—While these sea mounts may be generally associated with higher productivity, there is not enough evidence to suggest the area will predictably have a higher density of marine mammals, or that it is a specifically important feeding area, such that it is appropriate to limit activities in the area. During MISTCS, only one false killer whale, 3 short-finned pilot whales, 2 beaked whales, and 4 Brydes whales were sighted on the Western Mariana Ridge.

For (3) Western Edge of Mariana Trench and (4) Western Side of Main Mariana Islands, NRDC acknowledges that systematic analysis is needed before recommending these areas as protected areas, and NMFS concurs that there is not enough information to support protected areas in these spots. That said, as noted in NMFS' response to Comment 10, the Navy has modified their monitoring plan to collect exactly the sort of density and distribution data that we have noted above is limited in MIRC. Further, as noted above, the adaptive management provision in this rule will allow NMFS to use this new information (or other information, such as that generated from the cetacean hotspot workshop) to inform modifications to mitigation or monitoring measures, as appropriate.

Comment 12: NRDC included a copy of their comments on the Navy's EIS and suggested that some of those comments also pertained to the MMPA authorization.

Response: NMFS has addressed the issues that apply to our issuance of the MMPA authorization below:

(1) Additional Mitigation—NRDC recommends a suite of additional mitigation measures for the Navy to consider to protect various resources, including marine mammals. NMFS and the Navy have previously discussed either the specific measures listed in NRDC's comments on the Navy's EIS, or the general class of mitigation contemplated and have developed a section for the EIS that discusses the benefits of the proposed measure to marine mammals, the likely effectiveness of the measure, and the practicability of the measure for Navy implementation. Section 5.1.8 (begin page 5–18) of the MIRC EIS, entitled Alternative Mitigation Measures Considered But Eliminated, explains why these measures are not included in NMFS MMPA regulations and is hereby incorporated by reference.

(2) Dr. Bain's Critique of Risk Function—NRDC includes a comprehensive critique of the risk function that the Navy (and NMFS) uses to calculate takes. NMFS responded to Dr. Bain's comments in the Atlantic Fleet Active Sonar Training final rule (74 FR 4865) and hereby incorporates those comments by reference.

Comment 13: A few commenters expressed general opposition to Navy activities and NMFS' issuance of an MMPA authorization, because of the danger to marine mammals, and one suggested a proposed alternative to MFAS that would be less impactful and involved replacing the current technology with the use of a transponder.

Response: NMFS appreciates the commenters' concern for the marine mammals that live in the area of the proposed activities. The MMPA directs NMFS to issue an incidental take authorization if certain findings can be made. Under the MMPA, NMFS must make the decision of whether or not to issue an authorization based on the specified activity that the applicant submits; the MMPA does not contain a mechanism for NMFS to question the need for the action that the applicant has proposed. Similarly, any U.S. citizen (including the Navy) can request and receive a MMPA authorization as long as all of the necessary findings can be made. NMFS has determined that the Navy's MIRC training activities will have a negligible impact on the affected species or stocks and, therefore, we are issuing the necessary governing regulations and plan to issue the requested MMPA authorization.

Estimated Take of Marine Mammals

As mentioned previously, one of the main purposes of NMFS' effects assessments is to identify the permissible methods of taking: What caused the take (*e.g.,* exposure to anthropogenic noise vs. ship strike); the regulatory level of take (*i.e.,* mortality vs. Level A or Level B harassment) and the amount of take. In the Potential Effects of Exposure of Marine Mammal to MFAS/HFAS and Underwater Detonations section of the proposed rule, NMFS identified the lethal responses, physical trauma, sensory impairment (permanent and temporary threshold shifts and acoustic masking), physiological responses (particular stress responses), and behavioral responses that could potentially result from exposure to MFAS/HFAS or underwater explosive detonations. In this section, we will relate the potential effects to marine mammals from MFAS/HFAS and underwater detonation of explosives to the MMPA statutory definitions of Level A and Level B Harassment and attempt to quantify the effects that might occur from the specific training activities that the Navy is proposing in the MIRC study area.

In the Estimated Take of Marine Mammals section of the proposed rule, NMFS relates the potential effects to marine mammals from MFAS/HFAS and underwater detonations (discussed in the Potential Effects of Specified Activities on Marine Mammals Section) to the MMPA regulatory definitions of Level A and Level B Harassment and quantified (estimated) the effects on marine mammals that could result from the specific activities that the Navy intends to conduct. The subsections of that analysis are discussed individually below.

Definition of Harassment

The Definition of Harassment section of the proposed rule contains the definitions of Level A and Level B Harassment, and a discussion of which of the previously discussed potential effects of MFAS/HFAS or explosive detonations fall into the categories of Level A Harassment (permanent threshold shift (PTS), acoustically mediated bubble growth, behaviorally mediated bubble growth, and physical disruption of tissues resulting from explosive shock wave) or Level B Harassment (temporary threshold shift (TTS), acoustic masking and communication impairment, and behavioral disturbance rising to the level of harassment). See (74 FR 53795, page 53846). No changes have been made to the discussion contained in this section of the proposed rule.

Acoustic Take Criteria

In the Acoustic Take Criteria section of the proposed rule, NMFS described the development and application of the acoustic criteria for both MFAS/HFAS and explosive detonations (74 FR 53795, pages 53846–53852). No changes have been made to the discussion contained in this section of the proposed rule.

Estimates of Potential Marine Mammal Exposure

The proposed rule describes in detail how the Navy estimated the take that will result from their proposed activities (74 FR 53795, pages 53836–53837), which entails the following three

general steps: (1) A propagation model using marine mammal densities estimates animals exposed to sources at different levels; (2) further modeling determines number of exposures to levels indicated in criteria above (*i.e.,* number of takes); and (3) post-modeling corrections refine estimates to make them more accurate. More information regarding the models used, the assumptions used in the models, and the process of estimating take is available in Appendix F of the Navy's DEIS for MIRC.

Table 4 which is identical to the take table (Table 8) in the proposed rule with a few minor corrections (indicated in italics—differences of less than 7 Level B harassment, non-TTS, takes in all cases), indicates the number of takes that were modeled and that are being authorized yearly incidental to the Navy's activities, with the following allowances. The Navy has carefully characterized the training activities planned for the MIRC study area over the 5 years covered by these regulations; however, evolving real-world needs necessitate flexibility in annual activities, which in turn is reflected in annual variation in the potential take of marine mammals. Where it was mentioned more generally in the proposed rule, NMFS has now included language bounding this flexibility in the regulatory text (*see* § 218.102(c)). These potential annual variations were considered in the negligible impact analysis and the analysis in the proposed rule remains applicable. The new language indicates the following:

- That modeled annual takes (which must be provided with annual LOA applications) of any individual species may not exceed the annual amount indicated in the rule (*i.e.,* in Table 4, below) by more than 25% in any year;
- That modeled takes over the course of 5 years will not ultimately exceed the indicated 5-year total for that species indicated by the rule (Table 4) by more than 10%; and
- That modeled total annual take of all species combined may vary but will not exceed the combined amount for all species indicated in the rule (Table 4) by more than 10%.

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Species	Modeled Sonar Exposures to Indicated Thresholds			Modeled Explosive Exposures to Indicated Thresholds				NMFS Proposed Annual Take Authorization		
	Level B Exposures		Level A Exposures (PTS)	Level B Exposures		Level A Exposures	Mortality			
	Risk Function (Behavioral)	TTS		Sub-TTS	TTS			Level B Harassment	Level A Harassment	Mortality
ESA Species										
Blue whale	128	2	0	0	0	0	0	130	0	
Fin whale	180	2	0	0	0	0	0	182	0	
Humpback whale	*795*	10	0	0	*0*	0	0	*805*	0	
Sei whale	319	6	0	0	0	0	0	325	0	
Sperm whale	*806*	10	1	6	*2*	0	0	*824*	1	
Sei/Bryde's whale	61	1	0	0	0	0	0	62	0	
Unidentified Balaenopterid whale	71	1	0	0	0	0	0	72	0	
Mysticetes										
Bryde's whale	449	8	0	0	0	0	0	457	0	
Minke whale	438	7		0	0	0	0	445	0	
Odontocetes										
Blainville's beaked whale	758	12	0	0	0	0	0	770	0	10 over the course of 5-yr rule
Cuvier's beaked whale	3,567	44	0	12	*5*	0	0	*3628*	0	
Ginkgo-toothed beaked whale	423	7	0	0	0	0	0	430	0	
Longman's beaked whale	204	2	0	0	0	0	0	206	0	
Bottlenose dolphin	168	3	0	0	0	0	0	171	0	
Bottlenose/Rough-toothed dolphin	72	1	0					73	0	
Fraser's dolphin	*4,525*	74	0	12	4	0	0	*4615*	0	
Pantropical spotted dolphin	*31,970*	510	1	12	*7*	0	0	*32499*	1	
Rough-toothed dolphin	236	5	0	0	0	0	0	241	0	
Risso's dolphin	*6,629*	108	0	26	*10*	0	0	*6773*	0	
Short-beaked common dolphin	918	17	0	6	2	0	0	943	0	
Spinner dolphin	*2,100*	36	0	6	2	0	0	*2144*	0	
Striped dolphin	*8,715*	139	0	3	1	0	0	8858	0	
Unidentified delphinid	1,514	24	0	0	0	0	0	1538	0	
Dwarf/Pygmy sperm whale	*6,576*	103	0	20	*7*	0	0	*6706*	0	
False killer whale	1,266	23	0	0	0	0	0	1289	0	
Killer whale	226	4	0	0	0	0	0	230	0	
Melon-headed whale	2,809	46	0	6	2	0	0	2863	0	
Pygmy killer whale	158	2	0	0	0	0	0	160	0	
Short-finned pilot whale	2,238	36	0	0	0	0	0	2274	0	
Total	**78,319**	**1,243**	**2**	**109**	**42**	**0**	**0**	79713	2	

Table 6. Navy's estimated marine mammal exposures to the thresholds and NMFS proposed take authorization (changes from proposed rule noted in italics).

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Mortality

Evidence from five beaked whale strandings, all of which have taken place outside the MIRC study area, and have occurred over approximately a decade, suggests that the exposure of beaked whales to MFAS in the presence of certain conditions (*e.g.,* multiple units using active sonar, steep bathymetry, constricted channels, strong surface ducts, etc.) may result in strandings, potentially leading to mortality. Although these physical factors believed to have contributed to the likelihood of beaked whale strandings are not present, in the aggregate, in the MIRC study area, scientific uncertainty exists regarding what other factors, or combination of factors, may contribute to beaked whale strandings. Accordingly, to allow for scientific uncertainty regarding contributing causes of beaked whale strandings and the exact behavioral or physiological mechanisms that can lead to the ultimate physical effects (stranding and/or death), NMFS is authorizing take, by injury or mortality, of 10 beaked whales over the course of the 5-year regulations. Although the Navy has requested take by injury or mortality, the Navy's model did not predict injurious takes of beaked whales and neither NMFS nor the Navy anticipates that marine mammal strandings or mortality will result from the operation of MFAS during Navy exercises within the MIRC study area.

Effects on Marine Mammal Habitat

NMFS' proposed rule includes a section that addresses the effects of the Navy's activities on Marine Mammal Habitat (74 FR 53795, pages 53855–53857). The analysis preliminarily concluded that the Navy's activities would have minimal effects on marine mammal habitat. No changes have been made to the discussion contained in this section of the proposed rule and NMFS has concluded there would be minimal effects on marine mammal habitat.

Analysis and Negligible Impact Determination

Pursuant to NMFS' regulations implementing the MMPA, an applicant is required to estimate the number of animals that will be "taken" by the specified activities (*i.e.,* takes by Level B harassment only, Level A harassment, and/or death). This estimate informs the analysis that NMFS must perform to determine whether the activity will have a "negligible impact" on the affected species or stock. Level B (behavioral) harassment occurs at the level of the individual(s) and does not assume any resulting population-level consequences, though there are known avenues through which behavioral disturbance of individuals can result in population-level effects (for example: pink-footed geese (*Anser brachyrhynchus*) in undisturbed habitat gained body mass and had about a 46-percent reproductive success compared with geese in disturbed habitat (being consistently scared off the fields on which they were foraging), which did not gain mass and had 17-percent reproductive success). A negligible impact finding is based on the lack of likely adverse effects on annual rates of recruitment or survival (*i.e.,* population-level effects). An estimate of the number of Level B harassment takes, alone, is not enough information on which to base an impact determination. In addition to considering estimates of the number of marine mammals that might be "taken" through behavioral harassment, NMFS must consider other factors, such as the likely nature of any responses (their intensity, duration, etc.), the context of any responses (critical reproductive time or location, migration, etc.), as well as the number and nature of estimated Level A harassment takes, the number of estimated mortalities, and effects on habitat. Generally speaking, and especially with other factors being equal, the Navy and NMFS anticipate more severe effects from takes resulting from exposure to higher received levels (though this is in no way a strictly linear relationship throughout species, individuals, or circumstances) and less severe effects from takes resulting from exposure to lower received levels.

In the Analysis and Negligible Impact Determination section of the proposed rule, NMFS addressed the issues identified in the preceding paragraph in combination with additional detailed analysis regarding the severity of the anticipated effects, and including species (or group)-specific discussions, to determine that Navy training will have a negligible impact on the marine mammal species and stocks present in MIRC study area. No changes have been made to the discussion contained in this section of the proposed rule (74 FR 33828, pages 33884–33892), with the following exception.

As mentioned previously in the Estimated Take section, to allow for more flexibility in operations, NMFS has added language bounding the flexibility in annual variation of potential take of individual marine mammal species into the regulatory text (see § 218.102(c)). The new language indicates that modeled annual takes (which must be provided with annual LOA application) of any individual species may vary but will not ultimately exceed the indicated 5-year total for that species (indicated by Table 6) by more than 10% and will not exceed the indicated annual total by more than 25% in any given year; and that modeled total yearly take of all species combined may vary but will not exceed the combined amount indicated below in any given year by more than 10%. NMFS has considered these limitations in our negligible impact determination and the findings described in the proposed rule remain applicable.

Determination

Negligible Impact

Based on the analysis contained here and in the proposed rule (and other related documents) of the likely effects of the specified activity on marine mammals and their habitat and dependent upon the implementation of the mitigation and monitoring measures, NMFS finds that the total taking from Navy training exercises utilizing MFAS/HFAS and underwater explosives in the MIRC study area will have a negligible impact on the affected species or stocks. NMFS has proposed regulations for these exercises that prescribe the means of effecting the least practicable adverse impact on marine mammals and their habitat and set forth requirements pertaining to the monitoring and reporting of that taking.

Subsistence Harvest of Marine Mammals

There is no subsistence harvest of marine mammals in the Mariana Islands and, therefore, NMFS has determined that the issuance of 5-year regulations and subsequent LOAs for Navy training exercises in the MIRC would not have an unmitigable adverse impact on the availability of the affected species or stocks for subsistence use.

ESA

There are five marine mammal species and two sea turtle species that are listed as endangered under the ESA with confirmed or possible occurrence in the study area: Humpback whale, sei whale, fin whale, blue whale, sperm whale, hawksbill sea turtle and leatherback sea turtle. An additional three species of sea turtles are also listed as threatened under the ESA: green sea turtle, loggerhead sea turtle, and olive ridley sea turtle.

Pursuant to Section 7 of the ESA, the Navy has consulted with NMFS on this action. NMFS has also consulted internally on the issuance of regulations

under section 101(a)(5)(A) of the MMPA for this activity. In a Biological Opinion (BiOp), NMFS concluded that the Navy's activities in the MIRC and NMFS' issuance of these regulations are not likely to jeopardize the continued existence of threatened or endangered species or destroy or adversely modify any designated critical habitat.

Because of the difference between the statutes, it is possible that ESA analysis of the applicant's action could produce a take estimate that is different than the takes requested by the applicant (and analyzed for authorization by NMFS under the MMPA process), despite the fact that the same proposed action (i.e. number of sonar hours and explosive detonations) was being analyzed under each statute. When this occurs, NMFS staff coordinate to ensure that the most appropriate number of takes are authorized. For the Navy's proposed MIRC training, coordination with the Endangered Species Division indicates that they will likely allow for a lower level of take of ESA-listed marine mammals than were requested by the applicant (because their analysis indicates that fewer will be taken than estimated by the applicant). Therefore, the number of authorized takes in NMFS' LOA(s) will reflect the lower take numbers from the ESA consultation, though the specified activities (*i.e.,* number of sonar hours, etc.) will remain the same. Alternately, these regulations indicate the maximum number of takes that may be authorized under the MMPA.

The ITS(s) issued for each LOA will contain implementing terms and conditions to minimize the effect of the marine mammal take authorized through the 2010 LOA (and subsequent LOAs in 2011, 2012, 2013, and 2014). With respect to listed marine mammals, the terms and conditions of the ITSs will be incorporated into the LOAs.

NEPA

NMFS has participated as a cooperating agency on the Navy's Draft Environmental Impact Statement (DEIS) for MIRC, which was published on January 30, 2009. NMFS subsequently adopted the Navy's EIS for the purpose of complying with the MMPA.

Classification

This action does not contain any collection of information requirements for purposes of the Paperwork Reduction Act.

The Office of Management and Budget has determined that this final rule is not significant for purposes of Executive Order 12866.

Pursuant to the Regulatory Flexibility Act, the Chief Counsel for Regulation of the Department of Commerce has certified to the Chief Counsel for Advocacy of the Small Business Administration that this final rule, if adopted, would not have a significant economic impact on a substantial number of small entities. The Regulatory Flexibility Act requires Federal agencies to prepare an analysis of a rule's impact on small entities whenever the agency is required to publish a notice of proposed rulemaking. However, a Federal agency may certify, pursuant to 5 U.S.C. 605 (b), that the action will not have a significant economic impact on a substantial number of small entities. Because the action described in this rule involves the tactical use of mid-frequency active sonar sources and explosives on Navy ranges, and the Navy is the sole entity that may conduct these activities on the MIRC, only the Navy will be directly affected by this rulemaking, not small governmental jurisdictions, small organizations, or small businesses, as defined by the Regulatory Flexibility Act (RFA). Any requirements imposed by a Letter of Authorization issued pursuant to these regulations, and any monitoring or reporting requirements imposed by these regulations, will be applicable only to the Navy. NMFS does not expect the issuance of these regulations or the associated LOAs to result in any impacts to small entities pursuant to the RFA. Because this action, if adopted, would directly affect the Navy and not a small entity, NMFS concludes the action would not result in a significant economic impact on a substantial number of small entities.

The Assistant Administrator for Fisheries has determined that there is good cause under the Administrative Procedure Act (5 U.S.C. 553(d)(3)) to waive the 30-day delay in the effective date of the measures contained in the final rule. Navy, as the permittee, has informed NMFS that any delay of enacting the final rule would result in either: (1) A suspension of ongoing or planned naval training (including a major exercise currently scheduled for 2010 within the MIRC), which would disrupt vital training essential to national security; or (2) the Navy's procedural non-compliance with the MMPA (should the Navy conduct training/exercises without an LOA), thereby resulting in the potential for unauthorized takes of marine mammals. Moreover, the Navy is ready to implement the rule immediately. Accordingly, these measures will become effective upon publication.

List of Subjects in 50 CFR Part 218

Exports, Fish, Imports, Incidental take, Indians, Labeling, Marine mammals, Navy, Penalties, Reporting and recordkeeping requirements, Seafood, Sonar, Transportation.

Dated: July 20, 2010.

Samuel D. Rauch III,

Deputy Assistant Administrator for Regulatory Programs, National Marine Fisheries Service.

■ For reasons set forth in the preamble, 50 CFR part 218 is amended as follows:

PART 218—REGULATIONS GOVERNING THE TAKING AND IMPORTING OF MARINE MAMMALS

■ 1. The authority citation for part 218 continues to read as follows:

Authority: 16 U.S.C. 1361 *et seq.*

Subparts D through K [Reserved]

■ 2. Add and reserve Subparts D through K to part 218.

■ 3. Subpart L is added to part 218 to read as follows:

Subpart L—Taking and Importing Marine Mammals; U.S. Navy's Mariana Islands Range Complex (MIRC)

Sec.

218.100 Specified activity and geographical area.
218.101 Effective dates.
218.102 Permissible methods of taking.
218.103 Prohibitions.
218.104 Mitigation.
218.105 Requirements for monitoring and reporting.
218.106 Applications for Letters of Authorization.
218.107 Letters of Authorization.
218.108 Renewal of Letters of Authorization and adaptive management.
218.109 Modifications to Letters of Authorization.

Subpart L—Taking and Importing Marine Mammals; U.S. Navy's Mariana Islands Training Range Complex (MIRC)

§ 218.100 Specified activity and specified geographical area.

(a) Regulations in this subpart apply only to the U.S. Navy for the taking of marine mammals that occurs in the area outlined in paragraph (b) of this section and that occur incidental to the activities described in paragraph (c) of this section.

(b) The taking of marine mammals by the Navy may be authorized in a Letter of Authorization (LOA) if it occurs within the Mariana Islands Range Complex (MIRC) Study Area (as

depicted in Figure 1–1 in the Navy's application for MIRC), which is bounded by a pentagon with the following five corners: 16°46′29.3376″ N. lat., 138°00′59.835″ E. long.; 20°02′24.8094″ N. lat., 140°10′13.8642″ E. long.; 20°3′27.5538″ N. lat., 149°17′41.0388″ E. long.; 7°0′30.0702″ N. lat., 149°16′14.8542″ E. long; and 6°59′24.633″ N. lat, 138°1′29.7228″ E. long.

(c) The taking of marine mammals by the Navy may be authorized in an LOA if it occurs incidental to the following activities within the designated amounts of use:

(1) The use of the following mid-frequency active sonar (MFAS) and high frequency active sonar (HFAS) sources for U.S. Navy anti-submarine warfare (ASW) training, maintenance, and research, development, testing and evaluation (RDT&E):

(i) AN/SQS–53 (hull-mounted active sonar)—up to 10865 hours over the course of 5 years (an average of 2173 hours per year);

(ii) AN/SQS–56 (hull-mounted active sonar)–up to 705 hours over the course of 5 years (an average of 141 hours per year);

(iii) AN/SSQ–62 (Directional Command Activated Sonobuoy System (DICASS) sonobuoys)–up to 8270 sonobuoys over the course of 5 years (an average of 1654 sonobuoys per year);

(iv) AN/AQS–22 (helicopter dipping sonar)—up to 2,960 dips over the course of 5 years (an average of 592 dips per year);

(v) AN/BQQ–10 (submarine hull-mounted sonar)—up to 60 hours over the course of 5 years (an average of 12 hours per year);

(vi) MK–48, MK–46, or MK–54 (torpedoes)—up to 200 torpedoes over the course of 5 years (an average of 40 torpedoes per year);

(vii) AN/SSQ–110 (IEER)—up to 530 buoys deployed over the course of 5 years (an average of 106 per year);

(viii) AN/SSQ–125 (AEER)—up to 530 buoys deployed over the course of 5 years (an average of 106 per year);

(ix) Range Pingers—up to 1,400 hours over the course of 5 years (an average of 280 hours per year); and

(x) PUTR Transponder—up to 1,400 hours over the course of 5 years (an average of 280 hours per year).

(2) The detonation of the underwater explosives indicated in this paragraph (c)(2)(i) conducted as part of the training events indicated in this paragraph (c)(2)(ii):

(i) Underwater Explosives (Net Explosive Weight (NEW)):

(A) 5″ Naval Gunfire (9.5 lbs NEW);

(B) 76 mm rounds (1.6 lbs NEW);

(C) Maverick (78.5 lbs NEW);

(D) Harpoon (448 lbs NEW);

(E) MK–82 (238 lbs NEW);

(F) MK–83 (574 lbs NEW);

(G) MK–84 (945 lbs NEW);

(H) MK–48 (851 lbs NEW);

(I) Demolition Charges (10 lbs NEW);

(J) AN/SSQ–110A (IEER explosive sonobuoy—5 lbs NEW);

(K) Hellfire (16.5 lbs NEW);

(L) GBU 38/32/31.

(ii) Training Events:

(A) Gunnery Exercises (S–S GUNEX)—up to 60 exercises over the course of 5 years (an average of 12 per year);

(B) Bombing Exercises (BOMBEX)—up to 20 exercises over the course of 5 years (an average of 4 per year);

(C) Sinking Exercises (SINKEX)—up to 10 exercises over the course of 5 years (an average of 2 per year);

(D) Extended Echo Ranging and Improved Extended Echo Ranging (EER/IEER) Systems—up to 530 deployments over the course of 5 years (an average of 106 per year);

(E) Demolitions—up to 250 over the course of 5 years (an average of 50 per year); and

(F) Missile exercises (A–S MISSILEX)—up to 10 exercises over the course of 5 years (an average of 2 per year).

(d) The taking of marine mammals may also be authorized in an LOA for the activities and sources listed in § 218.100(c) should the amounts (*i.e.,* hours, dips, number of exercises) vary from those estimated in § 218.100(c), provided that the variation does not result in exceeding the amount of take indicated in § 218.102.

§ 218.101 Effective dates.

Regulations are effective August 3, 2010 through August 3, 2015.

§ 218.102 Permissible methods of taking.

(a) Under Letters of Authorization issued pursuant to §§ 216.106 and 218.107 of this chapter, the Holder of the Letter of Authorization (hereinafter "Navy") may incidentally, but not intentionally, take marine mammals within the area described in § 218.100(b), provided the activity is in compliance with all terms, conditions, and requirements of these regulations and the appropriate Letter of Authorization.

(b) The activities identified in § 218.100(c) must be conducted in a manner that minimizes, to the greatest extent practicable, any adverse impacts on marine mammals and their habitat.

(c) The incidental take of marine mammals under the activities identified in § 218.100(c) is limited to the species listed in this paragraph (4), (5), and (6) of this section (c) by the indicated method of take and the indicated number of times (estimated based on the authorized amounts of sound source operation), but with the following allowances for annual variation in activities:

(1) In any given year, annual take, by harassment, of any species of marine mammal may not exceed the amount identified in paragraphs (b)(4) and (b)(5) of this section, for that species by more than 25% (a post-calculation/estimation of which must be provided in the annual LOA application);

(2) In any given year, annual take by harassment of all marine mammal species combined may not exceed the estimated total of all species combined, indicated in paragraphs (b)(4) and (b)(5) of this section, by more than 10%; and

(3) Over the course of the effective period of this subpart, total take, by harassment, of any species may not exceed the 5-year amounts indicated in paragraphs (b)(4) and (b)(5) of this section by more than 10%. A running calculation/estimation of takes of each species over the course of the years covered by the rule must be maintained.

(4) Level B Harassment:

(i) Mysticetes:

(A) Humpback whale (*Megaptera novaeangliae*)—4,025 (an average of 805 annually);

(B) Fin whale (*Balaenoptera physalus*)—910 (an average of 182 annually);

(C) Blue whale (*Balaenoptera musculus*)—650 (an average of 130 annually);

(D) Sei whale (*Balaenoptera borealis)*—1,625 (an average of 325 annually);

(E) Minke whale (*Balaenoptera acutorostrata*)—2,225 (an average of 445 annually);

(F) Bryde's whale (*Balaenoptera edeni*)—2,285 (an average of 457 annually); and

(G) Unidentified Baleanopterid whales—360 (an average of 72 annually).

(ii) Odontocetes:

(A) Sperm whales (*Physeter macrocephalus*)—4,120 (an average of 824 annually);

(B) Killer whale (*Orcinus orca*)- 1,150 (an average of 230 annually);

(C) Pygmy or dwarf sperm whales (*Kogia breviceps or Kogia sima*)—33,530 (an average of 6,706 annually);

(D) Blainville's beaked whales (Mesoplodon densirostris);—3,850 (an average of 770 annually);

(E) Cuvier's beaked whales (*Ziphius cavirostris*)—18,140 (an average of 3,628 annually);

(F) Ginkgo-toothed beaked whales (*Mesoplodon ginkgodens*)—2,150 (an average of 430 annually);

(G) Longman's beaked whale (Indopacetus pacificus)—1,030 (an average of 206 annually);

(H) Short-finned pilot whale (*Globicephala macrorynchus*)—11,370 (an average of 2,274 annually);

(I) Melon-headed whale (*Peponocephala electra*)—14,315 (an average of 2,863 annually);

(J) Pygmy killer whale (*Feresa attenuata*)—800 (an average of 160 annually);

(K) False killer whale (*Pseudorca crassidens*)—6,445 (an average of 1,289 annually);

(L) Striped dolphin (*Stenella coeruleoalba*)—44,290 (an average of 8,858 annually);

(M) Short-beaked common dolphin (*Delphinus delphis*)—4,715 (an average of 943 annually);

(N) Risso's dolphin (*Grampus griseus*)—33,865 (an average of 6,773 annually);

(O) Bottlenose dolphin (*Tursiops truncates*)—855 (an average of 171 annually);

(P) Fraser's dolphin (*Lagenodelphis hosei*)—23,075 (an average of 4,615 annually);

(Q) Pantropical spotted dolphin (*Stenella attenuata*)—162,495 (an average of 32,499 annually);

(R) Rough-toothed dolphin (*Steno bredanensis*)—1,205 (an average of 241 annually);

(S) Spinner dolphin (*Stenella longirostris*)—10,720 (an average of 2,144 annually); and

(T) Unidentified delphinid—7,690 (an average of 1,538 annually).

(5) Level A Harassment:

(i) Sperm whale—5 (an average of 1 annually);

(ii) Pantropical spotted dolphin—5 (an average of 1 annually);

(6) Level A Harassment and/or mortality of no more than 10 beaked whales (total), of any of the species listed in § 218.102(c)(4)(ii)(D) through (G) over the course of the 5-year regulations.

§ 218.103 Prohibitions.

No person in connection with the activities described in § 218.100 may:

(a) Take any marine mammal not specified in § 218.102(c);

(b) Take any marine mammal specified in § 218.102(c) other than by incidental take as specified in §§ 218.102(c)(1) and (c)(2);

(c) Take a marine mammal specified in § 218.102(c) if such taking results in more than a negligible impact on the species or stocks of such marine mammal; or

(d) Violate, or fail to comply with, the terms, conditions, and requirements of these regulations or a Letter of Authorization issued under §§ 216.106 and 218.107 of this chapter.

§ 218.104 Mitigation.

(a) When conducting training and utilizing the sound sources or explosives identified in § 218.100(c), the mitigation measures contained in a Letter of Authorization issued under §§ 216.106 and 218.107 of this chapter must be implemented. These mitigation measures include, but are not limited to:

(1) Personnel Training:

(i) All commanding officers (COs), executive officers (XOs), lookouts, Officers of the Deck (OODs), junior OODs (JOODs), maritime patrol aircraft aircrews, and Anti-submarine Warfare (ASW)/Mine Warfare (MIW) helicopter crews shall complete the NMFS-approved Marine Species Awareness Training (MSAT) by viewing the U.S. Navy MSAT digital versatile disk (DVD). All bridge lookouts shall complete both parts one and two of the MSAT; part two is optional for other personnel.

(ii) Navy lookouts shall undertake extensive training in order to qualify as a watchstander in accordance with the Lookout Training Handbook (Naval Education and Training Command [NAVEDTRA] 12968–D).

(iii) Lookout training shall include on-the-job instruction under the supervision of a qualified, experienced lookout. Following successful completion of this supervised training period, lookouts shall complete the Personal Qualification Standard Program, certifying that they have demonstrated the necessary skills (such as detection and reporting of partially submerged objects). Personnel being trained as lookouts can be counted among required lookouts as long as supervisors monitor their progress and performance.

(iv) Lookouts shall be trained in the most effective means to ensure quick and effective communication within the command structure in order to facilitate implementation of protective measures if marine species are spotted.

(v) All lookouts onboard platforms involved in ASW training events will review the NMFS-approved Marine Species Awareness Training material prior to use of MFAS.

(vi) All COs, XOs, and officers standing watch on the bridge will review the Marine Species Awareness Training material prior to a training event employing the use of MFAS/HFAS.

(2) General Operating Procedures (for all training types):

(i) Prior to major exercises, a Letter of Instruction, Mitigation Measures Message or Environmental Annex to the Operational Order shall be issued to further disseminate the personnel training requirement and general marine species protective measures.

(ii) COs shall make use of marine species detection cues and information to limit interaction with marine mammals to the maximum extent possible consistent with safety of the ship.

(iii) While underway, surface vessels shall have at least two lookouts with binoculars; surfaced submarines shall have at least one lookout with binoculars. Lookouts already posted for safety of navigation and man-overboard precautions may be used to fill this requirement. As part of their regular duties, lookouts will watch for and report to the OOD the presence of marine mammals.

(iv) On surface vessels equipped with a multi-function active sensor, pedestal mounted "Big Eye" (20x110) binoculars shall be properly installed and in good working order to assist in the detection of marine mammals in the vicinity of the vessel.

(v) Personnel on lookout shall employ visual search procedures employing a scanning methodology in accordance with the Lookout Training Handbook (NAVEDTRA 12968–D).

(vi) After sunset and prior to sunrise, lookouts shall employ Night Lookouts Techniques in accordance with the Lookout Training Handbook (NAVEDTRA 12968–D).

(vii) While in transit, naval vessels shall be alert at all times, use extreme caution, and proceed at a "safe speed", which means the speed at which the CO can maintain crew safety and effectiveness of current operational directives, so that the vessel can take action to avoid a collision with any marine mammal.

(viii) When marine mammals have been sighted in the area, Navy vessels shall increase vigilance and take all reasonable actions to avoid collisions and close interaction of naval assets and marine mammals. Such action may include changing speed and/or direction and are dictated by environmental and other conditions (*e.g.,* safety, weather).

(ix) Navy aircraft participating in exercises at-sea shall conduct and maintain surveillance for marine mammals as long as it does not violate safety constraints or interfere with the accomplishment of primary operational duties.

(x) All marine mammal detections shall be immediately reported to assigned Aircraft Control Unit for

further dissemination to ships in the vicinity of the marine species as appropriate when it is reasonable to conclude that the course of the ship will likely result in a closing of the distance to the detected marine mammal.

(xi) Naval vessels will maneuver to keep at least 1,500 ft (500 yds) away from any observed whale in the vessel's path and avoid approaching whales head-on. These requirements do not apply if a vessel's safety is threatened, such as when change of course will create an imminent and serious threat to a person, vessel, or aircraft, and to the extent vessels are restricted in their ability to maneuver. Restricted maneuverability includes, but is not limited to, situations when vessels are engaged in dredging, submerged activities, launching and recovering aircraft or landing craft, minesweeping activities, replenishment while underway and towing activities that severely restrict a vessel's ability to deviate course. Vessels will take reasonable steps to alert other vessels in the vicinity of the whale. Given rapid swimming speeds and maneuverability of many dolphin species, naval vessels would maintain normal course and speed on sighting dolphins unless some condition indicated a need for the vessel to maneuver.

(3) Operating Procedures (for Anti-submarine Warfare (ASW) Operations):

(i) On the bridge of surface ships, there shall always be at least three people on watch whose duties include observing the water surface around the vessel.

(ii) All surface ships participating in ASW training events shall have, in addition to the three personnel on watch noted in (i), at least two additional personnel on watch as lookouts at all times during the exercise.

(iii) Personnel on lookout and officers on watch on the bridge will have at least one set of binoculars available for each person to aid in the detection of marine mammals.

(iv) Personnel on lookout shall be responsible for reporting all objects or anomalies sighted in the water (regardless of the distance from the vessel) to the Officer of the Deck, since any object or disturbance (*e.g.,* trash, periscope, surface disturbance, discoloration) in the water may be indicative of a threat to the vessel and its crew or indicative of a marine mammal that may need to be avoided.

(v) All personnel engaged in passive acoustic sonar operation (including aircraft, surface ships, or submarines) shall monitor for marine mammal vocalizations and report the detection of any marine mammal to the appropriate watch station for dissemination and appropriate action.

(vi) During MFAS operations, personnel shall utilize all available sensor and optical systems (such as night vision goggles) to aid in the detection of marine mammals.

(vii) Aircraft with deployed sonobuoys shall use only the passive capability of sonobuoys when marine mammals are detected within 200 yds (183 m) of the sonobuoy.

(viii) Helicopters shall observe/survey the vicinity of an ASW exercise for 10 minutes before the first deployment of active (dipping) sonar in the water.

(ix) Helicopters shall not dip their sonar within 200 yards of a marine mammal and shall cease pinging if a marine mammal closes within 200 yards after pinging has begun.

(x)(A) Safety Zones—When marine mammals are detected by any means (aircraft, shipboard lookout, or acoustically) the Navy shall ensure that sonar transmission levels are limited to at least 6 dB below normal operating levels if any detected marine mammals are within 1000 yards (914 m) of the sonar dome (the bow) (*i.e.,* limit to at most 229 dB for AN/SQS–53 and 219 dB for AN/SQS–56, etc.). Ships and submarines shall continue to limit maximum transmission levels by this 6-dB factor until the animal has been seen to leave the 1000-yd safety zone, has not been detected for 30 minutes, or the vessel has transited more than 2,000 yds (1829 m) beyond the location of the last detection.

(B) When marine mammals are detected by any means (aircraft, shipboard lookout, or acoustically) the Navy shall ensure that sonar transmission levels are limited to at least 10 dB below normal operating levels if any detected marine mammals are within 500 yards (457 m) of the sonar dome (the bow). Ships and submarines shall continue to limit maximum ping levels by this 10-dB factor until the animal has been seen to leave the 500-yd safety zone, has not been detected for 30 minutes, or the vessel has transited more than 2,000 yds (1829 m) beyond the location of the last detection.

(C) When marine mammals are detected by any means (aircraft, shipboard lookout, or acoustically) the Navy shall ensure that sonar transmission ceases if any detected marine mammals are within 200 yards (183 m) of the sonar dome (the bow). Sonar shall not resume until the animal has been seen to leave the 200-yd safety zone, has not been detected for 30 minutes, or the vessel has transited more than 2,000 yds (457 m) beyond the location of the last detection.

(D) Special conditions applicable for dolphins and porpoises only: If, after conducting an initial maneuver to avoid close quarters with dolphins or porpoises, the OOD concludes that dolphins or porpoises are deliberately closing to ride the vessel's bow wave, no further mitigation actions are necessary while the dolphins or porpoises continue to exhibit bow wave riding behavior.

(xi) Prior to start up or restart of active sonar, operators will check that the 1000-m Safety Zone radius around the sound source is clear of marine mammals.

(xii) Active sonar levels (generally)—Navy shall operate active sonar at the lowest practicable level, not to exceed 235 dB, except as required to meet tactical training objectives.

(xiii) Submarine sonar operators will review detection indicators of close-aboard marine mammals prior to the commencement of ASW training events involving MFAS.

(E) If the need for power-down should arise (as detailed in 218.114(a)(3)(x)) when the Navy is operating a hull-mounted or sub-mounted source above 235 dB (infrequent), the Navy shall follow the requirements as though they were operating at 235 dB—the normal operating level (*i.e.,* the first power-down will be to 229 dB, regardless of at what level above 235 dB active sonar was being operated).

(4) Operating Procedures for Underwater Detonations (up to 10-lb charges):

(i) Exclusion Zones—All demolitions and ship mine countermeasures training exercises involving the use of explosive charges must include exclusion zones for marine mammals to prevent physical and/or acoustic effects to those species. These exclusion zones shall extend in a 700-yard arc radius around the detonation site. Should a marine mammal be present within the the surveillance area, the explosive event shall not be started until the animal leaves the area.

(ii) Pre-Exercise Surveys—For Demolition and Ship Mine Countermeasures Operations, pre-exercise surveys shall be conducted for 30 minutes prior to the commencement of the scheduled explosive event. The survey may be conducted from the surface, by divers, and/or from the air, and personnel shall be alert to the presence of any marine mammal. Should such an animal be present within the survey area, the explosive event shall not be started until the animal voluntarily leaves the area. The

Navy will ensure the area is clear of marine mammals for a full 30 minutes prior to initiating the explosive event. Personnel will record any marine mammal observations during the exercise as well as measures taken if species are detected within the exclusion zone.

(iii) Post-Exercise Surveys—Surveys within the same exclusion zone radius shall also be conducted within 30 minutes after the completion of the explosive event.

(iv) Reporting—If there is evidence that a marine mammal may have been stranded, injured or killed by the action, Navy training activities shall be immediately suspended and the situation immediately reported by the participating unit to the Officer in Charge of the Exercise (OCE), who will follow Navy procedures for reporting the incident to Commander, Pacific Fleet, Commander, Navy Region Marianas, Environmental Director, and the chain-of-command. The situation shall also be reported to NMFS (see Stranding Plan for details).

(5) Sinking Exercise:

(i) All weapons firing shall be conducted during the period 1 hour after official sunrise to 30 minutes before official sunset.

(ii) An exclusion zone with a radius of 1.0 nm (1.9 km) will be established around each target. An additional buffer of 0.5 nm (0.9 km) will be added to account for errors, target drift, and animal movements. Additionally, a safety zone, which will extend beyond the buffer zone by an additional 0.5 nm (0.9 km), shall be surveyed. Together, the zone extends out 2 nm (3.7 km) from the target.

(iii) A series of surveillance over-flights shall be conducted within the 2-nm zone around the target, prior to and during the exercise, when feasible. Survey protocol shall be as follows:

(A) Overflights within the 2-nm zone around the target shall be conducted in a manner that optimizes the surface area of the water observed. This may be accomplished through the use of the Navy's Search and Rescue Tactical Aid, which provides the best search altitude, ground speed, and track spacing for the discovery of small, possibly dark objects in the water based on the environmental conditions of the day. These environmental conditions include the angle of sun inclination, amount of daylight, cloud cover, visibility, and sea state.

(B) All visual surveillance activities shall be conducted by Navy personnel trained in visual surveillance. At least one member of the mitigation team will have completed the Navy's marine mammal training program for lookouts.

(C) In addition to the overflights, the 2-nm zone around the target shall be monitored by passive acoustic means, when assets are available. This passive acoustic monitoring would be maintained throughout the exercise. Additionally, passive sonar onboard submarines may be utilized to detect any vocalizing marine mammals in the area. The OCE will be informed of any aural detection of marine mammals and will include this information in the determination of when it is safe to commence the exercise.

(D) On each day of the exercise, aerial surveillance of the 2-nm zone around the target shall commence 2 hours prior to the first firing.

(E) The results of all visual, aerial, and acoustic searches shall be reported immediately to the OCE. No weapons launches or firing may commence until the OCE declares this 2-nm zone around the target is free of marine mammals.

(F) If a marine mammal is observed within the 2-nm zone around the target, firing will be delayed until the animal is re-sighted outside the 2-nm zone around the target, or 30 minutes have elapsed. After 30 minutes, if the animal has not been re-sighted it can be assumed to have left the 2-nm zone around the target. The OCE will determine if the marine mammal is in danger of being adversely affected by commencement of the exercise.

(G) During breaks in the exercise of 30 minutes or more, the 2-nm zone around the target shall again be surveyed for any marine mammal. If marine mammals are sighted within the 2-nm zone around the target, the OCE shall be notified, and the procedures described in this section shall be followed.

(H) Upon sinking of the vessel, a final surveillance of the 2-nm zone around the target shall be monitored for 2 hours, or until sunset, to verify that no marine mammals were harmed.

(iv) Aerial surveillance shall be conducted using helicopters or other aircraft based on necessity and availability. The Navy has several types of aircraft capable of performing this task; however, not all types are available for every exercise. For each exercise, the available asset best suited for identifying objects on and near the surface of the ocean shall be used. These aircraft shall be capable of flying at the slow safe speeds necessary to enable viewing of marine vertebrates with unobstructed, or minimally obstructed, downward and outward visibility. The exclusion and safety zone surveys may be cancelled in the event that a mechanical problem, emergency search and rescue, or other similar and unexpected event preempts the use of one of the aircraft onsite for the exercise.

(v) Every attempt shall be made to conduct the exercise in sea states that are ideal for marine mammal sighting, Beaufort Sea State 3 or less. In the event of a 4 or above, survey efforts shall be increased within the 2-nm zone around the target. This shall be accomplished through the use of an additional aircraft, if available, and conducting tight search patterns.

(vi) The exercise shall not be conducted unless the 2-nm zone around the target could be adequately monitored visually. Should low cloud cover or surface visibility prevent adequate visual monitoring as described previously, the exercise would be delayed until conditions improved, and all of the above monitoring criteria could be met.

(vii) In the event that any marine mammals are observed to be harmed in the area, a detailed description of the animal shall be taken, the location noted, and if possible, photos taken of the marine mammal. This information shall be provided to NMFS via the Navy's regional environmental coordinator for purposes of identification (see the Stranding Plan for detail).

(viii) An after action report detailing the exercise's time line, the time the surveys commenced and terminated, amount, and types of all ordnance expended, and the results of survey efforts for each event shall be submitted to NMFS.

(6) Surface-to-Surface Gunnery (up to 5-inch Explosive Rounds):

(i) For exercises using targets towed by a vessel, target-towing vessels shall maintain a trained lookout for marine mammals when feasible. If a marine mammal is sighted in the vicinity, the tow vessel will immediately notify the firing vessel, which will suspend the exercise until the area is clear.

(ii) A 600 yard (585 m) radius buffer zone will be established around the intended target.

(iii) From the intended firing position, trained lookouts will survey the buffer zone for marine mammals prior to commencement and during the exercise as long as practicable. Due to the distance between the firing position and the buffer zone, lookouts are only expected to visually detect breaching whales, whale blows, and large pods of dolphins and porpoises.

(iv) The exercise will be conducted only when the buffer zone is visible and marine mammals are not detected within it.

(7) Surface-to-Surface Gunnery (non-explosive rounds):

(i) A 200-yd (183 m) radius buffer zone shall be established around the intended target.

(ii) From the intended firing position, trained lookouts shall survey the buffer zone for marine mammals prior to commencement and during the exercise as long as practicable.

(iii) If available, target towing vessels shall maintain a lookout (unmanned towing vessels will not have a lookout available). If a marine mammal is sighted in the vicinity of the exercise, the tow vessel shall immediately notify the firing vessel in order to secure gunnery firing until the area is clear.

(iv) The exercise shall be conducted only when the buffer zone is visible and marine mammals are not detected within the target area and the buffer zone.

(8) Surface-to-Air Gunnery (Explosive and Non-explosive Rounds):

(i) Vessels will orient the geometry of gunnery exercises in order to prevent debris from falling in the area of sighted marine mammals.

(ii) Vessels will attempt to recover any parachute deploying aerial targets to the extent practicable (and their parachutes if feasible) to reduce the potential for entanglement of marine mammals.

(iii) Target towing aircraft shall maintain a lookout if feasible. If a marine mammal is sighted in the vicinity of the exercise, the tow aircraft will immediately notify the firing vessel in order to secure gunnery firing until the area is clear.

(9) Air-to-Surface Gunnery (Explosive and Non-explosive Rounds):

(i) A 200 yard (183 m) radius buffer zone will be established around the intended target.

(ii) If surface vessels are involved, lookout(s) will visually survey the buffer zone for marine mammals to and during the exercise.

(iii) Aerial surveillance of the buffer zone for marine mammals will be conducted prior to commencement of the exercise. Aerial surveillance altitude of 500 feet to 1,500 feet (152–456 m) is optimum. Aircraft crew/pilot will maintain visual watch during exercises. Release of ordnance through cloud cover is prohibited; aircraft must be able to actually see ordnance impact areas.

(iv) The exercise will be conducted only if marine mammals are not visible within the buffer zone.

(10) Small Arms Training (Grenades, Explosive and Non-explosive Rounds)—Lookouts will visually survey for marine mammals. Weapons will not be fired in the direction of known or observed marine mammals.

(11) Air-to-Surface At-sea Bombing Exercises (explosive bombs and rockets):

(i) If surface vessels are involved, trained lookouts shall survey for marine mammals. Ordnance shall not be targeted to impact within 1,000 yds (914 m) of known or observed marine mammals.

(ii) A 1,000 yd (914 m) radius buffer zone shall be established around the intended target.

(iii) Aircraft shall visually survey the target and buffer zone for marine mammals prior to and during the exercise. The survey of the impact area shall be made by flying at 1,500 ft (152 m) or lower, if safe to do so, and at the slowest safe speed. When safety or other considerations require the release of weapons without the releasing pilot having visual sight of the target area, a second aircraft, the "wingman," will clear the target area and perform the clearance and observation functions required before the dropping plane may release its weapons. Both planes must have direct communication to assure immediate notification to the dropping plane that the target area may have been fouled by encroaching animals or people. The clearing aircraft will assure it has visual site of the target area at a maximum height of 1500 ft. The clearing plane will remain within visual sight of the target until required to clear the area for safety reasons. Survey aircraft shall employ most effective search tactics and capabilities.

(iv) The exercise will be conducted only if marine mammals are not visible within the buffer zone.

(12) Air-to-Surface At-Sea Bombing Exercises (Non-explosive Bombs and Rockets):

(i) If surface vessels are involved, trained lookouts will survey for marine mammals. Ordnance shall not be targeted to impact within 1,000 yards (914 m) of known or observed or marine mammals.

(ii) A 1,000 yard (914 m) radius buffer zone will be established around the intended target.

(iii) Aircraft will visually survey the target and buffer zone for marine mammals prior to and during the exercise. The survey of the impact area will be made by flying at 1,500 feet (456 m) or lower, if safe to do so, and at the slowest safe speed. When safety or other considerations require the release of weapons without the releasing pilot having visual sight of the target area, a second aircraft, the "wingman," will clear the target area and perform the clearance and observation functions required before the dropping plane may release its weapons. Both planes must have direct communication to assure immediate notification to the dropping plane that the target area may have been fouled by encroaching animals or people. The clearing aircraft will assure it has visual site of the target area at a maximum height of 1500 ft. The clearing plane will remain within visual sight of the target until required to clear the area for safety reasons. Survey aircraft shall employ most effective search tactics and capabilities.

(iv) The exercise will be conducted only if marine mammals and are not visible within the buffer zone.

(13) Air-to-Surface Missile Exercises (explosive and non-explosive):

(i) Aircraft will visually survey the target area for marine mammals. Visual inspection of the target area will be made by flying at 1,500 (457 m) feet or lower, if safe to do so, and at slowest safe speed. Firing or range clearance aircraft must be able to actually see ordnance impact areas.

(ii) Explosive ordnance shall not be targeted to impact within 1,800 yds (1646 m) of sighted marine mammals.

(14) Aircraft Training Activities Involving Non-Explosive Devices:

An exclusion zone of 200 yds around the target location, therefore, shall be clear of marine mammals. Pre- and post-surveillance and reporting requirements outlined for underwater detonations shall be implemented during Mining Training Activities.

(15) Extended Echo Ranging/Improved Extended Echo Ranging and Advanced Extended Echo-ranging (EER/IEER/AEER)—The following mitigation measures shall be used with the employment of IEER/AEER sonobuoys:

(i) Crews shall conduct visual reconnaissance of the drop area prior to laying their intended sonobuoy pattern. This search shall be conducted at an altitude below 500 yd (457 m) at a slow speed, if operationally feasible and weather conditions permit. In dual aircraft operations, crews are allowed to conduct coordinated area clearances.

(ii) For IEER (AN/SSQ–110A), crews shall conduct a minimum of 30 minutes of visual and aural monitoring of the search area prior to commanding the first post detonation. This 30-minute observation period may include pattern deployment time.

(iii) For any part of the intended sonobuoy pattern where a post (source/receiver sonobuoy pair) will be deployed within 1,000 yd (914 m) of observed marine mammal activity, the Navy shall deploy the receiver ONLY (i.e., not the source) and monitor while conducting a visual search. When marine mammals are no longer detected within 1,000 yd (914 m) of the intended

post position, the source sonobuoy (AN/SSQ–110A/SSQ–125) will be co-located with the receiver.

(iv) When operationally feasible, Navy crews shall conduct continuous visual and aural monitoring of marine mammal activity. This shall include monitoring of own-aircraft sensors from the time of the first sensor placement until the aircraft have left the area and are out of RF range of these sensors.

(v) *Aural Detection.* If the presence of marine mammals is detected aurally, then that shall cue the Navy aircrew to increase the diligence of their visual surveillance. Subsequently, if no marine mammals are visually detected, then the crew may continue multi-static active search.

(vi) *Visual Detection.* If marine mammals are visually detected within 1,000 yd (914 m) of the explosive source sonobuoy (AN/SSQ–110A/SSQ–125) intended for use, then that payload shall not be activated. Aircrews may utilize this post once the marine mammals have not been re-sighted for 30 minutes, or are observed to have moved outside the 1,000 yd (914 m) safety buffer. Aircrews may shift their multi-static active search to another post, where marine mammals are outside the 1,000 yd (914 m) safety buffer.

(vii) For IEER (AN/SSQ–110A), aircrews shall make every attempt to manually detonate the unexploded charges at each post in the pattern prior to departing the operations area by using the "Payload 1 Release" command followed by the "Payload 2 Release" command. Aircrews shall refrain from using the "Scuttle" command when two payloads remain at a given post. Aircrews shall ensure that a 1,000 yd (914 m) safety buffer, visually clear of marine mammals, is maintained around each post as is done during active search operations.

(viii) Aircrews shall only leave posts with unexploded charges in the event of a sonobuoy malfunction, an aircraft system malfunction, or when an aircraft must immediately depart the area due to issues such as fuel constraints, inclement weather, and in-flight emergencies. In these cases, the sonobuoy will self-scuttle using the secondary or tertiary method.

(ix) The Navy shall ensure all payloads are accounted for. Explosive source sonobuoys (AN/SSQ–110A) that cannot be scuttled shall be reported as unexploded ordnance via voice communications while airborne, then upon landing via naval message.

(x) Marine mammal monitoring shall continue until out of own-aircraft sensor range.

(16) The Navy shall implement the "Stranding Response Plan for Major Navy Training Exercises in the MIRC" (available at: *http://www.nmfs.noaa.gov/pr/permits/incidental.htm*), which is incorporated herein by reference, including the following measures:

(i) *Shutdown Procedures.* When an Uncommon Stranding Event (USE—defined in § 216.271) occurs during a Major Training Exercise (MTE) (as defined in the Stranding Plan, meaning including Multi-strike group exercises, Joint Expeditionary exercises, and Marine Air Ground Task Force exercises in the MIRC), the Navy shall implement the procedures described in this section.

(A) The Navy shall implement a Shutdown (as defined in the Stranding Response Plan for MIRC) when advised by a NMFS Office of Protected Resources Headquarters Senior Official designated in the MIRC Stranding Communication Protocol that a USE (as defined in the Stranding Response Plan for MIRC) involving live animals has been identified and that at least one live animal is located in the water. NMFS and Navy shall communicate, as needed, regarding the identification of the USE and the potential need to implement shutdown procedures.

(B) Any shutdown in a given area shall remain in effect in that area until NMFS advises the Navy that the subject(s) of the USE at that area die or are euthanized, or that all live animals involved in the USE at that area have left the area (either of their own volition or herded).

(C) If the Navy finds an injured or dead marine mammal floating at sea during an MTE, the Navy shall notify NMFS immediately or as soon as operational security considerations allow. The Navy shall provide NMFS with species or description of the animal(s), the condition of the animal(s) including carcass condition if the animal(s) is/are dead, location, time of first discovery, observed behaviors (if alive), and photo or video of the animals (if available). Based on the information provided, NMFS shall determine if, and advise the Navy whether, a modified shutdown is appropriate on a case-by-case basis.

(D) In the event, following a USE, that: (a) Qualified individuals are attempting to herd animals back out to the open ocean and animals are not willing to leave, or (b) animals are seen repeatedly heading for the open ocean but turning back to shore, NMFS and the Navy shall coordinate (including an investigation of other potential anthropogenic stressors in the area) to determine if the proximity of MFAS/HFAS activities or explosive detonations, though farther than 14 nm from the distressed animal(s), is likely decreasing the likelihood that the animals return to the open water. If so, NMFS and the Navy shall further coordinate to determine what measures are necessary to further minimize that likelihood and implement those measures as appropriate.

(ii) Within 72 hours of NMFS notifying the Navy of the presence of a USE, the Navy shall provide available information to NMFS (per the MIRC Communication Protocol) regarding the location, number and types of acoustic/explosive sources, direction and speed of units using MFAS/HFAS, and marine mammal sightings information associated with training activities occurring within 80 nm (148 km) and 72 hours prior to the USE event. Information not initially available regarding the 80 nm (148 km), 72 hours, period prior to the event shall be provided as soon as it becomes available. The Navy shall provide NMFS investigative teams with additional relevant unclassified information as requested, if available.

(b) [Reserved]

§ 218.105 Requirements for monitoring and reporting.

(a) *General Notification of Injured or Dead Marine Mammals.* Navy personnel shall ensure that NMFS is notified immediately ((see Communication Plan) or as soon as clearance procedures allow) if an injured, stranded, or dead marine mammal is found during or shortly after, and in the vicinity of, any Navy training exercise utilizing MFAS, HFAS, or underwater explosive detonations. The Navy will provide NMFS with the name of species or description of the animal(s), the condition of the animal(s) (including carcass condition if the animal is dead), location, time of first discovery, observed behaviors (if alive), and photo or video of the animal(s) (if available). In the event that an injured, stranded, or dead marine mammal is found by the Navy that is not in the vicinity of, or during or shortly after, MFAS, HFAS, or underwater explosive detonations, the Navy will report the same information as listed above as soon as operationally feasible and clearance procedures allow.

(b) *General Notification of Ship Strike.* In the event of a ship strike by any Navy vessel, at any time or place, the Navy shall do the following:

(1) Immediately report to NMFS the species identification (if known), location (lat/long) of the animal (or the strike if the animal has disappeared),

and whether the animal is alive or dead, or whether its status is unknown.

(2) Report to NMFS as soon as operationally feasible the size and length of animal, an estimate of the injury status (ex., dead, injured but alive, injured and moving, unknown, etc.), vessel class/type and operational status.

(3) Report to NMFS the vessel length, speed, and heading as soon as feasible.

(4) Provide NMFS a photo or video of the animal(s), if equipment is available.

(c) The Navy must conduct all monitoring and/or research required under the Letter of Authorization, including abiding by the annual MIRC Monitoring Plan. (*http://www.nmfs.noaa.gov/pr/permits/incidental.htm#applications*)

(d) *Report on Monitoring required in paragraph (c) of this section.* The Navy shall submit a report annually describing the implementation and results of the monitoring required in paragraph (c) of this section. Required submission date will be identified each year in the LOA. Navy will standardize data collection methods across ranges to allow for comparison in different geographic locations.

(e) *Sonar Exercise Notification.* The Navy shall submit to the NMFS Office of Protected Resources (specific contact information to be provided in LOA) either an electronic (preferably) or verbal report within fifteen calendar days after the completion of any Major Training Exercise for Reporting (MTER) indicating:

(1) Location of the exercise;

(2) Beginning and end dates of the exercise; and

(3) Type of exercise.

(f) *Annual MIRC Report.* The Navy will submit an Annual Exercise MIRC Report every year. This report shall contain the subsections and information indicated below.

(1) MFAS/HFAS Major Training Exercises—This section shall contain the following information for the following Coordinated and Strike Group exercises, which for simplicity will be referred to as MTERs: Joint Multi-strike Group Exercises; Joint Expeditionary Exercises; and Marine Air Ground Task Force MIRC:

(i) Exercise Information (for each MTER):

(A) Exercise designator;

(B) Date that exercise began and ended;

(C) Location;

(D) Number and types of active sources used in the exercise;

(E) Number and types of passive acoustic sources used in exercise;

(F) Number and types of vessels, aircraft, etc., participating in exercise;

(G) Total hours of observation by watchstanders;

(H) Total hours of all active sonar source operation;

(I) Total hours of each active sonar source (along with explanation of how hours are calculated for sources typically quantified in alternate way (buoys, torpedoes, etc.)); and

(J) Wave height (high, low, and average during exercise).

(ii) Individual marine mammal sighting info (for each sighting in each MTER):

(A) Location of sighting;

(B) Species (if not possible—indication of whale/dolphin/pinniped);

(C) Number of individuals;

(D) Calves observed (y/n);

(E) Initial Detection Sensor;

(F) Indication of specific type of platform observation made from (including, for example, what type of surface vessel, *i.e.,* FFG, DDG, or CG);

(G) Length of time observers maintained visual contact with marine mammal(s);

(H) Wave height (in feet);

(I) Visibility;

(J) Sonar source in use (y/n);

(K) Indication of whether animal is <200 yd, 200–500 yd, 500–1,000 yd, 1,000–2,000 yd, or >2,000 yd from sonar source in paragraph (f)(1)(i)(J) of this section;

(L) *Mitigation Implementation.* Whether operation of sonar sensor was delayed, or sonar was powered or shut down, and how long the delay was;

(M) If source in use in paragraph (f)(1)(i)(J) is hullmounted, true bearing of animal from ship, true direction of ship's travel, and estimation of animal's motion relative to ship (opening, closing, parallel); and

(N) *Observed behavior.* Watchstanders shall describe, in plain language and without trying to categorize in any way, the observed behavior of the animals (such as animal closing to bow ride, paralleling course/speed, floating on surface and not swimming, etc.).

(iii) An evaluation (based on data gathered during all of the MTERs) of the effectiveness of mitigation measures designed to avoid exposing marine mammals to MFAS. This evaluation shall identify the specific observations that support any conclusions the Navy reaches about the effectiveness of the mitigation.

(2) *ASW Summary.* This section shall include the following information as summarized from non-major training exercises (unit-level exercises, such as TRACKEXs):

(i) *Total Hours.* Total annual hours of each type of sonar source (along with explanation of how hours are calculated for sources typically quantified in alternate way (buoys, torpedoes, etc.));

(ii) *Cumulative Impacts.* To the extent practicable, the Navy, in coordination with NMFS, shall develop and implement a method of annually reporting non-major training (*i.e.,* ULT) utilizing hull-mounted sonar. The report shall present an annual (and seasonal, where practicable) depiction of non-major training exercises geographically across MIRC. The Navy shall include (in the MIRC annual report) a brief annual progress update on the status of the development of an effective and unclassified method to report this information until an agreed-upon (with NMFS) method has been developed and implemented.

(3) *Sinking Exercises (SINKEXs).* This section shall include the following information for each SINKEX completed that year:

(i) Exercise info:

(A) Location;

(B) Date and time exercise began and ended;

(C) Total hours of observation by watchstanders before, during, and after exercise;

(D) Total number and types of rounds expended/explosives detonated;

(E) Number and types of passive acoustic sources used in exercise;

(F) Total hours of passive acoustic search time;

(G) Number and types of vessels, aircraft, etc., participating in exercise;

(H) Wave height in feet (high, low and average during exercise); and

(I) Narrative description of sensors and platforms utilized for marine mammal detection and timeline illustrating how marine mammal detection was conducted.

(ii) Individual marine mammal observation during SINKEX (by Navy lookouts) information:

(A) Location of sighting;

(B) Species (if not possible—indication of whale/dolphin/pinniped);

(C) Number of individuals;

(D) Calves observed (y/n);

(E) Initial detection sensor;

(F) Length of time observers maintained visual contact with marine mammal;

(G) Wave height;

(H) Visibility;

(I) Whether sighting was before, during, or after detonations/exercise, and how many minutes before or after;

(J) Distance of marine mammal from actual detonations (or target spot if not yet detonated)—use four categories to define distance:

(*1*) The modeled injury threshold radius for the largest explosive used in that exercise type in that OPAREA (TBD m for SINKEX in MIRC);

(*2*) The required exclusion zone (1 nm for SINKEX in MIRC);

(*3*) The required observation distance (if different than the exclusion zone (2 nm for SINKEX in MIRC); and

(*4*) Greater than the required observed distance. For example, in this case, the observer shall indicate if < TBD m, from 426 m–1 nm, from 1 nm–2 nm, and >2 nm.

(K) Observed behavior—Watchstanders will describe, in plain language and without trying to categorize in any way, the observed behavior of the animals (such as animal closing to bow ride, paralleling course/speed, floating on surface and not swimming etc.), including speed and direction.

(L) Resulting mitigation implementation—Indicate whether explosive detonations were delayed, ceased, modified, or not modified due to marine mammal presence and for how long.

(M) If observation occurs while explosives are detonating in the water, indicate munitions type in use at time of marine mammal detection.

(4) Improved Extended Echo-Ranging System (IEER)/Advanced Extended Echo-Ranging (AEER) Summary:

(i) Total number of IEER and AEER events conducted in MIRC;

(ii) Total expended/detonated rounds (buoys); and

(iii) Total number of self-scuttled IEER rounds.

(5) *Explosives Summary.* The Navy is in the process of improving the methods used to track explosive use to provide increased granularity. To the extent practicable, the Navy shall provide the information described below for all of their explosive exercises. Until the Navy is able to report in full the information below, they will provide an annual update on the Navy's explosive tracking methods, including improvements from the previous year.

(i) Total annual number of each type of explosive exercise (of those identified as part of the "activity" in this Subpart) conducted in MIRC; and

(ii) Total annual expended/detonated rounds (missiles, bombs, etc.) for each explosive type.

(g) *MIRC 5-year Comprehensive Report.* The Navy shall submit to NMFS a draft report that analyzes and summarizes all of the multi-year marine mammal information gathered during ASW and explosive exercises for which annual reports are required (Annual MIRC Exercise Reports and MIRC Monitoring Plan Reports). This report will be submitted at the end of the fourth year of the rule (November 2014), covering activities that have occurred through July 15, 2014.

(h) *Comprehensive National ASW Report.* By June, 2014, the Navy shall submit a draft National Report that analyzes, compares, and summarizes the active sonar data gathered (through January 1, 2014) from the watchstanders and pursuant to the implementation of the Monitoring Plans for the Northwest Training Range Complex, the Southern California Range Complex, the Atlantic Fleet Active Sonar Training, the Hawaii Range Complex, the Mariana Islands Range Complex, and the Gulf of Alaska.

(i) The Navy shall comply with the 2009 Integrated Comprehensive Monitoring Program (ICMP) Plan and continue to improve the program in consultation with NMFS. Changes and improvements to the program made during 2010 (as prescribed in the 2009 ICMP and deemed appropriate by the Navy and NMFS) will be described in an updated 2010 ICMP and submitted to NMFS by October 31, 2010, for review. An updated 2010 ICMP will be finalized by December 31, 2010.

§ 218.106 Applications for Letters of Authorization.

To incidentally take marine mammals pursuant to these regulations, the U.S. Citizen (as defined by § 216.103) conducting the activity identified in § 218.100(c) (*i.e.,* the Navy) must apply for and obtain either an initial Letter of Authorization in accordance with § 218.107 or a renewal under § 218.108.

§ 218.107 Letters of Authorization.

(a) A Letter of Authorization, unless suspended or revoked, will be valid for a period of time not to exceed the period of validity of this subpart, but must be renewed annually subject to annual renewal conditions in § 218.108.

(b) Each Letter of Authorization shall set forth:

(1) Permissible methods of incidental taking;

(2) Means of effecting the least practicable adverse impact on the species, its habitat, and on the availability of the species for subsistence uses (*i.e.,* mitigation); and

(3) Requirements for mitigation, monitoring and reporting.

(c) Issuance and renewal of the Letter of Authorization shall be based on a determination that the total number of marine mammals taken by the activity as a whole will have no more than a negligible impact on the affected species or stock of marine mammal(s).

§ 218.108 Renewal of Letters of Authorization and adaptive management.

(a) A Letter of Authorization issued under § 216.106 and § 218.107 of this chapter for the activity identified in § 218.100(c) will be renewed annually upon:

(1) Notification to NMFS that the activity described in the application submitted under § 218.206 will be undertaken and that there will not be a substantial modification to the described work, mitigation or monitoring undertaken during the upcoming 12 months;

(2) Receipt of the monitoring reports and notifications within the timeframes indicated in the previous LOA; and

(3) A determination by NMFS that the mitigation, monitoring and reporting measures required under § 218.104 and the Letter of Authorization issued under §§ 216.106 and 218.107 of this chapter, were undertaken and will be undertaken during the upcoming annual period of validity of a renewed Letter of Authorization.

(b) If a request for a renewal of a Letter of Authorization issued under §§ 216.106 and 218.208 indicates that a substantial modification, as determined by NMFS, to the described work, mitigation or monitoring undertaken during the upcoming season will occur, NMFS will provide the public a period of 30 days for review and comment on the request.

(c) A notice of issuance or denial of a renewal of a Letter of Authorization will be published in the **Federal Register**.

(d) *Adaptive Management.* NMFS may modify or augment the existing mitigation or monitoring measures (after consulting with the Navy regarding the practicability of the modifications) if doing so creates a reasonable likelihood of more effectively accomplishing the goals of mitigation and monitoring set forth in the preamble of these regulations. Below are some of the possible sources of new data that could contribute to the decision to modify the mitigation or monitoring measures:

(1) Results from the Navy's monitoring from the previous year (either from the MIRC Study Area or other locations).

(2) Findings of the Monitoring Workshop that the Navy will convene in 2011.

(3) Compiled results of Navy funded research and development (R&D) studies (presented pursuant to the Integrated Comprehensive Monitoring Plan).

(4) Results from specific stranding investigations (either from the MIRC Study Area or other locations, and involving coincident MFAS/HFAS or explosives training or not involving coincident use).

(5) Results from the Long Term Prospective Study described in the preamble to these regulations.

(6) Results from general marine mammal and sound research.

(7) Any information which reveals that marine mammals may have been taken in a manner, extent or number not anticipated by these regulations or subsequent Letters of Authorization.

§ 218.109 Modifications to Letters of Authorization.

(a) Except as provided in paragraph (b) of this section, no substantive modification (including withdrawal or suspension) to the Letter of Authorization by NMFS, issued pursuant to §§ 216.106 and 218.107 of this chapter and subject to the provisions of this subpart, shall be made until after notification and an opportunity for public comment has been provided. For purposes of this paragraph, a renewal of a Letter of Authorization under § 218.108 without modification (except for the period of validity) is not considered a substantive modification.

(b) If the Assistant Administrator determines that an emergency exists that poses a significant risk to the well-being of the species or stocks of marine mammals specified in § 218.100(b), a Letter of Authorization issued pursuant to §§ 216.106 and 218.107 of this chapter may be substantively modified without prior notification and an opportunity for public comment. Notification will be published in the **Federal Register** within 30 days subsequent to the action.

[FR Doc. 2010–18222 Filed 8–2–10; 8:45 am]

BILLING CODE 3510–22–P

Proposed Rules

Federal Register
Vol. 75, No. 148
Tuesday, August 3, 2010

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

OFFICE OF PERSONNEL MANAGEMENT

5 CFR Part 532

RIN 3206–AM22

Prevailing Rate Systems; Definition of Tulsa County, OK, and Angelina County, TX, to Nonappropriated Fund Federal Wage System Wage Areas

AGENCY: Office of Personnel Management.

ACTION: Proposed rule with request for comments.

SUMMARY: The U.S. Office of Personnel Management is issuing a proposed rule that would define Tulsa County, Oklahoma, as an area of application to the Oklahoma, OK, nonappropriated fund (NAF) Federal Wage System (FWS) wage area and Angelina County, Texas, as an area of application to the Dallas, TX, NAF FWS wage area. These changes are necessary because there are NAF FWS employees working in Tulsa and Angelina Counties and the counties are not currently defined to NAF wage areas. In addition, this proposed rule would restore Appendix B to subpart B of part 532—Nationwide Schedule of Nonappropriated Fund Regular Wage Schedules by removing, under the State of California, "Santa Clara," which was abolished as a NAF FWS wage area by a final rule published on March 9, 2009.

DATES: We must receive comments on or before September 2, 2010.

ADDRESSES: Send or deliver comments to Jerome D. Mikowicz, Deputy Associate Director for Pay and Leave, Employee Services, U.S. Office of Personnel Management, Room 7H31, 1900 E Street, NW., Washington, DC 20415–8200; email *pay-performance-policy@opm.gov;* or FAX: (202) 606–4264.

FOR FURTHER INFORMATION CONTACT: Madeline Gonzalez, (202) 606–2838; e-mail *pay-performance-policy@opm.gov;* or FAX: (202) 606–4264.

SUPPLEMENTARY INFORMATION: The U.S. Office of Personnel Management (OPM) is issuing a proposed rule that would define Tulsa County, Oklahoma, as an area of application to the Oklahoma, OK, nonappropriated fund (NAF) Federal Wage System (FWS) wage area and Angelina County, Texas, as an area of application to the Dallas, TX, NAF FWS wage area. Veterans Canteen Service (VCS) now operates franchise coffee bars, staffed with NAF employees, at Outpatient Clinics in Tulsa and Angelina Counties. The Ernest Childers VA Outpatient Clinic in Tulsa County employs one NAF FWS employee and the Charles Wilson VA Outpatient Clinic in Angelina County employs two NAF FWS employees.

Under section 532.219 of title 5, Code of Federal Regulations, each NAF wage area "shall consist of one or more survey areas, along with nonsurvey areas, if any, having nonappropriated fund employees." Tulsa and Angelina Counties do not meet the regulatory criteria under 5 CFR 532.219 to be established as separate NAF wage areas; however, nonsurvey counties may be combined with a survey area to form a wage area. Section 532.219 lists the regulatory criteria that OPM considers when defining FWS wage area boundaries:

(i) Proximity of largest facilities activity in each county;

(ii) Transportation facilities and commuting patterns; and

(iii) Similarities of the counties in:

(A) Overall population;

(B) Private employment in major industry categories; and

(C) Kinds and sizes of private industrial establishments.

OPM recently completed reviews of the definitions of Tulsa and Angelina Counties and, based on analyses of the regulatory criteria for defining NAF wage areas, is proposing the changes described below. The Federal Prevailing Rate Advisory Committee, the national labor-management committee responsible for advising OPM on matters concerning the pay of FWS employees, recommended these changes by consensus. These changes would be effective on the first day of the first applicable pay period beginning on or after 30 days following publication of the final regulations.

Tulsa County, OK

Based on an analysis of the regulatory criteria for defining NAF wage areas, we recommend that Tulsa County, OK, be defined as an area of application to the Oklahoma, OK, NAF FWS wage area. The proximity criterion favors the Oklahoma wage area more than the Sedgwick, OK, wage area. The commuting patterns criterion does not favor one wage area more than another. Although the overall population, employment sizes, and kinds and sizes of private industrial establishments criterion does not favor one wage area more than another, the comparison of the total population and workforce, employment, and kinds and sizes of private industrial establishments for Tulsa County is similar to the Oklahoma survey area. The NAF FWS employee in Tulsa County works at the Ernest Childers VA Outpatient Clinic, which is a satellite activity attached to the Jack C. Montgomery VA Medical Center in Muskogee County. Muskogee County is already defined to the Oklahoma NAF wage area. Based on this analysis, OPM proposes to define Tulsa County to the Oklahoma NAF wage area.

The proposed Oklahoma NAF wage area would consist of one survey county, Oklahoma County, OK, and four area of application counties: Garfield, Muskogee, Pittsburgh, and Tulsa Counties, OK.

Angelina County, TX

Based on an analysis of the regulatory criteria for defining NAF wage areas, we recommend that Angelina County, TX, be defined as an area of application to the Dallas, TX, NAF FWS wage area. The proximity criterion favors the Rapides, LA, wage area. The commuting patterns criterion does not favor one wage area more than another. Although the overall population, employment sizes, and kinds and sizes of private industrial establishments criterion does not favor one wage area more than another, the industrial distribution pattern for Angelina County is similar to the Rapides survey area. However, the Department of Veterans Affairs has requested that OPM consider defining Angelina County to the Dallas wage area. The two NAF FWS employees in Angelina County work at the Charles Wilson VA Outpatient Clinic, which is a satellite activity of the Michael E. DeBakey VA Medical Center in Harris

County, which is in the Dallas wage area. Although a standard review of regulatory criteria shows that the proximity criterion favors defining Angelina County to the Rapides wage area, we believe the organizational relationship between the Charles Wilson VA Outpatient Clinic and its parent facility, the Michael E. DeBakey VA Medical Center, supports defining Angelina County to the Dallas wage area. An additional factor to consider is the relative proximity of the Medical Center to the Outpatient Clinic. There is a distance of only 128 miles (206 km) separating the two facilities. The distance from the Outpatient Clinic to the host activity in the Rapides wage area is 126 miles (203 km). The difference between these distances is only 2 miles. Based on our analysis of the organizational relationship and geographic proximity of the Medical Center and its Outpatient Clinic, OPM proposes to define Angelina County to the Dallas NAF wage area.

The proposed Dallas NAF wage area would consist of one survey county, Dallas County, TX, and four area of application counties: Angelina, Fannin, Galveston, and Harris Counties, TX.

Santa Clara, CA

On March 9, 2009, we published a final rule (74 FR 9951) that abolished the Santa Clara, CA, NAF FWS wage area. Therefore, "Santa Clara" should be removed under the State of California in Appendix B to subpart B of part 532—Nationwide Schedule of Nonappropriated Fund Regular Wage Schedules.

Regulatory Flexibility Act

I certify that these regulations would not have a significant economic impact on a substantial number of small entities because they would affect only Federal agencies and employees.

List of Subjects in 5 CFR Part 532

Administrative practice and procedure, Freedom of information, Government employees, Reporting and recordkeeping requirements, Wages.

U.S. Office of Personnel Management.

John Berry,

Director.

Accordingly, the U.S. Office of Personnel Management proposes to amend 5 CFR part 532 as follows:

PART 532—PREVAILING RATE SYSTEMS

1. The authority citation for part 532 continues to read as follows:

Authority: 5 U.S.C. 5343, 5346; § 532.707 also issued under 5 U.S.C. 552.

Appendix B to Subpart B of Part 532—[Amended]

2. Appendix B to subpart B is amended by removing, under the State of California, the entry for "Santa Clara."

3. Appendix D to subpart B is amended by revising the wage area listing for the Oklahoma, OK, and Dallas, TX, NAF wage areas to read as follows:

Appendix D to Subpart B of Part 532—Nonappropriated Fund Wage and Survey Areas

* * * * *

OKLAHOMA

* * * * *

Oklahoma

Survey Area

Oklahoma:
Oklahoma

Area of Application. Survey area plus:

Oklahoma:
Garfield
Muskogee
Pittsburg
Tulsa

* * * * * *

TEXAS

* * * * * *

Dallas

Survey Area

Texas:
Dallas

Area of Application. Survey area plus:

Texas:
Angelina
Fannin
Galveston
Harris

* * * * * *

[FR Doc. 2010–18903 Filed 8–2–10; 8:45 am]

BILLING CODE 6325–39–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. FAA–2010–0754; Directorate Identifier 2010–CE–039–AD]

RIN 2120–AA64

Airworthiness Directives; Empresa Brasileira de Aeronautica S.A. (EMBRAER) Model EMB–500 Airplanes

AGENCY: Federal Aviation Administration (FAA), Department of Transportation (DOT).

ACTION: Notice of proposed rulemaking (NPRM).

SUMMARY: We propose to adopt a new airworthiness directive (AD) for the products listed above. This proposed AD results from mandatory continuing airworthiness information (MCAI) originated by an aviation authority of another country to identify and correct an unsafe condition on an aviation product. The MCAI describes the unsafe condition as:

It has been found that certain regions of the elevators, elevators trim tabs, and ailerons do not present drain holes to avoid water accumulation inside of these flight control surfaces. Internal water accumulation may lead to flight control surfaces unbalancing possibly reducing the flutter margins, which could result in loss of airplane control.

Since this condition may occur in other airplanes of the same type and affects flight safety, a corrective action is required. Thus, sufficient reason exists to request compliance with this AD in the indicated time limit.

The proposed AD would require actions that are intended to address the unsafe condition described in the MCAI.

DATES: We must receive comments on this proposed AD by September 17, 2010.

ADDRESSES: You may send comments by any of the following methods:

- *Federal eRulemaking Portal:* Go to *http://www.regulations.gov.* Follow the instructions for submitting comments.
- *Fax:* (202) 493–2251.
- *Mail:* U.S. Department of Transportation, Docket Operations, M–30, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue, SE., Washington, DC 20590.
- *Hand Delivery:* U.S. Department of Transportation, Docket Operations, M–30, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue, SE., Washington, DC 20590, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

Examining the AD Docket

You may examine the AD docket on the Internet at *http://www.regulations.gov;* or in person at the Docket Management Facility between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The AD docket contains this proposed AD, the regulatory evaluation, any comments received, and other information. The street address for the Docket Office (telephone (800) 647–5527) is in the **ADDRESSES** section. Comments will be available in the AD docket shortly after receipt.

FOR FURTHER INFORMATION CONTACT: Karl Schletzbaum, Aerospace Engineer, FAA, Small Airplane Directorate, 901 Locust, Room 301, Kansas City, Missouri 64106; telephone: (816) 329–4146; fax: (816) 329–4090.

SUPPLEMENTARY INFORMATION:

Comments Invited

We invite you to send any written relevant data, views, or arguments about this proposed AD. Send your comments to an address listed under the **ADDRESSES** section. Include "Docket No. FAA–2010–0754; Directorate Identifier 2010–CE–039–AD" at the beginning of your comments. We specifically invite comments on the overall regulatory, economic, environmental, and energy aspects of this proposed AD. We will consider all comments received by the closing date and may amend this proposed AD because of those comments.

We will post all comments we receive, without change, to *http://www.regulations.gov,* including any personal information you provide. We will also post a report summarizing each substantive verbal contact we receive about this proposed AD.

Discussion

The AGÊNCIA NACIONAL DE AVIAÇÃO CIVIL—BRAZIL, which is the aviation authority for Brazil, has issued AD No.: 2010–07–01, dated August 9, 2010 (referred to after this as "the MCAI"), to correct an unsafe condition for the specified products. The MCAI states:

> It has been found that certain regions of the elevators, elevators trim tabs, and ailerons do not present drain holes to avoid water accumulation inside of these flight control surfaces. Internal water accumulation may lead to flight control surfaces unbalancing possibly reducing the flutter margins, which could result in loss of airplane control.
>
> Since this condition may occur in other airplanes of the same type and affects flight safety, a corrective action is required. Thus, sufficient reason exists to request compliance with this AD in the indicated time limit.

The MCAI requires you to drill new drain holes in the elevators, elevators trim tabs, and ailerons surfaces. You may obtain further information by examining the MCAI in the AD docket.

Relevant Service Information

Empresa Brasileira de Aeronáutica S.A. (EMBRAER) has issued Service Bulletin 500–57–0001, dated April 28, 2010. The actions described in this service information are intended to correct the unsafe condition identified in the MCAI.

FAA's Determination and Requirements of the Proposed AD

This product has been approved by the aviation authority of another country, and is approved for operation in the United States. Pursuant to our bilateral agreement with this State of Design Authority, they have notified us of the unsafe condition described in the MCAI and service information referenced above. We are proposing this AD because we evaluated all information and determined the unsafe condition exists and is likely to exist or develop on other products of the same type design.

Differences Between This Proposed AD and the MCAI or Service Information

We have reviewed the MCAI and related service information and, in general, agree with their substance. But we might have found it necessary to use different words from those in the MCAI to ensure the AD is clear for U.S. operators and is enforceable. In making these changes, we do not intend to differ substantively from the information provided in the MCAI and related service information.

We might also have proposed different actions in this AD from those in the MCAI in order to follow FAA policies. Any such differences are highlighted in a Note within the proposed AD.

Costs of Compliance

We estimate that this proposed AD will affect 78 products of U.S. registry. We also estimate that it would take about 18 work-hours per product to comply with the basic requirements of this proposed AD. The average labor rate is $85 per work-hour. Required parts would cost about $128 per product.

Based on these figures, we estimate the cost of the proposed AD on U.S. operators to be $129,324, or $1,658 per product.

Authority for This Rulemaking

Title 49 of the United States Code specifies the FAA's authority to issue rules on aviation safety. Subtitle I, section 106, describes the authority of the FAA Administrator. "Subtitle VII: Aviation Programs," describes in more detail the scope of the Agency's authority.

We are issuing this rulemaking under the authority described in "Subtitle VII, Part A, Subpart III, Section 44701: General requirements." Under that section, Congress charges the FAA with promoting safe flight of civil aircraft in air commerce by prescribing regulations for practices, methods, and procedures the Administrator finds necessary for safety in air commerce. This regulation is within the scope of that authority because it addresses an unsafe condition that is likely to exist or develop on products identified in this rulemaking action.

Regulatory Findings

We determined that this proposed AD would not have federalism implications under Executive Order 13132. This proposed AD would not have a substantial direct effect on the States, on the relationship between the national Government and the States, or on the distribution of power and responsibilities among the various levels of government.

For the reasons discussed above, I certify this proposed regulation:

1. Is not a "significant regulatory action" under Executive Order 12866;

2. Is not a "significant rule" under the DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979); and

3. Will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

We prepared a regulatory evaluation of the estimated costs to comply with this proposed AD and placed it in the AD docket.

List of Subjects in 14 CFR Part 39

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

The Proposed Amendment

Accordingly, under the authority delegated to me by the Administrator, the FAA proposes to amend 14 CFR part 39 as follows:

PART 39—AIRWORTHINESS DIRECTIVES

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

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

§ 39.13 [Amended]

2. The FAA amends § 39.13 by adding the following new AD:

Empresa Brasileira de Aeronautica S.A. (EMBRAER): Docket No. FAA–2010–0754; Directorate Identifier 2010–CE–039–AD.

Comments Due Date

(a) We must receive comments by September 17, 2010.

Affected ADs

(b) None.

Applicability

(c) This AD applies to Model EMB–500 airplanes, serial numbers 50000005 through 50000134, 50000136, 50000137, and 50000139 through 50000165, certificated in any category.

Subject

(d) Air Transport Association of America (ATA) Code 27: Flight Controls.

Reason

(e) The mandatory continuing airworthiness information (MCAI) states:

It has been found that certain regions of the elevators, elevators trim tabs, and ailerons do not present drain holes to avoid water accumulation inside of these flight control surfaces. Internal water accumulation may lead to flight control surfaces unbalancing possibly reducing the flutter margins, which could result in loss of airplane control.

Since this condition may occur in other airplanes of the same type and affects flight safety, a corrective action is required. Thus, sufficient reason exists to request compliance with this AD in the indicated time limit.

The MCAI requires you to drill new drain holes in the elevators, elevators trim tabs, and ailerons surfaces. You may obtain further information by examining the MCAI in the AD docket.

Actions and Compliance

(f) Unless already done, within the next 24 calendar months after the effective date of this AD, rework the elevators, elevators trim tabs, and ailerons surfaces by drilling additional drain holes in them following Empresa Brasileira de Aeronáutica S.A. (EMBRAER) Service Bulletin 500–57–0001, dated April 28, 2010.

FAA AD Differences

Note: This AD differs from the MCAI and/or service information as follows: No differences.

Other FAA AD Provisions

(g) The following provisions also apply to this AD:

(1) *Alternative Methods of Compliance (AMOCs):* The Manager, Standards Office, FAA, has the authority to approve AMOCs for this AD, if requested using the procedures found in 14 CFR 39.19. Send information to ATTN: Karl Schletzbaum, Aerospace Engineer, FAA, Small Airplane Directorate, 901 Locust, Room 301, Kansas City, Missouri 64106; telephone: (816) 329–4146; fax: (816) 329–4090. Before using any approved AMOC on any airplane to which the AMOC applies, notify your appropriate principal inspector (PI) in the FAA Flight Standards District Office (FSDO), or lacking a PI, your local FSDO.

(2) *Airworthy Product:* For any requirement in this AD to obtain corrective actions from a manufacturer or other source, use these actions if they are FAA-approved. Corrective actions are considered FAA-approved if they are approved by the State of Design Authority (or their delegated agent). You are required to assure the product is airworthy before it is returned to service.

(3) *Reporting Requirements:* For any reporting requirement in this AD, under the provisions of the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*), the Office of Management and Budget (OMB) has approved the information collection requirements and has assigned OMB Control Number 2120–0056.

Related Information

(h) Refer to MCAI AGÊNCIA NACIONAL DE AVIAÇÃO CIVIL—BRAZIL (ANAC), AD No.: 2010–07–01, dated August 9, 2010; and Empresa Brasileira de Aeronáutica S.A. (EMBRAER) Service Bulletin 500–57–0001, dated April 28, 2010, for related information.

Issued in Kansas City, Missouri, on July 26, 2010.

Christina L. Marsh,

Acting Manager, Small Airplane Directorate, Aircraft Certification Service.

[FR Doc. 2010–19019 Filed 8–2–10; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. FAA–2010–0755; Directorate Identifier 2010–NE–12–AD]

RIN 2120–AA64

Airworthiness Directives; Rolls-Royce plc (RR) RB211–Trent 800 Series Turbofan Engines

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of proposed rulemaking (NPRM).

SUMMARY: We propose to adopt a new airworthiness directive (AD) for the products listed above. This proposed AD results from mandatory continuing airworthiness information (MCAI) issued by an aviation authority of another country to identify and correct an unsafe condition on an aviation product. The MCAI describes the unsafe condition as:

Revision of the Critical Part lives has been necessary due to actual operational flight profiles not conforming to those assumed at entry into service and is associated with a revised Flight Profile Monitoring methodology (originally based on engine thrust rating but now based on operating shaft speeds) introduced by Rolls-Royce.

The new Flight Profile Monitoring methodology allows for seven new profiles replacing the previous three. Six of these profiles, A to F, are intended to cover the requirements of most operators. The Declared Life (in Standard Duty Cycles) is published for each part and life usage may be accounted by factoring the number of flights flown. The factor to be used is defined according to the Flight Profile which is applicable to the fleet.

The seventh profile, called "Heavy", will be applicable to fleets operating outside profiles A to F. A separate Declared Life (in Flight Cycles) is published for each part and life usage is accounted without factoring.

We are proposing this AD to prevent failure of critical rotating parts from exceeding the new, lower life limits, which could result in uncontained failure of the engine and damage to the airplane.

DATES: We must receive comments on this proposed AD by September 17, 2010.

ADDRESSES: You may send comments by any of the following methods:

- *Federal eRulemaking Portal:* Go to *http://www.regulations.gov* and follow the instructions for sending your comments electronically.
- *Mail:* Docket Management Facility, U.S. Department of Transportation, 1200 New Jersey Avenue, SE., West Building Ground Floor, Room W12–140, Washington, DC 20590–0001.
- *Hand Delivery:* Deliver to Mail address above between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.
- *Fax:* (202) 493–2251.

Contact Rolls-Royce plc, P.O. Box 31, Derby, DE24 8BJ, United Kingdom: Telephone 44 (0) 1332 242424; fax 44 (0) 1332 249936, for the service information identified in this proposed AD.

Examining the AD Docket

You may examine the AD docket on the Internet at *http://www.regulations.gov;* or in person at the Docket Operations office between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The AD docket contains this proposed AD, the regulatory evaluation, any comments received, and other information. The street address for the Docket Operations office (telephone (800) 647–5527) is the same as the Mail address provided in the **ADDRESSES** section. Comments will be available in the AD docket shortly after receipt.

FOR FURTHER INFORMATION CONTACT: James Lawrence, Aerospace Engineer, Engine Certification Office, FAA, Engine and Propeller Directorate, 12 New England Executive Park, Burlington, MA 01803; *e-mail: james.lawrence@faa.gov;* telephone (781) 238–7176; fax (781) 238–7199.

SUPPLEMENTARY INFORMATION:

Comments Invited

We invite you to send any written relevant data, views, or arguments about this proposed AD. Send your comments to an address listed under the **ADDRESSES** section. Include "Docket No. FAA–2010–0755; Directorate Identifier 2010–NE–12–AD" at the beginning of your comments. We specifically invite comments on the overall regulatory, economic, environmental, and energy aspects of this proposed AD. We will consider all comments received by the closing date and may amend this proposed AD based on those comments.

We will post all comments we receive, without change, to *http://www.regulations.gov,* including any personal information you provide. We will also post a report summarizing each substantive verbal contact with FAA personnel concerning this proposed AD. Using the search function of the Web site, anyone can find and read the comments in any of our dockets, including, if provided, the name of the individual who sent the comment (or signed the comment on behalf of an association, business, labor union, etc.). You may review the DOT's complete Privacy Act Statement in the **Federal Register** published on April 11, 2000 (65 FR 19477–78).

Discussion

The European Aviation Safety Agency (EASA), which is the Technical Agent for the Member States of the European Community, has issued EASA Airworthiness Directive 2007–0003R1, dated January 15, 2009 (referred to after this as "the MCAI"), to correct an unsafe condition for the specified products. The MCAI states:

The MCAI describes the unsafe condition as:

> Revision of the Critical Part lives has been necessary due to actual operational flight profiles not conforming to those assumed at entry into service and is associated with a revised Flight Profile Monitoring methodology (originally based on engine thrust rating but now based on operating shaft speeds) introduced by Rolls-Royce.
>
> The new Flight Profile Monitoring methodology allows for seven new profiles replacing the previous three. Six of these profiles, A to F, are intended to cover the requirements of most operators. The Declared Life (in Standard Duty Cycles) is published for each part and life usage may be accounted by factoring the number of flights flown. The factor to be used is defined according to the Flight Profile which is applicable to the fleet.
>
> The seventh profile, called "Heavy", will be applicable to fleets operating outside profiles A to F. A separate Declared Life (in Flight Cycles) is published for each part and life usage is accounted without factoring.

You may obtain further information by examining the MCAI in the AD docket.

Relevant Service Information

Rolls-Royce plc has issued RB211 Trent 800 Series Propulsion System Non-Modification Service Bulletin Alert RB.211–72–AE935, Revision 7, dated January 19, 2009. The actions described in this service information are intended to correct the unsafe condition identified in the MCAI.

FAA's Determination and Requirements of This Proposed AD

This product has been approved by the aviation authority of the United Kingdom, and is approved for operation in the United States. Pursuant to our bilateral agreement with the United Kingdom, they have notified us of the unsafe condition described in the MCAI and service information referenced above. We are proposing this AD because we evaluated all information provided by EASA, and determined the unsafe condition exists and is likely to exist or develop on other products of the same type design.

Differences Between This AD and the MCAI or Service Information

The MCAI requires incorporating the revised Trent 800 life limits no later than January 31, 2007. This proposed AD would require incorporating the revised Trent 800 life limits within 30 days after the effective date of this proposed AD.

Costs of Compliance

Based on the service information, we estimate that this proposed AD would affect about 16 products of U.S. registry. The average labor rate is $85 per work-hour; there is no labor cost because disks are replaced at scheduled maintenance intervals. Prorated cost of parts would cost about $45,000 per product. Based on these figures, we estimate the cost of the proposed AD on U.S. operators to be $720,000.

Authority for This Rulemaking

Title 49 of the United States Code specifies the FAA's authority to issue rules on aviation safety. Subtitle I, section 106, describes the authority of the FAA Administrator. "Subtitle VII: Aviation Programs," describes in more detail the scope of the Agency's authority.

We are issuing this rulemaking under the authority described in "Subtitle VII, Part A, Subpart III, Section 44701: General requirements." Under that section, Congress charges the FAA with promoting safe flight of civil aircraft in air commerce by prescribing regulations for practices, methods, and procedures the Administrator finds necessary for safety in air commerce. This regulation is within the scope of that authority because it addresses an unsafe condition that is likely to exist or develop on products identified in this rulemaking action.

Regulatory Findings

We determined that this proposed AD would not have federalism implications under Executive Order 13132. This proposed AD would not have a substantial direct effect on the States, on the relationship between the national Government and the States, or on the distribution of power and responsibilities among the various levels of government.

For the reasons discussed above, I certify this proposed regulation:

1. Is not a "significant regulatory action" under Executive Order 12866;

2. Is not a "significant rule" under the DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979); and

3. Will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

We prepared a regulatory evaluation of the estimated costs to comply with this proposed AD and placed it in the AD docket.

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Safety.

The Proposed Amendment

Accordingly, under the authority delegated to me by the Administrator, the FAA proposes to amend 14 CFR part 39 as follows:

PART 39—AIRWORTHINESS DIRECTIVES

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

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

§ 39.13 [Amended]

2. The FAA amends § 39.13 by adding the following new AD:

Rolls-Royce plc: Docket No. FAA–2010–0755; Directorate Identifier 2010–NE–12–AD.

Comments Due Date

(a) We must receive comments by September 17, 2010.

Affected Airworthiness Directives (ADs)

(b) None.

Applicability

(c) This AD applies to Rolls-Royce plc RB211–Trent 895–17, 892–17, 892B–17, 884–17, 884B–17, 877–17 and 875–17 turbofan engines. These engines are installed on, but not limited to, Boeing 777 series airplanes.

Reason

(d) This AD results from:

Revision of the Critical Part lives has been necessary due to actual operational flight profiles not conforming to those assumed at entry into service and is associated with a revised Flight Profile Monitoring methodology (originally based on engine thrust rating but now based on operating shaft speeds) introduced by Rolls-Royce.

The new Flight Profile Monitoring methodology allows for seven new profiles replacing the previous three. Six of these profiles, A to F, are intended to cover the requirements of most operators. The Declared Life (in Standard Duty Cycles) is published for each part and life usage may be accounted by factoring the number of flights flown. The factor to be used is defined according to the Flight Profile which is applicable to the fleet.

The seventh profile, called "Heavy", will be applicable to fleets operating outside profiles A to F. A separate Declared Life (in Flight Cycles) is published for each part and life usage is accounted without factoring.

This AD is necessary as life reductions are applicable in some cases and failure to comply with the revised life limits could result in an unsafe condition.

We are issuing this AD to prevent failure of critical rotating parts from exceeding the new, lower life limits, which could result in uncontained failure of the engine and damage to the airplane.

Actions and Compliance

(e) Compliance is required within 30 days after the effective date of this AD, unless already done, do the following actions.

(1) Revise the airworthiness limitations section (ALS) of your instructions for continued airworthiness (ICA) to incorporate Task 05–10–01–800–801, "Critical and Critical Group A Parts Lives—Multiple Flight Profile Monitoring" and Task 05–10–01–800–802, "Critical and Critical Group A Parts Lives in the HEAVY Flight Profile" of the Rolls-Royce Trent 800 Time Limits manual (TLM) dated June 15, 2009.

(2) Thereafter, do not revise the ALS of your ICA by incorporating any revision of the Rolls-Royce Trent 800 TLM dated prior to the June 15, 2009 revision.

FAA AD Differences

(f) This AD differs from the Mandatory Continuing Airworthiness Information (MCAI) and or service information as follows:

(1) The MCAI AD requires revising the airworthiness limitations section no later than January 31, 2007. This AD requires revising the airworthiness limitations section within 30 days after the effective date of this AD.

(2) This AD prohibits incorporating into the ALS of the ICA, any revision of the Rolls-Royce Trent 800 TLM earlier than the June 15, 2009.

Other FAA AD Provisions

(g) *Alternative Methods of Compliance (AMOCs):* The Manager, Engine Certification Office, FAA, has the authority to approve AMOCs for this AD, if requested using the procedures found in 14 CFR 39.19.

Related Information

(h) Refer to MCAI EASA Airworthiness Directive 2007–0003R1, dated January 15, 2009, and Rolls-Royce plc RB211 Trent 800 Series Propulsion System Non-Modification Service Bulletin Alert RB.211–72–AE935, Revision 7, dated January 19, 2009, for related information. Contact Rolls-Royce plc, P.O. Box 31, Derby, DE24 8BJ, United Kingdom: telephone 044 1332 242424; fax 044 1332 249936, for a copy of this service information.

(i) Contact James Lawrence, Aerospace Engineer, Engine Certification Office, FAA, Engine and Propeller Directorate, 12 New England Executive Park, Burlington, MA 01803; *e-mail: james.lawrence@faa.gov;* telephone (781) 238–7176; fax (781) 238–7199, for more information about this AD.

Issued in Burlington, Massachusetts, on July 19, 2010.

Thomas A. Boudreau,

Acting Manager, Engine and Propeller Directorate, Aircraft Certification Service.

[FR Doc. 2010–19027 Filed 8–2–10; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Office of the Secretary

14 CFR Parts 234, 244, 250, 253, 259, and 399

[Docket No. DOT–OST–2010–0140]

RIN No. 2105–AD92

Enhancing Airline Passenger Protections

AGENCY: Office of the Secretary (OST), Department of Transportation (DOT).

ACTION: Extension of comment period on proposed rule.

SUMMARY: This action extends the comment period for an NPRM on enhancing airline passenger protections that was published in the **Federal Register** on June 8, 2010. The Department of Transportation is extending the period for interested persons to submit comments on this rulemaking from August 9, 2010, to September 23, 2010. This extension is a result of requests from a number of airline associations, one airport association, and two airlines to extend the comment period for the proposal.

DATES: Comments must be received by September 23, 2010. Comments received after this date will be considered to the extent practicable.

ADDRESSES: You may file comments identified by the docket number DOT–OST–2010–0140 by any of the following methods:

- *Federal eRulemaking Portal:* Go to *http://www.regulations.gov* and follow the online instructions for submitting comments.
- *Mail:* Docket Management Facility, U.S. Department of Transportation, 1200 New Jersey Ave., SE., Room W12–140, Washington, DC 20590–0001.
- *Hand Delivery or Courier:* West Building Ground Floor, Room W12–140, 1200 New Jersey Ave., SE., between 9 a.m. and 5 p.m. ET, Monday through Friday, except Federal Holidays.
- *Fax:* (202) 493–2251.

Instructions: You must include the agency name and docket number DOT–OST–2010–0140 or the Regulatory Identification Number, RIN No. 2105–AD92, for the rulemaking at the beginning of your comment. All comments received will be posted without change to *http://www.regulations.gov*, including any personal information provided.

Privacy Act: Anyone is able to search the electronic form of all comments received in any of our dockets by the name of the individual submitting the comment (or signing the comment if submitted on behalf of an association, a business, a labor union, etc.). You may review DOT's complete Privacy Act statement in the **Federal Register** published on April 11, 2000 (65 FR 19477–78), or you may visit *http://DocketsInfo.dot.gov*.

Docket: For access to the docket to read background documents or comments received, go to *http://www.regulations.gov* or to the street address listed above. Follow the online instructions for accessing the docket.

FOR FURTHER INFORMATION CONTACT: Blane A. Workie or Daeleen Chesley, Office of the Assistant General Counsel for Aviation Enforcement and Proceedings, U.S. Department of Transportation, 1200 New Jersey Ave., SE., Washington, DC 20590, 202–366–9342 (phone), 202–366–7152 (fax), *blane.workie@dot.gov* or *daeleen.chesley@dot.gov* (e-mail).

SUPPLEMENTARY INFORMATION: On June 8, 2010, the Department published a Notice of Proposed Rulemaking (NPRM) on enhancing airline passenger protections that proposed to improve the air travel environment for

consumers by: (1) Increasing the number of carriers that are required to adopt tarmac delay contingency plans and the airports at which they must adhere to the plan's terms; (2) increasing the number of carriers that are required to report tarmac delay information to the Department; (3) expanding the group of carriers that are required to adopt, follow, and audit customer service plans and establishing minimum standards for the subjects all carriers must cover in such plans; (4) requiring carriers to include their contingency plans and customer service plans in their contracts of carriage; (5) increasing the number of carriers that must respond to consumer complaints; (6) enhancing protections afforded passengers in oversales situations, including increasing the maximum denied boarding compensation airlines must pay to passengers bumped from flights; (7) strengthening, codifying and clarifying the Department's enforcement policies concerning air transportation price advertising practices; (8) requiring carriers to notify consumers of optional fees related to air transportation and of increases in baggage fees; (9) prohibiting post-purchase price increases; (10) requiring carriers to provide passengers timely notice of flight status changes such as delays and cancellations; (11) prohibiting carriers from imposing unfair contract of carriage choice-of-forum provisions; and (12) soliciting comments on options to provide greater access to air travel for persons with peanut allergies. See 75 FR 32318 (June 8, 2010). Comments on the matters proposed were to be received 60 days after publication of the NPRM, or by August 9, 2010.

We received requests for an extension of time in the comment period for this rulemaking by the Airport Council International (ACI), Association of Asia Pacific Airlines (AAPA), Association of European Airlines (AEA), Latin American & Caribbean Air Transport Association (ALTA), National Airlines Council of Canada (NACC), International Air Carrier Association (IACA), International Air Transport Association (IATA) and Societe Air France & KLM Royal Dutch. We also received a joint statement in support of IATA's request for an extension of the comment period by the Air Transport Association (ATA), Regional Airline Association (RAA) and Air Carrier Association of America (ACAA). According to these requests, the extension of time is needed so the airlines have sufficient time to review and comment on the extensive and complex proposed rule. More specifically, the petitioners note, among other things, the need to consult with multiple offices on the cost, timing and feasibility of the proposals, the need to analyze any international law implications, the need to evaluate and respond to the preliminary regulatory analysis, the need to coordinate and assess several areas addressed in this proposal against other U.S. Government proposals or requirements, the need to understand the implications in this proposal considering its breadth, and the need to address the various specific issues discussed in the preamble on which comments are sought but for which there is no corresponding proposed regulatory text. Most of the petitioners requested an additional 60 days time, a few requested an additional 90 days time, and one supported an additional 30 days time.

While we concur with the requests for an extension of the comment period, we believe that a 90-day or 60-day extension would be excessive. We have decided to grant an extension of 45 days, or until September 23, 2010, for the public to comment on the NPRM. In doing so, we have balanced the stated need for additional time for comments with the need to proceed expeditiously with this important rulemaking. We take note of the fact that with the additional 45 days we are granting here, interested parties will have a total of 105 days to comment on the proposals, which we believe is adequate time for analysis and coordination regarding the proposals. Accordingly, the Department finds that good cause exists to extend the time for comments on the proposed rule from August 9, 2010, to September 23, 2010. We do not anticipate any further extension of the comment period for this rulemaking.

Issued this 29th day of July, 2010, in Washington, DC under authority assigned to me by 14 CFR 385.17(c).

Neil R. Eisner,

Assistant General Counsel, Office of Regulation and Enforcement, U.S. Department of Transportation.

[FR Doc. 2010–19123 Filed 8–2–10; 8:45 am]

BILLING CODE 4910–9X–P

DEPARTMENT OF THE TREASURY

31 CFR Part 50

RIN 1505–AC24

Terrorism Risk Insurance Program; Final Netting

AGENCY: Departmental Offices, Treasury.

ACTION: Notice of proposed rulemaking.

SUMMARY: The Department of the Treasury ("Treasury") is issuing this proposed rule as part of its implementation of Title I of the Terrorism Risk Insurance Act of 2002 ("TRIA" or "the Act"), as amended by the Terrorism Risk Insurance Extension Act of 2005 ("Extension Act") and the Terrorism Risk Insurance Program Reauthorization Act of 2007 ("Reauthorization Act"). The Act established a temporary Terrorism Risk Insurance Program ("TRIP" or "Program") under which the Federal Government would share the risk of insured losses from certified acts of terrorism with commercial property and casualty insurers. The Reauthorization Act has now extended the Program until December 31, 2014. This proposed rule is the latest in a series of regulations Treasury has issued to implement the Act. The proposed rule incorporates and implements statutory requirements of the Act for the final netting of payments under the Program. In particular, the proposed rule would establish procedures by which, after the Secretary has determined that claims for the Federal share of insured losses arising from a particular Program Year shall be considered final, a final netting of payments to or from insurers will be accomplished. The rule generally builds upon previous rules issued by Treasury.

DATES: Written comments must be received on or before October 4, 2010.

ADDRESSES: Submit comments electronically through the Federal eRulemaking Portal: *http://www.regulations.gov,* or by mail (if hard copy, preferably an original and two copies) to: Terrorism Risk Insurance Program, Public Comment Record, Suite 2100, Department of the Treasury, 1425 New York Avenue, NW., Washington, DC 20220. Because paper mail in the Washington, DC area may be subject to delay, it is recommended that comments be submitted electronically. All comments should be captioned with "TRIA Final Netting Proposed Rule Comments." Please include your name, affiliation, address, e-mail address, and telephone number in your comment. Comments received, including attachments and other supporting materials, are part of the public record and subject to public disclosure. Do not disclose any information in your comment or supporting materials that you consider confidential or inappropriate for public disclosure. Comments will be available for public inspection on the Federal eRulemaking Portal and by appointment at the TRIP Office. To make appointments, call (202) 622–6770 (not a toll-free number).

FOR FURTHER INFORMATION CONTACT: James P. Brown, Senior Analyst, Terrorism Risk Insurance Program, (202) 622–6770 (not a toll-free number).

SUPPLEMENTARY INFORMATION:

I. Background

On November 26, 2002, the Terrorism Risk Insurance Act of 2002 (Pub. L. 107–297, 116 Stat. 2322) was enacted. The Act was effective immediately. The Act's purposes are to address market disruptions, ensure the continued widespread availability and affordability of commercial property and casualty insurance for terrorism risk, and allow for a transition period for the private markets to stabilize and build capacity while preserving State insurance regulation and consumer protections.

Title I of the Act establishes a temporary federal program of shared public and private compensation for insured commercial property and casualty losses resulting from an act of terrorism. The Act authorizes Treasury to administer and implement the Terrorism Risk Insurance Program, including the issuance of regulations and procedures. The Program provides a federal backstop for insured losses from an act of terrorism.

The Program was originally set to expire on December 31, 2005. On December 22, 2005, the Terrorism Risk Insurance Extension Act of 2005 (Pub. L. 109–144, 119 Stat. 2660) was enacted, which extended the Program through December 31, 2007. On December 26, 2007, the Terrorism Risk Insurance Program Reauthorization Act of 2007 (Pub. L. 110–160, 121 Stat. 1839), which extends the Program through December 31, 2014, was enacted.

II. Previous Rulemaking

To assist insurers, policyholders, and other interested parties in complying with immediately applicable requirements of the Act, Treasury has issued interim guidances to be relied upon by insurers until superseded by regulations. Rules establishing general provisions implementing the Program, including key definitions, and requirements for policy disclosures and mandatory availability, can be found in Subparts A, B, and C of 31 CFR part 50. Treasury's rules applying provisions of the Act to State residual market insurance entities and State workers' compensation funds are at Subpart D of 31 CFR part 50. Rules setting forth procedures for filing claims for payment of the Federal share of compensation for insured losses are at Subpart F of 31 CFR part 50. Subpart G of 31 CFR part 50 contains rules on audit and recordkeeping requirements for insurers. Subpart H contains recoupment and surcharge procedures, while Subpart J of 31 CFR part 50 contains rules regarding the cap on annual liability. Subpart I of 31 CFR part 50 contains Treasury's rules implementing the litigation management provisions of section 107 of the Act.

III. The Proposed Rule

This proposed rule would add § 50.56 to subpart F of part 50, which comprises Treasury's regulations implementing the Act. It also proposes to amend § 50.53 of subpart F.

A. Overview

Pursuant to Section 103(e)(4) of the Act, the Secretary shall have sole discretion to determine the time at which claims relating to any insured loss or act of terrorism shall become final. Under this authority, this proposed rule would establish procedures by which, after the Secretary has determined that claims for the Federal share of insured losses arising from a particular Program Year shall be considered final, a final netting of payments to or from insurers will be accomplished.

The intent of this proposed rule is to provide a process by which Treasury would close out its claims operation for insured losses from a Program Year. The proposed rule includes some flexibility in how and when steps are taken to accomplish this in order to be able to effectively address future circumstances. As a simplified description, however, Treasury envisions that the steps in the process to close out its claims operation would likely be: (1) Treasury notifies insurers of the date by which all insured losses must be finally reported to Treasury; (2) insurers submit their certifications of loss by that date; (3) Treasury reviews the submissions and requires insurers to submit information supporting a commutation of claims for the Federal share of insured losses irrespective of claim status; (4) Treasury reviews insurer submissions and conducts claims audits as needed; and, (5) Treasury makes a final payment to each insurer that discharges Treasury's payment obligation to the insurer. The description of the proposed rule below provides more detail and discusses certain exceptions to this process for closing out the claims operation. Treasury seeks comment on all aspects of the proposed rule from interested persons and entities.

B. Description of the Proposed Rule

The major provisions of the proposed rule are as follows:

1. Final Netting Date

§ 50.56(b) of the proposed rule provides that the Secretary may determine a Final Netting Date for a Program Year. This would be the date by which an insurer must report to Treasury all underlying losses that have been reported to the insurer by its policyholders. Reporting to Treasury would be on the insurer's bordereaux in support of its Certifications of Loss. Rather than for a particular act of terrorism, the Final Netting Date would apply to a particular Program Year. Treasury believes that this is simpler and consistent operationally with how the TRIP claims process is administered, including treatment of deductibles, insured loss reporting and review of insurer claims for the Federal share of losses.

The criteria that would guide the determination of a Final Netting Date (§ 50.56(b)(1) of the proposed rule) primarily relate to amounts of insured losses that are yet to be paid, and the rate at which insured losses are developing. Certain lines of business may require longer periods for the losses to approach a final amount because of the nature of the losses. Based on discussions with experts in the field of reinsurance concerning sunset clauses in reinsurance contracts, general rules of thumb, and consideration of various statutes of limitation, Treasury believes that a reasonable period of time prior to Final Netting could be as long as 10 years, but is very likely to be in the range of 5–7 years. The proposed rule does not specify such timeframes, however. The determination of a Final Netting Date would be based on the following factors and considerations: (i) Amounts of case reserves previously reported by insurers to Treasury for open, underlying insured losses; (ii) the rate at which claims for the Federal share of compensation for insured losses are being made by insurers to Treasury; (iii) the rate at which new, underlying insured losses are being added by insurers to their bordereaux and reported; (iv) the predominant lines of business for which underlying insured losses are being reported; (v) tort and contract statutes of limitations relevant to insured losses; (vi) common business practices; (vii) issues that are delaying final resolution of insured losses; (viii) the applicability of the liability limitations and procedures under the Support Anti-terrorism by Fostering Effective Technologies Act of 2002 may

affect final resolution of insured losses; (ix) issues related to the cap on annual liability for insurer losses; (x) Treasury's claims administration costs; and (xi) such other factors as the Secretary considers important.

2. Notice of Final Netting Date

§ 50.56(b)(2) of the proposed rule provides that Treasury would give notice of a Final Netting Date and its application to a specific Program Year at least 180 days in advance of such a date.

3. Post-Final Netting Date Claims

Treasury has examined a couple of alternatives for defining and implementing the Final Netting Date. One possibility was to define the Final Netting Date as the date by which all insured losses would be considered final for purposes of claiming the Federal share. Such a specific cut-off could be problematic, however, for insured losses under litigation or otherwise unable to be settled. In addition, Treasury is concerned that this approach could encourage an imprudent rush to settle claims merely to ensure that they are eligible for the Federal share.

Another alternative, which is set forth in proposed § 50.56(c), is to define the Final Netting Date to be the cut-off for any new underlying insured losses to be reported to Treasury. After this date, supplemental certifications of loss for purposes of claiming the Federal share of compensation would only be allowed to provide updated information for the underlying losses already reported to Treasury. Such updated information may reflect a decision by a court of competent jurisdiction concerning a limitation of liability under the Support Anti-terrorism by Fostering Effective Technologies Act of 2002 (6 U.S.C. e*t seq.*). In the case of workers' compensation, where the TRIP bordereau requires the claim to be reported at the policy level with the number of claimants, but not a detailed listing of claimants, updated payment information would be allowed for the number of workers' compensation claimants already included, but no new claimants could be added. The Final Netting Date will be established long enough after the certified act of terrorism so that further significant loss development for reported losses is unlikely.

4. Commutation

A commutation generally is the payment of a lump sum present value of future loss payments in lieu of making payments for losses as they come due in the future. After the establishment of a Final Netting Date, proposed § 50.56(d) provides that Treasury may require, or consider an insurer's request for, a commutation of an insurer's future claims for the Federal share of compensation based on estimates for the underlying insured losses reported to Treasury on or before the Final Netting Date.

Commutation of reinsurance losses normally is heavily influenced by estimates of an insurer's Incurred but Not Reported (IBNR) amounts. Under Section 103(b) of TRIA, as a condition for Federal payment, a claim must first be filed with the insurer. In addition, pursuant to § 50.53(b)(2), the claim must have been paid (or must be paid within five business days upon receipt of an advance payment of the Federal share of compensation). Thus, Federal reimbursement ordinarily is based on paid losses while outstanding losses and IBNR amounts are not considered in computing the Federal share of insured losses. Nevertheless, once a Final Netting Date has been determined, it may be in Treasury's or an insurer's interest to commute the insurer's claim for the Federal share of insured losses that have been reported to the insurer and to Treasury, but have not yet been paid by the insurer.

Prior to consummating any commutation, Treasury may elect to conduct an audit of the insurer's insured losses. Treasury may require additional information to be supplied by the insurer, including an insurer's justification for a final payment amount with necessary actuarial factors and methodology, and pertinent information regarding the insurer's business relationships and other reinsurance recoverables. (*See* Procedural Requirements Section below.) If Treasury notifies an insurer of a commutation requirement, the insurer will have 90 days from the date of notification to submit material required in the notice or forfeit the right to future payments from Treasury. Treasury will evaluate such information in order to determine a final payment amount or (if applicable) an amount owed to the Government. Treasury does not anticipate mandating the use of specific discount factors in determining final payments for commuted amounts. Insurers will be required to justify the factors from which commutation amounts are derived and Treasury will consider them.

Payments of commuted amounts would not be considered to be advance payments requiring a segregated account as described in current § 50.54(d) of the TRIP claims regulations.

Treasury understands that a standard practice in commutation under insurance contracts is for the parties to enter into a commutation and release agreement that serves as the settlement and discharge of both parties' contractual obligations. Because Treasury makes payment of the Federal share of compensation under authority of the Act and not as a matter of contract, Treasury is not proposing that an insurer must sign a release as a condition for payment of a final commuted amount. The conditions for payment, including the discharge of Treasury's obligation and the circumstances under which Treasury may reclaim any payment, are set forth in the regulations. Treasury anticipates, however, that it may provide a statement with any final payment reciting those conditions.

The proposed rule provides that payment by Treasury of a final commuted amount to an insurer is final except under two circumstances. One such circumstance is where Treasury is put on notice that an insurer's claim was fraudulent or that other conditions for Federal payment were not met, in which case an insurer would be required to repay to Treasury those amounts that were not due the insurer. The other circumstance is that additional payments may be made by Treasury under the exception described below.

Because Treasury cannot consider IBNR amounts in establishing final payment, the proposed rule would allow an insurer to request Treasury's reconsideration of its insured losses if there were to be a significant increase due to losses reported to the insurer after the Final Netting Date. The proposed rule states that if within one year after the Final Netting Date, and regardless of commutation, an insurer has additional underlying insured losses that, in the absence of a Final Netting Date, would result in an increase of the Federal share of compensation to that insurer by 20% or more, the insurer may request Treasury to allow those underlying insured losses to be submitted as part of a certification of loss. Under such circumstances and provided other conditions for payment have been met, Treasury may reopen and/or extend the insurer's claim for the Federal share of compensation for insured losses for the pertinent Program Year.

5. Revision to § 50.53(b)(2)

The proposed rule proposes to amend existing § 50.53(b)(2)(i) of the TRIP claims regulations. § 50.53(b)(2) requires, in part, that an insurer certify

that the underlying losses on its bordereau either "have been paid by the insurer; or will be paid by the insurer upon receipt of an advance payment of the Federal share of compensation as soon as possible, consistent with the insurer's normal business practices, but no longer than five business days after receipt of the Federal share of compensation". The amendment adds the language "with current payment information" which restricts the certification to insured losses on the bordereau that are currently being paid by the insurer. This clarifies that the reporting of underlying losses that an insurer has not yet paid, nor is about to pay is allowed. The reporting of case reserve or other information may be appropriate even if losses are not currently being paid and this is particularly pertinent when an insurer must report to Treasury all losses reported to the insurer prior to the Final Netting Date.

IV. Procedural Requirements

Executive Order 12866, "*Regulatory Planning and Review*." This rule is a significant regulatory action for purposes of Executive Order 12866, "Regulatory Planning and Review," and has been reviewed by the Office of Management and Budget.

Regulatory Flexibility Act. Pursuant to the Regulatory Flexibility Act, 5 U.S.C. 601 *et seq.,* it is hereby certified that this rule, if promulgated, will not have a significant economic impact on a substantial number of small entities. TRIA requires all insurers, regardless of size or sophistication, which receive direct earned premiums for commercial property and casualty insurance, to participate in the Program. The Act also defines property and casualty insurance to mean commercial lines insurance, with certain specific exclusions, without any reference to the size or scope of the insurer. The proposed rule proposes that the Secretary of the Treasury may, as authorized by the Act, establish a Final Netting Date by which all underlying losses to an insurer's claim for the Federal share of compensation must be reported to Treasury. Insurers that are affected by these regulations tend to be large businesses; therefore, Treasury has determined that the rule will not affect a substantial number of small entities. In addition, Treasury has determined that the economic impact of the rule is not significant. Unless there is an act of terrorism, and a Federal sharing of compensation for insured losses, there is no economic impact at all. The only potential economic impact on insurers would be if they were to receive less than a full Federal share of compensation that would be due in the absence of a Final Netting process. The Final Netting Date, as proposed, will be established long enough after the certified act of terrorism so that further significant loss development for reported losses is unlikely. The rule proposes to provide for commutation of remaining losses, and includes a provision that allows for a reopening of an insurer's claim for the Federal share of losses if significant new claims are reported to the insurer subsequent to Final Netting. The economic impact on all commercial property and casualty insurers (including any that might be small entities) should thus be minimal. A regulatory flexibility analysis is therefore not required.

Paperwork Reduction Act. The collection of information contained in this proposed rule has been submitted to the Office of Management and Budget (OMB) for review under the requirements of the Paperwork Reduction Act, 44 U.S.C. 3507(d). Organizations and individuals desiring to submit comments concerning the collection of information in the proposed rule should direct them to: Office of Management and Budget, Attn: Desk Officer for the Department of the Treasury, Office of Information and Regulatory Affairs, Washington, DC 20503. A copy of the comments should also be sent to Treasury at the addresses previously specified. Comments on the collection of information should be received by October 4, 2010.

Treasury specifically invites comments on: (a) Whether the proposed collection of information is necessary for the proper performance of the mission of Treasury, and whether the information will have practical utility; (b) the accuracy of the estimate of the burden of the collections of information (*see below*); (c) ways to enhance the quality, utility, and clarity of the information collection; (d) ways to minimize the burden of the information collection, including through the use of automated collection techniques or other forms of information technology; and (e) estimates of capital or start-up costs and costs of operation, maintenance, and purchase of services to maintain the information.

Comments are being sought with respect to the collection of information in connection with commutation as proposed at § 50.56(d)(2). The required information and process follow normal business procedures of insurers interacting with their reinsurers. Information would include an insurer's justification for a final payment amount with necessary actuarial factors and methodology, and pertinent information regarding the insurer's business relationships and other reinsurance recoverables. Information must be supplied in enough detail to clearly show the expected future loss payments, how the present value amount has been determined, and reconciliation to the last Certification of Loss. Treasury will evaluate the submission in order to determine a final payment amount or (if applicable) an amount owed to the Government.

If an act of terrorism is certified under the Act, the number of insurers with losses will be determined by the size and nature of the certified act of terrorism. Because of the extreme uncertainty regarding any such event, a "best estimate" has been developed based on the considered judgment of Treasury. This estimate has 100 insurers sustaining insured losses. Out of this initial number, Treasury estimates that there would be 15 insurers involved in commutation after the determination of a Final Netting Date. The necessary data are routinely generated and reported in the insurance industry. Treasury estimates that an insurer would need 40 hours, on average, to assemble and analyze data and develop a submission to Treasury for commutation. The estimated total onetime burden would be 600 hours (15 insurers times 40 hours). At a blended, fully loaded hourly rate of $75, the cost would be $45,000.

List of Subjects in 31 CFR Part 50

Terrorism risk insurance.

Authority and Issuance

For the reasons set forth above, 31 CFR Part 50 is proposed to be amended as follows:

PART 50—TERRORISM RISK INSURANCE PROGRAM

1. The authority citation for part 50 continues to read as follows:

Authority: 5 U.S.C. 301; 31 U.S.C. 321; Title I, Pub. L. 107–297, 116 Stat. 2322, as amended by Pub. L. 109–144, 119 Stat. 2660 and Pub. L. 110–160, 121 Stat. 1839 (15 U.S.C. 6701 note).

2. In § 50.53, paragraph (b)(2)(i) is revised to read as follows:

§ 50.53 Loss certifications.

* * * * *

(b) * * *

(2) * * *

(i) The underlying insured losses listed with current payment information on the bordereau filed pursuant to § 50.53(b)(1) either: Have been paid by the insurer; or will be paid by the

insurer upon receipt of an advance payment of the Federal share of compensation as soon as possible, consistent with the insurer's normal business practices, but not longer than five business days after receipt of the Federal share of compensation;

* * * * *

3. Add § 50.56 to subpart F to read as follows:

§ 50.56 Final Netting

(a) *General.* Pursuant to Section 103(e)(4) of the Act, the Secretary shall have sole discretion to determine the time at which claims relating to any insured loss or act of terrorism shall become final.

(b) *Final Netting Date.* The Secretary may determine a Final Netting Date for a Program Year, which for purposes of this section is the date on or before which an insurer must report to Treasury all underlying insured losses that have been reported by its policyholders on the insurer's bordereaux (*see* § 50.53) in support of its Certifications of Loss for the Program Year.

(1) *Criteria for Final Netting Date.* The establishment of a Final Netting Date will be based on factors and considerations including:

(i) Amounts of case reserves previously reported by insurers to Treasury for open, underlying insured losses;

(ii) The rate at which claims for the Federal share of compensation for insured losses are being made by insurers to Treasury;

(iii) The rate at which new, underlying insured losses are being added by insurers to their bordereaux and reported;

(iv) The predominant lines of business for which underlying insured losses are being reported;

(v) Tort and contract statutes of limitations relevant to insured losses;

(vi) Common business practices;

(vii) Issues that are delaying final resolution of insured losses;

(viii) The applicability of the liability limitations and procedures under the Support Anti-terrorism by Fostering Effective Technologies Act of 2002 may affect final resolution of insured losses;

(ix) Issues related to the cap on annual liability for insurer losses;

(x) Treasury's claims administration costs; and

(xi) Such other factors as the Secretary considers important.

(2) *Notice of Final Netting Date.* Treasury shall announce and publish in the **Federal Register**, or in another manner Treasury deems appropriate, notice of a Final Netting Date and its application to a specific Program Year at least 180 days in advance of such date.

(c) *Post-Final Netting Date Claims.* After the Final Netting Date, insurers may only make further claims for the Federal share of compensation for insured losses by submission of Supplemental Certifications of Loss with updated information on underlying insured losses previously reported to Treasury. Such updated information may reflect a decision by a court of competent jurisdiction concerning a limitation of liability under the Support Anti-terrorism by Fostering Effective Technologies Act of 2002 (6 U.S.C. *et seq.*) In the case of workers' compensation losses, the insurer may provide updated information based on the number of workers' compensation claimants previously reported. An insurer may not report any new underlying insured losses, or increased workers' compensation loss amounts based on an increase in workers' compensation claimants, to Treasury after a Final Netting Date, except as provided in this section.

(d) *Commutation.* A commutation is the payment by Treasury of a lump sum present value of future payments to an insurer in lieu of making payments as they come due in the future, as provided in this section.

(1) In lieu of continued submission of Certifications of Loss after the Final Netting Date as provided in paragraph (c) of this section, Treasury may require, or consider an insurer's request for, a commutation of an insurer's future claims for the Federal share of compensation based on estimates for the underlying insured losses reported to Treasury on or before the Final Netting Date. The payment by Treasury of a final commuted amount to an insurer will discharge Treasury from all further liabilities to the insurer for the Federal share of compensation for insured losses for the applicable Program Year. In the case of an affiliated group of insurers, the requirements of § 50.54(f) apply, provided that payment of the final commuted amount to the designated insurer of the affiliated group discharges Treasury's payment obligation to the insurers in the affiliated group for insured losses for the applicable Program Year.

(2) If future claims are to be commuted, Treasury may require additional information to be supplied by the insurer, including an insurer's justification for a final payment amount with necessary actuarial factors and methodology, and pertinent information regarding the insurer's business relationships and other reinsurance recoverables. Insurers will be required to justify discount and other factors from which the final payment amounts are derived. If Treasury notifies an insurer of a commutation requirement, the insurer will have 90 days from the date of notification to submit material required in the notice or forfeit the right to future payments from Treasury. Treasury will evaluate such information in order to determine a final payment amount or (if applicable) an amount owed to the Government. Treasury may determine that it will not consider commutation until it has completed an audit of an insurer's insured losses.

(3) Payments of commuted amounts are not considered to be advance payments requiring a segregated account as described in § 50.54(d).

(4) Notwithstanding § 50.50(e), a payment by Treasury of a final commuted amount to an insurer is final unless:

(i) Treasury is put on notice that an insurer's claim was fraudulent or that other conditions for Federal payment were not met, in which case the insurer will be required to repay amounts that were not due; or

(ii) The exception in paragraph (e) of this section applies, in which case Treasury may make additional payments for insured losses, but only under the conditions described in paragraph (e).

(e) *Exception.* If within one year after the Final Netting Date, and regardless of commutation, an insurer has additional underlying reported insured losses that, in the absence of a Final Netting Date, would result in an increase of the Federal share of compensation to that insurer by 20% or more, the insurer may request Treasury to allow those underlying insured losses to be submitted as part of a certification of loss. Under such circumstances and provided other conditions for payment have been met, Treasury may reopen and/or extend the insurer's claim for the Federal share of compensation for insured losses for the pertinent Program Year.

Dated: July 14, 2010.

Michael S. Barr,

Assistant Secretary (Financial Institutions).

[FR Doc. 2010–18952 Filed 8–2–10; 8:45 am]

BILLING CODE 4810–25–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[EPA–R05–OAR–2010–0450; FRL–9182–3]

Approval and Promulgation of Air Quality Implementation Plans; Minnesota

AGENCY: Environmental Protection Agency (EPA).

ACTION: Proposed rule.

SUMMARY: EPA is proposing to approve Minnesota's request to amend its State Implementation Plan (SIP) for sulfur dioxide (SO_2). The Minnesota Pollution Control Agency submitted the SIP revision request to EPA on May 7, 2010. The proposed approval revises the Minnesota SIP by updating information regarding the heat and steam distributor facility located in Fridley, Minnesota. The source, formerly operated as United Defense, LP, Inc. was sold and is now operating as ELT Minneapolis, LLC. The revision replaces the joint Title I/Title V document currently approved in the SIP for the facility to reflect the change in ownership. These revisions do not change any of the SO_2 control requirements and will not result in an increase in SO_2 emissions at the facility because no emission limits were increased.

DATES: Comments must be received on or before **September 2, 2010.**

ADDRESSES: Submit your comments, identified by Docket ID No. EPA–R05–OAR–2010–0450, by one of the following methods:

1. *http://www.regulations.gov:* Follow the on-line instructions for submitting comments.
2. *E-mail: bortzer.jay@epa.gov.*
3. *Fax:* (312) 629–2054.
4. *Mail:* Jay Bortzer, Chief, Air Programs Branch (AR–18J), U.S. Environmental Protection Agency, 77 West Jackson Boulevard, Chicago, Illinois 60604.
5. *Hand Delivery:* Jay Bortzer, Chief, Air Programs Branch (AR–18J), U.S. Environmental Protection Agency, 77 West Jackson Boulevard, Chicago, Illinois 60604. Such deliveries are only accepted during the Regional Office normal hours of operation, and special arrangements should be made for deliveries of boxed information. The Regional Office official hours of business are Monday through Friday, 8:30 a.m. to 4:30 p.m., excluding Federal holidays.

Please see the direct final rule which is located in the Rules section of this **Federal Register** for detailed instructions on how to submit comments.

FOR FURTHER INFORMATION CONTACT: Charles Hatten, Environmental Engineer, Control Strategies Section, Air Programs Branch (AR–18J), U.S. Environmental Protection Agency, Region 5, 77 West Jackson Boulevard, Chicago, Illinois 60604, (312) 886–6031, *hatten.charles@epa.gov.*

SUPPLEMENTARY INFORMATION: In the Rules section of this **Federal Register,** EPA is approving the State's SIP submittal as a direct final rule without prior proposal because EPA views this as a noncontroversial submittal and anticipates no adverse comments. A detailed rationale for the approval is set forth in the direct final rule. If no adverse comments are received in response to this rule, no further activity is contemplated. If EPA receives adverse comments, the direct final rule will be withdrawn and all public comments received will be addressed in a subsequent final rule based on this proposed rule. EPA will not institute a second comment period. Any parties interested in commenting on this action should do so at this time. Please note that if EPA receives adverse comment on an amendment, paragraph, or section of this rule and if that provision may be severed from the remainder of the rule, EPA may adopt as final those provisions of the rule that are not the subject of an adverse comment. For additional information, see the direct final rule which is located in the Rules section of this **Federal Register.**

Dated: July 19, 2010.

Susan Hedman,

Regional Administrator, Region 5.

[FR Doc. 2010–18565 Filed 8–2–10; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[EPA–R04–OAR–2007–0228–201015; FRL–9184–3]

Approval and Promulgation of Implementation Plans and Designations of Areas for Air Quality Planning Purposes; Tennessee: Knoxville; Determination of Attainment for the 1997 8-Hour Ozone Standards

AGENCY: Environmental Protection Agency (EPA).

ACTION: Proposed rule.

SUMMARY: On February 19, 2010, the State of Tennessee, through the Tennessee Department of Environment and Conservation (TDEC), submitted a request to EPA to make a determination that the Knoxville, Tennessee nonattainment area has attained the 1997 8-hour ozone national ambient air quality standards (NAAQS) based on quality assured, quality controlled monitoring data from 2007–2009. The Knoxville, Tennessee 1997 8-hour ozone nonattainment area (hereafter referred to as the "Knoxville Area") is comprised of Anderson, Blount, Jefferson, Knox, Loudon and Sevier Counties in their entireties and a portion of Cocke County (Great Smoky Mountain National Park) in Tennessee. In this action, EPA is proposing to determine that the Knoxville Area has attained the 1997 8-hour ozone NAAQS. This proposed determination is based upon complete, quality assured, quality controlled, and certified ambient air monitoring data for the years 2007–2009 showing that the Knoxville Area has monitored attainment of the 1997 8-hour ozone NAAQS. Preliminary air quality monitoring data available for 2010 are consistent with continued attainment. If this proposed determination is made final, the requirement for the State of Tennessee to submit an attainment demonstration and associated reasonably available control measures (RACM), a reasonable further progress (RFP) plan, contingency measures, and other planning State Implementation Plans (SIPs) related to attainment of the 1997 8-hour ozone NAAQS for the Knoxville, Tennessee 8-hour ozone nonattainment area, shall be suspended for as long as the Knoxville Area continues to meet the 1997 8-hour ozone NAAQS.

DATES: Written comments must be received on or before September 2, 2010.

ADDRESSES: Submit your comments, identified by Docket ID No. EPA–R04–OAR–2007–0228 by one of the following methods:

1. *http://www.regulations.gov:* Follow the on-line instructions for submitting comments.
2. *E-mail: benjamin.lynorae@epa.gov.*
3. *Fax:* (404) 562–9019.
4. *Mail:* "EPA–R04–OAR–2007–0228," Regulatory Development Section, Air Planning Branch, Air, Pesticides and Toxics Management Division, U.S. Environmental Protection Agency, Region 4, 61 Forsyth Street, SW., Atlanta, Georgia 30303–8960.
5. *Hand Delivery or Courier:* Lynorae Benjamin, Chief, Regulatory Development Section, Air Planning Branch, Air, Pesticides and Toxics Management Division, U.S. Environmental Protection Agency,

Region 4, 61 Forsyth Street, SW., Atlanta, Georgia 30303–8960. Such deliveries are only accepted during the Regional Office's normal hours of operation. The Regional Office's official hours of business are Monday through Friday, 8:30 to 4:30, excluding Federal holidays.

Instructions: Direct your comments to Docket ID No. EPA–R04–OAR–2007–0228. EPA's policy is that all comments received will be included in the public docket without change and may be made available online at *http://www.regulations.gov,* including any personal information provided, unless the comment includes information claimed to be Confidential Business Information (CBI) or other information whose disclosure is restricted by statute. Do not submit through *http://www.regulations.gov* or by e-mail information that you consider to be CBI or otherwise protected. The *http://www.regulations.gov* Web site is an "anonymous access" system, which means EPA will not know your identity or contact information unless you provide it in the body of your comment. If you send an e-mail comment directly to EPA without going through *http://www.regulations.gov,* your e-mail address will be automatically captured and included as part of the comment that is placed in the public docket and made available on the Internet. If you submit an electronic comment, EPA recommends that you include your name and other contact information in the body of your comment and with any disk or CD–ROM you submit. If EPA cannot read your comment due to technical difficulties and cannot contact you for clarification, EPA may not be able to consider your comment. Electronic files should avoid the use of special characters, any form of encryption, and be free of any defects or viruses. For additional information about EPA's public docket visit the EPA Docket Center homepage at *http://www.epa.gov/epahome/dockets.htm.*

Docket: All documents in the electronic docket are listed in the *http://www.regulations.gov* index. Although listed in the index, some information is not publicly available, *i.e.,* CBI or other information whose disclosure is restricted by statute. Certain other material, such as copyrighted material, is not placed on the Internet and will be publicly available only in hard copy form. Publicly available docket materials are available either electronically in *http://www.regulations.gov* or in hard copy at the Regulatory Development Section, Air Planning Branch, Air, Pesticides and Toxics Management Division, U.S. Environmental Protection Agency, Region 4, 61 Forsyth Street, SW., Atlanta, Georgia 30303–8960. EPA requests that if at all possible, you contact the person listed in the **FOR FURTHER INFORMATION CONTACT** section to schedule your inspection. The Regional Office's official hours of business are Monday through Friday, 8:30 to 4:30, excluding Federal holidays.

FOR FURTHER INFORMATION CONTACT: Twunjala Bradley, Regulatory Development Section, Air Planning Branch, Air, Pesticides and Toxics Management Division, U.S. Environmental Protection Agency, Region 4, 61 Forsyth Street, SW., Atlanta, Georgia 30303–8960. Ms. Bradley may be reached by phone at (404) 562–9352 or via electronic mail at *bradley.twunjala@epa.gov.*

SUPPLEMENTARY INFORMATION:

I. What action is EPA taking?
II. What is the effect of this action?
III. What is the background for this action?
IV. What is EPA's analysis of the relevant air quality data?
V. Proposed Action
VI. Statutory and Executive Order Reviews

I. What action is EPA taking?

EPA is proposing to determine that the Knoxville Area has attained the 1997 8-hour ozone NAAQS. The Knoxville Area is comprised of Anderson, Blount, Jefferson, Knox, Loudon and Sevier Counties in their entireties and a portion of Cocke County (Great Smoky Mountains National Park) in Tennessee. EPA's determination is based upon complete, quality assured, quality controlled, and certified ambient air monitoring data for the years 2007–2009 showing that the Knoxville Area has monitored attainment of the 1997 8-hour ozone NAAQS. Preliminary air quality monitoring data available for 2010 are consistent with continued attainment. On March 12, 2008, EPA promulgated a revised 8-hour ozone NAAQS (also known as the 2008 8-hour ozone NAAQS). Subsequently, on January 19, 2010, EPA published a proposed rule to reconsider the 2008 8-hour ozone NAAQS, and to promulgate a revised (2010) 8-hour ozone NAAQS. Today's rulemaking does not address requirements for, or future revisions to, the 2008 or proposed 2010 8-hour ozone NAAQS.

II. What is the effect of this action?

If this determination is made final, under the provisions of EPA's ozone implementation rule (see 40 CFR 51.918), the requirements for the State of Tennessee to submit an attainment demonstration and associated RACM, RFP plan, contingency measures,[1] and any other planning SIPs related to attainment of the 1997 8-hour ozone NAAQS for the Knoxville Area, shall be suspended for as long as the Area continues to meet the 1997 8-hour ozone NAAQS.

On January 16, 2009 (74 FR 2936), EPA published a proposed rulemaking to address, among other issues, the United States Court of Appeals for the District of Columbia Circuit's (DC Circuit) vacatur of the classification system that EPA used to designate a subset of initial 1997 8-hour ozone nonattainment areas under title I, part D, subpart 1 of the Clean Air Act (CAA). In that rulemaking, EPA proposed that all areas designated nonattainment for the 1997 8-hour ozone NAAQS under subpart 1 would be classified as subpart 2 areas (hereafter referred to as the "Subpart 1/Subpart 2 1997 8-Hour Ozone Rulemaking"). The Knoxville Area is among those areas that would be classified if EPA's proposal is finalized. EPA has not yet completed its final rulemaking action for the Subpart 1/Subpart 2 1997 8-Hour Ozone Rulemaking. When the Subpart 1/Subpart 2 1997 8-Hour Ozone Rulemaking is finalized, and if the Knoxville Area continues in attainment for the 1997 8-hour ozone NAAQS, EPA will address in a future rulemaking the consequences of a determination of attainment for any requirements to which the Knoxville Area becomes subject as a result of its reclassification. If after the Knoxville Area is classified under Subpart 2, EPA determines in a future rulemaking that the Knoxville Area continues to be in attainment, then the obligation to submit the pertinent attainment-related requirements for its new classification would be suspended in accordance with 40 CFR 50.918.

As further discussed below, the proposed determination (the subject of this rulemaking) for the Knoxville Area would: (1) Suspend the requirement to submit an attainment demonstration and associated RACM (including reasonably available control technologies), RFP plan, contingency measures, and any other planning SIPs related to attainment of the 1997 8-hour ozone NAAQS; (2) continue until such time, if any, that EPA subsequently determines that the Knoxville Area has violated the 1997 8-hour ozone NAAQS; (3) be separate from, and not influence or otherwise affect, any future designation determination or

[1] Contingency measures associated with a maintenance plan (such as if the State opts to redesignate this Area to attainment for the 1997 8-hour ozone NAAQS) would still be required.

requirements for the Knoxville Area based on the revised or reconsidered 2008 8-hour ozone NAAQS or the proposed 2010 ozone NAAQS; and (4) remain in effect regardless of whether EPA designates the Knoxville Area as a nonattainment area for purposes of the revised or reconsidered 2008 8-hour ozone NAAQS or proposed 2010 8-hour ozone NAAQS.[2] Furthermore, as described below, a final clean data determination is not equivalent to the redesignation of the Knoxville Area to attainment for the 1997 8-hour ozone NAAQS.

If this rulemaking is finalized and EPA subsequently determines, after notice-and-comment rulemaking in the **Federal Register**, that the Knoxville Area has violated the 1997 8-hour ozone NAAQS, the basis for the suspension of the specific requirements, set forth at 40 CFR 51.918, would no longer exist, and the Knoxville Area would thereafter have to address pertinent requirements.

The determination that EPA proposes with this **Federal Register** notice is not equivalent to a redesignation of the Knoxville Area to attainment. Finalizing this proposed action would not constitute a redesignation of the Area to attainment of the 1997 8-hour ozone NAAQS under section 107(d)(3) of the CAA. Further, finalizing this proposed action does not involve approving maintenance plans for this Area as required under section 175A of the CAA, or would a determination that the Area has met all other requirements for redesignation. The designation status of the Knoxville Area would remain nonattainment for the 1997 8-hour ozone NAAQS until such time as EPA determines that it meets the CAA requirements for redesignation to attainment. The State of Tennessee is currently working on a redesignation request and maintenance plan to change the Knoxville Area's status from nonattainment to attainment for the 1997 8-hour ozone NAAQS. EPA will consider Tennessee's redesignation request and maintenance plan for the Knoxville Area in a rulemaking separate from today's proposed action.

This proposed action, if finalized, is limited to a determination that the Knoxville Area has attained the 1997 8-hour ozone NAAQS. As noted above, the 1997 8-hour ozone NAAQS became effective on July 18, 1997 (62 FR 38894), and are set forth at 40 CFR 50.10. On March 12, 2008, EPA promulgated revised 8-hour ozone NAAQS. Subsequently, on January 19, 2010, EPA published a proposed rule to reconsider the 2008 8-hour ozone NAAQS (75 FR 2938) and to propose a revised 2010 NAAQS. In view of these actions, EPA extended the deadline to make designation determinations for the 2008 8-hour ozone NAAQS. EPA has not yet made any designation determination for the Knoxville Area based on the revised 2008 8-hour ozone or proposed 2010 ozone NAAQS. Today's proposed determination for the Knoxville Area, and any final determination, will have no effect on, and is not related to, any future designation determination that EPA may make based on the revised or reconsidered 2008 or proposed 2010 8-hour ozone NAAQS for the Knoxville Area. Conversely, any future designation determination for the Knoxville Area, based on the revised or reconsidered 2008 or 2010 proposed 8-hour ozone NAAQS, will not have any effect on the determination proposed by this notice.

If this proposed determination is made final and the Knoxville Area continues to demonstrate attainment with the 1997 8-hour ozone NAAQS, the obligation for the State of Tennessee to submit for the Knoxville Area an attainment demonstration and associated RACM, RFP plan, contingency measures, and any other planning SIPs related to attainment of the 1997 8-hour ozone NAAQS will remain suspended regardless of whether EPA designates the Knoxville Area as a nonattainment area for purposes of the revised or reconsidered 2008 or proposed 2010 8-hour ozone NAAQS. Once the Knoxville Area is designated for the revised or reconsidered 2008 or proposed 2010 NAAQS, it will have to meet all applicable requirements for that designation.

III. What is the background for this action?

On July 18, 1997 (62 FR 38894), EPA promulgated a revised 8-hour ozone standard of 0.08 parts per million (ppm) for both the primary and secondary standards. These standards are more stringent than the previous 1-hour ozone standards. Under EPA regulations at 40 CFR part 50, the 8-hour ozone NAAQS is attained when the 3-year average of the annual fourth-highest daily maximum 8-hour average ambient air quality ozone concentrations is less than or equal to 0.08 ppm (*i.e.,* 0.084 ppm when rounding is considered). Ambient air quality monitoring data for the 3-year period must meet a data completeness requirement. The ambient air quality monitoring data completeness requirement is met when the average percent of days with valid ambient monitoring data is greater than 90 percent, and no single year has less than 75 percent data completeness as determined in Appendix I of part 50. Specifically, section 2.3 of 40 CFR part 50, Appendix I, "*Comparisons with the Primary and Secondary Ozone Standards*" states:

"The primary and secondary ozone ambient air quality standards are met at an ambient air quality monitoring site when the 3-year average of the annual fourth-highest daily maximum 8-hour average ozone concentration is less than or equal to 0.08 ppm. The number of significant figures in the level of the standard dictates the rounding convention for comparing the computed 3-year average annual fourth-highest daily maximum 8-hour average ozone concentration with the level of the standard. The third decimal place of the computed value is rounded, with values equal to or greater than 5 rounding up. Thus, a computed 3-year average ozone concentration of 0.085 ppm is the smallest value that is greater than 0.08 ppm."

On April 30, 2004 (69 FR 23857), EPA published its air quality designations and classifications for the 1997 8-hour ozone NAAQS based upon air quality monitoring data from those monitors for calendar years 2001–2003 (84 FR 23858). These designations became effective on June 15, 2004. The Knoxville Area is comprised of a portion of Cocke County (Great Smoky Mountains National Park), and the entire counties of Anderson, Blount, Jefferson, Knox, Loudon and Sevier; and was designated nonattainment for the 1997 8-hour ozone NAAQS (*see* 40 CFR part 81).

On February 19, 2010, the State of Tennessee, through TDEC, submitted a request to EPA to make a determination that the Knoxville Area has attained the 1997 8-hour ozone NAAQS based on complete, quality assured, quality controlled monitoring data from 2007 through 2009.

IV. What is EPA's analysis of the relevant air quality data?

EPA has reviewed the three most recent years of complete, certified, quality assured and quality controlled ambient air monitoring data for the 1997 8-hour ozone NAAQS, consistent with the requirements contained in 40 CFR part 50, as recorded in the EPA Air Quality System (AQS) database for the Knoxville Area. Based on that review, EPA has concluded that the Knoxville Area attained the 1997 8-hour ozone NAAQS during the 2007–2009 monitoring period. Under EPA

[2] As noted above, at this time the proposed determination of attainment, if finalized, would suspend only those requirements related to attainment that are currently applicable to the Knoxville Area.

regulations at 40 CFR 50.10, the 1997 8-hour primary and secondary ozone ambient air quality standards are met at an ambient air quality monitoring site when the three-year average of the annual fourth-highest daily maximum 8-hour average concentration is less than or equal to 0.08 ppm, as determined in accordance with appendix I of 40 CFR part 50.

Table 1 shows the design values (the metrics calculated in accordance with 40 CFR part 50, appendix I, for determining compliance with the NAAQS) for the 1997 8-hour ozone NAAQS for the Knoxville Area monitors for the years 2007–2009.

TABLE 1—DESIGN VALUES FOR COUNTIES IN THE KNOXVILLE, TENNESSEE NONATTAINMENT AREA FOR THE 1997 8-HOUR OZONE NAAQS

Location	AQS site ID	2007 (ppm)	2008 (ppm)	2009 (ppm)	2007–2009 design value (ppm)
Anderson County	Freels Bend Study Area (470010101–1)	0.080	0.073	0.065	0.072
Blount County	Look Rock, GSMNP (470090101–1)	0.088	0.082	0.069	0.079
	Cades Cove, GSMNP (470090102–1)	0.074	0.071	0.062	0.069
Jefferson County	1188 Lost Creek Road (470890002–1)	0.085	0.075	0.068	0.076
Knox County	9315 Rutledge Pike (470930021–1))	0.087	0.079	0.066	0.077
	4625 Mildred Drive (470931020–1)	0.092	0.086	0.068	0.082
Loudon County	130 Webb Drive (471050109–1)	0.088	0.077	0.067	0.077
Sevier County	Cove Mountain, GSMNP (471550101–1)	0.088	0.079	0.070	0.079

EPA's review of these data indicates that the Knoxville Area has met and continues to meet the 1997 8-hour ozone NAAQS. Preliminary air quality monitoring data available for 2010 also continue to demonstrate attainment. EPA is soliciting public comments on the issues discussed in this document. These comments will be considered before taking final action.

V. Proposed Action

EPA is proposing to determine that the Knoxville, Tennessee, 1997 8-hour nonattainment area has attained the 1997 8-hour ozone NAAQS based on 2007–2009 complete, quality-assured, quality-controlled and certified monitoring data. As provided in 40 CFR 51.918, if EPA finalizes this determination, it would suspend the requirements for the State of Tennessee to submit, for the Knoxville Area, an attainment demonstration and associated RACM, RFP plan, contingency measures, and any other planning SIPs related to attainment of the 1997 8-hour ozone NAAQS as long as the Area continues to attain the 1997 8-hour ozone NAAQS.

VI. Statutory and Executive Order Reviews

Under the CAA, the Administrator is required to approve a SIP submission or state request that complies with the provisions of the Act and applicable Federal regulations. 42 U.S.C. 7410(k); 40 CFR 52.02(a). Thus, in reviewing SIP submissions or state request, EPA's role is to approve state choices, provided that they meet the criteria of the CAA. Accordingly, this proposed action merely approves state law as meeting Federal requirements and does not impose additional requirements beyond those imposed by state law. For that reason, this proposed action:

- Is not a "significant regulatory action" subject to review by the Office of Management and Budget under Executive Order 12866 (58 FR 51735, October 4, 1993);
- Does not impose an information collection burden under the provisions of the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*);
- Is certified as not having a significant economic impact on a substantial number of small entities under the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*);
- Does not contain any unfunded mandate or significantly or uniquely affect small governments, as described in the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4);
- Does not have Federalism implications as specified in Executive Order 13132 (64 FR 43255, August 10, 1999);
- Is not an economically significant regulatory action based on health or safety risks subject to Executive Order 13045 (62 FR 19885, April 23, 1997);
- Is not a significant regulatory action subject to Executive Order 13211 (66 FR 28355, May 22, 2001);
- Is not subject to requirements of Section 12(d) of the National Technology Transfer and Advancement Act of 1995 (15 U.S.C. 272 note) because application of those requirements would be inconsistent with the CAA; and
- Does not provide EPA with the discretionary authority to address, as appropriate, disproportionate human health or environmental effects, using practicable and legally permissible methods, under Executive Order 12898 (59 FR 7629, February 16, 1994).

In addition, this action does not have tribal implications as specified by Executive Order 13175 (65 FR 67249, November 9, 2000), because the impacted area is not in Indian country located in the state, and EPA notes that it will not impose substantial direct costs on tribal governments or preempt tribal law.

List of Subjects in 40 CFR Part 52

Environmental protection, Air pollution control, Ozone, Volatile organic compounds.

Dated: July 23, 2010.

Beverly H. Banister,

Acting Regional Administrator, Region 4.

[FR Doc. 2010–19052 Filed 8–2–10; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 81

[EPA–R09–OAR–2010–0590; FRL–9184–7]

Determination of Attainment for PM_{10} for the Las Vegas Valley Nonattainment Area, NV

AGENCY: Environmental Protection Agency (EPA).

ACTION: Proposed rule.

SUMMARY: EPA proposes to determine that the Las Vegas Valley nonattainment area in Nevada attained the National Ambient Air Quality Standard (NAAQS) for particulate matter with an aerodynamic diameter of less than or equal to a nominal ten micrometers (PM_{10}) by the applicable attainment date (December 31, 2006), and that the Las Vegas Valley nonattainment area is currently attaining the standard.

DATES: Comments must be received on or before **September 2, 2010.**

ADDRESSES: Submit comments, identified by docket number EPA–R09–OAR–2010–0590, by one of the following methods:

1. *Federal eRulemaking Portal: http://www.regulations.gov.* Follow the on-line instructions.

2. *E-mail: tax.wienke@epa.gov.*

3. *Mail or deliver:* Wienke Tax, Air Planning Office, EPA Region IX, 75 Hawthorne Street, San Francisco, CA 94105–3901.

Please see the direct final rule which is located in the Rules section of this **Federal Register** for detailed instructions on how to submit comments.

FOR FURTHER INFORMATION CONTACT: Wienke Tax at telephone number: (415) 947–4192, e-mail address: *tax.wienke@epa.gov,* or the above EPA, Region IX address.

SUPPLEMENTARY INFORMATION: For further information, please see the direct final action, of the same title, which is located in the Rules section of this **Federal Register**. EPA is approving the attainment determination as a direct final rule without prior proposal because EPA views this as a noncontroversial action and anticipates no adverse comments. A detailed rationale for the approval is set forth in the preamble to the direct final rule. If EPA receives no adverse comments, EPA will not take further action on this proposed rule.

If EPA receives adverse comments, EPA will withdraw the direct final rule and it will not take effect. EPA will address all public comments in a subsequent final rule based on this proposed rule. EPA will not institute a second comment period on this action. Any parties interested in commenting on this action should do so at this time. Please note that if we receive adverse comment on an amendment, paragraph, or section of this rule and if that provision may be severed from the remainder of the rule, EPA may adopt as final those provisions of the rule that are not the subject of an adverse comment.

Dated: July 21, 2010.

Keith Takata,

Acting Regional Administrator, EPA Region IX.

[FR Doc. 2010–19062 Filed 8–2–10; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 112

[EPA–HQ–OPA–2009–0880; FRL–9184–2]

RIN 2050–AG59

Oil Pollution Prevention; Spill Prevention, Control, and Countermeasure (SPCC) Rule—Proposed Amendments

AGENCY: Environmental Protection Agency.

ACTION: Proposed rule; compliance date amendment.

SUMMARY: The U.S. Environmental Protection Agency (EPA or the Agency) is proposing to amend the date by which certain facilities must prepare or amend their Spill Prevention, Control, and Countermeasure (SPCC) Plans, and implement those Plans. This action would allow additional time for those affected in the regulated community to understand the revisions to the SPCC rule finalized in December 2008 and November 2009. In light of the recent uncertainty surrounding EPA's review of the final amendments to the December 2008 rule and the delay of that rule's effective date, the Agency is proposing to provide an additional year for certain facilities, with a new compliance date of November 10, 2011. Additionally, the Agency is proposing to further delay the compliance date for facilities with milk containers, associated piping and appurtenances that are constructed according to the current applicable 3–A Sanitary Standards, and subject to the current applicable Grade "A" Pasteurized Milk Ordinance (PMO) or a State dairy regulatory requirement equivalent to the current applicable PMO. The delay would allow the Agency to take final action on a January 15, 2009 action that proposed to exempt these containers from the SPCC requirements. The compliance date would be delayed one year from the effective date of a final rule specifically addressing SPCC requirements for these milk containers, associated piping and appurtenances, or as specified by a rule that otherwise establishes a new compliance date for these facilities. Both the extension and the delay would provide sufficient time for facilities to undertake the actions necessary to prepare or amend their SPCC Plans, as well as implement them. However, EPA is not proposing to extend the compliance date for drilling, production and workover facilities that are offshore or that have an offshore component, or for onshore facilities required to submit Facility Response Plans (FRPs).

DATES: Comments on this proposed rule must be received by August 18, 2010.

ADDRESSES: Submit your comments, identified by Docket ID No. EPA–HQ–OPA–2009–0880, by one of the following methods:

(1) *http://www.regulations.gov.* Follow the on-line instructions for submitting comments.

(2) *E-mail: Docket.RCRA@epa.gov,* Attention Docket ID No. EPA–HQ–OPA–2009–0880.

(3) *Fax:* 202–566–9744, Attention Docket ID No. EPA–HQ–OPA–2009–0880.

(4) *Mail:* EPA Docket Center (EPA/DC), Docket ID No. EPA–HQ–OPA–2009–0880, Mail Code 2822T, 1200 Pennsylvania Ave., NW., Washington, DC 20460.

(5) *Hand Delivery:* EPA Docket Center (EPA/DC), EPA West, Room 3334, 1301 Constitution Ave., NW., Washington DC 20460. Attention Docket ID No. EPA–HQ–OPA–2009–0880. Such deliveries are only accepted during the Docket's normal hours of operation, and special arrangements should be made for deliveries of boxed information.

Instructions: EPA's policy is that all comments received will be included in the public docket without change, and may be made available online at *http://www.regulations.gov,* including any personal information provided, unless the comment includes information claimed to be Confidential Business Information (CBI) or other information whose disclosure is restricted by statute. Do not submit information that you consider to be CBI or otherwise protected through regulations.gov or e-mail.

The Federal regulations.gov Web site is an "anonymous access" system, which means that EPA will not know your identity or contact information unless you provide it in the body of your comment. If you submit an electronic comment, EPA recommends that you include your name and other contact information in the body of the comment and along with any disk or CD–ROM you submit. If EPA cannot read your comment due to technical difficulties and cannot contact you for clarification, EPA may not be able to consider your comment. Electronic files should avoid the use of special characters, any form of encryption, and be free of any defects or viruses. For additional information about EPA's public docket, visit the EPA Docket Center homepage at *http://www.epa.gov/epahome/dockets.htm.*

Docket: All documents in the docket are listed in the docket index at

http://www.regulations.gov. Although listed in the index, some information is not publicly available (*i.e.,* CBI or other information whose disclosure is restricted by a statute). Certain material, such as copyrighted material, is not placed on the Internet and will be publicly available only in hard copy form.

Publicly available docket materials are available either electronically at *http://www.regulations.gov* or in hard copy at the EPA Docket Center, EPA/DC, EPA West, Room 3334, 1301 Constitution Ave., NW., Washington, DC. The Public Reading Room is open from 8:30 a.m. to 4:30 p.m., Monday through Friday, excluding legal holidays. The telephone number for the Public Reading Room is (202) 566–1744, and the telephone number to make an appointment to view the docket is (202) 566–0276.

FOR FURTHER INFORMATION CONTACT: For general information on the SPCC rule, contact the Superfund, TRI, EPCRA, RMP and Oil Information Center at (800) 424–9346 or TDD (800) 553–7672 (hearing impaired). In the Washington, DC metropolitan area, call (703) 412–9810 or TDD (703) 412–3323. For more detailed information on specific aspects of this proposed rule, contact either Vanessa Principe at (202) 564–7913 (*principe.vanessa@epa.gov*) or Mark W. Howard at (202) 564–1964 (*howard.markw@epa.gov*), U.S. Environmental Protection Agency, 1200 Pennsylvania Avenue, NW., Washington, DC 20460–0002, Mail Code 5104A.

SUPPLEMENTARY INFORMATION:

I. General Information

A. Does this action apply to me?

In the table below, EPA is providing a list of potentially affected entities. However, this proposed action may affect other entities not listed below. The Agency's goal is to provide a guide for readers to consider regarding entities that potentially could be affected by this action. If you have questions regarding the applicability of this action to a particular entity, consult the person listed in the preceding section titled **FOR FURTHER INFORMATION CONTACT**.

Industry sector	NAICS code
Oil Production	211111
Farms	111, 112
Electric Utility Plants	2211
Petroleum Refining and Related Industries	324
Chemical Manufacturing	325
Food Manufacturing	311, 312
Manufacturing Facilities Using and Storing Animal Fats and Vegetable Oils	311, 325
Metal Manufacturing	331, 332
Other Manufacturing	31–33
Real Estate Rental and Leasing	531–533
Retail Trade	441–446, 448, 451–454
Contract Construction	23
Wholesale Trade	42
Other Commercial	492, 541, 551, 561–562
Transportation	481–488
Arts Entertainment & Recreation	711–713
Other Services (Except Public Administration)	811–813
Petroleum Bulk Stations and Terminals	4247
Education	61
Hospitals & Other Health Care	621, 622
Accommodation and Food Services	721, 722
Fuel Oil Dealers	45431
Gasoline stations	4471
Information Finance and Insurance	51, 52
Mining	212
Warehousing and Storage	493
Religious Organizations	813110
Military Installations	928110
Pipelines	4861, 48691
Government	92

B. Tips for Preparing Your Comments

When submitting comments, remember to:

- Identify the rulemaking by docket number and other identifying information (subject heading, **Federal Register** date and page number).
- Follow directions—The agency may ask you to respond to specific questions or organize comments by referencing a Code of Federal Regulations (CFR) part or section number.
- Explain why you agree or disagree, suggest alternatives, and substitute language for your requested changes.
- Describe any assumptions and provide any technical information and/or data that you used.
- If you estimate potential costs or burdens, explain how you arrived at your estimate in sufficient detail to allow for it to be reproduced.
- Provide specific examples to illustrate your concerns, and suggest alternatives.
- Explain your views as clearly as possible.
- Make sure to submit your comments by the comment period deadline identified.

II. Authority

33 U.S.C. 1251 *et seq.*; 33 U.S.C. 2720; E.O. 12777 (October 18, 1991), 3 CFR, 1991 Comp., p. 351.

III. Background

On July 17, 2002, the Agency published a final rule that amended the Spill Prevention, Control and Countermeasure (SPCC) regulation (67 FR 47042). The rule became effective on August 16, 2002. The final rule included compliance dates in § 112.3 for preparing, amending, and implementing SPCC Plans. The dates for complying with amendments to the SPCC

regulations have been amended a number of times: On January 9, 2003 (68 FR 1348), on April 17, 2003 (68 FR 18890), on August 11, 2004 (69 FR 48794), on February 17, 2006 (71 FR 8462), on May 16, 2007 (72 FR 27444), and again on June 19, 2009 (74 FR 29136). These extensions alleviated the need for individual extension requests and provided additional time for the regulated community to, among other things: Understand the July 2002 SPCC amendments and the implications of the litigation (see 69 FR 29728, May 25, 2004 and 73 FR 71941, November 26, 2008); allow those potentially affected in the regulated community an opportunity to make changes to their facilities and to their SPCC Plans necessary to comply with amendments to the SPCC rule as finalized in December 2006, December 2008, and November 2009; and to understand the material presented in the *SPCC Guidance for Regional Inspectors* before preparing or amending their SPCC Plans. All of these changes and amendments were promulgated to provide increased clarity, to tailor requirements to particular industry sectors, and to streamline certain requirements for those facility owners or operators subject to the rule. The current date under § 112.3(a), (b) and (c) by which owners/operators of facilities must prepare or amend their SPCC Plans, and implement those Plans, is November 10, 2010.

In accordance with the January 20, 2009 White House memorandum entitled, "Regulatory Review," and the memorandum from the Office of Management and Budget entitled, "Implementation of Memorandum Concerning Regulatory Review" (M–09–08, January 21, 2009) (OMB memorandum), the effective date of the December 2008 rulemaking was delayed until April 4, 2009 (74 FR 5900, February 3, 2009) and then until January 14, 2010 (74 FR 14736, April 1, 2009). The Agency took this action to ensure that the rule reflected proper consideration of all relevant facts. In the February 3, 2009 notice, EPA requested public comment on the extension of the effective date and its duration, and on the regulatory amendments contained in the December 2008 final rule. Upon reviewing the record for the amendments and the additional comments, EPA promulgated further amendments to the SPCC rule on November 13, 2009 (74 FR 58784), making limited changes to the December 2008 amendments. The effective date for both the December 5, 2008 and the November 13, 2009 final rule is January 14, 2010, with a compliance date of November 10, 2010. Because of the uncertainty that surrounded EPA's review of the final amendments to the December 5, 2008 rule, publication of final rule amendments on November 13, 2009 and the delay of the effective date, the Agency is now proposing to further extend the compliance date for certain facilities.

On January 15, 2009, EPA proposed to exempt from the SPCC requirements milk containers, associated piping and appurtenances provided they are constructed according to current applicable 3–A Sanitary Standards, and are subject to the current applicable PMO or a State dairy regulatory requirement equivalent to the current applicable PMO (74 FR 2461). The Agency also proposed that the capacity of these milk containers would not be included in a facility's total oil storage capacity calculation. This action proposes to further delay the compliance date for facilities that would be impacted by the proposed rule to exempt milk containers, associated piping and appurtenances.

IV. Proposal To Amend Compliance Date

Under the current provisions in § 112.3(a), the owner or operator of a facility that was in operation on or before August 16, 2002 must maintain the facility's SPCC Plan, make any necessary amendments to the Plan, and fully implement it by November 10, 2010; the owner or operator of a facility that came into operation after August 16, 2002, but before November 10, 2010, must prepare and fully implement an SPCC Plan on or before November 10, 2010. Under § 112.3(b), the owner or operator of a facility (excluding oil production facilities) that becomes operational after November 10, 2010 must prepare and implement a Plan before beginning operations; the owner or operator of an oil production facility that becomes operational after November 10, 2010 must prepare and implement a Plan within six months after beginning operations. In addition, § 112.3(c) requires the owners and operators of onshore and offshore mobile or portable facilities to prepare, implement, and maintain an SPCC Plan, and to amend it, if necessary to ensure compliance with this part, on or before November 10, 2010. The owner or operator of any onshore or offshore mobile or portable facility that becomes operational after November 10, 2010, must prepare and implement a Plan before beginning operations.

This proposed rule would amend the dates in § 112.3(a), (b) and (c) by which the owners/operators of facilities (except drilling, production or workover facilities that are offshore or that have an offshore component, and all onshore facilities required to have and submit FRPs [1]) must prepare or amend their SPCC Plans, and implement those Plans, to November 10, 2011, which is one year from the current SPCC compliance date of November 10, 2010. This proposed extension of the compliance date does not apply to drilling, production or workover facilities that are completely offshore or that have both onshore and offshore components (*e.g.,* an oil production facility with offshore wellheads connected to an onshore tank battery by submerged flowlines). For offshore drilling, production or workover facilities, the Agency is concerned about the need to have the most up-to-date SPCC Plans due to the unusual combination of characteristics of these facilities: Continuous flow of oil at the facility, potential discharges being limited only by the capacity and pressure of the underground reservoir, and discharges that would have immediate and direct impact on water.

For onshore facilities, the Agency is concerned that further extending the existing compliance date for facilities with large oil storage capacities could further increase the potential to cause substantial harm if a discharge were to occur. Onshore facilities with large oil storage capacities have the potential to cause substantial harm as identified under the FRP regulation (40 CFR 112.20 and 112.21). FRP facilities are those with storage capacities of 1 million gallons or more that could cause substantial harm [2] or those with storage capacities at or above 42,000 gallons and that transfer oil to or from a vessel over water. The Agency believes that FRP facilities should also have the most up-to-date SPCC Plans. It should be noted the Agency has not changed any

[1] Offshore FRP facilities are addressed in the exception to the compliance date extension as part of the drilling, production or workover facilities that are offshore or that have an offshore component.

[2] A facility may pose "substantial harm" according to the FRP rule if it (1) has a total oil storage capacity greater than or equal to 42,000 gallons and it transfers oil over water to/from vessels; or (2) has a total oil storage capacity greater than or equal to one million gallons and meets one of the following conditions: (a) Does not have sufficient secondary containment for the capacity of the largest aboveground oil storage tank in each aboveground storage area; (b) is located at a distance such that a discharge from the facility could cause "injury" to fish, wildlife, and sensitive environments; (c) is located at a distance such that a discharge from the facility would shut down a public drinking water intake; or (d) has had, within the past five years, a reportable discharge greater than or equal to 10,000 gallons.

compliance dates with respect to the FRP regulations. Therefore, EPA is not proposing to extend the compliance date for drilling, production or workover facilities that are offshore or that have an offshore component, or all onshore facilities required to submit FRPs, due to the threats these facilities pose of significant oil spills to waters of the U.S. or adjoining shorelines.

The Agency is also proposing to delay the compliance date for facilities with milk containers, associated piping and appurtenances. The delay would be effective for facilities with milk containers that are constructed according to the current applicable 3–A Sanitary Standards, and subject to the current applicable Grade "A" Pasteurized Milk Ordinance (PMO) or a State dairy regulatory requirement equivalent to the current applicable PMO. The delay would be for one year from the effective date of a final rule addressing the SPCC requirements specifically for these milk containers, associated piping and appurtenances, or as specified by a rule that otherwise establishes a compliance date for these facilities. The Agency would establish the new compliance date and publish it in the **Federal Register** as part of any final action on the proposed exemption (74 FR 2461). The delay for these facilities is intended to provide the owner or operator of these facilities the opportunity to fully understand any regulatory amendments that may be finalized.

The Agency is making changes to the regulatory text in § 112.3 to reflect how the compliance date extension would apply for different facilities, as provided for in the proposed rule.

Proposal To Extend Compliance Date by One Year

This proposed rule would extend for most facilities the dates in § 112.3(a), (b) and (c) by which the owner or operator must prepare or amend and implement an SPCC Plan. Exclusions to this compliance date extension are described below. Today's proposed rule amends and combines the current § 112.3(a) with the current § 112.3(b)(1) and (c) to:

- Amend the compliance date for a facility, including a mobile or portable facility, in operation on or before August 16, 2002 that requires the owner or operator to make any necessary amendments to an SPCC Plan and fully implement the amended Plan by November 10, 2011.[3]
- Amend the compliance date for a facility, including a mobile or portable facility, which came into operation after August 16, 2002, but before November 10, 2011, that requires the owner or operator to prepare and fully implement an SPCC Plan on or before November 10, 2011.
- Amend the compliance date for a facility, including a mobile or portable facility, (except an oil production facility[4]) which becomes operational after November 10, 2011 that requires the owner or operator to prepare and implement an SPCC Plan before beginning operations.
- Incorporate the language under the current § 112.3(c) for mobile or portable facilities (such as an onshore drilling or workover rig, or a portable fueling facility) to amend the compliance date for these facilities to November 10, 2011 and maintain the language that allows mobile or portable facilities to prepare a general Plan.

An extension of the compliance date for these facilities is appropriate because it provides the owners or operators of SPCC-regulated facilities the opportunity to fully understand the regulatory amendments offered by revisions to the SPCC rule promulgated on December 5, 2008 (73 FR 74236) and November 13, 2009 (74 FR 58784).[5] Given the delay in the effective date for the December 2008 rule amendment, and the uncertainty that surrounded the final amendments because of this delay, this proposed extension would allow potentially affected facilities an additional year beyond the current compliance date of November 10, 2010 to make any changes to their facilities and SPCC Plans to comply with the revised SPCC requirements. Considering that the changes in the final November 2009 amendments were very limited, and that most of the December 2008 amendments offered compliance options and regulatory burden relief, a limited timeframe for this extension is appropriate. A one-year period from the current compliance date provides sufficient time to understand and implement the streamlined amendments to the SPCC rule.

The Agency seeks comment on the proposed compliance date by which owners and operators would be required to prepare, amend, and implement SPCC Plans in accordance with amendments to the SPCC rule. Any alternative dates suggested must include appropriate rationale and supporting data for the Agency to be able to consider them for final action.

Exceptions to the Proposal To Extend Compliance Date by One Year

The Agency is not proposing to extend the compliance date for drilling, production and workover facilities that are offshore or that have an offshore component; or for onshore facilities required to have and submit FRPs. The Agency is particularly concerned about the potential for immediate environmental impacts resulting from oil spills to waters of the U.S. or adjoining shorelines posed by these facilities. All of these facilities have potentially significant quantities of oil that could be discharged to navigable waters or adjoining shorelines. Offshore drilling, production and workover facilities (and those with an offshore component) have a constant flow of oil associated with them and discharges could be in amounts that far exceed the oil storage capacity of the facility. As in the case of the recent Gulf of Mexico oil spill, the Agency is concerned that any potential oil discharge may be limited only by the capacity and pressure of the underground petroleum reservoir. The Agency's concern regarding these facilities is reflected in the fact that they have a greater number of requirements under the SPCC rule because of their location over waters of the U.S. or adjoining shorelines (40 CFR 112.11). In addition to those facilities completely offshore, the Agency has identified many onshore facilities with offshore components, as in the case of over-water production platforms. While these facilities have their tank batteries located onshore, their wellhead and portions of the flow lines are below the surface of the water. Offshore components include, but are not limited to, flow lines, gathering lines, wellheads, shut in valves, pressure control and sensing devices, cathodic protection devices and related piping and appurtenances. Because the Agency is equally concerned with the potential for immediate environmental impacts resulting from oil spills from a facility's offshore components, it is also excluding these facilities from the proposed extension. FRP facilities are those with storage capacities of 1

[3] To be eligible for the compliance extension, owners or operators of facilities in operation before August 16, 2002 must continue to maintain their existing SPCC Plans.

[4] On December 5, 2008 (73 FR 74236) EPA finalized an amendment to allow a new oil production facility (*i.e.,* one that becomes operational after the compliance date) a period of six months after the start of operations to prepare and implement an SPCC Plan.

[5] A facility owner or operator in operation before August 16, 2002 must continue to maintain an existing Plan. A facility owner or operator who wants to take advantage of the 2002, 2006, 2008, and 2009 regulatory changes may do so, but will need to modify the existing Plan accordingly. Additionally, an owner or operator may need to amend the Plan prior to the new compliance date to address facility modifications for which more stringent requirements apply.

million gallons or more that could cause substantial harm, or those with storage capacities at or above 42,000 gallons and that transfer oil to or from a vessel over water. The Agency is proposing to exclude all onshore FRP facilities from the extension because of their large oil storage capacities and their potential to cause substantial harm in the event of a discharge as identified under the FRP regulation (40 CFR 112.20).

Today's proposed rule amends the current § 112.3(b)(1) to maintain the existing compliance date for this subset of facilities, and combines it with the current § 112.3(c) provision to indicate that the existing compliance date also applies to mobile or portable facilities within this subset:

- Maintain the existing compliance date for a drilling, production and workover facility, including a mobile or portable facility, that is offshore or that has an offshore component; or of an onshore facility required to have and submit an FRP, that was in operation on or before August 16, 2002, that requires the owner or operator to make any necessary amendments to an SPCC Plan and fully implement the amended Plan by November 10, 2010.[6]
- Maintain the existing compliance date for a drilling, production and workover facility, including a mobile or portable facility, that is offshore or that has an offshore component; or of an onshore facility required to have and submit an FRP, that came into operation after August 16, 2002, but before November 10, 2010, that requires the owner or operator to prepare and fully implement an SPCC Plan on or before November 10, 2010.
- Maintain the existing compliance date for a facility (except an oil production facility[7]) that is either: a drilling, production and workover facility, including a mobile or portable facility, that is offshore or that has an offshore component; or an onshore facility required to have and submit an FRP, that becomes operational after November 10, 2010, that requires the owner or operator to prepare and implement an SPCC Plan before beginning operations.
- Incorporate language under the current 112.3(c) to maintain the existing compliance date for mobile or portable facilities that fall within this subset of facilities (such as a barge mounted offshore drilling or workover rig), and maintains the language that allows mobile or portable facilities to prepare a general Plan.

The Agency seeks comment on the proposed exceptions to the compliance date extension. Any alternative exceptions suggested must include appropriate rationale and supporting data for the Agency to be able to consider them for final action.

Oil Production Facilities Beginning Operations After the Compliance Date

The Agency is proposing to amend the current § 112.3(b)(2) to distinguish the two separate compliance dates that would apply to oil production facilities that become operational after the proposed compliance dates. The Agency is also moving this provision to § 112.3(c). These changes are intended to reflect the amendments and rearranged provisions for § 112.3(a), (b), and (c). The new § 112.3(c) would be amended to:

- Maintain the existing compliance date for an oil production facility that is offshore or that has an offshore component; or of an onshore oil production facility required to submit an FRP, that becomes operational after November 10, 2010, and could reasonably be expected to have a discharge as described in § 112.1(b), that requires the owner or operator to prepare and implement a Plan within six months after beginning operations.
- Amend the compliance date for an onshore oil production facility (i.e. one that is not required to submit an FRP) that becomes operational after November 10, 2011, and could reasonably be expected to have a discharge as described in § 112.1(b), that requires the owner or operator to prepare and implement a Plan within six months after beginning operations.

The Agency seeks comment on the proposed extension of the compliance date by which owners and operators would be required to prepare, amend, and implement SPCC Plans in accordance with amendments to the SPCC rule. Any alternative dates or approaches suggested must include appropriate rationale and supporting data for the Agency to be able to consider them for final action.

Proposal for Facilities With Milk Containers, Associated Piping and Appurtenances

The Agency is proposing to further delay the compliance date for the owners and operators of facilities with milk containers, associated piping and appurtenances that are constructed according to the current applicable 3–A Sanitary Standards, and subject to the current applicable Grade "A" Pasteurized Milk Ordinance (PMO) or a State dairy regulatory requirement equivalent to the current applicable PMO. The Agency is taking this action for facilities that would be affected by any final determination on the proposed rule to exempt these milk containers from SPCC requirements (74 FR 2461; January 15, 2009). The compliance date would be delayed to one year from the effective date of a final rule addressing the SPCC requirements specifically for these milk containers, associated piping and appurtenances, or as specified by a rule that otherwise establishes a new compliance date for these facilities.[8] The Agency would establish the new compliance date and publish it in the **Federal Register** as part of any final action on the proposed exemption. The delay for these facilities is intended to provide the owner or operator of the facility the opportunity to fully understand any new regulatory amendments for milk containers, associated piping and appurtenances. Today's proposed rule amends § 112.3(b)(2) to:

- Further delay the compliance date for any facility that has milk containers, associated piping and appurtenances that are constructed according to the current applicable 3–A Sanitary Standards, and subject to the current applicable Grade "A" Pasteurized Milk Ordinance (PMO) or a State dairy regulatory requirement equivalent to the current applicable PMO. The delay would be for one year from the effective date of a final rule addressing the SPCC requirements specifically for these milk containers, associated piping and appurtenances, or as specified by a rule that otherwise establishes a new compliance date for these facilities.

The Agency seeks comment on the proposed delay of the compliance date by which owners and operators of facilities that have milk containers, associated piping and appurtenances would be required to prepare, amend, and implement SPCC Plans in accordance with amendments to the SPCC rule. Any alternative dates or approaches suggested must include appropriate rationale and supporting data for the Agency to be able to consider them for final action.

[6] As noted previously, owners or operators of facilities in operation before August 16, 2002 must continue to maintain existing SPCC Plans.

[7] On December 5, 2008 (73 FR 74236) EPA finalized an amendment to allow a new oil production facility (*i.e.,* one that becomes operational after the compliance date) a period of six months after the start of operations to prepare and implement an SPCC Plan.

[8] As noted previously in § 112.3(a) and (b)(1), to be eligible for the compliance extension, owners or operators of facilities in operation before August 16, 2002 must continue to maintain existing SPCC Plans. This includes facilities with milk containers, associated piping and appurtenances.

Alternative Approach to the Proposed Compliance Date Extension

While the Agency believes that a one-year compliance date extension is appropriate, as discussed previously, the Agency also is requesting comments on an alternative approach to extend the compliance date for these facilities. This approach would extend the compliance date to either May 10, 2011 or August 10, 2011 for all SPCC regulated facilities, except for: drilling, production and workover facilities that are offshore or that have an offshore component, or for onshore facilities required to have and submit an FRP, which must comply by November 10, 2010. This alternative approach would not impact the Agency's proposal to delay the compliance date for facilities with milk containers, associated piping and appurtenances that are constructed according to the current applicable 3–A Sanitary Standards, and subject to the current applicable Grade "A" Pasteurized Milk Ordinance (PMO) or a State dairy regulatory requirement equivalent to the current applicable PMO.

Specifically, for SPCC-regulated facilities, the Agency believes that a compliance date extension is appropriate for these facilities because of the multiple regulatory amendments to the SPCC rule. However, we are also requesting comment on whether it would be appropriate to consider a shorter compliance date extension, such as either six or nine months for them. In considering the shorter compliance date extension, we request comments as to the type of criteria to consider, such as discharge history, size and type of facility, the ability to come into compliance, or the potential risk presented. This extension would not apply to drilling, production and workover facilities that are offshore or that have an offshore component, or for onshore facilities required to have and submit an FRP, which must comply by November 10, 2010.

The Agency seeks comment on the alternative approach to the proposed compliance date extension. Any alternative dates or approaches suggested must include appropriate rationale and supporting data for the Agency to be able to consider them for final action.

Other Considerations

If an owner or operator of an SPCC-regulated facility requires additional time to comply with the SPCC rule, he may submit a written request to the Regional Administrator in accordance with § 112.3(f). Such requests may be granted if the Regional Administrator finds that the owner or operator cannot comply with all SPCC requirements by the compliance date as a result of either non-availability of qualified personnel, or delays in construction or equipment delivery beyond his control and without the fault of such owner or operator.

It should be noted that these proposed compliance date amendments would affect only the requirements of the July 2002, December 2006, December 2008, and November 2009 SPCC rule amendments (67 FR 47042, July 17, 2002; 71 FR 77266, December 26, 2006; 73 FR 74236, December 5, 2008; and 74 FR 29136, November 13, 2009) that are new (*i.e.,* requirements that did not exist or were not in effect prior to the 2002 amendments) or more stringent compliance obligations to those that were in effect in the 1973 SPCC rule. Provisions that provide regulatory relief to facilities are applicable as of the effective date of the amendment and would not require revisions to existing Plans "to ensure compliance" (*see* § 112.3). However, the facility owner or operator must amend the SPCC Plan to include new or more stringent provisions by the compliance date.

V. Statutory and Executive Order Reviews

A. Executive Order 12866: Regulatory Planning and Review

Under the terms of Executive Order 12866 (58 FR 51735, October 4, 1993), this action has been determined to be a "significant regulatory action." This rule was submitted to the Office of Management and Budget (OMB) for review. Any changes made in response to OMB's recommendations have been documented in the docket for this action.

B. Paperwork Reduction Act

This proposed action does not impose an information collection burden under the provisions of the *Paperwork Reduction Act,* 44 U.S.C. 3501 *et seq.* This proposed rule would merely extend the compliance date for certain facilities subject to the rule. The Office of Management and Budget (OMB) has previously approved the information collection requirements contained in the existing regulations at 40 CFR part 112 under the provisions of the *Paperwork Reduction Act,* 44 U.S.C. 3501 *et seq.* and has assigned OMB control number 2050–0021. The OMB control numbers for EPA's regulations in 40 CFR are listed in 40 CFR part 9.

C. Regulatory Flexibility Act

The Regulatory Flexibility Act generally requires an agency to prepare a regulatory flexibility analysis of any rule subject to notice and comment rulemaking requirements under the Administrative Procedure Act or any other statute unless the agency certifies that the rule will not have a significant economic impact on a substantial number of small entities. Small entities include small businesses, small organizations, and small governmental jurisdictions.

For purposes of assessing the impacts of today's proposed rule on small entities, small entity is defined as: (1) A small business as defined by the Small Business Administration's (SBA) regulations at 13 CFR 121.201; (2) a small governmental jurisdiction that is a government of a city, county, town, school district or special district with a population of less than 50,000; and (3) a small organization that is any not-for-profit enterprise that is independently owned and operated and is not dominant in its field.

After considering the economic impacts of today's proposed rule on small entities, I certify that this proposed action will not have a significant economic impact on a substantial number of small entities. In determining whether a rule has a significant economic impact on a substantial number of small entities, the impact of concern is any significant adverse economic impact on small entities, since the primary purpose of the regulatory flexibility analyses is to identify and address regulatory alternatives "which minimize any significant economic impact of the proposed rule on small entities." 5 U.S.C. 603 and 604. Thus, an agency may certify that a rule will not have a significant economic impact on a substantial number of small entities if the rule relieves regulatory burden, or otherwise has a positive economic effect on all of the small entities subject to the rule.

This proposed rule seeks to extend the compliance date in § 112.3(a) for most facilities by one year and to delay the compliance date in § 112.3(b)(2) for facilities with milk containers, associated piping and appurtenances that meet certain conditions for one year from the effective date of a final rule addressing the SPCC requirements specifically for these containers, or as specified by a rule that otherwise establishes a compliance date for these facilities. The changes in the final November 2009 amendments were very limited, and the December 2008

amendments offered compliance options and regulatory burden relief. We have therefore concluded that today's proposed rule will relieve regulatory burden for all affected small entities. We continue to be interested in the potential impacts of the proposed rule on small entities and welcome comments on issues related to such impacts.

D. Unfunded Mandates Reform Act

This proposed action contains no Federal mandates under the provisions of Title II of the Unfunded Mandates Reform Act of 1995 (UMRA), 2 U.S.C. 1531–1538 for State, local, or tribal governments or the private sector. The action imposes no enforceable duty on any State, local or tribal governments or the private sector. Therefore, this action is not subject to the requirements of sections 202 or 205 of the UMRA. This action is also not subject to the requirements of section 203 of UMRA because it contains no regulatory requirements that might significantly or uniquely affect small governments. This proposed rule would merely extend the compliance date for most facilities subject to the rule.

E. Executive Order 13132: Federalism

This proposed rule does not have federalism implications. It will not have substantial direct effects on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government, as specified in Executive Order 13132. Under CWA section 311(o), States may impose additional requirements, including more stringent requirements, relating to the prevention of oil discharges to navigable waters. EPA encourages States to supplement the Federal SPCC regulation and recognizes that some States have more stringent requirements (56 FR 54612, October 22, 1991). This proposed rule would not preempt State law or regulations. Thus, Executive Order 13132 does not apply to this proposed rule.

In the spirit of Executive Order 13132, and consistent with EPA policy to promote communications between EPA and State and local governments, EPA specifically solicits comment on this proposed action from State and local officials.

F. Executive Order 13175: Consultation and Coordination With Indian Tribal Governments

This proposed action does not have tribal implications, as specified in Executive Order 13175 (65 FR 67249, November 9, 2000). The proposed rule would not significantly or uniquely affect communities of Indian tribal governments. Thus, Executive Order 13175 does not apply to this action.

G. Executive Order 13045: Protection of Children From Environmental Health and Safety Risk

This proposed action is not subject to Executive Order 13045 (62 FR 19885, April 23, 1997) because it is not economically significant as defined in Executive Order 12866, and because the Agency does not believe the environmental health or safety risks addressed by this proposed action present a disproportionate risk to children. The public is invited to submit comments or identify peer-reviewed studies and data that assess the effects of early life exposure to oil as affected by the proposed revision to the compliance date.

H. Executive Order 13211: Actions That Significantly Affect Energy Supply, Distribution, or Use

This action is not a "significant energy action" as defined in Executive Order 13211, "Actions Concerning Regulations that Significantly Affect Energy Supply, Distribution, or Use" (66 FR 28355, May 22, 2001), because it is not likely to have a significant adverse effect on the supply, distribution, or use of energy. The overall effect of this action is to decrease the regulatory burden on facility owners or operators subject to its provisions.

I. National Technology Transfer and Advancement Act

Section 12(d) of the National Technology Transfer and Advancement Act of 1995 ("NTTAA"), Pub. L. 104–113, 12(d) (15 U.S.C. 272 note) directs EPA to use voluntary consensus standards in its regulatory activities unless to do so would be inconsistent with applicable law or otherwise impractical. Voluntary consensus standards are technical standards (*e.g.,* materials specifications, test methods, sampling procedures, and business practices) that are developed or adopted by voluntary consensus standards bodies. NTTAA directs EPA to provide Congress, through OMB, explanations when the Agency decides not to use available and applicable voluntary consensus standards.

This proposed rulemaking does not involve technical standards. Therefore, EPA is not considering the use of any voluntary consensus standards.

J. Executive Order 12898: Federal Actions To Address Environmental Justice in Minority Populations and Low-Income Populations

Executive Order 12898 (59 FR 7629, February 16, 1994) establishes Federal executive policy on environmental justice. Its main provision directs Federal agencies, to the greatest extent practicable and permitted by law, to make environmental justice part of their mission by identifying and addressing, as appropriate, disproportionately high and adverse human health or environmental effects of their programs, policies, and activities on minority populations and low-income populations in the United States.

EPA has determined that this proposed rule will not have disproportionately high and adverse human health or environmental effects on minority or low-income populations because it does not affect the level of protection provided to human health or the environment.

List of Subjects in 40 CFR Part 112

Environmental protection, Milk, Oil pollution, Penalties, Reporting and recordkeeping requirements.

Dated: July 28, 2010.

Lisa P. Jackson,

Administrator.

For the reasons set forth in the preamble, title 40, chapter I, of the Code of Federal Regulations is proposed to be amended as follows:

PART 112—OIL POLLUTION PREVENTION

1. The authority citation for part 112 continues to read as follows:

Authority: 33 U.S.C. 1251 *et seq.;* 33 U.S.C. 2720; E.O. 12777 (October 18, 1991), 3 CFR, 1991 Comp., p. 351.

2. Section 112.3 is amended by revising paragraphs (a), (b), and (c) to read as follows:

§ 112.3 Requirement to prepare and implement a Spill Prevention, Control, and Countermeasure Plan.

* * * * *

(a) If your facility, or mobile or portable facility, was in operation on or before August 16, 2002, you must maintain your Plan, but must amend it, if necessary to ensure compliance with this part, and implement the amended Plan no later than November 10, 2011. If such a facility becomes operational after August 16, 2002, through November 10, 2011, and could reasonably be expected to have a discharge as described in § 112.1(b), you must prepare and implement a Plan on

or before November 10, 2011. If such a facility (excluding oil production facilities) becomes operational after November 10, 2011, and could reasonably be expected to have a discharge as described in § 112.1(b), you must prepare and implement a Plan before you begin operations. You are not required to prepare a new Plan each time you move a mobile or portable facility to a new site; the Plan may be general. When you move the mobile or portable facility, you must locate and install it using the discharge prevention practices outlined in the Plan for the facility. The Plan is applicable only while the mobile or portable facility is in a fixed (non-transportation) operating mode.

(b) Notwithstanding the provisions of paragraph (a) of this section:

(1) If your drilling, production or workover facility, including a mobile or portable facility, is offshore or has an offshore component; or your onshore facility is required to have and submit a Facility Response Plan pursuant to 40 CFR 112.20(a), and was in operation on or before August 16, 2002, you must maintain your Plan, but must amend it, if necessary to ensure compliance with this part, and implement the amended Plan no later than November 10, 2010. If such a facility becomes operational after August 16, 2002, through November 10, 2010, and could reasonably be expected to have a discharge as described in § 112.1(b), you must prepare and implement a Plan on or before November 10, 2010. If such a facility (excluding oil production facilities) becomes operational after November 10, 2010, and could reasonably be expected to have a discharge as described in § 112.1(b), you must prepare and implement a Plan before you begin operations. You are not required to prepare a new Plan each time you move a mobile or portable facility to a new site; the Plan may be general. When you move the mobile or portable facility, you must locate and install it using the discharge prevention practices outlined in the Plan for the facility. The Plan is applicable only while the mobile or portable facility is in a fixed (non-transportation) operating mode.

(2) If your facility has milk containers, associated piping and appurtenances constructed according to current applicable 3–A Sanitary Standards, and subject to current applicable Grade "A" Pasteurized Milk Ordinance (PMO) or a State dairy regulatory requirement equivalent to current applicable PMO, the compliance date described in paragraphs (a) and (b)(1) of this section shall be one year from the effective date of a final rule addressing SPCC requirements specifically for these milk containers, associated piping and appurtenances; or until a rule that otherwise establishes the date by which you must comply with the provisions of this part.

(c) If your oil production facility as described in paragraph (a) of this section becomes operational after November 10, 2011, or as described in paragraph (b)(1) of this section becomes operational after November 10, 2010, and could reasonably be expected to have a discharge as described in § 112.1(b), you must prepare and implement a Plan within six months after you begin operations.

* * * * *

[FR Doc. 2010–19075 Filed 8–2–10; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 131

[EPA–HQ–OW–2009–0596; FRL–9185–2]

RIN 2040–AF11

Water Quality Standards for the State of Florida's Lakes and Flowing Waters; Supplemental Notice of Data Availability and Request for Comment

AGENCY: Environmental Protection Agency (EPA).

ACTION: Supplemental notice of data availability and request for comment.

SUMMARY: This action is a supplemental notice of data availability and a request for comment related to EPA's January 26, 2010, notice of proposed rulemaking (NPRM), proposing numeric nutrient water quality criteria to protect aquatic life in lakes and flowing waters within the State of Florida. In the January 2010 NPRM, EPA proposed to classify Florida's streams into four regions (referred to in the proposed rule as "Nutrient Watershed Regions") for application of total nitrogen (TN) and total phosphorus (TP) criteria. Streams within each of these regions (Panhandle, Bone Valley, Peninsula and North Central) reflect similar geographical characteristics including phosphorus-rich soils, nutrient concentrations and nutrient ratios. In this notice, EPA is requesting comment on revised stream region boundaries based on additional information about watershed delineations and phosphorus-rich geological formations in Florida. Based on comments and additional information, this revised regionalization approach would result in five Nutrient Watershed Regions for Florida's streams and a clarification of certain watershed boundaries for the Bone Valley and Peninsula regions. EPA is also requesting comment on basing the TN and TP criteria for the nutrient watershed regions on a combination of the 75th and 90th percentile values (depending on regions) of the benchmark sites outlined in the alternate approach at proposal. EPA is continuing to consider the primary approach proposed in January 2010 to use the 75th percentile of sites with healthy biological condition as measured by the Stream Condition Index (SCI). The January 2010 proposal also proposed application of the Vollenweider equation to ensure that nutrient criteria in streams are protective of downstream lakes and requested comment on alternative approaches such as the BATHTUB model and whether there should be an allowance for use of other models that are demonstrated to be protective and scientifically defensible. Today's notice also requests comment on using the BATHTUB model in place of the Vollenweider equation for deriving both TP and TN criteria to protect downstream lakes, allowing the use of alternative models under certain circumstances, and providing for an alternative approach to protect downstream lakes when limited data are available that would use the lake criteria themselves as criteria for upstream waters flowing into the lake. EPA is seeking comment on alternative stream regionalization approaches, use of the benchmark dataset to derive criteria, and derivation of lake downstream protection values discussed in more detail below, and will consider the comments received before finalizing the proposed rule, "Water Quality Standards for the State of Florida's Lakes and Flowing Waters." This supplemental notice focuses solely on the delineation of stream nutrient regions, resulting criteria associated with two approaches (EPA's SCI-based approach and the alternative benchmark distribution approach), and protection of downstream lakes in Florida. EPA is not soliciting comment on any other provisions of the January 2010 proposal.

DATES: Comments must be received on or before *September 2, 2010.*

ADDRESSES: Submit your comments, identified by Docket ID No. EPA–HQ–OW–2009–0596, by one of the following methods:

1. *http://www.regulations.gov:* Follow the on-line instructions for submitting comments.

2. *E-mail: ow-docket@epa.gov.*

3. *Mail to:* Water Docket, U.S. Environmental Protection Agency, Mail code: 2822T, 1200 Pennsylvania Avenue, NW., Washington, DC 20460, Attention: Docket ID No. EPA–HQ–OW–2009–0596.

4. *Hand Delivery:* EPA Docket Center, EPA West Room 3334, 1301 Constitution Avenue, NW., Washington, DC 20004, Attention Docket ID No. EPA–HQ–OW–2009–0596. Such deliveries are only accepted during the Docket's normal hours of operation, and special arrangements should be made for deliveries of boxed information.

Instructions: Direct your comments to Docket ID No. EPA–HQ–OW–2009–0596. EPA's policy is that all comments received will be included in the public docket without change and may be made available online at *http://www.regulations.gov,* including any personal information provided, unless the comment includes information claimed to be Confidential Business Information (CBI) or other information whose disclosure is restricted by statute. Do not submit information that you consider to be CBI or otherwise protected through *http://www.regulations.gov* or e-mail. The *http://www.regulations.gov* Web site is an "anonymous access" system, which means EPA will not know your identity or contact information unless you provide it in the body of your comment. If you send an e-mail comment directly to EPA without going through *http://www.regulations.gov* your e-mail address will be automatically captured and included as part of the comment that is placed in the public docket and made available on the Internet. If you submit an electronic comment, EPA recommends that you include your name and other contact information in the body of your comment and with any disk or CD–ROM you submit. If EPA cannot read your comment due to technical difficulties and cannot contact you for clarification, EPA may not be able to consider your comment. Electronic files should avoid the use of special characters, any form of encryption, and be free of any defects or viruses. For additional information about EPA's public docket visit the EPA Docket Center homepage at *http://www.epa.gov/epahome/dockets.htm.*

Docket: All documents in the docket are listed in the *http://www.regulations.gov* index. Although listed in the index, some information is not publicly available, *e.g.,* CBI or other information whose disclosure is restricted by statute. Certain other material, such as copyrighted material, will be publicly available only in hard copy. Publicly available docket materials are available either electronically in *http://www.regulations.gov* or in hard copy at a docket facility. The Office of Water (OW) Docket Center is open from 8:30 a.m. until 4:30 p.m., Monday through Friday, excluding legal holidays. The OW Docket Center telephone number is (202) 566–2426, and the Docket address is OW Docket, EPA West, Room 3334, 1301 Constitution Avenue, NW., Washington, DC 20004. The Public Reading Room is open from 8:30 a.m. to 4:30 p.m., Monday through Friday, excluding legal holidays. The telephone number for the Public Reading Room is (202) 566–1744.

FOR FURTHER INFORMATION CONTACT: Danielle Salvaterra, U.S. EPA Headquarters, Office of Water, Mailcode: 4305T, 1200 Pennsylvania Avenue, NW., Washington, DC 20460; telephone number: 202–564–1649; fax number: 202–566–9981; e-mail address: *salvaterra.danielle@epa.gov.*

SUPPLEMENTARY INFORMATION: This supplementary information section is organized as follows:

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I. General Information

A. What should I consider as I prepare my comments for EPA?

1. *Submitting CBI.* Do not submit this information to EPA through *http://www.regulations.gov* or e-mail. Clearly mark the part or all of the information that you claim to be CBI. For CBI information in a disk or CD–ROM that you mail to EPA, mark the outside of the disk or CD–ROM as CBI and then identify electronically within the disk or CD–ROM the specific information that is claimed as CBI. In addition to one complete version of the comment that includes information claimed as CBI, a copy of the comment that does not contain the information claimed as CBI must be submitted for inclusion in the public docket. Information so marked will not be disclosed except in accordance with procedures set forth in 40 CFR part 2.

2. *Tips for Preparing Your Comments.* When submitting comments, remember to:

1. Identify the rulemaking by docket number and other identifying information (subject heading, **Federal Register** date, and page number).

2. Follow directions—The agency may ask you to respond to specific questions or to address a particular issue.

3. Explain why you agree or disagree; suggest alternatives and substitute language for your requested changes.

4. Describe any assumptions and provide any technical information and/or data that you used.

5. Provide specific examples to illustrate your concerns, and suggest alternatives.

6. Make sure to submit your comments by the comment period deadline identified.

B. How can I get copies of this document and other related information?

1. *Docket.* EPA has established an official public docket for this action under Docket Id. No. EPA–HQ–OW–2009–0596. The official public docket consists of the document specifically referenced in this action, any public comments received, and other information related to this action. Although a part of the official docket, the public docket does not include CBI or other information whose disclosure is restricted by statute. The official public docket is the collection of materials that is available for public viewing at the OW Docket, EPA West, Room 3334, 1301 Constitution Ave., NW., Washington, DC 20004. This Docket Facility is open from 8:30 a.m. to 4:30 p.m., Monday through Friday, excluding legal holidays. The Docket telephone number is 202–566–1744. A reasonable fee will be charged for copies.

2. *Electronic Access.* You may access this **Federal Register** document electronically through the EPA Internet under the "**Federal Register**" listings at *http://www.epa.gov/fedrgstr/.*

An electronic version of the public docket is available through EPA's electronic public docket and comment system, EPA Dockets. You may use EPA Dockets at *http://www.regulations.gov* to view public comments, access the index listing of the contents of the official public docket, and to access those documents in the public docket that are available electronically. For additional information about EPA's public docket, visit the EPA Docket Center homepage at *http://www.epa.gov/epahome/dockets.htm.* Although not all docket materials may be available electronically, you may still access any of the publicly available docket materials through the Docket Facility identified in Section I.B.1.

II. Background

On January 26, 2010, EPA proposed "Water Quality Standards for the State of Florida's Lakes and Flowing Waters" (75 FR 4173). EPA conducted 13 public hearing sessions in six cities in Florida and held a 90-day public comment period as part of the proposed rule generating over 22,000 public comments. EPA is reviewing and considering these comments in preparation of the final rule, which is scheduled to be signed by the EPA Administrator on October 15, 2010.

Today's notice reflects a review of comments and new information received by the Agency as part of the public comment process, and requests further comment on possible revisions, additional options, and new information related to specific approaches and issues identified in the January 26, 2010 proposal. EPA is only seeking comment on the items presented in this supplemental notice. EPA is not soliciting comment on any other provisions of the January 2010 proposed rule.

III. Supplemental Information on Numeric Nutrient Criteria for the State of Florida's Lakes and Flowing Waters

A. Stream Regionalization and Alternative Approaches to Stream Criteria Derivation

EPA proposed classification of Florida's streams north of Lake Okeechobee by separating watersheds with substantially different stream molar ratios of TN to TP into Nutrient Watershed Regions (NWR). The resulting regions reflect the inherent differences in the natural factors that contribute to nutrient concentrations in streams (*e.g.,* geology, soil composition, and/or hydrology). Reliance on a watershed-based classification approach reflects the understanding that upstream water quality affects downstream water quality. EPA requested public comment on the stream regionalization approach as well as factoring in geological influences from phosphorus-rich soils when classifying stream regions (75 FR 4195–96). EPA received public comments and information that suggested refining the proposed stream regions to account for natural variability in soil nitrogen and phosphorus as well as clarifying the boundaries of the proposed stream regions.

Today, EPA is requesting comment on a revised approach to certain stream regions suggested by FDEP and other commenters. More specifically, EPA is considering additional information on the influence of phosphorus-rich soils and geology in Florida (associated with the Hawthorne Group) for areas in the northern Panhandle region. Based on comments and information received, the Agency is also considering further refinements to the regional boundaries separating the Peninsula region from the West Central region (referred to in the proposed rule as "Bone Valley").

Based on geological information,[1] EPA is considering dividing the proposed Panhandle region into a Panhandle West (less phosphorus-rich) and Panhandle East (more phosphorus-rich) region. In drawing the boundary between the two regions, EPA is continuing to rely on the watershed approach described in the proposed rule and is considering using the eastern boundary of the Apalachicola River watershed as the dividing line between the two regions. EPA believes that dividing the Panhandle region in this manner may more accurately represent the natural influences on stream TP concentrations and provide finer spatial resolution with respect to TP criteria; however, we request comment on this conclusion.

EPA is considering these adjustments in the Panhandle region to account for natural geological influences on stream phosphorus concentrations. EPA considered different approaches to classifying Florida's streams for application of TN criteria, such as the four Nutrient Watershed Regions discussed in the January 2010 proposal and two regions as originally suggested by FDEP. However, differences in the resulting TN criteria based on these stream classification schemes were minor and the approaches were comparable. Therefore, to assure consistency and clarity in applicability decisions and implementation, EPA is also considering using the same revised Panhandle delineation for stream TN criteria as well as the TP criteria. This consistency in regionalization for TN and TP provides clarity to the public on which stream criteria apply at any given location, which can help facilitate the State's implementation of both stream TN and TP criteria.

EPA also reexamined the watershed delineations of the West Central and Peninsula regions based on comments and information from FDEP and others. As a result of this review, EPA has gained greater knowledge of the watershed boundaries and is considering refining the boundary delineations accordingly. The result for the West Central region would be a modified western boundary that shifts from Florida's west coast shoreline inland to the east as explained in more detail below. EPA believes that these possible adjustments to the West Central and Peninsula stream region boundaries more accurately reflect the watershed boundaries; however, we request comment on this conclusion.

As a result of the new information and possible adjustments to the proposed stream regionalization approach that are outlined above, EPA is considering five Nutrient Watershed Regions for deriving TP and TN criteria for streams. The five Nutrient Watershed Regions would include a Panhandle West region encompassing Perdido Bay Watershed, Pensacola Bay Watershed, Choctawhatchee Bay Watershed, St. Andrew Bay Watershed, and Apalachicola Bay Watershed. It would also include a Panhandle East region encompassing Apalachee Bay Watershed, and Econfina/Steinhatchee Coastal Drainage Area. The West Central (Bone Valley) and Peninsula regions would be revised slightly to more accurately reflect watershed boundaries (*e.g.,* the Sarasota Bay and Charlotte Harbor Watersheds would move from the West Central (Bone Valley) to the Peninsula region). The proposed North Central region encompassing the Suwannee River Watershed would remain unchanged.

EPA is providing the following information in the docket to illustrate and delineate the revised Nutrient Watershed Regions under consideration: 1. Map of revised TN, TP regions, 2. Map of Hawthorne group overlaid on revised Panhandle regions, 3. GIS shapefile of revised TN, TP regions, 4. Florida geological information on the Hawthorne group (*see* footnote 1).

EPA is also providing additional information in this notice and in the docket on the TN and TP criteria that are based on the revised Nutrient Watershed Regions under consideration. Using EPA's previously proposed approach (75th percentile) and the revised stream regions discussed in this notice, the TN and TP criteria would be: Panhandle West—0.84 mg/L and 0.03 mg/L, respectively; Panhandle East—0.77 mg/L and 0.10 mg/L, respectively; North Central—1.48 mg/L and 0.36 mg/L, respectively; West Central—1.80 mg/L and 0.73 mg/L, respectively; and Peninsula—1.20 mg/L and 0.10 mg/L, respectively. To illustrate the derivation of stream criteria based on the revised regions, EPA has re-organized the same

[1] Scott, T.S., 1988, The lithostratigraphy of the Hawthorn Group (Miocene) of Florida: Florida Geological Survey Bulletin No. 59; 148 p.; Scott, T.S., K.M. Campbell, F.R. Rupert, J.D. Arthur, T.M. Missimer, J.M. Lloyd, J.W. Yon and J.G. Duncan, 2001, Geologic map of the state of Florida: Florida Geological Survey Map Series 146; Scott, T.S., 2001, Text to accompany the geologic map of Florida: Florida Geological Survey Open-File Report 80; 29 p.

nutrient dataset provided in the proposed rule and is making it available to the public in the docket for this notice. These data were organized on the basis of site averages to derive the proposed criteria outlined above.

At proposal, EPA also requested comment on the benchmark distribution approach. In response to comments, the Agency is considering using a combination of the 75th and 90th percentile values (depending on regions) based on benchmark sites, with additional data quality screens applied, to establish criteria. EPA is considering the 90th percentile for all regions except the West Central, where the Agency is considering the 75th percentile due to less data available. Using the benchmark distribution approach and the revised stream regions discussed in this notice, the TN and TP criteria would be: Panhandle West—0.62 mg/L and 0.04 mg/L, respectively; Panhandle East—0.97 mg/L and 0.11 mg/L, respectively; North Central—1.90 mg/L and 0.35 mg/L, respectively; West Central—1.30 mg/L and 0.35 mg/L, respectively; and Peninsula—1.67 mg/L and 0.11 mg/L, respectively. Included in the docket for today's notice is the benchmark dataset presented at proposal with the additional quality assurance screens applied, that was used to calculate these values. The stream criteria using this approach are calculated on the basis of Waterbody Identifiers (WBIDs) and the derivation is outlined in more detail in the docket for today's notice. EPA requests comment on this approach.

EPA is soliciting comment on the refined regionalization approach and criteria described in this supplemental notice. The Agency is specifically requesting comment on revised stream criteria using EPA's previously proposed approach (applied to the revised regions) as outlined above as well as alternative stream criteria based on utilization of the benchmark distribution approach applied to the revised regions, also outlined above. EPA will evaluate all data and information submitted by the close of the public comment period for this supplemental notice with regard to regionalization and criteria derivation for Florida's streams.

B. Downstream Protection of Lakes

In its January 2010 FRN, EPA proposed a phosphorus loading model equation first developed by Vollenweider [2] to relate a lake TP concentration criterion to the concentration necessary in incoming streams to support the lake criterion. EPA proposed to apply the equation's resulting stream concentration as the applicable criterion for all stream segments upstream of the lake if those concentrations were more stringent than the otherwise applicable instream criteria for the stream segments. EPA mathematically derived this equation, with allowable input of lake-specific characteristics, to calculate values intended to serve as protective criteria necessary to assure attainment and maintenance of the lake numeric nutrient criteria also included in the proposal (75 FR 4198).

The proposed Vollenweider model equation requires input of two lake-specific characteristics: The fraction of inflow due to stream flow and the hydraulic retention time. Because lake-specific input values may not always be readily available, EPA provided alternative preset values for percent contribution from stream flow and hydraulic retention time that could be used in those instances. EPA's January 2010 proposed rule discussed the flexibility for the State to use site-specific inputs to the Vollenweider equation for these two parameters, as long as the State determines that they are appropriate and documents the site-specific values.

EPA requested comment on several technical aspects of this equation and its application. In addition, EPA requested comment on the potential to develop a corollary approach for nitrogen. Several commenters suggested the need for protective TN values to protect downstream lakes that are nitrogen-limited (such as many of the lakes in the phosphorus-rich areas of the State). EPA recognized that more specific information may be readily available for individual lakes that could allow the use of alternative approaches such as the BATHTUB model [3] and requested comment in the January 2010 proposal on the availability and application of this model. EPA also requested comment on whether there should be a specific allowance for use of alternative lake-specific models where demonstrated to be protective and scientifically defensible based upon current and readily available data.

EPA received many comments on this proposed approach for protection of lakes downstream of rivers and streams. Some felt that that the Vollenweider equation was overly simplistic to represent all lakes in Florida and that it does not include the necessary factors to account for physical, hydrologic, chemical, and biological processes necessary to determine protective criteria. Comments included a recommendation to use models that can better represent site-specific conditions, such as BATHTUB.

BATHTUB is designed to apply empirical eutrophication models to morphometrically complex lakes and reservoirs. The program performs steady-state water and nutrient balance calculations, uses spatially segmented hydraulic networks, and accounts for advective and diffusive transport of nutrients. BATHTUB predicts nutrient-related water quality conditions such as total phosphorus, total nitrogen and chlorophyll a concentrations, transparency, and hypolimnetic oxygen depletion rates. The model can apply to a variety of lake sizes, shapes and transport characteristics. A high degree of flexibility is available for specifying model segments as well as multiple influent streams. Because water quality conditions are calculated using empirically-derived relationships, BATHTUB inherently accounts for internal loading of phosphorus from bottom sediments. Additional technical references are available that describe the model and its applications.[4]

For the provision of EPA's proposed rule for deriving criteria for protection of downstream lakes (§ 131.43(c)(2)(ii)), EPA is considering requiring the use of BATHTUB rather than a loading model equation based on Vollenweider. The rule would therefore require that the criteria for protection of downstream lakes would be the more stringent of the instream TP and TN criteria value or the

[2] Vollenweider, R.A. 1975. Input-output models with special reference to the phosphorus loading concept in limnology. Schweizerische Zeitschrift fur Hydrologie. 37:53–84; Vollenweider, R.A. 1976. Advances in differing critical loading levels for phosphorus in lake eutrophication. Mem. Ist. Ital. Idrobid. 33:53–83.

[3] Kennedy, R. H., 1995. *Application of the BATHTUB Model to Selected Southeastern Reservoirs.* Technical Report EL–95–14, U.S. Army Engineer Waterways Experiment Station, Vicksburg, MS.; Walker, W. W., 1985. *Empirical Methods for Predicting Eutrophication in Impoundments; Report 3, Phase II: Model Refinements.* Technical Report E–81–9, U.S. Army Engineer Waterways Experiment Station, Vicksburg, MS.; Walker, W. W., 1987. *Empirical Methods for Predicting Eutrophication in Impoundments; Report 4, Phase III: Applications Manual.* Technical Report E–81–9, U.S. Army Engineer Waterways Experiment Station, Vicksburg, MS.

[4] Walker, W.W., 1981. *Empirical Methods for Predicting Eutrophication in Impoundments; Report 1, Phase I: Data Base Development.* Technical Report E–81–9, U.S. Army Engineer Waterways Experiment Station, Vicksburg, MS.; Walker, W.W., 1982. *Empirical Methods for Predicting Eutrophication in Impoundments; Report 2, Phase II: Model Testing.* Technical Report E–81–9, U.S. Army Engineer Waterways Experiment Station, Vicksburg, MS.; Walker, W.W., 1999. *Simplified Procedures for Eutrophication Assessment and Prediction: User Manual;* Instruction Report W–96–2, U.S. Army Corps of Engineers Waterways Experiment Station, Vicksburg, M.S.

concentration of TP and TN derived from application of BATHTUB. The resulting criteria using BATHTUB could be either more or less stringent than the criteria derived using Vollenweider, depending on site-specific lake factors. EPA believes BATHTUB may be more appropriate for downstream protection value calculations than Vollenweider because BATHTUB has the capability to represent a greater number of site-specific variables, which may influence nutrient responses. In addition, BATHTUB can estimate TN concentrations. As noted above, a number of commenters observed that a limitation in EPA's original proposal was that it only addressed TP.

EPA is also considering additional rule language that would specifically authorize FDEP or EPA to use a model other than BATHTUB when either determines that it would be appropriate to use another scientifically defensible technical model or approach that demonstrates protection of downstream lakes. While BATHTUB is a peer reviewed and versatile model, there are other models that, when appropriately calibrated and applied, can offer additional capability to address more complex situations and address an even greater degree of site-specificity.

One example of an alternative model that FDEP or EPA might consider using for particularly complex site-specific conditions is the Water Quality Analysis Simulation Program (WASP) model. This model allows users to conduct detailed simulations of water quality responses to natural and manmade pollutant inputs. WASP is a dynamic compartment-modeling program for aquatic systems, including both the water column and the underlying benthos. WASP allows the user to simulate systems in 1, 2, or 3 dimensions, and a variety of pollutant types. The model can represent time varying processes of advection, dispersion, point and diffuse mass loading, and boundary exchange. WASP also can be linked with hydrodynamic and sediment transport models that can provide flows, depths, velocities, temperature, salinity and sediment fluxes. Additional technical information may be found at *http://www.epa.gov/athens/wwqtsc/html/wasp.html*.

EPA is considering recommending BATHTUB as the method for calculating the TN and TP downstream protective values in streams that flow into lakes because of its ability to incorporate site-specific factors in estimates, its use of data that may be readily available, and its ease of use and rapid processing time. BATHTUB has been used to model nutrients in lakes and reservoirs throughout the United States. BATHTUB allows for greater site-specificity than the Vollenweider approach, and input of more local information to calculate concentrations of both nitrogen and phosphorus in streams that assure downstream protection of lakes. In certain circumstances, a more complex model such as WASP may be appropriate, and EPA is considering and requesting comment on adding specific provisions to allow either the Agency or FDEP to use an alternative model such as WASP where greater spatial or temporal detail in model output is called for, or where water quality considerations that fall outside the scope of BATHTUB are to be explicitly considered.

EPA is also requesting comment on including a provision in this section of the rule that would provide that if data are not readily available to derive a TN or TP downstream protection value using BATHTUB or another scientifically defensible model, the lake criteria values for TN and TP would be used as the downstream protection values where they are more stringent than the instream values. EPA believes that this approach is protective because the allowable concentration of nutrients entering the lake would be equal to criteria that are protective of the lake water itself; however, this approach may result in the application of more stringent criteria in the streams entering the lake than would be calculated using BATHTUB or another scientifically defensible model if site-specific data were available.

EPA is soliciting comment on the approaches to protect downstream lakes described in this supplemental notice. EPA will evaluate all data and information submitted by the close of the public comment period for this supplemental notice with regard to nutrient criteria to protect downstream lakes in Florida.

Dated: July 29, 2010.

Peter S. Silva,

Assistant Administrator for Water.

[FR Doc. 2010–19140 Filed 7–30–10; 4:15 pm]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 272

[EPA–R02–RCRA–2010–0249; FRL–9178–7]

New York: Incorporation by Reference of State Hazardous Waste Management Program

AGENCY: Environmental Protection Agency (EPA).

ACTION: Proposed rule.

SUMMARY: The EPA proposes to revise the codification of New York's authorized hazardous waste program which is set forth in the regulations entitled "Approved State Hazardous Waste Management Programs", New York's authorized hazardous waste program. EPA will incorporate by reference into the Code of Federal Regulations (CFR) those provisions of the State regulations that are authorized and that EPA will enforce under the Solid Waste Disposal Act, as amended and commonly referred to as the Resource Conservation and Recovery Act (RCRA).

DATES: Send your written comments by September 2, 2010.

ADDRESSES: Submit your comments, identified by Docket ID No. EPA–R02–RCRA–2010–0249, by one of the following methods:

- *Federal eRulemaking Portal: http://www.regulations.gov.* Follow the on-line instructions for submitting comments.
- E-mail: *infurna.michael@epa.gov.*
- *Fax:* (212) 637–4437.
- *Mail:* Send written comments to Michael Infurna, Division of Environmental Planning and Protection, EPA, Region 2, 290 Broadway, 22nd Floor, New York, NY 10007.
- *Hand Delivery or Courier:* Deliver your comments to Michael Infurna, Division of Environmental Planning and Protection, EPA, Region 2, 290 Broadway, 22nd Floor, New York, NY 10007. Such deliveries are only accepted during the Regional Office's normal hours of operation. The public is advised to call in advance to verify the business hours. Special arrangements should be made for deliveries of boxed information.

Instructions: Direct your comments to Docket ID No. EPA–R02–RCRA–2010–0249. EPA's policy is that all comments received will be included in the public docket without change and may be made available on-line at *http://www.regulations.gov*, including any personal information provided, unless the comment includes information

claimed to be Confidential Business Information (CBI) or other information whose disclosure is restricted by statute. Do not submit information that you consider to be CBI or otherwise protected through *http://www.regulations.gov*, or e-mail. The Federal *http://www.regulations.gov* Web site is an "anonymous access" system, which means EPA will not know your identity or contact information unless you provide it in the body of your comment. If you send an e-mail comment directly to EPA without going through *http://www.regulations.gov*, your e-mail address will be automatically captured and included as part of the comment that is placed in the public docket and made available on the Internet. If you submit an electronic comment, EPA recommends that you include your name and other contact information in the body of your comment and with any disk or CD–ROM you submit. If EPA cannot read your comment due to technical difficulties, and cannot contact you for clarification, EPA may not be able to consider your comment. Electronic files should avoid the use of special characters or any form of encryption, and be free of any defects or viruses. (For additional information about EPA's public docket, visit the EPA Docket Center homepage at *http://www.epa.gov/dockets/*).

Docket: All documents in the docket are listed in the *http://www.regulations.gov* index. Although listed in the index, some information is not publicly available, *e.g.,* CBI or other information whose disclosure is restricted by statute. Certain other material, such as copyrighted material, will be publicly available only in hard copy. Publicly available docket materials are available either electronically in *http://www.regulations.gov* or in hard copy. You can view and copy the records related to this codification effort in the EPA Region 2 Library by appointment only. To make an appointment please call (212) 637–3185.

FOR FURTHER INFORMATION CONTACT: Michael Infurna, Division of Environmental Planning and Protection, EPA Region 2, 290 Broadway, 22nd floor, New York, NY 10007; telephone number (212) 637–4177; fax number: (212) 637–4377; e-mail address: *infurna.michael@epa.gov*.

SUPPLEMENTARY INFORMATION: In the "Rules and Regulations" section of this **Federal Register**, the EPA is codifying and incorporating by reference the State's hazardous waste program as a direct final rule. EPA did not make a proposal prior to the direct final rule because we believe these actions are not controversial and do not expect comments that oppose them. We have explained the reasons for this codification and incorporation by reference in the preamble to the direct final rule. Unless we get written comments which oppose this incorporation by reference during the comment period, the direct final rule will become effective on the date indicated, and we will not take further action on this proposal. If we get comments that oppose these actions, we will withdraw the direct final rule and it will not take effect. We will then respond to public comments in a later final rule based on this proposal. You may not have another opportunity for comment. If you want to comment on this action, you must do so at this time.

For additional information, please see the direct final rule published in the "Rules and Regulations" section of this **Federal Register**.

Dated: April 27, 2010.

Judith A. Enck,

Regional Administrator, Region 2.

[FR Doc. 2010–18928 Filed 8–2–10; 8:45 am]

BILLING CODE 6560–50–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Part 170

Planning and Establishment of State-Level Exchanges; Request for Comments Regarding Exchange-Related Provisions in Title I of the Patient Protection and Affordable Care Act

AGENCY: Office of Consumer Information and Insurance Oversight, Department of Health and Human Services.

ACTION: Request for comments.

SUMMARY: This document is a request for comments regarding the Exchange-related provisions of the Patient Protection and Affordable Care Act (the Affordable Care Act), enacted on March 23, 2010. The Department of Health and Human Services (HHS) invites public comments in advance of future rulemaking and grant solicitations.

DATES: Submit written or electronic comments by October 4, 2010.

ADDRESSES: In commenting, please refer to file code OCIIO–9989–NC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

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

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

• *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: OCIIO–9989–NC, P.O. Box 8010, Baltimore, MD 21244–8010.

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

• *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: OCIIO–9989–NC, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

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

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

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

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

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

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

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

FOR FURTHER INFORMATION CONTACT: Donna Laverdiere, Office of Consumer Information and Insurance Oversight, Department of Health and Human Services, at (301) 492–4100.

Customer Service Information: Individuals interested in obtaining information about the Patient Protection and Affordable Care Act may visit the Department of Health and Human Services' Web site (*http://www.HealthCare.gov*).

SUPPLEMENTARY INFORMATION:

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

Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at Room 445–G, Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, call 1–800–743–3951.

I. Background

A. General

Title I of the Patient Protection and Affordable Care Act (Affordable Care Act, or the Act), Public Law 111–148, enacted on March 23, 2010, expands access to health insurance through the establishment of American Health Benefits Exchanges ("Exchanges"). Sections 1311(b) and 1321 (b) of the Affordable Care Act provide that each State may elect to establish an Exchange that would (consistent with definitions relating to the individual and group markets and employer size established in Section 1304 of the Act): (1) Facilitate the purchase of qualified health plans (QHPs); (2) provide for the establishment of a Small Business Health Options Program ("SHOP Exchange") designed to assist qualified employers in facilitating the enrollment of their employees in QHPs offered in the SHOP Exchange; and (3) meet other requirements specified in the Act. Additionally, section 1321(c)(1) requires the Secretary to establish and operate an Exchange within States that do not elect to establish an Exchange, or if the Secretary determines, on or before January 1, 2013, that the State will not have an Exchange operable by January 1, 2014 or has not taken the actions necessary to meet required Exchange standards as defined by regulation or to implement other requirements in Subtitles A and C of the Affordable Care Act (relating to insurance market reforms). For purposes of the remainder of this notice, the term "Exchange" will refer to State-operated Exchanges and the Exchange operated by the Federal government on behalf of States that do not elect to establish an Exchange.

B. Requirements for Establishing and Operating Exchanges

Section 1311(d) of the Affordable Care Act specifies certain requirements for Exchanges, and section 1311(e) specifies the requirements for a plan to be certified by the Exchange as a QHP. Additionally, Section 1321 of the Affordable Care Act discusses State flexibility in the operation and enforcement of Exchanges and related requirements. The Secretary will issue regulations setting standards for meeting the requirements under Title I of the Act with respect to the establishment and operations of the Exchanges. Each State electing to establish and operate an Exchange must have in effect Federal standards or a State law or regulation that implements the Federal standards within the State. Also, section 1311(k) specifies that Exchanges may not establish rules that conflict with or prevent the application of regulations promulgated by the Secretary under Subtitle D of the Affordable Care Act.

Section 1321(c) of the Act provides the authority for the Secretary to establish and operate an Exchange on behalf of a State that does not elect to establish an Exchange or that the Secretary determines will not have an Exchange operable by January 1, 2014; or has not taken the necessary actions to implement the requirements in 1321(a) or other market reforms specified in Subtitles A and C of Title I of the Affordable Care Act.

1. General Requirements for Exchanges

Section 1311(d)(1) requires that an Exchange must be a governmental agency or nonprofit entity established by a State. Section 1311(d)(2) requires Exchanges to make QHPs available to eligible individuals and employers. Section 1311(d)(6) requires Exchanges to consult with various stakeholders relevant to carrying out their responsibilities.

Section 1311(d)(4) identifies the minimum functions that an Exchange must perform. These functions include, but are not limited to: Implementing procedures for certification, recertification, and decertification of QHPs; providing for the operation of a toll-free telephone hotline to respond to requests for assistance; maintaining an Internet website containing standardized comparative information on QHPs; assigning ratings to each QHP offered through the Exchange on the basis of relative quality and price, in accordance with criteria as defined by the Secretary; utilizing a standardized format for presenting health benefits options in the Exchange; consistent with requirements in Section 1413 of the Act, informing individuals of eligibility requirements for the Medicaid and CHIP programs or any applicable State or local public program, and enrolling individuals in those programs if the Exchange determines they are eligible through screening of the application by the Exchange; establishing and making available by electronic means a calculator to determine the actual cost of coverage after application of any premium tax credit and cost-sharing reduction; granting certifications to individuals relating to hardship or other exemptions; and establishing a Navigator program consistent with the requirements in Section 1311(i).

2. Requirements Relating to Plan Ratings and Internet Portals

Section 1311(c)(3) requires the Secretary to develop a rating system that would rate QHPs offered through an Exchange on the basis of the relative quality and price. Additionally, Section 1311(c)(4) requires the Secretary to develop an enrollee satisfaction system that would evaluate the level of satisfaction with QHPs that had more than 500 enrollees during the previous year that are offered through an Exchange. The Act requires Exchanges to include quality and enrollee satisfaction ratings in the information provided to individuals and employers through their Internet portals.

Section 1311(c)(5) directs the Secretary to make a model template available to Exchanges for an Internet portal that may be used to direct eligible individuals and employers to QHPs; assist individuals and employers in determining eligibility for participation in Exchanges, premium tax credits, or cost-sharing reductions; and present standardized information (including plan ratings) to assist consumers in making health insurance choices. The Affordable Care Act also directs the Secretary to continue operating, maintaining and updating the Federal Internet portal developed under Section 1103(a) and to assist States in developing and maintaining their own portals.

3. Requirements Relating to Navigator Programs

Section 1311(i) provides that an Exchange shall establish a Navigator program under which it awards grants to eligible entities that meet the law's criteria, including demonstrating to the Exchange that they have existing relationships or could establish relationships with employers and employees, consumers, or self-employed individuals likely to be eligible to enroll in a qualified health plan. The duties of entities that serve as Navigators under such a grant include: Conducting public education activities to raise awareness of the availability of QHPs; distributing fair and impartial information concerning enrollment in QHPs and the availability of premium tax credits and cost-sharing reductions; facilitating enrollment in QHPs; providing referrals to any applicable office of health insurance consumer assistance, health insurance ombudsman, or other State agency to address enrollee complaints and questions about their health plans and coverage determination; and providing information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange. The Affordable Care Act directs the Secretary, in collaboration with States, to develop standards to ensure that information made available by Navigators is fair, accurate and impartial.

4. Other Requirements Relating to Exchanges

Section 1311(c)(6) requires Exchanges to provide for an initial open enrollment period (as determined by the Secretary no later than July 1, 2012), annual open enrollment periods (as determined by the Secretary), and special enrollment periods.

Section 1311(d)(5)(A) specifies that States must ensure that their Exchanges are self-sustaining on or after January 1, 2015, including allowing Exchanges to charge assessments or user fees to participating health insurance issuers, or otherwise generate funding to support their operations. Section 1311(d)(5)(B) prohibits wasteful use of funds by Exchanges. Additionally, Section 1313 requires Exchanges to keep an accurate accounting of all activities, receipts, and expenditures, and annually submit to the Secretary a report concerning such accounting. Section 1313(a) also specifies that the Secretary has certain enforcement authority if an Exchange or a State has engaged in serious misconduct related to compliance with Title I of the Act.

5. Establishment of Exchanges in the Territories

Section 1323 of the Affordable Care Act provides an opportunity for U.S. Territories to elect to establish Exchanges and appropriates a fixed amount of funds to reduce the cost of coverage provided through an Exchange in the Territories. The Act stipulates that Territories' elections related to establishing Exchanges must be consistent with Section 1321, relating to standards for establishing and operating Exchanges, and received not later than October 1, 2013.

II. Solicitation of Comments

Section 1321(a)(2) of the Affordable Care Act requires the Secretary to consult with stakeholders to ensure balanced representation among interested parties. HHS is inviting public comment to aid in the development of standards for establishment and operation of the Exchanges, to address other Exchange-related provisions in Title I of the Affordable Care Act, and to inform for the awarding of grants to the States to assist them in planning and developing Exchanges. The Department is interested in comments from all interested parties. To assist interested parties in responding, this request for comments describes specific areas in which the Department is particularly interested.

Commenters should use the questions below to provide the Department with relevant information for the development of regulations regarding the Exchange-related provisions in Title I of the Affordable Care Act. However, it is not necessary for commenters to address every question below and commenters may also address additional issues under the Exchange-related provisions in Title I of the Affordable Care Act. Individuals, groups, and organizations interested in providing comments may do so at their discretion by following the above mentioned instructions.

Specific areas in which HHS is particularly interested include the following:

A. State Exchange Planning and Establishment Grants

Section 1311(a) directs the Secretary to make planning and establishment grant awards to States for activities related to establishing an Exchange. For each fiscal year, the Secretary must determine the total amount that will be made available to each State. Grants awarded under this Section may be renewed if a State is making sufficient progress toward establishing an Exchange, implementing other insurance market reforms, and meeting other benchmarks. The Secretary must make the initial grant awards under this Section no later than one year after enactment, and no grants shall be awarded after January 1, 2015.

1. What factors are States likely to consider in determining whether they will elect to offer an Exchange by January 1, 2014? To what extent are States currently planning to develop their own Exchanges by 2014 (*e.g.,* become electing States) versus choosing to opt-in to an Exchange operated by the Federal government for their State? When will this decision be made? Can planning grants assist in identifying and assessing relevant factors and making this decision?

2. To what extent have States already begun to plan for establishment of Exchanges? What kinds of activities are currently underway (*e.g.,* legislative, regulatory, etc.)? What internal and/or external entities are involved, or will likely be involved in this planning process?

a. What kinds of governance structures, rules or processes have States established or are they likely to establish related to operating Exchanges (*e.g.,* legal structure (such as placement in State agency or nonprofit organization), governance structure, requirements relating to governing board composition, etc.)?

b. To what extent have States begun developing business plans or budgets relating to Exchange implementation?

3. What are some of the major factors that States are likely to consider in determining how to structure their Exchanges (*e.g.,* separate or combined individual Exchanges and SHOP Exchanges; regional or interstate Exchanges; subsidiary Exchanges, State agency versus nonprofit entity)? What are the pros and cons of these various options?

4. What kinds of factors are likely to affect States' resource needs related to establishing Exchanges?

a. What is the estimated range of costs that States are likely to incur during the upcoming year (*e.g.,* calendar 2010 through calendar 2011) for each of the major categories of Exchange activities? Which of these expenses are fixed costs, and which costs are variable?

b. To what extent do States have existing resources that could be leveraged as a starting point for Exchange operations (*e.g.,* existing information technology (IT) systems, toll-free hotlines, Web sites, business processes, etc.)?

c. For what kinds of activities are States likely to seek funding using the Exchange establishment and planning grants?

5. What kinds of questions are States likely to receive during the initial planning and start-up phase of establishing Exchanges? How can HHS provide technical assistance, and in what forms, in helping States to answer these questions?

B. Implementation Timeframes and Considerations

Section 1321(b) requires each State that elects to establish an Exchange meeting the Secretary's requirements to have an Exchange operational by January 1, 2014. Section 1321(c) directs the Secretary to establish and operate an Exchange within each State that: (1) Does not elect to establish an Exchange; or (2) the Secretary determines will not have an Exchange operational by January 1, 2014, or has not taken the actions the Secretary determines necessary to implement the requirements in Section 1321(a) or the other insurance market reform requirements in Subtitles A and C of Title I of the Act.

Additionally, the Affordable Care Act includes several statutory deadlines for the Secretary related to establishment of Exchanges, including:

- Issuing regulations and/or guidance relating to requirements for Exchanges, requirements for QHPs, and risk adjustment as soon as practicable;
- Awarding State planning grants no later than one year after enactment (March 23, 2011);
- Determining the dates of the initial open enrollment period by July 1, 2012;
- No later than January 1, 2013, determining States' readiness to have Exchanges operational and implement required insurance market reforms by January 1, 2014;
- No later than July 1, 2013, issuing regulations for health choice compacts and the CO–OP program, and awarding CO–OP program grants; and
- Having in place additional insurance market reforms and providing cost-sharing reductions beginning on January 1, 2014.

In order to carry out the Federal implementation activities to ensure Exchanges are fully operational on January 1, 2014, the Department is seeking comments from stakeholders relating to implementation timeframes.

1. What are the key implementation tasks that need to be accomplished to meet Exchange formation deadlines and what is the timing for such tasks? What kinds of business functions will need to be operational before January 1, 2014, and how soon will they need to be operational?

2. What kinds of guidance or information would be helpful to States, plans, employers, consumers, and other groups or sectors as they begin the planning process?

3. What potential criteria could be considered in determining whether an electing State is making sufficient progress in establishing an Exchange and implementing the insurance market reforms in Subtitles A and C of Title I of the Affordable Care Act? What are important milestones for States to show they are making steady and sufficient progress to implement reforms by the statutory deadlines?

4. What other terms or provisions require additional clarification to facilitate implementation and compliance? What specific clarifications would be helpful?

C. State Exchange Operations

Section 1311(b) requires an Exchange to be established in each State not later than January 1, 2014 that: Facilitates the purchase of QHPs; provides for the establishment of a SHOP Exchange that assists small employers in facilitating the enrollment of their employees in QHPs offered in the small group market in the State; and meets additional requirements for Exchanges outlined in Section 1311(d). The Act requires the Secretary to publish regulations relating to the requirements for operating State Exchanges as soon as practicable, and provides various types of flexibility for States.

A number of additional programs established by the Act are closely related to the establishment of health insurance Exchanges, such as the Navigator program in Section 1311(i) and other consumer assistance programs. In addition, the insurance reforms, consumer protection provisions, and premium rating requirements will apply to plans both inside and outside the Exchanges.

1. What are some of the major considerations for States in planning for and establishing Exchanges?

2. For which aspects of Exchange operations or Exchange standards would uniformity be preferable? For which aspects of Exchange operations or Exchange standards is State flexibility likely to be particularly important?

3. What kinds of systems are States likely to need to enable important Exchange operational functions (*e.g.,* eligibility determination, plan qualification, data reporting, payment flows, etc.), to ensure adequate accounting and tracking of spending, provide transparency to Exchange functions, and facilitate financial audits? What are the relative costs and considerations associated with building Exchange operational, financial, and/or IT systems off of existing systems, versus building new stand-alone Exchange IT systems?

4. What are the tradeoffs for States to utilize a Federal IT solution for operating their Exchanges, as compared to building their own unique systems to conform to the current State environment? For what kinds of functions would it make more sense for States to build their own systems, or modify existing systems?

5. What are the considerations for States as they develop web portals for the Exchanges?

6. What factors should Exchanges consider in reviewing justifications for premium increases from insurers seeking certification as QHPs? How will States leverage/coordinate the work funded by the rate review grants to inform the decisions about which plans will be certified by QHPs?

7. To what extent are Territories likely to elect to establish their own Exchanges? What specific issues apply to establishing Exchanges in the Territories?

8. What specific planning steps should the Exchanges undertake to ensure that they are accessible and available to individuals from diverse cultural origins and those with low literacy, disabilities, and limited English proficiency?

9. What factors should the Secretary consider in determining what constitutes as wasteful spending (as outlined in Section 1311 (d)(5)(B))?

D. Qualified Health Plans (QHPs)

Section 1311(d)(2)(A) requires Exchanges to make QHPs available to qualified individuals and employers, and Section 1311(d)(4)(A) requires Exchanges to implement procedures for the certification, recertification, and decertification of health plans as QHPs, consistent with criteria developed by the Secretary under section 1311(c). This certification criteria include, at a minimum: Meeting marketing requirements; ensuring a sufficient choice of providers and providing information on the availability of providers; including essential community providers within health insurance plan networks; receiving appropriate accreditation; implementing a quality improvement strategy; utilizing a uniform enrollment form and a standard format to present health benefit plan options; and providing quality information to enrollees and prospective enrollees.

1. What are some of the major considerations involved in certifying QHPs under the Exchanges, and how do those considerations differ in the context of individual and SHOP State Exchanges, subsidiary Exchanges, regional or interstate Exchanges, or an Exchange operated by the Federal government on behalf of States that do not elect to establish an Exchange?

2. What factors should be considered in developing the Section 1311(c) certification criteria? To what extent do States currently have similar requirements or standards for plans in the individual and group markets?

a. What issues need to be considered in establishing appropriate standards for ensuring a sufficient choice of providers and providing information on the availability of providers?

b. What issues need to be considered in establishing appropriate minimum standards for marketing of QHPs and enforcement of those standards? What are appropriate Federal and State roles in marketing oversight?

3. What factors are needed to facilitate participation of a sufficient mix of QHPs in the Exchanges to meet the needs of consumers?

a. What timeframes and key milestones will be most important in assessing plans' participation in Exchanges?

b. What kinds of factors are likely to encourage or discourage competition among plans in the Exchanges based on price, quality, value, and other factors?

4. What health plan standards and bidding processes would help to facilitate getting the best value for consumers and taxpayers?

5. What factors are important in establishing minimum requirements for the actuarial value/level of coverage?

6. What factors, bidding requirements, and review/selection practices are likely to facilitate the participation of multiple plans in Exchanges? To what extent should the Exchanges accept all plans that meet minimum standards or select and negotiate with plans?

7. What are some important considerations related to establishing the program to offer loans or grants to foster the promotion of qualified nonprofit health plans under CO–OP plans? How prevalent are these organizations today? What is the likely demand for these loans and grants? What kinds of guidance are they likely to need from HHS and what legislative or regulatory changes are they likely to need from States?

8. Are there any special factors that are important for consideration in establishing standards for the participation of multi-State plans in Exchanges?

9. To what extent are States considering setting up State Basic Health Plans under Section 1331 of the Act?

E. Quality

The Affordable Care Act requires the Secretary to develop a health plan rating system on the basis of quality and prices that would be used by the Exchanges and to establish quality improvement criteria that health plans must meet in order to be qualified plans for Exchanges.

1. What factors are most important for consideration in establishing standards for a plan rating system?

a. How best can Exchanges help consumers understand the quality and cost implications of their plan choices?

b. Are the measures and standards that are being used to establish ratings for health plans in the Medicare Advantage program appropriate for rating QHPs in the Exchanges? Are there other State Medicaid or commercial models that could be considered?

c. How much flexibility is desirable with respect to establishing State-specific thresholds or quality requirements above the minimum Federal thresholds or quality requirements?

2. What are some minimum standards or other factors that could be considered with respect to establishing quality measurement and improvement thresholds or quality requirements that should be met by QHPs? What other strategies, including payment structures, could be used by plans to improve the practices of plan providers?

F. An Exchange for Non-Electing States

Section 1321(c) requires that in the case of States that do not elect to establish Exchanges, or that the Secretary determines will not have Exchanges operational by January 1, 2014 or have not taken the necessary actions to implement the requirements in Section 1321(a) or other insurance market reforms specified in Subtitles A and C of Title I of the Act, the Secretary shall establish (directly or through agreement with a not-for-profit entity) and operate an Exchange within the State.

1. How can the Federal government best work to implement an Exchange in States that do not elect to establish or are unable to establish their own Exchanges?

2. Are there considerations for an Exchange operated by the Federal government on behalf of States that do not elect to establish an Exchange that would be different from the State-run Exchanges?

G. Enrollment and Eligibility

Section 1411 of the Affordable Care Act requires the Secretary to establish a program for determining whether an individual meets certain eligibility requirements for Exchange participation, premium tax credits and cost-sharing reductions, and individual responsibility exemptions. Additionally, Sections 1412, 1413 and 2201 contain additional requirements to assist Exchanges by making advance determinations regarding income eligibility and cost-sharing reductions; providing for residents of each State to apply for enrollment in, receive a determination of eligibility for participation in, and continue participation in applicable State health subsidy programs; and simplifying and coordinating enrollment in the Exchanges, Medicaid and the Children's Health Insurance Program (CHIP).

1. What are the advantages and issues associated with various options for setting the duration of the open enrollment period for Exchanges for the first year and subsequent years? What factors are important for developing criteria for special enrollment periods?

2. What are some of the key considerations associated with conducting online enrollment?

3. How can eligibility and enrollment be effectively coordinated between Medicaid, CHIP, and Exchanges? How could eligibility systems be designed or adapted to accomplish this? What steps can be taken to ease consumer navigation between the programs and ease administrative burden? What are the key considerations related to States using Exchange or Medicaid/CHIP application information to determine eligibility for all three programs?

4. What kinds of data linkages do State Medicaid and CHIP agencies currently have with other Federal and State agencies and data sources? How can the implementation of Exchanges help to streamline these processes for States, and how can these linkages be leveraged to support Exchange operations?

5. How do States or other stakeholders envision facilitating the requirements of Section 1411 related to verification with Federal agencies of eligibility for enrollment through an Exchange?

6. What are the verification and data sharing functions that States are capable of performing to facilitate the determination of Exchange eligibility and enrollment?

7. What considerations should be taken into account in establishing

procedures for payment of the cost-sharing reductions to health plans?

H. Outreach

Section 1311(i) provides that Exchanges shall establish grant programs for Navigators, to conduct public education activities, distribute enrollment information, facilitate enrollment, and provide referrals for grievances, complaints, or questions.

1. What kinds of consumer enrollment, outreach, and educational activities are States and other entities likely to conduct relating to Exchanges, insurance market reforms, premium tax credits and cost-sharing reductions, available plan choices, etc., and what Federal resources or technical assistance are likely to be beneficial?

2. What resources are needed for Navigator programs? To what extent do States currently have programs in place that can be adapted to serve as patient Navigators?

3. What kinds of outreach strategies are likely to be most successful in enrolling individuals who are eligible for tax credits and cost-sharing reductions to purchase coverage through an Exchange, and retaining these individuals? How can these outreach efforts be coordinated with efforts for other public programs?

I. Rating Areas

Section 2701(a)(2) of the Public Health Service Act, as added by Section 1201 of the Affordable Care Act requires each State to establish one or more rating areas within the State for purposes of applying the requirements of Title I of the Affordable Care Act (including the Exchange provisions), subject to review by the Secretary.

1. To what extent do States currently utilize established premium rating areas? What are the typical geographical boundaries of these premium rating areas (*e.g.,* Statewide, regional, county, etc.)? What are the pros and cons associated with interstate, statewide, and sub-State premium rating areas? What insurance markets are typically required to utilize these premium rating areas?

2. To the extent that States utilize premium rating areas, how are they established? What kinds of criteria do States and other entities typically consider when determining the adequacy of premium rating areas? What other criteria could be considered?

J. Consumer Experience

1. What kinds of design features can help consumers obtain coverage through the Exchange? What information are consumers likely to find useful from Exchanges in making plan selections? Which kinds of enrollment venues are likely to be most helpful in facilitating individual enrollment in Exchanges and QHPs?

2. What kinds of information are likely to be most useful to consumers as they determine whether to enroll in an Exchange and which plans to select (within or outside of an Exchange)? What are some best practices in conveying information to consumers relating to health insurance, plan comparisons, and eligibility for premium tax credits, or eligibility for other public health insurance programs (*e.g.,* Medicaid)? What types of efforts could be taken to reach individuals from diverse cultural origins and those with low literacy, disabilities, and limited English proficiency?

3. What are best practices in implementing consumer protections standards?

4. Given that consumer complaints can be an important source of information in identifying compliance issues, what are the pros and cons of various options for collecting and reporting Exchange-related complaints (*e.g.,* collecting complaints at the Federal level, versus at the State or Exchange level)?

K. Employer Participation

Section 1311(b)(1)(B) provides for the establishment of Small Business Health Options Programs, referred to as SHOP Exchanges, which are designed to assist qualified employers in the State who are small employers in facilitating the enrollment of their employees in QHPs offered in the small group market in the State. Section 1304(b) provides that for plan years beginning before January 1, 2016, States have the option to define "small employers" as those with (1) 100 or fewer employees, or (2) 50 or fewer employees. Section 1312(f)(2)(B) specifies that beginning in 2017, States may elect to include issuers of health insurance coverage in the large group market to offer QHPs through the Exchange, and for large employers to purchase coverage through the Exchange.

In addition, employers that do not offer affordable coverage to their employees will also interact with the Exchanges including where their employees purchase coverage through the Exchange.

1. What Exchange design features are likely to be most important for employer participation, including the participation of large employers in the future? What are some relevant best practices?

2. What factors are important for consideration in determining the employer size limit (*e.g.,* 50 versus 100) for participation in a given State's Exchange?

3. What considerations are important in facilitating coordination between employers and Exchanges? What key issues will require collaboration?

4. What other issues are there of interest to employers with respect to their participation in Exchanges?

L. Risk Adjustment, Reinsurance, and Risk Corridors

Sections 1341, 1342, and 1343 of the Act provide for the establishment of transitional reinsurance programs, risk corridors, and risk adjustment systems for the individual and small group markets within States.

1. To what extent do States and other entities currently risk-adjust payments for health insurance coverage in order to counter adverse selection? In what markets (*e.g.,* Medicaid, CHIP, government employee plans, etc.) are these risk adjustment activities currently performed? To the extent that risk adjustment is or has been used, what methods have been utilized, and what are the pros and cons of such methods?

2. To what extent do States currently collect demographic and other information, such as health status, claims history, or medical conditions under treatment on enrollees in the individual and small group markets that could be used for risk adjustment? What kinds of resources and authorities would States need in order to collect information for risk adjustment of plans offered inside and outside of the Exchanges?

3. What issues are States likely to consider in carrying out risk adjustment for health plans inside and outside of the Exchanges? What kinds of technical assistance might be useful to States and QHPs?

4. What are some of the major administrative options for carrying out risk adjustment? What kinds of entities could potentially conduct risk adjustment or collect and distribute funds for risk adjustment? What are some of the options relating to the timing of payments, and what are the pros and cons of these options?

5. To what extent do States currently offer reinsurance in the health insurance arena (*e.g.,* Medicaid, State employee plans, etc.) or in other arenas? How is that reinsurance typically structured in terms of contributions, coverage levels, and eligibility? How much is typically taken in and paid out? Is the reinsurance fund capped in any way?

6. What kinds of non-profit entities currently exist in the marketplace that could potentially fulfill the role of an "applicable reinsurance entity" as defined in the Act?

7. What methods are typically used to determine which individuals are deemed high-risk or high cost for the purposes of reinsurance?

8. What challenges are States likely to face in implementing the temporary reinsurance program?

9. How do other programs (*e.g.,* Medicaid) use risk corridors to share profits and losses with health plans or other entities? How are the corridors defined and monitored under these programs? What mechanisms are used to collect and disburse payments?

10. Are there non-Federal instances in which reinsurance and/or risk corridors and/or risk adjustment were used together? What kinds of special considerations are important when implementing multiple risk selection mitigation strategies at once?

M. Comments Regarding Economic Analysis, Paperwork Reduction Act, and Regulatory Flexibility Act

Executive Order 12866 requires an assessment of the anticipated costs and benefits of a significant rulemaking action and the alternatives considered, using the guidance provided by the Office of Management and Budget. These costs and benefits are not limited to the Federal government, but pertain to the affected public as a whole. Under Executive Order 12866, a determination must be made whether implementation of the Exchange-related provisions in Title I of the Affordable Care Act will be economically significant. A rule that has an annual effect on the economy of $100 million or more is considered economically significant.

In addition, the Regulatory Flexibility Act may require the preparation of an analysis of the economic impact on small entities of proposed rules and regulatory alternatives. An analysis under the Regulatory Flexibility Act must generally include, among other things, an estimate of the number of small entities subject to the regulations (for this purpose, plans, employers, and in some contexts small governmental entities), the expense of the reporting, recordkeeping, and other compliance requirements (including the expense of using professional expertise), and a description of any significant regulatory alternatives considered that would accomplish the stated objectives of the statute and minimize the impact on small entities.

The Paperwork Reduction Act requires an estimate of how many "respondents" will be required to comply with any "collection of information" requirements contained in regulations and how much time and cost will be incurred as a result. A collection of information includes recordkeeping, reporting to governmental agencies, and third-party disclosures.

Furthermore, Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) requires that agencies assess anticipated costs and benefits and take certain other actions before issuing a final rule that includes any Federal mandate that may result in expenditure in any one year by State, local, or tribal governments, in the aggregate, or by the private sector, of $135 million.

The Department is requesting comments that may contribute to the analyses that will be performed under these requirements, both generally and with respect to the following specific areas:

1. What policies, procedures, or practices of plans, employers and States may be impacted by the Exchange-related provisions in Title I of the Affordable Care Act?

a. What direct or indirect costs and benefits would result?

b. Which stakeholders will be affected by such benefits and costs?

c. Are these impacts likely to vary by insurance market, plan type, or geographic area?

2. Are there unique effects for small entities subject to the Exchange-related provisions in Title I of the Affordable Care Act?

3. Are there unique benefits and costs affecting consumers? How will these consumer benefits be affected by States' Exchange design and flexibilities and the magnitude and substance of provisions mandated by the Act? Please discuss tangible and intangible benefits.

4. Are there paperwork burdens related to the Exchange-related provisions in Title I of the Affordable Care Act, and, if so, what estimated hours and costs are associated with those additional burdens?

N. Comments Regarding Exchange Operations

The Exchange-related provisions in Title I of the Affordable Care Act may affect/will involve various stakeholders. HHS wants to ensure receipt of all comments pertaining to the operations of the Exchanges.

1. What other considerations related to the operations of Exchanges should be addressed? If your questions related to the operations of Exchanges have not been asked, or you would like to add additional comments, you may do so here.

Signed at Washington, DC, this 27th day of July 2010.

Jay Angoff,

Director, Office of Consumer Information and Insurance Oversight, Department of Health and Human Services.

[FR Doc. 2010–18924 Filed 7–29–10; 11:15 am]

BILLING CODE 4150–65–P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 1

[WC Docket No. 07–245, GN Docket No. 09–51; FCC 10–84]

Implementation of Section 224 of the Act; A National Broadband Plan for Our Future

AGENCY: Federal Communications Commission.

ACTION: Proposed rule; correction.

SUMMARY: This document corrects a proposed rule published in the **Federal Register** on July 15, 2010, with respect to attachments to poles by any telecommunications carrier or cable operator providing telecommunications services. Specifically, this corrects how the maximum just and reasonable rate would be calculated under proposed rule § 1.1409(e)(2).

FOR FURTHER INFORMATION CONTACT: Marvin Sacks, 202–418–2017.

Correction

In proposed rule FR Doc. 2010–17048, beginning on page 41338 in the issue of July 15, 2010, make the following corrections in the **SUPPLEMENTARY INFORMATION** section. On page 41361 in the third column, under the proposed formula in § 1.1409(e)(2)(ii), delete the word "Maximum" before the word "Rate" and add the words "Maintenance and Administrative" before the words "Carrying Charge Rate," so the formula reads as follows:

Federal Communications Commission.

Bulah P. Wheeler,

Deputy Manager.

$$\text{Rate} = \text{Space Factor} \times \text{Net Cost of a Bare Pole} \times \left[\begin{array}{c}\text{Maintenance and Administrative}\\ \text{Carrying Charge Rate}\end{array}\right]$$

$$\text{Where Space Factor} = \left[\frac{\left(\begin{array}{c}\text{Space}\\ \text{Occupied}\end{array}\right) + \left(\frac{2}{3} \times \frac{\text{Unusable Space}}{\text{No. of Attaching Entities}}\right)}{\text{Pole Height}}\right]$$

[FR Doc. 2010–18908 Filed 8–2–10; 8:45 am]
BILLING CODE 6712–01–P

DEPARTMENT OF TRANSPORTATION

Pipeline and Hazardous Materials Safety Administration

49 CFR Part 192

[Docket No. PHMSA–2009–0203]

Pipeline Safety: Notice of Technical Pipeline Safety Advisory Committee Meetings

AGENCY: Pipeline and Hazardous Materials Safety Administration (PHMSA); DOT.

ACTION: Notice of technical pipeline safety advisory committee meetings.

SUMMARY: This notice announces a public meeting of the Technical Pipeline Safety Standards Committee (TPSSC) and of the Technical Hazardous Liquid Pipeline Safety Standards Committee (THLPSSC). The PHMSA staff will brief the committee members on pipeline regulatory actions and policy concerns. The purpose of the meeting is to keep the members updated on current safety concerns, proposed rules, and future proposals.

DATES: The meeting will be on Thursday, August 19, 2010, from 1 p.m. to 4 p.m. EST.

FOR FURTHER INFORMATION CONTACT: Cheryl Whetsel by phone at 202–366–4431 or by e-mail at *cheryl.whetsel@dot.gov.*

SUPPLEMENTARY INFORMATION:

I. Meeting Details

The TPSSC and the THLPSSC will take part in the meeting by telephone conference call. The public may attend the meeting at the U.S. Department of Transportation, 1200 New Jersey Avenue, SE., Washington, DC 20590, Room E27–302. Attendees should register in advance at *http://primis.phmsa.dot.gov/meetings/MtgHome.mtg?mtg=66.* PHMSA will post any new information or changes on the PHMSA/Office of Pipeline Safety web page (*http://PHMSA.dot.gov*) about 15 days before the meeting takes place.

Comments on the meeting may be submitted to the docket in the following ways:

E-Gov Web Site: http://www.regulations.gov. This site allows the public to enter comments on any **Federal Register** notice issued by any agency.

Fax: 1–202–493–2251.

Mail: Docket Management Facility; U.S. Department of Transportation (DOT), 1200 New Jersey Avenue, SE., West Building, Room W12–140, Washington, DC 20590–001.

Hand Delivery: Room W12–140 on the ground level of the DOT West Building, 1200 New Jersey Avenue, SE., Washington, DC, between 9 a.m. and 5 p.m., Monday through Friday, except Federal Holidays.

Instructions: Identify the docket number, PHMSA–2009–0203 at the beginning of your comments. Note that all comments received will be posted without change to *http://www.regulations.gov,* including any personal information provided. You should know that anyone is able to search the electronic form of all comments received into any of our dockets by the name of the individual submitting the comment (or signing the comment, if submitted on behalf of an association, business, labor union, etc.). Therefore, you may want to review DOT's complete Privacy Act Statement in the **Federal Register** published on April 11, 2000 (65 FR 19477) or view the Privacy Notice at *http://www.regulations.gov* before submitting any such comments.

Docket: For access to the docket or to read background documents or comments, go to *http://www.regulations.gov* at any time or to Room W12–140 on the ground level of the DOT West Building, 1200 New Jersey Avenue, SE., Washington, DC, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

If you wish to receive confirmation of receipt of your written comments, please include a self-addressed, stamped postcard with the following statement: "Comments on PHMSA–2009–0203." The Docket Clerk date stamps the postcard prior to returning it to you via the U.S. mail. Please note that due to delays in the delivery of U.S. mail to Federal offices in Washington, DC, we recommend that persons consider an alternative method (internet, fax, or professional delivery service) of submitting comments to the docket and ensuring their timely receipt at DOT.

Privacy Act Statement

Anyone may search the electronic form of comments received in response to any of our dockets by the name of the individual submitting the comment (or signing the comment, if submitted on behalf of an association, business, labor union, etc.). DOT's complete Privacy Act Statement was published in the **Federal Register** on April 11, 2000 (65 FR 19477).

Information on Services for Individuals With Disabilities

For information on facilities or services for individuals with disabilities, or to seek special assistance at the meetings, please contact Cheryl Whetsel at 202–366–4431 by August 16, 2010.

II. Committee Background

These two statutorily-mandated committees advise PHMSA on proposed safety standards, risk assessments, and safety policies for natural gas pipelines and for hazardous liquid pipelines. Both committees fall under the Federal Advisory Committee Act (Pub. L. 92–463, 5 U.S.C. App. 1) and both are mandated by the pipeline safety law (49 U.S.C. Chap. 601). Each committee consists of 15 members—with membership evenly divided among the Federal and State Government, the regulated industry, and the public. The committees advise PHMSA on technical feasibility, practicability, and cost-effectiveness of each proposed pipeline safety standard.

III. Preliminary Agenda

The PHMSA staff will brief the committees on several regulatory and policy initiatives including:

- Pipeline safety reauthorization.
- PHMSA accomplishments (National Transportation Safety Board, General Accounting Office, Congressional mandates).
- PHMSA priorities (new construction, damage prevention), and the status of PHMSA rulemaking initiatives.
- Administrative matters of the committee (charter, how we can best conduct business).

Authority: 49 U.S.C. 60102, 60115; 60118.

Issued in Washington, DC, on July 27, 2010.

Jeffrey D. Wiese,

Associate Administrator for Pipeline Safety.

[FR Doc. 2010–19063 Filed 8–2–10; 8:45 am]

BILLING CODE 4910–60–P

DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

50 CFR Part 17

[Docket No. FWS-R4-ES-2010-0003]
[MO 92210-0-0009-B4]

RIN 1018-AW55

Endangered and Threatened Wildlife and Plants; Designation of Critical Habitat for *Carex lutea* (Golden Sedge)

AGENCY: Fish and Wildlife Service, Interior.

ACTION: Revised proposed rule; reopening of comment period.

SUMMARY: We, the U.S. Fish and Wildlife Service (Service), announce the reopening of the comment period on our March 10, 2010 (75 FR 11080), proposed rule to designate critical habitat for *Carex lutea* (golden sedge) under the Endangered Species Act of 1973, as amended (Act). We also announce the availability of the draft economic analysis (DEA) associated with the proposed rule. In addition, in this document, we propose to enlarge two previously proposed subunits of critical habitat because we discovered that *Carex lutea* occupies an area at these two subunits that is greater than what we believed when we were preparing the March 10, 2010 proposed rule. We are reopening the comment period on the proposal for an additional 30 days to allow interested parties an opportunity to comment simultaneously on the revised proposed critical habitat designation, the associated DEA, and our amended required determinations section. Comments previously submitted need not be resubmitted and will be fully considered in preparation of the final rule.

DATES: We will consider public comments received or postmarked on or before September 2, 2010. Please note that if you are using the *Federal eRulemaking Portal* (see **ADDRESSES** section, below) the deadline for submitting an electronic comment is 11:59 p.m. Eastern Daylight Savings Time on this date.

ADDRESSES: You may submit comments by one of the following methods:

- Federal eRulemaking Portal: *http://www.regulations.gov*. Follow the instructions for submitting comments to Docket No. FWS-R4-ES-2010-0003.
- *U.S. mail or hand-delivery:* Public Comments Processing, Attn: FWS-R4-ES-2010-0003; Division of Policy and Directives Management; U.S. Fish and Wildlife Service; 4401 N. Fairfax Drive, Suite 222; Arlington, VA 22203.

We will post all comments on *http://www.regulations.gov*. This generally means that we will post any personal information you provide us (see the Public Comments section below for more information).

FOR FURTHER INFORMATION CONTACT: Pete Benjamin, Field Supervisor, U.S. Fish and Wildlife Service, Raleigh Fish and Wildlife Office, P.O. Box 33726, Raleigh, NC 27636-3726; by telephone 919-856-4520; or by facsimile 919-856-4556. Persons who use a telecommunications device for the deaf (TDD) may call the Federal Information Relay Service (FIRS) at 800-877-8339.

SUPPLEMENTARY INFORMATION:

Public Comments

We will accept written comments and information during this reopened comment period on the proposed designation of critical habitat for *Carex lutea* that we published in the **Federal Register** on March 10, 2010 (75 FR 11080), the two expanded subunits proposed as critical habitat and our amended required determinations section provided in this document, and the draft economic analysis (DEA) of the proposed designation of critical habitat for *Carex lutea.* We will consider information and recommendations from all interested parties. We are particularly interested in comments concerning:

(1) The reasons why we should or should not designate areas as "critical habitat" under section 4 of the Act (16 U.S.C. 1531 *et seq.*), including whether there are threats to *Carex lutea* from human activity, the degree of which can be expected to increase due to the designation, and whether the benefit of designation would outweigh threats to the species caused by the designation, such that the designation of critical habitat is prudent.

(2) Specific information on:

- The amount and distribution of *Carex lutea*;
- What areas containing features essential to the conservation of the species should be included in the designation and why;
- Special management considerations or protections for the physical and biological features essential to *Carex lutea* conservation that have been identified in the proposed rule that may be needed, including managing for the potential effects of climate change; and
- What areas not currently occupied by the species are essential to the conservation of the species and why.

(3) Specific information on *Carex lutea* and the habitat components (physical and biological features) essential to the conservation of this species.

(4) Any information on the biological or ecological requirements of this species.

(5) Land-use designations and current or planned activities in areas occupied by the species, and their possible impacts on the species and the proposed critical habitat.

(6) Any foreseeable economic, national security, or other potential impacts resulting from the proposed designation and, in particular, any impacts on small entities and the benefits of including or excluding areas that are subject to these impacts.

(7) Whether the benefits of excluding any particular area from critical habitat outweigh the benefits of including that area as critical habitat under section 4(b)(2) of the Act, after considering the potential impacts and benefits of the proposed critical habitat designation.

(8) Whether our approach to designating critical habitat could be improved or modified in any way to provide for greater public participation and understanding, or to assist us in accommodating public concerns and comments.

(9) Information on the extent to which the description of potential economic impacts in the DEA is complete and accurate.

You may submit your comments and materials concerning the proposed rule, this document, or the DEA by one of the methods listed in the **ADDRESSES** section.

If you submitted comments or information on the proposed critical habitat rule for *Carex lutea* that we

published on March 10, 2010 (75 FR 11080), you do not have to resubmit them. Your comments are included in the public record for this rulemaking, and we will fully consider them in the preparation of our final determination.

If you submit a comment via *http://www.regulations.gov*, your entire comment—including your personal identifying information—will be posted on the website. We will post all hardcopy comments on *http://www.regulations.gov* as well. If you submit a hardcopy comment that includes personal identifying information, you may request at the top of your document that we withhold this information from public review. However, we cannot guarantee that we will be able to do so. Please include sufficient information with your comments to allow us to verify any scientific or commercial information you include.

Comments and materials we receive, as well as supporting documentation used in preparing the proposed rule and DEA, will be available for public inspection on *http://www.regulations.gov*, or by appointment, during normal business hours, at the U.S. Fish and Wildlife Service's Raleigh Fish and Wildlife Office (see **FOR FURTHER INFORMATION CONTACT**). You may obtain copies of the proposed rule and the DEA on the Internet at *http://www.regulations.gov* at Docket Number: FWS-R4-ES-2010-0003, or by mail from the Raleigh Fish and Wildlife Office (see **FOR FURTHER INFORMATION CONTACT**).

Background

Species Information

Carex lutea is a perennial member of the sedge family (Cyperaceae). The species is endemic to the Black River section of the Coastal Plain Province of North Carolina. The North Carolina Natural Heritage Program (NCNHP) recognizes eight populations, all within a 16-by-5-mile (26-by-8-kilometer) area, extending southwest from the community of Maple Hill.

Carex lutea occurs in the Pine Savanna (Very Wet Clay Variant) natural community type characterized by an open to sparse canopy dominated by pond pine (*Pinus serotina*), and usually with some longleaf pine (*P. palustris*) and pond cypress (*Taxodium ascendens*).

Carex lutea is threatened by fire suppression; habitat alteration, such as land conversion for residential, commercial, or industrial development; mining; drainage for silviculture and agriculture; highway expansion; and herbicide use along utility and highway rights-of-way.

Previous Federal Actions

We listed *Carex lutea* as an endangered species on January 23, 2002 (67 FR 3120). We found that the designation of critical habitat was not prudent in the proposed listing rule (64 FR 44470, August 16, 1999). Upon reconsideration, we found that a critical habitat designation was prudent in the final listing rule (67 FR 3120, January 23, 2002); however, at that time, we deferred proposal of critical habitat due to budgetary and workload constraints.

On December 19, 2007, the Center for Biological Diversity filed a complaint for declaratory and injunctive relief challenging the Service's continuing failure to timely designate critical habitat for this species as well as three other plant species (*Center for Biological Diversity* v. *Kempthorne*, C-04-3240 JL (N. D. Cal.)). In a settlement agreement dated April 11, 2008, the Service agreed to submit for publication in the **Federal Register** a proposed designation of critical habitat, if prudent and determinable, on or before February 28, 2010, and a final determination by February 28, 2011. The Service determined that critical habitat was prudent for *Carex lutea* and published a proposed critical habitat designation on March 10, 2010 (75 FR 11080).

In total, approximately 189 acres (ac) (76 hectares (ha)) of land in Onslow and Pender Counties, North Carolina, fall within the areas that we proposed as critical habitat for this species on March 10, 2010.

Proposed Critical Habitat Designation—Amended

Additional field surveys at two extant *Carex lutea* subpopulations indicate that the extent of the golden sedge at those sites is actually greater than what was originally believed (Suiter 2010, pers. obs.). These two areas contain all of the primary consitutent elements that were identified in our previously published critical habitat designation for *Carex lutea*. Therefore, we propose the following changes to units 5 and 8.

Proposed Changes to Unit 5, Onslow County, North Carolina

Additional *Carex lutea* plants were found on the north side of the private sand road immediately adjacent to the area previously defined as subunit 5D (Sandy Run Savannas) in Onslow County, North Carolina. Due to their close proximity to each other, these plants are considered an extension of the subpopulation at subunit 5D. Although not discovered until 2010, it is extremely likely that this subpopulation was present at the time of listing. The area where the additional plants were found has been fire suppressed for several years, and it is believed that recent prescribed fires in the winter of 2010 opened this area to sunlight, allowing the *Carex lutea* plants to flourish. The fire also removed some thick, woody vegetation and allowed easy access for Service biologists to conduct surveys. This remnant pine savanna contains all of the primary constituent elements (PCEs) identified for *Carex lutea*.

Excluding the roadbed, subunit 5D, which was 0.3 ac (0.1 ha) in our March 10, 2010, proposed rule (75 FR 11080), would increase by 4.6 ac (1.9 ha) to a total of 4.9 ac (2.0 ha) in size. Based on this new information and the adjustment to our previously proposed critical habitat areas, Unit 5, all of which is owned by the N.C. Division of Parks and Recreation and managed as the Sandy Run Savannas State Natural Area, would increase from 20.6 ac (8.3 ha) to 25.2 ac (10.2 ha) of proposed critical habitat.

Proposed Changes to Unit 8, Pender County, North Carolina

The area we identified in our March 10, 2010, proposed rule (75 FR 11080), as subunit 8C (McLean Savanna) in Pender County, North Carolina, is owned by The Nature Conservancy (TNC) and a private company; however, TNC anticipates acquiring the privately owned section in the next 12 months. The *Carex lutea* plants in subunit 8C occupy an area larger than what was originally known (Suiter 2010, pers. obs.). Based on what we know about the biology of the species, we believe that the additional plants have been present for many years, but they were not discovered until May 2010, when the Service first thoroughly surveyed the site. Accordingly, the Service has expanded the area of proposed subunit 8C from 1.6 ac (0.6 ha) to 9.8 ac (4.0 ha), for an increase of 8.2 ac (3.3 ha). The revised proposed critical habitat area contains all of the PCEs identified for *Carex lutea*. Unit 8 would increase from 44.4 ac (17.9 ha) to 52.6 ac (21.3 ha) of proposed critical habitat.

With the inclusion of these additional areas, the Service is now proposing 8 units (21 subunits) totaling approximately 201.8 ac (81.7 ha) in Onslow and Pender Counties, North Carolina, as critical habitat for *Carex lutea*.

Section 3 of the Act defines critical habitat as the specific areas within the geographical area occupied by a species, at the time it is listed in accordance

with the Act, on which are found those physical or biological features essential to the conservation of the species and that may require special management considerations or protection, and specific areas outside the geographical area occupied by a species at the time it is listed, upon a determination that such areas are essential for the conservation of the species. If the proposed rule is made final, section 7 of the Act will prohibit destruction or adverse modification of critical habitat by any activity funded, authorized, or carried out by any Federal agency. Federal agencies proposing actions affecting critical habitat are required to consult with us on the effects of their proposed actions, under section 7(a)(2) of the Act.

Possible Exclusions from Critical Habitat and Draft Economic Analysis

Section 4(b)(2) of the Act requires that we designate critical habitat based upon the best scientific data available, after taking into consideration the economic impact, impact on national security, or any other relevant impact of specifying any particular area as critical habitat. We may exclude an area from critical habitat if we determine that the benefits of excluding the area outweigh the benefits of including the area as critical habitat, provided such exclusion will not result in the extinction of the species. We have not proposed to exclude any areas from critical habitat for *Carex lutea*. However, the final decision on whether to exclude any areas will be based on the best scientific data available at the time of the final designation, including information obtained during the comment period and information about the economic impact of designation. Accordingly, we have prepared a DEA concerning the proposed critical habitat designation, which is available for review and comment (see **ADDRESSES**).

The intent of the DEA is to identify and analyze the potential economic impacts associated with the proposed critical habitat designation for *Carex lutea* that we published in the **Federal Register** on March 10, 2010 (75 FR 11080) and the two additional areas proposed in this document. The DEA quantifies the economic impacts of all potential conservation efforts for *Carex lutea*, some of which will likely be incurred whether or not we designate critical habitat. The economic impact of the proposed critical habitat designation is analyzed by comparing scenarios both "with critical habitat" and "without critical habitat." The "without critical habitat" scenario represents the baseline for the analysis, considering protections already in place for the species (e.g., under the Federal listing and other Federal, State, and local regulations). The baseline, therefore, represents the costs incurred regardless of whether we designate critical habitat. The "with critical habitat" scenario describes the incremental impacts associated specifically with the designation of critical habitat for the species. The incremental conservation efforts and associated impacts are those not expected to occur absent the designation of critical habitat for the species. In other words, the incremental costs are those attributable solely to the designation of critical habitat, above and beyond the baseline costs; these are the costs we may consider in the final designation of critical habitat when evaluating the benefits of excluding particular areas under section 4(b)(2) of the Act. The analysis forecasts both baseline and incremental impacts likely to occur if we finalize the proposed designation of critical habitat.

The DEA describes economic impacts of *Carex lutea* conservation efforts associated with the following categories of activity: (1) Residential development, (2) silviculture activities, and (3) transportation and utilities projects. The DEA estimates that no economic impacts are likely to result from the designation of critical habitat for *Carex lutea*. This determination is based on the fact that more than 80 percent of the proposed critical habitat is already subject to conservation measures that benefit the plant. Economic impacts are unlikely in the remaining 20 percent, given the limited potential for future economic activity and the low probability of a Federal nexus that would require consultation with the Service.

The DEA also discusses the potential benefits associated with the designation of critical habitat. The primary intended benefit of critical habitat is to support the conservation of endangered and threatened species, such as *Carex lutea*. Quantification and monetization of species conservation benefits requires information on the incremental change in the probability of *Carex lutea* conservation that is expected to result from the designation. As described in the DEA, modifications to future projects are unlikely given the extensive baseline protections already provided to *Carex lutea* habitat and the lack of anticipated economic activity and a Federal nexus on privately-owned, unprotected parcels.

Required Determinations—Amended

In our March 10, 2010, proposed rule (75 FR 11080), we indicated that we would defer our determination of compliance with several statutes and Executive Orders until the information concerning potential economic impacts of the designation and potential effects on landowners and stakeholders became available in the DEA. We have now made use of the DEA data in making this determination. In this document, we affirm the information in our proposed rule concerning: *Regulatory Planning and Review* (E.O. 12866), E.O. 12630 (Takings), Executive Order (E.O.) 13132 (Federalism), E.O. 12988 (Civil Justice Reform), the Paperwork Reduction Act, the National Environmental Policy Act, and the President's memorandum of April 29, 1994, "Government-to-Government Relations with Native American Tribal Governments" (59 FR 22951). However, based on the DEA data, we are updating our required determinations concerning the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*), the Unfunded Mandates Reform Act (2 U.S.C. 1501 *et seq.*), and E.O. 13211 (Energy Supply, Distribution, or Use).

Regulatory Flexibility Act (5 U.S.C. 601 et seq.)

Under the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*, as amended by the Small Business Regulatory Enforcement Fairness Act (SBREFA) of 1996), whenever an agency is required to publish a notice of rulemaking for any proposed or final rule, it must prepare and make available for public comment a regulatory flexibility analysis that describes the effect of the rule on small entities (i.e., small businesses, small organizations, and small government jurisdictions), as described below. However, no regulatory flexibility analysis is required if the head of an agency certifies the rule will not have a significant economic impact on a substantial number of small entities. Based on the DEA of the proposed designation, we provide our analysis for determining whether the proposed rule would result in a significant economic impact on a substantial number of small entities. Based on comments we receive, we may revise this determination as part of a final rulemaking.

According to the Small Business Administration, small entities include small organizations, such as independent nonprofit organizations; small governmental jurisdictions, including school boards and city and town governments that serve fewer than 50,000 residents; and small businesses (13 CFR 121.201). Small businesses include manufacturing and mining concerns with fewer than 500 employees, wholesale trade entities

with fewer than 100 employees, retail and service businesses with less than $5 million in annual sales, general and heavy construction businesses with less than $27.5 million in annual business, special trade contractors doing less than $11.5 million in annual business, and agricultural businesses with annual sales less than $750,000. To determine if potential economic impacts to these small entities are significant, we considered the types of activities that might trigger regulatory impacts under this designation as well as types of project modifications that may result. In general, the term significant economic impact is meant to apply to a typical small business firm's business operations.

To determine if the proposed designation of critical habitat for *Carex lutea* would affect a substantial number of small entities, we considered the number of small entities affected within particular types of economic activities, such as residential and commercial development. In order to determine whether it is appropriate for our agency to certify that this rule would not have a significant economic impact on a substantial number of small entities, we considered each industry or category individually. In estimating the numbers of small entities potentially affected, we also considered whether their activities have any Federal involvement. Critical habitat designation will not affect activities that do not have any Federal involvement; designation of critical habitat only affects activities conducted, funded, permitted, or authorized by Federal agencies.

If we finalize this proposed critical habitat designation, Federal agencies must consult with us under section 7 of the Act if their activities may affect designated critical habitat. In areas where *Carex lutea* is present, Federal agencies would also be required to consult with us under section 7 of the Act, due to the endangered status of the species. Consultations to avoid the destruction or adverse modification of critical habitat would be incorporated into the same consultation process.

In the DEA, we evaluated the potential economic effects on small entities resulting from implementation of conservation actions related to the proposed designation of critical habitat for *Carex lutea*. The DEA estimates that no economic impacts are likely to result from the designation of critical habitat for *Carex lutea*. This determination is based on the fact that more than 80 percent of the proposed critical habitat is already subject to conservation measures that benefit the plant. Economic impacts are unlikely in the remaining 20 percent, given the limited potential for future economic activity and the low probability of a Federal nexus that would require consultation with the Service. Based on that analysis, no impacts to small entities are expected as a result of the proposed critical habitat designation. Please refer to Appendix A of the DEA of the proposed critical habitat designation for a more detailed discussion of our analysis.

In summary, we have considered whether the proposed designation would result in a significant economic impact on a substantial number of small entities. Information for this analysis was gathered from the Small Business Administration, stakeholders, and the Service. For the reasons discussed above, and based on currently available information, we certify that if promulgated, the proposed designation would not have a significant economic impact on a substantial number of small business entities. Therefore, an initial regulatory flexibility analysis is not required.

Unfunded Mandates Reform Act (2 U.S.C. 1501 et seq.)

In accordance with the Unfunded Mandates Reform Act (2 U.S.C. 1501 *et seq.*), we make the following findings:

(a) This revised rule would not produce a Federal mandate. In general, a Federal mandate is a provision in legislation, statute, or regulation that would impose an enforceable duty upon State, local, or Tribal governments, or the private sector, and includes both "Federal intergovernmental mandates" and "Federal private sector mandates." These terms are defined in 2 U.S.C. 658(5)-(7). "Federal intergovernmental mandate" includes a regulation that "would impose an enforceable duty upon State, local, or Tribal governments" with two exceptions. It excludes "a condition of Federal assistance." It also excludes "a duty arising from participation in a voluntary Federal program," unless the regulation "relates to a then-existing Federal program under which $500,000,000 or more is provided annually to State, local, and Tribal governments under entitlement authority," if the provision would "increase the stringency of conditions of assistance" or "place caps upon, or otherwise decrease, the Federal Government's responsibility to provide funding," and the State, local, or Tribal governments "lack authority" to adjust accordingly. At the time of enactment, these entitlement programs were: Medicaid; Aid to Families with Dependent Children work programs; Child Nutrition; Food Stamps; Social Services Block Grants; Vocational Rehabilitation State Grants; Foster Care, Adoption Assistance, and Independent Living; Family Support Welfare Services; and Child Support Enforcement. "Federal private sector mandate" includes a regulation that "would impose an enforceable duty upon the private sector, except (i) a condition of Federal assistance or (ii) a duty arising from participation in a voluntary Federal program."

The designation of critical habitat does not impose a legally binding duty on non-Federal government entities or private parties. Under the Act, the only regulatory effect is that Federal agencies must ensure that their actions do not jeopardize the continued existence of the species, or destroy or adversely modify critical habitat under section 7. While non-Federal entities that receive Federal funding, assistance, or permits, or that otherwise require approval or authorization from a Federal agency for an action, may be indirectly impacted by the designation of critical habitat, the legally binding duty to avoid destruction or adverse modification of critical habitat rests squarely on the Federal agency. Furthermore, to the extent that non-Federal entities are indirectly impacted because they receive Federal assistance or participate in a voluntary Federal aid program, the Unfunded Mandates Reform Act would not apply; nor would critical habitat shift the costs of the large entitlement programs listed above onto State governments.

(b) As discussed in the DEA of the proposed designation of critical habitat for *Carex lutea*, we do not believe that this rule would significantly or uniquely affect small governments because it would not produce a federal mandate of $100 million or greater in any year; that is, it is not a "significant regulatory action" under the Unfunded Mandates Refrom Act . The lands being proposed for critical habitat designation are owned by private individuals, The Nature Conservancy and the State of North Carolina (Division of Parks and Recreation, Department of Transportation and Wildlife Resources Commission). None of these government entities fit the definition of "small governmental jurisdiction." The DEA also identified no cost resulting from the critical habitat designation. Because no incremental costs are anticipated, no small entities are expected to be affected by the rule. Therefore, a Small Government Agency Plan is not required.

Energy Supply, Distribution, or Use

On May 18, 2001, the President issued an Executive Order (E.O. 13211; Actions Concerning Regulations That Significantly Affect Energy Supply, Distribution, or Use) on regulations that significantly affect energy supply, distribution, and use. E.O. 13211 requires agencies to prepare Statements of Energy Effects when undertaking certain actions. The OMB's guidance for implementing this Executive Order outlines nine outcomes that may constitute "a significant adverse effect" when compared to no regulatory action. As discussed in Appendix A, the DEA finds that none of these criteria are relevant to this analysis. The DEA concludes that since no modifications are anticipated to result from the designation of critical habitat, energy-related impacts are not expected. Since no incremental impacts are forecast associated specifically with this rulemaking on the production, distribution, or use of energy, designation of critical habitat for *Carex lueta* is not expected to lead to any adverse outcomes (such as a reduction in electricity production or an increase in the cost of energy production or distribution). A Statement of Energy Effects is not required.

Authors

The primary authors of this document are the staff members of the Raleigh Fish and Wildlife Office (see **FOR FURTHER INFORMATION CONTACT**).

List of Subjects in 50 CFR Part 17

Endangered and threatened species, Exports, Imports, Reporting and recordkeeping requirements, Transportation

Proposed Regulation Promulgation

Accordingly, we propose to further amend part 17, subchapter B of chapter I, title 50 of the Code of Federal Regulations, as proposed to be amended at 75 FR 11080 (March 10, 2010), as follows:

PART 17—[AMENDED]

1. The authority citation for part 17 continues to read as follows:

Authority: 16 U.S.C. 1361-1407; 16 U.S.C. 1531-1544; 16 U.S.C. 4201-4245; Pub. L. 99-625, 100 Stat. 3500; unless otherwise noted.

2. Critical habitat for *Carex lutea* (golden sedge) in § 17.96, which was proposed to be added to paragraph (a) on March 10, 2010, at 75 FR 11080, is proposed to be amended by revising the maps in paragraphs (5), (10)(vi), and (13)(iv), to read as follows:

§ 17.96 Critical habitat—plants.

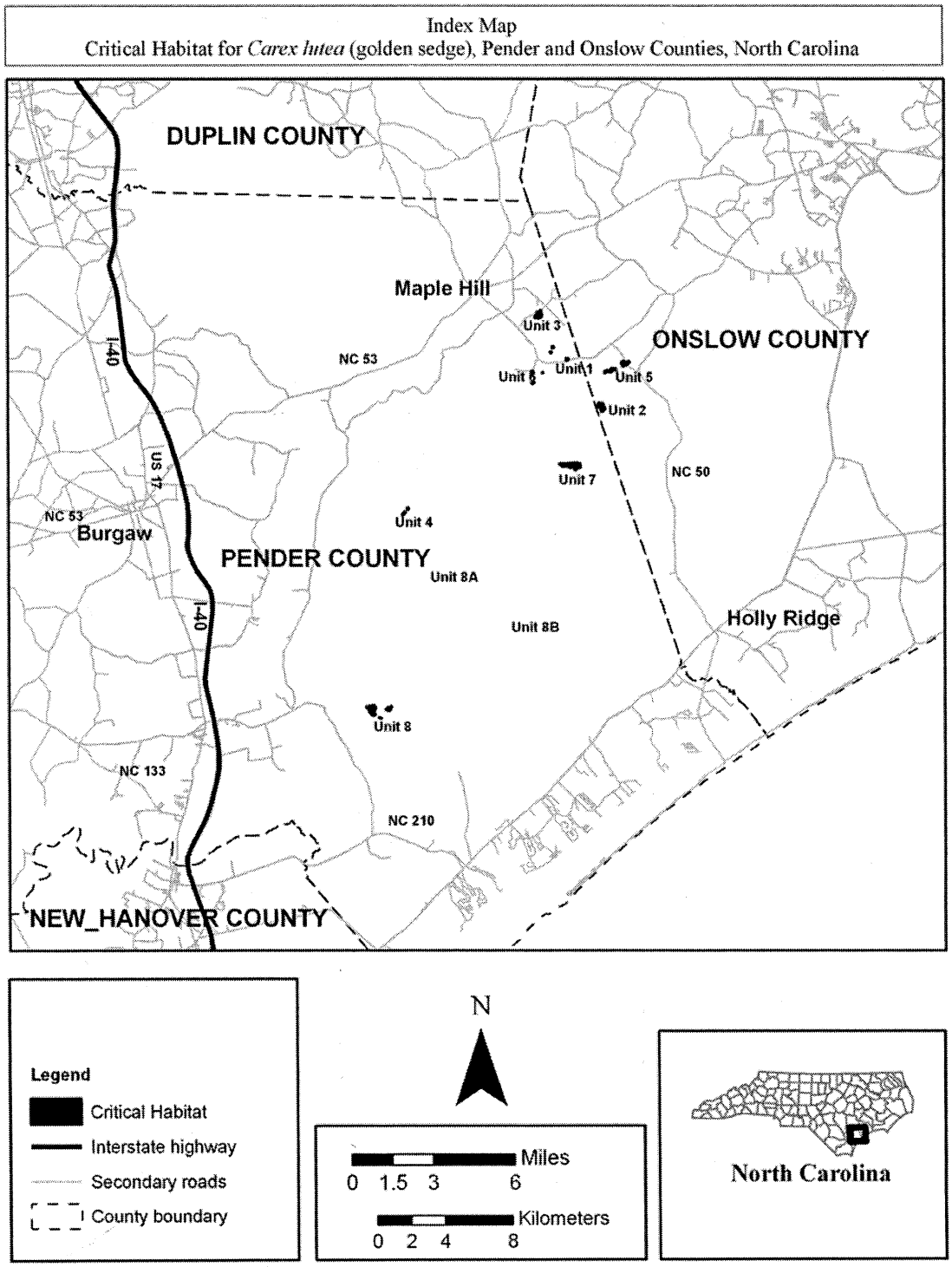
(a) Flowering plants.

* * * * *

Family Cyperaceae: *Carex lutea* (golden sedge)

* * * * *

(5) **Note:** Index Map (Map 1) follows:

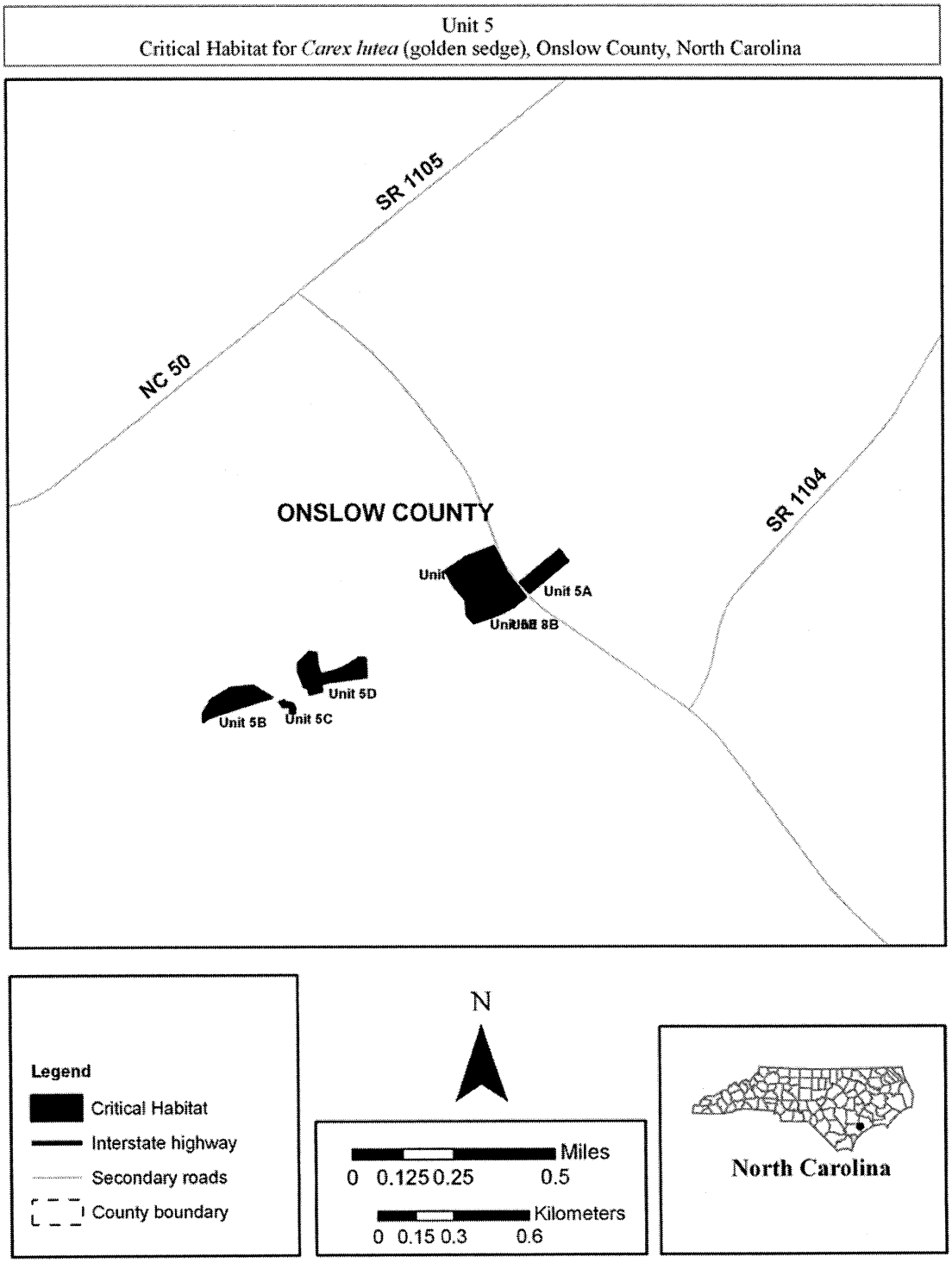


* * * * *

(10) * * *

* * * * *

(vi) Map of Unit 5 (Sandy Run Savannas) follows:



* * * * *

(13) * * *

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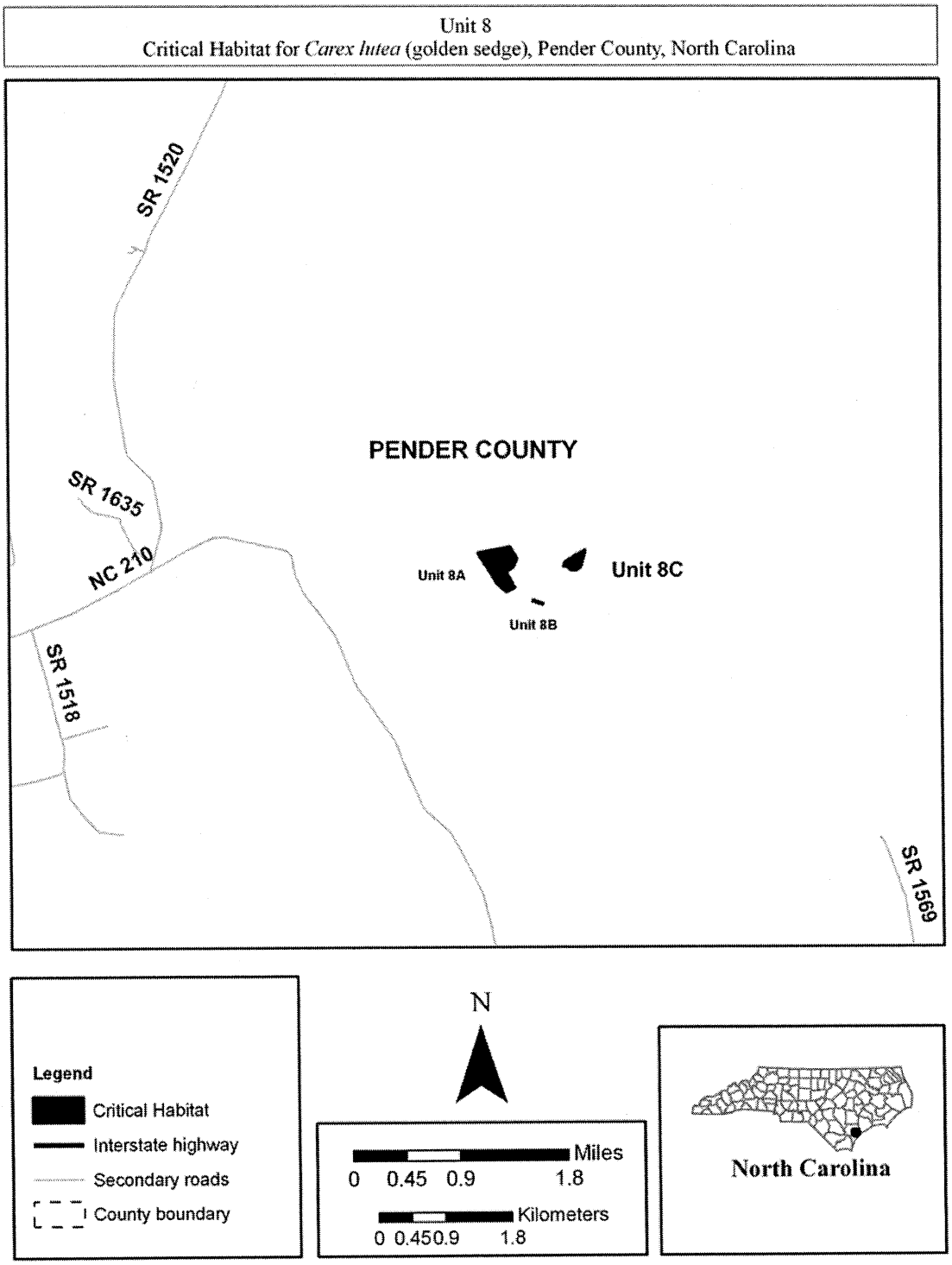
(iv) Map of Unit 8 (McLean Savanna) follows:



* * * * *

Dated: July 20, 2010

Thomas L. Strickland

Assistant Secretary for Fish and Wildlife and Parks

[FR Doc. 2010–18760 Filed 8–2–10; 8:45 am]

BILLING CODE 4310–55–S

Notices

Federal Register
Vol. 75, No. 148
Tuesday, August 3, 2010

This section of the FEDERAL REGISTER contains documents other than rules or proposed rules that are applicable to the public. Notices of hearings and investigations, committee meetings, agency decisions and rulings, delegations of authority, filing of petitions and applications and agency statements of organization and functions are examples of documents appearing in this section.

AFRICAN DEVELOPMENT FOUNDATION

African Development Foundation, Board of Directors Meeting

TIME: Tuesday, August 17, 2010, 8:30 a.m. to 1 p.m.

PLACE: African Development Foundation, Conference Room, 1400 I Street, NW., Suite 1000, Washington, DC 20005.

DATE: Tuesday, January 26, 2010.

STATUS: 1. Open session, Tuesday, January 26, 2010, 8:30 a.m. to 12 a.m.; and

2. Closed session, Tuesday, January 26, 2010, 12 p.m. to 1 p.m.

Due to security requirements and limited seating, all individuals wishing to attend the open session of the meeting must notify Michele M. Rivard at (202) 673–3916 or *mrivard@usadf.gov* of your request to attend by 5 p.m. on Thursday, August 12, 2010.

Doris Martin,

General Counsel, USADF.

[FR Doc. 2010–19005 Filed 8–2–10; 8:45 am]

BILLING CODE P

DEPARTMENT OF AGRICULTURE

Farm Service Agency

Information Collection: Emergency Conservation Program

AGENCY: Farm Service Agency, USDA.

ACTION: Notice; request for comments.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995, the Farm Service Agency (FSA) is seeking comments from all interested individuals and organizations on an extension with revision of currently approved information collection associated with the Emergency Conservation Program (ECP). To assist with the modernization of ECP, new forms, which allow for multiple practices and multiple farms and tracts, will be used in lieu of the AD–245 for application processed through the new web-based software.

DATES: We will consider comments that we receive by October 4, 2010. We will consider comments submitted after this date to extent possible.

ADDRESSES: We invite you to submit comments on this Notice. In your comment, include the volume, date, and page number of this issue of the **Federal Register**. You may submit comments by any of the following methods:

E-Mail: Send comments to: *Katina.Hanson@wdc.usda.gov.*

Fax: (202) 720–4619.

Mail: Katina Hanson, ECP Program Manager, Conservation and Environmental Programs Division, Farm Service Agency, United States Department of Agriculture, STOP 0513, 1400 Independence Avenue, SW., Washington, DC 20250–0513.

Comments also should be sent to the Desk Officer for Agriculture, Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, DC 20503.

FOR FURTHER INFORMATION CONTACT: Katina Hanson, ECP Program Manager, (202) 720–0062.

SUPPLEMENTARY INFORMATION:

Description of Information Collection

Title: Emergency Conservation Program.

OMB Control Number: 0560–0082.

Expiration Date: January 31, 2011.

Type of Request: Extension and Revision of a Currently Approved Information Collection.

Abstract: This information collection is to allow FSA to effectively administer the regulations under the ECP. The regulations at 7 CFR part 701 set forth basic policies, program provisions, and eligibility requirements for owners and operators to enter into agreement with, to apply for financial and technical assistance and for receiving cost-share payments under the ECP. The revision to the currently approved information collection is in response to the need to continue to service ECP customers and more efficiently collect information on cost-share requests, agreements, and performance by modernizing the ECP forms and software processes.

Estimate of Burden: Public reporting burden for this collection of information is estimated to average .3 hours (19 minutes) per response. The average travel time, which is included in the total annual burden, is estimated to be 1 hour per respondent.

Respondents: Owners, operators and other eligible agricultural producers on eligible farmland.

Number of Respondents: 40,000.

Estimated Number of Responses per Respondent: 1.

Estimated Annual Number of Respondents: 40,000.

Estimated Total Annual Burden Hours: 51,263.

We are requesting comments on all aspects of this information collection, and to help us to:

(1) Evaluate whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;

(2) Evaluate the accuracy of the agency's estimate of burden including the validity of the methodology and assumptions used;

(3) Enhance the quality, utility and clarity of the information to be collected;

(4) Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology.

All comments received in response to this notice, including names and addresses when provided, will be a matter of public record. Comments will be summarized and included in the submission for Office of Management and Budget approval.

Signed at Washington, DC, on July 27, 2010.

Jonathan W. Coppess,

Administrator, Farm Service Agency.

[FR Doc. 2010–19045 Filed 8–2–10; 8:45 am]

BILLING CODE 3410–05–P

DEPARTMENT OF AGRICULTURE

Farm Service Agency

Information Collection; Customer Data Worksheet Request for Service Center Information Management System (SCIMS) Record Changes

AGENCY: Farm Service Agency, USDA.

ACTION: Notice and request for comments.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995, the Farm Service Agency (FSA) is requesting comments from all interested individuals and organizations on an extension of a currently approved information collection to support Customer Data Worksheet Request for Service Center Information Management System (SCIMS) that contains the producer's personal information. Specifically, FSA is requesting comment on the form AD–2047, "Customer Data Worksheet Request for SCIMS Record Change." FSA is using the collected information in support of documenting critical producer data changes (customer name, current mailing address and tax identification number) in SCIMS made at the request of the producer to correct or update their information. The collection of critical producer data are being used to update existing producer record data and document when and who initiates and changes the record in SCIMS.

DATES: We will consider comments that we receive by October 4, 2010.

ADDRESSES: We invite you to submit comments on this notice. In your comments, include date, volume, and page number of this issue of the **Federal Register**. You may submit comments by any of the following methods:

- *Mail:* Mike Sienkiewicz, Agricultural Program Specialist, USDA, FSA, STOP 0517, 1400 Independence Avenue, SW., Washington, DC 20250–0517.
- *E-mail: mike.sienkiewicz@wdc.usda.gov.*
- *Fax:* 202–720–0051.

You may also send comments to the Desk Officer for Agriculture, Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, DC 20503.

SUPPLEMENTARY INFORMATION:

Title: Customer Data Worksheet Request for SCIMS Record Changes.

OMB Control Number: 0560–0265.

Type of Request: Extension of currently approved information collection.

Abstract: The information collection is necessary to effectively monitor critical producer data changes made in the SCIMS at the request of the producer to correct or update their information. The form of AD–2047, "Customer Data Worksheet Request for SCIMS Record Change", is used to collect the information from the producers to make changes to the information in SCIMS. The necessity to monitor critical producer data changes in the SCIMS database is a direct result of the OMB Circular A–123 Remediation/Corrective Action Plan for County Office Operations which requires effective internal controls to be in place for Federal programs. The FSA team was established and reviewed and documented key controls related to all material producer accounts. FSA also included the analysis on a review of the SCIMS.

Estimated Average Time to Respond: Public reporting burden for collection of this information is estimated to average .17 hours per response. The average travel time, which is included in the total annual burden, is estimated to be 1 hour per respondent.

Type of Respondents: FSA, NRCS, and RD customers currently residing in SCIMS.

Estimated Number of Respondents: 45,000.

Estimated Number of Responses per Respondent: 1.15.

Estimated Annual Number of Responses: 45,000.

Estimated Total Annual Burden Hours: 8,798.

We are requesting comments on all aspects of this information collection and to help us to:

(1) Evaluate whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;

(2) Evaluate the accuracy of the agency's estimate of burden, including the validity of the methodology and assumptions used;

(3) Enhance the quality, utility and clarity of the information to be collected; and

(4) Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology.

All comments received in response to this notice, including names and addresses when provided, will be a matter of public record. Comments will be summarized and included in the submission for Office of Management and Budget approval.

Signed at Washington, DC, on July 27, 2010.

Jonathan W. Coppess,

Administrator, Farm Service Agency.

[FR Doc. 2010–19047 Filed 8–2–10; 8:45 am]

BILLING CODE 3410–05–P

DEPARTMENT OF AGRICULTURE

Animal and Plant Health Inspection Service

[Docket No. APHIS-2010-0064]

Notice of Request for Extension of Approval of an Information Collection; Emerald Ash Borer; Host Material from Canada

AGENCY: Animal and Plant Health Inspection Service, USDA.

ACTION: Extension of approval of an information collection; comment request.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995, this notice announces the Animal and Plant Health Inspection Service's intention to request extension of approval of an information collection associated with regulations for the importation of certain articles from Canada to prevent the introduction and spread of emerald ash borer in the United States.

DATES: We will consider all comments that we receive on or before October 4, 2010.

ADDRESSES: You may submit comments by either of the following methods:

- Federal eRulemaking Portal: Go to (*http://www.regulations.gov/fdmspublic/component/main?main=DocketDetail&d=APHIS-2010-0064*) to submit or view comments and to view supporting and related materials available electronically.
- Postal Mail/Commercial Delivery: Please send one copy of your comment to Docket No. APHIS-2010-0064, Regulatory Analysis and Development, PPD, APHIS, Station 3A-03.8, 4700 River Road Unit 118, Riverdale, MD 20737-1238. Please state that your comment refers to Docket No. APHIS-2010-0064.

Reading Room: You may read any comments that we receive on this docket in our reading room. The reading room is located in room 1141 of the USDA South Building, 14th Street and Independence Avenue SW., Washington, DC. Normal reading room hours are 8 a.m. to 4:30 p.m., Monday through Friday, except holidays. To be sure someone is there to help you, please call (202) 690-2817 before coming.

Other Information: Additional information about APHIS and its programs is available on the Internet at (*http://www.aphis.usda.gov*).

FOR FURTHER INFORMATION CONTACT: For information on regulations for the importation of certain articles from Canada to prevent the introduction and

spread of emerald ash borer in the United States, contact Mr. David Lamb, Import Specialist, Regulations, Permits, and Manuals, PPQ, APHIS, 4700 River Road Unit 133, Riverdale, MD 20737; (301) 734-0627. For copies of more detailed information on the information collection, contact Mrs. Celeste Sickles, APHIS' Information Collection Coordinator, at (301) 851-2908.

SUPPLEMENTARY INFORMATION:

Title: Emerald Ash Borer; Host Material from Canada.

OMB Number: 0579-0319.

Type of Request: Extension of approval of an information collection.

Abstract: As authorized by the Plant Protection Act (7 U.S.C. 7701 *et seq.*) (PPA), the Secretary of Agriculture may prohibit or restrict the importation, entry, exportation, or movement in interstate commerce of any plant, plant product, biological control organism, noxious weed, means of conveyance, or other article if the Secretary determines that the prohibition or restriction is necessary to prevent a plant pest or noxious weed from being introduced into or disseminated within the United States. This authority has been delegated to the Animal and Plant Health Inspection Service (APHIS), which administers regulations to implement the PPA.

APHIS regulations in 7 CFR part 319 prohibit or restrict the importation of certain plants and plant products into the United States to prevent the introduction of plant pests. Subpart—Nursery Stock, Plants, Roots, Bulbs, Seeds, and Other Plant Products (7 CFR 319.37 through 319.37-14) restricts, among other things, the importation of living plants, plant parts, and seeds for propagation; and Subpart–Logs, Lumber, and Other Unmanufactured Wood Articles (7 CFR 310.40-1 through 319.40-11) governs the importation of various logs, lumber, and other unmanufactured wood products into the United States. Both subparts contain regulations that restrict or prohibit the importation of emerald ash borer host material from Canada to prevent the introduction and spread of EAB, a destructive wood-boring insect that attacks ash trees, in the United States. These regulations involve information collection activities, including phytosanitary certificates, permit applications, and certificates of inspection.

We are asking the Office of Management and Budget (OMB) to approve our use of these information collection activities for an additional 3 years.

The purpose of this notice is to solicit comments from the public (as well as affected agencies) concerning our information collection. These comments will help us:

(1) Evaluate whether the collection of information is necessary for the proper performance of the functions of the Agency, including whether the information will have practical utility;

(2) Evaluate the accuracy of our estimate of the burden of the information collection, including the validity of the methodology and assumptions used;

(3) Enhance the quality, utility, and clarity of the information to be collected; and

(4) Minimize the burden of the information collection on those who are to respond, through use, as appropriate, of automated, electronic, mechanical, and other collection technologies, e.g., permitting electronic submission of responses.

Estimate of burden: The public reporting burden for this collection of information is estimated to average 0.6666 hours per response.

Respondents: Importers of certain articles from Canada; and the Canadian Food Inspection Agency.

Estimated annual number of respondents: 6.

Estimated annual number of responses per respondent: 1.

Estimated annual number of responses: 6.

Estimated total annual burden on respondents: 4 hours. (Due to averaging, the total annual burden hours may not equal the product of the annual number of responses multiplied by the reporting burden per response.)

All responses to this notice will be summarized and included in the request for OMB approval. All comments will also become a matter of public record.

Done in Washington, DC, this 28th day of July 2010.

Kevin Shea

Acting Administrator, Animal and Plant Health Inspection Service.

[FR Doc. 2010–18989 Filed 8–2–10; 8:45 am]

BILLING CODE 3410–34–S

DEPARTMENT OF AGRICULTURE

Forest Service

Kern and Tulare Counties Resource Advisory Committee

AGENCY: Forest Service, USDA.

ACTION: Notice of meeting.

SUMMARY: The Kern and Tulare Counties Resource Advisory Committee (RAC) will meet in Porterville, Kernville, and Bakersfield, California. The committee is meeting as authorized under the Secure Rural Schools and Community Self-Determination Act (Pub. L. 110–343) and in compliance with the Federal Advisory Committee Act. The purpose of the meetings is to establish and implement a process to accept projects and determine which projects to recommend to the Forest Supervisor for funding under Title II of the Act.

DATES: The meetings will be held on August 26, September 23, September 29, October 28, and November 18, 2010. All meetings will begin at 5 p.m.

ADDRESSES: The August 26, September 29, October 28 meetings will be held at the Sequoia National Forest Headquarters, 1839 South Newcomb Street, Porterville, California. Videoconferencing for the August 26 meeting will be available only at the Kernville Office of the Kern River Ranger District, 105 Whitney Road, Kernville, California. The September 23 and November 18 meetings will be held at the County of Kern Administrative Office, 1115 Truxtun Avenue, Bakersfield, California.

Written comments should be sent to Priscilla Summers, Western Divide Ranger District, 32588 Highway 190, Springville, California 93265. Comments may also be sent via e-mail to *psummers@fs.fed.us,* or via facsimile to 559–539–2067.

All comments, including names and addresses when provided, are placed in the record and are available for public inspection and copying. The public may inspect comments received at Western Divide Ranger District, 32588 Highway 190, Springville, CA 93265. Visitors are encouraged to call ahead to 559–539–2607 to facilitate entry into the building and access to the record.

FOR FURTHER INFORMATION CONTACT: Penelope Shibley, RAC Coordinator, Kernville Ranger Station, P.O. Box 9, Kernville, CA 93238; (760) 376–3781; or e-mail: *pshibley@fs.fed.us.* Individuals who use telecommunication devices for the deaf (TDD) may call 559–781–6650 between 8 a.m. and 4:30 p.m., Pacific Daylight Time, Monday through Friday.

SUPPLEMENTARY INFORMATION: The meetings are open to the public. Committee discussions are limited to Forest Service staff and committee members. The following business will be conducted: (1) Introductions of all committee members, replacement members, and Forest Service personnel; (2) develop a procedure to receive, process, and recommend projects for funding; (3) develop a schedule for accepting and processing project applications; and (4) receive public comment. Persons who wish to bring

related matters to the attention of the Committee may file written statements with the Committee staff before or after the meeting.

Dated: July 28, 2010.

Tina J. Terrell,

Forest Supervisor.

[FR Doc. 2010–19023 Filed 8–2–10; 8:45 am]

BILLING CODE 3410–11–P

DEPARTMENT OF COMMERCE

International Trade Administration

Determination by the Department of Commerce on the Wholly Formed Requirement for Qualifying Woven Fabric Under the Dominican Republic Earned Import Allowance Program

July 29, 2010.

AGENCY: Department of Commerce, International Trade Administration.

ACTION: Notice.

SUMMARY: The Department of Commerce has determined to maintain the current interpretation of the wholly formed requirement of qualifying woven fabric under the Dominican Republic Earned Import Allowance Program (DREIAP).

FOR FURTHER INFORMATION CONTACT: Robert Carrigg, Office of Textiles and Apparel, Import Administration, U.S. Department of Commerce, (202) 482–2573.

SUPPLEMENTARY INFORMATION:

Authority: Section 2(a) of the Andean Trade Preference Extension Act of 2008 ("ATPEA"); Section 404(b)(2)(H) of the Dominican Republic-Central America-United States Free Trade Agreement ("CAFTA–DR FTA") Implementation Act, as amended; Imports of Certain Apparel Articles: Interim Procedures for the Implementation of the Earned Import Allowance Program Established Under the Andean Trade Preference Extension Act of 2008 (74 FR 3563, published January 21, 2009) ("Interim Procedures").

DATES: *Effective Date:* August 3, 2010.

Background

On December 1, 2008, the Department of Commerce implemented provisions under the Andean Trade Preference Extension Act of 2008 (Pub. L. 110–436, 122 Stat. 4976) (ATPEA or implementing legislation). Section 2 of the ATPEA amends Title IV of the CAFTA–DR FTA Implementation Act (Pub. L. 109–53; 119 Stat. 495). Specifically, Title IV of the CAFTA–DR FTA Implementation Act is amended by adding Section 404, creating a benefit for eligible apparel articles wholly assembled in the Dominican Republic that meet the requirements for a "2 for 1" earned import allowance. Section 2 of the ATPEA requires the Secretary of Commerce to establish a program to provide earned import allowance certificates to any producer or entity controlling production of eligible apparel articles in the Dominican Republic, such that apparel wholly assembled in the Dominican Republic from fabric or yarns, regardless of their source, and imported directly from the Dominican Republic, may enter the United States duty-free, pursuant to the satisfaction of the terms governing issuance of the earned import allowance certificate. The Secretary of Commerce has delegated his authority under the CAFTA–DR FTA Implementation Act to implement and administer the Earned Import Allowance Program to the International Trade Administration's Office of Textiles and Apparel ("OTEXA").

On January 21, 2009, OTEXA published interim procedures, 74 FR 3563, implementing Section 2 of the ATPEA. These procedures set forth the provisions OTEXA will follow in implementing the DREIAP. In accordance with these procedures, OTEXA issues certificates to qualifying apparel producers to accompany imports of eligible apparel articles wholly formed in the Dominican Republic and exported from the Dominican Republic. Such certificates will be issued as long as there is a sufficient balance of square meter equivalents available as a result of the purchase of qualifying woven fabric. "Qualifying woven fabric" is defined in Section 2 of the ATPEA and in OTEXA's interim procedures as "woven fabric of cotton wholly formed in the United States from yarns wholly formed in the United States" and intended for production of apparel in the Dominican Republic. *See* Section 2(e) of the *Interim Procedures;* Section 404(c)(4) of the CAFTA–DR FTA Implementation Act, as amended by Section 2 of the ATPEA. Neither the ATPEA nor the interim procedures define the term "wholly formed" as it is used in the definition of "qualifying woven fabric."

OTEXA received inquiries regarding the interpretation of "wholly formed" as a requirement under the definition of "qualifying woven fabric." Accordingly, on April 3, 2009 (74 FR 15254), OTEXA requested public comment on the intended meaning of the "wholly formed" requirement in the definition of "qualifying woven fabric" for the purposes of the DREIAP. In that request for public comment, OTEXA explained that it "currently interprets 'wholly formed' within the definition of 'qualifying woven fabric' to require that all production processes and finishing operations, starting with weaving and ending with a fabric ready for cutting or assembly without further processing, take place in the United States." *Id.,* 74 FR at 15255.

OTEXA received ten comments and has carefully analyzed the points raised in each submission. These comments are available on OTEXA's Web site at *http://web.ita.doc.gov/tacgi/otexa_dr_eiap_publiccomments.nsf/504ca249c786e20f85256284006da7ab?OpenView&Start=1.* Department officials have also discussed this matter on several occasions with interested stakeholders to ensure that all points have been considered.

Commentators that support OTEXA's current interpretation contend that the DREIAP was intended to improve the competitiveness of Dominican apparel producers and create new export opportunities for United States manufacturers of qualifying fabrics. These commentators suggest that from the beginning, it was clear that the intent was to base the program on the delivery of qualifying fabric ready for cutting and sewing into trousers. There was never any discussion of permitting greige fabric (raw fabric that has yet to be bleached or dyed) to be shipped to another country for finishing and allowing such fabric to qualify for benefits under the program because it was understood that support from United States industry was dependent on the requirement that fabric be produced and finished in the United States so that it would be ready for cutting and sewing upon arrival in the Dominican Republic. These commentators argue that effective enforcement of the program would be more difficult if third countries were able to participate as finishers. They also contend that the dyeing and finishing stage imparts distinct characteristics that only then make the fabric suitable for a specific apparel application as envisaged by the legislation. Unfinished fabric can be used for applications other than the assembly of trousers and similar garments. The commentators contend that although the program was enacted as an amendment to the CAFTA–DR FTA Implementation Act, it could have been implemented as a stand-alone bill or as an amendment to other relevant legislation. These commentators suggest that the connection between the program and the vehicle to which it was attached is one of legislative convenience. These commentators state that at no time was there an expression

to treat the program as other than a preferential program and at no time was it contemplated that the finishing of qualifying fabrics could take place outside the United States.

Furthermore, these commentators state that allowing finishing outside the United States does not preserve or promote the use of United States fabrics as intended by the program. Lastly, these commentators contend that there is more than sufficient capacity in the United States to dye, print, and finish the amount of fabric required by Dominican Republic apparel manufacturers for qualification under the program.

Commentators who disagree with OTEXA's current interpretation assert that the term "wholly formed" as used in the DREIAP does not require the fabric to be dyed and finished in the United States, and that such an interpretation negates the benefits of the program. These commentators contend that this issue was never addressed during the discussions leading to the creation of the program. As such, they contend that OTEXA's current interpretation was not contemplated in the drafting of the legislation and is not required under the express terms of the legislation. They argue that Customs and Border Protection ("CBP") interpreted the term "wholly formed" when used in the Caribbean Basin Trade Preference Act ("CBTPA") of 2000 (Pub. L. 106–200, 114 Stat, 251, 2766) as not requiring dyeing and finishing. These commentators contend that Congress did not amend the definition of "wholly formed" in the Trade Act of 2002 (Pub. L. 107–210), but only added a new requirement. These commentators state that because the DREIAP is not an amendment to the CAFTA–DR FTA, the requirements for dyeing and finishing specified in two footnotes in that agreement do not apply to the term in this program. They contend that there is no requirement to directly ship qualifying fabric to the Dominican Republic; therefore, dyeing and finishing of United States greige fabric is not precluded. They argue that OTEXA's interpretation is inconsistent with other similar programs. Finally, these commentators argue that originating apparel under free trade agreements need not be dyed or finished by the parties.

Analysis and Determination

After careful consideration of the interested party comments, OTEXA has determined it will continue to interpret "wholly formed" within the definition of "qualifying woven fabric" to require that all production processes and finishing operations, starting with weaving and ending with a fabric ready for cutting or assembly without further processing, take place in the United States under the DREIAP.

Neither the ATPEA nor the interim procedures define the term "wholly formed" as it is used in the definition of "qualifying woven fabric." Additionally, there is no legislative history regarding this term as it is used in this program. Although not controlling, OTEXA considered testimony given by former Special Textile Negotiator for the United States Trade Representative, Scott Quesenberry. See Testimony before the United States International Trade Commission on the matter of the Earned Import Allowance Program: Evaluation of the Effectiveness of the Program for Certain Apparel from the Dominican Republic (Investigation No.: 332–503) (Nov. 18, 2009). Mr. Quesenberry testified "through the course of many years of hard negotiation on this issue, plus several months of hard work on the legislative language, this issue never came up, so I can tell you that it was not the intent of the negotiator that finishing would be allowed from outside of the United States at the Dominican Republic. This was designed to be a program between those two countries."

Without any legislative history, OTEXA considered the interpretation of "wholly formed" in light of other programs it administers. The CBTPA, which was enacted pursuant to the Trade and Development Act of 2000 (Pub. L. 106–200, 114 Stat. 251, 2766), included the phrase "wholly formed," but did not define that term. In implementing the CBTPA, CBP promulgated regulations (United States-Caribbean Basin Trade Partnership Act and Caribbean Basin Innitiative, 65 FR 59650, October 5, 2000) which did not require finishing, dyeing, or printing to occur within the region for preferential treatment. Subsequent to the promulgation of the regulations implementing CBTPA, Congress enacted the Trade Act of 2002 (Pub. L. 107–210), which amended and extended the CBTPA and established the ATPDEA. In that Act, Congress amended the CBTPA and provided in the ATPDEA the wholly formed requirement that all dyeing, printing and finishing of fabrics be carried out in the United States (Pub. L. 107–210, 116 Stat, 1035–1036):

> Apparel articles entered on or after September 1, 2002, shall qualify under the preceding sentence only if all dyeing, printing, and finishing of the fabrics from which the articles are assembled, if the fabrics are knit fabrics, is carried out in the United States. Apparel articles entered on or after September 1, 2002, shall qualify under the first sentence of this clause only if all dyeing, printing, and finishing of the fabrics from which the articles are assembled, if the fabrics are woven fabrics, is carried out in the United States.

Further, the CAFTA–DR FTA uses the term "wholly formed" in two provisions, footnote 6 to Article 3.25(8) and footnote 7 to Article 3.26. In both provisions, the definition of "wholly formed" includes dyeing and finishing. Although the terminology is used in different instances in the DREIAP Implementation Act and the CAFTA–DR FTA, OTEXA considers it persuasive in defining the term here.

OTEXA agrees with the commentators who stated that the dyeing and finishing stages impart distinct characteristics which only then make the fabric suitable for a specific apparel application; *i.e.,* intended for production of apparel in the Dominican Republic as stated in the DREIAP Implementation Act. Unfinished fabric can be used for other applications beyond the assembly of trousers and similar garments covered by DREIAP. OTEXA does not believe that dyeing and finishing outside the United States would preserve or promote the use of United States fabrics as intended by the DREIAP. Furthermore, in OTEXA's experience administering trade preference programs, OTEXA understands that often over 50 percent of the value of a fabric is attributable to the dyeing, finishing and printing process. Thus, allowing offshore finishing undercuts critical benefits to the United States textile sector, contrary to an aim of the DREIAP.

OTEXA is also mindful of the manner in which Congress directed it to administer the program. Permitting finishing outside the United States prior to the fabric being shipped to the Dominican Republic would potentially involve one or more countries and companies involved, and it would be difficult if not impossible to verify that the fabric was eventually exported to the Dominican Republic from the United States for cutting and assembly. This is a critical determination for fabric to qualify for duty free importation into the United States. See Sections 4 and 6 of the Interim Procedures, 74 FR at 3565–66.

Based on the foregoing, OTEXA has determined it will continue to interpret the term "wholly formed" within the definition of "qualifying woven fabric" to require that all production processes and finishing operations, starting with weaving and ending with a fabric ready for cutting or assembly without further

processing, took place in the United States under the DREIAP.

Kim Glas,

Deputy Assistant Secretary, Office of Textiles and Apparel.

[FR Doc. 2010–19065 Filed 8–2–10; 8:45 am]

BILLING CODE 3510–DS–P

DEPARTMENT OF COMMERCE

International Trade Administration

[A–423–808]

Stainless Steel Plate in Coils From Belgium: Correction to Notice of Final Results of Antidumping Duty Administrative Review

AGENCY: Import Administration, International Trade Administration, Department of Commerce.

DATES: *Effective Date:* August 3, 2010.

FOR FURTHER INFORMATION CONTACT: Joy Zhang or George McMahon, AD/CVD Operations, Office 3, Import Administration, International Trade Administration, U.S. Department of Commerce, 14th Street and Constitution Avenue, NW., Washington DC 20230; telephone: (202) 482–1168 or (202) 482–1167, respectively.

SUPPLEMENTARY INFORMATION:

Correction

On October 19, 2009, the Department of Commerce ("the Department") published in the **Federal Register** the following notice: *Stainless Steel Plate in Coils From Belgium: Final Results of Antidumping Duty Administrative Review*, 74 FR 53468 (October 19, 2009) ("*Final Results*"). Subsequent to the publication of the notice in the **Federal Register**, we identified an inadvertent error in the *Final Results.* The Department made an error in the "Cash Deposit Requirements" section of the notice, by inadvertently including an incorrect "all others" rate for exporters and/or manufacturers not covered by the review for which the *Final Results* were published. Specifically, the "all others" rate should have been listed as 8.54 percent pursuant to the implementation of the findings of the World Trade Organization ("WTO") Panel in US—Zeroing (EC). *See Implementation of the Findings of the WTO Panel in US—Zeroing (EC): Notice of Determinations Under Section 129 of the Uruguay Round Agreements Act and Revocations and Partial Revocations of Certain Antidumping Duty Orders,* 72 FR 25261 (May 4, 2007). For reference, below is the corrected paragraph regarding the "all others" rate discussed in the *Final Results.*

Cash Deposit Requirements

The following antidumping duty deposit rates will be effective upon publication of the final results of this administrative review for all shipments of stainless steel plate in coils ("SSPC") from Belgium entered, or withdrawn from warehouse, for consumption on or after the publication date of these final results, as provided for by section 751(a)(1) of the Tariff Act of 1930, as amended ("the Act"): (1) For AMS Belgium, the cash deposit rate will be the rate established in the final results of this review; (2) if the exporter is not a firm covered in this review, but was covered in a previous review or the original less-than-fair-value ("LTFV") investigation, the cash deposit rate will continue to be the company-specific rate established for the most recent period; (3) if the exporter is not a firm covered in this review, a prior review, or the LTFV investigation, but the manufacturer is, the cash deposit rate will be the rate established for the most recent period for the manufacturer of the subject merchandise; and (4) if neither the exporter nor the manufacturer is a firm covered by this review, a prior review, or the LTFV investigation, the cash deposit rate will be 8.54 percent ad valorem, the "all-others" rate established in the implementation of the findings of the WTO Panel in US—Zeroing (EC). *See Implementation of the Findings of the WTO Panel in US—Zeroing (EC): Notice of Determinations Under Section 129 of the Uruguay Round Agreements Act and Revocations and Partial Revocations of Certain Antidumping Duty Orders*, 72 FR 25261 (May 4, 2007). These cash deposit rates shall remain in effect until further notice.

Conclusion

The Department clarifies that the "Cash Deposit Requirements" section of the *Final Results* inadvertently listed the "all others" rate as 9.86 percent and that the correct "all others" rate is 8.54 percent. The Department intends to issue revised cash deposit instructions to U.S. Customs and Border Protection (CBP) for entries made during the period of review of May 1, 2007, through April 30, 2008, which includes the corrected "all others" rate of 8.54 percent.

This notice is issued and published in accordance with sections 751(a)(1) and 777(i)(1) of the Act.

Dated: July 27, 2010.

Paul Piquado,

Acting Deputy Assistant Secretary for Import Administration.

[FR Doc. 2010–19064 Filed 8–2–10; 8:45 am]

BILLING CODE 3510–DS–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

RIN: 0648–XX96

Fisheries of the South Atlantic and Gulf of Mexico; Southeast Data, Assessment, and Review (SEDAR); assessment webinar 5 for SEDAR 22 yellowedge grouper and tilefish.

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

ACTION: Notice of SEDAR 22 Gulf of Mexico yellowedge grouper and tilefish assessment webinar 5.

SUMMARY: The SEDAR 22 assessments of the Gulf of Mexico stocks of yellowedge grouper and tilefish will consist of a series of workshops and webinars: a Data Workshop, a series of Assessment webinars, and a Review Workshop. See **SUPPLEMENTARY INFORMATION**.

DATES: The fifth SEDAR 22 Assessment Process webinar will be held on Monday, August 23, 2010 from 10 a.m. until approximately 2 p.m. (EDT). The established times may be adjusted as necessary to accommodate the timely completion of discussion relevant to the assessment process. Such adjustments may result in the meeting being extended from, or completed prior to the time established by this notice.

ADDRESSES: The meeting will be held via webinar. The webinar is open to members of the public. Those interested in participating should contact Julie Neer at SEDAR (See **FOR FURTHER INFORMATION CONTACT**) to request an invitation providing webinar access information.

A listening station will be available at the Gulf of Mexico Fishery Management Council office located at 2203 N Lois Avenue, Suite 1100, Tampa, FL 33607. Those interested in participating via the listening station should contact Julie A. Neer at SEDAR (See **FOR FURTHER INFORMATION CONTACT**) at least 1 day prior to the webinar.

FOR FURTHER INFORMATION CONTACT: Julie A Neer, SEDAR Coordinator, 4055 Faber Place, Suite 201, North Charleston, SC 29405; phone: (843) 571–4366; e-mail: *Julie.neer@safmc.net*

SUPPLEMENTARY INFORMATION: The Gulf of Mexico, South Atlantic, and Caribbean Fishery Management Councils, in conjunction with NOAA Fisheries and the Atlantic and Gulf States Marine Fisheries Commissions have implemented the Southeast Data, Assessment and Review (SEDAR)

process, a multi-step method for determining the status of fish stocks in the Southeast Region. SEDAR is a three-step process including: (1) Data Workshop, (2) Assessment Process utilizing webinars and (3) Review Workshop. The product of the Data Workshop is a data report which compiles and evaluates potential datasets and recommends which datasets are appropriate for assessment analyses. The product of the Assessment Process is a stock assessment report which describes the fisheries, evaluates the status of the stock, estimates biological benchmarks, projects future population conditions, and recommends research and monitoring needs. The assessment is independently peer reviewed at the Review Workshop. The product of the Review Workshop is a Summary documenting Panel opinions regarding the strengths and weaknesses of the stock assessment and input data. Participants for SEDAR Workshops are appointed by the Gulf of Mexico, South Atlantic, and Caribbean Fishery Management Councils and NOAA Fisheries Southeast Regional Office and Southeast Fisheries Science Center. Participants include data collectors and database managers; stock assessment scientists, biologists, and researchers; constituency representatives including fishermen, environmentalists, and NGO's; International experts; and staff of Councils, Commissions, and state and federal agencies.

SEDAR 22 Assessment Webinar V:

Using datasets recommended from the Data Workshop, participants will employ assessment models to evaluate stock status, estimate population benchmarks and management criteria, and project future conditions. Participants will recommend the most appropriate methods and configurations for determining stock status and estimating population parameters.

Although non-emergency issues not contained in this agenda may come before this group for discussion, those issues may not be the subject of formal action during this meeting. Action will be restricted to those issues specifically listed in this notice and any issues arising after publication of this notice that require emergency action under section 305(c) of the Magnuson-Stevens Fishery Conservation and Management Act, provided the public has been notified of the Council's intent to take final action to address the emergency.

Special Accommodations

This meeting is physically accessible to people with disabilities. Requests for sign language interpretation or other auxiliary aids should be directed to the Council office (see **ADDRESSES**) at least 5 business days prior to the meeting.

Dated: July 28, 2010.

Tracey L. Thompson,

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

[FR Doc. 2010–18964 Filed 8–2–10; 8:45 am]

BILLING CODE 3510–22–S

DEPARTMENT OF COMMERCE

International Trade Administration

Department of Commerce Measuring and Enhancing Services Trade Data Conference

AGENCY: International Trade Administration, U.S. Department of Commerce.

ACTION: Notice of kickoff event to improve services trade data.

SUMMARY: The International Trade Administration, in conjunction with the Bureau of Economic Analysis, the Census Bureau and the Bureau of Labor Statistics, is announcing a kick-off event for its services trade data initiative. DOC is working to ensure that the measurement of economic activity and trade in the services sector is more robust, granular and meaningful. Primary goals include enhancements to services data to ensure that it is effective for commercial decision-making, policy planning, and is relevant for trade agreements in support of increased US services exports. DOC has invited well-known policy leaders from the White House, the Department, and private sector innovators in the services information arena to speak on the topic.

DATES: The conference will be held on September 14, 2010.

Address all comments concerning this notice to the Office of Service Industries, U.S. Department of Commerce, 1401 Constitution Ave., NW., Room 1104, Washington, DC 20230.

FOR FURTHER INFORMATION CONTACT: Barb Rawdon, 202–482–0474 or *Barb.Rawdon@trade.gov*

SUPPLEMENTARY INFORMATION: There are significant weaknesses in data on services, even though services industries account for roughly 70 percent of the U.S. gross domestic product. Without timely, accurate information on the services sector, businesses and policy makers lack the information necessary to understand a major share of the economy and to develop modern trade and investment policy. As a first step in our Service Industry Statistical Initiative, DOC will hold a conference on September 14, 2010, to focus on measuring and enhancing services trade data.

The conference will include key players from the public and private sector with the main goal of seeking broader support and direction for improving the quality and timeliness of services trade data. A key outcome of the conference will be the development of an action plan and working groups to improve certain discrete elements of services data collection and dissemination by various public and private sector organizations.

Current issues regarding services statistics include: limitations of the industry classification system, granularity of data, adequacy of survey detail in tracking of services, accounting for intangible assets, and accuracy of service price indices.

The target audience for the conference includes senior managers from private sector companies and government, along with participants from the public policy community. The morning session will focus on the current and future status of services trade data along with innovative ideas for the future. The afternoon sessions will feature free-flowing industry-specific discussions designed to spark a dialogue on improvement ranging from readily available solutions to transformational technologies and analytics that enable better business and public policy decision-making.

DOC will accept registrations on a first-come-first-served basis. Participants will be charged $75 for attending these events if they register before September 7, 2010, and $100 if they register on or after September 7, 2010. Those who are interested in attending this event should call 703–925–9455 ext. 0.

Dated: July 29, 2010.

Barb Rawdon,

Director, Education, Healthcare and Professional Services.

[FR Doc. 2010–19059 Filed 8–2–10; 8:45 am]

BILLING CODE 3510–DR–P

COUNCIL ON ENVIRONMENTAL QUALITY

Interagency Ocean Policy Task Force—Final Recommendations of the Interagency Ocean Policy Task Force

AGENCY: Council on Environmental Quality.

ACTION: Notice of Availability, Interagency Ocean Policy Task Force's

"Final Recommendations of the Interagency Ocean Policy Task Force".

SUMMARY: On June 12, 2009, the President established an Interagency Ocean Policy Task Force, led by the Chair of the Council on Environmental Quality. The Task Force was charged with developing, with appropriate public input, a recommended national policy for the stewardship of the ocean, our coasts, and the Great Lakes; a framework for policy coordination, including specific recommendations to improve coordination and collaboration among Federal, State, tribal, and local authorities, and regional governance structures; an implementation strategy that identifies a set of priority objectives; and a framework for effective costal and marine spatial planning.

On July 19, 2010, the Task Force submitted its Final Recommendations to the President. They provide: (1) Our Nation's first ever *National Policy for the Stewardship of the Ocean, Our Coasts, and the Great Lakes;* (2) a strengthened governance structure to provide sustained, high-level, and coordinated attention to ocean, coastal, and Great Lakes issues; (3) a targeted implementation strategy that identifies and prioritizes nine categories for action that the United States should pursue; and (4) a framework for effective coastal and marine spatial planning that establishes a comprehensive, integrated, ecosystem-based approach to address conservation, economic activity, user conflict, and sustainable use of ocean, coastal, and Great Lakes resources.

DATES: None.

ADDRESSES: The Task Force's Final Recommendations are available at *http://www.whitehouse.gov/oceans* or by writing to The Council on Environmental Quality, Attn: Michael Weiss, 722 Jackson Place, NW., Washington, DC 20503.

FOR FURTHER INFORMATION CONTACT: Michael Weiss, Deputy Associate Director for Ocean and Coastal Policy, (202) 456–3892.

SUPPLEMENTARY INFORMATION: On June 12, 2009, President Obama issued a Memorandum to the Heads of Executive Departments and Agencies that established an Interagency Ocean Policy Task Force, led by the Chair of the Council on Environmental Quality. That Presidential memo charged the Task Force with, within 90 days, developing recommendations that include: (1) A national policy for the oceans, our coasts, and the Great Lakes; (2) a United States framework for policy coordination of efforts to improve stewardship of the oceans, our coasts, and the Great Lakes; and (3) an implementation strategy that identifies and prioritizes a set of objectives the United States should pursue to meet the objectives of a national policy. On September 17, 2009, the Task Force's Interim Report addressing these three items was issued for 30 days public comment. The comment period ended on October 17, 2009.

The Task Force was also charged with, within 180 days, developing a recommended framework for effective coastal and marine spatial planning. The memorandum provides that the framework should be "a comprehensive, integrated, ecosystem-based approach that addresses conservation, economic activity, user conflict, and sustainable use of ocean, coastal, and Great Lakes resources consistent with international law, including customary international law as reflected in the 1982 United Nations Convention on the Law of the Sea." On December 14, 2009, the Task Force's Interim Framework addressing this item was issued for 60 days public comment. The comment period ended on February 12, 2010.

In response to this direction, the Task Force has completed its *Final Recommendations of the Interagency Ocean Policy Task Force* (Final Recommendations). The Task Force Final Recommendations set a new direction for improved stewardship of the ocean, our coasts, and the Great Lakes. They provide: (1) Our Nation's first ever *National Policy for the Stewardship of the Ocean, Our Coasts, and the Great Lakes;* (2) a strengthened governance structure to provide sustained, high-level, and coordinated attention to ocean, coastal, and Great Lakes issues; (3) a targeted implementation strategy that identifies and prioritizes nine categories for action that the United States should pursue; and (4) a framework for effective coastal and marine spatial planning that establishes a comprehensive, integrated, ecosystem-based approach to address conservation, economic activity, user conflict, and sustainable use of ocean, coastal, and Great Lakes resources.

The Final Recommendations are now available at the National Ocean Council Web site at *http://www.whitehouse.gov/oceans.*

Dated: July 27, 2010.

Nancy Sutley,

Chair, Council on Environmental Quality.

[FR Doc. 2010–18950 Filed 8–2–10; 8:45 am]

BILLING CODE 3125–W0–P

DEPARTMENT OF ENERGY

[OE Docket No. EA–281–B]

Application To Export Electric Energy; Manitoba Hydro

AGENCY: Office of Electricity Delivery and Energy Reliability, DOE.

ACTION: Notice of application.

SUMMARY: Manitoba Hydro (Manitoba) has applied to renew its authority to transmit electric energy from the United States to Canada pursuant to section 202(e) of the Federal Power Act (FPA).

DATES: Comments, protests, or requests to intervene must be submitted on or before September 2, 2010.

ADDRESSES: Comments, protests or requests to intervene should be addressed as follows: Office of Electricity Delivery and Energy Reliability, Mail Code: OE–20, U.S. Department of Energy, 1000 Independence Avenue, SW., Washington, DC 20585–0350 (FAX 202–586–8008).

FOR FURTHER INFORMATION CONTACT: Christopher Lawrence (Program Office) 202–586–5260 or Michael Skinker (Program Attorney) 202–586–2793.

SUPPLEMENTARY INFORMATION: Exports of electricity from the United States to a foreign country are regulated by the Department of Energy (DOE) pursuant to sections 301(b) and 402(f) of the Department of Energy Organization Act (42 U.S.C. 7151(b), 7172(f)) and require authorization under section 202(e) of the FPA (16 U.S.C. 824a(e)).

On November 17, 2003, the Department of Energy (DOE) issued Order No. EA–281, which authorized Manitoba to transmit electric energy from the United States to Canada as a power marketer using existing international transmission facilities for a two-year term. DOE renewed the Manitoba export authorization as of November 17, 2005, in Order No. EA–281–A for an additional five-year term. That Order will expire on November 17, 2010. On July 15, 2010, Manitoba filed an application with DOE for renewal of the export authority contained in Order No. EA–281–A for an additional ten-year term.

The electric energy that Manitoba proposes to export to Canada would be surplus energy purchased from electric utilities, Federal power marketing agencies, and other entities within the United States. The existing international transmission facilities to be utilized by Manitoba have previously been authorized by Presidential permits issued pursuant to Executive Order 10485, as amended, and are appropriate

for open access transmission by third parties.

Procedural Matters: Any person desiring to become a party to these proceedings or to be heard by filing comments or protests to this application should file a petition to intervene, comment, or protest at the address provided above in accordance with §§ 385.211 or 385.214 of the Federal Energy Regulatory Commission's Rules of Practice and Procedure (18 CFR 385.211, 385.214). Fifteen copies of each petition and protest should be filed with DOE on or before the date listed above.

Comments on the Manitoba application to export electric energy to Canada should be clearly marked with Docket No. EA–281–B. Additional copies are to be filed directly with K. Jennifer Moroz, Manitoba Hydro Law Department, 360 Portage Avenue, Winnipeg, Manitoba Canada R3C 0G8 *and* Giuseppe Fina, Bruder, Gentile & Marcoux, L.L.P., 1701 Pennsylvania Avenue, NW., Suite 900, Washington, DC 20006. A final decision will be made on this application after the environmental impacts have been evaluated pursuant to DOE's National Environmental Policy Act Implementing Procedures (10 CFR part 1021) and after a determination is made by DOE that the proposed action will not adversely impact on the reliability of the U.S. electric power supply system.

Copies of this application will be made available, upon request, for public inspection and copying at the address provided above, by accessing the program Web site at *http://www.oe.energy.gov/permits_pending.htm,* or by e-mailing Odessa Hopkins at *Odessa.Hopkins@hq.doe.gov.*

Issued in Washington, DC, on July 28, 2010.

Anthony J. Como,

Director, Permitting and Siting, Office of Electricity Delivery and Energy Reliability.

[FR Doc. 2010–19018 Filed 8–2–10; 8:45 am]

BILLING CODE 6450–01–P

DEPARTMENT OF ENERGY

Energy Employees Occupational Illness Compensation Program Act of 2000; Corrected Revision to List of Covered Facilities

AGENCY: Department of Energy.

ACTION: Notice of corrected revision of list of covered facilities.

SUMMARY: The Department of Energy ("Department" or "DOE") periodically publishes or revises a list of facilities covered under the Energy Employees Occupational Illness Compensation Program Act of 2000, as amended ("EEOICPA" or "Act"). On June 30, 2010, DOE published a notice (75 FR 37781) that amended the previous lists. DOE has determined that the June 30, 2010, notice should be replaced. This corrected notice now replaces the previous lists by removing two facilities designated as atomic weapons employer (AWE) facilities that should not have been so designated. Previous lists or revisions were published on April 9, 2009, June 28, 2007, November 30, 2005, August 23, 2004, July 21, 2003, December 27, 2002, June 11, 2001, and January 17, 2001.

FOR FURTHER INFORMATION CONTACT: Patricia R. Worthington, Ph.D, Director, Office of Health and Safety (HS–10), (301) 903–5926.

ADDRESSES: The Department welcomes comments on this notice. Comments should be addressed to: Patricia R. Worthington, Ph.D, Director, Office of Health and Safety (HS–10), U.S. Department of Energy, 1000 Independence Avenue, SW., Washington, DC 20585.

SUPPLEMENTARY INFORMATION:

Purpose

The EEOICPA establishes a program to provide compensation to certain employees who develop illnesses as a result of their employment with AWEs, DOE and its predecessor Agencies, certain of its contractors and subcontractors, and listed beryllium vendors. Section 3621(4) of the Act (codified at 42 U.S.C. 7384l(4)) defines an AWE as "an entity, other than the United States, that—(A) processed or produced, for use by the United States, material that emitted radiation and was used in the production of an atomic weapon, excluding uranium mining and milling; and (B) is designated by the Secretary of Energy as an [AWE] for the purposes of the compensation program." Section 3621(5) defines an AWE facility as "a facility, owned by an [AWE], that is or was used to process or produce, for use by the United States, material that emitted radiation and was used in the production of an atomic weapon, excluding uranium mining or milling."

It has recently come to the attention of the Department that one facility was previously mistakenly designated as an AWE facility because the designated facility was owned by the U.S. Government, and the statutory definitions of AWE and AWE facility exclude facilities owned by the United States. A second entity identified as an AWE facility is being removed from the list because the work performed by that entity was not related to production of an atomic weapon and was not performed for, or on behalf of, DOE or its predecessor Agencies.

This notice formally makes the changes to the list as indicated below:

- Painsville Site (Diamond Magnesium Company) of Ohio is no longer designated as an AWE facility because the work performed at that site was not related to atomic weapons production and was not conducted by, or on behalf of, DOE or its predecessor Agencies.
- St. Louis Airport Storage Site is no longer designated as an AWE facility because the facility was owned by the U.S. Government. This change has no effect on the determination of the Department of Labor that the work site is a DOE facility.

Issued in Washington, DC, on July 26, 2010.

Glenn S. Podonsky,

Chief Health, Safety and Security Officer, Office of Health, Safety and Security.

[FR Doc. 2010–19020 Filed 8–2–10; 8:45 am]

BILLING CODE 6450–01–P

DEPARTMENT OF ENERGY

Blue Ribbon Commission on America's Nuclear Future, Transportation and Storage Subcommittee

AGENCY: Department of Energy, Office of Nuclear Energy.

ACTION: Notice of open meeting.

SUMMARY: This notice announces an open meeting of the Transportation and Storage (T&S) Subcommittee. The T&S Subcommittee is a subcommittee of the Blue Ribbon Commission on America's Nuclear Future (the Commission). The establishment of subcommittees is authorized in the Commission's charter. The Commission was organized pursuant to the Federal Advisory Committee Act (Pub. L. 92–463, 86 Stat. 770) (the Act). This notice is provided in accordance with the Act.

DATES: Thursday, August 19, 2010, 8:30 a.m.–5 p.m.

ADDRESSES: Washington Marriott Hotel, 1221 22nd Street, NW., Washington, DC.

FOR FURTHER INFORMATION CONTACT: Timothy A. Frazier, Designated Federal Officer, U.S. Department of Energy, 1000 Independence Avenue, SW., Washington, DC 20585; telephone (202) 586–4243 or facsimile (202) 586–0544; e-mail *CommissionDFO@nuclear.energy.gov.* Additional information will be available at *http://www.brc.gov.*

SUPPLEMENTARY INFORMATION:

Background: The President directed that the Blue Ribbon Commission on America's Nuclear Future (the Commission) be established to conduct a comprehensive review of policies for managing the back end of the nuclear fuel cycle. The Commission will provide advice and make recommendations on issues including alternatives for the storage, processing, and disposal of civilian and defense spent nuclear fuel and nuclear waste.

The Co-chairs of the Commission requested the formation of the T&S Subcommittee to answer the question: "[S]hould the U.S. change the way in which it is storing used nuclear fuel and high level waste while one or more final disposal locations are established?"

Purpose of the Meeting: The session will provide the T&S Subcommittee with a range of input from public health and safety officials, industry representatives, public policy experts, and nongovernmental organizations. The presenters will focus on technical, regulatory, safety, and risk perception issues related to onsite storage of spent nuclear fuel at operating and shutdown commercial nuclear facilities. Discussion will include issues related to ongoing and planned transport of such materials for eventual treatment and/or disposal.

Tentative Agenda: The public meeting will begin at approximately 8:30 a.m. at the Washington Marriott Hotel, 1221 22nd Street, NW., Washington, DC. The Subcommittee will hear presentations from a series of panelists, ask questions of presenters, and conclude with a public comment session. The public session is expected to conclude by 5 p.m.

Public Participation: Subcommittee meetings are not required to be open to the public; however, the Commission has elected to open the presentation sessions of the meeting to the public. Individuals and representatives of organizations who would like to offer comments and suggestions may do so at the end of the public session on Thursday, August 19, 2010. Approximately 45 minutes will be reserved for public comments from 4:15 p.m. to 5 p.m. Time allotted per speaker will depend on the number who wish to speak but will not exceed 5 minutes. The Designated Federal Officer is empowered to conduct the meeting in a fashion that will facilitate the orderly conduct of business. Those wishing to speak should register to do so beginning at 8 a.m. on August 19, 2010, at the Washington Marriott Hotel.

Those not able to attend the meeting or have insufficient time to address the subcommittee are invited to send a written statement to Timothy A. Frazier, U.S. Department of Energy, 1000 Independence Avenue, SW., Washington, DC 20585, e-mail to *CommissionDFO@nuclear.energy.gov,* or post comments on the Commission Web site at *http://www.brc.gov.*

Additionally, the meeting will be available via live video Webcast. The link will be available at *http://www.brc.gov.*

Minutes: The minutes of the meeting will be available at *http://www.brc.gov* or by contacting Mr. Frazier. He may be reached at the postal address or e-mail address above.

Issued in Washington, DC, on July 28, 2010.

Carol A. Matthews,

Committee Management Officer.

[FR Doc. 2010–19003 Filed 8–2–10; 8:45 am]

BILLING CODE 6450–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. IC10–542–000]

Commission Information Collection Activities (FERC–542); Comment Request; Extension

AGENCY: Federal Energy Regulatory Commission, DOE.

ACTION: Notice of proposed information collection and request for comments.

SUMMARY: In compliance with the requirements of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, 44 U.S.C. 3506(c)(2)(A) (2006) (Pub. L. 104–13), the Federal Energy Regulatory Commission (Commission or FERC) is soliciting public comment on the proposed information collection described below.

DATES: Comments in consideration of the collection of information are due October 4, 2010.

ADDRESSES: Comments may be filed either electronically (eFiled) or in paper format, and should refer to Docket No. IC10–542–000. Documents must be prepared in an acceptable filing format and in compliance with Commission submission guidelines at *http://www.ferc.gov/help/submission-guide.asp.* eFiling instructions are available at: *http://www.ferc.gov/docs-filing/efiling.asp.* First-time users must follow eRegister instructions at: *http://www.ferc.gov/docs-filing/eregistration.asp,* to establish a user name and password before eFiling. The Commission will send an automatic acknowledgement to the sender's e-mail address upon receipt of eFiled comments. Commenters making an eFiling should not make a paper filing. Commenters that are not able to file electronically must send an original and two (2) paper copies of their comments to: Federal Energy Regulatory Commission, Secretary of the Commission, 888 First Street, NE., Washington, DC 20426.

Users interested in receiving automatic notification of activity in this docket may do so through eSubscription at *http://www.ferc.gov/docs-filing/esubscription.asp.* In addition, all comments and FERC issuances may be viewed, printed or downloaded remotely through FERC's eLibrary at: *http://www.ferc.gov/docs-filing/elibrary.asp,* by searching on Docket No. IC10–542. For user assistance, contact FERC Online Support by e-mail at *ferconlinesupport@ferc.gov,* or by phone, toll-free, at: (866) 208–3676, or (202) 502–8659 for TTY.

FOR FURTHER INFORMATION CONTACT: Ellen Brown may be reached by e-mail at *DataClearance@FERC.gov,* telephone at (202) 502–8663, and fax at (202) 273–0873.

SUPPLEMENTARY INFORMATION: The information collected under the requirements of FERC–542 "Gas Pipeline Rates: Rate Tracking" (OMB No. 1902–0070) is used by the Commission to implement the statutory provisions of Title IV of the Natural Gas Policy Act (NGPA), 15 U.S.C. 3301–3432, and Sections 4, 5 and 16 of the Natural Gas Act (NGA) (Pub. L. 75–688) (15 U.S.C. 717–717w). These statutes empower the Commission to collect natural gas transmission cost information from interstate natural gas transporters for the purpose of verifying that these costs, which are passed on to pipeline customers, are just and reasonable.

Interstate natural gas pipeline companies are required by the Commission to track their transportation-associated costs to allow for the Commission's review and, where appropriate, approve the pass-through of these costs to pipeline customers. These FERC–542 tracking filings are accountings of the cost of (1) research, development, and deployment expenditures; (2) annual charge adjustments and (3) periodic rate adjustments.

Tracking filings may be submitted at any time or on a regularly scheduled basis in accordance with the pipeline company's tariff. Filings may be either: (1) Accepted; (2) suspended and set for hearing; (3) suspended, but not set for

hearing; or (4) suspended for further review, such as technical conference or some other type of Commission action. The Commission implements these filing requirements in the Code of Federal Regulations (CFR) under 18 CFR parts 154, 154.4, 154.7, 154.307, 154.201, 154.207–154.208 and 154.401–154.403.

Action: The Commission is requesting a three-year extension of the current expiration date, with no changes to the existing collection of data.

Burden Statement: Public reporting burden for this collection is estimated as:

FERC data collection	Annual number of respondents	Number of responses per respondent	Average burden hours per response	Total annual burden hours
	(1)	(2)	(3)	(1) × (2) × (3)
FERC–542	95	3.5	40	13,300

Estimated cost burden to respondents is $881,598 (13,300 hours/2,080 hours [1] times $137,874 [2]). The cost per respondent is $9,280.

The reporting burden includes the total time, effort, or financial resources expended to generate, maintain, retain, disclose, or provide the information including: (1) Reviewing instructions; (2) developing, acquiring, installing, and utilizing technology and systems for the purposes of collecting, validating, verifying, processing, maintaining, disclosing and providing information; (3) adjusting the existing ways to comply with any previously applicable instructions and requirements; (4) training personnel to respond to a collection of information; (5) searching data sources; (6) completing and reviewing the collection of information; and (7) transmitting, or otherwise disclosing the information.

The estimate of cost for respondents is based upon salaries for professional and clerical support, as well as direct and indirect overhead costs. Direct costs include all costs directly attributable to providing this information, such as administrative costs and the cost for information technology. Indirect or overhead costs are costs incurred by an organization in support of its mission. These costs apply to activities which benefit the whole organization rather than any one particular function or activity.

Comments are invited on: (1) Whether the proposed collection of information is necessary for the proper performance of the functions of the Commission, including whether the information will have practical utility; (2) the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used; (3) ways to enhance the quality, utility and clarity of the information to be collected; and (4) ways to minimize the burden of the collection of information on those who are to respond, including the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, *e.g.,* permitting electronic submission of responses.

[1] Number of hours an employee works each year.

[2] Average annual salary per employee.

Kimberly D. Bose,

Secretary.

[FR Doc. 2010–18970 Filed 8–2–10; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. CP05–92–007]

Liberty Gas Storage LLC; Notice of Amendment

Take notice that on July 26, Liberty Gas Storage LLC ("Liberty"), 101 Ash Street, San Diego, CA 92101, filed in the above referenced docket, an application pursuant to section 7 of the Natural Gas Act (NGA), to amend its Application to Amend Certificate of Public Convenience and Necessity that was filed with the Commission on December 14, 2009, all as more fully set forth in the application which is on file with the Commission and open to public inspection. The filing may also be viewed on the Web at *http://www.ferc.gov* using the "eLibrary" link. Enter the docket number excluding the last three digits in the docket number field to access the document. For assistance, please contact FERC Online Support at *FERCOnlineSupport@ferc.gov* or toll free at (866) 208–3676, or TTY, contact (202) 502–8659.

Any questions regarding this application should be directed to William Rapp, Liberty Gas Storage, 101 Ash Street, San Diego, CA 92101, phone (619) 699–5050.

The filing is available for review at the Commission in the Public Reference Room or may be viewed on the Commission's Web site at *http://www.ferc.gov* using the eLibrary link. Enter the docket number excluding the last three digits in the docket number field to access the document. For assistance, contact FERC at *FERCOnlineSupport@gerc.gov* or call toll-free, (886) 208–3676 or TYY, (202) 502–8659.

There are two ways to become involved in the Commission's review of this project. First, any person wishing to obtain legal status by becoming a party to the proceedings for this project should, on or before the comment date stated below file with the Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426, a motion to intervene in accordance with the requirements of the Commission's Rules of Practice and Procedure (18 CFR 385.214 or 385.211) and the Regulations under the NGA (18 CFR 157.10). A person obtaining party status will be placed on the service list maintained by the Secretary of the Commission and will receive copies of all documents filed by the applicant and by all other parties. A party must submit 14 copies of filings made in the proceeding with the Commission and must mail a copy to the applicant and to every other party. Only parties to the proceeding can ask for court review of Commission orders in the proceeding.

However, a person does not have to intervene in order to have comments considered. The second way to participate is by filing with the Secretary of the Commission, as soon as possible, an original and two copies of comments in support of or in opposition to this project. The Commission will consider these comments in determining the appropriate action to be taken, but the filing of a comment alone will not serve to make the filer a party to the proceeding. The Commission's rules require that persons filing comments in opposition to the project provide copies of their protests only to the party or parties directly involved in the protest.

Persons who wish to comment only on the environmental review of this project should submit an original and two copies of their comments to the Secretary of the Commission. Environmental commentors will be placed on the Commission's environmental mailing list, will receive copies of the environmental documents, and will be notified of meetings associated with the Commission's environmental review process. Environmental commentors will not be required to serve copies of filed documents on all other parties. However, the non-party commentors will not receive copies of all documents filed by other parties or issued by the Commission (except for the mailing of environmental documents issued by the Commission) and will not have the right to seek court review of the Commission's final order.

The Commission strongly encourages electronic filings of comments, protests and interventions in lieu of paper using the eFiling link at *http://www.ferc.gov.* Persons unable to file electronically should submit an original and 14 copies of the protest or intervention to the Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426.

This filing is accessible on-line at *http://www.ferc.gov,* using the eLibrary link and is available for review in the Commission's Public Reference Room in Washington, DC. There is an eSubscription link on the Web site that enables subscribers to receive email notification when a document is added to a subscribed docket(s). For assistance with any FERC Online service, please e-mail *FERCOnlineSupport@ferc.gov*, or call (866) 208–3676 (toll free). For TTY, call (202) 502–8659.

Comment Date: August 17, 2010.

Kimberly D. Bose,

Secretary.

[FR Doc. 2010–18969 Filed 8–2–10; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. CP10–471–000]

Texas Eastern Transmission LP; Notice of Application

July 27, 2010.

Take notice that on July 15, 2010, Texas Eastern Transmission (Texas Eastern), P.O. Box 1642, Houston, Texas 77251–1642, filed in Docket No. CP10–471–000, an application pursuant to Section 7(c) of the Natural Gas Act (NGA) and Part 157 of the Commission's regulations, requesting authorization to construct and operate approximately 8.4 miles of 16-inch diameter natural gas pipeline and associated facilities to enable Texas Eastern to provide up to 112,000 dekatherms per day (Dth/d) of firm lateral line transportation service to the Hot Spring Energy Facility in Hot Spring County, Arkansas and to establish initial recourse rates for firm and interruptible transportation service on the facilities to be constructed, all as more fully set forth in the application which is on file with the Commission and open to public inspection. This filing may also be viewed on the Commission's Web site at *http://www.ferc.gov* using the "eLibrary" link. Enter the docket number, excluding the last three digits, in the docket number field to access the document. For assistance, call (866) 208–3676 or TTY, (202) 502–8659.

Any questions regarding this application should be directed to Arthur C. Diestel, Analyst, Rates and Certificates, Texas Eastern Transmission, LP, P.O. Box 1642, Houston, Texas 77251–1642, or by calling (713) 627–5116 (telephone) or (713) 627–5947 (fax), *acdiestel@spectraenergy.com*, to Marcy F. Collins, Associate General Counsel, Texas Eastern Transmission, LP, P.O. Box 1642, Houston, Texas 77251–1642, or by calling (713) 627–6137 (telephone) or (713) 989–3191, *mfcollins@spectraenergy.com*, or to James D. Seegers, Vinson & Elkins L.L.P., 1001 Fannin, Suite 2500, Houston, Texas 77002, or by calling (713) 758–2939 (telephone) or (713) 615–5206 (fax), *jseegers@velaw.com*.

Pursuant to Section 157.9 of the Commission's rules, 18 CFR 157.9, within 90 days of this Notice the Commission staff will either: Complete its environmental assessment (EA) and place it into the Commission's public record (eLibrary) for this proceeding, or issue a Notice of Schedule for Environmental Review. If a Notice of Schedule for Environmental Review is issued, it will indicate, among other milestones, the anticipated date for the Commission staff's issuance of the final environmental impact statement (FEIS) or EA for this proposal. The filing of the EA in the Commission's public record for this proceeding or the issuance of a Notice of Schedule for Environmental Review will serve to notify federal and state agencies of the timing for the completion of all necessary reviews, and the subsequent need to complete all federal authorizations within 90 days of the date of issuance of the Commission staff's FEIS or EA.

There are two ways to become involved in the Commission's review of this project. First, any person wishing to obtain legal status by becoming a party to the proceedings for this project should, on or before the comment date stated below, file with the Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426, a motion to intervene in accordance with the requirements of the Commission's Rules of Practice and Procedure (18 CFR 385.214 or 385.211) and the Regulations under the NGA (18 CFR 157.10). A person obtaining party status will be placed on the service list maintained by the Secretary of the Commission and will receive copies of all documents filed by the applicant and by all other parties. A party must submit 14 copies of filings made with the Commission and must mail a copy to the applicant and to every other party in the proceeding. Only parties to the proceeding can ask for court review of Commission orders in the proceeding.

However, a person does not have to intervene in order to have comments considered. The second way to participate is by filing with the Secretary of the Commission, as soon as possible, an original and two copies of comments in support of or in opposition to this project. The Commission will consider these comments in determining the appropriate action to be taken, but the filing of a comment alone will not serve to make the filer a party to the proceeding. The Commission's rules require that persons filing comments in opposition to the project provide copies of their protests only to the party or parties directly involved in the protest.

Persons who wish to comment only on the environmental review of this project should submit an original and two copies of their comments to the Secretary of the Commission. Environmental commenters will be placed on the Commission's environmental mailing list, will receive copies of the environmental documents, and will be notified of meetings associated with the Commission's environmental review process. Environmental commenters will not be required to serve copies of filed documents on all other parties. However, the non-party commenters will not receive copies of all documents filed by other parties or issued by the Commission (except for the mailing of environmental documents issued by the Commission) and will not have the right to seek court review of the Commission's final order.

Motions to intervene, protests and comments may be filed electronically via the Internet in lieu of paper; see, 18 CFR 385.2001(a)(1)(iii) and the instructions on the Commission's Web site under the "e-Filing" link. The Commission strongly encourages electronic filings.

Comment Date: August 17, 2009.

Kimberly D. Bose,

Secretary.

[FR Doc. 2010–18968 Filed 8–2–10; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

Combined Notice of Filings #1

July 22, 2010.

Take notice that the Commission received the following exempt wholesale generator filings:

Docket Numbers: EG10–54–000.

Applicants: Solar Partners I, LLC.

Description: Notice of Self-Certification of Exempt Wholesale Generator Status of Solar Partners I, LLC.

Filed Date: 07/21/2010.

Accession Number: 20100721–5171.

Comment Date: 5 p.m. Eastern Time on Wednesday, August 11, 2010.

Docket Numbers: EG10–55–000.

Applicants: Solar Partners II, LLC.

Description: Notice of Self-Certification of Exempt Wholesale Generator Status of Solar Partners II, LLC.

Filed Date: 07/21/2010.

Accession Number: 20100721–5172.

Comment Date: 5 p.m. Eastern Time on Wednesday, August 11, 2010.

Docket Numbers: EG10–56–000.

Applicants: Solar Partners VIII, LLC.

Description: Notice of Self-Certification of Exempt Wholesale Generator Status of Solar Partners VIII, LLC.

Filed Date: 07/21/2010.

Accession Number: 20100721–5175.

Comment Date: 5 p.m. Eastern Time on Wednesday, August 11, 2010.

Take notice that the Commission received the following electric rate filings:

Docket Numbers: ER05–305–007; ER04–878–006.

Applicants: Pinelawn Power LLC; Equus Power I, L.P.

Description: J-Power North America Holding, Ltd submits revisions to the Market-Based Rate Tariffs for Pinelawn Power LLC *et al.*

Filed Date: 07/19/2010.

Accession Number: 20100719–0214.

Comment Date: 5 p.m. Eastern Time on Monday, August 9, 2010.

Docket Numbers: ER07–1106–007.

Applicants: ArcLight Energy Marketing, LLC.

Description: ArcLight Energy Marketing, LLC submits requested additional information as supplement to its SPP Region Triennial.

Filed Date: 07/16/2010.

Accession Number: 20100719–0064.

Comment Date: 5 p.m. Eastern Time on Friday, August 6, 2010.

Docket Numbers: ER08–695–004.

Applicants: New England Conference of Public Utilities.

Description: Errata filing of New York Independent System Operator, Inc.

Filed Date: 07/22/2010.

Accession Number: 20100722–5031.

Comment Date: 5 p.m. Eastern Time on Thursday, August 12, 2010.

Docket Numbers: ER08–770–004.

Applicants: Longview Power.

Description: Longview Power, LLC Change-In-Status Notification.

Filed Date: 07/21/2010.

Accession Number: 20100721–5181.

Comment Date: 5 p.m. Eastern Time on Wednesday, August 11, 2010.

Docket Numbers: ER10–1357–002.

Applicants: Southern California Edison Company.

Description: Southern California Edison Company submits tariff filing per 35: TOT_Sec 8_Amendment_072210 to be effective 6/1/2010.

Filed Date: 07/22/2010.

Accession Number: 20100722–5000.

Comment Date: 5 p.m. Eastern Time on Thursday, August 12, 2010.

Docket Numbers: ER10–1424–001.

Applicants: Eagle Industrial Power Services (IL), LLC.

Description: Eagle Industrial Power Services, LLC submits a substitute original tariff sheet for rate Schedule FERC 1.

Filed Date: 07/16/2010.

Accession Number: 20100719–0206.

Comment Date: 5 p.m. Eastern Time on Friday, August 6, 2010.

Docket Numbers: ER10–1425–001.

Applicants: EDF Industrial Power Services (NY), LLC.

Description: EDF Industrial NY submits Substitute Original Sheet 1 *et al.* to Rate Schedule FERC No 1.

Filed Date: 07/16/2010.

Accession Number: 20100719–0205.

Comment Date: 5 p.m. Eastern Time on Friday, August 6, 2010.

Docket Numbers: ER10–1463–002.

Applicants: Midwest Independent Transmission System Operator, Inc.

Description: Midwest Independent Transmission System Operator, Inc. submits an amendment to the June filing to update re the Interconnection Agreement.

Filed Date: 07/12/2010.

Accession Number: 20100712–0206.

Comment Date: 5 p.m. Eastern Time on Monday, August 2, 2010.

Docket Numbers: ER10–1818–000.

Applicants: Public Service Company of Colorado.

Description: Public Service Company of Colorado submits tariff filing per 35: 20100720_Baseline Filing to be effective 7/20/2010.

Filed Date: 07/20/2010.

Accession Number: 20100720–5084.

Comment Date: 5 p.m. Eastern Time on Tuesday, August 10, 2010.

Docket Numbers: ER10–1854–000.

Applicants: Doswell Limited Partnership.

Description: Doswell Limited Partnership submits tariff filing per 35.12: Doswell Baseline Filing to be effective 7/21/2010.

Filed Date: 07/21/2010.

Accession Number: 20100721–5133.

Comment Date: 5 p.m. Eastern Time on Wednesday, August 11, 2010.

Docket Numbers: ER10–1855–000.

Applicants: FPL Energy Burleigh County Wind, LLC.

Description: FPL Energy Burleigh County Wind, LLC submits tariff filing per 35.12: FPLE Burleigh Baseline Filing to be effective 7/21/2010.

Filed Date: 07/21/2010.

Accession Number: 20100721–5136.

Comment Date: 5 p.m. Eastern Time on Wednesday, August 11, 2010.

Docket Numbers: ER10–1856–000.

Applicants: FPL Energy Cabazon Wind, LLC.

Description: FPL Energy Cabazon Wind, LLC submits tariff filing per 35.12: FPLE Cabazon Baseline Filing to be effective 7/21/2010.

Filed Date: 07/21/2010.

Accession Number: 20100721–5137.

Comment Date: 5 p.m. Eastern Time on Wednesday, August 11, 2010.

Docket Numbers: ER10–1857–000.

Applicants: FPL Energy Cape, LLC.

Description: FPL Energy Cape, LLC submits tariff filing per 35.12: FPLE Cape Baseline Filing to be effective 7/21/2010.

Filed Date: 07/21/2010.

Accession Number: 20100721–5147.

Comment Date: 5 p.m. Eastern Time on Wednesday, August 11, 2010.

Docket Numbers: ER10–1858–000.

Applicants: TBG Cogen Partners.

Description: TBG Cogen Partners submits tariff filing per 35.12: Market-Based Rate Tariff in Compliance with Order No. 714 to be effective 7/21/2010.

Filed Date: 07/21/2010.
Accession Number: 20100721–5149.
Comment Date: 5 p.m. Eastern Time on Wednesday, August 11, 2010.

Docket Numbers: ER10–1859–000.
Applicants: Santa Rosa Energy Center, LLC.
Description: Santa Rosa Energy Center, LLC submits tariff filing per 35.12: Market-Based Rate Tariff in Compliance with Order No. 714 to be effective 7/21/2010.
Filed Date: 07/21/2010.
Accession Number: 20100721–5150.
Comment Date: 5 p.m. Eastern Time on Wednesday, August 11, 2010.

Docket Numbers: ER10–1860–000.
Applicants: Rocky Mountain Energy Center, LLC.
Description: Rocky Mountain Energy Center, LLC submits tariff filing per 35.12: Market-Based Rate Tariff in Compliance with Order No. 714 to be effective 7/21/2010.
Filed Date: 07/21/2010.
Accession Number: 20100721–5151.
Comment Date: 5 p.m. Eastern Time on Wednesday, August 11, 2010.

Docket Numbers: ER10–1861–000.
Applicants: Riverside Energy Center, LLC.
Description: Riverside Energy Center, LLC submits tariff filing per 35.12: Market-Based Rate Tariff in Compliance with Order No. 714 to be effective 7/21/2010.
Filed Date: 07/21/2010.
Accession Number: 20100721–5152.
Comment Date: 5 p.m. Eastern Time on Wednesday, August 11, 2010.

Docket Numbers: ER10–1862–000.
Applicants: Power Contract Financing, L.L.C.
Description: Power Contract Financing, L.L.C. submits tariff filing per 35.12: Market-Based Rate Tariff in Compliance with Order No. 714 to be effective 7/21/2010.
Filed Date: 07/21/2010.
Accession Number: 20100721–5153.
Comment Date: 5 p.m. Eastern Time on Wednesday, August 11, 2010.

Docket Numbers: ER10–1863–000.
Applicants: Pine Bluff Energy, LLC.
Description: Pine Bluff Energy, LLC submits tariff filing per 35.12: Market-Based Rate Tariff in Compliance with Order No. 714 to be effective 7/21/2010.
Filed Date: 07/21/2010.
Accession Number: 20100721–5154.
Comment Date: 5 p.m. Eastern Time on Wednesday, August 11, 2010.

Docket Numbers: ER10–1864–000.
Applicants: Pastoria Energy Center, LLC.
Description: Pastoria Energy Center, LLC submits tariff filing per 35.12: Market-Based Rate Tariff in Compliance with Order No. 714 to be effective 7/21/2010.
Filed Date: 07/21/2010.
Accession Number: 20100721–5155.
Comment Date: 5 p.m. Eastern Time on Wednesday, August 11, 2010.

Docket Numbers: ER10–1865–000.
Applicants: South Point Energy Center, LLC.
Description: South Point Energy Center, LLC submits tariff filing per 35.12: Market-Based Rate Tariff in Compliance with Order No. 714 to be effective 7/21/2010.
Filed Date: 07/21/2010.
Accession Number: 20100721–5156.
Comment Date: 5 p.m. Eastern Time on Wednesday, August 11, 2010.

Docket Numbers: ER10–1866–000.
Applicants: New York Independent System Operator, Inc.
Description: New York Independent System Operator submits tariff filing per 35.13(a)(2)(iii): Section 205 BPCG filing—Bluvas—072110 to be effective 9/30/2010.
Filed Date: 07/21/2010.
Accession Number: 20100721–5157.
Comment Date: 5 p.m. Eastern Time on Wednesday, August 11, 2010.

Docket Numbers: ER10–1867–000.
Applicants: PCF2, LLC.
Description: PCF2, LLC submits tariff filing per 35.12: Market-Based Rate Tariff in Compliance with Order No. 714 to be effective 7/21/2010.
Filed Date: 07/21/2010.
Accession Number: 20100721–5160.
Comment Date: 5 p.m. Eastern Time on Wednesday, August 11, 2010.

Docket Numbers: ER10–1868–000; ER10–1868–001.
Applicants: WSPP Inc.
Description: WSPP Inc. submits tariff filing per 35.12: Baseline Electronic Tariff Filing to be effective 7/22/2010 and also submit and amendment to this filing.
Filed Date: 07/22/2010.
Accession Number: 20100722–5019; 20100722–5093.
Comment Date: 5 p.m. Eastern Time on Thursday, August 12, 2010.

Docket Numbers: ER10–1869–000.
Applicants: Mirant Energy Trading, LLC.
Description: Mirant Energy Trading, LLC submits tariff filing per 35.12: Market-Based Rate Tariff in Compliance with Order No. 714 to be effective 7/22/2010.
Filed Date: 07/22/2010.
Accession Number: 20100722–5038.
Comment Date: 5 p.m. Eastern Time on Thursday, August 12, 2010.

Docket Numbers: ER10–1870–000.
Applicants: Nissequogue Cogen Partners.
Description: Nissequogue Cogen Partners submits tariff filing per 35.12: Market-Based Rate Tariff in Compliance with Order No. 714 to be effective 7/22/2010.
Filed Date: 07/22/2010.
Accession Number: 20100722–5039.
Comment Date: 5 p.m. Eastern Time on Thursday, August 12, 2010.

Docket Numbers: ER10–1871–000.
Applicants: Morgan Energy Center, LLC.
Description: Morgan Energy Center, LLC submits tariff filing per 35.12: Market-Based Rate Tariff in Compliance with Order No. 714 to be effective 7/22/2010.
Filed Date: 07/22/2010.
Accession Number: 20100722–5040.
Comment Date: 5 p.m. Eastern Time on Thursday, August 12, 2010.

Docket Numbers: ER10–1872–000.
Applicants: Mobile Energy, LLC.
Description: Mobile Energy, LLC submits tariff filing per 35.12: Market-Based Rate Tariff in Compliance with Order No. 714 to be effective 7/22/2010.
Filed Date: 07/22/2010.
Accession Number: 20100722–5041.
Comment Date: 5 p.m. Eastern Time on Thursday, August 12, 2010.

Docket Numbers: ER10–1873–000.
Applicants: Metcalf Energy Center, LLC.
Description: Metcalf Energy Center, LLC submits tariff filing per 35.12: Market-Based Rate Tariff in Compliance with Order No. 714 to be effective 7/22/2010.
Filed Date: 07/22/2010.
Accession Number: 20100722–5042.
Comment Date: 5 p.m. Eastern Time on Thursday, August 12, 2010.

Docket Numbers: ER10–1874–000.
Applicants: Mankato Energy Center, LLC.
Description: Mankato Energy Center, LLC submits tariff filing per 35.12: Market-Based Rate Tariff in Compliance with Order No. 714 to be effective 7/22/2010.
Filed Date: 07/22/2010.
Accession Number: 20100722–5043.
Comment Date: 5 p.m. Eastern Time on Thursday, August 12, 2010.

Docket Numbers: ER10–1875–000.
Applicants: Los Medanos Energy Center LLC.
Description: Los Medanos Energy Center LLC submits tariff filing per 35.12: Market-Based Rate Tariff in Compliance with Order No. 714 to be effective 7/22/2010.
Filed Date: 07/22/2010.
Accession Number: 20100722–5044.
Comment Date: 5 p.m. Eastern Time on Thursday, August 12, 2010.

Docket Numbers: ER10–1876–000.
Applicants: Los Esteros Critical Energy Facility, LLC.
Description: Los Esteros Critical Energy Facility, LLC submits tariff filing per 35.12: Market-Based Rate Tariff in Compliance with Order No. 714 to be effective 7/22/2010.
Filed Date: 07/22/2010.
Accession Number: 20100722–5045.
Comment Date: 5 p.m. Eastern Time on Thursday, August 12, 2010.

Docket Numbers: ER10–1877–000.
Applicants: Hermiston Power, LLC.
Description: Hermiston Power, LLC submits tariff filing per 35.12: Market-Based Rate Tariff in Compliance with Order No. 714 to be effective 7/22/2010.
Filed Date: 07/22/2010.
Accession Number: 20100722–5046.
Comment Date: 5 p.m. Eastern Time on Thursday, August 12, 2010.

Docket Numbers: ER10–1878–000.
Applicants: Goose Haven Energy Center, LLC.
Description: Goose Haven Energy Center, LLC submits tariff filing per 35.12: Market-Based Rate Tariff in Compliance with Order No. 714 to be effective 7/22/2010.
Filed Date: 07/22/2010.
Accession Number: 20100722–5047.
Comment Date: 5 p.m. Eastern Time on Thursday, August 12, 2010.

Docket Numbers: ER10–1879–000.
Applicants: Wabash Valley Power Association, Inc.
Description: Wabash Valley Power Association, Inc. submits tariff filing per 35: WVPA Baseline Formulary Rate Tariff to be effective 7/22/2010.
Filed Date: 07/22/2010.
Accession Number: 20100722–5048.
Comment Date: 5 p.m. Eastern Time on Thursday, August 12, 2010.

Docket Numbers: ER10–1880–000.
Applicants: MidAmerican Energy Company.
Description: MidAmerican Energy Company submits an agreement for Wholesale Distribution Service.
Filed Date: 07/22/2010.
Accession Number: 20100721–0215.
Comment Date: 5 p.m. Eastern Time on Thursday, August 12, 2010.

Docket Numbers: ER10–1881–000.
Applicants: Stuyvesant Energy LLC.
Description: Stuyvesant Energy, LLC submits the Application for Market-Based Rate Authorization and Request for Waivers and Blanket Approval and request for Expedited Treatment.
Filed Date: 07/22/2010.
Accession Number: 20100721–0214.
Comment Date: 5 p.m. Eastern Time on Thursday, August 12, 2010.

Docket Numbers: ER10–1882–000.
Applicants: Wisconsin River Power Company.
Description: Wisconsin River Power Company submits tariff filing per 35.12: Market Based Rate Tariff, Volume No. 1 to be effective 7/22/2010.
Filed Date: 07/22/2010.
Accession Number: 20100722–5064.
Comment Date: 5 p.m. Eastern Time on Thursday, August 12, 2010.

Docket Numbers: ER10–1883–000.
Applicants: Gilroy Energy Center, LLC.
Description: Gilroy Energy Center, LLC submits tariff filing per 35.12: Market-Based Rate Tariff in Compliance with Order No. 714 to be effective 7/22/2010.
Filed Date: 07/22/2010.
Accession Number: 20100722–5094.
Comment Date: 5 p.m. Eastern Time on Thursday, August 12, 2010.

Docket Numbers: ER10–1884–000.
Applicants: Geysers Power Company, LLC.
Description: Geysers Power Company, LLC submits tariff filing per 35.12: Market-Based Rate Tariff in Compliance with Order No. 714 to be effective 7/22/2010.
Filed Date: 07/22/2010.
Accession Number: 20100722–5095.
Comment Date: 5 p.m. Eastern Time on Thursday, August 12, 2010.

Any person desiring to intervene or to protest in any of the above proceedings must file in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211 and 385.214) on or before 5 p.m. Eastern time on the specified comment date. It is not necessary to separately intervene again in a subdocket related to a compliance filing if you have previously intervened in the same docket. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Anyone filing a motion to intervene or protest must serve a copy of that document on the Applicant. In reference to filings initiating a new proceeding, interventions or protests submitted on or before the comment deadline need not be served on persons other than the Applicant.

As it relates to any qualifying facility filings, the notices of self-certification [or self-recertification] listed above, do not institute a proceeding regarding qualifying facility status. A notice of self-certification [or self-recertification] simply provides notification that the entity making the filing has determined the facility named in the notice meets the applicable criteria to be a qualifying facility. Intervention and/or protest do not lie in dockets that are qualifying facility self-certifications or self-recertifications. Any person seeking to challenge such qualifying facility status may do so by filing a motion pursuant to 18 CFR 292.207(d)(iii). Intervention and protests may be filed in response to notices of qualifying facility dockets other than self-certifications and self-recertifications.

The Commission encourages electronic submission of protests and interventions in lieu of paper, using the FERC Online links at *http://www.ferc.gov.* To facilitate electronic service, persons with Internet access who will eFile a document and/or be listed as a contact for an intervenor must create and validate an eRegistration account using the eRegistration link. Select the eFiling link to log on and submit the intervention or protests.

Persons unable to file electronically should submit an original and 14 copies of the intervention or protest to the Federal Energy Regulatory Commission, 888 First St., NE., Washington, DC 20426.

The filings in the above proceedings are accessible in the Commission's eLibrary system by clicking on the appropriate link in the above list. They are also available for review in the Commission's Public Reference Room in Washington, DC. There is an eSubscription link on the web site that enables subscribers to receive e-mail notification when a document is added to a subscribed dockets(s). For assistance with any FERC Online service, please e-mail *FERCOnlineSupport@ferc.gov.* or call (866) 208–3676 (toll free). For TTY, call (202) 502–8659.

Nathaniel J. Davis, Sr.,

Deputy Secretary.

[FR Doc. 2010–18978 Filed 8–2–10; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

Combined Notice of Filings #1

July 26, 2010.

Take notice that the Commission received the following electric rate filings:

Docket Numbers: ER93–3–007.
Applicants: The United Illuminating Company.
Description: Response of The United Illuminating Company to Commission Staff Request.
Filed Date: 07/22/2010.

Accession Number: 20100722–5155.
Comment Date: 5 p.m. Eastern Time on Thursday, August 12, 2010.

Docket Numbers: ER01–48–019.
Applicants: Powerex Corp.
Description: Powerex Corp. Non-Material Change in Status.
Filed Date: 07/26/2010.
Accession Number: 20100726–5122.
Comment Date: 5 p.m. Eastern Time on Monday, August 16, 2010.

Docket Numbers: ER06–1399–007.
Applicants: Sunbury Generation LP.
Description: Notice of non-Material Change in Status of Sunbury Generation LP.
Filed Date: 07/26/2010.
Accession Number: 20100726–5133.
Comment Date: 5 p.m. Eastern Time on Monday, August 16, 2010.

Docket Numbers: ER08–695–004; EL07–39–006.
Applicants: New England Conference of Public Utilities.
Description: Errata filing of New York Independent System Operator, Inc.
Filed Date: 07/22/2010.
Accession Number: 20100722–5031.
Comment Date: 5 p.m. Eastern Time on Thursday, August 12, 2010.

Docket Numbers: ER10–1357–002.
Applicants: Southern California Edison Company.
Description: Southern California Edison Company submits tariff filing per 35: TOT_Sec 8_Amendment_072210 to be effective 6/1/2010.
Filed Date: 07/22/2010.
Accession Number: 20100722–5000.
Comment Date: 5 p.m. Eastern Time on Thursday, August 12, 2010.

Docket Numbers: ER10–1383–001; ER07–412–005; ER06–745–005; ER09–1099–004; ER10–1089–001; ER99–1714–009.
Applicants: Dighton Power, LLC; ECP Energy I, LLC; MASSPOWER; Empire Generating Co., LLC; EquiPower Resources Management, LLC; Lake Road Generating Company, L.P.
Description: ECP MBR Entities submits additional information in response to a discussion with Commission Staff on the Notice Filing.
Filed Date: 07/20/2010.
Accession Number: 20100720–0015.
Comment Date: 5 p.m. Eastern Time on Tuesday, August 10, 2010.

Docket Numbers: ER10–1789–001.
Applicants: PSEG Energy Resources & Trade LLC.
Description: PSEG Energy Resources & Trade LLC submits tariff filing per 35: Filing in compliance with FERC Letter Order of May 17, 2010 to be effective 7/1/2010.
Filed Date: 07/23/2010.
Accession Number: 20100723–5165.
Comment Date: 5 p.m. Eastern Time on Friday, August 13, 2010.

Docket Numbers: ER10–1885–000.
Applicants: Delta Energy Center, LLC.
Description: Delta Energy Center, LLC submits tariff filing per 35.12: Market-Based Rate Tariff in Compliance with Order No. 714 to be effective 7/22/2010.
Filed Date: 07/22/2010.
Accession Number: 20100722–5096.
Comment Date: 5 p.m. Eastern Time on Thursday, August 12, 2010.

Docket Numbers: ER10–1886–000.
Applicants: Decatur Energy Center, LLC.
Description: Decatur Energy Center, LLC submits tariff filing per 35.12: Market-Based Rate Tariff in Compliance with Order No. 714 to be effective 7/22/2010.
Filed Date: 07/22/2010.
Accession Number: 20100722–5097.
Comment Date: 5 p.m. Eastern Time on Thursday, August 12, 2010.

Docket Numbers: ER10–1887–000.
Applicants: FPL Energy Cowboy Wind, LLC.
Description: FPL Energy Cowboy Wind, LLC submits tariff filing per 35.12: Cowboy Baseline Filing to be effective 7/22/2010.
Filed Date: 07/22/2010.
Accession Number: 20100722–5099.
Comment Date: 5 p.m. Eastern Time on Thursday, August 12, 2010.

Docket Numbers: ER10–1888–000.
Applicants: Creed Energy Center, LLC.
Description: Creed Energy Center, LLC submits tariff filing per 35.12: Market-Based Rate Tariff in Compliance with Order No. 714 to be effective 7/22/2010.
Filed Date: 07/22/2010.
Accession Number: 20100722–5103.
Comment Date: 5 p.m. Eastern Time on Thursday, August 12, 2010.

Docket Numbers: ER10–1889–000.
Applicants: CPN Bethpage 3rd Turbine, Inc.
Description: CPN Bethpage 3rd Turbine, Inc. submits tariff filing per 35.12: Market-Based Rate Tariff in Compliance with Order No. 714 to be effective 7/22/2010.
Filed Date: 07/22/2010.
Accession Number: 20100722–5108.
Comment Date: 5 p.m. Eastern Time on Thursday, August 12, 2010.

Docket Numbers: ER10–1890–000.
Applicants: FPL Energy Green Power Wind, LLC.
Description: FPL Energy Green Power Wind, LLC submits tariff filing per 35.12: Green Power Baseline Filing to be effective 7/22/2010.
Filed Date: 07/22/2010.
Accession Number: 20100722–5110
Comment Date: 5 p.m. Eastern Time on Thursday, August 12, 2010

Docket Numbers: ER10–1891–000.
Applicants: Citigroup Energy Inc.
Description: Citigroup Energy Inc. submits tariff filing per 35.12: Citigroup Energy Inc. MBR Tariff to be effective 7/22/2010.
Filed Date: 07/22/2010.
Accession Number: 20100722–5115.
Comment Date: 5 p.m. Eastern Time on Thursday, August 12, 2010.

Docket Numbers: ER10–1892–000.
Applicants: Columbia Energy LLC.
Description: Columbia Energy LLC submits tariff filing per 35.12: Market-Based Rate Tariff in Compliance with Order No. 714 to be effective 7/22/2010.
Filed Date: 07/22/2010.
Accession Number: 20100722–5116.
Comment Date: 5 p.m. Eastern Time on Thursday, August 12, 2010.

Docket Numbers: ER10–1893–000.
Applicants: CES Marketing X, LLC.
Description: CES Marketing X, LLC submits tariff filing per 35.12: Market-Based Rate Tariff in Compliance with Order No. 714 to be effective 7/22/2010.
Filed Date: 07/22/2010.
Accession Number: 20100722–5117.
Comment Date: 5 p.m. Eastern Time on Thursday, August 12, 2010.

Docket Numbers: ER10–1894–000; ER10–1894–001.
Applicants: Wisconsin Public Service Corporation.
Description: Wisconsin Public Service Corporation submits tariff filing per 35.12: Market Based Rate Tariff, Volume No. 10 to be effective 7/22/2010.
Filed Date: 07/22/2010; 07/23/2010.
Accession Number: 20100722–5119; 20100723–5079.
Comment Date: 5 p.m. Eastern Time on Thursday, August 12, 2010.

Docket Numbers: ER10–1895–000.
Applicants: KIAC Partners.
Description: KIAC Partners submits tariff filing per 35.12: Market-Based Rate Tariff in Compliance with Order No. 714, to be effective 7/22/2010.
Filed Date: 07/22/2010.
Accession Number: 20100722–5121.
Comment Date: 5 p.m. Eastern Time on Thursday, August 12, 2010.

Docket Numbers: ER10–1896–000.
Applicants: Citigroup Energy Canada ULC.
Description: Citigroup Energy Canada ULC submits tariff filing per 35.12: Citigroup Energy Canada ULC MBR Tariff to be effective 7/22/2010.
Filed Date: 07/22/2010.
Accession Number: 20100722–5125.
Comment Date: 5 p.m. Eastern Time on Thursday, August 12, 2010.

Docket Numbers: ER10–1897–000.
Applicants: FPL Energy Hancock County Wind, LLC.
Description: FPL Energy Hancock County Wind, LLC submits tariff filing per 35.12: Hancock County Baseline Filing, to be effective 7/22/2010.
Filed Date: 07/22/2010.
Accession Number: 20100722–5127.
Comment Date: 5 p.m. Eastern Time on Thursday, August 12, 2010.

Docket Numbers: ER10–1898–000.
Applicants: CES Marketing V, L.P.
Description: CES Marketing V, L.P. submits tariff filing per 35.12: Market-Based Rate Tariff in Compliance with Order No. 714, to be effective 7/22/2010.
Filed Date: 07/22/2010.
Accession Number: 20100722–5128.
Comment Date: 5 p.m. Eastern Time on Thursday, August 12, 2010.

Docket Numbers: ER10–1899–000.
Applicants: FPL Energy Illinois Wind, LLC.
Description: FPL Energy Illinois Wind, LLC submits tariff filing per 35.12: Illinois Wind Baseline Filing 2, to be effective 7/22/2010.
Filed Date: 07/22/2010.
Accession Number: 20100722–5129.
Comment Date: 5 p.m. Eastern Time on Thursday, August 12, 2010.

Docket Numbers: ER10–1900–000.
Applicants: FPL Energy Maine Hydro, LLC.
Description: FPL Energy Maine Hydro, LLC submits tariff filing per 35.12: Maine Hydro Baseline Filing to be effective 7/22/2010.
Filed Date: 07/22/2010.
Accession Number: 20100722–5131.
Comment Date: 5 p.m. Eastern Time on Thursday, August 12, 2010.

Docket Numbers: ER10–1901–000.
Applicants: Upper Peninsula Power Company.
Description: Upper Peninsula Power Company submits tariff filing per 35.12: Market Based Rate Tariff, Volume No. 1 to be effective 7/22/2010.
Filed Date: 07/22/2010.
Accession Number: 20100722–5132.
Comment Date: 5 p.m. Eastern Time on Thursday, August 12, 2010.

Docket Numbers: ER10–1902–000.
Applicants: FPL Energy Marcus Hook, L.P.
Description: FPL Energy Marcus Hook, L.P. submits tariff filing per 35.12: Marcus Hook Baseline Filing to be effective 7/22/2010.
Filed Date: 07/22/2010.
Accession Number: 20100722–5133.
Comment Date: 5 p.m. Eastern Time on Thursday, August 12, 2010.

Docket Numbers: ER10–1903–000.
Applicants: FPL Energy MH50 L.P.
Description: FPL Energy MH50 L.P. submits tariff filing per 35.12: MH50 Baseline Filing, to be effective 7/22/2010.
Filed Date: 07/22/2010.
Accession Number: 20100722–5134.
Comment Date: 5 p.m. Eastern Time on Thursday, August 12, 2010.

Docket Numbers: ER10–1904–000.
Applicants: Dominion Energy Salem Harbor, LLC.
Description: Dominion Energy Salem Harbor, LLC submits tariff filing per 35.12: Baseline, to be effective 7/22/2010.
Filed Date: 07/22/2010.
Accession Number: 20100722–5135.
Comment Date: 5 p.m. Eastern Time on Thursday, August 12, 2010.

Docket Numbers: ER10–1905–000.
Applicants: FPL Energy Mower County, LLC.
Description: FPL Energy Mower County, LLC submits tariff filing per 35.12: Mower Baseline Filing, to be effective 7/22/2010.
Filed Date: 07/22/2010.
Accession Number: 20100722–5136.
Comment Date: 5 p.m. Eastern Time on Thursday, August 12, 2010.

Docket Numbers: ER10–1906–000.
Applicants: FPL Energy New Mexico Wind, LLC.
Description: FPL Energy New Mexico Wind, LLC submits tariff filing per 35.12: New Mexico Baseline Filing to be effective 7/22/2010.
Filed Date: 07/22/2010.
Accession Number: 20100722–5137.
Comment Date: 5 p.m. Eastern Time on Thursday, August 12, 2010.

Docket Numbers: ER10–1907–000.
Applicants: FPL Energy North Dakota Wind, LLC.
Description: FPL Energy North Dakota Wind, LLC submits tariff filing per 35.12: North Dakota Baseline Filing to be effective 7/22/2010.
Filed Date: 07/22/2010.
Accession Number: 20100722–5138.
Comment Date: 5 p.m. Eastern Time on Thursday, August 12, 2010.

Docket Numbers: ER10–1913–000.
Applicants: Midwest Independent Transmission System.
Description: Midwest Independent Transmission System Operator, Inc submits their Adjacent Balancing Authority Coordination Agreement with Western Area Power Administration etc.
Filed Date: 07/22/2010.
Accession Number: 20100723–0203.
Comment Date: 5 p.m. Eastern Time on Thursday, August 12, 2010.

Docket Numbers: ER10–1914–000.
Applicants: Michigan Waste Energy, Inc.
Description: Michigan Waste Energy, Inc submits a Notice of Cancellation of their initial FERC Electric Tariff, Original Volume 1.
Filed Date: 07/22/2010.
Accession Number: 20100723–0202.
Comment Date: 5 p.m. Eastern Time on Thursday, August 12, 2010.

Take notice that the Commission received the following PURPA 210(m)(3) filings:

Docket Numbers: QM10–5–000.
Applicants: Delmarva Power & Light Company, Potomac Electric Power Company, Atlantic City Electric Company.
Description: Application of Atlantic City Electric Company, Delmarva Power & Light Company and Potomac Electric Power Company to Terminate PURPA Purchase Obligation.
Filed Date: 07/22/2010.
Accession Number: 20100722–5153.
Comment Date: 5 p.m. Eastern Time on Thursday, August 19, 2010.

Any person desiring to intervene or to protest in any of the above proceedings must file in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211 and 385.214) on or before 5 p.m. Eastern time on the specified comment date. It is not necessary to separately intervene again in a subdocket related to a compliance filing if you have previously intervened in the same docket. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Anyone filing a motion to intervene or protest must serve a copy of that document on the Applicant. In reference to filings initiating a new proceeding, interventions or protests submitted on or before the comment deadline need not be served on persons other than the Applicant.

As it relates to any qualifying facility filings, the notices of self-certification [or self-recertification] listed above, do not institute a proceeding regarding qualifying facility status. A notice of self-certification [or self-recertification] simply provides notification that the entity making the filing has determined the facility named in the notice meets the applicable criteria to be a qualifying facility. Intervention and/or protest do not lie in dockets that are qualifying facility self-certifications or self-recertifications. Any person seeking to challenge such qualifying facility status may do so by filing a motion pursuant to 18 CFR 292.207(d)(iii). Intervention and protests may be filed in response to notices of qualifying facility dockets other than self-certifications and self-recertifications.

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Nathaniel J. Davis, Sr.,

Deputy Secretary.

[FR Doc. 2010–18982 Filed 8–2–10; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

Combined Notice of Filings #1

July 27, 2010.

Take notice that the Commission received the following electric rate filings:

Docket Numbers: ER00–2469–006.

Applicants: Williams Flexible Generation, LLC.

Description: Williams Flexible Generation, LLC submits an Amended Application for Finding as a Category 1 Seller.

Filed Date: 07/23/2010.

Accession Number: 20100726–0018.

Comment Date: 5 p.m. Eastern Time on Friday, August 13, 2010.

Docket Numbers: ER08–1226–007; ER08–1225–010; ER08–1111–008.

Applicants: Cloud County Wind Farm, LLC, Pioneer Prairie Wind Farm I, LLC, Arlington Wind Power Project LLC.

Description: Arlington Wind Power Project LLC, *et al.* Notice of Non-Material Change in Status in Compliance with Requirements set forth in Section 35.42.

Filed Date: 07/23/2010.

Accession Number: 20100723–5198.

Comment Date: 5 p.m. Eastern Time on Friday, August 13, 2010.

Docket Numbers: ER10–1850–000.

Applicants: Velocity Futures, L.P.

Description: Velocity Futures, LLC submits Notice of Cancellation of Market-based Rate Authority.

Filed Date: 07/21/2010.

Accession Number: 20100721–0211.

Comment Date: 5 p.m. Eastern Time on Wednesday, August 11, 2010.

Docket Numbers: ER10–1957–000.

Applicants: Northern Maine Independent System Administrator, Inc.

Description: Northern Maine Independent System Administrator, Inc. submits revisions to their FERC Electric Tariff Original Volume 1, effective September 24, 2010.

Filed Date: 07/26/2010.

Accession Number: 20100726–0207.

Comment Date: 5 p.m. Eastern Time on Monday, August 16, 2010.

Docket Numbers: ER10–1960–000.

Applicants: Southwest Power Pool, Inc.

Description: Southwest Power Pool, Inc. submits tariff filing per 35.12: Baseline Electronic Tariff Filing to be effective 7/26/2010.

Filed Date: 07/26/2010.

Accession Number: 20100726–5191.

Comment Date: 5 p.m. Eastern Time on Monday, August 16, 2010.

Docket Numbers: ER10–1961–000.

Applicants: High Majestic Wind Energy Center, LLC.

Description: High Majestic Wind Energy Center, LLC submits tariff filing per 35.12: High Majestic Baseline Filing to be effective 7/26/2010.

Filed Date: 07/26/2010.

Accession Number: 20100726–5198.

Comment Date: 5 p.m. Eastern Time on Monday, August 16, 2010.

Docket Numbers: ER10–1962–000.

Applicants: High Winds, LLC.

Description: High Winds, LLC submits tariff filing per 35.12: High Winds Baseline filing to be effective 7/26/2010.

Filed Date: 07/26/2010.

Accession Number: 20100726–5199.

Comment Date: 5 p.m. Eastern Time on Monday, August 16, 2010.

Docket Numbers: ER10–1963–000.

Applicants: Jamaica Bay Peaking Facility, LLC.

Description: Jamaica Bay Peaking Facility, LLC submits tariff filing per 35.12: Jamaica Bay Baseline Filing to be effective 7/26/2010.

Filed Date: 07/26/2010.

Accession Number: 20100726–5200.

Comment Date: 5 p.m. Eastern Time on Monday, August 16, 2010.

Docket Numbers: ER10–1964–000.

Applicants: Lake Benton Power Partners II, LLC.

Description: Lake Benton Power Partners II, LLC submits tariff filing per 35.12: Lake Benton II Baseline Filing to be effective 7/26/2010.

Filed Date: 07/26/2010.

Accession Number: 20100726–5202.

Comment Date: 5 p.m. Eastern Time on Monday, August 16, 2010.

Docket Numbers: ER10–1965–000.

Applicants: Langdon Wind, LLC.

Description: Langdon Wind, LLC submits tariff filing per 35.12: Langdon Baseline Filing to be effective 7/26/2010.

Filed Date: 07/26/2010.

Accession Number: 20100726–5206.

Comment Date: 5 p.m. Eastern Time on Monday, August 16, 2010.

Docket Numbers: ER10–1966–000.

Applicants: Logan Wind Energy LLC.

Description: Logan Wind Energy LLC submits tariff filing per 35.12: Logan Baseline Filing to be effective 7/26/2010.

Filed Date: 07/26/2010.

Accession Number: 20100726–5212.

Comment Date: 5 p.m. Eastern Time on Monday, August 16, 2010.

Docket Numbers: ER10–1967–000.

Applicants: Meyersdale Windpower LLC.

Description: Meyersdale Windpower LLC submits tariff filing per 35.12: Meyersdale Baseline Filing to be effective 7/26/2010.

Filed Date: 07/26/2010.

Accession Number: 20100726–5219.

Comment Date: 5 p.m. Eastern Time on Monday, August 16, 2010.

Docket Numbers: ER10–1968–000.

Applicants: Mill Run Windpower, LLC.

Description: Mill Run Windpower, LLC submits tariff filing per 35.12: Mill Run Baseline Filing to be effective 7/26/2010.

Filed Date: 07/26/2010.

Accession Number: 20100726–5225.

Comment Date: 5 p.m. Eastern Time on Monday, August 16, 2010.

Docket Numbers: ER10–1969–000.

Applicants: PJM Interconnection, LLC.

Description: PJM Interconnection, LLC submits two executed interconnection service agreements under ER10–1969.

Filed Date: 07/26/2010.

Accession Number: 20100726–0208.

Comment Date: 5 p.m. Eastern Time on Monday, August 16, 2010.

Docket Numbers: ER10–1970–000.
Applicants: NextEra Energy Duane Arnold, LLC.
Description: NextEra Energy Duane Arnold, LLC submits tariff filing per 35.12: Duane Arnold Baseline Filing to be effective 7/26/2010.
Filed Date: 07/26/2010.
Accession Number: 20100726–5232.
Comment Date: 5 p.m. Eastern Time on Monday, August 16, 2010.

Docket Numbers: ER10–1971–000.
Applicants: NextEra Energy Power Marketing, LLC.
Description: NextEra Energy Power Marketing, LLC submits tariff filing per 35.12: Power Marketing Baseline Filing to be effective 7/26/2010.
Filed Date: 07/26/2010.
Accession Number: 20100726–5234.
Comment Date: 5 p.m. Eastern Time on Monday, August 16, 2010.

Docket Numbers: ER10–1972–000.
Applicants: NextEra Energy Point Beach, LLC.
Description: NextEra Energy Point Beach, LLC submits tariff filing per 35.12: Point Beach Baseline Filing to be effective 7/26/2010.
Filed Date: 07/26/2010.
Accession Number: 20100726–5239.
Comment Date: 5 p.m. Eastern Time on Monday, August 16, 2010.

Docket Numbers: ER10–1973–000.
Applicants: NextEra Energy Seabrook, LLC.
Description: NextEra Energy Seabrook, LLC submits tariff filing per 35.12: Seabrook MBR Baseline Filing to be effective 7/26/2010.
Filed Date: 07/26/2010.
Accession Number: 20100726–5241.
Comment Date: 5 p.m. Eastern Time on Monday, August 16, 2010.

Docket Numbers: ER10–1974–000.
Applicants: Northeast Energy Associates, L.P.
Description: Northeast Energy Associates, L.P. submits tariff filing per 35.12: NEA Baseline Filing to be effective 7/26/2010.
Filed Date: 07/26/2010.
Accession Number: 20100726–5242.
Comment Date: 5 p.m. Eastern Time on Monday, August 16, 2010.

Docket Numbers: ER10–1975–000.
Applicants: North Jersey Energy Associates, L.P.
Description: North Jersey Energy Associates, L.P. submits tariff filing per 35.12: NJEA Baseline Filing to be effective 7/26/2010.
Filed Date: 07/26/2010.
Accession Number: 20100726–5243.
Comment Date: 5 p.m. Eastern Time on Monday, August 16, 2010.

Docket Numbers: ER10–1976–000.
Applicants: Northern Colorado Wind Energy, LLC.
Description: Northern Colorado Wind Energy, LLC submits tariff filing per 35.12: Northern Colorado Baseline Filing to be effective 7/26/2010.
Filed Date: 07/26/2010.
Accession Number: 20100726–5244.
Comment Date: 5 p.m. Eastern Time on Monday, August 16, 2010.

Docket Numbers: ER10–1977–000.
Applicants: New York Independent System Operator Inc.
Description: New York Independent System Operator submits tariff filing per 35.13(a)(2)(iii: Section 205 filing—IBRT—Lampi to be effective 9/30/2010.
Filed Date: 07/26/2010.
Accession Number: 20100726–5259.
Comment Date: 5 p.m. Eastern Time on Monday, August 16, 2010.

Docket Numbers: ER10–1978–000.
Applicants: Cleco Power LLC.
Description: Cleco Power LLC submits their baseline Open Access Transmission Tariff pursuant to Order No 714, to be effective 7/27/2010.
Filed: 07/27/2010.
Accession Number: 20100727–5003.
Comment Date: 5 p.m. Eastern Time on Tuesday, August 17, 2010.

Docket Numbers: ER10–1979–000.
Applicants: Southern California Edison Company.
Description: Southern California Edison Company submits a Small Generator Interconnection Agreement and a Service Agreement for Wholesale Distribution Service under FERC Electric Tariff, 2nd Revised Volume 5, effective 7/28/2010.
Filed Date: 07/27/2010.
Accession Number: 20100727–5005.
Comment Date: 5 p.m. Eastern Time on Tuesday, August 17, 2010.

Docket Numbers: ER10–1980–000.
Applicants: Consolidated Edison Company of New York.
Description: Consolidated Edison Company of New York, Inc. submits tariff filing per 35.12: Baseline Filing of Con Edison EDDS Rate Schedule No. 92 to be effective 7/27/2010.
Filed Date: 07/27/2010.
Accession Number: 20100727–5058.
Comment Date: 5 p.m. Eastern Time on Tuesday, August 17, 2010.

Docket Numbers: ER10–1981–000.
Applicants: Southern California Edison Company.
Description: Southern California Edison Company submits tariff filing per 35.13(a)(2)(iii): SGIA–DSA SA255&256 GBU N 072710 to be effective 7/28/2010.
Filed Date: 07/27/2010.
Accession Number: 20100727–5060.
Comment Date: 5 p.m. Eastern Time on Tuesday, August 17, 2010.

Docket Numbers: ER10–1982–000.
Applicants: Consolidated Edison Company of New York, Inc.
Description: Consolidated Edison Company of New York, Inc. submits tariff filing per 35.12: Baseline Filing of Con Edison MBR Tariff to be effective 7/27/2010.
Filed Date: 07/27/2010.
Accession Number: 20100727–5075.
Comment Date: 5 p.m. Eastern Time on Tuesday, August 17, 2010.

Docket Numbers: ER10–1983–000.
Applicants: Osceola Windpower, LLC.
Description: Osceola Windpower, LLC submits tariff filing per 35.12: Osceola Baseline Filing to be effective 7/27/2010.
Filed Date: 07/27/2010.
Accession Number: 20100727–5084.
Comment Date: 5 p.m. Eastern Time on Tuesday, August 17, 2010.

Docket Numbers: ER10–1984–000.
Applicants: Osceola Windpower II, LLC.
Description: Osceola Windpower II, LLC submits tariff filing per 35.12: Osceola II Baseline Filing to be effective 7/27/2010.
Filed Date: 07/27/2010.
Accession Number: 20100727–5085.
Comment Date: 5 p.m. Eastern Time on Tuesday, August 17, 2010.

Docket Numbers: ER10–1985–000.
Applicants: Peetz Table Wind Energy, LLC.
Description: Peetz Table Wind Energy, LLC submits tariff filing per 35.12: Peetz Table Baseline Filing to be effective 7/27/2010.
Filed Date: 07/27/2010.
Accession Number: 20100727–5088.
Comment Date: 5 p.m. Eastern Time on Tuesday, August 17, 2010.

Docket Numbers: ER10–1986–000.
Applicants: Pennsylvania Windfarms, Inc.
Description: Pennsylvania Windfarms, Inc. submits tariff filing per 35.12: Pennsylvania Baseline Filing to be effective 7/27/2010.
Filed Date: 07/27/2010.
Accession Number: 20100727–5089.
Comment Date: 5 p.m. Eastern Time on Tuesday, August 17, 2010.

Docket Numbers: ER10–1987–000.
Applicants: Ontario Power Generation Energy Trading, Inc.
Description: Ontario Power Generation Energy Trading, Inc. submits tariff filing per 35.12: Baseline for Ontario Power Generation Energy Trading, Inc. (Market-Based Rates) to be effective 7/27/2010.
Filed Date: 07/27/2010.

Accession Number: 20100727–5090.
Comment Date: 5 p.m. Eastern Time on Tuesday, August 17, 2010.

Docket Numbers: ER10–1988–000.
Applicants: Sagebrush, a California partnership.
Description: Sagebrush, a California partnership submits tariff filing per 35.12: Sagebrush Baseline Filing Final to be effective 7/27/2010.
Filed Date: 07/27/2010.
Accession Number: 20100727–5091.
Comment Date: 5 p.m. Eastern Time on Tuesday, August 17, 2010.

Docket Numbers: ER10–1989–000.
Applicants: Sky River LLC.
Description: Sky River LLC submits tariff filing per 35.12: Sky River Baseline Filing to be effective 7/27/2010.
Filed Date: 07/27/2010.
Accession Number: 20100727–5092.
Comment Date: 5 p.m. Eastern Time on Tuesday, August 17, 2010.

Docket Numbers: ER10–1990–000.
Applicants: Somerset Windpower, LLC.
Description: Somerset Windpower, LLC submits tariff filing per 35.12: Somerset Baseline Filing to be effective 7/27/2010.
Filed Date: 07/27/2010.
Accession Number: 20100727–5093.
Comment Date: 5 p.m. Eastern Time on Tuesday, August 17, 2010.

Docket Numbers: ER10–1991–000.
Applicants: Story Wind, LLC.
Description: Story Wind, LLC submits tariff filing per 35.12: Story Baseline Filing to be effective 7/27/2010.
Filed Date: 07/27/2010.
Accession Number: 20100727–5094.
Comment Date: 5 p.m. Eastern Time on Tuesday, August 17, 2010.

Docket Numbers: ER10–1992–000.
Applicants: Victory Garden Phase IV, LLC.
Description: Victory Garden Phase IV, LLC submits tariff filing per 35.12: VGIV Baseline Filing to be effective 7/27/2010.
Filed Date: 07/27/2010.
Accession Number: 20100727–5095.
Comment Date: 5 p.m. Eastern Time on Tuesday, August 17, 2010.

Docket Numbers: ER10–1993–000.
Applicants: Waymart Wind Farm, L.P.
Description: Waymart Wind Farm, L.P. submits tariff filing per 35.12: Waymart Baseline Filing to be effective 7/27/2010.
Filed Date: 07/27/2010.
Accession Number: 20100727–5097.
Comment Date: 5 p.m. Eastern Time on Tuesday, August 17, 2010.

Docket Numbers: ER10–1994–000.
Applicants: Wessington Wind Energy Center, LLC.
Description: Wessington Wind Energy Center, LLC submits tariff filing per 35.12: Wessington Baseline Filing to be effective 7/27/2010.
Filed Date: 07/27/2010.
Accession Number: 20100727–5098.
Comment Date: 5 p.m. Eastern Time on Tuesday, August 17, 2010.

Docket Numbers: ER10–1995–000.
Applicants: Wilton Wind II, LLC.
Description: Wilton Wind II, LLC submits tariff filing per 35.12: Wilton II Baseline Filing to be effective 7/27/2010.
Filed Date: 07/27/2010.
Accession Number: 20100727–5099.
Comment Date: 5 p.m. Eastern Time on Tuesday, August 17, 2010.

Docket Numbers: ER10–1996–000.
Applicants: Dominion Retail, Inc.
Description: Dominion Retail, Inc. submits tariff filing per 35.12: Baseline to be effective 7/27/2010.
Filed Date: 07/27/2010.
Accession Number: 20100727–5102.
Comment Date: 5 p.m. Eastern Time on Tuesday, August 17, 2010.

Docket Numbers: ER10–1997–000.
Applicants: Midwest Independent Transmission System Operator, Inc.
Description: Midwest Independent Transmission System Operator, Inc. submits tariff filing per 35.12: MISOBASELINE5 to be effective 7/28/2010.
Filed Date: 07/27/2010.
Accession Number: 20100727–5113.
Comment Date: 5 p.m. Eastern Time on Tuesday, August 17, 2010.

Docket Numbers: ER10–1998–000.
Applicants: California Independent System Operator Corporation.
Description: California Independent System Operator Corporation submits tariff filing per 35.13(a)(2)(iii): 2010–07–27 CAISO Price Correction Timing Amendment to be effective 9/30/2010.
Filed Date: 07/27/2010.
Accession Number: 20100727–5138.
Comment Date: 5 p.m. Eastern Time on Tuesday, August 17, 2010.

Take notice that the Commission received the following land acquisition reports:

Docket Numbers: LA10–2–000.
Applicants: Order 697–C 2010 1st Qtr Site Acquisition.
Description: Notice of change in status and Q2 2010 land acquisition report of Baltimore Gas and Electric Company, *et al.*
Filed Date: 07/27/2010.
Accession Number: 20100727–5077.
Comment Date: 5 p.m. Eastern Time on Tuesday, August 17, 2010.

Any person desiring to intervene or to protest in any of the above proceedings must file in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211 and 385.214) on or before 5 p.m. Eastern Time on the specified comment date. It is not necessary to separately intervene again in a subdocket related to a compliance filing if you have previously intervened in the same docket. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Anyone filing a motion to intervene or protest must serve a copy of that document on the Applicant. In reference to filings initiating a new proceeding, interventions or protests submitted on or before the comment deadline need not be served on persons other than the Applicant.

The Commission encourages electronic submission of protests and interventions in lieu of paper, using the FERC Online links at *http://www.ferc.gov.* To facilitate electronic service, persons with Internet access who will eFile a document and/or be listed as a contact for an intervenor must create and validate an eRegistration account using the eRegistration link. Select the eFiling link to log on and submit the intervention or protests.

Persons unable to file electronically should submit an original and 14 copies of the intervention or protest to the Federal Energy Regulatory Commission, 888 First St., NE., Washington, DC 20426.

The filings in the above proceedings are accessible in the Commission's eLibrary system by clicking on the appropriate link in the above list. They are also available for review in the Commission's Public Reference Room in Washington, DC. There is an eSubscription link on the Web site that enables subscribers to receive e-mail notification when a document is added to a subscribed docket(s). For assistance with any FERC Online service, please e-mail *FERCOnlineSupport@ferc.gov* or call (866) 208–3676 (toll free). For TTY, call (202) 502–8659.

Nathaniel J. Davis, Sr.,

Deputy Secretary.

[FR Doc. 2010–18980 Filed 8–2–10; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

Combined Notice of Filings #2

July 26, 2010.

Take notice that the Commission received the following electric rate filings:

Docket Numbers: ER10–1901–001.

Applicants: Upper Peninsula Power Company.

Description: Upper Peninsula Power Company submits tariff filing per 35: Joint Tariff For Sales of Ancillary Services, Volume No. 2 to be effective 7/23/2010.

Filed Date: 07/23/2010.

Accession Number: 20100723–5088.

Comment Date: 5 p.m. Eastern Time on Friday, August 13, 2010.

Docket Numbers: ER10–1908–000.

Applicants: Duquesne Conemaugh, LLC.

Description: Duquesne Conemaugh, LLC submits tariff filing per 35.12: Duquesne Conemaugh, LLC Market Rate Tariff Volume No. 1 to be effective 7/23/2010.

Filed Date: 07/23/2010.

Accession Number: 20100723–5000.

Comment Date: 5 p.m. Eastern Time on Friday, August 13, 2010.

Docket Numbers: ER10–1909–000.

Applicants: Duquesne Keystone, LLC.

Description: Duquesne Keystone, LLC submits tariff filing per 35.12: Duquesne Keystone, LLC Market Rate Tariff Volume No. 1 to be effective 7/23/2010.

Filed Date: 07/23/2010.

Accession Number: 20100723–5001.

Comment Date: 5 p.m. Eastern Time on Friday, August 13, 2010.

Docket Numbers: ER10–1910–000.

Applicants: Duquesne Light Company.

Description: Duquesne Light Company submits tariff filing per 35.12: Market Rate Tariff, Volume No. 3, to be effective 7/23/2010.

Filed Date: 07/23/2010.

Accession Number: 20100723–5002.

Comment Date: 5 p.m. Eastern Time on Friday, August 13, 2010.

Docket Numbers: ER10–1911–000.

Applicants: Duquesne Power, LLC.

Description: Duquesne Power, LLC submits tariff filing per 35.12: Duquesne Power, LLC Rate Schedule FERC No. 1 to be effective 7/23/2010.

Filed Date: 07/23/2010.

Accession Number: 20100723–5003.

Comment Date: 5 p.m. Eastern Time on Friday, August 13, 2010.

Docket Numbers: ER10–1912–000.

Applicants: Stand Energy Corporation.

Description: Stand Energy Corporation submits tariff filing per 35.12: Stand Energy Corporation FERC Electric Rate Schedule No. 1 to be effective 7/23/2010.

Filed Date: 07/23/2010.

Accession Number: 20100723–5004.

Comment Date: 5 p.m. Eastern Time on Friday, August 13, 2010.

Docket Numbers: ER10–1915–000.

Applicants: Bayswater Peaking Facility, LLC.

Description: Bayswater Peaking Facility, LLC submits tariff filing per 35.12: Bayswater Baseline Filing to be effective 7/23/2010.

Filed Date: 07/23/2010.

Accession Number: 20100723–5029.

Comment Date: 5 p.m. Eastern Time on Friday, August 13, 2010.

Docket Numbers: ER10–1916–000.

Applicants: Florida Power Corporation.

Description: Florida Power Corporation Notice of Cancellation of Service Agreement with Winter Park, Florida.

Filed Date: 07/23/2010.

Accession Number: 20100723–5050.

Comment Date: 5 p.m. Eastern Time on Friday, August 13, 2010.

Docket Numbers: ER10–1917–000.

Applicants: Dominion Nuclear Connecticut, Inc.

Description: Dominion Nuclear Connecticut, Inc. submits tariff filing per 35.12: Baseline to be effective 7/23/2010.

Filed Date: 07/23/2010.

Accession Number: 20100723–5086.

Comment Date: 5 p.m. Eastern Time on Friday, August 13, 2010.

Docket Numbers: ER10–1918–000.

Applicants: FPL Energy North Dakota Wind II, LLC.

Description: FPL Energy North Dakota Wind II, LLC submits tariff filing per 35.12: North Dakota II Baseline Filing to be effective 7/23/2010.

Filed Date: 07/23/2010.

Accession Number: 20100723–5092.

Comment Date: 5 p.m. Eastern Time on Friday, August 13, 2010.

Docket Numbers: ER10–1919–000.

Applicants: PJM Interconnection, L.L.C.

Description: PJM Interconnection, LLC submits notice of the cancellation of a wholesale market participation agreement with Vision Power Systems, Inc, designated as Original Service Agreement 2008.

Filed Date: 07/23/2010.

Accession Number: 20100723–0209.

Comment Date: 5 p.m. Eastern Time on Friday, August 13, 2010.

Docket Numbers: ER10–1920–000.

Applicants: FPL Energy Oklahoma Wind, LLC.

Description: FPL Energy Oklahoma Wind, LLC submits tariff filing per 35.12: Oklahoma Baseline Filing to be effective 7/23/2010.

Filed Date: 07/23/2010.

Accession Number: 20100723–5096.

Comment Date: 5 p.m. Eastern Time on Friday, August 13, 2010.

Docket Numbers: ER10–1921–000.

Applicants: PJM Interconnection, L.L.C.

Description: PJM Interconnection, LLC submits an executed Wholesale Market Participation Agreement with Sustainable Energy Holdings, LLC and Pennsylvania Electric Company.

Filed Date: 07/23/2010.

Accession Number: 20100723–0208.

Comment Date: 5 p.m. Eastern Time on Friday, August 13, 2010.

Docket Numbers: ER10–1922–000.

Applicants: PacifiCorp.

Description: PacifiCorp submits Notice of Termination for Service Agreement 379 under Seventh Revised Volume 11 Open Access Transmission Tariff, Long-Term Firm Point-to-Point Transmission Service Agreement.

Filed Date: 07/23/2010.

Accession Number: 20100723–0207.

Comment Date: 5 p.m. Eastern Time on Friday, August 13, 2010.

Docket Numbers: ER10–1923–000.

Applicants: PacifiCorp.

Description: PacifiCorp submits its Transmission System Interconnection Agreement dated 6/21/10 with Western Area Power Administration, Department of Energy designated as Rate Schedule FERC No 660.

Filed Date: 07/23/2010.

Accession Number: 20100723–0206.

Comment Date: 5 p.m. Eastern Time on Friday, August 13, 2010.

Docket Numbers: ER10–1924–000.

Applicants: Wisconsin Public Service Corporation.

Description: Wisconsin Public Service Corporation submits tariff filing per 35.12: Rate Schedule No. 87 to be effective 10/1/2010.

Filed Date: 07/23/2010.

Accession Number: 20100723–5106.

Comment Date: 5 p.m. Eastern Time on Friday, August 13, 2010.

Docket Numbers: ER10–1925–000.

Applicants: FPL Energy Oliver Wind I, LLC.

Description: FPL Energy Oliver Wind I, LLC submits tariff filing per 35.12: Oliver I Baseline Filing to be effective 7/23/2010.

Filed Date: 07/23/2010.

Accession Number: 20100723–5107.

Comment Date: 5 p.m. Eastern Time on Friday, August 13, 2010.

Docket Numbers: ER10–1926–000.
Applicants: Duke Energy Carolinas, LLC.
Description: Duke Energy Carolinas, LLC submits a Network Integration Transmission Service Agreement with the City of Seneca, South Carolina.
Filed Date: 07/23/2010.
Accession Number: 20100723–0205.
Comment Date: 5 p.m. Eastern Time on Friday, August 13, 2010.

Docket Numbers: ER10–1927–000.
Applicants: FPL Energy Oliver Wind II, LLC.
Description: FPL Energy Oliver Wind II, LLC submits tariff filing per 35.12: Oliver II Baseline Filing to be effective 7/23/2010.
Filed Date: 07/23/2010.
Accession Number: 20100723–5110.
Comment Date: 5 p.m. Eastern Time on Friday, August 13, 2010.

Docket Numbers: ER10–1928–000.
Applicants: FPL Energy Sooner Wind, LLC.
Description: FPL Energy Sooner Wind, LLC submits tariff filing per 35.12: Sooner Baseline Filing to be effective 7/23/2010.
Filed Date: 07/23/2010.
Accession Number: 20100723–5111.
Comment Date: 5 p.m. Eastern Time on Friday, August 13, 2010.

Docket Numbers: ER10–1929–000.
Applicants: FPL Energy South Dakota Wind, LLC.
Description: FPL Energy South Dakota Wind, LLC submits tariff filing per 35.12: South Dakota Baseline Filing, to be effective 7/23/2010.
Filed Date: 07/23/2010.
Accession Number: 20100723–5113.
Comment Date: 5 p.m. Eastern Time on Friday, August 13, 2010.

Docket Numbers: ER10–1930–000.
Applicants: FPL Energy Stateline II, Inc.
Description: FPL Energy Stateline II, Inc. submits tariff filing per 35.12: Stateline II Baseline Filing to be effective 7/23/2010.
Filed Date: 07/23/2010.
Accession Number: 20100723–5117.
Comment Date: 5 p.m. Eastern Time on Friday, August 13, 2010.

Docket Numbers: ER10–1931–000.
Applicants: FPL Energy Vansycle, L.L.C.
Description: FPL Energy Vansycle, L.L.C. submits tariff filing per 35.12: Vansycle Baseline Filing to be effective 7/23/2010.
Filed Date: 07/23/2010.
Accession Number: 20100723–5126.
Comment Date: 5 p.m. Eastern Time on Friday, August 13, 2010.

Docket Numbers: ER10–1932–000.
Applicants: FPL Energy Wyman, LLC.
Description: FPL Energy Wyman, LLC submits tariff filing per 35.12: Wyman Baseline Filing, to be effective 7/23/2010.
Filed Date: 07/23/2010.
Accession Number: 20100723–5128.
Comment Date: 5 p.m. Eastern Time on Friday, August 13, 2010.

Docket Numbers: ER10–1933–000.
Applicants: RockGen Energy, LLC.
Description: RockGen Energy, LLC submits tariff filing per 35.12: Market-Based Rate Tariff in Compliance with Order No. 714 to be effective 7/23/2010.
Filed Date: 07/23/2010.
Accession Number: 20100723–5135.
Comment Date: 5 p.m. Eastern Time on Friday, August 13, 2010.

Docket Numbers: ER10–1934–000.
Applicants: CES Marketing IX, LLC.
Description: CES Marketing IX, LLC submits tariff filing per 35.12: Market-Based Rate Tariff in Compliance with Order No. 714 to be effective 7/23/2010.
Filed Date: 07/23/2010.
Accession Number: 20100723–5136.
Comment Date: 5 p.m. Eastern Time on Friday, August 13, 2010.

Docket Numbers: ER10–1935–000.
Applicants: FPL Energy Wyman IV, LLC.
Description: FPL Energy Wyman IV, LLC submits tariff filing per 35.12: Wyman IV Baseline Filing to be effective 7/23/2010.
Filed Date: 07/23/2010.
Accession Number: 20100723–5137.
Comment Date: 5 p.m. Eastern Time on Friday, August 13, 2010.

Docket Numbers: ER10–1936–000.
Applicants: Carville Energy LLC.
Description: Carville Energy LLC submits tariff filing per 35.12: Market-Based Rate Tariff in Compliance with Order No. 714 to be effective 7/23/2010.
Filed Date: 07/23/2010.
Accession Number: 20100723–5140.
Comment Date: 5 p.m. Eastern Time on Friday, August 13, 2010.

Docket Numbers: ER10–1937–000.
Applicants: Calpine Power—OR, LLC.
Description: Calpine Power America—OR, LLC submits tariff filing per 35.12: Market-Based Rate Tariff in Compliance with Order No. 714 to be effective 7/23/2010.
Filed Date: 07/23/2010.
Accession Number: 20100723–5144.
Comment Date: 5 p.m. Eastern Time on Friday, August 13, 2010.

Docket Numbers: ER10–1938–000.
Applicants: Calpine Power America—CA, LLC.
Description: Calpine Power America—CA, LLC submits tariff filing per 35.12: Market-Based Rate Tariff in Compliance with Order No. 714 to be effective 7/23/2010.
Filed Date: 07/23/2010.
Accession Number: 20100723–5147.
Comment Date: 5 p.m. Eastern Time on Friday, August 13, 2010.

Docket Numbers: ER10–1939–000.
Applicants: PPL Electric Utilities Corporation.
Description: PPL Electric Utilities Corp submits a revised Interconnection Agreement with Metropolitan Edison Co.
Filed Date: 07/23/2010.
Accession Number: 20100723–0215.
Comment Date: 5 p.m. Eastern Time on Friday, August 13, 2010.

Docket Numbers: ER10–1940–000.
Applicants: Calpine Oneta Power, L.P.
Description: Calpine Oneta Power, L.P. submits tariff filing per 35.12: Market-Based Rate Tariff in Compliance with Order No. 714 to be effective 7/23/2010.
Filed Date: 07/23/2010.
Accession Number: 20100723–5148.
Comment Date: 5 p.m. Eastern Time on Friday, August 13, 2010.

Docket Numbers: ER10–1941–000.
Applicants: Calpine Gilroy Cogen, L.P.
Description: Calpine Gilroy Cogen, L.P. submits tariff filing per 35.12: Market-Based Rate Tariff in Compliance with Order No. 714 to be effective 7/23/2010.
Filed Date: 07/23/2010.
Accession Number: 20100723–5149.
Comment Date: 5 p.m. Eastern Time on Friday, August 13, 2010.

Docket Numbers: ER10–1942–000.
Applicants: Calpine Construction Finance Co., L.P.
Description: Calpine Construction Finance Co., L.P. submits tariff filing per 35.12: Market-Based Rate Tariff in Compliance with Order No. 714 to be effective 7/23/2010.
Filed Date: 07/23/2010.
Accession Number: 20100723–5150.
Comment Date: 5 p.m. Eastern Time on Friday, August 13, 2010.

Docket Numbers: ER10–1943–000.
Applicants: Blue Spruce Energy Center, LLC.
Description: Blue Spruce Energy Center, LLC submits tariff filing per 35.12: Market-Based Rate Tariff in Compliance with Order No. 714 to be effective 7/23/2010.
Filed Date: 07/23/2010.
Accession Number: 20100723–5152.
Comment Date: 5 p.m. Eastern Time on Friday, August 13, 2010.

Docket Numbers: ER10–1944–000.
Applicants: Bethpage Energy Center 3, LLC.

Description: Bethpage Energy Center 3, LLC submits tariff filing per 35.12: Market-Based Rate Tariff in Compliance with Order No. 714 to be effective 7/23/2010.

Filed Date: 07/23/2010.

Accession Number: 20100723–5158.

Comment Date: 5 p.m. Eastern Time on Friday, August 13, 2010.

Docket Numbers: ER10–1945–000.

Applicants: Auburndale Peaker Energy Center, L.L.C.

Description: Auburndale Peaker Energy Center, L.L.C. submits tariff filing per 35.12: Market-Based Rate Tariff in Compliance with Order No. 714 to be effective 7/23/2010.

Filed Date: 07/23/2010.

Accession Number: 20100723–5162.

Comment Date: 5 p.m. Eastern Time on Friday, August 13, 2010.

Docket Numbers: ER10–1946–000.

Applicants: Broad River Energy LLC.

Description: Broad River Energy LLC submits tariff filing per 35.12: Market-Based Rate Tariff in Compliance with Order No. 714 to be effective 7/23/2010.

Filed Date: 07/23/2010.

Accession Number: 20100723–5163.

Comment Date: 5 p.m. Eastern Time on Friday, August 13, 2010.

Docket Numbers: ER10–1947–000.

Applicants: Otay Mesa Energy Center, LLC.

Description: Otay Mesa Energy Center, LLC submits tariff filing per 35.12: Market-Based Rate Tariff in Compliance with Order No. 714 to be effective 7/23/2010.

Filed Date: 07/23/2010.

Accession Number: 20100723–5164.

Comment Date: 5 p.m. Eastern Time on Friday, August 13, 2010.

Docket Numbers: ER10–1948–000.

Applicants: FPL Energy Wyoming, LLC.

Description: FPL Energy Wyoming, LLC submits tariff filing per 35.12: Wyoming Baseline Filing to be effective 7/23/2010.

Filed Date: 07/23/2010.

Accession Number: 20100723–5166.

Comment Date: 5 p.m. Eastern Time on Friday, August 13, 2010.

Docket Numbers: ER10–1949–000.

Applicants: FPLE Rhode Island State Energy, L.P.

Description: FPLE Rhode Island State Energy, L.P. submits tariff filing per 35.12: FPLE RI Baseline Filing to be effective 7/23/2010.

Filed Date: 07/23/2010.

Accession Number: 20100723–5167.

Comment Date: 5 p.m. Eastern Time on Friday, August 13, 2010.

Docket Numbers: ER10–1950–000.

Applicants: Garden Wind, LLC.

Description: Garden Wind, LLC submits tariff filing per 35.12: Garden Baseline Filing to be effective 7/23/2010.

Filed Date: 07/23/2010.

Accession Number: 20100723–5172.

Comment Date: 5 p.m. Eastern Time on Friday, August 13, 2010.

Docket Numbers: ER10–1951–000.

Applicants: Gexa Energy L.L.C.

Description: Gexa Energy L.L.C. submits tariff filing per 35.12: Gexa Baseline Filing, to be effective 7/23/2010.

Filed Date: 07/23/2010.

Accession Number: 20100723–5179.

Comment Date: 5 p.m. Eastern Time on Friday, August 13, 2010.

Docket Numbers: ER10–1952–000.

Applicants: Gray County Wind Energy, LLC.

Description: Gray County Wind Energy, LLC submits tariff filing per 35.12: Gray County Baseline Filing to be effective 7/23/2010.

Filed Date: 07/23/2010.

Accession Number: 20100723–5182.

Comment Date: 5 p.m. Eastern Time on Friday, August 13, 2010.

Docket Numbers: ER10–1953–000.

Applicants: California Independent System Operator Corporation.

Description: California Independent System Operator Corporation submits tariff filing per 35: 2010–07–23 Transmission Constraints Filing, to be effective 7/13/2010.

Filed Date: 07/23/2010.

Accession Number: 20100723–5185.

Comment Date: 5 p.m. Eastern Time on Friday, August 13, 2010.

Docket Numbers: ER10–1955–000.

Applicants: Consolidated Edison Company of New York,

Description: Errata filing of Consolidated Edison Company of New York, Inc.

Filed Date: 07/26/2010.

Accession Number: 20100726–5168.

Comment Date: 5 p.m. Eastern Time on Monday, August 16, 2010.

Docket Numbers: ER10–1956–000.

Applicants: New York State Electric & Gas Corporation.

Description: New York State Electric & Gas Corporation submits an executed version of the Original Service Agreement 1601 between NYSEG and Standard under the NYISO Open Access Transmission Agreement etc.

Filed Date: 07/26/2010.

Accession Number: 20100726–0206.

Comment Date: 5 p.m. Eastern Time on Monday, August 16, 2010.

Docket Numbers: ER10–1958–000.

Applicants: Southern California Edison Company.

Description: Southern California Edison Company submits tariff filing per 35: LGIA_Alta Wind CPC East & West_Compliance_072610 to be effective 6/1/2010.

Filed Date: 07/26/2010.

Accession Number: 20100726–5108.

Comment Date: 5 p.m. Eastern Time on Monday, August 16, 2010.

Docket Numbers: ER10–1959–000.

Applicants: Lower Mount Bethel Energy, LLC

Description: Lower Mount Bethel Energy, LLC submits tariff filing per 35.12: Lower Mount Bethel Energy, LLC Baseline Filing to be effective 7/26/2010.

Filed Date: 07/26/2010.

Accession Number: 20100726–5125.

Comment Date: 5 p.m. Eastern Time on Monday, August 16, 2010.

Any person desiring to intervene or to protest in any of the above proceedings must file in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211 and 385.214) on or before 5 p.m. Eastern time on the specified comment date. It is not necessary to separately intervene again in a subdocket related to a compliance filing if you have previously intervened in the same docket. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Anyone filing a motion to intervene or protest must serve a copy of that document on the Applicant. In reference to filings initiating a new proceeding, interventions or protests submitted on or before the comment deadline need not be served on persons other than the Applicant.

The Commission encourages electronic submission of protests and interventions in lieu of paper, using the FERC Online links at *http://www.ferc.gov*. To facilitate electronic service, persons with Internet access who will eFile a document and/or be listed as a contact for an intervenor must create and validate an eRegistration account using the eRegistration link. Select the eFiling link to log on and submit the intervention or protests.

Persons unable to file electronically should submit an original and 14 copies of the intervention or protest to the Federal Energy Regulatory Commission, 888 First St., NE., Washington, DC 20426.

The filings in the above proceedings are accessible in the Commission's eLibrary system by clicking on the appropriate link in the above list. They are also available for review in the

Commission's Public Reference Room in Washington, DC. There is an eSubscription link on the web site that enables subscribers to receive e-mail notification when a document is added to a subscribed dockets(s). For assistance with any FERC Online service, please e-mail *FERCOnlineSupport@ferc.gov.* or call (866) 208–3676 (toll free). For TTY, call (202) 502–8659.

Nathaniel J. Davis, Sr.,

Deputy Secretary.

[FR Doc. 2010–18981 Filed 8–2–10; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. AD10–12–000]

Increasing Market and Planning Efficiency Through Improved Software; Notice Establishing Date for Comments

July 27, 2010.

In June 2010, Commission staff convened the following technical conferences regarding models and software related to wholesale electricity markets and planning: [1]

June 2–3 Enhanced Unit-Commitment Models.

June 9–10 Enhanced Wide-Area Planning Models.

June 23–24 Enhanced Optimal Power Flow Models.

Parties wishing to submit written comments regarding the matters discussed at the technical conferences should submit their comments in Docket No. AD10–12–000 on or before September 10, 2010.

Kimberly D. Bose,

Secretary.

[FR Doc. 2010–18967 Filed 8–2–10; 8:45 am]

BILLING CODE 6717–01–P

[1] *Notice of Technical Conference to Discuss Increasing Market and Planning Efficiency Through Improved Software,* 75 FR 27,341 (2010).

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. EL10–79–000]

Morris Energy Group, LLC v.PSEG Energy Resources & Trade LLC; PSEG Fossil LLC; and PSEG Power LLC; Notice of Complaint

July 27, 2010.

Take notice that on July 23, 2010, Morris Energy Group, LLC (Morris Energy) (Complainant) filed a complaint against PSEG Energy Resources & Trade, LLC, PSEG Fossil LLC and PSEG Power LLC (PSEG Power Companies) (Respondents), requesting that the Federal Energy Regulatory Commission (Commission) find that the PSEG Power Companies violated their market-based rate authority and engaged in market manipulation in connection with a preferential affiliate retail gas delivery rate.

Morris Energy certifies that copies of the complaint were served on the contacts listed for Respondent in the Commission's list of Corporate Officials.

Any person desiring to intervene or to protest this filing must file in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211, 385.214). Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a notice of intervention or motion to intervene, as appropriate. The Respondent's answer and all interventions, or protests must be filed on or before the comment date. The Respondent's answer, motions to intervene, and protests must be served on the Complainants.

The Commission encourages electronic submission of protests and interventions in lieu of paper using the "eFiling" link at *http://www.ferc.gov.* Persons unable to fileelectronically should submit an original and 14 copies of the protest or intervention to the Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426.

This filing is accessible on-line at *http://www.ferc.gov,* using the "eLibrary" link and is available for review in the Commission's Public Reference Room in Washington, DC. There is an "eSubscription" link on the Web site that enables subscribers to receive e-mail notification when a document is added to a subscribed docket(s). For assistance with any FERC Online service, please email *FERCOnlineSupport@ferc.gov*, or call (866) 208–3676 (toll free). For TTY, call (202) 502–8659.

Comment Date: 5 p.m. Eastern Time on August 12, 2010.

Kimberly D. Bose,

Secretary.

[FR Doc. 2010–18971 Filed 8–2–10; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Office of Energy Efficiency and Renewable Energy

[Case No. RF–014]

Energy Conservation Program for Consumer Products: Decision and Order Granting a Waiver to Samsung Electronics America, Inc. From the Department of Energy Residential Refrigerator and Refrigerator-Freezer Test Procedure

AGENCY: Office of Energy Efficiency and Renewable Energy, Department of Energy.

ACTION: Decision and Order.

SUMMARY: The U.S. Department of Energy (DOE) gives notice of the decision and order (Case No. RF–014) that grants to Samsung Electronics America, Inc. (Samsung) a waiver from the DOE electric refrigerator and refrigerator-freezer test procedure for certain basic models of residential refrigerator-freezers containing relative humidity sensors and adaptive control anti-sweat heaters. Under today's decision and order, Samsung shall be required to test and rate these refrigerator-freezers equipped with adaptive control anti-sweat heaters using an alternate test procedure that takes this technology into account when measuring energy consumption.

DATES: This decision and order is effective August 3, 2010.

FOR FURTHER INFORMATION CONTACT: Dr. Michael G. Raymond, U.S. Department of Energy, Building Technologies Program, Mailstop EE–2J, 1000 Independence Avenue, SW., Washington, DC 20585–0121. Telephone: (202) 586–9611, E-mail: *Michael.Raymond@ee.doe.gov.*

Jennifer Tiedeman, U.S. Department of Energy, Office of the General Counsel, Mail Stop GC–71, 1000 Independence Avenue, SW., Washington, DC 20585–0103, (202) 287–6111, E-mail: *Jennifer.Tiedeman@hq.doe.govmailto:.*

SUPPLEMENTARY INFORMATION: In accordance with Title 10 of the Code of Federal Regulations (10 CFR) 430.27(l), DOE gives notice of the issuance of its

decision and order as set forth below. The decision and order grants Samsung a waiver from the applicable residential refrigerator and refrigerator-freezer test procedure found in 10 CFR part 430, subpart B, appendix A1 for certain basic models of refrigerator-freezers with relative humidity sensors and adaptive control anti-sweat heaters, provided that Samsung tests and rates such products using the alternate test procedure described in this notice. Today's decision prohibits Samsung from making representations concerning the energy efficiency of these products unless the product has been tested consistent with the provisions and restrictions in the alternate test procedure set forth in the decision and order below, and any representations fairly disclose the test results. Distributors, retailers, and private labelers are held to the same standard when making representations regarding the energy efficiency of these products. 42 U.S.C. 6293(c).

Cathy Zoi,

Assistant Secretary, Energy Efficiency and Renewable Energy.

Decision and Order

In the Matter of: Samsung Electronics America, Inc. (Case No. RF–014).

Background

Title III of the Energy Policy and Conservation Act (EPCA) sets forth a variety of provisions concerning energy efficiency, including Part A, which provides for the "Energy Conservation Program for Consumer Products Other Than Automobiles." 42 U.S.C. 6291–6309. Part A of Title III includes definitions, test procedures, labeling provisions, energy conservation standards, and the authority to require information and reports from manufacturers. Further, EPCA authorizes the Secretary of Energy to prescribe test procedures that are reasonably designed to produce results that measure energy efficiency, energy use, or estimated operating costs, and that are not unduly burdensome to conduct. 42 U.S.C. 6293(b)(3).

Today's notice involves residential electric refrigerator and refrigerator-freezer products covered under Part A of Title III. The test procedure for residential electric refrigerators and refrigerator-freezers is contained in 10 CFR part 430, subpart B, appendix A1.

DOE's regulations for covered products contain provisions allowing a person to seek a waiver for a particular basic model from the test procedure requirements for covered consumer products when (1) the petitioner's basic model contains one or more design characteristics that prevent testing according to the prescribed test procedure, or (2) when prescribed test procedures may evaluate the basic model in a manner so unrepresentative of its true energy consumption characteristics as to provide materially inaccurate comparative data. (10 CFR 430.27(a)(1)) Petitioners must include in their petition any alternate test procedures known to them to evaluate the basic model in a manner representative of its energy consumption characteristics. (10 CFR 430.27(b)(1)(iii))

The Assistant Secretary for Energy Efficiency and Renewable Energy (the Assistant Secretary) may grant a waiver subject to conditions, including adherence to alternate test procedures. (10 CFR 430.27(l)) Waivers remain in effect pursuant to the provisions of 10 CFR 430.27(m).

The waiver process also allows any interested person who has submitted a petition for waiver to file an application for interim waiver of the applicable test procedure requirements. (10 CFR 430.27(a)(2)). The Assistant Secretary will grant an interim waiver request if it is determined that the applicant will experience economic hardship if the interim waiver is denied, if it appears likely that the petition for waiver will be granted, and/or the Assistant Secretary determines that it would be desirable for public policy reasons to grant immediate relief pending a determination on the petition for waiver. (10 CFR 430.27(g))

On September 9, 2009, Samsung filed a petition for waiver and application for interim waiver from the test procedure applicable to residential electric refrigerators and refrigerator-freezers set forth in 10 CFR Part 430, subpart B, appendix A1. The products covered by the petition employ relative humidity sensors, which detect and respond to temperature and humidity conditions, and then activate adaptive heaters as needed to evaporate excess moisture. DOE published Samsung's petition for waiver for residential refrigerator-freezers with adaptive anti-sweat heaters, as well as its grant of interim waiver to Samsung for these products, in the **Federal Register** on December 15, 2009. 74 FR 66340. DOE granted Samsung's petition for waiver on March 18, 2010. 75 FR 13120.

Assertions and Determinations

Samsung's Petition for Waiver:

On January 20, 2010, Samsung informed DOE that, after it filed its petition for waiver in September 2009, it developed additional basic models with adaptive anti-sweat heater technology. Samsung asserted that these new products function in the same manner as the basic models listed in Samsung's September 2009 petition with respect to the properties that made those products eligible for a waiver. Therefore, Samsung requested that DOE add these models to the list of basic models for which the interim waiver was granted. Samsung also requested that DOE grant a new waiver for these additional basic models. Samsung's petition was published in the **Federal Register** on April 16, 2010. 75 FR 19959.

Samsung requested that it be permitted to use the same alternate test procedure DOE prescribed for GE, Whirlpool, and other companies manufacturing refrigerators and refrigerator-freezers equipped with a similar technology. Specifically, DOE granted GE, Whirlpool, Electrolux, Samsung, and Haier waivers on February 27, 2008 (73 FR 10425), May 5, 2009 (74 FR 20695), December 15, 2009 (74 FR 66338), March 18, 2010 (75 FR 13122), and June 7, 2010 (75 FR 32175), respectively. The alternate test procedure simulates the energy used by the adaptive heaters in a typical consumer household, as explained in the respective decisions and orders referenced above. As DOE has stated in the past, it is in the public interest to have similar products tested and rated for energy consumption on a comparable basis.

Consultations With Other Agencies

DOE consulted with the Federal Trade Commission (FTC) staff concerning the Samsung petition for waiver. The FTC staff did not have any objections to granting a waiver to Samsung.

Conclusion

After careful consideration of all the material that was submitted by Samsung and consultation with the FTC staff, it is ordered that:

(1) The petition for waiver submitted by Samsung Electronics America, Inc. (Case No. RF–014) is hereby granted as set forth in the paragraphs below.

(2) Samsung shall not be required to test or rate the following Samsung models on the basis of the current test procedures contained in 10 CFR part 430, subpart B, appendix A1. Instead, it shall be required to test and rate such products according to the alternate test procedure as set forth in paragraph (3) below:

RB***H***, RF***H***, RF#***H***, RS***H***, RS#***H***.

(3) Samsung shall be required to test the products listed in paragraph (2)

above according to the test procedures for electric refrigerator-freezers prescribed by DOE at 10 CFR part 430, appendix A1, except that, for the Samsung products listed in paragraph (2) only:

(A) The following definition is added at the end of Section 1:

1.13 Variable anti-sweat heater control means an anti-sweat heater where power supplied to the device is determined by an operating condition variable(s) and/or ambient condition variable(s).

(B) Section 2.2 is revised to read as follows:

2.2 Operational conditions. The electric refrigerator or electric refrigerator-freezer shall be installed and its operating conditions maintained in accordance with HRF–1–1979, section 7.2 through section 7.4.3.3, except that the vertical ambient temperature gradient at locations 10 inches (25.4 cm) out from the centers of the two sides of the unit being tested is to be maintained during the test. Unless shields or baffles obstruct the area, the gradient is to be maintained from 2 inches (5.1 cm) above the floor or supporting platform to a height 1 foot (30.5 cm) above the unit under test. Defrost controls are to be operative. The anti-sweat heater switch is to be off during one test and on during the second test. In the case of an electric refrigerator-freezer equipped with variable anti-sweat heater control, the result of the second test will be derived by performing the calculation described in 6.2.3. Other exceptions are noted in 2.3, 2.4, and 5.1 below.

(C) New section 6.2.3 is inserted after section 6.2.2.2.

6.2.3 Variable anti-sweat heater control test. The energy consumption of an electric refrigerator-freezer with a variable anti-sweat heater control in the on position (E_{on}), expressed in kilowatt-hours per day, shall be calculated equivalent to:

E_{ON} = E + (Correction Factor)

where E is determined by sections 6.2.1.1, 6.2.1.2, 6.2.2.1, or 6.2.2.2, whichever is appropriate, with the anti-sweat heater switch in the off position.

Correction Factor = (Anti-sweat Heater Power × System-loss Factor) × (24 hrs/1 day) × (1 kW/1,000 W)

Where:

Anti-sweat Heater Power
= A1 * (Heater Watts at 5%RH)
+ A2 * (Heater Watts at 15%RH)
+ A3 * (Heater Watts at 25%RH)
+ A4 * (Heater Watts at 35%RH)
+ A5 * (Heater Watts at 45%RH)
+ A6 * (Heater Watts at 55%RH)
+ A7 * (Heater Watts at 65%RH)
+ A8 * (Heater Watts at 75%RH)
+ A9 * (Heater Watts at 85%RH)
+ A10 * (Heater Watts at 95%RH)

where A1–A10 are defined in the following table:

A1 = 0.034	A6 = 0.119
A2 = 0.211	A7 = 0.069
A3 = 0.204	A8 = 0.047
A4 = 0.166	A9 = 0.008
A5 = 0.126	A10 = 0.015

Heater Watts at a specific relative humidity = the nominal watts used by all heaters at that specific relative humidity, 72 °F ambient, and DOE reference temperatures of fresh food (FF) average temperature of 45 °F and freezer (FZ) average temperature of 5 °F. System-loss Factor = 1.3

(4) Representations. Samsung may make representations about the energy use of its adaptive control anti-sweat heater refrigerator-freezer products for compliance, marketing, or other purposes only to the extent that such products have been tested in accordance with the provisions outlined above and such representations fairly disclose the results of such testing.

(5) This waiver shall remain in effect consistent with the provisions of 10 CFR 430.27(m).

(6) This waiver is issued on the condition that the statements, representations, and documentary materials provided by the petitioner are valid. DOE may revoke or modify this waiver at any time if it determines the factual basis underlying the petition for waiver is incorrect, or the results from the alternate test procedure are unrepresentative of the basic models' true energy consumption characteristics.

Issued in Washington, DC, on July 27, 2010.

Cathy Zoi,

Assistant Secretary, Energy Efficiency and Renewable Energy.

[FR Doc. 2010–19022 Filed 8–2–10; 8:45 am]

BILLING CODE 6450–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Project No. 13356–000–RI]

Slatersville Hydro, LLC; Notice of Availability of Environmental Assessment

July 27, 2010.

In accordance with the National Environmental Policy Act of 1969 and the Federal Energy Regulatory Commission's regulations, 18 CFR part 380 (Order No. 486, 52 FR 47879), the Office of Energy Projects has reviewed the application for exemption from licensing for the Slatersville Hydroelectric Project, to be located on the Branch River, in Providence County, Rhode Island, and has prepared an Environmental Assessment (EA). In the EA, Commission staff analyze the potential environmental effects of the project and conclude that issuing an exemption for the project, with appropriate environmental measures, would not constitute a major Federal action significantly affecting the quality of the human environment.

A copy of the EA is on file with the Commission and is available for public inspection. The EA may also be viewed on the Commission's Web site at *http://www.ferc.gov* using the "eLibrary" link. Enter the docket number excluding the last three digits in the docket number field to access the document. For assistance, contact FERC Online Support at *FERCOnlineSupport@ferc.gov* or toll-free at 1–866–208–3676, or for TTY, (202) 502–8659.

Any comments should be filed within 30 days from the date of this notice. Comments may be filed electronically via the Internet. *See* 18 CFR 385.2001(a)(1)(iii) and the instructions on the Commission's Web site (*http://www.ferc.gov/docs-filing/ferconline.asp*) under the "eFiling" link. For a simpler method of submitting text only comments, click on "eComment." For assistance, please contact FERC Online Support at *FERCOnlineSupport@ferc.gov;* call toll-free at (866) 208–3676; or, for TTY, contact (202) 502–8659. Although the Commission strongly encourages electronic filing, documents may also be paper-filed. To paper-file, mail an original and eight copies to: Kimberly D. Bose, Secretary, Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426. Please affix Project No. 13356–000 to all comments. For further information, contact Tom Dean at (202) 502–6041.

Kimberly D. Bose,

Secretary.

[FR Doc. 2010–18973 Filed 8–2–10; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. ER10–1821–000]

Goshen Phase II LLC; Supplemental Notice That Initial Market-Based Rate Filing Includes Request for Blanket Section 204 Authorization

July 23, 2010.

This is a supplemental notice in the above-referenced proceeding, of Goshen Phase II LLC's application for market-based rate authority, with an accompanying rate schedule, noting that such application includes a request for blanket authorization, under 18 CFR part 34, of future issuances of securities and assumptions of liability.

Any person desiring to intervene or to protest should file with the Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426, in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211 and 385.214). Anyone filing a motion to intervene or protest must serve a copy of that document on the Applicant.

Notice is hereby given that the deadline for filing protests with regard to the applicant's request for blanket authorization, under 18 CFR part 34, of future issuances of securities and assumptions of liability is August 12, 2010.

The Commission encourages electronic submission of protests and interventions in lieu of paper, using the FERC Online links at *http://www.ferc.gov.* To facilitate electronic service, persons with Internet access who will eFile a document and/or be listed as a contact for an intervenor must create and validate an eRegistration account using the eRegistration link. Select the eFiling link to log on and submit the intervention or protests.

Persons unable to file electronically should submit an original and 14 copies of the intervention or protest to the Federal Energy Regulatory Commission, 888 First St., NE., Washington, DC 20426.

The filings in the above-referenced proceeding(s) are accessible in the Commission's eLibrary system by clicking on the appropriate link in the above list. They are also available for review in the Commission's Public Reference Room in Washington, DC. There is an eSubscription link on the Web site that enables subscribers to receive e-mail notification when a document is added to a subscribed docket(s). For assistance with any FERC Online service, please e-mail *FERCOnlineSupport@ferc.gov.* or call (866) 208–3676 (toll free). For TTY, call (202) 502–8659.

Nathaniel J. Davis, Sr.,

Deputy Secretary.

[FR Doc. 2010–18979 Filed 8–2–10; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. ER10–1881–000]

Stuyvesant Energy L.L.C.; Supplemental Notice That Initial Market-Based Rate Filing Includes Request for Blanket Section 204 Authorization

July 23, 2010.

This is a supplemental notice in the above-referenced proceeding, of Stuyvesant Energy L.L.C.'s application for market-based rate authority, with an accompanying rate schedule, noting that such application includes a request for blanket authorization, under 18 CFR Part 34, of future issuances of securities and assumptions of liability.

Any person desiring to intervene or to protest should file with the Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426, in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211 and 385.214). Anyone filing a motion to intervene or protest must serve a copy of that document on the Applicant.

Notice is hereby given that the deadline for filing protests with regard to the applicant's request for blanket authorization, under 18 CFR part 34, of future issuances of securities and assumptions of liability is August 12, 2010.

The Commission encourages electronic submission of protests and interventions in lieu of paper, using the FERC Online links at *http://www.ferc.gov.* To facilitate electronic service, persons with Internet access who will eFile a document and/or be listed as a contact for an intervenor must create and validate an eRegistration account using the eRegistration link. Select the eFiling link to log on and submit the intervention or protests.

Persons unable to file electronically should submit an original and 14 copies of the intervention or protest to the Federal Energy Regulatory Commission, 888 First St., NE., Washington, DC 20426.

The filings in the above-referenced proceeding(s) are accessible in the Commission's eLibrary system by clicking on the appropriate link in the above list. They are also available for review in the Commission's Public Reference Room in Washington, DC. There is an eSubscription link on the Web site that enables subscribers to receive e-mail notification when a document is added to a subscribed docket(s). For assistance with any FERC Online service, please e-mail *FERCOnlineSupport@ferc.gov* or call (866) 208–3676 (toll free). For TTY, call (202) 502–8659.

Nathaniel J. Davis, Sr.,

Deputy Secretary.

[FR Doc. 2010–18983 Filed 8–2–10; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. EL10–78–000]

PJM Interconnection, L.L.C.; Notice of Petition for Declaratory Order

July 27, 2010.

Take notice that on July 20, 2010, pursuant to Rule 207 of the Federal Energy Regulatory Commission's (Commission) Rules of Practice and Procedure (18 CFR 385.207), PJM Interconnection, L.L.C. (PJM) filed a Petition for Declaratory Order Or, In The Alternative Request for Limited Waiver of 18 CFR 35.34(j)(1)(i), requesting the Commission to issue a declaratory order to find that PJM's proposed application of methodology will allow, under limited circumstances, employees and board members of PJM to hold a financial interest in certain companies or their affiliates that are defined by the Commission as "Market Participants" but whose participation in PJM's markets are miniscule in relation to their overall business activities.

Any person desiring to intervene or to protest this filing must file in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211, 385.214). Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a notice of intervention or motion to intervene, as appropriate. Such notices, motions, or protests must be filed on or before the comment date. On or before the comment date, it is not necessary to

serve motions to intervene or protests on persons other than the Applicant.

The Commission encourages electronic submission of protests and interventions in lieu of paper using the "eFiling" link at *http://www.ferc.gov.* Persons unable to file electronically should submit an original and 14 copies of the protest or intervention to the Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426.

This filing is accessible on-line at *http://www.ferc.gov*, using the "eLibrary" link and is available for review in the Commission's Public Reference Room in Washington, DC. There is an "eSubscription" link on the Web site that enables subscribers to receive e-mail notification when a document is added to a subscribed docket(s). For assistance with any FERC Online service, please e-mail *FERCOnlineSupport@ferc.gov*, or call (866) 208–3676 (toll free). For TTY, call (202) 502–8659.

Comment Date: 5 p.m. Eastern Time on August 19, 2010.

Kimberly D. Bose,

Secretary.

[FR Doc. 2010–18972 Filed 8–2–10; 8:45 am]

BILLING CODE 6717–01–P

ENVIRONMENTAL PROTECTION AGENCY

[FRL–9184–5]

Office of Research and Development; Ambient Air Monitoring Reference and Equivalent Methods: Designation of One New Equivalent Method

AGENCY: Environmental Protection Agency.

ACTION: Notice of the designation of one new equivalent method for monitoring ambient air quality.

SUMMARY: Notice is hereby given that the Environmental Protection Agency (EPA) has designated, in accordance with 40 CFR part 53, one new equivalent method for measuring concentrations of lead (Pb) in total suspended particulate matter (TSP) in the ambient air.

FOR FURTHER INFORMATION CONTACT: Surender Kaushik, Human Exposure and Atmospheric Sciences Division (MD–D205–03), National Exposure Research Laboratory, U.S. EPA, Research Triangle Park, North Carolina 27711. Phone: (919) 541–5691, e-mail: *Kaushik.Surender@epa.gov.*

SUPPLEMENTARY INFORMATION: In accordance with regulations at 40 CFR part 53, the EPA evaluates various methods for monitoring the concentrations of those ambient air pollutants for which EPA has established National Ambient Air Quality Standards (NAAQSs) as set forth in 40 CFR part 50. Monitoring methods that are determined to meet specific requirements for adequacy are designated by the EPA as either reference methods or equivalent methods (as applicable), thereby permitting their use under 40 CFR part 58 by States and other agencies for determining compliance with the NAAQSs.

The EPA hereby announces the designation of one new equivalent method for measuring Pb in TSP in the ambient air. This designation is made under the provisions of 40 CFR part 53, as amended on November 12, 2008 (73 FR 67057–67059).

The new equivalent method for Pb is a manual method that uses the sampling procedure specified in the Reference Method for the Determination of Suspended Particulate Matter in the Atmosphere (High-Volume Method), 40 CFR part 50, appendix B, with an alternative extraction and analytical procedure. The method is identified as follows:

EQL–0710–192, "*Heated Nitric Acid Hot Block Digestion and ICP/MS Analysis for Lead (Pb) on TSP High-Volume Filters.*"

In this method, total suspended particulate matter (TSP) is collected on glass fiber filters according to 40 CFR Appendix B to part 50, *EPA Reference Method for the Determination of Suspended Particulate Matter in the Atmosphere (High-Volume Method),* extracted with a solution of nitric acid, heated on a hot block to 95°C for one hour, and brought to a final volume of 50 mL. The lead content of the sample extract is analyzed by Inductively Coupled Plasma-Mass Spectrometry (ICP–MS) based on EPA Method 200.8 and SW–846 Method 6020A.

The application for an equivalent method determination for this method was submitted by the Region 9 Laboratory, U.S. Environmental Protection Agency, 1337 South 46th Street, Bldg 201, Richmond, CA 94804 and was received by the Office of Research and Development on March 30, 2010.

The analytical procedure of this method has been tested in accordance with the applicable test procedures specified in 40 CFR part 53, as amended on November 12, 2008. After reviewing the results of those tests and other information submitted in the application, EPA has determined, in accordance with Part 53, that this method should be designated as an equivalent method for lead. The information in the application will be kept on file, either at EPA's National Exposure Research Laboratory, Research Triangle Park, North Carolina 27711 or in an approved archive storage facility, and will be available for inspection (with advance notice) to the extent consistent with 40 CFR part 2 (EPA's regulations implementing the Freedom of Information Act).

As a designated equivalent method, this method is acceptable for use by states and other air monitoring agencies under the requirements of 40 CFR part 58, Ambient Air Quality Surveillance. For such purposes, the method must be used in strict accordance with the complete operating procedure (SOP) associated with the method and subject to any specifications and limitations specified in the procedure.

Use of the method should also be in general accordance with the guidance and recommendations of applicable sections of the "Quality Assurance Handbook for Air Pollution Measurement Systems, Volume I," EPA/600/R–94/038a and "Quality Assurance Handbook for Air Pollution Measurement Systems, Volume II, Ambient Air Quality Monitoring Program" EPA–454/B–08–003, December, 2008. Provisions concerning modification of such methods by users are specified under Section 2.8 (Modifications of Methods by Users) of appendix C to 40 CFR part 58.

Consistent or repeated noncompliance with the method procedure/SOP should be reported to: Director, Human Exposure and Atmospheric Sciences Division (MD–E205–01), National Exposure Research Laboratory, U.S. Environmental Protection Agency, Research Triangle Park, North Carolina 27711.

Designation of this new equivalent method is intended to assist the States in establishing and operating their air quality surveillance systems under 40 CFR Part 58. Questions concerning the technical aspects of the method should be directed to the applicant.

Dated: July 26, 2010.

Jewel F. Morris,

Acting Director, National Exposure Research Laboratory.

[FR Doc. 2010–19055 Filed 8–2–10; 8:45 am]

BILLING CODE 6560–50–P

FEDERAL RESERVE SYSTEM

Formations of, Acquisitions by, and Mergers of Bank Holding Companies

The companies listed in this notice have applied to the Board for approval, pursuant to the Bank Holding Company Act of 1956 (12 U.S.C. 1841 *et seq.*) (BHC Act), Regulation Y (12 CFR Part 225), and all other applicable statutes and regulations to become a bank holding company and/or to acquire the assets or the ownership of, control of, or the power to vote shares of a bank or bank holding company and all of the banks and nonbanking companies owned by the bank holding company, including the companies listed below.

The applications listed below, as well as other related filings required by the Board, are available for immediate inspection at the Federal Reserve Bank indicated. The applications also will be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing on the standards enumerated in the BHC Act (12 U.S.C. 1842(c)). If the proposal also involves the acquisition of a nonbanking company, the review also includes whether the acquisition of the nonbanking company complies with the standards in section 4 of the BHC Act (12 U.S.C. 1843). Unless otherwise noted, nonbanking activities will be conducted throughout the United States. Additional information on all bank holding companies may be obtained from the National Information Center website at *www.ffiec.gov/nic/*.

Unless otherwise noted, comments regarding each of these applications must be received at the Reserve Bank indicated or the offices of the Board of Governors not later than August 27, 2010.

A. Federal Reserve Bank of Boston (Richard Walker, Community Affairs Officer) P.O. Box 55882, Boston, Massachusetts 02106–2204:

1. NBH Holdings Corp., Boston, Massachusetts; to become a bank holding company by acquiring 100 percent of the voting shares of Bank Midwest, National Association, Kansas City, Missouri.

B. Federal Reserve Bank of New York (Ivan Hurwitz, Vice President) 33 Liberty Street, New York, New York 10045–0001:

1. China Investment Corporation, Beijing, China; to acquire at least 5 percent of the voting shares of Morgan Stanley, New York, New York, and thereby indirectly acquire voting shares of Morgan Stanley Capital Management LLC; Morgan Stanley Domestic Holdings, Inc., both of New York, New York; Morgan Stanley Bank, National Association, Salt Lake City, Utah; Morgan Stanley Private Bank, National Association, Purchase, New York; and Morgan Stanley Trust National Association, Wilmington, Delaware. Comments regarding this application must be received not later than August 25, 2010.

C. Federal Reserve Bank of Atlanta (Clifford Stanford, Vice President) 1000 Peachtree Street, N.E., Atlanta, Georgia 30309:

1. Southeastern Bank Financial Corporation, Augusta, Georgia; to acquire 100 percent of the voting shares of Southern Bank & Trust, Aiken, South Carolina, upon its conversion to a state chartered bank.

Board of Governors of the Federal Reserve System, July 28, 2010.

Robert deV. Frierson,

Deputy Secretary of the Board.

[FR Doc. 2010–18963 Filed 8–2–10; 8:45 am]

BILLING CODE 6210–01–S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

Delayed Update of the HHS Poverty Guidelines for the Remainder of 2010

AGENCY: Department of Health and Human Services.

ACTION: Notice.

SUMMARY: This notice provides a delayed update of the Department of Health and Human Services (HHS) poverty guidelines for the remainder of 2010, and until the 2011 poverty guidelines are published, which is expected to occur in late January 2011. HHS is issuing this delayed update due to recent legislation that prohibited the Secretary of HHS from publishing 2010 poverty guidelines before May 31, 2010, and required that the 2009 poverty guidelines remain in effect until the Secretary of HHS published updated guidelines.

DATES: *Effective Date:* Date of publication, unless an office administering a program using the guidelines specifies a different effective date for that particular program.

ADDRESSES: Office of the Assistant Secretary for Planning and Evaluation, Room 404E, Humphrey Building, Department of Health and Human Services, Washington, DC 20201.

FOR FURTHER INFORMATION CONTACT: For information about how the guidelines are used or how income is defined in a particular program, contact the Federal, State, or local office that is responsible for that program. For information about poverty figures for immigration forms, the Hill-Burton Uncompensated Services Program, and the number of people in poverty, use the specific telephone numbers and addresses given below.

For general questions about the poverty guidelines themselves, contact Gordon Fisher, Office of the Assistant Secretary for Planning and Evaluation, Room 404E, Humphrey Building, Department of Health and Human Services, Washington, DC 20201—telephone: (202) 690–7507—or visit *http://aspe.hhs.gov/poverty/*.

For information about the percentage multiple of the poverty guidelines to be used on immigration forms such as USCIS Form I–864, Affidavit of Support, contact U.S. Citizenship and Immigration Services at 1–800–375–5283.

For information about the Hill-Burton Uncompensated Services Program (free or reduced-fee health care services at certain hospitals and other facilities for persons meeting eligibility criteria involving the poverty guidelines), contact the Office of the Director, Division of Facilities Compliance and Recovery, Health Resources and Services Administration, HHS, Room 10–105, Parklawn Building, 5600 Fishers Lane, Rockville, Maryland 20857. To speak to a staff member, please call (301) 443–5656. To receive a Hill-Burton information package, call 1–800–638–0742 (for callers outside Maryland) or 1–800–492–0359 (for callers in Maryland). You also may visit *http://www.hrsa.gov/hillburton/default.htm.*

For information about the number of people in poverty, visit the Poverty section of the Census Bureau's Web site at *http://www.census.gov/hhes/www/poverty/poverty.html* or contact the Census Bureau's Demographic Call Center Staff at (301) 763–2422 or 1–866–758–1060 (toll-free).

SUPPLEMENTARY INFORMATION:

Background

Section 673(2) of the Omnibus Budget Reconciliation Act (OBRA) of 1981 (42 U.S.C. 9902(2)) requires the Secretary of HHS to update the poverty guidelines at least annually, adjusting them on the basis of the Consumer Price Index for All Urban Consumers (CPI–U). The poverty guidelines are used as an eligibility criterion by the Community Services Block Grant program and a number of other Federal programs. The *poverty guidelines* issued here are a simplified version of the *poverty thresholds* that the Census Bureau uses

to prepare its estimates of the number of individuals and families in poverty.

However, provisions in three recent laws prohibited the Secretary of HHS from publishing updated poverty guidelines for 2010 before May 31, 2010, and required that the poverty guidelines published on January 23, 2009, remain in effect until updated poverty guidelines were published. These provisions were section 1012 of the Department of Defense Appropriations Act, 2010 (Pub. L. 111–118), section 7 of the Temporary Extension Act of 2010 (Pub. L. 111–144), and section 6 of the Continuing Extension Act of 2010 (Pub. L. 111–157).

The provisions included in these laws were in response to a decrease in the annual average CPI–U for 2009. In the absence of a legislative change, this decrease would have required HHS to issue 2010 poverty guidelines that were lower than the 2009 poverty guidelines, resulting in an adverse effect on potential and actual program beneficiaries. An explanatory statement in the December 16, 2009 *Congressional Record* described the first legislative provision to delay the publication of the 2010 guidelines as a "freeze" of the guidelines at 2009 levels "in order to prevent a reduction in eligibility for certain means-tested programs, including Medicaid, Supplemental Nutrition Assistance Program (SNAP), and child nutrition * * *." (*Congressional Record* (House), December 16, 2009, p. H15370).

Legislation to further delay the publication of the 2010 poverty guidelines beyond May 31, 2010, did not pass Congress. Accordingly, HHS is publishing poverty guidelines for the remainder of 2010 in this notice. These 2010 guidelines will remain in effect until HHS publishes the 2011 poverty guidelines, which is expected to occur in late January 2011.

If HHS had published the 2010 poverty guidelines in late January 2010, on the normal schedule, the update would have been based on the 2008 Census Bureau poverty thresholds and the percentage change in the annual average CPI–U from calendar year 2008 to calendar year 2009 (the period from January through December 2009). Since the publication of the 2010 poverty guidelines was delayed through May 31, 2010, HHS is basing this update on the 2008 Census Bureau poverty thresholds—which remain the most recent published thresholds available—and the percentage change in the average CPI–U from calendar year 2008 to the period beginning with January 2009 and ending on May 31, 2010. The average CPI–U for the January 2009–May 2010 period was 0.042 percent higher than the annual average CPI–U for calendar year 2008. (The Omnibus Budget Reconciliation Act of 1981 requires that the starting point for the update of the poverty guidelines shall be the latest published Census Bureau poverty thresholds, rather than the previous HHS poverty guidelines.) The percentage increase in the CPI–U was so small that after the rounding procedures used in the guidelines calculation, the guidelines for the remainder of 2010 showed no change from the 2009 guidelines.

The poverty guidelines are calculated each year using the latest published Census Bureau poverty thresholds as the starting point. They are not calculated from the previous year's poverty guidelines. As a result, the level of next year's poverty guidelines—the 2011 guidelines—will not be affected by the way in which these 2010 poverty guidelines were calculated.

The poverty guidelines for the remainder of 2010 are provided below. The guideline figures shown represent annual income. These guidelines will remain in effect until HHS publishes the 2011 poverty guidelines, which is expected in late January 2011.

2010 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA

Persons in family	Poverty guideline
1	$10,830
2	14,570
3	18,310
4	22,050
5	25,790
6	29,530
7	33,270
8	37,010

For families with more than 8 persons, add $3,740 for each additional person.

2010 POVERTY GUIDELINES FOR ALASKA

Persons in family	Poverty guideline
1	$13,530
2	18,210
3	22,890
4	27,570
5	32,250
6	36,930
7	41,610
8	46,290

For families with more than 8 persons, add $4,680 for each additional person.

2010 POVERTY GUIDELINES FOR HAWAII

Persons in family	Poverty guideline
1	$12,460
2	16,760
3	21,060
4	25,360
5	29,660
6	33,960
7	38,260
8	42,560

For families with more than 8 persons, add $4,300 for each additional person.

Dated: July 30, 2010.

Kathleen Sebelius,

Secretary of Health and Human Services.

[FR Doc. 2010–19129 Filed 7–30–10; 4:15 pm]

BILLING CODE 4151–05–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Solicitation of Nomination for Appointment to the Chronic Fatigue Syndrome Advisory Committee

AGENCY: Department of Health and Human Services, Office of the Secretary, Office of Public Health and Science.

ACTION: Notice.

Authority: 42 U.S.C. 217a, section 222 of the Public Health Service (PHS) Act, as amended. The committee is governed by the provisions of Public Law 92–463, as amended (5 U.S.C. App 2), which sets forth standards for the formation and use of advisory committees.

SUMMARY: The Office of Public Health and Science, Office on Women's Health, HHS, is seeking nominations of qualified candidates to be considered for appointment as a member of the Chronic Fatigue Syndrome Advisory Committee (CFSAC). CFSAC provides science-based advice and recommendations to the Secretary of Health and Human Services, through the Assistant Secretary for Health, on a broad range of issues and topics pertaining to chronic fatigue syndrome (CFS). CFSAC, which was formerly known as the Chronic Fatigue Syndrome Coordinating Committee, was established by the Secretary of Health and Human Services on September 5, 2002. Several Committee member appointments are scheduled to end on April 1, 2011. Nominations of qualified candidates are being sought to fill future vacancies.

DATES: Nominations for membership on the Committee must be received no later than 5 p.m. EDT on Wednesday,

September 15, 2010, at the address listed below.

ADDRESSES: All nominations should be mailed or delivered to Wanda K. Jones, Dr.P.H., Executive Secretary, Chronic Fatigue Syndrome Advisory Committee; C/O Office on Women's Health; Department of Health and Human Services; 200 Independence Avenue, SW.; Room 712E; Washington, DC20201. E-mail delivery of nominations will not be accepted.

FOR FURTHER INFORMATION CONTACT: Wanda K. Jones, Dr.P.H.; Department of Health and Human Services, C/O Office on Women's Health; 200 Independence Avenue, SW.; Room 712E; Washington, DC 20201; please refer all inquiries to *cfsac@hhs.gov*.

SUPPLEMENTARY INFORMATION: CFSAC was established on September 5, 2002. The Committee was established to advise, consult with, and make recommendations to the Secretary, through the Assistant Secretary for Health, on a broad range of topics including (1) the current state of the knowledge and research about the epidemiology and risk factors relating to chronic fatigue syndrome, and identifying potential opportunities in these areas; (2) current and proposed diagnosis and treatment methods for chronic fatigue syndrome; and (3) development and implementation of programs to inform the public, health care professionals, and the biomedical, academic, and research communities about chronic fatigue syndrome advances.

Nominations

The Office on Women's Health is requesting nominations to future committee member vacancies for the CFSAC. The positions are scheduled to become vacant on April 1, 2011. The Committee is composed of seven scientists with demonstrated expertise in biomedical research and four individuals with demonstrated expertise in health services, insurance, or voluntary organizations concerned with the problems of individuals with CFS. The vacant positions include the biomedical research and health services categories.

Individuals selected for appointment to the Committee will serve as voting members. Individuals selected for appointment to the Committee can be invited to serve terms of up to four years. Committee members receive a stipend for attending Committee meetings and conducting other business in the interest of the Committee. Committee members also are authorized to receive per diem and reimbursement for travel expenses incurred for conducting Committee business. To qualify for consideration of appointment to the Committee, an individual must possess demonstrated experience and expertise in the designated fields or disciplines, as well as expert knowledge of the broad issues and topics pertinent to chronic fatigue syndrome.

Nominations should be typewritten, and the original nomination and three copies submitted in one package. The following information must be part of the package submitted for each individual being nominated for consideration: (1) A letter of nomination that clearly states the name and affiliation of the nominee, the basis for the nomination (*i.e.,* specific attributes which qualify the nominee for service in this capacity), and a statement that the nominee is willing to serve as a member of the Committee; (2) the nominator's name, address, and daytime telephone number, and the home and/or work address, telephone number, and e-mail address of the individual being nominated; and (3) a current copy of the nominee's curriculum vitae. Federal employees should not be nominated for consideration of appointment to this Committee.

The Department makes every effort to ensure that the membership of HHS Federal advisory committees is fairly balanced in terms of points of view represented and the committee's function. Every effort is made to ensure that a broad representation of geographic areas, females, ethnic and minority groups, and people with disabilities are given consideration for membership on HHS Federal advisory committees. Appointment to this Committee shall be made without discrimination on the basis of age, race, ethnicity, gender, sexual orientation, disability, and cultural, religious, or socioeconomic status. Nominations must state that the nominee is willing to serve as a member of CFSAC and appears to have no conflict of interest that would preclude membership. Potential candidates are required to provide detailed information concerning such matters as financial holdings, consultancies, and research grants or contracts to permit evaluation of possible sources of conflict of interest.

Dated: July 28, 2010.

Wanda K. Jones,

Designated Federal Officer, Chronic Fatigue Syndrome Advisory Committee.

[FR Doc. 2010–19025 Filed 8–2–10; 8:45 am]

BILLING CODE 4150–42–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

Agency Information Collection Activities: Submission for OMB Review; Comment Request

Periodically, the Substance Abuse and Mental Health Services Administration (SAMHSA) will publish a summary of information collection requests under OMB review, in compliance with the Paperwork Reduction Act (44 U.S.C. Chapter 35). To request a copy of these documents, call the SAMHSA Reports Clearance Officer on (240) 276–1243.

Project: Survey of State Underage Drinking Prevention Policies and Practices—New

The *Sober Truth on Preventing Underage Drinking Act* (the "STOP Act") [1] states that the "Secretary [of Health and Human Services] shall * * * annually issue a report on each State's performance in enacting, enforcing, and creating laws, regulations, and programs to prevent or reduce underage drinking." The Secretary has delegated responsibility for this report to SAMHSA. Therefore, SAMHSA is developing a *Survey of State Underage Drinking Prevention Policies and Practices* (the "*State Survey*") to provide input for an *Annual Report on State Underage Drinking Prevention and Enforcement Activities* (the "State Report").

The STOP Act also requires the Secretary to develop "a set of measures to be used in preparing the report on best practices" and to consider categories including but not limited to the following:

Category #1: Sixteen specific underage drinking laws/regulations enacted at the State level (*e.g.,* laws prohibiting sales to minors; laws related to minors in possession of alcohol);

Category #2: Enforcement and educational programs to promote compliance with these laws/regulations;

Category #3: Programs targeted to youths, parents, and caregivers to deter underage drinking and the number of individuals served by these programs;

Category #4: The amount that each State invests, per youth capita, on the prevention of underage drinking broken into five categories: (a) Compliance check programs in retail outlets; (b) Checkpoints and saturation patrols that include the goal of reducing and

[1] Public Law 109–422. It is assumed Congress intended to include the District of Columbia as part of the State Report.

deterring underage drinking; (c) Community-based, school-based, and higher-education-based programs to prevent underage drinking; (d) Underage drinking prevention programs that target youth within the juvenile justice and child welfare systems; and (e) Any other State efforts or programs that target underage drinking.

Congress' purpose in mandating the collection of data on State policies and programs through the *State Survey is* to provide policymakers and the public with currently unavailable but much needed information regarding State underage drinking prevention policies and programs. SAMHSA and other Federal agencies that have underage drinking prevention as part of their mandate will use the results of the *State Survey* to inform Federal programmatic priorities. The information gathered by the *State Survey* will also establish a resource for State agencies and the general public for assessing policies and programs in their own State and for becoming familiar with the programs, policies, and funding priorities of other States. It is also consistent with SAMHSA's Strategic Initiative, "Prevention of Substance Abuse and Mental Illness," which includes the prevention of underage drinking and is designed to create prevention prepared communities where individuals, families, schools, workplaces, and communities take action to promote emotional health and prevent and reduce mental illness, substance abuse, and suicide across the lifespan.

Because of the broad scope of data required by the STOP Act, SAMHSA will rely on existing data sources where possible to minimize the survey burden on the States. SAMHSA will employ data on State underage drinking policies from the National Institute on Alcohol Abuse and Alcoholism's Alcohol Policy Information System (APIS), an authoritative compendium of State alcohol-related laws. The APIS data will be augmented by SAMHSA with original legal research on State laws and policies addressing underage drinking to include all of the STOP Act's requested laws and regulations (Category #1 of the four categories included in the STOP Act, as described above, page 2).

The STOP Act mandates that the *State Survey* assess "best practices" and emphasize the importance of building collaborations with Federally Recognized Tribal Governments ("Tribal Governments"). It also emphasizes the importance at the Federal level of promoting interagency collaboration and to that end established the Interagency Coordinating Committee on the Prevention of Underage Drinking (ICCPUD). SAMHSA has determined that to fulfill the Congressional intent, it is critical that the *State Survey* gather information from the States regarding the best practices standards that they apply to their underage drinking programs, collaborations between States and Tribal Governments, and the development of State-level interagency collaborations similar to ICCPUD.

SAMHSA has determined that data on Categories #2, #3, and #4 mandated in the STOP Act (as listed on page 2) (enforcement and educational programs; programs targeting youth, parents, and caregivers; and State expenditures) as well as States' best practices standards, collaborations with Tribal Governments, and State-level interagency collaborations *are not available from secondary sources* and therefore must be collected from the States themselves. The *State Survey* will therefore be necessary to fulfill the Congressional mandate found in the STOP Act.

The *State Survey* is a single document that is divided into four sections, as follows:

(1) Enforcement of underage drinking prevention laws;

(2) Underage drinking prevention programs, including data on State best practices standards and collaborations with Tribal Governments;

(3) State interagency collaborations used to implement the above programs; and

(4) Estimates of the State funds invested in the categories specified in the STOP Act (*see* description of Category #4, above, page 2) and descriptions of any dedicated fees, taxes or fines used to raise these funds.

The number of questions in each Section is as follows:

Section 1: 29 questions.
Section 2A: 18 questions.[2]
Section 2B: 6 questions.[3]
Section 2C: 6 questions.
Section 3: 12 questions.
Section 4: 19 questions.
Total: 90 Questions.

It is anticipated that respondents will actually respond to only a subset of this total. This is because the survey is designed with "skip logic," which means that many questions will only be directed to a subset of respondents who report the existence of particular programs or activities.

To ensure that the *State Survey* obtains the necessary data while minimizing the burden on the States, SAMHSA has conducted a lengthy and comprehensive planning process. It has sought advice from key stakeholders (as mandated by the STOP Act) including hosting an all-day stakeholders meeting, conducting two field tests with State officials likely to be responsible for completing the *State Survey,* and investigating and testing various *State Survey* formats, online delivery systems, and data collection methodologies.

Based on these investigations, SAMHSA has decided to collect the required data using an online survey instrument over an 8-week period. The *State Survey* will be sent to each State Governor's office and the Office of the Mayor of the District of Columbia, for a total of 51 survey respondents. Based on the feedback received from stakeholders and field pilot testers, it is anticipated that the State Governors will designate staff from State agencies that have access to the requested data (typically State Alcohol Beverage Control [ABC] agencies and State Substance Abuse Program agencies). SAMHSA will provide both telephone and online technical support to State agency staff and will emphasize that the States are only expected to provide data that is readily available and are not required to provide data that has not already been collected. The burden estimate below takes into account these assumptions.

The estimated annual response burden to collect this information is as follows:

[2] Note that the number of questions in Sections 2A is an estimate. This Section asks States to identify their programs that are *specific* to underage drinking prevention. For each program identified there are six follow-up questions. Based on feedback from stakeholders and pilot testers, it is anticipated that States will report an average of three programs for a total of 18 questions.

[3] Note that the number of questions in Section 2B is an estimate. This Section asks States to identify their programs that are *related* to underage drinking prevention. For each program identified there are two follow-up questions. Based on feedback from stakeholders and pilot testers, it is anticipated that States will report an average of three such programs for a total of six questions.

Instrument	Number of respondents	Responses/ respondent	Burden/ response (hrs)	Annual burden (hrs)
State Questionnaire	51	1	17.7	902.7

Written comments and recommendations concerning the proposed information collection should be sent by September 2, 2010 to: SAMHSA Desk Officer, Human Resources and Housing Branch, Office of Management and Budget, New Executive Office Building, Room 10235, Washington, DC 20503; due to potential delays in OMB's receipt and processing of mail sent through the U.S. Postal Service, respondents are encouraged to submit comments by fax to: 202–395–5806.

Dated: July 20, 2010.

Elaine Parry,

Director, Office of Program Services.

[FR Doc. 2010–19011 Filed 8–2–10; 8:45 am]

BILLING CODE 4162–20–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Proposed Information Collection Activity; Comment Request

Proposed Projects:

Title: Financial Institution Data Match.

OMB No.: 0970–0196.

Description: Section 466(a)(17) of the Social Security Act (the Act) requires States to establish procedures under which the State Child Support Enforcement IV–D agencies shall enter into agreements with financial institutions doing business in States for the purpose of securing information leading to the enforcement of child support orders. Under 452(l) and 466(a)(17)(A)(i) of the Act, the Secretary may aid State agencies conducting data matches with financial institutions doing business in multiple States by centrally matching through the Federal Parent Locator Service.

Respondents: Financial institutions doing business in two or more States.

ANNUAL BURDEN ESTIMATES

Instrument	Number of respondents	Number of responses per respondent	Average burden hours per response	Total burden hours
Financial Data Match Result File	259	4	0.33	341.88
Election Form	122	1	0.50	10.2

Estimated Total Annual Burden Hours: 402.88.

In compliance with the requirements of Section 506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Administration for Children and Families is soliciting public comment on the specific aspects of the information collection described above. Copies of the proposed collection of information can be obtained and comments may be forwarded by writing to the Administration for Children and Families, Office of Administration, Office of Information Services, 370 L'Enfant Promenade, SW., Washington, DC 20447, Attn: ACF Reports Clearance Officer. E-mail address: *infocollection@acf.hhs.gov.* All requests should be identified by the title of the information collection.

The Department specifically requests comments on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed collection of information; (c) the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology. Consideration will be given to comments and suggestions submitted within 60 days of this publication.

Dated: July 29, 2010.

Robert Sargis,

Reports Clearance Officer.

[FR Doc. 2010–19009 Filed 8–2–10; 8:45 am]

BILLING CODE 4184–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. FDA–2010–N–0382]

Animal Drug User Fee Rates and Payment Procedures for Fiscal Year 2011

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing the rates and payment procedures for fiscal year (FY) 2011 animal drug user fees. The Federal Food, Drug, and Cosmetic Act (the act), as amended by the Animal Drug User Fee Act of 2003 (ADUFA) and the Animal Drug User Fee Amendments of 2008 (ADUFA II), authorizes FDA to collect user fees for certain animal drug applications and supplements, on certain animal drug products, on certain establishments where such products are made, and on certain sponsors of such animal drug applications and/or investigational animal drug submissions. This notice establishes the fee rates for FY 2011.

FOR FURTHER INFORMATION CONTACT: Visit FDA's Web site at *http://www.fda.gov/ForIndustry/UserFees/AnimalDrugUserFeeActADUFA/default.htm* or contact Lisa Kable, Center for Veterinary Medicine (HFV–10), Food and Drug Administration, 7529 Standish Pl., Rockville, MD 20855, 240–276–9718. For general questions, you may also e-mail the Center for Veterinary Medicine (CVM) at: *cvmadufa@fda.hhs.gov.*

SUPPLEMENTARY INFORMATION:

I. Background

Section 740 of the act (21 U.S.C. 379j-12) establishes four different kinds of user fees: (1) Fees for certain types of animal drug applications and supplements, (2) annual fees for certain animal drug products, (3) annual fees for certain establishments where such products are made, and (4) annual fees for certain sponsors of animal drug applications and/or investigational animal drug submissions (21 U.S.C. 379j-12(a)). When certain conditions are met, FDA will waive or reduce fees (21 U.S.C. 379j-12(d)).

For FY 2009 through FY 2013, the act establishes aggregate yearly base revenue amounts for each of these fee categories. Base revenue amounts established for years after FY 2009 are subject to adjustment for workload. Fees for applications, establishments, products, and sponsors are to be established each year by FDA so that the revenue for each fee category will approximate the level established in the statute, after the level has been adjusted for workload.

For FY 2011, the animal drug user fee rates are: $316,200 for an animal drug application; $158,100 for a supplemental animal drug application for which safety or effectiveness data is required and for an animal drug application subject to the criteria set forth in section 512(d)(4) of the act (21 U.S.C. 360b(d)(4)); $7,235 for an annual product fee; $83,100 for an annual establishment fee; and $64,000 for an annual sponsor fee. FDA will issue invoices for FY 2011 product, establishment, and sponsor fees by December 31, 2010, and these invoices will be due and payable within 30 days of issuance of the invoice.

The application fee rates are effective for applications submitted on or after October 1, 2010, and will remain in effect through September 30, 2011. Applications will not be accepted for review until FDA has received full payment of application fees and any other animal drug user fees owed.

II. Revenue Amount for FY 2011

A. Statutory Fee Revenue Amounts

ADUFA II (Public Law 110–316 signed by the President on August 14, 2008) specifies that the aggregate revenue amount for FY 2011 for each of the 4 animal drug user fee categories is $4,862,000, before any adjustment for workload is made. (See 21 U.S.C. 379j-12(b)(1) through (b)(4).)

B. Inflation Adjustment to Fee Revenue Amount

The amounts established in ADUFA II for each year for FY 2009 through FY 2013 include an inflation adjustment; so, no further inflation adjustment is required.

C. Workload Adjustment to Inflation Adjusted Fee Revenue Amount

For each FY beginning in FY 2010, ADUFA provides that fee revenue amounts shall be further adjusted to reflect changes in review workload (21 U.S.C. 379j-12(c)(1)).

FDA calculated the average number of each of the five types of applications and submissions specified in the workload adjustment provision (animal drug applications, supplemental animal drug applications for which data with respect to safety or efficacy are required, manufacturing supplemental animal drug applications, investigational animal drug study submissions, and investigational animal drug protocol submissions) received over the 5-year period that ended on September 30, 2002 (the base years), and the average number of each of these types of applications and submissions over the most recent 5-year period that ended on June 30, 2010.

The results of these calculations are presented in the first two columns of table 1 of this document. Column 3 reflects the percent change in workload over the two 5-year periods. Column 4 shows the weighting factor for each type of application, reflecting how much of the total FDA animal drug review workload was accounted for by each type of application or submission in the table during the most recent 5 years. Column 5 of table 1 of this document is the weighted percent change in each category of workload, and was derived by multiplying the weighting factor in each line in column 4 by the percent change from the base years in column 3. At the bottom right of the table the sum of the values in column 5 is added, reflecting a total change in workload of -25% percent for FY 2011. This is the workload adjuster for FY 2011.

TABLE 1—WORKLOAD ADJUSTER CALCULATION (NUMBERS MAY NOT ADD DUE TO ROUNDING)

Application Type	Column 1 5-Year Average (Base Years)	Column 2 Latest 5-Year Average	Column 3 Percent Change	Column 4 Weighting Factor	Column 5 Weighted % Change
New Animal Drug Applications (NADAs)	28.8	12.2	-58%	0.0372	-2%
Supplemental NADAs With Safety or Efficacy Data	23.4	13.2	-44%	0.0241	-1%
Manufacturing Supplements	366.6	430.4	17%	0.1699	3%
Investigational Study Submissions	336.6	230.4	-32%	0.5431	-17%
Investigational Protocol Submissions	292.4	198.6	-32%	0.2257	-7%
FY 2011 Workload Adjuster					-25%

ADUFA specifies that the workload adjuster may not result in fees that are less than the fee revenue amount in the statute (21 U.S.C. 379j-12(c)(1)(B)). Because applying the FY 2011 workload adjuster would result in fees less than the statutory amount, the workload adjustment will not be applied in FY 2011. As a result, the statutory revenue target amount for each of the 4 categories of fees remains at $4,862,000 with the new total revenue target for fees in FY 2011 being $19,448,000.

III. Adjustment for Excess Collections in Previous Years

ADUFA II amended the annual offset provision of ADUFA I to require one offset when FY 2013 fees are set in August of 2012, if aggregate collections from FY 2009 through 2011 plus the amount of fees estimated to be collected for FY 2012 exceed aggregate appropriations over the same period (21 U.S.C. 379j-12(g)(4), as amended by ADUFA II). Therefore FDA is not offsetting for excess collections at this time.

IV. Application Fee Calculations for FY 2011

The terms "animal drug application" and "supplemental animal drug application" are defined in section 739 of the act (21 U.S.C. 379j-11(1) and (2)).

A. Application Fee Revenues and Numbers of Fee-Paying Applications

The application fee must be paid for any animal drug application or supplemental animal drug application that is subject to fees under ADUFA and that is submitted on or after September 1, 2003. The application fees are to be set so that they will generate $4,862,000 in fee revenue for FY 2011. This is the amount set out in the statute and no adjustments are required for FY 2011. The fee for a supplemental animal drug application for which safety or effectiveness data are required and for an animal drug application subject to criteria set forth in section 512(d)(4) of the act is to be set at 50 percent of the animal drug application fee. (See 21 U.S.C. 379j-12(a)(1)(A)(ii), as amended by ADUFA II.)

To set animal drug application fees and supplemental animal drug application fees to realize $4,862,000, FDA must first make some assumptions about the number of fee-paying applications and supplements the agency will receive in FY 2011.

The agency knows the number of applications that have been submitted in previous years. That number fluctuates significantly from year to year. In estimating the fee revenue to be generated by animal drug application fees in FY 2011, FDA is assuming that the number of applications that will pay fees in FY 2011 will equal the average number of submissions over the 4 most recent years (including an estimate for the current year). This may not fully account for possible year to year fluctuations in numbers of fee-paying applications, but FDA believes that this is a reasonable approach after 7 years of experience with this program.

Over the past 4 years, the average number of animal drug applications that would have been subject to the full fee was 8.5, including the number for the most recent year, estimated at 9. Over this same period, the average number of supplemental applications and applications subject to the criteria set forth in section 512(d)(4) of the act that would have been subject to half of the full fee was 13.75, including the number for the most recent year, estimated at 14.

Thus, for FY 2011, FDA estimates receipt of 8.5 fee paying original applications and 13.75 fee-paying supplemental animal drug applications and applications subject to the criteria set forth is section 512(d)(4) of the act which pay half of the full fee.

B. Fee Rates for FY 2011

FDA must set the fee rates for FY 2011 so that the estimated 8.5 applications that pay the full fee and the estimated 13.75 supplements and applications subject to the criteria set forth in section 512(d)(4) of the act that pay half of the full fee will generate a total of $4,862,000. To generate this amount, the fee for an animal drug application, rounded to the nearest hundred dollars, will have to be $316,200, and the fee for a supplemental animal drug application for which safety or effectiveness data are required and for applications subject to the criteria set forth in section 512(d)(4) of the act will have to be $158,100.

V. Product Fee Calculations for FY 20111

A. Product Fee Revenues and Numbers of Fee-Paying Products

The animal drug product fee (also referred to as the product fee) must be paid annually by the person named as the applicant in a new animal drug application or supplemental new animal drug application for an animal drug product submitted for listing under section 510 of the act (21 U.S.C. 360), and who had an animal drug application or supplemental animal drug application pending at FDA after September 1, 2003. (See 21 U.S.C. 379j-12(a)(2).) The term "animal drug product" is defined in 21 U.S.C. 379j-11(3). The product fees are to be set so that they will generate $4,862,000 in fee revenue for FY 2011. This is the amount set out in the statute and no adjustments are required for FY 2011.

To set animal drug product fees to realize $4,862,000, FDA must make some assumptions about the number of products for which these fees will be paid in FY 2011. FDA developed data on all animal drug products that have been submitted for listing under section 510 of the act, and matched this to the list of all persons who had an animal drug application or supplement pending after September 1, 2003. As of July 2010, FDA estimates that there are a total of 747 products submitted for listing by persons who had an animal drug application or supplemental animal drug application pending after September 1, 2003. Based on this, FDA estimates that a total of 747 products will be subject to this fee in FY 2011.

In estimating the fee revenue to be generated by animal drug product fees in FY 2011, FDA is again assuming that 10 percent of the products invoiced, or about 75, will not pay fees in FY 2011 due to fee waivers and reductions. Based on experience with other user fee programs and the first 7 years of ADUFA, FDA believes that this is a reasonable basis for estimating the number of fee-paying products in FY 2011.

Accordingly, the agency estimates that a total of 672 (747 minus 75) products will be subject to product fees in FY 2011.

B. Product Fee Rates for FY 2011

FDA must set the fee rates for FY 2011 so that the estimated 672 products that pay fees will generate a total of $4,862,000. To generate this amount will require the fee for an animal drug product, rounded to the nearest 5 dollars, to be $7,235.

VI. Establishment Fee Calculations for FY 2011

A. Establishment Fee Revenues and Numbers of Fee-Paying Establishments

The animal drug establishment fee (also referred to as the establishment fee) must be paid annually by the person who: (1) Owns or operates, directly or through an affiliate, an animal drug establishment; (2) is named as the applicant in an animal drug application or supplemental animal drug application for an animal drug product submitted for listing under section 510 of the act; (3) had an animal drug application or supplemental animal drug application pending at FDA after September 1, 2003; and (4) whose establishment engaged in the manufacture of the animal drug product during the fiscal year. (See 21 U.S.C. 379j-12(a)(3).) An establishment subject to animal drug establishment fees is assessed only 1 such fee per fiscal year. (See 21 U.S.C. 379j-12(a)(3).) The term "animal drug establishment" is defined in 21 U.S.C. 379j-11(4). The establishment fees are to be set so that they will generate $4,862,000 in fee revenue for FY 2011. This is the amount set out in the statute and no adjustments are required for FY 2011.

To set animal drug establishment fees to realize $4,862,000, FDA must make some assumptions about the number of establishments for which these fees will be paid in FY 2011. FDA developed data on all animal drug establishments and matched this to the list of all persons who had an animal drug application or supplement pending after September 1, 2003. As of July 2010, FDA estimates that there are a total of 65 establishments owned or operated by persons who had an animal drug application or supplemental animal drug application pending after September 1, 2003. Based on this, FDA believes that 65 establishments will be subject to this fee in FY 2011.

In estimating the fee revenue to be generated by animal drug establishment fees in FY 2011, FDA is assuming that 10 percent of the establishments invoiced, or 6.5, will not pay fees in FY 2011 due to fee waivers and reductions. Based on experience with the first 7 years of ADUFA, FDA believes that this is a reasonable basis for estimating the number of fee-paying establishments in FY 2011.

Accordingly, the agency estimates that a total of 58.5 establishments (65 minus 6.5) will be subject to establishment fees in FY 2011.

B. Establishment Fee Rates for FY 2011

FDA must set the fee rates for FY 2011 so that the estimated 58.5 establishments that pay fees will generate a total of $4,862,000. To generate this amount will require the fee for an animal drug establishment, rounded to the nearest 50 dollars, to be $83,100.

VII. Sponsor Fee Calculations for FY 2011

A. Sponsor Fee Revenues and Numbers of Fee-Paying Sponsors

The animal drug sponsor fee (also referred to as the sponsor fee) must be paid annually by each person who: (1) Is named as the applicant in an animal drug application, except for an approved application for which all subject products have been removed from listing under section 510 of the act or has submitted an investigational animal drug submission that has not been terminated or otherwise rendered inactive; and (2) had an animal drug application, supplemental animal drug application, or investigational animal drug submission pending at FDA after September 1, 2003. (See 21 U.S.C. 379j-11(6) and 379j-12(a)(4).) An animal drug sponsor is subject to only 1 such fee each fiscal year. (See 21 U.S.C. 379j-12(a)(4).) The sponsor fees are to be set so that they will generate $4,862,000 in fee revenue for FY 2011. This is the amount set out in the statute, and no adjustments are required for FY 2011.

To set animal drug sponsor fees to realize $4,862,000, FDA must make some assumptions about the number of sponsors who will pay these fees in FY 2011. Based on the number of firms that would have met this definition in each of the past 7 years, FDA estimates that a total of 162 sponsors will meet this definition in FY 2011.

Careful review indicates that about one third or 33 percent of all of these sponsors will qualify for minor use/minor species waiver or reduction (21 U.S.C. 379j-12(d)(1)(C)). Based on the agency's experience to date with sponsor fees, FDA's current best estimate is that an additional 20 percent will qualify for other waivers or reductions, for a total of 53 percent of the sponsors invoiced, or 86, who will not pay fees in FY 2011 due to fee waivers and reductions. FDA believes that this is a reasonable basis for estimating the number of fee-paying sponsors in FY 2011.

Accordingly, the agency estimates that a total of 76 sponsors (162 minus 86) will be subject to and pay sponsor fees in FY 2011.

B. Sponsor Fee Rates for FY 2011

FDA must set the fee rates for FY 2011 so that the estimated 76 sponsors that pay fees will generate a total of $4,862,000. To generate this amount will require the fee for an animal drug sponsor, rounded to the nearest 50 dollars, to be $64,000.

VIII. Fee Schedule for FY 2011

The fee rates for FY 2011 are summarized in table 2 of this document.

TABLE 2—FY 2011 FEE RATES

Animal Drug User Fee Category	Fee Rate for FY 2011
Animal Drug Application Fees	
Animal Drug Application	$316,200
Supplemental Animal Drug Application for Which Safety or Effectiveness Data are Required or Animal Drug Application Subject to the Criteria Set Forth in Section 512(d)(4) of the Act	$158,100
Animal Drug Product Fee	$7,235
Animal Drug Establishment Fee[1]	$83,100
Animal Drug Sponsor Fee[2]	$64,000

[1] An animal drug establishment is subject to only one such fee each fiscal year.
[2] An animal drug sponsor is subject to only one such fee each fiscal year.

IX. Procedures for Paying the FY 2011 Fees

A. Application Fees and Payment Instructions

The appropriate application fee established in the new fee schedule must be paid for an animal drug application or supplement subject to fees under ADUFA that is submitted after September 30, 2010. Payment must be made in U.S. currency by check, bank draft, or U.S. postal money order payable to the order of the Food and Drug Administration, by wire transfer, or electronically using Pay.gov. (The Pay.gov payment option is available to you after you submit a cover sheet. Click the "Pay Now" button.) On your check, bank draft, or U.S. postal money order, please write your application's unique Payment Identification Number (PIN), beginning with the letters AD, from the upper right-hand corner of your completed Animal Drug User Fee Cover Sheet. Also write the FDA post office box number (P.O. Box 953877) on the enclosed check, bank draft, or money order. Your payment and a copy of the completed Animal Drug User Fee Cover

Sheet can be mailed to: Food and Drug Administration, P.O. Box 953877, St. Louis, MO, 63195–3877.

If payment is made by wire transfer, send payment to: U.S. Department of Treasury, TREAS NYC, 33 Liberty St., New York, NY 10045, FDA Deposit Account Number: 75060099, U.S. Department of Treasury routing/transit number: 021030004, SWIFT Number: FRNYUS33. You are responsible for any administrative costs associated with the processing of a wire transfer. Contact your bank or financial institution regarding additional fees.

If you prefer to send a check by a courier such as Federal Express (FEDEX) or United Parcel Service (UPS), the courier may deliver the check and printed copy of the cover sheet to: U.S. Bank, Attn: Government Lockbox 953877, 1005 Convention Plaza, St. Louis, MO 63101. (Note: This address is for courier delivery only. If you have any questions concerning courier delivery contact the U.S. Bank at 314–418–4821. This telephone number is only for questions about courier delivery.)

The tax identification number of the Food and Drug Administration is 530196965. (Note: In no case should the payment for the fee be submitted to FDA with the application.)

It is helpful if the fee arrives at the bank at least a day or two before the application arrives at FDA's CVM. FDA records the official application receipt date as the later of the following: The date the application was received by FDA's CVM, or the date U.S. Bank notifies FDA that your payment in the full amount has been received, or when the U.S. Treasury notifies FDA of receipt of an electronic or wire transfer payment. U.S. Bank and the U.S. Treasury are required to notify FDA within 1 working day, using the PIN described previously.

B. Application Cover Sheet Procedures

Step One—Create a user account and password. Log on to the ADUFA Web site at *http://www.fda.gov/ForIndustry/UserFees/AnimalDrugUserFeeActADUFA/default.htm* and, under Tools and Resources click "The Animal Drug User Fee Cover Sheet" and then click "Create ADUFA User Fee Cover Sheet." For security reasons, each firm submitting an application will be assigned an organization identification number, and each user will also be required to set up a user account and password the first time you use this site. Online instructions will walk you through this process.

Step Two—Create an Animal Drug User Cover Sheet, transmit it to FDA, and print a copy. After logging into your account with your user name and password, complete the steps required to create an Animal Drug User Fee Cover Sheet. One cover sheet is needed for each animal drug application or supplement. Once you are satisfied that the data on the cover sheet is accurate and you have finalized the cover sheet, you will be able to transmit it electronically to FDA and you will be able to print a copy of your cover sheet showing your unique PIN.

Step Three—Send the payment for your application as described in section IX.A of this document.

Step Four—Please submit your application and a copy of the completed Animal Drug User Fee Cover Sheet to the following address: Food and Drug Administration, Center for Veterinary Medicine, Document Control Unit (HFV–199), 7500 Standish Pl., Rockville, MD 20855.

C. Product, Establishment, and Sponsor Fees

By December 31, 2010, FDA will issue invoices and payment instructions for product, establishment, and sponsor fees for FY 2011 using this Fee Schedule. Payment will be due and payable within 30 days of issuance of the invoice. FDA will issue invoices in November 2011 for any products, establishments, and sponsors subject to fees for FY 2011 that qualify for fees after the December 2010 billing.

Dated: July 29, 2010.

Leslie Kux,

Acting Assistant Commissioner for Policy.

[FR Doc. 2010–19037 Filed 8–2–10; 8:45 am]

BILLING CODE 4160–01–S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. FDA–2009–N–0340]

Animal Generic Drug User Fee Rates and Payment Procedures for Fiscal Year 2011

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing the rates and payment procedures for fiscal year (FY) 2011 generic new animal drug user fees. The Federal Food, Drug, and Cosmetic Act (the act), as amended by the Animal Generic Drug User Fee Act of 2008 (AGDUFA), authorizes FDA to collect user fees for certain abbreviated applications for generic new animal drugs, on certain generic new animal drug products, and on certain sponsors of such abbreviated applications for generic new animal drugs and/or investigational submissions for generic new animal drugs. This notice establishes the fee rates for FY 2011.

For FY 2011, the generic animal drug user fee rates are: $92,600 for each abbreviated application for a generic new animal drug; $5,440 for each generic new animal drug product; $55,950 for each generic new animal drug sponsor paying 100 percent of the sponsor fee; $41,963 for each generic new animal drug sponsor paying 75 percent of the sponsor fee; and $27,975 for a generic new animal drug sponsor paying 50 percent of the sponsor fee. FDA will issue invoices for FY 2011 product and sponsor fees by December 31, 2010. These fees will be due and payable within 30 days of the issuance of the invoices.

The application fee rates are effective for all abbreviated applications for a generic new animal drug submitted on or after October 1, 2010, and will remain in effect through September 30, 2011. Applications will not be accepted for review until FDA has received full payment of related application fees and any other fees owed under the Animal Generic Drug User Fee program.

FOR FURTHER INFORMATION CONTACT: Visit the FDA Web site at *http://www.fda.gov/ForIndustry/UserFees/AnimalGenericDrugUserFeeActAGDUFA/default.htm* or contact Bryan Walsh, Center for Veterinary Medicine (HFV–10), Food and Drug Administration, 7529 Standish Pl., Rockville, MD 20855, 240–276–9730. For general questions, you may also e-mail the Center for Veterinary Medicine (CVM) at: *cvmagdufa@fda.hhs.gov*.

SUPPLEMENTARY INFORMATION:

I. Background

Section 741 of the act (21 U.S.C. 379j–21) establishes three different kinds of user fees: (1) Fees for certain types of abbreviated applications for generic new animal drugs, (2) annual fees for certain generic new animal drug products, and (3) annual fees for certain sponsors of abbreviated applications for generic new animal drugs and/or investigational submissions for generic new animal drugs (21 U.S.C. 379j–21(a)). When certain conditions are met, FDA will waive or reduce fees for generic new animal drugs intended solely to provide for a minor use or minor species indication (21 U.S.C. 379j–21(d)).

For FY 2009 through FY 2013, the act establishes aggregate yearly base revenue amounts for each of these fee

categories. Base revenue amounts established for years after FY 2009 may be adjusted for workload. Fees for applications, products, and sponsors are to be established each year by FDA so that the revenue for each fee category will approximate the level established in the statute, after the level has been adjusted for workload.

II. Revenue Amount for FY 2011

A. Statutory Fee Revenue Amounts

AGDUFA (Title II of Public Law 110–316 signed by the President on August 14, 2008) specifies that the aggregate revenue amount for FY 2011 for abbreviated application fees is $1,619,000 and each of the other two generic new animal drug user fee categories, annual product fees and annual sponsor fees, is $1,889,000 each, before any adjustment for workload is made (see 21 U.S.C. 379j–21(b)).

B. Inflation Adjustment to Fee Revenue Amount

The amounts established in AGDUFA for each year for FY 2009 through FY 2013 include an inflation adjustment, so no inflation adjustment is required.

C. Workload Adjustment to Inflation Adjusted Fee Revenue Amount

For each FY beginning after FY 2009, AGDUFA provides that statutory fee revenue amounts shall be further adjusted to reflect changes in review workload (21 U.S.C. 379j–21(c)(1)).

FDA calculated the average number of each of the four types of applications and submissions specified in the workload adjustment provision (abbreviated applications for generic new animal drugs, manufacturing supplemental abbreviated applications for generic new animal drugs, investigational generic new animal drug study submissions, and investigational generic new animal drug protocol submissions) received over the 5-year period ended on September 30, 2008 (the base years), and the average number of each of these types of applications and submissions over the most recent 5-year period that ended on June 30, 2010.

The results of these calculations are presented in the first two columns of table 1 of this document. Column 3 reflects the percent change in workload over the two 5-year periods. Column 4 shows the weighting factor for each type of application, reflecting how much of the total FDA generic new animal drug review workload was accounted for by each type of application or submission in the table during the most recent 5 years. Column 5 of table 1 is the weighted percent change in each category of workload, and was derived by multiplying the weighting factor in each line in column 4 by the percent change from the base years in column 3. At the bottom right of table 1, the sum of the values in column 5 is calculated, reflecting a total change in workload of negative 24.47 percent for FY 2011. This is the workload adjuster for FY 2011.

TABLE 1—WORKLOAD ADJUSTER CALCULATION

Application Type	Column 1 5-Year Avg. 2004–2008 (Base Years)	Column 2 Latest 5-Year Avg. (thru June 30, 2010)	Column 3 Percent Change	Column 4 Weighting Factor	Colum 5 Weighted Percent Change
Abbreviated New Animal Drug Applications (ANADAs)	44.2	30.2	-32%	56%	-17.74%
Manufacturing Supplements ANADAs[1]	114.6	102.6	-10%	19%	-1.99%
Generic Investigational Study Submissions[2]	17.4	17.4	0%	10%	0.00%
Generic Investigational Protocol Submissions	21.6	15.2	-30%	16%	-4.74%
FY 2011 AGDUFA Workload Adjuster					-24.47%

[1] This number is slightly lower than the 114.8 shown in last year's notice because FDA refused to file some applications.
[2] This number is slightly lower than the 18 shown in last years notice because FDA refused to accept some submissions.

AGDUFA specifies that the workload adjuster may not result in fees for a fiscal year that are less than the statutory revenue amount (21 U.S.C. 379j–21(c)(1)(B)) for that fiscal year. Because applying the workload adjuster for FY 2011 would result in fees less than the statutory amount, the workload adjustment will not be applied in FY 2011. As a result, the statutory revenue amount for each category of fees for FY 2011 ($1,619,000 for application fees and $1,889,000 for both product and sponsor fees) becomes the revenue target for the fees in FY 2011, for a total fee revenue target in FY 2011 of $5,397,000 for fees from all three categories.

III. Abbreviated Application Fee Calculations for FY 2011

The term "abbreviated application for a generic new animal drug" is defined in 21 U.S.C. 379j–21(k)(1).

A. Application Fee Revenues and Numbers of Fee-Paying Applications

The application fee must be paid for abbreviated applications for a generic new animal drug that is subject to fees under AGDUFA and that is submitted on or after July 1, 2008. The application fees are to be set so that they will generate $1,619,000 in fee revenue for FY 2011. This is the amount set out in the statute.

To set fees for abbreviated applications for generic new animal drugs to realize $1,619,000, FDA must first make some assumptions about the number of fee-paying abbreviated applications it will receive during FY 2011.

The agency knows the number of applications that have been submitted in previous years. That number fluctuates significantly from year to year. FDA is making estimates and applying different assumptions for two types of submissions: Original submissions of abbreviated applications for generic new animal drugs and "reactivated" submissions of abbreviated applications for generic new animal drugs. Any original submissions of abbreviated applications for generic new animal drugs that were received by FDA before July 1, 2008, were not assessed

fees (21 U.S.C. 379j–21(a)(1)(A)). Some of these nonfee paying submissions were later resubmitted after July 1 because the initial submission was not approved by FDA (i.e. FDA marked the submission as incomplete and requested additional nonadministrative information) or because the original submission was withdrawn by the sponsor. Because these abbreviated applications for generic new animal drugs are resubmitted after July 1, 2008, they are assessed fees. In this notice, FDA refers to these resubmitted applications as "reactivated" applications.

Regarding original submissions of abbreviated applications for generic new animal drugs, FDA is assuming that the number of applications that will pay fees in FY 2011 will equal 30 percent less than the average number of submissions over the 5 most recent years. This 30-percent reduction is made because of the anticipated impact of fees on the number on submissions. During FY 2010, FDA estimates it will receive only 6 original submissions of abbreviated applications for generic new animal drugs, compared to average receipts of 14.4 per year over the latest 5 years, including our FY 2010 estimate. Applying a 30-percent reduction to the 14.4 average, the estimate for original submissions of abbreviated applications for generic new animal drugs for FY 2011 is 10.1. (If the number of original submissions of abbreviated applications for generic new animal drugs does not increase over the next year, a higher percent reduction will have to be applied a year from now when fees are set for FY 2012.)

Regarding reactivated submissions of abbreviated applications for generic new animal drugs, FDA is applying a 50-percent reduction based on the FDA's experience with these types of submissions during the third year of other user fee programs. This assumption is based on the fact that there were a limited number of original submissions of abbreviated applications for generic new animal drugs received by FDA before July 1, 2008, and which were not assessed fees. For these original submissions that were not approved before July 1, 2008, resubmission to FDA would trigger an application fee (21 U.S.C. 379j–21(a)(1)(A)). Once these initial original submissions of abbreviated applications for generic new animal drugs received by FDA before July 1, 2008, have either been withdrawn or resubmitted, "reactivation submissions" will cease completely. This reduction is consistent with estimates made when this user fee program was in the development process. During FY 2010, FDA estimates it will receive only 9 reactivated submissions of abbreviated applications for generic new animal drugs, compared to average receipts of 14.8 per year average over the most recent 5 years, including our estimate for FY 2010. Applying a 50-percent reduction to the 14.8 average, the estimate for reactivated submissions of abbreviated applications for generic new animal drugs for FY 2011 is 7.4. These reductions may not fully account for possible year to year fluctuations in numbers of fee-paying applications, but FDA believes that this is a reasonable approach after about 7 years of experience with a similar user fee program.

Based on the previous assumptions, FDA is estimating that it will receive a total of 17.5 fee paying generic new animal drug applications in FY 2011 (10.1 original applications and 7.4 reactivations).

B. Fee Rates for FY 2011

FDA must set the fee rates for FY 2011 so that the estimated 17.5 abbreviated applications that pay the fee will generate a total of $1,619,000. To generate this amount, the fee for a generic new animal drug application, rounded to the nearest hundred dollars, will have to be $92,600.

IV. Generic New Animal Drug Product Fee Calculations for FY 2011

A. Product Fee Revenues and Numbers of Fee-Paying Products

The generic new animal drug product fee (also referred to as the product fee) must be paid annually by the person named as the applicant in an abbreviated new animal drug application or supplemental abbreviated application for generic new animal drugs for an animal drug product submitted for listing under section 510 of the act (21 U.S.C. 360), and who had an abbreviated application for a generic new animal drug or supplemental abbreviated application for a generic new animal drug pending at FDA after September 1, 2008 (see 21 U.S.C. 379j–21(a)(2)). The term "generic new animal drug product" means each specific strength or potency of a particular active ingredient or ingredients in final dosage form marketed by a particular manufacturer or distributor, which is uniquely identified by the labeler code and product code portions of the national drug code, and for which an abbreviated application for a generic new animal drug or supplemental abbreviated application for a generic new animal drug has been approved (21 U.S.C. 379j–21(k)(6)). The product fees are to be set so that they will generate $1,889,000 in fee revenue for FY 2011. This is the amount set out in the statute and no further adjustments are required for FY 2011.

To set generic new animal drug product fees to realize $1,889,000, FDA must make some assumptions about the number of products for which these fees will be paid in FY 2011. FDA gathered data on all generic new animal drug products that have been submitted for listing under section 510 of the act, and matched this to the list of all persons who FDA estimated would have an abbreviated new animal drug application or supplemental abbreviated application pending after September 1, 2008. FDA estimates a total of 386 products submitted for listing by persons who had an abbreviated application for a generic new animal drug or supplemental abbreviated application for a generic new animal drug pending after September 1, 2008. Based on this, FDA believes that a total of 386 products will be subject to this fee in FY 2011. The number of products has dropped substantially from the numbers in last year's **Federal Register** fee notice because a number of products were de-listed and are no longer subject to fee. That also causes the fee per product to increase.

In estimating the fee revenue to be generated by generic new animal drug product fees in FY 2011, FDA is assuming that 10 percent of the products invoiced, or 38.6, will not pay fees in FY 2011 due to fee waivers and reductions. Based on experience with other user fee programs and the first 2 years of AGDUFA, FDA believes that this is a reasonable basis for estimating the number of fee-paying products in FY 2011.

Accordingly, the agency estimates that a total of 347.4 (386 minus 38.6) products will be subject to product fees in FY 2011.

B. Product Fee Rates for FY 2011

FDA must set the fee rates for FY 2011 so that the estimated 347.4 products that pay fees will generate a total of $1,889,000. To generate this amount will require the fee for a generic new animal drug product, rounded to the nearest five dollars, to be $5,440.

V. Generic New Animal Drug Sponsor Fee Calculations for FY 2011

A. Sponsor Fee Revenues and Numbers of Fee-Paying Sponsors

The generic new animal drug sponsor fee (also referred to as the sponsor fee) must be paid annually by each person who: (1) Is named as the applicant in an

abbreviated application for a new generic animal drug, except for an approved application for which all subject products have been removed from listing under section 510 of the act, or has submitted an investigational submission for a generic new animal drug that has not been terminated or otherwise rendered inactive; and (2) had an abbreviated application for a generic new animal drug, supplemental abbreviated application for a generic new animal drug, or investigational submission for a generic new animal drug pending at FDA after September 1, 2008 (see 21 U.S.C. 379j–21(k)(7) and 379j–21(a)(3)). A generic new animal drug sponsor is subject to only one such fee each fiscal year (see 21 U.S.C. 379j–21(a)(3)(B)). Applicants with more than 6 approved abbreviated applications will pay 100 percent of the sponsor fee, applicants with 2 to 6 approved abbreviated applications will pay 75 percent of the sponsor fee, and applicants with 1 or fewer approved abbreviated applications will pay 50 percent of the sponsor fee (see 21 U.S.C. 379j–21(a)(3)(B)). The sponsor fees are to be set so that they will generate $1,889,000 in fee revenue for FY 2011. This is the amount set out in the statute and no adjustments are required for FY 2011.

To set generic new animal drug sponsor fees to realize $1,889,000, FDA must make some assumptions about the number of sponsors who will pay these fees in FY 2011. Based on the number of firms that meet this definition, FDA estimates that in FY 2011, 12 sponsors will pay 100 percent fees, 12 sponsors will pay 75 percent fees, and 33 sponsors will pay 50 percent fees. That totals the equivalent of 37.5 full sponsor fees (12 times 100 percent or 12, plus 12 times 75 percent or 9, plus 33 times 50 percent or 16.5).

FDA estimates that about 10 percent of all of these sponsors, or 3.75, may qualify for a minor use/minor species waiver.

Accordingly, the agency estimates that the equivalent of 33.75 full sponsor fees (37.5 minus 3.75) are likely to be paid in FY 2011.

B. Sponsor Fee Rates for FY 2011

FDA must set the fee rates for FY 2011 so that the estimated equivalent of 33.75 full sponsor fees will generate a total of $1,889,000. To generate this amount will require the 100-percent fee for a generic new animal drug sponsor, rounded to the nearest $50, to be $55,950. Accordingly, the fee for those paying 75 percent of the full sponsor fee will be $41,963, and the fee for those paying 50 percent of the full sponsor fee will be $27,795.

VI. Fee Schedule for FY 2011

The fee rates for FY 2011 are summarized in table 2 of this document.

TABLE 2—FY 2011 FEE RATES

Generic New Animal Drug User Fee Category	Fee Rate for FY 2011
Abbreviated Application Fee for Generic New Animal Drug Application	$92,600
Generic New Animal Drug Product Fee	5,440
100 Percent Generic New Animal Drug Sponsor Fee[1]	55,950
75 Percent Generic New Animal Drug Sponsor Fee [1]	41,963
50 Percent Generic New Animal Drug Sponsor Fee [1]	27,975

[1] An animal drug sponsor is subject to only one fee each fiscal year.

VII. Procedures for Paying FY 2011 Generic New Animal Drug User Fees

A. Abbreviated Application Fees and Payment Instructions

The FY 2011 fee established in the new fee schedule must be paid for an abbreviated new animal drug application subject to fees under AGDUFA that is submitted on or after October 1, 2010. Payment must be made in U.S. currency by check, bank draft, or U.S. postal money order payable to the order of the Food and Drug Administration, by wire transfer, or by automatic clearing house (ACH) using Pay.gov. (The Pay.gov payment option is available to you after you submit a cover sheet. Click the "Pay Now" button). On your check, bank draft, U.S. or postal money order, please write your application's unique Payment Identification Number, beginning with the letters "AG", from the upper right-hand corner of your completed Animal Generic Drug User Fee Cover Sheet. Also write the FDA post office box number (PO Box 953877) on the enclosed check, bank draft, or money order. Your payment and a copy of the completed Animal Generic Drug User Fee Cover Sheet can be mailed to: Food and Drug Administration, P.O. Box 953877, St. Louis, MO, 63195–3877.

If payment is made via wire transfer, send payment to U.S. Department of the Treasury, TREAS NYC, 33 Liberty St., New York, NY 10045, Account Name: Food and Drug Administration, Account Number: 75060099, Routing Number: 021030004, Swift Number: FRNYUS33. You are responsible for any administrative costs associated with the processing of a wire transfer. Contact your bank or financial institution regarding the amount of the fees that need to be paid in addition to the wire transfer amount.

If you prefer to send a check by a courier such as FEDEX or UPS, the courier may deliver the check and printed copy of the cover sheet to: US Bank, Attn: Government Lockbox 953877, 1005 Convention Plaza, St. Louis, Missouri 63101. (Note: This address is for courier delivery only. If you have any questions concerning courier delivery contact the US Bank at 314–418–4821. This phone number is only for questions about courier delivery.)

The tax identification number of the Food and Drug Administration is 530196965. (Note: In no case should the payment for the fee be submitted to FDA with the application.)

It is helpful if the fee arrives at the bank at least a day or two before the abbreviated application arrives at FDA's Center for Veterinary Medicine. FDA records the official abbreviated application receipt date as the later of the following: The date the application was received by FDA's Center for Veterinary Medicine, or the date US Bank notifies FDA that your payment in the full amount has been received, or when the U.S. Department of the Treasury notifies FDA of payment. US Bank and the United States Treasury are required to notify FDA within 1 working day, using the Payment Identification Number described previously.

B. Application Cover Sheet Procedures

Step One—Create a user account and password. Log onto the AGDUFA Web site at *http://www.fda.gov/ForIndustry/UserFees/AnimalGenericDrugUserFeeActAGDUFA/ucm137049.htm* and scroll down the page until you find the link "Create AGDUFA User Fee Cover Sheet." Click on that link and follow the directions. For security reasons, each firm submitting an application will be assigned an organization identification number, and each user will also be required to set up a user account and password the first time you use this site. Online instructions will walk you through this process.

Step Two—Create an Animal Generic Drug User Fee Cover Sheet, transmit it to FDA, and print a copy. After logging into your account with your user name and password, complete the steps required to create an Animal Generic Drug User Fee Cover Sheet. One cover sheet is needed for each abbreviated animal drug application. Once you are

satisfied that the data on the cover sheet is accurate and you have finalized the Cover Sheet, you will be able to transmit it electronically to FDA and you will be able to print a copy of your cover sheet showing your unique Payment Identification Number.

Step Three—Send the Payment for your application as described in section VII.A of this document.

Step Four—Please submit your application and a copy of the completed Animal Generic Drug User Fee Cover Sheet to the following address: Food and Drug Administration, Center for Veterinary Medicine, Document Control Unit (HFV–199), 7500 Standish Pl., Rockville, MD 20855.

C. Product and Sponsor Fees

By December 31, 2010, FDA will issue invoices and payment instructions for product and sponsor fees for FY 2011 using this fee schedule. Fees will be due and payable 30 days after the issuance of the invoices. FDA will issue invoices in November 2012 for any products and sponsors subject to fees for FY 2011 that qualify for fees after the December 2010 billing.

Dated: July 29, 2010.

Leslie Kux,

Acting Assistant Commissioner for Policy.

[FR Doc. 2010–19040 Filed 8–2–10; 8:45 am]

BILLING CODE 4160–01–S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. FDA–2010–D–0246]

Draft Guidance for Industry on Residual Drug in Transdermal and Related Drug Delivery Systems; Availability

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing the availability of a draft guidance for industry entitled "Residual Drug in Transdermal and Related Drug Delivery Systems." This draft guidance provides recommendations to developers and manufacturers of transdermal drug delivery systems (TDDS), transmucosal drug delivery systems (TMDS), and topical patch products regarding use of an appropriate scientific approach during product design and development—as well as during manufacturing and product lifecycle management—to ensure that the amount of residual drug substance at the end of the labeled use period is minimized. The draft guidance is applicable to investigational new drug applications (INDs), new drug applications (NDAs), abbreviated new drug applications (ANDAs), and supplemental new drug applications (sNDAs) for TDDS, TMDS, and topical patch products.

DATES: Although you can comment on any guidance at any time (see 21 CFR 10.115(g)(5)), to ensure that the agency considers your comment on this draft guidance before it begins work on the final version of the guidance, submit either electronic or written comments on the draft guidance, including comments regarding the proposed collection of information, by November 1, 2010.

ADDRESSES: Submit written requests for single copies of the draft guidance to the Division of Drug Information, Center for Drug Evaluation and Research, Food and Drug Administration, 10903 New Hampshire Ave., Bldg. 51, rm. 2201, Silver Spring, MD 20993–0002. Send one self-addressed adhesive label to assist that office in processing your requests. See the **SUPPLEMENTARY INFORMATION** section for electronic access to the draft guidance document.

Submit electronic comments on the draft guidance to *http://www.regulations.gov*. Submit written comments on the draft guidance to the Division of Dockets Management (HFA–305), Food and Drug Administration, 5630 Fishers Lane, rm. 1061, Rockville, MD 20852.

FOR FURTHER INFORMATION CONTACT: Terrance Ocheltree, Center for Drug Evaluation and Research, Food and Drug Administration, Bldg. 21, rm. 1609, 10903 New Hampshire Ave., Silver Spring, MD 20993–0002, 301–796–1988.

SUPPLEMENTARY INFORMATION:

I. Background

FDA is announcing the availability of a draft guidance for industry entitled "Residual Drug in Transdermal and Related Drug Delivery Systems." This draft guidance provides recommendations to developers and manufacturers of TDDS, TMDS, and topical patch products regarding use of an appropriate scientific approach during product design and development—as well as during manufacturing and product lifecycle management—to ensure that the amount of residual drug substance at the end of the labeled use period is minimized.

Existing TDDS, TMDS, and topical patches contain a larger amount of the drug substance than what is intended to be delivered to the patient. This excess amount of drug substance is needed to facilitate delivery of the intended amount of the drug to the patient and remains as residual drug in the used system. The amount of residual drug substance in TDDS, TMDS, and topical patches has a significant potential to impact the products' quality, safety, and efficacy. Consequently, it is necessary to ensure that an appropriate scientific approach is used to design and develop these products. The approach should ensure that the amount of residual drug substance is minimized consistent with the current state of technology.

Currently marketed TDDS, TMDS, and topical patches may retain 10 to 95 percent of the initial total amount of drug after the intended use period. This raises a potential safety issue not only to the patient, but also to others including family members, caregivers, children, and pets. For example, adverse events due to a patient's failure to remove TDDS at the end of the intended use period have been reported and are generally related to an increased or prolonged pharmacological effect of the drug. Some children have died from inadvertent exposure to discarded TDDS. Reported adverse events resulting from various quality problems pertaining to TDDS have lead to product recalls, withdrawals, and public health advisories.

To reduce some of these risks, we recommend that an enhanced design and development approach—specifically Quality by Design (QbD), as described in the International Conference on Harmonization (ICH) guidance for industry Q8(R2) *Pharmaceutical Development*—be used when developing and manufacturing TDDS, TMDS, and topical patches. We also recommend that sufficient scientific justification to support the amount of residual drug in TDDS, TMDS, or topical patches be included in an application. The level of information in the justification should be sufficient to demonstrate product and process understanding and ensure that a scientific, risk-based approach has been taken to minimize the amount of residual drug in a system after use to the lowest possible level. Furthermore, it is expected that the amount of residual drug in a newly developed system will not exceed that of similar FDA-approved products.

This draft guidance is being issued consistent with FDA's good guidance practices regulation (21 CFR 10.115). The draft guidance, when finalized, will represent the Agency's current thinking on residual drug in transdermal and related drug delivery systems. It does not create or confer any rights for or on

any person and does not operate to bind FDA or the public. An alternative approach may be used if such approach satisfies the requirements of the applicable statutes and regulations.

II. Comments

Interested persons may submit to the Division of Dockets Management (see **ADDRESSES**) either electronic or written comments regarding this document. It is only necessary to send one set of comments. It is no longer necessary to send two copies of mailed comments. Identify comments with the docket number found in brackets in the heading of this document. Received comments may be seen in the Division of Dockets Management between 9 a.m. and 4 p.m., Monday through Friday.

III. The Paperwork Reduction Act of 1995

This draft guidance refers to previously approved collections of information found in FDA regulations. These collections of information are subject to review by the Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3520). Information in an application on the product and process development and justification for the final formulation and system design is approved by OMB under control numbers 0910–0001 and 0910–0014.

IV. Electronic Access

Persons with access to the Internet may obtain the document at either *http://www.fda.gov/Drugs/GuidanceComplianceRegulatoryInformation/Guidances/default.htm* or *http://www.regulations.gov*.

Dated: July 29, 2010.

Leslie Kux,

Acting Assistant Commissioner for Policy.

[FR Doc. 2010–19041 Filed 8–2–10; 8:45 am]

BILLING CODE 4160–01–S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. FDA–2009–D–0181]

Guidance for Industry on Label Comprehension Studies for Nonprescription Drug Products; Availability

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing the availability of a guidance for industry entitled "Label Comprehension Studies for Nonprescription Drug Products." The guidance provides recommendations on the design of label comprehension studies that can be used to assess the extent to which consumers understand the information conveyed by proposed nonprescription drug product labeling. This guidance finalizes the draft guidance published on May 1, 2009.

DATES: Submit either electronic or written comments on agency guidances at any time.

ADDRESSES: Submit written requests for single copies of this guidance to the Division of Drug Information, Center for Drug Evaluation and Research, Food and Drug Administration, 10903 New Hampshire Ave., Bldg. 51, rm. 2201, Silver Spring, MD 20993–0002. Send one self-addressed adhesive label to assist that office in processing your requests. See the **SUPPLEMENTARY INFORMATION** section for electronic access to the guidance document.

Submit electronic comments on the guidance to *http://www.regulations.gov*. Submit written comments to the Division of Dockets Management (HFA–305), Food and Drug Administration, 5630 Fishers Lane, rm. 1061, Rockville, MD 20852.

FOR FURTHER INFORMATION CONTACT: Murewa Oguntimein, Center for Drug Evaluation and Research, Food and Drug Administration, 10903 New Hampshire Ave., Bldg. 22, rm. 5475,Silver Spring, MD 20993–0002, 301–796–4869.

SUPPLEMENTARY INFORMATION:

I. Background

FDA is announcing the availability of a guidance for industry entitled "Label Comprehension Studies for Nonprescription Drug Products." This guidance is intended for individuals or organizations involved in the development of label comprehension studies for nonprescription drug products. This guidance discusses general concepts that should be considered in the design and conduct of a label comprehension study. This guidance also incorporates advice obtained from the September 25, 2006, meeting of the Nonprescription Drug Advisory Committee that considered issues related to the analysis and interpretation of consumer studies conducted to support marketing of nonprescription drug products, and comments submitted to the draft guidance published in the **Federal Register** of May 1, 2009 (74 FR 20322).

This guidance is being issued consistent with FDA's good guidance practices regulation (21 CFR 10.115). The guidance represents the agency's current thinking on label comprehension studies for nonprescription drug products. It does not create or confer any rights for or on any person and does not operate to bind FDA or the public. An alternative approach may be used if such approach satisfies the requirements of the applicable statutes and regulations.

II. The Paperwork Reduction Act of 1995

This guidance refers to previously approved collections of information that are subject to review by the Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3520). The collections of information in 21 CFR parts 312 and 314 have been approved under OMB control numbers 0910–0014 and 0910–0001, respectively.

III. Comments

Interested persons may submit to the Division of Dockets Management (see **ADDRESSES**) either electronic or written comments regarding this document. It is only necessary to send one set of comments. It is no longer necessary to send two copies of mailed comments. Identify comments with the docket number found in brackets in the heading of this document. Received comments may be seen in the Division of Dockets Management between 9 a.m. and 4 p.m., Monday through Friday.

IV. Electronic Access

Persons with access to the Internet may obtain the document at either *http://www.fda.gov/Drugs/GuidanceComplianceRegulatoryInformation/Guidances/default.htm* or *http://www.regulations.gov*.

Dated: July 29, 2010.

Leslie Kux,

Acting Assistant Commissioner for Policy.

[FR Doc. 2010–19043 Filed 8–2–10; 8:45 am]

BILLING CODE 4160–01–S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. FDA–2010–N–0363]

Medical Device User Fee Rates for Fiscal Year 2011

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing the

fee rates and payment procedures for medical device user fees for fiscal year (FY) 2011. The Federal Food, Drug, and Cosmetic Act (the act), as amended by the Medical Device User Fee Amendments of 2007 (title II of the Food and Drug Administration Amendments Act of 2007 (FDAAA)), authorizes FDA to collect user fees for certain medical device submissions, and annual fees both for certain periodic reports and for certain establishments subject to registration. The FY 2011 fee rates are provided in this document. These fees apply from October 1, 2010, through September 30, 2011. To avoid delay in the review of your application, you should pay the fee before or at the time you submit your application to FDA. The fee you must pay is the fee that is in effect on the later of the date that your application is received by FDA or the date your fee payment is received. If you want to pay a reduced small business fee, you must qualify as a small business before you make your submission to FDA; if you do not qualify as a small business before you make your submission to FDA, you will have to pay the higher standard fee. This document provides information on how the fees for FY 2011 were determined, the payment procedures you should follow, and how you may qualify for reduced small business fees.

FOR FURTHER INFORMATION CONTACT:

For information on MDUFMA: Visit FDA's Web site, *http://www.fda.gov/MedicalDevices/DeviceRegulationandGuidance/Overview/MedicalDeviceUserFeeandModernizationActMDUFMA/default.htm*.

For questions relating to this notice: David Miller, Office of Financial Management (HFA–100), Food and Drug Administration, 1350 Piccard Dr., Rockville, MD 20850, 301–796–7103.

SUPPLEMENTARY INFORMATION:

I. Background

Section 738 of the act (21 U.S.C. 379j) establishes fees for certain medical device applications, submissions, supplements, and notices (for simplicity, this document refers to these collectively as "submissions"); for periodic reporting on class III devices; and for the registration of certain establishments. Under statutorily-defined conditions, a qualified applicant may receive a fee waiver or may pay a lower small business fee. (See 21 U.S.C. 379j(d) and (e).)

Under the act, the fee rate for each type of submission is set at a specified percentage of the standard fee for a premarket application (a premarket application is a premarket approval application (PMA), a product development protocol (PDP), or a biologics license application (BLA)). The act specifies the standard fee for a premarket application for each year from FY 2008 through FY 2012; the standard fee for a premarket application received by FDA during FY 2011 is $236,298. From this starting point, this document establishes FY 2011 fee rates for other types of submissions, and for periodic reporting, by applying criteria specified in the act.

The act specifies the annual fee for establishment registration for each year from FY 2008 through FY 2012; the registration fee for FY 2011 is $2,179. There is no reduction in the registration fee for small businesses. An establishment must pay the registration fee if it is any of the following types of establishments:

- *Manufacturer.* An establishment that makes by any means any article that is a device, including an establishment that sterilizes or otherwise makes such article for or on behalf of a specification developer or any other person.
- *Single-Use Device Reprocessor.* An establishment that performs additional processing and manufacturing operations on a single-use device that has previously been used on a patient.
- *Specification Developer.* An establishment that develops specifications for a device that is distributed under the establishment's name but which performs no manufacturing, including an establishment that, in addition to developing specifications, also arranges for the manufacturing of devices labeled with another establishment's name by a contract manufacturer.

The fees for FY 2011 go into effect on October 1, 2010, and will remain in effect through September 30, 2011.

II. Fees for FY 2011

Under the act, all submission fees and the periodic reporting fee are set as a percent of the standard (full) fee for a premarket application (see 21 U.S.C. 379j(a)(2)(A)), and the act sets the standard fee for a premarket application, including a BLA, a premarket report, and an efficacy supplement, at $236,298 for FY 2011 (see 21 U.S.C. 379j(b)); this is referred to as the "base fee"). The fees set by reference to the base fee are:

- For a panel-track supplement, 75 percent of the base fee;
- For a 180-day supplement, 15 percent of the base fee;
- For a real-time supplement, 7 percent of the base fee;
- For a 30-day notice, 1.6 percent of the base fee;
- For a 510(k) premarket notification, 1.84 percent of the base fee;
- For a 513(g) (21 U.S.C. 360c(g)) request for classification information, 1.35 percent of the base fee; and
- For an annual fee for periodic reporting concerning a class III device, 3.5 percent of the base fee.

For all submissions other than a 510(k) premarket notification, a 30-day notice, and a 513(g) request for classification information, the small business fee is 25 percent of the standard (full) fee. (See 21 U.S.C. 379j(d)(2)(C).) For a 510(k) premarket notification submission, a 30-day notice, and a 513(g) request for classification information, the small business fee is 50 percent of the standard (full) fee. (See 21 U.S.C. 379j(e)(2)(C).)

The statute sets the annual fee for establishment registration at $2,179 in FY 2011, and there is no small business rate for the annual establishment registration fee; all establishments pay the same fee. The statute authorizes increases in the annual establishment fee for FY 2011 and subsequent years if the estimated number of establishments submitting fees for FY 2009 is fewer than 12,250. (See 21 U.S.C. 379j(c)(2)(A).) The number of establishments submitting fees in FY 2009 was in excess of 12,250, so no establishment fee increase is warranted under this provision of the statute.

Table 1 of this document sets out the FY 2011 rates for all medical device fees.

TABLE 1.—MEDICAL DEVICE FEES FOR FY 2011

Application Fee Type	Standard Fee, as a Percent of the Standard Fee for a Premarket Application	FY 2011 Standard Fee	FY 2011 Small Business Fee
Premarket application (a PMA submitted under section 515(c)(1) of the act (21 U.S.C. 360e(c)(1)), a PDP submitted under section 515(f) of the act, or a BLA submitted under section 351 of the Public Health Service (PHS) Act (42 U.S.C. 262))	Set in Statute	$236,298	$59,075
Premarket report (submitted under section 515(c)(2) of the act)	100%	$236,298	$59,075
Efficacy supplement (to an approved BLA under section 351 of the PHS Act)	100%	$236,298	$59,075
Panel-track supplement	75%	$177,224	$44,306
180-day supplement	15%	$35,445	$8,861
Real-time supplement	7%	$16,541	$4,135
510(k) premarket notification submission	1.84%	$4,348	$2,174
30-day notice	1.6%	$3,781	$1,890
513(g) request for classification information	1.35%	$3,190	$1,595
Annual Fee Type			
Annual fee for periodic reporting on a class III device	3.5%	$8,270	$2,068
Annual establishment registration fee (to be paid by each establishment that is a manufacturer, a single-use device reprocessor, or a specification developer, as defined by 21 U.S.C. 379i(13))	Set in Statute	$2,179	$2,179

III. How to Qualify as a Small Business for Purposes of Medical Device Fees

If your business has gross receipts or sales of no more than $100 million for the most-recent tax year, you may qualify for reduced small business fees. If your business has gross sales or receipts of no more than $30 million, you may also qualify for a waiver of the fee for your first premarket application (PMA, PDP, or BLA) or premarket report. You must include the gross receipts or sales of all of your affiliates along with your own gross receipts or sales when determining whether you meet the $100 million or $30 million threshold. If you want to pay the small business fee rate for a submission, or you want to receive a waiver of the fee for your first premarket application or premarket report, you should submit the materials showing you qualify as a small business 60 days before you send your submission to FDA. If you make a submission before FDA finds that you qualify as a small business, you must pay the standard fee for that submission.

If your business qualified as a small business for FY 2010, your status as a small business will expire at the close of business on September 30, 2010. You must re-qualify for FY 2011 in order to pay small business fees during FY 2011.

If you are a domestic (U.S.) business, and wish to qualify as a small business for FY 2011, you must submit the following to FDA:

1. A completed FY 2011 MDUFMA Small Business Qualification Certification (Form FDA 3602). This form is provided in FDA's guidance document, "FY 2011 Medical Device User Fee Small Business Qualification and Certification," available on FDA's Web site at *http://www.fda.gov/MedicalDevices/DeviceRegulationandGuidance/Overview/MedicalDeviceUserFeeandModernizationActMDUFMA/default.htm*. This form is not available separate from the guidance document.

2. A certified copy of your Federal (U.S.) Income Tax Return for the most recent tax year. The most recent tax year will be 2010, except—

- If you submit your FY 2011 MDUFMA Small Business Qualification before April 15, 2011, and you have not yet filed your return for 2010, you may use tax year 2009.
- If you submit your FY 2011 MDUFMA Small Business Qualification on or after April 15, 2011, and have not yet filed your 2010 return because you obtained an extension, you may submit your most-recent return filed prior to the extension.

3. For each of your affiliates, either—

- If the affiliate is a domestic (U.S.) business, a certified copy of the affiliate's Federal (U.S.) income tax return for the most recent tax year, or
- If the affiliate is a foreign business and cannot submit a Federal (U.S.) Income Tax Return, a National Taxing Authority Certification completed by, and bearing the official seal of, the National Taxing Authority of the country in which the firm is headquartered. The National Taxing Authority is the foreign equivalent of the U.S. Internal Revenue Service. This certification must show the amount of gross receipts or sales for the most recent tax year, in both U.S. dollars and the local currency of the country, the exchange rate used in converting the local currency to U.S. dollars, and the dates of the gross receipts or sales collected. The applicant should also submit a statement signed by the head of the applicant's firm or by its chief financial officer that the applicant has submitted certifications for all of its affiliates, identifying the name of each affiliate, or that the applicant has no affiliates.

If you are a foreign business, and wish to qualify as a small business for FY 2011, you must submit the following:

1. A completed FY 2011 MDUFMA Foreign Small Business Qualification Certification (Form FDA 3602A). This form is provided in FDA's guidance document, "FY 2011 Medical Device User Fee Small Business Qualification and Certification," available on FDA's Internet site at *http://www.fda.gov/cdrh/mdufma*. This form is not available separate from the guidance document.

2. A National Taxing Authority Certification, completed by, and bearing the official seal of, the National Taxing Authority of the country in which the firm is headquartered. This Certification must show the amount of gross receipts or sales for the most recent tax year, in both U.S. dollars and the local currency of the country, the exchange rate used in converting the local currency to U.S. dollars, and the dates of the gross receipts or sales collected.

3. For each of your affiliates, either—

• If the affiliate is a domestic (U.S.) business, a certified copy of the affiliate's Federal (U.S.) Income Tax Return for the most recent tax year (2009 or later), or

• If the affiliate is a foreign business and cannot submit a Federal (U.S.) Income Tax Return, a National Taxing Authority Certification completed by, and bearing the official seal of, the National Taxing Authority of the country in which the firm is headquartered. The National Taxing Authority is the foreign equivalent of the U.S. Internal Revenue Service. This certification must show the amount of gross receipts or sales for the most recent tax year, in both U.S. dollars and the local currency of the country, the exchange rate used in converting the local currency to U.S. dollars, and the dates for the gross receipts or sales collected. The applicant should also submit a statement signed by the head of the applicant's firm or by its chief financial officer that the applicant has submitted certifications for all of its affiliates, identifying the name of each affiliate, or that the applicant has no affiliates.

IV. Procedures for Paying Application and Annual Report Fees

If your application or submission is subject to a fee and your payment is received by FDA from October 1, 2010, through September 30, 2011, you must pay the fee in effect for FY 2011. The later of the date that the application or annual report is received in the reviewing center's document room or the date that the check is received by U.S. Bank determines whether the fee rates for FY 2010 or FY 2011 apply. FDA must receive the correct fee at the time that an application or annual report is submitted, or the application or annual report will not be accepted for filing or review.

FDA requests that you follow the steps below before submitting a medical device application or annual report subject to a fee. Please pay close attention to these procedures to ensure that FDA links the fee with the correct application. (Note: In no case should the check for the fee be submitted to FDA with the application.)

A. Step One—Secure a Payment Identification Number (PIN) and Medical Device User Fee Cover Sheet From FDA Before Submitting Either the Application or the Payment. (Note: Both the FY 2010 and FY 2011 fee rates will be available on the Cover Sheet Web Site beginning on the date of publication of this document, and only the FY 2011 rates will appear after September 30, 2010)

Log on to the MDUFMA Web site at: *http://www.fda.gov/MedicalDevices/DeviceRegulationandGuidance/Overview/MedicalDeviceUserFeeandModernizationActMDUFMA/default.htm* and, under the MDUFMA Forms heading, click on the link "Create a User Fee Cover Sheet." Complete the Medical Device User Fee cover sheet. Be sure you choose the correct application submission date range. (Two choices will be offered until October 1, 2010. One choice is for applications that will be received on or before September 30, 2010, which will be subject to FY 2010 fee rates. A second choice is for applications that will be received on or after October 1, 2010, which will be subject to FY 2011 fee rates.) After completing data entry, print a copy of the Medical Device User Fee cover sheet and note the unique PIN located in the upper right-hand corner of the printed cover sheet.

B. Step Two—Electronically Transmit a Copy of the Printed Cover Sheet With the PIN to FDA's Office of Financial Management

Once you are satisfied that the data on the cover sheet is accurate, electronically transmit that data to FDA according to instructions on the screen. Because electronic transmission is possible, applicants are required to set up a user account and use passwords to assure data security in the creation and electronic submission of cover sheets.

C. Step Three—Submit Payment for the Completed Medical Device User Fee Cover Sheet as Described in This Section, Depending on the Method You Will Use to Make Payment

(1) If paying with a paper check:

• All paper checks must be in U.S. currency from a U.S. bank and made payable to the Food and Drug Administration. (FDA's tax identification number is 53–0196965, should your accounting department need this information.)

• Please write your application's unique PIN, from the upper right-hand corner of your completed Medical Device User Fee cover sheet, on your check.

• Mail the paper check and a copy of the completed cover sheet to: Food and Drug Administration, P.O. Box 956733, St. Louis, MO, 63195–6733. (Please note that this address is for payments of application and annual report fees only and is not to be used for payment of annual establishment registration fees.)

If you prefer to send a check by a courier (such as Federal Express (FEDEX), DHL, United Parcel Service (UPS), etc.), the courier may deliver the check to: U.S. Bank, Attn: Government Lockbox 956733, 1005 Convention Plaza, St. Louis, MO 63101. (Note: This address is for courier delivery only. Contact the U.S. Bank at 314–418–4821 if you have any questions concerning courier delivery.)

It is helpful if the fee arrives at the bank at least 1 day before the application arrives at FDA. FDA records the official application receipt date as the later of the following: (1) The date the application was received by FDA or (2) the date U.S. Bank receives the payment. U.S. Bank is required to notify FDA within 1 working day, using the PIN described previously in this document.

(2) If Paying With Credit Card or Electronic Check (Automated Clearing House (ACH)):

FDA has partnered with the U.S. Department of the Treasury to utilize Pay.gov, a Web-based payment application, for online electronic payment. Pay.gov can now be used to submit online payments for cover sheets to FDA. You now have the option to make a payment via electronic check or credit card after submitting your coversheet. To pay online, select the "Pay Now" button. Credit card transactions for cover sheets are limited to $5,000.00.

(3) If paying with a wire transfer:

• Please include your application's unique PIN, from the upper right-hand corner of your completed Medical Device User Fee cover sheet, in your wire transfer. Without the PIN your payment may not be applied to your cover sheet and review of you application will be delayed.

• The originating financial institution usually charges a wire transfer fee

between $15.00 and $35.00. Please ask your financial institution about the fee and include it with your payment to ensure that your cover sheet is fully paid.

Use the following account information when sending a wire transfer: New York Federal Reserve Bank, U.S. Department of Treasury, TREAS NYC, 33 Liberty St., New York, NY 10045, Acct. No. 75060099, Routing No. 021030004, SWIFT: FRNYUS33, Beneficiary: FDA, 1350 Piccard Dr., Rockville, MD 20850.

D. Step Four—Submit Your Application to FDA With a Copy of the Completed Medical Device User Fee Cover Sheet

Please submit your application and a copy of the completed Medical Device User Fee cover sheet to one of the following addresses:

1. Medical device applications should be submitted to: Food and Drug Administration, Center for Devices and Radiological Health, Document Mail Center—WO66, rm. 0609, 10903 New Hampshire Ave., Silver Spring, MD 20993–0002.

2. Biologic applications should be sent to: Food and Drug Administration, Center for Biologics Evaluation and Research, Document Control Center (HFM–99), suite 200N, 1401 Rockville Pike, Rockville, MD 20852–1448.

V. Procedures for Paying Annual Establishment Fees

If you are required to pay an annual establishment registration fee, you must pay for each establishment prior to registration. Payment must be submitted by first creating a Device Facility User Fee (DFUF) order through the User Fee Web site at *https://fdasfinapp8.fda.gov/OA_HTML/fdaCAcdLogin.jsp*. (FDA has verified the Web site address, but FDA is not responsible for any subsequent changes to the Web site after this document publishes in the **Federal Register**.) You will be issued a PIN once you place your order. After payment has been processed, you will be issued a payment confirmation number (PCN). You will not be able to register your establishment if you do not have a PIN and a PCN. An establishment required to pay an annual establishment registration fee is not legally registered in FY 2011 until it has completed the steps below to register and pay any applicable fee. (See 21 U.S.C. 379j(f)(2).)

Companies that do not manufacture any product other than a licensed biologic are required to register in the Blood Establishment Registration (BER) system. FDA's Center for Biologics and Research (CBER) will send establishment registration fee invoices annually to these companies.

A. Step One—Submit a DFUF Order With a PIN From FDA Before Registering or Submitting Payment

To submit a DFUF order, you must create or have previously created a user account and password for the User Fee Web site listed previously in this section. After creating a user name and password, log into the Establishment Registration User Fee 2011 store. Complete the DFUF order by entering the number of establishments you are registering. Once you are satisfied that the data on the order is accurate, electronically transmit that data to FDA according to instructions on the screen. Print a copy of the final DFUF order and note the unique PIN located in the upper right-hand corner of the printed order.

B. Step Two—Pay For Your Device Facility User Fee Order

Unless paying by credit card, all payments must be in U.S. currency and drawn on a U.S. bank.

(1) If paying with credit card or electronic check (ACH):

The DFUF order will include payment information, including details on how you can pay online using a credit card or electronic checks. Follow the instructions provided to make an electronic payment.

(2) If paying with a paper check:

If you prefer not to pay online, you may pay by a check, in U.S. dollars and drawn on a U.S. bank, mailed to: Food and Drug Administration, P.O. Box 70961, Charlotte, NC 28272–0961. (Note: This address is different from the address for payments of application and annual report fees and is to be used only for payment of annual establishment registration fees.)

If a check is sent by a courier that requests a street address, the courier can deliver the check to: Wells Fargo, Attn: Food and Drug Administration—Lockbox 70961, rm. NC0810, 1525 West WT Harris Blvd., Charlotte, NC 28262. (Note: This Wells Fargo address is for courier delivery only; do not send mail to this address.)

Please make sure that both of the following are written on your check: (1) The FDA post office box number (P.O. Box 70961) and (2) the PIN that is printed on your order. A copy of your printed order should also be mailed along with your check. FDA's tax identification number is 53–0196965.

(3) If paying with a wire transfer:

Wire transfers may also be used to pay annual establishment fees. To send a wire transfer, please read and comply with the following information:

- Include your order's unique PIN, from the upper right-hand corner of your completed Medical Device User Fee order, in your wire transfer. Without the PIN your payment may not be applied to your facility and your registration will be delayed.
- The originating financial institution usually charges a wire transfer fee between $15.00 and $35.00. Please ask your financial institution about the fee and include it with your payment to ensure that your order is fully paid. Use the following account information when sending a wire transfer: New York Federal Reserve Bank, U.S. Dept of Treasury, TREAS NYC, 33 Liberty St., New York, NY 10045, Acct. No. 75060099, Routing No. 021030004, SWIFT: FRNYUS33, Beneficiary: FDA, 5600 Fishers Lane, Rockville, MD 20857.

C. Step Three—Complete the Information Online to Update Your Establishment's Annual Registration for FY 2011, or to Register a New Establishment for FY 2011

Go to CDRH's Web site at *http://www.fda.gov/MedicalDevices/DeviceRegulationandGuidance/HowtoMarketYourDevice/RegistrationandListing/default.htm* and click the "Access Electronic Registration" link on the left of the page. This opens up a new page with important information about the FDA Unified Registration and Listing System (FURLS). After reading this information, click on the link (Access Electronic Registration) at the bottom of the page. This link takes you to an FDA Industry Systems page with tutorials that demonstrate how to create a new FURLS user account if your establishment did not create an account in FY 2009 or FY 2010. Biologics manufacturers should register in the BER system at *http://www.fda.gov/BiologicsBloodVaccines/GuidanceComplianceRegulatoryInformation/EstablishmentRegistration/BloodEstablishmentRegistration/default.htm*.

Enter your existing account ID and password to log into FURLS. From the FURLS/FDA Industry Systems menu, there will be a button that you will click to go to the Device Registration and Listing Module (DRLM) of FURLS. New establishments will need to register and existing establishments will update their annual registration using choices on the DRLM menu. Once you choose to register or update your annual registration, the system will prompt you through the entry of information about your establishment and your devices. If

you have any problems with this process, e-mail: *reglist@cdrh.fda.gov* or call 301–796–7400 for assistance. (Note: this e-mail address and this telephone number are for assistance with establishment registration only, and not for any other aspects of medical device user fees.) Problems with BER should be directed to *bloodregis@fda.hhs.gov* or call 301–827–3546.

D. Step Four—Enter Your DFUF Order PIN and PCN

After completing your annual or initial registration and device listing, you will be prompted to enter your DFUF order PIN and PCN, when applicable. This process does not apply to licensed biologic devices. CBER will send invoices for payment of the establishment registration fee to companies who only manufacture licensed biologics devices. Fees are only required for those establishments defined in section I of this document.

Dated: July 29, 2010.

Leslie Kux,

Acting Assistant Commissioner for Policy.

[FR Doc. 2010–19038 Filed 8–2–10; 8:45 am]

BILLING CODE 4160–01–S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of Mental Health; Notice of Closed Meetings

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. App.), notice is hereby given of the following meetings.

The meetings will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The contract proposals and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the contract proposals, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Institute of Mental Health Special Emphasis Panel; SBIR Phase II Topic 60.

Date: August 18, 2010.

Time: 1 p.m. to 3 p.m.

Agenda: To review and evaluate contract proposals.

Place: National Institutes of Health, Neuroscience Center, 6001 Executive Boulevard, Rockville, MD 20852 (Telephone Conference Call).

Contact Person: Marina Broitman, PhD, Scientific Review Officer, Division of Extramural Activities, National Institute of Mental Health, NIH, Neuroscience Center, 6001 Executive Blvd., Room 6153, MSC 9608, Bethesda, MD 20892–9608, 301–402–8152, *mbroitma@mail.nih.gov.*

Name of Committee: National Institute of Mental Health Special Emphasis Panel; SBIR Phase II Topic 59.

Date: August 20, 2010.

Time: 1 p.m. to 4 p.m.

Agenda: To review and evaluate contract proposals.

Place: National Institutes of Health, Neuroscience Center, 6001 Executive Boulevard, Rockville, MD 20852 (Telephone Conference Call).

Contact Person: Marina Broitman, PhD, Scientific Review Officer, Division of Extramural Activities, National Institute of Mental Health, NIH, Neuroscience Center, 6001 Executive Blvd., Room 6153, MSC 9608, Bethesda, MD 20892–9608, 301–402–8152, *mbroitma@mail.nih.gov.*

(Catalogue of Federal Domestic Assistance Program Nos. 93.242, Mental Health Research Grants; 93.281, Scientist Development Award, Scientist Development Award for Clinicians, and Research Scientist Award; 93.282, Mental Health National Research Service Awards for Research Training, National Institutes of Health, HHS)

Dated: July 28, 2010.

Jennifer Spaeth,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 2010–19012 Filed 8–2–10; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. FDA–2010–N–0001]

Design of Clinical Trials of Aerosolized Antimicrobials for the Treatment of Cystic Fibrosis; Public Workshop

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice of public workshop.

SUMMARY: The Food and Drug Administration (FDA) is announcing a public workshop regarding scientific issues in clinical development of aerosolized antimicrobials for the management and/or treatment of patients with cystic fibrosis. Aerosolized antimicrobials are used to treat chronic bacterial infection in the lungs and thus improve the respiratory symptoms in patients with cystic fibrosis. This public workshop is intended to provide information for and gain perspective from health care providers, patients and patient advocacy organizations, academia, and industry on various aspects of the design of clinical trials of aerosolized antimicrobials in patients with cystic fibrosis. The input from this public workshop will help in developing topics for further discussion.

Dates and Times: The public workshop will be held on September 23, 2010, from 8:30 a.m. to 5:30 p.m. and on September 24, 2010, from 8 a.m. to 4 p.m.

Location: The public workshop will be held at the Crowne Plaza Hotel,8777 Georgia Ave., Silver Spring, MD 20910. Seating is limited and available only on a first-come, first-served basis.

Contact Persons: Chris Moser or Lori Benner, Center for Drug Evaluation and Research,Food and Drug Administration, Office of Antimicrobial Products, 10903 New Hampshire Ave., Bldg. 22, rm. 6209, Silver Spring, MD 20993–0002, 301–796–1300.

Registration: Registration is free for the public workshop. Interested parties are encouraged to register early because space is limited. Seating will be available on a first-come, first-served basis. To register electronically, e-mail registration information (including name, title, firm name, address, telephone, and fax number) to *CFWORKSHOP@fda.hhs.gov* Persons without access to the Internet can call 301–796–1300 to register. Persons needing a sign language interpreter or other special accommodations should notify Christine Moser or Lori Benner (see Contact Persons) at least 7 days in advance.

SUPPLEMENTARY INFORMATION: FDA is announcing a public workshop regarding scientific considerations in the design of clinical trials of aerosolized antimicrobials to treat chronic bacterial infection in the lungs and thus improve the respiratory symptoms in patients with cystic fibrosis. The development of clinical trial endpoints to establish efficacy is a major challenge in the design of informative clinical trials of aerosolized antimicrobials for the management and/or treatment of patients with cystic fibrosis. The workshop will include discussion of clinical trial endpoints to establish efficacy, such as timing and definitions of pulmonary exacerbations, changes in the results of pulmonary function testing, and changes on patient reported outcome measures. An important consideration will be the evaluation of new aerosolized antimicrobials in the context of approved aerosolized antimicrobials on the basis of these or other efficacy endpoints. Other issues in the design of clinical trials of aerosolized antimicrobials include: The development of drug resistance and

other safety concerns, microbiologic testing such as sputum bacterial density, the utility of in-vitro susceptibility testing, and the need for pediatric use information.

The agency encourages individuals, patient advocates, industry, consumer groups, health care professionals, researchers, and other interested persons to attend this public workshop.

Transcripts: Please be advised that as soon as a transcript is available, it will be accessible at *http://www.regulations.gov*. It may be viewed at the Division of Dockets Management (HFA–305), Food and Drug Administration, 5630 Fishers Lane, rm. 1061, Rockville, MD. A transcript will also be available in either hardcopy or on CD-ROM, after submission of a Freedom of Information request. Written requests are to be sent to Division of Freedom of Information (HFI–35), Office of Management Programs, Food and Drug Administration, 5600 Fishers Lane, rm. 6–30, Rockville, MD 20857. Transcripts will also be available on the Internet *http://www.fda.gov/Drugs/NewsEvents/ucm205809.htm* approximately 45 days after the workshop.

Dated: July 29, 2010.

Leslie Kux,

Acting Assistant Commissioner for Policy.

[FR Doc. 2010–19044 Filed 8–2–10; 8:45 am]

BILLING CODE 4160–01–S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Center for Scientific Review; Notice of Closed Meetings

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. App.), notice is hereby given of the following meetings.

The meetings will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: Center for Scientific Review Special Emphasis Panel, Member Conflict: Endocrinology and Obesity.

Date: August 17–18, 2010.

Time: 9 a.m. to 6 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, 6701 Rockledge Drive, Bethesda, MD 20892 (Virtual Meeting).

Contact Person: Ann A. Jerkins, PhD, Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 6154, MSC 7892, Bethesda, MD 20892, 301–435–4514, *jerkinsa@csr.nih.gov.*

Name of Committee: Center for Scientific Review Special Emphasis Panel, Member Conflict: Oral Microbiology.

Date: August 25, 2010.

Time: 2 p.m. to 5 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, 6701 Rockledge Drive, Bethesda, MD 20892 (Telephone Conference Call).

Contact Person: Baljit S. Moonga, PhD, Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 4214, MSC 7806, Bethesda, MD 20892, 301–435–1777, *moongabs@mail.nih.gov.*

(Catalogue of Federal Domestic Assistance Program Nos. 93.306, Comparative Medicine; 93.333, Clinical Research, 93.306, 93.333, 93.337, 93.393–93.396, 93.837–93.844, 93.846–93.878, 93.892, 93.893, National Institutes of Health, HHS)

Dated: July 28, 2010.

Jennifer Spaeth,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 2010–19014 Filed 8–2–10; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of General Medical Sciences; Notice of Closed Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. App.), notice is hereby given of the following meeting.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C. as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Institute of General Medical Sciences Special Emphasis Review of a Deferred Application.

Date: August 13, 2010.

Time: 1 p.m. to 5 p.m.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, Natcher Building, 45 Center Drive, Room 3AN12, Bethesda, MD 20892. (Telephone Conference Call)

Contact Person: Mona R. Trempe, PhD, Scientific Review Officer, Office of Scientific Review, National Institute of General Medical Sciences, National Institutes of Health, 45 Center Drive, Room 3AN12, Bethesda, MD 20892, 301–594–3998, *trempemo@mail.nih.gov.*

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

(Catalogue of Federal Domestic Assistance Program Nos. 93.375, Minority Biomedical Research Support; 93.821, Cell Biology and Biophysics Research; 93.859, Pharmacology, Physiology, and Biological Chemistry Research; 93.862, Genetics and Developmental Biology Research; 93.88, Minority Access to Research Careers; 93.96, Special Minority Initiatives, National Institutes of Health, HHS)

Dated: July 28, 2010.

Jennifer Spaeth,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 2010–19008 Filed 8–2–10; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Library of Medicine; Notice of Closed Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. App.), notice is hereby given of the following meeting.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable materials, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Library of Medicine Special Emphasis Panel, Conflicted Applications.

Date: September 22, 2010.

Time: 12 p.m. to 3 p.m.

Agenda: To review and evaluate grant applications.

Place: National Library of Medicine, 6705 Rockledge Drive, Suite 301, Bethesda, MD 20817. (Telephone Conference Call).

Contact Person: Zoe H. Huang, Scientific Review Officer, Extramural Programs, National Library of Medicine, NIH, 6705 Rockledge Drive, Suite 301, Bethesda, MD

20892–7968, (301) 594–4937, *huangz@mail.nih.gov.*

(Catalogue of Federal Domestic Assistance Program No. 93.879, Medical Library Assistance, National Institutes of Health, HHS).

Dated: July 28, 2010.

Jennifer S. Spaeth,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 2010–19010 Filed 8–2–10; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

[Docket No. USCG–2010–0605]

Certificate of Alternative Compliance for the Offshore Supply Vessel C-COURAGEOUS

AGENCY: Coast Guard, DHS.

ACTION: Notice.

SUMMARY: The Coast Guard announces that a Certificate of Alternative Compliance was issued for the offshore supply vessel C-COURAGEOUS as required by 33 U.S.C. 1605(c) and 33 CFR 81.18.

DATES: The Certificate of Alternate Compliance was issued on June 18, 2010.

ADDRESSES: The docket for this notice is available for inspection or copying at the Docket Management Facility (M–30), U.S. Department of Transportation, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue SE., Washington, DC 20590, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. You may also find this docket on the Internet by going to *http://www.regulations.gov,* inserting USCG–2010–0605 in the "Keyword" box, and then clicking "Search."

FOR FURTHER INFORMATION CONTACT: If you have questions on this notice, call LTJG Christine Dimitroff, District Eight, Prevention Branch, U.S. Coast Guard, telephone 504–671–2176. If you have questions on viewing or submitting material to the docket, call Renee V. Wright, Program Manager, Docket Operations, telephone 202–366–9826.

SUPPLEMENTARY INFORMATION:

Background and Purpose

A Certificate of Alternative Compliance, as allowed for under Title 33, Code of Federal Regulation, Parts 81 and 89, has been issued for the offshore supply vessel C-COURAGEOUS, O.N. 1060716. The horizontal distance between the forward and aft masthead lights may be 21′–8¾″. Placing the aft masthead light at the horizontal distance from the forward masthead light as required by Annex I, paragraph 3(a) of the 72 COLREGS, and Annex I, Section 84.05(a) of the Inland Rules Act, would result in an aft masthead light location directly over the cargo deck where it would interfere with loading and unloading operations.

The Certificate of Alternative Compliance allows for the horizontal separation of the forward and aft masthead lights to deviate from the requirements of Annex I, paragraph 3(a) of 72 COLREGS, and Annex I, Section 84.05(a) of the Inland Rules Act.

This notice is issued under authority of 33 U.S.C. 1605(c), and 33 CFR 81.18.

Dated: July 15, 2010.

R.S. Keister,

Commander, U.S. Coast Guard, Chief, Inspections & Investigations Branch, By Direction of the Commander, Eighth Coast Guard District.

[FR Doc. 2010–18948 Filed 8–2–10; 8:45 am]

BILLING CODE 9110–04–P

DEPARTMENT OF HOMELAND SECURITY

[Internal Agency Docket No. FEMA–1926–DR; Docket ID FEMA–2010–0002]

Oklahoma; Major Disaster and Related Determinations

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice.

SUMMARY: This is a notice of the Presidential declaration of a major disaster for the State of Oklahoma (FEMA–1926–DR), dated July 26, 2010, and related determinations.

DATES: *Effective Date:* July 26, 2010.

FOR FURTHER INFORMATION CONTACT: Peggy Miller, Recovery Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472, (202) 646–3886.

SUPPLEMENTARY INFORMATION: Notice is hereby given that, in a letter dated July 26, 2010, the President issued a major disaster declaration under the authority of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121 *et seq.* (the "Stafford Act"), as follows:

I have determined that the damage in certain areas of the State of Oklahoma resulting from severe storms, tornadoes, straight-line winds, and flooding during the period of June 13–15, 2010, is of sufficient severity and magnitude to warrant a major disaster declaration under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121 *et seq.* (the "Stafford Act"). Therefore, I declare that such a major disaster exists in the State of Oklahoma.

In order to provide Federal assistance, you are hereby authorized to allocate from funds available for these purposes such amounts as you find necessary for Federal disaster assistance and administrative expenses.

You are authorized to provide Public Assistance in the designated areas and Hazard Mitigation throughout the State. Consistent with the requirement that Federal assistance is supplemental, any Federal funds provided under the Stafford Act for Public Assistance and Hazard Mitigation will be limited to 75 percent of the total eligible costs.

Further, you are authorized to make changes to this declaration for the approved assistance to the extent allowable under the Stafford Act.

The Federal Emergency Management Agency (FEMA) hereby gives notice that pursuant to the authority vested in the Administrator, under Executive Order 12148, as amended, Gregory W. Eaton, of FEMA is appointed to act as the Federal Coordinating Officer for this major disaster.

The following areas of the State of Oklahoma have been designated as adversely affected by this major disaster:

Beaver, Cimarron, Lincoln, Logan, Major, Oklahoma, and Texas Counties for Public Assistance.

All counties within the State of Oklahoma are eligible to apply for assistance under the Hazard Mitigation Grant Program.

The following Catalog of Federal Domestic Assistance Numbers (CFDA) are to be used for reporting and drawing funds: 97.030, Community Disaster Loans; 97.031, Cora Brown Fund; 97.032, Crisis Counseling; 97.033, Disaster Legal Services; 97.034, Disaster Unemployment Assistance (DUA); 97.046, Fire Management Assistance Grant; 97.048, Disaster Housing Assistance to Individuals and Households In Presidentially Declared Disaster Areas; 97.049, Presidentially Declared Disaster Assistance—Disaster Housing Operations for Individuals and Households; 97.050, Presidentially Declared Disaster Assistance to Individuals and Households—Other Needs; 97.036, Disaster Grants—Public Assistance (Presidentially Declared Disasters); 97.039, Hazard Mitigation Grant.

W. Craig Fugate,

Administrator, Federal Emergency Management Agency.

[FR Doc. 2010–18940 Filed 8–2–10; 8:45 am]

BILLING CODE 9111–23–P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[LLWO350000.L14300000.PN0000]

Extension of Approval of Information Collection, OMB Control Number 1004–0009

AGENCY: Bureau of Land Management, Interior.

ACTION: 60-Day Notice and Request for Comments.

SUMMARY: In compliance with the Paperwork Reduction Act of 1995, the Bureau of Land Management (BLM) is announcing its intention to request approval to continue the collection of information from State and local governments and private citizens in applications to use, occupy, or develop public lands administered by the BLM. This information collection activity was previously approved by the Office of Management and Budget (OMB), and was assigned control number 1004–0009.

DATES: Submit comments on the proposed information collection by October 4, 2010.

ADDRESSES: Comments may be mailed to U.S. Department of the Interior, Bureau of Land Management, Mail Stop 401–LS, 1849 C St., NW., Washington, DC 20240. Comments may also be submitted electronically to *Jean_Sonneman@blm.gov* or by fax to Jean Sonneman at 202–912–7109. Please attach "Attn: 1004–0019" to any form of comment.

FOR FURTHER INFORMATION CONTACT: To receive a copy of the information collection request, contact Vanessa Engle, Division of Lands, Realty, and Cadastral Survey, at 202–912–7339. Persons who use a telecommunication device for the deaf (TDD) may call the Federal Information Relay Service (FIRS) at 1–800–877–8339, to leave a message for Ms. Engle.

SUPPLEMENTARY INFORMATION: OMB regulations at 5 CFR 1320, which implement provisions of the Paperwork Reduction Act, 44 U.S.C. 3501–3521, require that interested members of the public and affected agencies be given an opportunity to comment on information collection and recordkeeping activities (*see* 5 CFR 1320.8 (d) and 1320.12(a)). This notice identifies an information collection that the BLM will be submitting to OMB for approval. The Paperwork Reduction Act provides that an agency may not conduct or sponsor a collection of information unless it displays a currently valid OMB control number. Until OMB approves a collection of information, you are not obligated to respond.

The BLM will request a 3-year term of approval for this information collection activity. Comments are invited on: (1) The need for the collection of information for the performance of the functions of the agency; (2) the accuracy of the agency's burden estimates; (3) ways to enhance the quality, utility and clarity of the information collection; and (4) ways to minimize the information collection burden on respondents, such as use of automated means of collection of the information. A summary of the public comments will accompany our submission of the information collection requests to OMB.

Before including your address, telephone number, e-mail address, or other personal identifying information in your comment, be advised that your entire comment—including your personal identifying information—may be made publicly available at any time. While you can ask in your comment to withhold from public review your personal identifying information, we cannot guarantee that we will be able to do so.

The following information is provided for the information collection:

Title: Land Use Application and Permit (43 CFR Part 2920).

Forms:

- Form 2920–1, Land Use Application and Permit.

OMB Control Number: 1004–0009.

Abstract: Section 302 of the Federal Land Policy and Management Act of 1976 (FLPMA) (43 U.S.C. 1732) and regulations at 43 CFR part 2920 authorize the issuance of leases, permits, and easements for the use, occupancy, or development of public lands administered by the BLM. Respondents include individuals, private entities, and State or local governments. They use Form 2910–1 to apply for leases, permits, or easements, and the BLM uses the information collected on Form 2920–1 to determine whether or not to grant the applications.

A variety of land uses may be authorized under FLPMA Section 302 and 43 CFR part 2920: commercial filming, advertising displays, commercial or noncommercial croplands, apiaries, livestock holding or feeding areas not related to grazing permits and leases, harvesting of native or introduced species, temporary or permanent facilities for commercial purposes (other than mining claims), ski resorts, construction equipment storage sites, assembly yards, oil rig stacking sites, mining claim occupancy if the residential structures are not incidental to the mining operation, and water pipelines and well pumps related to irrigation and non-irrigation facilities. The complexity of the applications, and therefore the burdens to respondents, vary widely.

Frequency of Collection: On occasion.

Estimated Number and Description of Respondents: 519 applicants annually: 5 from individuals, 5 from State/local governments, and 509 from the private sector (499 applications from small entities, and 10 applications from large entities).

Estimated Reporting and Recordkeeping "Hour" Burden: The currently approved annual burden for this collection is 1709 hours: 5 hours for individuals, 5 hours for State and local government, and 1,699 hours for the private sector.

Jean Sonneman,

Bureau of Land Management, Acting Information Collection Clearance Officer, Bureau of Land Management.

[FR Doc. 2010–19058 Filed 8–2–10; 8:45 am]

BILLING CODE 4310–84–P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[AA–8103–06; LLAK965000–L14100000–HY0000–P]

Alaska Native Claims Selection

AGENCY: Bureau of Land Management, Interior.

ACTION: Notice of decision approving lands for conveyance.

SUMMARY: As required by 43 CFR 2650.7(d), notice is hereby given that the Bureau of Land Management (BLM) will issue an appealable decision approving the conveyance of the surface and subsurface estates for certain lands to Doyon, Limited, pursuant to the Alaska Native Claims Settlement Act. The lands are in the vicinity of Holy Cross, Alaska, and are located in:

Seward Meridian, Alaska

T. 23 N., R. 55 W.,
Secs. 19 and 20.
Containing 1,130.74 acres.

T. 24 N., R. 58 W.,
Secs. 6 to 10, inclusive;
Secs. 15, 16, and 17;
Secs. 20, 21, and 22;
Secs. 27 to 32, inclusive.
Containing 10,112.30 acres.

T. 23 N., R. 59 W.,
Secs. 25, 26, 35, and 36.
Containing 1,535.94 acres.
Aggregating 12,778.98 acres.

Notice of the decision will also be published four times in the Fairbanks Daily News Miner.

DATES: Any party claiming a property interest in the lands affected by the decision may appeal the decision within the following time limits:

1. Unknown parties, parties unable to be located after reasonable efforts have been expended to locate, parties who fail or refuse to sign their return receipt, and parties who receive a copy of the decision by regular mail which is not certified, return receipt requested, shall have until September 2, 2010 to file an appeal.

2. Parties receiving service of the decision by certified mail shall have 30 days from the date of receipt to file an appeal.

Parties who do not file an appeal in accordance with the requirements of 43 CFR part 4, subpart E, shall be deemed to have waived their rights.

ADDRESSES: A copy of the decision may be obtained from: Bureau of Land Management, Alaska State Office, 222 West Seventh Avenue, #13, Anchorage, Alaska 99513–7504.

FOR FURTHER INFORMATION CONTACT: The BLM by phone at 907–271–5960, by e-mail at *ak.blm.conveyance@blm.gov,* or by telecommunication device (TTD) through the Federal Information Relay Service (FIRS) at 1–800–877–8339, 24 hours a day, 7 days a week.

Suzette Claypool,

Land Law Examiner, Land Transfer Adjudication II Branch.

[FR Doc. 2010–19048 Filed 8–2–10; 8:45 am]

BILLING CODE 4310–JA–P

DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

[FWS–R6–ES–2010–N149; 60120–1113–0000–D2]

Endangered and Threatened Wildlife and Plants; Permits

AGENCY: Fish and Wildlife Service, Interior.

ACTION: Notice of receipt of applications for permits.

SUMMARY: We announce our receipt of an application to conduct certain activities pertaining to enhancement of survival of endangered species. The Endangered Species Act requires that we invite public comment on this permit application.

DATES: Written comments on this request for a permit must be received by September 2, 2010.

ADDRESSES: Submit written data or comments to the Assistant Regional Director-Ecological Services, U.S. Fish and Wildlife Service, P.O. Box 25486, Denver Federal Center, Denver, CO 80225–0486; facsimile 303–236–0027.

SUPPLEMENTARY INFORMATION:

Public Availability of Comments

Before including your address, phone number, e-mail address, or other personal indentifying information in your comment, you should be aware that your entire comment—including your personal identifying information—may be made publicly available at any time. While you can ask us in your comment to withhold your personal identifying information from public review, we cannot guarantee that we will be able to do so.

Document Availability

Documents and other information submitted with these applications are available for review, subject to the requirements of the Privacy Act (5 U.S.C. 552a) and Freedom of Information Act (5 U.S.C. 552), by any party who submits a request for a copy of such documents within 30 days of the date of publication of this notice to Kris Olsen, by mail (*see* **ADDRESSES**) or by telephone at 303–236–4256. All comments we receive from individuals become part of the official public record.

Application

The following applicant has requested issuance of enhancement of survival permit to conduct certain activities with endangered species pursuant to section 10(a)(1)(A) of the Endangered Species Act of 1973, as amended (16 U.S.C. 1531 *et seq.*).

Applicant: John Mull, Weber State University, Ogden, Utah, TE–207948. The applicant requests a permit amendment to remove and reduce to possession *Astragalus holmgreniorum* (Holmgren milk-vetch) in conjunction with recovery activities throughout the species' range for the purpose of enhancing its survival and recovery.

Dated: July 21, 2010.

Noreen E. Walsh,

Regional Director, Denver, Colorado.

[FR Doc. 2010–18726 Filed 8–2–10; 8:45 am]

BILLING CODE 4310–55–P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[LLCON06000 L16100000.DO]

Notice of Intent To Prepare a Resource Management Plan for the Dominguez-Escalante National Conservation Area and Dominguez Canyon Wilderness, Colorado and Associated Environmental Impact Statement

AGENCY: Bureau of Land Management, Interior.

ACTION: Notice of Intent.

SUMMARY: In compliance with the National Environmental Policy Act of 1969 (NEPA), as amended, the Federal Land Policy and Management Act of 1976 (FLPMA), as amended, and the Omnibus Public Lands Management Act of 2009 (Omnibus Act), the Bureau of Land Management (BLM) Grand Junction and Uncompahgre Field Offices, Grand Junction and Montrose, Colorado intend to prepare a Resource Management Plan (RMP) with an associated Environmental Impact Statement (EIS) for the Dominguez-Escalante National Conservation Area (NCA) and Dominguez Canyon Wilderness. By this notice, the BLM is announcing the beginning of the scoping process to solicit public comments and identify issues.

DATES: This notice initiates the public scoping process for the RMP with associated EIS. Comments on issues and planning criteria may be submitted in writing until September 2, 2010. The date(s) and location(s) of any scoping meetings will be announced at least 15 days in advance through local media, newspapers, and the Colorado BLM Web site at: *http://www.blm.gov/co/st/en/nca/denca/denca_rmp.html.* In order to be considered in the development of the Draft RMP/EIS, all comments must be received prior to the close of the 30 day scoping period or 30 days after the last public meeting, whichever is later. The BLM will provide additional opportunities for public participation upon publication of the Draft RMP/EIS.

ADDRESSES: You may submit comments on issues and planning criteria related to the Dominguez-Escalante NCA and Dominguez Canyon Wilderness RMP/EIS at any public scoping meeting or by any of the following methods:

- *Web site: http://www.blm.gov/co/st/en/nca/denca/denca_rmp.html.*
- *E-mail: dencarmp@blm.gov.*
- *Fax:* 970–244–3083.
- *Mail:* Grand Junction Field Office, 2815 H Road, Grand Junction, Colorado 81506.

Documents pertinent to this proposal may be examined at the Grand Junction Field Office.

FOR FURTHER INFORMATION CONTACT: For more information and/or to have you name added to our mailing list, contact Katie A. Stevens, Interim NCA Manager, telephone (970) 244–3049; address 2815 H Road, Grand Junction, Colorado 81506; or by e-mail: *Katie_A_Stevens@blm.gov.*

SUPPLEMENTARY INFORMATION: The RMP will replace portions of the existing 1987 Grand Junction Resource Area RMP and the 1989 Uncompahgre Basin RMP. This new planning process will allow the BLM to focus specifically on developing management to conserve, protect and enhance the resources and values of the NCA and the wilderness area as set forth in Section 2402(b) of the Omnibus Act, including the geological, cultural, archaeological, paleontological, natural, scientific, recreational, wilderness, wildlife, riparian, historical, educational, and scenic resources of the public land; and the water resources of area streams, based on seasonally available flows, that are necessary to support aquatic, riparian, and terrestrial species and communities. In developing new management for the NCA and Wilderness Area, the BLM will comply with the direction set forth in the Omnibus Act, which allows certain uses (including grazing, measures to control fire, insects and disease) to continue in accordance with current laws and regulations. The Omnibus Act also withdraws the NCA and the Wilderness Area from certain other uses, including all forms of entry, appropriation, or disposal under the public land laws; location, entry, and patent under the mining laws; and operation of the mineral leasing, mineral materials, and geothermal leasing laws, subject to valid existing rights. Congress' withdrawal of the area to these uses may foreclose certain alternatives. However, the withdrawal in and of itself does not necessarily preclude consideration of these uses in the RMP.

The planning area is located in Mesa, Delta, and Montrose Counties, Colorado and encompasses approximately 209,610 acres of public land. The purpose of the public scoping process is to determine relevant issues that will influence the scope of the environmental analysis, including alternatives, and guide the planning process. Preliminary issues for the planning area have been identified by BLM personnel, Federal, state, and local agencies, and other stakeholders. The issues include:

- Is special management needed to restore, maintain, or enhance priority species (including special status species) and their habitats?
- How should uses, including recreational, grazing, and motorized and mechanized vehicle use be managed to provide for wildlife (including special status species) habitat needs?
- What goals, objectives, and management actions, including desired future conditions and land restoration actions, are necessary to continue progress toward achieving land health standards?
- What goals, objectives and management actions, including desired future conditions and riparian and aquatic restoration actions, are necessary to ensure that these water resources are of sufficient quality and quantity to support aquatic, riparian, and terrestrial species and communities?
- How should the Dominguez Canyon Wilderness be managed to protect wilderness values and provide outstanding opportunities for solitude and/or primitive and unconfined recreation?
- Is special management still warranted for the relevant and important values recognized in the two existing Areas of Critical Environmental Concern (ACEC) nominations, and should additional lands be considered for ACEC status?
- What stream segments are suitable for designation as Wild, Scenic, or Recreational under the Wild and Scenic Rivers Act?
- What Visual Resource Management classes will be necessary outside the wilderness to provide adequate protection for the scenic resources and visual quality of the NCA?
- How should the cultural resources and archaeological values (prehistoric and historic) of the area be protected and preserved, while still allowing for appropriate information/education efforts?
- What recreational experiences and outcomes should be used to focus future recreation management in the NCA?

Preliminary planning criteria include:

- Completing the RMP in compliance with FLPMA, NEPA, the Omnibus Act, and all other applicable laws, rules, regulations, policies, and guidelines (including environmental laws and Executive Orders listed as supplemental authorities in Appendix 1 of the NEPA Handbook H–1790–1);
- Ensuring that proposed management within the wilderness is consistent with the Wilderness Act of 1964 and develop a Wilderness Management Plan during the RMP process;
- Initiating broad-based public participation as an integral part of the planning and EIS development process;
- Working with the Dominguez-Escalante National Conservation Area Advisory Council consistent with their established charter;
- Inviting cooperating agency and local government input;
- Consulting with Native American Tribes and other governments at required intervals;
- Developing adaptive management criteria and protocols and also clearly identify the criteria that would trigger re-evaluation of management;
- Developing a comprehensive travel management plan during the RMP process to identify all travel needs for the public, as well as administrative and resource management activities such as research and monitoring, permitting, or emergency or fire access;
- Designating all public lands within the planning area as open, limited, or closed to off-road vehicle use, mechanized use, and/or non-motorized use;
- Incorporating Standards for Public Land Health and Guidelines for Livestock Grazing Management into the planning process; and
- Responding to the Omnibus Act by developing management to "conserve and protect for the benefit and enjoyment of present and future generations [those resources and values identified as purposes in the legislation, including the] geological, cultural, archeological, paleontological, natural, scientific, recreational, wilderness, wildlife, riparian, historical, educational, and scenic resources of the public land; and the water resources of area streams, based on seasonally available flows, that are necessary to support aquatic, riparian, and terrestrial species and communities."

Before including your address, phone number, e-mail address, or other personal identifying information in your comment, you should be aware that your entire comment—including your personal identifying information—may be made publicly available at any time. While you can ask us in your comment to withhold your personal identifying information from public review, we cannot guarantee that we will be able to do so.

The minutes and list of attendees for each scoping meeting will be available to the public and open for 30 days after the meeting to any participant who wishes to clarify the views he or she expressed.

The BLM will evaluate identified issues to be addressed in the plan, and will place them into one of three categories:

1. Issues to be resolved in the plan;
2. Issues to be resolved through policy or administrative action; or
3. Issues beyond the scope of this plan. A public comment that suggests developing management for one of the resource uses from which the area was withdrawn by the legislation would likely fall within this category.

The BLM will provide an explanation in the Draft RMP/EIS as to why an issue was placed in category two or three. The public is also encouraged to help identify any management questions and concerns that should be addressed in the plan. The BLM will work collaboratively with interested parties to identify the management decisions that are best suited to local, regional, and national needs and concerns.

The BLM will use an interdisciplinary approach to develop the plan in order to consider the variety of resource issues and concerns identified. Specialists with expertise in the following disciplines will be involved in the planning process: rangeland management, minerals and geology, forestry, outdoor recreation, wilderness, archaeology, paleontology, wildlife and fisheries, lands and realty, hydrology, soils, sociology and economics.

Authority: 40 CFR 1501.7, 43 CFR 1610.

Lynn E. Rust,

Acting State Director.

[FR Doc. 2010–19060 Filed 8–2–10; 8:45 am]

BILLING CODE 4310–JB–P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[LLIDI03000.L71220000.EX0000. XXXX.LVTFD0977180; IDI–33145, IDI–35728]

Notice of Intent To Prepare an Environmental Impact Statement and Resource Management Plan Amendment for the Proposed Modification to the Thompson Creek Mine Plan of Operations, Section 404 Clean Water Act Permit Application, and Public Land Disposal, Custer and Bannock Counties, ID

AGENCY: Bureau of Land Management, Interior.

ACTION: Notice of Intent.

SUMMARY: In compliance with the National Environmental Policy Act of 1969, as amended (NEPA), and the Federal Land Policy and Management Act of 1976, as amended (FLPMA), the Bureau of Land Management (BLM), Challis Field Office, Idaho intends to prepare an Environmental Impact Statement (EIS) to analyze the potential environmental effects of the proposed approval by the BLM and U.S. Forest Service (Forest Service) of a modified mining plan of operations (MMPO) for the Thompson Creek molybdenum mine in Custer County, Idaho and the potential for disposal of BLM-administered public lands. The MMPO would allow an approximate 15-year extension of the mine life and an expansion of some facilities, requiring additional surface disturbance on approximately 350 acres of Federal lands and approximately 80 acres of private land. The EIS will include analysis of the potential environmental effects to waters of the United States that could occur under the MMPO. The Thompson Creek Mining Company (TCMC), has also proposed to exchange 900 acres of private lands owned by TCMC in Custer and Bannock counties for 5,000 acres of BLM-administered public land in the vicinity of the mine in Custer County, including the BLM-administered public land involved in the MMPO. The EIS will also evaluate a proposed amendment to the BLM Challis Field Office 1999 Resource Management Plan (RMP), to identify if the public land involved would be available for disposal pursuant to the FLPMA.

DATES: This notice initiates the public scoping process for the EIS. To be included in the Draft EIS comments must be submitted in writing using any of the methods described in the **ADDRESSES** section below until 30 days after publication of this notice in the **Federal Register** or 30 days after the last public meeting held to obtain scoping input, whichever is later. When a public meeting is held, documentation of that meeting and the list of attendees will be available to the public for 30 days so that any participant who wishes to clarify the views he or she expressed may do so. The date(s) and location(s) of any public scoping meetings will be announced at least 15 days in advance of the meetings through local media, newspapers, individual mailing, and the following BLM Web site: *http://www.blm.gov/id/st/en/info/nepa/nepa/thompson_creek_mine.html.* Additional opportunities for public participation will be provided upon publication of the Draft EIS.

ADDRESSES: You may submit comments regarding the proposed actions and planning criteria, and request to have your name added to the mailing list for the EIS by any of the following methods:

- *E-mail: tcm_eis@jbr.com;*
- *Fax:* (801) 942–1852, attention Brian Buck; or
- *Mail:* Thompson Creek Mine EIS, c/o Brian Buck, JBR Environmental Consultants, 8160 South Highland Drive, Sandy, Utah 84093.

The public may also examine documents pertinent to the proposed actions at the BLM Challis Field Office, 1151 Blue Mountain Road, Challis, Idaho 83226 during regular business hours (7:45 a.m. to 4:30 p.m.), Monday through Friday, except Federal holidays. Project information and documents will also be available on the following Web site: *http://www.blm.gov/id/st/en/info/nepa/nepa/thompson_creek_mine.html.*

FOR FURTHER INFORMATION CONTACT: BLM Challis Field Office, telephone (208) 879–6200; address 1151 Blue Mountain Road, Challis, Idaho 83226. Individuals who use telecommunication devices for the deaf (TDD) may call the Federal Information Relay Service (FIRS) at (800) 877–8339 between 8 a.m. and 8 p.m., Eastern Time, Monday through Friday.

SUPPLEMENTARY INFORMATION: TCMC owns and operates the Thompson Creek molybdenum mine, located 7 miles northwest of Clayton and 21 miles southwest of Challis in Custer County, Idaho. The mine has been in operation since 1981 and is permitted for about 3,400 acres of surface disturbance, of which approximately 2,300 acres are private land and approximately 1,100 acres are Federal lands administered by the BLM and the Forest Service.

TCMC has proposed to modify its mining plan of operations. The proposed MMPO would allow mining to be extended by about 15 years, ending around 2030. The MMPO would expand two waste rock storage facilities and the tailings impoundment, requiring additional surface disturbance on about 350 acres of Federal lands, and 80 acres of private land. As a separate action TCMC has proposed to exchange 900 acres of private land owned by TCMC in Custer and Bannock counties for 5,000 acres of BLM-administered land near the mine in Custer County. The BLM is currently conducting a feasibility analysis of the proposed exchange. Upon completion of the feasibility analysis, the BLM may enter into an Agreement to Initiate a Land Exchange with TCMC and subsequently publish a separate Notice of Exchange Proposal (NOEP) in the newspapers servicing Custer and Bannock counties. Public comments received in response to the NOEP would be considered in the EIS if the NOEP is issued.

In response to these proposals (1) The BLM will decide whether to approve the portion of the MMPO involving BLM-administered public land under BLM regulations at 43 CFR 3809; (2) the Forest Service will decide whether to approve the portion of the MMPO involving National Forest System lands under Forest Service regulations at 36 CFR part 228 subpart A; (3) the USACE will decide whether to issue a permit under section 404 of the CWA and USACE regulations at 33 CFR part 320 to discharge fill materials into waters of the United States; (4) the BLM will decide whether to amend the Challis RMP pursuant to Section 202 of FLPMA and BLM regulations at 43 CFR part 1600, and identify the public land involved for disposal; and (5) the BLM will decide whether to approve a land disposal action.

The authorizations by the Forest Service for National Forest System lands and USACE may be required to implement the MMPO regardless of whether the BLM approves a land disposal action. If TCMC obtains title to all of the BLM-administered land within the mine area, the BLM's approval of the MMPO would no longer be necessary because the BLM does not regulate mining operations on private land. On the other hand, if TCMC obtains title to only some of the BLM-administered land involved with the MMPO, then any continuing mining operations on BLM-administered land would require BLM authorization under 43 CFR part 3809.

The purpose and need of the proposed actions are for (1) The BLM to respond to TCMC's proposed MMPO, which would enable TCMC to continue reasonable development of the existing mine in compliance with BLM laws and regulations (FLPMA, 43 CFR 3809); (2) the Forest Service to similarly respond to the MMPO in compliance with Forest Service laws and regulations (Organic Act of 1897; 36 CFR 228, Subpart A); (3) the USACE to respond to TCMC's application for a permit to discharge fill materials into waters of the United States, as necessary in the MMPO, in compliance with USACE laws and regulations (CWA, 33 CFR 320); (4) the BLM to consider amending the Challis RMP to allow a land disposal in compliance with Section 102 of FLPMA, and (5) the BLM to respond to TCMC's proposal for a land exchange and determine if a public land disposal would be in the public interest pursuant to FLPMA.

The No Action alternative (*i.e.,* completion of mining and reclamation under the current mining plan of operations) and alternatives that consider the RMP amendment and various aspects of the proposed MMPO and public land disposal will be analyzed. Alternatives identified to date for the MMPO include using different locations for waste rock storage and alternative reclamation measures. Alternatives identified to date for the possible public land disposal include exchange of private land for public land; how the public and private lands would be managed if these lands were exchanged, including analysis of potential impacts of conducting the mining operations identified in the proposed MMPO under the applicable statutory and regulatory authority; and possible variations in the amount of public land and/or restrictions on the public land that might be exchanged. The planning criteria for the RMP amendment would include that lands identified for disposal would serve the national interest and that newly acquired lands or interests in lands would be managed for their highest potential or for the purposes for which they were acquired.

By this notice, the BLM is complying with the requirements in 43 CFR 1610.2(c) to notify the public of potential amendments to land use plans, predicated on the analysis in the EIS. The BLM will integrate the land use planning process with the NEPA process for the EIS. The BLM will utilize and coordinate the NEPA commenting process to satisfy the public involvement for section 106 of the National Historic Preservation Act (16 U.S.C. 470f) as provided for in 36 CFR 800.2(d)(3).

The BLM is the lead Federal agency for the NEPA analysis process and preparation of the EIS. The BLM anticipates that the Forest Service, the USACE; the U.S. Environmental Protection Agency, the Idaho Department of Environmental Quality, and the Idaho Department of will be cooperating agencies. Other cooperating agencies may be identified during the scoping process.

Native American tribal consultation will be conducted in accordance with policy, and tribal concerns will be given due consideration, including impacts on Indian trust assets. Federal, State, and local agencies, along with other stakeholders that may be interested or affected by the proposed actions subject to the EIS are invited to participate in the scoping process and, if eligible, may request or be requested by the BLM to participate as a cooperating agency.

The public is invited to submit comments and resource information as well as identify issues, concerns and alternatives to be analyzed in the EIS. Public input should be as specific as possible (*i.e.,* clearly articulate concerns and contentions) to best assist in the NEPA process. Before including your address, phone number, e-mail address, or other personal identifying information in your comment, you should be aware that your entire comment—including your personal identifying information—may be made publicly available at any time. While you may ask us in your comment to withhold your personal identifying information from public review, we cannot guarantee that we will be able to do so.

Authority: 42 U.S.C. 4321 et seq.; 33 CFR 325.3; 43 CFR 1610.2.

David Rosenkrance,

Field Manager.

[FR Doc. 2010–19054 Filed 8–2–10; 8:45 am]

BILLING CODE 4310–GG–P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[LLCAD070000 L16100000.DP0000]

Notice of Re-Opening of Comment Period for the Draft Imperial Sand Dunes Recreation Area Management Plan and Draft Environmental Impact Statement, California

AGENCY: Bureau of Land Management, Interior.

ACTION: Notice.

SUMMARY: The Bureau of Land Management (BLM) announces the re-opening of the comment period on the Draft Imperial Sand Dunes Recreation Area Management Plan (RAMP) and Draft Environmental Impact Statement (EIS). The original notice published in the **Federal Register** on March 26, 2010 [75 FR 14623] provided for a comment period ending on June 24, 2010. The BLM is re-opening the comment period to end on August 9, 2010.

DATES: To assure that comments will be considered, the BLM must receive written comments on the Draft RAMP/EIS by August 9, 2010.

ADDRESSES: You may submit comments at the public meetings or by any of the following methods:

- *E-mail: caisdrmp@ca.blm.gov.*
- *Fax:* (760) 337–4490.
- *Mail:* 1661 So. 4th St., El Centro, California 92243.

Copies of the Draft Imperial Sand Dunes RAMP/EIS are available in the El Centro Field Office at the above address and at the BLM California State Office, 2800 Cottage Way, Sacramento, California 95825. Interested persons may also review the Draft Resource

Management Plan (RMP)/EIS at the following Web site: *http://www.blm.gov/en/fo/elcentro.*

FOR FURTHER INFORMATION CONTACT: Tom Zale, BLM El Centro Field Office, 1661 S. 4th Street, El Centro, CA 92243. (760) 337–4400.

SUPPLEMENTARY INFORMATION: The original Notice of Availability provided for comments on the Draft RMP/Draft EIS to be received through June 24, 2010. The BLM is re-opening the comment period to accommodate numerous requests for additional time to review the document, given the complexity of the plan, and the broad public interest in its outcome. Comments on the Draft RMP and EIS will now be accepted through August 9, 2010. Before including your address, phone number, e-mail address, or other personal identifying information in your comment, you should be aware that your entire comment—including your personal identifying information—may be made publicly available at any time. While you can ask us in your comment to withhold your personal identifying information from public review, we cannot guarantee that we will be able to do so.

Authority: 40 CFR 1503.1 and 1506.6, and 43 CFR 1610.2.

Thomas Pogacnik,

Deputy State Director, Natural Resources.

[FR Doc. 2010–19051 Filed 8–2–10; 8:45 am]

BILLING CODE 4310–40–P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[LLWY–957400–10–L14200000–BJ0000]

Notice of Filing of Plats of Survey, Wyoming

AGENCY: Bureau of Land Management, Interior.

ACTION: Notice of Filing of Plats of Survey, Wyoming.

SUMMARY: The Bureau of Land Management (BLM) has filed the plats of survey of the lands described below in the BLM Wyoming State Office, Cheyenne, Wyoming, on the dates indicated.

FOR FURTHER INFORMATION CONTACT: Bureau of Land Management, 5353 Yellowstone Road, P.O. Box 1828, Cheyenne, Wyoming 82003.

SUPPLEMENTARY INFORMATION: These surveys were executed at the request of the Bureau of Land Management, and are necessary for the management of resources. The lands surveyed are:

The plat and field notes representing the dependent resurvey of portions of the Seventh Standard Parallel North through Ranges 108, 109 and 110 West, a portion of the Thirteenth Auxiliary Guide Meridian in Township 29 North, between Ranges 108 and 109 West, portions of the west boundary, and the subdivisional lines, Township 29 North, Range 109 West, Sixth Principal Meridian, Wyoming, Group No. 799, was accepted March 29, 2010.

The plat and field notes representing the dependent resurvey of a portion of the west boundary, a portion of the subdivisional lines, and the subdivision of certain sections, Township 29 North, Range 84 West, Sixth Principal Meridian, Wyoming, Group No. 713, was accepted March 29, 2010.

The plat and field notes representing the dependent resurvey of a portion of the subdivisional lines and the subdivision of section 12, Township 29 North, Range 85 West, Sixth Principal Meridian, Wyoming, Group No. 713, was accepted March 29, 2010.

The plat and field notes representing the dependent resurvey of a portion of the east boundary, a portion of the subdivisional lines, and the subdivision of certain sections, Township 30 North, Range 85 West, Sixth Principal Meridian, Wyoming, Group No. 714, was accepted March 29, 2010.

The supplemental plat showing the corrected Tract number for Tract 52A, Township 41 North, Range 117 West, Sixth Principal Meridian, Wyoming, was accepted March 29, 2010, and is based upon the plat accepted May 13, 2009.

The plat and field notes representing the dependent resurvey of a portion of Tracts 49 and 50, and the metes and bounds survey of Lot 10, Township 47 North, Range 88 West, Sixth Principal Meridian, Wyoming, Group No. 820, was accepted July 27, 2010.

The supplemental plat representing the segregation of Tract 51A from Tract 51 and Tract 54, and Lot 2 and Lot 3 in Section 23, Township 41 North, Range 117 West, Sixth Principal Meridian, Wyoming, Group No. 814, was accepted July 27, 2010.

The plat and field notes representing the dependent resurvey of a portion of the west and north boundaries, and a portion of the subdivisional lines, and the subdivision of certain sections, Township 27 North, Range 83 West, Sixth Principal Meridian, Wyoming, Group No. 725, was accepted July 27, 2010.

The plat and field notes representing the dependent resurvey of a portion of the west boundary, and a portion of the subdivisional lines, and the subdivision of certain sections, Township 28 North, Range 83 West, Sixth Principal Meridian, Wyoming, Group No. 725, was accepted July 27, 2010.

The plat and field notes representing the dependent resurvey of a portion of the subdivisional lines, and the subdivision of certain sections, Township 27 North, Range 84 West, Sixth Principal Meridian, Wyoming, Group No. 725, was accepted July 27, 2010.

The plat and field notes representing the dependent resurvey of a portion of the south boundary, and a portion of the subdivisional lines, and the subdivision of certain sections, Township 28 North, Range 84 West, Sixth Principal Meridian, Wyoming, Group No. 725, was accepted July 27, 2010.

The supplemental plat showing the subdivision of Tract 51–D into new Tracts 51–Q and 51–R, Township 43 North, Range 92 West, Sixth Principal Meridian, Wyoming, Group No. 824, was accepted July 27, 2010 and is based upon a survey performed in May 2006, by Sherman B. Allred, Wyoming Professional Engineer and Land Surveyor, Registration No. 2920.

Copies of the preceding described plats and field notes are available to the public at a cost of $1.10 per page.

Dated: July 28, 2010.

John P. Lee,

Chief Cadastral Surveyor, Division of Support Services.

[FR Doc. 2010–19021 Filed 8–2–10; 8:45 am]

BILLING CODE 4310–22–P

DEPARTMENT OF THE INTERIOR

National Park Service

Notice of Intent to Repatriate a Cultural Item: Taylor Museum of the Colorado Springs Fine Arts Center, Colorado Springs, CO

AGENCY: National Park Service, Interior.

ACTION: Notice.

Notice is here given in accordance with the Native American Graves Protection and Repatriation Act (NAGPRA), 25 U.S.C. 3005, of the intent to repatriate a cultural item in the possession of the Taylor Museum of the Colorado Springs Fine Arts Center, Colorado Springs, CO, that meets the definition of object of cultural patrimony under 25 U.S.C. 3001.

This notice is published as part of the National Park Service's administrative responsibilities under NAGPRA, 25 U.S.C. 3003(d)(3). The determinations in this notice are the sole responsibility of the museum, institution, or Federal

agency that has control of the cultural items. The National Park Service is not responsible for the determinations in this notice.

In 1951, the Taylor Museum purchased a Northwest Coast totem pole (TM 3991) from Ralph C. Altman/Lumber Yard of Joshua Marks, Los Angeles, CA. The piece was officially accessioned into the museum's collection on May 7, 1951.

The totem pole, dated circa 1870, is from the Haida village of Old Kasaan, Prince of Wales Island, southeastern Alaska. The totem pole originally stood in front of a house, and both were used by Chief Son-i-hat, "Southeast Wind," of the Eagle phratry and one of the great chiefs of Old Kasaan. The house was named Adolescent Girl House. Chief Son-i-Hat also had a home not far from present-day Kasaan, which is currently the only remaining traditional Haida longhouse in Alaska.

The pole was bought by a man from Los Angeles around 1908. The pole and house were taken to Los Angeles, and the dismantled house was rebuilt on a smaller scale. Chief Son-i-hat, who took along dancing paraphernalia, also accompanied the house and pole. Chief Son-i-hat stayed about two years, and according to his son, staged dances and gave speeches about the ways of his fellow Haida people. When the Taylor Museum of the Colorado Springs Fine Arts Center acquired the pole, it was laying in a lumber yard ready to be sawed up for wood pulp.

In approximately early 2007, the museum began researching the pole and started consultations with tribal representatives from the Organized Village of Kasaan. Totem poles in the Haida culture represent clans, serve as grave markers, and also relate important events. According to representatives of the Organized Village of Kasaan, the totem pole is clan property. A totem pole is not property owned by an individual, and no single individual can alienate or convey this clan property. Furthermore, the totem pole was clan property at the time of its alienation, and ownership of the totem pole and crest designs depicted are owned by the clan, Yaadas of Gasa'aan (Old Kasaan). Therefore, the totem pole is an object of cultural patrimony under NAGPRA.

Officials of the Taylor Museum of the Colorado Springs Fine Arts Center have determined that, pursuant to 25 U.S.C. 300(3)(D), the one cultural item described above has ongoing historical, traditional, or cultural importance central to the Native American group or culture itself, rather than property owned by an individual. Officials of the Taylor Museum of the Colorado Springs Fine Arts Center also have determined that, pursuant to 25 U.S.C. 3001(2), there is a relationship of shared group identity that can be reasonably traced between the object of cultural patrimony and the Organized Village of Kasaan

Representatives of any other Indian tribe that believes itself to be culturally affiliated with the object of cultural patrimony should contact Tariana Navas-Nieves, Curator of Hispanic and Native American Art, Taylor Museum of the Colorado Springs Fine Arts Center, 30 West Dale St., Colorado Springs, CO 80903, telephone (719) 477–4334, before September 2, 2010. Repatriation of the object of cultural patrimony to the Organized Village of Kasaan may proceed after that date if no additional claimants come forward.

The Taylor Museum of the Colorado Springs Fine Arts Center is responsible for notifying the Organized Village of Kasaan that this notice has been published.

Dated: July 26, 2010

Sherry Hutt,

Manager, National NAGPRA Program.

[FR Doc. 2010–18997 Filed 8–2–10; 8:45 am]

BILLING CODE 4312–50–S

DEPARTMENT OF THE INTERIOR

National Park Service

Notice of Inventory Completion: University of Colorado Museum, Boulder, CO

AGENCY: National Park Service, Interior.

ACTION: Notice.

Notice is here given in accordance with the Native American Graves Protection and Repatriation Act (NAGPRA), 25 U.S.C. 3003, of the completion of an inventory of human remains in the control of the University of Colorado Museum, Boulder, CO. The human remains were removed from Converse County, WY.

This notice is published as part of the National Park Service's administrative responsibilities under NAGPRA, 25 U.S.C. 3003(d)(3). The determinations in this notice are the sole responsibility of the museum, institution, or Federal agency that has control of the Native American human remains. The National Park Service is not responsible for the determinations in this notice.

A detailed assessment of the human remains was made by the University of Colorado Museum professional staff in consultation with representatives of the Apache Tribe of Oklahoma; Arapahoe Tribe of the Wind River Reservation, Wyoming; Assiniboine and Sioux Tribes of the Fort Peck Indian Reservation, Montana; Cheyenne and Arapaho Tribes, Oklahoma; Cheyenne River Sioux Tribe of the Cheyenne River Reservation, South Dakota; Comanche Nation, Oklahoma; Crow Tribe of Montana; Crow Creek Sioux Tribe of the Crow Creek Reservation, South Dakota; Flandreau Santee Sioux Tribe of South Dakota; Kiowa Indian Tribe of Oklahoma; Lower Brule Sioux Tribe of the Lower Brule Reservation, South Dakota; Northern Cheyenne Tribe of the Northern Cheyenne Indian Reservation, Montana; Oglala Sioux Tribe of the Pine Ridge Reservation, South Dakota; Rosebud Sioux Tribe of the Rosebud Indian Reservation, South Dakota; Santee Sioux Nation, Nebraska; Standing Rock Sioux Tribe of North & South Dakota; Three Affiliated Tribes of the Fort Berthold Reservation, North Dakota; and Yankton Sioux Tribe of South Dakota.

In 1948, 1949, 1952, 1956, or 1963, human remains representing a minimum of one individual were removed from a cave at Little Box Elder Site, in Converse County, WY. The human remains were removed by either a museum archeological crew, which excavated the site in 1948 (test), 1949, 1952, and 1956, or by Dr. Robinson, Paleontology Curator Emeritus, who excavated stratigraphically at the site in 1963. The property is private and belonged to Orsa D. Ferguson who passed away in the 1950s, and then it belonged to his brother-in-law, William Barber. The human remains were found in the Paleontology section of the museum during re-analysis and transferred to the Anthropology section of the museum for NAGPRA compliance. No known individual was identified. No associated funerary objects are present.

The human remains are Native American based on the biological assessment and the site context. The cave dates from recent time to 15,000 years before present. Evidence of human occupation was present in the upper levels. The earliest levels contained a "nest" of three spherical stones of material foreign to the cave deposits, suggesting the possibility of human occupation at that time. During preliminary re-study of material from the cave, two tools were identified. Both were made from elements of extinct horse (Equus conversidens). The site also yielded several tools made from mountain goat humeri and metapodial. Although not extinct, mountain goat is no longer present in the region of Little Box Elder.

Officials of the University of Colorado Museum have determined that,

pursuant to 25 U.S.C. 3001(9), the human remains described above represent the physical remains of one individual of Native American ancestry. Lastly, officials of the University of Colorado Museum have determined that, pursuant to 25 U.S.C. 3001(2), a relationship of shared group identity cannot reasonably be traced between the Native American human remains and any present-day Indian tribe.

The Native American Graves Protection and Repatriation Review Committee (Review Committee) is responsible for recommending specific actions for disposition of culturally unidentifiable human remains. In October 2009, the University of Colorado Museum requested that the Review Committee recommend disposition of the culturally unidentifiable human remains to the Arapahoe Tribe of the Wind River Reservation, Wyoming, based on Arapaho aboriginal land claims and supported by oral tradition, as well as the support of the other Indian tribes consulted. The Comanche Nation, Oklahoma, signed the disposition agreement in support of the disposition to the Arapahoe Tribe. Furthermore, none of the Indian tribes consulted objected to the determination of "culturally unidentifiable" status by the University of Colorado Museum and the disposition to the Arapahoe Tribe of the Wind River Reservation, Wyoming.

The Review Committee considered the proposal at its October 30–31, 2009, meeting and recommended disposition of the human remains to the Arapahoe Tribe of the Wind River Reservation, Wyoming. The Secretary of Interior agreed with the Review Committee's recommendation. An April 19, 2010, letter from the Designated Federal Officer, writing on behalf of the Secretary of the Interior, transmitted the authorization for the University of Colorado Museum to effect disposition of the physical remains of the culturally unidentifiable individual to the Arapahoe Tribe of the Wind River Reservation, Wyoming, contingent on the publication of a Notice of Inventory Completion in the **Federal Register**. This notice fulfills that requirement.

Representatives of any other Indian tribe that believes itself to be culturally affiliated with the human remains should contact Steve Lekson, Curator of Anthropology, University of Colorado Museum, in care of Jan Bernstein, NAGPRA Consultant, Bernstein & Associates, 1041 Lafayette St., Denver, CO 80218, telephone (303) 894-0648, before September 2, 2010. Disposition of the human remains to the Arapahoe Tribe of the Wind River Reservation, Wyoming, may proceed after that date if no additional claimants come forward.

The University of Colorado Museum is responsible for notifying the Apache Tribe of Oklahoma; Arapahoe Tribe of the Wind River Reservation, Wyoming; Assiniboine and Sioux Tribes of the Fort Peck Indian Reservation, Montana; Cheyenne and Arapaho Tribes, Oklahoma; Cheyenne River Sioux Tribe of the Cheyenne River Reservation, South Dakota; Comanche Nation, Oklahoma; Crow Tribe of Montana; Crow Creek Sioux Tribe of the Crow Creek Reservation, South Dakota; Flandreau Santee Sioux Tribe of South Dakota; Kiowa Indian Tribe of Oklahoma; Lower Brule Sioux Tribe of the Lower Brule Reservation, South Dakota; Northern Cheyenne Tribe of the Northern Cheyenne Indian Reservation, Montana; Oglala Sioux Tribe of the Pine Ridge Reservation, South Dakota; Rosebud Sioux Tribe of the Rosebud Indian Reservation, South Dakota; Santee Sioux Nation, Nebraska; Standing Rock Sioux Tribe of North & South Dakota; Three Affiliated Tribes of the Fort Berthold Reservation, North Dakota; and Yankton Sioux Tribe of South Dakota, that this notice has been published.

Dated: July 26, 2010

Sherry Hutt,

Manager, National NAGPRA Program.

[FR Doc. 2010–19004 Filed 8–2–10; 8:45 am]

BILLING CODE 4312–50–S

DEPARTMENT OF THE INTERIOR

National Park Service

Notice of Inventory Completion: U.S. Department of Agriculture, Forest Service, Siuslaw National Forest, Waldport, OR

AGENCY: National Park Service, Interior.

ACTION: Notice.

Notice is here given in accordance with the Native American Graves Protection and Repatriation Act (NAGPRA), 25 U.S.C. 3003, of the completion of an inventory of human remains in the possession of the U.S. Department of Agriculture, Forest Service, Siuslaw National Forest, Waldport, OR. The human remains were removed from the Cape Perpetua Visitor Center, Lincoln County, OR.

This notice is published as part of the National Park Service's administrative responsibilities under NAGPRA, 25 U.S.C. 3003(d)(3). The determinations in this notice are the sole responsibility of the museum, institution, or Federal agency that has control of the Native American human remains. The National Park Service is not responsible for the determinations in this notice.

A detailed assessment of the human remains was made by Siuslaw National Forest professional staff in consultation with representatives of the Confederated Tribes of the Coos, Lower Umpqua and Siuslaw Indians of Oregon; Confederated Tribes of the Grand Ronde Community of Oregon; Confederated Tribes of Siletz Indians of Oregon; and the Coquille Tribe of Oregon.

At an unknown date prior to 1988, human remains representing a minimum of one individual were removed near Cape Perpetua, near Yachats, Lincoln County, OR, and given to the Cape Perpetua Visitor Center. No known individual was identified. No associated funerary objects are present.

The Visitor Center held the human remains in secure storage until transferring to the Forest Archaeologist. No information accompanied the human remains regarding the specific location and conditions of discovery other than the remains were retrieved from a crevice in the rocky shoreline between Cape Perpetua and Yachats.

Consultation evidence and the ethnographic record show that this area was part of the ancestral territory of the Alsea Indians. At Contact, the territory of the Alsea extended along the Oregon coast and rivers from approximately 8 miles south of Yachats to approximately 10 miles north of Waldport. In 1855, this land base and the Alsea people were included within the Coast Indian Reservation. This reservation was later referred to as the Siletz Indian Reservation. For approximately 10 years during the reservation era, other tribes, including the Coos, Lower Umpqua, Coquille, and some Siuslaw people whose traditional territories lay to the south of the Alsea, were forcibly held at the Alsea Sub-agency of the Coast Indian Reservation, which was located at present-day Yachats. Of these tribal peoples, only the Alsea are known to have primarily practiced above ground interment at locations similar to that identified for this individual. Descendants of the Alsea are members of the Confederated Tribes of Siletz Indians of Oregon.

Officials of the Siuslaw National Forest have determined that, pursuant to 25 U.S.C. 3001(9), the human remains described above represent the physical remains of one individual of Native American ancestry. Officials of the Siuslaw National Forest also have determined that, pursuant to 25 U.S.C. 3001(2), there is a relationship of shared group identity that can be reasonably traced between the Native American

human remains and the Confederated Tribes of Siletz Indians of Oregon.

Representatives of any other Indian tribe that believes itself to be culturally affiliated with the human remains should contact Phyllis Steeves, Heritage Program Manager, Siuslaw National Forest, 1130 Forestry Lane/PO Box 400, Waldport, OR 97394, telephone (541) 563–8425, before September 2, 2010. Repatriation of the human remains to the Confederated Tribes of Siletz Indians of Oregon may proceed after that date if no additional claimants come forward.

The Siuslaw National Forest is responsible for notifying the Confederated Tribes of the Coos, Lower Umpqua and Siuslaw Indians of Oregon; Confederated Tribes of the Grand Ronde Community of Oregon; Confederated Tribes of Siletz Indians of Oregon; and the Coquille Tribe of Oregon, that this notice has been published.

Dated: July 26, 2010

Sherry Hutt,

Manager, National NAGPRA Program.

[FR Doc. 2010–19002 Filed 8–2–10; 8:45 am]

BILLING CODE 4312–50–S

DEPARTMENT OF THE INTERIOR

National Park Service

Notice of Inventory Completion: University of Colorado Museum, Boulder, CO

AGENCY: National Park Service, Interior.

ACTION: Notice.

Notice is here given in accordance with the Native American Graves Protection and Repatriation Act (NAGPRA), 25 U.S.C. 3003, of the completion of an inventory of human remains in the control of the University of Colorado Museum, Boulder, CO. The human remains were removed from Washington County, CO.

This notice is published as part of the National Park Service's administrative responsibilities under NAGPRA, 25 U.S.C. 3003(d)(3). The determinations in this notice are the sole responsibility of the museum, institution, or Federal agency that has control of the Native American human remains. The National Park Service is not responsible for the determinations in this notice.

A detailed assessment of the human remains was made by the University of Colorado Museum professional staff in consultation with representatives of the Apache Tribe of Oklahoma; Arapahoe Tribe of the Wind River Reservation, Wyoming; Cheyenne and Arapaho Tribes, Oklahoma; Cheyenne River Sioux Tribe of the Cheyenne River Reservation, South Dakota; Comanche Nation, Oklahoma; Crow Tribe of Montana; Fort Sill Apache Tribe of Oklahoma; Jicarilla Apache Nation, New Mexico; Kiowa Indian Tribe of Oklahoma; Mescalero Apache Tribe of the Mescalero Reservation, New Mexico; Northern Cheyenne Tribe of the Northern Cheyenne Indian Reservation, Montana; Oglala Sioux Tribe of the Pine Ridge Reservation, South Dakota; Pawnee Nation of Oklahoma; Rosebud Sioux Tribe of the Rosebud Indian Reservation, South Dakota; Southern Ute Indian Tribe of the Southern Ute Reservation, Colorado; Standing Rock Sioux Tribe of North & South Dakota; Three Affiliated Tribes of the Fort Berthold Reservation, North Dakota; Ute Indian Tribe of the Uintah & Ouray Reservation, Utah; and Ute Mountain Tribe of the Ute Mountain Reservation, Colorado, New Mexico & Utah.

In 1953, human remains representing a minimum of three individuals were removed from the Claypool site, Washington County, CO, by the University of Colorado Museum. Local residents had been collecting artifacts in that area for years. In January 2004, the human remains were discovered in the museum during an inventory. No known individuals were identified. No associated funerary objects are present.

The human remains are Native American based on the biological assessment and the site context. The Claypool site appears to have been a Cody Complex campsite. Diagnostic artifacts found there include Eden points, a Scottsbluff point, and a Cody knife. Other material culture consists of scrapers, numerous stone flakes, charred and uncharred bone, and pieces of grooved sandstone. The stratigraphy indicates the artifacts are postglacial and date from 10,000 to 7,000 years ago.

Officials of the University of Colorado Museum have determined that, pursuant to 25 U.S.C. 3001(9), the human remains described above represent the physical remains of three individuals of Native American ancestry. Lastly, officials of the University of Colorado Museum have determined that, pursuant to 25 U.S.C. 3001(2), a relationship of shared group identity cannot reasonably be traced between the Native American human remains and any present-day Indian tribe.

The Native American Graves Protection and Repatriation Review Committee (Review Committee) is responsible for recommending specific actions for disposition of culturally unidentifiable human remains. In October 2009, the University of Colorado Museum requested that the Review Committee recommend disposition of the culturally unidentifiable human remains to the Ute Mountain Tribe of the Ute Mountain Reservation, Colorado, New Mexico & Utah, based on aboriginal land claims supported by oral tradition, as well as the support of the other Indian tribes consulted. The Comanche Nation, Oklahoma, and Pawnee Nation of Oklahoma signed the disposition agreement in support of the disposition to the Ute Mountain Tribe. Furthermore, none of the Indian tribes consulted objected to the determination of "culturally unidentifiable" status by the University of Colorado Museum and the disposition to the Ute Mountain Tribe of the Ute Mountain Reservation, Colorado, New Mexico & Utah.

The Review Committee considered the proposal at its October 30–31, 2009, meeting and recommended disposition of the human remains to the Ute Mountain Tribe of the Ute Mountain Reservation, Colorado, New Mexico & Utah. The Secretary of the Interior agreed with the Review Committee's recommendation. An April 19, 2010, letter from the Designated Federal Officer, writing on behalf of the Secretary of the Interior, transmitted the authorization for the University of Colorado Museum to effect disposition of the physical remains of the culturally unidentifiable individuals to the Ute Mountain Tribe of the Ute Mountain Reservation, Colorado, New Mexico & Utah, contingent on the publication of a Notice of Inventory Completion in the **Federal Register**. This notice fulfills that requirement.

Representatives of any other Indian tribe that believes itself to be culturally affiliated with the human remains should contact Steve Lekson, Curator of Anthropology, University of Colorado Museum, in care of Jan Bernstein, NAGPRA Consultant, Bernstein & Associates, 1041 Lafayette Street, Denver, CO 80218, telephone (303) 894-0648, before September 2, 2010. Disposition of the human remains to the Ute Mountain Tribe of the Ute Mountain Reservation, Colorado, New Mexico & Utah, may proceed after that date if no additional claimants come forward.

The University of Colorado Museum is responsible for notifying the Apache Tribe of Oklahoma; Arapahoe Tribe of the Wind River Reservation, Wyoming; Cheyenne and Arapaho Tribes, Oklahoma; Cheyenne River Sioux Tribe of the Cheyenne River Reservation, South Dakota; Comanche Nation, Oklahoma; Crow Tribe of Montana; Fort Sill Apache Tribe of Oklahoma; Jicarilla Apache Nation, New Mexico; Kiowa

Indian Tribe of Oklahoma; Mescalero Apache Tribe of the Mescalero Reservation, New Mexico; Northern Cheyenne Tribe of the Northern Cheyenne Indian Reservation, Montana; Oglala Sioux Tribe of the Pine Ridge Reservation, South Dakota; Pawnee Nation of Oklahoma; Rosebud Sioux Tribe of the Rosebud Indian Reservation, South Dakota; Southern Ute Indian Tribe of the Southern Ute Reservation, Colorado; Standing Rock Sioux Tribe of North & South Dakota; Three Affiliated Tribes of the Fort Berthold Reservation, North Dakota; Ute Indian Tribe of the Uintah & Ouray Reservation, Utah; and Ute Mountain Tribe of the Ute Mountain Reservation, Colorado, New Mexico & Utah, that this notice has been published.

Dated: July 26, 2010

Sherry Hutt,

Manager, National NAGPRA Program.

[FR Doc. 2010–19001 Filed 8–2–10; 8:45 am]

BILLING CODE 4312–50–S

DEPARTMENT OF THE INTERIOR

National Park Service

Notice of Inventory Completion: Museum of Cultural and Natural History, Central Michigan University, Mt. Pleasant, MI; Correction

AGENCY: National Park Service, Interior.

ACTION: Notice; correction.

Notice is here given in accordance with the Native American Graves Protection and Repatriation Act (NAGPRA), 25 U.S.C. 3003, of the completion of an inventory of human remains and associated funerary objects in the possession of the Museum of Cultural and Natural History, Central Michigan University, Mt. Pleasant, MI. The human remains and associated funerary objects were removed from Arenac, Isabella, and Saginaw Counties, MI.

This notice is published as part of the National Park Service's administrative responsibilities under NAGPRA, 25 U.S.C. 3003(d)(3). The determinations in this notice are the sole responsibility of the museum, institution, or Federal agency that has control of the Native American human remains and associated funerary objects. The National Park Service is not responsible for the determinations in this notice.

This notice replaces a Notice of Inventory Completion previously published in the **Federal Register** (75 FR 16175–16176, March 31, 2010) in order to correctly list the name of an Indian tribe, and the listing of the Indian tribes that were parties to the disposition request.

A detailed assessment of the human remains was made by the Museum of Cultural and Natural History professional staff and physical anthropologists from Western Michigan University, Kalamazoo, MI, and the University of Western Ontario, Canada, and in consultation with representatives of the Little Traverse Bay Bands of Odawa Indians, Michigan, and the Saginaw Chippewa Indian Tribe of Michigan.

In 1970, human remains representing a minimum of two individuals were removed from Point Lookout, 20AC18, in Arenac County, MI. Students from Central Michigan University and amateur archeologists excavated the site and the material was immediately turned over to the Museum of Cultural and Natural History. No known individuals were identified. The 11 associated funerary objects are 2 (reconstructed) ceramic vessels, 1 piece of worked bone, 1 small sheet of copper, 1 bag of ochre sand, 1 stone object, 1 bag of ceramic sherds, 1 group of copper beads and bead fragments, 1stone tool, 1 bone needle, and 1 tooth from an unknown animal.

Archeological evidence dates the material from the Early Late Woodland Era, and the determination is supported by publications of the State Archaeologist's Office of Michigan. The human remains were identified as being of Native American ancestry based on archeological dating and osteological examination.

In 1970–1971, human remains representing a minimum of 18 individuals were removed from Indian Mound Park, 20IB1, in Isabella County, MI. Faculty and students from Central Michigan University excavated the site and the material was immediately turned over to the Museum of Cultural and Natural History. No known individuals were identified. The five associated funerary objects are one celt, one projectile point, and three ceramic sherds.

Archeological evidence dates the material from the Early Late Woodland Era, and the determination is supported by publications of the State Archaeologist's Office of Michigan. The human remains were identified as being of Native American ancestry based on archeological dating and osteological examination.

From 1968 to 1970, and in 1972, human remains representing a minimum 124 individuals were removed from the Frazier-Tyra site, 20SA9, in Saginaw County, MI. Amateur archeologists excavated the site from 1968 to 1970, and turned over the material to the Anthropology Department of Central Michigan University, which transferred it to the Museum of Cultural and Natural History in the early 1990s. Students from Central Michigan University excavated the site again in 1972, and immediately turned over the materials they found to the Museum of Cultural and Natural History. No known individuals were identified. The 372 associated funerary objects are 285 ceramic sherds, 76 pieces of lithic debitage, 4 scrapers, 1 piece of copper, 1 abrading stone, 1 projectile point, 1 piece of conch, 1 bag of ochre, 1 pipe and 1 pipe fragment.

Archeological evidence dates the material from the Early Late Woodland Era, and the determination is supported by publications of the State Archaeologist's Office of Michigan. The human remains were identified as being of Native American ancestry based on archeological dating and osteological examination.

The area of Arenac, Isabella, and Saginaw Counties in mid-Michigan has a long established history of Native American occupation before European encroachment in the early 17th century. The Anishnaabek, which is composed of the Odawa/Ottawa, Ojibwe/Chippewa and Potawatomi, have long called this area home. Officials of the Museum of Cultural and Natural History have reasonably determined that the individuals described above from Arenac, Isabella, and Saginaw Counties are Native American; however, officials of the Museum of Cultural and Natural History have determined that the evidence is insufficient to determine cultural affiliation with any present-day Indian tribe.

Officials of the Museum of Cultural and Natural History have determined that, pursuant to 25 U.S.C. 3001(9), the human remains described above represent the physical remains of 144 individuals of Native American ancestry. Officials of the Museum of Cultural and Natural History also have determined that, pursuant to 25 U.S.C. 3001(3)(A), the 388 objects described above are reasonably believed to have been placed with or near individual human remains at the time of death or later as part of the death rite or ceremony. Lastly, officials of the Museum of Cultural and Natural History have determined that, pursuant to 25 U.S.C. 3001(2), a relationship of shared group identity cannot be reasonably traced between the Native American human remains and associated funerary objects and any present-day Indian tribe.

The Native American Graves Protection and Repatriation Review Committee (Review Committee) is responsible for recommending specific actions for disposition of culturally unidentifiable human remains. In February 2009, the Museum of Cultural and Natural History requested that the Review Committee recommend disposition of the 144 culturally unidentifiable human remains and associated funerary objects. Supporters of the disposition were the Bay Mills Indian Community, Michigan; Grand Traverse Band of Ottawa and Chippewa Indians, Michigan; Hannahville Potawatomi Indian Community, Michigan; Keweenaw Bay Indian Community, Michigan; Lac Vieux Desert Band of Lake Superior Chippewa Indians, Michigan; Little River Band of Ottawa Indians, Michigan; Little Traverse Bay Bands of Odawa Indians, Michigan; Match-e-be-nash-she-wish Band of Pottawatomi Indians of Michigan; Pokagon Band of Potawatomi Indians, Michigan; Saginaw Chippewa Indian Tribe of Michigan; Sault Ste. Marie Tribe of Chippewa Indians of Michigan; Sac & Fox Nation, Oklahoma; and Wyandotte Nation, Oklahoma. According to documentation submitted by the museum, parties of the disposition agreement were the Bay Mills Indian Community, Michigan; Grand Traverse Band of Ottawa and Chippewa Indians, Michigan; Keweenaw Bay Indian Community, Michigan; Lac Vieux Desert Band of Lake Superior Chippewa Indians, Michigan; Little River Band of Ottawa Indians, Michigan; Little Traverse Bay Bands of Odawa Indians, Michigan; Match-e-be-nash-she-wish Band of Pottawatomi Indians of Michigan; Saginaw Chippewa Indian Tribe of Michigan; Sault Ste. Marie Tribe of Chippewa Indians of Michigan; and Wyandotte Nation, Oklahoma.

The Review Committee considered the proposal at its May 23 - 24, 2009, meeting and recommended disposition of the human remains and associated funerary objects to the Indian tribes. The Secretary of the Interior concurred with the Review Committee's recommendation. A September 16, 2009, letter on behalf of the Secretary of Interior from the Designated Federal Official transmitted the authorization for the museum to effect disposition of the culturally unidentifiable human remains and associated funerary objects contingent on the publication of a Notice of Inventory Completion in the **Federal Register**. This notice fulfills that requirement. In the same letter, the Secretary recommended the transfer of the associated funerary objects to the Indian tribes listed above to the extent allowed by Federal, state, or local law.

Representatives of any other Indian tribe that believes itself to be culturally affiliated with the human remains and associated funerary objects should contact Dr. Pamela Gates, NAGPRA Representative, Museum of Cultural and Natural History, 103 Rowe Hall, Central Michigan University, Mt. Pleasant, MI 48859, telephone (989) 774–3341, before September 2, 2010. Disposition of the human remains and associated funerary objects to the Bay Mills Indian Community, Michigan; Grand Traverse Band of Ottawa and Chippewa Indians, Michigan; Keweenaw Bay Indian Community, Michigan; Lac Vieux Desert Band of Lake Superior Chippewa Indians, Michigan; Little River Band of Ottawa Indians, Michigan; Little Traverse Bay Bands of Odawa Indians, Michigan; Match-e-be-nash-she-wish Band of Pottawatomi Indians of Michigan; Saginaw Chippewa Indian Tribe of Michigan; Sault Ste. Marie Tribe of Chippewa Indians of Michigan; and/or Wyandotte Nation, Oklahoma, may proceed after that date if no additional claimants come forward.

The Museum of Cultural and Natural History is responsible for notifying the Bay Mills Indian Community, Michigan; Grand Traverse Band of Ottawa and Chippewa Indians, Michigan; Hannahville Indian Community, Michigan; Keweenaw Bay Indian Community, Michigan; Lac Vieux Desert Band of Lake Superior Chippewa Indians, Michigan; Little River Band of Ottawa Indians, Michigan; Little Traverse Bay Bands of Odawa Indians, Michigan; Match-e-be-nash-she-wish Band of Pottawatomi Indians of Michigan; Pokagon Band of Potawatomi Indians, Michigan and Indiana; Sac & Fox Nation, Oklahoma; Saginaw Chippewa Indian Tribe of Michigan; Sault Ste. Marie Tribe of Chippewa Indians of Michigan; and Wyandotte Nation, Oklahoma, that this notice has been published.

Dated: July 26, 2010

Sherry Hutt,

Manager, National NAGPRA Program.

[FR Doc. 2010–19000 Filed 8–2–10; 8:45 am]

BILLING CODE 4312–50–S

DEPARTMENT OF THE INTERIOR

National Park Service

Notice of Inventory Completion: Field Museum of Natural History, Chicago, IL

AGENCY: National Park Service, Interior.

ACTION: Notice.

Notice is here given in accordance with the Native American Graves Protection and Repatriation Act (NAGPRA), 25 U.S.C. 3003, of the completion of an inventory of human remains and associated funerary objects in the possession of the Field Museum of Natural History, Chicago, IL. The human remains and associated funerary objects were removed from various locations on the Hopi Indian Reservation, Coconino County, AZ.

This notice is published as part of the National Park Service's administrative responsibilities under NAGPRA, 25 U.S.C. 3003(d)(3). The determinations in this notice are the sole responsibility of the museum, institution, or Federal agency that has control of the Native American human remains and associated funerary objects. The National Park Service is not responsible for the determinations in this notice.

A detailed assessment of the human remains was made by the Field Museum of Natural History professional staff in consultation with representatives of the Hopi Tribe of Arizona.

In 1900, human remains representing a minimum of 71 individuals were removed from Awatobi, Burned Corn House, Chukuli, Mishongovi, Old Mishongovi, Payapki, Kishuba, Shongopovi, and Sityatki, on the Hopi Indian Reservation, Coconino County, AZ, by Charles L. Owen for the Field Museum of Natural History (Field Museum accession number 709). No known individuals were identified. The 51 associated funerary objects are 5 ceramic jars, 26 bowls, 5 pots, 5 ladles, 2 vases, 2 mugs, 2 beads, 1 figure, 1 chert flake, 1 lot of paint, and 1 piki stone.

In 1901, human remains representing a minimum of 180 individuals were removed from Old Walpi on the Hopi Indian Reservation, Coconino County, AZ, by Charles L. Owen for the Field Museum of Natural History (Field Museum accession numbers 769, 780). No known individuals were identified. The 100 associated funerary objects are 30 ceramic jars, 26 bowls, 16 pots, 5 bahos, 4 pitchers, 6 ladles, 3 vases, 2 mugs, 1 lot of stone images, 1 lot of stone slabs, 4 faunal remains, 1 bead, and 1 seed.

The human remains have been identified as Native American based on the burial context and the specific cultural and geographic attribution in Field Museum of Natural History records. All of the remains were identified as "Hopi" from archeological sites on the Hopi Indian Reservation, AZ. "Hopi" descendants from the Hopi

Indian Reservation are represented by the present-day Hopi Tribe of Arizona.

Officials of the Field Museum of Natural History have determined that, pursuant to 25 U.S.C. 3001(9), the human remains described above represent the physical remains of 251 individuals of Native American ancestry. Officials of the Field Museum of Natural History also have determined that, pursuant to 25 U.S.C. 3001(3)(A), the 151 objects described above are reasonably believed to have been placed with or near individual human remains at the time of death or later as part of the death rite or ceremony. Officials of the Field Museum of Natural History have determined that, pursuant to 25 U.S.C. 3001(2), there is a relationship of shared group identity that can be reasonably traced between the Native American human remains and associated funerary objects and the Hopi Tribe of Arizona.

Representatives of any other Indian tribe that believes itself to be culturally affiliated with the human remains and associated funerary objects should contact Helen Robbins, Repatriation Director, Field Museum of Natural History, 1400 South Lake Shore Dr., Chicago, IL 60605–2496, telephone (312) 665–7317, before September 2, 2010. Repatriation of the human remains and associated funerary objects to the Hopi Tribe of Arizona may proceed after that date if no additional claimants come forward.

The Field Museum of Natural History is responsible for notifying the Hopi Tribe of Arizona that this notice has been published.

Dated: July 26, 2010

Sherry Hutt,

Manager, National NAGPRA Program.

[FR Doc. 2010–18990 Filed 8–2–10; 8:45 am]

BILLING CODE 4312–50–S

DEPARTMENT OF THE INTERIOR

National Park Service

Notice of Inventory Completion: Tennessee Department of Environment and Conservation, Division of Archaeology, Nashville, TN

AGENCY: National Park Service, Interior.

ACTION: Notice.

Notice is here given in accordance with the Native American Graves Protection and Repatriation Act (NAGPRA), 25 U.S.C. 3003, of the completion of an inventory of human remains and associated funerary objects in the possession of the Tennessee Department of Environment and Conservation, Division of Archaeology, Nashville, TN. The human remains and associated funerary objects were removed from the Fewkes archeological site (40WM1), Williamson County, TN.

This notice is published as part of the National Park Service's administrative responsibilities under NAGPRA, 25 U.S.C. 3003(d)(3) and 43 CFR 10.11(d). The determinations in this notice are the sole responsibility of the museum, institution, or Federal agency that has control of the Native American human remains and associated funerary objects. The National Park Service is not responsible for the determinations in this notice.

A detailed assessment of the human remains was made by the Tennessee Department of Environment and Conservation, Division of Archaeology, professional staff in consultation with representatives of the Absentee-Shawnee Tribe of Oklahoma; Alabama-Quassarte Tribal Town, Oklahoma; Cherokee Nation, Oklahoma; Chickasaw Nation, Oklahoma; Choctaw Nation of Oklahoma; Eastern Band of Cherokee Indians of North Carolina; Eastern Shawnee Tribe of Oklahoma; Kialegee Tribal Town, Oklahoma; Muscogee (Creek) Nation, Oklahoma; Poarch Band of Creek Indians, Alabama; Quapaw Tribe of Oklahoma; Seminole Nation of Oklahoma; Shawnee Tribe, Oklahoma; Thlopthlocco Tribal Town, Oklahoma; and the United Keetoowah Band of Cherokee Indians, Oklahoma.

In 1998, human remains representing a minimum of 21 individuals were removed from the Fewkes archeological site (40WM1), in Williamson County, TN, by a Tennessee Department of Transportation contractor during a data recovery excavation for a state-funded road improvement project. In August 1999, the individuals were transferred from the Tennessee Department of Transportation contractor to the Tennessee Department of Environment and Conservation, Division of Archaeology. In February 2008, the associated funerary objects were transferred. No known individuals were identified. The 17 associated funerary objects are 2 ceramic earplugs, 1 ceramic earplug fragment, 1 ceramic Beckwith Incised frog effigy jar, 1 ceramic human effigy hooded bottle, 1 ceramic Matthews Incised frog effigy jar, 1 ceramic disk, 1 Clovis biface/preform, 2 Madison-style projectile points, 1 Sand Mountain-style projectile point, 2 greenstone celts, 1 shale gorget, 1 turkey bone awl, 1 drilled dog tooth, and 1 bone pin fragment.

The Fewkes archeological site (40WM1) is a late prehistoric Mississippian period mound center located in Brentwood, Williamson County, TN. In October 1920, William E. Myer conducted the first recorded exploration of this site for the Smithsonian Institution. The results of this exploration were published in the 41st Annual Report of the Bureau of American Ethnology (pages 561–615), in 1928. Myer recorded five mounds (platform and burial), an extensive habitation area, and numerous "stone-box" graves during his investigation. Among the recovered artifacts were shell-tempered pottery jars, bowls, bottles, and pans. The recorded earthworks, stone-box graves, and shell-tempered ceramic vessels provide unequivocal evidence that this site dates to the Mississippian period in middle Tennessee, approximately A.D. 1000–1475. Results from modern archeological investigations at the site support this cultural assignment (Tennessee Department of Transportation, 1995–1998; Middle Tennessee State University, 2004; and Tennessee Department of Environment and Conservation, Division of Archaeology, 2006).

Extensive archeological research within the Middle Cumberland River valley has identified a virtual abandonment of the area by native residents around A.D. 1450 (K. Smith 1992; Moore et al. 2006; Moore and Smith 2009). This drastic population reduction has been studied as supporting evidence for the "Vacant Quarter" hypothesis (Williams 1990; Cobb and Butler 2002). This hypothesis notes the general abandonment of Mississippian sites within portions of the Ohio, Mississippi, Tennessee, and Cumberland River drainages around A.D. 1450–1550. Given the current level of archeological knowledge, and that there are no tribal lands in Tennessee, officials of the Tennessee Department of Environment and Conservation, Division of Archaeology, are not able to identify the descendants of the Fewkes site residents.

Officials of the Tennessee Department of Environment and Conservation, Division of Archaeology, have determined that, pursuant to 25 U.S.C. 3001(2), a relationship of shared group identity cannot be reasonably traced between the Native American human remains and associated funerary objects and any present-day Indian tribe.

The Eastern Band of Cherokee Indians of North Carolina is the aboriginal land tribe under 43 CFR 10.11(c)(1), according to the decision of the Indian Claims Commission (Land Claim Map 137). In addition, the Cherokee Nation, Oklahoma; Eastern Band of Cherokee Indians of North Carolina; and the

United Keetoowah Band of Cherokee Indians, Oklahoma, are named in treaties for 1784–1894 Land Cessions in Williamson County, TN (Map 13). On February 29, 2008 and June 26, 2008, the Tennessee Department of Environment and Conservation, Division of Archaeology, consulted with these Indian tribes recognized as aboriginal to the area from which these Native American human remains and associated funerary objects were removed.

The Secretary of the Interior may make a recommendation for the culturally unidentifiable human remains to be reinterred under State or other law. In May 2010, officials of the Tennessee Department of Environment and Conservation, Division of Archaeology, requested that the Secretary, through the Native American Graves Protection and Repatriation Review Committee (Review Committee), recommend reinterment of the Native American human remains and associated funerary objects according to State law, 43 CFR 10.11(c)(2)(ii). The request is to reinter under Tennessee state law (T.C.A. 11–6–119), which requires the reburial of Native American skeletal remains and associated funerary objects. In addition, the Chickasaw Nation, Oklahoma, will lead the reburial of the removed individuals and associated funerary objects on the Fewkes site property in a location selected by the Tennessee Department of Environment and Conservation, Division of Archaeology, and approved by the City of Brentwood, Williamson County, TN. The Chickasaw Nation has performed previous reburials of Mississippian period human remains and associated burial objects from middle Tennessee. Finally, the Tennessee Department of Environment and Conservation, Division of Archaeology, has provided proof that consultation has occurred with all Indian tribes from whose aboriginal lands the Native American human remains and associated funerary objects were removed, and that none have objected to the reinterment.

On June 11, 2010, the Review Committee considered the proposal for reinterment and concurred with the proposal. The Secretary of the Interior considered the Review Committee's recommendation in favor of the proposal and independently concurred with it. A June 16, 2010, letter from the Designated Federal Officer, writing on behalf of the Secretary of the Interior, transmitted the authorization for the Tennessee Department of Environment and Conservation, Division of Archaeology, to reinter the culturally unidentifiable individuals under Tennessee state law (T.C.A 11–6–119), contingent on the publication of a Notice of Inventory Completion in the **Federal Register**. This notice fulfills that requirement. In the same letter, the Secretary of the Interior recommended the reinterment of the associated funerary objects to the extent allowed by Federal, state, or local law.

Officials of the Tennessee Department of Environment and Conservation, Division of Archaeology, have determined that, pursuant to 25 U.S.C. 3001(9), the human remains described above represent the physical remains of 21 individuals of Native American ancestry. Officials of the Tennessee Department of Environment and Conservation, Division of Archaeology, also have determined that, pursuant to 25 U.S.C. 3001(3)(A), the 17 objects described above were placed with the individual human remains at the time of death or later as part of the death rite or ceremony. Lastly, officials of the Tennessee Department of Environment and Conservation, Division of Archaeology, have received a recommendation by the Secretary of the Interior, pursuant to 43 CFR 10.11(c)(2)(ii), that the human remains and associated funerary objects can be reinterred according to Tennessee state law (T.C.A 11–6–119).

Representatives of any Indian tribe that believes itself to be culturally affiliated with the human remains and associated funerary objects or any other Indian tribe that believes it satisfies the criteria in 43 CFR 10.11(c)(1) should contact Michael C. Moore, Tennessee Division of Archaeology, 1216 Foster Ave., Cole Bldg 13, Nashville, TN 37243, telephone (615) 741–1588, before September 2, 2010. The human remains and associated funerary objects may be reinterred after that date if no additional claimants come forward.

The Tennessee Department of Environment and Conservation, Division of Archaeology, is responsible for notifying the Absentee-Shawnee Tribe of Oklahoma; Alabama-Quassarte Tribal Town, Oklahoma; Cherokee Nation, Oklahoma; Chickasaw Nation, Oklahoma; Choctaw Nation of Oklahoma; Eastern Band of Cherokee Indians of North Carolina; Eastern Shawnee Tribe of Oklahoma; Kialegee Tribal Town, Oklahoma; Muscogee (Creek) Nation, Oklahoma; Poarch Band of Creek Indians, Alabama; Quapaw Tribe of Oklahoma; Seminole Nation of Oklahoma; Shawnee Tribe, Oklahoma; Thlopthlocco Tribal Town, Oklahoma; and the United Keetoowah Band of Cherokee Indians, Oklahoma, that this notice has been published.

Dated: July 26, 2010

Sherry Hutt,

Manager, National NAGPRA Program.

[FR Doc. 2010–18991 Filed 8–2–10; 8:45 am]

BILLING CODE 4312–50–S

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[LLIDB00100 L17110000.PH0000 241A 4500013040]

Notice of Permanent Closure on Public Lands in Ada County, ID

AGENCY: Bureau of Land Management, Interior.

ACTION: Notice of permanent closure.

SUMMARY: On April 12, 2010, Higby Cave and all public lands within 1,000 feet of the entrance were permanently closed to vehicle access and public use at all times, due to changes in the cave's structural integrity and related potential hazards. The cave entrance has been gated and access limited to BLM-permitted and administrative activities. Exempt from this order are BLM employees, authorized permittees, and other Federal, State and County employees while on official business of their respective agencies, including associated vehicle use for administrative and emergency purposes.

DATES: This closure of public land became effective on April 12, 2010.

FOR FURTHER INFORMATION CONTACT: Jarod Fluckiger, Outdoor Recreation Planner, Morley Nelson Snake River Birds of Prey National Conservation Area at the Boise District Office, 3948 Development Avenue, Boise, Idaho 83705, via e-mail at *jarod_fluckiger@blm.gov,* or phone (208) 384–3342.

SUPPLEMENTARY INFORMATION: Higby Cave lies in the S½NW¼ NW¼ and N½SW¼ NW¼ of Section 32, T.1 S., R.3 E., Boise Meridian, Ada County, Idaho, in an area containing approximately 72 acres. This closure is intended to provide for public safety and protect public land and resources from further degradation. The cave entrance has been enclosed with a bat-friendly gate, and vehicle access to the area around the cave is now blocked by the placement of large rocks at the closure perimeter. Signs have also been posted at routes leading into the area.

The decision to close Higby Cave was analyzed in the Snake River Birds of Prey National Conservation Area (NCA) Proposed Resource Management Plan/Final Environmental Impact Statement (2008), and in the Environmental

Assessment (2010) to implement the decision.

This closure is established and administered by the BLM under the authority of Section 303(a) of the Federal Land Policy and Management Act of 1976 (43 U.S.C. 1733(a)) and complies with 43 CFR 8364.1 (Closure and Restriction Orders). In accordance with 43 CFR 8360.0–7, violation of this order is punishable by a fine not to exceed $1,000 and/or imprisonment not to exceed 12 months. Violators may also be subject to the enhanced fines provided for in 18 U.S.C. 3571.

Definitions: (a) "Public lands" means any lands or interests in lands owned by the United States and administered by the Secretary of the Interior through the Bureau of Land Management; (b) "Administrative purposes" means any use by an employee or designated representative of the Federal government or one of its agents or contractors in the course of their employment or representation; and (c) "Emergency purposes" means actions related to fire, rescue or law enforcement activities.

Terry Humphrey,

Four Rivers Field Manager.

[FR Doc. 2010–19049 Filed 8–2–10; 8:45 am]

BILLING CODE 4310–GG–P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[LLCAC09000–14300000–ET; CACA 51408]

Notice of Proposed Withdrawal and Opportunity for Public Meeting; California

AGENCY: Bureau of Land Management, Interior.

ACTION: Notice.

SUMMARY: The Assistant Secretary of the Interior for Land and Minerals Management proposes to withdraw approximately 28,953 acres of public lands from location and entry under the United States mining laws (30 U.S.C. 22 *et seq.*) for a period of 20 years, on behalf of the Bureau of Land Management (BLM), to limit impacts to public safety and human health from naturally occurring asbestos and past mining activities within the Clear Creek Management Area (CCMA). This notice temporarily segregates the lands for up to 2 years from location and entry under the United States mining laws (30 U.S.C. 22 *et seq.*) while various studies and analyses are made to support a final decision on the withdrawal application. In addition, approximately 3,763 acres of non-Federal lands located inside of the boundary of the proposed withdrawal area, if acquired by or returned to the United States, would also be included in the proposed withdrawal and subject to the temporary segregation authorized by this notice.

DATES: Comments and meeting requests should be received on or before November 1, 2010.

ADDRESSES: Comments should be sent to Rick Cooper, Field Manager, Hollister Field Office, Bureau of Land Management, 20 Hamilton Court, Hollister, California 95023.

FOR FURTHER INFORMATION CONTACT: Dan Byrne, Hollister Field Office, BLM, 831–630–5031 or Brandon G. Anderson, California State Office, BLM, 916–978–4674.

SUPPLEMENTARY INFORMATION: The BLM ordered the temporary closure of 31,000 acres of public lands in the CCMA on May 1, 2008, based on the results of the Environmental Protection Agency's (EPA) CCMA Asbestos Exposure and Human Health Risk Assessment. Using activity-based air sampling methods, the EPA concluded that visiting the CCMA more than once per year can put adults and children above the EPA's acceptable risk range for exposure to carcinogens.

The applicant for the proposed withdrawal is the BLM at the address stated above. The petition/application requests the Assistant Secretary for Land and Minerals Management to withdraw, for a period of 20 years and subject to valid existing rights, the following described public lands from location and entry under the United States mining laws (30 U.S.C. 22 *et seq.*), but not the public land, mineral or geothermal leasing, or the mineral materials laws:

(a) Public Lands.

Mount Diablo Meridian

T. 17 S., R. 11 E.,
- Sec. 25, lots 5, 6, and 10 to 15, inclusive;
- Sec. 26, lots 15, 16, and 20;
- Sec. 34, lots 16, 18, 19, and Mineral Survey No. 5253, not patented;
- Sec. 35;
- Sec. 36, lots 10 to 16, inclusive.

T. 18 S., R. 11 E.,
- Sec. 1;
- Sec. 2, lots 1 to 9, inclusive, S½N½, NW¼SW¼, and N½SE¼;
- Sec. 3, S½NE¼, SE¼SW¼, and SE¼;
- Sec. 10, E½ and E½W½;
- Sec. 11, lots 1 to 4, inclusive, SW¼NE¼, W½, NW¼SE¼, and S½SE¼;
- Sec. 12, lots 1 to 5, inclusive, E½, NE¼SW¼, and S½SW¼;
- Sec. 13, lots 1 to 5, inclusive, NW¼NW¼, S½NW¼, and S½;
- Sec. 14;
- Sec. 15, NE¼, E½NW¼, NE¼SW¼, and N½SE¼;
- Sec. 23, N½NE¼, SE¼NE¼, and NE¼NW¼;
- Sec. 24, N½ and SE¼.

T. 17 S., R. 12 E.,
- Sec. 31, lots 3, 4, and 6 to 20, inclusive;
- Sec. 32, lots 11 to 14, inclusive, and 16;
- Sec. 33, W½W½ and SE¼SW¼.

T. 18 S., R. 12 E.,
- Sec. 3, SW¼NW¼, W½SW¼, and SE¼SW¼;
- Sec. 4, lots 1 to 17, inclusive, SW¼NW¼, SW¼, and S½SE¼;
- Secs. 5, 6, and 7;
- Sec. 8, lots 1, 2, 4, 5, 7, 8, 9, 11, 12, NW¼SW¼, and S½SW¼;
- Secs. 9 and 10;
- Sec. 11, lots 2, 3, 4, and SE¼;
- Sec. 12, SW¼;
- Sec. 13, lots 2 to 6, inclusive, lot 8, W½NE¼, NW¼, N½SW¼, and NW¼SE¼;
- Secs. 14 and 15;
- Sec. 17, lots 1 and 2, NE¼, NE¼NW¼, W½NW¼, and E½SE¼;
- Sec. 18, lots 1 to 14, inclusive, and N½NE¼;
- Sec. 19, lots 1 to 6, inclusive, S½NE¼, E½W½, and SE¼;
- Sec. 20, E½, S½NW¼, and SW¼;
- Sec. 21, N½;
- Sec. 22, NE¼NE¼, S½NE¼, NW¼, and S½;
- Secs. 23 and 24;
- Sec. 25, lots 1, 3 to 6, inclusive, 8, 9, 11, 14, W½, and W½SE¼;
- Sec. 26, N½;
- Sec. 27, N½, N½S½, and S½SE¼;
- Sec. 28, NE¼ and SE¼NW¼;
- Sec. 29, N½N½;
- Sec. 30, lot 1 and NE¼NE¼;
- Sec. 34, NE¼NE¼;
- Sec. 35, N½, NE¼SW¼, and N½SE¼.

T. 18 S., R. 13 E.,
- Sec. 16, NW¼SW¼;
- Sec. 17, SW¼NE¼ and S½;
- Sec. 18, lots 2, 3, 4, and E½SE¼;
- Sec. 19, lots 1 to 4, inclusive, and E½E½;
- Secs. 20 and 21;
- Sec. 22, NW¼NW¼, NE¼SW¼, and S½SW¼;
- Sec. 27, NW¼NE¼, NE¼NW¼, SW¼NW¼, W½SW¼, S½SE¼SW¼, and S½S½SE¼;
- Secs. 28 to 31, inclusive;
- Sec. 32, all excluding Mineral Survey Nos. 6696 and 6724, both patented;
- Sec. 33, all excluding that portion of Mineral Survey No. 6680, patented and contained therein;
- Sec. 34, N½ and N½S½ excluding that portion of Mineral Survey No. 6680, patented and contained therein;
- Sec. 35, N½N½NW¼.

T. 19 S., R. 13 E.,
- Sec. 2, lot 4 and SW¼NW¼;
- Sec. 3, lots 1 to 4, inclusive, S½NE¼, S½NW¼, and SW¼;
- Sec. 4, lots 1 to 4, inclusive, S½N½, and S½;
- Sec. 5, lots 1 to 4, inclusive, S½N½, N½S½, and SE¼SE¼;
- Sec. 6, lot 1 and SE¼NE¼.

The areas described aggregate 28,953.097 acres, more or less, in Fresno and San Benito Counties.

(b) The following described non-Federal lands are located within the boundaries of the proposed withdrawal areas. In the event that these non-Federal lands return to public ownership, they would be subject to the terms and conditions described above.

Mount Diablo Meridian

Non-Federal lands

T. 18 S., R. 11 E.,
Secs. 2, 11, and 12, Mineral Survey No. 29, patented;
Secs. 11 and 12, Mineral Survey No. 504, patented;
Sec. 13, Mineral Survey No. 1417, patented.
T. 18 S., R12 E.,
Sec. 4, Mineral Survey Nos. 1087, 1099, and 1185, all patented;
Secs. 7, 18, and 19, Mineral Survey No. 1417, patented;
Sec. 8, lots 3, 6, and 10, NE¼SW¼;
Sec. 13, lot 7, S½SW¼, and SW¼SE¼;
Sec. 16;
Sec. 17, SE¼NW¼, E½SW¼, and W½SE¼;
Secs. 17, 18, 19, and 20, Mineral Survey No. 1418, patented;
Sec. 20, lot 1 and NE¼NW¼;
Sec. 22, NW¼NE¼;
Sec. 25, lots 2, 7, 10, 12, and 13, Mineral Survey No. 4976, patented;
Sec. 26, S½;
Sec. 36.
T. 18 S., R. 13 E.,
Sec. 32, Mineral Survey Nos. 6696 and 6724, both patented;
Secs. 33 and 34, Mineral Survey No. 6680, both patented;
Sec. 34, S½S½.

The areas described aggregate 3,763 acres, more or less, in Fresno and San Benito Counties.

The BLM's petition has been approved by the Assistant Secretary for Land and Minerals Management. Therefore, the petition constitutes a withdrawal proposal of the Secretary of the Interior (43 CFR 2310.1–3(e)).

The purpose of the proposed withdrawal is to minimize impacts to human health and the environment from hazardous emissions of airborne asbestos fibers associated with mining activities on the 33,000-acre portion of the CCMA designated as the Serpentine Area of Critical and Environmental Concern (ACEC).

The use of a right-of-way, interagency agreement, or cooperative agreement would not adequately constrain non-discretionary uses that could irrevocably expose to excess lifetime cancer risks.

There are no suitable alternative sites for the requested withdrawal.

No water rights would be needed to fulfill the purpose of the requested withdrawal.

A preliminary review of mineral resources in the subject area determined that no mineral leases are known to exist in the subject area and no known potential for commercial fossil fuel or geothermal energy minerals exists in the subject area. Asbestos, mercury, chromite, and magnesite are among the only locatable minerals of interest in the area, although none are expected to be commercially important commodities in the foreseeable future. Nevertheless, the KCAC mine, formerly owned and operated by Union Carbide, Corp., is still considered an active mining claim, even though asbestos production ceased after 2002. Other locatable minerals of interest, including precious gem-quality benitoite and semi-precious jadeite, continue to be mined intermittently on a small-scale in the subject area. Mining and production of these gem minerals has been occurring for decades on public and privately owned lands in the ACEC. This proposed withdrawal would be subject to valid existing rights and therefore would not prohibit future exploration or mining activities on valid pre-existing claims.

Until November 1, 2010, all persons who wish to submit comments, suggestions, or objections in connection with the proposed withdrawal may present their views in writing, by the date specified above, to the Field Manager, Hollister Field Office, BLM, 20 Hamilton Court, Hollister, California 95023.

Comments, including names and street addresses for respondents, will be available for public review at the BLM's Hollister Field Office, during regular business hours, 7:30 a.m. to 4 p.m., Monday through Friday, except holidays. Individual respondents may request confidentiality. Before including your address, telephone number, e-mail address, or other personal identifying information in your comment, you should be aware the your entire comment—including your personal identifying information—may be publicly available at any time. While you can ask us in your comment to withhold your personal identifying information from public review, we cannot guarantee that we will be able to do so. All submissions from organization or businesses, and from individuals identifying themselves as representatives or officials of organizations or businesses, will be made available for public inspection in their entirety.

Notice is hereby given that at least one public meeting will be held in connection with the proposed withdrawal. Upon determination of the time and place a notice will be published in the **Federal Register** and a local newspaper at least 30 days prior to the scheduled date of the meetings. All interested persons who desire additional public meetings for the purpose of being heard on the proposed withdrawal must submit a written request to the Field Manager, Hollister Field Office, BLM, 20 Hamilton Court, Hollister, California 95023, no later than November 1, 2010.

The application will be processed in accordance with the regulations set forth in 43 CFR part 2300.

For a period of 2 years from August 3, 2010, the lands described in this notice will be segregated as specified above unless the application is denied or canceled or the withdrawal is approved prior to that date.

Licenses, permits, cooperative agreement, or discretionary land use authorizations of a temporary nature which will not significantly impact the values to be protected by the withdrawal may be allowed with the approval of the authorized officer of the BLM during the segregative period.

Authority: 43 CFR 2310.3–1(a).

Karla Norris,

Assistant Deputy State Director, Natural Resources (CA–930).

[FR Doc. 2010–19050 Filed 8–2–10; 8:45 am]

BILLING CODE 4310–40–P

INTERNATIONAL TRADE COMMISSION

[Inv. No. 337–TA–730]

In the Matter of: Certain Inkjet Ink Supplies and Components Thereof; Corrected Notice of Investigation

AGENCY: U.S. International Trade Commission.

ACTION: Institution of investigation pursuant to 19 U.S.C. 1337

SUMMARY: Notice is hereby given that a complaint was filed with the U.S. International Trade Commission on June 25, 2010, under section 337 of the Tariff Act of 1930, as amended, 19 U.S.C. 1337, on behalf of Hewlett-Packard Company of Palo Alto, California and Hewlett-Packard Development Company, L.P. of Houston, Texas. Letters supplementing the complaint were filed on July 15, 2010 and July 27, 2010. The complaint alleges violations of section 337 based upon the importation into the United States, the sale for importation, and the sale within the United States after importation of certain inkjet ink supplies and components thereof by reason of infringement of certain claims of U.S. Patent No. 6,959,985 ("the '985 patent") and U.S. Patent No. 7,104,630 ("the '630

patent"). The complaint further alleges that an industry in the United States exists as required by subsection (a)(2) of section 337.

The complainants request that the Commission institute an investigation and, after the investigation, issue an exclusion order and cease and desist orders.

ADDRESSES: The complaint, except for any confidential information contained therein, is available for inspection during official business hours (8:45 a.m. to 5:15 p.m.) in the Office of the Secretary, U.S. International Trade Commission, 500 E Street, SW., Room 112, Washington, DC 20436, telephone 202–205–2000. Hearing impaired individuals are advised that information on this matter can be obtained by contacting the Commission's TDD terminal on 202–205–1810. Persons with mobility impairments who will need special assistance in gaining access to the Commission should contact the Office of the Secretary at 202–205–2000. General information concerning the Commission may also be obtained by accessing its internet server at *http://www.usitc.gov.* The public record for this investigation may be viewed on the Commission's electronic docket (EDIS) at *http://edis.usitc.gov.*

FOR FURTHER INFORMATION CONTACT: Anne Goalwin, Esq., Office of Unfair Import Investigations, U.S. International Trade Commission, telephone (202) 205–2574.

Authority: The authority for institution of this investigation is contained in section 337 of the Tariff Act of 1930, as amended, and in section 210.10 of the Commission's Rules of Practice and Procedure, 19 CFR 210.10 (2010).

Scope of Investigation: Having considered the complaint, the U.S. International Trade Commission, on July 26, 2010, ordered that—

(1) Pursuant to subsection (b) of section 337 of the Tariff Act of 1930, as amended, an investigation be instituted to determine whether there is a violation of subsection (a)(1)(B) of section 337 in the importation into the United States, the sale for importation, or the sale within the United States after importation of certain inkjet ink supplies or components thereof that infringe one or more of claims 1–5, 7, 22–25, and 27–28 of the '985 patent and claims 1–7, 11–12, 14, 26–30, 32, and 34–35 of the '630 patent, and whether an industry in the United States exists as required by subsection (a)(2) of section 337;

(2) For the purpose of the investigation so instituted, the following are hereby named as parties upon which this notice of investigation shall be served:

(a) The complainants are:

Hewlett-Packard Company, 3000 Hanover Street, Palo Alto, California 94304;

Hewlett-Packard Development Company, L.P., 11455 Compaq Center Drive West, Houston, Texas 77070.

(b) The respondents are the following entities alleged to be in violation of section 337, and are the parties upon which the complaint is to be served:

Mipo International Ltd., 1600 Atlanta Financial Center, 3343 Peachtree Road, NE., Atlanta, Georgia 30326;

Mextec Group Inc., c/o The Law Office of Hongwei Shang, LLC, 9100 S. Dadeland Blvd., Suite 1500, Miami, Florida 33156;

Shanghai Angel Printer Supplies Co. Ltd., Room 1208, No. 495, Jiangning Road, Shanghai, China 200233;

Shenzhen Print Media Co., Ltd., #310, Huayuan Business Building, Xixiang Town, Baoan District, Shenzhen, Guangdong, China 518102;

Zhuhai National Resources & Jingjie Imaging, Products Co., Ltd., No. 1 Industrial Building, Pingdong 2 Road, Nanping S&T Industrial Community, Zhuhai, Guangdong, China 519060;

Tatrix International, 10 C, Garden Building, No. 1083 JiuZhou Road, Jida, Zhuhai, Guangdong, China 519015;

Ourway Image Co., Ltd., 15F, No. 125 Renmin East Road, Xiangzhong, Zhuhai, Guangdong, China 33156.

(c) The Commission investigative attorney, party to this investigation, is Anne Goalwin, Esq., Office of Unfair Import Investigations, U.S. International Trade Commission, 500 E Street, SW., Suite 401, Washington, DC 20436; and

(3) For the investigation so instituted, the Honorable Paul J. Luckern, Chief Administrative Law Judge, U.S. International Trade Commission, shall designate the presiding Administrative Law Judge.

Responses to the complaint and the notice of investigation must be submitted by the named respondents in accordance with section 210.13 of the Commission's Rules of Practice and Procedure, 19 CFR 210.13. Pursuant to 19 CFR 201.16(d)–(e) and 210.13(a), such responses will be considered by the Commission if received not later than 20 days after the date of service by the Commission of the complaint and the notice of investigation. Extensions of time for submitting responses to the complaint and the notice of investigation will not be granted unless good cause therefor is shown.

Failure of a respondent to file a timely response to each allegation in the complaint and in this notice may be deemed to constitute a waiver of the right to appear and contest the allegations of the complaint and this notice, and to authorize the administrative law judge and the Commission, without further notice to the respondent, to find the facts to be as alleged in the complaint and this notice and to enter an initial determination and a final determination containing such findings, and may result in the issuance of an exclusion order or a cease and desist order or both directed against the respondent.

By order of the Commission.

Issued: July 28, 2010.

Marilyn R. Abbott,

Secretary to the Commission.

[FR Doc. 2010–19006 Filed 8–2–10; 8:45 am]

BILLING CODE 7020–02–P

DEPARTMENT OF JUSTICE

Justice Management Division

[OMB Number 1103–0018]

Agency Information Collection Activities; Proposed Collection; Comments Requested

ACTION: 30-Day Notice of Information Collection Under Review: Extension of Previously Approved Collection, Department of Justice Procurement Blanket Clearance.

The Department of Justice (DOJ), Justice Management Division, will be submitting the following information collection request to the Office of Management and Budget (OMB) for review and approval in accordance with the Paperwork Reduction Act of 1995. The proposed information collection is published to obtain comments from the pubic and affected agencies. This proposed information collection was previously published in the **Federal Register** (Volume 75, Number 105, page 30858) on June 2, 2010, allowing for a 60 day public comment period.

The purpose of this notice is to allow an additional 30 days for public comments. Comments are encouraged and will be accepted until September 2, 2010. This process is conducted in accordance with 5 CFR 3120.10.

Written comments and/or suggestions regarding the items contained in this notice, especially regarding the estimated public burden and associated response time, should be directed to the Office of Management and Budget, Office of Information and Regulatory

Affairs, Attention: Department of Justice Desk Officer, Washington, DC 20503. Additionally, comments may be submitted to OMB via facsimile on 202–395–7285.

Written comments and suggestions from the public and affected agencies concerning the proposed collection of information are encouraged. Your comments should address one or more of the following four points:

—Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;

—Evaluate the accuracy of the agencies estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;

—Enhance the quality, utility, and clarity of the information to be collected; and

—Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, *e.g.,* permitting electronic submission of responses.

Overview of This Information Collection

(1) *Type of Information Collection:* Extension of a currently approved collection.

(2) *Title of the Form/Collection:* Department of Justice Procurement Blanket Clearance.

(3) *Agency form number, if any, and the applicable component of the Department of Justice sponsoring the collection: Form Number:* None. *Sponsor:* Justice Management Division.

(4) *Affected public who will be asked or required to respond, as well as a brief abstract. Primary:* Commercial organizations and individuals who voluntarily submit offers and bids to compete for contract awards to provide supplies and services required by the Government. All work statements and pricing data are required to evaluate the contractors bid or proposal.

(5) *An estimate of the total number of respondents and the amount of time estimated for an average respondent to respond:* It is estimated that 5,996 respondents will complete each form, with a total of 20 hours average response time.

(6) *An estimate of the total public burden (in hours) associated with the collection:* There are an estimated 119,920 total annual burden hours associated with this collection.

If additional information is required contact: Ms. Lynn Bryant, Department Clearance Officer, United States Department of Justice, Justice Management Division, Policy and Planning Staff, Two Constitution Square, 145 N Street, NE., Suite 2E–502, Washington, DC 20530.

Dated: July 21, 2010.

Lynn Bryant,

Department Clearance Officer, PRA, U.S. Department of Justice.

[FR Doc. 2010–18225 Filed 8–2–10; 8:45 am]

BILLING CODE 4410–FB–P

DEPARTMENT OF JUSTICE

[OMB Number 1105–0086]

Justice Management Division; Office of Attorney Recruitment and Management; Agency Information Collection Activities: Proposed Collection; Comments Requested

ACTION: 30-Day Notice of Information Collection Under Review: Applications for Attorney Student Loan Repayment Program.

The U.S. Department of Justice (DOJ), Justice Management Division, Office of Attorney Recruitment and Management (OARM), will be submitting the following information collection request for review and clearance in accordance with the Paperwork Reduction Act of 1995. Office of Management and Budget (OMB) approval is sought for the information collection listed below. This proposed information collection was previously published in the **Federal Register** on October 4, 2010, allowing for a 60-day public comment period.

The purpose of this notice is to allow an additional 30 days for public comment until October 4, 2010. This process is conducted in accordance with 5 CFR 1320.10.

Written comments and/or suggestions regarding the item(s) contained in this notice, especially regarding the estimated public burden and associated response time, should be directed to the Office of Management and Budget, Office of Information and Regulatory Affairs, Attention: Department of Justice Desk Officer, Washington, DC 20530. Additionally, comments may be submitted to OMB via facsimile to 202–395–7285. Comments may also be submitted to the Department Clearance Officer, United States Department of Justice, Suite 1600, 601 D Street, NW., Washington, DC 20530.

Written comments and suggestions from the public and affected agencies should address one or more of the following four points:

(1) Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;

(2) Evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;

(3) Enhance the quality, utility, and clarity of the information to be collected; and

(4) Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, *e.g.,* permitting electronic submission of responses.

Overview of This Information Collection

(1) *Type of Information Collection:* Proposed new collection.

(2) *Title of the Form/Collection:* Applications for Attorney Student Loan Repayment Program.

(3) *Agency form number, if any, and the applicable component of the Department sponsoring the collection: Form Number:* none. Office of Attorney Recruitment and Management, Justice Management Division, U.S. Department of Justice.

(4) *Affected public who will be asked or required to respond, as well as a brief abstract: Primary:* Individuals or households. *Other:* None. The Department of Justice Attorney Student Loan Repayment Program (ASLRP) is an agency recruitment and retention incentive program based on 5 U.S.C. 5379, as amended, and 5 CFR Part 537. The Department selects participants during an annual open season each spring. Any one currently employed as an attorney or hired to serve in an attorney position within the Department may request consideration for the ASLRP. The Department selects new attorneys each year for participation on a competitive basis and renews current beneficiaries who remain qualified for these benefits, subject to availability of funds. There are two types of application forms—one is for new requests, and the other for renewal requests. In addition, there is a three-year service agreement form, and a one-year service extension form.

(5) An estimate of the total number of respondents and the amount of time estimated for an average respondent to

respond/reply: The Department anticipates that on a yearly basis, about 300 respondents will complete the application for a new request. In addition, each year the Department expects to receive approximately 175 applications from attorneys and law clerks requesting renewal of the benefits they received in previous years. It is estimated that each new application will take one (1) hour to complete, and each renewal application approximately 15 minutes to complete.

(6) An estimate of the total public burden (in hours) associated with the collection: The total estimated annual public burden associated with this collection is 250 hours.

If additional information is required, contact Lynn Bryant, Department Clearance Officer, United States Department of Justice, Justice Management Division, Policy and Planning Staff, Two Constitution Square, 145 N Street, NE., Suite 2E–502, Washington, DC 20530.

Dated: July 21, 2010.

Lynn Bryant,

Department Clearance Officer, PRA, United States Department of Justice.

[FR Doc. 2010–18224 Filed 8–2–10; 8:45 am]

BILLING CODE 4410–PB–P

DEPARTMENT OF JUSTICE

Notice of Lodging of Consent Decree Under the Comprehensive Environmental Response, Compensation, and Liability Act of 1980 ("CERCLA")

Notice is hereby given that on July 28, 2010, a proposed Consent Decree in *United States* v. *BIM Investment Corp. et al.,* Civil Action No. 1:10-cv-11263, was lodged with the United States District Court for the District of Massachusetts.

The Consent Decree resolves claims brought by the United States, on behalf of the United States Environmental Protection Agency ("EPA"), against four parties ("Settling Defendants") under Sections 106 and 107 of the Comprehensive Environmental Response, Compensation, and Liability Act, 42 U.S.C. 9606 and 9607. In its Complaint, filed concurrently with the Consent Decree, the United States sought injunctive relief in order to address the release or threatened release of hazardous substances at or from the Blackburn and Union Privileges Superfund Site in Walpole, Massachusetts (the "Site"), along with the recovery of costs the United States incurred for response activities undertaken at the Site.

Under the Consent Decree, the Settling Defendants—BIM Investment Corporation, Shaffer Realty Nominee Trust, Tyco Healthcare Group LP, and W.R. Grace & Co.-Conn.—will implement the remedy selected by EPA for the Site, including the excavation of soil and sediment and the extraction and treatment of groundwater. The Consent Decree also requires the Settling Defendants to reimburse the United States for $1,431,860 in past response costs incurred at the Site, and to reimburse the United States for its future oversight costs at the Site, up to $2,000,000.

The Department of Justice will receive for a period of thirty (30) days from the date of this publication comments relating to the Consent Decree. Comments should be addressed to the Assistant Attorney General, Environment and Natural Resources Division, and either e-mailed to *pubcomment-ees.enrd@usdoj.gov* or mailed to P.O. Box 7611, U.S. Department of Justice, Washington, DC 20044–7611, and should refer to *United States* v. *BIM Investment Corp. et al.,* D.J. Ref. No. 90–11–3–09667.

The Consent Decree may be examined at the Office of the United States Attorney, District of Massachusetts, United States Courthouse, 1 Courthouse Way, Suite 9200, Boston, Massachusetts, 02210, and at U.S. EPA Region 1, 5 Post Office Square, Suite 100, Boston, Massachusetts, 02109. During the public comment period, the Consent Decree may also be examined on the following Department of Justice website: *http://www.justice.gov/enrd/Consent_Decrees.html.* A copy of the Consent Decree may also be obtained by mail from the Consent Decree Library, P.O. Box 7611, U.S. Department of Justice, Washington, DC 20044–7611 or by faxing or e-mailing a request to Tonia Fleetwood (*tonia.fleetwood@usdoj.gov*), fax no. (202) 514–0097, phone confirmation number (202) 514–1547. In requesting a copy from the Consent Decree Library, please enclose a check in the amount of $136.50 for a copy of the complete Consent Decree (25 cents per page reproduction cost), or $30.25 for a copy without Appendix A (the 425-page Record of Decision, which is available at *http://www.epa.gov/region1/superfund/sites/blackburn/293498.pdf*), payable to the U.S. Treasury or, if by email or fax, forward a check in that amount to the Consent Decree Library at the stated address.

Maureen Katz,

Assistant Section Chief, Environmental Enforcement Section, Environment and Natural Resources Division.

[FR Doc. 2010–18975 Filed 8–2–10; 8:45 am]

BILLING CODE 4410–15–P

DEPARTMENT OF JUSTICE

Notice of Lodging of Consent Decree Under Comprehensive Environmental Response, Compensation And Liability Act Under 28 CFR 50.7, notice is hereby given that on July 28, 2010, a proposed Consent Decree in *United States* v. *Anacomp, Inc., et al,* No. 3:10-cv-1158, was lodged with the United States District Court for the District of Connecticut.

The proposed Consent Decree resolves claims of the United States, on behalf of the Environmental Protection Agency ("EPA"), under the Comprehensive Environmental Response, Compensation, and Liability Act ("CERCLA"), 42 U.S.C. 9601 *et seq.,* in connection with the Solvents Recovery Service of New England, Inc. Superfund Site ("SRS Site") in Southington, Connecticut, against the defendants.

The proposed Consent Decree requires the seven settling defendants to pay $389,003 in aggregate.

The Consent Decree provides that the settlors are entitled to contribution protection as provided by Section 113(f)(2) of CERCLA, 42 U.S.C. 9613(f)(2), for matters addressed by the settlement.

The Department of Justice will receive for a period of 30 days from the date of this publication comments relating to the proposed Consent Decree. Comments should be addressed to the Assistant Attorney General of the Environment and Natural Resources Division, Department of Justice, Washington, DC 20530, and either emailed to *pubcomment-ees.enrd@usdoj.gov* or mailed to P.O. Box 7611, U.S. Department of Justice, Washington, D.C. 20044–7611, and should refer to *United States* v. *Anacomp, Inc., et al,* No. 3:10cv158, D.J. No. 90–7–1–23/10. Commenters may request an opportunity for a public meeting in the affected area, in accordance with Section 7003(d) of RCRA, 42 U.S.C. 6973(d).

The proposed Consent Decree may be examined at the Office of the United States Attorney, District of Connecticut, 157 Church Street, New Haven, CT 06510. During the public comment

period, the proposed Consent Decree may also be examined on the following Department of Justice website, *http://www.usdoj.gov/enrd/Consent_Decrees.html.* Copies of the proposed Consent Decree may be obtained by mail from the Consent Decree Library, P.O. Box 7611, U.S. Department of Justice, Washington, DC 20044–7611 or by faxing or e-mailing a request to Tonia Fleetwood (*tonia.fleetwood@usdoj.gov*), fax no. (202) 514–0097, phone confirmation number (202) 514–1547. In requesting a copy of the proposed Consent Decree, please enclose a check in the amount of $6.50 (25 cent per page reproduction cost), payable to the U.S. Treasury.

Maureen Katz,

Assistant Section Chief, Environmental Enforcement Section, Environment and Natural Resources Division.

[FR Doc. 2010–18974 Filed 8–2–10; 8:45 am]

BILLING CODE 4410–15–P

DEPARTMENT OF JUSTICE

Notice of Lodging of Consent Judgment Under the Clean Air Act

Notice is hereby given that on July 28, 2010, a proposed Consent Judgment in *United States* v. *Nassau Chromium Plating Co., Inc.,* No. CV–09–2706, was lodged with the United States District Court for the Eastern District of New York.

The proposed Consent Judgment resolves claims of the United States, on behalf of the Environmental Protection Agency ("EPA"), under the Clean Air Act, as amended, 42 U.S.C. 7401 *et seq.* (hereinafter, the "Act"), against Defendant Nassau Chromium Plating Co., Inc. ("Defendant"). The United States alleges that Defendant has owned and operated a facility located at 112–122 Second Street, Mineola, New York, that sprays paint and applies chromium on, among other things, aluminum and steel parts, at which Defendant violated Sections 101–114 of the Act, 42 U.S.C. 7401–7414, and its implementing regulations, 40 CFR part 63, subpart N.

The Consent Judgment requires the Defendant to pay a civil penalty of $4,000.00, which was calculated after conducting an ability-to-pay analysis. The Consent Judgment also provides for injunctive relief that requires Defendant to maintain compliance with the provisions of Sections 101–114 of the Act, 42 U.S.C. 7401–7414, and its implementing regulations, 40 CFR part 63, subpart N, and submit reports to EPA for a three-year period demonstrating such compliance.

The Department of Justice will receive for a period of 30 days from the date of this publication comments relating to the proposed Consent Judgment. Comments should be addressed to the Assistant Attorney General, Environment and Natural Resources Division, and either e-mailed to *pubcomment-ees.enrd@usdoj.gov* or mailed to P.O. Box 7611, U.S. Department of Justice, Washington, DC 20044–7611, and should refer to: *United States* v. *Nassau Chromium Plating Co., Inc.,* No. CV–09–2706 (E.D.N.Y.), D.J. Ref. 90–5–2–1–08190.

The proposed Consent Judgment may be examined at the Office of the United States Attorney, Eastern District of New York, 271 Cadman Plaza East, 7th Fl., Brooklyn, New York 11201, and at the United States Environmental Protection Agency, Region II, 290 Broadway, New York, New York 10007–1866. During the public comment period, the proposed Consent Judgment may also be examined on the following Department of Justice Web site, *http://www.usdoj.gov/enrd/Consent_Decrees.html.* A copy of the proposed Consent Judgment may also be obtained by mail from the Consent Decree Library, P.O. Box 7611, U.S. Department of Justice, Washington, DC 20044–7611 or by faxing or e-mailing a request to Tonia Fleetwood (*tonia.fleetwood@usdoj.gov*), fax no. (202) 514–0097, phone confirmation number (202) 514–1547. In requesting a copy from the Consent Decree Library, please enclose a check in the amount of $5.00 (25 cents per page reproduction cost), payable to the U.S. Treasury.

Maureen Katz,

Assistant Section Chief, Environmental Enforcement Section, Environment and Natural Resources Division, U.S. Department of Justice.

[FR Doc. 2010–18976 Filed 8–2–10; 8:45 am]

BILLING CODE 4410–15–P

DEPARTMENT OF JUSTICE

National Institute Of Corrections

Solicitation for a Cooperative Agreement: Strategies for Women Executives in Corrections

AGENCY: National Institute of Corrections, U.S. Department of Justice.

ACTION: Solicitation for a cooperative agreement.

SUMMARY: The National Institute of Corrections (NIC) is soliciting proposals from organizations, groups, or individuals to enter into an 18-month cooperative agreement to update its 36-hour Executive Leadership for Women in Corrections program, newly titled Strategic Development of the Executive Woman. The award recipient will update the current training and ensure it supports the learning process, leadership styles, and required competencies for executive women in corrections. The award includes responsibility for the updated Instructional Theory into Practice (ITIP) formatted curriculum, the contracting and training of NIC-approved faculty, and the administration of participant expenses, including the dispersal of program acceptance letters, coordination of registration, lodging, meals, and transportation. The recipient will also be responsible for conducting, in collaboration with the NIC Research and Evaluation Division, an evaluation of the initial program delivery using the NIC training evaluation protocol. This should represent a minimal cost to the award recipient. The project will also address strategies for additional learning and networking upon training completion. The training is anticipated to begin no later than August 2011.

The pilot will be held at the National Center for Educational Development in Norman, OK. This has proven to be a favorable site in the past and represents the accommodations and amenities expected for future programming.

DATES: Applications must be received by 2 p.m. EDT on Friday, August 20, 2010.

ADDRESSES: Mailed applications must be sent to: Director, National Institute of Corrections, 320 First Street, NW., Room 5007, Washington, DC 20534. Applicants are encouraged to use Federal Express, UPS, or similar service to ensure delivery by the due date.

Hand delivered applications should be brought to 500 First Street, NW., Washington, DC 20534. At the front desk, dial 7–3106, extension 0 for pickup.

Faxed applications will NOT be accepted. Electronic applications can be submitted only via *http://www.grants.gov.*

FOR FURTHER INFORMATION CONTACT: A copy of this announcement can be downloaded from the NIC web page at *http://www.nicic.gov.*

All technical or programmatic questions concerning this announcement should be directed to Evelyn Bush, Correctional Program Specialist, National Institute of Corrections. She can be reached at *e1bush@bop.gov.*

SUPPLEMENTARY INFORMATION:

Overview: NIC's Executive Leadership for Women in Corrections program

provides executive women leaders with critical competencies, self-awareness, and the confidence necessary to seek higher levels in an organization and perform their leadership responsibilities effectively. The program addresses three main objectives: Correctional leadership, barriers and promotional strategies, and career and life planning. Three assessment instruments (LSI, MBTI, and Change Style Indicator) with individual feedback, classroom presentations, and tabletop and outdoor activities center around the core set of developmental competencies. The developmental competencies were based on a gap analysis comparing the boss/peer/subordinate scores on each competency of the LEADERSHIP 360, a set of eight leadership abilities commonly found among most outstanding leaders. These scores were compared against the midrange point of a future leadership competency set. The result of this analysis provided the basis for three major competencies—strategy, communication, and consent—which are to be incorporated into NIC's new "Strategies for Women Executives in Corrections."

Additionally, over the last five years, NIC's Executive Leadership for Women in Corrections program has kept current with recent trends such as those that appear in the multigenerational workforce and that are noted in the NIC Correctional Competencies publication.

Background: The National Institute of Corrections Prisons Division offered the first Executive Training for Women program in 1994. The program was designed to address both the personal and professional aspects of women's correctional leadership in a nontraditional profession. Through a two-part series, NIC has sought to close the gap for women executives in their knowledge, recognition of their value to the organization, and self and observer perception.

Although the past three decades have witnessed a tremendous increase in the number of women working in corrections, increasing numbers of women in the workforce have not been matched by corresponding advancement in executive and senior level leadership positions. Women are underrepresented in senior level (CEO) leadership positions across all professions, but they are significantly underrepresented in the corrections field. To further complicate the issue, studies have found that few women have had the same quantity and quality of leadership development opportunities and experiences as men, thus thwarting their ability to compete adequately for higher level positions.

By 2012, women will comprise 47.5% of the workforce. With the anticipated rise of women in the ranks of senior level positions, NIC continues to build upon the success of its programming for a women's-only environment, where gender barriers are eliminated and acceleration of learning is possible.

The occurrence of strategic partnerships within and between organizations is on the rise. In a time of a changing workforce, security issues, technology advances and new government regulations, it is imperative that organizations and individuals learn to adapt. Getting individuals to do things differently is the measure of success or failure. Approaching leadership strategically is a learned skill. Forward-looking organizations proactively seek ways to advance the leadership capacities of the women they promote, or intend to promote, to senior and executive administration.

Target Audience: Women who are senior, upper-level correctional managers serving in jails, prisons, and community corrections, functioning administratively at the level of warden or superintendent and above, and who wish to enter the ranks of chief executives of state departments of corrections.

Intended Program Results: This program will assist women leaders in understanding their value to, and involvement with, moving themselves and an organization forward. It is an acknowledgement for their way of learning and thinking, without judgment. It is to provide the tools necessary to become more self aware, more strategic in assessing and isolating critical problems, more mission driven, politically savvy, and adept at teaming with others for success. The program also takes into account the best learning environment, the best setting for the greatest outcome, and a way to close the gap for women executives in their knowledge, self-awareness, and observer's perception of their value to an organization.

Learning Outcomes: It is intended that leaders will: Acknowledge the need for, and rely upon, the support system of other professionals who can offer feedback and advice; develop appreciation for teams, teamwork and the application of strategic teaming; extend their abilities to evaluate themselves and address their needs for developing mastery of the skills required in executive leadership; and grow in their understanding of self.

Products and Deliverables: A training curriculum designed with ITIP model instruction, which will contain an instructor/facilitator's guide with associated tools, materials, and resources with a final, agreed upon curriculum delivered to NIC no later than December 31, 2011; a participant resource guide to be used in conjunction with all training activities; instructional aides and materials, including presentation slide shows, CDs, charts, handouts, case studies, assessments, etc. to support instruction and facilitation; and training delivery and facilitation of a 36-hour classroom training for 20 participants with blended learning tools.

Training Program Description: The training program will be announced on NIC's website with its list of other training courses. A description follows but may be downloaded online at *http://nicic.gov/Library/023761.*

Scope of Project: The recipient of this cooperative agreement award must, at a minimum, do the following within the scope of this project: (1) In collaboration with the NIC Research and Evaluation Division, conduct a survey to query senior executives regarding critical leadership competencies or sets that organizations should be developing, (2) In collaboration with the NIC Research and evaluation Division, conduct a survey to capture barriers that women and minorities face when seeking promotion to senior executive positions in corrections, and (3) Use the NIC publication "Correctional Leadership Competencies for the 21st Century" as a resource to build upon.

The narrative portion of the cooperative agreement application should include, at a minimum, (1) a clear description of women's learning orientations and the methodology that will be used to take these into consideration as part of the newly revised curriculum, (2) a brief summary that indicates the applicant's understanding of the purpose of this cooperative agreement, (3) two to three paragraphs that detail the applicant's understanding of the need for this program, (4) a brief paragraph that summarizes the project goals and objectives, (5) a clear description of the methodology that will be used to complete the project and achieve its goals, (6) a clearly developed work plan with measurable project milestones and timelines for the completion of each milestone, (7) a description of the qualifications of the applicant and each project staff, (8) a description of the staffing plan, including the role and time commitment for each project staff member and a statement from individual staff that he/she will be available to work on this project, and (9) a budget that details all costs for the project, shows consideration for all

contingencies, and notes a commitment to work within the proposed budget. The application must also include a budget narrative that explains how all costs were determined.

Specific Requirements: The applicant will provide an example of several topics/modules that may be considered and their accompanying learning activity. The applicant must also demonstrate a recent working knowledge of leadership development programming specific to women. Experienced correctional professional(s) are expected to be on the project team. These person(s) can be project staff or consultants. The correctional experience cited as qualifications must be at the level of warden or above. Continuous consultation with the NIC Correctional Program Specialist (CPS) on both proposed curriculum content and training program strategies is necessary. The CPS will have final approval of both. The selected applicant will conduct a face-to-face training/planning meeting with the CPS and NIC-selected and approved trainers and/or faculty to deliver the program at least 60 days before the program start date and provide a climate of inclusion and support in which women can concentrate on the learning process. The awardee will be responsible for the preparation of all program training materials, negotiation, timely completion of faculty contracts, and coordination of all program site logistics. Participant/faculty lodging, meals, travel, and administration of the associated logistics are to be funded within this agreement, based on the complete meal package. Knowledge and previous use of level one and two evaluation methods is necessary. The use of blended learning tools, such as a live Web-based training environment or supplemental online information transfer, is expected.

Curriculum Specifications: The curriculum must be designed and developed, adhering to the following standards and specifications: (1) The curriculum and training design must be consistent with, and embrace the Instructional Theory into Practice (ITIP) model. A reference to this model can be found at *http://nicic.gov/Library/010714;*

(2) Written products are developed to support the training;

(3) The curriculum facilitation guide is written using a standard curriculum document format to include, at a minimum, module/sections and titles, performance objectives/expectations, a learning activities guide, practice/application activities, evaluation method and resources needed to conduct training activities; (4) Cited references support curriculum content and concepts; (5) Copyright permissions are secured for the use of copyright protected publications and materials with a minimum usage of three years; (6) All documents must be delivered electronically in both MS Word 2003 or higher and hard copy; (7) NIC will have final approval of the format, design, and organization of the curriculum documents.

Required Expertise: The successful applicant and/or project staff will possess knowledge, skills, and experience in the following areas: Program design, strategic processes, correctional organizational culture team dynamics, and change management. Demonstrated knowledge and experience with the dynamics affecting women in corrections is necessary. The applicant will provide an example of recent involvement in leadership development programming specific to women and possess knowledge and experience in curriculum development based on adult learning theory and the Instructional Theory into Practice (ITIP) format. Knowledge and expertise in a variety of instructional delivery strategies should utilize, but are not limited to, instructor led e-learning, including asynchronous computer/Web-based instructor led, synchronous Web-based, and social learning networks, etc. Skill in designing training curriculum linked to training objectives, knowledge of available training evaluation methods, and effective written and oral communication skills are necessary.

Review Considerations: Applications received under this announcement will be subject to the NIC Review Process. The criteria for the evaluation of each application will be as follows,

Programmatic (40%)

Are all the tasks adequately discussed? Is there a clear statement of how each of the tasks will be accomplished, including the staffing, resources, and strategies to be employed? Are there any innovative approaches, techniques, or design aspects proposed that will enhance the project?

Organizational (30%)

Do the skills, knowledge, and expertise of the organization and the proposed project staff demonstrate a high level of competency to carry out the tasks? Does the applicant organization have the necessary experience and organizational capacity to carry out all five goals of the project? Are the proposed project management and staffing plans realistic and sufficient to complete the project within the time frame?

Project Management/Administration (20%)

Does the applicant identify reasonable objectives, milestones, and measures to track progress? If consultants and/or partnerships are proposed, is there a reasonable justification for their inclusion in the project and a clear structure to insure effective coordination?

Fiscal (10%)

Is the proposed budget realistic, provide sufficient cost detail/narrative, and represent good value relative to the anticipated results?

Application Requirements: Applications should be concisely written, typed double spaced and reference the "NIC Funding Opportunity Number" and Title provided in this announcement. The application package must include: OMB Standard Form 424, Application for Federal Assistance; a cover letter that identifies the audit agency responsible for the applicant's financial accounts as well as the audit period or fiscal year that the applicant operates under (e.g., July 1 through June 30), an outline of projected costs, and the following forms: OMB Standard Form 424A, Budget Information—Non Construction Programs, OMB Standard Form 424B, Assurances—Non Construction Programs (available at *http://www.grants.gov*), and DOJ/NIC Certification Regarding Lobbying; Debarment, Suspension and Other Responsibility Matters; and Drug-Free Workplace Requirements (available at *http://www.nicic.gov/Downloads/PDF/certif-frm.pdf.*)

Applications may be submitted in hard copy, or electronically via *http://www.grants.gov.* If submitted in hard copy, there needs to be an original and three copies of the full proposal (program and budget narratives, application forms and assurances). The original should have the applicant's signature in blue ink. The program narrative text must be limited to 15 double-spaced pages, exclusive of resumes and summaries of experience. Please do not submit full curriculum vitae.

Authority: Public law 93–415.

Funds Available: NIC is seeking the applicant's best ideas regarding accomplishment of the scope of work and the related costs for achieving the goals of this solicitation. Funds (up to $100,000) may be used only for the activities that are linked to the desired outcome of the project.

This project will be a collaborative venture with the NIC Prisons Division.

Eligibility of Applicants: An eligible applicant is any private agency, educational institution, organization, individual or team with expertise in the areas described.

Review Considerations: Applications received under this announcement will be subjected to a 3- to 5-person NIC Peer Review Process.

Note: NIC will not award a cooperative agreement to an applicant who does not have a Dun and Bradstreet Database Universal Number (DUNS) and is not registered in the Central Contractor Registry.

A DUNS number can be received at no cost by calling the dedicated toll-free DUNS number request line at 1–800–333–0505 (if you are a sole proprietor, you would dial 1–866–705–5711 and select option 1).

Number of Awards: One.

NIC Funding Opportunity Number: 10P12. This number should appear as a reference line in the cover letter, where indicated on Standard Form 424, and outside of the envelope in which the application is sent.

Catalog of Federal Domestic Assistance Number: 16.601.

Executive Order 12372: This project is not subject to the provisions of Executive Order 12372.

Morris L. Thigpen,

Director, National Institute of Corrections.

[FR Doc. 2010–18962 Filed 8–2–10; 8:45 am]

BILLING CODE 4410–36–P

DEPARTMENT OF LABOR

Office of the Secretary

Submission for OMB Review: Comment Request

July 28, 2010.

The Department of Labor (DOL) hereby announces the submission of the following public information collection request (ICR) to the Office of Management and Budget (OMB) for review and approval in accordance with the Paperwork Reduction Act of 1995 (Pub. L. 104–13, 44 U.S.C. chapter 35). A copy of the ICR, with applicable supporting documentation; including, among other things, a description of the likely respondents, proposed frequency of response, and estimated total burden may be obtained from the RegInfo.gov Web site at *http://www.reginfo.gov/public/do/PRAMain* or by contacting Linda Watts Thomas on 202–693–2443 (this is not a toll-free number)/e-mail: *DOL_PRA_PUBLIC@dol.gov.*

Interested parties are encouraged to send comments to the Office of Information and Regulatory Affairs, Attn: OMB Desk Officer for the Department of Labor—Occupational Safety and Health Administration (OSHA), Office of Management and Budget, Room 10235, Washington, DC 20503, Telephone: 202–395–7316/Fax: 202–395–5806 (these are not toll-free numbers), E-mail: *OIRA_submission@omb.eop.gov* within 30 days from the date of this publication in the **Federal Register**. In order to ensure the appropriate consideration, comments should reference the OMB Control Number (*see below*).

The OMB is particularly interested in comments which:

- Evaluate whether the proposed information collection requirements are necessary for the proper performance of the Agency, including whether the information will have practical utility;
- Evaluate the accuracy of the Agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;
- Enhance the quality, utility, and clarity of the information to be collected; and
- Minimize the burden of the collections of information on those who are to respond including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, *e.g.,* permitting electronic submission of responses.

Agency: Occupational Safety and Health Administration.

Type of Review: Extension without change of a previously approved collection.

Title of Collection: Occupational Exposure to Noise (29 CFR 1910.95).

OMB Control Number: 1218–0048.

Affected Public: Business or other for-profits.

Estimated Number of Respondents: 254,475.

Estimated Total Annual Burden Hours: 2,604,597.

Estimated Total Annual Costs Burden (excludes hourly wage costs): $82,190,075.

Description: The information collection requirements specified in the Occupational Exposure to Noise Standard protect workers from suffering material hearing impairment. The information collection requirements of the Standard include conducting noise monitoring; notifying workers when they are exposed at or above an 8-hour time-weighted average of 85 decibels; providing workers with initial and annual audiograms; notifying workers of a loss in hearing based on comparing audiograms; training workers on the effects of noise, hearing protectors, and audiometric examinations; maintaining records of workplace noise exposure and workers' audiograms; and allowing workers, OSHA, and the National Institute for Occupational Safety and Health (NIOSH) access to materials and records required by the Standard. For additional information, see the related 60-day preclearance notice published in the **Federal Register** on May 5, 2010, (75 FR 24740).

Dated: July 28, 2010.

Linda Watts Thomas,

Acting Departmental Clearance Officer.

[FR Doc. 2010–18984 Filed 8–2–10; 8:45 am]

BILLING CODE 4510–26–P

DEPARTMENT OF LABOR

Office of the Secretary

Submission for OMB Review: Comment Request

July 28, 2010.

The Department of Labor (DOL) hereby announces the submission of the following public information collection request (ICR) to the Office of Management and Budget (OMB) for review and approval in accordance with the Paperwork Reduction Act of 1995 (Pub. L. 104–13, 44 U.S.C. chapter 35). A copy of the ICR, with applicable supporting documentation; including, among other things, a description of the likely respondents, proposed frequency of response, and estimated total burden may be obtained from the RegInfo.gov Web site at *http://www.reginfo.gov/public/do/PRAMain* or by contacting Linda Watts Thomas on 202–693–2443 (this is not a toll-free number)/e-mail: *DOL_PRA_PUBLIC@dol.gov.*

Interested parties are encouraged to send comments to the Office of Information and Regulatory Affairs, Attn: OMB Desk Officer for the Department of Labor—Occupational Safety and Health Administration (OSHA), Office of Management and Budget, Room 10235, Washington, DC 20503, Telephone: 202–395–7316/Fax: 202–395–5806 (these are not toll-free numbers), e-mail: *OIRA_submission@omb.eop.gov* within 30 days from the date of this publication in the **Federal Register**. In order to ensure the appropriate consideration, comments should reference the OMB Control Number (see below).

The OMB is particularly interested in comments which:

- Evaluate whether the proposed information collection requirements are necessary for the proper performance of

the Agency, including whether the information will have practical utility;

• Evaluate the accuracy of the Agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;

• Enhance the quality, utility, and clarity of the information to be collected; and

• Minimize the burden of the collections of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, *e.g.,* permitting electronic submission of responses.

Agency: Occupational Safety and Health Administration.

Type of Review: Extension without change of a previously approved collection.

Title of Collection: Derricks (29 CFR 1910.181).

OMB Control Number: 1218–0222.

Affected Public: Business or other for-profits.

Estimated Number of Respondents: 500.

Estimated Total Annual Burden Hours: 1,356.

Estimated Total Annual Costs Burden (excludes hourly wage costs): $0.

Description: The Standard specifies several paperwork requirements. The purpose of these requirements is to prevent death and serious injuries among workers by ensuring that the derrick is not used to lift loads beyond its rated capacity and that all the ropes are inspected for wear and tear. For additional information, see the related 60-day preclearance notice published in the **Federal Register** on April 14, 2010, (Vol. 75, No. 19423).

Dated: July 28, 2010.

Linda Watts Thomas,

Acting Departmental Clearance Officer.

[FR Doc. 2010–18966 Filed 8–2–10; 8:45 am]

BILLING CODE 4510–26–P

DEPARTMENT OF LABOR

Office of the Secretary

Submission for OMB Review: Comment Request

July 28, 2010.

The Department of Labor (DOL) hereby announces the submission of the following public information collection request (ICR) to the Office of Management and Budget (OMB) for review and approval in accordance with the Paperwork Reduction Act of 1995 (Pub. L. 104–13, 44 U.S.C. chapter 35). A copy of the ICR, with applicable supporting documentation; including, among other things, a description of the likely respondents, proposed frequency of response, and estimated total burden may be obtained from the RegInfo.gov Web site at *http://www.reginfo.gov/public/do/PRAMain* or by contacting Linda Watts Thomas on 202–693–2443 (this is not a toll-free number)/e-mail: *DOL_PRA_PUBLIC@dol.gov.*

Interested parties are encouraged to send comments to the Office of Information and Regulatory Affairs, Attn: OMB Desk Officer for the Department of Labor—Occupational Safety and Health Administration (OSHA), Office of Management and Budget, Room 10235, Washington, DC 20503, Telephone: 202–395–7316/Fax: 202–395–5806 (these are not toll-free numbers), E-mail: *OIRA_submission@omb.eop.gov* within 30 days from the date of this publication in the **Federal Register.** In order to ensure the appropriate consideration, comments should reference the OMB Control Number (*see below*).

The OMB is particularly interested in comments which:

• Evaluate whether the proposed information collection requirements are necessary for the proper performance of the Agency, including whether the information will have practical utility;

• Evaluate the accuracy of the Agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;

• Enhance the quality, utility, and clarity of the information to be collected; and

• Minimize the burden of the collections of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submission of responses.

Agency: Occupational Safety and Health Administration.

Type of Review: Extension without change of a previously approved collection.

Title of Collection: Asbestos in General Industry (29 CFR 1910.1001).

OMB Control Number: 1218–0133.

Affected Public: Business or other for-profits.

Estimated Number of Respondents: 243.

Estimated Total Annual Burden Hours: 11,933.

Estimated Total Annual Costs Burden (excludes hourly wage costs): $862,347.

Description: The basic purpose of the information collection requirements in the Standard is to document that employers in general industry are providing their workers with protection from hazardous asbestos exposure. Asbestos exposure results in asbestosis, an emphysema-like condition; lung cancer; mesothelioma; and gastrointestinal cancer.

Several provisions of the Standard specify paperwork requirements, including: Implementing an exposure monitoring program that notifies workers of their exposure monitoring results; establishing a written compliance program; and informing laundry personnel of the requirement to prevent release of airborne asbestos above the time-weighted average and excursion limit. Other provisions associated with paperwork requirements include: Maintaining records of information obtained concerning the presence, location, and quantity of asbestos-containing materials (ACMs) and/or presumed asbestos-containing materials (PACMs) in a building/facility; notifying housekeeping workers of the presence and location of ACMs and PACMs in areas they may contact during their work; posting warning signs demarcating regulated areas; posting signs in mechanical rooms/areas that workers may enter and that contain ACMs and PACMs, informing them of the identity and location of these materials and work practices that prevent disturbing the materials; and affixing warning labels to asbestos-containing products and to containers holding such products. Additional provisions that contain paperwork requirements include: Developing specific information and training programs for workers; using information, data, and analyses to demonstrate that PACMs do not contain asbestos; providing medical surveillance for workers potentially exposed to ACMs and/or PACMs, including administering a worker medical questionnaire, providing information to the examining physician, and providing the physician's written opinion to the worker; maintaining exposure monitoring records, objective data used for exposure determinations, and medical surveillance; making specified records (*e.g.,* exposure monitoring and medical surveillance records) available to designated parties; and transferring exposure monitoring and medical surveillance records to the National Institute for Occupational Safety and Health (NIOSH) on cessation of business, if so requested by NIOSH.

These paperwork requirements permit employers, workers and their designated

representatives, OSHA, and other specified parties to determine the effectiveness of an employer's asbestos-control program. Accordingly, the requirements ensure that workers exposed to asbestos receive all of the protection afforded by the Standard.

For additional information, see the related 60-day preclearance notice published in the **Federal Register** on April 5, 2010, (75 FR 17164).

Dated: July 28, 2010.

Linda Watts Thomas,

Acting Departmental Clearance Officer.

[FR Doc. 2010–18985 Filed 8–2–10; 8:45 am]

BILLING CODE P

DEPARTMENT OF LABOR

Office of the Secretary

Submission for OMB Review: Comment Request

July 28, 2010.

The Department of Labor (DOL) hereby announces the submission of the following public information collection request (ICR) to the Office of Management and Budget (OMB) for review and approval in accordance with the Paperwork Reduction Act of 1995 (Pub. L. 104–13, 44 U.S.C. chapter 35). A copy of the ICR, with applicable supporting documentation; including, among other things, a description of the likely respondents, proposed frequency of response, and estimated total burden may be obtained from the RegInfo.gov Web site at *http://www.reginfo.gov/public/do/PRAMain* or by contacting Linda Watts Thomas on 202–693–2443 (this is not a toll-free number)/e-mail: *DOL_PRA_PUBLIC@dol.gov.*

Interested parties are encouraged to send comments to the Office of Information and Regulatory Affairs, Attn: OMB Desk Officer for the Department of Labor—Occupational Safety and Health Administration (OSHA), Office of Management and Budget, Room 10235, Washington, DC 20503, Telephone: 202–395–7316/Fax: 202–395–5806 (these are not toll-free numbers), E-mail: *OIRA_submission@omb.eop.gov* within 30 days from the date of this publication in the **Federal Register.** In order to ensure the appropriate consideration, comments should reference the OMB Control Number (*see below*).

The OMB is particularly interested in comments which:

• Evaluate whether the proposed information collection requirements are necessary for the proper performance of the Agency, including whether the information will have practical utility;

• Evaluate the accuracy of the Agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;

• Enhance the quality, utility, and clarity of the information to be collected; and

• Minimize the burden of the collections of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submission of responses.

Agency: Occupational Safety and Health Administration.

Type of Review: Extension without change of a previously approved collection.

Title of Collection: Formaldehyde (29 CFR 1910.1048).

OMB Control Number: 1218–0145.

Affected Public: Business or other for-profits.

Estimated Number of Respondents: 103,511.

Estimated Total Annual Burden Hours: 327,535.

Estimated Total Annual Costs Burden (excludes hourly wage costs): $42,626,346.

Description: The Standard specifies a number of paperwork requirements. The following is a brief description of the collection of information requirements contained in the Formaldehyde Standard. The Formaldehyde Standard requires employers to conduct worker exposure monitoring to determine workers' exposure to formaldehyde, notify workers of their formaldehyde exposures, provide medical surveillance to workers, provide examining physicians with specific information, ensure that workers receive a copy of their medical examination results, maintain workers' exposure monitoring and medical records for specific periods, and provide access to these records by OSHA, the National Institute for Occupational Safety and Health, the affected workers, and their authorized representatives.

For additional information, see the related 60-day preclearance notice published in the **Federal Register** on April 5, 2010, (75 FR 17163).

Dated: July 28, 2010.

Linda Watts Thomas,

Acting Departmental Clearance Officer.

[FR Doc. 2010–18977 Filed 8–2–10; 8:45 am]

BILLING CODE P

OFFICE OF MANAGEMENT AND BUDGET

Collection of Information Under Review by Office of Management and Budget

AGENCY: Office of Management and Budget, Office of Federal Financial Management.

ACTION: Notice; request for comments.

SUMMARY: In accordance with the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*), the Office of Management and Budget (OMB) invites the general public and Federal agencies to comment on the renewal without change of two standard forms: SF–270, Request for Advance or Reimbursement and SF–271, Outlay and Request for Reimbursement for Construction Programs. We are particularly interested in comments on whether the information collected in the forms could be more consistent with other governmentwide grant-related information collections.

DATES: Comments must be received by September 2, 2010. Due to potential delays in OMB's receipt and processing of mail sent through the U.S. Postal Service, we encourage respondents to submit comments electronically to ensure timely receipt. We cannot guarantee that comments mailed will be received before the comment closing date.

ADDRESSES: Comments should be addressed to the OMB Desk Officer and sent via electronic mail to *oira_submission@omb.eop.gov* or faxed to (202) 395–5806. Written comments and suggestions from the public and affected agencies regarding items contained in this notice and especially with regard to the estimated public burden and associated response time should be directed to the Office of Information and Regulatory Affairs, Office of Management and Budget. Comments may also be sent to regulations.gov, a Federal E-Government Web site that allows the public to find, review, and submit comments on documents that agencies have published in the **Federal Register** and that are open for comment. Simply type "SF–270 PRA" (in quotes) in the Comment or Submission search box, click Go, and follow the instructions for submitting comments. Comments received by the date specified above will be included as part of the official record.

FOR FURTHER INFORMATION CONTACT: Marguerite Pridgen, Office of Federal Financial Management, Office of Management and Budget, 725 17th

Street, NW., Washington, DC 20503; telephone 202–395–7844; fax 202–395–3952; e-mail *mpridgen@omb.eop.gov.*

OMB Control No.: 0348–0004.

Title: Request for Advance or Reimbursement.

Form No.: SF–270.

Type of Review: Extension of a currently approved collection.

Respondents: States, Local Governments, Universities, Non-Profit Organizations.

Number of Responses: 100,000.

Estimated Time per Response: 60 minutes.

Needs and Uses: The SF–270 is used to request funds for all nonconstruction grant programs when letters of credit or predetermined advance payment methods are not used. The Federal awarding agencies use information reported on this form for the award and general management of Federal assistance program awards.

OMB Control No.: 0348–0002.

Title: Outlay and Request for Reimbursement for Construction Programs.

Form No.: SF–271.

Type of Review: Extension of a currently approved collection.

Respondents: States, Local Governments, Universities, Non-Profit Organizations.

Number of Responses: 40,000.

Estimated Time per Response: 60 minutes.

Needs and Uses: The SF–271 is used to request reimbursement for all construction grant programs. The Federal awarding agencies use information reported on this form for the award and general management of Federal assistance program awards.

Debra J. Bond,

Deputy Controller.

[FR Doc. 2010–18958 Filed 8–2–10; 8:45 am]

BILLING CODE P

OFFICE OF MANAGEMENT AND BUDGET

Compliance Assistance Resources and Points of Contact Available to Small Businesses

AGENCY: Office of Management and Budget, Executive Office of the President.

ACTION: Notice.

SUMMARY: In accordance with the Small Business Paperwork Relief Act of 2002 (44 U.S.C. 3520), the Office of Management and Budget (OMB) is publishing a "list of the compliance assistance resources available to small businesses" and a list of the points of contacts in agencies "to act as a liaison between the agency and small business concerns" with respect to the collection of information and the control of paperwork. This information is posted on the following Web site: *http://www.business.gov/business-law/contacts/federal/*

FOR FURTHER INFORMATION CONTACT: Wendy Liberante, Office of Information and Regulatory Affairs, Office of Management and Budget, E-mail: *wliberante@omb.eop.gov,* Telephone: (202) 395–3647. Inquiries may be submitted by facsimile to (202) 395–5167.

SUPPLEMENTARY INFORMATION: The Small Business Paperwork Relief Act of 2002 (Pub. L. 107–198) requires OMB to "publish in the **Federal Register** and make available on the Internet (in consultation with the Small Business Administration) on an annual basis a list of the compliance assistance resources available to small businesses" (44 U.S.C. 3504(c)(6)). OMB has, with the active assistance and support of the Small Business Administration (SBA) and Business.gov, assembled a list of the compliance assistance resources available to small businesses. This list is available today on the following Web site: *http://www.business.gov/business-law/contacts/federal/.* There is also a link to this information on the OMB Web site.

In addition, under another provision of this Act, "each agency shall, with respect to the collection of information and the control of paperwork, establish 1 point of contact in the agency to act as a liaison between the agency and small business concerns" (44 U.S.C. 3506(i)(1)). These contacts are also available at *http://www.business.gov/business-law/contacts/federal/.*

OMB and SBA have chosen to implement this statutory responsibility by publishing agency compliance contact information on Business.gov Web site. Business.gov delivers compliance information to the public more effectively than having businesses go to individual agency Web sites, thereby improving the probability of success for business owners and agency regulatory programs. The public is not only able to find agency points of contact for compliance under the "contacts and help" tab on Business.gov, but when users look for information in the "small business guides" on particular topics, the relevant agency points of contact automatically appear as part of the guide.

Cass Sunstein,

Administrator, Office of Information and Regulatory Affairs.

[FR Doc. 2010–18957 Filed 8–2–10; 8:45 am]

BILLING CODE P

NATIONAL AERONAUTICS AND SPACE ADMINISTRATION

[Notice: (10 –085)]

Opportunity To Comment on Proposed and/or Continuing Information Collection

AGENCY: National Aeronautics and Space Administration (NASA).

ACTION: Notice.

SUMMARY: The National Aeronautics and Space Administration, as part of its continuing effort to reduce paperwork and respondent burden, invites the general public and other Federal agencies to take this opportunity to comment on proposed and/or continuing information collections, as required by the Paperwork Reduction Act of 1995 (Pub. L. 104–13, 44 U.S.C. 3506(c)(2)(A)).

DATES: All comments should be submitted within 30 calendar days from the date of this publication.

ADDRESSES: All comments should be addressed to Lori Parker, National Aeronautics and Space Administration, Washington, DC 20546–0001.

FOR FURTHER INFORMATION CONTACT: Requests for additional information or copies of the information collection instrument(s) and instructions should be directed to Lori Parker, NASA PRA Officer, NASA Headquarters, 300 E Street, SW., JF000, Washington, DC 20546, (202) 358–1351, *Lori.Parker@nasa.gov.*

SUPPLEMENTARY INFORMATION:

I. Abstract

Information is needed to guide implementation of GLOBE (Global Learning and Observations to Benefit the Environment) based on feedback from participating teachers, students, and partners in order to help meet the Program's goal of improving student achievement in mathematics and science.

II. Method of Collection

The GLOBE Partner survey is Web-based on-line instrument. The survey gathers data on all activities related to GLOBE implementation for the year prior to administration of the survey.

III. Data

Title: GLOBE Program Evaluation.
OMB Number: 2700–0114.
Type of Review: Extension of currently approved collection.
Affected Public: State, Local, or Tribal Government; Individuals or households; and Not-for-profit institutions.
Number of Respondents: 258.
Responses per Respondent: 1.
Annual Responses: 258.
Hours per Request: 2.
Annual Burden Hours: 516.

IV. Request for Comments

Comments are invited on: (1) Whether the proposed collection of information is necessary for the proper performance of the functions of NASA, including whether the information collected has practical utility; (2) the accuracy of NASA's estimate of the burden (including hours and cost) of the proposed collection of information; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) ways to minimize the burden of the collection of information on respondents, including automated collection techniques or the use of other forms of information technology.

Comments submitted in response to this notice will be summarized and included in the request for OMB approval of this information collection. They will also become a matter of public record.

Lori Parker,

NASA PRA Clearance Officer.

[FR Doc. 2010–18937 Filed 8–2–10; 8:45 am]

BILLING CODE P

NATIONAL ARCHIVES AND RECORDS ADMINISTRATION

Privacy Act of 1974, as Amended; System of Records Notices

AGENCY: National Archives and Records Administration [NARA].

ACTION: Notice of the establishment of new privacy system of record, NARA 40.

SUMMARY: The National Archives and Records Administration (NARA) proposes to add a system of records to its existing inventory of systems subject to the Privacy Act of 1974, as amended (5 U.S.C. 552(a)) ("Privacy Act"). In this notice, NARA publishes NARA 40, the Office of Government Information Services (OGIS) Case Files.

DATES: This new system of records, NARA 40, will become effective September 2, 2010 without further notice unless comments are received that result in further revision. NARA will publish a new notice if the effective date is delayed to review comments or if changes are made based on comments received. To be assured of consideration, comments should be received on or before the date above.

ADDRESSES: You may submit comments, identified by SORN number NARA 40, by one of the following methods:

- *Federal e-Rulemaking Portal: http://www.regulations.gov.* Follow the instructions for submitting comments.
- *Fax:* 301–837–0293.
- *Mail:* Privacy Act Officer, Office of General Counsel (NGC), Room 3110, National Archives and Records Administration, 8601 Adelphi Road, College Park, MD 20740–6001.

FOR FURTHER INFORMATION CONTACT: Jay Olin, Deputy FOIA Officer, Office of General Counsel (NGC), Room 3110, National Archives and Records Administration, 8601 Adelphi Road, College Park, MD 20740–6001. Telephone: (301) 837–2025. Fax: 301–837–0293.

SUPPLEMENTARY INFORMATION: The OPEN Government Act of 2007 amended the Freedom of Information Act (5 U.S.C. Section 552) to create an Office of Government Information Services (OGIS) within the National Archives and Records Administration (NARA). OGIS's mission is to review policies and procedures of administrative agencies under the Freedom of Information Act (FOIA) and their compliance with FOIA by agencies; offer mediation services to resolve disputes between persons making FOIA requests and agencies (nonexclusive alternative to litigation); and serve as ombudsman, *i.e.* solicit and receive comments and questions from Federal agencies and the public regarding the administration of FOIA to improve FOIA processes and facilitate communication between agencies and FOIA requesters.

The notice for this system of records states the name and the location of the record system, the authority for and manner of its operation, the categories of individuals that it covers, the types of records that it contains, the sources of information in the records, and the proposed "routine uses" of the system of records. The notice also includes the business address of the NARA official who will inform interested persons of the procedures whereby they may gain access to, and correct, records pertaining to themselves.

One of the purposes of the Privacy Act, as stated in section 2(b)(4) of the Act, is to provide certain safeguards for an individual against an invasion of personal privacy by requiring Federal agencies to disseminate any record of identifiable personal information in a manner that assures that such action is for a necessary and lawful purpose, that the information is current and accurate for its intended use, and the adequate safeguards are provided to prevent misuse of such information. NARA intends to follow these principles in transferring information to another agency or individual as a "routine use," including assurance that the information is relevant for the purposes for which it is transferred.

Dated: July 28, 2010.

David S. Ferriero,

Archivist of the United States.

NARA Privacy Act Systems: NARA 40

SYSTEM NAME:

The Office of Government Information Services (OGIS) Case Files.

SYSTEM LOCATION:

The OGIS case files are maintained in the National Archives and Records Administration, Office of Government Information Services, Room 2510, 8601 Adelphi Road, College Park, MD 20740.

CATEGORIES OF INDIVIDUALS COVERED BY THE SYSTEM:

Individuals covered by this system include persons who request OGIS assistance in connection with the filing of a Freedom of Information (FOIA) and/or Privacy Act request or appeal to any Federal department or agency.

CATEGORIES OF RECORDS IN THE SYSTEM:

The OGIS case files include: correspondence, case notes, FOIA and Privacy Act request letters, appeal letters, agency replies to original requests and appeals, supporting documents, research, and other administrative forms used in the process. These files may also contain information or determinations furnished by, and correspondence with, other Federal agencies. OGIS case files may contain some or all of the following information about an individual: name, address, telephone number, e-mail address, Federal inmate register number, research interests, other information provided by the requester and by other agencies, and copies of documents furnished to the requester.

AUTHORITY FOR MAINTENANCE OF THE SYSTEM:

5 U.S.C. 552a(a)(3), as amended.

ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM, INCLUDING CATEGORIES OF USERS AND THE PURPOSES OF SUCH USES:

OGIS maintains case files on individuals to record: requests for assistance, actions taken on cases; and,

the status of cases in logs and databases. In addition, OGIS also serves as the FOIA Ombudsman in connection with its mission to review agency compliance with the FOIA. In this role, OGIS will capture and address systematic problems in FOIA administration as such individual case problems may serve as one of the bases to establish current systematic trends in the process. For this latter function, OGIS will remove personal information and use the remaining information collected for statistical purposes.

OGIS may disclose information in case files to agencies that have an equity in the subject FOIA and/or Privacy Act request and/or appeal in order for those agencies to participate in informal or formal mediation efforts. The routine use statements A, E, F, G and H, described in Appendix A following the NARA Notices, also apply to this system of records.

POLICIES AND PRACTICES FOR STORING, RETRIEVING, ACCESSING, RETAINING, AND DISPOSING OF RECORDS IN THE SYSTEM:

STORAGE:

Paper and electronic records.

RETRIEVABILITY:

Information in OGIS case files may be retrieved by one or more of the following data elements: the name of the individual and an alphanumeric case file number.

SAFEGUARDS:

OGIS case files are at all times maintained in buildings with security guards or secured doors, and all entrances are monitored by electronic surveillance equipment. During business hours, paper records are accessible only by authorized NARA personnel. Electronic records are accessible via passwords from terminals located in attended offices. After business hours, or when OGIS personnel are not present in the offices, the OGIS offices are secured in addition to building security.

RETENTION AND DISPOSAL:

OGIS case files are temporary records and are destroyed in accordance with the disposition instructions in the NARA records schedule contained in FILES 203, the NARA Files Maintenance and Records Disposition Manual. Individuals may request a copy of the disposition instructions from the NARA Privacy Act Officer.

SYSTEM MANAGER(S) AND ADDRESS:

For OGIS case files, the system manager is the Director of the OGIS, Room 2510, 8601 Adelphi Road, College Park, MD 20740.

NOTIFICATION PROCEDURE:

Individuals interested in inquiring about their records should notify the NARA Privacy Act Officer, whose address is listed above and in Appendix B to the Privacy Act of 1974 Republication of Systems of Records Notice (72 FR 56570, October 3, 2007).

RECORD ACCESS PROCEDURES:

Individuals who wish to gain access to their records should submit their request in writing to the NARA Privacy Act Officer at the address listed in Appendix B.

CONTESTING RECORD PROCEDURES:

NARA rules for contesting the contents and appealing initial determinations are found in 36 CFR part 1202.

RECORD SOURCE CATEGORIES:

Information in OGIS case files is obtained from persons who request assistance in connection with the submission of a FOIA and/or Privacy Act request or appeal to a Federal agency, and from agencies that have acted on the request or appeal.

[FR Doc. 2010–19130 Filed 8–2–10; 8:45 am]

BILLING CODE 7515–01–P

NATIONAL SCIENCE FOUNDATION

Notice of Permit Applications Received Under the Antarctic Conservation Act of 1978 (Pub. L. 95–541)

AGENCY: National Science Foundation.

ACTION: Notice of permit applications received under the Antarctic Conservation Act of 1978, Public Law 95–541.

SUMMARY: The National Science Foundation (NSF) is required to publish notice of permit applications received to conduct activities regulated under the Antarctic Conservation Act of 1978. NSF has published regulations under the Antarctic Conservation Act at Title 45 Part 670 of the Code of Federal Regulations. This is the required notice of permit applications received.

DATES: Interested parties are invited to submit written data, comments, or views with respect to this permit application by September 2, 2010. This application may be inspected by interested parties at the Permit Office, address below.

ADDRESSES: Comments should be addressed to Permit Office, Room 755, Office of Polar Programs, National Science Foundation, 4201 Wilson Boulevard, Arlington, Virginia 22230.

FOR FURTHER INFORMATION CONTACT: Nadene G. Kennedy at the above address or (703) 292–7405.

SUPPLEMENTARY INFORMATION: The National Science Foundation, as directed by the Antarctic Conservation Act of 1978 (Pub. L. 95–541), as amended by the Antarctic Science, Tourism and Conservation Act of 1996, has developed regulations for the establishment of a permit system for various activities in Antarctica and designation of certain animals and certain geographic areas a requiring special protection. The regulations establish such a permit system to designate Antarctic Specially Protected Areas.

The applications received are as follows:

Permit Application No. 2011–009

1. *Applicant:* Sam Feola, Director, Raytheon Polar Services Company, 7400 South Tucson Way, Centennaial, CO 80112.

Activity for Which Permit is Requested: Take. The applicant plans herd or remove seals and seabirds who venture onto McMurdo Station roads, airstrips and ice pier when they pose operational safety concerns as well as potential harm to the animals. Herding and removal activities will be conducted in accordance with "Wildlife Removal" standard operating procedures, which includes notification to station authorities and reporting such herding and removal activities to the Permit Office.

Location: McMurdo Station roads, airstrips, and ice pier.

Dates: September 1, 2010 to August 31, 2015.

Permit Application No. 2011–010

2. *Applicant:* Sam Feola, Director, Raytheon Polar Services Company, 7400 South Tucson Way, Centennial, CO 80112.

Activity for Which Permit is Requested: Take. The applicant plans herd or remove seals and seabirds who venture onto the Palmer Station pier and other operational areas when they pose operational safety concerns as well as potential harm to the animals. Herding and removal activities will be conducted by station management and science personnel in a non-lethal and humane manner in order to cause as little disturbance as possible.

Location: Palmer Station pier and operational areas.

Dates September 1, 2010 to August 31, 2015.

Permit Application No. 2011–011

3. *Applicant:* Sam Feola, Director, Raytheon Polar Services Company, 7400 South Tucson Way, Centennial, CO 80112.

Activity for Which Permit is Requested: Enter Antarctic Specially Protected Area. The applicant plans to enter Avian Island (ASPA 117) in support of research work conducted at the NOAA marine mammal research facility. Activities to be performed are the movement of personnel and supplies from ship to shore via zodiac or small boat, opening and closing tasks for the research facilities on shore, and maintenance and servicing of on-shore facilities and equipment.

Location: Avian Island (ASPA 117).

Dates: September 1, 2010 to August 31, 2015.

Permit Application No. 2011–012

4. *Applicant:* Sam Feola, Director, Raytheon Polar Services Company, 7400 South Tucson Way, Centennial, CO 80112.

Activity for Which Permit is Requested: Enter Antarctic Specially Protected Area. The applicant plans to enter Cape Shirreff (ASPA 149) in support of research work conducted at the NOAA marine mammal research facility. Activities to be performed are the movement of personnel and supplies from ship to shore via zodiac or small boat, opening and closing tasks for the research facilities on shore, and maintenance and servicing of on-shore facilities and equipment.

Location Cape Shirreff (ASPA 149).

Dates September 1, 2010 to August 31, 2015.

Permit Application No. 2011–013

5. *Applicant:* Sam Feola, Director, Raytheon Polar Services Company, 7400 South Tucson Way, Centennial, CO 80112.

Activity for Which Permit is Requested: Enter Antarctic Specially Protected Area. The applicant plans to enter "Copacabana" research site on the Western Shore of Admiralty Bay, King George Island (ASPA 128) in support of research work conducted at the USAP research facility. Activities to be performed are the movement of personnel and supplies from ship to shore via zodiac or small boat, opening and closing tasks for the research facilities on shore, and maintenance and servicing of on-shore facilities and equipment.

Location: Cape Shirreff (ASPA 128).

Dates: September 1, 2010 to August 31, 2015.

Permit Application No. 2011–014

6. *Applicant:* Sam Feola, Director, Raytheon Polar Services Company, 7400 South Tucson Way, Centennial, CO 80112.

Activity for Which Permit is Requested: Enter Antarctic Specially Protected Area. The applicant plans to enter Beaufort Island (ASPA 105), Cape Royds (ASPA 121), Arrival Heights (ASPA 122), Cape Crozier (ASPA 124), Tramway Ridge (ASPA 130), Canada Glacier (ASPA 131), Linnaeus Terrance (ASPA 138), and Botany Bay (ASPA 154) to review the sites' management plans and verify that the values being protected are maintained. Article 6.3 of Annex V to the Madrid Protocol requires "A review of the (ASPA) Management Plan shall be initiated at least every five years. The plans will be updated as necessary." The USAP Environmental team members will enter the sites in anticipation of the 5 year ASPA review, or to address any environmental concern or potential environmental release within the ASPA.

Location: Beaufort Island (ASPA 105), Cape Royds (ASPA 121), Arrival Heights (ASPA 122), Cape Crozier (ASPA 124), Tramway Ridge (ASPA 130), Canada Glacier (ASPA 131), Linnaeus Terrance (ASPA 138), and Botany Bay (ASPA 154)

Dates: September 1, 2010 to August 31, 2015.

Permit Application No. 2011–015

7 *Applicant:* Sam Feola, Director, Raytheon Polar Services Company, 7400 South Tucson Way, Centennial, CO 80112.

Activity for Which Permit is Requested: Enter Antarctic Specially Protected Area. The applicant plans to enter Litchfield Island (ASPA 113) to remove (for inspection and resupply) the survival cache located on Litchfield Island, and to return the cache. This cache is a requirement for boating safety purposes. Additionally, ongoing assessment of the ASPA notification signs at the three primary landing sites on the island is required.

Location: Litchfield Island (ASPA 113).

Dates: September 1, 2010 to August 31, 2015.

Nadene G. Kennedy,

Permit Officer, Office of Polar Programs.

[FR Doc. 2010–19028 Filed 8–2–10; 8:45 am]

BILLING CODE 7555–01–P

NUCLEAR REGULATORY COMMISSION

[Docket No. NRC–2010–0235]

Agency Information Collection Activities: Proposed Collection; Comment Request

AGENCY: U.S. Nuclear Regulatory Commission (NRC).

ACTION: Notice of pending NRC action to submit an information collection request to the Office of Management and Budget (OMB) and solicitation of public comment.

SUMMARY: The NRC invites public comment about our intention to request the OMB's approval for renewal of an existing information collection that is summarized below. We are required to publish this notice in the **Federal Register** under the provisions of the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35).

Information pertaining to the requirement to be submitted:

1. *The title of the information collection:* 10 CFR Part 39—Licenses and Radiation Safety Requirements for Well Logging.

2. *Current OMB approval number:* 3150–0130.

3. *How often the collection is required:* Applications for new licenses and amendments may be submitted at any time. Applications for renewal are submitted every 10 years. Reports are submitted as events occur.

4. *Who is required or asked to report:* Applicants for and holders of specific licenses authorizing the use of licensed radioactive material for well logging.

5. *The number of annual respondents:* 278 (34 NRC Licensees + 244 Agreement State Licensees).

6. *The number of hours needed annually to complete the requirement or request:* 60,296 hours (7,375 total NRC licensees hrs + 52,921 total Agreement State licensees hrs). The NRC licensees total burden is 7,375 hours (108 reporting hrs + 7,267 recordkeeping hrs). The Agreement State licensees total burden is 52,921 hours (767 reporting hrs + 52,154 recordkeeping hrs). The average burden per response for both NRC licensees and Agreement State licensees is 3.2 hours and the burden per recordkeeper is 214 hours.

7. *Abstract:* 10 CFR part 39 establishes radiation safety requirements for the use of radioactive material in well logging operations. The information in the applications, reports and records is used by the NRC staff to ensure that the health and safety of the public is protected and that licensee possession and use of source and byproduct

material is in compliance with license and regulatory requirements.

Submit, by October 4, 2010 comments that address the following questions:

1. Is the proposed collection of information necessary for the NRC to properly perform its functions? Does the information have practical utility?

2. Is the burden estimate accurate?

3. Is there a way to enhance the quality, utility, and clarity of the information to be collected?

4. How can the burden of the information collection be minimized, including the use of automated collection techniques or other forms of information technology?

A copy of the draft supporting statement may be viewed free of charge at the NRC Public Document Room, One White Flint North, 11555 Rockville Pike, Room O–1 F21, Rockville, Maryland 20852. OMB clearance requests are available at the NRC worldwide Web site: *http://www.nrc.gov/public-involve/doc-comment/omb/index.html.* The document will be available on the NRC home page site for 60 days after the signature date of this notice. Comments submitted in writing or in electronic form will be made available for public inspection. Because your comments will not be edited to remove any identifying or contact information, the NRC cautions you against including any information in your submission that you do not want to be publicly disclosed. Comments submitted should reference Docket No. NRC–2010–0235. You may submit your comments by any of the following methods. Electronic comments: Go to *http://www.regulations.gov* and search for Docket No. NRC–2010–0235. Mail comments to NRC Clearance Officer, Tremaine Donnell (T–5 F53), U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001. Questions about the information collection requirements may be directed to the NRC Clearance Officer, Tremaine Donnell (T–5 F53), U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001, by telephone at 301–415–6258, or by e-mail to *INFOCOLLECTS.Resource@NRC.GOV.*

Dated at Rockville, Maryland, this 26th day of July, 2010.

For the Nuclear Regulatory Commission.

Tremaine Donnell,

NRC Clearance Officer, Office of Information Services.

[FR Doc. 2010–19013 Filed 8–2–10; 8:45 am]

BILLING CODE 7590–01–P

NUCLEAR REGULATORY COMMISSION

[NRC–2010–0229]

Draft Regulatory Guide, DG–1216,"Plant-Specific Applicability of Transition Break Size Specified in 10 CFR 50.46a." Issuance, Availability; Extension of Comment Period

AGENCY: Nuclear Regulatory Commission.

ACTION: Extension of comment period.

FOR FURTHER INFORMATION CONTACT: Robert Tregoning, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001, telephone 301–251–7662, or e-mail *Robert.Tregoning@nrc.gov.*

SUMMARY: The U.S. Nuclear Regulatory Commission (NRC) is extending the public comment period for DG–1216 from August 25, 2010 to November 8, 2010.

DATES: The comment period closes on November 8, 2010.

ADDRESSES: You may submit comments by any one of the following methods. Please include Docket ID NRC–2010–0229 in the subject line of your comments. Comments submitted in writing or in electronic form will be posted on the NRC Web site and on the Federal rulemaking Web site *Regulations.gov.* Because your comments will not be edited to remove any identifying or contact information, the NRC cautions you against including any information in your submission that you do not want to be publicly disclosed.

The NRC requests that any party soliciting or aggregating comments received from other persons for submission to the NRC inform those persons that the NRC will not edit their comments to remove any identifying or contact information, and therefore, they should not include any information in their comments that they do not want publicly disclosed.

Federal Rulemaking Web site: Go to *http://www.regulations.gov* and search for documents filed under Docket ID NRC–2010–0229. Address questions about NRC dockets to Carol Gallagher 301–492–3668; e-mail *Carol.Gallagher@nrc.gov.*

Mail comments to: Cindy K. Bladey, Chief, Rules, Announcements, and Directives Branch (RADB), Division of Administrative Services, Office of Administration, Mail Stop: TWB–05–B01M, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001, or by fax to RDB at (301) 492–3446.

You can access publicly available documents related to this notice using the following methods:

NRC's Public Document Room (PDR): The public may examine and have copied for a fee publicly available documents at the NRC's PDR, Public File Area C1 F21, One White Flint North, 11555 Rockville Pike, Rockville, Maryland.

NRC's Agencywide Documents Access and Management System (ADAMS): Publicly available documents created or received at the NRC are available electronically at the NRC's Electronic Reading Room at *http://www.nrc.gov/reading-rm/adams.html.* From this page, the public can gain entry into ADAMS, which provides text and image files of NRC's public documents. If you do not have access to ADAMS or if there are problems in accessing the documents located in ADAMS, contact the NRC's PDR reference staff at 1–800–397–4209, 301–415–4737, or by e-mail to *pdr.resource@nrc.gov.* The Draft Regulatory Guide, DG–1216, "Plant-Specific Applicability of Transition Break Size Specified in 10 CFR 50.46a," is available electronically under ADAMS Accession Number ML100430356.

SUPPLEMENTARY INFORMATION: On June 28, 2010 (75 FR 36700), the NRC published a notice of issuance and availability of Draft Regulatory Guide DG–1216, "Plant-Specific Applicability of Transition Break Size Specified in 10 CFR 50.46a." By letter dated July 13, 2010, the Nuclear Energy Institute (ADAMS Accession No. ML102070019) requested an extension of the stated comment period for the purpose of gathering input from personnel with varied technical expertise. It is the desire of the NRC to receive comments of a high quality from all stakeholders. Several factors have been considered in granting an extension. 10 CFR 50.46a will be an optional regulation for licensees, the requested comment period extension is within the rulemaking period, and the rule encompasses complex technical bases. Therefore the comment submittal period is extended from the original date of August 25, 2010 to November 8, 2010.

Dated at Rockville, Maryland, this 26th day of July, 2010.

For the Nuclear Regulatory Commission.

Harriet Katagiannis,

Acting Chief, Regulatory Guide Development Branch, Division of Engineering, Office of Nuclear Regulatory Research.

[FR Doc. 2010–19016 Filed 8–2–10; 8:45 am]

BILLING CODE 7590–01–P

NUCLEAR REGULATORY COMMISSION

[NRC–2009–0303]

Notice of Availability of Interim Staff Guidance Document for Fuel Cycle Facilities

AGENCY: Nuclear Regulatory Commission.

ACTION: Notice of availability.

FOR FURTHER INFORMATION CONTACT: Tamara D. Powell, Nuclear Process Engineer, Technical Support Branch, Division of Fuel Cycle Safety and Safeguards, Office of Nuclear Material Safety and Safeguards, U.S. Nuclear Regulatory Commission, Washington, DC 20005–0001. Telephone: (301) 492–3211; Fax: (301) 492–3363; E-mail: *Tamara.Powell@nrc.gov.*

SUPPLEMENTARY INFORMATION:

I. Introduction

The Nuclear Regulatory Commission (NRC) prepares and issues Interim Staff Guidance (ISG) documents for fuel cycle facilities. These ISG documents provide clarifying guidance to the NRC staff when reviewing licensee's integrated safety analyses (ISA), license applications, amendment requests, or other related licensing activities for fuel cycle facilities under Title 10 of the *Code of Federal Regulations* (10 CFR) Part 70. This notice is being published to inform the public that after general revision based on NRC staff and public comment, FCSS–ISG–12, Revision 0, "10 CFR Part 70, Appendix A—Reportable Safety Events," Revision 0, has been issued and is provided for information, however additional comments will be accepted. The final disposition of the information addressed in this guidance may later be issued as an NRC Regulatory Guide.

II. Discussion of Significant Comments and Changes

On July 10, 2009, notice was given in the **Federal Register** (74 FR 33281) of the availability for public comment of the draft of FCSS–ISG–12 (then numbered FCSS–ISG–11). In response to comments received on the draft ISG, the following modifications were made.

The NRC made minor editorial changes and re-numbered the ISG to be consistent with existing Fuel Cycle Safety and Safeguards ISG documents. In addition, there was a general comment from one commentator about the NRC's interpretation of when event "discovery" occurs. The commentator considers event "discovery" to have occurred after the initial event has been observed, appropriate internal notifications made, and a licensee determination made that the event meets the applicable reporting requirements. The commentator further believes that the time of "discovery" will vary because it is driven by the culmination of three actions, and, as such, should not be determined based solely upon the occurrence of the actual event or the observation. The NRC agrees that event "discovery" will vary and starts when an individual who, by position or experience, is expected to understand that a particular condition or event adversely impacts safety observes, identifies, or is notified of a safety significant event or condition. The NRC, however, does not agree that the time of "discovery" is delayed until after the licensee has determined reportability. As stated in the guidance, the twenty-four hour time period for reportable events allows for this evaluation and determination step. The more substantive comments on the draft ISG are summarized below along with the NRC's response.

Proposed Time of Discovery Section

Some general editorial comments were suggested by the commentator related to the event "discovery" concern discussed above; however, the NRC determined that the proposed changes in wording could create ambiguity so no changes were made. There was also a recommendation that the third example in Table 1, "Examples of Discovery Determination," be changed to state that the time of "discovery" would be when the operator informed the supervisor of the possible exposure not when the operator realized that he would have been exposed. The staff reviewed the suggested revision and determined that a cognizant individual, as defined earlier in the guidance, may not necessarily be aware of the NRC reporting requirements, but should understand when a condition impacts safety. The NRC expects that operators would be trained to recognize, when possible, when they may have received an acute exposure to a hazardous material such as UF_6, therefore no change to the wording was made.

Loss or Degradation of Items Relied on for Safety (IROFS) Section

The last sentence of this section states that all situations where IROFS have failed or degraded are reportable. One commentator suggested that this section be edited to remove this statement because IROFS may have failed or become degraded without meeting the reporting requirement. The NRC disagreed with removing this statement, but rearranged the section for clarity. The intent of "all other situations" in the sentence in question was meant to apply to those situations not discussed in the section.

Inadequate ISA Section

The NRC did not receive any comments on this section, however substantial edits were made. The use of the concept "creditable controls" and the term "non-IROFS" were removed from this section. 10 CFR 70.61 (e) requires that the controls needed to meet the performance requirements be designated as IROFS. The NRC determined that using "non-IROFS" in combination with available IROFS to meet the performance requirements was not supported by the regulations.

Press Release Section

With respect to licensee-issued press releases, the guidance states that routine radiation releases are not specifically reportable under Appendix A unless the release receives media attention. One commentator indicated that 10 CFR Part 70 licensees issue semi-annual reports on effluent releases which are routine radiation releases of low safety significance. The commentator felt that simple media inquiries about these routine radiation releases should not result in a required report to the NRC. The regulation states that, "[a]ny event or situation related to the health and safety of the public or onsite personnel, or protection of the environment, for which a news release is planned…shall be reported." In the example of an effluent release which has some impact on the environment, media attention would likely result and should be reported. The NRC agrees that simple media inquiries may not necessarily result in reportability, but if a news release is planned in response to such inquiries, this would be reportable. The NRC revised the section to clarify that radiation releases that receive "significant media attention" would be reportable under paragraph (c) of Appendix A to 10 CFR Part 70.

Attachment C

The commentator provided a suggested revision to the flow chart in Attachment C. The NRC reviewed the suggested changes and determined that if followed, the revised flow chart would lead to the failure to report under paragraph (a)(5) of Appendix A. Therefore, the NRC did not incorporate the suggested revisions and removed the flow chart from the ISG.

Glossary Section

The NRC agreed with the commentator that the definition for "degraded IROFS" should be modified to ensure consistency of use throughout the guidance. The NRC incorporated, in part, the suggested change. The NRC did not incorporate that portion of the suggested change which would have stated that a degraded IROFS was also an IROFS that is "potentially unable to perform the required safety function." The NRC determined that an IROFS meeting this part of the definition would, in many cases, be considered a failed IROFS and did not include this portion in the revision. The NRC also removed the definitions of "non-IROFS" and "creditable control" for the reasons discussed earlier in this notice.

III. Further Information

The NRC maintains an Agencywide Documents Access and Management System (ADAMS), which provides text and image files of NRC's public documents. These documents may be accessed through the NRC's Public Electronic Reading Room on the Internet at *http://www.nrc.gov/reading-rm/adams.html.* The ADAMS accession number for the document related to this notice is provided in the following table.

Interim staff guidance	ADAMS accession No.
FCSS Interim Staff Guidance-12, Revision 0	ML102020267

This document may also be viewed electronically on the public computers located at the NRC's PDR, O1–F21, One White Flint North, 11555 Rockville Pike, Rockville, MD 20852. The PDR reproduction contractor will copy documents for a fee. Persons who do not have access to ADAMS or who encounter problems in accessing the documents located in ADAMS should contact the NRC Public Document Room (PDR) reference staff at 1(800) 397–4209, (301) 415–4737, or via e-mail to *pdr@nrc.gov.*

Dated at Rockville, Maryland, this 21 day of July 2010.

For the Nuclear Regulatory Commission.

Marissa G. Bailey,

Deputy Director,Special Projects and Technical Support Directorate, Division of Fuel Cycle Safety and Safeguards, Office of Nuclear Material Safety and Safeguards.

[FR Doc. 2010–19015 Filed 8–2–10; 8:45 am]

BILLING CODE 7590–01–P

NUCLEAR REGULATORY COMMISSION

[NRC–2010–0002]

Sunshine Federal Register Notice

AGENCY HOLDING THE MEETINGS: Nuclear Regulatory Commission [NRC–2010–0002].

DATE: Weeks of August 2, 9, 16, 23, 30, and September 6, 2010.

PLACE: Commissioners' Conference Room, 11555 Rockville Pike, Rockville, Maryland.

STATUS: Public and Closed.

Week of August 2, 2010

There are no meetings scheduled for the week of August 2, 2010.

Week of August 9, 2010—Tentative

Thursday, August 12, 2010

9:30 a.m. Meeting with Organization of Agreement States (OAS) and Conference of Radiation Control Program Directors (CRCPD) (Public Meeting) (Contact: Cindy Flannery, 301–415–0223).

This meeting will be webcast live at the Web address—*http://www.nrc.gov.*

Week of August 16, 2010—Tentative

There are no meetings scheduled for the week of August 16, 2010.

Week of August 23, 2010—Tentative

There are no meetings scheduled for the week of August 23, 2010.

Week of August 30, 2010—Tentative

There are no meetings scheduled for the week of August 30, 2010.

Week of September 6, 2010—Tentative

There are no meetings scheduled for the week of September 6, 2010.

* * * * *

*The schedule for Commission meetings is subject to change on short notice. To verify the status of meetings, call (recording)—(301) 415–1292. Contact person for more information: Rochelle Bavol, (301) 415–1651.

* * * * *

The NRC Commission Meeting Schedule can be found on the Internet at:*http://www.nrc.gov/about-nrc/policy-making/schedule.html.*

* * * * *

The NRC provides reasonable accommodation to individuals with disabilities where appropriate. If you need a reasonable accommodation to participate in these public meetings, or need this meeting notice or the transcript or other information from the public meetings in another format (*e.g.* braille, large print), please notify Angela Bolduc, Chief, Employee/Labor Relations and Work Life Branch, at 301–492–2230, TDD: 301–415–2100, or by e-mail at *angela.bolduc@nrc.gov. mailto:dlc@nrc.gov. mailto:aks@nrc.gov* Determinations on requests for reasonable accommodation will be made on a case-by-case basis.

* * * * *

This notice is distributed electronically to subscribers. If you no longer wish to receive it, or would like to be added to the distribution, please contact the Office of the Secretary, Washington, DC 20555 (301–415–1969), or send an e-mail to *darlene.wright@nrc.gov.*

Dated: July 29, 2010.

Richard J. Laufer,

Technical Coordinator, Office of the Secretary.

[FR Doc. 2010–19131 Filed 7–30–10; 4:15 pm]

BILLING CODE 7590–01–P

SMALL BUSINESS ADMINISTRATION

[Disaster Declaration #12248 and #12249]

Oklahoma Disaster #OK–00043

AGENCY: U.S. Small Business Administration.

ACTION: Notice.

SUMMARY: This is a Notice of the Presidential declaration of a major disaster for Public Assistance Only for the State of Oklahoma (FEMA–1926–DR), dated 07/26/2010.

Incident: Severe Storms, Tornadoes, Straight-line Winds, and Flooding.

Incident Period: 06/13/2010 through 06/15/2010.

DATES: *Effective Date:* 07/26/2010.

Physical Loan Application Deadline Date: 09/24/2010.

Economic Injury (EIDL) Loan Application Deadline Date: 04/26/2011.

ADDRESSES: Submit completed loan applications to: U.S. Small Business Administration,Processing and Disbursement Center, 14925 Kingsport Road, Fort Worth, TX 76155.

FOR FURTHER INFORMATION CONTACT: A. Escobar, Office of Disaster Assistance, U.S. Small Business Administration, 409 3rd Street, SW., Suite 6050, Washington, DC 20416.

SUPPLEMENTARY INFORMATION: Notice is hereby given that as a result of the President's major disaster declaration on 07/26/2010, Private Non-Profit organizations that provide essential services of governmental nature may file disaster loan applications at the address listed above or other locally announced locations.

The following areas have been determined to be adversely affected by the disaster:

Primary Counties: Beaver, Cimarron, Lincoln, Logan, Major, Oklahoma, Texas.

The Interest Rates are:

	Percent
For Physical Damage:	
Non-Profit Organizations With Credit Available Elsewhere	3.625
Non-Profit Organizations Without Credit Available Elsewhere	3.000
For Economic Injury:	
Non-Profit Organizations Without Credit Available Elsewhere	3.000

The number assigned to this disaster for physical damage is 12248B and for economic injury is 12249B.

(Catalog of Federal Domestic Assistance Numbers 59002 and 59008)

James E. Rivera,

Associate Administrator for Disaster Assistance.

[FR Doc. 2010–19030 Filed 8–2–10; 8:45 am]

BILLING CODE 8025–01–P

SMALL BUSINESS ADMINISTRATION

[Disaster Declaration #12224 and #12225]

Minnesota Disaster Number MN–00026

AGENCY: U.S. Small Business Administration.

ACTION: Amendment 1.

SUMMARY: This is an amendment of the Presidential declaration of a major disaster for Public Assistance Only for the State of Minnesota (FEMA–1921–DR), dated 07/02/2010.

Incident: Severe Storms, Tornadoes, and Flooding.

Incident Period: 06/17/2010 through 06/26/2010.

DATES: *Effective Date:* 07/26/2010.

Physical Loan Application Deadline Date: 08/31/2010.

Economic Injury (EIDL) Loan Application Deadline Date: 04/02/2011.

ADDRESSES: Submit completed loan applications to: U.S. Small Business Administration, Processing and Disbursement Center, 14925 Kingsport Road, Fort Worth, TX 76155.

FOR FURTHER INFORMATION CONTACT: A. Escobar, Office of Disaster Assistance, U.S. Small Business Administration, 409 3rd Street, SW., Suite 6050, Washington, DC 20416.

SUPPLEMENTARY INFORMATION: The notice of the President's major disaster declaration for Private Non-Profit organizations in the State of Minnesota, dated 07/02/2010, is hereby amended to include the following areas as adversely affected by the disaster.

Primary Counties: Blue Earth, Brown, Houston, Kittson, Nicollet, Sibley.

All other information in the original declaration remains unchanged.

(Catalog of Federal Domestic Assistance Numbers 59002 and 59008)

James E. Rivera,

Associate Administrator for Disaster Assistance.

[FR Doc. 2010–19035 Filed 8–2–10; 8:45 am]

BILLING CODE 8025–01–P

SMALL BUSINESS ADMINISTRATION

[Disaster Declaration #12240 and #12241]

Arizona Disaster #AZ–00010

AGENCY: U.S. Small Business Administration.

ACTION: Notice.

SUMMARY: This is a notice of an Administrative declaration of a disaster for the State of Arizona dated 07/27/2010.

Incident: Severe winter storm and snowstorm.

Incident Period: 01/18/2010 through 01/22/2010.

Effective Date: 07/27/2010.

Physical Loan Application Deadline Date: 09/27/2010.

Economic Injury (EIDL) Loan Application Deadline Date: 04/27/2011.

ADDRESSES: Submit completed loan applications to: U.S. Small Business Administration, Processing And Disbursement Center, 14925 Kingsport Road, Fort Worth, TX 76155.

FOR FURTHER INFORMATION CONTACT: A. Escobar, Office of Disaster Assistance, U.S. Small Business Administration, 409 3rd Street, SW, Suite 6050, Washington, DC 20416.

SUPPLEMENTARY INFORMATION: Notice is hereby given that as a result of the Administrator's disaster declaration, applications for disaster loans may be filed at the address listed above or other locally announced locations.

The following areas have been determined to be adversely affected by the disaster:

Primary Counties: Gila; Yavapai.

Contiguous Counties:

Arizona: Coconino, Graham, La Paz, Maricopa, Mohave, Navajo, Pinal.

The Interest Rates are:

	Percent
For Physical Damage:	
Homeowners with Credit Available Elsewhere	5.125
Homeowners without Credit Available Elsewhere	2.562
Businesses with Credit Available Elsewhere	6.000
Businesses without Credit Available Elsewhere	4.000
Non-Profit Organizations with Credit Available Elsewhere	3.625
Non-Profit Organizations without Credit Available Elsewhere	3.000
For Economic Injury:	
Businesses & Small Agricultural Cooperatives without Credit Available Elsewhere	4.000
Non-Profit Organizations without Credit Available Elsewhere	3.000

The number assigned to this disaster for physical damage is 12240 B and for economic injury is 12241 0.

The State which received an EIDL Declaration # is Arizona.

(Catalog of Federal Domestic Assistance Numbers 59002 and 59008)

Dated: July 27, 2010.

Karen G. Mills,

Administrator.

[FR Doc. 2010–19039 Filed 8–2–10; 8:45 am]

BILLING CODE 8025–01–P

SMALL BUSINESS ADMINISTRATION

[Disaster Declaration #12254 and #12255]

Louisiana Disaster #LA–00031

AGENCY: U.S. Small Business Administration.

ACTION: Notice.

SUMMARY: This is a notice of an Administrative declaration of a disaster for the State of LOUISIANA dated.

Incident: Severe storm and tornado.

Incident Period: 04/24/2010.

DATES: Effective Date: 07/29/2010.

Physical Loan Application Deadline Date: 09/27/2010.

Economic Injury (EIDL) Loan Application Deadline Date: 04/29/2011.

ADDRESSES: Submit completed loan applications to: U.S. Small Business Administration, Processing and Disbursement Center, 14925 Kingsport Road, Fort Worth, TX 76155.

FOR FURTHER INFORMATION CONTACT: A. Escobar, Office of Disaster Assistance, U.S. Small Business Administration, 409 3rd Street, SW., Suite 6050, Washington, DC 20416.

SUPPLEMENTARY INFORMATION: Notice is hereby given that as a result of the Administrator's disaster declaration, applications for disaster loans may be filed at the address listed above or other locally announced locations.

The following areas have been determined to be adversely affected by the disaster:

Primary Parishes: Madison.

Contiguous Parishes/Counties:

Louisiana: East Carroll, Franklin, Richland, Tensas.

Mississippi: Warren.

The Interest Rates are:

	Percent
For Physical Damage:	
Homeowners with Credit Available Elsewhere	5.500
Homeowners without Credit Available Elsewhere	2.750
Businesses with Credit Available Elsewhere	6.000
Businesses without Credit Available Elsewhere	4.000
Non-Profit organizations with Credit Available Elsewhere	3.625
Non-Profit Organizations without Credit Available Elsewhere	3.000
For Economic Injury:	
Businesses & Small Agricultural Cooperatives Without Credit Available Elsewhere	4.000
Non-Profit Organizations Without Credit Available Elsewhere	3.000

The number assigned to this disaster for physical damage is 12254 C and for economic injury is 12255 0.

The States which received an EIDL Declaration # are Louisiana and Mississippi.

(Catalog of Federal Domestic Assistance Numbers 59002 and 59008)

Dated; July 29, 2010.

Karen G. Mills,

Administrator.

[FR Doc. 2010–19068 Filed 8–2–10; 8:45 am]

BILLING CODE 8025–01–P

SMALL BUSINESS ADMINISTRATION

[Disaster Declaration #12233 and #12234]

Montana Disaster Number MT–00056

AGENCY: U.S. Small Business Administration.

ACTION: Amendment 1.

SUMMARY: This is an amendment of the Presidential declaration of a major disaster for Public Assistance Only for the State of Montana (FEMA–1922–DR), dated 07/10/2010.

Incident: Severe storms and flooding.

Incident Period: 06/15/2010 and continuing.

DATES: Effective Date: 07/28/2010.

Physical Loan Application Deadline Date: 09/08/2010.

Economic Injury (EIDL) Loan Application Deadline Date: 04/11/2011.

ADDRESSES: Submit completed loan applications to: U.S. Small Business Administration, Processing and Disbursement Center, 14925 Kingsport Road, Fort Worth, TX 76155.

FOR FURTHER INFORMATION CONTACT: A. Escobar, Office of Disaster Assistance, U.S. Small Business Administration, 409 3rd Street, SW., Suite 6050, Washington, DC 20416.

SUPPLEMENTARY INFORMATION: The notice of the President's major disaster declaration for Private Non-Profit organizations in the State of Montana, dated 07/10/2010, is hereby amended to include the following areas as adversely affected by the disaster.

Primary Counties: Chouteau.

All other information in the original declaration remains unchanged.

(Catalog of Federal Domestic Assistance Numbers 59002 and 59008)

James E. Rivera,

Associate Administrator for Disaster Assistance.

[FR Doc. 2010–19067 Filed 8–2–10; 8:45 am]

BILLING CODE 8025–01–P

SMALL BUSINESS ADMINISTRATION

[Disaster Declaration #12246 and #12247]

Massachusetts Disaster #MA–00028.

AGENCY: U.S. Small Business Administration.

ACTION: Notice.

SUMMARY: This is a notice of an Administrative declaration of a disaster for the Commonwealth of MASSACHUSETTS dated 07/27/2010.

Incident: Severe Storms and Flooding.

Incident Period: 07/10/2010.

DATES: *Effective Date:* 07/27/2010.

Physical Loan Application Deadline Date: 09/27/2010.

Economic Injury (EIDL) Loan Application Deadline Date: 04/27/2011.

ADDRESSES: Submit completed loan applications to: U.S. Small Business Administration,Processing and Disbursement Center, 14925 Kingsport Road, Fort Worth, TX 76155.

FOR FURTHER INFORMATION CONTACT: A. Escobar, Office of Disaster Assistance, U.S. Small Business Administration, 409 3rd Street, SW., Suite 6050, Washington, DC 20416.

SUPPLEMENTARY INFORMATION: Notice is hereby given that as a result of the Administrator's disaster declaration, applications for disaster loans may be filed at the address listed above or other locally announced locations.

The following areas have been determined to be adversely affected by the disaster:

Primary Counties: Middlesex.

Contiguous Counties:

Massachusetts: Essex, Norfolk, Suffolk, Worcester.

New Hampshire: Hillsborough.

The Interest Rates are:

	Percent
For Physical Damage:	
Homeowners With Credit Available Elsewhere	5.500
Homeowners Without Credit Available Elsewhere	2.750
Businesses With Credit Available Elsewhere	6.000
Businesses Without Credit Available Elsewhere	4.000
Non-Profit Organizations With Credit Available Elsewhere	3.625
Non-Profit Organizations Without Credit Available Elsewhere	3.000
For Economic Injury:	
Businesses & Small Agricultural Cooperatives Without Credit Available Elsewhere	4.000
Non-Profit Organizations Without Credit Available Elsewhere	3.000

The number assigned to this disaster for physical damage is 12246 6 and for economic injury is 12247 0.

The States which received an EIDL Declaration # are Massachusetts; New Hampshire.

(Catalog of Federal Domestic Assistance Numbers 59002 and 59008)

Dated: July 27, 2010.

Karen G. Mills,

Administrator.

[FR Doc. 2010–19036 Filed 8–2–10; 8:45 am]

BILLING CODE 8025–01–P

SMALL BUSINESS ADMINISTRATION

[Disaster Declaration #12252 and #12253]

Iowa Disaster #IA–00025

AGENCY: U.S. Small Business Administration.

ACTION: Notice.

SUMMARY: This is a Notice of the Presidential declaration of a major disaster for Public Assistance Only for the State of Iowa (FEMA–1928–DR), dated 07/27/2010.

Incident: Severe Storms and Flooding.

Incident Period: 05/12/2010 through 05/13/2010.

DATES: *Effective Date:* 07/27/2010.

Physical Loan Application Deadline Date: 09/27/2010.

Economic Injury (EIDL) Loan Application Deadline Date: 04/27/2011.

ADDRESSES: Submit completed loan applications to: U.S. Small Business Administration, Processing and Disbursement Center, 14925 Kingsport Road, Fort Worth, TX 76155.

FOR FURTHER INFORMATION CONTACT: A. Escobar, Office of Disaster Assistance, U.S. Small Business Administration, 409 3rd Street, SW., Suite 6050, Washington, DC 20416.

SUPPLEMENTARY INFORMATION: Notice is hereby given that as a result of the President's major disaster declaration on 07/27/2010, Private Non-Profit organizations that provide essential services of governmental nature may file disaster loan applications at the address listed above or other locally announced locations.

The following areas have been determined to be adversely affected by the disaster:

Primary Counties: Des Moines, Lee.

The Interest Rates are:

	Percent
For Physical Damage:	
Non-Profit Organizations With Credit Available Elsewhere	3.625
Non-Profit Organizations Without Credit Available Elsewhere	3.000
For Economic Injury:	
Non-Profit Organizations Without Credit Available Elsewhere	3.000

The number assigned to this disaster for physical damage is 12252B and for economic injury is 12253B.

(Catalog of Federal Domestic Assistance Numbers 59002 and 59008)

James E. Rivera,

Associate Administrator for Disaster Assistance.

[FR Doc. 2010–19034 Filed 8–2–10; 8:45 am]

BILLING CODE 8025–01–P

SMALL BUSINESS ADMINISTRATION

[Disaster Declaration #12250 and #12251]

Idaho Disaster #ID–00010

AGENCY: U.S. Small Business Administration.

ACTION: Notice.

SUMMARY: This is a Notice of the Presidential declaration of a major disaster for Public Assistance Only for the State of Idaho (FEMA–1927–DR), dated 07/27/2010.

Incident: Severe storms and flooding.

Incident Period: 06/02/2010 through 06/10/2010.

DATES: *Effective Date:* 07/27/2010.

Physical Loan Application Deadline Date: 09/27/2010.

Economic Injury (EIDL) Loan Application Deadline Date: 04/27/2011.

ADDRESSES: Submit completed loan applications to: U.S. Small Business Administration,Processing and Disbursement Center, 14925 Kingsport Road, Fort Worth, TX 76155.

FOR FURTHER INFORMATION CONTACT: A. Escobar, Office of Disaster Assistance, U.S. Small Business Administration, 409 3rd Street, SW., Suite 6050, Washington, DC 20416.

SUPPLEMENTARY INFORMATION: Notice is hereby given that as a result of the President's major disaster declaration on 07/27/2010, Private Non-Profit organizations that provide essential services of governmental nature may file disaster loan applications at the address listed above or other locally announced locations.

The following areas have been determined to be adversely affected by the disaster:

Primary Counties: Adams, Gem, Idaho, Lewis, Payette, Valley, Washington.

The Interest Rates are:

	Percent
For Physical Damage:	
Non-Profit Organizations with Credit Available Elsewhere	3.625
Non-Profit Organizations without Credit Available Elsewhere	3.000
For Economic Injury:	
Non-Profit Organizations without Credit Available Elsewhere	3.000

The number assigned to this disaster for physical damage is 12250B and for economic injury is 12251B.

(Catalog of Federal Domestic Assistance Numbers 59002 and 59008)

James E. Rivera,

Associate Administrator for Disaster Assistance.

[FR Doc. 2010–19032 Filed 8–2–10; 8:45 am]

BILLING CODE 8025–01–P

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–62573; File No. 4–533]

Joint Industry Plan; Notice of Filing and Immediate Effectiveness of Amendment to the National Market System Plan for the Selection and Reservation of Securities Symbols To Add EDGA Exchange, Inc. and EDGX Exchange, Inc., Each as a Party Thereto

July 26, 2010.

Pursuant to Section 11A(a)(3) of the Securities Exchange Act of 1934 ("Act")[1] and Rule 608 thereunder,[2] notice is hereby given that on July 7, 2009, EDGA Exchange, Inc. ("EDGA") and EDGX Exchange, Inc. ("EDGX") filed with the Securities and Exchange Commission ("Commission") an amendment to the National Market System Plan for the Selection and Reservation of Securities Symbols ("Symbology Plan" or "Plan").[3] The amendment proposes to add EDGA and EDGX, each as a party to the Symbology Plan. The Commission is publishing this notice to solicit comments on the proposed amendment from interested persons.

I. Description and Purpose of the Amendment

The current parties to the Symbology Plan are BATS Exchange, Inc. ("BATS"), NASDAQ OMX BX, Inc. ("BSE"), Chicago Board Options Exchange, Incorporated ("CBOE"), CHX, FINRA, the International Securities Exchange, LLC ("ISE"), Nasdaq, New York Stock Exchange LLC ("NYSE"), NYSE Arca, Inc. ("NYSE Arca"), NYSE Amex LLC ("NYSE Amex") (f/k/a "NYSE Alternext US LLC" ("NYSE Alternext")), NSX and Phlx.[4] The proposed amendment to the Symbology Plan would add EDGA and EDGX, each as a party to the Symbology Plan. A self-regulatory organization ("SRO") may become a party to the Symbology Plan if it satisfies the requirements of Section I(c) of the Plan. Specifically, an SRO may become a party to the Symbology Plan if: (i) It

[1] 15 U.S.C. 78k–1(a)(3).

[2] 17 CFR 242.608.

[3] On November 6, 2008, the Commission approved the Symbology Plan that was originally proposed by the Chicago Stock Exchange, Inc. ("CHX"), The Nasdaq Stock Market, Inc. ("Nasdaq"), National Association of Securities Dealers, Inc. ("NASD") (n/k/a Financial Industry Regulatory Authority, Inc. ("FINRA")), National Stock Exchange, Inc. ("NSX"), and Philadelphia Stock Exchange, Inc. ("Phlx"), subject to certain changes. *See* Securities Exchange Act Release No. 58904, 73 FR 67218 (November 13, 2008) (File No. 4–533).

[4] On November 18, 2008, ISE filed with the Commission an amendment to the Plan to add ISE as a member to the Plan. *See* Securities and Exchange Act Release No. 59024 (November 26, 2008), 73 FR 74538 (December 8, 2008) (File No. 4–533). On December 22, 2008, NYSE, NYSE Arca, and NYSE Alternext ("NYSE Group Exchanges") and CBOE filed with the Commission amendments to the Plan to add the NYSE Group Exchanges and CBOE as members to the Plan. *See* Securities Exchange Act Release No. 59162 (December 24, 2008), 74 FR 132 (January 2, 2009) (File No. 4–533). On December 24, 2008, BSE filed with the Commission an amendment to the Plan to add BSE as a member to the Plan. *See* Securities Exchange Act Release No. 59187 (December 30, 2008), 74 FR 729 (January 7, 2009) (File No. 4–533). On September 30, 2009, BATS filed with the Commission an amendment to the Plan to add BATS as a member to the Plan. *See* Securities Exchange Act Release No. 60856 (October 21, 2009), 74 FR 55276 (October 27, 2009) (File No. 4–533).

maintains a market for the listing or trading of Plan Securities [5] in accordance with rules approved by the Commission, which securities are identified by one, two, or three character symbols, on the one hand, or four or five character symbols, on the other hand, in each case prior to any suffix or special conditional identifier; (ii) it signs a current copy of the Plan; and (iii) it pays to the other parties a proportionate share of the aggregate development costs, based upon the number of symbols reserved by the new party during the first twelve (12) months of such party's membership.[6]

EDGA and EDGX have submitted a signed copy of the Symbology Plan to the Commission in accordance with the requirement set forth in the Symbology Plan regarding new parties to the plan.

II. Effectiveness of the Proposed Symbology Plan Amendment

The foregoing proposed Symbology Plan amendment has become effective pursuant to Rule 608(b)(3)(iii) [7] because it involves solely technical or ministerial matters. At any time within sixty days of the filing of the amendment, the Commission may summarily abrogate the amendment and require that it be refiled pursuant to paragraph (b)(1) of Rule 608,[8] if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors or the maintenance of fair and orderly markets, to remove impediments to, and perfect the mechanisms of, a national market system or otherwise in furtherance of the purposes of the Act.

III. Solicitation of Comments

Interested persons are invited to submit written data, views and arguments concerning the foregoing, including whether the amendment is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's Internet comment form (*http://www.sec.gov/rules/sro.shtml*); or
- Send an e-mail to *rule-comments@sec.gov.* Please include File Number 4–533 on the subject line.

Paper Comments

- Send paper comments in triplicate to Secretary, Securities and Exchange Commission, 100 F Street, NE., Washington, DC 20549–1090.

All submissions should refer to File Number 4–533. This file number should be included on the subject line if e-mail is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's Internet Web site (*http://www.sec.gov/rules/sro.shtml*). Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for Web site viewing and printing in the Commission's Public Reference Room, on official business days between the hours of 10 a.m. and 3 p.m. Copies of the filing also will be available for inspection and copying at the principal office of EDGA and EDGX. All comments received will be posted without change; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number 4–533 and should be submitted on or before August 24, 2010.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[9]

Florence E. Harmon,

Deputy Secretary.

[FR Doc. 2010–18935 Filed 8–2–10; 8:45 am]

BILLING CODE 8010–01–P

[5] "Plan Securities" are defined in the Symbology Plan as securities that: (i) Are NMS securities as currently defined in Rule 600(a)(46) under the Act; and (ii) any other equity securities quoted, traded and/or trade reported through an SRO facility.

[6] Sections I(c) and V(a) of the Plan.

[7] 17 CFR 242.608(b)(3)(iii).

[8] 17 CFR 242.608(b)(1).

[9] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–62580; File No. SR–NYSEArca–2010–69]

Self-Regulatory Organizations; NYSE Arca, Inc.; Notice of Filing of Proposed Rule Change Amending Rule 6.47

July 28, 2010.

Pursuant to Section 19(b)(1) [1] of the Securities Exchange Act of 1934 (the "Act") [2] and Rule 19b–4 thereunder,[3] notice is hereby given that, on July 20, 2010, NYSE Arca, Inc. ("NYSE Arca" or the "Exchange") filed with the Securities and Exchange Commission (the "Commission") the proposed rule change as described in Items I, II, and III below, which Items have been prepared by the self-regulatory organization. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

[1] 15 U.S.C. 78s(b)(1).

[2] 15 U.S.C. 78a.

[3] 17 CFR 240.19b–4.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The Exchange proposes to amend Rule 6.47 to describe new procedures for executing a cross transaction. The text of the proposed rule change is attached as Exhibit 5 to the 19b-4 form. A copy of this filing is available on the Exchange's Web site at *http://www.nyse.com,* at the Exchange's principal office, on the Commission's Web site at *http://www.sec.gov,* and at the Commission's Public Reference Room.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the Exchange included statements concerning the purpose of and basis for the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item IV below. The Exchange has prepared summaries, set forth in Sections A, B, and C below, of the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

NYSE Arca proposes to modify Rule 6.47(a) to describe new procedures for Floor Brokers wishing to execute a Non-Facilitation cross transaction.[4] Currently, after requesting a market, Floor Brokers are required to disclose the terms of a cross, after which Market Makers are allowed to revise their bids and offers to block the cross.

NYSE Arca proposes that Market Makers, after being informed of a potential cross, should provide their best bid and best offer, but not be allowed to step ahead of subsequently disclosed trading interest. The Exchange

[4] Facilitation Crosses are governed by Rule 6.47(b), and are not affected by this proposal.

intends for Market Makers to make markets and not prevent better priced trading interests from interacting with each other.

The proposed rule change would allow a Floor Broker to request, without revealing the size of the orders, a final quote for a cross from the Trading Crowd, and then to cross above the highest bid, or below the lowest offer, and, if not on a price provided by the Crowd, to execute the cross in its entirety. If the cross were to take place on the price provided by the Crowd, the Floor Broker would be obligated to trade with that interest prior to crossing the orders. The cross would be required to be within the National Best Bid/Offer, and would also be obligated to satisfy any bids or offers in the Consolidated Book equal to or better than the crossing price.

For example, if the prices of the orders to be crossed allowed for a range of possible crossing prices, and the Trading Crowd provided a final quote that was two or more Minimum Price Variations ("MPV") wide, the Floor Broker could bid above the Trading Crowd's bid and consummate the cross without trading on a final quote price.

If, alternatively, the final quote was only one MPV wide, (*i.e.,* 3.10 bid for 20 contracts at 3.20 offer for 50 contracts) the Floor Broker could not meet the obligation to the orders without trading on a final quote price. In this case, the Floor Broker would bid above the final quote bid (*i.e.,* bid 3.20) or offer below the final quote offer (*i.e.,* offer at 3.10), each instance of which is equal to a final quote price. The Floor Broker would then be obligated to trade with the final quote interest at that price (*i.e.,* buy 50 at 3.20 or sell 20 at 3.10) before crossing the balance of the orders.

Additionally, if, because of movement in the markets while the order was being brought to the crowd, the limit on one of the orders only allowed for a cross to be effected at a final quote price, regardless of the width of the final quote, the Floor Broker would be required to bid above the final quote bid or offer below the final quote offer yet still be at a final quote price. Again, the Floor Broker would be obligated to trade with the final quote interest at that price before crossing the balance of the orders. For instance, the electronic market in the series is 3.00 bid offered at 3.30, and the Floor Broker receives orders to cross at 3.10 or 3.20. When the Floor Broker requests a Final Quote, the crowd responds with a market of 3.20 bid at 3.30. In order to meet the obligation to execute the order, the Floor Broker would have to offer at 3.20, fill the bids in the crowd at 3.20, and then cross the balance of the orders.

Additionally, the Exchange proposes to add two commentaries to Rule 6.47. Commentary .01 would allow an OTP Holder to submit an order that has been solicited prior to transmittal to the Floor, but would not allow the new procedures to be used to circumvent limitations on principal transactions as described in Rule 6.47A, nor allow the OTP Holder to solicit a contra order from an NYSE Arca Market Maker assigned to the class of options to trade against an agency order.

Commentary .02 would state it is a violation of a Floor Broker's duty for best execution to cancel an agency order to avoid execution at a better price.

2. Statutory Basis

The Exchange believes the proposed rule change is consistent with and furthers the objectives of Section 6(b)(5) of the Act, in that it is designed to promote just and equitable principles of trade, remove impediments to and perfect the mechanisms of a free and open market and a national market system and, in general, to protect investors and the public interest. The proposed rule change will provide encouragement for Market Makers to provide their best prices earlier, upon the initial presentation of trading interest to the crowd, and the broker will be required to better the crowd's price in order to execute the cross transaction. The proposed new process should thus increase the possibility of price improvement for Customer orders.

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange does not believe that the proposed rule change will impose any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants or Others

No written comments were solicited or received with respect to the proposed rule change.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

Within 35 days of the date of publication of this notice in the **Federal Register** or within such longer period (i) as the Commission may designate up to 90 days of such date if it finds such longer period to be appropriate and publishes its reasons for so finding or (ii) as to which the self-regulatory organization consents, the Commission will:

(A) By order approve the proposed rule change, or

(B) Institute proceedings to determine whether the proposed rule change should be disapproved.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's Internet comment form (*http://www.sec.gov/rules/sro.shtml*); or
- Send an e-mail to *rule-comments@sec.gov.* Please include File Number SR–NYSEArca–2010–69 on the subject line.

Paper Comments

- Send paper comments in triplicate to Elizabeth M. Murphy, Secretary, Securities and Exchange Commission, 100 F Street, NE., Washington, DC 20549–1090.

All submissions should refer to File Number SR–NYSEArca–2010–69. This file number should be included on the subject line if e-mail is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's Internet Web site (*http://www.sec.gov/rules/sro.shtml*). Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for Web site viewing and printing in the Commission's Public Reference Room, 100 F Street, NE., Washington, DC 20549, on official business days between the hours of 10 a.m. and 3 p.m. Copies of such filing also will be available for inspection and copying at the principal office of the Exchange. All comments received will be posted without change; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make publicly available. All submissions should refer to File Number SR–

NYSEArca–2010–69 and should be submitted on or before August 24, 2010.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[5]

Florence E. Harmon,

Deputy Secretary.

[FR Doc. 2010–18998 Filed 8–2–10; 8:45 am]

BILLING CODE 8010–01–P

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–62584; File No. SR–FINRA–2010–035]

Self-Regulatory Organizations; Financial Industry Regulatory Authority, Inc.; Notice of Filing of Proposed Rule Change Amendments to the Discovery Guide and Rules 12506 and 12508 of the Code of Arbitration Procedure for Customer Disputes

July 28, 2010.

Pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 ("Act")[1] and Rule 19b–4 thereunder,[2] notice is hereby given that on July 12, 2010, the Financial Industry Regulatory Authority, Inc. ("FINRA") filed with the Securities and Exchange Commission ("SEC" or "Commission") the proposed rule change as described in Items I, II, and III below, which Items have been prepared by FINRA. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

FINRA is proposing to amend the Discovery Guide, which includes Document Production Lists, and to make conforming changes to Rules 12506 and 12508 of the Code of Arbitration Procedure for Customer Disputes ("Customer Code").

The text of the proposed rule change is available on FINRA's Web site at *http://www.finra.org,* at the principal office of FINRA and at the Commission's Public Reference Room.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, FINRA included statements concerning the purpose of and basis for the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item IV below. FINRA has prepared summaries, set forth in sections A, B, and C below, of the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

FINRA proposes to revise the Discovery Guide ("Guide") to expand the guidance FINRA gives to parties and arbitrators on the discovery process and to update the Document Production Lists ("Lists"). The proposal includes conforming changes to Rules 12506 and 12508 of the Customer Code.

Background

The SEC approved the current Guide in 1999 and FINRA made it available for use in arbitration proceedings involving customer disputes upon the publication of Notice to Members (NTM) 99–90 (November 1999). The Guide provides guidance to parties on which documents parties should exchange without arbitrator or staff intervention, and to arbitrators in determining which documents customers and member firms or associated persons are presumptively required to produce in customer arbitrations.

In March 2004, FINRA determined to review the Guide and consider whether FINRA should update the Guide after more than four years of use. A FINRA Advisory Committee, the National Arbitration and Mediation Committee ("NAMC"), conducted the review. The NAMC is a majority public committee made up of attorneys who represent investors, attorneys who represent brokerage firms, arbitrators, and mediators. In addition, FINRA staff met with other frequent users of the forum representing both the public and the industry to listen to the concerns of each side about the current lists, their proposals for changes, and their reactions to other constituents' proposals. FINRA worked for three years to build a consensus on revisions to the Guide.

In 2008, FINRA filed a proposed rule change with the SEC to update the Guide ("the 2008 proposal"). The 2008 proposal added clarifying and conforming language to the introduction in the Guide and updated the Lists. The SEC received 53 comment letters on the 2008 proposal that clearly signaled that the consensus reached on revisions to the Guide was not broad enough. In light of the comment letters, FINRA withdrew the filing.[3]

FINRA staff drafted a new Guide which would replace the current Guide in its entirety. The starting point was the 2008 proposal and the comment letters submitted to the SEC on the 2008 proposal. NAMC members shared the staff's draft with interested parties including, among others, attorneys who represent investors, in-house counsel at brokerage firms, and attorneys who handle investor claims at Law School clinics. The NAMC recommended that FINRA appoint a Subcommittee to review the proposal. The Subcommittee, comprised of public and industry NAMC members, reached consensus on a number of revisions to the Guide. The NAMC reviewed the Subcommittee's recommended changes and agreed to make additional revisions. The proposed rule change incorporates the NAMC's suggested revisions.

Commenters on the 2008 proposal suggested that it may be appropriate to eliminate the Lists for specific types of claims since claimants are not required to plead causes of action under the Customer Code. In response to these comments, FINRA proposes to replace the 14 current Lists (two general Lists and 12 separate Lists for specific types of claims) with two Lists. The Lists identify "presumptively discoverable" documents—one for firms/associated persons to produce and one for customers to produce. Although each item on the Lists (with a few exceptions) would be presumptively discoverable in every customer case, parties can still urge that certain documents should not be discoverable. Likewise, parties can ask arbitrators to order production of additional documents that are not on the Lists. The proposed rule change emphasizes that arbitrators retain the flexibility necessary to tailor the Guide to the facts and circumstances of each case. This is especially important because, with the reduction of the Lists from 14 to two, production is no longer dependent on the nature of the claim.

Proposed Revisions to the Guide's Introduction

FINRA is proposing a number of revisions to the Guide's introduction that expand the guidance given to parties and arbitrators on the discovery process generally and clarify how arbitrators should apply the Guide in arbitration proceedings.

The current Guide states that it does not intend to remove the arbitrators' and parties' flexibility in the discovery

[5] 17 CFR 200.30–3(a)(12).

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] FINRA filed SR–FINRA 2008–024 on June 11, 2008 and withdrew the filing on May 21, 2009.

process and that arbitrators can order parties to produce documents that are not on the Lists or alter the parties' production schedule. FINRA would revise the introduction to add that arbitrators also can order that parties do not have to produce certain documents on the Lists. The proposed revision would add clarity to the Guide by indicating that the arbitrator's flexibility also includes the ability to order that parties do not have to produce particular documents.

FINRA is proposing to add guidance on how arbitrators should handle objections based on cost or burden of production. The introduction would state that if a party demonstrates that the cost or burden is disproportionate to the need for the document, the arbitrators should determine if the document is relevant or likely to lead to relevant evidence. If the arbitrators determine that the document is relevant or likely to lead to relevant evidence they should consider whether there are alternatives that can lessen the impact of production, such as narrowing the time frame or scope of an item, or determining whether another document can provide the same information. Since FINRA is proposing to require production of most of the List items in every case, it is important to emphasize that arbitrators may consider alternative ways to facilitate discovery. FINRA believes the discussion will help arbitrators to balance the parties' discovery needs with the need to keep the arbitration process expeditious and cost effective.

FINRA is proposing to move to the introduction the content in current footnote one, which explains that only parties must produce documents pursuant to the Guide. FINRA is not proposing to make any substantive changes to the content of the footnote.

FINRA is proposing to state that certain items on the Lists may not be relevant in a particular case when the firm's business model (*e.g.,* full service firm, discount broker, or online broker) is considered. FINRA members create and retain various documents for business and regulatory purposes. Depending on how a firm operates, a particular item on the Lists may or may not be relevant. The proposed addition to the introduction would enhance the Guide because it makes parties and arbitrators aware that it is appropriate to recognize firm differences during the discovery process.

FINRA considers electronic files to be documents within the meaning of the Guide. FINRA is proposing to update the Guide by expressly stating that electronic files are documents within the meaning of the Guide and that arbitrators shall decide any disputes that arise about the form in which a party produces a document.

Commenters on the 2008 proposal expressed concerns that FINRA does not give arbitrators and parties enough guidance about what information they should treat as confidential. The commenters asked FINRA to incorporate into the Guide language from an article in FINRA's newsletter for arbitrators and mediators, the *Neutral Corner,*[4] that advises arbitrators that the party asserting confidentiality in the discovery process has the burden of establishing that the documents require confidential treatment and enumerates factors that arbitrators should consider when deciding questions about confidentiality. In response to the comments, FINRA is proposing to expand the discussion on confidentiality in the Guide to include the statement relating to the burden of establishing that documents require confidential treatment and to enumerate factors that arbitrators should consider when deciding questions about confidentiality. The factors include:

- Whether the disclosure would constitute an unwarranted invasion of personal privacy (*e.g.,* an individual's Social Security number, or medical information);
- Whether there is a threat of harm attendant to disclosure of the information;
- Whether the information contains proprietary confidential business plans and procedures or trade secrets;
- Whether the information has previously been published or produced without confidentiality or is already in the public domain;
- Whether an excessively broad confidentiality order could be against the public interest or could otherwise impede the interests of justice; and
- Whether there are legal or ethical issues which might be raised by excessive restrictions on the parties.

Currently, if a party states that no responsive documents for a particular item "exist," and the requesting party asks for an affirmation to that effect, the responding party is required to make such an affirmation. FINRA is proposing to delete the word "exist" and to refer instead to documents "in the party's possession, custody, or control." FINRA believes that "exist" is vague and that the new phrase would add clarity to the Guide by explaining which documents parties are required to produce. FINRA would clarify that, in appropriate cases, the arbitrators may order a party to provide an affirmation regarding a discovery request for documents beyond those contained in the Guide. FINRA also proposes to revise the Guide to emphasize that parties are not required to create documents in response to items on the Lists that are not already in the parties' possession, custody, or control.

List 1—Documents the Firm/Associated Persons Shall Produce in All Customer Cases

The documents identified in each numbered item are presumptively discoverable in every case unless the item specifically limits production to a specific type of claim. To distinguish between customers who are parties to an arbitration and other customers of a brokerage firm, the discussion below refers to customer parties as "claimants" throughout.

Proposed List 1, Item 1—In the current Guide, firms/associated persons are required to produce agreements with claimants relating to account opening documents, and new account forms, cash, margin, and option agreements, trading authorizations, discretionary authorizations, and powers of attorney (see current List 1, Item 1). FINRA is also proposing to expand this item to require firms/associated persons to produce account record information (including the claimants' names, tax identification numbers, addresses, telephone numbers, dates of birth, employment statuses, annual incomes, net worth, and account investment objectives) and documents relating to the claimants' risk tolerance. The account record contains information about the claimants that the firm recorded. The record also indicates whether the associated persons responsible for the account signed the record and whether a principal at the firm approved or accepted the record.

Proposed List 1, Item 2—The current Guide requires firms/associated persons to produce all correspondence between the claimants and the firm/associated person relating to the transactions at issue (see current List 1, item 5). Firms/associated persons are also required to produce account statements for the claimants' accounts (see current List 1, Item 2) and confirmations for the claimants' transactions at issue (see current List 1, Item 3).

FINRA is proposing to add clarity to the item by: (1) Specifying that the required documents are those that were sent to the claimants or received by the firm and relate to the accounts or

[4] The article, *Arbitrators and Orders of Confidentiality,* The Neutral Corner, April 2004, is available at: *http://www.finra.org/ArbitrationMediation/Neutrals/Education/NeutralCorner/P010040.*

transactions at issue; and (2) specifying that firms/associated persons are required to produce, among other documents, those that relate to asset allocation, diversification, trading strategies, and market conditions.

Commenters on the 2008 proposal requested that FINRA require firms/associated persons to produce statement inserts and marketing materials if requested. In response to the commenters' request, FINRA proposes to expand the item to require firms/associated persons to produce all advertising materials sent to customers of the firm that refer to the securities and/or account types that are at issue. This addition would provide claimants with documents the firm disseminated which advertised the specific products or account types that are at issue in the case, without requiring firms to produce all generic materials sent to all customers.

FINRA is proposing to eliminate the requirement that firms/associated persons produce account statements for the claimants' accounts and confirmations for the claimants' transactions at issue. In many instances, the claimants have retained account statements and/or confirmations, and requiring production of these documents in every case adds unnecessary delay and cost to the discovery process. If necessary, the claimants may request these documents separately.

Proposed List 1, Item 3—FINRA is proposing to require firms/associated persons to produce documents evidencing investment or trading strategies utilized or recommended in the claimants' accounts, including, but not limited to, options programs, and any supervisory review of such strategies. This new item in the Guide would ensure that claimants have access to evidence of trading strategies utilized or recommended that the firm/associated persons may not have publicly disseminated. The proposal also provides claimants with documentation of any management supervision over the accounts.

Proposed List 1, Item 4—In the current Guide, for claims alleging unauthorized trading, firms/associated persons are required to produce the documents they relied on to establish that claimants authorized the transactions at issue (See current List 11, Item 3). For claims alleging unauthorized trading, the proposed Guide would also require firms/associated persons to produce all documents relating to the claimants' authorization of transactions. This addition acknowledges that there may be documents in addition to those relied on by the firm that are relevant or could lead to relevant evidence.

Proposed List 1, Item 5—The current Guide requires firms/associated persons to produce, for specified claim types, all materials prepared or used by the firm/associated persons relating to the transactions or products at issue, including research reports, prospectuses, and other offering documents such as documents intended or identified as being "for internal use only," and worksheets or notes indicating the associated persons reviewed or read such documents. As an alternative, the firm/associated persons may produce a list of such documents that contains sufficient detail for the claimants to identify each document listed. Upon request by a party, the firm/associated persons are required to provide any documents identified on that alternative list (see current List 7 titled Misrepresentation/Omissions, List 9 titled Negligence/Breach of Fiduciary Duty, and List 13, Item 1 relating to claims alleging unsuitability).

FINRA is proposing to add clarity to this item by specifying that, in addition to materials prepared or used by the firm/associated persons, the firm/associated persons must produce the materials provided to the claimants. The amendments would also require production of sales materials and performance or risk data. FINRA is proposing to delete the alternative two-step production procedure to reduce delays in the discovery process.

Proposed List 1, Item 6—The current Guide requires firms/associated persons to produce all notes, including entries in any diary or calendar, relating to the claimants' accounts at issue (see current List 1, Item 6). FINRA is proposing to expand the scope of the item by requiring production of notes relating to the claimants in addition to the claimants' accounts or transactions at issue. For example, notes about the claimants' other accounts may provide evidence in the case.

Proposed List 1, Item 7—The current Guide requires firms/associated persons to produce records relating to the claimants' accounts at issue, such as internal reviews and exception and activity reports, which reference the claimants' accounts at issue (see current List 1, Item 11). FINRA is proposing to clarify the item by specifying that firms/associated persons would be required to produce notes or memoranda evidencing supervisory, compliance, or managerial review of the claimants' accounts or trades for the period at issue. The item would also require production of correspondence between the claimants and the firm/associated persons relating to the claimants' accounts or transactions that bear indications of managerial, compliance, or supervisory review of such correspondence. The Guide would address exception reports and supervisory reviews, among other documents, in proposed Item 13.

Proposed List 1, Item 8—The current Guide requires firms/associated persons to produce recordings and notes of telephone calls or conversations about the claimants' accounts at issue that occurred between the associated persons and the claimants (see current List 1, Item 7). FINRA proposes to expand this item to include telephone logs. Currently, telephone logs are only required in cases alleging unauthorized trading (see current List 11, Item 2). However, FINRA would narrow the item from records relating to the claimant's "accounts at issue" to records relating to the "transactions at issue." Producing recordings of telephone calls is labor intensive, expensive, and difficult for firms unless the claimants are able to specify a telephone call's date and time, provide the name of a person the claimants spoke to at the firm, and/or specify the trade placed during the conversation.

Proposed List 1, Item 9—FINRA is proposing to require firms/associated persons to produce writings reflecting communications between the associated persons assigned to the claimants' accounts at issue during the time period at issue and members of the firm's compliance department relating to the securities/products at issue and/or the claimants' accounts. FINRA believes that such writings may provide evidence relating to, among other matters, supervision of the associated persons handling the claimants' accounts. This item would be new in the Guide.

Proposed List 1, Item 10—The current Guide requires firms/associated persons to produce Forms RE–3, U–4, and U–5, including all amendments, customer complaints identified in the forms, and customer complaints of a similar nature against the associated persons handling the accounts at issue (see current List 1, Item 8).

FINRA proposes to amend this item to require that firms/associated persons produce Forms RE–3, U–4, and U–5, and the Disclosure Reporting Pages for the associated persons assigned to the claimants' accounts at issue during the time period at issue. Disclosure Reporting Pages, which are actually part of Forms U–4 and U–5, provide claimants with valuable, detailed information about prior customer

complaints. FINRA would narrow production of these forms to the associated persons assigned to the claimants' accounts at issue during the time period at issue, to ease the burden of production for the firms. Because of the sensitive nature of the personal information, FINRA would permit the firm to redact the associated persons' Social Security numbers.

Commenters on the 2008 proposal requested that FINRA require firms/associated persons to produce all customer complaints against the associated persons. To respond to these comments, FINRA proposes to require firms/associated persons to produce all customer complaints filed against the associated persons assigned to the accounts at issue that were generated between three years prior to the first transactions at issue through filing of the Statement of Claim, redacted to prevent disclosure of nonpublic personal information about complaining customers.

Proposed List 1, Item 11—The current Guide requires firms/associated persons to produce all sections of the firm's Compliance Manuals related to the claims alleged in the Statement of Claim, including any separate or supplemental manuals governing the duties and responsibilities of the associated persons and supervisors, any bulletins (or similar notices) issued by the compliance department, and the table of contents and index to each Manual (see current List 1, Item 9).

FINRA is proposing to amend this Item to replace compliance manuals with "manuals and all updates thereto" and compliance department with "firm." The proposal would clarify that the firm/associated persons must produce the manuals regardless of whether the firm characterizes them as "compliance manuals," and firms/associated persons must produce bulletins from any department issuing them. FINRA is also proposing to clarify that production of manuals, bulletins, and updates is required for all years in which the Statement of Claim alleges that the conduct occurred. Updates are material to establishing the firm procedures in place during a specified time frame.

FINRA would also amend the item to require firms/associated persons to provide a list of all of manuals and bulletins which may contain directives related to the conduct or product at issue in the claim. The list would enable claimants to identify any additional manual or bulletin sections that may be relevant to their claims.

Proposed List 1, Item 12—The current Guide requires firms/associated persons to produce all analyses and reconciliations of the claimants' accounts during the time period and/or relating to the transactions at issue (see current List 1, Item 10). FINRA is proposing to amend this item to clarify that production is limited to analyses and reconciliations "prepared" during the time period at issue, and includes analyses and reconciliations prepared as part of a review of the claimants' accounts or transactions at issue. These documents are valuable because they may contain firm findings concerning reviews of claimants' accounts.

Proposed List 1, Item 13—For claims alleging failure to supervise, the current Guide requires the production of all exception reports and supervisory activity reviews relating to the associated persons and/or the claimants' accounts generated not earlier than one year before or not later than one year after the transactions at issue, and all other documents reflecting supervision of the associated persons and the claimants' accounts (see current List 5, Item 2).

FINRA is proposing to require firms/associated persons to produce all exception reports, supervisory activity reviews, concentration reports, active account runs, and similar documents produced to review for activity in the claimants' accounts related to the allegations in the Statement of Claim or in which the transactions at issue are referenced or listed.

For claims alleging failure to supervise, FINRA is proposing to expand production beyond the review of activity in the claimants' accounts also to cover other customer accounts handled by associated persons at the firm. In such cases, FINRA is proposing to require firms/associated persons to produce all exception reports, supervisory activity reviews, concentration reports, active account runs, and similar documents produced to review for activity in customer accounts handled by associated persons and related to the allegations in the Statement of Claim that were generated not earlier than one year before or not later than one year after the transactions at issue.

FINRA would limit production to documents related to the allegations made in the Statement of Claim to ease the burden of production for firms/associated persons. FINRA believes that narrowing the item would not negatively impact claimants because firms/associated persons would continue to produce reports related to the claimants' claims.

Proposed List 1, Item 14—For claims alleging failure to supervise, the current Guide requires production of the portions of internal audit reports at the branch in which the claimants maintained accounts that focused on the associated persons or the transactions at issue, and were generated not earlier than one year before or not later than one year after the transactions at issue and discussed alleged improper behavior in the branch against other individuals similar to the improper conduct alleged in the Statement of Claim (see current List 5, Item 3). FINRA is not proposing any substantive changes to this Item.

Proposed List 1, Item 15—The current Guide requires the production of records of disciplinary action taken against associated persons by any regulator or employer for all sales practice violations or conduct similar to the conduct alleged to be at issue (see current List 1, Item 12). FINRA is not proposing any substantive changes to this item.

Proposed List 1, Item 16—FINRA is proposing to require firms/associated persons to produce all investigations, charges, or findings by any regulator (state, federal or self-regulatory organization) and the firm/associated persons' responses to such investigations, charges, or findings for the associated persons' alleged improper behavior similar to that alleged in the Statement of Claim. This new item in the Guide would expand the scope of documents that relate to the associated persons' disciplinary history.

Proposed List 1, Item 17—For claims alleging failure to supervise, the current Guide requires production of the portions of examination reports or similar reports following an examination or an inspection conducted by a state or federal agency or a self-regulatory organization that focused on the associated persons or the transactions at issue or that discussed alleged improper behavior in the branch against other individuals similar to the improper conduct alleged in the Statement of Claim (see current List 5, Item 4). Commenters on the 2008 proposal requested that FINRA include a time limit for production of these documents. In response to these comments, FINRA is proposing to limit production to those reports issued for the period one year before the transactions at issue through the filing of the Statement of Claim. FINRA believes that restricting the time frame for production would reduce the firms' burden of production and offset the expansion of this production to all cases while ensuring that claimants have access to the reports that relate to their claims.

Proposed List 1, Item 18—FINRA is proposing to require firms/associated persons to produce documents the respondents obtained by subpoena or by document requests directed to third parties. While this item would be new in the Guide, it is not a new requirement because the subpoena rule, Rule 12512(e), already requires production of subpoenaed documents. FINRA is proposing to cross-reference that rule in the Guide. FINRA would also add documents received by request directed to third parties at any time during the case to ensure that all parties have access to documents obtained without a subpoena from non-parties.

Proposed List 1, Items 19, 20, and 21—In the current Guide, firms/associated persons are required to produce documents relating to associated persons' commissions and/or compensation when claimants allege churning (see current List 3, Items 1–3), failure to supervise (see current List 5, Item 1), or unsuitability (see current List 13, Item 2).

Proposed List 1, Item 19—FINRA is proposing to require firms/associated persons to produce documents showing the associated persons' gross and net compensation for the transactions at issue in the Statement of Claim. This is new in the Guide. Documentation of compensation on an order-by-order basis provides parties with a clear understanding of how much firms paid associated persons for the trading at issue. If the accounts at issue were the subject of fee arrangements that are not based on remuneration per trade, firms/associated persons would be required to produce a record of compensation earned for the period when the transactions in the accounts took place.

Proposed List 1, Item 20—The current Guide requires firms/associated persons to produce commission runs relating to the claimants' accounts at issue or, in the alternative, a consolidated commission report relating to the accounts (see current List 3, Item 1). It also requires firms/associated persons to produce documents reflecting compensation of any kind, including commissions, from all sources generated by the associated persons assigned to the claimants' accounts for the two months preceding, through the two months following, the transactions at issue, or up to 12 months, whichever is longer. The firm may redact all information identifying customers who are not parties to the action except for the last four digits of the non-party customer account number for each transaction (see current List 3, Item 2).

In addition, for claims related to solicited trading activity, FINRA is proposing to require the firm/associated persons to produce a record of all compensation, monetary and non-monetary, including, but not limited to, monthly commission runs for the associated persons who handled the claimants' accounts. That record should reflect the securities traded, dates traded, whether the trades were solicited or unsolicited, and the gross and net commission from each trade. Firms would be required to produce this record for a period of time beginning three months before and ending three months after the trades at issue in the claimants' accounts. FINRA is proposing to impose this additional production only in claims relating to solicited trading activity because the records would be most relevant to such activity. The required documents may provide claimants with evidence regarding the extent to which the associated person recommended securities to other customers.

The firm may redact names and other non-public personal information concerning customers who are not parties to this claim, but would be required to provide sufficient information to identify: (1) The non-party customers' accounts, including the last four digits of the non-party customers' account numbers; (2) the associated persons' own and related accounts, including the last four digits of the associated persons' account numbers; and (3) the type of account (IRA, 401(k), etc.). Activity in the associated persons' account may be correlated to the transactions in the customers' accounts.

Proposed List 1, Item 21—The current Guide requires firms/associated persons to produce documents describing the basis upon which the firm compensated the associated persons during the years in which the transactions or occurrences in question occurred, including any bonus or incentive program, and compensation and commission schedules (see current List 3, Item 3 and current List 13, Item 2). FINRA would add clarity to this item by requiring production of a record of all agreements pertaining to the relationship between the associated person and the firm, summarizing the associated person's compensation arrangement or plan with the firm, including commission and concession schedules, bonus or incentive plans, and schedules showing compensation. If the firm based the associated persons' compensation on factors other than remuneration per trade, the item would require documentation of the method by which compensation was determined.

Proposed List 1, Item 22—For claims with allegations relating to an insurance product that includes a death benefit, FINRA is proposing to require firms/associated persons to produce all information concerning the claimants' insurance holdings and the recommendations, if any, to the claimants regarding insurance products. This new requirement in the Guide could provide parties with evidence in cases involving annuities.

Items Firms/Associated Persons Would No Longer Be Required To Produce

Holding Pages—In the current Guide, firms/associated persons are required to produce holding pages for the claimants' accounts at issue (see current List 1, Item 4). FINRA is proposing to delete this item from the Guide because holding pages (hand written records of transactions made and kept by associated persons) are, generally, no longer in use. Firms provide transaction information to customers on account statements and/or confirmations.

Order tickets—In the current Guide, firms/associated persons are required to produce order tickets for the claimants' transactions in cases alleging unauthorized trading (see current List 11, Item 1). FINRA is proposing to delete this requirement from the Guide because production of order tickets is burdensome and evidence relating to whether the claimants authorized a particular transaction would be produced under proposed List 1, Items 4, 6, and 8.

List 2—Documents the Customers Shall Produce in All Customer Cases

The documents identified in each numbered item are presumptively discoverable in every case unless the item specifically limits production to a specific type of claim.

As stated above, to distinguish between customers who are parties to an arbitration and other customers of a brokerage firm, the discussion below refers to customer parties as "claimants" throughout.

Proposed List 2, Item 1—In the current Guide, claimants are required to produce all claimant and claimant-owned business (including partnership or corporate) federal income tax returns, limited to pages 1 and 2 of Form 1040, Schedules B, D, and E, or the equivalent for any other type of return, for the three years prior to the first transaction at issue in the Statement of Claim through the date the Statement of Claim was filed (see current List 2, Item 1). FINRA is proposing to expand this item to require production of Form 1040 schedule A and the IRS worksheets

related to Schedules A, B, D, and E. The expanded production would provide parties with a broader understanding of the claimants' financial status and investment activity during the relevant period. The amendments would provide that the income tax returns must be identical to those that the claimants filed with the Internal Revenue Service.

Because of the sensitive nature of the personal information, FINRA would permit claimants to redact their Social Security numbers. FINRA would also permit claimants to redact information relating to medical and dental expenses and the names of charities on Schedule A unless the information relates to the allegations in the Statement of Claim.

Proposed List 2, Item 2—The current Guide requires claimants to produce financial statements or similar statements of the claimants' assets, liabilities, and/or net worth for the period covering the three years prior to the first transaction at issue in the Statement of Claim through the date the claimants filed the Statement of Claim (see current List 2, Item 2). FINRA is proposing to add clarity to this item by specifying that financial statements include statements within a loan application. The item would also provide that claimants are not required to create financial statements in order to comply with the item.

Proposed List 2, Item 3—The current Guide requires claimants to produce copies of all documents received from the firm/associated persons and from any entities in which the claimants invested through the firm/associated persons, including monthly statements, opening account forms, confirmations, prospectuses, annual and periodic reports, and correspondence (see current List 2, Item 3). FINRA is proposing to expand this item to include research reports. Research reports may provide evidence concerning the basis for the claimants' investment decisions.

FINRA is proposing to eliminate mandatory production of account statements and confirmations if claimants stipulate to having received them. The amendments would require claimants to produce any statements or confirmations with hand written notations on them or which are not identical to those sent by the firm. The amendments would decrease claimants' discovery costs while preserving the requirement to produce documents that may have probative value.

Proposed List 2, Item 4—The current Guide requires claimants to produce account statements and confirmations for accounts maintained at securities firms other than the respondent firm for the three years prior to the first transaction at issue in the Statement of Claim through the date the claimants filed the Statement of Claim (see current List 2, Item 4). FINRA is proposing to amend this item to permit claimants to provide written authorization allowing the firm/associated persons to obtain account statements directly from the securities firms instead of providing copies of the statements. If the claimants elect to provide written authorization to the firm/associated persons to obtain the account statements, the claimants would still be required to provide all account statements in the claimants' possession, custody, or control with hand written notations on them or which are not identical to those sent by the firm. The proposal would ensure that other parties to the matter have a complete understanding of the claimants' investing history. FINRA proposes to eliminate confirmations from the item to ease the burden for investors. If necessary, firms would be able to request confirmations separately.

Proposed List 2, Item 5—The current Guide requires claimants to produce agreements, forms, information, or documents relating to the accounts at issue signed by or provided by the claimants to the firm/associated persons (see current List 2, Item 5). FINRA is proposing to expand the scope of this item by requiring production of documents relating to accounts or transactions at the firm regardless of whether claimants signed the documents.

Proposed List 2, Item 6—The current Guide requires claimants to produce account analyses and reconciliations prepared by or for the claimants relating to the accounts at issue (see current List 2, Item 6). FINRA is proposing to provide clarity to this item by changing "the account(s) at issue" to "the accounts at the respondent firm or transactions with the respondent firm during the time period at issue."

Proposed List 2, Item 7—The current Guide requires claimants to produce notes, including entries in diaries or calendars, relating to the accounts at issue (see current List 2, Item 7). FINRA is proposing to amend this item to provide clarity by changing "the account(s) at issue" to "accounts at the respondent firm or transactions at issue with the respondent firm."

Proposed List 2, Item 8—The current Guide requires claimants to produce recordings and notes of telephone calls or conversations about the claimants' accounts at issue that occurred between the associated persons and the claimants (and any person purporting to act on behalf of the claimants) (see current List 2, Item 8). For claims alleging unauthorized trading, claimants are also required to produce telephone records, including telephone logs, evidencing telephonic contact between the claimants and the firm/associated persons (see current List 12, Item 1). FINRA is proposing to combine these items into new Item 8. FINRA is not proposing any substantive changes to the items.

Proposed List 2, Item 9—The current Guide requires claimants to produce correspondence between the claimants (and any person acting on behalf of the claimants) and the firm/associated persons relating to the accounts at issue (see current List 2, Item 9). FINRA is proposing to amend this item to broaden the scope of production by deleting the reference to firm/associated persons. The claimants may have corresponded with persons/entities unrelated to the firm concerning the transactions at issue.

Proposed List 2, Item 10—The current Guide requires claimants to produce previously prepared written statements by persons with knowledge of the facts and circumstances related to the accounts at issue, including those by accountants, tax advisors, financial planners, other associated persons, and any other third party (see current List 2, Item 10). FINRA is not proposing any substantive changes to the current item.

Proposed List 2, Item 11—The current Guide requires claimants to produce complaints/Statements of Claim and answers filed in all civil actions involving securities matters and securities arbitration proceedings, and all final decisions and awards entered in these matters (see current List 2, Item 12). FINRA is proposing to expand the scope of this item by requiring claimants to produce non-confidential settlements entered in these matters because the subject matter of non-confidential settlements may be relevant to the pending case. The item would specify that claimants must produce the documents for all claims or complaints filed prior to the filing of the current Statement of Claim.

FINRA is also proposing to add that, if a person is party to a confidential settlement agreement that by its terms does not preclude identification of the existence of the settlement agreement, the party must identify the documents comprising the confidential settlement agreement. The proposed change would state that, although not presumptively discoverable, the panel could order the claimants to produce a confidential settlement agreement. The proposal would ensure that parties are aware of

other securities actions in which the claimants were parties.

Proposed List 2, Item 12—For claims alleging misrepresentation/omissions (see current List 8, Item 1), negligence/breach of fiduciary duty (see current List 10, item 1), or unsuitability (see current List 14, Item 1), the current Guide requires claimants to produce documents showing the claimants' ownership in or control over any business entity, including general and limited partnerships and closely held corporations. FINRA is proposing to expand the scope of this item to require that if the claimants are Trustees, they must also provide documents showing all accounts over which they have trading authority. The Trustees' trading activity for other accounts may provide evidence of the Trustees' investment sophistication.

Proposed List 2, Item 13—For claims alleging unsuitability, the current Guide requires claimants to produce written documents they relied upon in making the investment decisions at issue (see current List 14, Item 2). FINRA is proposing to delete the reference to "documents relied upon" and require production of all documents the claimants "received, including documents found through the claimants' own efforts, relating to the investments at issue." Documents the claimants received that relate to the investment at issue could provide relevant evidence in a case even if the claimants did not rely on them in making an investment decision.

Proposed List 2, Item 14—For claims alleging unauthorized trading, the current Guide requires claimants to produce documents relied on to show that transactions were made without the claimants' knowledge or consent (see current List 12, Item 2). FINRA is not proposing any substantive changes to the item and is proposing to limit the item to claims alleging unauthorized trading.

Proposed List 2, Item 15—FINRA is proposing to require claimants to produce all materials received or obtained from any source relating to the transactions or products at issue, and other investment opportunities, including research reports, sales literature, performance or risk data, prospectuses, and other offering documents, including documents intended or identified as being "for internal use only," and worksheets or notes. This item would be new in the Guide. Production of these documents may provide evidence concerning the bases for claimants' trading decisions. Therefore, FINRA also is proposing to require claimants to produce any similar materials received or obtained relating to other investment opportunities.

Proposed List 2, Item 16—For claims alleging misrepresentation/omission (see current List 8, Item 2), negligence/breach of fiduciary duty (see current List 10, Item 2), or unsuitability (see current List 14, Item 3), claimants are required to produce a copy of their resumes. While FINRA is not proposing any substantive changes to the item, claimants would be required to produce the documents in every case.

Proposed List 2, Item 17—For claims alleging misrepresentation/omission (see current List 8, Item 3), negligence/breach of fiduciary duty (see current List 10, Item 3), or unsuitability (see current List 14, Item 4), claimants are required to produce documents showing their educational and employment background, or a description of their background if not set forth in a resume. While FINRA is not proposing any substantive changes to the item, claimants would be required to produce the documents in every case.

Proposed List 2, Item 18—FINRA is proposing to require claimants to produce documents the claimants obtained by subpoena or by document requests directed to third parties. While this item would be new in the Guide, it is not a new requirement because the subpoena rule, Rule 12512(e), already requires production of subpoenaed documents. FINRA is proposing to cross-reference that rule in the Guide. FINRA would also add documents received by request directed to third parties at any time during the case, to ensure that all parties have access to documents obtained without a subpoena from non-parties.

Proposed List 2, Item 19—For claims involving an insurance product that provides a death benefit, FINRA is proposing to require claimants to produce all insurance information received from an insurance sales agent or securities broker relating to the insurance. This new requirement in the Guide could provide parties with evidence that may be relevant in cases involving annuities.

Items Customers Would No Longer Be Required To Produce

Claimants' complaints—The current Guide requires claimants to produce all prior complaints by or on behalf of the claimants involving securities matters and the firm's/associated persons' responses (see current List 2, Item 11). FINRA is proposing to delete this item as unnecessary because the respondent firm/associated persons would be in possession of such complaints and any responsive documents.

Claimants' action to limit losses—The current Guide requires claimants to produce all documents showing action taken by the claimants to limit losses in the transactions at issue (see current List 2, Item 13). FINRA is proposing to delete this item because, in most instances, the firm/associated persons are in possession of any documents that would be responsive to this item. If necessary, firms would be able to request additional documents.

Conforming Changes

FINRA is proposing to amend Rules 12506 (Document Production Lists) and 12508 (Objecting to Discovery; Waiver of Objection) to remove references to Lists three through 14 since FINRA would delete these lists in the proposed Guide.

2. Statutory Basis

FINRA believes that the proposed rule change is consistent with the provisions of Section 15A(b)(6) of the Act,[5] which requires, among other things, that FINRA rules must be designed to prevent fraudulent and manipulative acts and practices, to promote just and equitable principles of trade, and, in general, to protect investors and the public interest. FINRA believes that these revisions to the Guide will reduce the number and limit the scope of disputes involving document production and other matters, thereby improving the arbitration process for the benefit of the public investors, broker-dealer firms, and associated persons who use the process.

B. Self-Regulatory Organization's Statement on Burden on Competition

FINRA does not believe that the proposed rule change will result in any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

Written comments were neither solicited nor received.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

Within 35 days of the date of publication of this notice in the **Federal Register** or within such longer period (i) as the Commission may designate up to 90 days of such date if it finds such longer period to be appropriate and publishes its reasons for so finding or

[5] 15 U.S.C. 78o–3(b)(6).

(ii) as to which the self-regulatory organization consents, the Commission will:

(A) By order approve such proposed rule change, or

(B) Institute proceedings to determine whether the proposed rule change should be disapproved.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's Internet comment form (*http://www.sec.gov/rules/sro.shtml*); or
- Send an e-mail to *rule-comments@sec.gov*. Please include File Number SR–FINRA–2010–035 on the subject line.

Paper Comments

- Send paper comments in triplicate to Elizabeth M. Murphy, Secretary, Securities and Exchange Commission, 100 F Street, NE., Washington, DC 20549–1090.

All submissions should refer to File Number SR–FINRA–2010–035. This file number should be included on the subject line if e-mail is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's Internet Web site (*http://www.sec.gov/rules/sro.shtml*). Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for Web site viewing and printing in the Commission's Public Reference Room, 100 F Street, NE., Washington, DC 20549, on official business days between the hours of 10 a.m. and 3 p.m. Copies of such filing also will be available for inspection and copying at the principal office of FINRA. All comments received will be posted without change; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR–FINRA–2010–035 and should be submitted on or before August 24, 2010.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[6]

Florence E. Harmon,

Deputy Secretary.

[FR Doc. 2010–18999 Filed 8–2–10; 8:45 am]

BILLING CODE 8010–01–P

SOCIAL SECURITY ADMINISTRATION

Agency Information Collection Activities: Proposed Request, Comment Request

The Social Security Administration (SSA) publishes a list of information collection packages requiring clearance by the Office of Management and Budget (OMB) in compliance with Public Law (Pub. L.) 104–13, the Paperwork Reduction Act of 1995, effective October 1, 1995. This notice includes extensions of OMB-approved information collections.

SSA is soliciting comments on the accuracy of the agency's burden estimate; the need for the information; its practical utility; ways to enhance its quality, utility, and clarity; and ways to minimize burden on respondents, including the use of automated collection techniques or other forms of information technology. Mail, email, or fax your comments and recommendations on the information collection(s) to the OMB Desk Officer and SSA Reports Clearance Director to the following addresses or fax numbers.

(OMB), Office of Management and Budget, Attn: Desk Officer for SSA, Fax: 202–395–6974, E-mail address: *OIRA_Submission@omb.eop.gov.*

(SSA), Social Security Administration, DCBFM, Attn: Reports Clearance Officer, 1333 Annex Building, 6401 Security Blvd., Baltimore, MD 21235, Fax: 410–965–6400, E-mail address: *OPLM.RCO@ssa.gov.*

I. The information collection below is pending at SSA. SSA will submit it to OMB within 60 days from the date of this notice. To be sure we consider your comments, we must receive them no later than October 4, 2010. Individuals can obtain copies of the collection instruments by calling the SSA Director for Reports Clearance at 410–965–0454 or by writing to the above e-mail address.

Work History Report—20 CFR 404.1515, 404.1560, 404.1565, 416.960 and 416.965–0960–0578. Under certain circumstances, SSA asks individuals about work they have performed in the past. Applicants use Form SSA–3369 to provide detailed information about jobs held prior to becoming unable to work. State Disability Determination Services evaluate the information, together with medical evidence, to determine eligibility for disability.

Type of Request: Revision of an OMB-approved information collection.

Collection method	Number of respondents	Frequency of response	Average burden per response (hours)	Estimated annual burden hours
SSA–3369 (Paper form)	1,090,346	1	1	1,090,346
EDCS 3369	607,122	1	1	607,122
Totals	1,697,468			1,697,468

II. SSA has submitted the information collections listed below to OMB for clearance. Your comments on the information collections would be most useful if OMB and SSA receive them within 30 days from the date of this publication. To be sure we consider your comments, we must receive them no later than September 2, 2010. You can obtain a copy of the OMB clearance packages by calling the SSA Director for Reports Clearance at 410–965–0454 or by writing to the above e-mail address.

Application for Child's Insurance Benefits—20 CFR 404.350–404.368, 404.603, & 416.350—0960–0010. SSA uses Form SSA–4–BK to determine if

[6] 17 CFR 200.30–3(a)(12).

children of living and deceased workers are entitled to their parents' monthly Social Security payments. The respondents are guardians completing the form on behalf of the children of living or deceased workers, or the children of living or deceased workers.

Type of Request: Revision of an OMB-approved information collection.

Collection method	Number of respondents	Frequency of response	Response time (minutes)	Burden (hours)
Life claims (paper)	8,052	1	12	1,610
Life Claims (MCS)	152,983	1	12	30,597
Life Claims- Signature Proxy	152,983	1	11	28,047
Death Claims (paper)	19,061	1	12	3,812
Death Claims (MCS)	362,150	1	12	72,430
Death Claims-Signature Proxy	362,150	1	11	66,394
Totals	1,057,379			202,890

Liz Davidson,

Director, Center for Reports Clearance, Social Security Administration.

[FR Doc. 2010–19024 Filed 8–2–10; 8:45 am]

BILLING CODE 4191–02–P

OFFICE OF THE UNITED STATES TRADE REPRESENTATIVE

Request for Comments and Notice of Public Hearing Concerning China's Compliance With WTO Commitments

AGENCY: Office of the United States Trade Representative.

ACTION: Request for comments and notice of public hearing concerning China's compliance with its WTO commitments.

SUMMARY: The interagency Trade Policy Staff Committee (TPSC) will convene a public hearing and seek public comment to assist the Office of the United States Trade Representative (USTR) in the preparation of its annual report to the Congress on China's compliance with the commitments made in connection with its accession to the World Trade Organization (WTO).

DATES: Persons wishing to testify at the hearing must provide written notification of their intention, as well as a copy of their testimony, by noon, Wednesday, September 22, 2010. Written comments are due by noon, Monday, September 27, 2010. A hearing will be held in Washington, DC, on Wednesday, October 6, 2010.

ADDRESSES: Comments should be submitted electronically via the Internet at *http://www.regulations.gov.* For alternatives to on-line submissions please contact Gloria Blue, Executive Secretary, Trade Policy Staff Committee, at (202) 395–3475.

FOR FURTHER INFORMATION CONTACT: For procedural questions concerning written comments or participation in the public hearing, contact Gloria Blue, (202) 395–3475. All other questions should be directed to Terrence J. McCartin, Deputy Assistant United States Trade Representative for China Enforcement, (202) 395–3900, or Eric I. Garfinkel, Chief Counsel for China Trade, (202) 395–3150.

SUPPLEMENTARY INFORMATION:

1. Background

China became a Member of the WTO on December 11, 2001. In accordance with section 421 of the U.S.-China Relations Act of 2000 (Pub. L. 106–286), USTR is required to submit, by December 11 of each year, a report to Congress on China's compliance with commitments made in connection with its accession to the WTO, including both multilateral commitments and any bilateral commitments made to the United States. In accordance with section 421, and to assist it in preparing this year's report, the TPSC is hereby soliciting public comment. Last year's report is available on USTR's Internet Web site (at *http://www.ustr.gov/sites/default/files/2009%20China%20Report%20to%20Congress.pdf*).

The terms of China's accession to the WTO are contained in the Protocol on the Accession of the People's Republic of China (including its annexes) (Protocol), the Report of the Working Party on the Accession of China (Working Party Report), and the WTO agreements. The Protocol and Working Party Report can be found on the Department of Commerce Webpage, *http://www.mac.doc.gov/China/WTOAccessionPackage.htm,* or on the WTO Web site, *http://docsonline.wto.org* (document symbols: WT/L/432, WT/MIN(01)/3, WT/MIN(01)/3/Add.1, WT/MIN(01)/3/Add.2).

2. Public Comment and Hearing

USTR invites written comments and/or oral testimony of interested persons on China's compliance with commitments made in connection with its accession to the WTO, including, but not limited to, commitments in the following areas: (a) Trading rights; (b) import regulation (e.g., tariffs, tariff-rate quotas, quotas, import licenses); (c) export regulation; (d) internal policies affecting trade (e.g., subsidies, standards and technical regulations, sanitary and phytosanitary measures, government procurement, trade-related investment measures, taxes and charges levied on imports and exports); (e) intellectual property rights (including intellectual property rights enforcement); (f) services; (g) rule of law issues (*e.g.,* transparency, judicial review, uniform administration of laws and regulations) and status of legal reform; and (h) other WTO commitments. In addition, given the United States' view that China should be held accountable as a full participant in, and beneficiary of, the international trading system, USTR requests that interested persons also specifically identify unresolved compliance issues that warrant review and evaluation by USTR's China Enforcement Task Force.

Written comments must be received no later than noon, Monday, September 27, 2010.

A hearing will be held on Wednesday, October 6, 2010, in Room 1, 1724 F Street, NW., Washington, DC 20508. If necessary, the hearing will continue on the next business day.

Persons wishing to testify orally at the hearing must provide written notification of their intention by noon, Wednesday, September 22, 2010. The notification should include: (1) The name, address, and telephone number of the person presenting the testimony; and (2) a short (one or two paragraph) summary of the presentation, including the commitments at issue and, as applicable, the product(s) (with HTSUS numbers), service sector(s), or other subjects to be discussed. A copy of the

testimony must accompany the notification. Remarks at the hearing should be limited to no more than five minutes to allow for possible questions from the TPSC.

All documents should be submitted in accordance with the instructions in section 3 below.

3. Requirements for Submissions

Persons submitting intent to testify and/or comments must do so in English and must identify (on the first page of the submission) "China's WTO Compliance."

In order to ensure the most timely and expeditious receipt and consideration of comments, USTR has arranged to accept on-line submissions via *http://www.regulations.gov.* To submit comments via *http://www.regulations.gov,* enter docket number USTR–2010–0019 on the home page and click "go". The site will provide a search-results page listing all documents associated with this docket. Find a reference to this notice by selecting "Notice" under "Document Type" on the left side of the search-results page, and click on the link entitled "Send a Comment or Submission." (For further information on using the *www.regulations.gov http://www.regulations.gov/*> Web site, please consult the resources provided on the website by clicking on "How to Use This Site" on the left side of the home page.)

The *http://www.regulations.gov* Web site provides the option of making submissions by filling in a "General Comments" field, or by attaching a document. We expect that most submissions will be provided in an attached document. If a document is attached, it is sufficient to type "See attached" in the "General Comments" field.

Submit any documents containing business confidential information, beginning with the characters "BC". Submit, as a separate submission, a public version of the submission with a file name beginning with the character "P". The "BC" and "P" should be followed by the name of the person or entity submitting the comments. For comments that contain no business confidential information, the file name should begin with the character "P", followed by the name of the person or entity submitting the comments. Electronic submissions should not attach separate cover letters; rather, information that might appear in a cover letter should be included in the comments you submit. Similarly, to the extent possible, please include any exhibits, annexes, or other attachments to a submission in the same file as the submission itself and not as separate files.

We strongly urge submitters to use electronic filing. If an on-line submission is impossible, alternative arrangements must be made with Ms. Blue prior to delivery for the receipt of such submissions. Ms. Blue may be contacted at (202) 395–3475.

General information concerning USTR may be obtained by accessing its Internet Web site (*http://www.ustr.gov*).

Carmen Suro-Bredie,

Chairman, Trade Policy Staff Committee.

[FR Doc. 2010–19066 Filed 8–2–10; 8:45 am]

BILLING CODE 3190–W0–P

DEPARTMENT OF TRANSPORTATION

ITS Joint Program Office; IntelliDrive℠ Task Force Meeting; Notice of Meeting

AGENCY: Research and Innovative Technology Administration, U.S. Department of Transportation.

ACTION: Notice.

The USDOT Intelligent Transportation Systems (ITS) Joint Program Office will hold a meeting with the Institute of Transportation Engineers (ITE) IntelliDrive Task Force on August 10 and 11, 2010 during the ITE's Annual meeting at the Vancouver Convention and Exhibit Center, 1055 Canada Place, Vancouver, BC V6C 0C3, Canada.

The purpose of the meeting is to review various aspects of the IntelliDrive research program and to obtain stakeholder input on user needs for the definition of the core IntelliDrive System. The ITE IntelliDrive Task Force represents transportation engineering professionals from the public and private sectors.

The meeting is open to the public at no charge (public attendees do not need to register for the ITE meeting). However please RSVP your intent to attend to Delores Colbert at *delores.colbert@dot.gov* and include the following in the subject line: ITE IntelliDrive Task Force Meeting.

Following is the meeting preliminary agenda: Day one; ITE IntelliDrive Task Force Committee Business, IntelliDrive mobility program summary, IntelliDrive safety program policy research roadmap, IntelliDrive infrastructure deployment scenarios research, and IntelliDrive systems engineering research project overview. Day two; IntelliDrive systems engineering user needs gathering exercise.

Information about the IntelliDrive research program is available at: *http://www.its.dot.gov/index.htm.* Additional opportunities to provide input to the IntelliDrive systems engineering research program are available on August 25–26, 2010 in Detroit, MI (9–4:30 local time) and September 1–2, 2010 in San Jose, CA (9–4:30 local time). Information is available at: *http://www.its.dot.gov/press/2010/intellidrive_user_workshop.htm.*

Issued in Washington, DC, on the 28th day of July 2010.

Linda Dodge,

Chief of Staff, ITS Joint Program Office.

[FR Doc. 2010–18992 Filed 8–2–10; 8:45 am]

BILLING CODE 4910–HY–P

DEPARTMENT OF TRANSPORTATION

Federal Transit Administration

[FTA Docket No. FTA–2010–0028]

Agency Information Collection Activity Under OMB Review

AGENCY: Federal Transit Administration, DOT.

ACTION: Notice of request for comments.

SUMMARY: The Federal Transit Administration invites public comment about our intention to request the Office of Management and Budget's (OMB) to approve the revision of the currently approved information collection: 49 U.S.C. Sections 5310 and 5311—Capital Assistance Program for Elderly Persons and Persons with Disabilities and Nonurbanized Area Formula Program. The **Federal Register** Notice with a 60-day comment period soliciting comments was published on May 21, 2010.

DATES: Comments must be submitted before September 2, 2010. A comment to OMB is most effective if OMB receives it within 30 days of publication.

FOR FURTHER INFORMATION CONTACT: LaStar Matthews, Office of Administration, Office of Management Planning, (202) 366–2295.

SUPPLEMENTARY INFORMATION:

Title: 49 U.S.C. Sections 5310 and 5311—Capital Assistance Program for Elderly Persons and Persons with Disabilities and Nonurbanized Area Formula Program (OMB Number 2132–0500)

Abstract: The Capital Assistance Program for Elderly Persons and Persons with Disabilities provides financial assistance for the specialized transportation service needs of elderly persons and persons with disabilities. The program is administered by the States and may be used in all areas,

urbanized, small urban, and rural. The Nonurbanized Area Formula Program provides financial assistance for the provision of public transportation services in nonurbanized areas and this program is also administered by the States. 49 U.S.C. sections 5310 and 5311 authorize FTA to review applications for federal financial assistance to determine eligibility and compliance with statutory and administrative requirements. Information collected during the application stage includes the project budget, which identifies funds requested for project implementation; a program of projects, which identifies subrecipients to be funded, amount of funding that each will receive, and a description of the projects to be funded; the project implementation plan; the State management plan; a list of annual certifications and assurances; and public hearings notice, certification and transcript. The applications must contain sufficient information to enable FTA to make the findings required by law to enforce the program requirements. Information collected during the project management stage includes an annual financial report, an annual program status report, and pre-award and post-delivery audits. The annual financial report and program status report provide a basis for monitoring approved projects to ensure timely and appropriate expenditure of federal funds by grant recipients.

Estimated Total Annual Burden: 11,775 hours.

ADDRESSES: All written comments must refer to the docket number that appears at the top of this document and be submitted to the Office of Information and Regulatory Affairs, Office of Management and Budget, 725—17th Street, NW. Washington, DC 20503, Attention: FTA Desk Officer.

Comments Are Invited On: Whether the proposed collection of information is necessary for the proper performance of the functions of the Department, including whether the information will have practical utility; the accuracy of the Department's estimate of the burden of the proposed information collection; ways to enhance the quality, utility, and clarity of the information to be collected; and ways to minimize the burden of the collection of information on respondents, including the use of automated collection techniques or other forms of information technology.

Issued: July 28, 2010.

Ann M. Linnertz,

Associate Administrator for Administration.

[FR Doc. 2010–18942 Filed 8–2–10; 8:45 am]

BILLING CODE P

DEPARTMENT OF TRANSPORTATION

Federal Highway Administration

Final Federal Agency Actions on Trans-Texas Corridor 35 (TTC–35) in Texas

AGENCY: Federal Highway Administration (FHWA), DOT.

ACTION: Notice of Limitation on Claims for Judicial Review of Actions by FHWA

SUMMARY: This notice announces actions taken by the FHWA that are final within the meaning of 23 U.S.C. 139(l)(1). The actions relate to a proposed transportation project, TTC–35, extending from the Texas-Oklahoma line to the City of Laredo, generally paralleling existing I–35 in the State of Texas.

DATES: By this notice, the FHWA is advising the public of final agency actions subject to 23 U.S.C. 139(l)(1). A claim seeking judicial review of the Federal agency actions on the highway project will be barred unless the claim is filed on or before January 31, 2011. If the Federal law that authorizes judicial review of a claim provides a time period of less than 180 days for filing such claim, then that shorter time period still applies.

FOR FURTHER INFORMATION CONTACT: Mr. Gregory Punske, P.E., District Engineer, District B (South), Federal Highway Administration, 300 East 8th Street, Room 826 Austin, Texas 78701; telephone: (512) 536–5960; e-mail: *gregory.punske@fhwa.dot.gov.* The FHWA Texas Division Office's normal business hours are 7:45 a.m. to 4:15 p.m. (central time) Monday through Friday. You may also contact Dianna Noble, P.E., Texas Department of Transportation, Environmental Affairs Division, 118 E. Riverside Drive, Austin, Texas 78704; telephone: (512) 416–2734; e-mail: *dnoble@dot.state.tx.us.* The Texas Department of Transportation's normal business hours are 8 a.m. to 5 p.m. (central time) Monday through Friday.

SUPPLEMENTARY INFORMATION: Notice is hereby given that the FHWA has taken final agency actions by issuing approval for the No Action Alternative for the following transportation project in the State of Texas: The TTC–35 project as proposed generally parallels I–35 from the Texas-Oklahoma state line to the City of Laredo. TTC–35 was envisioned as a multi-modal corridor to meet the transportation challenges of the I–35 corridor. EIS No. 20100133. The actions by the Federal agencies, and the laws under which such actions were taken, are described in the Final Environmental Impact Statement (FEIS) for the project, approved on February 24, 2010, in the FHWA Record of Decision (ROD) issued on July 20, 2010 and in other documents in the FHWA administrative record. The FEIS, ROD, and other documents in the FHWA administrative record file are available by contacting the FHWA or the Texas Department of Transportation at the addresses provided above.

This notice applies to all Federal agency decisions as of the issuance date of this notice and all laws under which such actions were taken, including but not limited to:

1. *General:* National Environmental Policy Act (NEPA) [42 U.S.C. 4321-4335]; Federal-Aid Highway Act [23 U.S.C. 109].

2. *Air:* Clean Air Act, 42 U.S.C. 7401–7671(q).

3. *Land:* Section 4(f) of the Department of Transportation Act of 1966 [49 U.S.C. 303].

4. *Wildlife:* Endangered Species Act [16 U.S.C. 1531–1544] Fish and Wildlife Coordination Act [16 U.S.C. 661–667(d)], Migratory Bird Treaty Act [16 U.S.C. 703–712].

5. *Historic and Cultural Resources:* Section 106 of the National Historic Preservation Act of 1966, as amended [16 U.S.C. 470(f) *et seq.*]; Archeological Resources Protection Act of 1977 [16 U.S.C. 470(aa)–(11)]ogical and Historic Preservation Act [16 U.S.C. 469–469(c)].

6. *Social and Economic:* Civil Rights Act of 1964 [42 U.S.C. 2000(d)-2000(d)(1)]; Farmland Protection Policy Act (FPPA) [7 U.S.C. 4201–4209].

7. *Wetlands and Water Resources:* Clean Water Act, 33 U.S.C. 1251–1342; Land and Water Conservation Fund (LWCF), 16 U.S.C. 4601–4604.

8. *Executive Orders:* E.O. 11990 Protection of Wetlands; E.O. 11988 Floodplain Management; E.O. 12898, Federal Actions to Address Environmental Justice in Minority Populations and Low Income Populations; E.O. 11514 Protection and Enhancement of Environmental Quality.

(Catalog of Federal Domestic Assistance Program Number 20.205, Highway Planning and Construction. The regulations implementing Executive Order 12372 regarding intergovernmental consultation on Federal programs and activities apply to this program.)

Authority: 23 U.S.C. 139(l)(1).

Issued on: July 27, 2010.

Gregory S. Punske,

District Engineer, Austin, Texas.

[FR Doc. 2010–18954 Filed 8–2–10; 8:45 am]

BILLING CODE 4910–22–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

[Summary Notice No. PE–2007–54]

Petition for Exemption; Summary of Petition Received

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of petition for exemption received.

SUMMARY: This notice contains a summary of a petition seeking relief from specified requirements of 14 CFR. The purpose of this notice is to improve the public's awareness of, and participation in, this aspect of FAA's regulatory activities. Neither publication of this notice nor the inclusion or omission of information in the summary is intended to affect the legal status of the petition or its final disposition.

DATES: Comments on this petition must identify the petition docket number involved and must be received on or before August 23, 2010.

ADDRESSES: You may send comments identified by Docket Number FAA–2009–0796 using any of the following methods:

- *Government-wide rulemaking Web site:* Go to *http://www.regulations.gov* and follow the instructions for sending your comments electronically.
- *Mail:* Send comments to the Docket Management Facility; U.S. Department of Transportation, 1200 New Jersey Avenue, SE., West Building Ground Floor, Room W12–140, Washington, DC 20590.
- *Fax:* Fax comments to the Docket Management Facility at 202–493–2251.
- *Hand Delivery:* Bring comments to the Docket Management Facility in Room W12–140 of the West Building Ground Floor at 1200 New Jersey Avenue, SE., Washington, DC, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

Privacy: We will post all comments we receive, without change, to *http://www.regulations.gov*, including any personal information you provide. Using the search function of our docket Web site, anyone can find and read the comments received into any of our dockets, including the name of the individual sending the comment (or signing the comment for an association, business, labor union, etc.). You may review DOT's complete Privacy Act Statement in the **Federal Register** published on April 11, 2000 (65 FR 19477–78).

Docket: To read background documents or comments received, go to *http://www.regulations.gov* at any time or to the Docket Management Facility in Room W12–140 of the West Building Ground Floor at 1200 New Jersey Avenue, SE., Washington, DC, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

FOR FURTHER INFORMATION CONTACT: Laverne Brunache, 202–267–3133, or Tyneka L. Thomas, 202–267–7626, Office of Rulemaking, Federal Aviation Administration, 800 Independence Avenue, SW., Washington, DC 20591.

This notice is published pursuant to 14 CFR 11.85.

Issued in Washington, DC, on July 28, 2010.

Pamela Hamilton-Powell,

Director, Office of Rulemaking.

Petition for Exemption

Docket No.: FAA–2009–0796.

Petitioner: Florida Air Transport, Inc.

Section of 14 CFR Affected: §§ 119.1(a)(2), 119.5(h), 119.23, and 125.1.

Description of Relief Sought: Florida Air Transport seeks an exemption from 14 CFR 119.1(a)(2), 119.5(h), 119.23, and 125.1 to operate DC–4 aircraft in common carriage with a payload greater than 6,000 pounds.

[FR Doc. 2010–18986 Filed 8–2–10; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Pipeline and Hazardous Materials Safety Administration

[Docket No. PHMSA–2010–0194]

Pipeline Safety: Personal Electronic Device Related Distractions

AGENCY: Pipeline and Hazardous Materials Safety Administration (PHMSA); DOT.

ACTION: Notice; Issuance of Advisory Bulletin.

SUMMARY: PHMSA is issuing an Advisory Bulletin to remind owners and operators of natural gas and hazardous liquid pipeline facilities of the risks associated with the use of personal electronic devices (PEDs) by individuals performing operations and maintenance activities on a pipeline facility.

FOR FURTHER INFORMATION CONTACT: Cameron Satterthwaite by phone at 202–366–1319 or by e-mail at *cameron.satterthwaite@dot.gov.* General information about the Department of Transportation initiative on distracted driving may be found at *http://www.distractions.gov.* Information about PHMSA may be found at *http://phmsa.dot.gov.*

SUPPLEMENTARY INFORMATION:

Background

The U.S. Department of Transportation is leading the effort to end the dangerous practice of distracted driving on our nation's roadways and in other modes of transportation. The use of PEDs, such as cellular telephones and mobile computers, while operating motor vehicles has been the subject of recent Departmental regulations and guidance. (*e.g.,* Restrictions on Railroad Operating Employees' Use of Cellular Telephones and Other Electronic Devices, 75 FR 9754, May 18, 2010; Limiting the Use of Wireless Communication Devices, 75 FR 16391, April 1, 2010.) In furtherance of this effort, PHMSA recognizes that the use of PEDs by pipeline employees who are performing operations and maintenance activities may pose a similar risk to safety if those individuals are distracted, especially when such use is for personal business.

The Federal pipeline safety regulations in 49 CFR Parts 190 through 199 prescribe minimum safety standards for pipeline transportation and for pipeline facilities. Owners and operators of natural gas and hazardous liquid pipeline facilities are required to have and follow written procedures for safely conducting operations and maintenance tasks. (49 CFR 192.605, 193.2503, and 195.402) Individuals performing those tasks, particularly activities that affect the operation or integrity of the pipeline facility, must be qualified under a program developed by each operator that ensures individuals are trained and have the knowledge, skills, and ability necessary to perform the tasks safely and to recognize and react to abnormal conditions. (49 CFR 192.805, 193.2707, and 195.505.)

There may be increased risks associated with the use of PEDs by personnel performing pipeline activities affecting operation or integrity. Pipeline operations and maintenance tasks require a critical level of attention and skill, which may be compromised by visual, manual, or cognitive distractions caused by the use of PEDs. Such distractions may also hinder their prompt recognition and reaction to abnormal operating conditions and emergencies.

PHMSA recommends that operators integrate into their written procedures for operations and maintenance appropriate controls regarding the use of PEDs by individuals performing pipeline tasks that may affect pipeline operation or integrity. PHMSA is not discouraging the use of PEDs as a part of normal business operations. PHMSA

also recommends that operators provide guidance and training for all personnel about the risks associated with the use of PEDs while driving, and while performing activities on behalf of the company if that use poses a risk to safety.

Advisory Bulletin (ADB–10–06)

To: Owners and Operators of Hazardous Liquid and Natural Gas Pipeline Systems.

Subject: Personal Electronic Device (PED) Related Distractions.

Advisory: As with other modes of transportation, PHMSA recognizes the use of PEDs by pipeline employees who are performing operations and maintenance activities may increase safety risks if those individuals become distracted. In furtherance of the Department's effort to end the dangerous practice of distractions caused by PEDs throughout the various modes of transportation, PHMSA is issuing this Advisory Bulletin about the potential for distractions affecting pipeline safety.

PHMSA reminds owners and operators of natural gas and hazardous liquid pipeline facilities that there may be increased risks associated with the use of PEDs by individuals performing activities that affect pipeline operation or integrity. Pipeline operations and maintenance tasks require a critical level of attention and skill, which may be compromised by visual, manual, and cognitive distractions caused by the use of PEDs. Such distractions may also hinder their prompt recognition and reaction to abnormal operating conditions and emergencies.

Owners and operators of natural gas and hazardous liquid pipeline facilities should integrate into their written procedures for operations and maintenance appropriate controls regarding the personal use of PEDs by individuals performing pipeline tasks that may affect the operation or integrity of a pipeline. PHMSA is not discouraging the use of PEDs as a part of normal business operations. Owners and operators should also provide guidance and training for all personnel about the risks associated with the use of PEDs while driving and while performing activities on behalf of the company if that use poses a risk to safety.

Issued in Washington, DC, on July 27, 2010.

Jeffrey D. Wiese,

Associate Administrator for Pipeline Safety.

[FR Doc. 2010–18947 Filed 8–2–10; 8:45 am]

BILLING CODE 4910–60–P

DEPARTMENT OF TRANSPORTATION

[Docket No. PHMSA–2010–0202; Notice No. 10–5]

Safety Advisory Notice: Personal Electronic Device Related Distractions

AGENCY: Pipeline and Hazardous Materials Safety Administration (PHMSA); DOT.

ACTION: Notice.

SUMMARY: PHMSA is issuing a safety advisory notice to remind offerors and carriers of hazardous materials of the risks associated with the use of personal electronic devices (PEDs) by individuals operating motor vehicles that contain hazardous materials.

FOR FURTHER INFORMATION CONTACT: Stuart Streck by telephone at (404) 832–1140 or by e-mail at *stuart.streck@dot.gov.* General information about the Department of Transportation initiative on distracted driving may be found at *http://www.distractions.gov.* Information about PHMSA may be found at *http://phmsa.dot.gov.*

SUPPLEMENTARY INFORMATION: Research conducted by the United States Department of Transportation (DOT) and other governmental and non-governmental organizations has shown the danger posed by drivers who are distracted by cellular telephones and other PEDs. For example, Virginia Tech Transportation Institute conducted a study under contract with Federal Motor Carrier Safety Administration (FMCSA) entitled "Driver Distraction in Commercial Vehicle Operations." The final report, released on October 1, 2009, found that text messaging on a cellular telephone increased the risk of a safety-critical event by 23.2 percent.

The DOT is leading the effort to end the dangerous practice of distracted driving on our nation's roadways and in other modes of transportation. The FMCSA recently initiated a rulemaking designed to prohibit texting by commercial motor vehicle (CMV) drivers operating in interstate commerce and to impose sanctions for drivers who fail to comply. *See* Limiting the Use of Wireless Communication Devices, 75 FR 16391 (proposed Apr. 1, 2010). The majority of the 50 states have forbidden the operation of PEDs while driving any motor vehicle. *See* DOT Distracted Driving Web site, *http://www.distractions.gov; see also* Insurance Institute for Highway Safety Web site, *http://www.iihs.org/.*

PHMSA's Office of Hazardous Materials Safety is the Federal safety authority for the transportation of hazardous materials by air, rail, highway, and water. Safety is at the core of PHMSA's mission. PHMSA strives to reduce the risk of harm from the transportation of hazardous materials. In light of PHMSA's vital safety mission, we issue this advisory bulletin to raise awareness of the problems and dangers presented by the use of PEDs by hazardous materials drivers.

Operators of vehicles transporting hazardous materials should guard against distraction, including the use of PEDs while operating a vehicle. All CMV drivers transporting hazardous materials should be aware that the use of a PED while driving constitutes a safety risk to themselves, other motorists, and bystanders. The consequences of using PEDs while driving can include state and local sanctions, FMCSA fines, and possible revocation of commercial driver's licenses.

In addition, businesses that prepare or transport hazardous materials in commerce should be aware that the dangers of distracted driving are heightened due to the risk of the release of hazardous materials in the event of an accident. Accordingly, hazardous materials companies should institute policies and provide awareness training to discourage the use of PEDs by drivers. PHMSA recognizes that there are already members of the hazardous materials transportation community with policies in place that exceed the legal requirements for curbing the risk of distracted driving. PHMSA applauds these and all other efforts to enhance the safety of hazardous materials transportation.

Issued in Washington, DC, on July 27, 2010.

Magdy El-Sibaie,

Associate Administrator for Hazardous Materials Safety.

[FR Doc. 2010–18944 Filed 8–2–10; 8:45 am]

BILLING CODE 4910–60–P

TENNESSEE VALLEY AUTHORITY

Paperwork Reduction Act of 1995, as Amended by Public Law 104–13; Proposed Collection, Comment Request

AGENCY: Tennessee Valley Authority.

ACTION: Proposed collection; comment request.

SUMMARY: The proposed information collection described below will be submitted to the Office of Management and Budget (OMB) for review, as required by the Paperwork Reduction Act of 1995 (44 U.S.C. chapter 35, as

amended). The Tennessee Valley Authority is soliciting public comments on this proposed collection as provided by 5 CFR 1320.8(d)(1). Requests for information, including copies of the information collection proposed and supporting documentation, should be directed to the Agency Clearance Officer: Mark Winter, Tennessee Valley Authority, 1101 Market Street (MP–3C), Chattanooga, Tennessee 37402–2801; (423) 751–6004.

Comments should be sent to the Agency Clearance Officer or to OMB Office of Information and Regulatory Affairs, Attention: Desk Officer for Tennessee Valley Authority, Washington, DC 20503, no later than *September 2, 2010.*

SUPPLEMENTARY INFORMATION:

Type of Request: Regular submission.

Title of Information Collection: Employment Application.

Frequency of Use: On Occasion.

Type of Affected Public: Individuals.

Small Businesses or Organizations Affected: No.

Federal Budget Functional Category Code: 999.

Estimated Number of Annual Responses: 39,925.

Estimated Total Annual Burden Hours: 35,161.

Estimated Average Burden Hours per Response: .88.

Need For and Use of Information: The employment application process collects information on qualifications, suitability for employment, and eligibility for veteran's preference. The information is used to make comparative appraisals and to assist in selections. The affected public consists of individuals who apply for TVA employment.

James W. Sample,

Director, Enterprise Information Security and Policy.

[FR Doc. 2010–18959 Filed 8–2–10; 8:45 am]

BILLING CODE 8120–08–P

Federal Register

Tuesday,
August 3, 2010

Book 2 of 3 Books
Pages 45699–46168

Part II

Department of Health and Human Services

Centers for Medicare and Medicaid

42 CFR Parts 410, 416 and 419

Medicare Program: Changes to the Hospital Outpatient Prospective Payment System and CY 2010 Payment Rates; Changes to the Ambulatory Surgical Center Payment System and CY 2010 Payment Rates; Corrections; Final Rule, Notice, and Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 410, 416, and 419

[CMS–1414–CN2]

RIN 0938–AP41

Medicare Program: Changes to the Hospital Outpatient Prospective Payment System and CY 2010 Payment Rates; Changes to the Ambulatory Surgical Center Payment System and CY 2010 Payment Rates; Corrections

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

ACTION: Correction of final rule with comment period.

SUMMARY: This document corrects technical errors that appeared in the final rule with comment period found in the **Federal Register** (FR) on November 20, 2009, entitled "Medicare Program: Changes to the Hospital Outpatient Prospective Payment System and CY 2010 Payment Rates; Changes to the Ambulatory Surgical Center Payment System and CY 2010 Payment Rates" and in the correction document found in the **Federal Register** on December 31, 2009, entitled "Medicare Program: Changes to the Hospital Outpatient Prospective Payment System and CY 2010 Payment Rates; Changes to the Ambulatory Surgical Center Payment System and CY 2010 Payment Rates."

DATES: *Effective Date:* This document is effective on August 3, 2010.

Applicability Date: The corrections in this document are applicable on and after January 1, 2010.

FOR FURTHER INFORMATION CONTACT: Alberta Dwivedi, (410) 786–0378.

SUPPLEMENTARY INFORMATION:

I. Background

In FR Doc. E0–26499 of November 20, 2009 (74 FR 60316) (hereinafter referred to as the CY 2010 OPPS/ASC final rule), there were several technical and typographic errors. Some of these errors were corrected in the correction document of December 31, 2009 (74 FR 69502) (hereinafter referred to as the December 31, 2009 CY 2010 OPPS/ASC correction document). We identified additional errors to the practice expense (PE) relative value units (RVUs) and the conversion factor (CF) for the Medicare Physician Fee Schedule (MPFS) in the November 25, 2009 Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2010 final rule with comment period (74 FR 61738) (hereinafter referred to as the CY 2010 MPFS final rule), which were corrected in the May 11, 2010 CY 2010 MPFS correction document (75 FR 26350). The revised ASC payment system uses the PE RVUs and the CF for the MPFS as part of the office-based and ancillary radiology payment methodology. This notice updates the CY 2010 OPPS/ASC final rule to include these additional corrections.

The provisions in this correction document are effective as if they had been included in the CY 2010 OPPS/ASC final rule appearing in the November 20, 2009 **Federal Register** (74 FR 60316). Accordingly, the corrections are effective January 1, 2010.

II. Summary of Errors

A. Errors in the December 31, 2009 Correction

In the December 31, 2009 CY 2010 OPPS/ASC correction document, we republished Addendum AA on pages 69505 through 69629 and Addendum BB on pages 69630 through 69675 to take into account updated CY 2010 MPFS information. As required under § 416.171(d), the revised ASC payment system limits payment for office-based procedures and covered ancillary radiology services to the lesser of the ASC rate or the amount calculated by multiplying the nonfacility PE RVUs for the service by the CF under the MPFS. However, the MPFS CF and PE RVUs listed for some CPT codes in Addendum B to the CY 2010 MPFS final rule (74 FR 62017) were incorrect due to certain technical errors and, consequently, were corrected in a December 10, 2009 correction document to the CY 2010 MPFS final rule (74 FR 65450). Since the ASC payment amounts for office-based procedures and covered ancillary radiology services are determined using the amounts in the MPFS final rule, we corrected the CY 2010 payment amounts for ASC procedures and services using the corrected MPFS amounts in the December 31, 2009 CY 2010 OPPS/ASC correction document.

Additional technical and typographical errors were discovered in the CY 2010 MPFS final rule, as well as the December 10, 2009 CY 2010 MPFS correction document. These changes were corrected in the May 11, 2010 CY 2010 MPFS correction document (75 FR 26350). That correction document:

- Made corrections to the PE and malpractice (MP) RVUs to align their values to the final CY 2010 MPFS policies for PE and MP RVUs; and
- Made corrections to the CF resulting from corrections to the PE and MP RVUs to align their values with the final CY 2010 MPFS policies for PE and MP RVUs, taking into consideration comments received from the public and further review following display of the CY 2010 MPFS final rule.

We refer readers to the May 11, 2010 CY 2010 MPFS correction document (75 FR 26350) for more information on the changes made to the MPFS.

In summary, addenda AA and BB in the December 31, 2009 CY 2010 OPPS/ASC correction document contained errors in the rates for surgical procedures designated as office-based and for covered ancillary radiology procedures which are corrected in this notice.

B. Correction of Errors in the December 31, 2010 Correction

The changes to the MPFS impacted multiple codes within Addenda AA and BB. Therefore, we are republishing Addenda AA and BB, which were republished on pages 69505 through 69629 and 69630 through 69675 of the December 31, 2009 CY 2010 OPPS/ASC correction document to take into account the updated CY 2010 MPFS information. The ASC payment amounts for office-based procedures and covered ancillary radiology services are determined using the MPFS final calendar year CF and PE RVUs. We must correct the CY 2010 payment amounts for covered office-based procedures and covered ancillary radiology services using the final CY 2010 corrected MPFS values. The revised rates continue to reflect the negative update to the MPFS for CY 2010 based on current law at the time of publication of the CY 2010 MPFS final rule and the corrections to the RVUs and CFs. The corrected payment amounts are reflected in Addenda AA and BB to this correction document and also are posted on the CMS Web site at: *http://www.cms.gov/ASCPayment.*

We note that the Department of Defense Appropriations Act, 2010 (Pub. L. 111–118), the Temporary Extension Act of 2010 (Pub. L. 111–144), and the Continuing Extension Act of 2010 (Pub. L. 111–157) extended a zero percent update for the MPFS from January 1, 2010 through May 31, 2010. We are publishing a notice around the same time as this correction document announcing certain provision of the Patient Protection and Affordable Care Act (Affordable Care Act), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA), for CY 2010. Because the changes required by the Affordable Care Act and HCERA are effective January 1, 2010, and because the public laws listed above

authorize a zero percent update for the MPFS for CY 2010 through May 31, 2010, the notice incorporates a zero percent update for MPFS payment. If Congress chooses not to extend the zero percent MPFS update beyond May 31, 2010 or chooses to revise the MPFS update to be something other than zero, we will recalculate the payment rates presented in that notice based on the CY 2010 MPFS payment rates calculated using the revised update factor.

The payment rates presented in this correction document technical corrections made to the CY 2010 OPPS/ASC final rule and will not be used for payment. The payment rates presented in the notice being published around the same time as this correction document are the final ASC payment rates from January 1, 2010, through May 31, 2010. We recalculated the ASC payment rates, including budget neutrality calculations, in that notice to reflect changes created by the Affordable Care Act and HCERA, and the technical corrections addressed in this correction document.

IV. Waiver of Proposed Rulemaking and Delay in Effective Date

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** to provide a period for public comment before the provisions of a notice such as this take effect, in accordance with the Administrative Procedure Act (APA) (5 U.S.C. 553(b)). We also ordinarily provide a 30-day delay in the effective date of the provisions of a notice in accordance with the APA (5 U.S.C. 553(d)). However, we can waive both the notice and comment procedures and the 30-day delay in the effective date if the Secretary finds, for good cause, that it is impracticable, unnecessary or contrary to the public interest to follow the notice and comment procedures or to comply with the 30-day delay in the effective date, and incorporates a statement of the finding and the reasons therefor in the notice. This correction document merely provides technical corrections to the CY 2010 OPPS/ASC final rule, as corrected by the December 31, 2009 CY 2010 OPPS/ASC correction document, that was effective on January 1, 2010. The provisions of the CY 2010 OPPS/ASC final rule were promulgated through notice and comment rulemaking, and the corrections contained in this document do not make substantive changes to the policies or payment methodologies that were finalized in the CY 2010 OPPS/ASC final rule. In addition, we believe it is in the public interest to have the correct information and to have it as soon as possible and not delay its dissemination. For the reasons stated above, we find that both notice and comment procedures and the 30-day delay in effective date for this correction document are unnecessary and contrary to the public interest. Therefore, we find there is good cause to waive notice and comment procedures and the 30-day delay in effective date for this correction document.

(Catalog of Federal Domestic Assistance Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: June 24, 2010.

Dawn L. Smalls,

Executive Secretary to the Department.

Therefore, CMS is republishing Addenda AA and BB, which were republished on pages 69505 through 69629 and 69630 through 69675 of the December 31, 2009, CY 2010 OPPS/ASC correction document to take into account the updated CY 2010 MPFS information.

Addendum AA -- Final ASC Covered Surgical Procedures for CY 2010 (Including Surgical Procedures for Which Payment is Packaged)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
0016T	Thermotx choroid vasc lesion	Y		R2	5.5965	$234.34
0017T	Photocoagulat macular drusen	Y		R2	5.5965	$234.34
0084T	Temp prostate urethral stent	N	CH	D5		
0086T	L ventricle fill pressure	N	CH	D5		
0099T*	Implant corneal ring	Y		R2	15.5449	$650.91
0100T	Prosth retina receive&gen	Y		G2	38.2338	$1,600.96
0101T	Extracorp shockwv tx,hi enrg	Y		G2	30.396	$1,272.77
0102T	Extracorp shockwv tx,anesth	Y		G2	30.396	$1,272.77
0123T	Scleral fistulization	Y		G2	23.3455	$977.55
0124T*	Conjunctival drug placement	Y		R2	4.3122	$180.56
0170T	Anorectal fistula plug rpr	N	CH	D5		
0176T	Aqu canal dilat w/o retent	Y		A2	37.7011	$1,578.66
0177T	Aqu canal dilat w retent	Y		A2	37.7011	$1,578.66
0186T	Suprachoroidal drug delivery	Y		G2	19.8176	$829.82
0190T	Place intraoc radiation src	Y		G2	19.8176	$829.82
0191T	Insert ant segment drain int	Y		G2	23.3455	$977.55
0192T	Insert ant segment drain ext	Y		G2	40.0704	$1,677.87
0193T	Rf bladder neck microremodel	Y	CH	G2	19.1572	$802.17
0200T	Perq sacral augmt unilat inj	Y		G2	21.0617	$881.92
0201T	Perq sacral augmt bilat inj	Y		G2	30.396	$1,272.77
0213T	Us facet jt inj cerv/t 1 lev	Y	NI	G2	6.8884	$288.44
0214T	Us facet jt inj cerv/t 2 lev	Y	NI	G2	2.4451	$102.38
0215T	Us facet jt inj cerv/t 3 lev	Y	NI	G2	2.4451	$102.38
0216T	Us facet jt inj ls 1 level	Y	NI	G2	6.8884	$288.44
0217T	Us facet jt inj ls 2 level	Y	NI	G2	2.4451	$102.38
0218T	Us facet jt inj ls 3 level	Y	NI	G2	2.4451	$102.38
10021	Fna w/o image	Y		P2	1.4457	$60.54
10022	Fna w/image	Y		G2	4.4	$184.24
10040	Acne surgery	Y		P2	0.8408	$35.21
10060	Drainage of skin abscess	Y		P3		$42.58
10061	Drainage of skin abscess	Y		P2	1.3927	$58.32
10080	Drainage of pilonidal cyst	Y		P2	1.3927	$58.32
10081	Drainage of pilonidal cyst	Y		P3		$108.15
10120	Remove foreign body	Y		P3		$59.04
10121	Remove foreign body	Y		A2	15.1023	$632.38
10140	Drainage of hematoma/fluid	Y		P3		$63.02
10160	Puncture drainage of lesion	Y	CH	P3		$52.52
10180	Complex drainage, wound	Y		A2	16.472	$689.73
11000	Debride infected skin	Y		P3		$20.15
11001	Debride infected skin add-on	Y		P3		$6.81
11010	Debride skin, fx	Y		A2	4.5669	$191.23

Addendum AA -- Final ASC Covered Surgical Procedures for CY 2010 (Including Surgical Procedures for Which Payment is Packaged)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
11011	Debride skin/muscle, fx	Y		A2	4.5669	$191.23
11012	Debride skin/muscle/bone, fx	Y		A2	4.5669	$191.23
11040	Debride skin, partial	Y		P3		$18.45
11041	Debride skin, full	Y		P3		$20.44
11042	Debride skin/tissue	Y		A2	2.947	$123.40
11043	Debride tissue/muscle	Y		A2	2.947	$123.40
11044	Debride tissue/muscle/bone	Y		A2	8.3025	$347.65
11055	Trim skin lesion	Y		P3		$21.86
11056	Trim skin lesions, 2 to 4	Y		P3		$23.84
11057	Trim skin lesions, over 4	Y	CH	P3		$26.68
11100	Biopsy, skin lesion	Y	CH	P3		$49.39
11101	Biopsy, skin add-on	Y		P3		$11.64
11200	Removal of skin tags	Y	CH	P3		$35.20
11201	Remove skin tags add-on	Y		P3		$4.83
11300	Shave skin lesion	Y	CH	P3		$33.21
11301	Shave skin lesion	Y		P2	0.8408	$35.21
11302	Shave skin lesion	Y		P2	0.8408	$35.21
11303	Shave skin lesion	Y	CH	P3		$55.64
11305	Shave skin lesion	Y	CH	P3		$29.52
11306	Shave skin lesion	Y		P2	0.8408	$35.21
11307	Shave skin lesion	Y		P2	0.8408	$35.21
11308	Shave skin lesion	Y		P2	0.8408	$35.21
11310	Shave skin lesion	Y		P2	0.8408	$35.21
11311	Shave skin lesion	Y		P2	0.8408	$35.21
11312	Shave skin lesion	Y		P2	0.8408	$35.21
11313	Shave skin lesion	Y		P2	0.8408	$35.21
11400	Exc tr-ext b9+marg 0.5 < cm	Y		P3		$56.21
11401	Exc tr-ext b9+marg 0.6-1 cm	Y		P3		$63.30
11402	Exc tr-ext b9+marg 1.1-2 cm	Y		P3		$69.55
11403	Exc tr-ext b9+marg 2.1-3 cm	Y		P3		$74.94
11404	Exc tr-ext b9+marg 3.1-4 cm	Y		A2	14.457	$605.36
11406	Exc tr-ext b9+marg > 4.0 cm	Y		A2	15.1023	$632.38
11420	Exc h-f-nk-sp b9+marg 0.5 <	Y		P3		$53.08
11421	Exc h-f-nk-sp b9+marg 0.6-1	Y		P3		$64.15
11422	Exc h-f-nk-sp b9+marg 1.1-2	Y		P3		$70.12
11423	Exc h-f-nk-sp b9+marg 2.1-3	Y		P3		$78.06
11424	Exc h-f-nk-sp b9+marg 3.1-4	Y		A2	15.1023	$632.38
11426	Exc h-f-nk-sp b9+marg > 4 cm	Y		A2	19.3292	$809.37
11440	Exc face-mm b9+marg 0.5 < cm	Y		P3		$60.18
11441	Exc face-mm b9+marg 0.6-1 cm	Y		P3		$69.83
11442	Exc face-mm b9+marg 1.1-2 cm	Y		P3		$76.93

Addendum AA -- Final ASC Covered Surgical Procedures for CY 2010 (Including Surgical Procedures for Which Payment is Packaged)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
11443	Exc face-mm b9+marg 2.1-3 cm	Y		P3		$85.44
11444	Exc face-mm b9+marg 3.1-4 cm	Y		A2	7.7878	$326.10
11446	Exc face-mm b9+marg > 4 cm	Y		A2	19.3292	$809.37
11450	Removal, sweat gland lesion	Y		A2	19.3292	$809.37
11451	Removal, sweat gland lesion	Y		A2	19.3292	$809.37
11462	Removal, sweat gland lesion	Y		A2	19.3292	$809.37
11463	Removal, sweat gland lesion	Y		A2	19.3292	$809.37
11470	Removal, sweat gland lesion	Y		A2	19.3292	$809.37
11471	Removal, sweat gland lesion	Y		A2	19.3292	$809.37
11600	Exc tr-ext mlg+marg 0.5 < cm	Y		P3		$80.05
11601	Exc tr-ext mlg+marg 0.6-1 cm	Y		P3		$95.95
11602	Exc tr-ext mlg+marg 1.1-2 cm	Y		P3		$105.32
11603	Exc tr-ext mlg+marg 2.1-3 cm	Y		P3		$112.41
11604	Exc tr-ext mlg+marg 3.1-4 cm	Y		A2	8.2762	$346.55
11606	Exc tr-ext mlg+marg > 4 cm	Y		A2	15.1023	$632.38
11620	Exc h-f-nk-sp mlg+marg 0.5 <	Y		P3		$82.32
11621	Exc h-f-nk-sp mlg+marg 0.6-1	Y		P3		$97.08
11622	Exc h-f-nk-sp mlg+marg 1.1-2	Y		P3		$107.59
11623	Exc h-f-nk-sp mlg+marg 2.1-3	Y		P3		$116.67
11624	Exc h-f-nk-sp mlg+marg 3.1-4	Y		A2	15.1023	$632.38
11626	Exc h-f-nk-sp mlg+mar > 4 cm	Y		A2	19.3292	$809.37
11640	Exc face-mm malig+marg 0.5 <	Y		P3		$86.86
11641	Exc face-mm malig+marg 0.6-1	Y		P3		$101.62
11642	Exc face-mm malig+marg 1.1-2	Y		P3		$113.26
11643	Exc face-mm malig+marg 2.1-3	Y		P3		$122.91
11644	Exc face-mm malig+marg 3.1-4	Y		A2	15.1023	$632.38
11646	Exc face-mm mlg+marg > 4 cm	Y		A2	19.3292	$809.37
11719	Trim nail(s)	Y		P3		$10.22
11720	Debride nail, 1-5	Y		P3		$12.49
11721	Debride nail, 6 or more	Y		P3		$15.05
11730	Removal of nail plate	Y		P2	0.8408	$35.21
11732	Remove nail plate, add-on	Y		P3		$15.05
11740	Drain blood from under nail	Y		P2	0.4244	$17.77
11750	Removal of nail bed	Y		P3		$80.90
11752	Remove nail bed/finger tip	Y		P3		$112.98
11755	Biopsy, nail unit	Y		P3		$55.64
11760	Repair of nail bed	Y		G2	1.2956	$54.25
11762	Reconstruction of nail bed	Y		P3		$104.18
11765	Excision of nail fold, toe	Y		P2	0.8408	$35.21
11770	Removal of pilonidal lesion	Y		A2	19.6948	$824.68
11771	Removal of pilonidal lesion	Y		A2	19.6948	$824.68

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
11772	Removal of pilonidal lesion	Y		A2	19.6948	$824.68
11900	Injection into skin lesions	Y		P3		$24.70
11901	Added skin lesions injection	Y	CH	P3		$27.25
11920	Correct skin color defects	Y		P3		$76.93
11921	Correct skin color defects	Y		P3		$85.44
11922	Correct skin color defects	Y		P3		$28.10
11950	Therapy for contour defects	Y		P3		$28.67
11951	Therapy for contour defects	Y		P3		$36.90
11952	Therapy for contour defects	Y	CH	P3		$47.12
11954	Therapy for contour defects	Y		P2	1.2956	$54.25
11960	Insert tissue expander(s)	Y		A2	19.7192	$825.70
11970	Replace tissue expander	Y		A2	36.3344	$1,521.43
11971	Remove tissue expander(s)	Y		A2	18.6836	$782.34
11976	Removal of contraceptive cap	Y		P3		$51.66
11980	Implant hormone pellet(s)	N		P2	0.6403	$26.81
11981	Insert drug implant device	N		P2	0.6403	$26.81
11982	Remove drug implant device	N		P2	0.6403	$26.81
11983	Remove/insert drug implant	N		P2	0.6403	$26.81
12001	Repair superficial wound(s)	Y	CH	P3		$53.65
12002	Repair superficial wound(s)	Y		P2	1.2956	$54.25
12004	Repair superficial wound(s)	Y		P2	1.2956	$54.25
12005	Repair superficial wound(s)	Y		A2	1.4926	$62.50
12006	Repair superficial wound(s)	Y		A2	1.4926	$62.50
12007	Repair superficial wound(s)	Y		A2	1.4926	$62.50
12011	Repair superficial wound(s)	Y		P2	1.2956	$54.25
12013	Repair superficial wound(s)	Y		P2	1.2956	$54.25
12014	Repair superficial wound(s)	Y		P2	1.2956	$54.25
12015	Repair superficial wound(s)	Y		G2	1.2956	$54.25
12016	Repair superficial wound(s)	Y		A2	1.4926	$62.50
12017	Repair superficial wound(s)	Y		A2	1.4926	$62.50
12018	Repair superficial wound(s)	Y		A2	1.4926	$62.50
12020	Closure of split wound	Y		A2	3.706	$155.18
12021	Closure of split wound	Y		A2	2.782	$116.49
12031	Intmd wnd repair s/tr/ext	Y		P2	1.2956	$54.25
12032	Intmd wnd repair s/tr/ext	Y		P2	3.0144	$126.22
12034	Intmd wnd repair s/tr/ext	Y		A2	1.4926	$62.50
12035	Intmd wnd repair s/tr/ext	Y		A2	1.4926	$62.50
12036	Intmd wnd repair s/tr/ext	Y		A2	2.782	$116.49
12037	Intmd wnd repair s/tr/ext	Y		A2	4.1074	$171.99
12041	Intmd wnd repair n-hf/genit	Y		P2	1.2956	$54.25
12042	Intmd wnd repair n-hg/genit	Y		P2	1.2956	$54.25

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
12044	Intmd wnd repair n-hg/genit	Y		A2	1.4926	$62.50
12045	Intmd wnd repair n-hg/genit	Y		A2	2.782	$116.49
12046	Intmd wnd repair n-hg/genit	Y		A2	2.782	$116.49
12047	Intmd wnd repair n-hg/genit	Y		A2	4.1074	$171.99
12051	Intmd wnd repair face/mm	Y		P2	1.2956	$54.25
12052	Intmd wnd repair face/mm	Y		P2	1.2956	$54.25
12053	Intmd wnd repair face/mm	Y		P2	1.2956	$54.25
12054	Intmd wnd repair, face/mm	Y		A2	1.4926	$62.50
12055	Intmd wnd repair face/mm	Y		A2	2.782	$116.49
12056	Intmd wnd repair face/mm	Y		A2	2.782	$116.49
12057	Intmd wnd repair face/mm	Y		A2	4.1074	$171.99
13100	Repair of wound or lesion	Y		A2	5.0314	$210.68
13101	Repair of wound or lesion	Y		A2	5.0314	$210.68
13102	Repair wound/lesion add-on	Y		A2	3.706	$155.18
13120	Repair of wound or lesion	Y		A2	2.782	$116.49
13121	Repair of wound or lesion	Y		A2	2.782	$116.49
13122	Repair wound/lesion add-on	Y		A2	1.4926	$62.50
13131	Repair of wound or lesion	Y		A2	2.782	$116.49
13132	Repair of wound or lesion	Y		A2	3.706	$155.18
13133	Repair wound/lesion add-on	Y		A2	2.782	$116.49
13150	Repair of wound or lesion	Y		A2	5.0314	$210.68
13151	Repair of wound or lesion	Y		A2	5.0314	$210.68
13152	Repair of wound or lesion	Y		A2	5.0314	$210.68
13153	Repair wound/lesion add-on	Y		A2	2.782	$116.49
13160	Late closure of wound	Y		A2	19.7192	$825.70
14000	Skin tissue rearrangement	Y		A2	14.0668	$589.02
14001	Skin tissue rearrangement	Y		A2	14.4325	$604.33
14020	Skin tissue rearrangement	Y		A2	14.4325	$604.33
14021	Skin tissue rearrangement	Y		A2	14.4325	$604.33
14040	Skin tissue rearrangement	Y		A2	14.0668	$589.02
14041	Skin tissue rearrangement	Y		A2	14.4325	$604.33
14060	Skin tissue rearrangement	Y		A2	14.4325	$604.33
14061	Skin tissue rearrangement	Y		A2	14.4325	$604.33
14300	Skin tissue rearrangement	N	CH	D5		
14301	Skin tissue rearrangement	Y	NI	G2	22.8955	$958.70
14302	Skin tissue rearrange add-on	Y	NI	G2	22.8955	$958.70
14350	Skin tissue rearrangement	Y		A2	20.0845	$841.00
15002	Wound prep, trk/arm/leg	Y		A2	5.0314	$210.68
15003	Wound prep, addl 100 cm	Y		A2	5.0314	$210.68
15004	Wound prep, f/n/hf/g	Y		A2	5.0314	$210.68
15005	Wnd prep, f/n/hf/g, addl cm	Y		A2	5.0314	$210.68

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
15040	Harvest cultured skin graft	Y		A2	2.782	$116.49
15050	Skin pinch graft	Y		A2	5.0314	$210.68
15100	Skin splt grft, trnk/arm/leg	Y		A2	19.7192	$825.70
15101	Skin splt grft t/a/l, add-on	Y		A2	20.0845	$841.00
15110	Epidrm autogrft trnk/arm/leg	Y		A2	5.7323	$240.03
15111	Epidrm autogrft t/a/l add-on	Y		A2	5.0868	$213.00
15115	Epidrm a-grft face/nck/hf/g	Y		A2	5.7323	$240.03
15116	Epidrm a-grft f/n/hf/g addl	Y		A2	5.0868	$213.00
15120	Skn splt a-grft fac/nck/hf/g	Y		A2	19.7192	$825.70
15121	Skn splt a-grft f/n/hf/g add	Y		A2	20.0845	$841.00
15130	Derm autograft, trnk/arm/leg	Y		A2	14.0668	$589.02
15131	Derm autograft t/a/l add-on	Y		A2	13.4213	$561.99
15135	Derm autograft face/nck/hf/g	Y		A2	14.0668	$589.02
15136	Derm autograft, f/n/hf/g add	Y		A2	13.4213	$561.99
15150	Cult epiderm grft t/arm/leg	Y		A2	5.7323	$240.03
15151	Cult epiderm grft t/a/l addl	Y		A2	5.0868	$213.00
15152	Cult epiderm graft t/a/l +%	Y		A2	5.0868	$213.00
15155	Cult epiderm graft, f/n/hf/g	Y		A2	5.7323	$240.03
15156	Cult epidrm grft f/n/hfg add	Y		A2	5.0868	$213.00
15157	Cult epiderm grft f/n/hfg +%	Y		A2	5.0868	$213.00
15170	Acell graft trunk/arms/legs	Y		G2	4.2464	$177.81
15171	Acell graft t/arm/leg add-on	Y		G2	3.0144	$126.22
15175	Acellular graft, f/n/hf/g	Y		G2	4.2464	$177.81
15176	Acell graft, f/n/hf/g add-on	Y		G2	4.2464	$177.81
15200	Skin full graft, trunk	Y		A2	14.4325	$604.33
15201	Skin full graft trunk add-on	Y		A2	13.3659	$559.67
15220	Skin full graft sclp/arm/leg	Y		A2	14.0668	$589.02
15221	Skin full graft add-on	Y		A2	5.0314	$210.68
15240	Skin full grft face/genit/hf	Y		A2	14.4325	$604.33
15241	Skin full graft add-on	Y		A2	5.0314	$210.68
15260	Skin full graft een & lips	Y		A2	14.0668	$589.02
15261	Skin full graft add-on	Y		A2	13.3659	$559.67
15300	Apply skinallogrft, t/arm/lg	Y		A2	5.0314	$210.68
15301	Apply sknallogrft t/a/l addl	Y		A2	5.0314	$210.68
15320	Apply skin allogrft f/n/hf/g	Y		A2	5.0314	$210.68
15321	Aply sknallogrft f/n/hfg add	Y		A2	5.0314	$210.68
15330	Aply acell alogrft t/arm/leg	Y		A2	5.0314	$210.68
15331	Aply acell grft t/a/l add-on	Y		A2	5.0314	$210.68
15335	Apply acell graft, f/n/hf/g	Y		A2	5.0314	$210.68
15336	Aply acell grft f/n/hf/g add	Y		A2	5.0314	$210.68
15340	Apply cult skin substitute	Y		G2	3.0144	$126.22

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
15341	Apply cult skin sub add-on	Y		G2	3.0144	$126.22
15360	Apply cult derm sub, t/a/l	Y		G2	3.0144	$126.22
15361	Aply cult derm sub t/a/l add	Y		G2	3.0144	$126.22
15365	Apply cult derm sub f/n/hf/g	Y		G2	3.0144	$126.22
15366	Apply cult derm f/hf/g add	Y		G2	3.0144	$126.22
15400	Apply skin xenograft, t/a/l	Y		A2	5.0314	$210.68
15401	Apply skn xenogrft t/a/l add	Y		A2	5.0314	$210.68
15420	Apply skin xgraft, f/n/hf/g	Y		A2	5.0314	$210.68
15421	Apply skn xgrft f/n/hf/g add	Y		A2	5.0314	$210.68
15430	Apply acellular xenograft	Y		A2	5.0314	$210.68
15431	Apply acellular xgraft add	Y		A2	5.0314	$210.68
15570	Form skin pedicle flap	Y		A2	20.0845	$841.00
15572	Form skin pedicle flap	Y		A2	20.0845	$841.00
15574	Form skin pedicle flap	Y		A2	20.0845	$841.00
15576	Form skin pedicle flap	Y		A2	20.0845	$841.00
15600	Skin graft	Y		A2	20.0845	$841.00
15610	Skin graft	Y		A2	20.0845	$841.00
15620	Skin graft	Y		A2	20.7702	$869.71
15630	Skin graft	Y		A2	20.0845	$841.00
15650	Transfer skin pedicle flap	Y		A2	21.2669	$890.51
15731	Forehead flap w/vasc pedicle	Y		A2	20.0845	$841.00
15732	Muscle-skin graft, head/neck	Y		A2	20.0845	$841.00
15734	Muscle-skin graft, trunk	Y		A2	20.0845	$841.00
15736	Muscle-skin graft, arm	Y		A2	20.0845	$841.00
15738	Muscle-skin graft, leg	Y		A2	20.0845	$841.00
15740	Island pedicle flap graft	Y		A2	14.0668	$589.02
15750	Neurovascular pedicle graft	Y		A2	19.7192	$825.70
15760	Composite skin graft	Y		A2	19.7192	$825.70
15770	Derma-fat-fascia graft	Y		A2	20.0845	$841.00
15775	Hair transplant punch grafts	Y		A2	2.818	$118.00
15776	Hair transplant punch grafts	Y		A2	2.818	$118.00
15780	Abrasion treatment of skin	Y		P3		$330.42
15781	Abrasion treatment of skin	Y		P2	4.1736	$174.76
15782	Abrasion treatment of skin	Y		P2	4.1736	$174.76
15783	Abrasion treatment of skin	Y		P2	2.677	$112.09
15786	Abrasion, lesion, single	Y		P2	0.8408	$35.21
15787	Abrasion, lesions, add-on	Y		P3		$24.70
15788	Chemical peel, face, epiderm	Y		P2	0.8408	$35.21
15789	Chemical peel, face, dermal	Y		P2	1.4745	$61.74
15792	Chemical peel, nonfacial	Y		P2	1.4745	$61.74
15793	Chemical peel, nonfacial	Y		P2	0.8408	$35.21

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
15819	Plastic surgery, neck	Y		G2	3.0144	$126.22
15820	Revision of lower eyelid	Y		A2	20.0845	$841.00
15821	Revision of lower eyelid	Y		A2	20.0845	$841.00
15822	Revision of upper eyelid	Y		A2	20.0845	$841.00
15823	Revision of upper eyelid	Y		A2	21.2669	$890.51
15824	Removal of forehead wrinkles	Y		A2	20.0845	$841.00
15825	Removal of neck wrinkles	Y		A2	20.0845	$841.00
15826	Removal of brow wrinkles	Y		A2	20.0845	$841.00
15828	Removal of face wrinkles	Y		A2	20.0845	$841.00
15829	Removal of skin wrinkles	Y		A2	21.2669	$890.51
15830	Exc skin abd	Y		A2	19.6948	$824.68
15832	Excise excessive skin tissue	Y		A2	19.6948	$824.68
15833	Excise excessive skin tissue	Y		A2	19.6948	$824.68
15834	Excise excessive skin tissue	Y		A2	19.6948	$824.68
15835	Excise excessive skin tissue	Y		A2	18.6282	$780.02
15836	Excise excessive skin tissue	Y		A2	15.468	$647.69
15837	Excise excessive skin tissue	Y		G2	16.7399	$700.95
15838	Excise excessive skin tissue	Y		G2	16.7399	$700.95
15839	Excise excessive skin tissue	Y		A2	15.468	$647.69
15840	Graft for face nerve palsy	Y		A2	20.7702	$869.71
15841	Graft for face nerve palsy	Y		A2	20.7702	$869.71
15842	Flap for face nerve palsy	Y		G2	22.8955	$958.70
15845	Skin and muscle repair, face	Y		A2	20.7702	$869.71
15847	Exc skin abd add-on	Y		A2	19.6948	$824.68
15850	Removal of sutures	Y		G2	2.677	$112.09
15851	Removal of sutures	Y		P3		$41.16
15852	Dressing change not for burn	N	CH	R2	0.6403	$26.81
15860	Test for blood flow in graft	N		G2	0.6403	$26.81
15876	Suction assisted lipectomy	Y		A2	20.0845	$841.00
15877	Suction assisted lipectomy	Y		A2	20.0845	$841.00
15878	Suction assisted lipectomy	Y		A2	20.0845	$841.00
15879	Suction assisted lipectomy	Y		A2	20.0845	$841.00
15920	Removal of tail bone ulcer	Y		A2	4.5669	$191.23
15922	Removal of tail bone ulcer	Y		A2	20.7702	$869.71
15931	Remove sacrum pressure sore	Y		A2	19.6948	$824.68
15933	Remove sacrum pressure sore	Y		A2	19.6948	$824.68
15934	Remove sacrum pressure sore	Y		A2	20.0845	$841.00
15935	Remove sacrum pressure sore	Y		A2	20.7702	$869.71
15936	Remove sacrum pressure sore	Y		A2	15.1179	$633.03
15937	Remove sacrum pressure sore	Y		A2	20.7702	$869.71
15940	Remove hip pressure sore	Y		A2	19.6948	$824.68

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
15941	Remove hip pressure sore	Y		A2	19.6948	$824.68
15944	Remove hip pressure sore	Y		A2	20.0845	$841.00
15945	Remove hip pressure sore	Y		A2	20.7702	$869.71
15946	Remove hip pressure sore	Y		A2	20.7702	$869.71
15950	Remove thigh pressure sore	Y		A2	19.6948	$824.68
15951	Remove thigh pressure sore	Y		A2	20.3802	$853.38
15952	Remove thigh pressure sore	Y		A2	14.4325	$604.33
15953	Remove thigh pressure sore	Y		A2	15.1179	$633.03
15956	Remove thigh pressure sore	Y		A2	14.4325	$604.33
15958	Remove thigh pressure sore	Y		A2	15.1179	$633.03
16000	Initial treatment of burn(s)	Y		P3		$22.71
16020	Dress/debrid p-thick burn, s	Y		P3		$34.06
16025	Dress/debrid p-thick burn, m	Y		A2	1.4893	$62.36
16030	Dress/debrid p-thick burn, l	Y		A2	1.676	$70.18
16035	Incision of burn scab, initi	Y		G2	1.4745	$61.74
17000	Destruct premalg lesion	Y		P2	0.8408	$35.21
17003	Destruct premalg les, 2-14	Y		P3		$3.12
17004	Destroy premlg lesions 15+	Y		P3		$69.55
17106	Destruction of skin lesions	Y		P2	2.677	$112.09
17107	Destruction of skin lesions	Y		P2	2.677	$112.09
17108	Destruction of skin lesions	Y		P2	2.677	$112.09
17110	Destruct b9 lesion, 1-14	Y		P2	0.8408	$35.21
17111	Destruct lesion, 15 or more	Y		P2	1.4745	$61.74
17250	Chemical cautery, tissue	Y		P3		$37.75
17260	Destruction of skin lesions	Y		P3		$39.46
17261	Destruction of skin lesions	Y		P2	1.4745	$61.74
17262	Destruction of skin lesions	Y		P2	1.4745	$61.74
17263	Destruction of skin lesions	Y		P2	1.4745	$61.74
17264	Destruction of skin lesions	Y		P2	1.4745	$61.74
17266	Destruction of skin lesions	Y	CH	P3		$94.81
17270	Destruction of skin lesions	Y		P2	1.4745	$61.74
17271	Destruction of skin lesions	Y		P2	1.4745	$61.74
17272	Destruction of skin lesions	Y		P2	1.4745	$61.74
17273	Destruction of skin lesions	Y	CH	P3		$86.01
17274	Destruction of skin lesions	Y	CH	P3		$97.37
17276	Destruction of skin lesions	Y	CH	P3		$106.73
17280	Destruction of skin lesions	Y		P2	1.4745	$61.74
17281	Destruction of skin lesions	Y		P3		$73.52
17282	Destruction of skin lesions	Y		P3		$84.02
17283	Destruction of skin lesions	Y	CH	P3		$96.52
17284	Destruction of skin lesions	Y	CH	P3		$108.44

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
17286	Destruction of skin lesions	Y		P2	2.677	$112.09
17311	Mohs, 1 stage, h/n/hf/g	Y		P2	4.7201	$197.64
17312	Mohs addl stage	Y	CH	P3		$192.46
17313	Mohs, 1 stage, t/a/l	Y		P2	4.7201	$197.64
17314	Mohs, addl stage, t/a/l	Y	CH	P3		$178.27
17315	Mohs surg, addl block	Y		P3		$32.64
17340	Cryotherapy of skin	Y		P3		$12.77
17360	Skin peel therapy	Y		P2	0.8408	$35.21
17380	Hair removal by electrolysis	Y		R2	0.8408	$35.21
19000	Drainage of breast lesion	Y		P3		$54.79
19001	Drain breast lesion add-on	Y		P3		$7.38
19020	Incision of breast lesion	Y		A2	16.472	$689.73
19030	Injection for breast x-ray	N		N1		
19100	Bx breast percut w/o image	Y		A2	4.6708	$195.58
19101	Biopsy of breast, open	Y		A2	20.3074	$850.33
19102	Bx breast percut w/image	Y		A2	6.978	$292.19
19103	Bx breast percut w/device	Y		A2	13.3824	$560.36
19105	Cryosurg ablate fa, each	Y	CH	P2	32.686	$1,368.66
19110	Nipple exploration	Y		A2	20.3074	$850.33
19112	Excise breast duct fistula	Y		A2	20.6727	$865.63
19120	Removal of breast lesion	Y		A2	20.6727	$865.63
19125	Excision, breast lesion	Y		A2	20.6727	$865.63
19126	Excision, addl breast lesion	Y		A2	20.6727	$865.63
19290	Place needle wire, breast	N		N1		
19291	Place needle wire, breast	N		N1		
19295	Place breast clip, percut	N		N1		
19296	Place po breast cath for rad	Y		A2	49.4283	$2,069.71
19297	Place breast cath for rad	Y		A2	49.4283	$2,069.71
19298	Place breast rad tube/caths	Y		A2	49.4283	$2,069.71
19300	Removal of breast tissue	Y		A2	21.3584	$894.34
19301	Partical mastectomy	Y		A2	20.6727	$865.63
19302	P-mastectomy w/ln removal	Y		A2	35.819	$1,499.85
19303	Mast, simple, complete	Y		A2	28.1131	$1,177.18
19304	Mast, subq	Y		A2	28.1131	$1,177.18
19316	Suspension of breast	Y		A2	28.1131	$1,177.18
19318	Reduction of large breast	Y		A2	33.7344	$1,412.56
19324	Enlarge breast	Y		A2	33.7344	$1,412.56
19325	Enlarge breast with implant	Y		A2	49.4283	$2,069.71
19328	Removal of breast implant	Y		A2	26.4165	$1,106.14
19330	Removal of implant material	Y		A2	26.4165	$1,106.14
19340	Immediate breast prosthesis	Y		A2	32.6834	$1,368.55

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
19342	Delayed breast prosthesis	Y		A2	44.693	$1,871.43
19350	Breast reconstruction	Y		A2	21.3584	$894.34
19355	Correct inverted nipple(s)	Y		A2	28.1131	$1,177.18
19357	Breast reconstruction	Y		A2	45.8754	$1,920.94
19366	Breast reconstruction	Y		A2	28.6098	$1,197.98
19370	Surgery of breast capsule	Y		A2	28.1131	$1,177.18
19371	Removal of breast capsule	Y		A2	28.1131	$1,177.18
19380	Revise breast reconstruction	Y		A2	34.2311	$1,433.36
19396	Design custom breast implant	Y		G2	32.686	$1,368.66
20000	Incision of abscess	Y		P2	1.3927	$58.32
20005	Incision of deep abscess	Y		A2	18.3436	$768.10
20103	Explore wound, extremity	Y		G2	12.0752	$505.62
20150	Excise epiphyseal bar	Y		G2	44.5617	$1,865.93
20200	Muscle biopsy	Y		A2	15.1023	$632.38
20205	Deep muscle biopsy	Y		A2	15.468	$647.69
20206	Needle biopsy, muscle	Y		A2	6.978	$292.19
20220	Bone biopsy, trocar/needle	Y		A2	7.3224	$306.61
20225	Bone biopsy, trocar/needle	Y		A2	14.9452	$625.80
20240	Bone biopsy, excisional	Y		A2	19.3292	$809.37
20245	Bone biopsy, excisional	Y		A2	19.6948	$824.68
20250	Open bone biopsy	Y		A2	18.7092	$783.41
20251	Open bone biopsy	Y		A2	18.7092	$783.41
20500	Injection of sinus tract	Y		P3		$43.72
20501	Inject sinus tract for x-ray	N		N1		
20520	Removal of foreign body	Y		P3		$79.48
20525	Removal of foreign body	Y		A2	19.6948	$824.68
20526	Ther injection, carp tunnel	Y		P3		$25.26
20550	Inj tendon sheath/ligament	Y		P3		$19.02
20551	Inj tendon origin/insertion	Y		P3		$19.30
20552	Inj trigger point, 1/2 muscl	Y		P3		$18.45
20553	Inject trigger points, =/> 3	Y		P3		$21.01
20555	Place ndl musc/tis for rt	Y	CH	R2	30.396	$1,272.77
20600	Drain/inject, joint/bursa	Y		P3		$19.30
20605	Drain/inject, joint/bursa	Y		P3		$21.86
20610	Drain/inject, joint/bursa	Y		P3		$31.23
20612	Aspirate/inj ganglion cyst	Y		P3		$21.01
20615	Treatment of bone cyst	Y		P3		$85.16
20650	Insert and remove bone pin	Y		A2	18.7092	$783.41
20662	Application of pelvis brace	Y		R2	21.0617	$881.92
20663	Application of thigh brace	Y		R2	21.0617	$881.92
20665	Removal of fixation device	N		G2	0.6403	$26.81

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20670	Removal of support implant	Y		A2	14.457	$605.36
20680	Removal of support implant	Y		A2	19.6948	$824.68
20690	Apply bone fixation device	Y		A2	25.3445	$1,061.25
20692	Apply bone fixation device	Y		A2	25.7101	$1,076.56
20693	Adjust bone fixation device	Y		A2	18.7092	$783.41
20694	Remove bone fixation device	Y		A2	17.6983	$741.08
20696	Comp multiplane ext fixation	Y		G2	30.396	$1,272.77
20697	Comp ext fixate strut change	Y		G2	17.5996	$736.95
20822	Replantation digit, complete	Y		G2	27.0149	$1,131.19
20900	Removal of bone for graft	Y		A2	25.7101	$1,076.56
20902	Removal of bone for graft	Y		A2	26.3955	$1,105.26
20910	Remove cartilage for graft	Y		A2	20.0845	$841.00
20912	Remove cartilage for graft	Y		A2	20.0845	$841.00
20920	Removal of fascia for graft	Y		A2	15.1179	$633.03
20922	Removal of fascia for graft	Y		A2	14.4325	$604.33
20924	Removal of tendon for graft	Y		A2	26.3955	$1,105.26
20926	Removal of tissue for graft	Y		A2	6.7834	$284.04
20950	Fluid pressure, muscle	Y		G2	1.3927	$58.32
20972	Bone/skin graft, metatarsal	Y		G2	50.2514	$2,104.18
20973	Bone/skin graft, great toe	Y		R2	50.2514	$2,104.18
20975	Electrical bone stimulation	N		N1		
20979	Us bone stimulation	N		P3		$19.02
20982	Ablate, bone tumor(s) perq	Y		G2	44.5617	$1,865.93
20985	Cptr-asst dir ms px	N		N1		
21010	Incision of jaw joint	Y		A2	20.4597	$856.71
21011	Exc face les sc < 2 cm	Y	NI	P3		$146.48
21012	Exc face les sc = 2 cm	Y	NI	R2	7.8476	$328.60
21013	Exc face tum deep < 2 cm	Y	NI	P3		$203.53
21014	Exc face tum deep = 2 cm	Y	NI	R2	7.8476	$328.60
21015*	Resect face tum < 2 cm	Y	NI	R2	16.7399	$700.95
21016	Resect face tum = 2 cm	Y	NI	G2	22.3753	$936.92
21025	Excision of bone, lower jaw	Y		A2	33.3886	$1,398.08
21026	Excision of facial bone(s)	Y		A2	33.3886	$1,398.08
21029	Contour of face bone lesion	Y		A2	33.3886	$1,398.08
21030	Excise max/zygoma b9 tumor	Y		P3		$208.08
21031	Remove exostosis, mandible	Y		P3		$171.17
21032	Remove exostosis, maxilla	Y		P3		$174.29
21034	Excise max/zygoma mlg tumor	Y		A2	33.7542	$1,413.39
21040	Excise mandible lesion	Y		A2	20.4597	$856.71
21044	Removal of jaw bone lesion	Y		A2	33.3886	$1,398.08
21046	Remove mandible cyst complex	Y		A2	33.3886	$1,398.08

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
21047	Excise lwr jaw cyst w/repair	Y		A2	33.3886	$1,398.08
21048	Remove maxilla cyst complex	Y		R2	41.1215	$1,721.88
21050	Removal of jaw joint	Y		A2	33.7542	$1,413.39
21060	Remove jaw joint cartilage	Y		A2	33.3886	$1,398.08
21070	Remove coronoid process	Y		A2	33.7542	$1,413.39
21073	Mnpj of tmj w/anesth	Y		P3		$159.82
21076	Prepare face/oral prosthesis	Y		P3		$286.71
21077	Prepare face/oral prosthesis	Y		P3		$689.80
21079	Prepare face/oral prosthesis	Y		P3		$494.50
21080	Prepare face/oral prosthesis	Y		P3		$565.47
21081	Prepare face/oral prosthesis	Y		P3		$521.18
21082	Prepare face/oral prosthesis	Y		P3		$499.89
21083	Prepare face/oral prosthesis	Y		P3		$490.81
21084	Prepare face/oral prosthesis	Y		P3		$561.77
21085	Prepare face/oral prosthesis	Y		P3		$224.54
21086	Prepare face/oral prosthesis	Y		P3		$489.67
21087	Prepare face/oral prosthesis	Y		P3		$488.54
21088	Prepare face/oral prosthesis	Y		R2	41.1215	$1,721.88
21100	Maxillofacial fixation	Y		A2	33.3886	$1,398.08
21110	Interdental fixation	Y		P2	7.2897	$305.24
21116	Injection, jaw joint x-ray	N		N1		
21120	Reconstruction of chin	Y		A2	23.5956	$988.02
21121	Reconstruction of chin	Y		A2	23.5956	$988.02
21122	Reconstruction of chin	Y		A2	23.5956	$988.02
21123	Reconstruction of chin	Y		A2	23.5956	$988.02
21125	Augmentation, lower jaw bone	Y		A2	23.5956	$988.02
21127	Augmentation, lower jaw bone	Y		A2	38.4895	$1,611.67
21137	Reduction of forehead	Y		G2	23.8828	$1,000.04
21138	Reduction of forehead	Y		G2	41.1215	$1,721.88
21139	Reduction of forehead	Y		G2	41.1215	$1,721.88
21150	Reconstruct midface, lefort	Y		G2	41.1215	$1,721.88
21181	Contour cranial bone lesion	Y		A2	23.5956	$988.02
21198	Reconstr lwr jaw segment	Y		G2	41.1215	$1,721.88
21199	Reconstr lwr jaw w/advance	Y		G2	41.1215	$1,721.88
21206	Reconstruct upper jaw bone	Y		A2	34.9366	$1,462.90
21208	Augmentation of facial bones	Y		A2	36.5245	$1,529.39
21209	Reduction of facial bones	Y		A2	34.9366	$1,462.90
21210	Face bone graft	Y		A2	36.5245	$1,529.39
21215	Lower jaw bone graft	Y		A2	36.5245	$1,529.39
21230	Rib cartilage graft	Y		A2	36.5245	$1,529.39
21235	Ear cartilage graft	Y		A2	23.5956	$988.02

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21240	Reconstruction of jaw joint	Y		A2	34.4396	$1,442.09
21242	Reconstruction of jaw joint	Y		A2	34.9366	$1,462.90
21243	Reconstruction of jaw joint	Y		A2	34.9366	$1,462.90
21244	Reconstruction of lower jaw	Y		A2	36.5245	$1,529.39
21245	Reconstruction of jaw	Y		A2	36.5245	$1,529.39
21246	Reconstruction of jaw	Y		A2	36.5245	$1,529.39
21248	Reconstruction of jaw	Y		A2	36.5245	$1,529.39
21249	Reconstruction of jaw	Y		A2	36.5245	$1,529.39
21260	Revise eye sockets	Y		G2	41.1215	$1,721.88
21267	Revise eye sockets	Y		A2	36.5245	$1,529.39
21270	Augmentation, cheek bone	Y		A2	34.9366	$1,462.90
21275	Revision, orbitofacial bones	Y		A2	36.5245	$1,529.39
21280	Revision of eyelid	Y		A2	34.9366	$1,462.90
21282	Revision of eyelid	Y		A2	16.4282	$687.90
21295	Revision of jaw muscle/bone	Y		A2	7.3694	$308.58
21296	Revision of jaw muscle/bone	Y		A2	19.8142	$829.68
21310	Treatment of nose fracture	Y		A2	1.6877	$70.67
21315	Treatment of nose fracture	Y		A2	13.1937	$552.46
21320	Treatment of nose fracture	Y		A2	14.8802	$623.08
21325	Treatment of nose fracture	Y		A2	21.5108	$900.72
21330	Treatment of nose fracture	Y		A2	22.0077	$921.53
21335	Treatment of nose fracture	Y		A2	23.5956	$988.02
21336	Treat nasal septal fracture	Y		A2	22.1427	$927.18
21337	Treat nasal septal fracture	Y		A2	14.8802	$623.08
21338	Treat nasoethmoid fracture	Y		A2	21.5108	$900.72
21339	Treat nasoethmoid fracture	Y		A2	22.0077	$921.53
21340	Treatment of nose fracture	Y		A2	34.4396	$1,442.09
21345	Treat nose/jaw fracture	Y		A2	23.5956	$988.02
21355	Treat cheek bone fracture	Y		A2	33.7542	$1,413.39
21356	Treat cheek bone fracture	Y		A2	20.8254	$872.02
21360	Treat cheek bone fracture	Y		G2	23.8828	$1,000.04
21390	Treat eye socket fracture	Y		G2	41.1215	$1,721.88
21400	Treat eye socket fracture	Y		A2	8.0147	$335.60
21401	Treat eye socket fracture	Y		A2	15.2459	$638.39
21406	Treat eye socket fracture	Y		G2	41.1215	$1,721.88
21407	Treat eye socket fracture	Y		G2	41.1215	$1,721.88
21421	Treat mouth roof fracture	Y		A2	21.5108	$900.72
21440	Treat dental ridge fracture	Y		P3		$280.46
21445	Treat dental ridge fracture	Y		A2	21.5108	$900.72
21450	Treat lower jaw fracture	Y		A2	3.3186	$138.96
21451	Treat lower jaw fracture	Y		A2	8.1184	$339.94

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
21452	Treat lower jaw fracture	Y		A2	14.8802	$623.08
21453	Treat lower jaw fracture	Y		A2	33.7542	$1,413.39
21454	Treat lower jaw fracture	Y		A2	22.0077	$921.53
21461	Treat lower jaw fracture	Y		A2	34.4396	$1,442.09
21462	Treat lower jaw fracture	Y		A2	34.9366	$1,462.90
21465	Treat lower jaw fracture	Y		A2	34.4396	$1,442.09
21480	Reset dislocated jaw	Y		A2	1.6877	$70.67
21485	Reset dislocated jaw	Y		A2	14.8802	$623.08
21490	Repair dislocated jaw	Y		A2	33.7542	$1,413.39
21495	Treat hyoid bone fracture	Y		G2	16.4437	$688.55
21497	Interdental wiring	Y		A2	14.8802	$623.08
21501	Drain neck/chest lesion	Y		A2	16.472	$689.73
21502	Drain chest lesion	Y		A2	18.3436	$768.10
21550	Biopsy of neck/chest	Y		G2	16.7399	$700.95
21552	Exc neck les sc = 3 cm	Y	NI	G2	22.3753	$936.92
21554	Exc neck tum deep = 5 cm	Y	NI	G2	22.3753	$936.92
21555*	Exc neck les sc < 3 cm	Y	NI	P3		$169.19
21556	Exc neck tum deep < 5 cm	Y	NI	G2	22.3753	$936.92
21557	Resect neck tum < 5 cm	Y	NI	G2	16.7399	$700.95
21558	Resect neck tum = 5 cm	Y	NI	G2	22.3753	$936.92
21600	Partial removal of rib	Y		A2	25.3445	$1,061.25
21610	Partial removal of rib	Y		A2	25.3445	$1,061.25
21685	Hyoid myotomy & suspension	Y		G2	7.2897	$305.24
21700	Revision of neck muscle	Y		A2	18.3436	$768.10
21720	Revision of neck muscle	Y		A2	18.7092	$783.41
21725	Revision of neck muscle	Y		A2	1.5497	$64.89
21800	Treatment of rib fracture	Y		A2	1.7811	$74.58
21805	Treatment of rib fracture	Y		A2	21.0916	$883.17
21820	Treat sternum fracture	Y		A2	1.7811	$74.58
21920	Biopsy soft tissue of back	Y		P3		$119.22
21925	Biopsy soft tissue of back	Y		A2	19.3292	$809.37
21930*	Exc back les sc < 3 cm	Y	NI	P3		$176.28
21931	Exc back les sc = 3 cm	Y	NI	G2	22.3753	$936.92
21932	Exc back tum deep < 5 cm	Y	NI	G2	16.7399	$700.95
21933	Exc back tum deep = 5 cm	Y	NI	G2	22.3753	$936.92
21935	Resect back tum < 5 cm	Y	NI	G2	16.7399	$700.95
21936	Resect back tum = 5 cm	Y	NI	G2	22.3753	$936.92
22102	Remove part, lumbar vertebra	Y		G2	47.0941	$1,971.97
22103	Remove extra spine segment	Y		G2	47.0941	$1,971.97
22305	Treat spine process fracture	Y		A2	1.7811	$74.58
22310	Treat spine fracture	Y		A2	4.0322	$168.84

Addendum AA -- Final ASC Covered Surgical Procedures for CY 2010 (Including Surgical Procedures for Which Payment is Packaged)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
22315	Treat spine fracture	Y		A2	13.7917	$577.50
22505	Manipulation of spine	Y		A2	13.5199	$566.12
22520	Percut vertebroplasty thor	Y		A2	30.4452	$1,274.83
22521	Percut vertebroplasty lumb	Y		A2	30.4452	$1,274.83
22522	Percut vertebroplasty addl	Y		A2	30.4452	$1,274.83
22523	Percut kyphoplasty, thor	Y		G2	84.8135	$3,551.40
22524	Percut kyphoplasty, lumbar	Y		G2	84.8135	$3,551.40
22525	Percut kyphoplasty, add-on	Y		G2	84.8135	$3,551.40
22900	Exc back tum deep < 5 cm	Y	NI	G2	22.3753	$936.92
22901	Exc back tum deep = 5 cm	Y	NI	G2	22.3753	$936.92
22902	Exc abd les sc < 3 cm	Y	NI	G2	16.7399	$700.95
22903	Exc abd les sc > 3 cm	Y	NI	G2	22.3753	$936.92
22904	Resect abd tum < 5 cm	Y	NI	G2	16.7399	$700.95
22905	Resect abd tum > 5 cm	Y	NI	G2	22.3753	$936.92
23000	Removal of calcium deposits	Y		A2	15.1023	$632.38
23020	Release shoulder joint	Y		A2	35.969	$1,506.13
23030	Drain shoulder lesion	Y		A2	15.8264	$662.70
23031	Drain shoulder bursa	Y		A2	16.8376	$705.04
23035	Drain shoulder bone lesion	Y		A2	18.7092	$783.41
23040	Exploratory shoulder surgery	Y		A2	25.7101	$1,076.56
23044	Exploratory shoulder surgery	Y		A2	26.3955	$1,105.26
23065	Biopsy shoulder tissues	Y		P3		$83.17
23066	Biopsy shoulder tissues	Y		A2	19.3292	$809.37
23071	Exc shoulder les sc > 3 cm	Y	NI	G2	22.3753	$936.92
23073	Exc shoulder tum deep > 5 cm	Y	NI	G2	22.3753	$936.92
23075*	Exc shoulder les sc < 3 cm	Y	NI	P3		$130.01
23076	Exc shoulder tum deep < 5 cm	Y	NI	G2	16.7399	$700.95
23077	Resect shoulder tum < 5 cm	Y	NI	G2	16.7399	$700.95
23078	Resect shoulder tum > 5 cm	Y	NI	G2	22.3753	$936.92
23100	Biopsy of shoulder joint	Y		A2	18.3436	$768.10
23101	Shoulder joint surgery	Y		A2	28.4804	$1,192.56
23105	Remove shoulder joint lining	Y		A2	26.3955	$1,105.26
23106	Incision of collarbone joint	Y		A2	26.3955	$1,105.26
23107	Explore treat shoulder joint	Y		A2	26.3955	$1,105.26
23120	Partial removal, collar bone	Y		A2	26.8925	$1,126.07
23125	Removal of collar bone	Y		A2	26.8925	$1,126.07
23130	Remove shoulder bone, part	Y		A2	37.5168	$1,570.94
23140	Removal of bone lesion	Y		A2	19.3946	$812.11
23145	Removal of bone lesion	Y		A2	26.8925	$1,126.07
23146	Removal of bone lesion	Y		A2	26.8925	$1,126.07
23150	Removal of humerus lesion	Y		A2	26.3955	$1,105.26

Addendum AA -- Final ASC Covered Surgical Procedures for CY 2010 (Including Surgical Procedures for Which Payment is Packaged)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
23155	Removal of humerus lesion	Y		A2	26.8925	$1,126.07
23156	Removal of humerus lesion	Y		A2	26.8925	$1,126.07
23170	Remove collar bone lesion	Y		A2	25.3445	$1,061.25
23172	Remove shoulder blade lesion	Y		A2	25.3445	$1,061.25
23174	Remove humerus lesion	Y		A2	25.3445	$1,061.25
23180	Remove collar bone lesion	Y		A2	26.3955	$1,105.26
23182	Remove shoulder blade lesion	Y		A2	26.3955	$1,105.26
23184	Remove humerus lesion	Y		A2	26.3955	$1,105.26
23190	Partial removal of scapula	Y		A2	26.3955	$1,105.26
23195	Removal of head of humerus	Y		A2	26.8925	$1,126.07
23330	Remove shoulder foreign body	Y		A2	7.7878	$326.10
23331	Remove shoulder foreign body	Y		A2	18.6836	$782.34
23350	Injection for shoulder x-ray	N		N1		
23395	Muscle transfer,shoulder/arm	Y		A2	37.5168	$1,570.94
23397	Muscle transfers	Y		A2	69.2933	$2,901.52
23400	Fixation of shoulder blade	Y		A2	28.4804	$1,192.56
23405	Incision of tendon & muscle	Y		A2	25.3445	$1,061.25
23406	Incise tendon(s) & muscle(s)	Y		A2	25.3445	$1,061.25
23410	Repair rotator cuff, acute	Y		A2	37.5168	$1,570.94
23412	Repair rotator cuff, chronic	Y		A2	39.1047	$1,637.43
23415	Release of shoulder ligament	Y		A2	37.5168	$1,570.94
23420	Repair of shoulder	Y		A2	39.1047	$1,637.43
23430	Repair biceps tendon	Y		A2	37.02	$1,550.14
23440	Remove/transplant tendon	Y		A2	37.02	$1,550.14
23450	Repair shoulder capsule	Y		A2	67.7054	$2,835.03
23455	Repair shoulder capsule	Y		A2	69.2933	$2,901.52
23460	Repair shoulder capsule	Y		A2	67.7054	$2,835.03
23462	Repair shoulder capsule	Y		A2	39.1047	$1,637.43
23465	Repair shoulder capsule	Y		A2	67.7054	$2,835.03
23466	Repair shoulder capsule	Y		A2	39.1047	$1,637.43
23480	Revision of collar bone	Y		A2	37.02	$1,550.14
23485	Revision of collar bone	Y		A2	69.2933	$2,901.52
23490	Reinforce clavicle	Y		A2	36.3344	$1,521.43
23491	Reinforce shoulder bones	Y		A2	66.5231	$2,785.52
23500	Treat clavicle fracture	Y		A2	1.7811	$74.58
23505	Treat clavicle fracture	Y		A2	13.7917	$577.50
23515	Treat clavicle fracture	Y		A2	49.8932	$2,089.18
23520	Treat clavicle dislocation	Y		A2	4.0322	$168.84
23525	Treat clavicle dislocation	Y		A2	4.0322	$168.84
23530	Treat clavicle dislocation	Y		A2	35.5372	$1,488.05
23532	Treat clavicle dislocation	Y		A2	22.1427	$927.18

Addendum AA -- Final ASC Covered Surgical Procedures for CY 2010 (Including Surgical Procedures for Which Payment is Packaged)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
23540	Treat clavicle dislocation	Y		A2	1.7811	$74.58
23545	Treat clavicle dislocation	Y		A2	4.0322	$168.84
23550	Treat clavicle dislocation	Y		A2	35.5372	$1,488.05
23552	Treat clavicle dislocation	Y		A2	36.2226	$1,516.75
23570	Treat shoulder blade fx	Y		A2	1.7811	$74.58
23575	Treat shoulder blade fx	Y		A2	4.0322	$168.84
23585	Treat scapula fracture	Y		A2	49.8932	$2,089.18
23600	Treat humerus fracture	Y		P2	1.5858	$66.40
23605	Treat humerus fracture	Y		A2	13.7917	$577.50
23615	Treat humerus fracture	Y		A2	50.5787	$2,117.88
23616	Treat humerus fracture	Y		A2	50.5787	$2,117.88
23620	Treat humerus fracture	Y		P2	1.5858	$66.40
23625	Treat humerus fracture	Y		A2	13.7917	$577.50
23630	Treat humerus fracture	Y		A2	51.0756	$2,138.69
23650	Treat shoulder dislocation	Y		A2	1.7811	$74.58
23655	Treat shoulder dislocation	Y		A2	12.8746	$539.10
23660	Treat shoulder dislocation	Y		A2	35.5372	$1,488.05
23665	Treat dislocation/fracture	Y		A2	4.0322	$168.84
23670	Treat dislocation/fracture	Y		A2	49.8932	$2,089.18
23675	Treat dislocation/fracture	Y		A2	1.7811	$74.58
23680	Treat dislocation/fracture	Y		A2	35.5372	$1,488.05
23700	Fixation of shoulder	Y		A2	12.8746	$539.10
23800	Fusion of shoulder joint	Y		A2	67.2085	$2,814.22
23802	Fusion of shoulder joint	Y		A2	39.1047	$1,637.43
23921	Amputation follow-up surgery	Y		A2	13.3659	$559.67
23930	Drainage of arm lesion	Y		A2	15.8264	$662.70
23931	Drainage of arm bursa	Y		A2	16.472	$689.73
23935	Drain arm/elbow bone lesion	Y		A2	18.3436	$768.10
24000	Exploratory elbow surgery	Y		A2	26.3955	$1,105.26
24006	Release elbow joint	Y		A2	26.3955	$1,105.26
24065	Biopsy arm/elbow soft tissue	Y		P3		$114.68
24066	Biopsy arm/elbow soft tissue	Y		A2	15.1023	$632.38
24071	Exc arm/elbow les sc = 3 cm	Y	NI	G2	22.3753	$936.92
24073	Ex arm/elbow tum deep > 5 cm	Y	NI	G2	22.3753	$936.92
24075*	Exc arm/elbow les sc < 3 cm	Y	NI	P3		$209.49
24076	Ex arm/elbow tum deep < 5 cm	Y	NI	G2	16.7399	$700.95
24077	Resect arm/elbow tum < 5 cm	Y	NI	G2	16.7399	$700.95
24079	Resect arm/elbow tum > 5 cm	Y	NI	G2	22.3753	$936.92
24100	Biopsy elbow joint lining	Y		A2	17.6983	$741.08
24101	Explore/treat elbow joint	Y		A2	26.3955	$1,105.26
24102	Remove elbow joint lining	Y		A2	26.3955	$1,105.26

Addendum AA -- Final ASC Covered Surgical Procedures for CY 2010 (Including Surgical Procedures for Which Payment is Packaged)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
24105	Removal of elbow bursa	Y		A2	18.7092	$783.41
24110	Remove humerus lesion	Y		A2	18.3436	$768.10
24115	Remove/graft bone lesion	Y		A2	25.7101	$1,076.56
24116	Remove/graft bone lesion	Y		A2	25.7101	$1,076.56
24120	Remove elbow lesion	Y		A2	18.7092	$783.41
24125	Remove/graft bone lesion	Y		A2	25.7101	$1,076.56
24126	Remove/graft bone lesion	Y		A2	25.7101	$1,076.56
24130	Removal of head of radius	Y		A2	25.7101	$1,076.56
24134	Removal of arm bone lesion	Y		A2	25.3445	$1,061.25
24136	Remove radius bone lesion	Y		A2	25.3445	$1,061.25
24138	Remove elbow bone lesion	Y		A2	25.3445	$1,061.25
24140	Partial removal of arm bone	Y		A2	25.7101	$1,076.56
24145	Partial removal of radius	Y		A2	25.7101	$1,076.56
24147	Partial removal of elbow	Y		A2	25.3445	$1,061.25
24149	Radical resection of elbow	Y		G2	30.396	$1,272.77
24152	Resect radius tumor	Y		G2	44.5617	$1,865.93
24153	Extensive radius surgery	N	CH	D5		
24155	Removal of elbow joint	Y		A2	36.3344	$1,521.43
24160	Remove elbow joint implant	Y		A2	25.3445	$1,061.25
24164	Remove radius head implant	Y		A2	25.7101	$1,076.56
24200	Removal of arm foreign body	Y		P3		$84.88
24201	Removal of arm foreign body	Y		A2	15.1023	$632.38
24220	Injection for elbow x-ray	N		N1		
24300	Manipulate elbow w/anesth	Y		G2	14.63	$612.60
24301	Muscle/tendon transfer	Y		A2	26.3955	$1,105.26
24305	Arm tendon lengthening	Y		A2	26.3955	$1,105.26
24310	Revision of arm tendon	Y		A2	18.7092	$783.41
24320	Repair of arm tendon	Y		A2	36.3344	$1,521.43
24330	Revision of arm muscles	Y		A2	66.5231	$2,785.52
24331	Revision of arm muscles	Y		A2	36.3344	$1,521.43
24332	Tenolysis, triceps	Y		G2	21.0617	$881.92
24340	Repair of biceps tendon	Y		A2	36.3344	$1,521.43
24341	Repair arm tendon/muscle	Y		A2	36.3344	$1,521.43
24342	Repair of ruptured tendon	Y		A2	36.3344	$1,521.43
24343	Repr elbow lat ligmnt w/tiss	Y		G2	30.396	$1,272.77
24344	Reconstruct elbow lat ligmnt	Y		G2	84.8135	$3,551.40
24345	Repr elbw med ligmnt w/tissu	Y		A2	25.3445	$1,061.25
24346	Reconstruct elbow med ligmnt	Y		G2	44.5617	$1,865.93
24357	Repair elbow, perc	Y		G2	30.396	$1,272.77
24358	Repair elbow w/deb, open	Y		G2	30.396	$1,272.77
24359	Repair elbow deb/attch open	Y		G2	30.396	$1,272.77

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
24360	Reconstruct elbow joint	Y		A2	32.7158	$1,369.91
24361	Reconstruct elbow joint	Y		H8	150.2992	$6,293.48
24362	Reconstruct elbow joint	Y		A2	45.772	$1,916.61
24363	Replace elbow joint	Y		H8	151.8871	$6,359.97
24365	Reconstruct head of radius	Y		A2	32.7158	$1,369.91
24366	Reconstruct head of radius	Y		H8	150.2992	$6,293.48
24400	Revision of humerus	Y		A2	37.02	$1,550.14
24410	Revision of humerus	Y		A2	37.02	$1,550.14
24420	Revision of humerus	Y		A2	36.3344	$1,521.43
24430	Repair of humerus	Y		A2	66.5231	$2,785.52
24435	Repair humerus with graft	Y		A2	67.2085	$2,814.22
24470	Revision of elbow joint	Y		A2	36.3344	$1,521.43
24495	Decompression of forearm	Y		A2	25.3445	$1,061.25
24498	Reinforce humerus	Y		A2	66.5231	$2,785.52
24500	Treat humerus fracture	Y		A2	1.7811	$74.58
24505	Treat humerus fracture	Y		A2	1.7811	$74.58
24515	Treat humerus fracture	Y		A2	50.5787	$2,117.88
24516	Treat humerus fracture	Y		A2	50.5787	$2,117.88
24530	Treat humerus fracture	Y		A2	1.7811	$74.58
24535	Treat humerus fracture	Y		A2	4.0322	$168.84
24538	Treat humerus fracture	Y		A2	21.0916	$883.17
24545	Treat humerus fracture	Y		A2	50.5787	$2,117.88
24546	Treat humerus fracture	Y		A2	51.0756	$2,138.69
24560	Treat humerus fracture	Y		A2	1.7811	$74.58
24565	Treat humerus fracture	Y		A2	1.7811	$74.58
24566	Treat humerus fracture	Y		A2	21.0916	$883.17
24575	Treat humerus fracture	Y		A2	49.8932	$2,089.18
24576	Treat humerus fracture	Y		A2	1.7811	$74.58
24577	Treat humerus fracture	Y		A2	4.0322	$168.84
24579	Treat humerus fracture	Y		A2	49.8932	$2,089.18
24582	Treat humerus fracture	Y		A2	21.0916	$883.17
24586	Treat elbow fracture	Y		A2	50.5787	$2,117.88
24587	Treat elbow fracture	Y		A2	51.0756	$2,138.69
24600	Treat elbow dislocation	Y		A2	1.7811	$74.58
24605	Treat elbow dislocation	Y		A2	13.5199	$566.12
24615	Treat elbow dislocation	Y		A2	49.8932	$2,089.18
24620	Treat elbow fracture	Y		A2	13.7917	$577.50
24635	Treat elbow fracture	Y		A2	49.8932	$2,089.18
24640	Treat elbow dislocation	Y		P3		$47.69
24650	Treat radius fracture	Y		P2	1.5858	$66.40
24655	Treat radius fracture	Y		A2	4.0322	$168.84

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
24665	Treat radius fracture	Y		A2	36.2226	$1,516.75
24666	Treat radius fracture	Y		A2	50.5787	$2,117.88
24670	Treat ulnar fracture	Y		A2	1.7811	$74.58
24675	Treat ulnar fracture	Y		A2	1.7811	$74.58
24685	Treat ulnar fracture	Y		A2	35.5372	$1,488.05
24800	Fusion of elbow joint	Y		A2	37.02	$1,550.14
24802	Fusion/graft of elbow joint	Y		A2	37.5168	$1,570.94
24925	Amputation follow-up surgery	Y		A2	18.7092	$783.41
25000	Incision of tendon sheath	Y		A2	18.7092	$783.41
25001	Incise flexor carpi radialis	Y		G2	21.0617	$881.92
25020	Decompress forearm 1 space	Y		A2	25.7101	$1,076.56
25023	Decompress forearm 1 space	Y		A2	25.7101	$1,076.56
25024	Decompress forearm 2 spaces	Y		A2	25.7101	$1,076.56
25025	Decompress forearm 2 spaces	Y		A2	25.7101	$1,076.56
25028	Drainage of forearm lesion	Y		A2	17.6983	$741.08
25031	Drainage of forearm bursa	Y		A2	18.3436	$768.10
25035	Treat forearm bone lesion	Y		A2	18.3436	$768.10
25040	Explore/treat wrist joint	Y		A2	26.8925	$1,126.07
25065	Biopsy forearm soft tissues	Y		P3		$116.39
25066	Biopsy forearm soft tissues	Y		A2	19.3292	$809.37
25071	Exc forearm les sc > 3 cm	Y	NI	G2	22.3753	$936.92
25073	Exc forearm tum deep = 3 cm	Y	NI	G2	22.3753	$936.92
25075*	Exc forearm les sc < 3 cm	Y	NI	P3		$140.23
25076	Exc forearm tum deep < 3 cm	Y	NI	G2	16.7399	$700.95
25077	Resect forearm/wrist tum<3cm	Y	NI	G2	16.7399	$700.95
25078	Resect forearm/wrist tum=3cm	Y	NI	G2	22.3753	$936.92
25085	Incision of wrist capsule	Y		A2	18.7092	$783.41
25100	Biopsy of wrist joint	Y		A2	18.3436	$768.10
25101	Explore/treat wrist joint	Y		A2	25.7101	$1,076.56
25105	Remove wrist joint lining	Y		A2	26.3955	$1,105.26
25107	Remove wrist joint cartilage	Y		A2	25.7101	$1,076.56
25109	Excise tendon forearm/wrist	Y		G2	21.0617	$881.92
25110	Remove wrist tendon lesion	Y		A2	18.7092	$783.41
25111	Remove wrist tendon lesion	Y		A2	18.7092	$783.41
25112	Reremove wrist tendon lesion	Y		A2	19.3946	$812.11
25115	Remove wrist/forearm lesion	Y		A2	19.3946	$812.11
25116	Remove wrist/forearm lesion	Y		A2	19.3946	$812.11
25118	Excise wrist tendon sheath	Y		A2	25.3445	$1,061.25
25119	Partial removal of ulna	Y		A2	25.7101	$1,076.56
25120	Removal of forearm lesion	Y		A2	25.7101	$1,076.56
25125	Remove/graft forearm lesion	Y		A2	25.7101	$1,076.56

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
25126	Remove/graft forearm lesion	Y		A2	25.7101	$1,076.56
25130	Removal of wrist lesion	Y		A2	25.7101	$1,076.56
25135	Remove & graft wrist lesion	Y		A2	25.7101	$1,076.56
25136	Remove & graft wrist lesion	Y		A2	25.7101	$1,076.56
25145	Remove forearm bone lesion	Y		A2	25.3445	$1,061.25
25150	Partial removal of ulna	Y		A2	25.3445	$1,061.25
25151	Partial removal of radius	Y		A2	25.3445	$1,061.25
25210	Removal of wrist bone	Y		A2	25.7101	$1,076.56
25215	Removal of wrist bones	Y		A2	26.3955	$1,105.26
25230	Partial removal of radius	Y		A2	26.3955	$1,105.26
25240	Partial removal of ulna	Y		A2	26.3955	$1,105.26
25246	Injection for wrist x-ray	N		N1		
25248	Remove forearm foreign body	Y		A2	18.3436	$768.10
25250	Removal of wrist prosthesis	Y		A2	24.699	$1,034.22
25251	Removal of wrist prosthesis	Y		A2	24.699	$1,034.22
25259	Manipulate wrist w/anesthes	Y		G2	17.5996	$736.95
25260	Repair forearm tendon/muscle	Y		A2	26.3955	$1,105.26
25263	Repair forearm tendon/muscle	Y		A2	25.3445	$1,061.25
25265	Repair forearm tendon/muscle	Y		A2	25.7101	$1,076.56
25270	Repair forearm tendon/muscle	Y		A2	26.3955	$1,105.26
25272	Repair forearm tendon/muscle	Y		A2	25.7101	$1,076.56
25274	Repair forearm tendon/muscle	Y		A2	26.3955	$1,105.26
25275	Repair forearm tendon sheath	Y		A2	26.3955	$1,105.26
25280	Revise wrist/forearm tendon	Y		A2	26.3955	$1,105.26
25290	Incise wrist/forearm tendon	Y		A2	25.7101	$1,076.56
25295	Release wrist/forearm tendon	Y		A2	18.7092	$783.41
25300	Fusion of tendons at wrist	Y		A2	25.7101	$1,076.56
25301	Fusion of tendons at wrist	Y		A2	25.7101	$1,076.56
25310	Transplant forearm tendon	Y		A2	36.3344	$1,521.43
25312	Transplant forearm tendon	Y		A2	37.02	$1,550.14
25315	Revise palsy hand tendon(s)	Y		A2	36.3344	$1,521.43
25316	Revise palsy hand tendon(s)	Y		A2	66.5231	$2,785.52
25320	Repair/revise wrist joint	Y		A2	36.3344	$1,521.43
25332	Revise wrist joint	Y		A2	32.7158	$1,369.91
25335	Realignment of hand	Y		A2	36.3344	$1,521.43
25337	Reconstruct ulna/radioulnar	Y		A2	37.5168	$1,570.94
25350	Revision of radius	Y		A2	36.3344	$1,521.43
25355	Revision of radius	Y		A2	36.3344	$1,521.43
25360	Revision of ulna	Y		A2	36.3344	$1,521.43
25365	Revise radius & ulna	Y		A2	36.3344	$1,521.43
25370	Revise radius or ulna	Y		A2	36.3344	$1,521.43

Addendum AA -- Final ASC Covered Surgical Procedures for CY 2010 (Including Surgical Procedures for Which Payment is Packaged)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
25375	Revise radius & ulna	Y		A2	37.02	$1,550.14
25390	Shorten radius or ulna	Y		A2	36.3344	$1,521.43
25391	Lengthen radius or ulna	Y		A2	37.02	$1,550.14
25392	Shorten radius & ulna	Y		A2	25.7101	$1,076.56
25393	Lengthen radius & ulna	Y		A2	37.02	$1,550.14
25394	Repair carpal bone, shorten	Y		G2	44.5617	$1,865.93
25400	Repair radius or ulna	Y		A2	36.3344	$1,521.43
25405	Repair/graft radius or ulna	Y		A2	67.2085	$2,814.22
25415	Repair radius & ulna	Y		A2	66.5231	$2,785.52
25420	Repair/graft radius & ulna	Y		A2	67.2085	$2,814.22
25425	Repair/graft radius or ulna	Y		A2	36.3344	$1,521.43
25426	Repair/graft radius & ulna	Y		A2	37.02	$1,550.14
25430	Vasc graft into carpal bone	Y		G2	44.5617	$1,865.93
25431	Repair nonunion carpal bone	Y		G2	44.5617	$1,865.93
25440	Repair/graft wrist bone	Y		A2	67.2085	$2,814.22
25441	Reconstruct wrist joint	Y		H8	150.2992	$6,293.48
25442	Reconstruct wrist joint	Y		H8	150.2992	$6,293.48
25443	Reconstruct wrist joint	Y		A2	45.772	$1,916.61
25444	Reconstruct wrist joint	Y		A2	45.772	$1,916.61
25445	Reconstruct wrist joint	Y		A2	45.772	$1,916.61
25446	Wrist replacement	Y		H8	151.8871	$6,359.97
25447	Repair wrist joint(s)	Y		A2	32.7158	$1,369.91
25449	Remove wrist joint implant	Y		A2	32.7158	$1,369.91
25450	Revision of wrist joint	Y		A2	36.3344	$1,521.43
25455	Revision of wrist joint	Y		A2	36.3344	$1,521.43
25490	Reinforce radius	Y		A2	36.3344	$1,521.43
25491	Reinforce ulna	Y		A2	36.3344	$1,521.43
25492	Reinforce radius and ulna	Y		A2	36.3344	$1,521.43
25500	Treat fracture of radius	Y		P2	1.5858	$66.40
25505	Treat fracture of radius	Y		A2	4.0322	$168.84
25515	Treat fracture of radius	Y		A2	35.5372	$1,488.05
25520	Treat fracture of radius	Y		A2	4.0322	$168.84
25525	Treat fracture of radius	Y		A2	36.2226	$1,516.75
25526	Treat fracture of radius	Y		A2	36.7196	$1,537.56
25530	Treat fracture of ulna	Y		P2	1.5858	$66.40
25535	Treat fracture of ulna	Y		A2	1.7811	$74.58
25545	Treat fracture of ulna	Y		A2	35.5372	$1,488.05
25560	Treat fracture radius & ulna	Y		P2	1.5858	$66.40
25565	Treat fracture radius & ulna	Y		A2	4.0322	$168.84
25574	Treat fracture radius & ulna	Y		A2	49.8932	$2,089.18
25575	Treat fracture radius/ulna	Y		A2	49.8932	$2,089.18

Addendum AA -- Final ASC Covered Surgical Procedures for CY 2010 (Including Surgical Procedures for Which Payment is Packaged)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
25600	Treat fracture radius/ulna	Y		P2	1.5858	$66.40
25605	Treat fracture radius/ulna	Y		A2	4.0322	$168.84
25606	Treat fx distal radial	Y		A2	21.4573	$898.48
25607	Treat fx rad extra-articul	Y		A2	51.0756	$2,138.69
25608	Treat fx rad intra-articul	Y		A2	51.0756	$2,138.69
25609	Treat fx radial 3+ frag	Y		A2	51.0756	$2,138.69
25622	Treat wrist bone fracture	Y		P2	1.5858	$66.40
25624	Treat wrist bone fracture	Y		A2	4.0322	$168.84
25628	Treat wrist bone fracture	Y		A2	35.5372	$1,488.05
25630	Treat wrist bone fracture	Y		P2	1.5858	$66.40
25635	Treat wrist bone fracture	Y		A2	4.0322	$168.84
25645	Treat wrist bone fracture	Y		A2	35.5372	$1,488.05
25650	Treat wrist bone fracture	Y		P2	1.5858	$66.40
25651	Pin ulnar styloid fracture	Y		G2	24.7255	$1,035.33
25652	Treat fracture ulnar styloid	Y		G2	43.499	$1,821.43
25660	Treat wrist dislocation	Y		A2	1.7811	$74.58
25670	Treat wrist dislocation	Y		A2	21.4573	$898.48
25671	Pin radioulnar dislocation	Y		A2	20.4461	$856.14
25675	Treat wrist dislocation	Y		A2	1.7811	$74.58
25676	Treat wrist dislocation	Y		A2	21.0916	$883.17
25680	Treat wrist fracture	Y		A2	1.7811	$74.58
25685	Treat wrist fracture	Y		A2	21.4573	$898.48
25690	Treat wrist dislocation	Y		A2	13.7917	$577.50
25695	Treat wrist dislocation	Y		A2	21.0916	$883.17
25800	Fusion of wrist joint	Y		A2	67.2085	$2,814.22
25805	Fusion/graft of wrist joint	Y		A2	37.5168	$1,570.94
25810	Fusion/graft of wrist joint	Y		A2	67.7054	$2,835.03
25820	Fusion of hand bones	Y		A2	37.02	$1,550.14
25825	Fuse hand bones with graft	Y		A2	67.7054	$2,835.03
25830	Fusion, radioulnar jnt/ulna	Y		A2	67.7054	$2,835.03
25907	Amputation follow-up surgery	Y		A2	18.7092	$783.41
25922	Amputate hand at wrist	Y		A2	18.7092	$783.41
25929	Amputation follow-up surgery	Y		A2	14.4325	$604.33
25931	Amputation follow-up surgery	Y		G2	21.0617	$881.92
26010	Drainage of finger abscess	Y		P2	1.3927	$58.32
26011	Drainage of finger abscess	Y		A2	10.9586	$458.87
26020	Drain hand tendon sheath	Y		A2	14.7756	$618.70
26025	Drainage of palm bursa	Y		A2	14.1301	$591.67
26030	Drainage of palm bursa(s)	Y		A2	14.7756	$618.70
26034	Treat hand bone lesion	Y		A2	14.7756	$618.70
26035	Decompress fingers/hand	Y		G2	16.3041	$682.70

Addendum AA -- Final ASC Covered Surgical Procedures for CY 2010 (Including Surgical Procedures for Which Payment is Packaged)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
26037	Decompress fingers/hand	Y	CH	G2	16.3041	$682.70
26040	Release palm contracture	Y		A2	23.8595	$999.07
26045	Release palm contracture	Y		A2	23.1741	$970.37
26055	Incise finger tendon sheath	Y		A2	14.7756	$618.70
26060	Incision of finger tendon	Y		A2	14.7756	$618.70
26070	Explore/treat hand joint	Y		A2	14.7756	$618.70
26075	Explore/treat finger joint	Y		A2	15.8267	$662.71
26080	Explore/treat finger joint	Y		A2	15.8267	$662.71
26100	Biopsy hand joint lining	Y		A2	14.7756	$618.70
26105	Biopsy finger joint lining	Y		A2	14.1301	$591.67
26110	Biopsy finger joint lining	Y		A2	14.1301	$591.67
26111	Exc hand les sc > 1.5 cm	Y	NI	G2	22.3753	$936.92
26113	Exc hand tum deep > 1.5 cm	Y	NI	G2	22.3753	$936.92
26115*	Exc hand les sc < 1.5 cm	Y	NI	P3		$286.42
26116	Exc hand tum deep < 1.5 cm	Y	NI	G2	16.7399	$700.95
26117	Exc hand tum ra < 3 cm	Y	NI	G2	16.7399	$700.95
26118	Exc hand tum ra > 3 cm	Y	NI	G2	22.3753	$936.92
26121	Release palm contracture	Y		A2	23.8595	$999.07
26123	Release palm contracture	Y		A2	23.8595	$999.07
26125	Release palm contracture	Y		A2	15.8267	$662.71
26130	Remove wrist joint lining	Y		A2	15.141	$634.00
26135	Revise finger joint, each	Y		A2	23.8595	$999.07
26140	Revise finger joint, each	Y		A2	14.7756	$618.70
26145	Tendon excision, palm/finger	Y		A2	15.141	$634.00
26160	Remove tendon sheath lesion	Y		A2	15.141	$634.00
26170	Removal of palm tendon, each	Y		A2	15.141	$634.00
26180	Removal of finger tendon	Y		A2	15.141	$634.00
26185	Remove finger bone	Y		A2	15.8267	$662.71
26200	Remove hand bone lesion	Y		A2	14.7756	$618.70
26205	Remove/graft bone lesion	Y		A2	23.1741	$970.37
26210	Removal of finger lesion	Y		A2	14.7756	$618.70
26215	Remove/graft finger lesion	Y		A2	15.141	$634.00
26230	Partial removal of hand bone	Y		A2	17.8996	$749.51
26235	Partial removal, finger bone	Y		A2	15.141	$634.00
26236	Partial removal, finger bone	Y		A2	15.141	$634.00
26250	Extensive hand surgery	Y		A2	15.141	$634.00
26255	Extensive hand surgery	N	CH	D5		
26260	Resect prox finger tumor	Y		A2	15.141	$634.00
26261	Extensive finger surgery	N	CH	D5		
26262	Resect distal finger tumor	Y		A2	14.7756	$618.70
26320	Removal of implant from hand	Y		A2	15.1023	$632.38

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
26340	Manipulate finger w/anesth	Y		G2	4.587	$192.07
26350	Repair finger/hand tendon	Y		A2	22.1632	$928.04
26352	Repair/graft hand tendon	Y		A2	23.8595	$999.07
26356	Repair finger/hand tendon	Y		A2	23.8595	$999.07
26357	Repair finger/hand tendon	Y		A2	23.8595	$999.07
26358	Repair/graft hand tendon	Y		A2	23.8595	$999.07
26370	Repair finger/hand tendon	Y		A2	23.8595	$999.07
26372	Repair/graft hand tendon	Y		A2	23.8595	$999.07
26373	Repair finger/hand tendon	Y		A2	23.1741	$970.37
26390	Revise hand/finger tendon	Y		A2	23.8595	$999.07
26392	Repair/graft hand tendon	Y		A2	23.1741	$970.37
26410	Repair hand tendon	Y		A2	15.141	$634.00
26412	Repair/graft hand tendon	Y		A2	23.1741	$970.37
26415	Excision, hand/finger tendon	Y		A2	23.8595	$999.07
26416	Graft hand or finger tendon	Y		A2	23.1741	$970.37
26418	Repair finger tendon	Y		A2	15.8267	$662.71
26420	Repair/graft finger tendon	Y		A2	23.8595	$999.07
26426	Repair finger/hand tendon	Y		A2	23.1741	$970.37
26428	Repair/graft finger tendon	Y		A2	23.1741	$970.37
26432	Repair finger tendon	Y		A2	15.141	$634.00
26433	Repair finger tendon	Y		A2	15.141	$634.00
26434	Repair/graft finger tendon	Y		A2	23.1741	$970.37
26437	Realignment of tendons	Y		A2	15.141	$634.00
26440	Release palm/finger tendon	Y		A2	15.141	$634.00
26442	Release palm & finger tendon	Y		A2	23.1741	$970.37
26445	Release hand/finger tendon	Y		A2	15.141	$634.00
26449	Release forearm/hand tendon	Y		A2	23.1741	$970.37
26450	Incision of palm tendon	Y		A2	15.141	$634.00
26455	Incision of finger tendon	Y		A2	15.141	$634.00
26460	Incise hand/finger tendon	Y		A2	15.141	$634.00
26471	Fusion of finger tendons	Y		A2	14.7756	$618.70
26474	Fusion of finger tendons	Y		A2	14.7756	$618.70
26476	Tendon lengthening	Y		A2	14.1301	$591.67
26477	Tendon shortening	Y		A2	14.1301	$591.67
26478	Lengthening of hand tendon	Y		A2	14.1301	$591.67
26479	Shortening of hand tendon	Y		A2	14.1301	$591.67
26480	Transplant hand tendon	Y		A2	23.1741	$970.37
26483	Transplant/graft hand tendon	Y		A2	23.1741	$970.37
26485	Transplant palm tendon	Y		A2	22.8085	$955.06
26489	Transplant/graft palm tendon	Y		A2	23.1741	$970.37
26490	Revise thumb tendon	Y		A2	23.1741	$970.37

Addendum AA -- Final ASC Covered Surgical Procedures for CY 2010 (Including Surgical Procedures for Which Payment is Packaged)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
26492	Tendon transfer with graft	Y		A2	23.1741	$970.37
26494	Hand tendon/muscle transfer	Y		A2	23.1741	$970.37
26496	Revise thumb tendon	Y		A2	23.1741	$970.37
26497	Finger tendon transfer	Y		A2	23.1741	$970.37
26498	Finger tendon transfer	Y		A2	23.8595	$999.07
26499	Revision of finger	Y		A2	23.1741	$970.37
26500	Hand tendon reconstruction	Y		A2	15.8267	$662.71
26502	Hand tendon reconstruction	Y		A2	23.8595	$999.07
26508	Release thumb contracture	Y		A2	15.141	$634.00
26510	Thumb tendon transfer	Y		A2	23.1741	$970.37
26516	Fusion of knuckle joint	Y		A2	22.1632	$928.04
26517	Fusion of knuckle joints	Y		A2	23.1741	$970.37
26518	Fusion of knuckle joints	Y		A2	23.1741	$970.37
26520	Release knuckle contracture	Y		A2	15.141	$634.00
26525	Release finger contracture	Y		A2	15.141	$634.00
26530	Revise knuckle joint	Y		A2	31.5334	$1,320.40
26531	Revise knuckle with implant	Y		A2	47.3599	$1,983.10
26535	Revise finger joint	Y		A2	32.7158	$1,369.91
26536	Revise/implant finger joint	Y		A2	45.772	$1,916.61
26540	Repair hand joint	Y		A2	15.8267	$662.71
26541	Repair hand joint with graft	Y		A2	25.9444	$1,086.37
26542	Repair hand joint with graft	Y		A2	15.8267	$662.71
26545	Reconstruct finger joint	Y		A2	23.8595	$999.07
26546	Repair nonunion hand	Y		A2	23.8595	$999.07
26548	Reconstruct finger joint	Y		A2	23.8595	$999.07
26550	Construct thumb replacement	Y		A2	22.8085	$955.06
26555	Positional change of finger	Y		A2	23.1741	$970.37
26560	Repair of web finger	Y		A2	14.7756	$618.70
26561	Repair of web finger	Y		A2	23.1741	$970.37
26562	Repair of web finger	Y		A2	23.8595	$999.07
26565	Correct metacarpal flaw	Y		A2	24.3565	$1,019.88
26567	Correct finger deformity	Y		A2	24.3565	$1,019.88
26568	Lengthen metacarpal/finger	Y		A2	23.1741	$970.37
26580	Repair hand deformity	Y		A2	16.3234	$683.51
26587	Reconstruct extra finger	Y		A2	16.3234	$683.51
26590	Repair finger deformity	Y		A2	16.3234	$683.51
26591	Repair muscles of hand	Y		A2	23.1741	$970.37
26593	Release muscles of hand	Y		A2	15.141	$634.00
26596	Excision constricting tissue	Y		A2	14.7756	$618.70
26600	Treat metacarpal fracture	Y		P2	1.5858	$66.40
26605	Treat metacarpal fracture	Y		A2	1.7811	$74.58

Addendum AA -- Final ASC Covered Surgical Procedures for CY 2010 (Including Surgical Procedures for Which Payment is Packaged)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
26607	Treat metacarpal fracture	Y		A2	13.7917	$577.50
26608	Treat metacarpal fracture	Y		A2	22.1427	$927.18
26615	Treat metacarpal fracture	Y		A2	36.2226	$1,516.75
26641	Treat thumb dislocation	Y		P2	1.5858	$66.40
26645	Treat thumb fracture	Y		A2	4.0322	$168.84
26650	Treat thumb fracture	Y		A2	21.0916	$883.17
26665	Treat thumb fracture	Y		A2	36.2226	$1,516.75
26670	Treat hand dislocation	Y		P2	1.5858	$66.40
26675	Treat hand dislocation	Y		A2	4.0322	$168.84
26676	Pin hand dislocation	Y		A2	21.0916	$883.17
26685	Treat hand dislocation	Y		A2	21.4573	$898.48
26686	Treat hand dislocation	Y		A2	49.8932	$2,089.18
26700	Treat knuckle dislocation	Y		P2	1.5858	$66.40
26705	Treat knuckle dislocation	Y		A2	1.7811	$74.58
26706	Pin knuckle dislocation	Y		A2	13.7917	$577.50
26715	Treat knuckle dislocation	Y		A2	22.1427	$927.18
26720	Treat finger fracture, each	Y		P2	1.5858	$66.40
26725	Treat finger fracture, each	Y		P2	1.5858	$66.40
26727	Treat finger fracture, each	Y		A2	24.2275	$1,014.48
26735	Treat finger fracture, each	Y		A2	22.1427	$927.18
26740	Treat finger fracture, each	Y		P2	1.5858	$66.40
26742	Treat finger fracture, each	Y		A2	1.7811	$74.58
26746	Treat finger fracture, each	Y		A2	22.6396	$947.99
26750	Treat finger fracture, each	Y		P2	1.5858	$66.40
26755	Treat finger fracture, each	Y		G2	1.5858	$66.40
26756	Pin finger fracture, each	Y		A2	21.0916	$883.17
26765	Treat finger fracture, each	Y		A2	22.1427	$927.18
26770	Treat finger dislocation	Y		G2	1.5858	$66.40
26775	Treat finger dislocation	Y		P3		$142.79
26776	Pin finger dislocation	Y		A2	21.0916	$883.17
26785	Treat finger dislocation	Y		A2	21.0916	$883.17
26820	Thumb fusion with graft	Y		A2	24.3565	$1,019.88
26841	Fusion of thumb	Y		A2	23.8595	$999.07
26842	Thumb fusion with graft	Y		A2	23.8595	$999.07
26843	Fusion of hand joint	Y		A2	23.1741	$970.37
26844	Fusion/graft of hand joint	Y		A2	23.1741	$970.37
26850	Fusion of knuckle	Y		A2	23.8595	$999.07
26852	Fusion of knuckle with graft	Y		A2	23.8595	$999.07
26860	Fusion of finger joint	Y		A2	23.1741	$970.37
26861	Fusion of finger jnt, add-on	Y		A2	22.8085	$955.06
26862	Fusion/graft of finger joint	Y		A2	23.8595	$999.07

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
26863	Fuse/graft added joint	Y		A2	23.1741	$970.37
26910	Amputate metacarpal bone	Y		A2	23.1741	$970.37
26951	Amputation of finger/thumb	Y		A2	14.7756	$618.70
26952	Amputation of finger/thumb	Y		A2	15.8267	$662.71
26990	Drainage of pelvis lesion	Y		A2	17.6983	$741.08
26991	Drainage of pelvis bursa	Y		A2	17.6983	$741.08
27000	Incision of hip tendon	Y		A2	18.3436	$768.10
27001	Incision of hip tendon	Y		A2	25.7101	$1,076.56
27003	Incision of hip tendon	Y		A2	25.7101	$1,076.56
27033	Exploration of hip joint	Y		A2	36.3344	$1,521.43
27035	Denervation of hip joint	Y		A2	37.02	$1,550.14
27040	Biopsy of soft tissues	Y		A2	7.7878	$326.10
27041	Biopsy of soft tissues	Y		A2	8.2762	$346.55
27043	Exc hip pelvis les sc > 3 cm	Y	NI	G2	22.3753	$936.92
27045	Exc hip/pelv tum deep > 5 cm	Y	NI	G2	22.3753	$936.92
27047*	Exc hip/pelvis les sc < 3 cm	Y	NI	P3		$199.56
27048	Exc hip/pelv tum deep < 5 cm	Y	NI	G2	16.7399	$700.95
27049	Resect hip/pelv tum < 5 cm	Y	NI	G2	16.7399	$700.95
27050	Biopsy of sacroiliac joint	Y		A2	18.7092	$783.41
27052	Biopsy of hip joint	Y		A2	18.7092	$783.41
27059	Resect hip/pelv tum > 5 cm	Y	NI	G2	22.3753	$936.92
27060	Removal of ischial bursa	Y		A2	19.8916	$832.92
27062	Remove femur lesion/bursa	Y		A2	19.8916	$832.92
27065	Removal of hip bone lesion	Y		A2	19.8916	$832.92
27066	Removal of hip bone lesion	Y		A2	26.8925	$1,126.07
27067	Remove/graft hip bone lesion	Y		A2	26.8925	$1,126.07
27080	Removal of tail bone	Y		A2	25.3445	$1,061.25
27086	Remove hip foreign body	Y		A2	7.7878	$326.10
27087	Remove hip foreign body	Y		A2	18.7092	$783.41
27093	Injection for hip x-ray	N		N1		
27095	Injection for hip x-ray	N		N1		
27097	Revision of hip tendon	Y		A2	25.7101	$1,076.56
27098	Transfer tendon to pelvis	Y		A2	25.7101	$1,076.56
27100	Transfer of abdominal muscle	Y		A2	37.02	$1,550.14
27105	Transfer of spinal muscle	Y		A2	37.02	$1,550.14
27110	Transfer of iliopsoas muscle	Y		A2	37.02	$1,550.14
27111	Transfer of iliopsoas muscle	Y		A2	37.02	$1,550.14
27193	Treat pelvic ring fracture	Y		A2	1.7811	$74.58
27194	Treat pelvic ring fracture	Y		A2	13.5199	$566.12
27200	Treat tail bone fracture	Y	CH	P3		$63.30
27202	Treat tail bone fracture	Y		A2	35.1716	$1,472.74

Addendum AA -- Final ASC Covered Surgical Procedures for CY 2010 (Including Surgical Procedures for Which Payment is Packaged)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
27220	Treat hip socket fracture	Y		G2	1.5858	$66.40
27230	Treat thigh fracture	Y		A2	1.7811	$74.58
27238	Treat thigh fracture	Y		A2	4.0322	$168.84
27246	Treat thigh fracture	Y		A2	4.0322	$168.84
27250	Treat hip dislocation	Y		A2	1.7811	$74.58
27252	Treat hip dislocation	Y		A2	13.5199	$566.12
27256	Treat hip dislocation	Y		G2	1.5858	$66.40
27257	Treat hip dislocation	Y		A2	13.8856	$581.43
27265	Treat hip dislocation	Y		A2	1.7811	$74.58
27266	Treat hip dislocation	Y		A2	13.5199	$566.12
27267	Cltx thigh fx	Y		G2	1.5858	$66.40
27275	Manipulation of hip joint	Y		A2	13.5199	$566.12
27301	Drain thigh/knee lesion	Y		A2	16.8376	$705.04
27305	Incise thigh tendon & fascia	Y		A2	18.3436	$768.10
27306	Incision of thigh tendon	Y		A2	18.7092	$783.41
27307	Incision of thigh tendons	Y		A2	18.7092	$783.41
27310	Exploration of knee joint	Y		A2	26.3955	$1,105.26
27323	Biopsy, thigh soft tissues	Y		A2	7.7878	$326.10
27324	Biopsy, thigh soft tissues	Y		A2	18.6836	$782.34
27325	Neurectomy, hamstring	Y		A2	15.9795	$669.11
27326	Neurectomy, popliteal	Y		A2	15.9795	$669.11
27327*	Exc thigh/knee les sc < 3 cm	Y	NI	P3		$181.68
27328	Exc thigh/knee tum deep <5cm	Y	NI	G2	16.7399	$700.95
27329	Resect thigh/knee tum < 5 cm	Y	NI	G2	16.7399	$700.95
27330	Biopsy, knee joint lining	Y		A2	26.3955	$1,105.26
27331	Explore/treat knee joint	Y		A2	26.3955	$1,105.26
27332	Removal of knee cartilage	Y		A2	26.3955	$1,105.26
27333	Removal of knee cartilage	Y		A2	26.3955	$1,105.26
27334	Remove knee joint lining	Y		A2	26.3955	$1,105.26
27335	Remove knee joint lining	Y		A2	26.3955	$1,105.26
27337	Exc thigh/knee les sc > 3 cm	Y	NI	G2	22.3753	$936.92
27339	Exc thigh/knee tum deep >5cm	Y	NI	G2	22.3753	$936.92
27340	Removal of kneecap bursa	Y		A2	18.7092	$783.41
27345	Removal of knee cyst	Y		A2	19.3946	$812.11
27347	Remove knee cyst	Y		A2	19.3946	$812.11
27350	Removal of kneecap	Y		A2	26.3955	$1,105.26
27355	Remove femur lesion	Y		A2	25.7101	$1,076.56
27356	Remove femur lesion/graft	Y		A2	26.3955	$1,105.26
27357	Remove femur lesion/graft	Y		A2	26.8925	$1,126.07
27358	Remove femur lesion/fixation	Y		A2	26.8925	$1,126.07
27360	Partial removal, leg bone(s)	Y		A2	26.8925	$1,126.07

Addendum AA -- Final ASC Covered Surgical Procedures for CY 2010 (Including Surgical Procedures for Which Payment is Packaged)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
27364	Resect thigh/knee tum >5 cm	Y	NI	G2	22.3753	$936.92
27370	Injection for knee x-ray	N		N1		
27372	Removal of foreign body	Y		A2	22.4651	$940.68
27380	Repair of kneecap tendon	Y		A2	17.6983	$741.08
27381	Repair/graft kneecap tendon	Y		A2	18.7092	$783.41
27385	Repair of thigh muscle	Y		A2	18.7092	$783.41
27386	Repair/graft of thigh muscle	Y		A2	18.7092	$783.41
27390	Incision of thigh tendon	Y		A2	17.6983	$741.08
27391	Incision of thigh tendons	Y		A2	18.3436	$768.10
27392	Incision of thigh tendons	Y		A2	18.7092	$783.41
27393	Lengthening of thigh tendon	Y		A2	25.3445	$1,061.25
27394	Lengthening of thigh tendons	Y		A2	25.7101	$1,076.56
27395	Lengthening of thigh tendons	Y		A2	36.3344	$1,521.43
27396	Transplant of thigh tendon	Y		A2	25.7101	$1,076.56
27397	Transplants of thigh tendons	Y		A2	36.3344	$1,521.43
27400	Revise thigh muscles/tendons	Y		A2	36.3344	$1,521.43
27403	Repair of knee cartilage	Y		A2	26.3955	$1,105.26
27405	Repair of knee ligament	Y		A2	37.02	$1,550.14
27407	Repair of knee ligament	Y		A2	67.2085	$2,814.22
27409	Repair of knee ligaments	Y		A2	37.02	$1,550.14
27416	Osteochondral knee autograft	Y		G2	44.5617	$1,865.93
27418	Repair degenerated kneecap	Y		A2	36.3344	$1,521.43
27420	Revision of unstable kneecap	Y		A2	36.3344	$1,521.43
27422	Revision of unstable kneecap	Y		A2	39.1047	$1,637.43
27424	Revision/removal of kneecap	Y		A2	36.3344	$1,521.43
27425	Lat retinacular release open	Y		A2	28.4804	$1,192.56
27427	Reconstruction, knee	Y		A2	36.3344	$1,521.43
27428	Reconstruction, knee	Y		A2	67.2085	$2,814.22
27429	Reconstruction, knee	Y		A2	67.2085	$2,814.22
27430	Revision of thigh muscles	Y		A2	37.02	$1,550.14
27435	Incision of knee joint	Y		A2	37.02	$1,550.14
27437	Revise kneecap	Y		A2	32.2191	$1,349.11
27438	Revise kneecap with implant	Y		A2	45.772	$1,916.61
27440	Revision of knee joint	Y		G2	38.1606	$1,597.90
27441	Revision of knee joint	Y		A2	32.7158	$1,369.91
27442	Revision of knee joint	Y		A2	32.7158	$1,369.91
27443	Revision of knee joint	Y		A2	32.7158	$1,369.91
27446	Revision of knee joint	Y		J8	158.2621	$6,626.91
27475	Surgery to stop leg growth	Y	CH	G2	30.396	$1,272.77
27479	Surgery to stop leg growth	Y	CH	G2	30.396	$1,272.77
27496	Decompression of thigh/knee	Y		A2	26.8925	$1,126.07

Addendum AA -- Final ASC Covered Surgical Procedures for CY 2010 (Including Surgical Procedures for Which Payment is Packaged)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
27497	Decompression of thigh/knee	Y		A2	18.7092	$783.41
27498	Decompression of thigh/knee	Y		A2	25.7101	$1,076.56
27499	Decompression of thigh/knee	Y		A2	25.7101	$1,076.56
27500	Treatment of thigh fracture	Y		A2	4.0322	$168.84
27501	Treatment of thigh fracture	Y		A2	1.7811	$74.58
27502	Treatment of thigh fracture	Y		A2	13.7917	$577.50
27503	Treatment of thigh fracture	Y		A2	1.7811	$74.58
27508	Treatment of thigh fracture	Y		A2	1.7811	$74.58
27509	Treatment of thigh fracture	Y		A2	21.4573	$898.48
27510	Treatment of thigh fracture	Y		A2	4.0322	$168.84
27516	Treat thigh fx growth plate	Y		A2	1.7811	$74.58
27517	Treat thigh fx growth plate	Y		A2	1.7811	$74.58
27520	Treat kneecap fracture	Y		A2	1.7811	$74.58
27530	Treat knee fracture	Y		A2	1.7811	$74.58
27532	Treat knee fracture	Y		A2	13.7917	$577.50
27538	Treat knee fracture(s)	Y		A2	1.7811	$74.58
27550	Treat knee dislocation	Y		A2	1.7811	$74.58
27552	Treat knee dislocation	Y		A2	12.8746	$539.10
27560	Treat kneecap dislocation	Y		A2	1.7811	$74.58
27562	Treat kneecap dislocation	Y		A2	12.8746	$539.10
27566	Treat kneecap dislocation	Y		A2	35.1716	$1,472.74
27570	Fixation of knee joint	Y		A2	12.8746	$539.10
27594	Amputation follow-up surgery	Y		A2	18.7092	$783.41
27600	Decompression of lower leg	Y		A2	18.7092	$783.41
27601	Decompression of lower leg	Y		A2	18.7092	$783.41
27602	Decompression of lower leg	Y		A2	18.7092	$783.41
27603	Drain lower leg lesion	Y		A2	16.472	$689.73
27604	Drain lower leg bursa	Y		A2	18.3436	$768.10
27605	Incision of achilles tendon	Y		A2	17.5755	$735.94
27606	Incision of achilles tendon	Y		A2	17.6983	$741.08
27607	Treat lower leg bone lesion	Y		A2	18.3436	$768.10
27610	Explore/treat ankle joint	Y		A2	25.3445	$1,061.25
27612	Exploration of ankle joint	Y		A2	25.7101	$1,076.56
27613	Biopsy lower leg soft tissue	Y		P3		$110.42
27614	Biopsy lower leg soft tissue	Y		A2	19.3292	$809.37
27615	Resect leg/ankle tum < 5 cm	Y	NI	G2	16.7399	$700.95
27616	Resect leg/ankle tum > 5 cm	Y	NI	G2	22.3753	$936.92
27618*	Exc leg/ankle tum < 3 cm	Y	NI	P3		$187.35
27619	Exc leg/ankle tum deep <5 cm	Y	NI	G2	16.7399	$700.95
27620	Explore/treat ankle joint	Y		A2	26.3955	$1,105.26
27625	Remove ankle joint lining	Y		A2	26.3955	$1,105.26

Addendum AA -- Final ASC Covered Surgical Procedures for CY 2010 (Including Surgical Procedures for Which Payment is Packaged)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
27626	Remove ankle joint lining	Y		A2	26.3955	$1,105.26
27630	Removal of tendon lesion	Y		A2	18.7092	$783.41
27632	Exc leg/ankle les sc > 3 cm	Y	NI	G2	22.3753	$936.92
27634	Exc leg/ankle tum deep >5 cm	Y	NI	G2	22.3753	$936.92
27635	Remove lower leg bone lesion	Y		A2	25.7101	$1,076.56
27637	Remove/graft leg bone lesion	Y		A2	25.7101	$1,076.56
27638	Remove/graft leg bone lesion	Y		A2	25.7101	$1,076.56
27640	Partial removal of tibia	Y		A2	35.969	$1,506.13
27641	Partial removal of fibula	Y		A2	25.3445	$1,061.25
27647	Resect talus/calcaneus tum	Y		A2	36.3344	$1,521.43
27648	Injection for ankle x-ray	N		N1		
27650	Repair achilles tendon	Y		A2	36.3344	$1,521.43
27652	Repair/graft achilles tendon	Y		A2	66.5231	$2,785.52
27654	Repair of achilles tendon	Y		A2	36.3344	$1,521.43
27656	Repair leg fascia defect	Y		A2	18.3436	$768.10
27658	Repair of leg tendon, each	Y		A2	17.6983	$741.08
27659	Repair of leg tendon, each	Y		A2	18.3436	$768.10
27664	Repair of leg tendon, each	Y		A2	25.3445	$1,061.25
27665	Repair of leg tendon, each	Y		A2	25.3445	$1,061.25
27675	Repair lower leg tendons	Y		A2	18.3436	$768.10
27676	Repair lower leg tendons	Y		A2	25.7101	$1,076.56
27680	Release of lower leg tendon	Y		A2	25.7101	$1,076.56
27681	Release of lower leg tendons	Y		A2	25.3445	$1,061.25
27685	Revision of lower leg tendon	Y		A2	25.7101	$1,076.56
27686	Revise lower leg tendons	Y		A2	25.7101	$1,076.56
27687	Revision of calf tendon	Y		A2	25.7101	$1,076.56
27690	Revise lower leg tendon	Y		A2	37.02	$1,550.14
27691	Revise lower leg tendon	Y		A2	37.02	$1,550.14
27692	Revise additional leg tendon	Y		A2	36.3344	$1,521.43
27695	Repair of ankle ligament	Y		A2	25.3445	$1,061.25
27696	Repair of ankle ligaments	Y		A2	25.3445	$1,061.25
27698	Repair of ankle ligament	Y		A2	25.3445	$1,061.25
27700	Revision of ankle joint	Y		A2	32.7158	$1,369.91
27704	Removal of ankle implant	Y		A2	18.3436	$768.10
27705	Incision of tibia	Y		A2	35.969	$1,506.13
27707	Incision of fibula	Y		A2	18.3436	$768.10
27709	Incision of tibia & fibula	Y		A2	25.3445	$1,061.25
27720	Repair of tibia	Y	CH	G2	43.499	$1,821.43
27726	Repair fibula nonunion	Y		G2	43.499	$1,821.43
27730	Repair of tibia epiphysis	Y		A2	25.3445	$1,061.25
27732	Repair of fibula epiphysis	Y		A2	25.3445	$1,061.25

Addendum AA -- Final ASC Covered Surgical Procedures for CY 2010 (Including Surgical Procedures for Which Payment is Packaged)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
27734	Repair lower leg epiphyses	Y		A2	25.3445	$1,061.25
27740	Repair of leg epiphyses	Y		A2	25.3445	$1,061.25
27742	Repair of leg epiphyses	Y		A2	35.969	$1,506.13
27745	Reinforce tibia	Y		A2	66.5231	$2,785.52
27750	Treatment of tibia fracture	Y		A2	1.7811	$74.58
27752	Treatment of tibia fracture	Y		A2	13.7917	$577.50
27756	Treatment of tibia fracture	Y		A2	21.4573	$898.48
27758	Treatment of tibia fracture	Y		A2	36.2226	$1,516.75
27759	Treatment of tibia fracture	Y		A2	50.5787	$2,117.88
27760	Cltx medial ankle fx	Y		A2	1.7811	$74.58
27762	Cltx med ankle fx w/mnpj	Y		A2	13.7917	$577.50
27766	Optx medial ankle fx	Y		A2	35.5372	$1,488.05
27767	Cltx post ankle fx	Y		G2	1.5858	$66.40
27768	Cltx post ankle fx w/mnpj	Y		G2	1.5858	$66.40
27769	Optx post ankle fx	Y		G2	43.499	$1,821.43
27780	Treatment of fibula fracture	Y		A2	1.7811	$74.58
27781	Treatment of fibula fracture	Y		A2	13.7917	$577.50
27784	Treatment of fibula fracture	Y		A2	35.5372	$1,488.05
27786	Treatment of ankle fracture	Y		A2	1.7811	$74.58
27788	Treatment of ankle fracture	Y		A2	1.7811	$74.58
27792	Treatment of ankle fracture	Y		A2	35.5372	$1,488.05
27808	Treatment of ankle fracture	Y		A2	1.7811	$74.58
27810	Treatment of ankle fracture	Y		A2	4.0322	$168.84
27814	Treatment of ankle fracture	Y		A2	35.5372	$1,488.05
27816	Treatment of ankle fracture	Y		A2	1.7811	$74.58
27818	Treatment of ankle fracture	Y		A2	4.0322	$168.84
27822	Treatment of ankle fracture	Y		A2	35.5372	$1,488.05
27823	Treatment of ankle fracture	Y		A2	49.8932	$2,089.18
27824	Treat lower leg fracture	Y		A2	1.7811	$74.58
27825	Treat lower leg fracture	Y		A2	13.7917	$577.50
27826	Treat lower leg fracture	Y		A2	35.5372	$1,488.05
27827	Treat lower leg fracture	Y		A2	49.8932	$2,089.18
27828	Treat lower leg fracture	Y		A2	50.5787	$2,117.88
27829	Treat lower leg joint	Y		A2	35.1716	$1,472.74
27830	Treat lower leg dislocation	Y		A2	1.7811	$74.58
27831	Treat lower leg dislocation	Y		A2	13.7917	$577.50
27832	Treat lower leg dislocation	Y		A2	35.1716	$1,472.74
27840	Treat ankle dislocation	Y		A2	4.0322	$168.84
27842	Treat ankle dislocation	Y		A2	12.8746	$539.10
27846	Treat ankle dislocation	Y		A2	35.5372	$1,488.05
27848	Treat ankle dislocation	Y		A2	35.5372	$1,488.05

Addendum AA -- Final ASC Covered Surgical Procedures for CY 2010 (Including Surgical Procedures for Which Payment is Packaged)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
27860	Fixation of ankle joint	Y		A2	12.8746	$539.10
27870	Fusion of ankle joint, open	Y		A2	67.2085	$2,814.22
27871	Fusion of tibiofibular joint	Y		A2	67.2085	$2,814.22
27884	Amputation follow-up surgery	Y		A2	18.7092	$783.41
27889	Amputation of foot at ankle	Y		A2	25.7101	$1,076.56
27892	Decompression of leg	Y		A2	25.7101	$1,076.56
27893	Decompression of leg	Y		A2	25.7101	$1,076.56
27894	Decompression of leg	Y		A2	25.7101	$1,076.56
28001	Drainage of bursa of foot	Y		P3		$109.29
28002	Treatment of foot infection	Y		A2	18.7092	$783.41
28003	Treatment of foot infection	Y		A2	18.7092	$783.41
28005	Treat foot bone lesion	Y		A2	18.5864	$778.27
28008	Incision of foot fascia	Y		A2	18.5864	$778.27
28010	Incision of toe tendon	Y		P3		$79.77
28011	Incision of toe tendons	Y		A2	18.5864	$778.27
28020	Exploration of foot joint	Y		A2	18.221	$762.97
28022	Exploration of foot joint	Y		A2	18.221	$762.97
28024	Exploration of toe joint	Y		A2	18.221	$762.97
28035	Decompression of tibia nerve	Y		A2	17.0305	$713.12
28039*	Exc foot/toe tum sc > 1.5 cm	Y	NI	P3		$198.99
28041*	Exc foot/toe tum deep >1.5cm	Y	NI	R2	22.3753	$936.92
28043*	Exc foot/toe tum sc < 1.5 cm	Y	NI	P3		$141.65
28045*	Exc foot/toe tum deep <1.5cm	Y	NI	P3		$194.17
28046*	Resect foot/toe tumor < 3 cm	Y	NI	R2	16.7399	$700.95
28047	Resect foot/toe tumor > 3 cm	Y	NI	G2	22.3753	$936.92
28050	Biopsy of foot joint lining	Y		A2	18.221	$762.97
28052	Biopsy of foot joint lining	Y		A2	18.221	$762.97
28054	Biopsy of toe joint lining	Y		A2	18.221	$762.97
28055	Neurectomy, foot	Y		A2	17.0305	$713.12
28060	Partial removal, foot fascia	Y		A2	18.221	$762.97
28062	Removal of foot fascia	Y		A2	18.5864	$778.27
28070	Removal of foot joint lining	Y		A2	18.5864	$778.27
28072	Removal of foot joint lining	Y		A2	18.5864	$778.27
28080	Removal of foot lesion	Y		A2	18.5864	$778.27
28086	Excise foot tendon sheath	Y		A2	18.221	$762.97
28088	Excise foot tendon sheath	Y		A2	18.221	$762.97
28090	Removal of foot lesion	Y		A2	18.5864	$778.27
28092	Removal of toe lesions	Y		A2	18.5864	$778.27
28100	Removal of ankle/heel lesion	Y		A2	18.221	$762.97
28102	Remove/graft foot lesion	Y		A2	40.6016	$1,700.11
28103	Remove/graft foot lesion	Y		A2	40.6016	$1,700.11

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
28104	Removal of foot lesion	Y		A2	18.221	$762.97
28106	Remove/graft foot lesion	Y		A2	40.6016	$1,700.11
28107	Remove/graft foot lesion	Y		A2	40.6016	$1,700.11
28108	Removal of toe lesions	Y		A2	18.221	$762.97
28110	Part removal of metatarsal	Y		A2	18.5864	$778.27
28111	Part removal of metatarsal	Y		A2	18.5864	$778.27
28112	Part removal of metatarsal	Y		A2	18.5864	$778.27
28113	Part removal of metatarsal	Y		A2	18.5864	$778.27
28114	Removal of metatarsal heads	Y		A2	18.5864	$778.27
28116	Revision of foot	Y		A2	18.5864	$778.27
28118	Removal of heel bone	Y		A2	19.2721	$806.98
28119	Removal of heel spur	Y		A2	19.2721	$806.98
28120	Part removal of ankle/heel	Y		A2	21.3567	$894.27
28122	Partial removal of foot bone	Y		A2	18.5864	$778.27
28124	Partial removal of toe	Y		P3		$185.08
28126	Partial removal of toe	Y		A2	18.5864	$778.27
28130	Removal of ankle bone	Y		A2	18.5864	$778.27
28140	Removal of metatarsal	Y		A2	18.5864	$778.27
28150	Removal of toe	Y		A2	18.5864	$778.27
28153	Partial removal of toe	Y		A2	18.5864	$778.27
28160	Partial removal of toe	Y		A2	18.5864	$778.27
28171	Resect tarsal tumor	Y		A2	18.5864	$778.27
28173	Resect metatarsal tumor	Y		A2	18.5864	$778.27
28175	Resect phalanx of toe tumor	Y		A2	18.5864	$778.27
28190	Removal of foot foreign body	Y		P3		$113.26
28192	Removal of foot foreign body	Y		A2	15.1023	$632.38
28193	Removal of foot foreign body	Y		A2	8.2762	$346.55
28200	Repair of foot tendon	Y		A2	18.5864	$778.27
28202	Repair/graft of foot tendon	Y		A2	18.5864	$778.27
28208	Repair of foot tendon	Y		A2	18.5864	$778.27
28210	Repair/graft of foot tendon	Y		A2	40.6016	$1,700.11
28220	Release of foot tendon	Y		P3		$174.86
28222	Release of foot tendons	Y		A2	17.5755	$735.94
28225	Release of foot tendon	Y		A2	17.5755	$735.94
28226	Release of foot tendons	Y		A2	17.5755	$735.94
28230	Incision of foot tendon(s)	Y		P3		$171.17
28232	Incision of toe tendon	Y		P3		$163.79
28234	Incision of foot tendon	Y		A2	18.221	$762.97
28238	Revision of foot tendon	Y		A2	40.6016	$1,700.11
28240	Release of big toe	Y		A2	18.221	$762.97
28250	Revision of foot fascia	Y		A2	18.5864	$778.27

Addendum AA -- Final ASC Covered Surgical Procedures for CY 2010 (Including Surgical Procedures for Which Payment is Packaged)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
28260	Release of midfoot joint	Y		A2	18.5864	$778.27
28261	Revision of foot tendon	Y		A2	18.5864	$778.27
28262	Revision of foot and ankle	Y		A2	19.2721	$806.98
28264	Release of midfoot joint	Y		A2	39.5907	$1,657.78
28270	Release of foot contracture	Y		A2	18.5864	$778.27
28272	Release of toe joint, each	Y		P3		$158.11
28280	Fusion of toes	Y		A2	18.221	$762.97
28285	Repair of hammertoe	Y		A2	18.5864	$778.27
28286	Repair of hammertoe	Y		A2	19.2721	$806.98
28288	Partial removal of foot bone	Y		A2	18.5864	$778.27
28289	Repair hallux rigidus	Y		A2	18.5864	$778.27
28290	Correction of bunion	Y		A2	25.1878	$1,054.69
28292	Correction of bunion	Y		A2	25.1878	$1,054.69
28293	Correction of bunion	Y		A2	25.5535	$1,070.00
28294	Correction of bunion	Y		A2	25.5535	$1,070.00
28296	Correction of bunion	Y		A2	25.5535	$1,070.00
28297	Correction of bunion	Y		A2	25.5535	$1,070.00
28298	Correction of bunion	Y		A2	25.5535	$1,070.00
28299	Correction of bunion	Y		A2	26.7358	$1,119.51
28300	Incision of heel bone	Y		A2	40.2362	$1,684.81
28302	Incision of ankle bone	Y		A2	18.221	$762.97
28304	Incision of midfoot bones	Y		A2	40.2362	$1,684.81
28305	Incise/graft midfoot bones	Y		A2	40.6016	$1,700.11
28306	Incision of metatarsal	Y		A2	19.2721	$806.98
28307	Incision of metatarsal	Y		A2	19.2721	$806.98
28308	Incision of metatarsal	Y		A2	18.221	$762.97
28309	Incision of metatarsals	Y		A2	41.2872	$1,728.82
28310	Revision of big toe	Y		A2	18.5864	$778.27
28312	Revision of toe	Y		A2	18.5864	$778.27
28313	Repair deformity of toe	Y		A2	18.221	$762.97
28315	Removal of sesamoid bone	Y		A2	19.2721	$806.98
28320	Repair of foot bones	Y		A2	41.2872	$1,728.82
28322	Repair of metatarsals	Y		A2	41.2872	$1,728.82
28340	Resect enlarged toe tissue	Y		A2	19.2721	$806.98
28341	Resect enlarged toe	Y		A2	19.2721	$806.98
28344	Repair extra toe(s)	Y		A2	19.2721	$806.98
28345	Repair webbed toe(s)	Y		A2	19.2721	$806.98
28400	Treatment of heel fracture	Y		A2	1.7811	$74.58
28405	Treatment of heel fracture	Y		A2	13.7917	$577.50
28406	Treatment of heel fracture	Y		A2	21.0916	$883.17
28415	Treat heel fracture	Y		A2	49.8932	$2,089.18

Addendum AA -- Final ASC Covered Surgical Procedures for CY 2010 (Including Surgical Procedures for Which Payment is Packaged)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
28420	Treat/graft heel fracture	Y		A2	36.2226	$1,516.75
28430	Treatment of ankle fracture	Y		P2	1.5858	$66.40
28435	Treatment of ankle fracture	Y		A2	1.7811	$74.58
28436	Treatment of ankle fracture	Y		A2	21.0916	$883.17
28445	Treat ankle fracture	Y		A2	35.5372	$1,488.05
28446	Osteochondral talus autogrft	Y		G2	50.2514	$2,104.18
28450	Treat midfoot fracture, each	Y		P2	1.5858	$66.40
28455	Treat midfoot fracture, each	Y		P2	1.5858	$66.40
28456	Treat midfoot fracture	Y		A2	21.0916	$883.17
28465	Treat midfoot fracture, each	Y		A2	35.5372	$1,488.05
28470	Treat metatarsal fracture	Y		P2	1.5858	$66.40
28475	Treat metatarsal fracture	Y		P2	1.5858	$66.40
28476	Treat metatarsal fracture	Y		A2	21.0916	$883.17
28485	Treat metatarsal fracture	Y		A2	36.2226	$1,516.75
28490	Treat big toe fracture	Y	CH	P3		$61.60
28495	Treat big toe fracture	Y		P2	1.5858	$66.40
28496	Treat big toe fracture	Y		A2	21.0916	$883.17
28505	Treat big toe fracture	Y		A2	21.4573	$898.48
28510	Treatment of toe fracture	Y		P3		$48.54
28515	Treatment of toe fracture	Y	CH	P3		$63.02
28525	Treat toe fracture	Y		A2	21.4573	$898.48
28530	Treat sesamoid bone fracture	Y		P3		$46.55
28531	Treat sesamoid bone fracture	Y		A2	21.4573	$898.48
28540	Treat foot dislocation	Y		P2	1.5858	$66.40
28545	Treat foot dislocation	Y		A2	20.4461	$856.14
28546	Treat foot dislocation	Y		A2	21.0916	$883.17
28555	Repair foot dislocation	Y		A2	35.1716	$1,472.74
28570	Treat foot dislocation	Y		P3		$67.28
28575	Treat foot dislocation	Y		A2	13.7917	$577.50
28576	Treat foot dislocation	Y		A2	21.4573	$898.48
28585	Repair foot dislocation	Y		A2	21.4573	$898.48
28600	Treat foot dislocation	Y		P2	1.5858	$66.40
28605	Treat foot dislocation	Y		A2	1.7811	$74.58
28606	Treat foot dislocation	Y		A2	21.0916	$883.17
28615	Repair foot dislocation	Y		A2	35.5372	$1,488.05
28630	Treat toe dislocation	Y	CH	P3		$52.80
28635	Treat toe dislocation	Y		A2	12.8746	$539.10
28636	Treat toe dislocation	Y		A2	21.4573	$898.48
28645	Repair toe dislocation	Y		A2	21.4573	$898.48
28660	Treat toe dislocation	Y		P3		$38.89
28665	Treat toe dislocation	Y		A2	12.8746	$539.10

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
28666	Treat toe dislocation	Y		A2	21.4573	$898.48
28675	Repair of toe dislocation	Y		A2	21.4573	$898.48
28705	Fusion of foot bones	Y		A2	41.2872	$1,728.82
28715	Fusion of foot bones	Y		A2	67.2085	$2,814.22
28725	Fusion of foot bones	Y		A2	41.2872	$1,728.82
28730	Fusion of foot bones	Y		A2	41.2872	$1,728.82
28735	Fusion of foot bones	Y		A2	41.2872	$1,728.82
28737	Revision of foot bones	Y		A2	41.784	$1,749.62
28740	Fusion of foot bones	Y		A2	41.2872	$1,728.82
28750	Fusion of big toe joint	Y		A2	41.2872	$1,728.82
28755	Fusion of big toe joint	Y		A2	19.2721	$806.98
28760	Fusion of big toe joint	Y		A2	41.2872	$1,728.82
28810	Amputation toe & metatarsal	Y		A2	18.221	$762.97
28820	Amputation of toe	Y		A2	18.221	$762.97
28825	Partial amputation of toe	Y		A2	18.221	$762.97
28890	High energy eswt, plantar f	Y		P3		$140.80
29000	Application of body cast	N		G2	1.0081	$42.21
29010	Application of body cast	N	CH	P3		$93.68
29015	Application of body cast	N		P2	2.2441	$93.97
29020	Application of body cast	N		G2	1.0081	$42.21
29025	Application of body cast	N		P2	1.0081	$42.21
29035	Application of body cast	N		P2	2.2441	$93.97
29040	Application of body cast	N		G2	1.0081	$42.21
29044	Application of body cast	N		P2	2.2441	$93.97
29046	Application of body cast	N		G2	2.2441	$93.97
29049	Application of figure eight	N		P3		$34.63
29055	Application of shoulder cast	N	CH	P3		$90.55
29058	Application of shoulder cast	N	CH	P3		$37.75
29065	Application of long arm cast	N		P3		$38.61
29075	Application of forearm cast	N		P3		$37.19
29085	Apply hand/wrist cast	N	CH	P3		$38.04
29086	Apply finger cast	N		P3		$31.79
29105	Apply long arm splint	N		P3		$33.50
29125	Apply forearm splint	N		P3		$29.24
29126	Apply forearm splint	N		P3		$30.94
29130	Application of finger splint	N		P3		$13.34
29131	Application of finger splint	N		P3		$19.02
29200	Strapping of chest	N		P3		$18.74
29220	Strapping of low back	N	CH	D5		
29240	Strapping of shoulder	N		P3		$20.44
29260	Strapping of elbow or wrist	N		P3		$19.87

Addendum AA -- Final ASC Covered Surgical Procedures for CY 2010 (Including Surgical Procedures for Which Payment is Packaged)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
29280	Strapping of hand or finger	N		P3		$20.15
29305	Application of hip cast	N		P2	2.2441	$93.97
29325	Application of hip casts	N		P2	2.2441	$93.97
29345	Application of long leg cast	N		P3		$50.53
29355	Application of long leg cast	N		P3		$49.68
29358	Apply long leg cast brace	N		P3		$62.17
29365	Application of long leg cast	N		P3		$47.69
29405	Apply short leg cast	N		P3		$35.48
29425	Apply short leg cast	N		P3		$36.05
29435	Apply short leg cast	N		P3		$45.70
29440	Addition of walker to cast	N		P3		$19.59
29445	Apply rigid leg cast	N		P3		$47.69
29450	Application of leg cast	N		P2	1.0081	$42.21
29505	Application, long leg splint	N		P3		$32.64
29515	Application lower leg splint	N		P3		$27.82
29520	Strapping of hip	N		P3		$19.30
29530	Strapping of knee	N		P3		$19.87
29540	Strapping of ankle and/or ft	N		P3		$14.76
29550	Strapping of toes	N		P3		$15.33
29580	Application of paste boot	N		P3		$20.44
29581	Apply multlay comprs lwr leg	N	NI	P2	1.0081	$42.21
29590	Application of foot splint	N		P3		$16.75
29700	Removal/revision of cast	N		P3		$27.54
29705	Removal/revision of cast	N		P3		$23.56
29710	Removal/revision of cast	N		P3		$42.30
29715	Removal/revision of cast	N	CH	P3		$33.21
29720	Repair of body cast	N		P3		$34.63
29730	Windowing of cast	N		P3		$22.71
29740	Wedging of cast	N		P3		$30.66
29750	Wedging of clubfoot cast	N		P3		$33.50
29800	Jaw arthroscopy/surgery	Y		A2	24.3811	$1,020.91
29804	Jaw arthroscopy/surgery	Y		A2	24.3811	$1,020.91
29805	Shoulder arthroscopy, dx	Y		A2	24.3811	$1,020.91
29806	Shoulder arthroscopy/surgery	Y		A2	37.9409	$1,588.70
29807	Shoulder arthroscopy/surgery	Y		A2	37.9409	$1,588.70
29819	Shoulder arthroscopy/surgery	Y		A2	37.9409	$1,588.70
29820	Shoulder arthroscopy/surgery	Y		A2	37.9409	$1,588.70
29821	Shoulder arthroscopy/surgery	Y		A2	37.9409	$1,588.70
29822	Shoulder arthroscopy/surgery	Y		A2	24.3811	$1,020.91
29823	Shoulder arthroscopy/surgery	Y		A2	37.9409	$1,588.70
29824	Shoulder arthroscopy/surgery	Y		A2	25.5635	$1,070.42

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
29825	Shoulder arthroscopy/surgery	Y		A2	37.9409	$1,588.70
29826	Shoulder arthroscopy/surgery	Y		A2	37.9409	$1,588.70
29827	Arthroscop rotator cuff repr	Y		A2	39.1233	$1,638.21
29828	Arthroscopy biceps tenodesis	Y		G2	46.7038	$1,955.63
29830	Elbow arthroscopy	Y		A2	24.3811	$1,020.91
29834	Elbow arthroscopy/surgery	Y		A2	24.3811	$1,020.91
29835	Elbow arthroscopy/surgery	Y		A2	24.3811	$1,020.91
29836	Elbow arthroscopy/surgery	Y		A2	24.3811	$1,020.91
29837	Elbow arthroscopy/surgery	Y		A2	24.3811	$1,020.91
29838	Elbow arthroscopy/surgery	Y		A2	24.3811	$1,020.91
29840	Wrist arthroscopy	Y		A2	24.3811	$1,020.91
29843	Wrist arthroscopy/surgery	Y		A2	24.3811	$1,020.91
29844	Wrist arthroscopy/surgery	Y		A2	24.3811	$1,020.91
29845	Wrist arthroscopy/surgery	Y		A2	24.3811	$1,020.91
29846	Wrist arthroscopy/surgery	Y		A2	24.3811	$1,020.91
29847	Wrist arthroscopy/surgery	Y		A2	37.9409	$1,588.70
29848	Wrist endoscopy/surgery	Y		A2	29.1164	$1,219.19
29850	Knee arthroscopy/surgery	Y		A2	25.0667	$1,049.62
29851	Knee arthroscopy/surgery	Y		A2	38.6263	$1,617.40
29855	Tibial arthroscopy/surgery	Y		A2	38.6263	$1,617.40
29856	Tibial arthroscopy/surgery	Y		A2	38.6263	$1,617.40
29860	Hip arthroscopy, dx	Y		A2	38.6263	$1,617.40
29861	Hip arthroscopy/surgery	Y		A2	38.6263	$1,617.40
29862	Hip arthroscopy/surgery	Y		A2	42.6762	$1,786.98
29863	Hip arthroscopy/surgery	Y		A2	38.6263	$1,617.40
29866	Autgrft implnt, knee w/scope	Y		G2	46.7038	$1,955.63
29870	Knee arthroscopy, dx	Y		A2	24.3811	$1,020.91
29871	Knee arthroscopy/drainage	Y		A2	24.3811	$1,020.91
29873	Knee arthroscopy/surgery	Y		A2	24.3811	$1,020.91
29874	Knee arthroscopy/surgery	Y		A2	24.3811	$1,020.91
29875	Knee arthroscopy/surgery	Y		A2	25.0667	$1,049.62
29876	Knee arthroscopy/surgery	Y		A2	25.0667	$1,049.62
29877	Knee arthroscopy/surgery	Y		A2	25.0667	$1,049.62
29879	Knee arthroscopy/surgery	Y		A2	24.3811	$1,020.91
29880	Knee arthroscopy/surgery	Y		A2	25.0667	$1,049.62
29881	Knee arthroscopy/surgery	Y		A2	25.0667	$1,049.62
29882	Knee arthroscopy/surgery	Y		A2	24.3811	$1,020.91
29883	Knee arthroscopy/surgery	Y		A2	24.3811	$1,020.91
29884	Knee arthroscopy/surgery	Y		A2	24.3811	$1,020.91
29885	Knee arthroscopy/surgery	Y		A2	37.9409	$1,588.70
29886	Knee arthroscopy/surgery	Y		A2	24.3811	$1,020.91

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
29887	Knee arthroscopy/surgery	Y		A2	24.3811	$1,020.91
29888	Knee arthroscopy/surgery	Y		A2	66.5231	$2,785.52
29889	Knee arthroscopy/surgery	Y		A2	66.5231	$2,785.52
29891	Ankle arthroscopy/surgery	Y		A2	37.9409	$1,588.70
29892	Ankle arthroscopy/surgery	Y		A2	66.5231	$2,785.52
29893	Scope, plantar fasciotomy	Y		A2	22.845	$956.59
29894	Ankle arthroscopy/surgery	Y		A2	24.3811	$1,020.91
29895	Ankle arthroscopy/surgery	Y		A2	24.3811	$1,020.91
29897	Ankle arthroscopy/surgery	Y		A2	24.3811	$1,020.91
29898	Ankle arthroscopy/surgery	Y		A2	24.3811	$1,020.91
29899	Ankle arthroscopy/surgery	Y		A2	37.9409	$1,588.70
29900	Mcp joint arthroscopy, dx	Y		A2	24.3811	$1,020.91
29901	Mcp joint arthroscopy, surg	Y		A2	24.3811	$1,020.91
29902	Mcp joint arthroscopy, surg	Y		A2	24.3811	$1,020.91
29904	Subtalar arthro w/fb rmvl	Y		G2	28.6243	$1,198.59
29905	Subtalar arthro w/exc	Y		G2	28.6243	$1,198.59
29906	Subtalar arthro w/deb	Y		G2	28.6243	$1,198.59
29907	Subtalar arthro w/fusion	Y		G2	46.7038	$1,955.63
30000	Drainage of nose lesion	Y	CH	P3		$118.66
30020	Drainage of nose lesion	Y	CH	P3		$114.97
30100	Intranasal biopsy	Y		P3		$70.97
30110	Removal of nose polyp(s)	Y		P3		$110.14
30115	Removal of nose polyp(s)	Y		A2	14.8802	$623.08
30117	Removal of intranasal lesion	Y		A2	15.2459	$638.39
30118	Removal of intranasal lesion	Y		A2	20.8254	$872.02
30120	Revision of nose	Y		A2	19.8142	$829.68
30124	Removal of nose lesion	Y		R2	7.2897	$305.24
30125	Removal of nose lesion	Y		A2	33.3886	$1,398.08
30130	Excise inferior turbinate	Y		A2	15.2459	$638.39
30140	Resect inferior turbinate	Y		A2	20.4597	$856.71
30150	Partial removal of nose	Y		A2	33.7542	$1,413.39
30160	Removal of nose	Y		A2	34.4396	$1,442.09
30200	Injection treatment of nose	Y		P3		$56.21
30210	Nasal sinus therapy	Y		P3		$71.25
30220	Insert nasal septal button	Y		A2	8.1184	$339.94
30300	Remove nasal foreign body	N		P2	0.6403	$26.81
30310	Remove nasal foreign body	Y		A2	14.2349	$596.06
30320	Remove nasal foreign body	Y		A2	14.8802	$623.08
30400	Reconstruction of nose	Y		A2	34.4396	$1,442.09
30410	Reconstruction of nose	Y		A2	34.9366	$1,462.90
30420	Reconstruction of nose	Y		A2	34.9366	$1,462.90

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
30430	Revision of nose	Y		A2	20.8254	$872.02
30435	Revision of nose	Y		A2	34.9366	$1,462.90
30450	Revision of nose	Y		A2	36.5245	$1,529.39
30460	Revision of nose	Y		A2	36.5245	$1,529.39
30462	Revision of nose	Y		A2	38.4895	$1,611.67
30465	Repair nasal stenosis	Y		A2	38.4895	$1,611.67
30520	Repair of nasal septum	Y		A2	21.5108	$900.72
30540	Repair nasal defect	Y		A2	34.9366	$1,462.90
30545	Repair nasal defect	Y		A2	34.9366	$1,462.90
30560	Release of nasal adhesions	Y		A2	3.3186	$138.96
30580	Repair upper jaw fistula	Y		A2	34.4396	$1,442.09
30600	Repair mouth/nose fistula	Y		A2	34.4396	$1,442.09
30620	Intranasal reconstruction	Y		A2	36.5245	$1,529.39
30630	Repair nasal septum defect	Y		A2	23.5956	$988.02
30801	Ablate inf turbinate, superf	Y		A2	7.3694	$308.58
30802	Ablate inf turbinate submuc	Y		A2	14.2349	$596.06
30901	Control of nosebleed	Y	CH	P3		$38.32
30903	Control of nosebleed	Y		A2	1.2409	$51.96
30905	Control of nosebleed	Y		A2	1.2409	$51.96
30906	Repeat control of nosebleed	Y		A2	1.2409	$51.96
30915	Ligation, nasal sinus artery	Y		A2	21.613	$905.00
30920	Ligation, upper jaw artery	Y		A2	21.9786	$920.31
30930	Ther fx, nasal inf turbinate	Y		A2	15.9313	$667.09
31000	Irrigation, maxillary sinus	Y		P3		$90.84
31002	Irrigation, sphenoid sinus	Y		R2	7.2897	$305.24
31020	Exploration, maxillary sinus	Y		A2	20.4597	$856.71
31030	Exploration, maxillary sinus	Y		A2	33.7542	$1,413.39
31032	Explore sinus, remove polyps	Y		A2	34.4396	$1,442.09
31040	Exploration behind upper jaw	Y		R2	23.8828	$1,000.04
31050	Exploration, sphenoid sinus	Y		A2	33.3886	$1,398.08
31051	Sphenoid sinus surgery	Y		A2	34.4396	$1,442.09
31070	Exploration of frontal sinus	Y		A2	20.4597	$856.71
31075	Exploration of frontal sinus	Y		A2	34.4396	$1,442.09
31080	Removal of frontal sinus	Y		A2	34.4396	$1,442.09
31081	Removal of frontal sinus	Y		A2	34.4396	$1,442.09
31084	Removal of frontal sinus	Y		A2	34.4396	$1,442.09
31085	Removal of frontal sinus	Y		A2	34.4396	$1,442.09
31086	Removal of frontal sinus	Y		A2	34.4396	$1,442.09
31087	Removal of frontal sinus	Y		A2	34.4396	$1,442.09
31090	Exploration of sinuses	Y		A2	34.9366	$1,462.90
31200	Removal of ethmoid sinus	Y		A2	33.3886	$1,398.08

Addendum AA -- Final ASC Covered Surgical Procedures for CY 2010 (Including Surgical Procedures for Which Payment is Packaged)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
31201	Removal of ethmoid sinus	Y		A2	34.9366	$1,462.90
31205	Removal of ethmoid sinus	Y		A2	33.7542	$1,413.39
31231	Nasal endoscopy, dx	Y		P2	1.7627	$73.81
31233	Nasal/sinus endoscopy, dx	Y		A2	1.8155	$76.02
31235	Nasal/sinus endoscopy, dx	Y		A2	17.4415	$730.33
31237	Nasal/sinus endoscopy, surg	Y		A2	18.0871	$757.36
31238	Nasal/sinus endoscopy, surg	Y		A2	17.4415	$730.33
31239	Nasal/sinus endoscopy, surg	Y		A2	24.6018	$1,030.15
31240	Nasal/sinus endoscopy, surg	Y		A2	18.0871	$757.36
31254	Revision of ethmoid sinus	Y		A2	23.9164	$1,001.45
31255	Removal of ethmoid sinus	Y		A2	25.0988	$1,050.96
31256	Exploration maxillary sinus	Y		A2	23.9164	$1,001.45
31267	Endoscopy, maxillary sinus	Y		A2	23.9164	$1,001.45
31276	Sinus endoscopy, surgical	Y		A2	23.9164	$1,001.45
31287	Nasal/sinus endoscopy, surg	Y		A2	23.9164	$1,001.45
31288	Nasal/sinus endoscopy, surg	Y		A2	23.9164	$1,001.45
31300	Removal of larynx lesion	Y		A2	22.0077	$921.53
31320	Diagnostic incision, larynx	Y		A2	33.3886	$1,398.08
31400	Revision of larynx	Y		A2	33.3886	$1,398.08
31420	Removal of epiglottis	Y		A2	33.3886	$1,398.08
31500	Insert emergency airway	N		G2	2.349	$98.36
31502	Change of windpipe airway	N		G2	1.353	$56.65
31505	Diagnostic laryngoscopy	Y		P2	0.766	$32.07
31510	Laryngoscopy with biopsy	Y		A2	18.0871	$757.36
31511	Remove foreign body, larynx	Y		A2	1.8155	$76.02
31512	Removal of larynx lesion	Y		A2	18.0871	$757.36
31513	Injection into vocal cord	Y		A2	1.8155	$76.02
31515	Laryngoscopy for aspiration	Y		A2	17.4415	$730.33
31520	Dx laryngoscopy, newborn	Y		G2	1.7627	$73.81
31525	Dx laryngoscopy excl nb	Y		A2	17.4415	$730.33
31526	Dx laryngoscopy w/oper scope	Y		A2	18.0871	$757.36
31527	Laryngoscopy for treatment	Y		A2	22.9055	$959.12
31528	Laryngoscopy and dilation	Y		A2	18.0871	$757.36
31529	Laryngoscopy and dilation	Y		A2	18.0871	$757.36
31530	Laryngoscopy w/fb removal	Y		A2	18.0871	$757.36
31531	Laryngoscopy w/fb & op scope	Y		A2	18.4525	$772.66
31535	Laryngoscopy w/biopsy	Y		A2	18.0871	$757.36
31536	Laryngoscopy w/bx & op scope	Y		A2	18.4525	$772.66
31540	Laryngoscopy w/exc of tumor	Y		A2	18.4525	$772.66
31541	Larynscop w/tumr exc + scope	Y		A2	19.1381	$801.37
31545	Remove vc lesion w/scope	Y		A2	24.6018	$1,030.15

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
31546	Remove vc lesion scope/graft	Y		A2	24.6018	$1,030.15
31560	Laryngoscop w/arytenoidectom	Y		A2	25.0988	$1,050.96
31561	Larynscop, remve cart + scop	Y		A2	25.0988	$1,050.96
31570	Laryngoscope w/vc inj	Y		A2	18.0871	$757.36
31571	Laryngoscop w/vc inj + scope	Y		A2	23.5507	$986.14
31575	Diagnostic laryngoscopy	Y		P3		$50.81
31576	Laryngoscopy with biopsy	Y		A2	18.0871	$757.36
31577	Remove foreign body, larynx	Y		A2	4.516	$189.10
31578	Removal of larynx lesion	Y		A2	23.5507	$986.14
31579	Diagnostic laryngoscopy	Y		P3		$89.99
31580	Revision of larynx	Y		A2	34.9366	$1,462.90
31582	Revision of larynx	Y		A2	34.9366	$1,462.90
31588	Revision of larynx	Y		A2	34.9366	$1,462.90
31590	Reinnervate larynx	Y		A2	34.9366	$1,462.90
31595	Larynx nerve surgery	Y		A2	33.3886	$1,398.08
31603	Incision of windpipe	Y		A2	7.3694	$308.58
31605	Incision of windpipe	Y		G2	7.2897	$305.24
31611	Surgery/speech prosthesis	Y		A2	20.8254	$872.02
31612	Puncture/clear windpipe	Y		A2	19.8142	$829.68
31613	Repair windpipe opening	Y		A2	20.4597	$856.71
31614	Repair windpipe opening	Y		A2	33.3886	$1,398.08
31615	Visualization of windpipe	Y		A2	7.3694	$308.58
31620	Endobronchial us add-on	N		N1		
31622	Dx bronchoscope/wash	Y		A2	9.3433	$391.23
31623	Dx bronchoscope/brush	Y		A2	9.9888	$418.26
31624	Dx bronchoscope/lavage	Y		A2	9.9888	$418.26
31625	Bronchoscopy w/biopsy(s)	Y		A2	9.9888	$418.26
31626	Bronchoscopy w/markers	Y	NI	G2	9.9216	$415.45
31627	Navigational bronchoscopy	N	NI	N1		
31628	Bronchoscopy/lung bx, each	Y		A2	9.9888	$418.26
31629	Bronchoscopy/needle bx, each	Y		A2	9.9888	$418.26
31630	Bronchoscopy dilate/fx repr	Y		A2	21.1332	$884.91
31631	Bronchoscopy, dilate w/stent	Y		A2	21.1332	$884.91
31632	Bronchoscopy/lung bx, addl	Y		G2	9.9216	$415.45
31633	Bronchoscopy/needle bx addl	Y		G2	9.9216	$415.45
31635	Bronchoscopy w/fb removal	Y		A2	9.9888	$418.26
31636	Bronchoscopy, bronch stents	Y		A2	21.1332	$884.91
31637	Bronchoscopy, stent add-on	Y		A2	9.3433	$391.23
31638	Bronchoscopy, revise stent	Y		A2	21.1332	$884.91
31640	Bronchoscopy w/tumor excise	Y		A2	21.1332	$884.91
31641	Bronchoscopy, treat blockage	Y		A2	21.1332	$884.91

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
31643	Diag bronchoscope/catheter	Y		A2	9.9888	$418.26
31645	Bronchoscopy, clear airways	Y		A2	9.3433	$391.23
31646	Bronchoscopy, reclear airway	Y		A2	9.3433	$391.23
31656	Bronchoscopy, inj for x-ray	Y		A2	9.3433	$391.23
31715	Injection for bronchus x-ray	N		N1		
31717	Bronchial brush biopsy	Y		A2	4.516	$189.10
31720	Clearance of airways	N		A2	0.5615	$23.51
31730	Intro, windpipe wire/tube	Y		A2	4.516	$189.10
31750	Repair of windpipe	Y		A2	34.9366	$1,462.90
31755	Repair of windpipe	Y		A2	33.3886	$1,398.08
31820	Closure of windpipe lesion	Y		A2	19.8142	$829.68
31825	Repair of windpipe defect	Y		A2	20.4597	$856.71
31830	Revise windpipe scar	Y		A2	20.4597	$856.71
32400	Needle biopsy chest lining	Y		A2	8.8382	$370.08
32405	Biopsy, lung or mediastinum	Y		A2	8.8382	$370.08
32420	Puncture/clear lung	Y		A2	5.2561	$220.09
32421	Thoracentesis for aspiration	Y		A2	5.2561	$220.09
32422	Thoracentesis w/tube insert	Y		G2	5.3117	$222.42
32550	Insert pleural cath	Y		G2	29.1413	$1,220.23
32552	Remove lung catheter	N	NI	G2	1.353	$56.65
32553	Ins mark thor for rt perq	N	NI	G2	13.1619	$551.13
32960	Therapeutic pneumothorax	Y		G2	5.3117	$222.42
32998	Perq rf ablate tx, pul tumor	Y		G2	49.1378	$2,057.55
33010	Drainage of heart sac	Y		A2	5.2561	$220.09
33011	Repeat drainage of heart sac	Y		A2	5.2561	$220.09
33206	Insertion of heart pacemaker	Y		J8	169.4488	$7,095.33
33207	Insertion of heart pacemaker	Y		J8	169.4488	$7,095.33
33208	Insertion of heart pacemaker	Y		J8	205.4713	$8,603.70
33210	Insertion of heart electrode	Y		G2	46.8172	$1,960.38
33211	Insertion of heart electrode	Y		G2	46.8172	$1,960.38
33212	Insertion of pulse generator	Y		H8	138.5387	$5,801.03
33213	Insertion of pulse generator	Y		H8	152.6905	$6,393.61
33214	Upgrade of pacemaker system	Y		J8	205.4713	$8,603.70
33215	Reposition pacing-defib lead	Y		G2	21.9478	$919.02
33216	Insert 1 electrode pm-defib	Y		G2	46.8172	$1,960.38
33217	Insert 2 electrode pm-defib	Y		G2	46.8172	$1,960.38
33218	Repair lead pace-defib, one	Y		G2	21.9478	$919.02
33220	Repair lead pace-defib, dual	Y		G2	21.9478	$919.02
33222	Revise pocket, pacemaker	Y		A2	14.0668	$589.02
33223	Revise pocket for defib	Y		A2	14.0668	$589.02
33224	Insert pacing lead & connect	Y		J8	303.507	$12,708.75

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
33225	L ventric pacing lead add-on	Y		J8	303.507	$12,708.75
33226	Reposition l ventric lead	Y		G2	21.9478	$919.02
33233	Removal of pacemaker system	Y		A2	19.0084	$795.94
33234	Removal of pacemaker system	Y		G2	21.9478	$919.02
33235	Removal pacemaker electrode	Y		G2	21.9478	$919.02
33240	Insert pulse generator	Y		J8	500.9758	$20,977.36
33241	Remove pulse generator	Y		G2	21.9478	$919.02
33249	Eltrd/insert pace-defib	Y		J8	632.2356	$26,473.60
33282	Implant pat-active ht record	N		J8	111.8317	$4,682.73
33284	Remove pat-active ht record	Y		G2	7.8476	$328.60
33508	Endoscopic vein harvest	N		N1		
34490	Removal of vein clot	Y		G2	39.1293	$1,638.46
35188	Repair blood vessel lesion	Y		A2	32.9456	$1,379.53
35207	Repair blood vessel lesion	Y		A2	32.9456	$1,379.53
35460	Repair venous blockage	Y	CH	G2	48.4864	$2,030.27
35473	Repair arterial blockage	Y		G2	48.4864	$2,030.27
35475	Repair arterial blockage	Y	CH	G2	48.4864	$2,030.27
35476	Repair venous blockage	Y		G2	48.4864	$2,030.27
35492	Atherectomy, percutaneous	Y		G2	89.2835	$3,738.57
35572	Harvest femoropopliteal vein	N		N1		
35761	Exploration of artery/vein	Y		G2	34.0556	$1,426.01
35875	Removal of clot in graft	Y		A2	36.9952	$1,549.10
35876	Removal of clot in graft	Y		A2	36.9952	$1,549.10
36000	Place needle in vein	N		N1		
36002	Pseudoaneurysm injection trt	N		G2	2.2009	$92.16
36005	Injection ext venography	N		N1		
36010	Place catheter in vein	N		N1		
36011	Place catheter in vein	N		N1		
36012	Place catheter in vein	N		N1		
36013	Place catheter in artery	N		N1		
36014	Place catheter in artery	N		N1		
36015	Place catheter in artery	N		N1		
36100	Establish access to artery	N		N1		
36120	Establish access to artery	N		N1		
36140	Establish access to artery	N		N1		
36145	Artery to vein shunt	N	CH	D5		
36147	Access av dial grft for eval	Y	NI	P2	2.2917	$95.96
36148	Access av dial grft for proc	N	NI	N1		
36160	Establish access to aorta	N		N1		
36200	Place catheter in aorta	N		N1		
36215	Place catheter in artery	N		N1		

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36216	Place catheter in artery	N		N1		
36217	Place catheter in artery	N		N1		
36218	Place catheter in artery	N		N1		
36245	Place catheter in artery	N		N1		
36246	Place catheter in artery	N		N1		
36247	Place catheter in artery	N		N1		
36248	Place catheter in artery	N		N1		
36260	Insertion of infusion pump	Y		A2	24.7544	$1,036.54
36261	Revision of infusion pump	Y		A2	19.0084	$795.94
36262	Removal of infusion pump	Y		A2	18.3631	$768.92
36400	Bl draw < 3 yrs fem/jugular	N		N1		
36405	Bl draw < 3 yrs scalp vein	N		N1		
36406	Bl draw < 3 yrs other vein	N		N1		
36410	Non-routine bl draw > 3 yrs	N		N1		
36416	Capillary blood draw	N		N1		
36420	Vein access cutdown < 1 yr	N	CH	R2	0.222	$9.30
36425	Vein access cutdown > 1 yr	N		R2	0.222	$9.30
36430	Blood transfusion service	N		P3		$25.83
36440	Bl push transfuse, 2 yr or <	N		R2	3.2345	$135.44
36450	Bl exchange/transfuse, nb	N		R2	3.2345	$135.44
36455	Bl exchange/transfuse non-nb	N		G2	3.2345	$135.44
36468	Injection(s), spider veins	Y		R2	0.8408	$35.21
36469	Injection(s), spider veins	Y		R2	0.8408	$35.21
36470	Injection therapy of vein	Y		P2	0.8408	$35.21
36471	Injection therapy of veins	Y		P2	0.8408	$35.21
36475	Endovenous rf, 1st vein	Y		A2	39.958	$1,673.16
36476	Endovenous rf, vein add-on	Y		A2	26.7139	$1,118.59
36478	Endovenous laser, 1st vein	Y		A2	26.7139	$1,118.59
36479	Endovenous laser vein addon	Y		A2	26.7139	$1,118.59
36481	Insertion of catheter, vein	N		N1		
36500	Insertion of catheter, vein	N		N1		
36510	Insertion of catheter, vein	N		N1		
36511	Apheresis wbc	N		G2	11.4253	$478.41
36512	Apheresis rbc	N		G2	11.4253	$478.41
36513	Apheresis platelets	N		G2	11.4253	$478.41
36514	Apheresis plasma	N		G2	11.4253	$478.41
36515	Apheresis, adsorp/reinfuse	N		P2	31.8778	$1,334.82
36516	Apheresis, selective	N		P2	31.8778	$1,334.82
36522	Photopheresis	N		G2	31.8778	$1,334.82
36555	Insert non-tunnel cv cath	Y		A2	9.914	$415.13
36556	Insert non-tunnel cv cath	Y		A2	9.914	$415.13

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
36557	Insert tunneled cv cath	Y		A2	20.7258	$867.85
36558	Insert tunneled cv cath	Y		A2	20.7258	$867.85
36560	Insert tunneled cv cath	Y		A2	24.7544	$1,036.54
36561	Insert tunneled cv cath	Y		A2	24.7544	$1,036.54
36563	Insert tunneled cv cath	Y		A2	24.7544	$1,036.54
36565	Insert tunneled cv cath	Y		A2	24.7544	$1,036.54
36566	Insert tunneled cv cath	Y		A2	24.7544	$1,036.54
36568	Insert picc cath	Y		A2	9.914	$415.13
36569	Insert picc cath	Y		A2	9.914	$415.13
36570	Insert picvad cath	Y		A2	21.0912	$883.15
36571	Insert picvad cath	Y		A2	21.0912	$883.15
36575	Repair tunneled cv cath	Y		A2	7.1211	$298.18
36576	Repair tunneled cv cath	Y		A2	10.5593	$442.15
36578	Replace tunneled cv cath	Y		A2	20.7258	$867.85
36580	Replace cvad cath	Y		A2	9.914	$415.13
36581	Replace tunneled cv cath	Y		A2	20.7258	$867.85
36582	Replace tunneled cv cath	Y		A2	24.7544	$1,036.54
36583	Replace tunneled cv cath	Y		A2	24.7544	$1,036.54
36584	Replace picc cath	Y		A2	9.914	$415.13
36585	Replace picvad cath	Y		A2	21.0912	$883.15
36589	Removal tunneled cv cath	Y		A2	6.4758	$271.16
36590	Removal tunneled cv cath	Y		A2	9.914	$415.13
36591	Draw blood off venous device	N		N1		
36592	Collect blood from picc	N		N1		
36593	Declot vascular device	Y		P3		$20.15
36595	Mech remov tunneled cv cath	Y		G2	24.2374	$1,014.89
36596	Mech remov tunneled cv cath	Y		G2	10.6825	$447.31
36597	Reposition venous catheter	Y		G2	10.6825	$447.31
36598	Inj w/fluor, eval cv device	Y		P3		$63.59
36600	Withdrawal of arterial blood	N		N1		
36620	Insertion catheter, artery	N		N1		
36625	Insertion catheter, artery	N		N1		
36640	Insertion catheter, artery	Y		A2	23.7432	$994.20
36680	Insert needle, bone cavity	Y		G2	1.4457	$60.54
36800	Insertion of cannula	Y		A2	25.1408	$1,052.72
36810	Insertion of cannula	Y		A2	25.1408	$1,052.72
36815	Insertion of cannula	Y		A2	25.1408	$1,052.72
36818	Av fuse, uppr arm, cephalic	Y		A2	32.2599	$1,350.82
36819	Av fuse, uppr arm, basilic	Y		A2	32.2599	$1,350.82
36820	Av fusion/forearm vein	Y		A2	32.2599	$1,350.82
36821	Av fusion direct any site	Y		A2	32.2599	$1,350.82

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
36825	Artery-vein autograft	Y		A2	32.9456	$1,379.53
36830	Artery-vein nonautograft	Y		A2	32.9456	$1,379.53
36831	Open thrombect av fistula	Y		A2	36.9952	$1,549.10
36832	Av fistula revision, open	Y		A2	32.9456	$1,379.53
36833	Av fistula revision	Y		A2	32.9456	$1,379.53
36834	Repair A-V aneurysm	N	CH	D5		
36835	Artery to vein shunt	Y		A2	25.8262	$1,081.42
36860	External cannula declotting	Y		A2	2.4464	$102.44
36861	Cannula declotting	Y		A2	25.1408	$1,052.72
36870	Percut thrombect av fistula	Y		A2	41.1482	$1,723.00
37184	Prim art mech thrombectomy	Y		G2	39.1293	$1,638.46
37185	Prim art m-thrombect add-on	Y		G2	39.1293	$1,638.46
37186	Sec art m-thrombect add-on	Y		G2	39.1293	$1,638.46
37187	Venous mech thrombectomy	Y		G2	39.1293	$1,638.46
37188	Venous m-thrombectomy add-on	Y		G2	39.1293	$1,638.46
37200	Transcatheter biopsy	Y		G2	29.1216	$1,219.41
37203	Transcatheter retrieval	Y		G2	29.1216	$1,219.41
37250	Iv us first vessel add-on	N		N1		
37251	Iv us each add vessel add-on	N		N1		
37500	Endoscopy ligate perf veins	Y		A2	35.2227	$1,474.88
37607	Ligation of a-v fistula	Y		A2	21.9786	$920.31
37609	Temporal artery procedure	Y		A2	15.1023	$632.38
37650	Revision of major vein	Y		A2	21.613	$905.00
37700	Revise leg vein	Y		A2	21.613	$905.00
37718	Ligate/strip short leg vein	Y		A2	21.9786	$920.31
37722	Ligate/strip long leg vein	Y		A2	35.2227	$1,474.88
37735	Removal of leg veins/lesion	Y		A2	35.2227	$1,474.88
37760	Ligate leg veins radical	Y		A2	21.9786	$920.31
37761*	Ligate leg veins open	Y	NI	R2	25.4208	$1,064.45
37765	Phleb veins - extrem - to 20	Y		R2	25.4208	$1,064.45
37766	Phleb veins - extrem 20+	Y		R2	25.4208	$1,064.45
37780	Revision of leg vein	Y		A2	21.9786	$920.31
37785	Ligate/divide/excise vein	Y		A2	21.9786	$920.31
37790	Penile venous occlusion	Y		A2	27.9431	$1,170.06
38200	Injection for spleen x-ray	N		N1		
38204	Bl donor search management	N		N1		
38206	Harvest auto stem cells	N		G2	11.4253	$478.41
38220	Bone marrow aspiration	Y		P3		$81.19
38221	Bone marrow biopsy	Y		P3		$84.59
38230	Bone marrow collection	N		G2	31.8778	$1,334.82
38241	Bone marrow/stem transplant	N		G2	31.8778	$1,334.82

Addendum AA -- Final ASC Covered Surgical Procedures for CY 2010 (Including Surgical Procedures for Which Payment is Packaged)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
38242	Lymphocyte infuse transplant	N		R2	11.4253	$478.41
38300	Drainage, lymph node lesion	Y		A2	10.9586	$458.87
38305	Drainage, lymph node lesion	Y		A2	16.472	$689.73
38308	Incision of lymph channels	Y		A2	20.2092	$846.22
38500	Biopsy/removal, lymph nodes	Y		A2	20.2092	$846.22
38505	Needle biopsy, lymph nodes	Y		A2	6.978	$292.19
38510	Biopsy/removal, lymph nodes	Y		A2	20.2092	$846.22
38520	Biopsy/removal, lymph nodes	Y		A2	20.2092	$846.22
38525	Biopsy/removal, lymph nodes	Y		A2	20.2092	$846.22
38530	Biopsy/removal, lymph nodes	Y		A2	20.2092	$846.22
38542	Explore deep node(s), neck	Y		A2	37.5311	$1,571.54
38550	Removal, neck/armpit lesion	Y		A2	20.5746	$861.52
38555	Removal, neck/armpit lesion	Y		A2	21.2602	$890.23
38570	Laparoscopy, lymph node biop	Y		A2	41.2571	$1,727.56
38571	Laparoscopy, lymphadenectomy	Y		A2	59.9976	$2,512.28
38572	Laparoscopy, lymphadenectomy	Y		A2	41.2571	$1,727.56
38700	Removal of lymph nodes, neck	Y		G2	23.5488	$986.06
38740	Remove armpit lymph nodes	Y		A2	37.5311	$1,571.54
38745	Remove armpit lymph nodes	Y		A2	38.5821	$1,615.55
38760	Remove groin lymph nodes	Y		A2	20.2092	$846.22
38790	Inject for lymphatic x-ray	N		N1		
38792	Identify sentinel node	N		N1		
38794	Access thoracic lymph duct	N		N1		
40490	Biopsy of lip	Y		P3		$56.77
40500	Partial excision of lip	Y		A2	14.8802	$623.08
40510	Partial excision of lip	Y		A2	20.4597	$856.71
40520	Partial excision of lip	Y		A2	14.8802	$623.08
40525	Reconstruct lip with flap	Y		A2	20.4597	$856.71
40527	Reconstruct lip with flap	Y		A2	20.4597	$856.71
40530	Partial removal of lip	Y		A2	20.4597	$856.71
40650	Repair lip	Y		A2	8.1184	$339.94
40652	Repair lip	Y		A2	8.1184	$339.94
40654	Repair lip	Y		A2	8.1184	$339.94
40700	Repair cleft lip/nasal	Y		A2	36.5245	$1,529.39
40701	Repair cleft lip/nasal	Y		A2	36.5245	$1,529.39
40702	Repair cleft lip/nasal	Y		R2	41.1215	$1,721.88
40720	Repair cleft lip/nasal	Y		A2	36.5245	$1,529.39
40761	Repair cleft lip/nasal	Y		A2	33.7542	$1,413.39
40800	Drainage of mouth lesion	Y		P2	1.3927	$58.32
40801	Drainage of mouth lesion	Y		A2	8.0147	$335.60
40804	Removal, foreign body, mouth	N		P2	0.6403	$26.81

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
40805	Removal, foreign body, mouth	Y		P3		$144.20
40806	Incision of lip fold	Y		P3		$64.44
40808	Biopsy of mouth lesion	Y		P3		$98.79
40810	Excision of mouth lesion	Y		P3		$102.48
40812	Excise/repair mouth lesion	Y		P3		$129.44
40814	Excise/repair mouth lesion	Y		A2	14.8802	$623.08
40816	Excision of mouth lesion	Y		A2	20.4597	$856.71
40818	Excise oral mucosa for graft	Y		A2	3.3186	$138.96
40819	Excise lip or cheek fold	Y		A2	7.3694	$308.58
40820	Treatment of mouth lesion	Y		P3		$145.91
40830	Repair mouth laceration	Y		G2	3.2767	$137.21
40831	Repair mouth laceration	Y		A2	7.3694	$308.58
40840	Reconstruction of mouth	Y		A2	20.4597	$856.71
40842	Reconstruction of mouth	Y		A2	20.8254	$872.02
40843	Reconstruction of mouth	Y		A2	20.8254	$872.02
40844	Reconstruction of mouth	Y		A2	34.9366	$1,462.90
40845	Reconstruction of mouth	Y		A2	34.9366	$1,462.90
41000	Drainage of mouth lesion	Y		P3		$73.52
41005	Drainage of mouth lesion	Y		A2	3.3186	$138.96
41006	Drainage of mouth lesion	Y		A2	19.8142	$829.68
41007	Drainage of mouth lesion	Y		A2	14.2349	$596.06
41008	Drainage of mouth lesion	Y		A2	14.2349	$596.06
41009	Drainage of mouth lesion	Y		A2	3.3186	$138.96
41010	Incision of tongue fold	Y		A2	7.3694	$308.58
41015	Drainage of mouth lesion	Y		A2	3.3186	$138.96
41016	Drainage of mouth lesion	Y		A2	7.3694	$308.58
41017	Drainage of mouth lesion	Y		A2	7.3694	$308.58
41018	Drainage of mouth lesion	Y		A2	7.3694	$308.58
41019	Place needles h&n for rt	Y		G2	23.8828	$1,000.04
41100	Biopsy of tongue	Y		P3		$77.21
41105	Biopsy of tongue	Y		P3		$76.64
41108	Biopsy of floor of mouth	Y		P3		$70.97
41110	Excision of tongue lesion	Y		P3		$102.76
41112	Excision of tongue lesion	Y		A2	14.8802	$623.08
41113	Excision of tongue lesion	Y		A2	14.8802	$623.08
41114	Excision of tongue lesion	Y		A2	20.4597	$856.71
41115	Excision of tongue fold	Y		P3		$118.94
41116	Excision of mouth lesion	Y		A2	14.2349	$596.06
41120	Partial removal of tongue	Y		A2	22.0077	$921.53
41250	Repair tongue laceration	Y		A2	1.6877	$70.67
41251	Repair tongue laceration	Y		A2	3.3186	$138.96

Addendum AA -- Final ASC Covered Surgical Procedures for CY 2010 (Including Surgical Procedures for Which Payment is Packaged)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
41252	Repair tongue laceration	Y		A2	8.0147	$335.60
41500	Fixation of tongue	Y		A2	19.8142	$829.68
41510	Tongue to lip surgery	Y		A2	14.2349	$596.06
41512	Tongue suspension	Y	CH	G2	7.2897	$305.24
41520	Reconstruction, tongue fold	Y		A2	8.0147	$335.60
41530	Tongue base vol reduction	Y		G2	23.8828	$1,000.04
41800	Drainage of gum lesion	Y		A2	1.5497	$64.89
41805	Removal foreign body, gum	Y		P3		$132.00
41806	Removal foreign body,jawbone	Y		P3		$158.68
41820	Excision, gum, each quadrant	Y		R2	7.2897	$305.24
41821	Excision of gum flap	Y		G2	7.2897	$305.24
41822	Excision of gum lesion	Y		P3		$130.58
41823	Excision of gum lesion	Y		P3		$189.34
41825	Excision of gum lesion	Y		P3		$104.18
41826	Excision of gum lesion	Y		P3		$135.41
41827	Excision of gum lesion	Y		A2	20.4597	$856.71
41828	Excision of gum lesion	Y		P3		$120.36
41830	Removal of gum tissue	Y		P3		$169.75
41850	Treatment of gum lesion	Y		R2	16.4437	$688.55
41870	Gum graft	Y		G2	23.8828	$1,000.04
41872	Repair gum	Y		P3		$167.48
41874	Repair tooth socket	Y		P3		$163.51
42000	Drainage mouth roof lesion	Y		A2	3.3186	$138.96
42100	Biopsy roof of mouth	Y		P3		$65.86
42104	Excision lesion, mouth roof	Y		P3		$98.79
42106	Excision lesion, mouth roof	Y		P3		$123.77
42107	Excision lesion, mouth roof	Y		A2	20.4597	$856.71
42120	Remove palate/lesion	Y		A2	34.4396	$1,442.09
42140	Excision of uvula	Y		A2	8.0147	$335.60
42145	Repair palate, pharynx/uvula	Y		A2	22.0077	$921.53
42160	Treatment mouth roof lesion	Y		P3		$114.40
42180	Repair palate	Y		A2	3.3186	$138.96
42182	Repair palate	Y		A2	33.3886	$1,398.08
42200	Reconstruct cleft palate	Y		A2	34.9366	$1,462.90
42205	Reconstruct cleft palate	Y		A2	34.9366	$1,462.90
42210	Reconstruct cleft palate	Y		A2	34.9366	$1,462.90
42215	Reconstruct cleft palate	Y		A2	36.5245	$1,529.39
42220	Reconstruct cleft palate	Y		A2	34.9366	$1,462.90
42225	Reconstruct cleft palate	Y	CH	G2	41.1215	$1,721.88
42226	Lengthening of palate	Y		A2	34.9366	$1,462.90
42227	Lengthening of palate	Y	CH	G2	41.1215	$1,721.88

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
42235	Repair palate	Y		A2	16.4282	$687.90
42260	Repair nose to lip fistula	Y		A2	21.5108	$900.72
42280	Preparation, palate mold	Y		P3		$65.29
42281	Insertion, palate prosthesis	Y		G2	16.4437	$688.55
42300	Drainage of salivary gland	Y		A2	14.2349	$596.06
42305	Drainage of salivary gland	Y		A2	14.8802	$623.08
42310	Drainage of salivary gland	Y		A2	3.3186	$138.96
42320	Drainage of salivary gland	Y		A2	3.3186	$138.96
42330	Removal of salivary stone	Y		P3		$99.35
42335	Removal of salivary stone	Y		P3		$164.93
42340	Removal of salivary stone	Y		A2	14.8802	$623.08
42400	Biopsy of salivary gland	Y		P3		$55.07
42405	Biopsy of salivary gland	Y		A2	20.4597	$856.71
42408	Excision of salivary cyst	Y		A2	15.2459	$638.39
42409	Drainage of salivary cyst	Y		A2	15.2459	$638.39
42410	Excise parotid gland/lesion	Y		A2	33.7542	$1,413.39
42415	Excise parotid gland/lesion	Y		A2	36.5245	$1,529.39
42420	Excise parotid gland/lesion	Y		A2	36.5245	$1,529.39
42425	Excise parotid gland/lesion	Y		A2	36.5245	$1,529.39
42440	Excise submaxillary gland	Y		A2	33.7542	$1,413.39
42450	Excise sublingual gland	Y		A2	20.4597	$856.71
42500	Repair salivary duct	Y		A2	20.8254	$872.02
42505	Repair salivary duct	Y		A2	34.4396	$1,442.09
42507	Parotid duct diversion	Y		A2	33.7542	$1,413.39
42508	Parotid duct diversion	Y		A2	34.4396	$1,442.09
42509	Parotid duct diversion	Y		A2	34.4396	$1,442.09
42510	Parotid duct diversion	Y		A2	34.4396	$1,442.09
42550	Injection for salivary x-ray	N		N1		
42600	Closure of salivary fistula	Y		A2	14.2349	$596.06
42650	Dilation of salivary duct	Y		P3		$36.62
42660	Dilation of salivary duct	Y		P3		$43.15
42665	Ligation of salivary duct	Y		A2	23.5956	$988.02
42700	Drainage of tonsil abscess	Y		A2	3.3186	$138.96
42720	Drainage of throat abscess	Y		A2	14.2349	$596.06
42725	Drainage of throat abscess	Y		A2	33.3886	$1,398.08
42800	Biopsy of throat	Y		P3		$70.68
42802	Biopsy of throat	Y		A2	14.2349	$596.06
42804	Biopsy of upper nose/throat	Y		A2	14.2349	$596.06
42806	Biopsy of upper nose/throat	Y		A2	20.4597	$856.71
42808	Excise pharynx lesion	Y		A2	20.4597	$856.71
42809	Remove pharynx foreign body	N		G2	0.6403	$26.81

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
42810	Excision of neck cyst	Y		A2	20.8254	$872.02
42815	Excision of neck cyst	Y		A2	34.9366	$1,462.90
42820	Remove tonsils and adenoids	Y		A2	20.8254	$872.02
42821	Remove tonsils and adenoids	Y		A2	22.0077	$921.53
42825	Removal of tonsils	Y		A2	21.5108	$900.72
42826	Removal of tonsils	Y		A2	21.5108	$900.72
42830	Removal of adenoids	Y		A2	21.5108	$900.72
42831	Removal of adenoids	Y		A2	21.5108	$900.72
42835	Removal of adenoids	Y		A2	21.5108	$900.72
42836	Removal of adenoids	Y		A2	21.5108	$900.72
42860	Excision of tonsil tags	Y		A2	20.8254	$872.02
42870	Excision of lingual tonsil	Y		A2	20.8254	$872.02
42890	Partial removal of pharynx	Y		A2	36.5245	$1,529.39
42892	Revision of pharyngeal walls	Y		A2	36.5245	$1,529.39
42900	Repair throat wound	Y		A2	7.3694	$308.58
42950	Reconstruction of throat	Y		A2	20.4597	$856.71
42955	Surgical opening of throat	Y		A2	20.4597	$856.71
42960	Control throat bleeding	Y		A2	1.2409	$51.96
42962	Control throat bleeding	Y		A2	33.3886	$1,398.08
42970	Control nose/throat bleeding	Y		R2	1.1023	$46.16
42972	Control nose/throat bleeding	Y		A2	15.2459	$638.39
43030	Throat muscle surgery	Y		G2	16.4437	$688.55
43130	Removal of esophagus pouch	Y	CH	G2	41.1215	$1,721.88
43200	Esophagus endoscopy	Y		A2	8.1776	$342.42
43201	Esoph scope w/submucous inj	Y		A2	8.1776	$342.42
43202	Esophagus endoscopy, biopsy	Y		A2	8.1776	$342.42
43204	Esoph scope w/sclerosis inj	Y		A2	8.1776	$342.42
43205	Esophagus endoscopy/ligation	Y		A2	8.1776	$342.42
43215	Esophagus endoscopy	Y		A2	8.1776	$342.42
43216	Esophagus endoscopy/lesion	Y		A2	8.1776	$342.42
43217	Esophagus endoscopy	Y		A2	8.1776	$342.42
43219	Esophagus endoscopy	Y		A2	20.9104	$875.58
43220	Esoph endoscopy, dilation	Y		A2	8.1776	$342.42
43226	Esoph endoscopy, dilation	Y		A2	8.1776	$342.42
43227	Esoph endoscopy, repair	Y		A2	8.8231	$369.45
43228	Esoph endoscopy, ablation	Y		A2	19.962	$835.87
43231	Esoph endoscopy w/us exam	Y		A2	8.8231	$369.45
43232	Esoph endoscopy w/us fn bx	Y		A2	8.8231	$369.45
43234	Upper GI endoscopy, exam	Y		A2	8.1776	$342.42
43235	Uppr gi endoscopy, diagnosis	Y		A2	8.1776	$342.42
43236	Uppr gi scope w/submuc inj	Y		A2	8.8231	$369.45

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43237	Endoscopic us exam, esoph	Y		A2	8.8231	$369.45
43238	Uppr gi endoscopy w/us fn bx	Y		A2	8.8231	$369.45
43239	Upper GI endoscopy, biopsy	Y		A2	8.8231	$369.45
43240	Esoph endoscope w/drain cyst	Y		A2	8.8231	$369.45
43241	Upper GI endoscopy with tube	Y		A2	8.8231	$369.45
43242	Uppr gi endoscopy w/us fn bx	Y		A2	8.8231	$369.45
43243	Upper gi endoscopy & inject	Y		A2	8.8231	$369.45
43244	Upper GI endoscopy/ligation	Y		A2	8.8231	$369.45
43245	Uppr gi scope dilate strictr	Y		A2	8.8231	$369.45
43246	Place gastrostomy tube	Y		A2	8.8231	$369.45
43247	Operative upper GI endoscopy	Y		A2	8.8231	$369.45
43248	Uppr gi endoscopy/guide wire	Y		A2	8.8231	$369.45
43249	Esoph endoscopy, dilation	Y		A2	8.8231	$369.45
43250	Upper GI endoscopy/tumor	Y		A2	8.8231	$369.45
43251	Operative upper GI endoscopy	Y		A2	8.8231	$369.45
43255	Operative upper GI endoscopy	Y		A2	8.8231	$369.45
43256	Uppr gi endoscopy w/stent	Y		A2	21.9213	$917.91
43257	Uppr gi scope w/thrml txmnt	Y		A2	20.3277	$851.18
43258	Operative upper GI endoscopy	Y		A2	9.1887	$384.76
43259	Endoscopic ultrasound exam	Y		A2	9.1887	$384.76
43260	Endo cholangiopancreatograph	Y		A2	18.7713	$786.01
43261	Endo cholangiopancreatograph	Y		A2	18.7713	$786.01
43262	Endo cholangiopancreatograph	Y		A2	18.7713	$786.01
43263	Endo cholangiopancreatograph	Y		A2	18.7713	$786.01
43264	Endo cholangiopancreatograph	Y		A2	18.7713	$786.01
43265	Endo cholangiopancreatograph	Y		A2	18.7713	$786.01
43267	Endo cholangiopancreatograph	Y		A2	18.7713	$786.01
43268	Endo cholangiopancreatograph	Y		A2	21.5557	$902.60
43269	Endo cholangiopancreatograph	Y		A2	21.5557	$902.60
43271	Endo cholangiopancreatograph	Y		A2	18.7713	$786.01
43272	Endo cholangiopancreatograph	Y		A2	18.7713	$786.01
43273	Endoscopic pancreatoscopy	Y		G2	21.632	$905.80
43450	Dilate esophagus	Y		A2	6.1801	$258.78
43453	Dilate esophagus	Y		A2	6.1801	$258.78
43456	Dilate esophagus	Y		A2	6.194	$259.36
43458	Dilate esophagus	Y		A2	8.1914	$343.00
43600	Biopsy of stomach	Y		A2	8.1776	$342.42
43653	Laparoscopy, gastrostomy	Y		A2	41.2571	$1,727.56
43752	Nasal/orogastric w/stent	N	CH	G2	1.2143	$50.85
43760	Change gastrostomy tube	Y		A2	2.547	$106.65
43761	Reposition gastrostomy tube	Y		A2	8.1776	$342.42

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43870	Repair stomach opening	Y		A2	8.1776	$342.42
43886	Revise gastric port, open	Y		G2	22.8955	$958.70
43887	Remove gastric port, open	Y		G2	4.2464	$177.81
43888	Change gastric port, open	Y		G2	22.8955	$958.70
44100	Biopsy of bowel	Y		A2	8.1776	$342.42
44312	Revision of ileostomy	Y		A2	19.0736	$798.67
44340	Revision of colostomy	Y		A2	20.0845	$841.00
44360	Small bowel endoscopy	Y		A2	9.6153	$402.62
44361	Small bowel endoscopy/biopsy	Y		A2	9.6153	$402.62
44363	Small bowel endoscopy	Y		A2	9.6153	$402.62
44364	Small bowel endoscopy	Y		A2	9.6153	$402.62
44365	Small bowel endoscopy	Y		A2	9.6153	$402.62
44366	Small bowel endoscopy	Y		A2	9.6153	$402.62
44369	Small bowel endoscopy	Y		A2	9.6153	$402.62
44370	Small bowel endoscopy/stent	Y		A2	26.6566	$1,116.19
44372	Small bowel endoscopy	Y		A2	9.6153	$402.62
44373	Small bowel endoscopy	Y		A2	9.6153	$402.62
44376	Small bowel endoscopy	Y		A2	9.6153	$402.62
44377	Small bowel endoscopy/biopsy	Y		A2	9.6153	$402.62
44378	Small bowel endoscopy	Y		A2	9.6153	$402.62
44379	S bowel endoscope w/stent	Y		A2	26.6566	$1,116.19
44380	Small bowel endoscopy	Y		A2	8.97	$375.60
44382	Small bowel endoscopy	Y		A2	8.97	$375.60
44383	Ileoscopy w/stent	Y		A2	26.6566	$1,116.19
44385	Endoscopy of bowel pouch	Y		A2	8.4353	$353.21
44386	Endoscopy, bowel pouch/biop	Y		A2	8.4353	$353.21
44388	Colonoscopy	Y		A2	8.4353	$353.21
44389	Colonoscopy with biopsy	Y		A2	8.4353	$353.21
44390	Colonoscopy for foreign body	Y		A2	8.4353	$353.21
44391	Colonoscopy for bleeding	Y		A2	8.4353	$353.21
44392	Colonoscopy & polypectomy	Y		A2	8.4353	$353.21
44393	Colonoscopy, lesion removal	Y		A2	8.4353	$353.21
44394	Colonoscopy w/snare	Y		A2	8.4353	$353.21
44397	Colonoscopy w/stent	Y		A2	20.9104	$875.58
44500	Intro, gastrointestinal tube	Y		G2	6.0982	$255.35
44701	Intraop colon lavage add-on	N		N1		
45000	Drainage of pelvic abscess	Y		A2	11.9098	$498.70
45005	Drainage of rectal abscess	Y		A2	12.6748	$530.73
45020	Drainage of rectal abscess	Y		A2	12.6748	$530.73
45100	Biopsy of rectum	Y		A2	19.1013	$799.83
45108	Removal of anorectal lesion	Y		A2	19.7469	$826.86

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
45150	Excision of rectal stricture	Y		A2	19.7469	$826.86
45160	Excision of rectal lesion	Y		A2	19.7469	$826.86
45170	Excision of rectal lesion	N	CH	D5		
45171	Exc rect tum transanal part	Y	NI	G2	13.5029	$565.41
45172	Exc rect tum transanal full	Y	NI	G2	22.9324	$960.25
45190	Destruction, rectal tumor	Y		A2	24.8475	$1,040.44
45300	Proctosigmoidoscopy dx	Y		P3		$55.64
45303	Proctosigmoidoscopy dilate	Y		P2	8.8447	$370.35
45305	Proctosigmoidoscopy w/bx	Y		A2	8.5358	$357.42
45307	Proctosigmoidoscopy fb	Y		A2	18.2767	$765.30
45308	Proctosigmoidoscopy removal	Y		A2	8.5358	$357.42
45309	Proctosigmoidoscopy removal	Y		A2	8.5358	$357.42
45315	Proctosigmoidoscopy removal	Y		A2	8.5358	$357.42
45317	Proctosigmoidoscopy bleed	Y		A2	8.5358	$357.42
45320	Proctosigmoidoscopy ablate	Y		A2	18.2767	$765.30
45321	Proctosigmoidoscopy volvul	Y		A2	18.2767	$765.30
45327	Proctosigmoidoscopy w/stent	Y		A2	20.9104	$875.58
45330	Diagnostic sigmoidoscopy	Y		P3		$70.12
45331	Sigmoidoscopy and biopsy	Y		A2	5.8527	$245.07
45332	Sigmoidoscopy w/fb removal	Y		A2	5.8527	$245.07
45333	Sigmoidoscopy & polypectomy	Y		A2	8.5358	$357.42
45334	Sigmoidoscopy for bleeding	Y		A2	8.5358	$357.42
45335	Sigmoidoscopy w/submuc inj	Y		A2	5.8527	$245.07
45337	Sigmoidoscopy & decompress	Y		A2	5.8527	$245.07
45338	Sigmoidoscopy w/tumr remove	Y		A2	8.5358	$357.42
45339	Sigmoidoscopy w/ablate tumr	Y		A2	8.5358	$357.42
45340	Sig w/balloon dilation	Y		A2	8.5358	$357.42
45341	Sigmoidoscopy w/ultrasound	Y		A2	8.5358	$357.42
45342	Sigmoidoscopy w/us guide bx	Y		A2	8.5358	$357.42
45345	Sigmoidoscopy w/stent	Y		A2	20.9104	$875.58
45355	Surgical colonoscopy	Y		A2	8.4353	$353.21
45378	Diagnostic colonoscopy	Y		A2	9.0806	$380.23
45379	Colonoscopy w/fb removal	Y		A2	9.0806	$380.23
45380	Colonoscopy and biopsy	Y		A2	9.0806	$380.23
45381	Colonoscopy, submucous inj	Y		A2	9.0806	$380.23
45382	Colonoscopy/control bleeding	Y		A2	9.0806	$380.23
45383	Lesion removal colonoscopy	Y		A2	9.0806	$380.23
45384	Lesion remove colonoscopy	Y		A2	9.0806	$380.23
45385	Lesion removal colonoscopy	Y		A2	9.0806	$380.23
45386	Colonoscopy dilate stricture	Y		A2	9.0806	$380.23
45387	Colonoscopy w/stent	Y		A2	20.9104	$875.58

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
45391	Colonoscopy w/endoscope us	Y		A2	9.0806	$380.23
45392	Colonoscopy w/endoscopic fnb	Y		A2	9.0806	$380.23
45500	Repair of rectum	Y		A2	19.7469	$826.86
45505	Repair of rectum	Y		A2	25.6382	$1,073.55
45520	Treatment of rectal prolapse	Y		P2	0.8408	$35.21
45541	Correct rectal prolapse	Y	CH	G2	30.7878	$1,289.18
45560	Repair of rectocele	Y		A2	25.6382	$1,073.55
45900	Reduction of rectal prolapse	Y		A2	5.632	$235.83
45905	Dilation of anal sphincter	Y		A2	19.1013	$799.83
45910	Dilation of rectal narrowing	Y		A2	19.1013	$799.83
45915	Remove rectal obstruction	Y		A2	11.9098	$498.70
45990	Surg dx exam, anorectal	Y		A2	18.9819	$794.83
46020	Placement of seton	Y		A2	20.1125	$842.17
46030	Removal of rectal marker	Y		A2	5.632	$235.83
46040	Incision of rectal abscess	Y		A2	20.1125	$842.17
46045	Incision of rectal abscess	Y		A2	19.7469	$826.86
46050	Incision of anal abscess	Y		A2	11.9098	$498.70
46060	Incision of rectal abscess	Y		A2	19.7469	$826.86
46070	Incision of anal septum	Y		G2	13.5029	$565.41
46080	Incision of anal sphincter	Y		A2	20.1125	$842.17
46083	Incise external hemorrhoid	Y	CH	P3		$78.63
46200	Removal of anal fissure	Y		A2	19.7469	$826.86
46210	Removal of anal crypt	N	CH	D5		
46211	Removal of anal crypts	N	CH	D5		
46220	Excise anal ext tag/papilla	Y		A2	12.0292	$503.70
46221	Ligation of hemorrhoid(s)	Y		P3		$105.03
46230	Removal of anal tags	Y		A2	19.1013	$799.83
46250	Remove ext hem groups = 2	Y		A2	20.1125	$842.17
46255	Remove int/ext hem 1 group	Y		A2	20.1125	$842.17
46257	Remove in/ex hem grp & fiss	Y		A2	20.1125	$842.17
46258	Remove in/ex hem grp w/fistu	Y		A2	20.1125	$842.17
46260	Remove in/ex hem groups = 2	Y		A2	20.1125	$842.17
46261	Remove in/ex hem grps & fiss	Y		A2	20.7979	$870.87
46262	Remove in/ex hem grps w/fist	Y		A2	20.7979	$870.87
46270	Remove anal fist subq	Y		A2	20.1125	$842.17
46275	Remove anal fist inter	Y		A2	20.1125	$842.17
46280	Remove anal fist complex	Y		A2	20.7979	$870.87
46285	Remove anal fist 2 stage	Y		A2	19.1013	$799.83
46288	Repair anal fistula	Y		A2	20.7979	$870.87
46320	Removal of hemorrhoid clot	Y		P3		$70.97
46500	Injection into hemorrhoid(s)	Y		P3		$99.07

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46505	Chemodenervation anal musc	Y		G2	22.9324	$960.25
46600	Diagnostic anoscopy	N		P2	0.6403	$26.81
46604	Anoscopy and dilation	Y	CH	P3		$342.34
46606	Anoscopy and biopsy	Y		P3		$113.26
46608	Anoscopy, remove for body	Y		A2	8.5358	$357.42
46610	Anoscopy, remove lesion	Y		A2	18.2767	$765.30
46611	Anoscopy	Y		A2	8.5358	$357.42
46612	Anoscopy, remove lesions	Y		A2	18.2767	$765.30
46614	Anoscopy, control bleeding	Y		P3		$59.04
46615	Anoscopy	Y		A2	18.922	$792.32
46700	Repair of anal stricture	Y		A2	20.1125	$842.17
46706	Repr of anal fistula w/glue	Y		A2	24.9927	$1,046.52
46707	Repair anorectal fist w/plug	Y	NI	G2	30.7878	$1,289.18
46750	Repair of anal sphincter	Y		A2	26.0039	$1,088.86
46753	Reconstruction of anus	Y		A2	20.1125	$842.17
46754	Removal of suture from anus	Y		A2	19.7469	$826.86
46760	Repair of anal sphincter	Y		A2	25.6382	$1,073.55
46761	Repair of anal sphincter	Y		A2	26.0039	$1,088.86
46762	Implant artificial sphincter	Y		A2	28.7742	$1,204.86
46900	Destruction, anal lesion(s)	Y	CH	P3		$102.48
46910	Destruction, anal lesion(s)	Y		P3		$109.86
46916	Cryosurgery, anal lesion(s)	Y		P2	1.4745	$61.74
46917	Laser surgery, anal lesions	Y		A2	17.1605	$718.56
46922	Excision of anal lesion(s)	Y		A2	17.1605	$718.56
46924	Destruction, anal lesion(s)	Y		A2	17.1605	$718.56
46930*	Destroy internal hemorrhoids	Y		P3		$100.21
46937	Cryotherapy of rectal lesion	N	CH	D5		
46938	Cryotherapy of rectal lesion	N	CH	D5		
46940	Treatment of anal fissure	Y		P3		$80.62
46942	Treatment of anal fissure	Y		P3		$78.92
46945	Remove by ligat int hem grp	Y		P3		$131.43
46946	Remove by ligat int hem grps	Y		A2	12.0292	$503.70
46947	Hemorrhoidopexy by stapling	Y		A2	28.7742	$1,204.86
47000	Needle biopsy of liver	Y		A2	8.8382	$370.08
47001	Needle biopsy, liver add-on	N		N1		
47382	Percut ablate liver rf	Y		G2	49.1378	$2,057.55
47500	Injection for liver x-rays	N		N1		
47505	Injection for liver x-rays	N		N1		
47510	Insert catheter, bile duct	Y		A2	24.6063	$1,030.34
47511	Insert bile duct drain	Y		A2	29.1751	$1,221.65
47525	Change bile duct catheter	Y		A2	12.8875	$539.64

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
47530	Revise/reinsert bile tube	Y		A2	12.8875	$539.64
47552	Biliary endoscopy thru skin	Y		A2	24.6063	$1,030.34
47553	Biliary endoscopy thru skin	Y		A2	24.9719	$1,045.65
47554	Biliary endoscopy thru skin	Y		A2	24.9719	$1,045.65
47555	Biliary endoscopy thru skin	Y		A2	24.9719	$1,045.65
47556	Biliary endoscopy thru skin	Y		A2	29.1751	$1,221.65
47560	Laparoscopy w/cholangio	Y		A2	30.2178	$1,265.31
47561	Laparo w/cholangio/biopsy	Y		A2	30.2178	$1,265.31
47562	Laparoscopic cholecystectomy	Y		G2	44.8118	$1,876.40
47563	Laparo cholecystectomy/graph	Y		G2	44.8118	$1,876.40
47564	Laparo cholecystectomy/explr	Y		G2	44.8118	$1,876.40
47630	Remove bile duct stone	Y		A2	24.9719	$1,045.65
48102	Needle biopsy, pancreas	Y		A2	8.8382	$370.08
49080	Puncture, peritoneal cavity	Y		A2	5.2561	$220.09
49081	Removal of abdominal fluid	Y		A2	5.2561	$220.09
49180	Biopsy, abdominal mass	Y		A2	8.8382	$370.08
49250	Excision of umbilicus	Y		A2	23.1049	$967.47
49320	Diag laparo separate proc	Y		A2	30.2178	$1,265.31
49321	Laparoscopy, biopsy	Y		A2	30.9032	$1,294.01
49322	Laparoscopy, aspiration	Y		A2	30.9032	$1,294.01
49324	Lap insertion perm ip cath	Y		G2	36.4063	$1,524.44
49325	Lap revision perm ip cath	Y		G2	36.4063	$1,524.44
49326	Lap w/omentopexy add-on	Y		G2	36.4063	$1,524.44
49400	Air injection into abdomen	N		N1		
49402	Remove foreign body, adbomen	Y		A2	22.0538	$923.46
49411	Ins mark abd/pel for rt perq	N	NI	P3		$280.18
49419	Insrt abdom cath for chemotx	Y		A2	24.1299	$1,010.39
49420	Insert abdom drain, temp	Y		A2	23.758	$994.82
49421	Insert abdom drain, perm	Y		A2	23.758	$994.82
49422	Remove perm cannula/catheter	Y		A2	18.3631	$768.92
49423	Exchange drainage catheter	Y		G2	14.6474	$613.33
49424	Assess cyst, contrast inject	N		N1		
49426	Revise abdomen-venous shunt	Y		A2	22.0538	$923.46
49427	Injection, abdominal shunt	N		N1		
49429	Removal of shunt	Y		G2	21.9478	$919.02
49435	Insert subq exten to ip cath	Y	CH	G2	14.6474	$613.33
49436	Embedded ip cath exit-site	Y	CH	G2	14.6474	$613.33
49440	Place gastrostomy tube perc	Y		G2	8.3675	$350.37
49441	Place duod/jej tube perc	Y		G2	8.3675	$350.37
49442	Place cecostomy tube perc	Y	CH	G2	13.5029	$565.41
49446	Change g-tube to g-j perc	Y		G2	8.3675	$350.37

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49450	Replace g/c tube perc	Y		G2	6.0982	$255.35
49451	Replace duod/jej tube perc	Y		G2	6.0982	$255.35
49452	Replace g-j tube perc	Y		G2	6.0982	$255.35
49460	Fix g/colon tube w/device	Y		G2	6.0982	$255.35
49465	Fluoro exam of g/colon tube	N		N1		
49495	Rpr ing hernia baby, reduc	Y		A2	26.5364	$1,111.16
49496	Rpr ing hernia baby, blocked	Y		A2	26.5364	$1,111.16
49500	Rpr ing hernia, init, reduce	Y		A2	26.5364	$1,111.16
49501	Rpr ing hernia, init blocked	Y		A2	30.5863	$1,280.74
49505	Prp i/hern init reduc >5 yr	Y		A2	26.5364	$1,111.16
49507	Prp i/hern init block >5 yr	Y		A2	30.5863	$1,280.74
49520	Rerepair ing hernia, reduce	Y		A2	28.6213	$1,198.46
49521	Rerepair ing hernia, blocked	Y		A2	30.5863	$1,280.74
49525	Repair ing hernia, sliding	Y		A2	26.5364	$1,111.16
49540	Repair lumbar hernia	Y		A2	25.4854	$1,067.15
49550	Rpr rem hernia, init, reduce	Y		A2	27.0334	$1,131.97
49553	Rpr fem hernia, init blocked	Y		A2	30.5863	$1,280.74
49555	Rerepair fem hernia, reduce	Y		A2	27.0334	$1,131.97
49557	Rerepair fem hernia, blocked	Y		A2	30.5863	$1,280.74
49560	Rpr ventral hern init, reduc	Y		A2	26.5364	$1,111.16
49561	Rpr ventral hern init, block	Y		A2	30.5863	$1,280.74
49565	Rerepair ventrl hern, reduce	Y		A2	26.5364	$1,111.16
49566	Rerepair ventrl hern, block	Y		A2	30.5863	$1,280.74
49568	Hernia repair w/mesh	Y		A2	28.6213	$1,198.46
49570	Rpr epigastric hern, reduce	Y		A2	26.5364	$1,111.16
49572	Rpr epigastric hern, blocked	Y		A2	30.5863	$1,280.74
49580	Rpr umbil hern, reduc < 5 yr	Y		A2	26.5364	$1,111.16
49582	Rpr umbil hern, block < 5 yr	Y		A2	30.5863	$1,280.74
49585	Rpr umbil hern, reduc > 5 yr	Y		A2	26.5364	$1,111.16
49587	Rpr umbil hern, block > 5 yr	Y		A2	30.5863	$1,280.74
49590	Repair spigelian hernia	Y		A2	25.851	$1,082.46
49600	Repair umbilical lesion	Y		A2	26.5364	$1,111.16
49650	Lap ing hernia repair init	Y		A2	37.2073	$1,557.98
49651	Lap ing hernia repair recur	Y		A2	39.2921	$1,645.28
49652	Lap vent/abd hernia repair	Y		G2	69.7991	$2,922.70
49653	Lap vent/abd hern proc comp	Y		G2	69.7991	$2,922.70
49654	Lap inc hernia repair	Y		G2	69.7991	$2,922.70
49655	Lap inc hern repair comp	Y		G2	69.7991	$2,922.70
49656	Lap inc hernia repair recur	Y		G2	69.7991	$2,922.70
49657	Lap inc hern recur comp	Y		G2	69.7991	$2,922.70
50080	Removal of kidney stone	Y	CH	G2	44.6588	$1,870.00

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50081	Removal of kidney stone	Y	CH	G2	44.6588	$1,870.00
50200	Renal biopsy perq	Y		A2	8.8382	$370.08
50382	Change ureter stent, percut	Y		G2	24.4172	$1,022.42
50384	Remove ureter stent, percut	Y		G2	16.2968	$682.40
50385	Change stent via transureth	Y		G2	24.4172	$1,022.42
50386	Remove stent via transureth	Y	CH	P2	6.8253	$285.80
50387	Change ext/int ureter stent	Y		G2	14.6474	$613.33
50389	Remove renal tube w/fluoro	Y		G2	6.8253	$285.80
50390	Drainage of kidney lesion	Y		A2	8.8382	$370.08
50391	Instll rx agnt into rnal tub	Y	CH	P3		$42.30
50392	Insert kidney drain	Y		A2	14.1246	$591.44
50393	Insert ureteral tube	Y		A2	20.2152	$846.47
50394	Injection for kidney x-ray	N		N1		
50395	Create passage to kidney	Y		A2	20.2152	$846.47
50396	Measure kidney pressure	Y		A2	2.2002	$92.13
50398	Change kidney tube	Y		A2	12.8875	$539.64
50551	Kidney endoscopy	Y		A2	7.021	$293.99
50553	Kidney endoscopy	Y		A2	20.2152	$846.47
50555	Kidney endoscopy & biopsy	Y		A2	7.021	$293.99
50557	Kidney endoscopy & treatment	Y		A2	20.2152	$846.47
50561	Kidney endoscopy & treatment	Y		A2	20.2152	$846.47
50562	Renal scope w/tumor resect	Y		G2	6.8253	$285.80
50570	Kidney endoscopy	Y		G2	6.8253	$285.80
50572	Kidney endoscopy	Y		G2	6.8253	$285.80
50574	Kidney endoscopy & biopsy	Y		G2	6.8253	$285.80
50575	Kidney endoscopy	Y		G2	34.6334	$1,450.20
50576	Kidney endoscopy & treatment	Y		G2	16.2968	$682.40
50580	Kidney endoscopy & treatment	Y		G2	16.2968	$682.40
50590	Fragmenting of kidney stone	Y		G2	39.5716	$1,656.98
50592	Perc rf ablate renal tumor	Y		G2	49.1378	$2,057.55
50684	Injection for ureter x-ray	N		N1		
50686	Measure ureter pressure	Y	CH	P3		$37.47
50688	Change of ureter tube/stent	Y		A2	12.8875	$539.64
50690	Injection for ureter x-ray	N		N1		
50727	Revise ureter	Y	CH	G2	19.1572	$802.17
50947	Laparo new ureter/bladder	Y		A2	41.2571	$1,727.56
50948	Laparo new ureter/bladder	Y		A2	41.2571	$1,727.56
50951	Endoscopy of ureter	Y		A2	7.021	$293.99
50953	Endoscopy of ureter	Y		A2	7.021	$293.99
50955	Ureter endoscopy & biopsy	Y		A2	20.2152	$846.47
50957	Ureter endoscopy & treatment	Y		A2	20.2152	$846.47

Addendum AA -- Final ASC Covered Surgical Procedures for CY 2010 (Including Surgical Procedures for Which Payment is Packaged)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
50961	Ureter endoscopy & treatment	Y		A2	20.2152	$846.47
50970	Ureter endoscopy	Y		A2	7.021	$293.99
50972	Ureter endoscopy & catheter	Y		A2	7.021	$293.99
50974	Ureter endoscopy & biopsy	Y		A2	14.1246	$591.44
50976	Ureter endoscopy & treatment	Y		A2	14.1246	$591.44
50980	Ureter endoscopy & treatment	Y		A2	20.2152	$846.47
51020	Incise & treat bladder	Y		A2	21.9115	$917.50
51030	Incise & treat bladder	Y		A2	21.9115	$917.50
51040	Incise & drain bladder	Y		A2	21.9115	$917.50
51045	Incise bladder/drain ureter	Y		A2	7.3993	$309.83
51050	Removal of bladder stone	Y		A2	21.9115	$917.50
51065	Remove ureter calculus	Y		A2	21.9115	$917.50
51080	Drainage of bladder abscess	Y		A2	15.8264	$662.70
51100	Drain bladder by needle	Y		P3		$24.98
51101	Drain bladder by trocar/cath	Y		P2	1.0484	$43.90
51102	Drain bl w/cath insertion	Y		A2	16.2699	$681.27
51500	Removal of bladder cyst	Y		A2	26.5364	$1,111.16
51520	Removal of bladder lesion	Y		A2	21.9115	$917.50
51535	Repair of ureter lesion	Y	CH	G2	24.4172	$1,022.42
51600	Injection for bladder x-ray	N		N1		
51605	Preparation for bladder xray	N		N1		
51610	Injection for bladder x-ray	N		N1		
51700	Irrigation of bladder	Y		P3		$41.44
51701	Insert bladder catheter	N		P2	0.6403	$26.81
51702	Insert temp bladder cath	N		P2	0.6403	$26.81
51703	Insert bladder cath, complex	Y		P2	1.0484	$43.90
51705	Change of bladder tube	Y	CH	P3		$56.49
51710	Change of bladder tube	Y		A2	6.4758	$271.16
51715	Endoscopic injection/implant	Y		A2	25.4269	$1,064.70
51720	Treatment of bladder lesion	Y		P3		$45.42
51725	Simple cystometrogram	Y	CH	P3		$106.17
51726	Complex cystometrogram	Y		A2	3.3645	$140.88
51727	Cystometrogram w/up	Y	NI	P2	2.8906	$121.04
51728	Cystometrogram w/vp	Y	NI	P2	2.8906	$121.04
51729	Cystometrogram w/vp&up	Y	NI	P2	2.8906	$121.04
51736	Urine flow measurement	Y		P3		$17.03
51741	Electro-uroflowmetry, first	Y		P3		$19.59
51772	Urethra pressure profile	N	CH	D5		
51784	Anal/urinary muscle study	Y		P2	1.0484	$43.90
51785	Anal/urinary muscle study	Y		A2	1.8313	$76.68
51792	Urinary reflex study	Y		P2	1.0484	$43.90

Addendum AA -- Final ASC Covered Surgical Procedures for CY 2010 (Including Surgical Procedures for Which Payment is Packaged)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
51795	Urine voiding pressure study	N	CH	D5		
51797	Intraabdominal pressure test	Y	CH	P3		$74.37
51798	Us urine capacity measure	N		P3		$14.48
51880	Repair of bladder opening	Y		A2	20.2152	$846.47
51992	Laparo sling operation	Y		A2	37.7042	$1,578.79
52000	Cystoscopy	Y		A2	7.021	$293.99
52001	Cystoscopy, removal of clots	Y		A2	14.5029	$607.28
52005	Cystoscopy & ureter catheter	Y		A2	20.8605	$873.49
52007	Cystoscopy and biopsy	Y		A2	20.8605	$873.49
52010	Cystoscopy & duct catheter	Y		A2	7.3993	$309.83
52204	Cystoscopy w/biopsy(s)	Y		A2	20.8605	$873.49
52214	Cystoscopy and treatment	Y		A2	20.8605	$873.49
52224	Cystoscopy and treatment	Y		A2	20.8605	$873.49
52234	Cystoscopy and treatment	Y		A2	20.8605	$873.49
52235	Cystoscopy and treatment	Y		A2	21.2261	$888.80
52240	Cystoscopy and treatment	Y		A2	21.2261	$888.80
52250	Cystoscopy and radiotracer	Y		A2	21.9115	$917.50
52260	Cystoscopy and treatment	Y		A2	14.7699	$618.46
52265	Cystoscopy and treatment	Y	CH	P3		$235.04
52270	Cystoscopy & revise urethra	Y		A2	14.7699	$618.46
52275	Cystoscopy & revise urethra	Y		A2	20.8605	$873.49
52276	Cystoscopy and treatment	Y		A2	21.2261	$888.80
52277	Cystoscopy and treatment	Y		A2	20.8605	$873.49
52281	Cystoscopy and treatment	Y		A2	14.7699	$618.46
52282	Cystoscopy, implant stent	Y		A2	33.6233	$1,407.91
52283	Cystoscopy and treatment	Y		A2	20.8605	$873.49
52285	Cystoscopy and treatment	Y		A2	14.7699	$618.46
52290	Cystoscopy and treatment	Y		A2	20.8605	$873.49
52300	Cystoscopy and treatment	Y		A2	20.8605	$873.49
52301	Cystoscopy and treatment	Y		A2	21.2261	$888.80
52305	Cystoscopy and treatment	Y		A2	20.8605	$873.49
52310	Cystoscopy and treatment	Y		A2	14.5029	$607.28
52315	Cystoscopy and treatment	Y		A2	20.8605	$873.49
52317	Remove bladder stone	Y		A2	20.2152	$846.47
52318	Remove bladder stone	Y		A2	20.8605	$873.49
52320	Cystoscopy and treatment	Y		A2	22.4085	$938.31
52325	Cystoscopy, stone removal	Y		A2	21.9115	$917.50
52327	Cystoscopy, inject material	Y		A2	28.5224	$1,194.32
52330	Cystoscopy and treatment	Y		A2	20.8605	$873.49
52332	Cystoscopy and treatment	Y		A2	20.8605	$873.49
52334	Create passage to kidney	Y		A2	21.2261	$888.80

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
52341	Cysto w/ureter stricture tx	Y		A2	21.2261	$888.80
52342	Cysto w/up stricture tx	Y		A2	21.2261	$888.80
52343	Cysto w/renal stricture tx	Y		A2	21.2261	$888.80
52344	Cysto/uretero, stricture tx	Y		A2	21.2261	$888.80
52345	Cysto/uretero w/up stricture	Y		A2	21.2261	$888.80
52346	Cystouretero w/renal strict	Y		A2	21.2261	$888.80
52351	Cystouretero & or pyeloscope	Y		A2	21.2261	$888.80
52352	Cystouretero w/stone remove	Y		A2	21.9115	$917.50
52353	Cystouretero w/lithotripsy	Y		A2	29.5735	$1,238.33
52354	Cystouretero w/biopsy	Y		A2	21.9115	$917.50
52355	Cystouretero w/excise tumor	Y		A2	21.9115	$917.50
52400	Cystouretero w/congen repr	Y		A2	21.2261	$888.80
52402	Cystourethro cut ejacul duct	Y		A2	21.2261	$888.80
52450	Incision of prostate	Y		A2	21.2261	$888.80
52500	Revision of bladder neck	Y		A2	21.2261	$888.80
52601	Prostatectomy (TURP)	Y		A2	29.5735	$1,238.33
52630	Remove prostate regrowth	Y		A2	28.5224	$1,194.32
52640	Relieve bladder contracture	Y		A2	20.8605	$873.49
52647	Laser surgery of prostate	Y		A2	41.1423	$1,722.75
52648	Laser surgery of prostate	Y		A2	41.1423	$1,722.75
52700	Drainage of prostate abscess	Y		A2	20.8605	$873.49
53000	Incision of urethra	Y		A2	16.4949	$690.69
53010	Incision of urethra	Y		A2	16.4949	$690.69
53020	Incision of urethra	Y		A2	16.4949	$690.69
53025	Incision of urethra	Y		R2	19.4568	$814.71
53040	Drainage of urethra abscess	Y		A2	17.1402	$717.71
53060	Drainage of urethra abscess	Y		P3		$58.48
53080	Drainage of urinary leakage	Y		A2	17.5058	$733.02
53085	Drainage of urinary leakage	Y		G2	19.4568	$814.71
53200	Biopsy of urethra	Y		A2	16.4949	$690.69
53210	Removal of urethra	Y		A2	26.6093	$1,114.21
53215	Removal of urethra	Y		A2	18.6882	$782.53
53220	Treatment of urethra lesion	Y		A2	25.0613	$1,049.39
53230	Removal of urethra lesion	Y		A2	25.0613	$1,049.39
53235	Removal of urethra lesion	Y		A2	17.5058	$733.02
53240	Surgery for urethra pouch	Y		A2	25.0613	$1,049.39
53250	Removal of urethra gland	Y		A2	17.1402	$717.71
53260	Treatment of urethra lesion	Y		A2	17.1402	$717.71
53265	Treatment of urethra lesion	Y		A2	17.1402	$717.71
53270	Removal of urethra gland	Y		A2	17.1402	$717.71
53275	Repair of urethra defect	Y		A2	17.1402	$717.71

Addendum AA -- Final ASC Covered Surgical Procedures for CY 2010 (Including Surgical Procedures for Which Payment is Packaged)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
53400	Revise urethra, stage 1	Y		A2	25.4269	$1,064.70
53405	Revise urethra, stage 2	Y		A2	25.0613	$1,049.39
53410	Reconstruction of urethra	Y		A2	25.0613	$1,049.39
53420	Reconstruct urethra, stage 1	Y		A2	25.4269	$1,064.70
53425	Reconstruct urethra, stage 2	Y		A2	25.0613	$1,049.39
53430	Reconstruction of urethra	Y		A2	25.0613	$1,049.39
53431	Reconstruct urethra/bladder	Y		A2	25.0613	$1,049.39
53440	Male sling procedure	N		H8	124.7551	$5,223.87
53442	Remove/revise male sling	Y		A2	24.416	$1,022.37
53444	Insert tandem cuff	N		H8	124.7551	$5,223.87
53445	Insert uro/ves nck sphincter	N		H8	223.2126	$9,346.58
53446	Remove uro sphincter	Y		A2	24.416	$1,022.37
53447	Remove/replace ur sphincter	N		H8	223.2126	$9,346.58
53449	Repair uro sphincter	Y		A2	24.416	$1,022.37
53450	Revision of urethra	Y		A2	24.416	$1,022.37
53460	Revision of urethra	Y		A2	16.4949	$690.69
53502	Repair of urethra injury	Y		A2	17.1402	$717.71
53505	Repair of urethra injury	Y		A2	25.0613	$1,049.39
53510	Repair of urethra injury	Y		A2	17.1402	$717.71
53515	Repair of urethra injury	Y		A2	25.0613	$1,049.39
53520	Repair of urethra defect	Y		A2	25.0613	$1,049.39
53600	Dilate urethra stricture	Y		P3		$31.79
53601	Dilate urethra stricture	Y	CH	P3		$36.62
53605	Dilate urethra stricture	Y		A2	14.7699	$618.46
53620	Dilate urethra stricture	Y		P3		$48.54
53621	Dilate urethra stricture	Y		P3		$50.81
53660	Dilation of urethra	Y	CH	P3		$36.05
53661	Dilation of urethra	Y	CH	P3		$35.20
53665	Dilation of urethra	Y		A2	16.4949	$690.69
53850	Prostatic microwave thermotx	Y	CH	P3		$1,563.83
53852	Prostatic rf thermotx	Y	CH	P3		$1,475.55
53855	Insert prost urethral stent	Y	NI	P2	1.932	$80.90
54000	Slitting of prepuce	Y		A2	17.1402	$717.71
54001	Slitting of prepuce	Y		A2	17.1402	$717.71
54015	Drain penis lesion	Y		A2	17.523	$733.74
54050	Destruction, penis lesion(s)	Y		P2	0.8408	$35.21
54055	Destruction, penis lesion(s)	Y		P3		$53.08
54056	Cryosurgery, penis lesion(s)	Y		P2	0.8408	$35.21
54057	Laser surg, penis lesion(s)	Y		A2	17.1605	$718.56
54060	Excision of penis lesion(s)	Y		A2	17.1605	$718.56
54065	Destruction, penis lesion(s)	Y		A2	17.1605	$718.56

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
54100	Biopsy of penis	Y		A2	14.457	$605.36
54105	Biopsy of penis	Y		A2	18.6836	$782.34
54110	Treatment of penis lesion	Y		A2	27.5774	$1,154.75
54111	Treat penis lesion, graft	Y		A2	27.5774	$1,154.75
54112	Treat penis lesion, graft	Y		A2	27.5774	$1,154.75
54115	Treatment of penis lesion	Y		A2	15.8264	$662.70
54120	Partial removal of penis	Y		A2	27.5774	$1,154.75
54150	Circumcision w/regionl block	Y		A2	18.6086	$779.20
54160	Circumcision, neonate	Y		A2	19.2542	$806.23
54161	Circum 28 days or older	Y		A2	19.2542	$806.23
54162	Lysis penil circumic lesion	Y		A2	19.2542	$806.23
54163	Repair of circumcision	Y		A2	19.2542	$806.23
54164	Frenulotomy of penis	Y		A2	19.2542	$806.23
54200	Treatment of penis lesion	Y		P3		$53.93
54205	Treatment of penis lesion	Y		A2	28.6285	$1,198.76
54220	Treatment of penis lesion	Y		A2	2.2002	$92.13
54230	Prepare penis study	N		N1		
54231	Dynamic cavernosometry	Y		P3		$50.81
54235	Penile injection	Y		P3		$36.34
54240	Penis study	Y		P3		$25.83
54250	Penis study	Y		P3		$9.08
54300	Revision of penis	Y		A2	27.9431	$1,170.06
54304	Revision of penis	Y		A2	27.9431	$1,170.06
54308	Reconstruction of urethra	Y		A2	27.9431	$1,170.06
54312	Reconstruction of urethra	Y		A2	27.9431	$1,170.06
54316	Reconstruction of urethra	Y		A2	27.9431	$1,170.06
54318	Reconstruction of urethra	Y		A2	27.9431	$1,170.06
54322	Reconstruction of urethra	Y		A2	27.9431	$1,170.06
54324	Reconstruction of urethra	Y		A2	27.9431	$1,170.06
54326	Reconstruction of urethra	Y		A2	27.9431	$1,170.06
54328	Revise penis/urethra	Y		A2	27.9431	$1,170.06
54340	Secondary urethral surgery	Y		A2	27.9431	$1,170.06
54344	Secondary urethral surgery	Y		A2	27.9431	$1,170.06
54348	Secondary urethral surgery	Y		A2	27.9431	$1,170.06
54352	Reconstruct urethra/penis	Y		A2	27.9431	$1,170.06
54360	Penis plastic surgery	Y		A2	27.9431	$1,170.06
54380	Repair penis	Y		A2	27.9431	$1,170.06
54385	Repair penis	Y		A2	27.9431	$1,170.06
54400	Insert semi-rigid prosthesis	N		H8	125.1205	$5,239.17
54401	Insert self-contd prosthesis	N		H8	224.2235	$9,388.91
54405	Insert multi-comp penis pros	N		H8	224.2235	$9,388.91

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54406	Remove muti-comp penis pros	Y		A2	27.9431	$1,170.06
54408	Repair multi-comp penis pros	Y		A2	27.9431	$1,170.06
54410	Remove/replace penis prosth	N		H8	224.2235	$9,388.91
54415	Remove self-contd penis pros	Y		A2	27.9431	$1,170.06
54416	Remv/repl penis contain pros	N		H8	224.2235	$9,388.91
54420	Revision of penis	Y		A2	28.6285	$1,198.76
54435	Revision of penis	Y		A2	28.6285	$1,198.76
54440	Repair of penis	Y		A2	28.6285	$1,198.76
54450	Preputial stretching	Y		A2	3.3645	$140.88
54500	Biopsy of testis	Y		A2	13.0239	$545.35
54505	Biopsy of testis	Y		A2	18.6086	$779.20
54512	Excise lesion testis	Y		A2	19.2542	$806.23
54520	Removal of testis	Y		A2	19.6196	$821.53
54522	Orchiectomy, partial	Y		A2	19.6196	$821.53
54530	Removal of testis	Y		A2	26.5364	$1,111.16
54550	Exploration for testis	Y		A2	26.5364	$1,111.16
54560	Exploration for testis	Y		G2	22.2756	$932.75
54600	Reduce testis torsion	Y		A2	20.3052	$850.24
54620	Suspension of testis	Y		A2	19.6196	$821.53
54640	Suspension of testis	Y		A2	26.5364	$1,111.16
54660	Revision of testis	Y		A2	19.2542	$806.23
54670	Repair testis injury	Y		A2	19.6196	$821.53
54680	Relocation of testis(es)	Y		A2	19.6196	$821.53
54690	Laparoscopy, orchiectomy	Y		A2	41.2571	$1,727.56
54692	Laparoscopy, orchiopexy	Y		G2	69.7991	$2,922.70
54700	Drainage of scrotum	Y		A2	19.2542	$806.23
54800	Biopsy of epididymis	Y		A2	4.0262	$168.59
54830	Remove epididymis lesion	Y		A2	19.6196	$821.53
54840	Remove epididymis lesion	Y		A2	20.3052	$850.24
54860	Removal of epididymis	Y		A2	19.6196	$821.53
54861	Removal of epididymis	Y		A2	20.3052	$850.24
54865	Explore epididymis	Y		A2	18.6086	$779.20
54900	Fusion of spermatic ducts	Y		A2	20.3052	$850.24
54901	Fusion of spermatic ducts	Y		A2	20.3052	$850.24
55000	Drainage of hydrocele	Y		P3		$52.52
55040	Removal of hydrocele	Y		A2	25.851	$1,082.46
55041	Removal of hydroceles	Y		A2	27.0334	$1,131.97
55060	Repair of hydrocele	Y		A2	20.3052	$850.24
55100	Drainage of scrotum abscess	Y		A2	10.9586	$458.87
55110	Explore scrotum	Y		A2	19.2542	$806.23
55120	Removal of scrotum lesion	Y		A2	19.2542	$806.23

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55150	Removal of scrotum	Y		A2	18.6086	$779.20
55175	Revision of scrotum	Y		A2	18.6086	$779.20
55180	Revision of scrotum	Y		A2	19.2542	$806.23
55200	Incision of sperm duct	Y		A2	19.2542	$806.23
55250	Removal of sperm duct(s)	Y		A2	19.2542	$806.23
55300	Prepare, sperm duct x-ray	N		N1		
55400	Repair of sperm duct	Y		A2	18.6086	$779.20
55450	Ligation of sperm duct	Y		P3		$166.35
55500	Removal of hydrocele	Y		A2	19.6196	$821.53
55520	Removal of sperm cord lesion	Y		A2	20.3052	$850.24
55530	Revise spermatic cord veins	Y		A2	20.3052	$850.24
55535	Revise spermatic cord veins	Y		A2	26.5364	$1,111.16
55540	Revise hernia & sperm veins	Y		A2	27.0334	$1,131.97
55550	Laparo ligate spermatic vein	Y		A2	41.2571	$1,727.56
55600	Incise sperm duct pouch	Y		R2	22.2756	$932.75
55680	Remove sperm pouch lesion	Y		A2	18.6086	$779.20
55700	Biopsy of prostate	Y		A2	10.8951	$456.21
55705	Biopsy of prostate	Y		A2	10.8951	$456.21
55706	Prostate saturation sampling	Y		G2	11.893	$498.00
55720	Drainage of prostate abscess	Y		A2	20.2152	$846.47
55725	Drainage of prostate abscess	Y		A2	20.8605	$873.49
55860	Surgical exposure, prostate	Y		G2	19.1572	$802.17
55870	Electroejaculation	Y		P3		$63.02
55873	Cryoablate prostate	Y		H8	146.626	$6,139.67
55875	Transperi needle place, pros	N		A2	33.6233	$1,407.91
55876	Place rt device/marker, pros	N		P3		$57.34
55920	Place needles pelvic for rt	Y		G2	26.0084	$1,089.05
56405	I & D of vulva/perineum	Y		P3		$35.48
56420	Drainage of gland abscess	Y	CH	P3		$48.54
56440	Surgery for vulva lesion	Y		A2	16.9305	$708.93
56441	Lysis of labial lesion(s)	Y		A2	16.285	$681.90
56442	Hymenotomy	Y		A2	16.285	$681.90
56501	Destroy, vulva lesions, sim	Y		P3		$48.26
56515	Destroy vulva lesion/s compl	Y		A2	18.1714	$760.89
56605	Biopsy of vulva/perineum	Y		P3		$27.82
56606	Biopsy of vulva/perineum	Y		P3		$11.35
56620	Partial removal of vulva	Y		A2	18.4785	$773.75
56625	Complete removal of vulva	Y		A2	20.0664	$840.24
56700	Partial removal of hymen	Y		A2	16.285	$681.90
56740	Remove vagina gland lesion	Y		A2	17.2961	$724.24
56800	Repair of vagina	Y		A2	17.2961	$724.24

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
56805	Repair clitoris	Y		G2	19.1772	$803.01
56810	Repair of perineum	Y		A2	18.4785	$773.75
56820	Exam of vulva w/scope	Y		P3		$36.05
56821	Exam/biopsy of vulva w/scope	Y	CH	P3		$46.55
57000	Exploration of vagina	Y		A2	16.285	$681.90
57010	Drainage of pelvic abscess	Y		A2	16.9305	$708.93
57020	Drainage of pelvic fluid	Y		A2	7.2135	$302.05
57022	I & d vaginal hematoma, pp	Y	CH	R2	12.0752	$505.62
57023	I & d vag hematoma, non-ob	Y		A2	15.8264	$662.70
57061	Destroy vag lesions, simple	Y		P3		$44.57
57065	Destroy vag lesions, complex	Y		A2	16.285	$681.90
57100	Biopsy of vagina	Y		P3		$28.67
57105	Biopsy of vagina	Y		A2	16.9305	$708.93
57130	Remove vagina lesion	Y		A2	16.9305	$708.93
57135	Remove vagina lesion	Y		A2	16.9305	$708.93
57150	Treat vagina infection	Y		P3		$19.87
57155	Insert uteri tandems/ovoids	Y		A2	7.2135	$302.05
57160	Insert pessary/other device	Y		P3		$29.81
57170	Fitting of diaphragm/cap	Y		P2	0.1263	$5.29
57180	Treat vaginal bleeding	Y		A2	2.1133	$88.49
57200	Repair of vagina	Y		A2	16.285	$681.90
57210	Repair vagina/perineum	Y		A2	16.9305	$708.93
57220	Revision of urethra	Y		A2	35.194	$1,473.68
57230	Repair of urethral lesion	Y		A2	28.2177	$1,181.56
57240	Repair bladder & vagina	Y		A2	29.4001	$1,231.07
57250	Repair rectum & vagina	Y		A2	29.4001	$1,231.07
57260	Repair of vagina	Y		A2	29.4001	$1,231.07
57265	Extensive repair of vagina	Y		A2	37.9643	$1,589.68
57267	Insert mesh/pelvic flr addon	Y		A2	30.988	$1,297.56
57268	Repair of bowel bulge	Y		A2	28.2177	$1,181.56
57287	Revise/remove sling repair	Y		G2	33.7396	$1,412.78
57288	Repair bladder defect	Y		A2	36.3764	$1,523.19
57289	Repair bladder & vagina	Y		A2	29.4001	$1,231.07
57291	Construction of vagina	Y		A2	29.4001	$1,231.07
57295	Revise vag graft via vagina	Y	CH	G2	19.1772	$803.01
57300	Repair rectum-vagina fistula	Y		A2	28.2177	$1,181.56
57320	Repair bladder-vagina lesion	Y		G2	33.7396	$1,412.78
57400	Dilation of vagina	Y		A2	16.9305	$708.93
57410	Pelvic examination	Y		A2	16.9305	$708.93
57415	Remove vaginal foreign body	Y		A2	16.9305	$708.93
57420	Exam of vagina w/scope	Y		P3		$37.19

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57421	Exam/biopsy of vag w/scope	Y		P3		$48.54
57426	Revise prosth vag graft lap	Y	NI	G2	19.1772	$803.01
57452	Exam of cervix w/scope	Y		P3		$34.92
57454	Bx/curett of cervix w/scope	Y		P3		$43.15
57455	Biopsy of cervix w/scope	Y		P3		$45.42
57456	Endocerv curettage w/scope	Y		P3		$44.00
57460	Bx of cervix w/scope, leep	Y		P3		$130.58
57461	Conz of cervix w/scope, leep	Y		P3		$139.38
57500	Biopsy of cervix	Y		P3		$60.18
57505	Endocervical curettage	Y		P3		$38.89
57510	Cauterization of cervix	Y		P3		$40.03
57511	Cryocautery of cervix	Y	CH	P3		$48.26
57513	Laser surgery of cervix	Y		A2	16.9305	$708.93
57520	Conization of cervix	Y		A2	16.9305	$708.93
57522	Conization of cervix	Y		A2	16.9305	$708.93
57530	Removal of cervix	Y		A2	28.2177	$1,181.56
57550	Removal of residual cervix	Y		A2	28.2177	$1,181.56
57556	Remove cervix, repair bowel	Y		A2	36.3764	$1,523.19
57558	D&c of cervical stump	Y		A2	17.2961	$724.24
57700	Revision of cervix	Y		A2	16.285	$681.90
57720	Revision of cervix	Y		A2	17.2961	$724.24
57800	Dilation of cervical canal	Y		P3		$21.01
58100	Biopsy of uterus lining	Y		P3		$34.63
58110	Bx done w/colposcopy add-on	N		N1		
58120	Dilation and curettage	Y		A2	16.9305	$708.93
58145	Myomectomy vag method	Y		A2	29.4001	$1,231.07
58301	Remove intrauterine device	Y		P3		$32.36
58321	Artificial insemination	Y		P3		$30.37
58322	Artificial insemination	Y		P3		$30.94
58323	Sperm washing	Y		P3		$6.53
58340	Catheter for hysterography	N		N1		
58345	Reopen fallopian tube	Y		R2	19.1772	$803.01
58346	Insert heyman uteri capsule	Y		A2	16.9305	$708.93
58350	Reopen fallopian tube	Y		A2	28.2177	$1,181.56
58353	Endometr ablate, thermal	Y		A2	30.988	$1,297.56
58356	Endometrial cryoablation	Y	CH	P3		$1,298.13
58545	Laparoscopic myomectomy	Y		A2	34.9531	$1,463.59
58546	Laparo-myomectomy, complex	Y		A2	41.2571	$1,727.56
58550	Laparo-asst vag hysterectomy	Y		A2	59.9976	$2,512.28
58552	Laparo-vag hyst incl t/o	Y		G2	44.8118	$1,876.40
58555	Hysteroscopy, dx, sep proc	Y		A2	18.1129	$758.44

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58558	Hysteroscopy, biopsy	Y		A2	19.1238	$800.77
58559	Hysteroscopy, lysis	Y		A2	18.7584	$785.47
58560	Hysteroscopy, resect septum	Y		A2	29.6193	$1,240.25
58561	Hysteroscopy, remove myoma	Y		A2	29.6193	$1,240.25
58562	Hysteroscopy, remove fb	Y		A2	19.1238	$800.77
58563	Hysteroscopy, ablation	Y		A2	34.3546	$1,438.53
58565	Hysteroscopy, sterilization	Y		A2	39.9293	$1,671.96
58600	Division of fallopian tube	Y		G2	33.7396	$1,412.78
58615	Occlude fallopian tube(s)	Y		G2	19.1772	$803.01
58660	Laparoscopy, lysis	Y		A2	37.7042	$1,578.79
58661	Laparoscopy, remove adnexa	Y		A2	37.7042	$1,578.79
58662	Laparoscopy, excise lesions	Y		A2	37.7042	$1,578.79
58670	Laparoscopy, tubal cautery	Y		A2	36.5219	$1,529.28
58671	Laparoscopy, tubal block	Y		A2	36.5219	$1,529.28
58672	Laparoscopy, fimbrioplasty	Y		A2	37.7042	$1,578.79
58673	Laparoscopy, salpingostomy	Y		A2	37.7042	$1,578.79
58800	Drainage of ovarian cyst(s)	Y		A2	17.2961	$724.24
58805	Drainage of ovarian cyst(s)	Y		G2	33.7396	$1,412.78
58820	Drain ovary abscess, open	Y		A2	28.2177	$1,181.56
58900	Biopsy of ovary(s)	Y		A2	17.2961	$724.24
58970	Retrieval of oocyte	Y		A2	3.8502	$161.22
58974	Transfer of embryo	Y		A2	3.8502	$161.22
58976	Transfer of embryo	Y		A2	3.8502	$161.22
59000	Amniocentesis, diagnostic	Y		P3		$51.66
59001	Amniocentesis, therapeutic	Y		R2	6.5007	$272.20
59012	Fetal cord puncture,prenatal	Y		G2	3.2609	$136.54
59015	Chorion biopsy	Y		P3		$43.15
59020	Fetal contract stress test	Y		P3		$22.43
59025	Fetal non-stress test	Y		P3		$11.92
59070	Transabdom amnioinfus w/us	Y		G2	1.4616	$61.20
59072	Umbilical cord occlud w/us	Y		G2	3.2609	$136.54
59076	Fetal shunt placement, w/us	Y		G2	3.2609	$136.54
59100	Remove uterus lesion	Y		R2	33.7396	$1,412.78
59150	Treat ectopic pregnancy	Y		G2	44.8118	$1,876.40
59151	Treat ectopic pregnancy	Y		G2	44.8118	$1,876.40
59160	D & c after delivery	Y		A2	17.2961	$724.24
59200	Insert cervical dilator	Y		P3		$28.39
59300	Episiotomy or vaginal repair	Y		P3		$62.73
59320	Revision of cervix	Y		A2	16.285	$681.90
59412	Antepartum manipulation	Y		G2	19.1772	$803.01
59414	Deliver placenta	Y		G2	19.1772	$803.01

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59812	Treatment of miscarriage	Y		A2	18.4785	$773.75
59820	Care of miscarriage	Y		A2	18.4785	$773.75
59821	Treatment of miscarriage	Y		A2	18.4785	$773.75
59840	Abortion	Y		A2	18.4785	$773.75
59841	Abortion	Y		A2	18.4785	$773.75
59866	Abortion (mpr)	Y		G2	3.2609	$136.54
59870	Evacuate mole of uterus	Y		A2	18.4785	$773.75
59871	Remove cerclage suture	Y		A2	18.4785	$773.75
60000	Drain thyroid/tongue cyst	Y		A2	7.3694	$308.58
60100	Biopsy of thyroid	Y		P3		$38.32
60200	Remove thyroid lesion	Y		A2	37.5311	$1,571.54
60210	Partial thyroid excision	Y	CH	G2	46.645	$1,953.17
60212	Partial thyroid excision	Y	CH	G2	46.645	$1,953.17
60220	Partial removal of thyroid	Y	CH	G2	46.645	$1,953.17
60225	Partial removal of thyroid	Y	CH	G2	46.645	$1,953.17
60280	Remove thyroid duct lesion	Y		A2	38.5821	$1,615.55
60281	Remove thyroid duct lesion	Y		A2	38.5821	$1,615.55
60300	Aspir/inj thyroid cyst	Y		P3		$51.95
61000	Remove cranial cavity fluid	Y		R2	6.8884	$288.44
61001	Remove cranial cavity fluid	Y		R2	6.8884	$288.44
61020	Remove brain cavity fluid	Y		A2	6.2164	$260.30
61026	Injection into brain canal	Y		A2	6.2164	$260.30
61050	Remove brain canal fluid	Y		A2	6.2164	$260.30
61055	Injection into brain canal	Y		A2	6.2164	$260.30
61070	Brain canal shunt procedure	Y		A2	5.6237	$235.48
61215	Insert brain-fluid device	Y		A2	32.3524	$1,354.69
61330	Decompress eye socket	Y		G2	41.1215	$1,721.88
61334	Explore orbit/remove object	Y		G2	41.1215	$1,721.88
61770	Incise skull for treatment	Y	CH	G2	35.6664	$1,493.46
61790	Treat trigeminal nerve	Y		A2	16.3451	$684.42
61791	Treat trigeminal tract	Y		A2	11.5129	$482.08
61795	Brain surgery using computer	N		N1		
61880	Revise/remove neuroelectrode	Y		G2	18.7878	$786.70
61885	Insrt/redo neurostim 1 array	N		H8	307.5302	$12,877.21
61886	Implant neurostim arrays	N		H8	416.231	$17,428.84
61888	Revise/remove neuroreceiver	Y		A2	22.4689	$940.84
62160	Neuroendoscopy add-on	N		N1		
62194	Replace/irrigate catheter	Y		A2	7.0685	$295.98
62225	Replace/irrigate catheter	Y		A2	12.8875	$539.64
62230	Replace/revise brain shunt	Y		A2	31.9867	$1,339.38
62252	Csf shunt reprogram	N		P3		$39.17

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62263	Epidural lysis mult sessions	Y		A2	7.0685	$295.98
62264	Epidural lysis on single day	Y		A2	11.405	$477.56
62267	Interdiscal perq aspir, dx	Y		G2	4.4	$184.24
62268	Drain spinal cord cyst	Y		A2	6.2164	$260.30
62269	Needle biopsy, spinal cord	Y		A2	8.8382	$370.08
62270	Spinal fluid tap, diagnostic	Y		A2	3.4648	$145.08
62272	Drain cerebro spinal fluid	Y		A2	3.4648	$145.08
62273	Inject epidural patch	Y		A2	4.5729	$191.48
62280	Treat spinal cord lesion	Y		A2	7.0685	$295.98
62281	Treat spinal cord lesion	Y		A2	7.0685	$295.98
62282	Treat spinal canal lesion	Y		A2	7.0685	$295.98
62284	Injection for myelogram	N		N1		
62287	Percutaneous diskectomy	Y		A2	34.3981	$1,440.35
62290	Inject for spine disk x-ray	N		N1		
62291	Inject for spine disk x-ray	N		N1		
62292	Injection into disk lesion	Y		R2	6.8884	$288.44
62294	Injection into spinal artery	Y		A2	6.2164	$260.30
62310	Inject spine c/t	Y		A2	7.0685	$295.98
62311	Inject spine l/s (cd)	Y		A2	7.0685	$295.98
62318	Inject spine w/cath, c/t	Y		A2	7.0685	$295.98
62319	Inject spine w/cath l/s (cd)	Y		A2	7.0685	$295.98
62350	Implant spinal canal cath	Y		A2	31.9867	$1,339.38
62355	Remove spinal canal catheter	Y		A2	12.0502	$504.58
62360	Insert spine infusion device	Y		A2	31.9867	$1,339.38
62361	Implant spine infusion pump	Y		H8	291.6404	$12,211.86
62362	Implant spine infusion pump	Y		H8	291.6404	$12,211.86
62365	Remove spine infusion device	Y		A2	29.2974	$1,226.77
62367	Analyze spine infusion pump	N		P3		$14.76
62368	Analyze spine infusion pump	N		P3		$19.30
63600	Remove spinal cord lesion	Y		A2	15.9795	$669.11
63610	Stimulation of spinal cord	Y		A2	15.3342	$642.09
63615	Remove lesion of spinal cord	Y		R2	17.9094	$749.92
63650	Implant neuroelectrodes	N		H8	83.4896	$3,495.96
63655	Implant neuroelectrodes	N		J8	118.6891	$4,969.87
63660	Revise/remove neuroelectrode	N	CH	D5		
63661	Remove spine eltrd perq aray	Y	NI	G2	18.7878	$786.70
63662	Remove spine eltrd plate	Y	NI	G2	18.7878	$786.70
63663	Revise spine eltrd perq aray	Y	NI	G2	18.7878	$786.70
63664	Revise spine eltrd plate	Y	NI	G2	18.7878	$786.70
63685	Insrt/redo spine n generator	N		H8	307.5302	$12,877.21
63688	Revise/remove neuroreceiver	Y		A2	22.4689	$940.84

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63744	Revision of spinal shunt	Y		A2	32.3524	$1,354.69
63746	Removal of spinal shunt	Y		A2	12.0502	$504.58
64400	N block inj, trigeminal	Y		P3		$46.27
64402	N block inj, facial	Y		P3		$44.00
64405	N block inj, occipital	Y		P3		$38.04
64408	N block inj, vagus	Y		P3		$45.70
64410	N block inj, phrenic	Y		A2	7.0685	$295.98
64412	N block inj, spinal accessor	Y		P3		$68.98
64413	N block inj, cervical plexus	Y		P3		$42.58
64415	N block inj, brachial plexus	Y		A2	3.4648	$145.08
64416	N block cont infuse, b plex	Y		G2	6.8884	$288.44
64417	N block inj, axillary	Y		A2	3.4648	$145.08
64418	N block inj, suprascapular	Y		P3		$59.61
64420	N block inj, intercost, sng	Y		A2	3.4648	$145.08
64421	N block inj, intercost, mlt	Y		A2	7.0685	$295.98
64425	N block inj, ilio-ing/hypogi	Y		P3		$42.58
64430	N block inj, pudendal	Y		A2	5.9604	$249.58
64435	N block inj, paracervical	Y		P3		$59.33
64445	N block inj, sciatic, sng	Y		P3		$54.22
64446	N blk inj, sciatic, cont inf	Y		G2	6.8884	$288.44
64447	N block inj fem, single	Y		R2	3.5609	$149.11
64448	N block inj fem, cont inf	Y		G2	6.8884	$288.44
64449	N block inj, lumbar plexus	Y		G2	6.8884	$288.44
64450	N block, other peripheral	Y		P3		$37.19
64455*	N block inj, plantar digit	Y		P3		$15.61
64470	Inj paravertebral c/t	N	CH	D5		
64472	Inj paravertebral c/t add-on	N	CH	D5		
64475	Inj paravertebral l/s	N	CH	D5		
64476	Inj paravertebral l/s add-on	N	CH	D5		
64479	Inj foramen epidural c/t	Y		A2	7.0685	$295.98
64480	Inj foramen epidural add-on	Y		A2	4.5729	$191.48
64483	Inj foramen epidural l/s	Y		A2	7.0685	$295.98
64484	Inj foramen epidural add-on	Y		A2	4.5729	$191.48
64490	Inj paravert f jnt c/t 1 lev	Y	NI	G2	6.8884	$288.44
64491	Inj paravert f jnt c/t 2 lev	Y	NI	G2	2.4451	$102.38
64492	Inj paravert f jnt c/t 3 lev	Y	NI	G2	2.4451	$102.38
64493	Inj paravert f jnt l/s 1 lev	Y	NI	G2	6.8884	$288.44
64494	Inj paravert f jnt l/s 2 lev	Y	NI	G2	2.4451	$102.38
64495	Inj paravert f jnt l/s 3 lev	Y	NI	G2	2.4451	$102.38
64505	N block, spenopalatine gangl	Y		P3		$32.93
64508	N block, carotid sinus s/p	Y		P3		$74.66

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64510	N block, stellate ganglion	Y		A2	7.0685	$295.98
64517	N block inj, hypogas plxs	Y		A2	5.9604	$249.58
64520	N block, lumbar/thoracic	Y		A2	7.0685	$295.98
64530	N block inj, celiac pelus	Y		A2	7.0685	$295.98
64553	Implant neuroelectrodes	N		H8	82.8441	$3,468.93
64555	Implant neuroelectrodes	N		J8	87.5994	$3,668.05
64560	Implant neuroelectrodes	N		J8	87.5994	$3,668.05
64561	Implant neuroelectrodes	N		H8	83.8552	$3,511.27
64565	Implant neuroelectrodes	N		J8	87.5994	$3,668.05
64573	Implant neuroelectrodes	N		H8	218.1981	$9,136.61
64575	Implant neuroelectrodes	N		H8	113.0528	$4,733.86
64577	Implant neuroelectrodes	N		H8	113.0528	$4,733.86
64580	Implant neuroelectrodes	N		H8	113.0528	$4,733.86
64581	Implant neuroelectrodes	N		H8	114.064	$4,776.20
64585	Revise/remove neuroelectrode	Y		A2	15.9929	$669.67
64590	Insrt/redo pn/gastr stimul	N		H8	307.5302	$12,877.21
64595	Revise/rmv pn/gastr stimul	Y		A2	22.4689	$940.84
64600	Injection treatment of nerve	Y		A2	11.405	$477.56
64605	Injection treatment of nerve	Y		A2	15.3342	$642.09
64610	Injection treatment of nerve	Y		A2	15.3342	$642.09
64612	Destroy nerve, face muscle	Y		P3		$54.79
64613	Destroy nerve, neck muscle	Y		P3		$51.95
64614	Destroy nerve, extrem musc	Y		P3		$59.04
64620	Injection treatment of nerve	Y		A2	7.0685	$295.98
64622	Destr paravertebrl nerve l/s	Y		A2	11.405	$477.56
64623	Destr paravertebral n add-on	Y		A2	7.0685	$295.98
64626	Destr paravertebrl nerve c/t	Y		A2	7.0685	$295.98
64627	Destr paravertebral n add-on	Y		A2	3.7361	$156.44
64630	Injection treatment of nerve	Y		A2	7.1765	$300.50
64632*	N block inj, common digit	Y		P3		$28.39
64640	Injection treatment of nerve	Y		P3		$80.62
64650	Chemodenerv eccrine glands	Y		P3		$28.67
64653	Chemodenerv eccrine glands	Y		P3		$31.51
64680	Injection treatment of nerve	Y		A2	7.3995	$309.84
64681	Injection treatment of nerve	Y		A2	12.0502	$504.58
64702	Revise finger/toe nerve	Y		A2	15.3342	$642.09
64704	Revise hand/foot nerve	Y		A2	15.3342	$642.09
64708	Revise arm/leg nerve	Y		A2	15.9795	$669.11
64712	Revision of sciatic nerve	Y		A2	15.9795	$669.11
64713	Revision of arm nerve(s)	Y		A2	15.9795	$669.11
64714	Revise low back nerve(s)	Y		A2	15.9795	$669.11

Addendum AA -- Final ASC Covered Surgical Procedures for CY 2010 (Including Surgical Procedures for Which Payment is Packaged)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
64716	Revision of cranial nerve	Y		A2	16.3451	$684.42
64718	Revise ulnar nerve at elbow	Y		A2	15.9795	$669.11
64719	Revise ulnar nerve at wrist	Y		A2	15.9795	$669.11
64721	Carpal tunnel surgery	Y		A2	15.9795	$669.11
64722	Relieve pressure on nerve(s)	Y		A2	15.3342	$642.09
64726	Release foot/toe nerve	Y		A2	15.3342	$642.09
64727	Internal nerve revision	Y		A2	15.3342	$642.09
64732	Incision of brow nerve	Y		A2	15.9795	$669.11
64734	Incision of cheek nerve	Y		A2	15.9795	$669.11
64736	Incision of chin nerve	Y		A2	15.9795	$669.11
64738	Incision of jaw nerve	Y		A2	15.9795	$669.11
64740	Incision of tongue nerve	Y		A2	15.9795	$669.11
64742	Incision of facial nerve	Y		A2	15.9795	$669.11
64744	Incise nerve, back of head	Y		A2	15.9795	$669.11
64746	Incise diaphragm nerve	Y		A2	15.9795	$669.11
64761	Incision of pelvis nerve	Y		G2	17.9094	$749.92
64763	Incise hip/thigh nerve	Y		G2	17.9094	$749.92
64766	Incise hip/thigh nerve	Y		G2	35.6664	$1,493.46
64771	Sever cranial nerve	Y		A2	15.9795	$669.11
64772	Incision of spinal nerve	Y		A2	15.9795	$669.11
64774	Remove skin nerve lesion	Y		A2	15.9795	$669.11
64776	Remove digit nerve lesion	Y		A2	16.3451	$684.42
64778	Digit nerve surgery add-on	Y		A2	15.9795	$669.11
64782	Remove limb nerve lesion	Y		A2	16.3451	$684.42
64783	Limb nerve surgery add-on	Y		A2	15.9795	$669.11
64784	Remove nerve lesion	Y		A2	16.3451	$684.42
64786	Remove sciatic nerve lesion	Y		A2	29.6628	$1,242.07
64787	Implant nerve end	Y		A2	15.9795	$669.11
64788	Remove skin nerve lesion	Y		A2	16.3451	$684.42
64790	Removal of nerve lesion	Y		A2	16.3451	$684.42
64792	Removal of nerve lesion	Y		A2	29.6628	$1,242.07
64795	Biopsy of nerve	Y		A2	15.9795	$669.11
64802	Remove sympathetic nerves	Y		A2	15.9795	$669.11
64820	Remove sympathetic nerves	Y		G2	17.9094	$749.92
64821	Remove sympathetic nerves	Y		A2	23.8595	$999.07
64822	Remove sympathetic nerves	Y		G2	27.0149	$1,131.19
64823	Remove sympathetic nerves	Y		G2	27.0149	$1,131.19
64831	Repair of digit nerve	Y		A2	30.3484	$1,270.78
64832	Repair nerve add-on	Y		A2	28.6519	$1,199.74
64834	Repair of hand or foot nerve	Y		A2	29.2974	$1,226.77
64835	Repair of hand or foot nerve	Y		A2	29.6628	$1,242.07

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
64836	Repair of hand or foot nerve	Y		A2	29.6628	$1,242.07
64837	Repair nerve add-on	Y		A2	28.6519	$1,199.74
64840	Repair of leg nerve	Y		A2	29.2974	$1,226.77
64856	Repair/transpose nerve	Y		A2	29.2974	$1,226.77
64857	Repair arm/leg nerve	Y		A2	29.2974	$1,226.77
64858	Repair sciatic nerve	Y		A2	29.2974	$1,226.77
64859	Nerve surgery	Y		A2	28.6519	$1,199.74
64861	Repair of arm nerves	Y		A2	29.6628	$1,242.07
64862	Repair of low back nerves	Y		A2	29.6628	$1,242.07
64864	Repair of facial nerve	Y		A2	29.6628	$1,242.07
64865	Repair of facial nerve	Y		A2	30.3484	$1,270.78
64870	Fusion of facial/other nerve	Y		A2	30.3484	$1,270.78
64872	Subsequent repair of nerve	Y		A2	29.2974	$1,226.77
64874	Repair & revise nerve add-on	Y		A2	29.6628	$1,242.07
64876	Repair nerve/shorten bone	Y		A2	29.6628	$1,242.07
64885	Nerve graft, head or neck	Y		A2	29.2974	$1,226.77
64886	Nerve graft, head or neck	Y		A2	29.2974	$1,226.77
64890	Nerve graft, hand or foot	Y		A2	29.2974	$1,226.77
64891	Nerve graft, hand or foot	Y		A2	29.2974	$1,226.77
64892	Nerve graft, arm or leg	Y		A2	29.2974	$1,226.77
64893	Nerve graft, arm or leg	Y		A2	29.2974	$1,226.77
64895	Nerve graft, hand or foot	Y		A2	29.6628	$1,242.07
64896	Nerve graft, hand or foot	Y		A2	29.6628	$1,242.07
64897	Nerve graft, arm or leg	Y		A2	29.6628	$1,242.07
64898	Nerve graft, arm or leg	Y		A2	29.6628	$1,242.07
64901	Nerve graft add-on	Y		A2	29.2974	$1,226.77
64902	Nerve graft add-on	Y		A2	29.2974	$1,226.77
64905	Nerve pedicle transfer	Y		A2	29.2974	$1,226.77
64907	Nerve pedicle transfer	Y		A2	28.6519	$1,199.74
64910	Nerve repair w/allograft	Y		G2	35.6664	$1,493.46
65091	Revise eye	Y		A2	30.9049	$1,294.08
65093	Revise eye with implant	Y		A2	30.9049	$1,294.08
65101	Removal of eye	Y		A2	30.9049	$1,294.08
65103	Remove eye/insert implant	Y		A2	30.9049	$1,294.08
65105	Remove eye/attach implant	Y		A2	31.5903	$1,322.78
65110	Removal of eye	Y		A2	32.0873	$1,343.59
65112	Remove eye/revise socket	Y		A2	33.6752	$1,410.08
65114	Remove eye/revise socket	Y		A2	33.6752	$1,410.08
65125	Revise ocular implant	Y		G2	25.6774	$1,075.19
65130	Insert ocular implant	Y		A2	22.1711	$928.37
65135	Insert ocular implant	Y		A2	21.8055	$913.06

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
65140	Attach ocular implant	Y		A2	30.9049	$1,294.08
65150	Revise ocular implant	Y		A2	21.8055	$913.06
65155	Reinsert ocular implant	Y		A2	30.9049	$1,294.08
65175	Removal of ocular implant	Y		A2	14.9309	$625.20
65205	Remove foreign body from eye	N		P3		$17.88
65210	Remove foreign body from eye	N		P3		$22.71
65220	Remove foreign body from eye	N		G2	0.9139	$38.27
65222	Remove foreign body from eye	N		P3		$24.98
65235	Remove foreign body from eye	Y		A2	14.2061	$594.85
65260	Remove foreign body from eye	Y		A2	7.1103	$297.73
65265	Remove foreign body from eye	Y		A2	18.4618	$773.05
65270	Repair of eye wound	Y		A2	15.5764	$652.23
65272	Repair of eye wound	Y		A2	20.0566	$839.83
65275	Repair of eye wound	Y		A2	21.1076	$883.84
65280	Repair of eye wound	Y		A2	18.4618	$773.05
65285	Repair of eye wound	Y		A2	32.274	$1,351.41
65286	Repair of eye wound	Y		P2	4.3122	$180.56
65290	Repair of eye socket wound	Y		A2	19.7528	$827.11
65400	Removal of eye lesion	Y		A2	13.5608	$567.83
65410	Biopsy of cornea	Y		A2	14.2061	$594.85
65420	Removal of eye lesion	Y		A2	14.2061	$594.85
65426	Removal of eye lesion	Y		A2	21.6046	$904.65
65430	Corneal smear	N	CH	P3		$35.77
65435	Curette/treat cornea	Y		P3		$27.54
65436	Curette/treat cornea	Y		P3		$122.06
65450	Treatment of corneal lesion	N		G2	1.8727	$78.42
65600	Revision of cornea	Y		P3		$141.93
65710	Corneal transplant	Y		A2	32.6184	$1,365.83
65730	Corneal transplant	Y		A2	32.6184	$1,365.83
65750	Corneal transplant	Y		A2	32.6184	$1,365.83
65755	Corneal transplant	Y		A2	32.6184	$1,365.83
65756	Corneal trnspl, endothelial	Y		G2	35.9134	$1,503.80
65757	Prep corneal endo allograft	N		N1		
65770	Revise cornea with implant	Y		H8	134.3348	$5,625.00
65772	Correction of astigmatism	Y		A2	15.2571	$638.86
65775	Correction of astigmatism	Y		A2	15.2571	$638.86
65780	Ocular reconst, transplant	Y		A2	31.0305	$1,299.34
65781	Ocular reconst, transplant	Y		A2	31.0305	$1,299.34
65782	Ocular reconst, transplant	Y		A2	31.0305	$1,299.34
65800	Drainage of eye	Y		A2	13.5608	$567.83
65805	Drainage of eye	Y		A2	13.5608	$567.83

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
65810	Drainage of eye	Y		A2	20.4222	$855.14
65815	Drainage of eye	Y		A2	20.0566	$839.83
65820	Relieve inner eye pressure	Y		A2	5.1362	$215.07
65850	Incision of eye	Y		A2	21.1076	$883.84
65855	Laser surgery of eye	Y		P3		$114.97
65860	Incise inner eye adhesions	Y		P3		$107.02
65865	Incise inner eye adhesions	Y		A2	13.5608	$567.83
65870	Incise inner eye adhesions	Y		A2	21.1076	$883.84
65875	Incise inner eye adhesions	Y		A2	21.1076	$883.84
65880	Incise inner eye adhesions	Y		A2	15.2571	$638.86
65900	Remove eye lesion	Y		A2	15.7541	$659.67
65920	Remove implant of eye	Y		A2	23.1925	$971.14
65930	Remove blood clot from eye	Y		A2	21.6046	$904.65
66020	Injection treatment of eye	Y		A2	13.5608	$567.83
66030	Injection treatment of eye	Y		A2	5.1362	$215.07
66130	Remove eye lesion	Y		A2	23.1925	$971.14
66150	Glaucoma surgery	Y		A2	21.1076	$883.84
66155	Glaucoma surgery	Y		A2	21.1076	$883.84
66160	Glaucoma surgery	Y		A2	20.0566	$839.83
66165	Glaucoma surgery	Y		A2	21.1076	$883.84
66170	Glaucoma surgery	Y		A2	21.1076	$883.84
66172	Incision of eye	Y		A2	21.1076	$883.84
66180	Implant eye shunt	Y		A2	34.1483	$1,429.89
66185	Revise eye shunt	Y		A2	20.0566	$839.83
66220	Repair eye lesion	Y		A2	31.5886	$1,322.71
66225	Repair/graft eye lesion	Y		A2	33.6513	$1,409.08
66250	Follow-up surgery of eye	Y		A2	14.2061	$594.85
66500	Incision of iris	Y		A2	5.1362	$215.07
66505	Incision of iris	Y		A2	5.1362	$215.07
66600	Remove iris and lesion	Y		A2	20.4222	$855.14
66605	Removal of iris	Y		A2	20.4222	$855.14
66625	Removal of iris	Y		A2	13.7888	$577.38
66630	Removal of iris	Y		A2	20.4222	$855.14
66635	Removal of iris	Y		A2	20.4222	$855.14
66680	Repair iris & ciliary body	Y		A2	20.4222	$855.14
66682	Repair iris & ciliary body	Y		A2	20.0566	$839.83
66700	Destruction, ciliary body	Y		A2	14.2061	$594.85
66710	Ciliary transscleral therapy	Y		A2	14.2061	$594.85
66711	Ciliary endoscopic ablation	Y		A2	14.2061	$594.85
66720	Destruction, ciliary body	Y		A2	14.2061	$594.85
66740	Destruction, ciliary body	Y		A2	20.0566	$839.83

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
66761	Revision of iris	Y		P3		$160.67
66762	Revision of iris	Y		P3		$163.79
66770	Removal of inner eye lesion	Y	CH	P3		$177.70
66820	Incision, secondary cataract	Y		G2	4.3122	$180.56
66821	After cataract laser surgery	Y		A2	5.589	$234.03
66825	Reposition intraocular lens	Y		A2	21.1076	$883.84
66830	Removal of lens lesion	Y		A2	5.3646	$224.63
66840	Removal of lens material	Y		A2	14.9416	$625.65
66850	Removal of lens material	Y		A2	27.4454	$1,149.22
66852	Removal of lens material	Y		A2	25.3605	$1,061.92
66920	Extraction of lens	Y		A2	25.3605	$1,061.92
66930	Extraction of lens	Y		A2	25.8575	$1,082.73
66940	Extraction of lens	Y		A2	15.4386	$646.46
66982	Cataract surgery, complex	Y		A2	22.9847	$962.44
66983	Cataract surg w/iol, 1 stage	Y		A2	22.9847	$962.44
66984	Cataract surg w/iol, 1 stage	Y		A2	22.9847	$962.44
66985	Insert lens prosthesis	Y		A2	22.1453	$927.29
66986	Exchange lens prosthesis	Y		A2	22.1453	$927.29
66990	Ophthalmic endoscope add-on	N		N1		
67005	Partial removal of eye fluid	Y		A2	18.4618	$773.05
67010	Partial removal of eye fluid	Y		A2	32.274	$1,351.41
67015	Release of eye fluid	Y		A2	30.5775	$1,280.37
67025	Replace eye fluid	Y		A2	16.7652	$702.01
67027	Implant eye drug system	Y		A2	32.274	$1,351.41
67028	Injection eye drug	Y		P3		$71.25
67030	Incise inner eye strands	Y		A2	16.7652	$702.01
67031	Laser surgery, eye strands	Y		A2	5.589	$234.03
67036	Removal of inner eye fluid	Y		A2	32.274	$1,351.41
67039	Laser treatment of retina	Y		A2	34.3589	$1,438.71
67040	Laser treatment of retina	Y		A2	34.3589	$1,438.71
67041	Vit for macular pucker	Y		G2	38.2338	$1,600.96
67042	Vit for macular hole	Y		G2	38.2338	$1,600.96
67043	Vit for membrane dissect	Y		G2	38.2338	$1,600.96
67101	Repair detached retina	Y	CH	P3		$270.53
67105	Repair detached retina	Y		P2	5.0718	$212.37
67107	Repair detached retina	Y		A2	32.771	$1,372.22
67108	Repair detached retina	Y		A2	34.3589	$1,438.71
67110	Repair detached retina	Y		P3		$290.11
67112	Rerepair detached retina	Y		A2	34.3589	$1,438.71
67113	Repair retinal detach, cplx	Y		G2	38.2338	$1,600.96
67115	Release encircling material	Y		A2	17.4107	$729.04

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
67120	Remove eye implant material	Y		A2	17.4107	$729.04
67121	Remove eye implant material	Y		A2	17.4107	$729.04
67141	Treatment of retina	Y		A2	5.5783	$233.58
67145	Treatment of retina	Y		P3		$171.74
67208	Treatment of retinal lesion	Y		P3		$184.23
67210	Treatment of retinal lesion	Y	CH	P3		$196.72
67218	Treatment of retinal lesion	Y		A2	18.9585	$793.85
67220	Treatment of choroid lesion	Y		P2	5.5965	$234.34
67221	Ocular photodynamic ther	Y		P3		$100.21
67225	Eye photodynamic ther add-on	Y		P3		$7.10
67227	Treatment of retinal lesion	Y		A2	16.7652	$702.01
67228	Treatment of retinal lesion	Y		P2	5.0718	$212.37
67229*	Tr retinal les preterm inf	Y		R2	5.0718	$212.37
67250	Reinforce eye wall	Y		A2	15.942	$667.54
67255	Reinforce/graft eye wall	Y		A2	17.7761	$744.34
67311	Revise eye muscle	Y		A2	19.7528	$827.11
67312	Revise two eye muscles	Y		A2	20.4385	$855.82
67314	Revise eye muscle	Y		A2	20.4385	$855.82
67316	Revise two eye muscles	Y		A2	20.4385	$855.82
67318	Revise eye muscle(s)	Y		A2	20.4385	$855.82
67320	Revise eye muscle(s) add-on	Y		A2	20.4385	$855.82
67331	Eye surgery follow-up add-on	Y		A2	20.4385	$855.82
67332	Rerevise eye muscles add-on	Y		A2	20.4385	$855.82
67334	Revise eye muscle w/suture	Y		A2	20.4385	$855.82
67335	Eye suture during surgery	Y		A2	20.4385	$855.82
67340	Revise eye muscle add-on	Y		A2	20.4385	$855.82
67343	Release eye tissue	Y		A2	22.5231	$943.11
67345	Destroy nerve of eye muscle	Y		P3		$71.53
67346	Biopsy, eye muscle	Y		A2	13.053	$546.57
67400	Explore/biopsy eye socket	Y		A2	15.942	$667.54
67405	Explore/drain eye socket	Y		A2	22.8565	$957.07
67412	Explore/treat eye socket	Y		A2	17.1244	$717.05
67413	Explore/treat eye socket	Y		A2	23.3535	$977.88
67414	Explr/decompress eye socket	Y		G2	37.3223	$1,562.80
67415	Aspiration, orbital contents	Y		A2	14.9309	$625.20
67420	Explore/treat eye socket	Y		A2	32.0873	$1,343.59
67430	Explore/treat eye socket	Y		A2	32.0873	$1,343.59
67440	Explore/drain eye socket	Y		A2	32.0873	$1,343.59
67445	Explr/decompress eye socket	Y		A2	32.0873	$1,343.59
67450	Explore/biopsy eye socket	Y		A2	32.0873	$1,343.59
67500	Inject/treat eye socket	N		G2	1.8727	$78.42

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67505	Inject/treat eye socket	Y		P3		$23.84
67515	Inject/treat eye socket	Y		P3		$24.41
67550	Insert eye socket implant	Y		A2	31.5903	$1,322.78
67560	Revise eye socket implant	Y		A2	21.8055	$913.06
67570	Decompress optic nerve	Y		A2	31.5903	$1,322.78
67700	Drainage of eyelid abscess	Y		P2	3.087	$129.26
67710	Incision of eyelid	Y		P3		$119.51
67715	Incision of eyelid fold	Y		A2	14.9309	$625.20
67800	Remove eyelid lesion	Y		P3		$44.85
67801	Remove eyelid lesions	Y		P3		$54.50
67805	Remove eyelid lesions	Y		P3		$70.68
67808	Remove eyelid lesion(s)	Y		A2	15.5764	$652.23
67810	Biopsy of eyelid	Y	CH	P3		$108.44
67820	Revise eyelashes	N		P3		$14.76
67825	Revise eyelashes	Y		P3		$45.70
67830	Revise eyelashes	Y		A2	8.031	$336.28
67835	Revise eyelashes	Y		A2	15.5764	$652.23
67840	Remove eyelid lesion	Y		P3		$126.61
67850	Treat eyelid lesion	Y		P3		$99.64
67875	Closure of eyelid by suture	Y		G2	7.3112	$306.14
67880	Revision of eyelid	Y		A2	14.5717	$610.16
67882	Revision of eyelid	Y		A2	15.942	$667.54
67900	Repair brow defect	Y		A2	22.8565	$957.07
67901	Repair eyelid defect	Y		A2	17.1244	$717.05
67902	Repair eyelid defect	Y		A2	23.3535	$977.88
67903	Repair eyelid defect	Y		A2	16.6274	$696.24
67904	Repair eyelid defect	Y		A2	16.6274	$696.24
67906	Repair eyelid defect	Y		A2	17.1244	$717.05
67908	Repair eyelid defect	Y		A2	16.6274	$696.24
67909	Revise eyelid defect	Y		A2	16.6274	$696.24
67911	Revise eyelid defect	Y		A2	15.942	$667.54
67912	Correction eyelid w/implant	Y		A2	15.942	$667.54
67914	Repair eyelid defect	Y		A2	15.942	$667.54
67915	Repair eyelid defect	Y		P3		$141.65
67916	Repair eyelid defect	Y		A2	16.6274	$696.24
67917	Repair eyelid defect	Y		A2	16.6274	$696.24
67921	Repair eyelid defect	Y		A2	15.942	$667.54
67922	Repair eyelid defect	Y		P3		$137.68
67923	Repair eyelid defect	Y		A2	16.6274	$696.24
67924	Repair eyelid defect	Y		A2	16.6274	$696.24
67930	Repair eyelid wound	Y		P3		$142.50

Addendum AA -- Final ASC Covered Surgical Procedures for CY 2010 (Including Surgical Procedures for Which Payment is Packaged)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
67935	Repair eyelid wound	Y		A2	15.5764	$652.23
67938	Remove eyelid foreign body	N		P2	1.8727	$78.42
67950	Revision of eyelid	Y		A2	15.5764	$652.23
67961	Revision of eyelid	Y		A2	15.942	$667.54
67966	Revision of eyelid	Y		A2	15.942	$667.54
67971	Reconstruction of eyelid	Y		A2	15.942	$667.54
67973	Reconstruction of eyelid	Y		A2	22.1711	$928.37
67974	Reconstruction of eyelid	Y		A2	15.942	$667.54
67975	Reconstruction of eyelid	Y		A2	15.942	$667.54
68020	Incise/drain eyelid lining	Y		P3		$40.03
68040	Treatment of eyelid lesions	N		P3		$19.87
68100	Biopsy of eyelid lining	Y		P3		$76.36
68110	Remove eyelid lining lesion	Y		P3		$99.07
68115	Remove eyelid lining lesion	Y		A2	15.5764	$652.23
68130	Remove eyelid lining lesion	Y		A2	14.2061	$594.85
68135	Remove eyelid lining lesion	Y		P3		$51.38
68200	Treat eyelid by injection	N		P3		$14.48
68320	Revise/graft eyelid lining	Y		A2	22.8565	$957.07
68325	Revise/graft eyelid lining	Y		A2	22.8565	$957.07
68326	Revise/graft eyelid lining	Y		A2	16.6274	$696.24
68328	Revise/graft eyelid lining	Y		A2	22.8565	$957.07
68330	Revise eyelid lining	Y		A2	21.1076	$883.84
68335	Revise/graft eyelid lining	Y		A2	22.8565	$957.07
68340	Separate eyelid adhesions	Y		A2	16.6274	$696.24
68360	Revise eyelid lining	Y		A2	20.0566	$839.83
68362	Revise eyelid lining	Y		A2	20.0566	$839.83
68371	Harvest eye tissue, alograft	Y		A2	14.2061	$594.85
68400	Incise/drain tear gland	Y		P2	3.087	$129.26
68420	Incise/drain tear sac	Y		P3		$147.61
68440	Incise tear duct opening	Y		P3		$43.15
68500	Removal of tear gland	Y		A2	22.1711	$928.37
68505	Partial removal, tear gland	Y		A2	22.1711	$928.37
68510	Biopsy of tear gland	Y		A2	14.9309	$625.20
68520	Removal of tear sac	Y		A2	22.1711	$928.37
68525	Biopsy of tear sac	Y		A2	14.9309	$625.20
68530	Clearance of tear duct	Y		P2	3.087	$129.26
68540	Remove tear gland lesion	Y		A2	15.942	$667.54
68550	Remove tear gland lesion	Y		A2	22.1711	$928.37
68700	Repair tear ducts	Y		A2	15.5764	$652.23
68705	Revise tear duct opening	Y		P3		$99.35
68720	Create tear sac drain	Y		A2	22.8565	$957.07

Addendum AA -- Final ASC Covered Surgical Procedures for CY 2010 (Including Surgical Procedures for Which Payment is Packaged)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
68745	Create tear duct drain	Y		A2	22.8565	$957.07
68750	Create tear duct drain	Y		A2	22.8565	$957.07
68760	Close tear duct opening	Y		P3		$84.59
68761	Close tear duct opening	Y		P3		$58.76
68770	Close tear system fistula	Y		A2	22.8565	$957.07
68801	Dilate tear duct opening	N		P2	0.9139	$38.27
68810	Probe nasolacrimal duct	Y		A2	3.0683	$128.48
68811	Probe nasolacrimal duct	Y		A2	15.5764	$652.23
68815	Probe nasolacrimal duct	Y		A2	15.5764	$652.23
68816	Probe nl duct w/balloon	Y		G2	17.3718	$727.41
68840	Explore/irrigate tear ducts	N		P3		$47.12
68850	Injection for tear sac x-ray	N		N1		
69000	Drain external ear lesion	Y		P2	1.3927	$58.32
69005	Drain external ear lesion	Y		P3		$88.85
69020	Drain outer ear canal lesion	Y		P2	1.3927	$58.32
69100	Biopsy of external ear	Y		P3		$51.10
69105	Biopsy of external ear canal	Y		P3		$74.66
69110	Remove external ear, partial	Y		A2	14.457	$605.36
69120	Removal of external ear	Y		A2	20.4597	$856.71
69140	Remove ear canal lesion(s)	Y		A2	20.4597	$856.71
69145	Remove ear canal lesion(s)	Y		A2	15.1023	$632.38
69150	Extensive ear canal surgery	Y		A2	8.1184	$339.94
69200	Clear outer ear canal	N		P2	0.6403	$26.81
69205	Clear outer ear canal	Y		A2	18.6836	$782.34
69210	Remove impacted ear wax	N		P3		$17.88
69220	Clean out mastoid cavity	Y		P2	0.8408	$35.21
69222	Clean out mastoid cavity	Y		P3		$114.40
69300	Revise external ear	Y		A2	20.8254	$872.02
69310	Rebuild outer ear canal	Y		A2	33.7542	$1,413.39
69320	Rebuild outer ear canal	Y		A2	36.5245	$1,529.39
69400	Inflate middle ear canal	Y		P3		$77.78
69401	Inflate middle ear canal	Y		P3		$41.16
69405	Catheterize middle ear canal	Y		P3		$107.87
69420	Incision of eardrum	Y		P3		$95.66
69421	Incision of eardrum	Y		A2	15.2459	$638.39
69424	Remove ventilating tube	Y		P3		$66.71
69433	Create eardrum opening	Y		P3		$95.66
69436	Create eardrum opening	Y		A2	15.2459	$638.39
69440	Exploration of middle ear	Y		A2	20.8254	$872.02
69450	Eardrum revision	Y		A2	32.7433	$1,371.06
69501	Mastoidectomy	Y		A2	36.5245	$1,529.39

Addendum AA -- Final ASC Covered Surgical Procedures for CY 2010 (Including Surgical Procedures for Which Payment is Packaged)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
69502	Mastoidectomy	Y		A2	23.5956	$988.02
69505	Remove mastoid structures	Y		A2	36.5245	$1,529.39
69511	Extensive mastoid surgery	Y		A2	36.5245	$1,529.39
69530	Extensive mastoid surgery	Y		A2	36.5245	$1,529.39
69540	Remove ear lesion	Y		P3		$111.84
69550	Remove ear lesion	Y		A2	34.9366	$1,462.90
69552	Remove ear lesion	Y		A2	36.5245	$1,529.39
69601	Mastoid surgery revision	Y		A2	36.5245	$1,529.39
69602	Mastoid surgery revision	Y		A2	36.5245	$1,529.39
69603	Mastoid surgery revision	Y		A2	36.5245	$1,529.39
69604	Mastoid surgery revision	Y		A2	36.5245	$1,529.39
69605	Mastoid surgery revision	Y		A2	36.5245	$1,529.39
69610	Repair of eardrum	Y		P3		$150.45
69620	Repair of eardrum	Y		A2	20.4597	$856.71
69631	Repair eardrum structures	Y		A2	34.9366	$1,462.90
69632	Rebuild eardrum structures	Y		A2	34.9366	$1,462.90
69633	Rebuild eardrum structures	Y		A2	34.9366	$1,462.90
69635	Repair eardrum structures	Y		A2	36.5245	$1,529.39
69636	Rebuild eardrum structures	Y		A2	36.5245	$1,529.39
69637	Rebuild eardrum structures	Y		A2	36.5245	$1,529.39
69641	Revise middle ear & mastoid	Y		A2	36.5245	$1,529.39
69642	Revise middle ear & mastoid	Y		A2	36.5245	$1,529.39
69643	Revise middle ear & mastoid	Y		A2	36.5245	$1,529.39
69644	Revise middle ear & mastoid	Y		A2	36.5245	$1,529.39
69645	Revise middle ear & mastoid	Y		A2	36.5245	$1,529.39
69646	Revise middle ear & mastoid	Y		A2	36.5245	$1,529.39
69650	Release middle ear bone	Y		A2	23.5956	$988.02
69660	Revise middle ear bone	Y		A2	34.9366	$1,462.90
69661	Revise middle ear bone	Y		A2	34.9366	$1,462.90
69662	Revise middle ear bone	Y		A2	34.9366	$1,462.90
69666	Repair middle ear structures	Y		A2	34.4396	$1,442.09
69667	Repair middle ear structures	Y		A2	34.4396	$1,442.09
69670	Remove mastoid air cells	Y		A2	33.7542	$1,413.39
69676	Remove middle ear nerve	Y		A2	33.7542	$1,413.39
69700	Close mastoid fistula	Y		A2	33.7542	$1,413.39
69711	Remove/repair hearing aid	Y		A2	32.7433	$1,371.06
69714	Implant temple bone w/stimul	Y		H8	153.8521	$6,442.25
69715	Temple bne implnt w/stimulat	Y		H8	153.8521	$6,442.25
69717	Temple bone implant revision	Y		H8	153.8521	$6,442.25
69718	Revise temple bone implant	Y		H8	153.8521	$6,442.25
69720	Release facial nerve	Y		A2	34.9366	$1,462.90

Addendum AA -- Final ASC Covered Surgical Procedures for CY 2010 (Including Surgical Procedures for Which Payment is Packaged)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
69740	Repair facial nerve	Y		A2	34.9366	$1,462.90
69745	Repair facial nerve	Y		A2	34.9366	$1,462.90
69801	Incise inner ear	Y		A2	22.0077	$921.53
69802	Incise inner ear	Y		A2	23.5956	$988.02
69805	Explore inner ear	Y		A2	36.5245	$1,529.39
69806	Explore inner ear	Y		A2	36.5245	$1,529.39
69820	Establish inner ear window	Y		A2	34.9366	$1,462.90
69840	Revise inner ear window	Y		A2	34.9366	$1,462.90
69905	Remove inner ear	Y		A2	36.5245	$1,529.39
69910	Remove inner ear & mastoid	Y		A2	36.5245	$1,529.39
69915	Incise inner ear nerve	Y		A2	36.5245	$1,529.39
69930	Implant cochlear device	Y		H8	636.8197	$26,665.55
69990	Microsurgery add-on	N		N1		
C9716	Radiofrequency energy to anu	Y		G2	30.7878	$1,289.18
C9724	EPS gast cardia plic	Y		G2	23.2194	$972.27
C9725	Place endorectal app	Y		G2	5.1327	$214.92
C9726	Rxt breast appl place/remov	Y		G2	23.6799	$991.55
C9727	Insert palate implants	Y		G2	7.2897	$305.24
C9728	Place device/marker, non pro	N		R2	13.1619	$551.13
G0104	CA screen;flexi sigmoidscope	N		P3		$70.12
G0105	Colorectal scrn; hi risk ind	Y		A2	8.3531	$349.77
G0121	Colon ca scrn not hi rsk ind	Y		A2	8.3531	$349.77
G0127	Trim nail(s)	Y		P3		$10.22
G0186	Dstry eye lesn,fdr vssl tech	Y		R2	5.5965	$234.34
G0247	Routine footcare pt w lops	Y		P3		$18.45
G0259	Inject for sacroiliac joint	N		N1		
G0260	Inj for sacroiliac jt anesth	Y		A2	7.0685	$295.98
G0268	Removal of impacted wax md	N		N1		
G0269	Occlusive device in vein art	N		N1		
G0289	Arthro, loose body + chondro	N		N1		
G0364	Bone marrow aspirate &biopsy	N		P3		$4.54
G0392	AV fistula or graft arterial	N	CH	D5		
G0393	AV fistula or graft venous	N	CH	D5		

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Addendum AA -- Final ASC Covered Surgical Procedures for CY 2010 (Including Surgical Procedures for Which Payment is Packaged)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
NOTE 2: Payment indicators for "office-based" procedures (P2, P3) are based on a comparison of the final rates according to the ASC standard ratesetting methodology and the MPFS. Under current law, the MPFS payment rates will have a negative update for CY 2010. For a discussion of those rates, we refer readers to the CY 2010 MPFS final rule, as corrected.						
*: Asterisked codes(*) indicate that the procedure's "office-based," designation is temporary because we have insufficient claims data. We will reconsider this designation when new claims data become available.						

Addendum BB -- Final ASC Covered Ancillary Services Integral to Covered Surgical Procedures for CY 2010 (Including Ancillary Services for Which Payment is Packaged)

HCPCS Code	Short Descriptor	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
0042T	Ct perfusion w/contrast, cbf		N1		
0067T	Ct colonography;dx	CH	D5		
0073T	Delivery, comp imrt		Z2	5.9784	$250.33
0126T	Chd risk imt study		N1		
0144T	CT heart wo dye; qual calc	CH	D5		
0145T	CT heart w/wo dye funct	CH	D5		
0146T	CCTA w/wo dye	CH	D5		
0147T	CCTA w/wo, quan calcium	CH	D5		
0148T	CCTA w/wo, strxr	CH	D5		
0149T	CCTA w/wo, strxr quan calc	CH	D5		
0150T	CCTA w/wo, disease strxr	CH	D5		
0151T	CT heart funct add-on	CH	D5		
0159T	Cad breast mri		N1		
0174T	Cad cxr with interp		N1		
0175T	Cad cxr remote		N1		
0182T	Hdr elect brachytherapy		Z2	11.0358	$462.10
0185T	Comptr probability analysis		N1		
70010	Contrast x-ray of brain		N1		
70015	Contrast x-ray of brain		N1		
70030	X-ray eye for foreign body		Z3		$14.48
70100	X-ray exam of jaw		Z3		$16.18
70110	X-ray exam of jaw		Z3		$19.59
70120	X-ray exam of mastoids		Z3		$18.17
70130	X-ray exam of mastoids		Z2	0.6373	$26.69
70134	X-ray exam of middle ear		Z3		$21.29
70140	X-ray exam of facial bones		Z3		$14.48
70150	X-ray exam of facial bones	CH	Z3		$21.29
70160	X-ray exam of nasal bones		Z3		$17.32
70170	X-ray exam of tear duct		N1		
70190	X-ray exam of eye sockets		Z3		$18.17
70200	X-ray exam of eye sockets	CH	Z3		$21.57
70210	X-ray exam of sinuses		Z3		$15.61
70220	X-ray exam of sinuses		Z3		$19.30
70240	X-ray exam, pituitary saddle		Z3		$14.48
70250	X-ray exam of skull		Z3		$17.60
70260	X-ray exam of skull		Z3		$22.14
70300	X-ray exam of teeth		Z3		$6.25
70310	X-ray exam of teeth		Z2	0.4275	$17.90
70320	Full mouth x-ray of teeth		Z2	0.4275	$17.90

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NOTE 2: Payment indicators for radiology services (Z2, Z3) are based on a comparison of the final rates according to the ASC standard rate setting methodology and the MPFS. Under current law, the MPFS payment rates will have a negative update for CY 2010. For a discussion of those rates, we refer readers to the CY 2010 MPFS final rule.

Addendum BB -- Final ASC Covered Ancillary Services Integral to Covered Surgical Procedures for CY 2010 (Including Ancillary Services for Which Payment is Packaged)

HCPCS Code	Short Descriptor	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
70328	X-ray exam of jaw joint		Z3		$15.33
70330	X-ray exam of jaw joints	CH	Z3		$25.55
70332	X-ray exam of jaw joint		N1		
70336	Magnetic image, jaw joint		Z2	4.961	$207.73
70350	X-ray head for orthodontia		Z3		$8.52
70355	Panoramic x-ray of jaws		Z3		$8.23
70360	X-ray exam of neck		Z3		$13.63
70370	Throat x-ray & fluoroscopy	CH	Z3		$44.57
70371	Speech evaluation, complex	CH	Z3		$39.17
70373	Contrast x-ray of larynx		N1		
70380	X-ray exam of salivary gland		Z3		$21.01
70390	X-ray exam of salivary duct		N1		
70450	Ct head/brain w/o dye		Z2	2.7687	$115.93
70460	Ct head/brain w/dye	CH	Z3		$151.59
70470	Ct head/brain w/o & w/dye	CH	Z3		$186.79
70480	Ct orbit/ear/fossa w/o dye		Z2	2.7687	$115.93
70481	Ct orbit/ear/fossa w/dye		Z2	4.2158	$176.53
70482	Ct orbit/ear/fossa w/o&w/dye		Z2	4.7337	$198.21
70486	Ct maxillofacial w/o dye		Z2	2.7687	$115.93
70487	Ct maxillofacial w/dye		Z2	4.2158	$176.53
70488	Ct maxillofacial w/o & w/dye		Z2	4.7337	$198.21
70490	Ct soft tissue neck w/o dye		Z2	2.7687	$115.93
70491	Ct soft tissue neck w/dye		Z2	4.2158	$176.53
70492	Ct sft tsue nck w/o & w/dye		Z2	4.7337	$198.21
70496	Ct angiography, head		Z2	4.8324	$202.35
70498	Ct angiography, neck		Z2	4.8324	$202.35
70540	Mri orbit/face/neck w/o dye		Z2	4.961	$207.73
70542	Mri orbit/face/neck w/dye		Z2	6.0177	$251.98
70543	Mri orbt/fac/nck w/o & w/dye		Z2	7.5993	$318.21
70544	Mr angiography head w/o dye		Z2	4.961	$207.73
70545	Mr angiography head w/dye		Z2	6.0177	$251.98
70546	Mr angiograph head w/o&w/dye		Z2	7.5993	$318.21
70547	Mr angiography neck w/o dye		Z2	4.961	$207.73
70548	Mr angiography neck w/dye		Z2	6.0177	$251.98
70549	Mr angiograph neck w/o&w/dye		Z2	7.5993	$318.21
70551	Mri brain w/o dye		Z2	4.961	$207.73
70552	Mri brain w/dye		Z2	6.0177	$251.98
70553	Mri brain w/o & w/dye		Z2	7.5993	$318.21

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Addendum BB -- Final ASC Covered Ancillary Services Integral to Covered Surgical Procedures for CY 2010 (Including Ancillary Services for Which Payment is Packaged)

HCPCS Code	Short Descriptor	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
70554	Fmri brain by tech		Z2	4.961	$207.73
70555	Fmri brain by phys/psych		Z2	4.961	$207.73
70557	Mri brain w/o dye		Z2	4.961	$207.73
70558	Mri brain w/dye		Z2	6.0177	$251.98
70559	Mri brain w/o & w/dye		Z2	7.5993	$318.21
71010	Chest x-ray		Z3		$10.79
71015	Chest x-ray		Z3		$14.19
71020	Chest x-ray		Z3		$14.76
71021	Chest x-ray		Z3		$17.88
71022	Chest x-ray	CH	Z3		$22.43
71023	Chest x-ray and fluoroscopy		Z3		$35.48
71030	Chest x-ray	CH	Z3		$22.43
71034	Chest x-ray and fluoroscopy	CH	Z3		$48.26
71035	Chest x-ray		Z3		$18.74
71040	Contrast x-ray of bronchi		N1		
71060	Contrast x-ray of bronchi		N1		
71090	X-ray & pacemaker insertion		N1		
71100	X-ray exam of ribs		Z3		$15.61
71101	X-ray exam of ribs/chest		Z3		$18.74
71110	X-ray exam of ribs		Z3		$19.59
71111	X-ray exam of ribs/chest		Z3		$26.40
71120	X-ray exam of breastbone		Z3		$16.18
71130	X-ray exam of breastbone		Z3		$19.02
71250	Ct thorax w/o dye		Z2	2.7687	$115.93
71260	Ct thorax w/dye		Z2	4.2158	$176.53
71270	Ct thorax w/o & w/dye		Z2	4.7337	$198.21
71275	Ct angiography, chest		Z2	4.8324	$202.35
71550	Mri chest w/o dye		Z2	4.961	$207.73
71551	Mri chest w/dye		Z2	6.0177	$251.98
71552	Mri chest w/o & w/dye		Z2	7.5993	$318.21
72010	X-ray exam of spine	CH	Z3		$35.77
72020	X-ray exam of spine		Z3		$11.64
72040	X-ray exam of neck spine		Z3		$19.02
72050	X-ray exam of neck spine		Z3		$26.68
72052	X-ray exam of neck spine	CH	Z3		$34.63
72069	X-ray exam of trunk spine		Z3		$17.88
72070	X-ray exam of thoracic spine		Z3		$16.18
72072	X-ray exam of thoracic spine		Z3		$19.59

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HCPCS Code	Short Descriptor	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
72074	X-ray exam of thoracic spine	CH	Z3		$24.41
72080	X-ray exam of trunk spine		Z3		$17.60
72090	X-ray exam of trunk spine		Z3		$24.13
72100	X-ray exam of lower spine		Z3		$20.44
72110	X-ray exam of lower spine		Z3		$28.10
72114	X-ray exam of lower spine	CH	Z3		$39.17
72120	X-ray exam of lower spine		Z3		$27.82
72125	Ct neck spine w/o dye		Z2	2.7687	$115.93
72126	Ct neck spine w/dye		Z2	4.2158	$176.53
72127	Ct neck spine w/o & w/dye		Z2	4.7337	$198.21
72128	Ct chest spine w/o dye		Z2	2.7687	$115.93
72129	Ct chest spine w/dye		Z2	4.2158	$176.53
72130	Ct chest spine w/o & w/dye		Z2	4.7337	$198.21
72131	Ct lumbar spine w/o dye		Z2	2.7687	$115.93
72132	Ct lumbar spine w/dye		Z2	4.2158	$176.53
72133	Ct lumbar spine w/o & w/dye		Z2	4.7337	$198.21
72141	Mri neck spine w/o dye		Z2	4.961	$207.73
72142	Mri neck spine w/dye		Z2	6.0177	$251.98
72146	Mri chest spine w/o dye		Z2	4.961	$207.73
72147	Mri chest spine w/dye		Z2	6.0177	$251.98
72148	Mri lumbar spine w/o dye		Z2	4.961	$207.73
72149	Mri lumbar spine w/dye		Z2	6.0177	$251.98
72156	Mri neck spine w/o & w/dye		Z2	7.5993	$318.21
72157	Mri chest spine w/o & w/dye		Z2	7.5993	$318.21
72158	Mri lumbar spine w/o & w/dye		Z2	7.5993	$318.21
72170	X-ray exam of pelvis		Z3		$12.77
72190	X-ray exam of pelvis	CH	Z3		$21.29
72191	Ct angiograph pelv w/o&w/dye		Z2	4.8324	$202.35
72192	Ct pelvis w/o dye		Z2	2.7687	$115.93
72193	Ct pelvis w/dye		Z2	4.2158	$176.53
72194	Ct pelvis w/o & w/dye		Z2	4.7337	$198.21
72195	Mri pelvis w/o dye		Z2	4.961	$207.73
72196	Mri pelvis w/dye		Z2	6.0177	$251.98
72197	Mri pelvis w/o & w/dye		Z2	7.5993	$318.21
72200	X-ray exam sacroiliac joints		Z3		$15.05
72202	X-ray exam sacroiliac joints		Z3		$18.17
72220	X-ray exam of tailbone		Z3		$14.76
72240	Contrast x-ray of neck spine		N1		

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72255	Contrast x-ray, thorax spine		N1		
72265	Contrast x-ray, lower spine		N1		
72270	Contrast x-ray, spine		N1		
72275	Epidurography		N1		
72285	X-ray c/t spine disk		N1		
72291	Perq verte/sacroplsty, fluor		N1		
72292	Perq verte/sacroplsty, ct		N1		
72295	X-ray of lower spine disk		N1		
73000	X-ray exam of collar bone		Z3		$14.19
73010	X-ray exam of shoulder blade		Z3		$14.76
73020	X-ray exam of shoulder		Z3		$11.64
73030	X-ray exam of shoulder		Z3		$14.76
73040	Contrast x-ray of shoulder		N1		
73050	X-ray exam of shoulders		Z3		$19.02
73060	X-ray exam of humerus		Z3		$14.76
73070	X-ray exam of elbow		Z3		$14.48
73080	X-ray exam of elbow		Z3		$19.02
73085	Contrast x-ray of elbow		N1		
73090	X-ray exam of forearm		Z3		$14.19
73092	X-ray exam of arm, infant		Z3		$15.05
73100	X-ray exam of wrist		Z3		$15.33
73110	X-ray exam of wrist		Z3		$19.30
73115	Contrast x-ray of wrist		N1		
73120	X-ray exam of hand		Z3		$13.91
73130	X-ray exam of hand		Z3		$16.46
73140	X-ray exam of finger(s)		Z3		$16.75
73200	Ct upper extremity w/o dye		Z2	2.7687	$115.93
73201	Ct upper extremity w/dye		Z2	4.2158	$176.53
73202	Ct uppr extremity w/o&w/dye		Z2	4.7337	$198.21
73206	Ct angio upr extrm w/o&w/dye		Z2	4.8324	$202.35
73218	Mri upper extremity w/o dye		Z2	4.961	$207.73
73219	Mri upper extremity w/dye		Z2	6.0177	$251.98
73220	Mri uppr extremity w/o&w/dye		Z2	7.5993	$318.21
73221	Mri joint upr extrem w/o dye		Z2	4.961	$207.73
73222	Mri joint upr extrem w/dye		Z2	6.0177	$251.98
73223	Mri joint upr extr w/o&w/dye		Z2	7.5993	$318.21
73500	X-ray exam of hip		Z3		$12.21
73510	X-ray exam of hip		Z3		$19.02

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73520	X-ray exam of hips		Z3		$19.30
73525	Contrast x-ray of hip		N1		
73530	X-ray exam of hip		N1		
73540	X-ray exam of pelvis & hips		Z3		$20.44
73542	X-ray exam, sacroiliac joint		N1		
73550	X-ray exam of thigh		Z3		$13.91
73560	X-ray exam of knee, 1 or 2		Z3		$14.76
73562	X-ray exam of knee, 3		Z3		$18.45
73564	X-ray exam, knee, 4 or more		Z3		$21.29
73565	X-ray exam of knees		Z3		$16.46
73580	Contrast x-ray of knee joint		N1		
73590	X-ray exam of lower leg		Z3		$13.63
73592	X-ray exam of leg, infant		Z3		$15.33
73600	X-ray exam of ankle		Z3		$14.19
73610	X-ray exam of ankle		Z3		$16.75
73615	Contrast x-ray of ankle		N1		
73620	X-ray exam of foot		Z3		$13.63
73630	X-ray exam of foot		Z3		$16.46
73650	X-ray exam of heel		Z3		$13.91
73660	X-ray exam of toe(s)		Z3		$15.61
73700	Ct lower extremity w/o dye		Z2	2.7687	$115.93
73701	Ct lower extremity w/dye		Z2	4.2158	$176.53
73702	Ct lwr extremity w/o&w/dye		Z2	4.7337	$198.21
73706	Ct angio lwr extr w/o&w/dye		Z2	4.8324	$202.35
73718	Mri lower extremity w/o dye		Z2	4.961	$207.73
73719	Mri lower extremity w/dye		Z2	6.0177	$251.98
73720	Mri lwr extremity w/o&w/dye		Z2	7.5993	$318.21
73721	Mri jnt of lwr extre w/o dye		Z2	4.961	$207.73
73722	Mri joint of lwr extr w/dye		Z2	6.0177	$251.98
73723	Mri joint lwr extr w/o&w/dye		Z2	7.5993	$318.21
74000	X-ray exam of abdomen		Z3		$11.92
74010	X-ray exam of abdomen		Z3		$19.02
74020	X-ray exam of abdomen		Z3		$19.30
74022	X-ray exam series, abdomen		Z3		$23.28
74150	Ct abdomen w/o dye		Z2	2.7687	$115.93
74160	Ct abdomen w/dye		Z2	4.2158	$176.53
74170	Ct abdomen w/o & w/dye		Z2	4.7337	$198.21
74175	Ct angio abdom w/o & w/dye		Z2	4.8324	$202.35

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74181	Mri abdomen w/o dye		Z2	4.961	$207.73
74182	Mri abdomen w/dye		Z2	6.0177	$251.98
74183	Mri abdomen w/o & w/dye		Z2	7.5993	$318.21
74190	X-ray exam of peritoneum		N1		
74210	Contrst x-ray exam of throat	CH	Z3		$43.15
74220	Contrast x-ray, esophagus	CH	Z3		$47.97
74230	Cine/vid x-ray, throat/esoph	CH	Z3		$46.27
74235	Remove esophagus obstruction		N1		
74240	X-ray exam, upper gi tract		Z2	1.2423	$52.02
74241	X-ray exam, upper gi tract		Z2	1.2423	$52.02
74245	X-ray exam, upper gi tract		Z2	2.0092	$84.13
74246	Contrst x-ray uppr gi tract		Z2	1.2423	$52.02
74247	Contrst x-ray uppr gi tract		Z2	1.2423	$52.02
74249	Contrst x-ray uppr gi tract		Z2	2.0092	$84.13
74250	X-ray exam of small bowel		Z2	1.2423	$52.02
74251	X-ray exam of small bowel		Z2	2.0092	$84.13
74260	X-ray exam of small bowel		Z2	1.2423	$52.02
74261	Ct colonography, w/o dye	NI	Z2	2.7687	$115.93
74262	Ct colonography, w/dye	NI	Z2	4.2158	$176.53
74270	Contrast x-ray exam of colon		Z2	1.2423	$52.02
74280	Contrast x-ray exam of colon		Z2	2.0092	$84.13
74283	Contrast x-ray exam of colon		Z2	1.2423	$52.02
74290	Contrast x-ray, gallbladder		Z3		$36.90
74291	Contrast x-rays, gallbladder		Z3		$36.34
74300	X-ray bile ducts/pancreas		N1		
74301	X-rays at surgery add-on		N1		
74305	X-ray bile ducts/pancreas		N1		
74320	Contrast x-ray of bile ducts		N1		
74327	X-ray bile stone removal		N1		
74328	X-ray bile duct endoscopy		N1		
74329	X-ray for pancreas endoscopy		N1		
74330	X-ray bile/panc endoscopy		N1		
74340	X-ray guide for GI tube		N1		
74355	X-ray guide, intestinal tube		N1		
74360	X-ray guide, GI dilation		N1		
74363	X-ray, bile duct dilation		N1		
74400	Contrst x-ray, urinary tract		Z3		$62.73
74410	Contrst x-ray, urinary tract		Z3		$65.86

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74415	Contrst x-ray, urinary tract		Z3		$80.05
74420	Contrst x-ray, urinary tract		Z2	2.4358	$101.99
74425	Contrst x-ray, urinary tract		N1		
74430	Contrast x-ray, bladder		N1		
74440	X-ray, male genital tract		N1		
74445	X-ray exam of penis		N1		
74450	X-ray, urethra/bladder		N1		
74455	X-ray, urethra/bladder		N1		
74470	X-ray exam of kidney lesion		N1		
74475	X-ray control, cath insert		N1		
74480	X-ray control, cath insert		N1		
74485	X-ray guide, GU dilation		N1		
74710	X-ray measurement of pelvis		Z3		$17.60
74740	X-ray, female genital tract		N1		
74742	X-ray, fallopian tube		N1		
74775	X-ray exam of perineum		Z2	2.4358	$101.99
75557	Cardiac mri for morph		Z2	4.961	$207.73
75559	Cardiac mri w/stress img		Z2	4.961	$207.73
75561	Cardiac mri for morph w/dye		Z2	7.5993	$318.21
75563	Card mri w/stress img & dye		Z2	7.5993	$318.21
75565	Card mri vel flw map add-on	NI	N1		
75571	Ct hrt w/o dye w/ca test	NI	Z2	0.6403	$26.81
75572	Ct hrt w/3d image	NI	Z2	3.82	$159.95
75573	Ct hrt w/3d image, congen	NI	Z2	3.82	$159.95
75574	Ct angio hrt w/3d image	NI	Z2	3.82	$159.95
75600	Contrast x-ray exam of aorta		N1		
75605	Contrast x-ray exam of aorta		N1		
75625	Contrast x-ray exam of aorta		N1		
75630	X-ray aorta, leg arteries		N1		
75635	Ct angio abdominal arteries		N1		
75650	Artery x-rays, head & neck		N1		
75658	Artery x-rays, arm		N1		
75660	Artery x-rays, head & neck		N1		
75662	Artery x-rays, head & neck		N1		
75665	Artery x-rays, head & neck		N1		
75671	Artery x-rays, head & neck		N1		
75676	Artery x-rays, neck		N1		
75680	Artery x-rays, neck		N1		

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75685	Artery x-rays, spine		N1		
75705	Artery x-rays, spine		N1		
75710	Artery x-rays, arm/leg		N1		
75716	Artery x-rays, arms/legs		N1		
75722	Artery x-rays, kidney		N1		
75724	Artery x-rays, kidneys		N1		
75726	Artery x-rays, abdomen		N1		
75731	Artery x-rays, adrenal gland		N1		
75733	Artery x-rays, adrenals		N1		
75736	Artery x-rays, pelvis		N1		
75741	Artery x-rays, lung		N1		
75743	Artery x-rays, lungs		N1		
75746	Artery x-rays, lung		N1		
75756	Artery x-rays, chest		N1		
75774	Artery x-ray, each vessel		N1		
75790	Visualize A-V shunt	CH	D5		
75791	Av dialysis shunt imaging	NI	N1		
75801	Lymph vessel x-ray, arm/leg		N1		
75803	Lymph vessel x-ray,arms/legs		N1		
75805	Lymph vessel x-ray, trunk		N1		
75807	Lymph vessel x-ray, trunk		N1		
75809	Nonvascular shunt, x-ray		N1		
75810	Vein x-ray, spleen/liver		N1		
75820	Vein x-ray, arm/leg		N1		
75822	Vein x-ray, arms/legs		N1		
75825	Vein x-ray, trunk		N1		
75827	Vein x-ray, chest		N1		
75831	Vein x-ray, kidney		N1		
75833	Vein x-ray, kidneys		N1		
75840	Vein x-ray, adrenal gland		N1		
75842	Vein x-ray, adrenal glands		N1		
75860	Vein x-ray, neck		N1		
75870	Vein x-ray, skull		N1		
75872	Vein x-ray, skull		N1		
75880	Vein x-ray, eye socket		N1		
75885	Vein x-ray, liver		N1		
75887	Vein x-ray, liver		N1		
75889	Vein x-ray, liver		N1		

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75891	Vein x-ray, liver		N1		
75893	Venous sampling by catheter		N1		
75894	X-rays, transcath therapy		N1		
75896	X-rays, transcath therapy		N1		
75898	Follow-up angiography		N1		
75901	Remove cva device obstruct		N1		
75902	Remove cva lumen obstruct		N1		
75940	X-ray placement, vein filter		N1		
75945	Intravascular us		N1		
75946	Intravascular us add-on		N1		
75960	Transcath iv stent rs&i		N1		
75961	Retrieval, broken catheter		N1		
75962	Repair arterial blockage		N1		
75964	Repair artery blockage, each		N1		
75966	Repair arterial blockage		N1		
75968	Repair artery blockage, each		N1		
75970	Vascular biopsy		N1		
75978	Repair venous blockage		N1		
75980	Contrast xray exam bile duct		N1		
75982	Contrast xray exam bile duct		N1		
75984	Xray control catheter change		N1		
75989	Abscess drainage under x-ray		N1		
75992	Atherectomy, x-ray exam		N1		
75993	Atherectomy, x-ray exam		N1		
75994	Atherectomy, x-ray exam		N1		
75995	Atherectomy, x-ray exam		N1		
75996	Atherectomy, x-ray exam		N1		
76000	Fluoroscope examination		N1		
76001	Fluoroscope exam, extensive		N1		
76010	X-ray, nose to rectum		Z3		$13.63
76080	X-ray exam of fistula		N1		
76098	X-ray exam, breast specimen	CH	N1		
76100	X-ray exam of body section		Z2	1.0678	$44.71
76101	Complex body section x-ray	CH	Z3		$110.71
76102	Complex body section x-rays		Z2	2.9841	$124.95
76120	Cine/video x-rays	CH	Z3		$42.01
76125	Cine/video x-rays add-on		N1		
76150	X-ray exam, dry process		Z3		$14.48

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76350	Special x-ray contrast study		N1		
76376	3d render w/o postprocess		N1		
76377	3d rendering w/postprocess		N1		
76380	CAT scan follow-up study		Z2	1.5586	$65.26
76496	Fluoroscopic procedure		Z2	1.2143	$50.85
76497	Ct procedure		Z2	1.5586	$65.26
76498	Mri procedure		Z2	4.961	$207.73
76499	Radiographic procedure		Z2	0.6373	$26.69
76506	Echo exam of head		Z2	0.8866	$37.12
76510	Ophth us, b & quant a		Z3		$52.23
76511	Ophth us, quant a only		Z3		$35.20
76512	Ophth us, b w/non-quant a		Z3		$29.52
76513	Echo exam of eye, water bath		Z3		$37.75
76514	Echo exam of eye, thickness		Z3		$2.84
76516	Echo exam of eye		Z3		$29.81
76519	Echo exam of eye		Z3		$33.21
76529	Echo exam of eye		Z3		$28.95
76536	Us exam of head and neck		Z2	1.3809	$57.82
76604	Us exam, chest		Z2	0.8866	$37.12
76645	Us exam, breast(s)		Z2	0.8866	$37.12
76700	Us exam, abdom, complete		Z2	1.3809	$57.82
76705	Echo exam of abdomen	CH	Z3		$55.35
76770	Us exam abdo back wall, comp		Z2	1.3809	$57.82
76775	Us exam abdo back wall, lim		Z2	1.3809	$57.82
76776	Us exam k transpl w/doppler		Z2	1.3809	$57.82
76800	Us exam, spinal canal	CH	Z3		$53.08
76801	Ob us < 14 wks, single fetus		Z2	1.3809	$57.82
76802	Ob us < 14 wks, addl fetus		Z3		$21.57
76805	Ob us >/= 14 wks, sngl fetus		Z2	1.3809	$57.82
76810	Ob us >/= 14 wks, addl fetus		Z3		$35.48
76811	Ob us, detailed, sngl fetus	CH	Z3		$74.37
76812	Ob us, detailed, addl fetus		Z2	0.8866	$37.12
76813	Ob us nuchal meas, 1 gest		Z2	0.8866	$37.12
76814	Ob us nuchal meas, add-on		Z3		$23.56
76815	Ob us, limited, fetus(s)		Z2	0.8866	$37.12
76816	Ob us, follow-up, per fetus		Z2	0.8866	$37.12
76817	Transvaginal us, obstetric		Z2	0.8866	$37.12
76818	Fetal biophys profile w/nst	CH	Z3		$50.81

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76819	Fetal biophys profil w/o nst		Z3		$39.46
76820	Umbilical artery echo		Z3		$17.88
76821	Middle cerebral artery echo		Z2	0.8866	$37.12
76825	Echo exam of fetal heart		Z3		$95.95
76826	Echo exam of fetal heart		Z3		$58.48
76827	Echo exam of fetal heart	CH	Z3		$29.24
76828	Echo exam of fetal heart		Z3		$16.46
76830	Transvaginal us, non-ob		Z2	1.3809	$57.82
76831	Echo exam, uterus		Z3		$63.87
76856	Us exam, pelvic, complete		Z2	1.3809	$57.82
76857	Us exam, pelvic, limited		Z2	0.8866	$37.12
76870	Us exam, scrotum		Z2	1.3809	$57.82
76872	Us, transrectal		Z2	1.3809	$57.82
76873	Echograp trans r, pros study		Z2	1.3809	$57.82
76880	Us exam, extremity		Z2	1.3809	$57.82
76885	Us exam infant hips, dynamic		Z2	0.8866	$37.12
76886	Us exam infant hips, static		Z2	0.8866	$37.12
76930	Echo guide, cardiocentesis		N1		
76932	Echo guide for heart biopsy		N1		
76936	Echo guide for artery repair		Z2	1.5379	$64.40
76937	Us guide, vascular access		N1		
76940	Us guide, tissue ablation		N1		
76941	Echo guide for transfusion		N1		
76942	Echo guide for biopsy		N1		
76945	Echo guide, villus sampling		N1		
76946	Echo guide for amniocentesis		N1		
76948	Echo guide, ova aspiration		N1		
76950	Echo guidance radiotherapy		N1		
76965	Echo guidance radiotherapy		N1		
76970	Ultrasound exam follow-up		Z2	0.8866	$37.12
76975	GI endoscopic ultrasound		N1		
76977	Us bone density measure		Z3		$6.53
76998	Us guide, intraop		N1		
76999	Echo examination procedure		Z2	0.8866	$37.12
77001	Fluoroguide for vein device		N1		
77002	Needle localization by xray		N1		
77003	Fluoroguide for spine inject		N1		
77011	Ct scan for localization		N1		

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77012	Ct scan for needle biopsy		N1		
77013	Ct guide for tissue ablation		N1		
77014	Ct scan for therapy guide		N1		
77021	Mr guidance for needle place		N1		
77022	Mri for tissue ablation		N1		
77031	Stereotact guide for brst bx		N1		
77032	Guidance for needle, breast		N1		
77053	X-ray of mammary duct		N1		
77054	X-ray of mammary ducts		N1		
77071	X-ray stress view		Z3		$19.59
77072	X-rays for bone age		Z3		$9.94
77073	X-rays, bone length studies		Z3		$17.32
77074	X-rays, bone survey, limited		Z3		$33.78
77075	X-rays, bone survey complete		Z2	1.0678	$44.71
77076	X-rays, bone survey, infant		Z2	1.0678	$44.71
77077	Joint survey, single view		Z3		$18.74
77078	Ct bone density, axial		Z2	1.0289	$43.08
77079	Ct bone density, peripheral		Z3		$32.08
77080	Dxa bone density, axial	CH	Z3		$40.03
77081	Dxa bone density/peripheral		Z3		$13.34
77082	Dxa bone density, vert fx		Z3		$14.76
77083	Radiographic absorptiometry		Z3		$11.35
77084	Magnetic image, bone marrow		Z2	4.961	$207.73
77280	Set radiation therapy field		Z2	1.461	$61.18
77285	Set radiation therapy field		Z2	3.7799	$158.28
77290	Set radiation therapy field		Z2	3.7799	$158.28
77295	Set radiation therapy field		Z3		$284.15
77299	Radiation therapy planning		Z2	1.461	$61.18
77300	Radiation therapy dose plan		Z3		$28.95
77301	Radiotherapy dose plan, imrt		Z2	13.1619	$551.13
77305	Teletx isodose plan simple		Z3		$24.98
77310	Teletx isodose plan intermed		Z3		$32.93
77315	Teletx isodose plan complex		Z3		$49.68
77321	Special teletx port plan		Z3		$48.54
77326	Brachytx isodose calc simp		Z2	1.461	$61.18
77327	Brachytx isodose calc interm		Z3		$99.92
77328	Brachytx isodose plan compl	CH	Z3		$128.31
77331	Special radiation dosimetry		Z3		$14.19

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77332	Radiation treatment aid(s)		Z3		$37.75
77333	Radiation treatment aid(s)		Z3		$15.61
77334	Radiation treatment aid(s)		Z3		$69.26
77336	Radiation physics consult		Z3		$41.73
77338	Design mlc device for imrt	NI	Z2	2.7055	$113.29
77370	Radiation physics consult		Z2	1.461	$61.18
77371	Srs, multisource		Z2	104.238	$4,364.76
77399	External radiation dosimetry		Z2	1.461	$61.18
77401	Radiation treatment delivery		Z3		$20.15
77402	Radiation treatment delivery		Z2	1.3168	$55.14
77403	Radiation treatment delivery		Z2	1.3168	$55.14
77404	Radiation treatment delivery		Z2	1.3168	$55.14
77406	Radiation treatment delivery		Z2	2.2033	$92.26
77407	Radiation treatment delivery		Z2	1.3168	$55.14
77408	Radiation treatment delivery		Z2	1.3168	$55.14
77409	Radiation treatment delivery		Z2	1.3168	$55.14
77411	Radiation treatment delivery		Z2	2.2033	$92.26
77412	Radiation treatment delivery		Z2	2.2033	$92.26
77413	Radiation treatment delivery		Z2	2.2033	$92.26
77414	Radiation treatment delivery		Z2	2.2033	$92.26
77416	Radiation treatment delivery		Z2	2.2033	$92.26
77417	Radiology port film(s)		N1		
77418	Radiation tx delivery, imrt		Z2	5.9784	$250.33
77421	Stereoscopic x-ray guidance		N1		
77422	Neutron beam tx, simple		Z2	2.2033	$92.26
77423	Neutron beam tx, complex		Z2	2.2033	$92.26
77435	Sbrt management		N1		
77470	Special radiation treatment		Z3		$88.00
77520	Proton trmt, simple w/o comp		Z2	13.3743	$560.02
77522	Proton trmt, simple w/comp		Z2	13.3743	$560.02
77523	Proton trmt, intermediate		Z2	17.4955	$732.59
77525	Proton treatment, complex		Z2	17.4955	$732.59
77600	Hyperthermia treatment		Z2	5.4016	$226.18
77605	Hyperthermia treatment		Z2	5.4016	$226.18
77610	Hyperthermia treatment		Z2	5.4016	$226.18
77615	Hyperthermia treatment		Z2	5.4016	$226.18
77620	Hyperthermia treatment		Z2	5.4016	$226.18
77750	Infuse radioactive materials		Z3		$72.10

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77761	Apply intrcav radiat simple		Z3		$126.61
77762	Apply intrcav radiat interm		Z3		$148.46
77763	Apply intrcav radiat compl	CH	Z2	4.2904	$179.65
77776	Apply interstit radiat simpl		Z3		$135.97
77777	Apply interstit radiat inter		Z3		$147.04
77778	Apply interstit radiat compl		Z3		$197.57
77785	Hdr brachytx, 1 channel		Z3		$97.93
77786	Hdr brachytx, 2-12 channel		Z3		$302.89
77787	Hdr brachytx over 12 chan		Z2	11.0358	$462.10
77789	Apply surface radiation		Z3		$38.04
77790	Radiation handling		N1		
77799	Radium/radioisotope therapy		Z2	4.2904	$179.65
78000	Thyroid, single uptake		Z3		$44.28
78001	Thyroid, multiple uptakes	CH	Z3		$55.92
78003	Thyroid suppress/stimul		Z3		$45.14
78006	Thyroid imaging with uptake		Z2	3.147	$131.77
78007	Thyroid image, mult uptakes		Z3		$99.35
78010	Thyroid imaging		Z2	2.066	$86.51
78011	Thyroid imaging with flow		Z2	2.066	$86.51
78015	Thyroid met imaging		Z3		$128.02
78016	Thyroid met imaging/studies		Z2	4.1171	$172.40
78018	Thyroid met imaging, body		Z2	4.1171	$172.40
78020	Thyroid met uptake		N1		
78070	Parathyroid nuclear imaging		Z3		$93.39
78075	Adrenal nuclear imaging		Z3		$277.34
78099	Endocrine nuclear procedure		Z2	2.066	$86.51
78102	Bone marrow imaging, ltd		Z3		$99.07
78103	Bone marrow imaging, mult	CH	Z3		$131.71
78104	Bone marrow imaging, body	CH	Z3		
78110	Plasma volume, single		Z3		$51.10
78111	Plasma volume, multiple		Z3		$59.04
78120	Red cell mass, single		Z3		$53.93
78121	Red cell mass, multiple		Z3		$59.90
78122	Blood volume		Z3		$70.97
78130	Red cell survival study		Z3		$89.13
78135	Red cell survival kinetics	CH	Z3		$217.73
78140	Red cell sequestration		Z3		$81.19
78185	Spleen imaging	CH	Z3		$126.04

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78190	Platelet survival, kinetics		Z2	2.5656	$107.43
78191	Platelet survival		Z2	2.5656	$107.43
78195	Lymph system imaging		Z2	3.6682	$153.60
78199	Blood/lymph nuclear exam		Z2	3.6682	$153.60
78201	Liver imaging		Z3		$114.68
78202	Liver imaging with flow	CH	Z3		$128.59
78205	Liver imaging (3D)	CH	Z3		$142.79
78206	Liver image (3d) with flow		Z2	4.1271	$172.81
78215	Liver and spleen imaging		Z3		$118.94
78216	Liver & spleen image/flow		Z3		$76.93
78220	Liver function study		Z3		$84.02
78223	Hepatobiliary imaging		Z2	4.1271	$172.81
78230	Salivary gland imaging		Z3		$100.77
78231	Serial salivary imaging		Z3		$75.79
78232	Salivary gland function exam		Z3		$74.94
78258	Esophageal motility study	CH	Z3		$137.39
78261	Gastric mucosa imaging		Z2	3.5113	$147.03
78262	Gastroesophageal reflux exam		Z2	3.5113	$147.03
78264	Gastric emptying study		Z2	3.5113	$147.03
78270	Vit B-12 absorption exam		Z3		$50.53
78271	Vit b-12 absrp exam, int fac		Z3		$53.37
78272	Vit B-12 absorp, combined		Z3		$55.92
78278	Acute GI blood loss imaging		Z2	3.5113	$147.03
78282	GI protein loss exam		Z2	3.5113	$147.03
78290	Meckels divert exam		Z2	3.5113	$147.03
78291	Leveen/shunt patency exam		Z2	3.5113	$147.03
78299	GI nuclear procedure		Z2	3.5113	$147.03
78300	Bone imaging, limited area		Z3		$102.48
78305	Bone imaging, multiple areas	CH	Z3		$135.41
78306	Bone imaging, whole body		Z2	3.5118	$147.05
78315	Bone imaging, 3 phase		Z2	3.5118	$147.05
78320	Bone imaging (3D)	CH	Z3		$142.50
78399	Musculoskeletal nuclear exam		Z2	3.5118	$147.05
78414	Non-imaging heart function		Z2	4.3402	$181.74
78428	Cardiac shunt imaging		Z3		$114.11
78445	Vascular flow imaging	CH	Z3		$104.75
78451	Ht muscle image spect, sing	NI	Z3		$193.60
78452	Ht muscle image spect, mult	NI	Z3		$283.30

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78453	Ht muscle image,planar,sing	NI	Z3		$173.44
78454	Ht musc image, planar, mult	NI	Z3		$249.80
78456	Acute venous thrombus image		Z2	2.8394	$118.89
78457	Venous thrombosis imaging	CH	Z3		$111.84
78458	Ven thrombosis images, bilat	CH	Z3		$114.97
78459	Heart muscle imaging (PET)		Z2	20.3369	$851.57
78460	Heart muscle blood, single	CH	D5		
78461	Heart muscle blood, multiple	CH	D5		
78464	Heart image (3d), single	CH	D5		
78465	Heart image (3d), multiple	CH	D5		
78466	Heart infarct image		Z3		$105.03
78468	Heart infarct image (ef)		Z3		$132.00
78469	Heart infarct image (3D)	CH	Z3		$151.02
78472	Gated heart, planar, single	CH	Z3		$149.88
78473	Gated heart, multiple		Z2	4.3402	$181.74
78478	Heart wall motion add-on	CH	D5		
78480	Heart function add-on	CH	D5		
78481	Heart first pass, single		Z3		$122.06
78483	Heart first pass, multiple	CH	Z3		$166.35
78491	Heart image (pet), single		Z2	20.3369	$851.57
78492	Heart image (pet), multiple		Z2	20.3369	$851.57
78494	Heart image, spect	CH	Z3		$156.41
78496	Heart first pass add-on		N1		
78499	Cardiovascular nuclear exam		Z2	4.3402	$181.74
78580	Lung perfusion imaging		Z2	2.9299	$122.68
78584	Lung V/Q image single breath		Z3		$75.79
78585	Lung V/Q imaging		Z2	4.5952	$192.41
78586	Aerosol lung image, single	CH	Z3		$103.33
78587	Aerosol lung image, multiple		Z2	2.9299	$122.68
78588	Perfusion lung image		Z2	4.5952	$192.41
78591	Vent image, 1 breath, 1 proj	CH	Z3		$104.46
78593	Vent image, 1 proj, gas	CH	Z3		$121.78
78594	Vent image, mult proj, gas		Z2	2.9299	$122.68
78596	Lung differential function		Z2	4.5952	$192.41
78599	Respiratory nuclear exam		Z2	2.9299	$122.68
78600	Brain image < 4 views	CH	Z3		$112.13
78601	Brain image w/flow < 4 views	CH	Z3		$133.42
78605	Brain image 4+ views		Z2	2.7917	$116.90

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78606	Brain image w/flow 4 + views		Z3		$206.09
78607	Brain imaging (3D)		Z3		$218.01
78608	Brain imaging (PET)		Z2	14.7231	$616.50
78610	Brain flow imaging only	CH	Z2	2.7917	$116.90
78630	Cerebrospinal fluid scan		Z3		$214.04
78635	CSF ventriculography		Z3		$201.26
78645	CSF shunt evaluation		Z2	2.7917	$116.90
78647	Cerebrospinal fluid scan		Z3		$206.09
78650	CSF leakage imaging		Z3		$210.63
78660	Nuclear exam of tear flow	CH	Z3		$102.76
78699	Nervous system nuclear exam		Z2	2.7917	$116.90
78700	Kidney imaging, morphol		Z3		$109.01
78701	Kidney imaging with flow		Z3		$134.27
78707	K flow/funct image w/o drug		Z3		$137.96
78708	K flow/funct image w/drug		Z3		$91.12
78709	K flow/funct image, multiple		Z2	4.6133	$193.17
78710	Kidney imaging (3D)		Z3		$141.37
78725	Kidney function study		Z3		$59.61
78730	Urinary bladder retention		Z3		$48.54
78740	Ureteral reflux study		Z3		$133.70
78761	Testicular imaging w/flow		Z3		$124.90
78799	Genitourinary nuclear exam		Z2	4.6133	$193.17
78800	Tumor imaging, limited area		Z3		$110.71
78801	Tumor imaging, mult areas		Z3		$151.02
78802	Tumor imaging, whole body		Z3		$203.82
78803	Tumor imaging (3D)		Z3		$216.59
78804	Tumor imaging, whole body		Z3		$380.95
78805	Abscess imaging, ltd area		Z3		$106.45
78806	Abscess imaging, whole body		Z3		$213.47
78807	Nuclear localization/abscess	CH	Z2	4.1171	$172.40
78808	Iv inj ra drug dx study		N1		
78811	Pet image, ltd area		Z2	14.7231	$616.50
78812	Pet image, skull-thigh		Z2	14.7231	$616.50
78813	Pet image, full body		Z2	14.7231	$616.50
78814	Pet image w/ct, lmtd		Z2	14.7231	$616.50
78815	Pet image w/ct, skull-thigh		Z2	14.7231	$616.50
78816	Pet image w/ct, full body		Z2	14.7231	$616.50
78999	Nuclear diagnostic exam		Z2	1.5972	$66.88

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79005	Nuclear rx, oral admin		Z3		$42.30
79101	Nuclear rx, iv admin		Z3		$45.99
79200	Nuclear rx, intracav admin		Z3		$51.10
79300	Nuclr rx, interstit colloid		Z2	3.0955	$129.62
79403	Hematopoietic nuclear tx		Z3		$71.53
79440	Nuclear rx, intra-articular		Z3		$40.31
79445	Nuclear rx, intra-arterial		Z2	3.0955	$129.62
79999	Nuclear medicine therapy		Z2	3.0955	$129.62
90371	Hep b ig, im		K2		$111.20
90375	Rabies ig, im/sc		K2		$142.79
90376	Rabies ig, heat treated		K2		$130.16
90378	Rsv, mab, im, 50mg		K2		$937.29
90385	Rh ig, minidose, im		N1		
90396	Varicella-zoster ig, im		K2		$130.49
90476	Adenovirus vaccine, type 4	CH	K2		$72.17
90585	Bcg vaccine, percut		K2		$111.66
90632	Hep a vaccine, adult im		N1		
90633	Hep a vacc, ped/adol, 2 dose		N1		
90634	Hep a vacc, ped/adol, 3 dose		N1		
90636	Hep a/hep b vacc, adult im		N1		
90645	Hib vaccine, hboc, im		N1		
90646	Hib vaccine, prp-d, im		N1		
90647	Hib vaccine, prp-omp, im		N1		
90648	Hib vaccine, prp-t, im		N1		
90655	Flu vaccine no preserv 6-35m		L1		
90656	Flu vaccine no preserv 3 & >		L1		
90657	Flu vaccine, 3 yrs, im		L1		
90658	Flu vaccine, 3 yrs & >, im		L1		
90660	Flu vaccine, nasal		L1		
90665	Lyme disease vaccine, im		K2		$0.93
90669	Pneumococcal vacc, 7 val im		L1		
90675	Rabies vaccine, im		K2		$151.97
90676	Rabies vaccine, id		K2		$96.27
90680	Rotovirus vacc 3 dose, oral	CH	K2		$72.37
90681	Rotavirus vacc 2 dose oral		K2		$106.60
90690	Typhoid vaccine, oral		N1		
90691	Typhoid vaccine, im		N1		
90692	Typhoid vaccine, h-p, sc/id		N1		

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90696	Dtap-ipv vacc 4-6 yr im	CH	N1		
90698	Dtap-hib-ip vaccine, im		N1		
90700	Dtap vaccine, < 7 yrs, im		N1		
90701	Dtp vaccine, im		N1		
90702	Dt vaccine < 7, im		N1		
90703	Tetanus vaccine, im		N1		
90704	Mumps vaccine, sc		N1		
90705	Measles vaccine, sc		N1		
90706	Rubella vaccine, sc		N1		
90707	Mmr vaccine, sc		N1		
90708	Measles-rubella vaccine, sc		N1		
90710	Mmrv vaccine, sc		N1		
90712	Oral poliovirus vaccine		N1		
90713	Poliovirus, ipv, sc/im		N1		
90714	Td vaccine no prsrv >/= 7 im		N1		
90715	Tdap vaccine >7 im		N1		
90717	Yellow fever vaccine, sc		N1		
90718	Td vaccine > 7, im		N1		
90719	Diphtheria vaccine, im		N1		
90720	Dtp/hib vaccine, im		N1		
90721	Dtap/hib vaccine, im		N1		
90725	Cholera vaccine, injectable	CH	K2		$0.16
90732	Pneumococcal vaccine		L1		
90733	Meningococcal vaccine, sc		K2		$96.66
90734	Meningococcal vaccine, im		K2		$102.46
90735	Encephalitis vaccine, sc	CH	K2		$100.15
90740	Hepb vacc, ill pat 3 dose im		F4		
90743	Hep b vacc, adol, 2 dose, im		F4		
90744	Hepb vacc ped/adol 3 dose im		F4		
90746	Hep b vaccine, adult, im		F4		
90747	Hepb vacc, ill pat 4 dose im		F4		
90749	Vaccine toxoid		N1		
A4218	Sterile saline or water		N1		
A4220	Infusion pump refill kit		N1		
A4248	Chlorhexidine antisept		N1		
A4262	Temporary tear duct plug		N1		
A4263	Permanent tear duct plug		N1		
A4270	Disposable endoscope sheath		N1		

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A4300	Cath impl vasc access portal		N1		
A4301	Implantable access syst perc		N1		
A4305	Drug delivery system >=50 ML		N1		
A4306	Drug delivery system <=50 ml		N1		
A4641	Radiopharm dx agent noc		N1		
A4642	In111 satumomab		N1		
A4648	Implantable tissue marker		N1		
A4650	Implant radiation dosimeter		N1		
A9500	Tc99m sestamibi		N1		
A9501	Technetium TC-99m teboroxime		N1		
A9502	Tc99m tetrofosmin		N1		
A9503	Tc99m medronate		N1		
A9504	Tc99m apcitide		N1		
A9505	TL201 thallium		N1		
A9507	In111 capromab		N1		
A9508	I131 iodobenguate, dx		N1		
A9509	Iodine I-123 sod iodide mil		N1		
A9510	Tc99m disofenin		N1		
A9512	Tc99m pertechnetate		N1		
A9516	Iodine I-123 sod iodide mic		N1		
A9521	Tc99m exametazime		N1		
A9524	I131 serum albumin, dx		N1		
A9526	Nitrogen N-13 ammonia		N1		
A9527	Iodine I-125 sodium iodide	CH	H2		$37.92
A9528	Iodine I-131 iodide cap, dx		N1		
A9529	I131 iodide sol, dx		N1		
A9531	I131 max 100uCi		N1		
A9532	I125 serum albumin, dx		N1		
A9535	Injection, methylene blue	CH	D5		
A9536	Tc99m depreotide		N1		
A9537	Tc99m mebrofenin		N1		
A9538	Tc99m pyrophosphate		N1		
A9539	Tc99m pentetate		N1		
A9540	Tc99m MAA		N1		
A9541	Tc99m sulfur colloid		N1		
A9542	In111 ibritumomab, dx		N1		
A9544	I131 tositumomab, dx		N1		
A9546	Co57/58		N1		

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A9547	In111 oxyquinoline		N1		
A9548	In111 pentetate		N1		
A9550	Tc99m gluceptate		N1		
A9551	Tc99m succimer		N1		
A9552	F18 fdg		N1		
A9553	Cr51 chromate		N1		
A9554	I125 iothalamate, dx		N1		
A9555	Rb82 rubidium		N1		
A9556	Ga67 gallium		N1		
A9557	Tc99m bicisate		N1		
A9558	Xe133 xenon 10mci		N1		
A9559	Co57 cyano		N1		
A9560	Tc99m labeled rbc		N1		
A9561	Tc99m oxidronate		N1		
A9562	Tc99m mertiatide		N1		
A9566	Tc99m fanolesomab		N1		
A9567	Technetium TC-99m aerosol		N1		
A9568	Technetium tc99m arcitumomab		N1		
A9569	Technetium TC-99m auto WBC		N1		
A9570	Indium In-111 auto WBC		N1		
A9571	Indium IN-111 auto platelet		N1		
A9572	Indium In-111 pentetreotide		N1		
A9576	Inj prohance multipack		N1		
A9577	Inj multihance		N1		
A9578	Inj multihance multipack		N1		
A9579	Gad-base MR contrast NOS,1ml		N1		
A9580	Sodium fluoride F-18		N1		
A9581	Gadoxetate disodium inj	NI	K2		$13.50
A9582	Iodine I-123 iobenguane	NI	K2		$2,329.83
A9583	Gadofosveset trisodium inj	NI	K2		$1.29
A9698	Non-rad contrast materialNOC		N1		
C1713	Anchor/screw bn/bn,tis/bn		N1		
C1714	Cath, trans atherectomy, dir		N1		
C1715	Brachytherapy needle		N1		
C1716	Brachytx, non-str, Gold-198	CH	H2		$42.85
C1717	Brachytx, non-str,HDR Ir-192	CH	H2		$231.38
C1719	Brachytx, NS, Non-HDRIr-192	CH	H2		$64.02
C1721	AICD, dual chamber		N1		

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C1722	AICD, single chamber		N1		
C1724	Cath, trans atherec,rotation		N1		
C1725	Cath, translumin non-laser		N1		
C1726	Cath, bal dil, non-vascular		N1		
C1727	Cath, bal tis dis, non-vas		N1		
C1728	Cath, brachytx seed adm		N1		
C1729	Cath, drainage		N1		
C1730	Cath, EP, 19 or few elect		N1		
C1731	Cath, EP, 20 or more elec		N1		
C1732	Cath, EP, diag/abl, 3D/vect		N1		
C1733	Cath, EP, othr than cool-tip		N1		
C1750	Cath, hemodialysis,long-term		N1		
C1751	Cath, inf, per/cent/midline		N1		
C1752	Cath,hemodialysis,short-term		N1		
C1753	Cath, intravas ultrasound		N1		
C1754	Catheter, intradiscal		N1		
C1755	Catheter, intraspinal		N1		
C1756	Cath, pacing, transesoph		N1		
C1757	Cath, thrombectomy/embolect		N1		
C1758	Catheter, ureteral		N1		
C1759	Cath, intra echocardiography		N1		
C1760	Closure dev, vasc		N1		
C1762	Conn tiss, human(inc fascia)		N1		
C1763	Conn tiss, non-human		N1		
C1764	Event recorder, cardiac		N1		
C1765	Adhesion barrier		N1		
C1766	Intro/sheath,strble,non-peel		N1		
C1767	Generator, neuro non-recharg		N1		
C1768	Graft, vascular		N1		
C1769	Guide wire		N1		
C1770	Imaging coil, MR, insertable		N1		
C1771	Rep dev, urinary, w/sling		N1		
C1772	Infusion pump, programmable		N1		
C1773	Ret dev, insertable		N1		
C1776	Joint device (implantable)		N1		
C1777	Lead, AICD, endo single coil		N1		
C1778	Lead, neurostimulator		N1		
C1779	Lead, pmkr, transvenous VDD		N1		

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C1780	Lens, intraocular (new tech)		N1		
C1781	Mesh (implantable)		N1		
C1782	Morcellator		N1		
C1783	Ocular imp, aqueous drain de		N1		
C1784	Ocular dev, intraop, det ret		N1		
C1785	Pmkr, dual, rate-resp		N1		
C1786	Pmkr, single, rate-resp		N1		
C1787	Patient progr, neurostim		N1		
C1788	Port, indwelling, imp		N1		
C1789	Prosthesis, breast, imp		N1		
C1813	Prosthesis, penile, inflatab		N1		
C1814	Retinal tamp, silicone oil		N1		
C1815	Pros, urinary sph, imp		N1		
C1816	Receiver/transmitter, neuro		N1		
C1817	Septal defect imp sys		N1		
C1818	Integrated keratoprosthesis		N1		
C1819	Tissue localization-excision		N1		
C1820	Generator neuro rechg bat sy		N1		
C1821	Interspinous implant		N1		
C1874	Stent, coated/cov w/del sys		N1		
C1875	Stent, coated/cov w/o del sy		N1		
C1876	Stent, non-coa/non-cov w/del		N1		
C1877	Stent, non-coat/cov w/o del		N1		
C1878	Matrl for vocal cord		N1		
C1879	Tissue marker, implantable		N1		
C1880	Vena cava filter		N1		
C1881	Dialysis access system		N1		
C1882	AICD, other than sing/dual		N1		
C1883	Adapt/ext, pacing/neuro lead		N1		
C1884	Embolization Protect syst		N1		
C1885	Cath, translumin angio laser		N1		
C1887	Catheter, guiding		N1		
C1888	Endovas non-cardiac abl cath		N1		
C1891	Infusion pump,non-prog, perm		N1		
C1892	Intro/sheath,fixed,peel-away		N1		
C1893	Intro/sheath, fixed,non-peel		N1		
C1894	Intro/sheath, non-laser		N1		
C1895	Lead, AICD, endo dual coil		N1		

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C1896	Lead, AICD, non sing/dual		N1		
C1897	Lead, neurostim test kit		N1		
C1898	Lead, pmkr, other than trans		N1		
C1899	Lead, pmkr/AICD combination		N1		
C1900	Lead, coronary venous		N1		
C2614	Probe, perc lumb disc		N1		
C2615	Sealant, pulmonary, liquid		N1		
C2616	Brachytx, non-str,Yttrium-90	CH	H2		$15,779.35
C2617	Stent, non-cor, tem w/o del		N1		
C2618	Probe, cryoablation		N1		
C2619	Pmkr, dual, non rate-resp		N1		
C2620	Pmkr, single, non rate-resp		N1		
C2621	Pmkr, other than sing/dual		N1		
C2622	Prosthesis, penile, non-inf		N1		
C2625	Stent, non-cor, tem w/del sy		N1		
C2626	Infusion pump, non-prog,temp		N1		
C2627	Cath, suprapubic/cystoscopic		N1		
C2628	Catheter, occlusion		N1		
C2629	Intro/sheath, laser		N1		
C2630	Cath, EP, cool-tip		N1		
C2631	Rep dev, urinary, w/o sling		N1		
C2634	Brachytx, non-str, HA, I-125	CH	H2		$59.80
C2635	Brachytx, non-str, HA, P-103	CH	H2		$28.59
C2636	Brachy linear, non-str,P-103	CH	H2		$19.37
C2638	Brachytx, stranded, I-125	CH	H2		$42.48
C2639	Brachytx, non-stranded,I-125	CH	H2		$36.18
C2640	Brachytx, stranded, P-103	CH	H2		$60.36
C2641	Brachytx, non-stranded,P-103	CH	H2		$57.12
C2642	Brachytx, stranded, C-131	CH	H2		$109.84
C2643	Brachytx, non-stranded,C-131	CH	H2		$66.09
C2698	Brachytx, stranded, NOS	CH	H2		$42.48
C2699	Brachytx, non-stranded, NOS	CH	H2		$28.59
C8900	MRA w/cont, abd		Z2	6.0177	$251.98
C8901	MRA w/o cont, abd		Z2	4.961	$207.73
C8902	MRA w/o fol w/cont, abd		Z2	7.5993	$318.21
C8903	MRI w/cont, breast, uni		Z2	6.0177	$251.98
C8904	MRI w/o cont, breast, uni		Z2	4.961	$207.73
C8905	MRI w/o fol w/cont, brst, un		Z2	7.5993	$318.21

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C8906	MRI w/cont, breast, bi		Z2	6.0177	$251.98
C8907	MRI w/o cont, breast, bi		Z2	4.961	$207.73
C8908	MRI w/o fol w/cont, breast,		Z2	7.5993	$318.21
C8909	MRA w/cont, chest		Z2	6.0177	$251.98
C8910	MRA w/o cont, chest		Z2	4.961	$207.73
C8911	MRA w/o fol w/cont, chest		Z2	7.5993	$318.21
C8912	MRA w/cont, lwr ext		Z2	6.0177	$251.98
C8913	MRA w/o cont, lwr ext		Z2	4.961	$207.73
C8914	MRA w/o fol w/cont, lwr ext		Z2	7.5993	$318.21
C8918	MRA w/cont, pelvis		Z2	6.0177	$251.98
C8919	MRA w/o cont, pelvis		Z2	4.961	$207.73
C8920	MRA w/o fol w/cont, pelvis		Z2	7.5993	$318.21
C9113	Inj pantoprazole sodium, via		N1		
C9121	Injection, argatroban		K2		$18.10
C9245	Injection, romiplostim	CH	D5		
C9246	Inj, gadoxetate disodium	CH	D5		
C9247	Inj, iobenguane, I-123, dx	CH	D5		
C9248	Inj, clevidipine butyrate		K2		$3.39
C9249	Inj, certolizumab pegol	CH	D5		
C9250	Artiss fibrin sealant		K2		$138.20
C9251	Inj, C1 esterase inhibitor	CH	D5		
C9252	Injection, plerixafor	CH	D5		
C9253	Injection, temozolomide	CH	D5		
C9254	Injection, lacosamide	NI	K2		$0.18
C9255	Paliperidone palmitate inj	NI	K2		$6.71
C9256	Dexamethasone intravitreal	NI	K2		$196.10
C9257	Bevacizumab injection	NI	K2		$1.41
C9352	Neuragen nerve guide, per cm		N1		
C9353	Neurawrap nerve protector,cm		N1		
C9354	Veritas collagen matrix, cm2	CH	N1		
C9355	Neuromatrix nerve cuff, cm	CH	N1		
C9356	TenoGlide tendon prot, cm2		K2		$24.86
C9358	SurgiMend, fetal		K2		$10.76
C9359	Implnt,bon void filler-putty		K2		$63.54
C9360	SurgiMend, neonatal		K2		$10.67
C9361	NeuroMend nerve wrap		K2		$247.29
C9362	Implnt,bon void filler-strip		K2		$63.60
C9363	Integra Meshed Bil Wound Mat		K2		$25.62

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C9364	Porcine implant, Permacol		K2		$17.21
C9399	Unclassified drugs or biolog		K7		
E0616	Cardiac event recorder		N1		
E0749	Elec osteogen stim implanted		N1		
E0782	Non-programble infusion pump		N1		
E0783	Programmable infusion pump		N1		
E0785	Replacement impl pump cathet		N1		
E0786	Implantable pump replacement		N1		
G0130	Single energy x-ray study		Z3		$15.90
G0173	Linear acc stereo radsur com		Z2	50.6947	$2,122.74
G0251	Linear acc based stero radio		Z2	13.6624	$572.09
G0288	Recon, CTA for surg plan		N1		
G0339	Robot lin-radsurg com, first		Z2	50.6947	$2,122.74
G0340	Robt lin-radsurg fractx 2-5		Z2	35.3136	$1,478.69
J0120	Tetracyclin injection		N1		
J0129	Abatacept injection		K2		$18.98
J0130	Abciximab injection		K2		$459.36
J0132	Acetylcysteine injection		K2		$2.29
J0133	Acyclovir injection		N1		
J0135	Adalimumab injection		K2		$357.53
J0150	Injection adenosine 6 MG		K2		$9.50
J0152	Adenosine injection		K2		$76.42
J0170	Adrenalin epinephrin inject		N1		
J0180	Agalsidase beta injection		K2		$133.69
J0190	Inj biperiden lactate/5 mg		N1		
J0200	Alatrofloxacin mesylate		N1		
J0205	Alglucerase injection		K2		$41.19
J0207	Amifostine		K2		$350.07
J0210	Methyldopate hcl injection		K2		$27.64
J0215	Alefacept		K2		$30.02
J0220	Alglucosidase alfa injection		K2		$124.69
J0256	Alpha 1 proteinase inhibitor		K2		$3.63
J0278	Amikacin sulfate injection		N1		
J0280	Aminophyllin 250 MG inj		N1		
J0282	Amiodarone HCl		N1		
J0285	Amphotericin B		N1		
J0287	Amphotericin b lipid complex		K2		$9.66
J0288	Ampho b cholesteryl sulfate		K2		$13.74

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Addendum BB -- Final ASC Covered Ancillary Services Integral to Covered Surgical Procedures for CY 2010 (Including Ancillary Services for Which Payment is Packaged)

HCPCS Code	Short Descriptor	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
J0289	Amphotericin b liposome inj		K2		$14.96
J0290	Ampicillin 500 MG inj		N1		
J0295	Ampicillin sodium per 1.5 gm		N1		
J0300	Amobarbital 125 MG inj		N1		
J0330	Succinycholine chloride inj		N1		
J0348	Anidulafungin injection		K2		$1.21
J0360	Hydralazine hcl injection		N1		
J0364	Apomorphine hydrochloride		N1		
J0365	Aprotonin, 10,000 kiu		K2		$2.60
J0380	Inj metaraminol bitartrate		N1		
J0390	Chloroquine injection		N1		
J0400	Aripiprazole injection		N1		
J0456	Azithromycin		N1		
J0460	Atropine sulfate injection	CH	D5		
J0461	Atropine sulfate injection	NI	N1		
J0470	Dimecaprol injection		K2		$26.81
J0475	Baclofen 10 MG injection		K2		$195.31
J0476	Baclofen intrathecal trial		K2		$71.24
J0480	Basiliximab		K2		$1,624.44
J0500	Dicyclomine injection		N1		
J0515	Inj benztropine mesylate		N1		
J0520	Bethanechol chloride inject		N1		
J0530	Penicillin g benzathine inj	CH	D5		
J0540	Penicillin g benzathine inj	CH	D5		
J0550	Penicillin g benzathine inj	CH	D5		
J0559	PenG benzathine/procaine inj	NI	N1		
J0560	Penicillin g benzathine inj		N1		
J0570	Penicillin g benzathine inj		N1		
J0580	Penicillin g benzathine inj		N1		
J0583	Bivalirudin		K2		$2.40
J0585	Injection,onabotulinumtoxinA		K2		$5.40
J0586	AbobotulinumtoxintypeA	NI	K2		$8.23
J0587	Inj, rimabotulinumtoxinB		K2		$10.38
J0592	Buprenorphine hydrochloride		N1		
J0594	Busulfan injection		K2		$14.18
J0595	Butorphanol tartrate 1 mg		N1		
J0598	C1 esterase inhibitor inj	NI	K2		$41.34
J0600	Edetate calcium disodium inj		K2		$78.86

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J0610	Calcium gluconate injection		N1		
J0620	Calcium glycer & lact/10 ML		N1		
J0630	Calcitonin salmon injection		K2		$48.37
J0636	Inj calcitriol per 0.1 mcg		N1		
J0637	Caspofungin acetate		K2		$11.52
J0640	Leucovorin calcium injection		N1		
J0641	Levoleucovorin injection		K2		$0.99
J0670	Inj mepivacaine HCL/10 ml		N1		
J0690	Cefazolin sodium injection		N1		
J0692	Cefepime HCl for injection		N1		
J0694	Cefoxitin sodium injection		N1		
J0696	Ceftriaxone sodium injection		N1		
J0697	Sterile cefuroxime injection		N1		
J0698	Cefotaxime sodium injection		N1		
J0702	Betamethasone acet&sod phosp		N1		
J0704	Betamethasone sod phosp/4 MG		N1		
J0706	Caffeine citrate injection		N1		
J0710	Cephapirin sodium injection		N1		
J0713	Inj ceftazidime per 500 mg		N1		
J0715	Ceftizoxime sodium / 500 MG		N1		
J0718	Certolizumab pegol inj	NI	K2		$3.80
J0720	Chloramphenicol sodium injec		N1		
J0725	Chorionic gonadotropin/1000u		N1		
J0735	Clonidine hydrochloride		K2		$109.75
J0740	Cidofovir injection		K2		$746.46
J0743	Cilastatin sodium injection		N1		
J0744	Ciprofloxacin iv		N1		
J0745	Inj codeine phosphate /30 MG		N1		
J0760	Colchicine injection		N1		
J0770	Colistimethate sodium inj		N1		
J0780	Prochlorperazine injection		N1		
J0795	Corticorelin ovine triflutal		K2		$4.24
J0800	Corticotropin injection		K2		$2,394.93
J0833	Cosyntropin injection NOS	NI	K2		$91.84
J0834	Cosyntropin cortrosyn inj	NI	K2		$91.84
J0835	Inj cosyntropin per 0.25 MG	CH	D5		
J0850	Cytomegalovirus imm IV /vial		K2		$862.24
J0878	Daptomycin injection		K2		$0.40

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J0881	Darbepoetin alfa, non-esrd		K2		$2.76
J0885	Epoetin alfa, non-esrd		K2		$9.40
J0894	Decitabine injection		K2		$28.42
J0895	Deferoxamine mesylate inj		N1		
J0900	Testosterone enanthate inj		N1		
J0945	Brompheniramine maleate inj	CH	K2		$0.75
J0970	Estradiol valerate injection		N1		
J1000	Depo-estradiol cypionate inj		N1		
J1020	Methylprednisolone 20 MG inj		N1		
J1030	Methylprednisolone 40 MG inj		N1		
J1040	Methylprednisolone 80 MG inj		N1		
J1051	Medroxyprogesterone inj		N1		
J1060	Testosterone cypionate 1 ML		N1		
J1070	Testosterone cypionat 100 MG		N1		
J1080	Testosterone cypionat 200 MG		N1		
J1094	Inj dexamethasone acetate		N1		
J1100	Dexamethasone sodium phos		N1		
J1110	Inj dihydroergotamine mesylt		N1		
J1120	Acetazolamid sodium injectio		N1		
J1160	Digoxin injection		N1		
J1162	Digoxin immune fab (ovine)		K2		$474.73
J1165	Phenytoin sodium injection		N1		
J1170	Hydromorphone injection		N1		
J1180	Dyphylline injection		N1		
J1190	Dexrazoxane HCl injection		K2		$340.03
J1200	Diphenhydramine hcl injectio		N1		
J1205	Chlorothiazide sodium inj		K2		$292.02
J1212	Dimethyl sulfoxide 50% 50 ML		K2		$67.46
J1230	Methadone injection		N1		
J1240	Dimenhydrinate injection		N1		
J1245	Dipyridamole injection		N1		
J1250	Inj dobutamine HCL/250 mg		N1		
J1260	Dolasetron mesylate	CH	N1		
J1265	Dopamine injection		N1		
J1267	Doripenem injection		K2		$0.57
J1270	Injection, doxercalciferol		N1		
J1300	Eculizumab injection		K2		$177.57
J1320	Amitriptyline injection		N1		

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J1324	Enfuvirtide injection	CH	K2		$0.47
J1325	Epoprostenol injection		N1		
J1327	Eptifibatide injection		K2		$18.57
J1330	Ergonovine maleate injection		N1		
J1335	Ertapenem injection		N1		
J1364	Erythro lactobionate /500 MG		N1		
J1380	Estradiol valerate 10 MG inj		N1		
J1390	Estradiol valerate 20 MG inj		N1		
J1410	Inj estrogen conjugate 25 MG		K2		$83.21
J1430	Ethanolamine oleate 100 mg		K2		$147.14
J1435	Injection estrone per 1 MG		N1		
J1436	Etidronate disodium inj		K2		$70.06
J1438	Etanercept injection		K2		$183.61
J1440	Filgrastim 300 mcg injection		K2		$208.54
J1441	Filgrastim 480 mcg injection		K2		$324.44
J1450	Fluconazole		N1		
J1451	Fomepizole, 15 mg		K2		$7.99
J1453	Fosaprepitant injection		K2		$1.58
J1455	Foscarnet sodium injection	CH	N1		
J1457	Gallium nitrate injection		K2		$1.71
J1458	Galsulfase injection		K2		$339.04
J1459	Inj IVIG privigen 500 mg		K2		$35.05
J1460	Gamma globulin 1 CC inj		K2		$15.05
J1470	Gamma globulin 2 CC inj		K2		$30.10
J1480	Gamma globulin 3 CC inj		K2		$45.14
J1490	Gamma globulin 4 CC inj		K2		$60.20
J1500	Gamma globulin 5 CC inj		K2		$75.26
J1510	Gamma globulin 6 CC inj		K2		$90.35
J1520	Gamma globulin 7 CC inj		K2		$105.27
J1530	Gamma globulin 8 CC inj		K2		$120.40
J1540	Gamma globulin 9 CC inj		K2		$150.50
J1550	Gamma globulin 10 CC inj		K2		$150.50
J1560	Gamma globulin > 10 CC inj		K2		$150.50
J1561	Gamunex injection		K2		$36.71
J1562	Vivaglobin, inj		K2		$7.05
J1565	RSV-ivig	CH	D5		
J1566	Immune globulin, powder		K2		$29.83
J1568	Octagam injection		K2		$37.03

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J1569	Gammagard liquid injection		K2		$37.85
J1570	Ganciclovir sodium injection		N1		
J1571	Hepagam b im injection		K2		$50.04
J1572	Flebogamma injection		K2		$36.51
J1573	Hepagam b intravenous, inj		K2		$50.04
J1580	Garamycin gentamicin inj		N1		
J1590	Gatifloxacin injection		N1		
J1595	Injection glatiramer acetate		K2		$81.23
J1600	Gold sodium thiomaleate inj		N1		
J1610	Glucagon hydrochloride/1 MG		K2		$79.20
J1620	Gonadorelin hydroch/ 100 mcg		K2		$176.89
J1626	Granisetron hcl injection	CH	N1		
J1630	Haloperidol injection		N1		
J1631	Haloperidol decanoate inj		N1		
J1640	Hemin, 1 mg		K2		$7.73
J1642	Inj heparin sodium per 10 u		N1		
J1644	Inj heparin sodium per 1000u		N1		
J1645	Dalteparin sodium		N1		
J1650	Inj enoxaparin sodium		N1		
J1652	Fondaparinux sodium		K2		$5.98
J1655	Tinzaparin sodium injection		N1		
J1670	Tetanus immune globulin inj		K2		$199.91
J1680	Human fibrinogen conc inj	NI	K2		$96.46
J1700	Hydrocortisone acetate inj		N1		
J1710	Hydrocortisone sodium ph inj		N1		
J1720	Hydrocortisone sodium succ i		N1		
J1730	Diazoxide injection		K2		$112.16
J1740	Ibandronate sodium injection		K2		$139.22
J1742	Ibutilide fumarate injection		K2		$404.01
J1743	Idursulfase injection		K2		$446.44
J1745	Infliximab injection		K2		$57.60
J1750	Inj iron dextran		K2		$14.11
J1756	Iron sucrose injection		K2		$0.37
J1785	Injection imiglucerase /unit		K2		$4.12
J1790	Droperidol injection		N1		
J1800	Propranolol injection		N1		
J1815	Insulin injection		N1		
J1817	Insulin for insulin pump use	CH	K2		$3.34

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J1830	Interferon beta-1b / .25 MG		K2		$168.90
J1835	Itraconazole injection	CH	N1		
J1840	Kanamycin sulfate 500 MG inj		N1		
J1850	Kanamycin sulfate 75 MG inj		N1		
J1885	Ketorolac tromethamine inj		N1		
J1890	Cephalothin sodium injection		N1		
J1930	Lanreotide injection		K2		$28.65
J1931	Laronidase injection		K2		$25.08
J1940	Furosemide injection		N1		
J1945	Lepirudin		K2		$174.51
J1950	Leuprolide acetate /3.75 MG		K2		$480.20
J1953	Levetiracetam injection		K2		$0.75
J1956	Levofloxacin injection		N1		
J1960	Levorphanol tartrate inj		N1		
J1980	Hyoscyamine sulfate inj		N1		
J1990	Chlordiazepoxide injection		N1		
J2001	Lidocaine injection		N1		
J2010	Lincomycin injection		N1		
J2020	Linezolid injection		K2		$29.37
J2060	Lorazepam injection		N1		
J2150	Mannitol injection		N1		
J2170	Mecasermin injection		N1		
J2175	Meperidine hydrochl /100 MG		N1		
J2180	Meperidine/promethazine inj		N1		
J2185	Meropenem		N1		
J2210	Methylergonovin maleate inj		N1		
J2248	Micafungin sodium injection		K2		$1.08
J2250	Inj midazolam hydrochloride		N1		
J2260	Inj milrinone lactate / 5 MG		N1		
J2270	Morphine sulfate injection		N1		
J2271	Morphine so4 injection 100mg		N1		
J2275	Morphine sulfate injection		N1		
J2278	Ziconotide injection		K2		$6.65
J2280	Inj, moxifloxacin 100 mg		N1		
J2300	Inj nalbuphine hydrochloride		N1		
J2310	Inj naloxone hydrochloride		N1		
J2315	Naltrexone, depot form		K2		$2.14
J2320	Nandrolone decanoate 50 MG	CH	K2		$7.00

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J2321	Nandrolone decanoate 100 MG	CH	K2		$7.00
J2322	Nandrolone decanoate 200 MG	CH	K2		$14.74
J2323	Natalizumab injection		K2		$8.32
J2325	Nesiritide injection		K2		$36.07
J2353	Octreotide injection, depot		K2		$105.27
J2354	Octreotide inj, non-depot		N1		
J2355	Oprelvekin injection		K2		$242.16
J2357	Omalizumab injection		K2		$18.86
J2360	Orphenadrine injection		N1		
J2370	Phenylephrine hcl injection		N1		
J2400	Chloroprocaine hcl injection		N1		
J2405	Ondansetron hcl injection	CH	N1		
J2410	Oxymorphone hcl injection		N1		
J2425	Palifermin injection		K2		$11.06
J2430	Pamidronate disodium /30 MG		K2		$18.42
J2440	Papaverin hcl injection		N1		
J2469	Palonosetron hcl		K2		$17.19
J2501	Paricalcitol		N1		
J2503	Pegaptanib sodium injection		K2		$1,014.11
J2504	Pegademase bovine, 25 iu		K2		$242.67
J2505	Injection, pegfilgrastim 6mg		K2		$2,222.07
J2510	Penicillin g procaine inj		N1		
J2513	Pentastarch 10% solution		K2		$1,270.88
J2515	Pentobarbital sodium inj	CH	N1		
J2540	Penicillin g potassium inj		N1		
J2543	Piperacillin/tazobactam		N1		
J2550	Promethazine hcl injection		N1		
J2560	Phenobarbital sodium inj		N1		
J2562	Plerixafor injection	NI	K2		$268.51
J2590	Oxytocin injection		N1		
J2597	Inj desmopressin acetate		N1		
J2650	Prednisolone acetate inj		N1		
J2670	Totazoline hcl injection		N1		
J2675	Inj progesterone per 50 MG		N1		
J2680	Fluphenazine decanoate 25 MG		N1		
J2690	Procainamide hcl injection		N1		
J2700	Oxacillin sodium injeciton		N1		
J2710	Neostigmine methylslfte inj		N1		

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J2720	Inj protamine sulfate/10 MG		N1		
J2724	Protein c concentrate		K2		$11.96
J2725	Inj protirelin per 250 mcg		N1		
J2730	Pralidoxime chloride inj		K2		$85.83
J2760	Phentolaine mesylate inj		N1		
J2765	Metoclopramide hcl injection		N1		
J2770	Quinupristin/dalfopristin		K2		$144.08
J2778	Ranibizumab injection		K2		$398.11
J2780	Ranitidine hydrochloride inj		N1		
J2783	Rasburicase		K2		$164.00
J2785	Regadenoson injection		K2		$50.78
J2788	Rho d immune globulin 50 mcg		K2		$25.76
J2790	Rho d immune globulin inj		K2		$84.39
J2791	Rhophylac injection		K2		$5.13
J2792	Rho(D) immune globulin h, sd		K2		$18.39
J2793	Rilonacept injection	NI	K2		$23.64
J2794	Risperidone, long acting		K2		$4.93
J2795	Ropivacaine HCl injection		N1		
J2796	Romiplostim injection	NI	K2		$43.75
J2800	Methocarbamol injection		N1		
J2805	Sincalide injection	CH	N1		
J2810	Inj theophylline per 40 MG		N1		
J2820	Sargramostim injection		K2		$23.31
J2850	Inj secretin synthetic human		K2		$19.93
J2910	Aurothioglucose injeciton		N1		
J2916	Na ferric gluconate complex		N1		
J2920	Methylprednisolone injection		N1		
J2930	Methylprednisolone injection		N1		
J2940	Somatrem injection		K2		$43.99
J2941	Somatropin injection		K2		$53.47
J2950	Promazine hcl injection		N1		
J2993	Reteplase injection		K2		$1,230.80
J2995	Inj streptokinase /250000 IU		K2		$78.00
J2997	Alteplase recombinant		K2		$35.03
J3000	Streptomycin injection		N1		
J3010	Fentanyl citrate injeciton		N1		
J3030	Sumatriptan succinate / 6 MG		K2		$55.49
J3070	Pentazocine injection		N1		

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HCPCS Code	Short Descriptor	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
J3101	Tenecteplase injection		K2		$40.10
J3105	Terbutaline sulfate inj		N1		
J3120	Testosterone enanthate inj		N1		
J3130	Testosterone enanthate inj		N1		
J3140	Testosterone suspension inj		N1		
J3150	Testosteron propionate inj		N1		
J3230	Chlorpromazine hcl injection		N1		
J3240	Thyrotropin injection		K2		$948.38
J3243	Tigecycline injection		K2		$1.15
J3246	Tirofiban HCl		K2		$7.83
J3250	Trimethobenzamide hcl inj		N1		
J3260	Tobramycin sulfate injection		N1		
J3265	Injection torsemide 10 mg/ml		N1		
J3280	Thiethylperazine maleate inj		N1		
J3285	Treprostinil injection		K2		$54.83
J3300	Triamcinolone A inj PRS-free		K2		$3.20
J3301	Triamcinolone acet inj NOS		N1		
J3302	Triamcinolone diacetate inj		N1		
J3303	Triamcinolone hexacetonl inj		N1		
J3305	Inj trimetrexate glucoronate		K2		$124.80
J3310	Perphenazine injeciton		N1		
J3315	Triptorelin pamoate		K2		$160.83
J3320	Spectinomycn di-hcl inj		N1		
J3350	Urea injection	CH	N1		
J3355	Urofollitropin, 75 iu		K2		$59.26
J3360	Diazepam injection		N1		
J3364	Urokinase 5000 IU injection		N1		
J3365	Urokinase 250,000 IU inj		K2		$449.09
J3370	Vancomycin hcl injection		N1		
J3396	Verteporfin injection		K2		$9.31
J3400	Triflupromazine hcl inj	CH	N1		
J3410	Hydroxyzine hcl injection		N1		
J3411	Thiamine hcl 100 mg		N1		
J3415	Pyridoxine hcl 100 mg		N1		
J3420	Vitamin b12 injection		N1		
J3430	Vitamin k phytonadione inj		N1		
J3465	Injection, voriconazole		K2		$5.26
J3470	Hyaluronidase injection		N1		

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Addendum BB -- Final ASC Covered Ancillary Services Integral to Covered Surgical Procedures for CY 2010 (Including Ancillary Services for Which Payment is Packaged)

HCPCS Code	Short Descriptor	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
J3471	Ovine, up to 999 USP units		N1		
J3472	Ovine, 1000 USP units	CH	N1		
J3473	Hyaluronidase recombinant	CH	N1		
J3475	Inj magnesium sulfate		N1		
J3480	Inj potassium chloride		N1		
J3485	Zidovudine		N1		
J3486	Ziprasidone mesylate		N1		
J3487	Zoledronic acid		K2		$214.94
J3488	Reclast injection		K2		$218.59
J3490	Drugs unclassified injection		N1		
J3530	Nasal vaccine inhalation		N1		
J3590	Unclassified biologics		N1		
J7030	Normal saline solution infus		N1		
J7040	Normal saline solution infus		N1		
J7042	5% dextrose/normal saline		N1		
J7050	Normal saline solution infus		N1		
J7060	5% dextrose/water		N1		
J7070	D5w infusion		N1		
J7100	Dextran 40 infusion		N1		
J7110	Dextran 75 infusion		N1		
J7120	Ringers lactate infusion		N1		
J7130	Hypertonic saline solution		N1		
J7185	Xyntha inj	NI	K2		$1.06
J7186	Antihemophilic viii/vwf comp		K2		$0.84
J7187	Humate-P, inj		K2		$0.87
J7189	Factor viia		K2		$1.29
J7190	Factor viii		K2		$0.84
J7191	Factor VIII (porcine)		K2		$2.00
J7192	Factor viii recombinant NOS		K2		$1.08
J7193	Factor IX non-recombinant		K2		$0.88
J7194	Factor ix complex		K2		$0.85
J7195	Factor IX recombinant		K2		$1.06
J7197	Antithrombin iii injection	CH	K2		$2.28
J7198	Anti-inhibitor		K2		$1.53
J7308	Aminolevulinic acid hcl top		K2		$127.60
J7310	Ganciclovir long act implant		K2		$16,640.00
J7311	Fluocinolone acetonide implt		K2		$18,980.00
J7321	Hyalgan/supartz inj per dose		K2		$91.87

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Addendum BB -- Final ASC Covered Ancillary Services Integral to Covered Surgical Procedures for CY 2010 (Including Ancillary Services for Which Payment is Packaged)

HCPCS Code	Short Descriptor	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
J7322	Synvisc inj per dose	CH	D5		
J7323	Euflexxa inj per dose		K2		$113.96
J7324	Orthovisc inj per dose		K2		$177.68
J7325	Synvisc or Synvisc-One	NI	K2		$11.47
J7500	Azathioprine oral 50mg		N1		
J7501	Azathioprine parenteral		K2		$90.64
J7502	Cyclosporine oral 100 mg		K2		$3.22
J7504	Lymphocyte immune globulin		K2		$453.67
J7505	Monoclonal antibodies		K2		$1,109.45
J7506	Prednisone oral		N1		
J7507	Tacrolimus oral per 1 MG		K2		$3.96
J7509	Methylprednisolone oral		N1		
J7510	Prednisolone oral per 5 mg		N1		
J7511	Antithymocyte globuln rabbit		K2		$414.44
J7513	Daclizumab, parenteral		K2		$378.20
J7515	Cyclosporine oral 25 mg	CH	K2		$0.82
J7516	Cyclosporin parenteral 250mg		K2		$21.24
J7517	Mycophenolate mofetil oral		K2		$2.45
J7518	Mycophenolic acid	CH	N1		
J7520	Sirolimus, oral		K2		$9.44
J7525	Tacrolimus injection		K2		$136.82
J7599	Immunosuppressive drug noc		N1		
J7674	Methacholine chloride, neb		N1		
J7799	Non-inhalation drug for DME		N1		
J8501	Oral aprepitant		K2		$5.42
J8510	Oral busulfan	CH	N1		
J8520	Capecitabine, oral, 150 mg		K2		$5.68
J8521	Capecitabine, oral, 500 mg		K2		$18.73
J8530	Cyclophosphamide oral 25 MG		N1		
J8540	Oral dexamethasone		N1		
J8560	Etoposide oral 50 MG		K2		$0.45
J8597	Antiemetic drug oral NOS		N1		
J8600	Melphalan oral 2 MG		N1		
J8610	Methotrexate oral 2.5 MG		N1		
J8650	Nabilone oral	CH	N1		
J8700	Temozolomide		K2		$8.59
J8705	Topotecan oral		K2		$71.35
J9000	Doxorubicin hcl injection		N1		

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Addendum BB -- Final ASC Covered Ancillary Services Integral to Covered Surgical Procedures for CY 2010 (Including Ancillary Services for Which Payment is Packaged)

HCPCS Code	Short Descriptor	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
J9001	Doxorubicin hcl liposome inj		K2		$450.51
J9010	Alemtuzumab injection		K2		$559.46
J9015	Aldesleukin injection		K2		$831.49
J9017	Arsenic trioxide injection		K2		$36.73
J9020	Asparaginase injection		K2		$56.92
J9025	Azacitidine injection		K2		$4.78
J9027	Clofarabine injection		K2		$114.21
J9031	Bcg live intravesical vac		K2		$111.08
J9033	Bendamustine injection		K2		$18.53
J9035	Bevacizumab injection		K2		$56.39
J9040	Bleomycin sulfate injection		N1		
J9041	Bortezomib injection		K2		$36.54
J9045	Carboplatin injection		N1		
J9050	Carmustine injection		K2		$173.73
J9055	Cetuximab injection		K2		$48.79
J9060	Cisplatin 10 MG injection		N1		
J9062	Cisplatin 50 MG injection		N1		
J9065	Inj cladribine per 1 MG		K2		$25.15
J9070	Cyclophosphamide 100 MG inj		N1		
J9080	Cyclophosphamide 200 MG inj		N1		
J9090	Cyclophosphamide 500 MG inj		N1		
J9091	Cyclophosphamide 1.0 grm inj		N1		
J9092	Cyclophosphamide 2.0 grm inj		N1		
J9093	Cyclophosphamide lyophilized		N1		
J9094	Cyclophosphamide lyophilized		N1		
J9095	Cyclophosphamide lyophilized		N1		
J9096	Cyclophosphamide lyophilized		N1		
J9097	Cyclophosphamide lyophilized		N1		
J9098	Cytarabine liposome inj		K2		$480.19
J9100	Cytarabine hcl 100 MG inj		N1		
J9110	Cytarabine hcl 500 MG inj		N1		
J9120	Dactinomycin injection		K2		$533.21
J9130	Dacarbazine 100 mg inj		N1		
J9140	Dacarbazine 200 MG inj		N1		
J9150	Daunorubicin injection		K2		$14.95
J9151	Daunorubicin citrate inj		K2		$55.27
J9155	Degarelix injection	NI	K2		$2.23
J9160	Denileukin diftitox inj		K2		$1,448.32

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Addendum BB -- Final ASC Covered Ancillary Services Integral to Covered Surgical Procedures for CY 2010 (Including Ancillary Services for Which Payment is Packaged)

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J9165	Diethylstilbestrol injection		K2		$1,257.36
J9170	Docetaxel injection	CH	D5		
J9171	Docetaxel injection	NI	K2		$16.95
J9175	Elliotts b solution per ml		N1		
J9178	Inj, epirubicin hcl, 2 mg		K2		$2.55
J9181	Etoposide injection		N1		
J9185	Fludarabine phosphate inj		K2		$151.36
J9190	Fluorouracil injection		N1		
J9200	Floxuridine injection		K2		$46.60
J9201	Gemcitabine hcl injection		K2		$139.10
J9202	Goserelin acetate implant		K2		$193.02
J9206	Irinotecan injection		K2		$13.18
J9207	Ixabepilone injection		K2		$63.74
J9208	Ifosfomide injection		K2		$29.39
J9209	Mesna injection		K2		$4.34
J9211	Idarubicin hcl injection		K2		$96.70
J9212	Interferon alfacon-1 inj	CH	K2		$6.75
J9213	Interferon alfa-2a inj		K2		$10.60
J9214	Interferon alfa-2b inj		K2		$15.54
J9215	Interferon alfa-n3 inj		K2		$17.89
J9216	Interferon gamma 1-b inj		K2		$294.03
J9217	Leuprolide acetate suspnsion		K2		$210.52
J9218	Leuprolide acetate injeciton		K2		$5.29
J9219	Leuprolide acetate implant		K2		$4,728.88
J9225	Vantas implant		K2		$1,473.60
J9226	Supprelin LA implant		K2		$14,875.43
J9230	Mechlorethamine hcl inj		K2		$144.56
J9245	Inj melphalan hydrochl 50 MG		K2		$1,622.81
J9250	Methotrexate sodium inj		N1		
J9260	Methotrexate sodium inj		N1		
J9261	Nelarabine injection		K2		$101.28
J9263	Oxaliplatin		K2		$9.55
J9264	Paclitaxel protein bound		K2		$9.09
J9265	Paclitaxel injection	CH	N1		
J9266	Pegaspargase injection		K2		$2,695.67
J9268	Pentostatin injection		K2		$1,399.56
J9270	Plicamycin (mithramycin) inj	CH	N1		
J9280	Mitomycin 5 MG inj		K2		$17.74

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Addendum BB -- Final ASC Covered Ancillary Services Integral to Covered Surgical Procedures for CY 2010 (Including Ancillary Services for Which Payment is Packaged)

HCPCS Code	Short Descriptor	CY 2010 Comment Indicator	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
J9290	Mitomycin 20 MG inj		K2		$70.98
J9291	Mitomycin 40 MG inj		K2		$141.95
J9293	Mitoxantrone hydrochl / 5 MG		K2		$65.51
J9300	Gemtuzumab ozogamicin inj		K2		$2,572.82
J9303	Panitumumab injection		K2		$85.21
J9305	Pemetrexed injection		K2		$48.50
J9310	Rituximab injection		K2		$552.70
J9320	Streptozocin injection		K2		$278.35
J9328	Temozolomide injection	NI	K2		$4.90
J9330	Temsirolimus injection		K2		$47.93
J9340	Thiotepa injection		K2		$97.69
J9350	Topotecan injection		K2		$988.88
J9355	Trastuzumab injection		K2		$63.51
J9357	Valrubicin injection		K2		$953.16
J9360	Vinblastine sulfate inj		N1		
J9370	Vincristine sulfate 1 MG inj		N1		
J9375	Vincristine sulfate 2 MG inj		N1		
J9380	Vincristine sulfate 5 MG inj		N1		
J9390	Vinorelbine tartrate inj	CH	N1		
J9395	Injection, Fulvestrant		K2		$80.63
J9600	Porfimer sodium injection		K2		$2,745.46
J9999	Chemotherapy drug		N1		
L8600	Implant breast silicone/eq		N1		
L8603	Collagen imp urinary 2.5 ml		N1		
L8604	Dextranomer/hyaluronic acid		N1		
L8606	Synthetic implnt urinary 1ml		N1		
L8609	Artificial cornea		N1		
L8610	Ocular implant		N1		
L8612	Aqueous shunt prosthesis		N1		
L8613	Ossicular implant		N1		
L8614	Cochlear device		N1		
L8630	Metacarpophalangeal implant		N1		
L8631	MCP joint repl 2 pc or more		N1		
L8641	Metatarsal joint implant		N1		
L8642	Hallux implant		N1		
L8658	Interphalangeal joint spacer		N1		
L8659	Interphalangeal joint repl		N1		
L8670	Vascular graft, synthetic		N1		

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L8682	Implt neurostim radiofq rec		N1		
L8690	Aud osseo dev, int/ext comp		N1		
L8699	Prosthetic implant NOS		N1		
P9041	Albumin (human),5%, 50ml		K2		$16.89
P9045	Albumin (human), 5%, 250 ml		K2		$60.58
P9046	Albumin (human), 25%, 20 ml		K2		$25.67
P9047	Albumin (human), 25%, 50ml		K2		$62.05
Q0138	Ferumoxytol, non-esrd	NI	K2		$0.82
Q0163	Diphenhydramine HCl 50mg		N1		
Q0164	Prochlorperazine maleate 5mg		N1		
Q0166	Granisetron hcl 1 mg oral	CH	N1		
Q0167	Dronabinol 2.5mg oral		N1		
Q0169	Promethazine HCl 12.5mg oral		N1		
Q0171	Chlorpromazine HCl 10mg oral		N1		
Q0173	Trimethobenzamide HCl 250mg		N1		
Q0174	Thiethylperazine maleate10mg		N1		
Q0175	Perphenazine 4mg oral		N1		
Q0177	Hydroxyzine pamoate 25mg		N1		
Q0179	Ondansetron hcl 8 mg oral	CH	N1		
Q0180	Dolasetron mesylate oral	CH	N1		
Q0515	Sermorelin acetate injection		K2		$1.77
Q1003	Ntiol category 3		L6		$50.00
Q2004	Bladder calculi irrig sol	CH	K2		$29.28
Q2009	Fosphenytoin inj PE		N1		
Q2017	Teniposide, 50 mg		K2		$319.43
Q2023	Xyntha, inj	CH	D5		
Q2024	Bevacizumab injection	CH	D5		
Q3025	IM inj interferon beta 1-a		K2		$187.24
Q4100	Skin substitute, NOS		N1		
Q4101	Apligraf skin sub		K2		$32.16
Q4102	Oasis wound matrix skin sub		K2		$4.12
Q4103	Oasis burn matrix skin sub		K2		$4.12
Q4104	Integra BMWD skin sub		K2		$11.77
Q4105	Integra DRT skin sub		K2		$11.77
Q4106	Dermagraft skin sub		K2		$39.25
Q4107	Graftjacket skin sub		K2		$89.23
Q4108	Integra matrix skin sub		K2		$17.98
Q4109	Tissuemend skin sub		N1		

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Q4110	Primatrix skin sub		K2		$33.99
Q4111	Gammagraft skin sub		K2		$7.13
Q4112	Cymetra allograft		K2		$327.47
Q4113	Graftjacket express allograf		K2		$327.47
Q4114	Integra flowable wound matri		K2		$907.36
Q4115	Alloskin skin sub		K2		$9.36
Q4116	Alloderm skin sub		K2		$31.72
Q9951	LOCM >= 400 mg/ml iodine,1ml		N1		
Q9953	Inj Fe-based MR contrast,1ml		N1		
Q9954	Oral MR contrast, 100 ml		N1		
Q9955	Inj perflexane lip micros,ml		N1		
Q9956	Inj octafluoropropane mic,ml		N1		
Q9957	Inj perflutren lip micros,ml		N1		
Q9958	HOCM <=149 mg/ml iodine, 1ml		N1		
Q9959	HOCM 150-199mg/ml iodine,1ml		N1		
Q9960	HOCM 200-249mg/ml iodine,1ml		N1		
Q9961	HOCM 250-299mg/ml iodine,1ml		N1		
Q9962	HOCM 300-349mg/ml iodine,1ml		N1		
Q9963	HOCM 350-399mg/ml iodine,1ml		N1		
Q9964	HOCM>= 400mg/ml iodine, 1ml		N1		
Q9965	LOCM 100-199mg/ml iodine,1ml		N1		
Q9966	LOCM 200-299mg/ml iodine,1ml		N1		
Q9967	LOCM 300-399mg/ml iodine,1ml		N1		
Q9968	Visualization adjunct	NI	K2		$4.11
V2630	Anter chamber intraocul lens		N1		
V2631	Iris support intraoclr lens		N1		
V2632	Post chmbr intraocular lens		N1		
V2785	Corneal tissue processing		F4		
V2790	Amniotic membrane		N1		

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[FR Doc. 2010–16043 Filed 7–2–10; 2:30 pm]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1504–N]

RIN 0938–AQ08

Medicare Program; Changes to the Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System for CY 2010, and Extension of Part B Payment for Services Furnished by Hospitals or Clinics Operated by the Indian Health Service, Indian Tribes, or Tribal Organizations Made by the Affordable Care Act

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

ACTION: Notice.

SUMMARY: This Notice contains the final wage indices, hospital reclassifications, payment rates, impacts and addenda for payments made under the Medicare hospital outpatient payment system (OPPS) for CY 2010. This Notice also contains the payment rates and addenda for payments made under the Medicare Ambulatory Surgical Center (ASC) payment system for CY 2010. The final rates, wage indices, addenda and impacts for the OPPS and as applicable for the ASC payment system contained in this Notice reflect the provisions of the Affordable Care Act. It also announces the extension of payment under Medicare Part B to hospitals and ambulatory care clinics operated by the Indian Health Service, Indian Tribes, or Tribal Organizations.

DATES: *Effective Date:* The revised CY 2010 national unadjusted OPPS and ASC payment rates described in this Notice are effective for payments for services furnished on or after January 1, 2010.

FOR FURTHER INFORMATION CONTACT: Alberta Dwivedi, (410) 786–0378.

SUPPLEMENTARY INFORMATION:

I. Provisions of the Notice

A. Medicare Hospital Outpatient Prospective Payment System (OPPS)

1. Background

We finalized changes to the payment rates and factors under the hospital outpatient prospective payment system (OPPS) in the CY 2010 OPPS/ASC final rule with comment period appearing in the November 20, 2009 **Federal Register**. On March 23, 2010, subsequent to the publication of the CY 2010 OPPS/ASC final rule, the Patient Protection and Affordable Care Act (Pub. L. 111–148) was signed into law. Shortly thereafter, on March 30, 2010, the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152) was signed into law. These two laws are discussed in this Notice and are collectively referred to as the "Affordable Care Act" throughout this Notice. As discussed in detail below, several provisions of these public laws revised components of the OPPS, and those revisions required us to revise the payment rates and various factors under the CY 2010 OPPS. This Notice addresses the provisions of the Affordable Care Act that impact the CY 2010 OPPS final wage index tables, rates, and impacts. We note that the payment rates and policies set forth in the CY 2010 OPPS/ASC final rule with comment period appearing in the November 20, 2009 **Federal Register** continue to apply to those aspects of the OPPS that are unaffected by the Affordable Care Act. This Notice makes no changes to the OPPS payment methodologies or policies.

2. CY 2010 OPPS OPD Fee Schedule Increase Factor

Section 1833(t)(3)(C)(ii) of the Act requires us to update the conversion factor used to determine payment rates under the OPPS on an annual basis using the OPD fee schedule increase factor in 1833(t)(3)(C)(iv) of the Act for the year involved. For purposes of section 1833(t)(3)(C)(iv) of the Act, subject to 1833(t)(17) and 1833(t)(3)(F), the OPD fee schedule increase factor is equal to the market basket percentage increase applicable under section 1886(b)(3)(B)(iii) of the Act to hospital discharges occurring during the fiscal year ending in such year, reduced by 1 percentage point for such factor for services furnished in each of 2000 and 2002. In addition, under 1833(t)(17) of the Act, hospitals that fail to meet the reporting requirements of the Hospital Outpatient Quality Data Reporting Program (HOP QDRP) are subject to a reduction of 2.0 percentage points from the OPD fee schedule increase factor. In accordance with 1833(t)(3)(C)(iv), the CY 2010 OPD fee schedule increase factor (commonly referred to as the "hospital operating market basket increase factor") finalized in the CY 2010 OPPS final rule was 2.1 percent (74 FR 60419). In addition, under the CY 2010 OPPS/ASC final rule (74 FR 60419), a hospital that fails to meet the reporting requirements of the HOP QDRP reporting requirements receives a .1 percent update (that is, the CY 2010 estimate of the OPD fee schedule increase factor of 2.1 percent minus 2.0 percentage points) for services to which the OPD fee schedule increase factor applies.

Section 1833(t)(3)(F)(ii) and (G)(i) of the Social Security Act, as added by section 3401(i) of the Public Law 111–148, and as amended by section 10319(g) of such Act and section 1105(e) of Public Law 111–152, required the Secretary after calculating the OPD fee schedule increase factor, to reduce such factor by an adjustment of 0.25 percentage point, effective for services furnished on or after January 1, 2010 and before January 1, 2011. (In addition, new 1833(t)(3)(F) of the Act also provides that application of this subparagraph [1833(t)(3)(F)] may result in the increase factor under section 1833(t)(3)(C)(iv) of the Act being less than 0.0 for a year, and may result in payment rates under the payment system under this subsection for a year being less than such payment rates for the preceding year.) Therefore, the reduction of 0.25 percentage point applied to the full hospital operating market basket increase factor of 2.1 percent results in a revised hospital operating market basket increase factor of 1.85 percent. A hospital that failed to meet the reporting requirements of the HOP QDRP reporting requirements receives a negative 0.15 percent hospital operating market basket increase factor (that is, the revised hospital operating market basket increase factor of 1.85 percent minus 2.0 percentage points.)

3. CY 2010 OPPS Conversion Factor

To calculate the OPPS conversion factor for CY 2010 in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60419), we increased the CY 2009 conversion factor of $66.059 by 2.1 percent. We then adjusted the conversion factor for CY 2010 to ensure that any revisions we made to our updates for a revised wage index and rural adjustment were budget neutral. We calculated an overall budget neutrality factor of 0.9997 for wage index changes by comparing total payments from our simulation model using the FY 2010 IPPS final wage index values to those total payments using the FY 2009 IPPS final wage index values. For CY 2010, we did not propose a change to our rural adjustment policy. Therefore, the budget neutrality factor for the rural adjustment was 1.0000. For the CY 2010 OPPS/ASC final rule, we estimated that pass-through spending for both drugs and biologicals and devices for CY 2010 will equal approximately $45.5 million, which represents 0.14 percent of total projected CY 2010 OPPS spending. Therefore, the conversion factor was also adjusted by the difference between

the 0.11 percent estimate of pass-through spending set aside for CY 2009 and the 0.14 percent estimate for CY 2010 pass-through spending. Finally, estimated payments for outliers remain at 1.0 percent of total OPPS payments for CY 2010. In our November 20, 2009 CY 2010 OPPS/ASC final rule with public comment, we announced a full conversion factor of $67.406 for the CY 2010 OPPS.

As indicated previously, hospitals that fail to meet the reporting requirements of the Hospital Outpatient Quality Data Reporting Program (HOP QDRP) are subject to a reduction of 2.0 percentage points from the OPD fee schedule increase factor, which is applied to the conversion factor that is used to calculate their payment rates. To calculate the CY 2010 reduced OPD fee schedule increase factor for those hospitals that fail to meet the requirements of the HOP QDRP for the full CY 2010 payment update in the CY 2010 OPPS/ASC final rule, we made all other adjustments described above, but used a reduced OPD fee schedule increase factor of 0.1 percent. This resulted in a reduced conversion factor of $66.086 for those hospitals that fail to meet the HOP QDRP reporting requirements.

As discussed previously, section 1833(t)(3)(F)(ii) and (G)(i) of the Social Security Act, as added by section 3401(i) of the Affordable Care Act, and as amended by section 10319(g) of such Act and section 1105(e) of Public Law 111–152, requires the Secretary, after calculating the OPD fee schedule increase factor, to reduce such factor by an adjustment of 0.25 percentage point effective for services furnished on and after January 1, 2010 through December 31, 2010. Moreover, as discussed in more detail in section I.A.4 below, section 3137 of the Affordable Care Act extended section 508 reclassifications and special exception wage indices from October 1, 2009 to September 30, 2010. Section 3137(a) also required the Secretary, for the second half of the year, to recalculate wage indices by excluding section 508 and special exception hospital wage data in certain circumstances. The OPPS adopts the final fiscal year IPPS wage index on a calendar year basis. We use both the OPD fee schedule increase factor and the budget neutrality adjustment which accounts for the effects of adopting the new fiscal year IPPS wage index on a calendar year basis in the calculation of the OPPS conversion factor. Therefore, the reduction of 0.25 percentage point applied to the OPD fee schedule increase factor of 2.1 percent and the revised wage index budget neutrality factor of 0.9997 required us to recalculate the CY 2010 OPPS conversion factor. We note that none of the other components of the conversion factor calculation, specifically the adjustment to account for estimated cost of pass through drugs and non-implantable biologicals, and device categories and the proportion of estimated total OPPS payments for outlier payments changed as a result of the provisions of Affordable Care Act. The budget neutrality adjustment for the rural adjustment continues to be 1.0000 because we did not propose and the Affordable Care Act did not authorize any changes to the rural adjustment. Therefore, the only changes to the conversion factor, and thus to the CY 2010 OPPS payment rates, that are reflected in this Notice are caused by the statutorily required reduction applied to the OPD fee schedule increase factor and the statutory changes to the wage index.

To calculate the revised OPPS conversion factor for CY 2010 that is effective for covered OPD services furnished on or after January 1, 2010 through December 31, 2010, we used the same methodology that was used in the CY 2010 OPPS/ASC final rule (74 FR 60419). We first increased the CY 2009 conversion factor of $66.059 by the revised OPD fee schedule increase factor of 1.85 percent (2.1 percent which is the full inpatient operating market basket percentage increase applicable to hospital discharges under section 1886(b)(3)(B)(iii) of the Act less the 0.25 percentage point reduction) for CY 2010. We further adjusted the conversion factor to ensure that any revisions we made to our updates accounting for the statutorily required changes to the wage index were made on a budget neutral basis. We calculated an overall budget neutrality adjustment factor of 0.9997 for wage index changes by comparing total payments from our simulation model using the FY 2010 IPPS final wage index values, as adjusted by the Affordable Care Act (*see* discussion in section I.A.4.), to those payments using the final FY 2009 IPPS wage index values and multiplied this by the conversion factor which already was adjusted to reflect the revised OPD fee schedule increase factor. For purposes of calculating the overall budget neutrality adjustment for wage index changes, we created a single CY 2010 average wage index with 50 percent of the wage index in effect between January 1, 2010 and June 30, 2010 and 50 percent of the wage index in effect between July 1, 2010 and December 31, 2010. We note that the wage index adjustment of 0.9997 that we recalculated using the wage index values that resulted from the Affordable Care Act provisions is identical (when rounded to the 4th decimal) to the wage index adjustment that we calculated for the CY 2010 OPPS conversion factor that we published on November 20, 2009. Next, we multiplied the wage adjusted conversion factor by the budget neutrality factor for the rural adjustment of 1.0000 that was finalized in the CY 2010 OPPS/ASC final rule (74 FR 60419). Therefore, the final revised full conversion factor for CY 2010 resulting from the above-described steps is $67.241 for services furnished on and after January 1, 2010 and before January 1, 2011. We then adjusted the CY 2009 conversion factor to reflect changes in our estimate of total OPPS expenditures that would be dedicated to pass-through payments in CY 2010 that were finalized in the CY 2010 OPPS/ASC final rule (74 FR 60419). Finally, estimated payments for outliers remained at 1.0 percent of total OPPS payments for CY 2010 (74 FR 60419).

To calculate the revised final CY 2010 reduced market basket conversion factor for those hospitals that fail to meet the requirements of the HOP QDRP for the full CY 2010 payment update, we used the same methodology and adjustments discussed above, except that we used a reduced OPD fee schedule increase factor of negative 0.15 percent (that is, the revised OPD fee schedule increase factor of 1.85 percent minus 2.0 percentage points). This resulted in a final reduced conversion factor for CY 2010 of $65.921 for those hospitals that fail to meet the HOP QDRP requirement effective for covered OPD services furnished on or after January 1, 2010 through December 31, 2010. To calculate the reduced payment for these hospitals in our claims processing systems we apply a reduction ratio, that we refer to as the "reporting ratio" of 0.980, which remains unchanged from the reporting ratio we published on November 20, 2009 (74 FR 60641), notwithstanding the changes to the hospital operating market basket and wage index values for some hospitals required by the Affordable Care Act.

The recalculated CY 2010 final conversion factor of $67.241 is reflected in the revised CY 2010 OPPS payment rates and rate dependent files that are posted on the CMS Web site at *http://www.cms.gov/HospitalOutpatientPPS/*. Because the conversion factor was revised, we were required to recalculate a number of aspects of the CY 2010 OPPS using our established methodologies as set forth in the CY 2010 OPPS/ASC final rule (74 FR

60316) using the revised conversion factor, including the OPPS payment rates that rely on the conversion factor and other components of the payment system that depend on OPPS payment rates for CY 2010 OPPS using our established methodologies to take this revision into account.

These include CY 2010 OPPS APC payment rates that are printed in Addenda A and B of this Notice. We use the conversion factor to calculate OPPS payment rates for services in APCs with the following status indicators, "P", "Q1", "Q2", "Q3", "R", "S", "T", "V", "X", and "U". The components of the payment system that are impacted by these changes include: The offset amounts for devices (devices and implantable biologicals), "policy packaged" drugs (diagnostic radiopharmaceuticals and contrast agents), and "threshold packaged" drugs (drugs and non-implantable biologicals that maybe packaged under the drug packaging threshold) that are used for assessment of pass-through applications and reductions to payment for certain device-dependent procedures, nuclear medicine procedures, or other imaging procedures using contrast agents, when a diagnostic radiopharmaceutical, device or implantable biological, or contrast agent is receiving pass through payment (74 FR 60462 through 60463, and 60480 through 60484). The revised offset amounts are not published as addenda to OPPS update rules but are available at *www.cms.hhs.gov/HospitalOutpatientPPS/* under "Annual Policy Files." These revisions are effective for covered OPD services furnished on or after January 1, 2010 through December 31, 2010.

The offset amount for each group of items, devices, "threshold packaged" drugs and nonimplantable biologicals, and "policy packaged" drugs and biologicals, are calculated using the same methodology. For a discussion of the methodology we use for devices and implantable biologicals, *see* our CY 2008 final rule with comment period (72 FR 66751 through 66752 and 74 FR 60463), and for our discussion of the methodology we use for diagnostic radiopharmaceuticals and contrast agents, *see* our CY 2010 final rule with comment period discussion at 74 FR 60482. We use these offset amounts in our cost significance calculation when evaluating an application for pass-through payment for both drugs and nonimplantable biologicals, and devices including implantable biologicals. Finally, for a subset of the device-dependent procedures, we reduce OPPS payment by the device offset amount when a hospital furnishes a device received at no cost or full credit and by half of the device offset amount when a hospital furnishes a device received for partial credit (74 FR 60464 through 60466).

4. Revision of Hospital Wage Index Values for CY 2010 as Required by Section 3137(a) of Affordable Care Act

Section 1833(t)(2)(D) of the Act requires the Secretary to determine a wage adjustment factor to adjust, for geographic wage differences, the portion of the OPPS payment rate, which includes copayment, that is attributable to labor and labor-related cost. This adjustment must be made in a budget neutral manner. The OPPS labor-related share is 60 percent of the national OPPS payment. The OPPS has consistently adopted the final fiscal year IPPS wage indices as the wage index values for adjusting the OPPS standard payment amounts for labor market differences. Thus, the wage index that applies to a particular acute care short-stay hospital under the IPPS would also apply to that hospital under the OPPS. We discuss our wage index policy in the CY 2010 OPPS/ASC final rule with comment (74 FR 60419).

In accordance with section 1886(d)(3)(E) of the Act, the IPPS wage index is updated annually. The IPPS wage index values that we adopted in the CY 2010 OPPS included all reclassifications that were approved by the Medicare Geographic Classification Review Board (MGCRB) for FY 2010. Reclassifications under section 508 of Public Law 108–173 (MMA) and the assignment of certain special exception wage indices that were extended by section 106(a) of Public Law 109–432 (MIEA–TRHCA), section 117(a)(1) of Public Law 110–173 (MMSEA), and section 124 of Public Law 110–275 (MIPPA) were set to terminate on September 30, 2009. Similar to our treatment of section 508 reclassifications extended under Public Law 110–173 as described in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68586), we expected hospitals with section 508 reclassifications to revert to their home area wage index, with out-migration adjustment if applicable, or a current MGCRB reclassification, from October 1, 2009 to December 31, 2009 after section 508 reclassifications expired. We also extended the assignment of certain special exceptions wage indices for certain hospitals from January 1, 2009 through December 31, 2009, under the OPPS, in order to give these hospitals their special exception wage index under the OPPS for the same time period as under the IPPS. We refer readers to the Federal Register Notice published subsequent to the FY 2009 IPPS final rule for a detailed discussion of the changes to the wage index values as required by section 124 of Public Law 110–275 (73 FR 57888). Because the provisions of section 124 of Public Law 110–275 expired in 2009 and because the Affordable Care Act had not yet passed, we did not propose to recognize section 508 reclassifications and wage indices for certain special exceptions hospitals for the OPPS wage indices for CY 2010 (74 FR 60419).

Section 3137(a), as amended by section 10317, of the Affordable Care Act extended the wage index reclassifications originally designated under section 508 of Public Law 108–173 and certain special exception wage indices effective for services furnished on and after October 1, 2009 through September 30, 2010. We will implement the section 508 wage indices for OPPS payments for fiscal year 2010 under the OPPS. As indicated, the extended section 508 reclassifications will expire on September 30, 2010. Hospitals with a section 508 reclassification wage index will revert to their home area wage index, with out-migration adjustment if applicable, or a current MGCRB reclassification, from October 1, 2010 to December 31, 2010 after the section 508 reclassifications expire on September 30, 2010.

Further, as we did for CY 2009, the OPPS will recognize the special exception wage indices for certain hospitals from January 1, 2010 through December 31, 2010, under the OPPS, in order to give these hospitals the special exception wage index values under the OPPS for the same time period as under the IPPS. Finally, provisions of section 3137(a) required us to recalculate wage indices for certain areas to exclude the wage data of section 508 and special exception hospitals in certain circumstances. This recalculation resulted in revised wage indices beginning on April 1, or midway through the fiscal year. To implement the same policy on a calendar year basis, the OPPS will adopt these revised wage indices midway through the calendar year beginning July 1, 2010. The revised wage indices that would apply for all providers that are paid under the OPPS are on public display on the CMS Web site at *http://www.cms.gov/AcuteInpatientPPS/WIFN/itemdetail.asp.* The revised wage indices also have been published by CMS in the June 2, 2010 **Federal Register** (75 FR 31147). We used these wage indices along with the wage indices that we finalized in our CY 2010 OPPS/ASC final rule with comment

period and in effect in the OPPS between January 1, 2010 and June 30, 2010 to calculate the budget neutrality adjustment for CY 2010 to the conversion factor discussed in I.A.3.above. As a result of the changes to the wage indices that are required by section 3137, we estimate a budget neutrality adjustment for the revised wage index of 0.9997 that we used for calculating the revised CY 2010 OPPS conversion factor of $67.241.

We also note that section 3137(a), as amended by Section 10317, specifies that if the Section 508 or special exception hospital's wage index applicable for the period beginning on October 1, 2009, and ending on March 31, 2010, is lower than for the period beginning on April 1, 2010, and ending on September 30, 2010, the hospital shall be paid an additional amount that reflects the difference between the wage indices. To apply this provision to both inpatient and outpatient hospital payments we compared the two wage index values applicable for the period beginning on October 1, 2009, and ending on March 31, 2010, and for the period beginning on April 1, 2010, and ending on September 30, 2010 and assigned each Section 508 and special exception hospital the higher of the two wage index values. Consistent with our typical application of the wage index for these two sets of providers, we assigned the Section 508 providers their higher FY 2010 wage index from October 1, 2009 through September 30, 2010 and assigned the special exception providers their higher FY 2010 wage index from January 1, 2010 through December 31, 2010.

5. Extension of Transitional Outpatient Payments (TOPs) for Small Rural Hospitals That Are Not Sole Community Hospitals and That Have 100 or Fewer Beds and Extension of TOPs to All SCHs (Including EACHs), Irrespective of the 100 Bed Limitation

Section 5105 of the Deficit Reduction Act of 2005 (DRA) reinstituted TOPs for covered OPD services furnished on or after January 1, 2006 and before January 1, 2009, for rural hospitals having 100 or fewer beds that are not sole community hospitals (SCHs). When the OPPS payment was less than the provider's pre-BBA amount, the amount of payment was increased by 95 percent of the amount of the difference between these two amounts for CY 2006, by 90 percent in CY 2007, and 85 percent in CY 2008. Section 147 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) extended the period of TOPs for small rural hospitals with 100 or fewer beds through December 31, 2009; when the OPPS payment was less than the provider's pre-BBA amount, the amount of payment was increased by 85 percent of the amount of the difference between these two amounts for CY 2009. Section 147 also provided 85 percent of the hold harmless amount from January 1, 2009 through December 31, 2009 to sole community hospitals (SCHs) including essential access community hospitals (EACHs) with 100 or fewer beds. We note that EACHs are considered to be SCHs under section 1886(d)(5)(D)(iii)(III) of the Act. Accordingly, under the statute, EACHs are treated as SCHs.

Section 3121 of the Affordable Care Act extends the hold harmless provision for small rural hospitals with 100 or fewer beds and that are not sole community hospitals (as defined in section 1886(d)(5)(iii) of the Social Security Act) for an additional year through December 31, 2010, at 85 percent of the hold harmless amount. Thus, for covered OPD services furnished on or after January 1, 2010 through December 31, 2010, for which the PPS amount is less than the pre-BBA amount, the amount of payment shall be increased by 85 percent of the amount of the difference between these two amounts for CY 2010. In addition, section 3121 of the Affordable Care Act extended for an additional year the period of TOPs payments for SCHs (as defined in section 1886(d)(5)(iii) of the Act). As stated previously, EACHs fall within the definition of an SCH as set forth in 1886(d)(5)(iii) of the Act. Further, section 3121(b) of the Affordable Care Act amended section 1833(t)(7)(D)(i)(III) of the Act to provide that in the case of covered OPD services furnished on or after January 1, 2010 and before January 1, 2011, the 100-bed limitation will not be applied for SCHs (including EACHs) under 1833(t)(3)(D)(i)(III) of the Act. Therefore, under section 1833(t)(3)(D)(i)(III) of the Act, payment will be increased under section 1833(t) of the Act to SCHs (including EACHs) for covered OPD services furnished on or after January 1, 2010 through December 31, 2010, by 85 percent of the amount of the difference between these two amounts when the PPS amount is less that the pre-BBA amount without regard to the 100-bed limitation. Cancer and children's hospitals are permanently held harmless under section 1833(t)(7)(D)(ii) of the Social Security Act and continue to receive TOPs payments in CY 2010.

B. Ambulatory Surgical Center Payment System

1. Background

In the CY 2010 OPPS/ASC final rule with comment period (74 FR 60596), we updated and finalized the CY 2010 ASC rates and lists of covered surgical procedures and covered ancillary services. We also corrected some of those ASC rates in a correction notice published in the **Federal Register** on December 31, 2009 (74 FR 69502). In that correction notice, we revised the ASC rates to reflect changes in the Medicare Physician Fee Schedule (MPFS) conversion factor and practice expense (PE) relative value units (RVUs) listed for some CPT codes in Addendum B to the CY 2010 MPFS final rule with comment period (74 FR 62017), which were incorrect due to certain technical errors and, consequently, were corrected in a correction notice to that final rule (74 FR 65449). We are also publishing a second correction notice in the **Federal Register** around the same time as this Notice to address changes to the ASC rates resulting from corrections to the PE RVUs and to the MPFS conversion factor identified subsequent to publication of the December 31, 2009 correction notice. In this Notice, we discuss changes to the ASC payment rates due to changes to the OPPS and MPFS under the Affordable Care Act. The rates in this Notice also reflect technical corrections to the CY 2010 ASC payment rates published in the CY 2010 OPPS/ASC final rule with comment period as corrected by the two correction notices. None of these changes affected ASC payment methodologies or policies.

2. Changes to the CY 2010 Ambulatory Surgical Center Payment System Required by the Changes to the Hospital Outpatient Prospective Payment System and the Medicare Physician Fee Schedule

Under the revised ASC payment system, for most covered surgical procedures, we use the OPPS APCs to group services paid under the ASC payment system and we use the APC relative payment weights developed under the OPPS as the basis for ASC relative payment weights for calculating ASC payment rates. Specifically, we multiply an ASC relative payment weight derived from the OPPS APC relative weight by a budget neutral ASC conversion factor to calculate national unadjusted ASC payment rates each year. We refer to this as the standard ratesetting methodology for the ASC payment system. We transitioned to the standard ratesetting methodology over a

four-year period for procedures on the CY 2007 list of covered surgical procedures. CY 2010 is the third year of this four-year transition to fully implementing the standard ratesetting methodology. ASC payment rates for CY 2010 are a transitional blend of 25 percent of the CY 2007 ASC payment rate for a covered surgical procedure on the CY 2007 ASC list of surgical procedures and 75 percent of the payment rate for the procedure calculated under the standard ratesetting methodology. We discuss the standard ratesetting methodology and our transition to the full implementation of the standard ratesetting methodology in our August 2, 2007 ASC final rule (72 FR 42491 through 42493, 42519 through 42521). We update the ASC relative payment weights annually using the OPPS relative payment weights for that calendar year. Because the standard ratesetting methodology adopts the OPPS relative payment weights (not rates), reductions to OPPS payments created by the Affordable Care Act as discussed in section I.A.3. above do not impact payment made under the standard ratesetting methodology as the Affordable Care Act did not change any OPPS APC relative weights for CY 2010.

However, the ASC payment system establishes the payment rates for several services using other methodologies that are impacted by the Affordable Care Act. Specifically, the calculation of device-intensive services, brachytherapy services, and bone density scans (a type of covered ancillary radiology service) under the ASC payment system rely directly on the actual payment rates under the OPPS and MPFS, which are impacted by the provisions of the Affordable Care Act discussed above and below. The Affordable Care Act changed the OPPS payment rates for any service where the OPPS conversion factor is used in its calculation, because the Affordable Care Act revised the CY 2010 OPD fee schedule increase factor (*see* I.A.3. of this Notice). This change impacted payments for device-intensive services and brachytherapy services, which are dependent on payments established under the OPPS.

We use a modified ASC methodology based on OPPS data to establish payment rates for the device-intensive procedures under the ASC payment system. ASC device-intensive services are covered surgical procedures that are assigned to the OPPS device-dependent APCs with a device offset percentage (*i.e.,* the proportion of the APC relative weight attributable to devices under the OPPS) greater than 50 percent of the APC cost under the OPPS. Under the ASC payment system, we sum the device portion and the service portion to derive the ASC payment rate for each service's device dependent APC. The device portion is equal to the device offset amount multiplied by the OPPS payment rate, which is the OPPS conversion factor multiplied by the OPPS relative payment weight, for each service's device dependent APC. The service portion is equal to the ASC standard ratesetting methodology (or blended payment rates during the transition period) applied to the service portion of the OPPS relative payment weight (72 FR 42503 through 42508). Because CY 2010 OPPS APC payment rates have changed as a result of the Affordable Care Act, the device offset amount, and therefore the device portion of the ASC payment rate for device-intensive services also changed.

The ASC Payment System also employs a modification to the standard ratesetting methodology to establish payment for brachytherapy sources. As discussed in our August 2, 2007 ASC final rule (72 FR 42498 to 42499), we finalized a policy to pay for brachytherapy services at the OPPS payment rates if OPPS rates were available, and if unavailable, to pay at contractor-priced rates. The CY 2010 OPPS established payment rates for brachytherapy sources based on a relative weight and the OPPS conversion factor, which has changed as a result of the Affordable Care Act. Because the ASC payment system adopts the final payment rate from the OPPS, these payment rates have changed for the ASC payment system.

Finally, payment for bone density scans under the ASC payment system is impacted by the changes made to the MPFS under section 3111 of the Affordable Care Act. Under the ASC payment system, payment for covered ancillary radiology services, which includes bone density scans, is capped at the lesser of the MPFS non-facility practice expense payment amount (calculated by multiplying the non-facility practice expense RVU by the MPFS conversion factor) or the ASC rate developed according to the ASC standard ratesetting methodology. Section 3111 of the Affordable Care Act requires that, for CY 2010, payment under the MPFS for certain bone density scans be established at 70 percent of the product of the CY 2006 MPFS relative value units for the service, the CY 2006 MPFS conversion factor and the CY 2010 geographic adjustment factor for the service. Therefore, the final payment rate for these bone density scans depends on both the ASC payment and the MPFS non-facility practice expense payment amount, which changed under the Affordable Care Act.

In addition to the changes made under the Affordable Care Act, the ASC payment rates in this Notice reflect the technical corrections to the CY 2010 ASC payment rates published in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60316), and as corrected in a December 31, 2009 correction notice and a second correction notice that will be published around the same time as this Notice to address changes to covered office-based and covered ancillary radiology services payment rates resulting from technical corrections to the MPFS non-facility practice expense payment amounts for CY 2010. Office-based procedures are procedures added to the ASC list of covered surgical procedures in CY 2008 or later years that we determine are performed predominantly (more than 50 percent of the time) in physicians' offices and are paid based on the same methodology as covered ancillary radiology services (*i.e.,* the lesser of the MPFS rate or the ASC rate under the standard methodology). We have already implemented the changes made by these correction notices.

We note that the Department of Defense Appropriations Act, 2010 (Pub. L. 111–118), the Temporary Extension Act of 2010 (Pub. L. 111–144), and the Continuing Extension Act of 2010 (Pub. L. 111–157) extended a zero percent update for the MPFS from January 1, 2010 through May 31, 2010. Because the Affordable Care Act changes are effective January 1, 2010, and because the public laws listed above authorize a zero percent update for the MPFS for CY 2010 through May 31, 2010, this Notice incorporates a zero percent update for MPFS payment. On June 25, 2010 the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 (Pub L. 111–192) authorized a 2.2 percent update for the MPFS from June 1, 2010 through November 30, 2010. As is our standard practice, we will recalculate the revised ASC CY 2010 payment rates based on CY 2010 MPFS payment rates using the 2.2 percent update factor, and we will make these revised payment rates available on our Web site under "Addenda Updates" at *http://www.cms.gov/ASCPayment/11_Addenda_Updates.asp#TopOfPage.*

Because of these changes to payment for device-intensive services, brachytherapy sources, and bone density scans created by the Affordable Care Act, and changes to MPFS non-facility practice expense payment amounts and the MPFS conversion factor for covered office-based services

and ancillary radiology services created by technical corrections that we explained in the correction notices, we recalculated budget neutrality for the CY 2010 ASC payment system as part of this Notice.

We discuss our budget neutrality methodology in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60625 through 60629). Using updated payment amounts for the OPPS and MPFS for the services affected by the Affordable Care Act and additional changes to the CY 2010 MPFS non-facility practice expensive payment amounts based on the correction notices, we followed our standard scaling methodology to take into account the changes in the OPPS and MPFS payment amounts. We used the same claims data and scaling methodology described in the CY 2010 OPPS/ASC final rule with comment period to calculate a revised CY 2010 ASC payment weight scalar of 0.9556. (We previously finalized a CY 2010 ASC payment weight scalar of 0.9567 (74 FR 60628)). After scaling the weights, we calculated a wage index adjustment of 0.9996 and a final ASC conversion factor of $41.873. Both of these numbers did not change from what we previously finalized for CY 2010 (74 FR 60629). The Affordable Care Act did not impact the pre-floor, pre-reclassification wage indices that we adopt in the ASC payment system or the CPI–U. Therefore, the wage index adjustment and the final ASC conversion factor remained the same. We note that the technical corrections in the second correction notice impacted covered office-based procedures and covered ancillary radiology services with payment indicators of "P3" and "Z3". When we recalculated budget neutrality to address Affordable Care Act changes in this Notice, we also reflected the technical changes made in previous correction notices; therefore, the CY 2010 payment for many covered office-based procedures and covered ancillary radiology services changed at least modestly.

We historically also have reported the payment weight scalar that we would have calculated if we proposed to fully implement the ASC payment system in the coming calendar year without further transition. In the CY 2010 OPPS/ASC final rule, we published a fully implemented CY 2010 ASC payment weight scalar of 0.9338 (74 FR 60674). Using the same claims data and budget neutrality methodology, including adjusting for changes in the wage index, and updating the OPPS and MPFS inputs, we calculated a revised fully implemented CY 2010 ASC payment weight scalar of 0.9326.

Using the revised scaled ASC payment weights and the conversion factor of $41.873, the revised OPPS payment amounts, and the revised MPFS non-facility practice expense payment amounts, we recalculated the revised CY 2010 ASC payment rates for all services, including device-intensive services, brachytherapy sources, and office-based and ancillary radiology services, appearing in Addenda AA and BB of this notice. These payment rates are effective for services furnished on and after January 1, 2010 through December 31, 2010. These files also may be viewed as supporting documentation to this Notice at *http://www.cms.gov/ASCPayment.*

For purposes of applying the policy to reduce ASC payment for procedures involving devices furnished without cost or at reduced cost (74 FR 60613 through 60618), the revised offset amounts of the ASC payment are not published as addenda to the ASC update rules but are available at *http://www.cms.gov/ASCPayment* under "Annual Policy Files."

C. Elimination of Sunset for Reimbursement for All Medicare Part B Services in Hospitals and Clinics Operated by the Indian Health Service, Indian Tribes, or Tribal Organizations

Section 2902 of the Affordable Care Act indefinitely extends Section 630 of the MMA, retroactive to January 1, 2010. The specific Part B services are:

- Ambulance services;
- Clinical laboratory services;
- Part B drugs processed by the J4 A/B MAC and the DME MACs;
- Influenza and pneumonia vaccinations;
- Durable medical equipment;
- Therapeutic shoes;
- Prosthetics and orthotics;
- Surgical dressings, splints, and casts; and
- Screening and preventive services not covered prior to the implementation of section 630 of the MMA

Section 2902 of the Affordable Care Act indefinitely extends section 630 of the MMA to provide coverage for all Medicare Part B services listed above that were previously not covered under the Social Security Act. Hospitals operated by the Indian Health Service, Indian Tribes, or Tribal Organizations, however, will continue to be paid for Part B services under an all inclusive rate for hospital outpatient services rather than under the OPPS.

II. Other Required Information

A. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995.

B. Waiver of Proposed Rulemaking

We ordinarily publish a Notice of proposed rulemaking in the **Federal Register** and invite public comment prior to a rule taking effect in accordance with section 553(b) of the Administrative Procedures Act (APA) and section 1871 of the Act. In addition in accordance with section 553(d) of the APA and section 1871(e)(1)(B)(i) of the Act, we ordinarily provide a 30-day delay to a substantive rule's effective date. For substantive rules that constitute major rules, in accordance with 5 U.S.C. 801, we ordinarily provide a 60-day delay in the effective date.

None of the above processes or effective date requirements apply, however, when the rule in question is interpretive, a general statement of policy or a rule of agency organization, procedure or practice. They also do not apply when Congress, itself, has created the rules that are to be applied, leaving no discretion or gaps for an agency to fill in through rulemaking.

In addition, an agency may waive notice and comment rulemaking, as well as any delay in effective date, when the agency for good cause finds that notice and public comment on the rule, as well as the effective date, are impracticable, unnecessary or contrary to the public interest. In cases where an agency finds good cause, the agency must incorporate a statement of this finding and its reason in the rule issued.

The policies being publicized in this Notice do not constitute agency rulemaking. Rather, Congress, in the Affordable Care Act, has already required that the agency make these changes and we are simply notifying the public of the statutory requirements and their effect on payments made under the CY 2010 OPPS and ASC payment system. Specifically, we are notifying the public of the changes to payments for the CY 2010 OPPS that result from the reduction to the OPD fee schedule increase factor and the changes to the wage indices required by the Affordable Care Act. We are also notifying the public of the extension of section 508 reclassifications and special exception wage indices for FY 2010 (which apply to the OPPS for CY 2010), as well as the

wage Indices resulting from Congress' requirement that certain reclassification wage indices be recalculated (effective April 1, 2010) to account for such extensions. We are also notifying the public that Congress extended transitional outpatient payments (TOPs) for a rural hospital that has not more than 100 beds and that is not a sole community hospital as well as for sole community hospitals such that the sole community hospital need not satisfy the 100-bed limitation for covered OPD service furnished on or after January 1, 2010 and before January 1, 2011. We are notifying the public that Congress extended Medicare payments to the Indian Health Service, Indian Tribes, or Tribal Organizations for selected Part B services. We are notifying the public of changes made to ASC payment rates due to changes to the OPPS conversion factor under the Affordable Care Act. Lastly, we are notifying the public that Congress has changed payment for bone density scans under the MPFS, which may impact payment for these services furnished in ASCs on or after January 1, 2010. As this Notice merely informs the public of these required modifications to the CY 2010 payment rates under the OPPS and, indirectly, to the ASC payment system, it is not a rule and does not require any notice and comment rulemaking. Additionally, for the ASC payment system, the payment rates announced in this Notice reflect technical corrections made to the MPFS that impact the ASC payment rates that we addressed in prior ASC correction notices; we are simply notifying the public of the effect on payment made under the CY 2010 ASC payment system based on these prior correction notices. To the extent that any of the policies articulated in this Notice constitute interpretations of Congress's requirements or procedures that will be used to implement Congress's directives, they are interpretative rules, general statements of policy and/or rules of agency procedure or practice, which are not subject to notice and comment rulemaking or a delayed effective date.

However, to the extent that notice and comment rulemaking or a delay in effective date or both would otherwise apply, we find good cause to waive such requirements. Specifically, we find it unnecessary to undertake notice and comment rulemaking in this instance because the provisions of the Affordable Care Act are self-implementing, and further many are already effective and have been implemented. Therefore, we would be unable to change any of the policies governing the OPPS and ASC payment systems for CY 2010, or the other changes made by the Affordable Care in response to public comment on this Notice. As the changes outlined in this Notice have already taken effect and are a result of the statutory effective dates, it would also be impracticable to undertake notice and comment rulemaking. Additionally, this Notice does not make any changes to the policies and payment methodologies for the OPPS and ASC payment system that were finalized in the CY 2010 OPPS/ASC final rule with comment period. Further, we believe it is in the public interest to have the accurate information and to have it as soon as possible and not delay its dissemination. For these reasons, we also find that a waiver of any delay in effective date, if it were otherwise applicable, is necessary to comply with the requirements of sections 2902, 3111, 3121, 3137, 3401 and 10319 of the Patient Protection and Affordable Care Act and section 1105 of the Health Care and Education Reconciliation Act of 2010. Therefore we find good cause to waive notice and comment procedures as well as any delay in effective date, if such procedures or delays are required at all.

III. Regulatory Impact Statement or Analysis

A. Overall Impact

Although this Notice merely announces provisions of the Affordable Care Act, and does not constitute a substantive rule, we are nevertheless preparing this impact analysis in the interest of ensuring that the impact of these changes are fully understood. The changes in this Notice are already in effect, with changes made to the OPPS pricer and the ASC payment system and have been announced through a Joint Signature Memorandum of instruction to Medicare contractors. We have, nevertheless, examined the impacts of this Notice as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), Executive Order 13132 on Federalism, and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules that have economically significant effects ($100 million or more in any 1 year) or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal government or communities.

We estimate that the effects of the OPPS provisions that are announced in this Notice will not result in expenditures exceeding $100 million in any 1 year and therefore are not economically significant. We estimate the difference between CY 2010 OPPS expenditures required by or resulting from the Affordable Care Act that are announced in this Notice, when compared to the estimated expenditures announced in our November 20, 2009 CY 2010 final rule, (74 FR 60316) to be a decrease of approximately $98 million. Because this Notice is not a major rule, and because, furthermore, the expected change in expenditures resulting from the Affordable Care Act does not reach the $100 million threshold for a RIA, we are not required to provide a regulatory impact analysis.

However, because the changes required by the Affordable Care Act for the CY 2010 OPPS affect payment, we have prepared a regulatory impact analysis of changes to the OPPS payment system that, to the best of our ability, presents the costs and benefits of this Notice. Table I of this Notice displays the redistributional impact of the CY 2010 changes required by the Affordable Care Act on OPPS payment. The provisions of the Affordable Care Act result in a change in OPPS payments for CY 2010 as announced in this Notice compared to the CY 2010 payments established under the CY 2010 OPPS/ASC final rule appearing in the November 20, 2009 **Federal Register**. Table I presents only the changes in CY OPPS 2010 payments that result from the Affordable Care Act. We estimate that the effects of the changes to the CY 2010 OPPS and the non-facility MPFS PE RVUs resulting from the Affordable Care Act on the ASC payment system that are announced by this Notice will not exceed $100 million in any 1 year and, therefore, are not economically significant. Overall, we observe no change in aggregate expenditures under the CY 2010 ASC Payment System resulting from changes to the CY 2010 OPPS and MPFS as required by the Affordable Care Act and by technical changes implemented by prior correction notices.

The RFA requires agencies to analyze options for regulatory relief of small businesses if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Many hospitals, other providers, ASCs, and other suppliers are considered to be small entities, either by being nonprofit organizations or by meeting the Small Business Administration (SBA) definition of a small business (hospitals having revenues of $34.5 million or less in any 1 year and ASCs having revenues of $10 million or less in any 1 year). (For details on the latest standards for health care providers, we refer readers to the SBA's Web site at: *http://sba.gov/idc/groups/public/documents/sba_homepage/serv_sstd_tablepdf.pdf* (refer to the 620000 series).)

For purposes of the RFA, we have determined that many hospitals and most ASCs would be considered small entities according to the SBA size standards. Individuals and States are not included in the definition of a small entity. Therefore, the Secretary has determined that this Notice will have a significant impact on a substantial number of small entities. We acknowledge that many of the affected entities are small entities. The discussion presented in this Notice and the impact analysis presented in Table I constitute our regulatory flexibility analysis of the impact of the provisions of the Affordable Care Act on small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we now define a small rural hospital as a hospital that is located outside an urban area and has fewer than 100 beds. Section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98–21) designated hospitals in certain New England counties as belonging to the adjacent urban areas. Thus, for OPPS purposes, we continue to classify these hospitals as urban hospitals.

We believe that the changes to the OPPS announced by this Notice affect both a substantial number of rural hospitals as well as other classes of hospitals and that the effects on some may be significant. Therefore, the Secretary has determined that this Notice has a significant impact on the operations of a substantial number of small rural hospitals. Specifically, section 3121 of the Affordable Care Act extends TOPs payment for small rural hospitals that are not sole community hospitals and that have 100 or fewer beds and payments for SCHs (including EACHs), that meet applicable requirements regardless of the 100-bed limitation for covered OPD services furnished on and after January 1, 2010 through December 31, 2010. *See* our discussion of this change in section I.A.5 above. In addition, section 3137 as amended by section 10317 of the Affordable Care Act extends section 508 reclassifications and special exception wage index values from October 1, 2009 through September 30. It also resulted in the recalculation of wage index values to exclude the wage data of section 508/special exception hospitals in certain circumstances, thereby changing the final wage index values, effective April 1 for IPPS and July 1 for OPPS. These wage index changes affect some small rural hospitals. *See* section I.A.4 of this Notice for a discussion of the wage index changes required by Affordable Care Act. We also anticipate that Affordable Care Act changes impacting ASC payment in general will impact payment to rural ASCs.

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. That threshold level is currently approximately $133 million. This Notice will not mandate any requirements for State, local, or tribal governments, nor will it affect private sector costs.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct costs on State and local governments, preempts State law, or otherwise has Federalism implications. We have examined the provisions included in this Notice in accordance with Executive Order 13132, Federalism, and have determined that they will not have a substantial direct effect on State, local or tribal governments, preempt State law, or otherwise have a Federalism implication.

The following analysis, in conjunction with the remainder of this document, demonstrates that this Notice is consistent with the regulatory philosophy and principles identified in Executive Order 12866, the RFA, and section 1102(b) of the Act. The changes to the payment amounts under CY 2010 OPPS that are required by the Affordable Care Act and that are announced in this Notice will affect payments to a substantial number of small rural hospitals and a small number of rural ASCs, as well as other classes of hospitals and ASCs, and some effects may be significant.

The impact analysis presented in the CY 2010 OPPS/ASC final rule (74 FR 60662 through 60673) showed the estimated impact of changes to payments for CY 2010 OPPS compared to the estimated payments for CY 2009 OPPS. In contrast, the impact analysis presented in this Notice shows the estimated impact of changes to payment for CY 2010 as a result of the implementation of the changes required by the Affordable Care Act. The Affordable Care Act changed payments for services for which the payment is calculated using the conversion factor. In addition, we note that none of the APC relative weights changed because the relative weight calculations are not made using the conversion factor. For an assessment of distributional impact of changes to the relative weights between CY 2009 and CY 2010 please see the CY 2010 OPPS/ASC final rule (74 FR 60667 through 60672). Therefore, the decrease of 0.1 percent reflects changes to the total OPPS payment that would have been made in CY 2010 absent the provisions of the Affordable Care Act (This impact does not include the impact of changes to TOPs). However, we note that hospitals continue to receive a positive payment increase relative to CY 2009. When we compare the estimated total payments for the CY 2010 OPPS, including the provisions of the Affordable Care Act, to the estimated total payments for the CY 2009 OPPS, we find that for CY 2010, we expect that hospitals will see an aggregate increase in total OPPS payment of approximately $500 million, compared to CY 2009.

Effects of OPPS Changes in This Notice

This Notice announces changes to the OPPS and ASC payments for services furnished in CY 2010 that are required as a result of Sections 3121, 3401, 3137 and 10319 of the Patient Protection and Affordable Care Act and section 1105 of the Health Care and Education Reconciliation Act of 2010. These changes are discussed in detail in I.A of this Notice. Under the recalculated OPPS payment rates announced in this Notice, we estimate that the revised update to the conversion factor and other adjustments as provided by the statute will decrease total OPPS

payments by 0.1 percent in CY 2010 compared to payment rates under the November 20, 2009 CY 2010 OPPS/ASC final rule.

The distributional impacts presented here are the projected effects of changes to the CY 2010 payments on various hospital groups, comparing the estimated CY 2010 OPPS payments under this Notice to the estimated payments under the November 20, 2009 CY 2010 OPPS/ASC final rule. We post on the CMS Web site our hospital-specific estimated payments for CY 2010 with the other supporting documentation for this Notice. To view the hospital-specific estimates of CY 2010 OPPS payments that we calculated including the effects of the changes made by the Affordable Care Act, we refer readers to the CMS Web site at: *http://www.cms.gov/HospitalOutpatientPPS/*. Select "regulations and Notices" from the left side of the page and then select "CMS–1504–N" from the list of regulations and Notices. The hospital-specific file layout and the hospital-specific file are listed with the other supporting documentation for this Notice of changes to the CY 2010 payment rates. We show hospital-specific data only for hospitals whose claims were used for modeling the impacts shown in Table I below. We do not show hospital-specific impacts for hospitals whose claims we were unable to use. We refer readers to section II.A.2. of the CY 2010 OPPS final rule (75 FR 60347) for a discussion of the hospitals whose claims we do not use for ratesetting and impact purposes.

We estimate the effects of the individual policy changes by estimating payments per service, while holding all other payment policies constant. We use the best data available, but do not attempt to predict behavioral responses to our policy changes. In addition, we do not make adjustments for future changes in variables such as service volume, service mix, or number of encounters.

Table 1 below shows the estimated impact of the changes on hospitals' CY 2010 OPPS payment as a result of the Affordable Care Act. Historically, the first line of the impact table, which estimates the change in payments to all hospitals, has always included cancer and children's hospitals, which are held harmless to their pre-BBA payment-to-cost ratio. We also are including CMHCs in the first line that includes all providers because we included CMHCs in our CY 2010 weight scaler estimate discussed in our November 20, 2009 CY 2010 OPPS/ASC final rule with comment period (74 FR 60408).

We present separate impacts for CMHCs in Table 1 because CMHCs are paid under only two APCs for services under the OPPS: APC 0172 (Level 1 Partial Hospitalization (3 units of service)) and APC 0173 (Level II Partial Hospitalization (4 or more units of service)). We note that CMHCs are also a different provider type.

The estimated decrease in the total payments made under the CY 2010 OPPS is a result of the decrease in the OPD fee schedule update factor as required by sections 3401 and 10319 of the Patient Protection and Affordable Care Act and section 1105 of the Health Care and Education Reconciliation Act of 2010, and the influence of the changes to the wage index required by section 3137 as amended by section 10317 of the Affordable Care Act. The distributional impacts presented do not include assumptions about changes in volume and service mix. The enactment of Public Law 108–173 on December 8, 2003, provided for the additional payment outside of the budget neutrality requirement for wage index for specific hospitals reclassified under section 508. Section 3137 as amended by section 10317 of the Affordable Care Act extended these section 508 reclassifications for October 1, 2009 through September 30, 2010. The amounts attributable to these reclassifications are incorporated into the CY 2010 estimates in the final column of Table 1.

Table 1 shows the estimated redistribution of hospital and CMHC payments among providers between payments under the November 20, 2009 CY 2010 OPPS/ASC final rule published for CY 2010 and the CY 2010 payments announced in this Notice as a result of APC reconfiguration and recalibration (Column 2; which remain unchanged from the publication of the CY 2010 OPPS on November 20, 2009 because there were no changes made by the Affordable Care Act to the assignment of services to APCs or the median costs from which the scaled relative weights are derived); wage index changes (Column 3; which reflect the changes made by section 3137 (amended by section 10317) of the Affordable Care Act)); the combined impact of the APC recalibration, wage index effects, and the reduction applied to the OPD fee schedule increase factor (which is revised as required by sections 3401 and 10319 of the Patient Protection and Affordable Care Act and section 1105 of the Health Care and Education Reconciliation Act of 2010) which is used to update the conversion factor (Column 4); and, finally, estimated redistribution considering all payments for CY 2010 under this Notice relative to all CY 2010 payments under the November 20, 2009 CY 2010 OPPS/ASC final rule (Column 5). Because the reduction that applies to the OPD fee schedule increase factor as required by the Affordable Care Act, is applied uniformly across services for which the conversion factor is used to calculate OPPS payment, observed redistributions of payments in the impact table for hospitals largely depend on the impact of the wage index changes under section 3137 including changes to the wage index for the second half of the year and the extension of the section 508 reclassifications for part of CY 2010. However, total payments made under this system and the extent to which the changes required by Affordable Care Act would redistribute money during implementation also depend on volume, practice patterns, and the mix of services billed by various groups of hospitals, which CMS cannot forecast.

Overall, the revised CY 2010 OPPS rates are expected to have a negative effect for providers paid under the OPPS, resulting in a 0.1 percent estimated decrease in Medicare payments compared to CY 2010 OPPS rates announced in the November 20, 2009 final rule with comment period. Removing cancer and children's hospitals, because their payments are held harmless to the pre-BBA ratio between payment and cost, and CMHCs because they are a different provider type paid under two specific APCs, suggests that the required changes will continue to result in a 0.1 percent estimated decrease in Medicare payments to all other hospitals.

Table 1 contains the standard content that is provided in every OPPS impact table published in the **Federal Register**. Specifically, Column 1 contains the number of hospitals in total and by category for which we calculated an impact. These are the same hospitals whose claims were used for ratesetting and modeling of impacts for the CY 2010 OPPS that was published on November 20, 2010. Column 2 displays the CY 2010 APC changes due to the reassignment and recalibration under this Notice, relative to the November 20, 2009 CY 2010 OPPS/ASC final rule (74 FR 60431). Because nothing in the Affordable Care Act changed APC assignment or calibration, there are no changes in this column. Column 3 displays the effect of the new wage index changes required by the Affordable Care Act compared to the previous FY 2010 wage index adopted in the November 20, 2009 CY 2010 OPPS/ASC final rule. Although there are changes to the wage indices for some

hospitals for half of the year because of changes made by the Affordable Care Act, the impact does not rise to a tenth of a percent for any category of provider. Column 4 displays the effect of the budget neutrality changes between the November 20, 2009 CY 2010 OPPS/ASC final rule and the payment rates for CY 2010 as announced by this Notice, specifically the reduction applied to the OPD fee schedule update factor as a result of the Affordable Care Act. Because not all OPPS payments are based on the conversion factor (*e.g.* separately paid drugs and biologicals are paid at ASP+4 percent for CY 2010), the impact of the 0.25 percentage point reduction to the OPD fee schedule update factor does not affect payment for all services and therefore the impact of the reduction is slightly less than 0.25. Column 5 displays the combined impact of all changes made for CY 2010, including changes in the section 508 reclassification wage index as required by the Affordable Care Act relative to payments announced in the November 20, 2009 CY2010 OPPS/ASC final rule. Therefore it incorporates the changes in payment that are outside of budget neutrality for section 508 and certain special exception hospitals. The increase in payment outside budget neutrality for section 508 hospitals is present throughout column 5 and is isolated as a 1.8 percent increase in the last row of Table 1.

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TABLE 1.—ESTIMATED IMPACT OF CHANGES TO CY 2010 PAYMENTS FOR HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM CREATED BY PROVISIONS IN THE AFFORDABLE CARE ACT

		Number of Hospitals (1)	APC Recalibration (No Changes from ACA) (2)	Revised Wage Index Resulting from ACA (3)	Combines (cols 2,3) with revised Market Basket Update (4)	All Changes (Includes Extension of Section 508 Reclass Wage Index)
ALL PROVIDERS *		4,222	0.0	0.0	-0.2	-0.1
ALL HOSPITALS		3,942	0.0	0.0	-0.2	-0.1
(excludes hospitals permanently held harmless and CMHCs)						
URBAN HOSPITALS		2,951	0.0	0.0	-0.2	-0.1
	LARGE URBAN	1,608	0.0	0.0	-0.2	-0.2
	(GT 1 MILL.)					
	OTHER URBAN	1,343	0.0	0.0	-0.2	-0.1
	(LE 1 MILL.)					
RURAL HOSPITALS		991	0.0	0.0	-0.2	-0.1
	SOLE COMMUNITY**	391	0.0	0.0	-0.2	0.0
	OTHER RURAL	600	0.0	0.0	-0.2	-0.2
BEDS (URBAN)						
	0 - 99 BEDS	1,005	0.0	0.0	-0.2	-0.2
	100-199 BEDS	881	0.0	0.0	-0.2	-0.1
	200-299 BEDS	460	0.0	0.0	-0.2	-0.2
	300-499 BEDS	407	0.0	0.0	-0.2	-0.1
	500 + BEDS	198	0.0	0.0	-0.2	-0.1
BEDS (RURAL)						
	0 - 49 BEDS**	359	0.0	0.0	-0.2	-0.1
	50- 100 BEDS**	375	0.0	0.0	-0.2	-0.1
	101- 149 BEDS	148	0.0	0.0	-0.2	-0.2
	150- 199 BEDS	64	0.0	0.0	-0.2	-0.1
	200 + BEDS	45	0.0	0.0	-0.2	-0.1

		Number of Hospitals (1)	APC Recalibration (No Changes from ACA) (2)	Revised Wage Index Resulting from ACA (3)	Combines (cols 2,3) with revised Market Basket Update (4)	All Changes (Includes Extension of Section 508 Reclass Wage Index)
VOLUME (URBAN)						
	LT 5,000 Lines	604	0.0	0.0	-0.2	-0.2
	5,000 - 10,999 Lines	174	0.0	0.0	-0.2	-0.1
	11,000 - 20,999 Lines	250	0.0	0.0	-0.2	-0.2
	21,000 - 42,999 Lines	514	0.0	0.0	-0.2	-0.2
	GT 42,999 Lines	1,409	0.0	0.0	-0.2	-0.1
VOLUME (RURAL)						
	LT 5,000 Lines	80	0.0	0.0	-0.2	-0.2
	5,000 - 10,999 Lines	89	0.0	0.0	-0.2	-0.2
	11,000 - 20,999 Lines	186	0.0	0.0	-0.2	0.0
	21,000 - 42,999 Lines	323	0.0	0.0	-0.2	-0.2
	GT 42,999 Lines	313	0.0	0.0	-0.2	-0.1
REGION (URBAN)						
	NEW ENGLAND	150	0.0	0.0	-0.2	0.0
	MIDDLE ATLANTIC	370	0.0	0.3	-0.2	0.0
	SOUTH ATLANTIC	455	0.0	0.0	-0.2	-0.2
	EAST NORTH CENT.	470	0.0	0.0	-0.2	0.0
	EAST SOUTH	188	0.0	0.0	-0.2	-0.2

		Number of Hospitals (1)	APC Recalibration (No Changes from ACA) (2)	Revised Wage Index Resulting from ACA (3)	Combines (cols 2,3) with revised Market Basket Update (4)	All Changes (Includes Extension of Section 508 Reclass Wage Index)
	CENT.					
	WEST NORTH CENT.	197	0.0	0.0	-0.2	-0.2
	WEST SOUTH CENT.	486	0.0	0.0	-0.2	-0.2
	MOUNTAIN	192	0.0	0.0	-0.2	-0.2
	PACIFIC	393	0.0	0.0	-0.3	-0.3
	PUERTO RICO	50	0.0	0.0	-0.2	-0.2
REGION (RURAL)						
	NEW ENGLAND	24	0.0	0.0	-0.2	-0.2
	MIDDLE ATLANTIC	68	0.0	0.0	-0.2	-0.2
	SOUTH ATLANTIC	169	0.0	0.0	-0.2	-0.2
	EAST NORTH CENT.	130	0.0	0.0	-0.2	-0.1
	EAST SOUTH CENT.	177	0.0	0.0	-0.2	-0.2
	WEST NORTH CENT.	104	0.0	0.0	-0.2	0.1
	WEST SOUTH CENT.	216	0.0	0.0	-0.2	-0.2
	MOUNTAIN	72	0.0	0.0	-0.2	0.0
	PACIFIC	31	0.0	0.0	-0.3	0.0
TEACHING STATUS						
	NON-TEACHING	2,952	0.0	0.0	-0.2	-0.2
	MINOR	706	0.0	0.0	-0.2	-0.1
	MAJOR	284	0.0	0.0	-0.2	-0.1
DSH PATIENT PERCENT						

		Number of Hospitals (1)	APC Recalibration (No Changes from ACA) (2)	Revised Wage Index Resulting from ACA (3)	Combines (cols 2,3) with revised Market Basket Update (4)	All Changes (Includes Extension of Section 508 Reclass Wage Index)
	0	9	0.0	0.0	-0.2	-0.2
	GT 0 - 0.10	401	0.0	0.0	-0.2	-0.1
	0.10 - 0.16	434	0.0	0.0	-0.2	-0.1
	0.16 - 0.23	763	0.0	0.0	-0.2	-0.1
	0.23 - 0.35	974	0.0	0.0	-0.2	-0.1
	GE 0.35	744	0.0	0.0	-0.2	-0.2
	DSH NOT AVAILABLE ***	617	0.0	0.0	-0.3	-0.2
URBAN TEACHING/DSH						
	TEACHING & DSH	894	0.0	0.0	-0.2	-0.1
	NO TEACHING/DSH	1,468	0.0	0.0	-0.2	-0.2
	NO TEACHING/NO DSH	8	0.0	0.0	-0.2	-0.2
	DSH NOT AVAILABLE***	581	0.0	0.0	-0.3	-0.3
TYPE OF OWNERSHIP						
	VOLUNTARY	2,100	0.0	0.0	-0.2	-0.1
	PROPRIETARY	1,257	0.0	0.0	-0.2	-0.2
	GOVERNMENT	585	0.0	0.0	-0.2	-0.2
CMHCs		221	0.0	0.0	-0.2	-0.2
Hospitals not Reclassified		3029	0.0	0.0	-0.2	-0.2
Hospitals Reclassified – not Section 508		810	0.0	0.0	-0.2	-0.2
Hospitals Reclassified per Section 508		103	0.0	0.0	-0.3	1.8

Column (1) shows total hospitals.
Column (2) shows that Affordable Care Act did not change the reclassification of HCPCS codes among APC groups and the recalibration of APC weights for CY 2010 payment.
Column (3) shows the impact of revising final wage index values by excluding wage data for special exception/section 508 hospitals in certain circumstances from July 1, 2010 to December 31, 2010. These wage index revisions are subject to budget neutrality and included in column (3).
Column (4) shows the impact of the Affordable Care Act required 0.25 percentage point reduction to the OPD fee schedule increase factor.
Column (5) shows the combined effects of the Affordable Care Act resulting in a revised conversion factor, the revised wage index from column (3), and change in payments to hospitals reclassified under section 508, which expire on September 30, 2010.
* These 4,222 providers include children and cancer hospitals, which are held harmless to their pre-BBA payments, and CMHCs.
** Section 3121 of the Affordable Care Act extended "hold harmless" status for sole community hospitals, including essential access hospitals, irrespective of the 100-bed limitation for covered OPD-services furnished on or after January 1, 2010 through December 31, 2010, and for small rural hospitals that are not sole community hospitals with 100 or fewer beds through December 31, 2010.
*** Complete DSH numbers are not available for providers that are not paid under IPPS, including rehabilitation hospitals, freestanding psychiatric hospitals, and long-term care hospitals.

5. Estimated Effect of This Notice on Beneficiaries

For services for which the beneficiary pays a copayment of 20 percent of the payment rate, the beneficiary share of payment will increase for services for which the OPPS payments will rise and will decrease for services for which the OPPS payments will fall. In all cases, the statute limits beneficiary liability for copayment for a procedure to the hospital inpatient deductible for the applicable year. The CY 2010 hospital inpatient deductible is $1,100.

In order to better understand the impact of changes in copayment on beneficiaries, we modeled the percent change in total copayment liability. We estimate, using the claims of the 4,222 hospitals and CMHCs on which our modeling is based, that total beneficiary liability for copayments continues to be 22.6 percent, as estimated in the November 20, 2009 CY 2010 OPPS/ASC final rule (74 FR 60673). To assess whether there are changes to the aggregate percentage of beneficiary liability, we recalculated the percentage using the revised conversion factor and wage indices on which the revised payments being announced in this Notice are based.

6. Conclusion

The changes announced in this Notice will affect all classes of hospitals and CMHCs. We estimated that most classes of hospitals will experience minor losses or remain neutral and that all classes of hospitals will experience negative updates in OPPS payments in CY 2010 compared to the payments announced in the November 20, 2009 CY 2010 OPPS/ASC final rule as a result of the provisions of the Affordable Care Act.

Table 1 demonstrates the estimated distributional impact of the OPPS budget neutrality requirements that are expected to result in a 0.1 percent decrease in payments for all services paid under the OPPS in CY 2010 under this Notice when compared to the November 20, 2009 CY 2010 OPPS/ASC final rule, after considering the OPD fee schedule increase factor (revised by the Affordable Care Act), wage index changes (including the effects of the extension of the section 508 reclassifications), estimated payment for outliers (which did not change as a result of the Affordable Care Act), and changes to the pass-through payment estimate (which did not change as a result of the Affordable Care Act). The accompanying discussion, in combination with the rest of this Notice, constitutes a regulatory impact analysis.

7. Accounting Statement

As required by OMB Circular A–4 (available at *http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf*), in Table 2, we have prepared an accounting statement showing the CY 2010 estimated hospital OPPS incurred benefit impact associated with the changes to the CY 2010 OPD fee schedule increase factor and budget neutral wage index changes (as revised by the Affordable Care Act) shown in this Notice based on the baseline for the 2010 Medicare Trustees Report. All estimated impacts are classified as transfers.

TABLE 2--ACCOUNTING STATEMENT: CY 2010 ESTIMATED HOSPITAL OPPS INCURRED BENEFIT IMPACT ASSOCIATED WITH THE CY 2010 OPD FEE SCHEDULE INCREASE FACTOR AND BUDGET NEUTRAL WAGE INDEX CHANGES AS REVISED BY THE AFFORDABLE CARE ACT

Category	Transfers
Annualized Monetized Transfers	$0.1 billion
From Whom to Whom	Outpatient hospitals and other providers who received payment under the hospital OPPS to Federal Government
Total	$0.1 billion

BILLING CODE 4120–01–P

Addendum A.-OPPS APCs for CY 2010 as Revised by the Affordable Care Act

APC	Group Title	SI	Relative Weight	Payment rate	National Unadjusted Copayment	Minimum Unadjusted Copayment	* Indicates a Change
0001	Level I Photochemotherapy	S	0.5302	$35.65	.	$7.13	*
0002	Fine Needle Biopsy/Aspiration	T	1.5111	$101.61	.	$20.33	*
0003	Bone Marrow Biopsy/Aspiration	T	3.0998	$208.43	.	$41.69	*
0004	Level I Needle Biopsy/ Aspiration Except Bone Marrow	T	4.5991	$309.25	.	$61.85	*
0005	Level II Needle Biopsy/Aspiration Except Bone Marrow	T	7.8145	$525.45	.	$105.09	*
0006	Level I Incision & Drainage	T	1.4557	$97.88	.	$19.58	*
0007	Level II Incision & Drainage	T	12.6217	$848.70	.	$169.74	*
0008	Level III Incision and Drainage	T	19.4063	$1,304.90	.	$260.98	*
0012	Level I Debridement & Destruction	T	0.4436	$29.83	.	$5.97	*
0013	Level II Debridement & Destruction	T	0.8789	$59.10	.	$11.82	*
0015	Level III Debridement & Destruction	T	1.5412	$103.63	.	$20.73	*
0016	Level IV Debridement & Destruction	T	2.7982	$188.15	.	$37.63	*
0017	Level VI Debridement & Destruction	T	21.2653	$1,429.90	.	$285.98	*
0019	Level I Excision/ Biopsy	T	4.3625	$293.34	$64.35	$58.67	*
0020	Level II Excision/ Biopsy	T	8.2028	$551.56	.	$110.32	*
0021	Level III Excision/ Biopsy	T	17.4975	$1,176.55	.	$235.31	*
0022	Level IV Excision/ Biopsy	T	23.3880	$1,572.63	$354.45	$314.53	*
0028	Level I Breast Surgery	T	24.7516	$1,664.32	.	$332.87	*
0029	Level II Breast Surgery	T	34.1654	$2,297.32	$581.52	$459.47	*
0030	Level III Breast Surgery	T	41.9997	$2,824.10	$747.07	$564.82	*
0031	Smoking Cessation Services	X	0.3448	$23.18	.	$4.64	*
0034	Mental Health Services Composite	S	3.1286	$210.37	.	$42.08	*
0035	Vascular Puncture and Minor Diagnostic Procedures	X	0.2320	$15.60	.	$3.12	*
0037	Level IV Needle Biopsy/Aspiration Except Bone Marrow	T	15.5003	$1,042.26	$228.76	$208.46	*
0039	Level I Implantation of Neurostimulator Generator	S	206.1011	$13,858.44	.	$2,771.69	*
0040	Percutaneous Implantation of Neurostimulator Electrodes	S	65.7095	$4,418.37	.	$883.68	*

APC	Group Title	SI	Relative Weight	Payment rate	National Unadjusted Copayment	Minimum Unadjusted Copayment	* Indicates a Change
0041	Level I Arthroscopy	T	29.9198	$2,011.84	.	$402.37	*
0042	Level II Arthroscopy	T	48.8176	$3,282.54	$804.74	$656.51	*
0045	Bone/Joint Manipulation Under Anesthesia	T	15.2922	$1,028.26	$268.44	$205.66	*
0047	Arthroplasty without Prosthesis	T	39.8877	$2,682.09	$537.03	$536.42	*
0048	Level I Arthroplasty or Implantation with Prosthesis	T	58.0838	$3,905.61	.	$781.13	*
0049	Level I Musculoskeletal Procedures Except Hand and Foot	T	22.0149	$1,480.30	.	$296.06	*
0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	31.7717	$2,136.36	.	$427.28	*
0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	46.5786	$3,131.99	.	$626.40	*
0052	Level IV Musculoskeletal Procedures Except Hand and Foot	T	88.6521	$5,961.06	.	$1,192.22	*
0053	Level I Hand Musculoskeletal Procedures	T	17.0420	$1,145.92	$253.49	$229.19	*
0054	Level II Hand Musculoskeletal Procedures	T	28.2376	$1,898.72	.	$379.75	*
0055	Level I Foot Musculoskeletal Procedures	T	21.8439	$1,468.81	$355.34	$293.77	*
0056	Level II Foot Musculoskeletal Procedures	T	52.5258	$3,531.89	.	$706.38	*
0057	Bunion Procedures	T	31.5534	$2,121.68	$475.91	$424.34	*
0058	Level I Strapping and Cast Application	S	1.0537	$70.85	.	$14.17	*
0060	Manipulation Therapy	S	0.3808	$25.61	.	$5.13	*
0061	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electr	S	86.5171	$5,817.50	.	$1,163.50	*
0062	Level I Treatment Fracture/Dislocation	T	25.8446	$1,737.82	$372.87	$347.57	*
0063	Level II Treatment Fracture/Dislocation	T	45.4678	$3,057.30	.	$611.46	*
0064	Level III Treatment Fracture/Dislocation	T	65.4752	$4,402.62	.	$880.53	*
0065	Level I Stereotactic Radiosurgery, MRgFUS, and MEG	S	14.2808	$960.26	.	$192.06	*
0066	Level II Stereotactic Radiosurgery, MRgFUS, and MEG	S	36.9119	$2,481.99	.	$496.40	*
0067	Level III Stereotactic Radiosurgery, MRgFUS, and MEG	S	52.9891	$3,563.04	.	$712.61	*
0069	Thoracoscopy	T	34.0084	$2,286.76	$591.64	$457.36	*
0070	Thoracentesis/Lavage Procedures	T	5.5521	$373.33	.	$74.67	*
0071	Level I Endoscopy Upper Airway	T	0.8007	$53.84	$11.11	$10.77	*

APC	Group Title	SI	Relative Weight	Payment rate	National Unadjusted Copayment	Minimum Unadjusted Copayment	* Indicates a Change
0072	Level II Endoscopy Upper Airway	T	1.8425	$123.89	.	$24.78	*
0073	Level III Endoscopy Upper Airway	T	4.4119	$296.66	$69.15	$59.34	*
0074	Level IV Endoscopy Upper Airway	T	21.6572	$1,456.25	$292.25	$291.25	*
0075	Level V Endoscopy Upper Airway	T	29.2718	$1,968.27	$445.92	$393.66	*
0076	Level I Endoscopy Lower Airway	T	10.3707	$697.34	$189.82	$139.47	*
0077	Level I Pulmonary Treatment	S	0.4058	$27.29	$7.74	$5.46	*
0078	Level III Pulmonary Treatment	S	1.4142	$95.09	.	$19.02	*
0079	Ventilation Initiation and Management	S	3.0865	$207.54	.	$41.51	*
0080	Diagnostic Cardiac Catheterization	T	39.8099	$2,676.86	$838.92	$535.38	*
0082	Coronary or Non-Coronary Atherectomy	T	93.3244	$6,275.23	.	$1,255.05	*
0083	Coronary or Non-Coronary Angioplasty and Percutaneous Valvuloplasty	T	50.6809	$3,407.83	.	$681.57	*
0084	Level I Electrophysiologic Procedures	S	10.8110	$726.94	.	$145.39	*
0085	Level II Electrophysiologic Procedures	T	52.3882	$3,522.63	.	$704.53	*
0086	Level III Electrophysiologic Procedures	T	106.9978	$7,194.64	.	$1,438.93	*
0088	Thrombectomy	T	40.9003	$2,750.18	$655.22	$550.04	*
0089	Insertion/Replacement of Permanent Pacemaker and Electrodes	T	118.8826	$7,993.78	$1,682.28	$1,598.76	*
0090	Insertion/Replacement of Pacemaker Pulse Generator	T	98.1576	$6,600.22	$1,597.43	$1,320.05	*
0091	Level II Vascular Ligation	T	45.0292	$3,027.81	.	$605.57	*
0092	Level I Vascular Ligation	T	26.5713	$1,786.68	.	$357.34	*
0093	Vascular Reconstruction/Fistula Repair without Device	T	35.5969	$2,393.57	.	$478.72	*
0094	Level I Resuscitation and Cardioversion	S	2.4553	$165.10	$46.29	$33.02	*
0095	Cardiac Rehabilitation	S	0.5691	$38.27	$13.86	$7.66	*
0096	Level II Noninvasive Physiologic Studies	S	1.6075	$108.09	$37.42	$21.62	*
0097	Level I Noninvasive Physiologic Studies	S	0.9848	$66.22	$23.79	$13.25	*
0099	Electrocardiograms	S	0.3940	$26.49	.	$5.30	*
0100	Cardiac Stress Tests	X	2.6136	$175.74	$41.44	$35.15	*
0101	Tilt Table Evaluation	S	4.3705	$293.88	$100.24	$58.78	*
0102	Level II Pulmonary Treatment	S	0.7486	$50.34	.	$10.07	*

APC	Group Title	SI	Relative Weight	Payment rate	National Unadjusted Copayment	Minimum Unadjusted Copayment	* Indicates a Change
0103	Miscellaneous Vascular Procedures	T	17.8436	$1,199.82	.	$239.97	*
0104	Transcatheter Placement of Intracoronary Stents	T	84.7773	$5,700.51	.	$1,140.11	*
0105	Repair/Revision/Removal of Pacemakers, AICDs, or Vascular Devices	T	22.9412	$1,542.59	.	$308.52	*
0106	Insertion/Replacement of Pacemaker Leads and/or Electrodes	T	48.9361	$3,290.51	.	$658.11	*
0107	Insertion of Cardioverter-Defibrillator	T	325.8288	$21,909.05	.	$4,381.81	*
0108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads	T	412.3722	$27,728.32	.	$5,545.67	*
0110	Transfusion	S	3.3809	$227.34	.	$45.47	*
0111	Blood Product Exchange	S	11.9424	$803.02	$198.40	$160.61	*
0112	Apheresis and Stem Cell Procedures	S	33.3206	$2,240.51	.	$448.11	*
0113	Excision Lymphatic System	T	24.6146	$1,655.11	.	$331.03	*
0114	Thyroid/Lymphadenectomy Procedures	T	48.7561	$3,278.41	.	$655.69	*
0115	Cannula/Access Device Procedures	T	30.9784	$2,083.02	.	$416.61	*
0121	Level I Tube or Catheter Changes or Repositioning	T	6.3742	$428.61	.	$85.73	*
0126	Level I Urinary and Anal Procedures	T	1.0958	$73.68	$16.21	$14.74	*
0127	Level IV Stereotactic Radiosurgery, MRgFUS, and MEG	S	108.9558	$7,326.30	.	$1,465.26	*
0128	Echocardiogram with Contrast	S	9.6604	$649.57	$216.29	$129.92	*
0129	Level I Closed Treatment Fracture Finger/Toe/Trunk	T	1.6576	$111.46	.	$22.30	*
0130	Level I Laparoscopy	T	38.0540	$2,558.79	$659.53	$511.76	*
0131	Level II Laparoscopy	T	46.8400	$3,149.57	$1,001.89	$629.92	*
0132	Level III Laparoscopy	T	72.9582	$4,905.78	$1,239.22	$981.16	*
0133	Level I Skin Repair	T	1.3542	$91.06	$25.67	$18.22	*
0134	Level II Skin Repair	T	3.1508	$211.86	.	$42.38	*
0135	Level III Skin Repair	T	4.4386	$298.46	.	$59.70	*
0136	Level IV Skin Repair	T	16.0542	$1,079.50	.	$215.90	*
0137	Level V Skin Repair	T	23.9317	$1,609.19	.	$321.84	*
0138	Level II Closed Treatment Fracture Finger/Toe/Trunk	T	4.7946	$322.39	.	$64.48	*
0139	Level III Closed Treatment Fracture Finger/Toe/Trunk	T	18.3962	$1,236.98	.	$247.40	*

APC	Group Title	SI	Relative Weight	Payment rate	National Unadjusted Copayment	Minimum Unadjusted Copayment	* Indicates a Change
0140	Esophageal Dilation without Endoscopy	T	5.9622	$400.90	$84.58	$80.18	*
0141	Level I Upper GI Procedures	T	8.7462	$588.10	$143.38	$117.62	*
0142	Small Intestine Endoscopy	T	9.8503	$662.34	$152.78	$132.47	*
0143	Lower GI Endoscopy	T	9.1051	$612.24	$186.06	$122.45	*
0146	Level I Sigmoidoscopy and Anoscopy	T	5.7747	$388.30	.	$77.66	*
0147	Level II Sigmoidoscopy and Anoscopy	T	9.2450	$621.64	.	$124.33	*
0148	Level I Anal/Rectal Procedures	T	5.3650	$360.75	.	$72.15	*
0149	Level III Anal/Rectal Procedures	T	23.9703	$1,611.79	.	$322.36	*
0150	Level IV Anal/Rectal Procedures	T	32.1812	$2,163.90	$437.12	$432.78	*
0151	Endoscopic Retrograde Cholangio-Pancreatography (ERCP)	T	22.6111	$1,520.39	.	$304.08	*
0152	Level I Percutaneous Abdominal and Biliary Procedures	T	30.7430	$2,067.19	.	$413.44	*
0153	Peritoneal and Abdominal Procedures	T	27.1855	$1,827.98	$376.05	$365.60	*
0154	Hernia/Hydrocele Procedures	T	31.9682	$2,149.57	$464.85	$429.92	*
0155	Level II Anal/Rectal Procedures	T	14.1140	$949.04	.	$189.81	*
0156	Level III Urinary and Anal Procedures	T	3.0214	$203.16	.	$40.64	*
0157	Colorectal Cancer Screening: Barium Enema	S	1.2511	$84.13	.	$16.83	*
0158	Colorectal Cancer Screening: Colonoscopy	T	8.0912	$544.06	.	$136.02	*
0159	Colorectal Cancer Screening: Flexible Sigmoidoscopy	S	3.7227	$250.32	.	$62.58	*
0160	Level I Cystourethroscopy and other Genitourinary Procedures	T	7.1342	$479.71	.	$95.95	*
0161	Level II Cystourethroscopy and other Genitourinary Procedures	T	17.0344	$1,145.41	.	$229.09	*
0162	Level III Cystourethroscopy and other Genitourinary Procedures	T	25.5223	$1,716.14	.	$343.23	*
0163	Level IV Cystourethroscopy and other Genitourinary Procedures	T	36.2009	$2,434.18	.	$486.84	*
0164	Level II Urinary and Anal Procedures	T	2.0194	$135.79	.	$27.16	*
0165	Level IV Urinary and Anal Procedures	T	20.0243	$1,346.45	.	$269.29	*
0166	Level I Urethral Procedures	T	20.3374	$1,367.51	.	$273.51	*
0168	Level II Urethral Procedures	T	31.3770	$2,109.82	.	$421.97	*
0169	Lithotripsy	T	41.3626	$2,781.26	$997.74	$556.26	*

APC	Group Title	SI	Relative Weight	Payment rate	National Unadjusted Copayment	Minimum Unadjusted Copayment	* Indicates a Change
0170	Dialysis	S	6.8212	$458.66	.	$91.74	*
0172	Level I Partial Hospitalization (3 services)	P	2.2230	$149.48	.	$29.90	*
0173	Level II Partial Hospitalization (4 or more services)	P	3.1286	$210.37	.	$42.08	*
0174	Level IV Laparoscopy	T	109.9237	$7,391.38	$2,064.24	$1,478.28	*
0181	Level II Male Genital Procedures	T	34.8837	$2,345.61	$620.84	$469.13	*
0183	Level I Male Genital Procedures	T	23.2838	$1,565.63	.	$313.13	*
0184	Prostate Biopsy	T	12.4313	$835.89	.	$167.18	*
0188	Level II Female Reproductive Proc	T	1.5277	$102.72	.	$20.55	*
0189	Level III Female Reproductive Proc	T	3.4085	$229.19	.	$45.84	*
0190	Level I Hysteroscopy	T	22.5926	$1,519.15	$424.28	$303.83	*
0191	Level I Female Reproductive Proc	T	0.1320	$8.88	$2.08	$1.78	*
0192	Level IV Female Reproductive Proc	T	6.7949	$456.90	.	$91.38	*
0193	Level V Female Reproductive Proc	T	20.0452	$1,347.86	.	$269.58	*
0195	Level VI Female Reproductive Procedures	T	35.2666	$2,371.36	$483.80	$474.28	*
0202	Level VII Female Reproductive Procedures	T	44.9894	$3,025.13	$981.50	$605.03	*
0203	Level IV Nerve Injections	T	13.2439	$890.53	$225.43	$178.11	*
0204	Level I Nerve Injections	T	2.5558	$171.85	$40.13	$34.37	*
0206	Level II Nerve Injections	T	3.7221	$250.28	$51.76	$50.06	*
0207	Level III Nerve Injections	T	7.2002	$484.15	.	$96.83	*
0208	Laminotomies and Laminectomies	T	49.2256	$3,309.98	.	$662.00	*
0209	Level II Extended EEG, Sleep, and Cardiovascular Studies	S	11.4315	$768.67	$268.73	$153.74	*
0213	Level I Extended EEG, Sleep, and Cardiovascular Studies	S	2.4043	$161.67	$53.58	$32.34	*
0215	Level I Nerve and Muscle Tests	S	0.6135	$41.25	.	$8.25	*
0216	Level III Nerve and Muscle Tests	S	2.6831	$180.41	.	$36.09	*
0218	Level II Nerve and Muscle Tests	S	1.1965	$80.45	.	$16.09	*
0220	Level I Nerve Procedures	T	18.7200	$1,258.75	.	$251.75	*
0221	Level II Nerve Procedures	T	37.2806	$2,506.78	.	$501.36	*
0224	Implantation of Catheter/Reservoir/Shunt	T	41.0288	$2,758.82	.	$551.77	*

APC	Group Title	SI	Relative Weight	Payment rate	National Unadjusted Copayment	Minimum Unadjusted Copayment	* Indicates a Change
0225	Implantation of Neurostimulator Electrodes, Cranial Nerve	S	157.9390	$10,619.98	.	$2,124.00	*
0227	Implantation of Drug Infusion Device	T	198.6572	$13,357.91	.	$2,671.59	*
0229	Transcatherter Placement of Intravascular Shunts	T	97.2910	$6,541.94	.	$1,308.39	*
0230	Level I Eye Tests & Treatments	S	0.5945	$39.97	.	$8.00	*
0231	Level III Eye Tests & Treatments	S	1.9575	$131.62	.	$26.33	*
0232	Level I Anterior Segment Eye Procedures	T	4.5074	$303.08	$75.93	$60.62	*
0233	Level II Anterior Segment Eye Procedures	T	16.2485	$1,092.57	$263.12	$218.52	*
0234	Level III Anterior Segment Eye Procedures	T	24.4021	$1,640.82	$511.31	$328.17	*
0235	Level I Posterior Segment Eye Procedures	T	5.8498	$393.35	.	$78.67	*
0237	Level II Posterior Segment Eye Procedures	T	20.7145	$1,392.86	.	$278.58	*
0238	Level I Repair and Plastic Eye Procedures	T	3.2267	$216.97	.	$43.40	*
0239	Level II Repair and Plastic Eye Procedures	T	7.6421	$513.86	.	$102.78	*
0240	Level III Repair and Plastic Eye Procedures	T	18.1580	$1,220.96	$296.20	$244.20	*
0241	Level IV Repair and Plastic Eye Procedures	T	26.8396	$1,804.72	$383.45	$360.95	*
0242	Level V Repair and Plastic Eye Procedures	T	39.0115	$2,623.17	$597.36	$524.64	*
0243	Strabismus/Muscle Procedures	T	23.4694	$1,578.11	$416.98	$315.63	*
0244	Corneal and Amniotic Membrane Transplant	T	37.5388	$2,524.15	$803.26	$504.83	*
0245	Level I Cataract Procedures without IOL Insert	T	15.8085	$1,062.98	$214.11	$212.60	*
0246	Cataract Procedures with IOL Insert	T	24.2879	$1,633.14	$495.96	$326.63	*
0247	Laser Eye Procedures	T	5.3014	$356.47	$104.31	$71.30	*
0249	Level II Cataract Procedures without IOL Insert	T	30.3293	$2,039.37	$516.99	$407.88	*
0250	Level I ENT Procedures	T	1.1522	$77.48	$25.10	$15.50	*
0251	Level II ENT Procedures	T	3.4250	$230.30	.	$46.06	*
0252	Level III ENT Procedures	T	7.6196	$512.35	$109.16	$102.47	*
0253	Level IV ENT Procedures	T	17.1879	$1,155.73	$282.29	$231.15	*
0254	Level V ENT Procedures	T	24.9637	$1,678.58	.	$335.72	*
0256	Level VI ENT Procedures	T	42.9827	$2,890.20	.	$578.04	*
0259	Level VII ENT Procedures	T	428.8363	$28,835.38	$8,543.66	$5,767.08	*
0260	Level I Plain Film Except Teeth	X	0.6661	$44.79	.	$8.96	*

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0261	Level II Plain Film Except Teeth Including Bone Density Measurement	X	1.1161	$75.05	.	$15.01	*
0262	Plain Film of Teeth	X	0.4469	$30.05	.	$6.01	*
0263	Level I Miscellaneous Radiology Procedures	X	3.1192	$209.74	.	$41.95	*
0265	Level I Diagnostic and Screening Ultrasound	S	0.9267	$62.31	$22.28	$12.47	*
0266	Level II Diagnostic and Screening Ultrasound	S	1.4434	$97.06	$37.53	$19.42	*
0267	Level III Diagnostic and Screening Ultrasound	S	2.3005	$154.69	$60.50	$30.94	*
0269	Level II Echocardiogram Without Contrast	S	6.6903	$449.86	.	$89.98	*
0270	Level III Echocardiogram Without Contrast	S	8.8425	$594.58	$141.32	$118.92	*
0272	Fluoroscopy	X	1.2693	$85.35	$31.15	$17.07	*
0274	Myelography	S	7.2260	$485.88	.	$97.18	*
0275	Arthrography	S	3.9361	$264.67	$68.90	$52.94	*
0276	Level I Digestive Radiology	S	1.2985	$87.31	$34.66	$17.47	*
0277	Level II Digestive Radiology	S	2.1001	$141.21	$53.90	$28.25	*
0278	Diagnostic Urography	S	2.5460	$171.20	$58.44	$34.24	*
0279	Level II Angiography and Venography	S	29.1126	$1,957.56	.	$391.52	*
0280	Level III Angiography and Venography	S	45.8793	$3,084.97	.	$617.00	*
0282	Miscellaneous Computed Axial Tomography	S	1.6291	$109.54	$37.81	$21.91	*
0283	Computed Tomography with Contrast	S	4.4066	$296.30	$96.62	$59.26	*
0284	Magnetic Resonance Imaging and Magnetic Resonance Angiography with Contrast	S	6.2901	$422.95	$146.85	$84.59	*
0288	Bone Density:Axial Skeleton	S	1.0755	$72.32	$28.66	$14.47	*
0293	Level V Anterior Segment Eye Procedures	T	101.0161	$6,792.42	.	$1,358.49	*
0299	Hyperthermia and Radiation Treatment Procedures	S	5.6461	$379.65	.	$75.93	*
0300	Level I Radiation Therapy	S	1.3764	$92.55	.	$18.51	*
0301	Level II Radiation Therapy	S	2.3030	$154.86	.	$30.98	*
0303	Treatment Device Construction	X	2.8279	$190.15	$66.95	$38.03	*
0304	Level I Therapeutic Radiation Treatment Preparation	X	1.5271	$102.68	$34.63	$20.54	*
0305	Level II Therapeutic Radiation Treatment Preparation	X	3.9510	$265.67	$91.38	$53.14	*
0307	Myocardial Positron Emission Tomography (PET) imaging	S	21.2573	$1,429.36	.	$285.88	*

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0308	Non-Myocardial Positron Emission Tomography (PET) imaging	S	15.3895	$1,034.81	.	$206.97	*
0310	Level III Therapeutic Radiation Treatment Preparation	X	13.7576	$925.07	$325.27	$185.02	*
0312	Radioelement Applications	S	4.4846	$301.55	.	$60.31	*
0313	Brachytherapy	S	11.5353	$775.65	$293.30	$155.13	*
0315	Level II Implantation of Neurostimulator Generator	S	274.7397	$18,473.77	.	$3,694.76	*
0317	Level II Miscellaneous Radiology Procedures	X	5.6012	$376.63	.	$75.33	*
0320	Electroconvulsive Therapy	S	5.8620	$394.17	$80.06	$78.84	*
0322	Brief Individual Psychotherapy	S	1.1958	$80.41	.	$16.09	*
0323	Extended Individual Psychotherapy	S	1.6690	$112.23	.	$22.45	*
0324	Family Psychotherapy	S	2.2103	$148.62	.	$29.73	*
0325	Group Psychotherapy	S	0.8905	$59.88	$12.77	$11.98	*
0330	Dental Procedures	S	10.3227	$694.11	.	$138.83	*
0332	Computed Tomography without Contrast	S	2.8940	$194.60	$75.24	$38.92	*
0333	Computed Tomography without Contrast followed by Contrast	S	4.9479	$332.70	$116.13	$66.54	*
0336	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast	S	5.1855	$348.68	$137.40	$69.74	*
0337	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast followed by Contrast	S	7.9432	$534.11	$197.83	$106.83	*
0340	Minor Ancillary Procedures	X	0.6693	$45.00	.	$9.00	*
0341	Skin Tests	X	0.0799	$5.37	$2.09	$1.08	*
0342	Level I Pathology	X	0.1546	$10.40	.	$2.08	*
0343	Level III Pathology	X	0.5301	$35.64	$10.84	$7.13	*
0344	Level IV Pathology	X	0.8028	$53.98	$15.56	$10.80	*
0345	Level I Transfusion Laboratory Procedures	X	0.2195	$14.76	.	$2.96	*
0346	Level II Transfusion Laboratory Procedures	X	0.3734	$25.11	.	$5.03	*
0347	Level III Transfusion Laboratory Procedures	X	0.7384	$49.65	$9.94	$9.93	*
0350	Administration of flu and PPV vaccine	S	0.3809	$25.61	.	$0.00	*
0360	Level I Alimentary Tests	X	1.5203	$102.23	$33.88	$20.45	*
0361	Level II Alimentary Tests	X	4.0839	$274.61	$83.23	$54.93	*

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0363	Level I Otorhinolaryngologic Function Tests	X	0.9061	$60.93	$17.10	$12.19	*
0364	Level I Audiometry	X	0.4700	$31.60	$7.06	$6.32	*
0365	Level II Audiometry	X	1.2675	$85.23	$18.52	$17.05	*
0366	Level III Audiometry	X	1.6243	$109.22	$24.94	$21.85	*
0367	Level I Pulmonary Test	X	0.5968	$40.13	$13.76	$8.03	*
0368	Level II Pulmonary Tests	X	0.8495	$57.12	$20.93	$11.43	*
0369	Level III Pulmonary Tests	X	2.6228	$176.36	$42.19	$35.28	*
0370	Allergy Tests	X	1.4598	$98.16	.	$19.64	*
0373	Level I Neuropsychological Testing	X	0.9758	$65.61	.	$13.13	*
0375	Ancillary Outpatient Services When Patient Expires	S	88.5075	$5,951.33	.	$1,190.27	*
0377	Level II Cardiac Imaging	S	11.4989	$773.20	.	$154.64	*
0378	Level II Pulmonary Imaging	S	4.8032	$322.97	$124.64	$64.60	*
0379	Injection adenosine 6 MG	K		$10.01		$2.00	
0381	Single Allergy Tests	X	0.4312	$28.99	.	$5.80	*
0382	Level II Neuropsychological Testing	X	2.6683	$179.42	.	$35.89	*
0383	Cardiac Computed Tomographic Imaging	S	3.9929	$268.49	.	$53.70	*
0384	GI Procedures with Stents	T	26.4913	$1,781.30	.	$356.26	*
0385	Level I Prosthetic Urological Procedures	S	98.0867	$6,595.45	.	$1,319.09	*
0386	Level II Prosthetic Urological Procedures	S	164.3200	$11,049.04	.	$2,209.81	*
0387	Level II Hysteroscopy	T	37.2199	$2,502.70	$655.55	$500.54	*
0388	Discography	S	25.8604	$1,738.88	.	$347.78	*
0389	Level I Non-imaging Nuclear Medicine	S	1.6695	$112.26	$29.94	$22.46	*
0390	Level I Endocrine Imaging	S	2.1595	$145.21	$52.15	$29.05	*
0391	Level II Endocrine Imaging	S	3.2894	$221.18	$65.96	$44.24	*
0392	Level II Non-imaging Nuclear Medicine	S	2.6817	$180.32	$43.95	$36.07	*
0393	Hematologic Processing & Studies	S	5.7873	$389.14	$79.77	$77.83	*
0394	Hepatobiliary Imaging	S	4.3139	$290.07	$99.32	$58.02	*
0395	GI Tract Imaging	S	3.6702	$246.79	$89.73	$49.36	*
0396	Bone Imaging	S	3.6707	$246.82	$95.02	$49.37	*

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0397	Vascular Imaging	S	2.9679	$199.56	$46.29	$39.92	*
0398	Level I Cardiac Imaging	S	4.5366	$305.05	$97.71	$61.01	*
0400	Hematopoietic Imaging	S	3.8342	$257.82	$91.52	$51.57	*
0401	Level I Pulmonary Imaging	S	3.0625	$205.93	$74.45	$41.19	*
0402	Level II Nervous System Imaging	S	8.5845	$577.23	.	$115.45	*
0403	Level I Nervous System Imaging	S	2.9181	$196.22	$72.42	$39.25	*
0404	Renal and Genitourinary Studies	S	4.8221	$324.24	$82.90	$64.85	*
0406	Level I Tumor/Infection Imaging	S	4.3034	$289.36	$88.01	$57.88	*
0407	Level I Radionuclide Therapy	S	3.2356	$217.56	$78.13	$43.52	*
0408	Level III Tumor/Infection Imaging	S	14.2874	$960.70	.	$192.14	*
0409	Red Blood Cell Tests	X	0.1161	$7.81	$2.20	$1.57	*
0412	IMRT Treatment Delivery	S	6.2490	$420.19	.	$84.04	*
0413	Level II Radionuclide Therapy	S	5.2007	$349.70	.	$69.94	*
0414	Level II Tumor/Infection Imaging	S	7.5722	$509.16	.	$101.84	*
0415	Level II Endoscopy Lower Airway	T	25.9024	$1,741.70	$459.92	$348.34	*
0418	Insertion of Left Ventricular Pacing Elect.	T	204.1256	$13,725.61	.	$2,745.13	*
0422	Level II Upper GI Procedures	T	24.2703	$1,631.96	$436.89	$326.40	*
0423	Level II Percutaneous Abdominal and Biliary Procedures	T	51.3618	$3,453.62	.	$690.73	*
0425	Level II Arthroplasty or Implantation with Prosthesis	T	118.7670	$7,986.01	.	$1,597.21	*
0426	Level II Strapping and Cast Application	S	2.3457	$157.73	.	$31.55	*
0427	Level II Tube or Catheter Changes or Repositioning	T	15.3103	$1,029.48	.	$205.90	*
0428	Level III Sigmoidoscopy and Anoscopy	T	22.8208	$1,534.49	.	$306.90	*
0429	Level V Cystourethroscopy and other Genitourinary Procedures	T	46.6800	$3,138.81	.	$627.77	*
0432	Health and Behavior Services	S	0.6013	$40.43	.	$8.09	*
0433	Level II Pathology	X	0.2482	$16.69	$5.17	$3.34	*
0434	Cardiac Defect Repair	T	147.3728	$9,909.49	.	$1,981.90	*
0436	Level I Drug Administration	S	0.3809	$25.61	.	$5.13	*
0437	Level II Drug Administration	S	0.5555	$37.35	.	$7.47	*

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0438	Level III Drug Administration	S	1.1229	$75.50	.	$15.10	*
0439	Level IV Drug Administration	S	1.8808	$126.47	.	$25.30	*
0440	Level V Drug Administration	S	3.2632	$219.42	.	$43.89	*
0442	Dosimetric Drug Administration	S	25.7674	$1,732.63	.	$346.53	*
0604	Level 1 Hospital Clinic Visits	V	0.8593	$57.78	.	$11.56	*
0605	Level 2 Hospital Clinic Visits	V	1.0337	$69.51	.	$13.91	*
0606	Level 3 Hospital Clinic Visits	V	1.3222	$88.91	.	$17.79	*
0607	Level 4 Hospital Clinic Visits	V	1.6830	$113.17	.	$22.64	*
0608	Level 5 Hospital Clinic Visits	V	2.4853	$167.11	.	$33.43	*
0609	Level 1 Type A Emergency Visits	V	0.7886	$53.03	$12.70	$10.61	*
0613	Level 2 Type A Emergency Visits	V	1.3033	$87.64	$21.06	$17.53	*
0614	Level 3 Type A Emergency Visits	V	2.0796	$139.83	$34.50	$27.97	*
0615	Level 4 Type A Emergency Visits	V	3.3109	$222.63	$48.49	$44.53	*
0616	Level 5 Type A Emergency Visits	V	4.8917	$328.92	$72.86	$65.79	*
0617	Critical Care	S	7.3492	$494.17	$111.59	$98.84	*
0618	Trauma Response with Critical Care	S	12.3717	$831.89	.	$166.38	*
0621	Level I Vascular Access Procedures	T	11.1660	$750.81	.	$150.17	*
0622	Level II Vascular Access Procedures	T	25.3344	$1,703.51	.	$340.71	*
0623	Level III Vascular Access Procedures	T	30.4396	$2,046.79	.	$409.36	*
0624	Phlebotomy and Minor Vascular Access Device Procedures	X	0.6132	$41.23	$12.65	$8.25	*
0626	Level 1 Type B Emergency Visits	V	0.6796	$45.70	.	$9.14	*
0627	Level 2 Type B Emergency Visits	V	0.9229	$62.06	.	$12.42	*
0628	Level 3 Type B Emergency Visits	V	1.4572	$97.98	.	$19.60	*
0629	Level 4 Type B Emergency Visits	V	2.1041	$141.48	.	$28.30	*
0630	Level 5 Type B Emergency Visits	V	3.4466	$231.75	$52.13	$46.35	*
0648	Level IV Breast Surgery	T	58.2278	$3,915.30	.	$783.06	*
0651	Complex Interstitial Radiation Source Application	S	13.2555	$891.31	.	$178.27	*
0652	Insertion of Intraperitoneal and Pleural Catheters	T	30.4602	$2,048.17	.	$409.64	*
0653	Vascular Reconstruction/Fistula Repair with Device	T	46.6883	$3,139.37	.	$627.88	*

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0654	Insertion/Replacement of a permanent dual chamber pacemaker	T	108.1692	$7,273.41	.	$1,454.69	*
0655	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker	T	142.1623	$9,559.14	.	$1,911.83	*
0656	Transcatheter Placement of Intracoronary Drug-Eluting Stents	T	110.7870	$7,449.43	.	$1,489.89	*
0659	Hyperbaric Oxygen	S	1.5880	$106.78	.	$21.36	*
0660	Level II Otorhinolaryngologic Function Tests	X	1.5019	$100.99	$27.10	$20.20	*
0661	Level V Pathology	X	2.4450	$164.40	$57.69	$32.88	*
0662	CT Angiography	S	5.0511	$339.64	$114.75	$67.93	*
0664	Level I Proton Beam Radiation Therapy	S	13.9796	$940.00	.	$188.00	*
0665	Bone Density:AppendicularSkeleton	S	0.4318	$29.03	$11.60	$5.81	*
0667	Level II Proton Beam Radiation Therapy	S	18.2873	$1,229.66	.	$245.94	*
0668	Level I Angiography and Venography	S	10.2978	$692.43	.	$138.49	*
0672	Level III Posterior Segment Eye Procedures	T	39.9643	$2,687.24	.	$537.45	*
0673	Level IV Anterior Segment Eye Procedures	T	41.8840	$2,816.32	$649.56	$563.27	*
0674	Prostate Cryoablation	T	113.8626	$7,656.24	.	$1,531.25	*
0676	Thrombolysis and Other Device Revisions	T	2.3954	$161.07	.	$32.22	*
0678	External Counterpulsation	T	1.5463	$103.97	.	$20.80	*
0679	Level II Resuscitation and Cardioversion	S	5.5047	$370.14	$95.30	$74.03	*
0680	Insertion of Patient Activated Event Recorders	S	78.0661	$5,249.24	.	$1,049.85	*
0683	Level II Photochemotherapy	S	2.6790	$180.14	.	$36.03	*
0685	Level III Needle Biopsy/Aspiration Except Bone Marrow	T	9.6666	$649.99	.	$130.00	*
0687	Revision/Removal of Neurostimulator Electrodes	T	19.6381	$1,320.49	$397.37	$264.10	*
0688	Revision/Removal of Neurostimulator Pulse Generator Receiver	T	28.6636	$1,927.37	$768.94	$385.48	*
0689	Level II Electronic Analysis of Devices	S	0.5680	$38.19	.	$7.64	*
0690	Level I Electronic Analysis of Devices	S	0.3506	$23.57	$8.67	$4.72	*
0691	Level IV Electronic Analysis of Devices	S	2.5406	$170.83	$50.49	$34.17	*
0692	Level III Electronic Analysis of Devices	S	1.6000	$107.59	.	$21.52	*
0694	Mohs Surgery	T	4.9337	$331.75	$91.69	$66.35	*

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0697	Level I Echocardiogram Without Contrast	S	3.9223	$263.74	.	$52.75	*
0698	Level II Eye Tests & Treatments	S	0.9553	$64.24	.	$12.85	*
0699	Level IV Eye Tests & Treatments	T	15.5407	$1,044.97	.	$209.00	*
0701	Sr89 strontium	K		$778.98		$155.80	
0726	Dexrazoxane HCl injection	K		$367.10		$73.42	
0728	Filgrastim 300 mcg injection	K		$215.57		$43.11	
0730	Pamidronate disodium	K		$19.98		$4.00	
0731	Sargramostim injection	K		$23.81		$4.76	
0732	Mesna injection	K		$4.55		$0.91	
0735	Ampho b cholesteryl sulfate	K		$13.74		$2.75	
0736	Amphotericin b liposome inj	K		$15.51		$3.10	
0738	Rasburicase	K		$169.23		$33.85	
0747	Chlorothiazide sodium inj	K		$304.91		$60.98	
0751	Mechlorethamine hcl inj	K		$151.24		$30.25	
0752	Dactinomycin injection	K		$556.34		$111.27	
0759	Naltrexone, depot form	K		$2.10		$0.42	
0760	Anidulafungin injection	K		$1.22		$0.24	
0800	Leuprolide acetate	K		$483.41		$96.68	
0802	Etoposide oral	K		$29.69		$5.94	
0807	Aldesleukin injection	K		$830.93		$166.19	
0809	Bcg live intravesical vac	K		$108.55		$21.71	
0810	Goserelin acetate implant	K		$200.02		$40.00	
0812	Carmustine injection	K		$173.53		$34.71	
0814	Asparaginase injection	K		$59.27		$11.85	
0820	Daunorubicin injection	K		$16.65		$3.33	
0821	Daunorubicin citrate inj	K		$55.33		$11.07	
0823	Docetaxel injection	K		$17.29		$3.46	
0825	Nelarabine injection	K		$101.35		$20.27	
0827	Floxuridine injection	K		$42.85		$8.57	

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0828	Gemcitabine hcl injection	K		$142.20		$28.44	
0830	Irinotecan injection	K		$6.81		$1.36	
0831	Ifosfomide injection	K		$29.51		$5.90	
0832	Idarubicin hcl injection	K		$100.89		$20.18	
0834	Interferon alfa-2a inj	K		$10.60		$2.12	
0835	Cosyntropin injection NOS	K		$64.19		$12.84	
0836	Interferon alfa-2b inj	K		$15.54		$3.11	
0838	Interferon gamma 1-b inj	K		$294.03		$58.81	
0840	Inj melphalan hydrochl	K		$1,520.24		$304.05	
0842	Fludarabine phosphate inj	K		$158.63		$31.73	
0843	Pegaspargase injection	K		$2,695.46		$539.09	
0844	Pentostatin injection	K		$1,318.44		$263.69	
0849	Rituximab injection	K		$553.12		$110.62	
0850	Streptozocin injection	K		$278.77		$55.75	
0851	Thiotepa injection	K		$103.08		$20.62	
0852	Topotecan injection	K		$1,012.44		$202.49	
0856	Porfimer sodium injection	K		$2,748.96		$549.79	
0858	Inj cladribine	K		$23.52		$4.70	
0861	Leuprolide acetate injection	K		$4.68		$0.94	
0864	Mitoxantrone hydrochl	K		$46.87		$9.37	
0865	Interferon alfa-n3 inj	K		$17.89		$3.58	
0868	Oral aprepitant	K		$5.42		$1.09	
0873	Hyalgan/supartz inj per dose	K		$90.54		$18.11	
0874	Synvisc or synvisc-one	K		$11.52		$2.30	
0875	Euflexxa inj per dose	K		$111.88		$22.38	
0877	Orthovisc inj per dose	K		$172.73		$34.55	
0878	Gallium nitrate injection	K		$1.97		$0.39	
0884	Rho d immune globulin inj	K		$84.51		$16.90	
0887	Azathioprine parenteral	K		$93.84		$18.77	

APC	Group Title	SI	Relative Weight	Payment rate	National Unadjusted Copayment	Minimum Unadjusted Copayment	* Indicates a Change
0890	Lymphocyte immune globulin	K		$456.47		$91.29	
0891	Tacrolimus oral	K		$3.57		$0.71	
0900	Alglucerase injection	K		$41.20		$8.24	
0901	Alpha 1 proteinase inhibitor	K		$3.67		$0.73	
0902	Injection,onabotulinumtoxinA	K		$5.40		$1.08	
0903	Cytomegalovirus imm IV /vial	K		$862.24		$172.45	
0904	Gamma globulin 4 CC inj	K		$63.39		$12.68	
0910	Interferon beta-1b / .25 MG	K		$175.51		$35.10	
0913	Ganciclovir long act implant	K		$16,640.00		$3,328.00	
0916	Injection imiglucerase /unit	K		$4.12		$0.83	
0917	Adenosine injection	K		$79.40		$15.88	
0920	Gamma globulin 6 CC inj	K		$95.12		$19.02	
0921	Gamma globulin 7 CC inj	K		$110.86		$22.17	
0922	Gamma globulin 8 CC inj	K		$126.78		$25.36	
0923	Gamma globulin 9 CC inj	K		$158.48		$31.70	
0924	Gamma globulin 10 CC inj	K		$158.48		$31.70	
0925	Factor viii	K		$0.85		$0.17	
0927	Factor viii recombinant	K		$1.08		$0.22	
0928	Factor ix complex	K		$0.86		$0.17	
0929	Anti-inhibitor	K		$1.52		$0.30	
0931	Factor IX non-recombinant	K		$0.87		$0.17	
0932	Factor IX recombinant	K		$1.09		$0.22	
0933	Gamma globulin > 10 CC inj	K		$158.48		$31.70	
0934	Capecitabine, oral	K		$20.04		$4.01	
0935	Clonidine hydrochloride	K		$110.46		$22.09	
0943	Octagam injection	K		$37.00		$7.40	
0944	Gammagard liquid injection	K		$37.81		$7.56	
0945	Rhophylac injection	K		$5.12		$1.02	
0946	Hepagam b im injection	G		$50.22		$9.85	

APC	Group Title	SI	Relative Weight	Payment rate	National Unadjusted Copayment	Minimum Unadjusted Copayment	* Indicates a Change
0947	Flebogamma injection	K		$36.42		$7.28	
0948	Gamunex injection	K		$36.91		$7.38	
0949	Frozen plasma, pooled, sd	R	0.7589	$51.03	.	$10.21	*
0950	Whole blood for transfusion	R	3.0598	$205.74	.	$41.15	*
0951	Reclast injection	K		$218.49		$43.70	
0952	Cryoprecipitate each unit	R	0.6910	$46.46	.	$9.30	*
0954	RBC leukocytes reduced	R	2.7703	$186.28	.	$37.26	*
0955	Plasma, frz between 8-24hour	R	1.1491	$77.27	.	$15.46	*
0956	Plasma protein fract,5%,50ml	R	0.9754	$65.59	.	$13.12	*
0957	Platelets, each unit	R	0.9882	$66.45	.	$13.29	*
0958	Plaelet rich plasma unit	R	2.0294	$136.46	.	$27.30	*
0959	Red blood cells unit	R	2.1027	$141.39	.	$28.28	*
0960	Washed red blood cells unit	R	3.6495	$245.40	.	$49.08	*
0961	Albumin (human),5%, 50ml	K		$16.89		$3.38	
0963	Albumin (human), 5%, 250 ml	K		$60.58		$12.12	
0964	Albumin (human), 25%, 20 ml	K		$25.67		$5.13	
0965	Albumin (human), 25%, 50ml	K		$62.05		$12.41	
0966	Plasmaprotein fract,5%,250ml	R	1.6017	$107.70	.	$21.54	*
0967	Blood split unit	R	1.2965	$87.18	.	$17.44	*
0968	Platelets leukoreduced irrad	R	1.9576	$131.63	.	$26.33	*
0969	RBC leukoreduced irradiated	R	3.6350	$244.42	.	$48.89	*
1009	Cryoprecipitatereducedplasma	R	1.4035	$94.37	.	$18.88	*
1010	Blood, l/r, cmv-neg	R	2.0076	$134.99	.	$27.00	*
1011	Platelets, hla-m, l/r, unit	R	10.9290	$734.88	.	$146.98	*
1013	Platelets leukocytes reduced	R	1.5541	$104.50	.	$20.90	*
1015	Injection glatiramer acetate	K		$81.34		$16.27	
1016	Blood, l/r, froz/degly/wash	R	1.5373	$103.37	.	$20.68	*
1017	Plt, aph/pher, l/r, cmv-neg	R	6.2195	$418.21	.	$83.65	*
1018	Blood, l/r, irradiated	R	2.4502	$164.75	.	$32.95	*

APC	Group Title	SI	Relative Weight	Payment rate	National Unadjusted Copayment	Minimum Unadjusted Copayment	* Indicates a Change
1019	Plate pheres leukoredu irrad	R	10.0373	$674.92	.	$134.99	*
1020	Plt, pher, l/r cmv-neg, irr	R	9.7428	$655.12	.	$131.03	*
1021	RBC, frz/deg/wsh, l/r, irrad	R	5.3858	$362.15	.	$72.43	*
1022	RBC, l/r, cmv-neg, irrad	R	4.3604	$293.20	.	$58.64	*
1023	Pralidoxime chloride inj	K		$89.08		$17.82	
1052	Injection, voriconazole	K		$5.56		$1.11	
1064	I131 iodide cap, rx	K		$16.51		$3.30	
1083	Adalimumab injection	K		$359.89		$71.98	
1084	Denileukin diftitox inj	K		$1,467.55		$293.51	
1086	Temozolomide	K		$8.63		$1.73	
1138	Hepagam b intravenous, inj	G		$50.22		$9.85	
1139	Protein c concentrate	K		$11.96		$2.40	
1142	Supprelin LA implant	G		$14,841.08		$2,912.21	
1150	I131 iodide sol, rx	K		$11.02		$2.20	
1166	Cytarabine liposome inj	K		$480.16		$96.03	
1167	Inj, epirubicin hcl	K		$2.60		$0.52	
1168	Inj, temsirolimus	K		$48.90		$9.78	
1178	Busulfan injection	K		$14.18		$2.84	
1203	Verteporfin injection	K		$9.31		$1.87	
1204	Cyclosporin parenteral	K		$23.37		$4.67	
1207	Octreotide injection, depot	K		$106.19		$21.24	
1209	Diethylstilbestrol injection	K		$3.83		$0.77	
1213	Antihemophilic viii/vwf comp	K		$0.90		$0.18	
1214	Inj IVIG privigen 500 mg	G		$35.14		$6.89	
1216	Lyme disease vaccine, im	K		$0.93		$0.19	
1220	Calcitonin salmon injection	K		$48.34		$9.67	
1221	Dimethyl sulfoxide 50%	K		$68.40		$13.68	
1222	Pentastarch 10% solution	K		$158.77		$31.75	
1225	Somatrem injection	K		$4.89		$0.98	

APC	Group Title	SI	Relative Weight	Payment rate	National Unadjusted Copayment	Minimum Unadjusted Copayment	* Indicates a Change
1226	Inj streptokinase /250000 IU	K		$78.00		$15.60	
1232	Mitomycin 5 MG inj	K		$16.83		$3.37	
1233	Mitomycin 20 MG inj	K		$67.30		$13.46	
1234	Mitomycin 40 MG inj	K		$134.60		$26.92	
1235	Valrubicin injection	K		$933.57		$186.71	
1236	Levoleucovorin injection	G		$1.36		$0.27	
1237	Inj iron dextran	K		$12.69		$2.54	
1238	Topotecan oral	G		$73.00		$14.33	
1239	Rotavirus vacc 2 dose oral	K		$106.60		$21.32	
1240	Apligraf skin sub	K		$32.10		$6.42	
1241	Oasis wound matrix skin sub	K		$4.30		$0.86	
1242	Oasis burn matrix skin sub	K		$4.30		$0.86	
1243	Integra BMWD skin sub	K		$14.65		$2.93	
1244	Integra DRT skin sub	K		$10.57		$2.11	
1245	Dermagraft skin sub	K		$39.37		$7.87	
1246	Graftjacket skin sub	K		$89.87		$17.97	
1247	Integra matrix skin sub	K		$18.78		$3.76	
1248	Primatrix skin sub	K		$35.09		$7.02	
1249	Cymetra allograft	K		$338.32		$67.66	
1250	Graftjacket express allograf	K		$338.32		$67.66	
1251	Integra flowable wound matri	G		$910.19		$178.60	
1252	Gammagraft skin sub	K		$7.64		$1.53	
1253	Triamcinolone A inj PRS-free	K		$3.16		$0.63	
1254	Adenovirus vaccine, type 4	K		$72.17		$14.43	
1255	Rotovirus vacc 3 dose, oral	K		$72.37		$14.47	
1256	Brompheniramine maleate inj	K		$9.24		$1.85	
1257	Enfuvirtide injection	K		$0.48		$0.10	
1260	Nandrolone decanoate 100 MG	K		$7.00		$1.40	
1263	Antithrombin iii injection	K		$2.28		$0.46	

APC	Group Title	SI	Relative Weight	Payment rate	National Unadjusted Copayment	Minimum Unadjusted Copayment	* Indicates a Change
1266	Interferon alfacon-1 inj	K		$4.71		$0.94	
1268	Xyntha inj	K		$1.07		$0.21	
1270	Alloderm skin sub	K		$31.78		$6.36	
1271	Cholera vaccine, injectable	K		$103.90		$20.78	
1272	Acetylcysteine injection	K		$2.33		$0.47	
1273	Dimecaprol injection	K		$26.88		$5.38	
1274	Edetate calcium disodium inj	K		$78.86		$15.78	
1275	Vivaglobin, inj	K		$7.04		$1.41	
1276	Fondaparinux sodium	K		$6.04		$1.21	
1277	Insulin for insulin pump use	K		$3.37		$0.67	
1279	Factor VIII (porcine)	K		$8.21		$1.64	
1280	Corticotropin injection	K		$2,394.31		$478.86	
1281	Bevacizumab injection	K		$1.41		$0.28	
1282	Gamma globulin 2 CC inj	K		$31.70		$6.34	
1283	Gamma globulin 3 CC inj	K		$47.53		$9.51	
1284	Gamma globulin 5 CC inj	K		$79.24		$15.85	
1285	Nandrolone decanoate 50 MG	K		$7.00		$1.40	
1286	Nandrolone decanoate 200 MG	K		$14.73		$2.95	
1287	Alloskin skin sub	K		$9.36		$1.88	
1288	Visualization adjunct	K		$2.46		$0.49	
1289	AbobotulinumtoxinA	K		$7.93		$1.59	
1290	Human fibrinogen conc inj	G		$0.24		$0.05	
1291	Rilonacept injection	K		$23.64		$4.73	
1292	Cyclosporine oral 100 mg	K		$3.12		$0.62	
1293	Bladder calculi irrig sol	K		$5.11		$1.02	
1294	Cyclosporine oral 25 mg	K		$0.81		$0.16	
1295	Sm 153 lexidronam	K		$5,504.70		$1,100.94	
1296	Degarelix injection	G		$2.87		$0.56	
1297	Ferumoxytol, non-esrd	G		$0.82		$0.16	

APC	Group Title	SI	Relative Weight	Payment rate	National Unadjusted Copayment	Minimum Unadjusted Copayment	* Indicates a Change
1298	Cosyntropin cortrosyn inj	K		$89.48		$17.90	
1299	Gadofosveset trisodium inj	G		$12.89		$0.00	*
1436	Etidronate disodium inj	K		$25.02		$5.00	
1491	New Technology - Level IA ($0-$10)	S		$5.00	.	$1.00	
1492	New Technology - Level IB ($10-$20)	S		$15.00	.	$3.00	
1493	New Technology - Level IC ($20-$30)	S		$25.00	.	$5.00	
1494	New Technology - Level ID ($30-$40)	S		$35.00	.	$7.00	
1495	New Technology - Level IE ($40-$50)	S		$45.00	.	$9.00	
1496	New Technology - Level IA ($0-$10)	T		$5.00	.	$1.00	
1497	New Technology - Level IB($10-$20)	T		$15.00	.	$3.00	
1498	New Technology - Level IC ($20-$30)	T		$25.00	.	$5.00	
1499	New Technology - Level ID($30-$40)	T		$35.00	.	$7.00	
1500	New Technology - Level IE ($40-$50)	T		$45.00	.	$9.00	
1502	New Technology - Level II ($50 - $100)	S		$75.00	.	$15.00	
1503	New Technology - Level III ($100 - $200)	S		$150.00	.	$30.00	
1504	New Technology - Level IV ($200 - $300)	S		$250.00	.	$50.00	
1505	New Technology - Level V ($300 - $400)	S		$350.00	.	$70.00	
1506	New Technology - Level VI ($400 - $500)	S		$450.00	.	$90.00	
1507	New Technology - Level VII ($500 - $600)	S		$550.00	.	$110.00	
1508	New Technology - Level VIII ($600 - $700)	S		$650.00	.	$130.00	
1509	New Technology - Level IX ($700 - $800)	S		$750.00	.	$150.00	
1510	New Technology - Level X ($800 - $900)	S		$850.00	.	$170.00	
1511	New Technology - Level XI ($900 - $1000)	S		$950.00	.	$190.00	
1512	New Technology - Level XII ($1000 - $1100)	S		$1,050.00	.	$210.00	
1513	New Technology - Level XIII ($1100 - $1200)	S		$1,150.00	.	$230.00	
1514	New Technology - Level XIV ($1200- $1300)	S		$1,250.00	.	$250.00	
1515	New Technology - Level XV ($1300 - $1400)	S		$1,350.00	.	$270.00	
1516	New Technology - Level XVI ($1400 - $1500)	S		$1,450.00	.	$290.00	
1517	New Technology - Level XVII ($1500-$1600)	S		$1,550.00	.	$310.00	

APC	Group Title	SI	Relative Weight	Payment rate	National Unadjusted Copayment	Minimum Unadjusted Copayment	* Indicates a Change
1518	New Technology - Level XVIII ($1600-$1700)	S		$1,650.00	.	$330.00	
1519	New Technology - Level IXX ($1700-$1800)	S		$1,750.00	.	$350.00	
1520	New Technology - Level XX ($1800-$1900)	S		$1,850.00	.	$370.00	
1521	New Technology - Level XXI ($1900-$2000)	S		$1,950.00	.	$390.00	
1522	New Technology - Level XXII ($2000-$2500)	S		$2,250.00	.	$450.00	
1523	New Technology - Level XXIII ($2500-$3000)	S		$2,750.00	.	$550.00	
1524	New Technology - Level XXIV ($3000-$3500)	S		$3,250.00	.	$650.00	
1525	New Technology - Level XXV ($3500-$4000)	S		$3,750.00	.	$750.00	
1526	New Technology - Level XXVI ($4000-$4500)	S		$4,250.00	.	$850.00	
1527	New Technology - Level XXVII ($4500-$5000)	S		$4,750.00	.	$950.00	
1528	New Technology - Level XXVIII ($5000-$5500)	S		$5,250.00	.	$1,050.00	
1529	New Technology - Level XXIX ($5500-$6000)	S		$5,750.00	.	$1,150.00	
1530	New Technology - Level XXX ($6000-$6500)	S		$6,250.00	.	$1,250.00	
1531	New Technology - Level XXXI ($6500-$7000)	S		$6,750.00	.	$1,350.00	
1532	New Technology - Level XXXII ($7000-$7500)	S		$7,250.00	.	$1,450.00	
1533	New Technology - Level XXXIII ($7500-$8000)	S		$7,750.00	.	$1,550.00	
1534	New Technology - Level XXXIV ($8000-$8500)	S		$8,250.00	.	$1,650.00	
1535	New Technology - Level XXXV ($8500-$9000)	S		$8,750.00	.	$1,750.00	
1536	New Technology - Level XXXVI ($9000-$9500)	S		$9,250.00	.	$1,850.00	
1537	New Technology - Level XXXVII ($9500-$10000)	S		$9,750.00	.	$1,950.00	
1539	New Technology - Level II ($50 - $100)	T		$75.00	.	$15.00	
1540	New Technology - Level III ($100 - $200)	T		$150.00	.	$30.00	
1541	New Technology - Level IV ($200 - $300)	T		$250.00	.	$50.00	
1542	New Technology - Level V ($300 - $400)	T		$350.00	.	$70.00	
1543	New Technology - Level VI ($400 - $500)	T		$450.00	.	$90.00	
1544	New Technology - Level VII ($500 - $600)	T		$550.00	.	$110.00	
1545	New Technology - Level VIII ($600 - $700)	T		$650.00	.	$130.00	
1546	New Technology - Level IX ($700 - $800)	T		$750.00	.	$150.00	
1547	New Technology - Level X ($800 - $900)	T		$850.00	.	$170.00	

APC	Group Title	SI	Relative Weight	Payment rate	National Unadjusted Copayment	Minimum Unadjusted Copayment	* Indicates a Change
1548	New Technology - Level XI ($900 - $1000)	T		$950.00	.	$190.00	
1549	New Technology - Level XII ($1000 - $1100)	T		$1,050.00	.	$210.00	
1550	New Technology - Level XIII ($1100 - $1200)	T		$1,150.00	.	$230.00	
1551	New Technology - Level XIV ($1200- $1300)	T		$1,250.00	.	$250.00	
1552	New Technology - Level XV ($1300 - $1400)	T		$1,350.00	.	$270.00	
1553	New Technology - Level XVI ($1400 - $1500)	T		$1,450.00	.	$290.00	
1554	New Technology - Level XVII ($1500-$1600)	T		$1,550.00	.	$310.00	
1555	New Technology - Level XVIII ($1600-$1700)	T		$1,650.00	.	$330.00	
1556	New Technology - Level XIX ($1700-$1800)	T		$1,750.00	.	$350.00	
1557	New Technology - Level XX ($1800-$1900)	T		$1,850.00	.	$370.00	
1558	New Technology - Level XXI ($1900-$2000)	T		$1,950.00	.	$390.00	
1559	New Technology - Level XXII ($2000-$2500)	T		$2,250.00	.	$450.00	
1560	New Technology - Level XXIII ($2500-$3000)	T		$2,750.00	.	$550.00	
1561	New Technology - Level XXIV ($3000-$3500)	T		$3,250.00	.	$650.00	
1562	New Technology - Level XXV ($3500-$4000)	T		$3,750.00	.	$750.00	
1563	New Technology - Level XXVI ($4000-$4500)	T		$4,250.00	.	$850.00	
1564	New Technology - Level XXVII ($4500-$5000)	T		$4,750.00	.	$950.00	
1565	New Technology - Level XXVIII ($5000-$5500)	T		$5,250.00	.	$1,050.00	
1566	New Technology - Level XXIX ($5500-$6000)	T		$5,750.00	.	$1,150.00	
1567	New Technology - Level XXX ($6000-$6500)	T		$6,250.00	.	$1,250.00	
1568	New Technology - Level XXXI ($6500-$7000)	T		$6,750.00	.	$1,350.00	
1569	New Technology - Level XXXII ($7000-$7500)	T		$7,250.00	.	$1,450.00	
1570	New Technology - Level XXXIII ($7500-$8000)	T		$7,750.00	.	$1,550.00	
1571	New Technology - Level XXXIV ($8000-$8500)	T		$8,250.00	.	$1,650.00	
1572	New Technology - Level XXXV ($8500-$9000)	T		$8,750.00	.	$1,750.00	
1573	New Technology - Level XXXVI ($9000-$9500)	T		$9,250.00	.	$1,850.00	
1574	New Technology - Level XXXVII ($9500-$10000)	T		$9,750.00	.	$1,950.00	
1605	Abciximab injection	K		$454.71		$90.94	
1607	Eptifibatide injection	K		$18.50		$3.70	

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1608	Etanercept injection	K		$188.41		$37.68	
1609	Rho(D) immune globulin h, sd	K		$18.22		$3.64	
1612	Daclizumab, parenteral	K		$381.18		$76.24	
1613	Trastuzumab injection	K		$63.56		$12.71	
1630	Hep b ig, im	K		$114.20		$22.84	
1631	Baclofen intrathecal trial	K		$73.00		$14.60	
1633	Alefacept	K		$30.14		$6.03	
1643	Y90 ibritumomab, rx	K		$30,110.81		$6,022.16	
1645	I131 tositumomab, rx	K		$22,693.52		$4,538.70	
1670	Tetanus immune globulin inj	K		$207.82		$41.56	
1675	P32 Na phosphate	K		$196.49		$39.30	
1676	P32 chromic phosphate	K		$113.44		$22.69	
1682	Aprotonin, 10,000 kiu	K		$2.60		$0.52	
1683	Basiliximab	K		$1,696.29		$339.26	
1684	Corticorelin ovine triflutal	K		$4.22		$0.84	
1685	Darbepoetin alfa, non-esrd	K		$2.78		$0.56	
1686	Epoetin alfa, non-esrd	K		$9.36		$1.87	
1687	Digoxin immune fab (ovine)	K		$467.59		$93.52	
1688	Ethanolamine oleate	K		$147.14		$29.43	
1689	Fomepizole	K		$7.56		$1.51	
1690	Hemin	K		$7.98		$1.60	
1693	Lepirudin	K		$226.90		$45.38	
1694	Ziconotide injection	K		$6.38		$1.28	
1695	Nesiritide injection	K		$37.25		$7.45	
1696	Palifermin injection	K		$11.11		$2.22	
1697	Pegaptanib sodium injection	K		$1,014.11		$202.83	
1700	Inj secretin synthetic human	K		$19.93		$3.99	
1701	Treprostinil injection	K		$54.83		$10.97	
1704	Humate-P, inj	K		$0.86		$0.17	

APC	Group Title	SI	Relative Weight	Payment rate	National Unadjusted Copayment	Minimum Unadjusted Copayment	* Indicates a Change
1705	Factor viia	K		$1.30		$0.26	
1709	Azacitidine injection	K		$4.79		$0.96	
1710	Clofarabine injection	K		$113.36		$22.67	
1711	Vantas implant	G		$1,462.69		$287.02	
1712	Paclitaxel protein bound	K		$9.20		$1.84	
1716	Brachytx, non-str, Gold-198	U	0.6357	$42.75	.	$8.55	*
1717	Brachytx, non-str, HDR Ir-192	U	3.4326	$230.81	.	$46.17	*
1719	Brachytx, NS, Non-HDRIr-192	U	0.9497	$63.86	.	$12.78	*
1738	Oxaliplatin	K		$7.47		$1.49	
1739	Pegademase bovine, 25 iu	K		$242.67		$48.54	
1740	Diazoxide injection	K		$112.16		$22.44	
1741	Urofollitropin, 75 iu	K		$57.43		$11.49	
2210	Methyldopate hcl injection	K		$32.60		$6.52	
2616	Brachytx, non-str,Yttrium-90	U	234.0942	$15,740.73	.	$3,148.15	*
2632	Iodine I-125 sodium iodide	U	0.5626	$37.83	.	$7.57	*
2634	Brachytx, non-str, HA, I-125	U	0.8871	$59.65	.	$11.93	*
2635	Brachytx, non-str, HA, P-103	U	0.4242	$28.52	.	$5.71	*
2636	Brachy linear, non-str,P-103	U	0.2873	$19.32	.	$3.87	*
2638	Brachytx, stranded, I-125	U	0.6302	$42.38	.	$8.48	*
2639	Brachytx, non-stranded,I-125	U	0.5368	$36.09	.	$7.22	*
2640	Brachytx, stranded, P-103	U	0.8955	$60.21	.	$12.05	*
2641	Brachytx, non-stranded,P-103	U	0.8474	$56.98	.	$11.40	*
2642	Brachytx, stranded, C-131	U	1.6295	$109.57	.	$21.92	*
2643	Brachytx, non-stranded,C-131	U	0.9805	$65.93	.	$13.19	*
2698	Brachytx, stranded, NOS	U	0.6302	$42.38	.	$8.48	*
2699	Brachytx, non-stranded, NOS	U	0.4242	$28.52	.	$5.71	*
2731	Immune globulin, powder	K		$29.90		$5.98	
2770	Quinupristin/dalfopristin	K		$144.34		$28.87	
3030	Sumatriptan succinate	K		$42.72		$8.54	

APC	Group Title	SI	Relative Weight	Payment rate	National Unadjusted Copayment	Minimum Unadjusted Copayment	* Indicates a Change
3041	Bivalirudin	K		$2.41		$0.48	
3043	Gamma globulin 1 CC inj	K		$15.85		$3.17	
3050	Sermorelin acetate injection	K		$1.77		$0.36	
7000	Amifostine	K		$333.69		$66.74	
7005	Gonadorelin hydroch	K		$32.12		$6.42	
7011	Oprelvekin injection	K		$241.17		$48.23	
7034	Somatropin injection	K		$54.38		$10.88	
7035	Teniposide	K		$319.21		$63.84	
7036	Urokinase 250,000 IU inj	K		$449.09		$89.82	
7038	Monoclonal antibodies	K		$1,111.55		$222.31	
7041	Tirofiban HCl	K		$7.74		$1.55	
7042	Capecitabine, oral	K		$6.11		$1.22	
7043	Infliximab injection	K		$57.56		$11.51	
7045	Inj trimetrexate glucoronate	K		$146.89		$29.38	
7046	Doxorubicin hcl liposome inj	K		$462.49		$92.50	
7048	Alteplase recombinant	K		$36.23		$7.25	
7049	Filgrastim 480 mcg injection	K		$336.26		$67.25	
7051	Leuprolide acetate implant	K		$4,728.88		$945.78	
7308	Aminolevulinic acid hcl top	K		$127.08		$25.42	
8000	Cardiac Electrophysiologic Evaluation and Ablation Composite	T	150.1090	$10,093.48	.	$2,018.70	*
8001	LDR Prostate Brachytherapy Composite	T	46.1770	$3,104.99	.	$621.00	*
8002	Level I Extended Assessment & Management Composite	V	5.6573	$380.40	.	$76.08	*
8003	Level II Extended Assessment & Management Composite	V	10.4630	$703.54	.	$140.71	*
8004	Ultrasound Composite	S	2.8400	$190.96	.	$38.20	*
8005	CT and CTA without Contrast Composite	S	6.2228	$418.43	.	$83.69	*
8006	CT and CTA with Contrast Composite	S	9.3240	$626.96	.	$125.40	*
8007	MRI and MRA without Contrast Composite	S	10.5672	$710.55	.	$142.11	*
8008	MRI and MRA with Contrast Composite	S	14.7694	$993.11	.	$198.63	*

APC	Group Title	SI	Relative Weight	Payment rate	National Unadjusted Copayment	Minimum Unadjusted Copayment	* Indicates a Change
9001	Linezolid injection	K		$30.94		$6.19	
9002	Tenecteplase injection	K		$41.84		$8.37	
9003	Palivizumab	K		$634.00		$126.80	
9004	Gemtuzumab ozogamicin inj	K		$2,573.49		$514.70	
9005	Reteplase injection	K		$1,258.72		$251.74	
9006	Tacrolimus injection	K		$137.01		$27.40	
9012	Arsenic trioxide injection	K		$36.83		$7.37	
9015	Mycophenolate mofetil oral	K		$2.55		$0.51	
9018	Inj, rimabotulinumtoxinB	K		$10.38		$2.08	
9019	Caspofungin acetate	K		$11.54		$2.31	
9020	Sirolimus, oral	K		$9.47		$1.89	
9022	IM inj interferon beta 1-a	K		$187.31		$37.46	
9023	Rho d immune globulin	K		$25.47		$5.09	
9024	Amphotericin b lipid complex	K		$9.47		$1.89	
9032	Baclofen 10 MG injection	K		$199.42		$39.88	
9033	Cidofovir injection	K		$746.87		$149.37	
9038	Inj estrogen conjugate	K		$87.05		$17.41	
9042	Glucagon hydrochloride	K		$82.64		$16.53	
9044	Ibutilide fumarate injection	K		$395.62		$79.12	
9046	Iron sucrose injection	K		$0.37		$0.08	
9104	Antithymocyte globuln rabbit	K		$401.93		$80.39	
9108	Thyrotropin injection	K		$1,043.80		$208.76	
9110	Alemtuzumab injection	K		$555.50		$111.10	
9115	Zoledronic acid	K		$215.25		$43.05	
9119	Injection, pegfilgrastim 6mg	K		$2,320.08		$464.02	
9120	Injection, Fulvestrant	K		$80.66		$16.13	
9121	Injection, argatroban	K		$17.87		$3.57	
9122	Triptorelin pamoate	K		$153.42		$30.68	
9124	Daptomycin injection	K		$0.42		$0.08	

APC	Group Title	SI	Relative Weight	Payment rate	National Unadjusted Copayment	Minimum Unadjusted Copayment	* Indicates a Change
9125	Risperidone, long acting	K		$4.94		$0.99	
9126	Natalizumab injection	K		$8.08		$1.62	
9133	Rabies ig, im/sc	K		$150.91		$30.18	
9134	Rabies ig, heat treated	K		$140.06		$28.01	
9135	Varicella-zoster ig, im	K		$147.58		$29.52	
9137	Bcg vaccine, precut	K		$108.14		$21.63	
9139	Rabies vaccine, im	K		$173.25		$34.65	
9140	Rabies vaccine, id	K		$96.27		$19.25	
9143	Meningococcal vaccine, sc	K		$98.54		$19.71	
9144	Encephalitis vaccine, sc	K		$100.15		$20.03	
9145	Meningococcal vaccine, im	K		$102.46		$20.50	
9207	Bortezomib injection	K		$37.52		$7.50	
9208	Agalsidase beta injection	K		$133.68		$26.74	
9209	Laronidase injection	K		$25.08		$5.02	
9210	Palonosetron hcl	K		$17.18		$3.44	
9213	Pemetrexed injection	K		$49.63		$9.93	
9214	Bevacizumab injection	K		$56.37		$11.27	
9215	Cetuximab injection	K		$48.79		$9.76	
9217	Leuprolide acetate suspension	K		$202.62		$40.52	
9224	Galsulfase injection	K		$334.14		$66.83	
9225	Fluocinolone acetonide implt	K		$18,980.00		$3,796.00	
9227	Micafungin sodium injection	K		$1.11		$0.22	
9228	Tigecycline injection	K		$1.15		$0.23	
9229	Ibandronate sodium injection	K		$138.94		$27.79	
9230	Abatacept injection	K		$19.15		$3.83	
9231	Decitabine injection	K		$28.68		$5.74	
9232	Idursulfase injection	K		$446.44		$89.29	
9233	Ranibizumab injection	K		$397.01		$79.40	
9234	Alglucosidase alfa injection	K		$124.69		$24.94	

APC	Group Title	SI	Relative Weight	Payment rate	National Unadjusted Copayment	Minimum Unadjusted Copayment	* Indicates a Change
9235	Panitumumab injection	K		$85.35		$17.07	
9236	Eculizumab injection	K		$177.56		$35.51	
9237	Inj, lanreotide acetate	K		$26.62		$5.32	
9238	Inj, levetiracetam	G		$0.46		$0.09	
9240	Injection, ixabepilone	G		$63.74		$12.51	
9241	Injection, doripenem	G		$0.55		$0.11	
9242	Injection, fosaprepitant	G		$1.57		$0.31	
9243	Bendamustine injection	G		$18.51		$3.63	
9244	Regadenoson injection	G		$50.85		$9.98	
9245	Romiplostim injection	G		$43.60		$8.55	
9246	Gadoxetate disodium inj	G		$13.50		$0.00	*
9247	Inj, iobenguane, I-123, dx	G		$2,284.77		$0.00	*
9248	Inj, clevidipine butyrate	G		$3.10		$0.61	
9249	Certolizumab pegol inj	G		$3.72		$0.73	
9250	Artiss fibrin sealant	G		$135.36		$26.56	
9251	C1 esterase inhibitor inj	G		$41.40		$8.12	
9252	Plerixafor injection	G		$268.72		$52.73	
9253	Temozolomide injection	G		$4.90		$0.96	
9254	Injection, lacosamide	K		$0.18		$0.04	
9255	Paliperidone palmitate inj	G		$6.71		$1.32	
9256	Dexamethasone intravitreal	G		$196.10		$38.48	
9300	Omalizumab injection	K		$18.86		$3.78	
9356	TenoGlide tendon prot, cm2	G		$26.37		$0.00	*
9358	SurgiMend, fetal	G		$10.64		$2.09	
9359	Implnt,bon void filler-putty	G		$61.47		$0.00	*
9360	SurgiMend, neonatal	G		$11.14		$2.19	
9361	NeuroMend nerve wrap	G		$250.53		$0.00	*
9362	Implnt,bon void filler-strip	G		$63.60		$0.00	
9363	Integra Meshed Bil Wound Mat	G		$28.30		$5.55	

APC	Group Title	SI	Relative Weight	Payment rate	National Unadjusted Copayment	Minimum Unadjusted Copayment	* Indicates a Change
9364	Porcine implant, Permacol	G		$18.09		$0.00	*
9500	Platelets, irradiated	R	2.2320	$150.08	.	$30.02	*
9501	Platelet pheres leukoreduced	R	7.5974	$510.86	.	$102.18	*
9502	Platelet pheresis irradiated	R	5.3105	$357.08	.	$71.42	*
9503	Fr frz plasma donor retested	R	1.0664	$71.71	.	$14.35	*
9504	RBC deglycerolized	R	5.3988	$363.02	.	$72.61	*
9505	RBC irradiated	R	3.3499	$225.25	.	$45.05	*
9506	Granulocytes, pheresis unit	R	0.6664	$44.81	.	$8.97	*
9507	Platelets, pheresis	R	6.9594	$467.96	.	$93.60	*
9508	Plasma 1 donor frz w/in 8 hr	R	1.1278	$75.83	.	$15.17	*

Addendum AA -- Revised ASC Covered Surgical Procedures for CY 2010 (Including Surgical Procedures for Which Payment is Packaged) to Reflect Retroactive Provisions of the Affordable Care Act

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
0016T	Thermotx choroid vasc lesion	Y	R2	5.5901	$234.07
0017T	Photocoagulat macular drusen	Y	R2	5.5901	$234.07
0084T	Temp prostate urethral stent	N	D5		
0086T	L ventricle fill pressure	N	D5		
0099T*	Implant corneal ring	Y	R2	15.5271	$650.17
0100T	Prosth retina receive&gen	Y	G2	38.1899	$1,599.13
0101T	Extracorp shockwv tx,hi enrg	Y	G2	30.361	$1,271.31
0102T	Extracorp shockwv tx,anesth	Y	G2	30.361	$1,271.31
0123T	Scleral fistulization	Y	G2	23.3186	$976.42
0124T*	Conjunctival drug placement	Y	R2	4.3073	$180.36
0170T	Anorectal fistula plug rpr	N	D5		
0176T	Aqu canal dilat w/o retent	Y	A2	37.6577	$1,576.84
0177T	Aqu canal dilat w retent	Y	A2	37.6577	$1,576.84
0186T	Suprachoroidal drug delivery	Y	G2	19.7948	$828.87
0190T	Place intraoc radiation src	Y	G2	19.7948	$828.87
0191T	Insert ant segment drain int	Y	G2	23.3186	$976.42
0192T	Insert ant segment drain ext	Y	G2	40.0244	$1,675.94
0193T	Rf bladder neck microremodel	Y	G2	19.1352	$801.25
0200T	Perq sacral augmt unilat inj	Y	G2	21.0374	$880.90
0201T	Perq sacral augmt bilat inj	Y	G2	30.361	$1,271.31
0213T	Us facet jt inj cerv/t 1 lev	Y	G2	6.8805	$288.11
0214T	Us facet jt inj cerv/t 2 lev	Y	G2	2.4423	$102.27
0215T	Us facet jt inj cerv/t 3 lev	Y	G2	2.4423	$102.27
0216T	Us facet jt inj ls 1 level	Y	G2	6.8805	$288.11
0217T	Us facet jt inj ls 2 level	Y	G2	2.4423	$102.27
0218T	Us facet jt inj ls 3 level	Y	G2	2.4423	$102.27
10021	Fna w/o image	Y	P2	1.444	$60.46
10022	Fna w/image	Y	G2	4.3949	$184.03
10040	Acne surgery	Y	P2	0.8399	$35.17
10060	Drainage of skin abscess	Y	P3		$54.12
10061	Drainage of skin abscess	Y	P2	1.3911	$58.25
10080	Drainage of pilonidal cyst	Y	P2	1.3911	$58.25
10081	Drainage of pilonidal cyst	Y	P3		$137.46
10120	Remove foreign body	Y	P3		$75.04
10121	Remove foreign body	Y	A2	15.0849	$631.65
10140	Drainage of hematoma/fluid	Y	P3		$80.10
10160	Puncture drainage of lesion	Y	P2	1.3911	$58.25
10180	Complex drainage, wound	Y	A2	16.4531	$688.94
11000	Debride infected skin	Y	P3		$25.62
11001	Debride infected skin add-on	Y	P3		$8.66
11010	Debride skin, fx	Y	A2	4.5617	$191.01
11011	Debride skin/muscle, fx	Y	A2	4.5617	$191.01
11012	Debride skin/muscle/bone, fx	Y	A2	4.5617	$191.01
11040	Debride skin, partial	Y	P3		$23.45
11041	Debride skin, full	Y	P3		$25.98
11042	Debride skin/tissue	Y	A2	2.9437	$123.26
11043	Debride tissue/muscle	Y	A2	2.9437	$123.26
11044	Debride tissue/muscle/bone	Y	A2	8.2929	$347.25
11055	Trim skin lesion	Y	P3		$27.78
11056	Trim skin lesions, 2 to 4	Y	P3		$30.31
11057	Trim skin lesions, over 4	Y	P3		$33.91
11100	Biopsy, skin lesion	Y	P2	1.4728	$61.67
11101	Biopsy, skin add-on	Y	P3		$14.79
11200	Removal of skin tags	Y	P2	0.8399	$35.17
11201	Remove skin tags add-on	Y	P3		$6.13
11300	Shave skin lesion	Y	P2	0.8399	$35.17
11301	Shave skin lesion	Y	P2	0.8399	$35.17
11302	Shave skin lesion	Y	P2	0.8399	$35.17
11303	Shave skin lesion	Y	P2	1.4728	$61.67
11305	Shave skin lesion	Y	P2	0.8399	$35.17

11306	Shave skin lesion	Y	P2	0.8399	$35.17
11307	Shave skin lesion	Y	P2	0.8399	$35.17
11308	Shave skin lesion	Y	P2	0.8399	$35.17
11310	Shave skin lesion	Y	P2	0.8399	$35.17
11311	Shave skin lesion	Y	P2	0.8399	$35.17
11312	Shave skin lesion	Y	P2	0.8399	$35.17
11313	Shave skin lesion	Y	P2	0.8399	$35.17
11400	Exc tr-ext b9+marg 0.5 < cm	Y	P3		$71.44
11401	Exc tr-ext b9+marg 0.6-1 cm	Y	P3		$80.46
11402	Exc tr-ext b9+marg 1.1-2 cm	Y	P3		$88.39
11403	Exc tr-ext b9+marg 2.1-3 cm	Y	P3		$95.25
11404	Exc tr-ext b9+marg 3.1-4 cm	Y	A2	14.4403	$604.66
11406	Exc tr-ext b9+marg > 4.0 cm	Y	A2	15.0849	$631.65
11420	Exc h-f-nk-sp b9+marg 0.5 <	Y	P3		$67.47
11421	Exc h-f-nk-sp b9+marg 0.6-1	Y	P3		$81.54
11422	Exc h-f-nk-sp b9+marg 1.1-2	Y	P3		$89.12
11423	Exc h-f-nk-sp b9+marg 2.1-3	Y	P3		$99.22
11424	Exc h-f-nk-sp b9+marg 3.1-4	Y	A2	15.0849	$631.65
11426	Exc h-f-nk-sp b9+marg > 4 cm	Y	A2	19.307	$808.44
11440	Exc face-mm b9+marg 0.5 < cm	Y	P3		$76.49
11441	Exc face-mm b9+marg 0.6-1 cm	Y	P3		$88.75
11442	Exc face-mm b9+marg 1.1-2 cm	Y	P3		$97.77
11443	Exc face-mm b9+marg 2.1-3 cm	Y	P3		$108.60
11444	Exc face-mm b9+marg 3.1-4 cm	Y	A2	7.779	$325.73
11446	Exc face-mm b9+marg > 4 cm	Y	A2	19.307	$808.44
11450	Removal, sweat gland lesion	Y	A2	19.307	$808.44
11451	Removal, sweat gland lesion	Y	A2	19.307	$808.44
11462	Removal, sweat gland lesion	Y	A2	19.307	$808.44
11463	Removal, sweat gland lesion	Y	A2	19.307	$808.44
11470	Removal, sweat gland lesion	Y	A2	19.307	$808.44
11471	Removal, sweat gland lesion	Y	A2	19.307	$808.44

11600	Exc tr-ext mlg+marg 0.5 < cm	Y	P3		$101.74
11601	Exc tr-ext mlg+marg 0.6-1 cm	Y	P3		$121.95
11602	Exc tr-ext mlg+marg 1.1-2 cm	Y	P3		$133.85
11603	Exc tr-ext mlg+marg 2.1-3 cm	Y	P3		$142.87
11604	Exc tr-ext mlg+marg 3.1-4 cm	Y	A2	8.2667	$346.15
11606	Exc tr-ext mlg+marg > 4 cm	Y	A2	15.0849	$631.65
11620	Exc h-f-nk-sp mlg+marg 0.5 <	Y	P3		$104.63
11621	Exc h-f-nk-sp mlg+marg 0.6-1	Y	P3		$123.39
11622	Exc h-f-nk-sp mlg+marg 1.1-2	Y	P3		$136.74
11623	Exc h-f-nk-sp mlg+marg 2.1-3	Y	P3		$148.29
11624	Exc h-f-nk-sp mlg+marg 3.1-4	Y	A2	15.0849	$631.65
11626	Exc h-f-nk-sp mlg+mar > 4 cm	Y	A2	19.307	$808.44
11640	Exc face-mm malig+marg 0.5 <	Y	P3		$110.40
11641	Exc face-mm malig+marg 0.6-1	Y	P3		$129.16
11642	Exc face-mm malig+marg 1.1-2	Y	P3		$143.96
11643	Exc face-mm malig+marg 2.1-3	Y	P3		$156.22
11644	Exc face-mm malig+marg 3.1-4	Y	A2	15.0849	$631.65
11646	Exc face-mm mlg+marg > 4 cm	Y	A2	19.307	$808.44
11719	Trim nail(s)	Y	P3		$12.99
11720	Debride nail, 1-5	Y	P3		$15.87
11721	Debride nail, 6 or more	Y	P3		$19.12
11730	Removal of nail plate	Y	P2	0.8399	$35.17
11732	Remove nail plate, add-on	Y	P3		$19.12
11740	Drain blood from under nail	Y	P2	0.4239	$17.75
11750	Removal of nail bed	Y	P3		$102.83
11752	Remove nail bed/finger tip	Y	P3		$143.59
11755	Biopsy, nail unit	Y	P3		$70.72
11760	Repair of nail bed	Y	G2	1.2941	$54.19
11762	Reconstruction of nail bed	Y	P3		$132.41
11765	Excision of nail fold, toe	Y	P2	0.8399	$35.17
11770	Removal of pilonidal lesion	Y	A2	19.6721	$823.73

11771	Removal of pilonidal lesion	Y	A2	19.6721	$823.73
11772	Removal of pilonidal lesion	Y	A2	19.6721	$823.73
11900	Injection into skin lesions	Y	P3		$31.39
11901	Added skin lesions injection	Y	P2	0.8399	$35.17
11920	Correct skin color defects	Y	P3		$97.77
11921	Correct skin color defects	Y	P3		$108.60
11922	Correct skin color defects	Y	P3		$35.72
11950	Therapy for contour defects	Y	P3		$36.44
11951	Therapy for contour defects	Y	P3		$46.90
11952	Therapy for contour defects	Y	P2	1.2941	$54.19
11954	Therapy for contour defects	Y	P2	1.2941	$54.19
11960	Insert tissue expander(s)	Y	A2	19.6965	$824.75
11970	Replace tissue expander	Y	A2	36.2926	$1,519.68
11971	Remove tissue expander(s)	Y	A2	18.6621	$781.44
11976	Removal of contraceptive cap	Y	P3		$65.66
11980	Implant hormone pellet(s)	N	P2	0.6396	$26.78
11981	Insert drug implant device	N	P2	0.6396	$26.78
11982	Remove drug implant device	N	P2	0.6396	$26.78
11983	Remove/insert drug implant	N	P2	0.6396	$26.78
12001	Repair superficial wound(s)	Y	P2	1.2941	$54.19
12002	Repair superficial wound(s)	Y	P2	1.2941	$54.19
12004	Repair superficial wound(s)	Y	P2	1.2941	$54.19
12005	Repair superficial wound(s)	Y	A2	1.4909	$62.43
12006	Repair superficial wound(s)	Y	A2	1.4909	$62.43
12007	Repair superficial wound(s)	Y	A2	1.4909	$62.43
12011	Repair superficial wound(s)	Y	P2	1.2941	$54.19
12013	Repair superficial wound(s)	Y	P2	1.2941	$54.19
12014	Repair superficial wound(s)	Y	P2	1.2941	$54.19
12015	Repair superficial wound(s)	Y	G2	1.2941	$54.19
12016	Repair superficial wound(s)	Y	A2	1.4909	$62.43
12017	Repair superficial wound(s)	Y	A2	1.4909	$62.43
12018	Repair superficial wound(s)	Y	A2	1.4909	$62.43
12020	Closure of split wound	Y	A2	3.7017	$155.00
12021	Closure of split wound	Y	A2	2.7786	$116.35
12031	Intmd wnd repair s/tr/ext	Y	P2	1.2941	$54.19
12032	Intmd wnd repair s/tr/ext	Y	P2	3.0109	$126.08
12034	Intmd wnd repair s/tr/ext	Y	A2	1.4909	$62.43
12035	Intmd wnd repair s/tr/ext	Y	A2	1.4909	$62.43
12036	Intmd wnd repair s/tr/ext	Y	A2	2.7786	$116.35
12037	Intmd wnd repair s/tr/ext	Y	A2	4.1024	$171.78
12041	Intmd wnd repair n-hf/genit	Y	P2	1.2941	$54.19
12042	Intmd wnd repair n-hg/genit	Y	P2	1.2941	$54.19
12044	Intmd wnd repair n-hg/genit	Y	A2	1.4909	$62.43
12045	Intmd wnd repair n-hg/genit	Y	A2	2.7786	$116.35
12046	Intmd wnd repair n-hg/genit	Y	A2	2.7786	$116.35
12047	Intmd wnd repair n-hg/genit	Y	A2	4.1024	$171.78
12051	Intmd wnd repair face/mm	Y	P2	1.2941	$54.19
12052	Intmd wnd repair face/mm	Y	P2	1.2941	$54.19
12053	Intmd wnd repair face/mm	Y	P2	1.2941	$54.19
12054	Intmd wnd repair, face/mm	Y	A2	1.4909	$62.43
12055	Intmd wnd repair face/mm	Y	A2	2.7786	$116.35
12056	Intmd wnd repair face/mm	Y	A2	2.7786	$116.35
12057	Intmd wnd repair face/mm	Y	A2	4.1024	$171.78
13100	Repair of wound or lesion	Y	A2	5.0257	$210.44
13101	Repair of wound or lesion	Y	A2	5.0257	$210.44
13102	Repair wound/lesion add-on	Y	A2	3.7017	$155.00
13120	Repair of wound or lesion	Y	A2	2.7786	$116.35
13121	Repair of wound or lesion	Y	A2	2.7786	$116.35
13122	Repair wound/lesion add-on	Y	A2	1.4909	$62.43
13131	Repair of wound or lesion	Y	A2	2.7786	$116.35
13132	Repair of wound or lesion	Y	A2	3.7017	$155.00
13133	Repair wound/lesion add-on	Y	A2	2.7786	$116.35

13150	Repair of wound or lesion	Y	A2	5.0257	$210.44
13151	Repair of wound or lesion	Y	A2	5.0257	$210.44
13152	Repair of wound or lesion	Y	A2	5.0257	$210.44
13153	Repair wound/lesion add-on	Y	A2	2.7786	$116.35
13160	Late closure of wound	Y	A2	19.6965	$824.75
14000	Skin tissue rearrangement	Y	A2	14.0506	$588.34
14001	Skin tissue rearrangement	Y	A2	14.4157	$603.63
14020	Skin tissue rearrangement	Y	A2	14.4157	$603.63
14021	Skin tissue rearrangement	Y	A2	14.4157	$603.63
14040	Skin tissue rearrangement	Y	A2	14.0506	$588.34
14041	Skin tissue rearrangement	Y	A2	14.4157	$603.63
14060	Skin tissue rearrangement	Y	A2	14.4157	$603.63
14061	Skin tissue rearrangement	Y	A2	14.4157	$603.63
14300	Skin tissue rearrangement	N	D5		
14301	Skin tissue rearrangement	Y	G2	22.8691	$957.60
14302	Skin tissue rearrange add-on	Y	G2	22.8691	$957.60
14350	Skin tissue rearrangement	Y	A2	20.0616	$840.04
15002	Wound prep, trk/arm/leg	Y	A2	5.0257	$210.44
15003	Wound prep, addl 100 cm	Y	A2	5.0257	$210.44
15004	Wound prep, f/n/hf/g	Y	A2	5.0257	$210.44
15005	Wnd prep, f/n/hf/g, addl cm	Y	A2	5.0257	$210.44
15040	Harvest cultured skin graft	Y	A2	2.7786	$116.35
15050	Skin pinch graft	Y	A2	5.0257	$210.44
15100	Skin splt grft, trnk/arm/leg	Y	A2	19.6965	$824.75
15101	Skin splt grft t/a/l, add-on	Y	A2	20.0616	$840.04
15110	Epidrm autogrft trnk/arm/leg	Y	A2	5.7259	$239.76
15111	Epidrm autogrft t/a/l add-on	Y	A2	5.0811	$212.76
15115	Epidrm a-grft face/nck/hf/g	Y	A2	5.7259	$239.76
15116	Epidrm a-grft f/n/hf/g addl	Y	A2	5.0811	$212.76
15120	Skn splt a-grft fac/nck/hf/g	Y	A2	19.6965	$824.75
15121	Skn splt a-grft f/n/hf/g add	Y	A2	20.0616	$840.04

15130	Derm autograft, trnk/arm/leg	Y	A2	14.0506	$588.34
15131	Derm autograft t/a/l add-on	Y	A2	13.406	$561.35
15135	Derm autograft face/nck/hf/g	Y	A2	14.0506	$588.34
15136	Derm autograft, f/n/hf/g add	Y	A2	13.406	$561.35
15150	Cult epiderm grft t/arm/leg	Y	A2	5.7259	$239.76
15151	Cult epiderm grft t/a/l addl	Y	A2	5.0811	$212.76
15152	Cult epiderm graft t/a/l +%	Y	A2	5.0811	$212.76
15155	Cult epiderm graft, f/n/hf/g	Y	A2	5.7259	$239.76
15156	Cult epidrm grft f/n/hfg add	Y	A2	5.0811	$212.76
15157	Cult epiderm grft f/n/hfg +%	Y	A2	5.0811	$212.76
15170	Acell graft trunk/arms/legs	Y	G2	4.2415	$177.60
15171	Acell graft t/arm/leg add-on	Y	G2	3.0109	$126.08
15175	Acellular graft, f/n/hf/g	Y	G2	4.2415	$177.60
15176	Acell graft, f/n/hf/g add-on	Y	G2	4.2415	$177.60
15200	Skin full graft, trunk	Y	A2	14.4157	$603.63
15201	Skin full graft trunk add-on	Y	A2	13.3504	$559.02
15220	Skin full graft sclp/arm/leg	Y	A2	14.0506	$588.34
15221	Skin full graft add-on	Y	A2	5.0257	$210.44
15240	Skin full grft face/genit/hf	Y	A2	14.4157	$603.63
15241	Skin full graft add-on	Y	A2	5.0257	$210.44
15260	Skin full graft een & lips	Y	A2	14.0506	$588.34
15261	Skin full graft add-on	Y	A2	13.3504	$559.02
15300	Apply skinallogrft, t/arm/lg	Y	A2	5.0257	$210.44
15301	Apply sknallogrft t/a/l addl	Y	A2	5.0257	$210.44
15320	Apply skin allogrft f/n/hf/g	Y	A2	5.0257	$210.44
15321	Aply sknallogrft f/n/hfg add	Y	A2	5.0257	$210.44
15330	Aply acell alogrft t/arm/leg	Y	A2	5.0257	$210.44
15331	Aply acell grft t/a/l add-on	Y	A2	5.0257	$210.44
15335	Apply acell graft, f/n/hf/g	Y	A2	5.0257	$210.44
15336	Aply acell grft f/n/hf/g add	Y	A2	5.0257	$210.44
15340	Apply cult skin substitute	Y	G2	3.0109	$126.08

15341	Apply cult skin sub add-on	Y	G2	3.0109	$126.08
15360	Apply cult derm sub, t/a/l	Y	G2	3.0109	$126.08
15361	Aply cult derm sub t/a/l add	Y	G2	3.0109	$126.08
15365	Apply cult derm sub f/n/hf/g	Y	G2	3.0109	$126.08
15366	Apply cult derm f/hf/g add	Y	G2	3.0109	$126.08
15400	Apply skin xenograft, t/a/l	Y	A2	5.0257	$210.44
15401	Apply skn xenogrft t/a/l add	Y	A2	5.0257	$210.44
15420	Apply skin xgraft, f/n/hf/g	Y	A2	5.0257	$210.44
15421	Apply skn xgrft f/n/hf/g add	Y	A2	5.0257	$210.44
15430	Apply acellular xenograft	Y	A2	5.0257	$210.44
15431	Apply acellular xgraft add	Y	A2	5.0257	$210.44
15570	Form skin pedicle flap	Y	A2	20.0616	$840.04
15572	Form skin pedicle flap	Y	A2	20.0616	$840.04
15574	Form skin pedicle flap	Y	A2	20.0616	$840.04
15576	Form skin pedicle flap	Y	A2	20.0616	$840.04
15600	Skin graft	Y	A2	20.0616	$840.04
15610	Skin graft	Y	A2	20.0616	$840.04
15620	Skin graft	Y	A2	20.7463	$868.71
15630	Skin graft	Y	A2	20.0616	$840.04
15650	Transfer skin pedicle flap	Y	A2	21.2426	$889.49
15731	Forehead flap w/vasc pedicle	Y	A2	20.0616	$840.04
15732	Muscle-skin graft, head/neck	Y	A2	20.0616	$840.04
15734	Muscle-skin graft, trunk	Y	A2	20.0616	$840.04
15736	Muscle-skin graft, arm	Y	A2	20.0616	$840.04
15738	Muscle-skin graft, leg	Y	A2	20.0616	$840.04
15740	Island pedicle flap graft	Y	A2	14.0506	$588.34
15750	Neurovascular pedicle graft	Y	A2	19.6965	$824.75
15760	Composite skin graft	Y	A2	19.6965	$824.75
15770	Derma-fat-fascia graft	Y	A2	20.0616	$840.04
15775	Hair transplant punch grafts	Y	A2	2.8149	$117.87
15776	Hair transplant punch grafts	Y	A2	2.8149	$117.87

15780	Abrasion treatment of skin	Y	P3		$419.96
15781	Abrasion treatment of skin	Y	P2	4.1688	$174.56
15782	Abrasion treatment of skin	Y	P2	4.1688	$174.56
15783	Abrasion treatment of skin	Y	P2	2.674	$111.97
15786	Abrasion, lesion, single	Y	P2	0.8399	$35.17
15787	Abrasion, lesions, add-on	Y	P3		$31.39
15788	Chemical peel, face, epiderm	Y	P2	0.8399	$35.17
15789	Chemical peel, face, dermal	Y	P2	1.4728	$61.67
15792	Chemical peel, nonfacial	Y	P2	1.4728	$61.67
15793	Chemical peel, nonfacial	Y	P2	0.8399	$35.17
15819	Plastic surgery, neck	Y	G2	3.0109	$126.08
15820	Revision of lower eyelid	Y	A2	20.0616	$840.04
15821	Revision of lower eyelid	Y	A2	20.0616	$840.04
15822	Revision of upper eyelid	Y	A2	20.0616	$840.04
15823	Revision of upper eyelid	Y	A2	21.2426	$889.49
15824	Removal of forehead wrinkles	Y	A2	20.0616	$840.04
15825	Removal of neck wrinkles	Y	A2	20.0616	$840.04
15826	Removal of brow wrinkles	Y	A2	20.0616	$840.04
15828	Removal of face wrinkles	Y	A2	20.0616	$840.04
15829	Removal of skin wrinkles	Y	A2	21.2426	$889.49
15830	Exc skin abd	Y	A2	19.6721	$823.73
15832	Excise excessive skin tissue	Y	A2	19.6721	$823.73
15833	Excise excessive skin tissue	Y	A2	19.6721	$823.73
15834	Excise excessive skin tissue	Y	A2	19.6721	$823.73
15835	Excise excessive skin tissue	Y	A2	18.6067	$779.12
15836	Excise excessive skin tissue	Y	A2	15.4501	$646.94
15837	Excise excessive skin tissue	Y	G2	16.7206	$700.14
15838	Excise excessive skin tissue	Y	G2	16.7206	$700.14
15839	Excise excessive skin tissue	Y	A2	15.4501	$646.94
15840	Graft for face nerve palsy	Y	A2	20.7463	$868.71
15841	Graft for face nerve palsy	Y	A2	20.7463	$868.71

15842	Flap for face nerve palsy	Y	G2	22.8691	$957.60
15845	Skin and muscle repair, face	Y	A2	20.7463	$868.71
15847	Exc skin abd add-on	Y	A2	19.6721	$823.73
15850	Removal of sutures	Y	G2	2.674	$111.97
15851	Removal of sutures	Y	P3		$52.31
15852	Dressing change not for burn	N	R2	0.6396	$26.78
15860	Test for blood flow in graft	N	G2	0.6396	$26.78
15876	Suction assisted lipectomy	Y	A2	20.0616	$840.04
15877	Suction assisted lipectomy	Y	A2	20.0616	$840.04
15878	Suction assisted lipectomy	Y	A2	20.0616	$840.04
15879	Suction assisted lipectomy	Y	A2	20.0616	$840.04
15920	Removal of tail bone ulcer	Y	A2	4.5617	$191.01
15922	Removal of tail bone ulcer	Y	A2	20.7463	$868.71
15931	Remove sacrum pressure sore	Y	A2	19.6721	$823.73
15933	Remove sacrum pressure sore	Y	A2	19.6721	$823.73
15934	Remove sacrum pressure sore	Y	A2	20.0616	$840.04
15935	Remove sacrum pressure sore	Y	A2	20.7463	$868.71
15936	Remove sacrum pressure sore	Y	A2	15.1004	$632.30
15937	Remove sacrum pressure sore	Y	A2	20.7463	$868.71
15940	Remove hip pressure sore	Y	A2	19.6721	$823.73
15941	Remove hip pressure sore	Y	A2	19.6721	$823.73
15944	Remove hip pressure sore	Y	A2	20.0616	$840.04
15945	Remove hip pressure sore	Y	A2	20.7463	$868.71
15946	Remove hip pressure sore	Y	A2	20.7463	$868.71
15950	Remove thigh pressure sore	Y	A2	19.6721	$823.73
15951	Remove thigh pressure sore	Y	A2	20.3566	$852.39
15952	Remove thigh pressure sore	Y	A2	14.4157	$603.63
15953	Remove thigh pressure sore	Y	A2	15.1004	$632.30
15956	Remove thigh pressure sore	Y	A2	14.4157	$603.63
15958	Remove thigh pressure sore	Y	A2	15.1004	$632.30
16000	Initial treatment of burn(s)	Y	P3		$28.86

16020	Dress/debrid p-thick burn, s	Y	P3		$43.29
16025	Dress/debrid p-thick burn, m	Y	A2	1.4874	$62.28
16030	Dress/debrid p-thick burn, l	Y	A2	1.6739	$70.09
16035	Incision of burn scab, initi	Y	G2	1.4728	$61.67
17000	Destruct premalg lesion	Y	P2	0.8399	$35.17
17003	Destruct premalg les, 2-14	Y	P3		$3.97
17004	Destroy premlg lesions 15+	Y	P3		$88.39
17106	Destruction of skin lesions	Y	P2	2.674	$111.97
17107	Destruction of skin lesions	Y	P2	2.674	$111.97
17108	Destruction of skin lesions	Y	P2	2.674	$111.97
17110	Destruct b9 lesion, 1-14	Y	P2	0.8399	$35.17
17111	Destruct lesion, 15 or more	Y	P2	1.4728	$61.67
17250	Chemical cautery, tissue	Y	P3		$47.99
17260	Destruction of skin lesions	Y	P3		$50.15
17261	Destruction of skin lesions	Y	P2	1.4728	$61.67
17262	Destruction of skin lesions	Y	P2	1.4728	$61.67
17263	Destruction of skin lesions	Y	P2	1.4728	$61.67
17264	Destruction of skin lesions	Y	P2	1.4728	$61.67
17266	Destruction of skin lesions	Y	P2	2.674	$111.97
17270	Destruction of skin lesions	Y	P2	1.4728	$61.67
17271	Destruction of skin lesions	Y	P2	1.4728	$61.67
17272	Destruction of skin lesions	Y	P2	1.4728	$61.67
17273	Destruction of skin lesions	Y	P2	2.674	$111.97
17274	Destruction of skin lesions	Y	P2	2.674	$111.97
17276	Destruction of skin lesions	Y	P2	2.674	$111.97
17280	Destruction of skin lesions	Y	P2	1.4728	$61.67
17281	Destruction of skin lesions	Y	P3		$93.44
17282	Destruction of skin lesions	Y	P3		$106.79
17283	Destruction of skin lesions	Y	P2	2.674	$111.97
17284	Destruction of skin lesions	Y	P2	2.674	$111.97
17286	Destruction of skin lesions	Y	P2	2.674	$111.97

17311	Mohs, 1 stage, h/n/hf/g	Y	P2	4.7146	$197.41
17312	Mohs addl stage	Y	P2	4.7146	$197.41
17313	Mohs, 1 stage, t/a/l	Y	P2	4.7146	$197.41
17314	Mohs, addl stage, t/a/l	Y	P2	4.7146	$197.41
17315	Mohs surg, addl block	Y	P3		$41.49
17340	Cryotherapy of skin	Y	P3		$16.24
17360	Skin peel therapy	Y	P2	0.8399	$35.17
17380	Hair removal by electrolysis	Y	R2	0.8399	$35.17
19000	Drainage of breast lesion	Y	P3		$69.63
19001	Drain breast lesion add-on	Y	P3		$9.38
19020	Incision of breast lesion	Y	A2	16.4531	$688.94
19030	Injection for breast x-ray	N	N1		
19100	Bx breast percut w/o image	Y	A2	4.6655	$195.36
19101	Biopsy of breast, open	Y	A2	20.284	$849.35
19102	Bx breast percut w/image	Y	A2	6.9699	$291.85
19103	Bx breast percut w/device	Y	A2	13.3668	$559.71
19105	Cryosurg ablate fa, each	Y	P2	32.6485	$1,367.09
19110	Nipple exploration	Y	A2	20.284	$849.35
19112	Excise breast duct fistula	Y	A2	20.6491	$864.64
19120	Removal of breast lesion	Y	A2	20.6491	$864.64
19125	Excision, breast lesion	Y	A2	20.6491	$864.64
19126	Excision, addl breast lesion	Y	A2	20.6491	$864.64
19290	Place needle wire, breast	N	N1		
19291	Place needle wire, breast	N	N1		
19295	Place breast clip, percut	N	N1		
19296	Place po breast cath for rad	Y	A2	49.3714	$2,067.33
19297	Place breast cath for rad	Y	A2	49.3714	$2,067.33
19298	Place breast rad tube/caths	Y	A2	49.3714	$2,067.33
19300	Removal of breast tissue	Y	A2	21.3338	$893.31
19301	Partical mastectomy	Y	A2	20.6491	$864.64
19302	P-mastectomy w/ln removal	Y	A2	35.7779	$1,498.13

19303	Mast, simple, complete	Y	A2	28.0806	$1,175.82
19304	Mast, subq	Y	A2	28.0806	$1,175.82
19316	Suspension of breast	Y	A2	28.0806	$1,175.82
19318	Reduction of large breast	Y	A2	33.6955	$1,410.93
19324	Enlarge breast	Y	A2	33.6955	$1,410.93
19325	Enlarge breast with implant	Y	A2	49.3714	$2,067.33
19328	Removal of breast implant	Y	A2	26.3862	$1,104.87
19330	Removal of implant material	Y	A2	26.3862	$1,104.87
19340	Immediate breast prosthesis	Y	A2	32.6459	$1,366.98
19342	Delayed breast prosthesis	Y	A2	44.6417	$1,869.28
19350	Breast reconstruction	Y	A2	21.3338	$893.31
19355	Correct inverted nipple(s)	Y	A2	28.0806	$1,175.82
19357	Breast reconstruction	Y	A2	45.8226	$1,918.73
19366	Breast reconstruction	Y	A2	28.5771	$1,196.61
19370	Surgery of breast capsule	Y	A2	28.0806	$1,175.82
19371	Removal of breast capsule	Y	A2	28.0806	$1,175.82
19380	Revise breast reconstruction	Y	A2	34.192	$1,431.72
19396	Design custom breast implant	Y	G2	32.6485	$1,367.09
20000	Incision of abscess	Y	P2	1.3911	$58.25
20005	Incision of deep abscess	Y	A2	18.3225	$767.22
20103	Explore wound, extremity	Y	G2	12.0613	$505.04
20150	Excise epiphyseal bar	Y	G2	44.5105	$1,863.79
20200	Muscle biopsy	Y	A2	15.0849	$631.65
20205	Deep muscle biopsy	Y	A2	15.4501	$646.94
20206	Needle biopsy, muscle	Y	A2	6.9699	$291.85
20220	Bone biopsy, trocar/needle	Y	A2	7.314	$306.26
20225	Bone biopsy, trocar/needle	Y	A2	14.928	$625.08
20240	Bone biopsy, excisional	Y	A2	19.307	$808.44
20245	Bone biopsy, excisional	Y	A2	19.6721	$823.73
20250	Open bone biopsy	Y	A2	18.6877	$782.51
20251	Open bone biopsy	Y	A2	18.6877	$782.51

20500	Injection of sinus tract	Y	P3		$55.56
20501	Inject sinus tract for x-ray	N	N1		
20520	Removal of foreign body	Y	P3		$101.02
20525	Removal of foreign body	Y	A2	19.6721	$823.73
20526	Ther injection, carp tunnel	Y	P3		$32.11
20550	Inj tendon sheath/ligament	Y	P3		$24.17
20551	Inj tendon origin/insertion	Y	P3		$24.53
20552	Inj trigger point, 1/2 muscl	Y	P3		$23.45
20553	Inject trigger points, =/> 3	Y	P3		$26.70
20555	Place ndl musc/tis for rt	Y	R2	30.361	$1,271.31
20600	Drain/inject, joint/bursa	Y	P3		$24.53
20605	Drain/inject, joint/bursa	Y	P3		$27.78
20610	Drain/inject, joint/bursa	Y	P3		$39.69
20612	Aspirate/inj ganglion cyst	Y	P3		$26.70
20615	Treatment of bone cyst	Y	P3		$108.24
20650	Insert and remove bone pin	Y	A2	18.6877	$782.51
20662	Application of pelvis brace	Y	R2	21.0374	$880.90
20663	Application of thigh brace	Y	R2	21.0374	$880.90
20665	Removal of fixation device	N	G2	0.6396	$26.78
20670	Removal of support implant	Y	A2	14.4403	$604.66
20680	Removal of support implant	Y	A2	19.6721	$823.73
20690	Apply bone fixation device	Y	A2	25.3154	$1,060.03
20692	Apply bone fixation device	Y	A2	25.6805	$1,075.32
20693	Adjust bone fixation device	Y	A2	18.6877	$782.51
20694	Remove bone fixation device	Y	A2	17.678	$740.23
20696	Comp multiplane ext fixation	Y	G2	30.361	$1,271.31
20697	Comp ext fixate strut change	Y	G2	17.5794	$736.10
20822	Replantation digit, complete	Y	G2	26.9839	$1,129.90
20900	Removal of bone for graft	Y	A2	25.6805	$1,075.32
20902	Removal of bone for graft	Y	A2	26.3652	$1,103.99
20910	Remove cartilage for graft	Y	A2	20.0616	$840.04

20912	Remove cartilage for graft	Y	A2	20.0616	$840.04
20920	Removal of fascia for graft	Y	A2	15.1004	$632.30
20922	Removal of fascia for graft	Y	A2	14.4157	$603.63
20924	Removal of tendon for graft	Y	A2	26.3652	$1,103.99
20926	Removal of tissue for graft	Y	A2	6.7755	$283.71
20950	Fluid pressure, muscle	Y	G2	1.3911	$58.25
20972	Bone/skin graft, metatarsal	Y	G2	50.1937	$2,101.76
20973	Bone/skin graft, great toe	Y	R2	50.1937	$2,101.76
20975	Electrical bone stimulation	N	N1		
20979	Us bone stimulation	N	P3		$24.17
20982	Ablate, bone tumor(s) perq	Y	G2	44.5105	$1,863.79
20985	Cptr-asst dir ms px	N	N1		
21010	Incision of jaw joint	Y	A2	20.4361	$855.72
21011	Exc face les sc < 2 cm	Y	P3		$186.17
21012	Exc face les sc = 2 cm	Y	R2	7.8386	$328.23
21013	Exc face tum deep < 2 cm	Y	P3		$258.69
21014	Exc face tum deep = 2 cm	Y	R2	7.8386	$328.23
21015*	Resect face tum < 2 cm	Y	R2	16.7206	$700.14
21016	Resect face tum = 2 cm	Y	G2	22.3496	$935.84
21025	Excision of bone, lower jaw	Y	A2	33.3501	$1,396.47
21026	Excision of facial bone(s)	Y	A2	33.3501	$1,396.47
21029	Contour of face bone lesion	Y	A2	33.3501	$1,396.47
21030	Excise max/zygoma b9 tumor	Y	P3		$264.46
21031	Remove exostosis, mandible	Y	P3		$217.56
21032	Remove exostosis, maxilla	Y	P3		$221.53
21034	Excise max/zygoma mlg tumor	Y	A2	33.7153	$1,411.76
21040	Excise mandible lesion	Y	A2	20.4361	$855.72
21044	Removal of jaw bone lesion	Y	A2	33.3501	$1,396.47
21046	Remove mandible cyst complex	Y	A2	33.3501	$1,396.47
21047	Excise lwr jaw cyst w/repair	Y	A2	33.3501	$1,396.47
21048	Remove maxilla cyst complex	Y	R2	41.0743	$1,719.90

21050	Removal of jaw joint	Y	A2	33.7153	$1,411.76
21060	Remove jaw joint cartilage	Y	A2	33.3501	$1,396.47
21070	Remove coronoid process	Y	A2	33.7153	$1,411.76
21073	Mnpj of tmj w/anesth	Y	P3		$203.13
21076	Prepare face/oral prosthesis	Y	P3		$364.40
21077	Prepare face/oral prosthesis	Y	P3		$876.72
21079	Prepare face/oral prosthesis	Y	P3		$628.50
21080	Prepare face/oral prosthesis	Y	P3		$718.70
21081	Prepare face/oral prosthesis	Y	P3		$662.41
21082	Prepare face/oral prosthesis	Y	P3		$635.35
21083	Prepare face/oral prosthesis	Y	P3		$623.81
21084	Prepare face/oral prosthesis	Y	P3		$714.01
21085	Prepare face/oral prosthesis	Y	P3		$285.39
21086	Prepare face/oral prosthesis	Y	P3		$622.36
21087	Prepare face/oral prosthesis	Y	P3		$620.92
21088	Prepare face/oral prosthesis	Y	R2	41.0743	$1,719.90
21100	Maxillofacial fixation	Y	A2	33.3501	$1,396.47
21110	Interdental fixation	Y	P2	7.2813	$304.89
21116	Injection, jaw joint x-ray	N	N1		
21120	Reconstruction of chin	Y	A2	23.5684	$986.88
21121	Reconstruction of chin	Y	A2	23.5684	$986.88
21122	Reconstruction of chin	Y	A2	23.5684	$986.88
21123	Reconstruction of chin	Y	A2	23.5684	$986.88
21125	Augmentation, lower jaw bone	Y	A2	23.5684	$986.88
21127	Augmentation, lower jaw bone	Y	A2	38.4451	$1,609.81
21137	Reduction of forehead	Y	G2	23.8553	$998.89
21138	Reduction of forehead	Y	G2	41.0743	$1,719.90
21139	Reduction of forehead	Y	G2	41.0743	$1,719.90
21150	Reconstruct midface, lefort	Y	G2	41.0743	$1,719.90
21181	Contour cranial bone lesion	Y	A2	23.5684	$986.88
21198	Reconstr lwr jaw segment	Y	G2	41.0743	$1,719.90

21199	Reconstr lwr jaw w/advance	Y	G2	41.0743	$1,719.90
21206	Reconstruct upper jaw bone	Y	A2	34.8965	$1,461.22
21208	Augmentation of facial bones	Y	A2	36.4825	$1,527.63
21209	Reduction of facial bones	Y	A2	34.8965	$1,461.22
21210	Face bone graft	Y	A2	36.4825	$1,527.63
21215	Lower jaw bone graft	Y	A2	36.4825	$1,527.63
21230	Rib cartilage graft	Y	A2	36.4825	$1,527.63
21235	Ear cartilage graft	Y	A2	23.5684	$986.88
21240	Reconstruction of jaw joint	Y	A2	34.4	$1,440.43
21242	Reconstruction of jaw joint	Y	A2	34.8965	$1,461.22
21243	Reconstruction of jaw joint	Y	A2	34.8965	$1,461.22
21244	Reconstruction of lower jaw	Y	A2	36.4825	$1,527.63
21245	Reconstruction of jaw	Y	A2	36.4825	$1,527.63
21246	Reconstruction of jaw	Y	A2	36.4825	$1,527.63
21248	Reconstruction of jaw	Y	A2	36.4825	$1,527.63
21249	Reconstruction of jaw	Y	A2	36.4825	$1,527.63
21260	Revise eye sockets	Y	G2	41.0743	$1,719.90
21267	Revise eye sockets	Y	A2	36.4825	$1,527.63
21270	Augmentation, cheek bone	Y	A2	34.8965	$1,461.22
21275	Revision, orbitofacial bones	Y	A2	36.4825	$1,527.63
21280	Revision of eyelid	Y	A2	34.8965	$1,461.22
21282	Revision of eyelid	Y	A2	16.4091	$687.10
21295	Revision of jaw muscle/bone	Y	A2	7.3608	$308.22
21296	Revision of jaw muscle/bone	Y	A2	19.7915	$828.73
21310	Treatment of nose fracture	Y	A2	1.6858	$70.59
21315	Treatment of nose fracture	Y	A2	13.1784	$551.82
21320	Treatment of nose fracture	Y	A2	14.863	$622.36
21325	Treatment of nose fracture	Y	A2	21.4859	$899.68
21330	Treatment of nose fracture	Y	A2	21.9824	$920.47
21335	Treatment of nose fracture	Y	A2	23.5684	$986.88
21336	Treat nasal septal fracture	Y	A2	22.1171	$926.11

21337	Treat nasal septal fracture	Y	A2	14.863	$622.36
21338	Treat nasoethmoid fracture	Y	A2	21.4859	$899.68
21339	Treat nasoethmoid fracture	Y	A2	21.9824	$920.47
21340	Treatment of nose fracture	Y	A2	34.4	$1,440.43
21345	Treat nose/jaw fracture	Y	A2	23.5684	$986.88
21355	Treat cheek bone fracture	Y	A2	33.7153	$1,411.76
21356	Treat cheek bone fracture	Y	A2	20.8012	$871.01
21360	Treat cheek bone fracture	Y	G2	23.8553	$998.89
21390	Treat eye socket fracture	Y	G2	41.0743	$1,719.90
21400	Treat eye socket fracture	Y	A2	8.0056	$335.22
21401	Treat eye socket fracture	Y	A2	15.2282	$637.65
21406	Treat eye socket fracture	Y	G2	41.0743	$1,719.90
21407	Treat eye socket fracture	Y	G2	41.0743	$1,719.90
21421	Treat mouth roof fracture	Y	A2	21.4859	$899.68
21440	Treat dental ridge fracture	Y	P3		$356.46
21445	Treat dental ridge fracture	Y	A2	21.4859	$899.68
21450	Treat lower jaw fracture	Y	A2	3.3145	$138.79
21451	Treat lower jaw fracture	Y	A2	8.109	$339.55
21452	Treat lower jaw fracture	Y	A2	14.863	$622.36
21453	Treat lower jaw fracture	Y	A2	33.7153	$1,411.76
21454	Treat lower jaw fracture	Y	A2	21.9824	$920.47
21461	Treat lower jaw fracture	Y	A2	34.4	$1,440.43
21462	Treat lower jaw fracture	Y	A2	34.8965	$1,461.22
21465	Treat lower jaw fracture	Y	A2	34.4	$1,440.43
21480	Reset dislocated jaw	Y	A2	1.6858	$70.59
21485	Reset dislocated jaw	Y	A2	14.863	$622.36
21490	Repair dislocated jaw	Y	A2	33.7153	$1,411.76
21495	Treat hyoid bone fracture	Y	G2	16.4248	$687.76
21497	Interdental wiring	Y	A2	14.863	$622.36
21501	Drain neck/chest lesion	Y	A2	16.4531	$688.94
21502	Drain chest lesion	Y	A2	18.3225	$767.22

21550	Biopsy of neck/chest	Y	G2	16.7206	$700.14
21552	Exc neck les sc = 3 cm	Y	G2	22.3496	$935.84
21554	Exc neck tum deep = 5 cm	Y	G2	22.3496	$935.84
21555*	Exc neck les sc < 3 cm	Y	P3		$215.03
21556	Exc neck tum deep < 5 cm	Y	G2	22.3496	$935.84
21557	Resect neck tum < 5 cm	Y	G2	16.7206	$700.14
21558	Resect neck tum = 5 cm	Y	G2	22.3496	$935.84
21600	Partial removal of rib	Y	A2	25.3154	$1,060.03
21610	Partial removal of rib	Y	A2	25.3154	$1,060.03
21685	Hyoid myotomy & suspension	Y	G2	7.2813	$304.89
21700	Revision of neck muscle	Y	A2	18.3225	$767.22
21720	Revision of neck muscle	Y	A2	18.6877	$782.51
21725	Revision of neck muscle	Y	A2	1.5478	$64.81
21800	Treatment of rib fracture	Y	A2	1.7792	$74.50
21805	Treatment of rib fracture	Y	A2	21.0673	$882.15
21820	Treat sternum fracture	Y	A2	1.7792	$74.50
21920	Biopsy soft tissue of back	Y	P3		$151.53
21925	Biopsy soft tissue of back	Y	A2	19.307	$808.44
21930*	Exc back les sc < 3 cm	Y	P3		$224.05
21931	Exc back les sc = 3 cm	Y	G2	22.3496	$935.84
21932	Exc back tum deep < 5 cm	Y	G2	16.7206	$700.14
21933	Exc back tum deep = 5 cm	Y	G2	22.3496	$935.84
21935	Resect back tum < 5 cm	Y	G2	16.7206	$700.14
21936	Resect back tum = 5 cm	Y	G2	22.3496	$935.84
22102	Remove part, lumbar vertebra	Y	G2	47.04	$1,969.71
22103	Remove extra spine segment	Y	G2	47.04	$1,969.71
22305	Treat spine process fracture	Y	A2	1.7792	$74.50
22310	Treat spine fracture	Y	A2	4.0274	$168.64
22315	Treat spine fracture	Y	A2	13.7757	$576.83
22505	Manipulation of spine	Y	A2	13.5044	$565.47
22520	Percut vertebroplasty thor	Y	A2	30.4103	$1,273.37

22521	Percut vertebroplasty lumb	Y	A2	30.4103	$1,273.37
22522	Percut vertebroplasty addl	Y	A2	30.4103	$1,273.37
22523	Percut kyphoplasty, thor	Y	G2	84.7159	$3,547.31
22524	Percut kyphoplasty, lumbar	Y	G2	84.7159	$3,547.31
22525	Percut kyphoplasty, add-on	Y	G2	84.7159	$3,547.31
22900	Exc back tum deep < 5 cm	Y	G2	22.3496	$935.84
22901	Exc back tum deep = 5 cm	Y	G2	22.3496	$935.84
22902	Exc abd les sc < 3 cm	Y	G2	16.7206	$700.14
22903	Exc abd les sc > 3 cm	Y	G2	22.3496	$935.84
22904	Resect abd tum < 5 cm	Y	G2	16.7206	$700.14
22905	Resect abd tum > 5 cm	Y	G2	22.3496	$935.84
23000	Removal of calcium deposits	Y	A2	15.0849	$631.65
23020	Release shoulder joint	Y	A2	35.9274	$1,504.39
23030	Drain shoulder lesion	Y	A2	15.8083	$661.94
23031	Drain shoulder bursa	Y	A2	16.8182	$704.23
23035	Drain shoulder bone lesion	Y	A2	18.6877	$782.51
23040	Exploratory shoulder surgery	Y	A2	25.6805	$1,075.32
23044	Exploratory shoulder surgery	Y	A2	26.3652	$1,103.99
23065	Biopsy shoulder tissues	Y	P3		$105.71
23066	Biopsy shoulder tissues	Y	A2	19.307	$808.44
23071	Exc shoulder les sc > 3 cm	Y	G2	22.3496	$935.84
23073	Exc shoulder tum deep > 5 cm	Y	G2	22.3496	$935.84
23075*	Exc shoulder les sc < 3 cm	Y	P3		$165.24
23076	Exc shoulder tum deep < 5 cm	Y	G2	16.7206	$700.14
23077	Resect shoulder tum < 5 cm	Y	G2	16.7206	$700.14
23078	Resect shoulder tum > 5 cm	Y	G2	22.3496	$935.84
23100	Biopsy of shoulder joint	Y	A2	18.3225	$767.22
23101	Shoulder joint surgery	Y	A2	28.4477	$1,191.19
23105	Remove shoulder joint lining	Y	A2	26.3652	$1,103.99
23106	Incision of collarbone joint	Y	A2	26.3652	$1,103.99
23107	Explore treat shoulder joint	Y	A2	26.3652	$1,103.99

23120	Partial removal, collar bone	Y	A2	26.8615	$1,124.77
23125	Removal of collar bone	Y	A2	26.8615	$1,124.77
23130	Remove shoulder bone, part	Y	A2	37.4736	$1,569.13
23140	Removal of bone lesion	Y	A2	19.3724	$811.18
23145	Removal of bone lesion	Y	A2	26.8615	$1,124.77
23146	Removal of bone lesion	Y	A2	26.8615	$1,124.77
23150	Removal of humerus lesion	Y	A2	26.3652	$1,103.99
23155	Removal of humerus lesion	Y	A2	26.8615	$1,124.77
23156	Removal of humerus lesion	Y	A2	26.8615	$1,124.77
23170	Remove collar bone lesion	Y	A2	25.3154	$1,060.03
23172	Remove shoulder blade lesion	Y	A2	25.3154	$1,060.03
23174	Remove humerus lesion	Y	A2	25.3154	$1,060.03
23180	Remove collar bone lesion	Y	A2	26.3652	$1,103.99
23182	Remove shoulder blade lesion	Y	A2	26.3652	$1,103.99
23184	Remove humerus lesion	Y	A2	26.3652	$1,103.99
23190	Partial removal of scapula	Y	A2	26.3652	$1,103.99
23195	Removal of head of humerus	Y	A2	26.8615	$1,124.77
23330	Remove shoulder foreign body	Y	A2	7.779	$325.73
23331	Remove shoulder foreign body	Y	A2	18.6621	$781.44
23350	Injection for shoulder x-ray	N	N1		
23395	Muscle transfer,shoulder/arm	Y	A2	37.4736	$1,569.13
23397	Muscle transfers	Y	A2	69.2138	$2,898.19
23400	Fixation of shoulder blade	Y	A2	28.4477	$1,191.19
23405	Incision of tendon & muscle	Y	A2	25.3154	$1,060.03
23406	Incise tendon(s) & muscle(s)	Y	A2	25.3154	$1,060.03
23410	Repair rotator cuff, acute	Y	A2	37.4736	$1,569.13
23412	Repair rotator cuff, chronic	Y	A2	39.0598	$1,635.55
23415	Release of shoulder ligament	Y	A2	37.4736	$1,569.13
23420	Repair of shoulder	Y	A2	39.0598	$1,635.55
23430	Repair biceps tendon	Y	A2	36.9773	$1,548.35
23440	Remove/transplant tendon	Y	A2	36.9773	$1,548.35

23450	Repair shoulder capsule	Y	A2	67.6276	$2,831.77
23455	Repair shoulder capsule	Y	A2	69.2138	$2,898.19
23460	Repair shoulder capsule	Y	A2	67.6276	$2,831.77
23462	Repair shoulder capsule	Y	A2	39.0598	$1,635.55
23465	Repair shoulder capsule	Y	A2	67.6276	$2,831.77
23466	Repair shoulder capsule	Y	A2	39.0598	$1,635.55
23480	Revision of collar bone	Y	A2	36.9773	$1,548.35
23485	Revision of collar bone	Y	A2	69.2138	$2,898.19
23490	Reinforce clavicle	Y	A2	36.2926	$1,519.68
23491	Reinforce shoulder bones	Y	A2	66.4466	$2,782.32
23500	Treat clavicle fracture	Y	A2	1.7792	$74.50
23505	Treat clavicle fracture	Y	A2	13.7757	$576.83
23515	Treat clavicle fracture	Y	A2	49.8357	$2,086.77
23520	Treat clavicle dislocation	Y	A2	4.0274	$168.64
23525	Treat clavicle dislocation	Y	A2	4.0274	$168.64
23530	Treat clavicle dislocation	Y	A2	35.4964	$1,486.34
23532	Treat clavicle dislocation	Y	A2	22.1171	$926.11
23540	Treat clavicle dislocation	Y	A2	1.7792	$74.50
23545	Treat clavicle dislocation	Y	A2	4.0274	$168.64
23550	Treat clavicle dislocation	Y	A2	35.4964	$1,486.34
23552	Treat clavicle dislocation	Y	A2	36.1811	$1,515.01
23570	Treat shoulder blade fx	Y	A2	1.7792	$74.50
23575	Treat shoulder blade fx	Y	A2	4.0274	$168.64
23585	Treat scapula fracture	Y	A2	49.8357	$2,086.77
23600	Treat humerus fracture	Y	P2	1.584	$66.33
23605	Treat humerus fracture	Y	A2	13.7757	$576.83
23615	Treat humerus fracture	Y	A2	50.5204	$2,115.44
23616	Treat humerus fracture	Y	A2	50.5204	$2,115.44
23620	Treat humerus fracture	Y	P2	1.584	$66.33
23625	Treat humerus fracture	Y	A2	13.7757	$576.83
23630	Treat humerus fracture	Y	A2	51.0166	$2,136.22

23650	Treat shoulder dislocation	Y	A2	1.7792	$74.50
23655	Treat shoulder dislocation	Y	A2	12.8598	$538.48
23660	Treat shoulder dislocation	Y	A2	35.4964	$1,486.34
23665	Treat dislocation/fracture	Y	A2	4.0274	$168.64
23670	Treat dislocation/fracture	Y	A2	49.8357	$2,086.77
23675	Treat dislocation/fracture	Y	A2	1.7792	$74.50
23680	Treat dislocation/fracture	Y	A2	35.4964	$1,486.34
23700	Fixation of shoulder	Y	A2	12.8598	$538.48
23800	Fusion of shoulder joint	Y	A2	67.1313	$2,810.99
23802	Fusion of shoulder joint	Y	A2	39.0598	$1,635.55
23921	Amputation follow-up surgery	Y	A2	13.3504	$559.02
23930	Drainage of arm lesion	Y	A2	15.8083	$661.94
23931	Drainage of arm bursa	Y	A2	16.4531	$688.94
23935	Drain arm/elbow bone lesion	Y	A2	18.3225	$767.22
24000	Exploratory elbow surgery	Y	A2	26.3652	$1,103.99
24006	Release elbow joint	Y	A2	26.3652	$1,103.99
24065	Biopsy arm/elbow soft tissue	Y	P3		$145.76
24066	Biopsy arm/elbow soft tissue	Y	A2	15.0849	$631.65
24071	Exc arm/elbow les sc = 3 cm	Y	G2	22.3496	$935.84
24073	Ex arm/elbow tum deep > 5 cm	Y	G2	22.3496	$935.84
24075*	Exc arm/elbow les sc < 3 cm	Y	P3		$266.26
24076	Ex arm/elbow tum deep < 5 cm	Y	G2	16.7206	$700.14
24077	Resect arm/elbow tum < 5 cm	Y	G2	16.7206	$700.14
24079	Resect arm/elbow tum > 5 cm	Y	G2	22.3496	$935.84
24100	Biopsy elbow joint lining	Y	A2	17.678	$740.23
24101	Explore/treat elbow joint	Y	A2	26.3652	$1,103.99
24102	Remove elbow joint lining	Y	A2	26.3652	$1,103.99
24105	Removal of elbow bursa	Y	A2	18.6877	$782.51
24110	Remove humerus lesion	Y	A2	18.3225	$767.22
24115	Remove/graft bone lesion	Y	A2	25.6805	$1,075.32
24116	Remove/graft bone lesion	Y	A2	25.6805	$1,075.32

24120	Remove elbow lesion	Y	A2	18.6877	$782.51
24125	Remove/graft bone lesion	Y	A2	25.6805	$1,075.32
24126	Remove/graft bone lesion	Y	A2	25.6805	$1,075.32
24130	Removal of head of radius	Y	A2	25.6805	$1,075.32
24134	Removal of arm bone lesion	Y	A2	25.3154	$1,060.03
24136	Remove radius bone lesion	Y	A2	25.3154	$1,060.03
24138	Remove elbow bone lesion	Y	A2	25.3154	$1,060.03
24140	Partial removal of arm bone	Y	A2	25.6805	$1,075.32
24145	Partial removal of radius	Y	A2	25.6805	$1,075.32
24147	Partial removal of elbow	Y	A2	25.3154	$1,060.03
24149	Radical resection of elbow	Y	G2	30.361	$1,271.31
24152	Resect radius tumor	Y	G2	44.5105	$1,863.79
24153	Extensive radius surgery	N	D5		
24155	Removal of elbow joint	Y	A2	36.2926	$1,519.68
24160	Remove elbow joint implant	Y	A2	25.3154	$1,060.03
24164	Remove radius head implant	Y	A2	25.6805	$1,075.32
24200	Removal of arm foreign body	Y	P3		$107.88
24201	Removal of arm foreign body	Y	A2	15.0849	$631.65
24220	Injection for elbow x-ray	N	N1		
24300	Manipulate elbow w/anesth	Y	G2	14.6132	$611.90
24301	Muscle/tendon transfer	Y	A2	26.3652	$1,103.99
24305	Arm tendon lengthening	Y	A2	26.3652	$1,103.99
24310	Revision of arm tendon	Y	A2	18.6877	$782.51
24320	Repair of arm tendon	Y	A2	36.2926	$1,519.68
24330	Revision of arm muscles	Y	A2	66.4466	$2,782.32
24331	Revision of arm muscles	Y	A2	36.2926	$1,519.68
24332	Tenolysis, triceps	Y	G2	21.0374	$880.90
24340	Repair of biceps tendon	Y	A2	36.2926	$1,519.68
24341	Repair arm tendon/muscle	Y	A2	36.2926	$1,519.68
24342	Repair of ruptured tendon	Y	A2	36.2926	$1,519.68
24343	Repr elbow lat ligmnt w/tiss	Y	G2	30.361	$1,271.31

24344	Reconstruct elbow lat ligmnt	Y	G2	84.7159	$3,547.31
24345	Repr elbw med ligmnt w/tissu	Y	A2	25.3154	$1,060.03
24346	Reconstruct elbow med ligmnt	Y	G2	44.5105	$1,863.79
24357	Repair elbow, perc	Y	G2	30.361	$1,271.31
24358	Repair elbow w/deb, open	Y	G2	30.361	$1,271.31
24359	Repair elbow deb/attch open	Y	G2	30.361	$1,271.31
24360	Reconstruct elbow joint	Y	A2	32.6783	$1,368.34
24361	Reconstruct elbow joint	Y	H8	149.9835	$6,280.26
24362	Reconstruct elbow joint	Y	A2	45.7192	$1,914.40
24363	Replace elbow joint	Y	H8	151.5697	$6,346.68
24365	Reconstruct head of radius	Y	A2	32.6783	$1,368.34
24366	Reconstruct head of radius	Y	H8	149.9835	$6,280.26
24400	Revision of humerus	Y	A2	36.9773	$1,548.35
24410	Revision of humerus	Y	A2	36.9773	$1,548.35
24420	Revision of humerus	Y	A2	36.2926	$1,519.68
24430	Repair of humerus	Y	A2	66.4466	$2,782.32
24435	Repair humerus with graft	Y	A2	67.1313	$2,810.99
24470	Revision of elbow joint	Y	A2	36.2926	$1,519.68
24495	Decompression of forearm	Y	A2	25.3154	$1,060.03
24498	Reinforce humerus	Y	A2	66.4466	$2,782.32
24500	Treat humerus fracture	Y	A2	1.7792	$74.50
24505	Treat humerus fracture	Y	A2	1.7792	$74.50
24515	Treat humerus fracture	Y	A2	50.5204	$2,115.44
24516	Treat humerus fracture	Y	A2	50.5204	$2,115.44
24530	Treat humerus fracture	Y	A2	1.7792	$74.50
24535	Treat humerus fracture	Y	A2	4.0274	$168.64
24538	Treat humerus fracture	Y	A2	21.0673	$882.15
24545	Treat humerus fracture	Y	A2	50.5204	$2,115.44
24546	Treat humerus fracture	Y	A2	51.0166	$2,136.22
24560	Treat humerus fracture	Y	A2	1.7792	$74.50
24565	Treat humerus fracture	Y	A2	1.7792	$74.50

24566	Treat humerus fracture	Y	A2	21.0673	$882.15
24575	Treat humerus fracture	Y	A2	49.8357	$2,086.77
24576	Treat humerus fracture	Y	A2	1.7792	$74.50
24577	Treat humerus fracture	Y	A2	4.0274	$168.64
24579	Treat humerus fracture	Y	A2	49.8357	$2,086.77
24582	Treat humerus fracture	Y	A2	21.0673	$882.15
24586	Treat elbow fracture	Y	A2	50.5204	$2,115.44
24587	Treat elbow fracture	Y	A2	51.0166	$2,136.22
24600	Treat elbow dislocation	Y	A2	1.7792	$74.50
24605	Treat elbow dislocation	Y	A2	13.5044	$565.47
24615	Treat elbow dislocation	Y	A2	49.8357	$2,086.77
24620	Treat elbow fracture	Y	A2	13.7757	$576.83
24635	Treat elbow fracture	Y	A2	49.8357	$2,086.77
24640	Treat elbow dislocation	Y	P3		$60.61
24650	Treat radius fracture	Y	P2	1.584	$66.33
24655	Treat radius fracture	Y	A2	4.0274	$168.64
24665	Treat radius fracture	Y	A2	36.1811	$1,515.01
24666	Treat radius fracture	Y	A2	50.5204	$2,115.44
24670	Treat ulnar fracture	Y	A2	1.7792	$74.50
24675	Treat ulnar fracture	Y	A2	1.7792	$74.50
24685	Treat ulnar fracture	Y	A2	35.4964	$1,486.34
24800	Fusion of elbow joint	Y	A2	36.9773	$1,548.35
24802	Fusion/graft of elbow joint	Y	A2	37.4736	$1,569.13
24925	Amputation follow-up surgery	Y	A2	18.6877	$782.51
25000	Incision of tendon sheath	Y	A2	18.6877	$782.51
25001	Incise flexor carpi radialis	Y	G2	21.0374	$880.90
25020	Decompress forearm 1 space	Y	A2	25.6805	$1,075.32
25023	Decompress forearm 1 space	Y	A2	25.6805	$1,075.32
25024	Decompress forearm 2 spaces	Y	A2	25.6805	$1,075.32
25025	Decompress forearm 2 spaces	Y	A2	25.6805	$1,075.32
25028	Drainage of forearm lesion	Y	A2	17.678	$740.23

25031	Drainage of forearm bursa	Y	A2	18.3225	$767.22
25035	Treat forearm bone lesion	Y	A2	18.3225	$767.22
25040	Explore/treat wrist joint	Y	A2	26.8615	$1,124.77
25065	Biopsy forearm soft tissues	Y	P3		$147.92
25066	Biopsy forearm soft tissues	Y	A2	19.307	$808.44
25071	Exc forearm les sc > 3 cm	Y	G2	22.3496	$935.84
25073	Exc forearm tum deep = 3 cm	Y	G2	22.3496	$935.84
25075*	Exc forearm les sc < 3 cm	Y	P3		$178.23
25076	Exc forearm tum deep < 3 cm	Y	G2	16.7206	$700.14
25077	Resect forearm/wrist tum<3cm	Y	G2	16.7206	$700.14
25078	Resect forearm/wrist tum=3cm	Y	G2	22.3496	$935.84
25085	Incision of wrist capsule	Y	A2	18.6877	$782.51
25100	Biopsy of wrist joint	Y	A2	18.3225	$767.22
25101	Explore/treat wrist joint	Y	A2	25.6805	$1,075.32
25105	Remove wrist joint lining	Y	A2	26.3652	$1,103.99
25107	Remove wrist joint cartilage	Y	A2	25.6805	$1,075.32
25109	Excise tendon forearm/wrist	Y	G2	21.0374	$880.90
25110	Remove wrist tendon lesion	Y	A2	18.6877	$782.51
25111	Remove wrist tendon lesion	Y	A2	18.6877	$782.51
25112	Reremove wrist tendon lesion	Y	A2	19.3724	$811.18
25115	Remove wrist/forearm lesion	Y	A2	19.3724	$811.18
25116	Remove wrist/forearm lesion	Y	A2	19.3724	$811.18
25118	Excise wrist tendon sheath	Y	A2	25.3154	$1,060.03
25119	Partial removal of ulna	Y	A2	25.6805	$1,075.32
25120	Removal of forearm lesion	Y	A2	25.6805	$1,075.32
25125	Remove/graft forearm lesion	Y	A2	25.6805	$1,075.32
25126	Remove/graft forearm lesion	Y	A2	25.6805	$1,075.32
25130	Removal of wrist lesion	Y	A2	25.6805	$1,075.32
25135	Remove & graft wrist lesion	Y	A2	25.6805	$1,075.32
25136	Remove & graft wrist lesion	Y	A2	25.6805	$1,075.32
25145	Remove forearm bone lesion	Y	A2	25.3154	$1,060.03

25150	Partial removal of ulna	Y	A2	25.3154	$1,060.03
25151	Partial removal of radius	Y	A2	25.3154	$1,060.03
25210	Removal of wrist bone	Y	A2	25.6805	$1,075.32
25215	Removal of wrist bones	Y	A2	26.3652	$1,103.99
25230	Partial removal of radius	Y	A2	26.3652	$1,103.99
25240	Partial removal of ulna	Y	A2	26.3652	$1,103.99
25246	Injection for wrist x-ray	N	N1		
25248	Remove forearm foreign body	Y	A2	18.3225	$767.22
25250	Removal of wrist prosthesis	Y	A2	24.6708	$1,033.04
25251	Removal of wrist prosthesis	Y	A2	24.6708	$1,033.04
25259	Manipulate wrist w/anesthes	Y	G2	17.5794	$736.10
25260	Repair forearm tendon/muscle	Y	A2	26.3652	$1,103.99
25263	Repair forearm tendon/muscle	Y	A2	25.3154	$1,060.03
25265	Repair forearm tendon/muscle	Y	A2	25.6805	$1,075.32
25270	Repair forearm tendon/muscle	Y	A2	26.3652	$1,103.99
25272	Repair forearm tendon/muscle	Y	A2	25.6805	$1,075.32
25274	Repair forearm tendon/muscle	Y	A2	26.3652	$1,103.99
25275	Repair forearm tendon sheath	Y	A2	26.3652	$1,103.99
25280	Revise wrist/forearm tendon	Y	A2	26.3652	$1,103.99
25290	Incise wrist/forearm tendon	Y	A2	25.6805	$1,075.32
25295	Release wrist/forearm tendon	Y	A2	18.6877	$782.51
25300	Fusion of tendons at wrist	Y	A2	25.6805	$1,075.32
25301	Fusion of tendons at wrist	Y	A2	25.6805	$1,075.32
25310	Transplant forearm tendon	Y	A2	36.2926	$1,519.68
25312	Transplant forearm tendon	Y	A2	36.9773	$1,548.35
25315	Revise palsy hand tendon(s)	Y	A2	36.2926	$1,519.68
25316	Revise palsy hand tendon(s)	Y	A2	66.4466	$2,782.32
25320	Repair/revise wrist joint	Y	A2	36.2926	$1,519.68
25332	Revise wrist joint	Y	A2	32.6783	$1,368.34
25335	Realignment of hand	Y	A2	36.2926	$1,519.68
25337	Reconstruct ulna/radioulnar	Y	A2	37.4736	$1,569.13

25350	Revision of radius	Y	A2	36.2926	$1,519.68
25355	Revision of radius	Y	A2	36.2926	$1,519.68
25360	Revision of ulna	Y	A2	36.2926	$1,519.68
25365	Revise radius & ulna	Y	A2	36.2926	$1,519.68
25370	Revise radius or ulna	Y	A2	36.2926	$1,519.68
25375	Revise radius & ulna	Y	A2	36.9773	$1,548.35
25390	Shorten radius or ulna	Y	A2	36.2926	$1,519.68
25391	Lengthen radius or ulna	Y	A2	36.9773	$1,548.35
25392	Shorten radius & ulna	Y	A2	25.6805	$1,075.32
25393	Lengthen radius & ulna	Y	A2	36.9773	$1,548.35
25394	Repair carpal bone, shorten	Y	G2	44.5105	$1,863.79
25400	Repair radius or ulna	Y	A2	36.2926	$1,519.68
25405	Repair/graft radius or ulna	Y	A2	67.1313	$2,810.99
25415	Repair radius & ulna	Y	A2	66.4466	$2,782.32
25420	Repair/graft radius & ulna	Y	A2	67.1313	$2,810.99
25425	Repair/graft radius or ulna	Y	A2	36.2926	$1,519.68
25426	Repair/graft radius & ulna	Y	A2	36.9773	$1,548.35
25430	Vasc graft into carpal bone	Y	G2	44.5105	$1,863.79
25431	Repair nonunion carpal bone	Y	G2	44.5105	$1,863.79
25440	Repair/graft wrist bone	Y	A2	67.1313	$2,810.99
25441	Reconstruct wrist joint	Y	H8	149.9835	$6,280.26
25442	Reconstruct wrist joint	Y	H8	149.9835	$6,280.26
25443	Reconstruct wrist joint	Y	A2	45.7192	$1,914.40
25444	Reconstruct wrist joint	Y	A2	45.7192	$1,914.40
25445	Reconstruct wrist joint	Y	A2	45.7192	$1,914.40
25446	Wrist replacement	Y	H8	151.5697	$6,346.68
25447	Repair wrist joint(s)	Y	A2	32.6783	$1,368.34
25449	Remove wrist joint implant	Y	A2	32.6783	$1,368.34
25450	Revision of wrist joint	Y	A2	36.2926	$1,519.68
25455	Revision of wrist joint	Y	A2	36.2926	$1,519.68
25490	Reinforce radius	Y	A2	36.2926	$1,519.68

25491	Reinforce ulna	Y	A2	36.2926	$1,519.68
25492	Reinforce radius and ulna	Y	A2	36.2926	$1,519.68
25500	Treat fracture of radius	Y	P2	1.584	$66.33
25505	Treat fracture of radius	Y	A2	4.0274	$168.64
25515	Treat fracture of radius	Y	A2	35.4964	$1,486.34
25520	Treat fracture of radius	Y	A2	4.0274	$168.64
25525	Treat fracture of radius	Y	A2	36.1811	$1,515.01
25526	Treat fracture of radius	Y	A2	36.6776	$1,535.80
25530	Treat fracture of ulna	Y	P2	1.584	$66.33
25535	Treat fracture of ulna	Y	A2	1.7792	$74.50
25545	Treat fracture of ulna	Y	A2	35.4964	$1,486.34
25560	Treat fracture radius & ulna	Y	P2	1.584	$66.33
25565	Treat fracture radius & ulna	Y	A2	4.0274	$168.64
25574	Treat fracture radius & ulna	Y	A2	49.8357	$2,086.77
25575	Treat fracture radius/ulna	Y	A2	49.8357	$2,086.77
25600	Treat fracture radius/ulna	Y	P2	1.584	$66.33
25605	Treat fracture radius/ulna	Y	A2	4.0274	$168.64
25606	Treat fx distal radial	Y	A2	21.4324	$897.44
25607	Treat fx rad extra-articul	Y	A2	51.0166	$2,136.22
25608	Treat fx rad intra-articul	Y	A2	51.0166	$2,136.22
25609	Treat fx radial 3+ frag	Y	A2	51.0166	$2,136.22
25622	Treat wrist bone fracture	Y	P2	1.584	$66.33
25624	Treat wrist bone fracture	Y	A2	4.0274	$168.64
25628	Treat wrist bone fracture	Y	A2	35.4964	$1,486.34
25630	Treat wrist bone fracture	Y	P2	1.584	$66.33
25635	Treat wrist bone fracture	Y	A2	4.0274	$168.64
25645	Treat wrist bone fracture	Y	A2	35.4964	$1,486.34
25650	Treat wrist bone fracture	Y	P2	1.584	$66.33
25651	Pin ulnar styloid fracture	Y	G2	24.6971	$1,034.14
25652	Treat fracture ulnar styloid	Y	G2	43.449	$1,819.34
25660	Treat wrist dislocation	Y	A2	1.7792	$74.50
25670	Treat wrist dislocation	Y	A2	21.4324	$897.44
25671	Pin radioulnar dislocation	Y	A2	20.4227	$855.16
25675	Treat wrist dislocation	Y	A2	1.7792	$74.50
25676	Treat wrist dislocation	Y	A2	21.0673	$882.15
25680	Treat wrist fracture	Y	A2	1.7792	$74.50
25685	Treat wrist fracture	Y	A2	21.4324	$897.44
25690	Treat wrist dislocation	Y	A2	13.7757	$576.83
25695	Treat wrist dislocation	Y	A2	21.0673	$882.15
25800	Fusion of wrist joint	Y	A2	67.1313	$2,810.99
25805	Fusion/graft of wrist joint	Y	A2	37.4736	$1,569.13
25810	Fusion/graft of wrist joint	Y	A2	67.6276	$2,831.77
25820	Fusion of hand bones	Y	A2	36.9773	$1,548.35
25825	Fuse hand bones with graft	Y	A2	67.6276	$2,831.77
25830	Fusion, radioulnar jnt/ulna	Y	A2	67.6276	$2,831.77
25907	Amputation follow-up surgery	Y	A2	18.6877	$782.51
25922	Amputate hand at wrist	Y	A2	18.6877	$782.51
25929	Amputation follow-up surgery	Y	A2	14.4157	$603.63
25931	Amputation follow-up surgery	Y	G2	21.0374	$880.90
26010	Drainage of finger abscess	Y	P2	1.3911	$58.25
26011	Drainage of finger abscess	Y	A2	10.9457	$458.33
26020	Drain hand tendon sheath	Y	A2	14.7587	$617.99
26025	Drainage of palm bursa	Y	A2	14.1139	$590.99
26030	Drainage of palm bursa(s)	Y	A2	14.7587	$617.99
26034	Treat hand bone lesion	Y	A2	14.7587	$617.99
26035	Decompress fingers/hand	Y	G2	16.2853	$681.91
26037	Decompress fingers/hand	Y	G2	16.2853	$681.91
26040	Release palm contracture	Y	A2	23.8321	$997.92
26045	Release palm contracture	Y	A2	23.1476	$969.26
26055	Incise finger tendon sheath	Y	A2	14.7587	$617.99
26060	Incision of finger tendon	Y	A2	14.7587	$617.99
26070	Explore/treat hand joint	Y	A2	14.7587	$617.99

26075	Explore/treat finger joint	Y	A2	15.8085	$661.95
26080	Explore/treat finger joint	Y	A2	15.8085	$661.95
26100	Biopsy hand joint lining	Y	A2	14.7587	$617.99
26105	Biopsy finger joint lining	Y	A2	14.1139	$590.99
26110	Biopsy finger joint lining	Y	A2	14.1139	$590.99
26111	Exc hand les sc > 1.5 cm	Y	G2	22.3496	$935.84
26113	Exc hand tum deep > 1.5 cm	Y	G2	22.3496	$935.84
26115*	Exc hand les sc < 1.5 cm	Y	P3		$364.04
26116	Exc hand tum deep < 1.5 cm	Y	G2	16.7206	$700.14
26117	Exc hand tum ra < 3 cm	Y	G2	16.7206	$700.14
26118	Exc hand tum ra > 3 cm	Y	G2	22.3496	$935.84
26121	Release palm contracture	Y	A2	23.8321	$997.92
26123	Release palm contracture	Y	A2	23.8321	$997.92
26125	Release palm contracture	Y	A2	15.8085	$661.95
26130	Remove wrist joint lining	Y	A2	15.1238	$633.28
26135	Revise finger joint, each	Y	A2	23.8321	$997.92
26140	Revise finger joint, each	Y	A2	14.7587	$617.99
26145	Tendon excision, palm/finger	Y	A2	15.1238	$633.28
26160	Remove tendon sheath lesion	Y	A2	15.1238	$633.28
26170	Removal of palm tendon, each	Y	A2	15.1238	$633.28
26180	Removal of finger tendon	Y	A2	15.1238	$633.28
26185	Remove finger bone	Y	A2	15.8085	$661.95
26200	Remove hand bone lesion	Y	A2	14.7587	$617.99
26205	Remove/graft bone lesion	Y	A2	23.1476	$969.26
26210	Removal of finger lesion	Y	A2	14.7587	$617.99
26215	Remove/graft finger lesion	Y	A2	15.1238	$633.28
26230	Partial removal of hand bone	Y	A2	17.8793	$748.66
26235	Partial removal, finger bone	Y	A2	15.1238	$633.28
26236	Partial removal, finger bone	Y	A2	15.1238	$633.28
26250	Extensive hand surgery	Y	A2	15.1238	$633.28
26255	Extensive hand surgery	N	D5		

26260	Resect prox finger tumor	Y	A2	15.1238	$633.28
26261	Extensive finger surgery	N	D5		
26262	Resect distal finger tumor	Y	A2	14.7587	$617.99
26320	Removal of implant from hand	Y	A2	15.0849	$631.65
26340	Manipulate finger w/anesth	Y	G2	4.5817	$191.85
26350	Repair finger/hand tendon	Y	A2	22.1377	$926.97
26352	Repair/graft hand tendon	Y	A2	23.8321	$997.92
26356	Repair finger/hand tendon	Y	A2	23.8321	$997.92
26357	Repair finger/hand tendon	Y	A2	23.8321	$997.92
26358	Repair/graft hand tendon	Y	A2	23.8321	$997.92
26370	Repair finger/hand tendon	Y	A2	23.8321	$997.92
26372	Repair/graft hand tendon	Y	A2	23.8321	$997.92
26373	Repair finger/hand tendon	Y	A2	23.1476	$969.26
26390	Revise hand/finger tendon	Y	A2	23.8321	$997.92
26392	Repair/graft hand tendon	Y	A2	23.1476	$969.26
26410	Repair hand tendon	Y	A2	15.1238	$633.28
26412	Repair/graft hand tendon	Y	A2	23.1476	$969.26
26415	Excision, hand/finger tendon	Y	A2	23.8321	$997.92
26416	Graft hand or finger tendon	Y	A2	23.1476	$969.26
26418	Repair finger tendon	Y	A2	15.8085	$661.95
26420	Repair/graft finger tendon	Y	A2	23.8321	$997.92
26426	Repair finger/hand tendon	Y	A2	23.1476	$969.26
26428	Repair/graft finger tendon	Y	A2	23.1476	$969.26
26432	Repair finger tendon	Y	A2	15.1238	$633.28
26433	Repair finger tendon	Y	A2	15.1238	$633.28
26434	Repair/graft finger tendon	Y	A2	23.1476	$969.26
26437	Realignment of tendons	Y	A2	15.1238	$633.28
26440	Release palm/finger tendon	Y	A2	15.1238	$633.28
26442	Release palm & finger tendon	Y	A2	23.1476	$969.26
26445	Release hand/finger tendon	Y	A2	15.1238	$633.28
26449	Release forearm/hand tendon	Y	A2	23.1476	$969.26

26450	Incision of palm tendon	Y	A2	15.1238	$633.28
26455	Incision of finger tendon	Y	A2	15.1238	$633.28
26460	Incise hand/finger tendon	Y	A2	15.1238	$633.28
26471	Fusion of finger tendons	Y	A2	14.7587	$617.99
26474	Fusion of finger tendons	Y	A2	14.7587	$617.99
26476	Tendon lengthening	Y	A2	14.1139	$590.99
26477	Tendon shortening	Y	A2	14.1139	$590.99
26478	Lengthening of hand tendon	Y	A2	14.1139	$590.99
26479	Shortening of hand tendon	Y	A2	14.1139	$590.99
26480	Transplant hand tendon	Y	A2	23.1476	$969.26
26483	Transplant/graft hand tendon	Y	A2	23.1476	$969.26
26485	Transplant palm tendon	Y	A2	22.7825	$953.97
26489	Transplant/graft palm tendon	Y	A2	23.1476	$969.26
26490	Revise thumb tendon	Y	A2	23.1476	$969.26
26492	Tendon transfer with graft	Y	A2	23.1476	$969.26
26494	Hand tendon/muscle transfer	Y	A2	23.1476	$969.26
26496	Revise thumb tendon	Y	A2	23.1476	$969.26
26497	Finger tendon transfer	Y	A2	23.1476	$969.26
26498	Finger tendon transfer	Y	A2	23.8321	$997.92
26499	Revision of finger	Y	A2	23.1476	$969.26
26500	Hand tendon reconstruction	Y	A2	15.8085	$661.95
26502	Hand tendon reconstruction	Y	A2	23.8321	$997.92
26508	Release thumb contracture	Y	A2	15.1238	$633.28
26510	Thumb tendon transfer	Y	A2	23.1476	$969.26
26516	Fusion of knuckle joint	Y	A2	22.1377	$926.97
26517	Fusion of knuckle joints	Y	A2	23.1476	$969.26
26518	Fusion of knuckle joints	Y	A2	23.1476	$969.26
26520	Release knuckle contracture	Y	A2	15.1238	$633.28
26525	Release finger contracture	Y	A2	15.1238	$633.28
26530	Revise knuckle joint	Y	A2	31.4971	$1,318.88
26531	Revise knuckle with implant	Y	A2	47.3054	$1,980.82

26535	Revise finger joint	Y	A2	32.6783	$1,368.34
26536	Revise/implant finger joint	Y	A2	45.7192	$1,914.40
26540	Repair hand joint	Y	A2	15.8085	$661.95
26541	Repair hand joint with graft	Y	A2	25.9146	$1,085.12
26542	Repair hand joint with graft	Y	A2	15.8085	$661.95
26545	Reconstruct finger joint	Y	A2	23.8321	$997.92
26546	Repair nonunion hand	Y	A2	23.8321	$997.92
26548	Reconstruct finger joint	Y	A2	23.8321	$997.92
26550	Construct thumb replacement	Y	A2	22.7825	$953.97
26555	Positional change of finger	Y	A2	23.1476	$969.26
26560	Repair of web finger	Y	A2	14.7587	$617.99
26561	Repair of web finger	Y	A2	23.1476	$969.26
26562	Repair of web finger	Y	A2	23.8321	$997.92
26565	Correct metacarpal flaw	Y	A2	24.3286	$1,018.71
26567	Correct finger deformity	Y	A2	24.3286	$1,018.71
26568	Lengthen metacarpal/finger	Y	A2	23.1476	$969.26
26580	Repair hand deformity	Y	A2	16.3048	$682.73
26587	Reconstruct extra finger	Y	A2	16.3048	$682.73
26590	Repair finger deformity	Y	A2	16.3048	$682.73
26591	Repair muscles of hand	Y	A2	23.1476	$969.26
26593	Release muscles of hand	Y	A2	15.1238	$633.28
26596	Excision constricting tissue	Y	A2	14.7587	$617.99
26600	Treat metacarpal fracture	Y	P2	1.584	$66.33
26605	Treat metacarpal fracture	Y	A2	1.7792	$74.50
26607	Treat metacarpal fracture	Y	A2	13.7757	$576.83
26608	Treat metacarpal fracture	Y	A2	22.1171	$926.11
26615	Treat metacarpal fracture	Y	A2	36.1811	$1,515.01
26641	Treat thumb dislocation	Y	P2	1.584	$66.33
26645	Treat thumb fracture	Y	A2	4.0274	$168.64
26650	Treat thumb fracture	Y	A2	21.0673	$882.15
26665	Treat thumb fracture	Y	A2	36.1811	$1,515.01

26670	Treat hand dislocation	Y	P2	1.584	$66.33
26675	Treat hand dislocation	Y	A2	4.0274	$168.64
26676	Pin hand dislocation	Y	A2	21.0673	$882.15
26685	Treat hand dislocation	Y	A2	21.4324	$897.44
26686	Treat hand dislocation	Y	A2	49.8357	$2,086.77
26700	Treat knuckle dislocation	Y	P2	1.584	$66.33
26705	Treat knuckle dislocation	Y	A2	1.7792	$74.50
26706	Pin knuckle dislocation	Y	A2	13.7757	$576.83
26715	Treat knuckle dislocation	Y	A2	22.1171	$926.11
26720	Treat finger fracture, each	Y	P2	1.584	$66.33
26725	Treat finger fracture, each	Y	P2	1.584	$66.33
26727	Treat finger fracture, each	Y	A2	24.1996	$1,013.31
26735	Treat finger fracture, each	Y	A2	22.1171	$926.11
26740	Treat finger fracture, each	Y	P2	1.584	$66.33
26742	Treat finger fracture, each	Y	A2	1.7792	$74.50
26746	Treat finger fracture, each	Y	A2	22.6136	$946.90
26750	Treat finger fracture, each	Y	P2	1.584	$66.33
26755	Treat finger fracture, each	Y	G2	1.584	$66.33
26756	Pin finger fracture, each	Y	A2	21.0673	$882.15
26765	Treat finger fracture, each	Y	A2	22.1171	$926.11
26770	Treat finger dislocation	Y	G2	1.584	$66.33
26775	Treat finger dislocation	Y	P3		$181.48
26776	Pin finger dislocation	Y	A2	21.0673	$882.15
26785	Treat finger dislocation	Y	A2	21.0673	$882.15
26820	Thumb fusion with graft	Y	A2	24.3286	$1,018.71
26841	Fusion of thumb	Y	A2	23.8321	$997.92
26842	Thumb fusion with graft	Y	A2	23.8321	$997.92
26843	Fusion of hand joint	Y	A2	23.1476	$969.26
26844	Fusion/graft of hand joint	Y	A2	23.1476	$969.26
26850	Fusion of knuckle	Y	A2	23.8321	$997.92
26852	Fusion of knuckle with graft	Y	A2	23.8321	$997.92

26860	Fusion of finger joint	Y	A2	23.1476	$969.26
26861	Fusion of finger jnt, add-on	Y	A2	22.7825	$953.97
26862	Fusion/graft of finger joint	Y	A2	23.8321	$997.92
26863	Fuse/graft added joint	Y	A2	23.1476	$969.26
26910	Amputate metacarpal bone	Y	A2	23.1476	$969.26
26951	Amputation of finger/thumb	Y	A2	14.7587	$617.99
26952	Amputation of finger/thumb	Y	A2	15.8085	$661.95
26990	Drainage of pelvis lesion	Y	A2	17.678	$740.23
26991	Drainage of pelvis bursa	Y	A2	17.678	$740.23
27000	Incision of hip tendon	Y	A2	18.3225	$767.22
27001	Incision of hip tendon	Y	A2	25.6805	$1,075.32
27003	Incision of hip tendon	Y	A2	25.6805	$1,075.32
27033	Exploration of hip joint	Y	A2	36.2926	$1,519.68
27035	Denervation of hip joint	Y	A2	36.9773	$1,548.35
27040	Biopsy of soft tissues	Y	A2	7.779	$325.73
27041	Biopsy of soft tissues	Y	A2	8.2667	$346.15
27043	Exc hip pelvis les sc > 3 cm	Y	G2	22.3496	$935.84
27045	Exc hip/pelv tum deep > 5 cm	Y	G2	22.3496	$935.84
27047*	Exc hip/pelvis les sc < 3 cm	Y	P3		$253.64
27048	Exc hip/pelv tum deep < 5 cm	Y	G2	16.7206	$700.14
27049	Resect hip/pelv tum < 5 cm	Y	G2	16.7206	$700.14
27050	Biopsy of sacroiliac joint	Y	A2	18.6877	$782.51
27052	Biopsy of hip joint	Y	A2	18.6877	$782.51
27059	Resect hip/pelv tum > 5 cm	Y	G2	22.3496	$935.84
27060	Removal of ischial bursa	Y	A2	19.8689	$831.97
27062	Remove femur lesion/bursa	Y	A2	19.8689	$831.97
27065	Removal of hip bone lesion	Y	A2	19.8689	$831.97
27066	Removal of hip bone lesion	Y	A2	26.8615	$1,124.77
27067	Remove/graft hip bone lesion	Y	A2	26.8615	$1,124.77
27080	Removal of tail bone	Y	A2	25.3154	$1,060.03
27086	Remove hip foreign body	Y	A2	7.779	$325.73

27087	Remove hip foreign body	Y	A2	18.6877	$782.51
27093	Injection for hip x-ray	N	N1		
27095	Injection for hip x-ray	N	N1		
27097	Revision of hip tendon	Y	A2	25.6805	$1,075.32
27098	Transfer tendon to pelvis	Y	A2	25.6805	$1,075.32
27100	Transfer of abdominal muscle	Y	A2	36.9773	$1,548.35
27105	Transfer of spinal muscle	Y	A2	36.9773	$1,548.35
27110	Transfer of iliopsoas muscle	Y	A2	36.9773	$1,548.35
27111	Transfer of iliopsoas muscle	Y	A2	36.9773	$1,548.35
27193	Treat pelvic ring fracture	Y	A2	1.7792	$74.50
27194	Treat pelvic ring fracture	Y	A2	13.5044	$565.47
27200	Treat tail bone fracture	Y	P2	1.584	$66.33
27202	Treat tail bone fracture	Y	A2	35.1312	$1,471.05
27220	Treat hip socket fracture	Y	G2	1.584	$66.33
27230	Treat thigh fracture	Y	A2	1.7792	$74.50
27238	Treat thigh fracture	Y	A2	4.0274	$168.64
27246	Treat thigh fracture	Y	A2	4.0274	$168.64
27250	Treat hip dislocation	Y	A2	1.7792	$74.50
27252	Treat hip dislocation	Y	A2	13.5044	$565.47
27256	Treat hip dislocation	Y	G2	1.584	$66.33
27257	Treat hip dislocation	Y	A2	13.8696	$580.76
27265	Treat hip dislocation	Y	A2	1.7792	$74.50
27266	Treat hip dislocation	Y	A2	13.5044	$565.47
27267	Cltx thigh fx	Y	G2	1.584	$66.33
27275	Manipulation of hip joint	Y	A2	13.5044	$565.47
27301	Drain thigh/knee lesion	Y	A2	16.8182	$704.23
27305	Incise thigh tendon & fascia	Y	A2	18.3225	$767.22
27306	Incision of thigh tendon	Y	A2	18.6877	$782.51
27307	Incision of thigh tendons	Y	A2	18.6877	$782.51
27310	Exploration of knee joint	Y	A2	26.3652	$1,103.99
27323	Biopsy, thigh soft tissues	Y	A2	7.779	$325.73

27324	Biopsy, thigh soft tissues	Y	A2	18.6621	$781.44
27325	Neurectomy, hamstring	Y	A2	15.9611	$668.34
27326	Neurectomy, popliteal	Y	A2	15.9611	$668.34
27327*	Exc thigh/knee les sc < 3 cm	Y	P3		$230.91
27328	Exc thigh/knee tum deep <5cm	Y	G2	16.7206	$700.14
27329	Resect thigh/knee tum < 5 cm	Y	G2	16.7206	$700.14
27330	Biopsy, knee joint lining	Y	A2	26.3652	$1,103.99
27331	Explore/treat knee joint	Y	A2	26.3652	$1,103.99
27332	Removal of knee cartilage	Y	A2	26.3652	$1,103.99
27333	Removal of knee cartilage	Y	A2	26.3652	$1,103.99
27334	Remove knee joint lining	Y	A2	26.3652	$1,103.99
27335	Remove knee joint lining	Y	A2	26.3652	$1,103.99
27337	Exc thigh/knee les sc > 3 cm	Y	G2	22.3496	$935.84
27339	Exc thigh/knee tum deep >5cm	Y	G2	22.3496	$935.84
27340	Removal of kneecap bursa	Y	A2	18.6877	$782.51
27345	Removal of knee cyst	Y	A2	19.3724	$811.18
27347	Remove knee cyst	Y	A2	19.3724	$811.18
27350	Removal of kneecap	Y	A2	26.3652	$1,103.99
27355	Remove femur lesion	Y	A2	25.6805	$1,075.32
27356	Remove femur lesion/graft	Y	A2	26.3652	$1,103.99
27357	Remove femur lesion/graft	Y	A2	26.8615	$1,124.77
27358	Remove femur lesion/fixation	Y	A2	26.8615	$1,124.77
27360	Partial removal, leg bone(s)	Y	A2	26.8615	$1,124.77
27364	Resect thigh/knee tum >5 cm	Y	G2	22.3496	$935.84
27370	Injection for knee x-ray	N	N1		
27372	Removal of foreign body	Y	A2	22.439	$939.59
27380	Repair of kneecap tendon	Y	A2	17.678	$740.23
27381	Repair/graft kneecap tendon	Y	A2	18.6877	$782.51
27385	Repair of thigh muscle	Y	A2	18.6877	$782.51
27386	Repair/graft of thigh muscle	Y	A2	18.6877	$782.51
27390	Incision of thigh tendon	Y	A2	17.678	$740.23

27391	Incision of thigh tendons	Y	A2	18.3225	$767.22
27392	Incision of thigh tendons	Y	A2	18.6877	$782.51
27393	Lengthening of thigh tendon	Y	A2	25.3154	$1,060.03
27394	Lengthening of thigh tendons	Y	A2	25.6805	$1,075.32
27395	Lengthening of thigh tendons	Y	A2	36.2926	$1,519.68
27396	Transplant of thigh tendon	Y	A2	25.6805	$1,075.32
27397	Transplants of thigh tendons	Y	A2	36.2926	$1,519.68
27400	Revise thigh muscles/tendons	Y	A2	36.2926	$1,519.68
27403	Repair of knee cartilage	Y	A2	26.3652	$1,103.99
27405	Repair of knee ligament	Y	A2	36.9773	$1,548.35
27407	Repair of knee ligament	Y	A2	67.1313	$2,810.99
27409	Repair of knee ligaments	Y	A2	36.9773	$1,548.35
27416	Osteochondral knee autograft	Y	G2	44.5105	$1,863.79
27418	Repair degenerated kneecap	Y	A2	36.2926	$1,519.68
27420	Revision of unstable kneecap	Y	A2	36.2926	$1,519.68
27422	Revision of unstable kneecap	Y	A2	39.0598	$1,635.55
27424	Revision/removal of kneecap	Y	A2	36.2926	$1,519.68
27425	Lat retinacular release open	Y	A2	28.4477	$1,191.19
27427	Reconstruction, knee	Y	A2	36.2926	$1,519.68
27428	Reconstruction, knee	Y	A2	67.1313	$2,810.99
27429	Reconstruction, knee	Y	A2	67.1313	$2,810.99
27430	Revision of thigh muscles	Y	A2	36.9773	$1,548.35
27435	Incision of knee joint	Y	A2	36.9773	$1,548.35
27437	Revise kneecap	Y	A2	32.1818	$1,347.55
27438	Revise kneecap with implant	Y	A2	45.7192	$1,914.40
27440	Revision of knee joint	Y	G2	38.1167	$1,596.06
27441	Revision of knee joint	Y	A2	32.6783	$1,368.34
27442	Revision of knee joint	Y	A2	32.6783	$1,368.34
27443	Revision of knee joint	Y	A2	32.6783	$1,368.34
27446	Revision of knee joint	Y	J8	157.9373	$6,613.31
27475	Surgery to stop leg growth	Y	G2	30.361	$1,271.31

27479	Surgery to stop leg growth	Y	G2	30.361	$1,271.31
27496	Decompression of thigh/knee	Y	A2	26.8615	$1,124.77
27497	Decompression of thigh/knee	Y	A2	18.6877	$782.51
27498	Decompression of thigh/knee	Y	A2	25.6805	$1,075.32
27499	Decompression of thigh/knee	Y	A2	25.6805	$1,075.32
27500	Treatment of thigh fracture	Y	A2	4.0274	$168.64
27501	Treatment of thigh fracture	Y	A2	1.7792	$74.50
27502	Treatment of thigh fracture	Y	A2	13.7757	$576.83
27503	Treatment of thigh fracture	Y	A2	1.7792	$74.50
27508	Treatment of thigh fracture	Y	A2	1.7792	$74.50
27509	Treatment of thigh fracture	Y	A2	21.4324	$897.44
27510	Treatment of thigh fracture	Y	A2	4.0274	$168.64
27516	Treat thigh fx growth plate	Y	A2	1.7792	$74.50
27517	Treat thigh fx growth plate	Y	A2	1.7792	$74.50
27520	Treat kneecap fracture	Y	A2	1.7792	$74.50
27530	Treat knee fracture	Y	A2	1.7792	$74.50
27532	Treat knee fracture	Y	A2	13.7757	$576.83
27538	Treat knee fracture(s)	Y	A2	1.7792	$74.50
27550	Treat knee dislocation	Y	A2	1.7792	$74.50
27552	Treat knee dislocation	Y	A2	12.8598	$538.48
27560	Treat kneecap dislocation	Y	A2	1.7792	$74.50
27562	Treat kneecap dislocation	Y	A2	12.8598	$538.48
27566	Treat kneecap dislocation	Y	A2	35.1312	$1,471.05
27570	Fixation of knee joint	Y	A2	12.8598	$538.48
27594	Amputation follow-up surgery	Y	A2	18.6877	$782.51
27600	Decompression of lower leg	Y	A2	18.6877	$782.51
27601	Decompression of lower leg	Y	A2	18.6877	$782.51
27602	Decompression of lower leg	Y	A2	18.6877	$782.51
27603	Drain lower leg lesion	Y	A2	16.4531	$688.94
27604	Drain lower leg bursa	Y	A2	18.3225	$767.22
27605	Incision of achilles tendon	Y	A2	17.5555	$735.10

27606	Incision of achilles tendon	Y	A2	17.678	$740.23
27607	Treat lower leg bone lesion	Y	A2	18.3225	$767.22
27610	Explore/treat ankle joint	Y	A2	25.3154	$1,060.03
27612	Exploration of ankle joint	Y	A2	25.6805	$1,075.32
27613	Biopsy lower leg soft tissue	Y	P3		$140.35
27614	Biopsy lower leg soft tissue	Y	A2	19.307	$808.44
27615	Resect leg/ankle tum < 5 cm	Y	G2	16.7206	$700.14
27616	Resect leg/ankle tum > 5 cm	Y	G2	22.3496	$935.84
27618*	Exc leg/ankle tum < 3 cm	Y	P3		$238.12
27619	Exc leg/ankle tum deep <5 cm	Y	G2	16.7206	$700.14
27620	Explore/treat ankle joint	Y	A2	26.3652	$1,103.99
27625	Remove ankle joint lining	Y	A2	26.3652	$1,103.99
27626	Remove ankle joint lining	Y	A2	26.3652	$1,103.99
27630	Removal of tendon lesion	Y	A2	18.6877	$782.51
27632	Exc leg/ankle les sc > 3 cm	Y	G2	22.3496	$935.84
27634	Exc leg/ankle tum deep >5 cm	Y	G2	22.3496	$935.84
27635	Remove lower leg bone lesion	Y	A2	25.6805	$1,075.32
27637	Remove/graft leg bone lesion	Y	A2	25.6805	$1,075.32
27638	Remove/graft leg bone lesion	Y	A2	25.6805	$1,075.32
27640	Partial removal of tibia	Y	A2	35.9274	$1,504.39
27641	Partial removal of fibula	Y	A2	25.3154	$1,060.03
27647	Resect talus/calcaneus tum	Y	A2	36.2926	$1,519.68
27648	Injection for ankle x-ray	N	N1		
27650	Repair achilles tendon	Y	A2	36.2926	$1,519.68
27652	Repair/graft achilles tendon	Y	A2	66.4466	$2,782.32
27654	Repair of achilles tendon	Y	A2	36.2926	$1,519.68
27656	Repair leg fascia defect	Y	A2	18.3225	$767.22
27658	Repair of leg tendon, each	Y	A2	17.678	$740.23
27659	Repair of leg tendon, each	Y	A2	18.3225	$767.22
27664	Repair of leg tendon, each	Y	A2	25.3154	$1,060.03
27665	Repair of leg tendon, each	Y	A2	25.3154	$1,060.03

27675	Repair lower leg tendons	Y	A2	18.3225	$767.22
27676	Repair lower leg tendons	Y	A2	25.6805	$1,075.32
27680	Release of lower leg tendon	Y	A2	25.6805	$1,075.32
27681	Release of lower leg tendons	Y	A2	25.3154	$1,060.03
27685	Revision of lower leg tendon	Y	A2	25.6805	$1,075.32
27686	Revise lower leg tendons	Y	A2	25.6805	$1,075.32
27687	Revision of calf tendon	Y	A2	25.6805	$1,075.32
27690	Revise lower leg tendon	Y	A2	36.9773	$1,548.35
27691	Revise lower leg tendon	Y	A2	36.9773	$1,548.35
27692	Revise additional leg tendon	Y	A2	36.2926	$1,519.68
27695	Repair of ankle ligament	Y	A2	25.3154	$1,060.03
27696	Repair of ankle ligaments	Y	A2	25.3154	$1,060.03
27698	Repair of ankle ligament	Y	A2	25.3154	$1,060.03
27700	Revision of ankle joint	Y	A2	32.6783	$1,368.34
27704	Removal of ankle implant	Y	A2	18.3225	$767.22
27705	Incision of tibia	Y	A2	35.9274	$1,504.39
27707	Incision of fibula	Y	A2	18.3225	$767.22
27709	Incision of tibia & fibula	Y	A2	25.3154	$1,060.03
27720	Repair of tibia	Y	G2	43.449	$1,819.34
27726	Repair fibula nonunion	Y	G2	43.449	$1,819.34
27730	Repair of tibia epiphysis	Y	A2	25.3154	$1,060.03
27732	Repair of fibula epiphysis	Y	A2	25.3154	$1,060.03
27734	Repair lower leg epiphyses	Y	A2	25.3154	$1,060.03
27740	Repair of leg epiphyses	Y	A2	25.3154	$1,060.03
27742	Repair of leg epiphyses	Y	A2	35.9274	$1,504.39
27745	Reinforce tibia	Y	A2	66.4466	$2,782.32
27750	Treatment of tibia fracture	Y	A2	1.7792	$74.50
27752	Treatment of tibia fracture	Y	A2	13.7757	$576.83
27756	Treatment of tibia fracture	Y	A2	21.4324	$897.44
27758	Treatment of tibia fracture	Y	A2	36.1811	$1,515.01
27759	Treatment of tibia fracture	Y	A2	50.5204	$2,115.44

27760	Cltx medial ankle fx	Y	A2	1.7792	$74.50
27762	Cltx med ankle fx w/mnpj	Y	A2	13.7757	$576.83
27766	Optx medial ankle fx	Y	A2	35.4964	$1,486.34
27767	Cltx post ankle fx	Y	G2	1.584	$66.33
27768	Cltx post ankle fx w/mnpj	Y	G2	1.584	$66.33
27769	Optx post ankle fx	Y	G2	43.449	$1,819.34
27780	Treatment of fibula fracture	Y	A2	1.7792	$74.50
27781	Treatment of fibula fracture	Y	A2	13.7757	$576.83
27784	Treatment of fibula fracture	Y	A2	35.4964	$1,486.34
27786	Treatment of ankle fracture	Y	A2	1.7792	$74.50
27788	Treatment of ankle fracture	Y	A2	1.7792	$74.50
27792	Treatment of ankle fracture	Y	A2	35.4964	$1,486.34
27808	Treatment of ankle fracture	Y	A2	1.7792	$74.50
27810	Treatment of ankle fracture	Y	A2	4.0274	$168.64
27814	Treatment of ankle fracture	Y	A2	35.4964	$1,486.34
27816	Treatment of ankle fracture	Y	A2	1.7792	$74.50
27818	Treatment of ankle fracture	Y	A2	4.0274	$168.64
27822	Treatment of ankle fracture	Y	A2	35.4964	$1,486.34
27823	Treatment of ankle fracture	Y	A2	49.8357	$2,086.77
27824	Treat lower leg fracture	Y	A2	1.7792	$74.50
27825	Treat lower leg fracture	Y	A2	13.7757	$576.83
27826	Treat lower leg fracture	Y	A2	35.4964	$1,486.34
27827	Treat lower leg fracture	Y	A2	49.8357	$2,086.77
27828	Treat lower leg fracture	Y	A2	50.5204	$2,115.44
27829	Treat lower leg joint	Y	A2	35.1312	$1,471.05
27830	Treat lower leg dislocation	Y	A2	1.7792	$74.50
27831	Treat lower leg dislocation	Y	A2	13.7757	$576.83
27832	Treat lower leg dislocation	Y	A2	35.1312	$1,471.05
27840	Treat ankle dislocation	Y	A2	4.0274	$168.64
27842	Treat ankle dislocation	Y	A2	12.8598	$538.48
27846	Treat ankle dislocation	Y	A2	35.4964	$1,486.34

27848	Treat ankle dislocation	Y	A2	35.4964	$1,486.34
27860	Fixation of ankle joint	Y	A2	12.8598	$538.48
27870	Fusion of ankle joint, open	Y	A2	67.1313	$2,810.99
27871	Fusion of tibiofibular joint	Y	A2	67.1313	$2,810.99
27884	Amputation follow-up surgery	Y	A2	18.6877	$782.51
27889	Amputation of foot at ankle	Y	A2	25.6805	$1,075.32
27892	Decompression of leg	Y	A2	25.6805	$1,075.32
27893	Decompression of leg	Y	A2	25.6805	$1,075.32
27894	Decompression of leg	Y	A2	25.6805	$1,075.32
28001	Drainage of bursa of foot	Y	P3		$138.90
28002	Treatment of foot infection	Y	A2	18.6877	$782.51
28003	Treatment of foot infection	Y	A2	18.6877	$782.51
28005	Treat foot bone lesion	Y	A2	18.5652	$777.38
28008	Incision of foot fascia	Y	A2	18.5652	$777.38
28010	Incision of toe tendon	Y	P3		$101.38
28011	Incision of toe tendons	Y	A2	18.5652	$777.38
28020	Exploration of foot joint	Y	A2	18.2	$762.09
28022	Exploration of foot joint	Y	A2	18.2	$762.09
28024	Exploration of toe joint	Y	A2	18.2	$762.09
28035	Decompression of tibia nerve	Y	A2	17.011	$712.30
28039*	Exc foot/toe tum sc > 1.5 cm	Y	P3		$252.91
28041*	Exc foot/toe tum deep >1.5cm	Y	R2	22.3496	$935.84
28043*	Exc foot/toe tum sc < 1.5 cm	Y	P3		$180.03
28045*	Exc foot/toe tum deep <1.5cm	Y	P3		$246.78
28046*	Resect foot/toe tumor < 3 cm	Y	R2	16.7206	$700.14
28047	Resect foot/toe tumor > 3 cm	Y	G2	22.3496	$935.84
28050	Biopsy of foot joint lining	Y	A2	18.2	$762.09
28052	Biopsy of foot joint lining	Y	A2	18.2	$762.09
28054	Biopsy of toe joint lining	Y	A2	18.2	$762.09
28055	Neurectomy, foot	Y	A2	17.011	$712.30
28060	Partial removal, foot fascia	Y	A2	18.2	$762.09

28062	Removal of foot fascia	Y	A2	18.5652	$777.38
28070	Removal of foot joint lining	Y	A2	18.5652	$777.38
28072	Removal of foot joint lining	Y	A2	18.5652	$777.38
28080	Removal of foot lesion	Y	A2	18.5652	$777.38
28086	Excise foot tendon sheath	Y	A2	18.2	$762.09
28088	Excise foot tendon sheath	Y	A2	18.2	$762.09
28090	Removal of foot lesion	Y	A2	18.5652	$777.38
28092	Removal of toe lesions	Y	A2	18.5652	$777.38
28100	Removal of ankle/heel lesion	Y	A2	18.2	$762.09
28102	Remove/graft foot lesion	Y	A2	40.555	$1,698.16
28103	Remove/graft foot lesion	Y	A2	40.555	$1,698.16
28104	Removal of foot lesion	Y	A2	18.2	$762.09
28106	Remove/graft foot lesion	Y	A2	40.555	$1,698.16
28107	Remove/graft foot lesion	Y	A2	40.555	$1,698.16
28108	Removal of toe lesions	Y	A2	18.2	$762.09
28110	Part removal of metatarsal	Y	A2	18.5652	$777.38
28111	Part removal of metatarsal	Y	A2	18.5652	$777.38
28112	Part removal of metatarsal	Y	A2	18.5652	$777.38
28113	Part removal of metatarsal	Y	A2	18.5652	$777.38
28114	Removal of metatarsal heads	Y	A2	18.5652	$777.38
28116	Revision of foot	Y	A2	18.5652	$777.38
28118	Removal of heel bone	Y	A2	19.2499	$806.05
28119	Removal of heel spur	Y	A2	19.2499	$806.05
28120	Part removal of ankle/heel	Y	A2	21.3324	$893.25
28122	Partial removal of foot bone	Y	A2	18.5652	$777.38
28124	Partial removal of toe	Y	P3		$235.24
28126	Partial removal of toe	Y	A2	18.5652	$777.38
28130	Removal of ankle bone	Y	A2	18.5652	$777.38
28140	Removal of metatarsal	Y	A2	18.5652	$777.38
28150	Removal of toe	Y	A2	18.5652	$777.38
28153	Partial removal of toe	Y	A2	18.5652	$777.38

28160	Partial removal of toe	Y	A2	18.5652	$777.38
28171	Resect tarsal tumor	Y	A2	18.5652	$777.38
28173	Resect metatarsal tumor	Y	A2	18.5652	$777.38
28175	Resect phalanx of toe tumor	Y	A2	18.5652	$777.38
28190	Removal of foot foreign body	Y	P3		$143.96
28192	Removal of foot foreign body	Y	A2	15.0849	$631.65
28193	Removal of foot foreign body	Y	A2	8.2667	$346.15
28200	Repair of foot tendon	Y	A2	18.5652	$777.38
28202	Repair/graft of foot tendon	Y	A2	18.5652	$777.38
28208	Repair of foot tendon	Y	A2	18.5652	$777.38
28210	Repair/graft of foot tendon	Y	A2	40.555	$1,698.16
28220	Release of foot tendon	Y	P3		$222.25
28222	Release of foot tendons	Y	A2	17.5555	$735.10
28225	Release of foot tendon	Y	A2	17.5555	$735.10
28226	Release of foot tendons	Y	A2	17.5555	$735.10
28230	Incision of foot tendon(s)	Y	P3		$217.56
28232	Incision of toe tendon	Y	P3		$208.18
28234	Incision of foot tendon	Y	A2	18.2	$762.09
28238	Revision of foot tendon	Y	A2	40.555	$1,698.16
28240	Release of big toe	Y	A2	18.2	$762.09
28250	Revision of foot fascia	Y	A2	18.5652	$777.38
28260	Release of midfoot joint	Y	A2	18.5652	$777.38
28261	Revision of foot tendon	Y	A2	18.5652	$777.38
28262	Revision of foot and ankle	Y	A2	19.2499	$806.05
28264	Release of midfoot joint	Y	A2	39.5451	$1,655.87
28270	Release of foot contracture	Y	A2	18.5652	$777.38
28272	Release of toe joint, each	Y	P3		$200.96
28280	Fusion of toes	Y	A2	18.2	$762.09
28285	Repair of hammertoe	Y	A2	18.5652	$777.38
28286	Repair of hammertoe	Y	A2	19.2499	$806.05
28288	Partial removal of foot bone	Y	A2	18.5652	$777.38

28289	Repair hallux rigidus	Y	A2	18.5652	$777.38
28290	Correction of bunion	Y	A2	25.1589	$1,053.48
28292	Correction of bunion	Y	A2	25.1589	$1,053.48
28293	Correction of bunion	Y	A2	25.5241	$1,068.77
28294	Correction of bunion	Y	A2	25.5241	$1,068.77
28296	Correction of bunion	Y	A2	25.5241	$1,068.77
28297	Correction of bunion	Y	A2	25.5241	$1,068.77
28298	Correction of bunion	Y	A2	25.5241	$1,068.77
28299	Correction of bunion	Y	A2	26.7053	$1,118.23
28300	Incision of heel bone	Y	A2	40.1899	$1,682.87
28302	Incision of ankle bone	Y	A2	18.2	$762.09
28304	Incision of midfoot bones	Y	A2	40.1899	$1,682.87
28305	Incise/graft midfoot bones	Y	A2	40.555	$1,698.16
28306	Incision of metatarsal	Y	A2	19.2499	$806.05
28307	Incision of metatarsal	Y	A2	19.2499	$806.05
28308	Incision of metatarsal	Y	A2	18.2	$762.09
28309	Incision of metatarsals	Y	A2	41.2397	$1,726.83
28310	Revision of big toe	Y	A2	18.5652	$777.38
28312	Revision of toe	Y	A2	18.5652	$777.38
28313	Repair deformity of toe	Y	A2	18.2	$762.09
28315	Removal of sesamoid bone	Y	A2	19.2499	$806.05
28320	Repair of foot bones	Y	A2	41.2397	$1,726.83
28322	Repair of metatarsals	Y	A2	41.2397	$1,726.83
28340	Resect enlarged toe tissue	Y	A2	19.2499	$806.05
28341	Resect enlarged toe	Y	A2	19.2499	$806.05
28344	Repair extra toe(s)	Y	A2	19.2499	$806.05
28345	Repair webbed toe(s)	Y	A2	19.2499	$806.05
28400	Treatment of heel fracture	Y	A2	1.7792	$74.50
28405	Treatment of heel fracture	Y	A2	13.7757	$576.83
28406	Treatment of heel fracture	Y	A2	21.0673	$882.15
28415	Treat heel fracture	Y	A2	49.8357	$2,086.77
28420	Treat/graft heel fracture	Y	A2	36.1811	$1,515.01
28430	Treatment of ankle fracture	Y	P2	1.584	$66.33
28435	Treatment of ankle fracture	Y	A2	1.7792	$74.50
28436	Treatment of ankle fracture	Y	A2	21.0673	$882.15
28445	Treat ankle fracture	Y	A2	35.4964	$1,486.34
28446	Osteochondral talus autogrft	Y	G2	50.1937	$2,101.76
28450	Treat midfoot fracture, each	Y	P2	1.584	$66.33
28455	Treat midfoot fracture, each	Y	P2	1.584	$66.33
28456	Treat midfoot fracture	Y	A2	21.0673	$882.15
28465	Treat midfoot fracture, each	Y	A2	35.4964	$1,486.34
28470	Treat metatarsal fracture	Y	P2	1.584	$66.33
28475	Treat metatarsal fracture	Y	P2	1.584	$66.33
28476	Treat metatarsal fracture	Y	A2	21.0673	$882.15
28485	Treat metatarsal fracture	Y	A2	36.1811	$1,515.01
28490	Treat big toe fracture	Y	P2	1.584	$66.33
28495	Treat big toe fracture	Y	P2	1.584	$66.33
28496	Treat big toe fracture	Y	A2	21.0673	$882.15
28505	Treat big toe fracture	Y	A2	21.4324	$897.44
28510	Treatment of toe fracture	Y	P3		$61.70
28515	Treatment of toe fracture	Y	P2	1.584	$66.33
28525	Treat toe fracture	Y	A2	21.4324	$897.44
28530	Treat sesamoid bone fracture	Y	P3		$59.17
28531	Treat sesamoid bone fracture	Y	A2	21.4324	$897.44
28540	Treat foot dislocation	Y	P2	1.584	$66.33
28545	Treat foot dislocation	Y	A2	20.4227	$855.16
28546	Treat foot dislocation	Y	A2	21.0673	$882.15
28555	Repair foot dislocation	Y	A2	35.1312	$1,471.05
28570	Treat foot dislocation	Y	P3		$85.51
28575	Treat foot dislocation	Y	A2	13.7757	$576.83
28576	Treat foot dislocation	Y	A2	21.4324	$897.44
28585	Repair foot dislocation	Y	A2	21.4324	$897.44

28600	Treat foot dislocation	Y	P2	1.584	$66.33
28605	Treat foot dislocation	Y	A2	1.7792	$74.50
28606	Treat foot dislocation	Y	A2	21.0673	$882.15
28615	Repair foot dislocation	Y	A2	35.4964	$1,486.34
28630	Treat toe dislocation	Y	P2	1.584	$66.33
28635	Treat toe dislocation	Y	A2	12.8598	$538.48
28636	Treat toe dislocation	Y	A2	21.4324	$897.44
28645	Repair toe dislocation	Y	A2	21.4324	$897.44
28660	Treat toe dislocation	Y	P3		$49.43
28665	Treat toe dislocation	Y	A2	12.8598	$538.48
28666	Treat toe dislocation	Y	A2	21.4324	$897.44
28675	Repair of toe dislocation	Y	A2	21.4324	$897.44
28705	Fusion of foot bones	Y	A2	41.2397	$1,726.83
28715	Fusion of foot bones	Y	A2	67.1313	$2,810.99
28725	Fusion of foot bones	Y	A2	41.2397	$1,726.83
28730	Fusion of foot bones	Y	A2	41.2397	$1,726.83
28735	Fusion of foot bones	Y	A2	41.2397	$1,726.83
28737	Revision of foot bones	Y	A2	41.736	$1,747.61
28740	Fusion of foot bones	Y	A2	41.2397	$1,726.83
28750	Fusion of big toe joint	Y	A2	41.2397	$1,726.83
28755	Fusion of big toe joint	Y	A2	19.2499	$806.05
28760	Fusion of big toe joint	Y	A2	41.2397	$1,726.83
28810	Amputation toe & metatarsal	Y	A2	18.2	$762.09
28820	Amputation of toe	Y	A2	18.2	$762.09
28825	Partial amputation of toe	Y	A2	18.2	$762.09
28890	High energy eswt, plantar f	Y	P3		$178.95
29000	Application of body cast	N	G2	1.0069	$42.16
29010	Application of body cast	N	P2	2.2416	$93.86
29015	Application of body cast	N	P2	2.2416	$93.86
29020	Application of body cast	N	G2	1.0069	$42.16
29025	Application of body cast	N	P2	1.0069	$42.16
29035	Application of body cast	N	P2	2.2416	$93.86
29040	Application of body cast	N	G2	1.0069	$42.16
29044	Application of body cast	N	P2	2.2416	$93.86
29046	Application of body cast	N	G2	2.2416	$93.86
29049	Application of figure eight	N	P2	1.0069	$42.16
29055	Application of shoulder cast	N	P2	2.2416	$93.86
29058	Application of shoulder cast	N	P2	1.0069	$42.16
29065	Application of long arm cast	N	P3		$49.07
29075	Application of forearm cast	N	P3		$47.26
29085	Apply hand/wrist cast	N	P2	1.0069	$42.16
29086	Apply finger cast	N	P3		$40.41
29105	Apply long arm splint	N	P2	1.0069	$42.16
29125	Apply forearm splint	N	P3		$37.16
29126	Apply forearm splint	N	P3		$39.33
29130	Application of finger splint	N	P3		$16.96
29131	Application of finger splint	N	P3		$24.17
29200	Strapping of chest	N	P3		$23.81
29220	Strapping of low back	N	D5		
29240	Strapping of shoulder	N	P3		$25.98
29260	Strapping of elbow or wrist	N	P3		$25.26
29280	Strapping of hand or finger	N	P3		$25.62
29305	Application of hip cast	N	P2	2.2416	$93.86
29325	Application of hip casts	N	P2	2.2416	$93.86
29345	Application of long leg cast	N	P3		$64.22
29355	Application of long leg cast	N	P3		$63.14
29358	Apply long leg cast brace	N	P3		$79.01
29365	Application of long leg cast	N	P3		$60.61
29405	Apply short leg cast	N	P3		$45.10
29425	Apply short leg cast	N	P3		$45.82
29435	Apply short leg cast	N	P3		$58.09
29440	Addition of walker to cast	N	P3		$24.89

29445	Apply rigid leg cast	N	P3		$60.61
29450	Application of leg cast	N	P2	1.0069	$42.16
29505	Application, long leg splint	N	P2	1.0069	$42.16
29515	Application lower leg splint	N	P3		$35.36
29520	Strapping of hip	N	P3		$24.53
29530	Strapping of knee	N	P3		$25.26
29540	Strapping of ankle and/or ft	N	P3		$18.76
29550	Strapping of toes	N	P3		$19.48
29580	Application of paste boot	N	P3		$25.98
29581	Apply multlay comprs lwr leg	N	P2	1.0069	$42.16
29590	Application of foot splint	N	P3		$21.29
29700	Removal/revision of cast	N	P3		$35.00
29705	Removal/revision of cast	N	P3		$29.95
29710	Removal/revision of cast	N	P3		$53.76
29715	Removal/revision of cast	N	P2	1.0069	$42.16
29720	Repair of body cast	N	P2	1.0069	$42.16
29730	Windowing of cast	N	P3		$28.86
29740	Wedging of cast	N	P3		$38.97
29750	Wedging of clubfoot cast	N	P2	1.0069	$42.16
29800	Jaw arthroscopy/surgery	Y	A2	24.3532	$1,019.74
29804	Jaw arthroscopy/surgery	Y	A2	24.3532	$1,019.74
29805	Shoulder arthroscopy, dx	Y	A2	24.3532	$1,019.74
29806	Shoulder arthroscopy/surgery	Y	A2	37.8972	$1,586.87
29807	Shoulder arthroscopy/surgery	Y	A2	37.8972	$1,586.87
29819	Shoulder arthroscopy/surgery	Y	A2	37.8972	$1,586.87
29820	Shoulder arthroscopy/surgery	Y	A2	37.8972	$1,586.87
29821	Shoulder arthroscopy/surgery	Y	A2	37.8972	$1,586.87
29822	Shoulder arthroscopy/surgery	Y	A2	24.3532	$1,019.74
29823	Shoulder arthroscopy/surgery	Y	A2	37.8972	$1,586.87
29824	Shoulder arthroscopy/surgery	Y	A2	25.5341	$1,069.19
29825	Shoulder arthroscopy/surgery	Y	A2	37.8972	$1,586.87
29826	Shoulder arthroscopy/surgery	Y	A2	37.8972	$1,586.87
29827	Arthroscop rotator cuff repr	Y	A2	39.0784	$1,636.33
29828	Arthroscopy biceps tenodesis	Y	G2	46.6501	$1,953.38
29830	Elbow arthroscopy	Y	A2	24.3532	$1,019.74
29834	Elbow arthroscopy/surgery	Y	A2	24.3532	$1,019.74
29835	Elbow arthroscopy/surgery	Y	A2	24.3532	$1,019.74
29836	Elbow arthroscopy/surgery	Y	A2	24.3532	$1,019.74
29837	Elbow arthroscopy/surgery	Y	A2	24.3532	$1,019.74
29838	Elbow arthroscopy/surgery	Y	A2	24.3532	$1,019.74
29840	Wrist arthroscopy	Y	A2	24.3532	$1,019.74
29843	Wrist arthroscopy/surgery	Y	A2	24.3532	$1,019.74
29844	Wrist arthroscopy/surgery	Y	A2	24.3532	$1,019.74
29845	Wrist arthroscopy/surgery	Y	A2	24.3532	$1,019.74
29846	Wrist arthroscopy/surgery	Y	A2	24.3532	$1,019.74
29847	Wrist arthroscopy/surgery	Y	A2	37.8972	$1,586.87
29848	Wrist endoscopy/surgery	Y	A2	29.0829	$1,217.79
29850	Knee arthroscopy/surgery	Y	A2	25.0379	$1,048.41
29851	Knee arthroscopy/surgery	Y	A2	38.5819	$1,615.54
29855	Tibial arthroscopy/surgery	Y	A2	38.5819	$1,615.54
29856	Tibial arthroscopy/surgery	Y	A2	38.5819	$1,615.54
29860	Hip arthroscopy, dx	Y	A2	38.5819	$1,615.54
29861	Hip arthroscopy/surgery	Y	A2	38.5819	$1,615.54
29862	Hip arthroscopy/surgery	Y	A2	42.627	$1,784.92
29863	Hip arthroscopy/surgery	Y	A2	38.5819	$1,615.54
29866	Autgrft implnt, knee w/scope	Y	G2	46.6501	$1,953.38
29870	Knee arthroscopy, dx	Y	A2	24.3532	$1,019.74
29871	Knee arthroscopy/drainage	Y	A2	24.3532	$1,019.74
29873	Knee arthroscopy/surgery	Y	A2	24.3532	$1,019.74
29874	Knee arthroscopy/surgery	Y	A2	24.3532	$1,019.74
29875	Knee arthroscopy/surgery	Y	A2	25.0379	$1,048.41
29876	Knee arthroscopy/surgery	Y	A2	25.0379	$1,048.41

29877	Knee arthroscopy/surgery	Y	A2	25.0379	$1,048.41
29879	Knee arthroscopy/surgery	Y	A2	24.3532	$1,019.74
29880	Knee arthroscopy/surgery	Y	A2	25.0379	$1,048.41
29881	Knee arthroscopy/surgery	Y	A2	25.0379	$1,048.41
29882	Knee arthroscopy/surgery	Y	A2	24.3532	$1,019.74
29883	Knee arthroscopy/surgery	Y	A2	24.3532	$1,019.74
29884	Knee arthroscopy/surgery	Y	A2	24.3532	$1,019.74
29885	Knee arthroscopy/surgery	Y	A2	37.8972	$1,586.87
29886	Knee arthroscopy/surgery	Y	A2	24.3532	$1,019.74
29887	Knee arthroscopy/surgery	Y	A2	24.3532	$1,019.74
29888	Knee arthroscopy/surgery	Y	A2	66.4466	$2,782.32
29889	Knee arthroscopy/surgery	Y	A2	66.4466	$2,782.32
29891	Ankle arthroscopy/surgery	Y	A2	37.8972	$1,586.87
29892	Ankle arthroscopy/surgery	Y	A2	66.4466	$2,782.32
29893	Scope, plantar fasciotomy	Y	A2	22.819	$955.50
29894	Ankle arthroscopy/surgery	Y	A2	24.3532	$1,019.74
29895	Ankle arthroscopy/surgery	Y	A2	24.3532	$1,019.74
29897	Ankle arthroscopy/surgery	Y	A2	24.3532	$1,019.74
29898	Ankle arthroscopy/surgery	Y	A2	24.3532	$1,019.74
29899	Ankle arthroscopy/surgery	Y	A2	37.8972	$1,586.87
29900	Mcp joint arthroscopy, dx	Y	A2	24.3532	$1,019.74
29901	Mcp joint arthroscopy, surg	Y	A2	24.3532	$1,019.74
29902	Mcp joint arthroscopy, surg	Y	A2	24.3532	$1,019.74
29904	Subtalar arthro w/fb rmvl	Y	G2	28.5914	$1,197.21
29905	Subtalar arthro w/exc	Y	G2	28.5914	$1,197.21
29906	Subtalar arthro w/deb	Y	G2	28.5914	$1,197.21
29907	Subtalar arthro w/fusion	Y	G2	46.6501	$1,953.38
30000	Drainage of nose lesion	Y	P2	3.2729	$137.05
30020	Drainage of nose lesion	Y	P2	3.2729	$137.05
30100	Intranasal biopsy	Y	P3		$90.20
30110	Removal of nose polyp(s)	Y	P3		$139.99

30115	Removal of nose polyp(s)	Y	A2	14.863	$622.36
30117	Removal of intranasal lesion	Y	A2	15.2282	$637.65
30118	Removal of intranasal lesion	Y	A2	20.8012	$871.01
30120	Revision of nose	Y	A2	19.7915	$828.73
30124	Removal of nose lesion	Y	R2	7.2813	$304.89
30125	Removal of nose lesion	Y	A2	33.3501	$1,396.47
30130	Excise inferior turbinate	Y	A2	15.2282	$637.65
30140	Resect inferior turbinate	Y	A2	20.4361	$855.72
30150	Partial removal of nose	Y	A2	33.7153	$1,411.76
30160	Removal of nose	Y	A2	34.4	$1,440.43
30200	Injection treatment of nose	Y	P3		$71.44
30210	Nasal sinus therapy	Y	P3		$90.56
30220	Insert nasal septal button	Y	A2	8.109	$339.55
30300	Remove nasal foreign body	N	P2	0.6396	$26.78
30310	Remove nasal foreign body	Y	A2	14.2185	$595.37
30320	Remove nasal foreign body	Y	A2	14.863	$622.36
30400	Reconstruction of nose	Y	A2	34.4	$1,440.43
30410	Reconstruction of nose	Y	A2	34.8965	$1,461.22
30420	Reconstruction of nose	Y	A2	34.8965	$1,461.22
30430	Revision of nose	Y	A2	20.8012	$871.01
30435	Revision of nose	Y	A2	34.8965	$1,461.22
30450	Revision of nose	Y	A2	36.4825	$1,527.63
30460	Revision of nose	Y	A2	36.4825	$1,527.63
30462	Revision of nose	Y	A2	38.4451	$1,609.81
30465	Repair nasal stenosis	Y	A2	38.4451	$1,609.81
30520	Repair of nasal septum	Y	A2	21.4859	$899.68
30540	Repair nasal defect	Y	A2	34.8965	$1,461.22
30545	Repair nasal defect	Y	A2	34.8965	$1,461.22
30560	Release of nasal adhesions	Y	A2	3.3145	$138.79
30580	Repair upper jaw fistula	Y	A2	34.4	$1,440.43
30600	Repair mouth/nose fistula	Y	A2	34.4	$1,440.43

30620	Intranasal reconstruction	Y	A2	36.4825	$1,527.63
30630	Repair nasal septum defect	Y	A2	23.5684	$986.88
30801	Ablate inf turbinate, superf	Y	A2	7.3608	$308.22
30802	Ablate inf turbinate submuc	Y	A2	14.2185	$595.37
30901	Control of nosebleed	Y	P2	1.101	$46.10
30903	Control of nosebleed	Y	A2	1.2395	$51.90
30905	Control of nosebleed	Y	A2	1.2395	$51.90
30906	Repeat control of nosebleed	Y	A2	1.2395	$51.90
30915	Ligation, nasal sinus artery	Y	A2	21.5881	$903.96
30920	Ligation, upper jaw artery	Y	A2	21.9533	$919.25
30930	Ther fx, nasal inf turbinate	Y	A2	15.9129	$666.32
31000	Irrigation, maxillary sinus	Y	P3		$115.45
31002	Irrigation, sphenoid sinus	Y	R2	7.2813	$304.89
31020	Exploration, maxillary sinus	Y	A2	20.4361	$855.72
31030	Exploration, maxillary sinus	Y	A2	33.7153	$1,411.76
31032	Explore sinus, remove polyps	Y	A2	34.4	$1,440.43
31040	Exploration behind upper jaw	Y	R2	23.8553	$998.89
31050	Exploration, sphenoid sinus	Y	A2	33.3501	$1,396.47
31051	Sphenoid sinus surgery	Y	A2	34.4	$1,440.43
31070	Exploration of frontal sinus	Y	A2	20.4361	$855.72
31075	Exploration of frontal sinus	Y	A2	34.4	$1,440.43
31080	Removal of frontal sinus	Y	A2	34.4	$1,440.43
31081	Removal of frontal sinus	Y	A2	34.4	$1,440.43
31084	Removal of frontal sinus	Y	A2	34.4	$1,440.43
31085	Removal of frontal sinus	Y	A2	34.4	$1,440.43
31086	Removal of frontal sinus	Y	A2	34.4	$1,440.43
31087	Removal of frontal sinus	Y	A2	34.4	$1,440.43
31090	Exploration of sinuses	Y	A2	34.8965	$1,461.22
31200	Removal of ethmoid sinus	Y	A2	33.3501	$1,396.47
31201	Removal of ethmoid sinus	Y	A2	34.8965	$1,461.22
31205	Removal of ethmoid sinus	Y	A2	33.7153	$1,411.76

31231	Nasal endoscopy, dx	Y	P2	1.7607	$73.73
31233	Nasal/sinus endoscopy, dx	Y	A2	1.8133	$75.93
31235	Nasal/sinus endoscopy, dx	Y	A2	17.4217	$729.50
31237	Nasal/sinus endoscopy, surg	Y	A2	18.0663	$756.49
31238	Nasal/sinus endoscopy, surg	Y	A2	17.4217	$729.50
31239	Nasal/sinus endoscopy, surg	Y	A2	24.5736	$1,028.97
31240	Nasal/sinus endoscopy, surg	Y	A2	18.0663	$756.49
31254	Revision of ethmoid sinus	Y	A2	23.8889	$1,000.30
31255	Removal of ethmoid sinus	Y	A2	25.0699	$1,049.75
31256	Exploration maxillary sinus	Y	A2	23.8889	$1,000.30
31267	Endoscopy, maxillary sinus	Y	A2	23.8889	$1,000.30
31276	Sinus endoscopy, surgical	Y	A2	23.8889	$1,000.30
31287	Nasal/sinus endoscopy, surg	Y	A2	23.8889	$1,000.30
31288	Nasal/sinus endoscopy, surg	Y	A2	23.8889	$1,000.30
31300	Removal of larynx lesion	Y	A2	21.9824	$920.47
31320	Diagnostic incision, larynx	Y	A2	33.3501	$1,396.47
31400	Revision of larynx	Y	A2	33.3501	$1,396.47
31420	Removal of epiglottis	Y	A2	33.3501	$1,396.47
31500	Insert emergency airway	N	G2	2.3463	$98.25
31502	Change of windpipe airway	N	G2	1.3514	$56.59
31505	Diagnostic laryngoscopy	Y	P2	0.7651	$32.04
31510	Laryngoscopy with biopsy	Y	A2	18.0663	$756.49
31511	Remove foreign body, larynx	Y	A2	1.8133	$75.93
31512	Removal of larynx lesion	Y	A2	18.0663	$756.49
31513	Injection into vocal cord	Y	A2	1.8133	$75.93
31515	Laryngoscopy for aspiration	Y	A2	17.4217	$729.50
31520	Dx laryngoscopy, newborn	Y	G2	1.7607	$73.73
31525	Dx laryngoscopy excl nb	Y	A2	17.4217	$729.50
31526	Dx laryngoscopy w/oper scope	Y	A2	18.0663	$756.49
31527	Laryngoscopy for treatment	Y	A2	22.8789	$958.01
31528	Laryngoscopy and dilation	Y	A2	18.0663	$756.49

31529	Laryngoscopy and dilation	Y	A2	18.0663	$756.49
31530	Laryngoscopy w/fb removal	Y	A2	18.0663	$756.49
31531	Laryngoscopy w/fb & op scope	Y	A2	18.4314	$771.78
31535	Laryngoscopy w/biopsy	Y	A2	18.0663	$756.49
31536	Laryngoscopy w/bx & op scope	Y	A2	18.4314	$771.78
31540	Laryngoscopy w/exc of tumor	Y	A2	18.4314	$771.78
31541	Larynscop w/tumr exc + scope	Y	A2	19.1161	$800.45
31545	Remove vc lesion w/scope	Y	A2	24.5736	$1,028.97
31546	Remove vc lesion scope/graft	Y	A2	24.5736	$1,028.97
31560	Laryngoscop w/arytenoidectom	Y	A2	25.0699	$1,049.75
31561	Larynscop, remve cart + scop	Y	A2	25.0699	$1,049.75
31570	Laryngoscope w/vc inj	Y	A2	18.0663	$756.49
31571	Laryngoscop w/vc inj + scope	Y	A2	23.5238	$985.01
31575	Diagnostic laryngoscopy	Y	P3		$64.58
31576	Laryngoscopy with biopsy	Y	A2	18.0663	$756.49
31577	Remove foreign body, larynx	Y	A2	4.511	$188.89
31578	Removal of larynx lesion	Y	A2	23.5238	$985.01
31579	Diagnostic laryngoscopy	Y	P3		$114.37
31580	Revision of larynx	Y	A2	34.8965	$1,461.22
31582	Revision of larynx	Y	A2	34.8965	$1,461.22
31588	Revision of larynx	Y	A2	34.8965	$1,461.22
31590	Reinnervate larynx	Y	A2	34.8965	$1,461.22
31595	Larynx nerve surgery	Y	A2	33.3501	$1,396.47
31603	Incision of windpipe	Y	A2	7.3608	$308.22
31605	Incision of windpipe	Y	G2	7.2813	$304.89
31611	Surgery/speech prosthesis	Y	A2	20.8012	$871.01
31612	Puncture/clear windpipe	Y	A2	19.7915	$828.73
31613	Repair windpipe opening	Y	A2	20.4361	$855.72
31614	Repair windpipe opening	Y	A2	33.3501	$1,396.47
31615	Visualization of windpipe	Y	A2	7.3608	$308.22
31620	Endobronchial us add-on	N	N1		

31622	Dx bronchoscope/wash	Y	A2	9.3325	$390.78
31623	Dx bronchoscope/brush	Y	A2	9.9773	$417.78
31624	Dx bronchoscope/lavage	Y	A2	9.9773	$417.78
31625	Bronchoscopy w/biopsy(s)	Y	A2	9.9773	$417.78
31626	Bronchoscopy w/markers	Y	G2	9.9102	$414.97
31627	Navigational bronchoscopy	N	N1		
31628	Bronchoscopy/lung bx, each	Y	A2	9.9773	$417.78
31629	Bronchoscopy/needle bx, each	Y	A2	9.9773	$417.78
31630	Bronchoscopy dilate/fx repr	Y	A2	21.1088	$883.89
31631	Bronchoscopy, dilate w/stent	Y	A2	21.1088	$883.89
31632	Bronchoscopy/lung bx, addl	Y	G2	9.9102	$414.97
31633	Bronchoscopy/needle bx addl	Y	G2	9.9102	$414.97
31635	Bronchoscopy w/fb removal	Y	A2	9.9773	$417.78
31636	Bronchoscopy, bronch stents	Y	A2	21.1088	$883.89
31637	Bronchoscopy, stent add-on	Y	A2	9.3325	$390.78
31638	Bronchoscopy, revise stent	Y	A2	21.1088	$883.89
31640	Bronchoscopy w/tumor excise	Y	A2	21.1088	$883.89
31641	Bronchoscopy, treat blockage	Y	A2	21.1088	$883.89
31643	Diag bronchoscope/catheter	Y	A2	9.9773	$417.78
31645	Bronchoscopy, clear airways	Y	A2	9.3325	$390.78
31646	Bronchoscopy, reclear airway	Y	A2	9.3325	$390.78
31656	Bronchoscopy, inj for x-ray	Y	A2	9.3325	$390.78
31715	Injection for bronchus x-ray	N	N1		
31717	Bronchial brush biopsy	Y	A2	4.511	$188.89
31720	Clearance of airways	N	A2	0.5607	$23.48
31730	Intro, windpipe wire/tube	Y	A2	4.511	$188.89
31750	Repair of windpipe	Y	A2	34.8965	$1,461.22
31755	Repair of windpipe	Y	A2	33.3501	$1,396.47
31820	Closure of windpipe lesion	Y	A2	19.7915	$828.73
31825	Repair of windpipe defect	Y	A2	20.4361	$855.72
31830	Revise windpipe scar	Y	A2	20.4361	$855.72

32400	Needle biopsy chest lining	Y	A2	8.8279	$369.65
32405	Biopsy, lung or mediastinum	Y	A2	8.8279	$369.65
32420	Puncture/clear lung	Y	A2	5.2502	$219.84
32421	Thoracentesis for aspiration	Y	A2	5.2502	$219.84
32422	Thoracentesis w/tube insert	Y	G2	5.3056	$222.16
32550	Insert pleural cath	Y	G2	29.1078	$1,218.83
32552	Remove lung catheter	N	G2	1.3514	$56.59
32553	Ins mark thor for rt perq	N	G2	13.1468	$550.50
32960	Therapeutic pneumothorax	Y	G2	5.3056	$222.16
32998	Perq rf ablate tx, pul tumor	Y	G2	49.0813	$2,055.18
33010	Drainage of heart sac	Y	A2	5.2502	$219.84
33011	Repeat drainage of heart sac	Y	A2	5.2502	$219.84
33206	Insertion of heart pacemaker	Y	J8	169.0755	$7,079.70
33207	Insertion of heart pacemaker	Y	J8	169.0755	$7,079.70
33208	Insertion of heart pacemaker	Y	J8	205.0128	$8,584.50
33210	Insertion of heart electrode	Y	G2	46.7633	$1,958.12
33211	Insertion of heart electrode	Y	G2	46.7633	$1,958.12
33212	Insertion of pulse generator	Y	H8	138.2268	$5,787.97
33213	Insertion of pulse generator	Y	H8	152.3459	$6,379.18
33214	Upgrade of pacemaker system	Y	J8	205.0128	$8,584.50
33215	Reposition pacing-defib lead	Y	G2	21.9226	$917.97
33216	Insert 1 electrode pm-defib	Y	G2	46.7633	$1,958.12
33217	Insert 2 electrode pm-defib	Y	G2	46.7633	$1,958.12
33218	Repair lead pace-defib, one	Y	G2	21.9226	$917.97
33220	Repair lead pace-defib, dual	Y	G2	21.9226	$917.97
33222	Revise pocket, pacemaker	Y	A2	14.0506	$588.34
33223	Revise pocket for defib	Y	A2	14.0506	$588.34
33224	Insert pacing lead & connect	Y	J8	302.8118	$12,679.64
33225	L ventric pacing lead add-on	Y	J8	302.8118	$12,679.64
33226	Reposition l ventric lead	Y	G2	21.9226	$917.97
33233	Removal of pacemaker system	Y	A2	18.9867	$795.03
33234	Removal of pacemaker system	Y	G2	21.9226	$917.97
33235	Removal pacemaker electrode	Y	G2	21.9226	$917.97
33240	Insert pulse generator	Y	J8	499.7939	$20,927.87
33241	Remove pulse generator	Y	G2	21.9226	$917.97
33249	Eltrd/insert pace-defib	Y	J8	630.748	$26,411.31
33282	Implant pat-active ht record	N	J8	111.5846	$4,672.38
33284	Remove pat-active ht record	Y	G2	7.8386	$328.23
33508	Endoscopic vein harvest	N	N1		
34490	Removal of vein clot	Y	G2	39.0843	$1,636.58
35188	Repair blood vessel lesion	Y	A2	32.9076	$1,377.94
35207	Repair blood vessel lesion	Y	A2	32.9076	$1,377.94
35460	Repair venous blockage	Y	G2	48.4307	$2,027.94
35473	Repair arterial blockage	Y	G2	48.4307	$2,027.94
35475	Repair arterial blockage	Y	G2	48.4307	$2,027.94
35476	Repair venous blockage	Y	G2	48.4307	$2,027.94
35492	Atherectomy, percutaneous	Y	G2	89.1808	$3,734.27
35572	Harvest femoropopliteal vein	N	N1		
35761	Exploration of artery/vein	Y	G2	34.0164	$1,424.37
35875	Removal of clot in graft	Y	A2	36.9527	$1,547.32
35876	Removal of clot in graft	Y	A2	36.9527	$1,547.32
36000	Place needle in vein	N	N1		
36002	Pseudoaneurysm injection trt	N	G2	2.1984	$92.05
36005	Injection ext venography	N	N1		
36010	Place catheter in vein	N	N1		
36011	Place catheter in vein	N	N1		
36012	Place catheter in vein	N	N1		
36013	Place catheter in artery	N	N1		
36014	Place catheter in artery	N	N1		
36015	Place catheter in artery	N	N1		
36100	Establish access to artery	N	N1		
36120	Establish access to artery	N	N1		

36140	Establish access to artery	N	N1		
36145	Artery to vein shunt	N	D5		
36147	Access av dial grft for eval	Y	P2	2.289	$95.85
36148	Access av dial grft for proc	N	N1		
36160	Establish access to aorta	N	N1		
36200	Place catheter in aorta	N	N1		
36215	Place catheter in artery	N	N1		
36216	Place catheter in artery	N	N1		
36217	Place catheter in artery	N	N1		
36218	Place catheter in artery	N	N1		
36245	Place catheter in artery	N	N1		
36246	Place catheter in artery	N	N1		
36247	Place catheter in artery	N	N1		
36248	Place catheter in artery	N	N1		
36260	Insertion of infusion pump	Y	A2	24.726	$1,035.35
36261	Revision of infusion pump	Y	A2	18.9867	$795.03
36262	Removal of infusion pump	Y	A2	18.3419	$768.03
36400	Bl draw < 3 yrs fem/jugular	N	N1		
36405	Bl draw < 3 yrs scalp vein	N	N1		
36406	Bl draw < 3 yrs other vein	N	N1		
36410	Non-routine bl draw > 3 yrs	N	N1		
36416	Capillary blood draw	N	N1		
36420	Vein access cutdown < 1 yr	N	R2	0.2217	$9.28
36425	Vein access cutdown > 1 yr	N	R2	0.2217	$9.28
36430	Blood transfusion service	N	P3		$32.83
36440	Bl push transfuse, 2 yr or <	N	R2	3.2308	$135.28
36450	Bl exchange/transfuse, nb	N	R2	3.2308	$135.28
36455	Bl exchange/transfuse non-nb	N	G2	3.2308	$135.28
36468	Injection(s), spider veins	Y	R2	0.8399	$35.17
36469	Injection(s), spider veins	Y	R2	0.8399	$35.17
36470	Injection therapy of vein	Y	P2	0.8399	$35.17

36471	Injection therapy of veins	Y	P2	0.8399	$35.17
36475	Endovenous rf, 1st vein	Y	A2	39.9119	$1,671.23
36476	Endovenous rf, vein add-on	Y	A2	26.6831	$1,117.30
36478	Endovenous laser, 1st vein	Y	A2	26.6831	$1,117.30
36479	Endovenous laser vein addon	Y	A2	26.6831	$1,117.30
36481	Insertion of catheter, vein	N	N1		
36500	Insertion of catheter, vein	N	N1		
36510	Insertion of catheter, vein	N	N1		
36511	Apheresis wbc	N	G2	11.4122	$477.86
36512	Apheresis rbc	N	G2	11.4122	$477.86
36513	Apheresis platelets	N	G2	11.4122	$477.86
36514	Apheresis plasma	N	G2	11.4122	$477.86
36515	Apheresis, adsorp/reinfuse	N	P2	31.8412	$1,333.29
36516	Apheresis, selective	N	P2	31.8412	$1,333.29
36522	Photopheresis	N	G2	31.8412	$1,333.29
36555	Insert non-tunnel cv cath	Y	A2	9.9026	$414.65
36556	Insert non-tunnel cv cath	Y	A2	9.9026	$414.65
36557	Insert tunneled cv cath	Y	A2	20.7019	$866.85
36558	Insert tunneled cv cath	Y	A2	20.7019	$866.85
36560	Insert tunneled cv cath	Y	A2	24.726	$1,035.35
36561	Insert tunneled cv cath	Y	A2	24.726	$1,035.35
36563	Insert tunneled cv cath	Y	A2	24.726	$1,035.35
36565	Insert tunneled cv cath	Y	A2	24.726	$1,035.35
36566	Insert tunneled cv cath	Y	A2	24.726	$1,035.35
36568	Insert picc cath	Y	A2	9.9026	$414.65
36569	Insert picc cath	Y	A2	9.9026	$414.65
36570	Insert picvad cath	Y	A2	21.067	$882.14
36571	Insert picvad cath	Y	A2	21.067	$882.14
36575	Repair tunneled cv cath	Y	A2	7.1129	$297.84
36576	Repair tunneled cv cath	Y	A2	10.5471	$441.64
36578	Replace tunneled cv cath	Y	A2	20.7019	$866.85

36580	Replace cvad cath	Y	A2	9.9026	$414.65
36581	Replace tunneled cv cath	Y	A2	20.7019	$866.85
36582	Replace tunneled cv cath	Y	A2	24.726	$1,035.35
36583	Replace tunneled cv cath	Y	A2	24.726	$1,035.35
36584	Replace picc cath	Y	A2	9.9026	$414.65
36585	Replace picvad cath	Y	A2	21.067	$882.14
36589	Removal tunneled cv cath	Y	A2	6.4684	$270.85
36590	Removal tunneled cv cath	Y	A2	9.9026	$414.65
36591	Draw blood off venous device	N	N1		
36592	Collect blood from picc	N	N1		
36593	Declot vascular device	Y	P3		$25.62
36595	Mech remov tunneled cv cath	Y	G2	24.2096	$1,013.73
36596	Mech remov tunneled cv cath	Y	G2	10.6702	$446.79
36597	Reposition venous catheter	Y	G2	10.6702	$446.79
36598	Inj w/fluor, eval cv device	Y	P3		$80.82
36600	Withdrawal of arterial blood	N	N1		
36620	Insertion catheter, artery	N	N1		
36625	Insertion catheter, artery	N	N1		
36640	Insertion catheter, artery	Y	A2	23.716	$993.06
36680	Insert needle, bone cavity	Y	G2	1.444	$60.46
36800	Insertion of cannula	Y	A2	25.1121	$1,051.52
36810	Insertion of cannula	Y	A2	25.1121	$1,051.52
36815	Insertion of cannula	Y	A2	25.1121	$1,051.52
36818	Av fuse, uppr arm, cephalic	Y	A2	32.2229	$1,349.27
36819	Av fuse, uppr arm, basilic	Y	A2	32.2229	$1,349.27
36820	Av fusion/forearm vein	Y	A2	32.2229	$1,349.27
36821	Av fusion direct any site	Y	A2	32.2229	$1,349.27
36825	Artery-vein autograft	Y	A2	32.9076	$1,377.94
36830	Artery-vein nonautograft	Y	A2	32.9076	$1,377.94
36831	Open thrombect av fistula	Y	A2	36.9527	$1,547.32
36832	Av fistula revision, open	Y	A2	32.9076	$1,377.94
36833	Av fistula revision	Y	A2	32.9076	$1,377.94
36834	Repair A-V aneurysm	N	D5		
36835	Artery to vein shunt	Y	A2	25.7966	$1,080.18
36860	External cannula declotting	Y	A2	2.4436	$102.32
36861	Cannula declotting	Y	A2	25.1121	$1,051.52
36870	Percut thrombect av fistula	Y	A2	41.1009	$1,721.02
37184	Prim art mech thrombectomy	Y	G2	39.0843	$1,636.58
37185	Prim art m-thrombect add-on	Y	G2	39.0843	$1,636.58
37186	Sec art m-thrombect add-on	Y	G2	39.0843	$1,636.58
37187	Venous mech thrombectomy	Y	G2	39.0843	$1,636.58
37188	Venous m-thrombectomy add-on	Y	G2	39.0843	$1,636.58
37200	Transcatheter biopsy	Y	G2	29.0881	$1,218.01
37203	Transcatheter retrieval	Y	G2	29.0881	$1,218.01
37250	Iv us first vessel add-on	N	N1		
37251	Iv us each add vessel add-on	N	N1		
37500	Endoscopy ligate perf veins	Y	A2	35.1821	$1,473.18
37607	Ligation of a-v fistula	Y	A2	21.9533	$919.25
37609	Temporal artery procedure	Y	A2	15.0849	$631.65
37650	Revision of major vein	Y	A2	21.5881	$903.96
37700	Revise leg vein	Y	A2	21.5881	$903.96
37718	Ligate/strip short leg vein	Y	A2	21.9533	$919.25
37722	Ligate/strip long leg vein	Y	A2	35.1821	$1,473.18
37735	Removal of leg veins/lesion	Y	A2	35.1821	$1,473.18
37760	Ligate leg veins radical	Y	A2	21.9533	$919.25
37761*	Ligate leg veins open	Y	R2	25.3915	$1,063.22
37765	Phleb veins - extrem - to 20	Y	R2	25.3915	$1,063.22
37766	Phleb veins - extrem 20+	Y	R2	25.3915	$1,063.22
37780	Revision of leg vein	Y	A2	21.9533	$919.25
37785	Ligate/divide/excise vein	Y	A2	21.9533	$919.25
37790	Penile venous occlusion	Y	A2	27.9111	$1,168.72
38200	Injection for spleen x-ray	N	N1		

38204	BI donor search management	N	N1		
38206	Harvest auto stem cells	N	G2	11.4122	$477.86
38220	Bone marrow aspiration	Y	P3		$103.19
38221	Bone marrow biopsy	Y	P3		$107.52
38230	Bone marrow collection	N	G2	31.8412	$1,333.29
38241	Bone marrow/stem transplant	N	G2	31.8412	$1,333.29
38242	Lymphocyte infuse transplant	N	R2	11.4122	$477.86
38300	Drainage, lymph node lesion	Y	A2	10.9457	$458.33
38305	Drainage, lymph node lesion	Y	A2	16.4531	$688.94
38308	Incision of lymph channels	Y	A2	20.186	$845.25
38500	Biopsy/removal, lymph nodes	Y	A2	20.186	$845.25
38505	Needle biopsy, lymph nodes	Y	A2	6.9699	$291.85
38510	Biopsy/removal, lymph nodes	Y	A2	20.186	$845.25
38520	Biopsy/removal, lymph nodes	Y	A2	20.186	$845.25
38525	Biopsy/removal, lymph nodes	Y	A2	20.186	$845.25
38530	Biopsy/removal, lymph nodes	Y	A2	20.186	$845.25
38542	Explore deep node(s), neck	Y	A2	37.4879	$1,569.73
38550	Removal, neck/armpit lesion	Y	A2	20.5512	$860.54
38555	Removal, neck/armpit lesion	Y	A2	21.2356	$889.20
38570	Laparoscopy, lymph node biop	Y	A2	41.2096	$1,725.57
38571	Laparoscopy, lymphadenectomy	Y	A2	59.9286	$2,509.39
38572	Laparoscopy, lymphadenectomy	Y	A2	41.2096	$1,725.57
38700	Removal of lymph nodes, neck	Y	G2	23.5217	$984.92
38740	Remove armpit lymph nodes	Y	A2	37.4879	$1,569.73
38745	Remove armpit lymph nodes	Y	A2	38.5377	$1,613.69
38760	Remove groin lymph nodes	Y	A2	20.186	$845.25
38790	Inject for lymphatic x-ray	N	N1		
38792	Identify sentinel node	N	N1		
38794	Access thoracic lymph duct	N	N1		
40490	Biopsy of lip	Y	P3		$72.16
40500	Partial excision of lip	Y	A2	14.863	$622.36

40510	Partial excision of lip	Y	A2	20.4361	$855.72
40520	Partial excision of lip	Y	A2	14.863	$622.36
40525	Reconstruct lip with flap	Y	A2	20.4361	$855.72
40527	Reconstruct lip with flap	Y	A2	20.4361	$855.72
40530	Partial removal of lip	Y	A2	20.4361	$855.72
40650	Repair lip	Y	A2	8.109	$339.55
40652	Repair lip	Y	A2	8.109	$339.55
40654	Repair lip	Y	A2	8.109	$339.55
40700	Repair cleft lip/nasal	Y	A2	36.4825	$1,527.63
40701	Repair cleft lip/nasal	Y	A2	36.4825	$1,527.63
40702	Repair cleft lip/nasal	Y	R2	41.0743	$1,719.90
40720	Repair cleft lip/nasal	Y	A2	36.4825	$1,527.63
40761	Repair cleft lip/nasal	Y	A2	33.7153	$1,411.76
40800	Drainage of mouth lesion	Y	P2	1.3911	$58.25
40801	Drainage of mouth lesion	Y	A2	8.0056	$335.22
40804	Removal, foreign body, mouth	N	P2	0.6396	$26.78
40805	Removal, foreign body, mouth	Y	P3		$183.28
40806	Incision of lip fold	Y	P3		$81.90
40808	Biopsy of mouth lesion	Y	P3		$125.56
40810	Excision of mouth lesion	Y	P3		$130.25
40812	Excise/repair mouth lesion	Y	P3		$164.52
40814	Excise/repair mouth lesion	Y	A2	14.863	$622.36
40816	Excision of mouth lesion	Y	A2	20.4361	$855.72
40818	Excise oral mucosa for graft	Y	A2	3.3145	$138.79
40819	Excise lip or cheek fold	Y	A2	7.3608	$308.22
40820	Treatment of mouth lesion	Y	P3		$185.45
40830	Repair mouth laceration	Y	G2	3.2729	$137.05
40831	Repair mouth laceration	Y	A2	7.3608	$308.22
40840	Reconstruction of mouth	Y	A2	20.4361	$855.72
40842	Reconstruction of mouth	Y	A2	20.8012	$871.01
40843	Reconstruction of mouth	Y	A2	20.8012	$871.01

40844	Reconstruction of mouth	Y	A2	34.8965	$1,461.22
40845	Reconstruction of mouth	Y	A2	34.8965	$1,461.22
41000	Drainage of mouth lesion	Y	P3		$93.44
41005	Drainage of mouth lesion	Y	A2	3.3145	$138.79
41006	Drainage of mouth lesion	Y	A2	19.7915	$828.73
41007	Drainage of mouth lesion	Y	A2	14.2185	$595.37
41008	Drainage of mouth lesion	Y	A2	14.2185	$595.37
41009	Drainage of mouth lesion	Y	A2	3.3145	$138.79
41010	Incision of tongue fold	Y	A2	7.3608	$308.22
41015	Drainage of mouth lesion	Y	A2	3.3145	$138.79
41016	Drainage of mouth lesion	Y	A2	7.3608	$308.22
41017	Drainage of mouth lesion	Y	A2	7.3608	$308.22
41018	Drainage of mouth lesion	Y	A2	7.3608	$308.22
41019	Place needles h&n for rt	Y	G2	23.8553	$998.89
41100	Biopsy of tongue	Y	P3		$98.14
41105	Biopsy of tongue	Y	P3		$97.41
41108	Biopsy of floor of mouth	Y	P3		$90.20
41110	Excision of tongue lesion	Y	P3		$130.61
41112	Excision of tongue lesion	Y	A2	14.863	$622.36
41113	Excision of tongue lesion	Y	A2	14.863	$622.36
41114	Excision of tongue lesion	Y	A2	20.4361	$855.72
41115	Excision of tongue fold	Y	P3		$151.17
41116	Excision of mouth lesion	Y	A2	14.2185	$595.37
41120	Partial removal of tongue	Y	A2	21.9824	$920.47
41250	Repair tongue laceration	Y	A2	1.6858	$70.59
41251	Repair tongue laceration	Y	A2	3.3145	$138.79
41252	Repair tongue laceration	Y	A2	8.0056	$335.22
41500	Fixation of tongue	Y	A2	19.7915	$828.73
41510	Tongue to lip surgery	Y	A2	14.2185	$595.37
41512	Tongue suspension	Y	G2	7.2813	$304.89
41520	Reconstruction, tongue fold	Y	A2	8.0056	$335.22

41530	Tongue base vol reduction	Y	G2	23.8553	$998.89
41800	Drainage of gum lesion	Y	A2	1.5478	$64.81
41805	Removal foreign body, gum	Y	P3		$167.77
41806	Removal foreign body,jawbone	Y	P3		$201.68
41820	Excision, gum, each quadrant	Y	R2	7.2813	$304.89
41821	Excision of gum flap	Y	G2	7.2813	$304.89
41822	Excision of gum lesion	Y	P3		$165.96
41823	Excision of gum lesion	Y	P3		$240.65
41825	Excision of gum lesion	Y	P3		$132.41
41826	Excision of gum lesion	Y	P3		$172.10
41827	Excision of gum lesion	Y	A2	20.4361	$855.72
41828	Excision of gum lesion	Y	P3		$152.98
41830	Removal of gum tissue	Y	P3		$215.75
41850	Treatment of gum lesion	Y	R2	16.4248	$687.76
41870	Gum graft	Y	G2	23.8553	$998.89
41872	Repair gum	Y	P3		$212.87
41874	Repair tooth socket	Y	P3		$207.82
42000	Drainage mouth roof lesion	Y	A2	3.3145	$138.79
42100	Biopsy roof of mouth	Y	P3		$83.70
42104	Excision lesion, mouth roof	Y	P3		$125.56
42106	Excision lesion, mouth roof	Y	P3		$157.30
42107	Excision lesion, mouth roof	Y	A2	20.4361	$855.72
42120	Remove palate/lesion	Y	A2	34.4	$1,440.43
42140	Excision of uvula	Y	A2	8.0056	$335.22
42145	Repair palate, pharynx/uvula	Y	A2	21.9824	$920.47
42160	Treatment mouth roof lesion	Y	P3		$145.40
42180	Repair palate	Y	A2	3.3145	$138.79
42182	Repair palate	Y	A2	33.3501	$1,396.47
42200	Reconstruct cleft palate	Y	A2	34.8965	$1,461.22
42205	Reconstruct cleft palate	Y	A2	34.8965	$1,461.22
42210	Reconstruct cleft palate	Y	A2	34.8965	$1,461.22

42215	Reconstruct cleft palate	Y	A2	36.4825	$1,527.63
42220	Reconstruct cleft palate	Y	A2	34.8965	$1,461.22
42225	Reconstruct cleft palate	Y	G2	41.0743	$1,719.90
42226	Lengthening of palate	Y	A2	34.8965	$1,461.22
42227	Lengthening of palate	Y	G2	41.0743	$1,719.90
42235	Repair palate	Y	A2	16.4091	$687.10
42260	Repair nose to lip fistula	Y	A2	21.4859	$899.68
42280	Preparation, palate mold	Y	P3		$82.98
42281	Insertion, palate prosthesis	Y	G2	16.4248	$687.76
42300	Drainage of salivary gland	Y	A2	14.2185	$595.37
42305	Drainage of salivary gland	Y	A2	14.863	$622.36
42310	Drainage of salivary gland	Y	A2	3.3145	$138.79
42320	Drainage of salivary gland	Y	A2	3.3145	$138.79
42330	Removal of salivary stone	Y	P3		$126.28
42335	Removal of salivary stone	Y	P3		$209.62
42340	Removal of salivary stone	Y	A2	14.863	$622.36
42400	Biopsy of salivary gland	Y	P3		$69.99
42405	Biopsy of salivary gland	Y	A2	20.4361	$855.72
42408	Excision of salivary cyst	Y	A2	15.2282	$637.65
42409	Drainage of salivary cyst	Y	A2	15.2282	$637.65
42410	Excise parotid gland/lesion	Y	A2	33.7153	$1,411.76
42415	Excise parotid gland/lesion	Y	A2	36.4825	$1,527.63
42420	Excise parotid gland/lesion	Y	A2	36.4825	$1,527.63
42425	Excise parotid gland/lesion	Y	A2	36.4825	$1,527.63
42440	Excise submaxillary gland	Y	A2	33.7153	$1,411.76
42450	Excise sublingual gland	Y	A2	20.4361	$855.72
42500	Repair salivary duct	Y	A2	20.8012	$871.01
42505	Repair salivary duct	Y	A2	34.4	$1,440.43
42507	Parotid duct diversion	Y	A2	33.7153	$1,411.76
42508	Parotid duct diversion	Y	A2	34.4	$1,440.43
42509	Parotid duct diversion	Y	A2	34.4	$1,440.43

42510	Parotid duct diversion	Y	A2	34.4	$1,440.43
42550	Injection for salivary x-ray	N	N1		
42600	Closure of salivary fistula	Y	A2	14.2185	$595.37
42650	Dilation of salivary duct	Y	P3		$46.54
42660	Dilation of salivary duct	Y	P3		$54.84
42665	Ligation of salivary duct	Y	A2	23.5684	$986.88
42700	Drainage of tonsil abscess	Y	A2	3.3145	$138.79
42720	Drainage of throat abscess	Y	A2	14.2185	$595.37
42725	Drainage of throat abscess	Y	A2	33.3501	$1,396.47
42800	Biopsy of throat	Y	P3		$89.84
42802	Biopsy of throat	Y	A2	14.2185	$595.37
42804	Biopsy of upper nose/throat	Y	A2	14.2185	$595.37
42806	Biopsy of upper nose/throat	Y	A2	20.4361	$855.72
42808	Excise pharynx lesion	Y	A2	20.4361	$855.72
42809	Remove pharynx foreign body	N	G2	0.6396	$26.78
42810	Excision of neck cyst	Y	A2	20.8012	$871.01
42815	Excision of neck cyst	Y	A2	34.8965	$1,461.22
42820	Remove tonsils and adenoids	Y	A2	20.8012	$871.01
42821	Remove tonsils and adenoids	Y	A2	21.9824	$920.47
42825	Removal of tonsils	Y	A2	21.4859	$899.68
42826	Removal of tonsils	Y	A2	21.4859	$899.68
42830	Removal of adenoids	Y	A2	21.4859	$899.68
42831	Removal of adenoids	Y	A2	21.4859	$899.68
42835	Removal of adenoids	Y	A2	21.4859	$899.68
42836	Removal of adenoids	Y	A2	21.4859	$899.68
42860	Excision of tonsil tags	Y	A2	20.8012	$871.01
42870	Excision of lingual tonsil	Y	A2	20.8012	$871.01
42890	Partial removal of pharynx	Y	A2	36.4825	$1,527.63
42892	Revision of pharyngeal walls	Y	A2	36.4825	$1,527.63
42900	Repair throat wound	Y	A2	7.3608	$308.22
42950	Reconstruction of throat	Y	A2	20.4361	$855.72

42955	Surgical opening of throat	Y	A2	20.4361	$855.72
42960	Control throat bleeding	Y	A2	1.2395	$51.90
42962	Control throat bleeding	Y	A2	33.3501	$1,396.47
42970	Control nose/throat bleeding	Y	R2	1.101	$46.10
42972	Control nose/throat bleeding	Y	A2	15.2282	$637.65
43030	Throat muscle surgery	Y	G2	16.4248	$687.76
43130	Removal of esophagus pouch	Y	G2	41.0743	$1,719.90
43200	Esophagus endoscopy	Y	A2	8.1683	$342.03
43201	Esoph scope w/submucous inj	Y	A2	8.1683	$342.03
43202	Esophagus endoscopy, biopsy	Y	A2	8.1683	$342.03
43204	Esoph scope w/sclerosis inj	Y	A2	8.1683	$342.03
43205	Esophagus endoscopy/ligation	Y	A2	8.1683	$342.03
43215	Esophagus endoscopy	Y	A2	8.1683	$342.03
43216	Esophagus endoscopy/lesion	Y	A2	8.1683	$342.03
43217	Esophagus endoscopy	Y	A2	8.1683	$342.03
43219	Esophagus endoscopy	Y	A2	20.8863	$874.57
43220	Esoph endoscopy, dilation	Y	A2	8.1683	$342.03
43226	Esoph endoscopy, dilation	Y	A2	8.1683	$342.03
43227	Esoph endoscopy, repair	Y	A2	8.8131	$369.03
43228	Esoph endoscopy, ablation	Y	A2	19.9391	$834.91
43231	Esoph endoscopy w/us exam	Y	A2	8.8131	$369.03
43232	Esoph endoscopy w/us fn bx	Y	A2	8.8131	$369.03
43234	Upper GI endoscopy, exam	Y	A2	8.1683	$342.03
43235	Uppr gi endoscopy, diagnosis	Y	A2	8.1683	$342.03
43236	Uppr gi scope w/submuc inj	Y	A2	8.8131	$369.03
43237	Endoscopic us exam, esoph	Y	A2	8.8131	$369.03
43238	Uppr gi endoscopy w/us fn bx	Y	A2	8.8131	$369.03
43239	Upper GI endoscopy, biopsy	Y	A2	8.8131	$369.03
43240	Esoph endoscope w/drain cyst	Y	A2	8.8131	$369.03
43241	Upper GI endoscopy with tube	Y	A2	8.8131	$369.03
43242	Uppr gi endoscopy w/us fn bx	Y	A2	8.8131	$369.03
43243	Upper gi endoscopy & inject	Y	A2	8.8131	$369.03
43244	Upper GI endoscopy/ligation	Y	A2	8.8131	$369.03
43245	Uppr gi scope dilate strictr	Y	A2	8.8131	$369.03
43246	Place gastrostomy tube	Y	A2	8.8131	$369.03
43247	Operative upper GI endoscopy	Y	A2	8.8131	$369.03
43248	Uppr gi endoscopy/guide wire	Y	A2	8.8131	$369.03
43249	Esoph endoscopy, dilation	Y	A2	8.8131	$369.03
43250	Upper GI endoscopy/tumor	Y	A2	8.8131	$369.03
43251	Operative upper GI endoscopy	Y	A2	8.8131	$369.03
43255	Operative upper GI endoscopy	Y	A2	8.8131	$369.03
43256	Uppr gi endoscopy w/stent	Y	A2	21.896	$916.85
43257	Uppr gi scope w/thrml txmnt	Y	A2	20.3043	$850.20
43258	Operative upper GI endoscopy	Y	A2	9.1782	$384.32
43259	Endoscopic ultrasound exam	Y	A2	9.1782	$384.32
43260	Endo cholangiopancreatograph	Y	A2	18.7498	$785.11
43261	Endo cholangiopancreatograph	Y	A2	18.7498	$785.11
43262	Endo cholangiopancreatograph	Y	A2	18.7498	$785.11
43263	Endo cholangiopancreatograph	Y	A2	18.7498	$785.11
43264	Endo cholangiopancreatograph	Y	A2	18.7498	$785.11
43265	Endo cholangiopancreatograph	Y	A2	18.7498	$785.11
43267	Endo cholangiopancreatograph	Y	A2	18.7498	$785.11
43268	Endo cholangiopancreatograph	Y	A2	21.5308	$901.56
43269	Endo cholangiopancreatograph	Y	A2	21.5308	$901.56
43271	Endo cholangiopancreatograph	Y	A2	18.7498	$785.11
43272	Endo cholangiopancreatograph	Y	A2	18.7498	$785.11
43273	Endoscopic pancreatoscopy	Y	G2	21.6072	$904.76
43450	Dilate esophagus	Y	A2	6.1732	$258.49
43453	Dilate esophagus	Y	A2	6.1732	$258.49
43456	Dilate esophagus	Y	A2	6.1868	$259.06
43458	Dilate esophagus	Y	A2	8.1821	$342.61
43600	Biopsy of stomach	Y	A2	8.1683	$342.03

43653	Laparoscopy, gastrostomy	Y	A2	41.2096	$1,725.57
43752	Nasal/orogastric w/stent	N	G2	1.2129	$50.79
43760	Change gastrostomy tube	Y	A2	2.5439	$106.52
43761	Reposition gastrostomy tube	Y	A2	8.1683	$342.03
43870	Repair stomach opening	Y	A2	8.1683	$342.03
43886	Revise gastric port, open	Y	G2	22.8691	$957.60
43887	Remove gastric port, open	Y	G2	4.2415	$177.60
43888	Change gastric port, open	Y	G2	22.8691	$957.60
44100	Biopsy of bowel	Y	A2	8.1683	$342.03
44312	Revision of ileostomy	Y	A2	19.0517	$797.75
44340	Revision of colostomy	Y	A2	20.0616	$840.04
44360	Small bowel endoscopy	Y	A2	9.6043	$402.16
44361	Small bowel endoscopy/biopsy	Y	A2	9.6043	$402.16
44363	Small bowel endoscopy	Y	A2	9.6043	$402.16
44364	Small bowel endoscopy	Y	A2	9.6043	$402.16
44365	Small bowel endoscopy	Y	A2	9.6043	$402.16
44366	Small bowel endoscopy	Y	A2	9.6043	$402.16
44369	Small bowel endoscopy	Y	A2	9.6043	$402.16
44370	Small bowel endoscopy/stent	Y	A2	26.6257	$1,114.90
44372	Small bowel endoscopy	Y	A2	9.6043	$402.16
44373	Small bowel endoscopy	Y	A2	9.6043	$402.16
44376	Small bowel endoscopy	Y	A2	9.6043	$402.16
44377	Small bowel endoscopy/biopsy	Y	A2	9.6043	$402.16
44378	Small bowel endoscopy	Y	A2	9.6043	$402.16
44379	S bowel endoscope w/stent	Y	A2	26.6257	$1,114.90
44380	Small bowel endoscopy	Y	A2	8.9597	$375.17
44382	Small bowel endoscopy	Y	A2	8.9597	$375.17
44383	Ileoscopy w/stent	Y	A2	26.6257	$1,114.90
44385	Endoscopy of bowel pouch	Y	A2	8.4255	$352.80
44386	Endoscopy, bowel pouch/biop	Y	A2	8.4255	$352.80
44388	Colonoscopy	Y	A2	8.4255	$352.80
44389	Colonoscopy with biopsy	Y	A2	8.4255	$352.80
44390	Colonoscopy for foreign body	Y	A2	8.4255	$352.80
44391	Colonoscopy for bleeding	Y	A2	8.4255	$352.80
44392	Colonoscopy & polypectomy	Y	A2	8.4255	$352.80
44393	Colonoscopy, lesion removal	Y	A2	8.4255	$352.80
44394	Colonoscopy w/snare	Y	A2	8.4255	$352.80
44397	Colonoscopy w/stent	Y	A2	20.8863	$874.57
44500	Intro, gastrointestinal tube	Y	G2	6.0912	$255.06
44701	Intraop colon lavage add-on	N	N1		
45000	Drainage of pelvic abscess	Y	A2	11.896	$498.12
45005	Drainage of rectal abscess	Y	A2	12.6602	$530.12
45020	Drainage of rectal abscess	Y	A2	12.6602	$530.12
45100	Biopsy of rectum	Y	A2	19.0796	$798.92
45108	Removal of anorectal lesion	Y	A2	19.7242	$825.91
45150	Excision of rectal stricture	Y	A2	19.7242	$825.91
45160	Excision of rectal lesion	Y	A2	19.7242	$825.91
45170	Excision of rectal lesion	N	D5		
45171	Exc rect tum transanal part	Y	G2	13.4873	$564.75
45172	Exc rect tum transanal full	Y	G2	22.906	$959.14
45190	Destruction, rectal tumor	Y	A2	24.8191	$1,039.25
45300	Proctosigmoidoscopy dx	Y	P3		$70.72
45303	Proctosigmoidoscopy dilate	Y	P2	8.8345	$369.93
45305	Proctosigmoidoscopy w/bx	Y	A2	8.5258	$357.00
45307	Proctosigmoidoscopy fb	Y	A2	18.2557	$764.42
45308	Proctosigmoidoscopy removal	Y	A2	8.5258	$357.00
45309	Proctosigmoidoscopy removal	Y	A2	8.5258	$357.00
45315	Proctosigmoidoscopy removal	Y	A2	8.5258	$357.00
45317	Proctosigmoidoscopy bleed	Y	A2	8.5258	$357.00
45320	Proctosigmoidoscopy ablate	Y	A2	18.2557	$764.42
45321	Proctosigmoidoscopy volvul	Y	A2	18.2557	$764.42
45327	Proctosigmoidoscopy w/stent	Y	A2	20.8863	$874.57

45330	Diagnostic sigmoidoscopy	Y	P3		$89.12
45331	Sigmoidoscopy and biopsy	Y	A2	5.8458	$244.78
45332	Sigmoidoscopy w/fb removal	Y	A2	5.8458	$244.78
45333	Sigmoidoscopy & polypectomy	Y	A2	8.5258	$357.00
45334	Sigmoidoscopy for bleeding	Y	A2	8.5258	$357.00
45335	Sigmoidoscopy w/submuc inj	Y	A2	5.8458	$244.78
45337	Sigmoidoscopy & decompress	Y	A2	5.8458	$244.78
45338	Sigmoidoscopy w/tumr remove	Y	A2	8.5258	$357.00
45339	Sigmoidoscopy w/ablate tumr	Y	A2	8.5258	$357.00
45340	Sig w/balloon dilation	Y	A2	8.5258	$357.00
45341	Sigmoidoscopy w/ultrasound	Y	A2	8.5258	$357.00
45342	Sigmoidoscopy w/us guide bx	Y	A2	8.5258	$357.00
45345	Sigmoidoscopy w/stent	Y	A2	20.8863	$874.57
45355	Surgical colonoscopy	Y	A2	8.4255	$352.80
45378	Diagnostic colonoscopy	Y	A2	9.0703	$379.80
45379	Colonoscopy w/fb removal	Y	A2	9.0703	$379.80
45380	Colonoscopy and biopsy	Y	A2	9.0703	$379.80
45381	Colonoscopy, submucous inj	Y	A2	9.0703	$379.80
45382	Colonoscopy/control bleeding	Y	A2	9.0703	$379.80
45383	Lesion removal colonoscopy	Y	A2	9.0703	$379.80
45384	Lesion remove colonoscopy	Y	A2	9.0703	$379.80
45385	Lesion removal colonoscopy	Y	A2	9.0703	$379.80
45386	Colonoscopy dilate stricture	Y	A2	9.0703	$379.80
45387	Colonoscopy w/stent	Y	A2	20.8863	$874.57
45391	Colonoscopy w/endoscope us	Y	A2	9.0703	$379.80
45392	Colonoscopy w/endoscopic fnb	Y	A2	9.0703	$379.80
45500	Repair of rectum	Y	A2	19.7242	$825.91
45505	Repair of rectum	Y	A2	25.6089	$1,072.32
45520	Treatment of rectal prolapse	Y	P2	0.8399	$35.17
45541	Correct rectal prolapse	Y	G2	30.7524	$1,287.70
45560	Repair of rectocele	Y	A2	25.6089	$1,072.32

45900	Reduction of rectal prolapse	Y	A2	5.6256	$235.56
45905	Dilation of anal sphincter	Y	A2	19.0796	$798.92
45910	Dilation of rectal narrowing	Y	A2	19.0796	$798.92
45915	Remove rectal obstruction	Y	A2	11.896	$498.12
45990	Surg dx exam, anorectal	Y	A2	18.9602	$793.92
46020	Placement of seton	Y	A2	20.0893	$841.20
46030	Removal of rectal marker	Y	A2	5.6256	$235.56
46040	Incision of rectal abscess	Y	A2	20.0893	$841.20
46045	Incision of rectal abscess	Y	A2	19.7242	$825.91
46050	Incision of anal abscess	Y	A2	11.896	$498.12
46060	Incision of rectal abscess	Y	A2	19.7242	$825.91
46070	Incision of anal septum	Y	G2	13.4873	$564.75
46080	Incision of anal sphincter	Y	A2	20.0893	$841.20
46083	Incise external hemorrhoid	Y	P2	1.9297	$80.80
46200	Removal of anal fissure	Y	A2	19.7242	$825.91
46210	Removal of anal crypt	N	D5		
46211	Removal of anal crypts	N	D5		
46220	Excise anal ext tag/papilla	Y	A2	12.0154	$503.12
46221	Ligation of hemorrhoid(s)	Y	P3		$133.49
46230	Removal of anal tags	Y	A2	19.0796	$798.92
46250	Remove ext hem groups = 2	Y	A2	20.0893	$841.20
46255	Remove int/ext hem 1 group	Y	A2	20.0893	$841.20
46257	Remove in/ex hem grp & fiss	Y	A2	20.0893	$841.20
46258	Remove in/ex hem grp w/fistu	Y	A2	20.0893	$841.20
46260	Remove in/ex hem groups = 2	Y	A2	20.0893	$841.20
46261	Remove in/ex hem grps & fiss	Y	A2	20.774	$869.87
46262	Remove in/ex hem grps w/fist	Y	A2	20.774	$869.87
46270	Remove anal fist subq	Y	A2	20.0893	$841.20
46275	Remove anal fist inter	Y	A2	20.0893	$841.20
46280	Remove anal fist complex	Y	A2	20.774	$869.87
46285	Remove anal fist 2 stage	Y	A2	19.0796	$798.92

46288	Repair anal fistula	Y	A2	20.774	$869.87
46320	Removal of hemorrhoid clot	Y	P3		$90.20
46500	Injection into hemorrhoid(s)	Y	P3		$125.92
46505	Chemodenervation anal musc	Y	G2	22.906	$959.14
46600	Diagnostic anoscopy	N	P2	0.6396	$26.78
46604	Anoscopy and dilation	Y	P2	8.8345	$369.93
46606	Anoscopy and biopsy	Y	P3		$143.96
46608	Anoscopy, remove for body	Y	A2	8.5258	$357.00
46610	Anoscopy, remove lesion	Y	A2	18.2557	$764.42
46611	Anoscopy	Y	A2	8.5258	$357.00
46612	Anoscopy, remove lesions	Y	A2	18.2557	$764.42
46614	Anoscopy, control bleeding	Y	P3		$75.04
46615	Anoscopy	Y	A2	18.9002	$791.41
46700	Repair of anal stricture	Y	A2	20.0893	$841.20
46706	Repr of anal fistula w/glue	Y	A2	24.9641	$1,045.32
46707	Repair anorectal fist w/plug	Y	G2	30.7524	$1,287.70
46750	Repair of anal sphincter	Y	A2	25.974	$1,087.61
46753	Reconstruction of anus	Y	A2	20.0893	$841.20
46754	Removal of suture from anus	Y	A2	19.7242	$825.91
46760	Repair of anal sphincter	Y	A2	25.6089	$1,072.32
46761	Repair of anal sphincter	Y	A2	25.974	$1,087.61
46762	Implant artificial sphincter	Y	A2	28.741	$1,203.47
46900	Destruction, anal lesion(s)	Y	P2	2.674	$111.97
46910	Destruction, anal lesion(s)	Y	P3		$139.63
46916	Cryosurgery, anal lesion(s)	Y	P2	1.4728	$61.67
46917	Laser surgery, anal lesions	Y	A2	17.1406	$717.73
46922	Excision of anal lesion(s)	Y	A2	17.1406	$717.73
46924	Destruction, anal lesion(s)	Y	A2	17.1406	$717.73
46930*	Destroy internal hemorrhoids	Y	P3		$127.36
46937	Cryotherapy of rectal lesion	N	D5		
46938	Cryotherapy of rectal lesion	N	D5		

46940	Treatment of anal fissure	Y	P3		$102.46
46942	Treatment of anal fissure	Y	P3		$100.30
46945	Remove by ligat int hem grp	Y	P3		$167.05
46946	Remove by ligat int hem grps	Y	A2	12.0154	$503.12
46947	Hemorrhoidopexy by stapling	Y	A2	28.741	$1,203.47
47000	Needle biopsy of liver	Y	A2	8.8279	$369.65
47001	Needle biopsy, liver add-on	N	N1		
47382	Percut ablate liver rf	Y	G2	49.0813	$2,055.18
47500	Injection for liver x-rays	N	N1		
47505	Injection for liver x-rays	N	N1		
47510	Insert catheter, bile duct	Y	A2	24.5779	$1,029.15
47511	Insert bile duct drain	Y	A2	29.1415	$1,220.24
47525	Change bile duct catheter	Y	A2	12.873	$539.03
47530	Revise/reinsert bile tube	Y	A2	12.873	$539.03
47552	Biliary endoscopy thru skin	Y	A2	24.5779	$1,029.15
47553	Biliary endoscopy thru skin	Y	A2	24.943	$1,044.44
47554	Biliary endoscopy thru skin	Y	A2	24.943	$1,044.44
47555	Biliary endoscopy thru skin	Y	A2	24.943	$1,044.44
47556	Biliary endoscopy thru skin	Y	A2	29.1415	$1,220.24
47560	Laparoscopy w/cholangio	Y	A2	30.1832	$1,263.86
47561	Laparo w/cholangio/biopsy	Y	A2	30.1832	$1,263.86
47562	Laparoscopic cholecystectomy	Y	G2	44.7603	$1,874.25
47563	Laparo cholecystectomy/graph	Y	G2	44.7603	$1,874.25
47564	Laparo cholecystectomy/explr	Y	G2	44.7603	$1,874.25
47630	Remove bile duct stone	Y	A2	24.943	$1,044.44
48102	Needle biopsy, pancreas	Y	A2	8.8279	$369.65
49080	Puncture, peritoneal cavity	Y	A2	5.2502	$219.84
49081	Removal of abdominal fluid	Y	A2	5.2502	$219.84
49180	Biopsy, abdominal mass	Y	A2	8.8279	$369.65
49250	Excision of umbilicus	Y	A2	23.0784	$966.36
49320	Diag laparo separate proc	Y	A2	30.1832	$1,263.86

49321	Laparoscopy, biopsy	Y	A2	30.8676	$1,292.52
49322	Laparoscopy, aspiration	Y	A2	30.8676	$1,292.52
49324	Lap insertion perm ip cath	Y	G2	36.3644	$1,522.69
49325	Lap revision perm ip cath	Y	G2	36.3644	$1,522.69
49326	Lap w/omentopexy add-on	Y	G2	36.3644	$1,522.69
49400	Air injection into abdomen	N	N1		
49402	Remove foreign body, adbomen	Y	A2	22.0285	$922.40
49411	Ins mark abd/pel for rt perq	N	P3		$356.10
49419	Insrt abdom cath for chemotx	Y	A2	24.1022	$1,009.23
49420	Insert abdom drain, temp	Y	A2	23.7308	$993.68
49421	Insert abdom drain, perm	Y	A2	23.7308	$993.68
49422	Remove perm cannula/catheter	Y	A2	18.3419	$768.03
49423	Exchange drainage catheter	Y	G2	14.6305	$612.62
49424	Assess cyst, contrast inject	N	N1		
49426	Revise abdomen-venous shunt	Y	A2	22.0285	$922.40
49427	Injection, abdominal shunt	N	N1		
49429	Removal of shunt	Y	G2	21.9226	$917.97
49435	Insert subq exten to ip cath	Y	G2	14.6305	$612.62
49436	Embedded ip cath exit-site	Y	G2	14.6305	$612.62
49440	Place gastrostomy tube perc	Y	G2	8.3579	$349.97
49441	Place duod/jej tube perc	Y	G2	8.3579	$349.97
49442	Place cecostomy tube perc	Y	G2	13.4873	$564.75
49446	Change g-tube to g-j perc	Y	G2	8.3579	$349.97
49450	Replace g/c tube perc	Y	G2	6.0912	$255.06
49451	Replace duod/jej tube perc	Y	G2	6.0912	$255.06
49452	Replace g-j tube perc	Y	G2	6.0912	$255.06
49460	Fix g/colon tube w/device	Y	G2	6.0912	$255.06
49465	Fluoro exam of g/colon tube	N	N1		
49495	Rpr ing hernia baby, reduc	Y	A2	26.5059	$1,109.88
49496	Rpr ing hernia baby, blocked	Y	A2	26.5059	$1,109.88
49500	Rpr ing hernia, init, reduce	Y	A2	26.5059	$1,109.88

49501	Rpr ing hernia, init blocked	Y	A2	30.551	$1,279.26
49505	Prp i/hern init reduc >5 yr	Y	A2	26.5059	$1,109.88
49507	Prp i/hern init block >5 yr	Y	A2	30.551	$1,279.26
49520	Rerepair ing hernia, reduce	Y	A2	28.5884	$1,197.08
49521	Rerepair ing hernia, blocked	Y	A2	30.551	$1,279.26
49525	Repair ing hernia, sliding	Y	A2	26.5059	$1,109.88
49540	Repair lumbar hernia	Y	A2	25.4563	$1,065.93
49550	Rpr rem hernia, init, reduce	Y	A2	27.0024	$1,130.67
49553	Rpr fem hernia, init blocked	Y	A2	30.551	$1,279.26
49555	Rerepair fem hernia, reduce	Y	A2	27.0024	$1,130.67
49557	Rerepair fem hernia, blocked	Y	A2	30.551	$1,279.26
49560	Rpr ventral hern init, reduc	Y	A2	26.5059	$1,109.88
49561	Rpr ventral hern init, block	Y	A2	30.551	$1,279.26
49565	Rerepair ventrl hern, reduce	Y	A2	26.5059	$1,109.88
49566	Rerepair ventrl hern, block	Y	A2	30.551	$1,279.26
49568	Hernia repair w/mesh	Y	A2	28.5884	$1,197.08
49570	Rpr epigastric hern, reduce	Y	A2	26.5059	$1,109.88
49572	Rpr epigastric hern, blocked	Y	A2	30.551	$1,279.26
49580	Rpr umbil hern, reduc < 5 yr	Y	A2	26.5059	$1,109.88
49582	Rpr umbil hern, block < 5 yr	Y	A2	30.551	$1,279.26
49585	Rpr umbil hern, reduc > 5 yr	Y	A2	26.5059	$1,109.88
49587	Rpr umbil hern, block > 5 yr	Y	A2	30.551	$1,279.26
49590	Repair spigelian hernia	Y	A2	25.8214	$1,081.22
49600	Repair umbilical lesion	Y	A2	26.5059	$1,109.88
49650	Lap ing hernia repair init	Y	A2	37.1645	$1,556.19
49651	Lap ing hernia repair recur	Y	A2	39.247	$1,643.39
49652	Lap vent/abd hernia repair	Y	G2	69.7189	$2,919.34
49653	Lap vent/abd hern proc comp	Y	G2	69.7189	$2,919.34
49654	Lap inc hernia repair	Y	G2	69.7189	$2,919.34
49655	Lap inc hern repair comp	Y	G2	69.7189	$2,919.34
49656	Lap inc hernia repair recur	Y	G2	69.7189	$2,919.34

49657	Lap inc hern recur comp	Y	G2	69.7189	$2,919.34
50080	Removal of kidney stone	Y	G2	44.6074	$1,867.85
50081	Removal of kidney stone	Y	G2	44.6074	$1,867.85
50200	Renal biopsy perq	Y	A2	8.8279	$369.65
50382	Change ureter stent, percut	Y	G2	24.3891	$1,021.24
50384	Remove ureter stent, percut	Y	G2	16.2781	$681.61
50385	Change stent via transureth	Y	G2	24.3891	$1,021.24
50386	Remove stent via transureth	Y	P2	6.8174	$285.46
50387	Change ext/int ureter stent	Y	G2	14.6305	$612.62
50389	Remove renal tube w/fluoro	Y	G2	6.8174	$285.46
50390	Drainage of kidney lesion	Y	A2	8.8279	$369.65
50391	Instll rx agnt into rnal tub	Y	P2	1.0471	$43.85
50392	Insert kidney drain	Y	A2	14.1084	$590.76
50393	Insert ureteral tube	Y	A2	20.1918	$845.49
50394	Injection for kidney x-ray	N	N1		
50395	Create passage to kidney	Y	A2	20.1918	$845.49
50396	Measure kidney pressure	Y	A2	2.1976	$92.02
50398	Change kidney tube	Y	A2	12.873	$539.03
50551	Kidney endoscopy	Y	A2	7.0131	$293.66
50553	Kidney endoscopy	Y	A2	20.1918	$845.49
50555	Kidney endoscopy & biopsy	Y	A2	7.0131	$293.66
50557	Kidney endoscopy & treatment	Y	A2	20.1918	$845.49
50561	Kidney endoscopy & treatment	Y	A2	20.1918	$845.49
50562	Renal scope w/tumor resect	Y	G2	6.8174	$285.46
50570	Kidney endoscopy	Y	G2	6.8174	$285.46
50572	Kidney endoscopy	Y	G2	6.8174	$285.46
50574	Kidney endoscopy & biopsy	Y	G2	6.8174	$285.46
50575	Kidney endoscopy	Y	G2	34.5936	$1,448.54
50576	Kidney endoscopy & treatment	Y	G2	16.2781	$681.61
50580	Kidney endoscopy & treatment	Y	G2	16.2781	$681.61
50590	Fragmenting of kidney stone	Y	G2	39.5261	$1,655.08

50592	Perc rf ablate renal tumor	Y	G2	49.0813	$2,055.18
50684	Injection for ureter x-ray	N	N1		
50686	Measure ureter pressure	Y	P2	1.0471	$43.85
50688	Change of ureter tube/stent	Y	A2	12.873	$539.03
50690	Injection for ureter x-ray	N	N1		
50727	Revise ureter	Y	G2	19.1352	$801.25
50947	Laparo new ureter/bladder	Y	A2	41.2096	$1,725.57
50948	Laparo new ureter/bladder	Y	A2	41.2096	$1,725.57
50951	Endoscopy of ureter	Y	A2	7.0131	$293.66
50953	Endoscopy of ureter	Y	A2	7.0131	$293.66
50955	Ureter endoscopy & biopsy	Y	A2	20.1918	$845.49
50957	Ureter endoscopy & treatment	Y	A2	20.1918	$845.49
50961	Ureter endoscopy & treatment	Y	A2	20.1918	$845.49
50970	Ureter endoscopy	Y	A2	7.0131	$293.66
50972	Ureter endoscopy & catheter	Y	A2	7.0131	$293.66
50974	Ureter endoscopy & biopsy	Y	A2	14.1084	$590.76
50976	Ureter endoscopy & treatment	Y	A2	14.1084	$590.76
50980	Ureter endoscopy & treatment	Y	A2	20.1918	$845.49
51020	Incise & treat bladder	Y	A2	21.8862	$916.44
51030	Incise & treat bladder	Y	A2	21.8862	$916.44
51040	Incise & drain bladder	Y	A2	21.8862	$916.44
51045	Incise bladder/drain ureter	Y	A2	7.3909	$309.48
51050	Removal of bladder stone	Y	A2	21.8862	$916.44
51065	Remove ureter calculus	Y	A2	21.8862	$916.44
51080	Drainage of bladder abscess	Y	A2	15.8083	$661.94
51100	Drain bladder by needle	Y	P3		$31.75
51101	Drain bladder by trocar/cath	Y	P2	1.0471	$43.85
51102	Drain bl w/cath insertion	Y	A2	16.2513	$680.49
51500	Removal of bladder cyst	Y	A2	26.5059	$1,109.88
51520	Removal of bladder lesion	Y	A2	21.8862	$916.44
51535	Repair of ureter lesion	Y	G2	24.3891	$1,021.24

51600	Injection for bladder x-ray	N	N1		
51605	Preparation for bladder xray	N	N1		
51610	Injection for bladder x-ray	N	N1		
51700	Irrigation of bladder	Y	P3		$52.68
51701	Insert bladder catheter	N	P2	0.6396	$26.78
51702	Insert temp bladder cath	N	P2	0.6396	$26.78
51703	Insert bladder cath, complex	Y	P2	1.0471	$43.85
51705	Change of bladder tube	Y	P3		$71.80
51710	Change of bladder tube	Y	A2	6.4684	$270.85
51715	Endoscopic injection/implant	Y	A2	25.3978	$1,063.48
51720	Treatment of bladder lesion	Y	P3		$57.73
51725	Simple cystometrogram	Y	P2	2.8872	$120.90
51726	Complex cystometrogram	Y	A2	3.3606	$140.72
51727	Cystometrogram w/up	Y	P2	2.8872	$120.90
51728	Cystometrogram w/vp	Y	P2	2.8872	$120.90
51729	Cystometrogram w/vp&up	Y	P2	2.8872	$120.90
51736	Urine flow measurement	Y	P3		$21.65
51741	Electro-uroflowmetry, first	Y	P3		$24.89
51772	Urethra pressure profile	N	D5		
51784	Anal/urinary muscle study	Y	P2	1.0471	$43.85
51785	Anal/urinary muscle study	Y	A2	1.8291	$76.59
51792	Urinary reflex study	Y	P2	1.0471	$43.85
51795	Urine voiding pressure study	N	D5		
51797	Intraabdominal pressure test	Y	P2	1.9297	$80.80
51798	Us urine capacity measure	N	P3		$18.40
51880	Repair of bladder opening	Y	A2	20.1918	$845.49
51992	Laparo sling operation	Y	A2	37.661	$1,576.98
52000	Cystoscopy	Y	A2	7.0131	$293.66
52001	Cystoscopy, removal of clots	Y	A2	14.4864	$606.59
52005	Cystoscopy & ureter catheter	Y	A2	20.8366	$872.49
52007	Cystoscopy and biopsy	Y	A2	20.8366	$872.49
52010	Cystoscopy & duct catheter	Y	A2	7.3909	$309.48
52204	Cystoscopy w/biopsy(s)	Y	A2	20.8366	$872.49
52214	Cystoscopy and treatment	Y	A2	20.8366	$872.49
52224	Cystoscopy and treatment	Y	A2	20.8366	$872.49
52234	Cystoscopy and treatment	Y	A2	20.8366	$872.49
52235	Cystoscopy and treatment	Y	A2	21.2017	$887.78
52240	Cystoscopy and treatment	Y	A2	21.2017	$887.78
52250	Cystoscopy and radiotracer	Y	A2	21.8862	$916.44
52260	Cystoscopy and treatment	Y	A2	14.7532	$617.76
52265	Cystoscopy and treatment	Y	P2	6.8174	$285.46
52270	Cystoscopy & revise urethra	Y	A2	14.7532	$617.76
52275	Cystoscopy & revise urethra	Y	A2	20.8366	$872.49
52276	Cystoscopy and treatment	Y	A2	21.2017	$887.78
52277	Cystoscopy and treatment	Y	A2	20.8366	$872.49
52281	Cystoscopy and treatment	Y	A2	14.7532	$617.76
52282	Cystoscopy, implant stent	Y	A2	33.5846	$1,406.29
52283	Cystoscopy and treatment	Y	A2	20.8366	$872.49
52285	Cystoscopy and treatment	Y	A2	14.7532	$617.76
52290	Cystoscopy and treatment	Y	A2	20.8366	$872.49
52300	Cystoscopy and treatment	Y	A2	20.8366	$872.49
52301	Cystoscopy and treatment	Y	A2	21.2017	$887.78
52305	Cystoscopy and treatment	Y	A2	20.8366	$872.49
52310	Cystoscopy and treatment	Y	A2	14.4864	$606.59
52315	Cystoscopy and treatment	Y	A2	20.8366	$872.49
52317	Remove bladder stone	Y	A2	20.1918	$845.49
52318	Remove bladder stone	Y	A2	20.8366	$872.49
52320	Cystoscopy and treatment	Y	A2	22.3827	$937.23
52325	Cystoscopy, stone removal	Y	A2	21.8862	$916.44
52327	Cystoscopy, inject material	Y	A2	28.4897	$1,192.95
52330	Cystoscopy and treatment	Y	A2	20.8366	$872.49
52332	Cystoscopy and treatment	Y	A2	20.8366	$872.49

52334	Create passage to kidney	Y	A2	21.2017	$887.78
52341	Cysto w/ureter stricture tx	Y	A2	21.2017	$887.78
52342	Cysto w/up stricture tx	Y	A2	21.2017	$887.78
52343	Cysto w/renal stricture tx	Y	A2	21.2017	$887.78
52344	Cysto/uretero, stricture tx	Y	A2	21.2017	$887.78
52345	Cysto/uretero w/up stricture	Y	A2	21.2017	$887.78
52346	Cystouretero w/renal strict	Y	A2	21.2017	$887.78
52351	Cystouretero & or pyeloscope	Y	A2	21.2017	$887.78
52352	Cystouretero w/stone remove	Y	A2	21.8862	$916.44
52353	Cystouretero w/lithotripsy	Y	A2	29.5396	$1,236.91
52354	Cystouretero w/biopsy	Y	A2	21.8862	$916.44
52355	Cystouretero w/excise tumor	Y	A2	21.8862	$916.44
52400	Cystouretero w/congen repr	Y	A2	21.2017	$887.78
52402	Cystourethro cut ejacul duct	Y	A2	21.2017	$887.78
52450	Incision of prostate	Y	A2	21.2017	$887.78
52500	Revision of bladder neck	Y	A2	21.2017	$887.78
52601	Prostatectomy (TURP)	Y	A2	29.5396	$1,236.91
52630	Remove prostate regrowth	Y	A2	28.4897	$1,192.95
52640	Relieve bladder contracture	Y	A2	20.8366	$872.49
52647	Laser surgery of prostate	Y	A2	41.095	$1,720.77
52648	Laser surgery of prostate	Y	A2	41.095	$1,720.77
52700	Drainage of prostate abscess	Y	A2	20.8366	$872.49
53000	Incision of urethra	Y	A2	16.4758	$689.89
53010	Incision of urethra	Y	A2	16.4758	$689.89
53020	Incision of urethra	Y	A2	16.4758	$689.89
53025	Incision of urethra	Y	R2	19.4344	$813.78
53040	Drainage of urethra abscess	Y	A2	17.1203	$716.88
53060	Drainage of urethra abscess	Y	P3		$74.32
53080	Drainage of urinary leakage	Y	A2	17.4855	$732.17
53085	Drainage of urinary leakage	Y	G2	19.4344	$813.78
53200	Biopsy of urethra	Y	A2	16.4758	$689.89

53210	Removal of urethra	Y	A2	26.5787	$1,112.93
53215	Removal of urethra	Y	A2	18.6667	$781.63
53220	Treatment of urethra lesion	Y	A2	25.0326	$1,048.19
53230	Removal of urethra lesion	Y	A2	25.0326	$1,048.19
53235	Removal of urethra lesion	Y	A2	17.4855	$732.17
53240	Surgery for urethra pouch	Y	A2	25.0326	$1,048.19
53250	Removal of urethra gland	Y	A2	17.1203	$716.88
53260	Treatment of urethra lesion	Y	A2	17.1203	$716.88
53265	Treatment of urethra lesion	Y	A2	17.1203	$716.88
53270	Removal of urethra gland	Y	A2	17.1203	$716.88
53275	Repair of urethra defect	Y	A2	17.1203	$716.88
53400	Revise urethra, stage 1	Y	A2	25.3978	$1,063.48
53405	Revise urethra, stage 2	Y	A2	25.0326	$1,048.19
53410	Reconstruction of urethra	Y	A2	25.0326	$1,048.19
53420	Reconstruct urethra, stage 1	Y	A2	25.3978	$1,063.48
53425	Reconstruct urethra, stage 2	Y	A2	25.0326	$1,048.19
53430	Reconstruction of urethra	Y	A2	25.0326	$1,048.19
53431	Reconstruct urethra/bladder	Y	A2	25.0326	$1,048.19
53440	Male sling procedure	N	H8	124.4902	$5,212.78
53442	Remove/revise male sling	Y	A2	24.3878	$1,021.19
53444	Insert tandem cuff	N	H8	124.4902	$5,212.78
53445	Insert uro/ves nck sphincter	N	H8	222.7139	$9,325.70
53446	Remove uro sphincter	Y	A2	24.3878	$1,021.19
53447	Remove/replace ur sphincter	N	H8	222.7139	$9,325.70
53449	Repair uro sphincter	Y	A2	24.3878	$1,021.19
53450	Revision of urethra	Y	A2	24.3878	$1,021.19
53460	Revision of urethra	Y	A2	16.4758	$689.89
53502	Repair of urethra injury	Y	A2	17.1203	$716.88
53505	Repair of urethra injury	Y	A2	25.0326	$1,048.19
53510	Repair of urethra injury	Y	A2	17.1203	$716.88
53515	Repair of urethra injury	Y	A2	25.0326	$1,048.19

53520	Repair of urethra defect	Y	A2	25.0326	$1,048.19
53600	Dilate urethra stricture	Y	P3		$40.41
53601	Dilate urethra stricture	Y	P2	1.0471	$43.85
53605	Dilate urethra stricture	Y	A2	14.7532	$617.76
53620	Dilate urethra stricture	Y	P3		$61.70
53621	Dilate urethra stricture	Y	P3		$64.58
53660	Dilation of urethra	Y	P2	1.0471	$43.85
53661	Dilation of urethra	Y	P2	1.0471	$43.85
53665	Dilation of urethra	Y	A2	16.4758	$689.89
53850	Prostatic microwave thermotx	Y	P2	44.6074	$1,867.85
53852	Prostatic rf thermotx	Y	P2	44.6074	$1,867.85
53855	Insert prost urethral stent	Y	P2	1.9297	$80.80
54000	Slitting of prepuce	Y	A2	17.1203	$716.88
54001	Slitting of prepuce	Y	A2	17.1203	$716.88
54015	Drain penis lesion	Y	A2	17.5029	$732.90
54050	Destruction, penis lesion(s)	Y	P2	0.8399	$35.17
54055	Destruction, penis lesion(s)	Y	P3		$67.47
54056	Cryosurgery, penis lesion(s)	Y	P2	0.8399	$35.17
54057	Laser surg, penis lesion(s)	Y	A2	17.1406	$717.73
54060	Excision of penis lesion(s)	Y	A2	17.1406	$717.73
54065	Destruction, penis lesion(s)	Y	A2	17.1406	$717.73
54100	Biopsy of penis	Y	A2	14.4403	$604.66
54105	Biopsy of penis	Y	A2	18.6621	$781.44
54110	Treatment of penis lesion	Y	A2	27.5459	$1,153.43
54111	Treat penis lesion, graft	Y	A2	27.5459	$1,153.43
54112	Treat penis lesion, graft	Y	A2	27.5459	$1,153.43
54115	Treatment of penis lesion	Y	A2	15.8083	$661.94
54120	Partial removal of penis	Y	A2	27.5459	$1,153.43
54150	Circumcision w/regionl block	Y	A2	18.5874	$778.31
54160	Circumcision, neonate	Y	A2	19.232	$805.30
54161	Circum 28 days or older	Y	A2	19.232	$805.30

54162	Lysis penil circumic lesion	Y	A2	19.232	$805.30
54163	Repair of circumcision	Y	A2	19.232	$805.30
54164	Frenulotomy of penis	Y	A2	19.232	$805.30
54200	Treatment of penis lesion	Y	P3		$68.55
54205	Treatment of penis lesion	Y	A2	28.5958	$1,197.39
54220	Treatment of penis lesion	Y	A2	2.1976	$92.02
54230	Prepare penis study	N	N1		
54231	Dynamic cavernosometry	Y	P3		$64.58
54235	Penile injection	Y	P3		$46.18
54240	Penis study	Y	P3		$32.83
54250	Penis study	Y	P3		$11.55
54300	Revision of penis	Y	A2	27.9111	$1,168.72
54304	Revision of penis	Y	A2	27.9111	$1,168.72
54308	Reconstruction of urethra	Y	A2	27.9111	$1,168.72
54312	Reconstruction of urethra	Y	A2	27.9111	$1,168.72
54316	Reconstruction of urethra	Y	A2	27.9111	$1,168.72
54318	Reconstruction of urethra	Y	A2	27.9111	$1,168.72
54322	Reconstruction of urethra	Y	A2	27.9111	$1,168.72
54324	Reconstruction of urethra	Y	A2	27.9111	$1,168.72
54326	Reconstruction of urethra	Y	A2	27.9111	$1,168.72
54328	Revise penis/urethra	Y	A2	27.9111	$1,168.72
54340	Secondary urethral surgery	Y	A2	27.9111	$1,168.72
54344	Secondary urethral surgery	Y	A2	27.9111	$1,168.72
54348	Secondary urethral surgery	Y	A2	27.9111	$1,168.72
54352	Reconstruct urethra/penis	Y	A2	27.9111	$1,168.72
54360	Penis plastic surgery	Y	A2	27.9111	$1,168.72
54380	Repair penis	Y	A2	27.9111	$1,168.72
54385	Repair penis	Y	A2	27.9111	$1,168.72
54400	Insert semi-rigid prosthesis	N	H8	124.8554	$5,228.07
54401	Insert self-contd prosthesis	N	H8	223.7236	$9,367.98
54405	Insert multi-comp penis pros	N	H8	223.7236	$9,367.98

54406	Remove muti-comp penis pros	Y	A2	27.9111	$1,168.72
54408	Repair multi-comp penis pros	Y	A2	27.9111	$1,168.72
54410	Remove/replace penis prosth	N	H8	223.7236	$9,367.98
54415	Remove self-contd penis pros	Y	A2	27.9111	$1,168.72
54416	Remv/repl penis contain pros	N	H8	223.7236	$9,367.98
54420	Revision of penis	Y	A2	28.5958	$1,197.39
54435	Revision of penis	Y	A2	28.5958	$1,197.39
54440	Repair of penis	Y	A2	28.5958	$1,197.39
54450	Preputial stretching	Y	A2	3.3606	$140.72
54500	Biopsy of testis	Y	A2	13.0089	$544.72
54505	Biopsy of testis	Y	A2	18.5874	$778.31
54512	Excise lesion testis	Y	A2	19.232	$805.30
54520	Removal of testis	Y	A2	19.5971	$820.59
54522	Orchiectomy, partial	Y	A2	19.5971	$820.59
54530	Removal of testis	Y	A2	26.5059	$1,109.88
54550	Exploration for testis	Y	A2	26.5059	$1,109.88
54560	Exploration for testis	Y	G2	22.25	$931.67
54600	Reduce testis torsion	Y	A2	20.2818	$849.26
54620	Suspension of testis	Y	A2	19.5971	$820.59
54640	Suspension of testis	Y	A2	26.5059	$1,109.88
54660	Revision of testis	Y	A2	19.232	$805.30
54670	Repair testis injury	Y	A2	19.5971	$820.59
54680	Relocation of testis(es)	Y	A2	19.5971	$820.59
54690	Laparoscopy, orchiectomy	Y	A2	41.2096	$1,725.57
54692	Laparoscopy, orchiopexy	Y	G2	69.7189	$2,919.34
54700	Drainage of scrotum	Y	A2	19.232	$805.30
54800	Biopsy of epididymis	Y	A2	4.0217	$168.40
54830	Remove epididymis lesion	Y	A2	19.5971	$820.59
54840	Remove epididymis lesion	Y	A2	20.2818	$849.26
54860	Removal of epididymis	Y	A2	19.5971	$820.59
54861	Removal of epididymis	Y	A2	20.2818	$849.26

54865	Explore epididymis	Y	A2	18.5874	$778.31
54900	Fusion of spermatic ducts	Y	A2	20.2818	$849.26
54901	Fusion of spermatic ducts	Y	A2	20.2818	$849.26
55000	Drainage of hydrocele	Y	P3		$66.75
55040	Removal of hydrocele	Y	A2	25.8214	$1,081.22
55041	Removal of hydroceles	Y	A2	27.0024	$1,130.67
55060	Repair of hydrocele	Y	A2	20.2818	$849.26
55100	Drainage of scrotum abscess	Y	A2	10.9457	$458.33
55110	Explore scrotum	Y	A2	19.232	$805.30
55120	Removal of scrotum lesion	Y	A2	19.232	$805.30
55150	Removal of scrotum	Y	A2	18.5874	$778.31
55175	Revision of scrotum	Y	A2	18.5874	$778.31
55180	Revision of scrotum	Y	A2	19.232	$805.30
55200	Incision of sperm duct	Y	A2	19.232	$805.30
55250	Removal of sperm duct(s)	Y	A2	19.232	$805.30
55300	Prepare, sperm duct x-ray	N	N1		
55400	Repair of sperm duct	Y	A2	18.5874	$778.31
55450	Ligation of sperm duct	Y	P3		$211.42
55500	Removal of hydrocele	Y	A2	19.5971	$820.59
55520	Removal of sperm cord lesion	Y	A2	20.2818	$849.26
55530	Revise spermatic cord veins	Y	A2	20.2818	$849.26
55535	Revise spermatic cord veins	Y	A2	26.5059	$1,109.88
55540	Revise hernia & sperm veins	Y	A2	27.0024	$1,130.67
55550	Laparo ligate spermatic vein	Y	A2	41.2096	$1,725.57
55600	Incise sperm duct pouch	Y	R2	22.25	$931.67
55680	Remove sperm pouch lesion	Y	A2	18.5874	$778.31
55700	Biopsy of prostate	Y	A2	10.8827	$455.69
55705	Biopsy of prostate	Y	A2	10.8827	$455.69
55706	Prostate saturation sampling	Y	G2	11.8794	$497.43
55720	Drainage of prostate abscess	Y	A2	20.1918	$845.49
55725	Drainage of prostate abscess	Y	A2	20.8366	$872.49

55860	Surgical exposure, prostate	Y	G2	19.1352	$801.25
55870	Electroejaculation	Y	P3		$80.10
55873	Cryoablate prostate	Y	H8	146.3234	$6,127.00
55875	Transperi needle place, pros	N	A2	33.5846	$1,406.29
55876	Place rt device/marker, pros	N	P3		$72.88
55920	Place needles pelvic for rt	Y	G2	25.9785	$1,087.80
56405	I & D of vulva/perineum	Y	P3		$45.10
56420	Drainage of gland abscess	Y	P2	1.4599	$61.13
56440	Surgery for vulva lesion	Y	A2	16.9109	$708.11
56441	Lysis of labial lesion(s)	Y	A2	16.2661	$681.11
56442	Hymenotomy	Y	A2	16.2661	$681.11
56501	Destroy, vulva lesions, sim	Y	P3		$61.33
56515	Destroy vulva lesion/s compl	Y	A2	18.1504	$760.01
56605	Biopsy of vulva/perineum	Y	P3		$35.36
56606	Biopsy of vulva/perineum	Y	P3		$14.43
56620	Partial removal of vulva	Y	A2	18.457	$772.85
56625	Complete removal of vulva	Y	A2	20.0432	$839.27
56700	Partial removal of hymen	Y	A2	16.2661	$681.11
56740	Remove vagina gland lesion	Y	A2	17.276	$723.40
56800	Repair of vagina	Y	A2	17.276	$723.40
56805	Repair clitoris	Y	G2	19.1552	$802.09
56810	Repair of perineum	Y	A2	18.457	$772.85
56820	Exam of vulva w/scope	Y	P3		$45.82
56821	Exam/biopsy of vulva w/scope	Y	P3		$59.17
57000	Exploration of vagina	Y	A2	16.2661	$681.11
57010	Drainage of pelvic abscess	Y	A2	16.9109	$708.11
57020	Drainage of pelvic fluid	Y	A2	7.2054	$301.71
57022	I & d vaginal hematoma, pp	Y	R2	12.0613	$505.04
57023	I & d vag hematoma, non-ob	Y	A2	15.8083	$661.94
57061	Destroy vag lesions, simple	Y	P3		$56.64
57065	Destroy vag lesions, complex	Y	A2	16.2661	$681.11

57100	Biopsy of vagina	Y	P3		$36.44
57105	Biopsy of vagina	Y	A2	16.9109	$708.11
57130	Remove vagina lesion	Y	A2	16.9109	$708.11
57135	Remove vagina lesion	Y	A2	16.9109	$708.11
57150	Treat vagina infection	Y	P3		$25.26
57155	Insert uteri tandems/ovoids	Y	A2	7.2054	$301.71
57160	Insert pessary/other device	Y	P3		$37.88
57170	Fitting of diaphragm/cap	Y	P2	0.1261	$5.28
57180	Treat vaginal bleeding	Y	A2	2.1107	$88.38
57200	Repair of vagina	Y	A2	16.2661	$681.11
57210	Repair vagina/perineum	Y	A2	16.9109	$708.11
57220	Revision of urethra	Y	A2	35.1537	$1,471.99
57230	Repair of urethral lesion	Y	A2	28.1852	$1,180.20
57240	Repair bladder & vagina	Y	A2	29.3662	$1,229.65
57250	Repair rectum & vagina	Y	A2	29.3662	$1,229.65
57260	Repair of vagina	Y	A2	29.3662	$1,229.65
57265	Extensive repair of vagina	Y	A2	37.9209	$1,587.86
57267	Insert mesh/pelvic flr addon	Y	A2	30.9524	$1,296.07
57268	Repair of bowel bulge	Y	A2	28.1852	$1,180.20
57287	Revise/remove sling repair	Y	G2	33.7008	$1,411.15
57288	Repair bladder defect	Y	A2	36.3346	$1,521.44
57289	Repair bladder & vagina	Y	A2	29.3662	$1,229.65
57291	Construction of vagina	Y	A2	29.3662	$1,229.65
57295	Revise vag graft via vagina	Y	G2	19.1552	$802.09
57300	Repair rectum-vagina fistula	Y	A2	28.1852	$1,180.20
57320	Repair bladder-vagina lesion	Y	G2	33.7008	$1,411.15
57400	Dilation of vagina	Y	A2	16.9109	$708.11
57410	Pelvic examination	Y	A2	16.9109	$708.11
57415	Remove vaginal foreign body	Y	A2	16.9109	$708.11
57420	Exam of vagina w/scope	Y	P3		$47.26
57421	Exam/biopsy of vag w/scope	Y	P3		$61.70

57426	Revise prosth vag graft lap	Y	G2	19.1552	$802.09
57452	Exam of cervix w/scope	Y	P3		$44.38
57454	Bx/curett of cervix w/scope	Y	P3		$54.84
57455	Biopsy of cervix w/scope	Y	P3		$57.73
57456	Endocerv curettage w/scope	Y	P3		$55.92
57460	Bx of cervix w/scope, leep	Y	P3		$165.96
57461	Conz of cervix w/scope, leep	Y	P3		$177.15
57500	Biopsy of cervix	Y	P3		$76.49
57505	Endocervical curettage	Y	P3		$49.43
57510	Cauterization of cervix	Y	P3		$50.87
57511	Cryocautery of cervix	Y	P2	1.4599	$61.13
57513	Laser surgery of cervix	Y	A2	16.9109	$708.11
57520	Conization of cervix	Y	A2	16.9109	$708.11
57522	Conization of cervix	Y	A2	16.9109	$708.11
57530	Removal of cervix	Y	A2	28.1852	$1,180.20
57550	Removal of residual cervix	Y	A2	28.1852	$1,180.20
57556	Remove cervix, repair bowel	Y	A2	36.3346	$1,521.44
57558	D&c of cervical stump	Y	A2	17.276	$723.40
57700	Revision of cervix	Y	A2	16.2661	$681.11
57720	Revision of cervix	Y	A2	17.276	$723.40
57800	Dilation of cervical canal	Y	P3		$26.70
58100	Biopsy of uterus lining	Y	P3		$44.02
58110	Bx done w/colposcopy add-on	N	N1		
58120	Dilation and curettage	Y	A2	16.9109	$708.11
58145	Myomectomy vag method	Y	A2	29.3662	$1,229.65
58301	Remove intrauterine device	Y	P3		$41.13
58321	Artificial insemination	Y	P3		$38.60
58322	Artificial insemination	Y	P3		$39.33
58323	Sperm washing	Y	P3		$8.30
58340	Catheter for hysterography	N	N1		
58345	Reopen fallopian tube	Y	R2	19.1552	$802.09

58346	Insert heyman uteri capsule	Y	A2	16.9109	$708.11
58350	Reopen fallopian tube	Y	A2	28.1852	$1,180.20
58353	Endometr ablate, thermal	Y	A2	30.9524	$1,296.07
58356	Endometrial cryoablation	Y	P3		$1,649.90
58545	Laparoscopic myomectomy	Y	A2	34.9127	$1,461.90
58546	Laparo-myomectomy, complex	Y	A2	41.2096	$1,725.57
58550	Laparo-asst vag hysterectomy	Y	A2	59.9286	$2,509.39
58552	Laparo-vag hyst incl t/o	Y	G2	44.7603	$1,874.25
58555	Hysteroscopy, dx, sep proc	Y	A2	18.0921	$757.57
58558	Hysteroscopy, biopsy	Y	A2	19.1018	$799.85
58559	Hysteroscopy, lysis	Y	A2	18.7367	$784.56
58560	Hysteroscopy, resect septum	Y	A2	29.5852	$1,238.82
58561	Hysteroscopy, remove myoma	Y	A2	29.5852	$1,238.82
58562	Hysteroscopy, remove fb	Y	A2	19.1018	$799.85
58563	Hysteroscopy, ablation	Y	A2	34.315	$1,436.87
58565	Hysteroscopy, sterilization	Y	A2	39.8835	$1,670.04
58600	Division of fallopian tube	Y	G2	33.7008	$1,411.15
58615	Occlude fallopian tube(s)	Y	G2	19.1552	$802.09
58660	Laparoscopy, lysis	Y	A2	37.661	$1,576.98
58661	Laparoscopy, remove adnexa	Y	A2	37.661	$1,576.98
58662	Laparoscopy, excise lesions	Y	A2	37.661	$1,576.98
58670	Laparoscopy, tubal cautery	Y	A2	36.4801	$1,527.53
58671	Laparoscopy, tubal block	Y	A2	36.4801	$1,527.53
58672	Laparoscopy, fimbrioplasty	Y	A2	37.661	$1,576.98
58673	Laparoscopy, salpingostomy	Y	A2	37.661	$1,576.98
58800	Drainage of ovarian cyst(s)	Y	A2	17.276	$723.40
58805	Drainage of ovarian cyst(s)	Y	G2	33.7008	$1,411.15
58820	Drain ovary abscess, open	Y	A2	28.1852	$1,180.20
58900	Biopsy of ovary(s)	Y	A2	17.276	$723.40
58970	Retrieval of oocyte	Y	A2	3.8459	$161.04
58974	Transfer of embryo	Y	A2	3.8459	$161.04

58976	Transfer of embryo	Y	A2	3.8459	$161.04
59000	Amniocentesis, diagnostic	Y	P3		$65.66
59001	Amniocentesis, therapeutic	Y	R2	6.4932	$271.89
59012	Fetal cord puncture,prenatal	Y	G2	3.2572	$136.39
59015	Chorion biopsy	Y	P3		$54.84
59020	Fetal contract stress test	Y	P3		$28.50
59025	Fetal non-stress test	Y	P3		$15.15
59070	Transabdom amnioinfus w/us	Y	G2	1.4599	$61.13
59072	Umbilical cord occlud w/us	Y	G2	3.2572	$136.39
59076	Fetal shunt placement, w/us	Y	G2	3.2572	$136.39
59100	Remove uterus lesion	Y	R2	33.7008	$1,411.15
59150	Treat ectopic pregnancy	Y	G2	44.7603	$1,874.25
59151	Treat ectopic pregnancy	Y	G2	44.7603	$1,874.25
59160	D & c after delivery	Y	A2	17.276	$723.40
59200	Insert cervical dilator	Y	P3		$36.08
59300	Episiotomy or vaginal repair	Y	P3		$79.73
59320	Revision of cervix	Y	A2	16.2661	$681.11
59412	Antepartum manipulation	Y	G2	19.1552	$802.09
59414	Deliver placenta	Y	G2	19.1552	$802.09
59812	Treatment of miscarriage	Y	A2	18.457	$772.85
59820	Care of miscarriage	Y	A2	18.457	$772.85
59821	Treatment of miscarriage	Y	A2	18.457	$772.85
59840	Abortion	Y	A2	18.457	$772.85
59841	Abortion	Y	A2	18.457	$772.85
59866	Abortion (mpr)	Y	G2	3.2572	$136.39
59870	Evacuate mole of uterus	Y	A2	18.457	$772.85
59871	Remove cerclage suture	Y	A2	18.457	$772.85
60000	Drain thyroid/tongue cyst	Y	A2	7.3608	$308.22
60100	Biopsy of thyroid	Y	P3		$48.71
60200	Remove thyroid lesion	Y	A2	37.4879	$1,569.73
60210	Partial thyroid excision	Y	G2	46.5913	$1,950.92
60212	Partial thyroid excision	Y	G2	46.5913	$1,950.92
60220	Partial removal of thyroid	Y	G2	46.5913	$1,950.92
60225	Partial removal of thyroid	Y	G2	46.5913	$1,950.92
60280	Remove thyroid duct lesion	Y	A2	38.5377	$1,613.69
60281	Remove thyroid duct lesion	Y	A2	38.5377	$1,613.69
60300	Aspir/inj thyroid cyst	Y	P3		$66.02
61000	Remove cranial cavity fluid	Y	R2	6.8805	$288.11
61001	Remove cranial cavity fluid	Y	R2	6.8805	$288.11
61020	Remove brain cavity fluid	Y	A2	6.209	$259.99
61026	Injection into brain canal	Y	A2	6.209	$259.99
61050	Remove brain canal fluid	Y	A2	6.209	$259.99
61055	Injection into brain canal	Y	A2	6.209	$259.99
61070	Brain canal shunt procedure	Y	A2	5.6172	$235.21
61215	Insert brain-fluid device	Y	A2	32.3151	$1,353.13
61330	Decompress eye socket	Y	G2	41.0743	$1,719.90
61334	Explore orbit/remove object	Y	G2	41.0743	$1,719.90
61770	Incise skull for treatment	Y	G2	35.6253	$1,491.74
61790	Treat trigeminal nerve	Y	A2	16.3263	$683.63
61791	Treat trigeminal tract	Y	A2	11.4998	$481.53
61795	Brain surgery using computer	N	N1		
61880	Revise/remove neuroelectrode	Y	G2	18.7662	$785.80
61885	Insrt/redo neurostim 1 array	N	H8	306.8087	$12,847.00
61886	Implant neurostim arrays	N	H8	415.2461	$17,387.60
61888	Revise/remove neuroreceiver	Y	A2	22.4431	$939.76
62160	Neuroendoscopy add-on	N	N1		
62194	Replace/irrigate catheter	Y	A2	7.0602	$295.63
62225	Replace/irrigate catheter	Y	A2	12.873	$539.03
62230	Replace/revise brain shunt	Y	A2	31.9499	$1,337.84
62252	Csf shunt reprogram	N	P3		$49.79
62263	Epidural lysis mult sessions	Y	A2	7.0602	$295.63
62264	Epidural lysis on single day	Y	A2	11.3918	$477.01

62267	Interdiscal perq aspir, dx	Y	G2	4.3949	$184.03
62268	Drain spinal cord cyst	Y	A2	6.209	$259.99
62269	Needle biopsy, spinal cord	Y	A2	8.8279	$369.65
62270	Spinal fluid tap, diagnostic	Y	A2	3.4607	$144.91
62272	Drain cerebro spinal fluid	Y	A2	3.4607	$144.91
62273	Inject epidural patch	Y	A2	4.5676	$191.26
62280	Treat spinal cord lesion	Y	A2	7.0602	$295.63
62281	Treat spinal cord lesion	Y	A2	7.0602	$295.63
62282	Treat spinal canal lesion	Y	A2	7.0602	$295.63
62284	Injection for myelogram	N	N1		
62287	Percutaneous diskectomy	Y	A2	34.3584	$1,438.69
62290	Inject for spine disk x-ray	N	N1		
62291	Inject for spine disk x-ray	N	N1		
62292	Injection into disk lesion	Y	R2	6.8805	$288.11
62294	Injection into spinal artery	Y	A2	6.209	$259.99
62310	Inject spine c/t	Y	A2	7.0602	$295.63
62311	Inject spine l/s (cd)	Y	A2	7.0602	$295.63
62318	Inject spine w/cath, c/t	Y	A2	7.0602	$295.63
62319	Inject spine w/cath l/s (cd)	Y	A2	7.0602	$295.63
62350	Implant spinal canal cath	Y	A2	31.9499	$1,337.84
62355	Remove spinal canal catheter	Y	A2	12.0364	$504.00
62360	Insert spine infusion device	Y	A2	31.9499	$1,337.84
62361	Implant spine infusion pump	Y	H8	290.962	$12,183.45
62362	Implant spine infusion pump	Y	H8	290.962	$12,183.45
62365	Remove spine infusion device	Y	A2	29.2635	$1,225.35
62367	Analyze spine infusion pump	N	P3		$18.76
62368	Analyze spine infusion pump	N	P3		$24.53
63600	Remove spinal cord lesion	Y	A2	15.9611	$668.34
63610	Stimulation of spinal cord	Y	A2	15.3166	$641.35
63615	Remove lesion of spinal cord	Y	R2	17.8888	$749.06
63650	Implant neuroelectrodes	N	H8	83.3143	$3,488.62

63655	Implant neuroelectrodes	N	J8	118.4379	$4,959.35
63660	Revise/remove neuroelectrode	N	D5		
63661	Remove spine eltrd perq aray	Y	G2	18.7662	$785.80
63662	Remove spine eltrd plate	Y	G2	18.7662	$785.80
63663	Revise spine eltrd perq aray	Y	G2	18.7662	$785.80
63664	Revise spine eltrd plate	Y	G2	18.7662	$785.80
63685	Insrt/redo spine n generator	N	H8	306.8087	$12,847.00
63688	Revise/remove neuroreceiver	Y	A2	22.4431	$939.76
63744	Revision of spinal shunt	Y	A2	32.3151	$1,353.13
63746	Removal of spinal shunt	Y	A2	12.0364	$504.00
64400	N block inj, trigeminal	Y	P3		$58.81
64402	N block inj, facial	Y	P3		$55.92
64405	N block inj, occipital	Y	P3		$48.35
64408	N block inj, vagus	Y	P3		$58.09
64410	N block inj, phrenic	Y	A2	7.0602	$295.63
64412	N block inj, spinal accessor	Y	P3		$87.67
64413	N block inj, cervical plexus	Y	P3		$54.12
64415	N block inj, brachial plexus	Y	A2	3.4607	$144.91
64416	N block cont infuse, b plex	Y	G2	6.8805	$288.11
64417	N block inj, axillary	Y	A2	3.4607	$144.91
64418	N block inj, suprascapular	Y	P3		$75.77
64420	N block inj, intercost, sng	Y	A2	3.4607	$144.91
64421	N block inj, intercost, mlt	Y	A2	7.0602	$295.63
64425	N block inj, ilio-ing/hypogi	Y	P3		$54.12
64430	N block inj, pudendal	Y	A2	5.9532	$249.28
64435	N block inj, paracervical	Y	P3		$75.41
64445	N block inj, sciatic, sng	Y	P3		$68.91
64446	N blk inj, sciatic, cont inf	Y	G2	6.8805	$288.11
64447	N block inj fem, single	Y	R2	3.5568	$148.93
64448	N block inj fem, cont inf	Y	G2	6.8805	$288.11
64449	N block inj, lumbar plexus	Y	G2	6.8805	$288.11

64450	N block, other peripheral	Y	P3		$47.26
64455*	N block inj, plantar digit	Y	P3		$19.84
64470	Inj paravertebral c/t	N	D5		
64472	Inj paravertebral c/t add-on	N	D5		
64475	Inj paravertebral l/s	N	D5		
64476	Inj paravertebral l/s add-on	N	D5		
64479	Inj foramen epidural c/t	Y	A2	7.0602	$295.63
64480	Inj foramen epidural add-on	Y	A2	4.5676	$191.26
64483	Inj foramen epidural l/s	Y	A2	7.0602	$295.63
64484	Inj foramen epidural add-on	Y	A2	4.5676	$191.26
64490	Inj paravert f jnt c/t 1 lev	Y	G2	6.8805	$288.11
64491	Inj paravert f jnt c/t 2 lev	Y	G2	2.4423	$102.27
64492	Inj paravert f jnt c/t 3 lev	Y	G2	2.4423	$102.27
64493	Inj paravert f jnt l/s 1 lev	Y	G2	6.8805	$288.11
64494	Inj paravert f jnt l/s 2 lev	Y	G2	2.4423	$102.27
64495	Inj paravert f jnt l/s 3 lev	Y	G2	2.4423	$102.27
64505	N block, spenopalatine gangl	Y	P3		$41.85
64508	N block, carotid sinus s/p	Y	P3		$94.89
64510	N block, stellate ganglion	Y	A2	7.0602	$295.63
64517	N block inj, hypogas plxs	Y	A2	5.9532	$249.28
64520	N block, lumbar/thoracic	Y	A2	7.0602	$295.63
64530	N block inj, celiac pelus	Y	A2	7.0602	$295.63
64553	Implant neuroelectrodes	N	H8	82.6695	$3,461.62
64555	Implant neuroelectrodes	N	J8	87.4193	$3,660.51
64560	Implant neuroelectrodes	N	J8	87.4193	$3,660.51
64561	Implant neuroelectrodes	N	H8	83.6795	$3,503.91
64565	Implant neuroelectrodes	N	J8	87.4193	$3,660.51
64573	Implant neuroelectrodes	N	H8	217.7062	$9,116.01
64575	Implant neuroelectrodes	N	H8	112.808	$4,723.61
64577	Implant neuroelectrodes	N	H8	112.808	$4,723.61
64580	Implant neuroelectrodes	N	H8	112.808	$4,723.61

64581	Implant neuroelectrodes	N	H8	113.818	$4,765.90
64585	Revise/remove neuroelectrode	Y	A2	15.9745	$668.90
64590	Insrt/redo pn/gastr stimul	N	H8	306.8087	$12,847.00
64595	Revise/rmv pn/gastr stimul	Y	A2	22.4431	$939.76
64600	Injection treatment of nerve	Y	A2	11.3918	$477.01
64605	Injection treatment of nerve	Y	A2	15.3166	$641.35
64610	Injection treatment of nerve	Y	A2	15.3166	$641.35
64612	Destroy nerve, face muscle	Y	P3		$69.63
64613	Destroy nerve, neck muscle	Y	P3		$66.02
64614	Destroy nerve, extrem musc	Y	P3		$75.04
64620	Injection treatment of nerve	Y	A2	7.0602	$295.63
64622	Destr paravertebrl nerve l/s	Y	A2	11.3918	$477.01
64623	Destr paravertebral n add-on	Y	A2	7.0602	$295.63
64626	Destr paravertebrl nerve c/t	Y	A2	7.0602	$295.63
64627	Destr paravertebral n add-on	Y	A2	3.7318	$156.26
64630	Injection treatment of nerve	Y	A2	7.1681	$300.15
64632*	N block inj, common digit	Y	P3		$36.08
64640	Injection treatment of nerve	Y	P3		$102.46
64650	Chemodenerv eccrine glands	Y	P3		$36.44
64653	Chemodenerv eccrine glands	Y	P3		$40.05
64680	Injection treatment of nerve	Y	A2	7.3907	$309.47
64681	Injection treatment of nerve	Y	A2	12.0364	$504.00
64702	Revise finger/toe nerve	Y	A2	15.3166	$641.35
64704	Revise hand/foot nerve	Y	A2	15.3166	$641.35
64708	Revise arm/leg nerve	Y	A2	15.9611	$668.34
64712	Revision of sciatic nerve	Y	A2	15.9611	$668.34
64713	Revision of arm nerve(s)	Y	A2	15.9611	$668.34
64714	Revise low back nerve(s)	Y	A2	15.9611	$668.34
64716	Revision of cranial nerve	Y	A2	16.3263	$683.63
64718	Revise ulnar nerve at elbow	Y	A2	15.9611	$668.34
64719	Revise ulnar nerve at wrist	Y	A2	15.9611	$668.34

64721	Carpal tunnel surgery	Y	A2	15.9611	$668.34
64722	Relieve pressure on nerve(s)	Y	A2	15.3166	$641.35
64726	Release foot/toe nerve	Y	A2	15.3166	$641.35
64727	Internal nerve revision	Y	A2	15.3166	$641.35
64732	Incision of brow nerve	Y	A2	15.9611	$668.34
64734	Incision of cheek nerve	Y	A2	15.9611	$668.34
64736	Incision of chin nerve	Y	A2	15.9611	$668.34
64738	Incision of jaw nerve	Y	A2	15.9611	$668.34
64740	Incision of tongue nerve	Y	A2	15.9611	$668.34
64742	Incision of facial nerve	Y	A2	15.9611	$668.34
64744	Incise nerve, back of head	Y	A2	15.9611	$668.34
64746	Incise diaphragm nerve	Y	A2	15.9611	$668.34
64761	Incision of pelvis nerve	Y	G2	17.8888	$749.06
64763	Incise hip/thigh nerve	Y	G2	17.8888	$749.06
64766	Incise hip/thigh nerve	Y	G2	35.6253	$1,491.74
64771	Sever cranial nerve	Y	A2	15.9611	$668.34
64772	Incision of spinal nerve	Y	A2	15.9611	$668.34
64774	Remove skin nerve lesion	Y	A2	15.9611	$668.34
64776	Remove digit nerve lesion	Y	A2	16.3263	$683.63
64778	Digit nerve surgery add-on	Y	A2	15.9611	$668.34
64782	Remove limb nerve lesion	Y	A2	16.3263	$683.63
64783	Limb nerve surgery add-on	Y	A2	15.9611	$668.34
64784	Remove nerve lesion	Y	A2	16.3263	$683.63
64786	Remove sciatic nerve lesion	Y	A2	29.6286	$1,240.64
64787	Implant nerve end	Y	A2	15.9611	$668.34
64788	Remove skin nerve lesion	Y	A2	16.3263	$683.63
64790	Removal of nerve lesion	Y	A2	16.3263	$683.63
64792	Removal of nerve lesion	Y	A2	29.6286	$1,240.64
64795	Biopsy of nerve	Y	A2	15.9611	$668.34
64802	Remove sympathetic nerves	Y	A2	15.9611	$668.34
64820	Remove sympathetic nerves	Y	G2	17.8888	$749.06

64821	Remove sympathetic nerves	Y	A2	23.8321	$997.92
64822	Remove sympathetic nerves	Y	G2	26.9839	$1,129.90
64823	Remove sympathetic nerves	Y	G2	26.9839	$1,129.90
64831	Repair of digit nerve	Y	A2	30.3133	$1,269.31
64832	Repair nerve add-on	Y	A2	28.6189	$1,198.36
64834	Repair of hand or foot nerve	Y	A2	29.2635	$1,225.35
64835	Repair of hand or foot nerve	Y	A2	29.6286	$1,240.64
64836	Repair of hand or foot nerve	Y	A2	29.6286	$1,240.64
64837	Repair nerve add-on	Y	A2	28.6189	$1,198.36
64840	Repair of leg nerve	Y	A2	29.2635	$1,225.35
64856	Repair/transpose nerve	Y	A2	29.2635	$1,225.35
64857	Repair arm/leg nerve	Y	A2	29.2635	$1,225.35
64858	Repair sciatic nerve	Y	A2	29.2635	$1,225.35
64859	Nerve surgery	Y	A2	28.6189	$1,198.36
64861	Repair of arm nerves	Y	A2	29.6286	$1,240.64
64862	Repair of low back nerves	Y	A2	29.6286	$1,240.64
64864	Repair of facial nerve	Y	A2	29.6286	$1,240.64
64865	Repair of facial nerve	Y	A2	30.3133	$1,269.31
64870	Fusion of facial/other nerve	Y	A2	30.3133	$1,269.31
64872	Subsequent repair of nerve	Y	A2	29.2635	$1,225.35
64874	Repair & revise nerve add-on	Y	A2	29.6286	$1,240.64
64876	Repair nerve/shorten bone	Y	A2	29.6286	$1,240.64
64885	Nerve graft, head or neck	Y	A2	29.2635	$1,225.35
64886	Nerve graft, head or neck	Y	A2	29.2635	$1,225.35
64890	Nerve graft, hand or foot	Y	A2	29.2635	$1,225.35
64891	Nerve graft, hand or foot	Y	A2	29.2635	$1,225.35
64892	Nerve graft, arm or leg	Y	A2	29.2635	$1,225.35
64893	Nerve graft, arm or leg	Y	A2	29.2635	$1,225.35
64895	Nerve graft, hand or foot	Y	A2	29.6286	$1,240.64
64896	Nerve graft, hand or foot	Y	A2	29.6286	$1,240.64
64897	Nerve graft, arm or leg	Y	A2	29.6286	$1,240.64

64898	Nerve graft, arm or leg	Y	A2	29.6286	$1,240.64
64901	Nerve graft add-on	Y	A2	29.2635	$1,225.35
64902	Nerve graft add-on	Y	A2	29.2635	$1,225.35
64905	Nerve pedicle transfer	Y	A2	29.2635	$1,225.35
64907	Nerve pedicle transfer	Y	A2	28.6189	$1,198.36
64910	Nerve repair w/allograft	Y	G2	35.6253	$1,491.74
65091	Revise eye	Y	A2	30.8693	$1,292.59
65093	Revise eye with implant	Y	A2	30.8693	$1,292.59
65101	Removal of eye	Y	A2	30.8693	$1,292.59
65103	Remove eye/insert implant	Y	A2	30.8693	$1,292.59
65105	Remove eye/attach implant	Y	A2	31.554	$1,321.26
65110	Removal of eye	Y	A2	32.0502	$1,342.04
65112	Remove eye/revise socket	Y	A2	33.6365	$1,408.46
65114	Remove eye/revise socket	Y	A2	33.6365	$1,408.46
65125	Revise ocular implant	Y	G2	25.6479	$1,073.95
65130	Insert ocular implant	Y	A2	22.1455	$927.30
65135	Insert ocular implant	Y	A2	21.7804	$912.01
65140	Attach ocular implant	Y	A2	30.8693	$1,292.59
65150	Revise ocular implant	Y	A2	21.7804	$912.01
65155	Reinsert ocular implant	Y	A2	30.8693	$1,292.59
65175	Removal of ocular implant	Y	A2	14.9137	$624.48
65205	Remove foreign body from eye	N	P3		$22.73
65210	Remove foreign body from eye	N	P3		$28.86
65220	Remove foreign body from eye	N	G2	0.9129	$38.23
65222	Remove foreign body from eye	N	P3		$31.75
65235	Remove foreign body from eye	Y	A2	14.1898	$594.17
65260	Remove foreign body from eye	Y	A2	7.1022	$297.39
65265	Remove foreign body from eye	Y	A2	18.4405	$772.16
65270	Repair of eye wound	Y	A2	15.5585	$651.48
65272	Repair of eye wound	Y	A2	20.0334	$838.86
65275	Repair of eye wound	Y	A2	21.0833	$882.82

65280	Repair of eye wound	Y	A2	18.4405	$772.16
65285	Repair of eye wound	Y	A2	32.2368	$1,349.85
65286	Repair of eye wound	Y	P2	4.3073	$180.36
65290	Repair of eye socket wound	Y	A2	19.7301	$826.16
65400	Removal of eye lesion	Y	A2	13.545	$567.17
65410	Biopsy of cornea	Y	A2	14.1898	$594.17
65420	Removal of eye lesion	Y	A2	14.1898	$594.17
65426	Removal of eye lesion	Y	A2	21.5798	$903.61
65430	Corneal smear	N	P2	0.9129	$38.23
65435	Curette/treat cornea	Y	P3		$35.00
65436	Curette/treat cornea	Y	P3		$155.14
65450	Treatment of corneal lesion	N	G2	1.8706	$78.33
65600	Revision of cornea	Y	P3		$180.40
65710	Corneal transplant	Y	A2	32.5809	$1,364.26
65730	Corneal transplant	Y	A2	32.5809	$1,364.26
65750	Corneal transplant	Y	A2	32.5809	$1,364.26
65755	Corneal transplant	Y	A2	32.5809	$1,364.26
65756	Corneal trnspl, endothelial	Y	G2	35.8721	$1,502.07
65757	Prep corneal endo allograft	N	N1		
65770	Revise cornea with implant	Y	H8	134.0489	$5,613.03
65772	Correction of astigmatism	Y	A2	15.2397	$638.13
65775	Correction of astigmatism	Y	A2	15.2397	$638.13
65780	Ocular reconst, transplant	Y	A2	30.9947	$1,297.84
65781	Ocular reconst, transplant	Y	A2	30.9947	$1,297.84
65782	Ocular reconst, transplant	Y	A2	30.9947	$1,297.84
65800	Drainage of eye	Y	A2	13.545	$567.17
65805	Drainage of eye	Y	A2	13.545	$567.17
65810	Drainage of eye	Y	A2	20.3986	$854.15
65815	Drainage of eye	Y	A2	20.0334	$838.86
65820	Relieve inner eye pressure	Y	A2	5.1303	$214.82
65850	Incision of eye	Y	A2	21.0833	$882.82

65855	Laser surgery of eye	Y	P3		$146.12
65860	Incise inner eye adhesions	Y	P3		$136.02
65865	Incise inner eye adhesions	Y	A2	13.545	$567.17
65870	Incise inner eye adhesions	Y	A2	21.0833	$882.82
65875	Incise inner eye adhesions	Y	A2	21.0833	$882.82
65880	Incise inner eye adhesions	Y	A2	15.2397	$638.13
65900	Remove eye lesion	Y	A2	15.7359	$658.91
65920	Remove implant of eye	Y	A2	23.1658	$970.02
65930	Remove blood clot from eye	Y	A2	21.5798	$903.61
66020	Injection treatment of eye	Y	A2	13.545	$567.17
66030	Injection treatment of eye	Y	A2	5.1303	$214.82
66130	Remove eye lesion	Y	A2	23.1658	$970.02
66150	Glaucoma surgery	Y	A2	21.0833	$882.82
66155	Glaucoma surgery	Y	A2	21.0833	$882.82
66160	Glaucoma surgery	Y	A2	20.0334	$838.86
66165	Glaucoma surgery	Y	A2	21.0833	$882.82
66170	Glaucoma surgery	Y	A2	21.0833	$882.82
66172	Incision of eye	Y	A2	21.0833	$882.82
66180	Implant eye shunt	Y	A2	34.1091	$1,428.25
66185	Revise eye shunt	Y	A2	20.0334	$838.86
66220	Repair eye lesion	Y	A2	31.5523	$1,321.19
66225	Repair/graft eye lesion	Y	A2	33.6126	$1,407.46
66250	Follow-up surgery of eye	Y	A2	14.1898	$594.17
66500	Incision of iris	Y	A2	5.1303	$214.82
66505	Incision of iris	Y	A2	5.1303	$214.82
66600	Remove iris and lesion	Y	A2	20.3986	$854.15
66605	Removal of iris	Y	A2	20.3986	$854.15
66625	Removal of iris	Y	A2	13.7731	$576.72
66630	Removal of iris	Y	A2	20.3986	$854.15
66635	Removal of iris	Y	A2	20.3986	$854.15
66680	Repair iris & ciliary body	Y	A2	20.3986	$854.15

66682	Repair iris & ciliary body	Y	A2	20.0334	$838.86
66700	Destruction, ciliary body	Y	A2	14.1898	$594.17
66710	Ciliary transsleral therapy	Y	A2	14.1898	$594.17
66711	Ciliary endoscopic ablation	Y	A2	14.1898	$594.17
66720	Destruction, ciliary body	Y	A2	14.1898	$594.17
66740	Destruction, ciliary body	Y	A2	20.0334	$838.86
66761	Revision of iris	Y	P3		$204.21
66762	Revision of iris	Y	P2	5.066	$212.13
66770	Removal of inner eye lesion	Y	P2	5.066	$212.13
66820	Incision, secondary cataract	Y	G2	4.3073	$180.36
66821	After cataract laser surgery	Y	A2	5.5824	$233.75
66825	Reposition intraocular lens	Y	A2	21.0833	$882.82
66830	Removal of lens lesion	Y	A2	5.3583	$224.37
66840	Removal of lens material	Y	A2	14.9244	$624.93
66850	Removal of lens material	Y	A2	27.4138	$1,147.90
66852	Removal of lens material	Y	A2	25.3314	$1,060.70
66920	Extraction of lens	Y	A2	25.3314	$1,060.70
66930	Extraction of lens	Y	A2	25.8276	$1,081.48
66940	Extraction of lens	Y	A2	15.4207	$645.71
66982	Cataract surgery, complex	Y	A2	22.9585	$961.34
66983	Cataract surg w/iol, 1 stage	Y	A2	22.9585	$961.34
66984	Cataract surg w/iol, 1 stage	Y	A2	22.9585	$961.34
66985	Insert lens prosthesis	Y	A2	22.1197	$926.22
66986	Exchange lens prosthesis	Y	A2	22.1197	$926.22
66990	Ophthalmic endoscope add-on	N	N1		
67005	Partial removal of eye fluid	Y	A2	18.4405	$772.16
67010	Partial removal of eye fluid	Y	A2	32.2368	$1,349.85
67015	Release of eye fluid	Y	A2	30.5424	$1,278.90
67025	Replace eye fluid	Y	A2	16.7461	$701.21
67027	Implant eye drug system	Y	A2	32.2368	$1,349.85
67028	Injection eye drug	Y	P3		$90.56

67030	Incise inner eye strands	Y	A2	16.7461	$701.21
67031	Laser surgery, eye strands	Y	A2	5.5824	$233.75
67036	Removal of inner eye fluid	Y	A2	32.2368	$1,349.85
67039	Laser treatment of retina	Y	A2	34.3193	$1,437.05
67040	Laser treatment of retina	Y	A2	34.3193	$1,437.05
67041	Vit for macular pucker	Y	G2	38.1899	$1,599.13
67042	Vit for macular hole	Y	G2	38.1899	$1,599.13
67043	Vit for membrane dissect	Y	G2	38.1899	$1,599.13
67101	Repair detached retina	Y	P3		$343.83
67105	Repair detached retina	Y	P2	5.066	$212.13
67107	Repair detached retina	Y	A2	32.7333	$1,370.64
67108	Repair detached retina	Y	A2	34.3193	$1,437.05
67110	Repair detached retina	Y	P3		$368.73
67112	Rerepair detached retina	Y	A2	34.3193	$1,437.05
67113	Repair retinal detach, cplx	Y	G2	38.1899	$1,599.13
67115	Release encircling material	Y	A2	17.3907	$728.20
67120	Remove eye implant material	Y	A2	17.3907	$728.20
67121	Remove eye implant material	Y	A2	17.3907	$728.20
67141	Treatment of retina	Y	A2	5.5718	$233.31
67145	Treatment of retina	Y	P2	5.066	$212.13
67208	Treatment of retinal lesion	Y	P2	5.5901	$234.07
67210	Treatment of retinal lesion	Y	P2	5.066	$212.13
67218	Treatment of retinal lesion	Y	A2	18.9368	$792.94
67220	Treatment of choroid lesion	Y	P2	5.5901	$234.07
67221	Ocular photodynamic ther	Y	P3		$127.36
67225	Eye photodynamic ther add-on	Y	P3		$9.02
67227	Treatment of retinal lesion	Y	A2	16.7461	$701.21
67228	Treatment of retinal lesion	Y	P2	5.066	$212.13
67229*	Tr retinal les preterm inf	Y	R2	5.066	$212.13
67250	Reinforce eye wall	Y	A2	15.9236	$666.77
67255	Reinforce/graft eye wall	Y	A2	17.7558	$743.49

67311	Revise eye muscle	Y	A2	19.7301	$826.16
67312	Revise two eye muscles	Y	A2	20.4148	$854.83
67314	Revise eye muscle	Y	A2	20.4148	$854.83
67316	Revise two eye muscles	Y	A2	20.4148	$854.83
67318	Revise eye muscle(s)	Y	A2	20.4148	$854.83
67320	Revise eye muscle(s) add-on	Y	A2	20.4148	$854.83
67331	Eye surgery follow-up add-on	Y	A2	20.4148	$854.83
67332	Rerevise eye muscles add-on	Y	A2	20.4148	$854.83
67334	Revise eye muscle w/suture	Y	A2	20.4148	$854.83
67335	Eye suture during surgery	Y	A2	20.4148	$854.83
67340	Revise eye muscle add-on	Y	A2	20.4148	$854.83
67343	Release eye tissue	Y	A2	22.4973	$942.03
67345	Destroy nerve of eye muscle	Y	P3		$90.92
67346	Biopsy, eye muscle	Y	A2	13.038	$545.94
67400	Explore/biopsy eye socket	Y	A2	15.9236	$666.77
67405	Explore/drain eye socket	Y	A2	22.8302	$955.97
67412	Explore/treat eye socket	Y	A2	17.1046	$716.22
67413	Explore/treat eye socket	Y	A2	23.3265	$976.75
67414	Explr/decompress eye socket	Y	G2	37.2794	$1,561.00
67415	Aspiration, orbital contents	Y	A2	14.9137	$624.48
67420	Explore/treat eye socket	Y	A2	32.0502	$1,342.04
67430	Explore/treat eye socket	Y	A2	32.0502	$1,342.04
67440	Explore/drain eye socket	Y	A2	32.0502	$1,342.04
67445	Explr/decompress eye socket	Y	A2	32.0502	$1,342.04
67450	Explore/biopsy eye socket	Y	A2	32.0502	$1,342.04
67500	Inject/treat eye socket	N	G2	1.8706	$78.33
67505	Inject/treat eye socket	Y	P3		$30.31
67515	Inject/treat eye socket	Y	P3		$31.03
67550	Insert eye socket implant	Y	A2	31.554	$1,321.26
67560	Revise eye socket implant	Y	A2	21.7804	$912.01
67570	Decompress optic nerve	Y	A2	31.554	$1,321.26

67700	Drainage of eyelid abscess	Y	P2	3.0834	$129.11
67710	Incision of eyelid	Y	P3		$151.89
67715	Incision of eyelid fold	Y	A2	14.9137	$624.48
67800	Remove eyelid lesion	Y	P3		$57.00
67801	Remove eyelid lesions	Y	P3		$69.27
67805	Remove eyelid lesions	Y	P3		$89.84
67808	Remove eyelid lesion(s)	Y	A2	15.5585	$651.48
67810	Biopsy of eyelid	Y	P2	3.0834	$129.11
67820	Revise eyelashes	N	P3		$18.76
67825	Revise eyelashes	Y	P3		$58.09
67830	Revise eyelashes	Y	A2	8.0216	$335.89
67835	Revise eyelashes	Y	A2	15.5585	$651.48
67840	Remove eyelid lesion	Y	P3		$160.91
67850	Treat eyelid lesion	Y	P3		$126.64
67875	Closure of eyelid by suture	Y	G2	7.3028	$305.79
67880	Revision of eyelid	Y	A2	14.555	$609.46
67882	Revision of eyelid	Y	A2	15.9236	$666.77
67900	Repair brow defect	Y	A2	22.8302	$955.97
67901	Repair eyelid defect	Y	A2	17.1046	$716.22
67902	Repair eyelid defect	Y	A2	23.3265	$976.75
67903	Repair eyelid defect	Y	A2	16.6081	$695.43
67904	Repair eyelid defect	Y	A2	16.6081	$695.43
67906	Repair eyelid defect	Y	A2	17.1046	$716.22
67908	Repair eyelid defect	Y	A2	16.6081	$695.43
67909	Revise eyelid defect	Y	A2	16.6081	$695.43
67911	Revise eyelid defect	Y	A2	15.9236	$666.77
67912	Correction eyelid w/implant	Y	A2	15.9236	$666.77
67914	Repair eyelid defect	Y	A2	15.9236	$666.77
67915	Repair eyelid defect	Y	P3		$180.03
67916	Repair eyelid defect	Y	A2	16.6081	$695.43
67917	Repair eyelid defect	Y	A2	16.6081	$695.43

67921	Repair eyelid defect	Y	A2	15.9236	$666.77
67922	Repair eyelid defect	Y	P3		$174.98
67923	Repair eyelid defect	Y	A2	16.6081	$695.43
67924	Repair eyelid defect	Y	A2	16.6081	$695.43
67930	Repair eyelid wound	Y	P3		$181.12
67935	Repair eyelid wound	Y	A2	15.5585	$651.48
67938	Remove eyelid foreign body	N	P2	1.8706	$78.33
67950	Revision of eyelid	Y	A2	15.5585	$651.48
67961	Revision of eyelid	Y	A2	15.9236	$666.77
67966	Revision of eyelid	Y	A2	15.9236	$666.77
67971	Reconstruction of eyelid	Y	A2	15.9236	$666.77
67973	Reconstruction of eyelid	Y	A2	22.1455	$927.30
67974	Reconstruction of eyelid	Y	A2	15.9236	$666.77
67975	Reconstruction of eyelid	Y	A2	15.9236	$666.77
68020	Incise/drain eyelid lining	Y	P3		$50.87
68040	Treatment of eyelid lesions	N	P3		$25.26
68100	Biopsy of eyelid lining	Y	P3		$97.05
68110	Remove eyelid lining lesion	Y	P3		$125.92
68115	Remove eyelid lining lesion	Y	A2	15.5585	$651.48
68130	Remove eyelid lining lesion	Y	A2	14.1898	$594.17
68135	Remove eyelid lining lesion	Y	P3		$65.30
68200	Treat eyelid by injection	N	P3		$18.40
68320	Revise/graft eyelid lining	Y	A2	22.8302	$955.97
68325	Revise/graft eyelid lining	Y	A2	22.8302	$955.97
68326	Revise/graft eyelid lining	Y	A2	16.6081	$695.43
68328	Revise/graft eyelid lining	Y	A2	22.8302	$955.97
68330	Revise eyelid lining	Y	A2	21.0833	$882.82
68335	Revise/graft eyelid lining	Y	A2	22.8302	$955.97
68340	Separate eyelid adhesions	Y	A2	16.6081	$695.43
68360	Revise eyelid lining	Y	A2	20.0334	$838.86
68362	Revise eyelid lining	Y	A2	20.0334	$838.86

68371	Harvest eye tissue, alograft	Y	A2	14.1898	$594.17
68400	Incise/drain tear gland	Y	P2	3.0834	$129.11
68420	Incise/drain tear sac	Y	P3		$187.61
68440	Incise tear duct opening	Y	P3		$54.84
68500	Removal of tear gland	Y	A2	22.1455	$927.30
68505	Partial removal, tear gland	Y	A2	22.1455	$927.30
68510	Biopsy of tear gland	Y	A2	14.9137	$624.48
68520	Removal of tear sac	Y	A2	22.1455	$927.30
68525	Biopsy of tear sac	Y	A2	14.9137	$624.48
68530	Clearance of tear duct	Y	P2	3.0834	$129.11
68540	Remove tear gland lesion	Y	A2	15.9236	$666.77
68550	Remove tear gland lesion	Y	A2	22.1455	$927.30
68700	Repair tear ducts	Y	A2	15.5585	$651.48
68705	Revise tear duct opening	Y	P2	3.0834	$129.11
68720	Create tear sac drain	Y	A2	22.8302	$955.97
68745	Create tear duct drain	Y	A2	22.8302	$955.97
68750	Create tear duct drain	Y	A2	22.8302	$955.97
68760	Close tear duct opening	Y	P3		$107.52
68761	Close tear duct opening	Y	P3		$74.68
68770	Close tear system fistula	Y	A2	22.8302	$955.97
68801	Dilate tear duct opening	N	P2	0.9129	$38.23
68810	Probe nasolacrimal duct	Y	A2	3.0647	$128.33
68811	Probe nasolacrimal duct	Y	A2	15.5585	$651.48
68815	Probe nasolacrimal duct	Y	A2	15.5585	$651.48
68816	Probe nl duct w/balloon	Y	G2	17.3518	$726.57
68840	Explore/irrigate tear ducts	N	P3		$59.89
68850	Injection for tear sac x-ray	N	N1		
69000	Drain external ear lesion	Y	P2	1.3911	$58.25
69005	Drain external ear lesion	Y	P3		$112.93
69020	Drain outer ear canal lesion	Y	P2	1.3911	$58.25
69100	Biopsy of external ear	Y	P3		$64.94
69105	Biopsy of external ear canal	Y	P3		$94.89
69110	Remove external ear, partial	Y	A2	14.4403	$604.66
69120	Removal of external ear	Y	A2	20.4361	$855.72
69140	Remove ear canal lesion(s)	Y	A2	20.4361	$855.72
69145	Remove ear canal lesion(s)	Y	A2	15.0849	$631.65
69150	Extensive ear canal surgery	Y	A2	8.109	$339.55
69200	Clear outer ear canal	N	P2	0.6396	$26.78
69205	Clear outer ear canal	Y	A2	18.6621	$781.44
69210	Remove impacted ear wax	N	P3		$22.73
69220	Clean out mastoid cavity	Y	P2	0.8399	$35.17
69222	Clean out mastoid cavity	Y	P3		$145.40
69300	Revise external ear	Y	A2	20.8012	$871.01
69310	Rebuild outer ear canal	Y	A2	33.7153	$1,411.76
69320	Rebuild outer ear canal	Y	A2	36.4825	$1,527.63
69400	Inflate middle ear canal	Y	P3		$98.86
69401	Inflate middle ear canal	Y	P3		$52.31
69405	Catheterize middle ear canal	Y	P3		$137.10
69420	Incision of eardrum	Y	P3		$121.59
69421	Incision of eardrum	Y	A2	15.2282	$637.65
69424	Remove ventilating tube	Y	P3		$84.79
69433	Create eardrum opening	Y	P3		$121.59
69436	Create eardrum opening	Y	A2	15.2282	$637.65
69440	Exploration of middle ear	Y	A2	20.8012	$871.01
69450	Eardrum revision	Y	A2	32.7056	$1,369.48
69501	Mastoidectomy	Y	A2	36.4825	$1,527.63
69502	Mastoidectomy	Y	A2	23.5684	$986.88
69505	Remove mastoid structures	Y	A2	36.4825	$1,527.63
69511	Extensive mastoid surgery	Y	A2	36.4825	$1,527.63
69530	Extensive mastoid surgery	Y	A2	36.4825	$1,527.63
69540	Remove ear lesion	Y	P3		$142.15
69550	Remove ear lesion	Y	A2	34.8965	$1,461.22

69552	Remove ear lesion	Y	A2	36.4825	$1,527.63
69601	Mastoid surgery revision	Y	A2	36.4825	$1,527.63
69602	Mastoid surgery revision	Y	A2	36.4825	$1,527.63
69603	Mastoid surgery revision	Y	A2	36.4825	$1,527.63
69604	Mastoid surgery revision	Y	A2	36.4825	$1,527.63
69605	Mastoid surgery revision	Y	A2	36.4825	$1,527.63
69610	Repair of eardrum	Y	P3		$191.22
69620	Repair of eardrum	Y	A2	20.4361	$855.72
69631	Repair eardrum structures	Y	A2	34.8965	$1,461.22
69632	Rebuild eardrum structures	Y	A2	34.8965	$1,461.22
69633	Rebuild eardrum structures	Y	A2	34.8965	$1,461.22
69635	Repair eardrum structures	Y	A2	36.4825	$1,527.63
69636	Rebuild eardrum structures	Y	A2	36.4825	$1,527.63
69637	Rebuild eardrum structures	Y	A2	36.4825	$1,527.63
69641	Revise middle ear & mastoid	Y	A2	36.4825	$1,527.63
69642	Revise middle ear & mastoid	Y	A2	36.4825	$1,527.63
69643	Revise middle ear & mastoid	Y	A2	36.4825	$1,527.63
69644	Revise middle ear & mastoid	Y	A2	36.4825	$1,527.63
69645	Revise middle ear & mastoid	Y	A2	36.4825	$1,527.63
69646	Revise middle ear & mastoid	Y	A2	36.4825	$1,527.63
69650	Release middle ear bone	Y	A2	23.5684	$986.88
69660	Revise middle ear bone	Y	A2	34.8965	$1,461.22
69661	Revise middle ear bone	Y	A2	34.8965	$1,461.22
69662	Revise middle ear bone	Y	A2	34.8965	$1,461.22
69666	Repair middle ear structures	Y	A2	34.4	$1,440.43
69667	Repair middle ear structures	Y	A2	34.4	$1,440.43
69670	Remove mastoid air cells	Y	A2	33.7153	$1,411.76
69676	Remove middle ear nerve	Y	A2	33.7153	$1,411.76
69700	Close mastoid fistula	Y	A2	33.7153	$1,411.76
69711	Remove/repair hearing aid	Y	A2	32.7056	$1,369.48
69714	Implant temple bone w/stimul	Y	H8	153.5323	$6,428.86
69715	Temple bne implnt w/stimulat	Y	H8	153.5323	$6,428.86
69717	Temple bone implant revision	Y	H8	153.5323	$6,428.86
69718	Revise temple bone implant	Y	H8	153.5323	$6,428.86
69720	Release facial nerve	Y	A2	34.8965	$1,461.22
69740	Repair facial nerve	Y	A2	34.8965	$1,461.22
69745	Repair facial nerve	Y	A2	34.8965	$1,461.22
69801	Incise inner ear	Y	A2	21.9824	$920.47
69802	Incise inner ear	Y	A2	23.5684	$986.88
69805	Explore inner ear	Y	A2	36.4825	$1,527.63
69806	Explore inner ear	Y	A2	36.4825	$1,527.63
69820	Establish inner ear window	Y	A2	34.8965	$1,461.22
69840	Revise inner ear window	Y	A2	34.8965	$1,461.22
69905	Remove inner ear	Y	A2	36.4825	$1,527.63
69910	Remove inner ear & mastoid	Y	A2	36.4825	$1,527.63
69915	Incise inner ear nerve	Y	A2	36.4825	$1,527.63
69930	Implant cochlear device	Y	H8	635.3299	$26,603.17
69990	Microsurgery add-on	N	N1		
C9716	Radiofrequency energy to anu	Y	G2	30.7524	$1,287.70
C9724	EPS gast cardia plic	Y	G2	23.1927	$971.15
C9725	Place endorectal app	Y	G2	5.1268	$214.67
C9726	Rxt breast appl place/remov	Y	G2	23.6526	$990.41
C9727	Insert palate implants	Y	G2	7.2813	$304.89
C9728	Place device/marker, non pro	N	R2	13.1468	$550.50
G0104	CA screen;flexi sigmoidscope	N	P3		$89.12
G0105	Colorectal scrn; hi risk ind	Y	A2	8.3436	$349.37
G0121	Colon ca scrn not hi rsk ind	Y	A2	8.3436	$349.37
G0127	Trim nail(s)	Y	P3		$12.99
G0186	Dstry eye lesn,fdr vssl tech	Y	R2	5.5901	$234.07
G0247	Routine footcare pt w lops	Y	P3		$23.45
G0259	Inject for sacroiliac joint	N	N1		
G0260	Inj for sacroiliac jt anesth	Y	A2	7.0602	$295.63

G0268	Removal of impacted wax md	N	N1		
G0269	Occlusive device in vein art	N	N1		
G0289	Arthro, loose body + chondro	N	N1		
G0364	Bone marrow aspirate &biopsy	N	P3		$5.77
G0392	AV fistula or graft arterial	N	D5		
G0393	AV fistula or graft venous	N	D5		

NOTE 1: The Medicare program payment is 80 percent of the total payment amount and beneficiary coinsurance is 20 percent of the total payment amount, except for screening flexible sigmoidoscopies and screening colonoscopies for which the program payment is 75 percent and the beneficiary coinsurance is 25 percent.

NOTE 2: Payment indicators for "office-based" procedures (P2, P3) are based on a comparison of the final rates according to the ASC standard ratesetting methodology and the MPFS. Under current law, the MPFS payment rates will have a zero percent update. For discussion of those rates, we refer readers to the CY 2010 MPFS final rule and correction notice.

*: Asterisked codes(*) indicate that the procedure's "office-based," designation is temporary because we have insufficient claims data. We will reconsider this designation when new claims data become available.

Addendum AA -- Revised ASC Covered Surgical Procedures for CY 2010 (Including Surgical Procedures for Which Payment is Packaged) to Reflect Retroactive Provisions of the Affordable Care Act and Technical Corrections to Medicare Physician Fee Schedule Payment Rates

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
0016T	Thermotx choroid vasc lesion	Y	R2	5.5901	$234.07
0017T	Photocoagulat macular drusen	Y	R2	5.5901	$234.07
0084T	Temp prostate urethral stent	N	D5		
0086T	L ventricle fill pressure	N	D5		
0099T*	Implant corneal ring	Y	R2	15.5271	$650.17
0100T	Prosth retina receive&gen	Y	G2	38.1899	$1,599.13
0101T	Extracorp shockwv tx,hi enrg	Y	G2	30.361	$1,271.31
0102T	Extracorp shockwv tx,anesth	Y	G2	30.361	$1,271.31
0123T	Scleral fistulization	Y	G2	23.3186	$976.42
0124T*	Conjunctival drug placement	Y	R2	4.3073	$180.36
0170T	Anorectal fistula plug rpr	N	D5		
0176T	Aqu canal dilat w/o retent	Y	A2	37.6577	$1,576.84
0177T	Aqu canal dilat w retent	Y	A2	37.6577	$1,576.84
0186T	Suprachoroidal drug delivery	Y	G2	19.7948	$828.87
0190T	Place intraoc radiation src	Y	G2	19.7948	$828.87
0191T	Insert ant segment drain int	Y	G2	23.3186	$976.42
0192T	Insert ant segment drain ext	Y	G2	40.0244	$1,675.94
0193T	Rf bladder neck microremodel	Y	G2	19.1352	$801.25
0200T	Perq sacral augmt unilat inj	Y	G2	21.0374	$880.90
0201T	Perq sacral augmt bilat inj	Y	G2	30.361	$1,271.31
0213T	Us facet jt inj cerv/t 1 lev	Y	G2	6.8805	$288.11
0214T	Us facet jt inj cerv/t 2 lev	Y	G2	2.4423	$102.27
0215T	Us facet jt inj cerv/t 3 lev	Y	G2	2.4423	$102.27
0216T	Us facet jt inj ls 1 level	Y	G2	6.8805	$288.11
0217T	Us facet jt inj ls 2 level	Y	G2	2.4423	$102.27
0218T	Us facet jt inj ls 3 level	Y	G2	2.4423	$102.27
10021	Fna w/o image	Y	P2	1.444	$60.46

10022	Fna w/image	Y	G2	4.3949	$184.03
10040	Acne surgery	Y	P2	0.8399	$35.17
10060	Drainage of skin abscess	Y	P3		$54.12
10061	Drainage of skin abscess	Y	P2	1.3911	$58.25
10080	Drainage of pilonidal cyst	Y	P2	1.3911	$58.25
10081	Drainage of pilonidal cyst	Y	P3		$137.46
10120	Remove foreign body	Y	P3		$75.04
10121	Remove foreign body	Y	A2	15.0849	$631.65
10140	Drainage of hematoma/fluid	Y	P3		$80.10
10160	Puncture drainage of lesion	Y	P2	1.3911	$58.25
10180	Complex drainage, wound	Y	A2	16.4531	$688.94
11000	Debride infected skin	Y	P3		$25.62
11001	Debride infected skin add-on	Y	P3		$8.66
11010	Debride skin, fx	Y	A2	4.5617	$191.01
11011	Debride skin/muscle, fx	Y	A2	4.5617	$191.01
11012	Debride skin/muscle/bone, fx	Y	A2	4.5617	$191.01
11040	Debride skin, partial	Y	P3		$23.45
11041	Debride skin, full	Y	P3		$25.98
11042	Debride skin/tissue	Y	A2	2.9437	$123.26
11043	Debride tissue/muscle	Y	A2	2.9437	$123.26
11044	Debride tissue/muscle/bone	Y	A2	8.2929	$347.25
11055	Trim skin lesion	Y	P3		$27.78
11056	Trim skin lesions, 2 to 4	Y	P3		$30.31
11057	Trim skin lesions, over 4	Y	P3		$33.91
11100	Biopsy, skin lesion	Y	P2	1.4728	$61.67
11101	Biopsy, skin add-on	Y	P3		$14.79
11200	Removal of skin tags	Y	P2	0.8399	$35.17
11201	Remove skin tags add-on	Y	P3		$6.13
11300	Shave skin lesion	Y	P2	0.8399	$35.17
11301	Shave skin lesion	Y	P2	0.8399	$35.17
11302	Shave skin lesion	Y	P2	0.8399	$35.17
11303	Shave skin lesion	Y	P2	1.4728	$61.67
11305	Shave skin lesion	Y	P2	0.8399	$35.17
11306	Shave skin lesion	Y	P2	0.8399	$35.17
11307	Shave skin lesion	Y	P2	0.8399	$35.17
11308	Shave skin lesion	Y	P2	0.8399	$35.17
11310	Shave skin lesion	Y	P2	0.8399	$35.17
11311	Shave skin lesion	Y	P2	0.8399	$35.17
11312	Shave skin lesion	Y	P2	0.8399	$35.17
11313	Shave skin lesion	Y	P2	0.8399	$35.17
11400	Exc tr-ext b9+marg 0.5 < cm	Y	P3		$71.44
11401	Exc tr-ext b9+marg 0.6-1 cm	Y	P3		$80.46
11402	Exc tr-ext b9+marg 1.1-2 cm	Y	P3		$88.39
11403	Exc tr-ext b9+marg 2.1-3 cm	Y	P3		$95.25
11404	Exc tr-ext b9+marg 3.1-4 cm	Y	A2	14.4403	$604.66
11406	Exc tr-ext b9+marg > 4.0 cm	Y	A2	15.0849	$631.65
11420	Exc h-f-nk-sp b9+marg 0.5 <	Y	P3		$67.47
11421	Exc h-f-nk-sp b9+marg 0.6-1	Y	P3		$81.54
11422	Exc h-f-nk-sp b9+marg 1.1-2	Y	P3		$89.12
11423	Exc h-f-nk-sp b9+marg 2.1-3	Y	P3		$99.22
11424	Exc h-f-nk-sp b9+marg 3.1-4	Y	A2	15.0849	$631.65
11426	Exc h-f-nk-sp b9+marg > 4 cm	Y	A2	19.307	$808.44
11440	Exc face-mm b9+marg 0.5 < cm	Y	P3		$76.49
11441	Exc face-mm b9+marg 0.6-1 cm	Y	P3		$88.75
11442	Exc face-mm b9+marg 1.1-2 cm	Y	P3		$97.77
11443	Exc face-mm b9+marg 2.1-3 cm	Y	P3		$108.60
11444	Exc face-mm b9+marg 3.1-4 cm	Y	A2	7.779	$325.73
11446	Exc face-mm b9+marg > 4 cm	Y	A2	19.307	$808.44
11450	Removal, sweat gland lesion	Y	A2	19.307	$808.44
11451	Removal, sweat gland lesion	Y	A2	19.307	$808.44
11462	Removal, sweat gland lesion	Y	A2	19.307	$808.44
11463	Removal, sweat gland lesion	Y	A2	19.307	$808.44

11470	Removal, sweat gland lesion	Y	A2	19.307	$808.44
11471	Removal, sweat gland lesion	Y	A2	19.307	$808.44
11600	Exc tr-ext mlg+marg 0.5 < cm	Y	P3		$101.74
11601	Exc tr-ext mlg+marg 0.6-1 cm	Y	P3		$121.95
11602	Exc tr-ext mlg+marg 1.1-2 cm	Y	P3		$133.85
11603	Exc tr-ext mlg+marg 2.1-3 cm	Y	P3		$142.87
11604	Exc tr-ext mlg+marg 3.1-4 cm	Y	A2	8.2667	$346.15
11606	Exc tr-ext mlg+marg > 4 cm	Y	A2	15.0849	$631.65
11620	Exc h-f-nk-sp mlg+marg 0.5 <	Y	P3		$104.63
11621	Exc h-f-nk-sp mlg+marg 0.6-1	Y	P3		$123.39
11622	Exc h-f-nk-sp mlg+marg 1.1-2	Y	P3		$136.74
11623	Exc h-f-nk-sp mlg+marg 2.1-3	Y	P3		$148.29
11624	Exc h-f-nk-sp mlg+marg 3.1-4	Y	A2	15.0849	$631.65
11626	Exc h-f-nk-sp mlg+mar > 4 cm	Y	A2	19.307	$808.44
11640	Exc face-mm malig+marg 0.5 <	Y	P3		$110.40
11641	Exc face-mm malig+marg 0.6-1	Y	P3		$129.16
11642	Exc face-mm malig+marg 1.1-2	Y	P3		$143.96
11643	Exc face-mm malig+marg 2.1-3	Y	P3		$156.22
11644	Exc face-mm malig+marg 3.1-4	Y	A2	15.0849	$631.65
11646	Exc face-mm mlg+marg > 4 cm	Y	A2	19.307	$808.44
11719	Trim nail(s)	Y	P3		$12.99
11720	Debride nail, 1-5	Y	P3		$15.87
11721	Debride nail, 6 or more	Y	P3		$19.12
11730	Removal of nail plate	Y	P2	0.8399	$35.17
11732	Remove nail plate, add-on	Y	P3		$19.12
11740	Drain blood from under nail	Y	P2	0.4239	$17.75
11750	Removal of nail bed	Y	P3		$102.83
11752	Remove nail bed/finger tip	Y	P3		$143.59
11755	Biopsy, nail unit	Y	P3		$70.72
11760	Repair of nail bed	Y	G2	1.2941	$54.19
11762	Reconstruction of nail bed	Y	P3		$132.41

11765	Excision of nail fold, toe	Y	P2	0.8399	$35.17
11770	Removal of pilonidal lesion	Y	A2	19.6721	$823.73
11771	Removal of pilonidal lesion	Y	A2	19.6721	$823.73
11772	Removal of pilonidal lesion	Y	A2	19.6721	$823.73
11900	Injection into skin lesions	Y	P3		$31.39
11901	Added skin lesions injection	Y	P2	0.8399	$35.17
11920	Correct skin color defects	Y	P3		$97.77
11921	Correct skin color defects	Y	P3		$108.60
11922	Correct skin color defects	Y	P3		$35.72
11950	Therapy for contour defects	Y	P3		$36.44
11951	Therapy for contour defects	Y	P3		$46.90
11952	Therapy for contour defects	Y	P2	1.2941	$54.19
11954	Therapy for contour defects	Y	P2	1.2941	$54.19
11960	Insert tissue expander(s)	Y	A2	19.6965	$824.75
11970	Replace tissue expander	Y	A2	36.2926	$1,519.68
11971	Remove tissue expander(s)	Y	A2	18.6621	$781.44
11976	Removal of contraceptive cap	Y	P3		$65.66
11980	Implant hormone pellet(s)	N	P2	0.6396	$26.78
11981	Insert drug implant device	N	P2	0.6396	$26.78
11982	Remove drug implant device	N	P2	0.6396	$26.78
11983	Remove/insert drug implant	N	P2	0.6396	$26.78
12001	Repair superficial wound(s)	Y	P2	1.2941	$54.19
12002	Repair superficial wound(s)	Y	P2	1.2941	$54.19
12004	Repair superficial wound(s)	Y	P2	1.2941	$54.19
12005	Repair superficial wound(s)	Y	A2	1.4909	$62.43
12006	Repair superficial wound(s)	Y	A2	1.4909	$62.43
12007	Repair superficial wound(s)	Y	A2	1.4909	$62.43
12011	Repair superficial wound(s)	Y	P2	1.2941	$54.19
12013	Repair superficial wound(s)	Y	P2	1.2941	$54.19
12014	Repair superficial wound(s)	Y	P2	1.2941	$54.19
12015	Repair superficial wound(s)	Y	G2	1.2941	$54.19

12016	Repair superficial wound(s)	Y	A2	1.4909	$62.43
12017	Repair superficial wound(s)	Y	A2	1.4909	$62.43
12018	Repair superficial wound(s)	Y	A2	1.4909	$62.43
12020	Closure of split wound	Y	A2	3.7017	$155.00
12021	Closure of split wound	Y	A2	2.7786	$116.35
12031	Intmd wnd repair s/tr/ext	Y	P2	1.2941	$54.19
12032	Intmd wnd repair s/tr/ext	Y	P2	3.0109	$126.08
12034	Intmd wnd repair s/tr/ext	Y	A2	1.4909	$62.43
12035	Intmd wnd repair s/tr/ext	Y	A2	1.4909	$62.43
12036	Intmd wnd repair s/tr/ext	Y	A2	2.7786	$116.35
12037	Intmd wnd repair s/tr/ext	Y	A2	4.1024	$171.78
12041	Intmd wnd repair n-hf/genit	Y	P2	1.2941	$54.19
12042	Intmd wnd repair n-hg/genit	Y	P2	1.2941	$54.19
12044	Intmd wnd repair n-hg/genit	Y	A2	1.4909	$62.43
12045	Intmd wnd repair n-hg/genit	Y	A2	2.7786	$116.35
12046	Intmd wnd repair n-hg/genit	Y	A2	2.7786	$116.35
12047	Intmd wnd repair n-hg/genit	Y	A2	4.1024	$171.78
12051	Intmd wnd repair face/mm	Y	P2	1.2941	$54.19
12052	Intmd wnd repair face/mm	Y	P2	1.2941	$54.19
12053	Intmd wnd repair face/mm	Y	P2	1.2941	$54.19
12054	Intmd wnd repair, face/mm	Y	A2	1.4909	$62.43
12055	Intmd wnd repair face/mm	Y	A2	2.7786	$116.35
12056	Intmd wnd repair face/mm	Y	A2	2.7786	$116.35
12057	Intmd wnd repair face/mm	Y	A2	4.1024	$171.78
13100	Repair of wound or lesion	Y	A2	5.0257	$210.44
13101	Repair of wound or lesion	Y	A2	5.0257	$210.44
13102	Repair wound/lesion add-on	Y	A2	3.7017	$155.00
13120	Repair of wound or lesion	Y	A2	2.7786	$116.35
13121	Repair of wound or lesion	Y	A2	2.7786	$116.35
13122	Repair wound/lesion add-on	Y	A2	1.4909	$62.43
13131	Repair of wound or lesion	Y	A2	2.7786	$116.35

13132	Repair of wound or lesion	Y	A2	3.7017	$155.00
13133	Repair wound/lesion add-on	Y	A2	2.7786	$116.35
13150	Repair of wound or lesion	Y	A2	5.0257	$210.44
13151	Repair of wound or lesion	Y	A2	5.0257	$210.44
13152	Repair of wound or lesion	Y	A2	5.0257	$210.44
13153	Repair wound/lesion add-on	Y	A2	2.7786	$116.35
13160	Late closure of wound	Y	A2	19.6965	$824.75
14000	Skin tissue rearrangement	Y	A2	14.0506	$588.34
14001	Skin tissue rearrangement	Y	A2	14.4157	$603.63
14020	Skin tissue rearrangement	Y	A2	14.4157	$603.63
14021	Skin tissue rearrangement	Y	A2	14.4157	$603.63
14040	Skin tissue rearrangement	Y	A2	14.0506	$588.34
14041	Skin tissue rearrangement	Y	A2	14.4157	$603.63
14060	Skin tissue rearrangement	Y	A2	14.4157	$603.63
14061	Skin tissue rearrangement	Y	A2	14.4157	$603.63
14300	Skin tissue rearrangement	N	D5		
14301	Skin tissue rearrangement	Y	G2	22.8691	$957.60
14302	Skin tissue rearrange add-on	Y	G2	22.8691	$957.60
14350	Skin tissue rearrangement	Y	A2	20.0616	$840.04
15002	Wound prep, trk/arm/leg	Y	A2	5.0257	$210.44
15003	Wound prep, addl 100 cm	Y	A2	5.0257	$210.44
15004	Wound prep, f/n/hf/g	Y	A2	5.0257	$210.44
15005	Wnd prep, f/n/hf/g, addl cm	Y	A2	5.0257	$210.44
15040	Harvest cultured skin graft	Y	A2	2.7786	$116.35
15050	Skin pinch graft	Y	A2	5.0257	$210.44
15100	Skin splt grft, trnk/arm/leg	Y	A2	19.6965	$824.75
15101	Skin splt grft t/a/l, add-on	Y	A2	20.0616	$840.04
15110	Epidrm autogrft trnk/arm/leg	Y	A2	5.7259	$239.76
15111	Epidrm autogrft t/a/l add-on	Y	A2	5.0811	$212.76
15115	Epidrm a-grft face/nck/hf/g	Y	A2	5.7259	$239.76
15116	Epidrm a-grft f/n/hf/g addl	Y	A2	5.0811	$212.76

15120	Skn splt a-grft fac/nck/hf/g	Y	A2	19.6965	$824.75
15121	Skn splt a-grft f/n/hf/g add	Y	A2	20.0616	$840.04
15130	Derm autograft, trnk/arm/leg	Y	A2	14.0506	$588.34
15131	Derm autograft t/a/l add-on	Y	A2	13.406	$561.35
15135	Derm autograft face/nck/hf/g	Y	A2	14.0506	$588.34
15136	Derm autograft, f/n/hf/g add	Y	A2	13.406	$561.35
15150	Cult epiderm grft t/arm/leg	Y	A2	5.7259	$239.76
15151	Cult epiderm grft t/a/l addl	Y	A2	5.0811	$212.76
15152	Cult epiderm graft t/a/l +%	Y	A2	5.0811	$212.76
15155	Cult epiderm graft, f/n/hf/g	Y	A2	5.7259	$239.76
15156	Cult epidrm grft f/n/hfg add	Y	A2	5.0811	$212.76
15157	Cult epiderm grft f/n/hfg +%	Y	A2	5.0811	$212.76
15170	Acell graft trunk/arms/legs	Y	G2	4.2415	$177.60
15171	Acell graft t/arm/leg add-on	Y	G2	3.0109	$126.08
15175	Acellular graft, f/n/hf/g	Y	G2	4.2415	$177.60
15176	Acell graft, f/n/hf/g add-on	Y	G2	4.2415	$177.60
15200	Skin full graft, trunk	Y	A2	14.4157	$603.63
15201	Skin full graft trunk add-on	Y	A2	13.3504	$559.02
15220	Skin full graft sclp/arm/leg	Y	A2	14.0506	$588.34
15221	Skin full graft add-on	Y	A2	5.0257	$210.44
15240	Skin full grft face/genit/hf	Y	A2	14.4157	$603.63
15241	Skin full graft add-on	Y	A2	5.0257	$210.44
15260	Skin full graft een & lips	Y	A2	14.0506	$588.34
15261	Skin full graft add-on	Y	A2	13.3504	$559.02
15300	Apply skinallogrft, t/arm/lg	Y	A2	5.0257	$210.44
15301	Apply sknallogrft t/a/l addl	Y	A2	5.0257	$210.44
15320	Apply skin allogrft f/n/hf/g	Y	A2	5.0257	$210.44
15321	Aply sknallogrft f/n/hfg add	Y	A2	5.0257	$210.44
15330	Aply acell alogrft t/arm/leg	Y	A2	5.0257	$210.44
15331	Aply acell grft t/a/l add-on	Y	A2	5.0257	$210.44
15335	Apply acell graft, f/n/hf/g	Y	A2	5.0257	$210.44
15336	Aply acell grft f/n/hf/g add	Y	A2	5.0257	$210.44
15340	Apply cult skin substitute	Y	G2	3.0109	$126.08
15341	Apply cult skin sub add-on	Y	G2	3.0109	$126.08
15360	Apply cult derm sub, t/a/l	Y	G2	3.0109	$126.08
15361	Aply cult derm sub t/a/l add	Y	G2	3.0109	$126.08
15365	Apply cult derm sub f/n/hf/g	Y	G2	3.0109	$126.08
15366	Apply cult derm f/hf/g add	Y	G2	3.0109	$126.08
15400	Apply skin xenograft, t/a/l	Y	A2	5.0257	$210.44
15401	Apply skn xenogrft t/a/l add	Y	A2	5.0257	$210.44
15420	Apply skin xgraft, f/n/hf/g	Y	A2	5.0257	$210.44
15421	Apply skn xgrft f/n/hf/g add	Y	A2	5.0257	$210.44
15430	Apply acellular xenograft	Y	A2	5.0257	$210.44
15431	Apply acellular xgraft add	Y	A2	5.0257	$210.44
15570	Form skin pedicle flap	Y	A2	20.0616	$840.04
15572	Form skin pedicle flap	Y	A2	20.0616	$840.04
15574	Form skin pedicle flap	Y	A2	20.0616	$840.04
15576	Form skin pedicle flap	Y	A2	20.0616	$840.04
15600	Skin graft	Y	A2	20.0616	$840.04
15610	Skin graft	Y	A2	20.0616	$840.04
15620	Skin graft	Y	A2	20.7463	$868.71
15630	Skin graft	Y	A2	20.0616	$840.04
15650	Transfer skin pedicle flap	Y	A2	21.2426	$889.49
15731	Forehead flap w/vasc pedicle	Y	A2	20.0616	$840.04
15732	Muscle-skin graft, head/neck	Y	A2	20.0616	$840.04
15734	Muscle-skin graft, trunk	Y	A2	20.0616	$840.04
15736	Muscle-skin graft, arm	Y	A2	20.0616	$840.04
15738	Muscle-skin graft, leg	Y	A2	20.0616	$840.04
15740	Island pedicle flap graft	Y	A2	14.0506	$588.34
15750	Neurovascular pedicle graft	Y	A2	19.6965	$824.75
15760	Composite skin graft	Y	A2	19.6965	$824.75
15770	Derma-fat-fascia graft	Y	A2	20.0616	$840.04

15775	Hair transplant punch grafts	Y	A2	2.8149	$117.87
15776	Hair transplant punch grafts	Y	A2	2.8149	$117.87
15780	Abrasion treatment of skin	Y	P3		$419.96
15781	Abrasion treatment of skin	Y	P2	4.1688	$174.56
15782	Abrasion treatment of skin	Y	P2	4.1688	$174.56
15783	Abrasion treatment of skin	Y	P2	2.674	$111.97
15786	Abrasion, lesion, single	Y	P2	0.8399	$35.17
15787	Abrasion, lesions, add-on	Y	P3		$31.39
15788	Chemical peel, face, epiderm	Y	P2	0.8399	$35.17
15789	Chemical peel, face, dermal	Y	P2	1.4728	$61.67
15792	Chemical peel, nonfacial	Y	P2	1.4728	$61.67
15793	Chemical peel, nonfacial	Y	P2	0.8399	$35.17
15819	Plastic surgery, neck	Y	G2	3.0109	$126.08
15820	Revision of lower eyelid	Y	A2	20.0616	$840.04
15821	Revision of lower eyelid	Y	A2	20.0616	$840.04
15822	Revision of upper eyelid	Y	A2	20.0616	$840.04
15823	Revision of upper eyelid	Y	A2	21.2426	$889.49
15824	Removal of forehead wrinkles	Y	A2	20.0616	$840.04
15825	Removal of neck wrinkles	Y	A2	20.0616	$840.04
15826	Removal of brow wrinkles	Y	A2	20.0616	$840.04
15828	Removal of face wrinkles	Y	A2	20.0616	$840.04
15829	Removal of skin wrinkles	Y	A2	21.2426	$889.49
15830	Exc skin abd	Y	A2	19.6721	$823.73
15832	Excise excessive skin tissue	Y	A2	19.6721	$823.73
15833	Excise excessive skin tissue	Y	A2	19.6721	$823.73
15834	Excise excessive skin tissue	Y	A2	19.6721	$823.73
15835	Excise excessive skin tissue	Y	A2	18.6067	$779.12
15836	Excise excessive skin tissue	Y	A2	15.4501	$646.94
15837	Excise excessive skin tissue	Y	G2	16.7206	$700.14
15838	Excise excessive skin tissue	Y	G2	16.7206	$700.14
15839	Excise excessive skin tissue	Y	A2	15.4501	$646.94

15840	Graft for face nerve palsy	Y	A2	20.7463	$868.71
15841	Graft for face nerve palsy	Y	A2	20.7463	$868.71
15842	Flap for face nerve palsy	Y	G2	22.8691	$957.60
15845	Skin and muscle repair, face	Y	A2	20.7463	$868.71
15847	Exc skin abd add-on	Y	A2	19.6721	$823.73
15850	Removal of sutures	Y	G2	2.674	$111.97
15851	Removal of sutures	Y	P3		$52.31
15852	Dressing change not for burn	N	R2	0.6396	$26.78
15860	Test for blood flow in graft	N	G2	0.6396	$26.78
15876	Suction assisted lipectomy	Y	A2	20.0616	$840.04
15877	Suction assisted lipectomy	Y	A2	20.0616	$840.04
15878	Suction assisted lipectomy	Y	A2	20.0616	$840.04
15879	Suction assisted lipectomy	Y	A2	20.0616	$840.04
15920	Removal of tail bone ulcer	Y	A2	4.5617	$191.01
15922	Removal of tail bone ulcer	Y	A2	20.7463	$868.71
15931	Remove sacrum pressure sore	Y	A2	19.6721	$823.73
15933	Remove sacrum pressure sore	Y	A2	19.6721	$823.73
15934	Remove sacrum pressure sore	Y	A2	20.0616	$840.04
15935	Remove sacrum pressure sore	Y	A2	20.7463	$868.71
15936	Remove sacrum pressure sore	Y	A2	15.1004	$632.30
15937	Remove sacrum pressure sore	Y	A2	20.7463	$868.71
15940	Remove hip pressure sore	Y	A2	19.6721	$823.73
15941	Remove hip pressure sore	Y	A2	19.6721	$823.73
15944	Remove hip pressure sore	Y	A2	20.0616	$840.04
15945	Remove hip pressure sore	Y	A2	20.7463	$868.71
15946	Remove hip pressure sore	Y	A2	20.7463	$868.71
15950	Remove thigh pressure sore	Y	A2	19.6721	$823.73
15951	Remove thigh pressure sore	Y	A2	20.3566	$852.39
15952	Remove thigh pressure sore	Y	A2	14.4157	$603.63
15953	Remove thigh pressure sore	Y	A2	15.1004	$632.30
15956	Remove thigh pressure sore	Y	A2	14.4157	$603.63

15958	Remove thigh pressure sore	Y	A2	15.1004	$632.30
16000	Initial treatment of burn(s)	Y	P3		$28.86
16020	Dress/debrid p-thick burn, s	Y	P3		$43.29
16025	Dress/debrid p-thick burn, m	Y	A2	1.4874	$62.28
16030	Dress/debrid p-thick burn, l	Y	A2	1.6739	$70.09
16035	Incision of burn scab, initi	Y	G2	1.4728	$61.67
17000	Destruct premalg lesion	Y	P2	0.8399	$35.17
17003	Destruct premalg les, 2-14	Y	P3		$3.97
17004	Destroy premlg lesions 15+	Y	P3		$88.39
17106	Destruction of skin lesions	Y	P2	2.674	$111.97
17107	Destruction of skin lesions	Y	P2	2.674	$111.97
17108	Destruction of skin lesions	Y	P2	2.674	$111.97
17110	Destruct b9 lesion, 1-14	Y	P2	0.8399	$35.17
17111	Destruct lesion, 15 or more	Y	P2	1.4728	$61.67
17250	Chemical cautery, tissue	Y	P3		$47.99
17260	Destruction of skin lesions	Y	P3		$50.15
17261	Destruction of skin lesions	Y	P2	1.4728	$61.67
17262	Destruction of skin lesions	Y	P2	1.4728	$61.67
17263	Destruction of skin lesions	Y	P2	1.4728	$61.67
17264	Destruction of skin lesions	Y	P2	1.4728	$61.67
17266	Destruction of skin lesions	Y	P2	2.674	$111.97
17270	Destruction of skin lesions	Y	P2	1.4728	$61.67
17271	Destruction of skin lesions	Y	P2	1.4728	$61.67
17272	Destruction of skin lesions	Y	P2	1.4728	$61.67
17273	Destruction of skin lesions	Y	P2	2.674	$111.97
17274	Destruction of skin lesions	Y	P2	2.674	$111.97
17276	Destruction of skin lesions	Y	P2	2.674	$111.97
17280	Destruction of skin lesions	Y	P2	1.4728	$61.67
17281	Destruction of skin lesions	Y	P3		$93.44
17282	Destruction of skin lesions	Y	P3		$106.79
17283	Destruction of skin lesions	Y	P2	2.674	$111.97

17284	Destruction of skin lesions	Y	P2	2.674	$111.97
17286	Destruction of skin lesions	Y	P2	2.674	$111.97
17311	Mohs, 1 stage, h/n/hf/g	Y	P2	4.7146	$197.41
17312	Mohs addl stage	Y	P2	4.7146	$197.41
17313	Mohs, 1 stage, t/a/l	Y	P2	4.7146	$197.41
17314	Mohs, addl stage, t/a/l	Y	P2	4.7146	$197.41
17315	Mohs surg, addl block	Y	P3		$41.49
17340	Cryotherapy of skin	Y	P3		$16.24
17360	Skin peel therapy	Y	P2	0.8399	$35.17
17380	Hair removal by electrolysis	Y	R2	0.8399	$35.17
19000	Drainage of breast lesion	Y	P3		$69.63
19001	Drain breast lesion add-on	Y	P3		$9.38
19020	Incision of breast lesion	Y	A2	16.4531	$688.94
19030	Injection for breast x-ray	N	N1		
19100	Bx breast percut w/o image	Y	A2	4.6655	$195.36
19101	Biopsy of breast, open	Y	A2	20.284	$849.35
19102	Bx breast percut w/image	Y	A2	6.9699	$291.85
19103	Bx breast percut w/device	Y	A2	13.3668	$559.71
19105	Cryosurg ablate fa, each	Y	P2	32.6485	$1,367.09
19110	Nipple exploration	Y	A2	20.284	$849.35
19112	Excise breast duct fistula	Y	A2	20.6491	$864.64
19120	Removal of breast lesion	Y	A2	20.6491	$864.64
19125	Excision, breast lesion	Y	A2	20.6491	$864.64
19126	Excision, addl breast lesion	Y	A2	20.6491	$864.64
19290	Place needle wire, breast	N	N1		
19291	Place needle wire, breast	N	N1		
19295	Place breast clip, percut	N	N1		
19296	Place po breast cath for rad	Y	A2	49.3714	$2,067.33
19297	Place breast cath for rad	Y	A2	49.3714	$2,067.33
19298	Place breast rad tube/caths	Y	A2	49.3714	$2,067.33
19300	Removal of breast tissue	Y	A2	21.3338	$893.31

19301	Partical mastectomy	Y	A2	20.6491	$864.64
19302	P-mastectomy w/ln removal	Y	A2	35.7779	$1,498.13
19303	Mast, simple, complete	Y	A2	28.0806	$1,175.82
19304	Mast, subq	Y	A2	28.0806	$1,175.82
19316	Suspension of breast	Y	A2	28.0806	$1,175.82
19318	Reduction of large breast	Y	A2	33.6955	$1,410.93
19324	Enlarge breast	Y	A2	33.6955	$1,410.93
19325	Enlarge breast with implant	Y	A2	49.3714	$2,067.33
19328	Removal of breast implant	Y	A2	26.3862	$1,104.87
19330	Removal of implant material	Y	A2	26.3862	$1,104.87
19340	Immediate breast prosthesis	Y	A2	32.6459	$1,366.98
19342	Delayed breast prosthesis	Y	A2	44.6417	$1,869.28
19350	Breast reconstruction	Y	A2	21.3338	$893.31
19355	Correct inverted nipple(s)	Y	A2	28.0806	$1,175.82
19357	Breast reconstruction	Y	A2	45.8226	$1,918.73
19366	Breast reconstruction	Y	A2	28.5771	$1,196.61
19370	Surgery of breast capsule	Y	A2	28.0806	$1,175.82
19371	Removal of breast capsule	Y	A2	28.0806	$1,175.82
19380	Revise breast reconstruction	Y	A2	34.192	$1,431.72
19396	Design custom breast implant	Y	G2	32.6485	$1,367.09
20000	Incision of abscess	Y	P2	1.3911	$58.25
20005	Incision of deep abscess	Y	A2	18.3225	$767.22
20103	Explore wound, extremity	Y	G2	12.0613	$505.04
20150	Excise epiphyseal bar	Y	G2	44.5105	$1,863.79
20200	Muscle biopsy	Y	A2	15.0849	$631.65
20205	Deep muscle biopsy	Y	A2	15.4501	$646.94
20206	Needle biopsy, muscle	Y	A2	6.9699	$291.85
20220	Bone biopsy, trocar/needle	Y	A2	7.314	$306.26
20225	Bone biopsy, trocar/needle	Y	A2	14.928	$625.08
20240	Bone biopsy, excisional	Y	A2	19.307	$808.44
20245	Bone biopsy, excisional	Y	A2	19.6721	$823.73

20250	Open bone biopsy	Y	A2	18.6877	$782.51
20251	Open bone biopsy	Y	A2	18.6877	$782.51
20500	Injection of sinus tract	Y	P3		$55.56
20501	Inject sinus tract for x-ray	N	N1		
20520	Removal of foreign body	Y	P3		$101.02
20525	Removal of foreign body	Y	A2	19.6721	$823.73
20526	Ther injection, carp tunnel	Y	P3		$32.11
20550	Inj tendon sheath/ligament	Y	P3		$24.17
20551	Inj tendon origin/insertion	Y	P3		$24.53
20552	Inj trigger point, 1/2 muscl	Y	P3		$23.45
20553	Inject trigger points, =/> 3	Y	P3		$26.70
20555	Place ndl musc/tis for rt	Y	R2	30.361	$1,271.31
20600	Drain/inject, joint/bursa	Y	P3		$24.53
20605	Drain/inject, joint/bursa	Y	P3		$27.78
20610	Drain/inject, joint/bursa	Y	P3		$39.69
20612	Aspirate/inj ganglion cyst	Y	P3		$26.70
20615	Treatment of bone cyst	Y	P3		$108.24
20650	Insert and remove bone pin	Y	A2	18.6877	$782.51
20662	Application of pelvis brace	Y	R2	21.0374	$880.90
20663	Application of thigh brace	Y	R2	21.0374	$880.90
20665	Removal of fixation device	N	G2	0.6396	$26.78
20670	Removal of support implant	Y	A2	14.4403	$604.66
20680	Removal of support implant	Y	A2	19.6721	$823.73
20690	Apply bone fixation device	Y	A2	25.3154	$1,060.03
20692	Apply bone fixation device	Y	A2	25.6805	$1,075.32
20693	Adjust bone fixation device	Y	A2	18.6877	$782.51
20694	Remove bone fixation device	Y	A2	17.678	$740.23
20696	Comp multiplane ext fixation	Y	G2	30.361	$1,271.31
20697	Comp ext fixate strut change	Y	G2	17.5794	$736.10
20822	Replantation digit, complete	Y	G2	26.9839	$1,129.90
20900	Removal of bone for graft	Y	A2	25.6805	$1,075.32

20902	Removal of bone for graft	Y	A2	26.3652	$1,103.99
20910	Remove cartilage for graft	Y	A2	20.0616	$840.04
20912	Remove cartilage for graft	Y	A2	20.0616	$840.04
20920	Removal of fascia for graft	Y	A2	15.1004	$632.30
20922	Removal of fascia for graft	Y	A2	14.4157	$603.63
20924	Removal of tendon for graft	Y	A2	26.3652	$1,103.99
20926	Removal of tissue for graft	Y	A2	6.7755	$283.71
20950	Fluid pressure, muscle	Y	G2	1.3911	$58.25
20972	Bone/skin graft, metatarsal	Y	G2	50.1937	$2,101.76
20973	Bone/skin graft, great toe	Y	R2	50.1937	$2,101.76
20975	Electrical bone stimulation	N	N1		
20979	Us bone stimulation	N	P3		$24.17
20982	Ablate, bone tumor(s) perq	Y	G2	44.5105	$1,863.79
20985	Cptr-asst dir ms px	N	N1		
21010	Incision of jaw joint	Y	A2	20.4361	$855.72
21011	Exc face les sc < 2 cm	Y	P3		$186.17
21012	Exc face les sc = 2 cm	Y	R2	7.8386	$328.23
21013	Exc face tum deep < 2 cm	Y	P3		$258.69
21014	Exc face tum deep = 2 cm	Y	R2	7.8386	$328.23
21015*	Resect face tum < 2 cm	Y	R2	16.7206	$700.14
21016	Resect face tum = 2 cm	Y	G2	22.3496	$935.84
21025	Excision of bone, lower jaw	Y	A2	33.3501	$1,396.47
21026	Excision of facial bone(s)	Y	A2	33.3501	$1,396.47
21029	Contour of face bone lesion	Y	A2	33.3501	$1,396.47
21030	Excise max/zygoma b9 tumor	Y	P3		$264.46
21031	Remove exostosis, mandible	Y	P3		$217.56
21032	Remove exostosis, maxilla	Y	P3		$221.53
21034	Excise max/zygoma mlg tumor	Y	A2	33.7153	$1,411.76
21040	Excise mandible lesion	Y	A2	20.4361	$855.72
21044	Removal of jaw bone lesion	Y	A2	33.3501	$1,396.47
21046	Remove mandible cyst complex	Y	A2	33.3501	$1,396.47
21047	Excise lwr jaw cyst w/repair	Y	A2	33.3501	$1,396.47
21048	Remove maxilla cyst complex	Y	R2	41.0743	$1,719.90
21050	Removal of jaw joint	Y	A2	33.7153	$1,411.76
21060	Remove jaw joint cartilage	Y	A2	33.3501	$1,396.47
21070	Remove coronoid process	Y	A2	33.7153	$1,411.76
21073	Mnpj of tmj w/anesth	Y	P3		$203.13
21076	Prepare face/oral prosthesis	Y	P3		$364.40
21077	Prepare face/oral prosthesis	Y	P3		$876.72
21079	Prepare face/oral prosthesis	Y	P3		$628.50
21080	Prepare face/oral prosthesis	Y	P3		$718.70
21081	Prepare face/oral prosthesis	Y	P3		$662.41
21082	Prepare face/oral prosthesis	Y	P3		$635.35
21083	Prepare face/oral prosthesis	Y	P3		$623.81
21084	Prepare face/oral prosthesis	Y	P3		$714.01
21085	Prepare face/oral prosthesis	Y	P3		$285.39
21086	Prepare face/oral prosthesis	Y	P3		$622.36
21087	Prepare face/oral prosthesis	Y	P3		$620.92
21088	Prepare face/oral prosthesis	Y	R2	41.0743	$1,719.90
21100	Maxillofacial fixation	Y	A2	33.3501	$1,396.47
21110	Interdental fixation	Y	P2	7.2813	$304.89
21116	Injection, jaw joint x-ray	N	N1		
21120	Reconstruction of chin	Y	A2	23.5684	$986.88
21121	Reconstruction of chin	Y	A2	23.5684	$986.88
21122	Reconstruction of chin	Y	A2	23.5684	$986.88
21123	Reconstruction of chin	Y	A2	23.5684	$986.88
21125	Augmentation, lower jaw bone	Y	A2	23.5684	$986.88
21127	Augmentation, lower jaw bone	Y	A2	38.4451	$1,609.81
21137	Reduction of forehead	Y	G2	23.8553	$998.89
21138	Reduction of forehead	Y	G2	41.0743	$1,719.90
21139	Reduction of forehead	Y	G2	41.0743	$1,719.90
21150	Reconstruct midface, lefort	Y	G2	41.0743	$1,719.90

21181	Contour cranial bone lesion	Y	A2	23.5684	$986.88
21198	Reconstr lwr jaw segment	Y	G2	41.0743	$1,719.90
21199	Reconstr lwr jaw w/advance	Y	G2	41.0743	$1,719.90
21206	Reconstruct upper jaw bone	Y	A2	34.8965	$1,461.22
21208	Augmentation of facial bones	Y	A2	36.4825	$1,527.63
21209	Reduction of facial bones	Y	A2	34.8965	$1,461.22
21210	Face bone graft	Y	A2	36.4825	$1,527.63
21215	Lower jaw bone graft	Y	A2	36.4825	$1,527.63
21230	Rib cartilage graft	Y	A2	36.4825	$1,527.63
21235	Ear cartilage graft	Y	A2	23.5684	$986.88
21240	Reconstruction of jaw joint	Y	A2	34.4	$1,440.43
21242	Reconstruction of jaw joint	Y	A2	34.8965	$1,461.22
21243	Reconstruction of jaw joint	Y	A2	34.8965	$1,461.22
21244	Reconstruction of lower jaw	Y	A2	36.4825	$1,527.63
21245	Reconstruction of jaw	Y	A2	36.4825	$1,527.63
21246	Reconstruction of jaw	Y	A2	36.4825	$1,527.63
21248	Reconstruction of jaw	Y	A2	36.4825	$1,527.63
21249	Reconstruction of jaw	Y	A2	36.4825	$1,527.63
21260	Revise eye sockets	Y	G2	41.0743	$1,719.90
21267	Revise eye sockets	Y	A2	36.4825	$1,527.63
21270	Augmentation, cheek bone	Y	A2	34.8965	$1,461.22
21275	Revision, orbitofacial bones	Y	A2	36.4825	$1,527.63
21280	Revision of eyelid	Y	A2	34.8965	$1,461.22
21282	Revision of eyelid	Y	A2	16.4091	$687.10
21295	Revision of jaw muscle/bone	Y	A2	7.3608	$308.22
21296	Revision of jaw muscle/bone	Y	A2	19.7915	$828.73
21310	Treatment of nose fracture	Y	A2	1.6858	$70.59
21315	Treatment of nose fracture	Y	A2	13.1784	$551.82
21320	Treatment of nose fracture	Y	A2	14.863	$622.36
21325	Treatment of nose fracture	Y	A2	21.4859	$899.68
21330	Treatment of nose fracture	Y	A2	21.9824	$920.47

21335	Treatment of nose fracture	Y	A2	23.5684	$986.88
21336	Treat nasal septal fracture	Y	A2	22.1171	$926.11
21337	Treat nasal septal fracture	Y	A2	14.863	$622.36
21338	Treat nasoethmoid fracture	Y	A2	21.4859	$899.68
21339	Treat nasoethmoid fracture	Y	A2	21.9824	$920.47
21340	Treatment of nose fracture	Y	A2	34.4	$1,440.43
21345	Treat nose/jaw fracture	Y	A2	23.5684	$986.88
21355	Treat cheek bone fracture	Y	A2	33.7153	$1,411.76
21356	Treat cheek bone fracture	Y	A2	20.8012	$871.01
21360	Treat cheek bone fracture	Y	G2	23.8553	$998.89
21390	Treat eye socket fracture	Y	G2	41.0743	$1,719.90
21400	Treat eye socket fracture	Y	A2	8.0056	$335.22
21401	Treat eye socket fracture	Y	A2	15.2282	$637.65
21406	Treat eye socket fracture	Y	G2	41.0743	$1,719.90
21407	Treat eye socket fracture	Y	G2	41.0743	$1,719.90
21421	Treat mouth roof fracture	Y	A2	21.4859	$899.68
21440	Treat dental ridge fracture	Y	P3		$356.46
21445	Treat dental ridge fracture	Y	A2	21.4859	$899.68
21450	Treat lower jaw fracture	Y	A2	3.3145	$138.79
21451	Treat lower jaw fracture	Y	A2	8.109	$339.55
21452	Treat lower jaw fracture	Y	A2	14.863	$622.36
21453	Treat lower jaw fracture	Y	A2	33.7153	$1,411.76
21454	Treat lower jaw fracture	Y	A2	21.9824	$920.47
21461	Treat lower jaw fracture	Y	A2	34.4	$1,440.43
21462	Treat lower jaw fracture	Y	A2	34.8965	$1,461.22
21465	Treat lower jaw fracture	Y	A2	34.4	$1,440.43
21480	Reset dislocated jaw	Y	A2	1.6858	$70.59
21485	Reset dislocated jaw	Y	A2	14.863	$622.36
21490	Repair dislocated jaw	Y	A2	33.7153	$1,411.76
21495	Treat hyoid bone fracture	Y	G2	16.4248	$687.76
21497	Interdental wiring	Y	A2	14.863	$622.36

21501	Drain neck/chest lesion	Y	A2	16.4531	$688.94
21502	Drain chest lesion	Y	A2	18.3225	$767.22
21550	Biopsy of neck/chest	Y	G2	16.7206	$700.14
21552	Exc neck les sc = 3 cm	Y	G2	22.3496	$935.84
21554	Exc neck tum deep = 5 cm	Y	G2	22.3496	$935.84
21555*	Exc neck les sc < 3 cm	Y	P3		$215.03
21556	Exc neck tum deep < 5 cm	Y	G2	22.3496	$935.84
21557	Resect neck tum < 5 cm	Y	G2	16.7206	$700.14
21558	Resect neck tum = 5 cm	Y	G2	22.3496	$935.84
21600	Partial removal of rib	Y	A2	25.3154	$1,060.03
21610	Partial removal of rib	Y	A2	25.3154	$1,060.03
21685	Hyoid myotomy & suspension	Y	G2	7.2813	$304.89
21700	Revision of neck muscle	Y	A2	18.3225	$767.22
21720	Revision of neck muscle	Y	A2	18.6877	$782.51
21725	Revision of neck muscle	Y	A2	1.5478	$64.81
21800	Treatment of rib fracture	Y	A2	1.7792	$74.50
21805	Treatment of rib fracture	Y	A2	21.0673	$882.15
21820	Treat sternum fracture	Y	A2	1.7792	$74.50
21920	Biopsy soft tissue of back	Y	P3		$151.53
21925	Biopsy soft tissue of back	Y	A2	19.307	$808.44
21930*	Exc back les sc < 3 cm	Y	P3		$224.05
21931	Exc back les sc = 3 cm	Y	G2	22.3496	$935.84
21932	Exc back tum deep < 5 cm	Y	G2	16.7206	$700.14
21933	Exc back tum deep = 5 cm	Y	G2	22.3496	$935.84
21935	Resect back tum < 5 cm	Y	G2	16.7206	$700.14
21936	Resect back tum = 5 cm	Y	G2	22.3496	$935.84
22102	Remove part, lumbar vertebra	Y	G2	47.04	$1,969.71
22103	Remove extra spine segment	Y	G2	47.04	$1,969.71
22305	Treat spine process fracture	Y	A2	1.7792	$74.50
22310	Treat spine fracture	Y	A2	4.0274	$168.64
22315	Treat spine fracture	Y	A2	13.7757	$576.83

22505	Manipulation of spine	Y	A2	13.5044	$565.47
22520	Percut vertebroplasty thor	Y	A2	30.4103	$1,273.37
22521	Percut vertebroplasty lumb	Y	A2	30.4103	$1,273.37
22522	Percut vertebroplasty addl	Y	A2	30.4103	$1,273.37
22523	Percut kyphoplasty, thor	Y	G2	84.7159	$3,547.31
22524	Percut kyphoplasty, lumbar	Y	G2	84.7159	$3,547.31
22525	Percut kyphoplasty, add-on	Y	G2	84.7159	$3,547.31
22900	Exc back tum deep < 5 cm	Y	G2	22.3496	$935.84
22901	Exc back tum deep = 5 cm	Y	G2	22.3496	$935.84
22902	Exc abd les sc < 3 cm	Y	G2	16.7206	$700.14
22903	Exc abd les sc > 3 cm	Y	G2	22.3496	$935.84
22904	Resect abd tum < 5 cm	Y	G2	16.7206	$700.14
22905	Resect abd tum > 5 cm	Y	G2	22.3496	$935.84
23000	Removal of calcium deposits	Y	A2	15.0849	$631.65
23020	Release shoulder joint	Y	A2	35.9274	$1,504.39
23030	Drain shoulder lesion	Y	A2	15.8083	$661.94
23031	Drain shoulder bursa	Y	A2	16.8182	$704.23
23035	Drain shoulder bone lesion	Y	A2	18.6877	$782.51
23040	Exploratory shoulder surgery	Y	A2	25.6805	$1,075.32
23044	Exploratory shoulder surgery	Y	A2	26.3652	$1,103.99
23065	Biopsy shoulder tissues	Y	P3		$105.71
23066	Biopsy shoulder tissues	Y	A2	19.307	$808.44
23071	Exc shoulder les sc > 3 cm	Y	G2	22.3496	$935.84
23073	Exc shoulder tum deep > 5 cm	Y	G2	22.3496	$935.84
23075*	Exc shoulder les sc < 3 cm	Y	P3		$165.24
23076	Exc shoulder tum deep < 5 cm	Y	G2	16.7206	$700.14
23077	Resect shoulder tum < 5 cm	Y	G2	16.7206	$700.14
23078	Resect shoulder tum > 5 cm	Y	G2	22.3496	$935.84
23100	Biopsy of shoulder joint	Y	A2	18.3225	$767.22
23101	Shoulder joint surgery	Y	A2	28.4477	$1,191.19
23105	Remove shoulder joint lining	Y	A2	26.3652	$1,103.99

23106	Incision of collarbone joint	Y	A2	26.3652	$1,103.99
23107	Explore treat shoulder joint	Y	A2	26.3652	$1,103.99
23120	Partial removal, collar bone	Y	A2	26.8615	$1,124.77
23125	Removal of collar bone	Y	A2	26.8615	$1,124.77
23130	Remove shoulder bone, part	Y	A2	37.4736	$1,569.13
23140	Removal of bone lesion	Y	A2	19.3724	$811.18
23145	Removal of bone lesion	Y	A2	26.8615	$1,124.77
23146	Removal of bone lesion	Y	A2	26.8615	$1,124.77
23150	Removal of humerus lesion	Y	A2	26.3652	$1,103.99
23155	Removal of humerus lesion	Y	A2	26.8615	$1,124.77
23156	Removal of humerus lesion	Y	A2	26.8615	$1,124.77
23170	Remove collar bone lesion	Y	A2	25.3154	$1,060.03
23172	Remove shoulder blade lesion	Y	A2	25.3154	$1,060.03
23174	Remove humerus lesion	Y	A2	25.3154	$1,060.03
23180	Remove collar bone lesion	Y	A2	26.3652	$1,103.99
23182	Remove shoulder blade lesion	Y	A2	26.3652	$1,103.99
23184	Remove humerus lesion	Y	A2	26.3652	$1,103.99
23190	Partial removal of scapula	Y	A2	26.3652	$1,103.99
23195	Removal of head of humerus	Y	A2	26.8615	$1,124.77
23330	Remove shoulder foreign body	Y	A2	7.779	$325.73
23331	Remove shoulder foreign body	Y	A2	18.6621	$781.44
23350	Injection for shoulder x-ray	N	N1		
23395	Muscle transfer,shoulder/arm	Y	A2	37.4736	$1,569.13
23397	Muscle transfers	Y	A2	69.2138	$2,898.19
23400	Fixation of shoulder blade	Y	A2	28.4477	$1,191.19
23405	Incision of tendon & muscle	Y	A2	25.3154	$1,060.03
23406	Incise tendon(s) & muscle(s)	Y	A2	25.3154	$1,060.03
23410	Repair rotator cuff, acute	Y	A2	37.4736	$1,569.13
23412	Repair rotator cuff, chronic	Y	A2	39.0598	$1,635.55
23415	Release of shoulder ligament	Y	A2	37.4736	$1,569.13
23420	Repair of shoulder	Y	A2	39.0598	$1,635.55
23430	Repair biceps tendon	Y	A2	36.9773	$1,548.35
23440	Remove/transplant tendon	Y	A2	36.9773	$1,548.35
23450	Repair shoulder capsule	Y	A2	67.6276	$2,831.77
23455	Repair shoulder capsule	Y	A2	69.2138	$2,898.19
23460	Repair shoulder capsule	Y	A2	67.6276	$2,831.77
23462	Repair shoulder capsule	Y	A2	39.0598	$1,635.55
23465	Repair shoulder capsule	Y	A2	67.6276	$2,831.77
23466	Repair shoulder capsule	Y	A2	39.0598	$1,635.55
23480	Revision of collar bone	Y	A2	36.9773	$1,548.35
23485	Revision of collar bone	Y	A2	69.2138	$2,898.19
23490	Reinforce clavicle	Y	A2	36.2926	$1,519.68
23491	Reinforce shoulder bones	Y	A2	66.4466	$2,782.32
23500	Treat clavicle fracture	Y	A2	1.7792	$74.50
23505	Treat clavicle fracture	Y	A2	13.7757	$576.83
23515	Treat clavicle fracture	Y	A2	49.8357	$2,086.77
23520	Treat clavicle dislocation	Y	A2	4.0274	$168.64
23525	Treat clavicle dislocation	Y	A2	4.0274	$168.64
23530	Treat clavicle dislocation	Y	A2	35.4964	$1,486.34
23532	Treat clavicle dislocation	Y	A2	22.1171	$926.11
23540	Treat clavicle dislocation	Y	A2	1.7792	$74.50
23545	Treat clavicle dislocation	Y	A2	4.0274	$168.64
23550	Treat clavicle dislocation	Y	A2	35.4964	$1,486.34
23552	Treat clavicle dislocation	Y	A2	36.1811	$1,515.01
23570	Treat shoulder blade fx	Y	A2	1.7792	$74.50
23575	Treat shoulder blade fx	Y	A2	4.0274	$168.64
23585	Treat scapula fracture	Y	A2	49.8357	$2,086.77
23600	Treat humerus fracture	Y	P2	1.584	$66.33
23605	Treat humerus fracture	Y	A2	13.7757	$576.83
23615	Treat humerus fracture	Y	A2	50.5204	$2,115.44
23616	Treat humerus fracture	Y	A2	50.5204	$2,115.44
23620	Treat humerus fracture	Y	P2	1.584	$66.33

23625	Treat humerus fracture	Y	A2	13.7757	$576.83
23630	Treat humerus fracture	Y	A2	51.0166	$2,136.22
23650	Treat shoulder dislocation	Y	A2	1.7792	$74.50
23655	Treat shoulder dislocation	Y	A2	12.8598	$538.48
23660	Treat shoulder dislocation	Y	A2	35.4964	$1,486.34
23665	Treat dislocation/fracture	Y	A2	4.0274	$168.64
23670	Treat dislocation/fracture	Y	A2	49.8357	$2,086.77
23675	Treat dislocation/fracture	Y	A2	1.7792	$74.50
23680	Treat dislocation/fracture	Y	A2	35.4964	$1,486.34
23700	Fixation of shoulder	Y	A2	12.8598	$538.48
23800	Fusion of shoulder joint	Y	A2	67.1313	$2,810.99
23802	Fusion of shoulder joint	Y	A2	39.0598	$1,635.55
23921	Amputation follow-up surgery	Y	A2	13.3504	$559.02
23930	Drainage of arm lesion	Y	A2	15.8083	$661.94
23931	Drainage of arm bursa	Y	A2	16.4531	$688.94
23935	Drain arm/elbow bone lesion	Y	A2	18.3225	$767.22
24000	Exploratory elbow surgery	Y	A2	26.3652	$1,103.99
24006	Release elbow joint	Y	A2	26.3652	$1,103.99
24065	Biopsy arm/elbow soft tissue	Y	P3		$145.76
24066	Biopsy arm/elbow soft tissue	Y	A2	15.0849	$631.65
24071	Exc arm/elbow les sc = 3 cm	Y	G2	22.3496	$935.84
24073	Ex arm/elbow tum deep > 5 cm	Y	G2	22.3496	$935.84
24075*	Exc arm/elbow les sc < 3 cm	Y	P3		$266.26
24076	Ex arm/elbow tum deep < 5 cm	Y	G2	16.7206	$700.14
24077	Resect arm/elbow tum < 5 cm	Y	G2	16.7206	$700.14
24079	Resect arm/elbow tum > 5 cm	Y	G2	22.3496	$935.84
24100	Biopsy elbow joint lining	Y	A2	17.678	$740.23
24101	Explore/treat elbow joint	Y	A2	26.3652	$1,103.99
24102	Remove elbow joint lining	Y	A2	26.3652	$1,103.99
24105	Removal of elbow bursa	Y	A2	18.6877	$782.51
24110	Remove humerus lesion	Y	A2	18.3225	$767.22

24115	Remove/graft bone lesion	Y	A2	25.6805	$1,075.32
24116	Remove/graft bone lesion	Y	A2	25.6805	$1,075.32
24120	Remove elbow lesion	Y	A2	18.6877	$782.51
24125	Remove/graft bone lesion	Y	A2	25.6805	$1,075.32
24126	Remove/graft bone lesion	Y	A2	25.6805	$1,075.32
24130	Removal of head of radius	Y	A2	25.6805	$1,075.32
24134	Removal of arm bone lesion	Y	A2	25.3154	$1,060.03
24136	Remove radius bone lesion	Y	A2	25.3154	$1,060.03
24138	Remove elbow bone lesion	Y	A2	25.3154	$1,060.03
24140	Partial removal of arm bone	Y	A2	25.6805	$1,075.32
24145	Partial removal of radius	Y	A2	25.6805	$1,075.32
24147	Partial removal of elbow	Y	A2	25.3154	$1,060.03
24149	Radical resection of elbow	Y	G2	30.361	$1,271.31
24152	Resect radius tumor	Y	G2	44.5105	$1,863.79
24153	Extensive radius surgery	N	D5		
24155	Removal of elbow joint	Y	A2	36.2926	$1,519.68
24160	Remove elbow joint implant	Y	A2	25.3154	$1,060.03
24164	Remove radius head implant	Y	A2	25.6805	$1,075.32
24200	Removal of arm foreign body	Y	P3		$107.88
24201	Removal of arm foreign body	Y	A2	15.0849	$631.65
24220	Injection for elbow x-ray	N	N1		
24300	Manipulate elbow w/anesth	Y	G2	14.6132	$611.90
24301	Muscle/tendon transfer	Y	A2	26.3652	$1,103.99
24305	Arm tendon lengthening	Y	A2	26.3652	$1,103.99
24310	Revision of arm tendon	Y	A2	18.6877	$782.51
24320	Repair of arm tendon	Y	A2	36.2926	$1,519.68
24330	Revision of arm muscles	Y	A2	66.4466	$2,782.32
24331	Revision of arm muscles	Y	A2	36.2926	$1,519.68
24332	Tenolysis, triceps	Y	G2	21.0374	$880.90
24340	Repair of biceps tendon	Y	A2	36.2926	$1,519.68
24341	Repair arm tendon/muscle	Y	A2	36.2926	$1,519.68

24342	Repair of ruptured tendon	Y	A2	36.2926	$1,519.68
24343	Repr elbow lat ligmnt w/tiss	Y	G2	30.361	$1,271.31
24344	Reconstruct elbow lat ligmnt	Y	G2	84.7159	$3,547.31
24345	Repr elbw med ligmnt w/tissu	Y	A2	25.3154	$1,060.03
24346	Reconstruct elbow med ligmnt	Y	G2	44.5105	$1,863.79
24357	Repair elbow, perc	Y	G2	30.361	$1,271.31
24358	Repair elbow w/deb, open	Y	G2	30.361	$1,271.31
24359	Repair elbow deb/attch open	Y	G2	30.361	$1,271.31
24360	Reconstruct elbow joint	Y	A2	32.6783	$1,368.34
24361	Reconstruct elbow joint	Y	H8	149.9835	$6,280.26
24362	Reconstruct elbow joint	Y	A2	45.7192	$1,914.40
24363	Replace elbow joint	Y	H8	151.5697	$6,346.68
24365	Reconstruct head of radius	Y	A2	32.6783	$1,368.34
24366	Reconstruct head of radius	Y	H8	149.9835	$6,280.26
24400	Revision of humerus	Y	A2	36.9773	$1,548.35
24410	Revision of humerus	Y	A2	36.9773	$1,548.35
24420	Revision of humerus	Y	A2	36.2926	$1,519.68
24430	Repair of humerus	Y	A2	66.4466	$2,782.32
24435	Repair humerus with graft	Y	A2	67.1313	$2,810.99
24470	Revision of elbow joint	Y	A2	36.2926	$1,519.68
24495	Decompression of forearm	Y	A2	25.3154	$1,060.03
24498	Reinforce humerus	Y	A2	66.4466	$2,782.32
24500	Treat humerus fracture	Y	A2	1.7792	$74.50
24505	Treat humerus fracture	Y	A2	1.7792	$74.50
24515	Treat humerus fracture	Y	A2	50.5204	$2,115.44
24516	Treat humerus fracture	Y	A2	50.5204	$2,115.44
24530	Treat humerus fracture	Y	A2	1.7792	$74.50
24535	Treat humerus fracture	Y	A2	4.0274	$168.64
24538	Treat humerus fracture	Y	A2	21.0673	$882.15
24545	Treat humerus fracture	Y	A2	50.5204	$2,115.44
24546	Treat humerus fracture	Y	A2	51.0166	$2,136.22

24560	Treat humerus fracture	Y	A2	1.7792	$74.50
24565	Treat humerus fracture	Y	A2	1.7792	$74.50
24566	Treat humerus fracture	Y	A2	21.0673	$882.15
24575	Treat humerus fracture	Y	A2	49.8357	$2,086.77
24576	Treat humerus fracture	Y	A2	1.7792	$74.50
24577	Treat humerus fracture	Y	A2	4.0274	$168.64
24579	Treat humerus fracture	Y	A2	49.8357	$2,086.77
24582	Treat humerus fracture	Y	A2	21.0673	$882.15
24586	Treat elbow fracture	Y	A2	50.5204	$2,115.44
24587	Treat elbow fracture	Y	A2	51.0166	$2,136.22
24600	Treat elbow dislocation	Y	A2	1.7792	$74.50
24605	Treat elbow dislocation	Y	A2	13.5044	$565.47
24615	Treat elbow dislocation	Y	A2	49.8357	$2,086.77
24620	Treat elbow fracture	Y	A2	13.7757	$576.83
24635	Treat elbow fracture	Y	A2	49.8357	$2,086.77
24640	Treat elbow dislocation	Y	P3		$60.61
24650	Treat radius fracture	Y	P2	1.584	$66.33
24655	Treat radius fracture	Y	A2	4.0274	$168.64
24665	Treat radius fracture	Y	A2	36.1811	$1,515.01
24666	Treat radius fracture	Y	A2	50.5204	$2,115.44
24670	Treat ulnar fracture	Y	A2	1.7792	$74.50
24675	Treat ulnar fracture	Y	A2	1.7792	$74.50
24685	Treat ulnar fracture	Y	A2	35.4964	$1,486.34
24800	Fusion of elbow joint	Y	A2	36.9773	$1,548.35
24802	Fusion/graft of elbow joint	Y	A2	37.4736	$1,569.13
24925	Amputation follow-up surgery	Y	A2	18.6877	$782.51
25000	Incision of tendon sheath	Y	A2	18.6877	$782.51
25001	Incise flexor carpi radialis	Y	G2	21.0374	$880.90
25020	Decompress forearm 1 space	Y	A2	25.6805	$1,075.32
25023	Decompress forearm 1 space	Y	A2	25.6805	$1,075.32
25024	Decompress forearm 2 spaces	Y	A2	25.6805	$1,075.32

25025	Decompress forearm 2 spaces	Y	A2	25.6805	$1,075.32
25028	Drainage of forearm lesion	Y	A2	17.678	$740.23
25031	Drainage of forearm bursa	Y	A2	18.3225	$767.22
25035	Treat forearm bone lesion	Y	A2	18.3225	$767.22
25040	Explore/treat wrist joint	Y	A2	26.8615	$1,124.77
25065	Biopsy forearm soft tissues	Y	P3		$147.92
25066	Biopsy forearm soft tissues	Y	A2	19.307	$808.44
25071	Exc forearm les sc > 3 cm	Y	G2	22.3496	$935.84
25073	Exc forearm tum deep = 3 cm	Y	G2	22.3496	$935.84
25075*	Exc forearm les sc < 3 cm	Y	P3		$178.23
25076	Exc forearm tum deep < 3 cm	Y	G2	16.7206	$700.14
25077	Resect forearm/wrist tum<3cm	Y	G2	16.7206	$700.14
25078	Resect forearm/wrist tum=3cm	Y	G2	22.3496	$935.84
25085	Incision of wrist capsule	Y	A2	18.6877	$782.51
25100	Biopsy of wrist joint	Y	A2	18.3225	$767.22
25101	Explore/treat wrist joint	Y	A2	25.6805	$1,075.32
25105	Remove wrist joint lining	Y	A2	26.3652	$1,103.99
25107	Remove wrist joint cartilage	Y	A2	25.6805	$1,075.32
25109	Excise tendon forearm/wrist	Y	G2	21.0374	$880.90
25110	Remove wrist tendon lesion	Y	A2	18.6877	$782.51
25111	Remove wrist tendon lesion	Y	A2	18.6877	$782.51
25112	Reremove wrist tendon lesion	Y	A2	19.3724	$811.18
25115	Remove wrist/forearm lesion	Y	A2	19.3724	$811.18
25116	Remove wrist/forearm lesion	Y	A2	19.3724	$811.18
25118	Excise wrist tendon sheath	Y	A2	25.3154	$1,060.03
25119	Partial removal of ulna	Y	A2	25.6805	$1,075.32
25120	Removal of forearm lesion	Y	A2	25.6805	$1,075.32
25125	Remove/graft forearm lesion	Y	A2	25.6805	$1,075.32
25126	Remove/graft forearm lesion	Y	A2	25.6805	$1,075.32
25130	Removal of wrist lesion	Y	A2	25.6805	$1,075.32
25135	Remove & graft wrist lesion	Y	A2	25.6805	$1,075.32

25136	Remove & graft wrist lesion	Y	A2	25.6805	$1,075.32
25145	Remove forearm bone lesion	Y	A2	25.3154	$1,060.03
25150	Partial removal of ulna	Y	A2	25.3154	$1,060.03
25151	Partial removal of radius	Y	A2	25.3154	$1,060.03
25210	Removal of wrist bone	Y	A2	25.6805	$1,075.32
25215	Removal of wrist bones	Y	A2	26.3652	$1,103.99
25230	Partial removal of radius	Y	A2	26.3652	$1,103.99
25240	Partial removal of ulna	Y	A2	26.3652	$1,103.99
25246	Injection for wrist x-ray	N	N1		
25248	Remove forearm foreign body	Y	A2	18.3225	$767.22
25250	Removal of wrist prosthesis	Y	A2	24.6708	$1,033.04
25251	Removal of wrist prosthesis	Y	A2	24.6708	$1,033.04
25259	Manipulate wrist w/anesthes	Y	G2	17.5794	$736.10
25260	Repair forearm tendon/muscle	Y	A2	26.3652	$1,103.99
25263	Repair forearm tendon/muscle	Y	A2	25.3154	$1,060.03
25265	Repair forearm tendon/muscle	Y	A2	25.6805	$1,075.32
25270	Repair forearm tendon/muscle	Y	A2	26.3652	$1,103.99
25272	Repair forearm tendon/muscle	Y	A2	25.6805	$1,075.32
25274	Repair forearm tendon/muscle	Y	A2	26.3652	$1,103.99
25275	Repair forearm tendon sheath	Y	A2	26.3652	$1,103.99
25280	Revise wrist/forearm tendon	Y	A2	26.3652	$1,103.99
25290	Incise wrist/forearm tendon	Y	A2	25.6805	$1,075.32
25295	Release wrist/forearm tendon	Y	A2	18.6877	$782.51
25300	Fusion of tendons at wrist	Y	A2	25.6805	$1,075.32
25301	Fusion of tendons at wrist	Y	A2	25.6805	$1,075.32
25310	Transplant forearm tendon	Y	A2	36.2926	$1,519.68
25312	Transplant forearm tendon	Y	A2	36.9773	$1,548.35
25315	Revise palsy hand tendon(s)	Y	A2	36.2926	$1,519.68
25316	Revise palsy hand tendon(s)	Y	A2	66.4466	$2,782.32
25320	Repair/revise wrist joint	Y	A2	36.2926	$1,519.68
25332	Revise wrist joint	Y	A2	32.6783	$1,368.34

25335	Realignment of hand	Y	A2	36.2926	$1,519.68
25337	Reconstruct ulna/radioulnar	Y	A2	37.4736	$1,569.13
25350	Revision of radius	Y	A2	36.2926	$1,519.68
25355	Revision of radius	Y	A2	36.2926	$1,519.68
25360	Revision of ulna	Y	A2	36.2926	$1,519.68
25365	Revise radius & ulna	Y	A2	36.2926	$1,519.68
25370	Revise radius or ulna	Y	A2	36.2926	$1,519.68
25375	Revise radius & ulna	Y	A2	36.9773	$1,548.35
25390	Shorten radius or ulna	Y	A2	36.2926	$1,519.68
25391	Lengthen radius or ulna	Y	A2	36.9773	$1,548.35
25392	Shorten radius & ulna	Y	A2	25.6805	$1,075.32
25393	Lengthen radius & ulna	Y	A2	36.9773	$1,548.35
25394	Repair carpal bone, shorten	Y	G2	44.5105	$1,863.79
25400	Repair radius or ulna	Y	A2	36.2926	$1,519.68
25405	Repair/graft radius or ulna	Y	A2	67.1313	$2,810.99
25415	Repair radius & ulna	Y	A2	66.4466	$2,782.32
25420	Repair/graft radius & ulna	Y	A2	67.1313	$2,810.99
25425	Repair/graft radius or ulna	Y	A2	36.2926	$1,519.68
25426	Repair/graft radius & ulna	Y	A2	36.9773	$1,548.35
25430	Vasc graft into carpal bone	Y	G2	44.5105	$1,863.79
25431	Repair nonunion carpal bone	Y	G2	44.5105	$1,863.79
25440	Repair/graft wrist bone	Y	A2	67.1313	$2,810.99
25441	Reconstruct wrist joint	Y	H8	149.9835	$6,280.26
25442	Reconstruct wrist joint	Y	H8	149.9835	$6,280.26
25443	Reconstruct wrist joint	Y	A2	45.7192	$1,914.40
25444	Reconstruct wrist joint	Y	A2	45.7192	$1,914.40
25445	Reconstruct wrist joint	Y	A2	45.7192	$1,914.40
25446	Wrist replacement	Y	H8	151.5697	$6,346.68
25447	Repair wrist joint(s)	Y	A2	32.6783	$1,368.34
25449	Remove wrist joint implant	Y	A2	32.6783	$1,368.34
25450	Revision of wrist joint	Y	A2	36.2926	$1,519.68

25455	Revision of wrist joint	Y	A2	36.2926	$1,519.68
25490	Reinforce radius	Y	A2	36.2926	$1,519.68
25491	Reinforce ulna	Y	A2	36.2926	$1,519.68
25492	Reinforce radius and ulna	Y	A2	36.2926	$1,519.68
25500	Treat fracture of radius	Y	P2	1.584	$66.33
25505	Treat fracture of radius	Y	A2	4.0274	$168.64
25515	Treat fracture of radius	Y	A2	35.4964	$1,486.34
25520	Treat fracture of radius	Y	A2	4.0274	$168.64
25525	Treat fracture of radius	Y	A2	36.1811	$1,515.01
25526	Treat fracture of radius	Y	A2	36.6776	$1,535.80
25530	Treat fracture of ulna	Y	P2	1.584	$66.33
25535	Treat fracture of ulna	Y	A2	1.7792	$74.50
25545	Treat fracture of ulna	Y	A2	35.4964	$1,486.34
25560	Treat fracture radius & ulna	Y	P2	1.584	$66.33
25565	Treat fracture radius & ulna	Y	A2	4.0274	$168.64
25574	Treat fracture radius & ulna	Y	A2	49.8357	$2,086.77
25575	Treat fracture radius/ulna	Y	A2	49.8357	$2,086.77
25600	Treat fracture radius/ulna	Y	P2	1.584	$66.33
25605	Treat fracture radius/ulna	Y	A2	4.0274	$168.64
25606	Treat fx distal radial	Y	A2	21.4324	$897.44
25607	Treat fx rad extra-articul	Y	A2	51.0166	$2,136.22
25608	Treat fx rad intra-articul	Y	A2	51.0166	$2,136.22
25609	Treat fx radial 3+ frag	Y	A2	51.0166	$2,136.22
25622	Treat wrist bone fracture	Y	P2	1.584	$66.33
25624	Treat wrist bone fracture	Y	A2	4.0274	$168.64
25628	Treat wrist bone fracture	Y	A2	35.4964	$1,486.34
25630	Treat wrist bone fracture	Y	P2	1.584	$66.33
25635	Treat wrist bone fracture	Y	A2	4.0274	$168.64
25645	Treat wrist bone fracture	Y	A2	35.4964	$1,486.34
25650	Treat wrist bone fracture	Y	P2	1.584	$66.33
25651	Pin ulnar styloid fracture	Y	G2	24.6971	$1,034.14

25652	Treat fracture ulnar styloid	Y	G2	43.449	$1,819.34
25660	Treat wrist dislocation	Y	A2	1.7792	$74.50
25670	Treat wrist dislocation	Y	A2	21.4324	$897.44
25671	Pin radioulnar dislocation	Y	A2	20.4227	$855.16
25675	Treat wrist dislocation	Y	A2	1.7792	$74.50
25676	Treat wrist dislocation	Y	A2	21.0673	$882.15
25680	Treat wrist fracture	Y	A2	1.7792	$74.50
25685	Treat wrist fracture	Y	A2	21.4324	$897.44
25690	Treat wrist dislocation	Y	A2	13.7757	$576.83
25695	Treat wrist dislocation	Y	A2	21.0673	$882.15
25800	Fusion of wrist joint	Y	A2	67.1313	$2,810.99
25805	Fusion/graft of wrist joint	Y	A2	37.4736	$1,569.13
25810	Fusion/graft of wrist joint	Y	A2	67.6276	$2,831.77
25820	Fusion of hand bones	Y	A2	36.9773	$1,548.35
25825	Fuse hand bones with graft	Y	A2	67.6276	$2,831.77
25830	Fusion, radioulnar jnt/ulna	Y	A2	67.6276	$2,831.77
25907	Amputation follow-up surgery	Y	A2	18.6877	$782.51
25922	Amputate hand at wrist	Y	A2	18.6877	$782.51
25929	Amputation follow-up surgery	Y	A2	14.4157	$603.63
25931	Amputation follow-up surgery	Y	G2	21.0374	$880.90
26010	Drainage of finger abscess	Y	P2	1.3911	$58.25
26011	Drainage of finger abscess	Y	A2	10.9457	$458.33
26020	Drain hand tendon sheath	Y	A2	14.7587	$617.99
26025	Drainage of palm bursa	Y	A2	14.1139	$590.99
26030	Drainage of palm bursa(s)	Y	A2	14.7587	$617.99
26034	Treat hand bone lesion	Y	A2	14.7587	$617.99
26035	Decompress fingers/hand	Y	G2	16.2853	$681.91
26037	Decompress fingers/hand	Y	G2	16.2853	$681.91
26040	Release palm contracture	Y	A2	23.8321	$997.92
26045	Release palm contracture	Y	A2	23.1476	$969.26
26055	Incise finger tendon sheath	Y	A2	14.7587	$617.99
26060	Incision of finger tendon	Y	A2	14.7587	$617.99
26070	Explore/treat hand joint	Y	A2	14.7587	$617.99
26075	Explore/treat finger joint	Y	A2	15.8085	$661.95
26080	Explore/treat finger joint	Y	A2	15.8085	$661.95
26100	Biopsy hand joint lining	Y	A2	14.7587	$617.99
26105	Biopsy finger joint lining	Y	A2	14.1139	$590.99
26110	Biopsy finger joint lining	Y	A2	14.1139	$590.99
26111	Exc hand les sc > 1.5 cm	Y	G2	22.3496	$935.84
26113	Exc hand tum deep > 1.5 cm	Y	G2	22.3496	$935.84
26115*	Exc hand les sc < 1.5 cm	Y	P3		$364.04
26116	Exc hand tum deep < 1.5 cm	Y	G2	16.7206	$700.14
26117	Exc hand tum ra < 3 cm	Y	G2	16.7206	$700.14
26118	Exc hand tum ra > 3 cm	Y	G2	22.3496	$935.84
26121	Release palm contracture	Y	A2	23.8321	$997.92
26123	Release palm contracture	Y	A2	23.8321	$997.92
26125	Release palm contracture	Y	A2	15.8085	$661.95
26130	Remove wrist joint lining	Y	A2	15.1238	$633.28
26135	Revise finger joint, each	Y	A2	23.8321	$997.92
26140	Revise finger joint, each	Y	A2	14.7587	$617.99
26145	Tendon excision, palm/finger	Y	A2	15.1238	$633.28
26160	Remove tendon sheath lesion	Y	A2	15.1238	$633.28
26170	Removal of palm tendon, each	Y	A2	15.1238	$633.28
26180	Removal of finger tendon	Y	A2	15.1238	$633.28
26185	Remove finger bone	Y	A2	15.8085	$661.95
26200	Remove hand bone lesion	Y	A2	14.7587	$617.99
26205	Remove/graft bone lesion	Y	A2	23.1476	$969.26
26210	Removal of finger lesion	Y	A2	14.7587	$617.99
26215	Remove/graft finger lesion	Y	A2	15.1238	$633.28
26230	Partial removal of hand bone	Y	A2	17.8793	$748.66
26235	Partial removal, finger bone	Y	A2	15.1238	$633.28
26236	Partial removal, finger bone	Y	A2	15.1238	$633.28

26250	Extensive hand surgery	Y	A2	15.1238	$633.28
26255	Extensive hand surgery	N	D5		
26260	Resect prox finger tumor	Y	A2	15.1238	$633.28
26261	Extensive finger surgery	N	D5		
26262	Resect distal finger tumor	Y	A2	14.7587	$617.99
26320	Removal of implant from hand	Y	A2	15.0849	$631.65
26340	Manipulate finger w/anesth	Y	G2	4.5817	$191.85
26350	Repair finger/hand tendon	Y	A2	22.1377	$926.97
26352	Repair/graft hand tendon	Y	A2	23.8321	$997.92
26356	Repair finger/hand tendon	Y	A2	23.8321	$997.92
26357	Repair finger/hand tendon	Y	A2	23.8321	$997.92
26358	Repair/graft hand tendon	Y	A2	23.8321	$997.92
26370	Repair finger/hand tendon	Y	A2	23.8321	$997.92
26372	Repair/graft hand tendon	Y	A2	23.8321	$997.92
26373	Repair finger/hand tendon	Y	A2	23.1476	$969.26
26390	Revise hand/finger tendon	Y	A2	23.8321	$997.92
26392	Repair/graft hand tendon	Y	A2	23.1476	$969.26
26410	Repair hand tendon	Y	A2	15.1238	$633.28
26412	Repair/graft hand tendon	Y	A2	23.1476	$969.26
26415	Excision, hand/finger tendon	Y	A2	23.8321	$997.92
26416	Graft hand or finger tendon	Y	A2	23.1476	$969.26
26418	Repair finger tendon	Y	A2	15.8085	$661.95
26420	Repair/graft finger tendon	Y	A2	23.8321	$997.92
26426	Repair finger/hand tendon	Y	A2	23.1476	$969.26
26428	Repair/graft finger tendon	Y	A2	23.1476	$969.26
26432	Repair finger tendon	Y	A2	15.1238	$633.28
26433	Repair finger tendon	Y	A2	15.1238	$633.28
26434	Repair/graft finger tendon	Y	A2	23.1476	$969.26
26437	Realignment of tendons	Y	A2	15.1238	$633.28
26440	Release palm/finger tendon	Y	A2	15.1238	$633.28
26442	Release palm & finger tendon	Y	A2	23.1476	$969.26

26445	Release hand/finger tendon	Y	A2	15.1238	$633.28
26449	Release forearm/hand tendon	Y	A2	23.1476	$969.26
26450	Incision of palm tendon	Y	A2	15.1238	$633.28
26455	Incision of finger tendon	Y	A2	15.1238	$633.28
26460	Incise hand/finger tendon	Y	A2	15.1238	$633.28
26471	Fusion of finger tendons	Y	A2	14.7587	$617.99
26474	Fusion of finger tendons	Y	A2	14.7587	$617.99
26476	Tendon lengthening	Y	A2	14.1139	$590.99
26477	Tendon shortening	Y	A2	14.1139	$590.99
26478	Lengthening of hand tendon	Y	A2	14.1139	$590.99
26479	Shortening of hand tendon	Y	A2	14.1139	$590.99
26480	Transplant hand tendon	Y	A2	23.1476	$969.26
26483	Transplant/graft hand tendon	Y	A2	23.1476	$969.26
26485	Transplant palm tendon	Y	A2	22.7825	$953.97
26489	Transplant/graft palm tendon	Y	A2	23.1476	$969.26
26490	Revise thumb tendon	Y	A2	23.1476	$969.26
26492	Tendon transfer with graft	Y	A2	23.1476	$969.26
26494	Hand tendon/muscle transfer	Y	A2	23.1476	$969.26
26496	Revise thumb tendon	Y	A2	23.1476	$969.26
26497	Finger tendon transfer	Y	A2	23.1476	$969.26
26498	Finger tendon transfer	Y	A2	23.8321	$997.92
26499	Revision of finger	Y	A2	23.1476	$969.26
26500	Hand tendon reconstruction	Y	A2	15.8085	$661.95
26502	Hand tendon reconstruction	Y	A2	23.8321	$997.92
26508	Release thumb contracture	Y	A2	15.1238	$633.28
26510	Thumb tendon transfer	Y	A2	23.1476	$969.26
26516	Fusion of knuckle joint	Y	A2	22.1377	$926.97
26517	Fusion of knuckle joints	Y	A2	23.1476	$969.26
26518	Fusion of knuckle joints	Y	A2	23.1476	$969.26
26520	Release knuckle contracture	Y	A2	15.1238	$633.28
26525	Release finger contracture	Y	A2	15.1238	$633.28

26530	Revise knuckle joint	Y	A2	31.4971	$1,318.88
26531	Revise knuckle with implant	Y	A2	47.3054	$1,980.82
26535	Revise finger joint	Y	A2	32.6783	$1,368.34
26536	Revise/implant finger joint	Y	A2	45.7192	$1,914.40
26540	Repair hand joint	Y	A2	15.8085	$661.95
26541	Repair hand joint with graft	Y	A2	25.9146	$1,085.12
26542	Repair hand joint with graft	Y	A2	15.8085	$661.95
26545	Reconstruct finger joint	Y	A2	23.8321	$997.92
26546	Repair nonunion hand	Y	A2	23.8321	$997.92
26548	Reconstruct finger joint	Y	A2	23.8321	$997.92
26550	Construct thumb replacement	Y	A2	22.7825	$953.97
26555	Positional change of finger	Y	A2	23.1476	$969.26
26560	Repair of web finger	Y	A2	14.7587	$617.99
26561	Repair of web finger	Y	A2	23.1476	$969.26
26562	Repair of web finger	Y	A2	23.8321	$997.92
26565	Correct metacarpal flaw	Y	A2	24.3286	$1,018.71
26567	Correct finger deformity	Y	A2	24.3286	$1,018.71
26568	Lengthen metacarpal/finger	Y	A2	23.1476	$969.26
26580	Repair hand deformity	Y	A2	16.3048	$682.73
26587	Reconstruct extra finger	Y	A2	16.3048	$682.73
26590	Repair finger deformity	Y	A2	16.3048	$682.73
26591	Repair muscles of hand	Y	A2	23.1476	$969.26
26593	Release muscles of hand	Y	A2	15.1238	$633.28
26596	Excision constricting tissue	Y	A2	14.7587	$617.99
26600	Treat metacarpal fracture	Y	P2	1.584	$66.33
26605	Treat metacarpal fracture	Y	A2	1.7792	$74.50
26607	Treat metacarpal fracture	Y	A2	13.7757	$576.83
26608	Treat metacarpal fracture	Y	A2	22.1171	$926.11
26615	Treat metacarpal fracture	Y	A2	36.1811	$1,515.01
26641	Treat thumb dislocation	Y	P2	1.584	$66.33
26645	Treat thumb fracture	Y	A2	4.0274	$168.64

26650	Treat thumb fracture	Y	A2	21.0673	$882.15
26665	Treat thumb fracture	Y	A2	36.1811	$1,515.01
26670	Treat hand dislocation	Y	P2	1.584	$66.33
26675	Treat hand dislocation	Y	A2	4.0274	$168.64
26676	Pin hand dislocation	Y	A2	21.0673	$882.15
26685	Treat hand dislocation	Y	A2	21.4324	$897.44
26686	Treat hand dislocation	Y	A2	49.8357	$2,086.77
26700	Treat knuckle dislocation	Y	P2	1.584	$66.33
26705	Treat knuckle dislocation	Y	A2	1.7792	$74.50
26706	Pin knuckle dislocation	Y	A2	13.7757	$576.83
26715	Treat knuckle dislocation	Y	A2	22.1171	$926.11
26720	Treat finger fracture, each	Y	P2	1.584	$66.33
26725	Treat finger fracture, each	Y	P2	1.584	$66.33
26727	Treat finger fracture, each	Y	A2	24.1996	$1,013.31
26735	Treat finger fracture, each	Y	A2	22.1171	$926.11
26740	Treat finger fracture, each	Y	P2	1.584	$66.33
26742	Treat finger fracture, each	Y	A2	1.7792	$74.50
26746	Treat finger fracture, each	Y	A2	22.6136	$946.90
26750	Treat finger fracture, each	Y	P2	1.584	$66.33
26755	Treat finger fracture, each	Y	G2	1.584	$66.33
26756	Pin finger fracture, each	Y	A2	21.0673	$882.15
26765	Treat finger fracture, each	Y	A2	22.1171	$926.11
26770	Treat finger dislocation	Y	G2	1.584	$66.33
26775	Treat finger dislocation	Y	P3		$181.48
26776	Pin finger dislocation	Y	A2	21.0673	$882.15
26785	Treat finger dislocation	Y	A2	21.0673	$882.15
26820	Thumb fusion with graft	Y	A2	24.3286	$1,018.71
26841	Fusion of thumb	Y	A2	23.8321	$997.92
26842	Thumb fusion with graft	Y	A2	23.8321	$997.92
26843	Fusion of hand joint	Y	A2	23.1476	$969.26
26844	Fusion/graft of hand joint	Y	A2	23.1476	$969.26

26850	Fusion of knuckle	Y	A2	23.8321	$997.92
26852	Fusion of knuckle with graft	Y	A2	23.8321	$997.92
26860	Fusion of finger joint	Y	A2	23.1476	$969.26
26861	Fusion of finger jnt, add-on	Y	A2	22.7825	$953.97
26862	Fusion/graft of finger joint	Y	A2	23.8321	$997.92
26863	Fuse/graft added joint	Y	A2	23.1476	$969.26
26910	Amputate metacarpal bone	Y	A2	23.1476	$969.26
26951	Amputation of finger/thumb	Y	A2	14.7587	$617.99
26952	Amputation of finger/thumb	Y	A2	15.8085	$661.95
26990	Drainage of pelvis lesion	Y	A2	17.678	$740.23
26991	Drainage of pelvis bursa	Y	A2	17.678	$740.23
27000	Incision of hip tendon	Y	A2	18.3225	$767.22
27001	Incision of hip tendon	Y	A2	25.6805	$1,075.32
27003	Incision of hip tendon	Y	A2	25.6805	$1,075.32
27033	Exploration of hip joint	Y	A2	36.2926	$1,519.68
27035	Denervation of hip joint	Y	A2	36.9773	$1,548.35
27040	Biopsy of soft tissues	Y	A2	7.779	$325.73
27041	Biopsy of soft tissues	Y	A2	8.2667	$346.15
27043	Exc hip pelvis les sc > 3 cm	Y	G2	22.3496	$935.84
27045	Exc hip/pelv tum deep > 5 cm	Y	G2	22.3496	$935.84
27047*	Exc hip/pelvis les sc < 3 cm	Y	P3		$253.64
27048	Exc hip/pelv tum deep < 5 cm	Y	G2	16.7206	$700.14
27049	Resect hip/pelv tum < 5 cm	Y	G2	16.7206	$700.14
27050	Biopsy of sacroiliac joint	Y	A2	18.6877	$782.51
27052	Biopsy of hip joint	Y	A2	18.6877	$782.51
27059	Resect hip/pelv tum > 5 cm	Y	G2	22.3496	$935.84
27060	Removal of ischial bursa	Y	A2	19.8689	$831.97
27062	Remove femur lesion/bursa	Y	A2	19.8689	$831.97
27065	Removal of hip bone lesion	Y	A2	19.8689	$831.97
27066	Removal of hip bone lesion	Y	A2	26.8615	$1,124.77
27067	Remove/graft hip bone lesion	Y	A2	26.8615	$1,124.77

27080	Removal of tail bone	Y	A2	25.3154	$1,060.03
27086	Remove hip foreign body	Y	A2	7.779	$325.73
27087	Remove hip foreign body	Y	A2	18.6877	$782.51
27093	Injection for hip x-ray	N	N1		
27095	Injection for hip x-ray	N	N1		
27097	Revision of hip tendon	Y	A2	25.6805	$1,075.32
27098	Transfer tendon to pelvis	Y	A2	25.6805	$1,075.32
27100	Transfer of abdominal muscle	Y	A2	36.9773	$1,548.35
27105	Transfer of spinal muscle	Y	A2	36.9773	$1,548.35
27110	Transfer of iliopsoas muscle	Y	A2	36.9773	$1,548.35
27111	Transfer of iliopsoas muscle	Y	A2	36.9773	$1,548.35
27193	Treat pelvic ring fracture	Y	A2	1.7792	$74.50
27194	Treat pelvic ring fracture	Y	A2	13.5044	$565.47
27200	Treat tail bone fracture	Y	P2	1.584	$66.33
27202	Treat tail bone fracture	Y	A2	35.1312	$1,471.05
27220	Treat hip socket fracture	Y	G2	1.584	$66.33
27230	Treat thigh fracture	Y	A2	1.7792	$74.50
27238	Treat thigh fracture	Y	A2	4.0274	$168.64
27246	Treat thigh fracture	Y	A2	4.0274	$168.64
27250	Treat hip dislocation	Y	A2	1.7792	$74.50
27252	Treat hip dislocation	Y	A2	13.5044	$565.47
27256	Treat hip dislocation	Y	G2	1.584	$66.33
27257	Treat hip dislocation	Y	A2	13.8696	$580.76
27265	Treat hip dislocation	Y	A2	1.7792	$74.50
27266	Treat hip dislocation	Y	A2	13.5044	$565.47
27267	Cltx thigh fx	Y	G2	1.584	$66.33
27275	Manipulation of hip joint	Y	A2	13.5044	$565.47
27301	Drain thigh/knee lesion	Y	A2	16.8182	$704.23
27305	Incise thigh tendon & fascia	Y	A2	18.3225	$767.22
27306	Incision of thigh tendon	Y	A2	18.6877	$782.51
27307	Incision of thigh tendons	Y	A2	18.6877	$782.51

27310	Exploration of knee joint	Y	A2	26.3652	$1,103.99
27323	Biopsy, thigh soft tissues	Y	A2	7.779	$325.73
27324	Biopsy, thigh soft tissues	Y	A2	18.6621	$781.44
27325	Neurectomy, hamstring	Y	A2	15.9611	$668.34
27326	Neurectomy, popliteal	Y	A2	15.9611	$668.34
27327*	Exc thigh/knee les sc < 3 cm	Y	P3		$230.91
27328	Exc thigh/knee tum deep <5cm	Y	G2	16.7206	$700.14
27329	Resect thigh/knee tum < 5 cm	Y	G2	16.7206	$700.14
27330	Biopsy, knee joint lining	Y	A2	26.3652	$1,103.99
27331	Explore/treat knee joint	Y	A2	26.3652	$1,103.99
27332	Removal of knee cartilage	Y	A2	26.3652	$1,103.99
27333	Removal of knee cartilage	Y	A2	26.3652	$1,103.99
27334	Remove knee joint lining	Y	A2	26.3652	$1,103.99
27335	Remove knee joint lining	Y	A2	26.3652	$1,103.99
27337	Exc thigh/knee les sc > 3 cm	Y	G2	22.3496	$935.84
27339	Exc thigh/knee tum deep >5cm	Y	G2	22.3496	$935.84
27340	Removal of kneecap bursa	Y	A2	18.6877	$782.51
27345	Removal of knee cyst	Y	A2	19.3724	$811.18
27347	Remove knee cyst	Y	A2	19.3724	$811.18
27350	Removal of kneecap	Y	A2	26.3652	$1,103.99
27355	Remove femur lesion	Y	A2	25.6805	$1,075.32
27356	Remove femur lesion/graft	Y	A2	26.3652	$1,103.99
27357	Remove femur lesion/graft	Y	A2	26.8615	$1,124.77
27358	Remove femur lesion/fixation	Y	A2	26.8615	$1,124.77
27360	Partial removal, leg bone(s)	Y	A2	26.8615	$1,124.77
27364	Resect thigh/knee tum >5 cm	Y	G2	22.3496	$935.84
27370	Injection for knee x-ray	N	N1		
27372	Removal of foreign body	Y	A2	22.439	$939.59
27380	Repair of kneecap tendon	Y	A2	17.678	$740.23
27381	Repair/graft kneecap tendon	Y	A2	18.6877	$782.51
27385	Repair of thigh muscle	Y	A2	18.6877	$782.51

27386	Repair/graft of thigh muscle	Y	A2	18.6877	$782.51
27390	Incision of thigh tendon	Y	A2	17.678	$740.23
27391	Incision of thigh tendons	Y	A2	18.3225	$767.22
27392	Incision of thigh tendons	Y	A2	18.6877	$782.51
27393	Lengthening of thigh tendon	Y	A2	25.3154	$1,060.03
27394	Lengthening of thigh tendons	Y	A2	25.6805	$1,075.32
27395	Lengthening of thigh tendons	Y	A2	36.2926	$1,519.68
27396	Transplant of thigh tendon	Y	A2	25.6805	$1,075.32
27397	Transplants of thigh tendons	Y	A2	36.2926	$1,519.68
27400	Revise thigh muscles/tendons	Y	A2	36.2926	$1,519.68
27403	Repair of knee cartilage	Y	A2	26.3652	$1,103.99
27405	Repair of knee ligament	Y	A2	36.9773	$1,548.35
27407	Repair of knee ligament	Y	A2	67.1313	$2,810.99
27409	Repair of knee ligaments	Y	A2	36.9773	$1,548.35
27416	Osteochondral knee autograft	Y	G2	44.5105	$1,863.79
27418	Repair degenerated kneecap	Y	A2	36.2926	$1,519.68
27420	Revision of unstable kneecap	Y	A2	36.2926	$1,519.68
27422	Revision of unstable kneecap	Y	A2	39.0598	$1,635.55
27424	Revision/removal of kneecap	Y	A2	36.2926	$1,519.68
27425	Lat retinacular release open	Y	A2	28.4477	$1,191.19
27427	Reconstruction, knee	Y	A2	36.2926	$1,519.68
27428	Reconstruction, knee	Y	A2	67.1313	$2,810.99
27429	Reconstruction, knee	Y	A2	67.1313	$2,810.99
27430	Revision of thigh muscles	Y	A2	36.9773	$1,548.35
27435	Incision of knee joint	Y	A2	36.9773	$1,548.35
27437	Revise kneecap	Y	A2	32.1818	$1,347.55
27438	Revise kneecap with implant	Y	A2	45.7192	$1,914.40
27440	Revision of knee joint	Y	G2	38.1167	$1,596.06
27441	Revision of knee joint	Y	A2	32.6783	$1,368.34
27442	Revision of knee joint	Y	A2	32.6783	$1,368.34
27443	Revision of knee joint	Y	A2	32.6783	$1,368.34

27446	Revision of knee joint	Y	J8	157.9373	$6,613.31
27475	Surgery to stop leg growth	Y	G2	30.361	$1,271.31
27479	Surgery to stop leg growth	Y	G2	30.361	$1,271.31
27496	Decompression of thigh/knee	Y	A2	26.8615	$1,124.77
27497	Decompression of thigh/knee	Y	A2	18.6877	$782.51
27498	Decompression of thigh/knee	Y	A2	25.6805	$1,075.32
27499	Decompression of thigh/knee	Y	A2	25.6805	$1,075.32
27500	Treatment of thigh fracture	Y	A2	4.0274	$168.64
27501	Treatment of thigh fracture	Y	A2	1.7792	$74.50
27502	Treatment of thigh fracture	Y	A2	13.7757	$576.83
27503	Treatment of thigh fracture	Y	A2	1.7792	$74.50
27508	Treatment of thigh fracture	Y	A2	1.7792	$74.50
27509	Treatment of thigh fracture	Y	A2	21.4324	$897.44
27510	Treatment of thigh fracture	Y	A2	4.0274	$168.64
27516	Treat thigh fx growth plate	Y	A2	1.7792	$74.50
27517	Treat thigh fx growth plate	Y	A2	1.7792	$74.50
27520	Treat kneecap fracture	Y	A2	1.7792	$74.50
27530	Treat knee fracture	Y	A2	1.7792	$74.50
27532	Treat knee fracture	Y	A2	13.7757	$576.83
27538	Treat knee fracture(s)	Y	A2	1.7792	$74.50
27550	Treat knee dislocation	Y	A2	1.7792	$74.50
27552	Treat knee dislocation	Y	A2	12.8598	$538.48
27560	Treat kneecap dislocation	Y	A2	1.7792	$74.50
27562	Treat kneecap dislocation	Y	A2	12.8598	$538.48
27566	Treat kneecap dislocation	Y	A2	35.1312	$1,471.05
27570	Fixation of knee joint	Y	A2	12.8598	$538.48
27594	Amputation follow-up surgery	Y	A2	18.6877	$782.51
27600	Decompression of lower leg	Y	A2	18.6877	$782.51
27601	Decompression of lower leg	Y	A2	18.6877	$782.51
27602	Decompression of lower leg	Y	A2	18.6877	$782.51
27603	Drain lower leg lesion	Y	A2	16.4531	$688.94

27604	Drain lower leg bursa	Y	A2	18.3225	$767.22
27605	Incision of achilles tendon	Y	A2	17.5555	$735.10
27606	Incision of achilles tendon	Y	A2	17.678	$740.23
27607	Treat lower leg bone lesion	Y	A2	18.3225	$767.22
27610	Explore/treat ankle joint	Y	A2	25.3154	$1,060.03
27612	Exploration of ankle joint	Y	A2	25.6805	$1,075.32
27613	Biopsy lower leg soft tissue	Y	P3		$140.35
27614	Biopsy lower leg soft tissue	Y	A2	19.307	$808.44
27615	Resect leg/ankle tum < 5 cm	Y	G2	16.7206	$700.14
27616	Resect leg/ankle tum > 5 cm	Y	G2	22.3496	$935.84
27618*	Exc leg/ankle tum < 3 cm	Y	P3		$238.12
27619	Exc leg/ankle tum deep <5 cm	Y	G2	16.7206	$700.14
27620	Explore/treat ankle joint	Y	A2	26.3652	$1,103.99
27625	Remove ankle joint lining	Y	A2	26.3652	$1,103.99
27626	Remove ankle joint lining	Y	A2	26.3652	$1,103.99
27630	Removal of tendon lesion	Y	A2	18.6877	$782.51
27632	Exc leg/ankle les sc > 3 cm	Y	G2	22.3496	$935.84
27634	Exc leg/ankle tum deep >5 cm	Y	G2	22.3496	$935.84
27635	Remove lower leg bone lesion	Y	A2	25.6805	$1,075.32
27637	Remove/graft leg bone lesion	Y	A2	25.6805	$1,075.32
27638	Remove/graft leg bone lesion	Y	A2	25.6805	$1,075.32
27640	Partial removal of tibia	Y	A2	35.9274	$1,504.39
27641	Partial removal of fibula	Y	A2	25.3154	$1,060.03
27647	Resect talus/calcaneus tum	Y	A2	36.2926	$1,519.68
27648	Injection for ankle x-ray	N	N1		
27650	Repair achilles tendon	Y	A2	36.2926	$1,519.68
27652	Repair/graft achilles tendon	Y	A2	66.4466	$2,782.32
27654	Repair of achilles tendon	Y	A2	36.2926	$1,519.68
27656	Repair leg fascia defect	Y	A2	18.3225	$767.22
27658	Repair of leg tendon, each	Y	A2	17.678	$740.23
27659	Repair of leg tendon, each	Y	A2	18.3225	$767.22

27664	Repair of leg tendon, each	Y	A2	25.3154	$1,060.03
27665	Repair of leg tendon, each	Y	A2	25.3154	$1,060.03
27675	Repair lower leg tendons	Y	A2	18.3225	$767.22
27676	Repair lower leg tendons	Y	A2	25.6805	$1,075.32
27680	Release of lower leg tendon	Y	A2	25.6805	$1,075.32
27681	Release of lower leg tendons	Y	A2	25.3154	$1,060.03
27685	Revision of lower leg tendon	Y	A2	25.6805	$1,075.32
27686	Revise lower leg tendons	Y	A2	25.6805	$1,075.32
27687	Revision of calf tendon	Y	A2	25.6805	$1,075.32
27690	Revise lower leg tendon	Y	A2	36.9773	$1,548.35
27691	Revise lower leg tendon	Y	A2	36.9773	$1,548.35
27692	Revise additional leg tendon	Y	A2	36.2926	$1,519.68
27695	Repair of ankle ligament	Y	A2	25.3154	$1,060.03
27696	Repair of ankle ligaments	Y	A2	25.3154	$1,060.03
27698	Repair of ankle ligament	Y	A2	25.3154	$1,060.03
27700	Revision of ankle joint	Y	A2	32.6783	$1,368.34
27704	Removal of ankle implant	Y	A2	18.3225	$767.22
27705	Incision of tibia	Y	A2	35.9274	$1,504.39
27707	Incision of fibula	Y	A2	18.3225	$767.22
27709	Incision of tibia & fibula	Y	A2	25.3154	$1,060.03
27720	Repair of tibia	Y	G2	43.449	$1,819.34
27726	Repair fibula nonunion	Y	G2	43.449	$1,819.34
27730	Repair of tibia epiphysis	Y	A2	25.3154	$1,060.03
27732	Repair of fibula epiphysis	Y	A2	25.3154	$1,060.03
27734	Repair lower leg epiphyses	Y	A2	25.3154	$1,060.03
27740	Repair of leg epiphyses	Y	A2	25.3154	$1,060.03
27742	Repair of leg epiphyses	Y	A2	35.9274	$1,504.39
27745	Reinforce tibia	Y	A2	66.4466	$2,782.32
27750	Treatment of tibia fracture	Y	A2	1.7792	$74.50
27752	Treatment of tibia fracture	Y	A2	13.7757	$576.83
27756	Treatment of tibia fracture	Y	A2	21.4324	$897.44

27758	Treatment of tibia fracture	Y	A2	36.1811	$1,515.01
27759	Treatment of tibia fracture	Y	A2	50.5204	$2,115.44
27760	Cltx medial ankle fx	Y	A2	1.7792	$74.50
27762	Cltx med ankle fx w/mnpj	Y	A2	13.7757	$576.83
27766	Optx medial ankle fx	Y	A2	35.4964	$1,486.34
27767	Cltx post ankle fx	Y	G2	1.584	$66.33
27768	Cltx post ankle fx w/mnpj	Y	G2	1.584	$66.33
27769	Optx post ankle fx	Y	G2	43.449	$1,819.34
27780	Treatment of fibula fracture	Y	A2	1.7792	$74.50
27781	Treatment of fibula fracture	Y	A2	13.7757	$576.83
27784	Treatment of fibula fracture	Y	A2	35.4964	$1,486.34
27786	Treatment of ankle fracture	Y	A2	1.7792	$74.50
27788	Treatment of ankle fracture	Y	A2	1.7792	$74.50
27792	Treatment of ankle fracture	Y	A2	35.4964	$1,486.34
27808	Treatment of ankle fracture	Y	A2	1.7792	$74.50
27810	Treatment of ankle fracture	Y	A2	4.0274	$168.64
27814	Treatment of ankle fracture	Y	A2	35.4964	$1,486.34
27816	Treatment of ankle fracture	Y	A2	1.7792	$74.50
27818	Treatment of ankle fracture	Y	A2	4.0274	$168.64
27822	Treatment of ankle fracture	Y	A2	35.4964	$1,486.34
27823	Treatment of ankle fracture	Y	A2	49.8357	$2,086.77
27824	Treat lower leg fracture	Y	A2	1.7792	$74.50
27825	Treat lower leg fracture	Y	A2	13.7757	$576.83
27826	Treat lower leg fracture	Y	A2	35.4964	$1,486.34
27827	Treat lower leg fracture	Y	A2	49.8357	$2,086.77
27828	Treat lower leg fracture	Y	A2	50.5204	$2,115.44
27829	Treat lower leg joint	Y	A2	35.1312	$1,471.05
27830	Treat lower leg dislocation	Y	A2	1.7792	$74.50
27831	Treat lower leg dislocation	Y	A2	13.7757	$576.83
27832	Treat lower leg dislocation	Y	A2	35.1312	$1,471.05
27840	Treat ankle dislocation	Y	A2	4.0274	$168.64

27842	Treat ankle dislocation	Y	A2	12.8598	$538.48
27846	Treat ankle dislocation	Y	A2	35.4964	$1,486.34
27848	Treat ankle dislocation	Y	A2	35.4964	$1,486.34
27860	Fixation of ankle joint	Y	A2	12.8598	$538.48
27870	Fusion of ankle joint, open	Y	A2	67.1313	$2,810.99
27871	Fusion of tibiofibular joint	Y	A2	67.1313	$2,810.99
27884	Amputation follow-up surgery	Y	A2	18.6877	$782.51
27889	Amputation of foot at ankle	Y	A2	25.6805	$1,075.32
27892	Decompression of leg	Y	A2	25.6805	$1,075.32
27893	Decompression of leg	Y	A2	25.6805	$1,075.32
27894	Decompression of leg	Y	A2	25.6805	$1,075.32
28001	Drainage of bursa of foot	Y	P3		$138.90
28002	Treatment of foot infection	Y	A2	18.6877	$782.51
28003	Treatment of foot infection	Y	A2	18.6877	$782.51
28005	Treat foot bone lesion	Y	A2	18.5652	$777.38
28008	Incision of foot fascia	Y	A2	18.5652	$777.38
28010	Incision of toe tendon	Y	P3		$101.38
28011	Incision of toe tendons	Y	A2	18.5652	$777.38
28020	Exploration of foot joint	Y	A2	18.2	$762.09
28022	Exploration of foot joint	Y	A2	18.2	$762.09
28024	Exploration of toe joint	Y	A2	18.2	$762.09
28035	Decompression of tibia nerve	Y	A2	17.011	$712.30
28039*	Exc foot/toe tum sc > 1.5 cm	Y	P3		$252.91
28041*	Exc foot/toe tum deep >1.5cm	Y	R2	22.3496	$935.84
28043*	Exc foot/toe tum sc < 1.5 cm	Y	P3		$180.03
28045*	Exc foot/toe tum deep <1.5cm	Y	P3		$246.78
28046*	Resect foot/toe tumor < 3 cm	Y	R2	16.7206	$700.14
28047	Resect foot/toe tumor > 3 cm	Y	G2	22.3496	$935.84
28050	Biopsy of foot joint lining	Y	A2	18.2	$762.09
28052	Biopsy of foot joint lining	Y	A2	18.2	$762.09
28054	Biopsy of toe joint lining	Y	A2	18.2	$762.09

28055	Neurectomy, foot	Y	A2	17.011	$712.30
28060	Partial removal, foot fascia	Y	A2	18.2	$762.09
28062	Removal of foot fascia	Y	A2	18.5652	$777.38
28070	Removal of foot joint lining	Y	A2	18.5652	$777.38
28072	Removal of foot joint lining	Y	A2	18.5652	$777.38
28080	Removal of foot lesion	Y	A2	18.5652	$777.38
28086	Excise foot tendon sheath	Y	A2	18.2	$762.09
28088	Excise foot tendon sheath	Y	A2	18.2	$762.09
28090	Removal of foot lesion	Y	A2	18.5652	$777.38
28092	Removal of toe lesions	Y	A2	18.5652	$777.38
28100	Removal of ankle/heel lesion	Y	A2	18.2	$762.09
28102	Remove/graft foot lesion	Y	A2	40.555	$1,698.16
28103	Remove/graft foot lesion	Y	A2	40.555	$1,698.16
28104	Removal of foot lesion	Y	A2	18.2	$762.09
28106	Remove/graft foot lesion	Y	A2	40.555	$1,698.16
28107	Remove/graft foot lesion	Y	A2	40.555	$1,698.16
28108	Removal of toe lesions	Y	A2	18.2	$762.09
28110	Part removal of metatarsal	Y	A2	18.5652	$777.38
28111	Part removal of metatarsal	Y	A2	18.5652	$777.38
28112	Part removal of metatarsal	Y	A2	18.5652	$777.38
28113	Part removal of metatarsal	Y	A2	18.5652	$777.38
28114	Removal of metatarsal heads	Y	A2	18.5652	$777.38
28116	Revision of foot	Y	A2	18.5652	$777.38
28118	Removal of heel bone	Y	A2	19.2499	$806.05
28119	Removal of heel spur	Y	A2	19.2499	$806.05
28120	Part removal of ankle/heel	Y	A2	21.3324	$893.25
28122	Partial removal of foot bone	Y	A2	18.5652	$777.38
28124	Partial removal of toe	Y	P3		$235.24
28126	Partial removal of toe	Y	A2	18.5652	$777.38
28130	Removal of ankle bone	Y	A2	18.5652	$777.38
28140	Removal of metatarsal	Y	A2	18.5652	$777.38

28150	Removal of toe	Y	A2	18.5652	$777.38
28153	Partial removal of toe	Y	A2	18.5652	$777.38
28160	Partial removal of toe	Y	A2	18.5652	$777.38
28171	Resect tarsal tumor	Y	A2	18.5652	$777.38
28173	Resect metatarsal tumor	Y	A2	18.5652	$777.38
28175	Resect phalanx of toe tumor	Y	A2	18.5652	$777.38
28190	Removal of foot foreign body	Y	P3		$143.96
28192	Removal of foot foreign body	Y	A2	15.0849	$631.65
28193	Removal of foot foreign body	Y	A2	8.2667	$346.15
28200	Repair of foot tendon	Y	A2	18.5652	$777.38
28202	Repair/graft of foot tendon	Y	A2	18.5652	$777.38
28208	Repair of foot tendon	Y	A2	18.5652	$777.38
28210	Repair/graft of foot tendon	Y	A2	40.555	$1,698.16
28220	Release of foot tendon	Y	P3		$222.25
28222	Release of foot tendons	Y	A2	17.5555	$735.10
28225	Release of foot tendon	Y	A2	17.5555	$735.10
28226	Release of foot tendons	Y	A2	17.5555	$735.10
28230	Incision of foot tendon(s)	Y	P3		$217.56
28232	Incision of toe tendon	Y	P3		$208.18
28234	Incision of foot tendon	Y	A2	18.2	$762.09
28238	Revision of foot tendon	Y	A2	40.555	$1,698.16
28240	Release of big toe	Y	A2	18.2	$762.09
28250	Revision of foot fascia	Y	A2	18.5652	$777.38
28260	Release of midfoot joint	Y	A2	18.5652	$777.38
28261	Revision of foot tendon	Y	A2	18.5652	$777.38
28262	Revision of foot and ankle	Y	A2	19.2499	$806.05
28264	Release of midfoot joint	Y	A2	39.5451	$1,655.87
28270	Release of foot contracture	Y	A2	18.5652	$777.38
28272	Release of toe joint, each	Y	P3		$200.96
28280	Fusion of toes	Y	A2	18.2	$762.09
28285	Repair of hammertoe	Y	A2	18.5652	$777.38

28286	Repair of hammertoe	Y	A2	19.2499	$806.05
28288	Partial removal of foot bone	Y	A2	18.5652	$777.38
28289	Repair hallux rigidus	Y	A2	18.5652	$777.38
28290	Correction of bunion	Y	A2	25.1589	$1,053.48
28292	Correction of bunion	Y	A2	25.1589	$1,053.48
28293	Correction of bunion	Y	A2	25.5241	$1,068.77
28294	Correction of bunion	Y	A2	25.5241	$1,068.77
28296	Correction of bunion	Y	A2	25.5241	$1,068.77
28297	Correction of bunion	Y	A2	25.5241	$1,068.77
28298	Correction of bunion	Y	A2	25.5241	$1,068.77
28299	Correction of bunion	Y	A2	26.7053	$1,118.23
28300	Incision of heel bone	Y	A2	40.1899	$1,682.87
28302	Incision of ankle bone	Y	A2	18.2	$762.09
28304	Incision of midfoot bones	Y	A2	40.1899	$1,682.87
28305	Incise/graft midfoot bones	Y	A2	40.555	$1,698.16
28306	Incision of metatarsal	Y	A2	19.2499	$806.05
28307	Incision of metatarsal	Y	A2	19.2499	$806.05
28308	Incision of metatarsal	Y	A2	18.2	$762.09
28309	Incision of metatarsals	Y	A2	41.2397	$1,726.83
28310	Revision of big toe	Y	A2	18.5652	$777.38
28312	Revision of toe	Y	A2	18.5652	$777.38
28313	Repair deformity of toe	Y	A2	18.2	$762.09
28315	Removal of sesamoid bone	Y	A2	19.2499	$806.05
28320	Repair of foot bones	Y	A2	41.2397	$1,726.83
28322	Repair of metatarsals	Y	A2	41.2397	$1,726.83
28340	Resect enlarged toe tissue	Y	A2	19.2499	$806.05
28341	Resect enlarged toe	Y	A2	19.2499	$806.05
28344	Repair extra toe(s)	Y	A2	19.2499	$806.05
28345	Repair webbed toe(s)	Y	A2	19.2499	$806.05
28400	Treatment of heel fracture	Y	A2	1.7792	$74.50
28405	Treatment of heel fracture	Y	A2	13.7757	$576.83

28406	Treatment of heel fracture	Y	A2	21.0673	$882.15
28415	Treat heel fracture	Y	A2	49.8357	$2,086.77
28420	Treat/graft heel fracture	Y	A2	36.1811	$1,515.01
28430	Treatment of ankle fracture	Y	P2	1.584	$66.33
28435	Treatment of ankle fracture	Y	A2	1.7792	$74.50
28436	Treatment of ankle fracture	Y	A2	21.0673	$882.15
28445	Treat ankle fracture	Y	A2	35.4964	$1,486.34
28446	Osteochondral talus autogrft	Y	G2	50.1937	$2,101.76
28450	Treat midfoot fracture, each	Y	P2	1.584	$66.33
28455	Treat midfoot fracture, each	Y	P2	1.584	$66.33
28456	Treat midfoot fracture	Y	A2	21.0673	$882.15
28465	Treat midfoot fracture, each	Y	A2	35.4964	$1,486.34
28470	Treat metatarsal fracture	Y	P2	1.584	$66.33
28475	Treat metatarsal fracture	Y	P2	1.584	$66.33
28476	Treat metatarsal fracture	Y	A2	21.0673	$882.15
28485	Treat metatarsal fracture	Y	A2	36.1811	$1,515.01
28490	Treat big toe fracture	Y	P2	1.584	$66.33
28495	Treat big toe fracture	Y	P2	1.584	$66.33
28496	Treat big toe fracture	Y	A2	21.0673	$882.15
28505	Treat big toe fracture	Y	A2	21.4324	$897.44
28510	Treatment of toe fracture	Y	P3		$61.70
28515	Treatment of toe fracture	Y	P2	1.584	$66.33
28525	Treat toe fracture	Y	A2	21.4324	$897.44
28530	Treat sesamoid bone fracture	Y	P3		$59.17
28531	Treat sesamoid bone fracture	Y	A2	21.4324	$897.44
28540	Treat foot dislocation	Y	P2	1.584	$66.33
28545	Treat foot dislocation	Y	A2	20.4227	$855.16
28546	Treat foot dislocation	Y	A2	21.0673	$882.15
28555	Repair foot dislocation	Y	A2	35.1312	$1,471.05
28570	Treat foot dislocation	Y	P3		$85.51
28575	Treat foot dislocation	Y	A2	13.7757	$576.83

28576	Treat foot dislocation	Y	A2	21.4324	$897.44
28585	Repair foot dislocation	Y	A2	21.4324	$897.44
28600	Treat foot dislocation	Y	P2	1.584	$66.33
28605	Treat foot dislocation	Y	A2	1.7792	$74.50
28606	Treat foot dislocation	Y	A2	21.0673	$882.15
28615	Repair foot dislocation	Y	A2	35.4964	$1,486.34
28630	Treat toe dislocation	Y	P2	1.584	$66.33
28635	Treat toe dislocation	Y	A2	12.8598	$538.48
28636	Treat toe dislocation	Y	A2	21.4324	$897.44
28645	Repair toe dislocation	Y	A2	21.4324	$897.44
28660	Treat toe dislocation	Y	P3		$49.43
28665	Treat toe dislocation	Y	A2	12.8598	$538.48
28666	Treat toe dislocation	Y	A2	21.4324	$897.44
28675	Repair of toe dislocation	Y	A2	21.4324	$897.44
28705	Fusion of foot bones	Y	A2	41.2397	$1,726.83
28715	Fusion of foot bones	Y	A2	67.1313	$2,810.99
28725	Fusion of foot bones	Y	A2	41.2397	$1,726.83
28730	Fusion of foot bones	Y	A2	41.2397	$1,726.83
28735	Fusion of foot bones	Y	A2	41.2397	$1,726.83
28737	Revision of foot bones	Y	A2	41.736	$1,747.61
28740	Fusion of foot bones	Y	A2	41.2397	$1,726.83
28750	Fusion of big toe joint	Y	A2	41.2397	$1,726.83
28755	Fusion of big toe joint	Y	A2	19.2499	$806.05
28760	Fusion of big toe joint	Y	A2	41.2397	$1,726.83
28810	Amputation toe & metatarsal	Y	A2	18.2	$762.09
28820	Amputation of toe	Y	A2	18.2	$762.09
28825	Partial amputation of toe	Y	A2	18.2	$762.09
28890	High energy eswt, plantar f	Y	P3		$178.95
29000	Application of body cast	N	G2	1.0069	$42.16
29010	Application of body cast	N	P2	2.2416	$93.86
29015	Application of body cast	N	P2	2.2416	$93.86

29020	Application of body cast	N	G2	1.0069	$42.16
29025	Application of body cast	N	P2	1.0069	$42.16
29035	Application of body cast	N	P2	2.2416	$93.86
29040	Application of body cast	N	G2	1.0069	$42.16
29044	Application of body cast	N	P2	2.2416	$93.86
29046	Application of body cast	N	G2	2.2416	$93.86
29049	Application of figure eight	N	P2	1.0069	$42.16
29055	Application of shoulder cast	N	P2	2.2416	$93.86
29058	Application of shoulder cast	N	P2	1.0069	$42.16
29065	Application of long arm cast	N	P3		$49.07
29075	Application of forearm cast	N	P3		$47.26
29085	Apply hand/wrist cast	N	P2	1.0069	$42.16
29086	Apply finger cast	N	P3		$40.41
29105	Apply long arm splint	N	P2	1.0069	$42.16
29125	Apply forearm splint	N	P3		$37.16
29126	Apply forearm splint	N	P3		$39.33
29130	Application of finger splint	N	P3		$16.96
29131	Application of finger splint	N	P3		$24.17
29200	Strapping of chest	N	P3		$23.81
29220	Strapping of low back	N	D5		
29240	Strapping of shoulder	N	P3		$25.98
29260	Strapping of elbow or wrist	N	P3		$25.26
29280	Strapping of hand or finger	N	P3		$25.62
29305	Application of hip cast	N	P2	2.2416	$93.86
29325	Application of hip casts	N	P2	2.2416	$93.86
29345	Application of long leg cast	N	P3		$64.22
29355	Application of long leg cast	N	P3		$63.14
29358	Apply long leg cast brace	N	P3		$79.01
29365	Application of long leg cast	N	P3		$60.61
29405	Apply short leg cast	N	P3		$45.10
29425	Apply short leg cast	N	P3		$45.82

29435	Apply short leg cast	N	P3		$58.09
29440	Addition of walker to cast	N	P3		$24.89
29445	Apply rigid leg cast	N	P3		$60.61
29450	Application of leg cast	N	P2	1.0069	$42.16
29505	Application, long leg splint	N	P2	1.0069	$42.16
29515	Application lower leg splint	N	P3		$35.36
29520	Strapping of hip	N	P3		$24.53
29530	Strapping of knee	N	P3		$25.26
29540	Strapping of ankle and/or ft	N	P3		$18.76
29550	Strapping of toes	N	P3		$19.48
29580	Application of paste boot	N	P3		$25.98
29581	Apply multlay comprs lwr leg	N	P2	1.0069	$42.16
29590	Application of foot splint	N	P3		$21.29
29700	Removal/revision of cast	N	P3		$35.00
29705	Removal/revision of cast	N	P3		$29.95
29710	Removal/revision of cast	N	P3		$53.76
29715	Removal/revision of cast	N	P2	1.0069	$42.16
29720	Repair of body cast	N	P2	1.0069	$42.16
29730	Windowing of cast	N	P3		$28.86
29740	Wedging of cast	N	P3		$38.97
29750	Wedging of clubfoot cast	N	P2	1.0069	$42.16
29800	Jaw arthroscopy/surgery	Y	A2	24.3532	$1,019.74
29804	Jaw arthroscopy/surgery	Y	A2	24.3532	$1,019.74
29805	Shoulder arthroscopy, dx	Y	A2	24.3532	$1,019.74
29806	Shoulder arthroscopy/surgery	Y	A2	37.8972	$1,586.87
29807	Shoulder arthroscopy/surgery	Y	A2	37.8972	$1,586.87
29819	Shoulder arthroscopy/surgery	Y	A2	37.8972	$1,586.87
29820	Shoulder arthroscopy/surgery	Y	A2	37.8972	$1,586.87
29821	Shoulder arthroscopy/surgery	Y	A2	37.8972	$1,586.87
29822	Shoulder arthroscopy/surgery	Y	A2	24.3532	$1,019.74
29823	Shoulder arthroscopy/surgery	Y	A2	37.8972	$1,586.87

29824	Shoulder arthroscopy/surgery	Y	A2	25.5341	$1,069.19
29825	Shoulder arthroscopy/surgery	Y	A2	37.8972	$1,586.87
29826	Shoulder arthroscopy/surgery	Y	A2	37.8972	$1,586.87
29827	Arthroscop rotator cuff repr	Y	A2	39.0784	$1,636.33
29828	Arthroscopy biceps tenodesis	Y	G2	46.6501	$1,953.38
29830	Elbow arthroscopy	Y	A2	24.3532	$1,019.74
29834	Elbow arthroscopy/surgery	Y	A2	24.3532	$1,019.74
29835	Elbow arthroscopy/surgery	Y	A2	24.3532	$1,019.74
29836	Elbow arthroscopy/surgery	Y	A2	24.3532	$1,019.74
29837	Elbow arthroscopy/surgery	Y	A2	24.3532	$1,019.74
29838	Elbow arthroscopy/surgery	Y	A2	24.3532	$1,019.74
29840	Wrist arthroscopy	Y	A2	24.3532	$1,019.74
29843	Wrist arthroscopy/surgery	Y	A2	24.3532	$1,019.74
29844	Wrist arthroscopy/surgery	Y	A2	24.3532	$1,019.74
29845	Wrist arthroscopy/surgery	Y	A2	24.3532	$1,019.74
29846	Wrist arthroscopy/surgery	Y	A2	24.3532	$1,019.74
29847	Wrist arthroscopy/surgery	Y	A2	37.8972	$1,586.87
29848	Wrist endoscopy/surgery	Y	A2	29.0829	$1,217.79
29850	Knee arthroscopy/surgery	Y	A2	25.0379	$1,048.41
29851	Knee arthroscopy/surgery	Y	A2	38.5819	$1,615.54
29855	Tibial arthroscopy/surgery	Y	A2	38.5819	$1,615.54
29856	Tibial arthroscopy/surgery	Y	A2	38.5819	$1,615.54
29860	Hip arthroscopy, dx	Y	A2	38.5819	$1,615.54
29861	Hip arthroscopy/surgery	Y	A2	38.5819	$1,615.54
29862	Hip arthroscopy/surgery	Y	A2	42.627	$1,784.92
29863	Hip arthroscopy/surgery	Y	A2	38.5819	$1,615.54
29866	Autgrft implnt, knee w/scope	Y	G2	46.6501	$1,953.38
29870	Knee arthroscopy, dx	Y	A2	24.3532	$1,019.74
29871	Knee arthroscopy/drainage	Y	A2	24.3532	$1,019.74
29873	Knee arthroscopy/surgery	Y	A2	24.3532	$1,019.74
29874	Knee arthroscopy/surgery	Y	A2	24.3532	$1,019.74
29875	Knee arthroscopy/surgery	Y	A2	25.0379	$1,048.41
29876	Knee arthroscopy/surgery	Y	A2	25.0379	$1,048.41
29877	Knee arthroscopy/surgery	Y	A2	25.0379	$1,048.41
29879	Knee arthroscopy/surgery	Y	A2	24.3532	$1,019.74
29880	Knee arthroscopy/surgery	Y	A2	25.0379	$1,048.41
29881	Knee arthroscopy/surgery	Y	A2	25.0379	$1,048.41
29882	Knee arthroscopy/surgery	Y	A2	24.3532	$1,019.74
29883	Knee arthroscopy/surgery	Y	A2	24.3532	$1,019.74
29884	Knee arthroscopy/surgery	Y	A2	24.3532	$1,019.74
29885	Knee arthroscopy/surgery	Y	A2	37.8972	$1,586.87
29886	Knee arthroscopy/surgery	Y	A2	24.3532	$1,019.74
29887	Knee arthroscopy/surgery	Y	A2	24.3532	$1,019.74
29888	Knee arthroscopy/surgery	Y	A2	66.4466	$2,782.32
29889	Knee arthroscopy/surgery	Y	A2	66.4466	$2,782.32
29891	Ankle arthroscopy/surgery	Y	A2	37.8972	$1,586.87
29892	Ankle arthroscopy/surgery	Y	A2	66.4466	$2,782.32
29893	Scope, plantar fasciotomy	Y	A2	22.819	$955.50
29894	Ankle arthroscopy/surgery	Y	A2	24.3532	$1,019.74
29895	Ankle arthroscopy/surgery	Y	A2	24.3532	$1,019.74
29897	Ankle arthroscopy/surgery	Y	A2	24.3532	$1,019.74
29898	Ankle arthroscopy/surgery	Y	A2	24.3532	$1,019.74
29899	Ankle arthroscopy/surgery	Y	A2	37.8972	$1,586.87
29900	Mcp joint arthroscopy, dx	Y	A2	24.3532	$1,019.74
29901	Mcp joint arthroscopy, surg	Y	A2	24.3532	$1,019.74
29902	Mcp joint arthroscopy, surg	Y	A2	24.3532	$1,019.74
29904	Subtalar arthro w/fb rmvl	Y	G2	28.5914	$1,197.21
29905	Subtalar arthro w/exc	Y	G2	28.5914	$1,197.21
29906	Subtalar arthro w/deb	Y	G2	28.5914	$1,197.21
29907	Subtalar arthro w/fusion	Y	G2	46.6501	$1,953.38
30000	Drainage of nose lesion	Y	P2	3.2729	$137.05
30020	Drainage of nose lesion	Y	P2	3.2729	$137.05

30100	Intranasal biopsy	Y	P3		$90.20
30110	Removal of nose polyp(s)	Y	P3		$139.99
30115	Removal of nose polyp(s)	Y	A2	14.863	$622.36
30117	Removal of intranasal lesion	Y	A2	15.2282	$637.65
30118	Removal of intranasal lesion	Y	A2	20.8012	$871.01
30120	Revision of nose	Y	A2	19.7915	$828.73
30124	Removal of nose lesion	Y	R2	7.2813	$304.89
30125	Removal of nose lesion	Y	A2	33.3501	$1,396.47
30130	Excise inferior turbinate	Y	A2	15.2282	$637.65
30140	Resect inferior turbinate	Y	A2	20.4361	$855.72
30150	Partial removal of nose	Y	A2	33.7153	$1,411.76
30160	Removal of nose	Y	A2	34.4	$1,440.43
30200	Injection treatment of nose	Y	P3		$71.44
30210	Nasal sinus therapy	Y	P3		$90.56
30220	Insert nasal septal button	Y	A2	8.109	$339.55
30300	Remove nasal foreign body	N	P2	0.6396	$26.78
30310	Remove nasal foreign body	Y	A2	14.2185	$595.37
30320	Remove nasal foreign body	Y	A2	14.863	$622.36
30400	Reconstruction of nose	Y	A2	34.4	$1,440.43
30410	Reconstruction of nose	Y	A2	34.8965	$1,461.22
30420	Reconstruction of nose	Y	A2	34.8965	$1,461.22
30430	Revision of nose	Y	A2	20.8012	$871.01
30435	Revision of nose	Y	A2	34.8965	$1,461.22
30450	Revision of nose	Y	A2	36.4825	$1,527.63
30460	Revision of nose	Y	A2	36.4825	$1,527.63
30462	Revision of nose	Y	A2	38.4451	$1,609.81
30465	Repair nasal stenosis	Y	A2	38.4451	$1,609.81
30520	Repair of nasal septum	Y	A2	21.4859	$899.68
30540	Repair nasal defect	Y	A2	34.8965	$1,461.22
30545	Repair nasal defect	Y	A2	34.8965	$1,461.22
30560	Release of nasal adhesions	Y	A2	3.3145	$138.79
30580	Repair upper jaw fistula	Y	A2	34.4	$1,440.43
30600	Repair mouth/nose fistula	Y	A2	34.4	$1,440.43
30620	Intranasal reconstruction	Y	A2	36.4825	$1,527.63
30630	Repair nasal septum defect	Y	A2	23.5684	$986.88
30801	Ablate inf turbinate, superf	Y	A2	7.3608	$308.22
30802	Ablate inf turbinate submuc	Y	A2	14.2185	$595.37
30901	Control of nosebleed	Y	P2	1.101	$46.10
30903	Control of nosebleed	Y	A2	1.2395	$51.90
30905	Control of nosebleed	Y	A2	1.2395	$51.90
30906	Repeat control of nosebleed	Y	A2	1.2395	$51.90
30915	Ligation, nasal sinus artery	Y	A2	21.5881	$903.96
30920	Ligation, upper jaw artery	Y	A2	21.9533	$919.25
30930	Ther fx, nasal inf turbinate	Y	A2	15.9129	$666.32
31000	Irrigation, maxillary sinus	Y	P3		$115.45
31002	Irrigation, sphenoid sinus	Y	R2	7.2813	$304.89
31020	Exploration, maxillary sinus	Y	A2	20.4361	$855.72
31030	Exploration, maxillary sinus	Y	A2	33.7153	$1,411.76
31032	Explore sinus, remove polyps	Y	A2	34.4	$1,440.43
31040	Exploration behind upper jaw	Y	R2	23.8553	$998.89
31050	Exploration, sphenoid sinus	Y	A2	33.3501	$1,396.47
31051	Sphenoid sinus surgery	Y	A2	34.4	$1,440.43
31070	Exploration of frontal sinus	Y	A2	20.4361	$855.72
31075	Exploration of frontal sinus	Y	A2	34.4	$1,440.43
31080	Removal of frontal sinus	Y	A2	34.4	$1,440.43
31081	Removal of frontal sinus	Y	A2	34.4	$1,440.43
31084	Removal of frontal sinus	Y	A2	34.4	$1,440.43
31085	Removal of frontal sinus	Y	A2	34.4	$1,440.43
31086	Removal of frontal sinus	Y	A2	34.4	$1,440.43
31087	Removal of frontal sinus	Y	A2	34.4	$1,440.43
31090	Exploration of sinuses	Y	A2	34.8965	$1,461.22
31200	Removal of ethmoid sinus	Y	A2	33.3501	$1,396.47

31201	Removal of ethmoid sinus	Y	A2	34.8965	$1,461.22
31205	Removal of ethmoid sinus	Y	A2	33.7153	$1,411.76
31231	Nasal endoscopy, dx	Y	P2	1.7607	$73.73
31233	Nasal/sinus endoscopy, dx	Y	A2	1.8133	$75.93
31235	Nasal/sinus endoscopy, dx	Y	A2	17.4217	$729.50
31237	Nasal/sinus endoscopy, surg	Y	A2	18.0663	$756.49
31238	Nasal/sinus endoscopy, surg	Y	A2	17.4217	$729.50
31239	Nasal/sinus endoscopy, surg	Y	A2	24.5736	$1,028.97
31240	Nasal/sinus endoscopy, surg	Y	A2	18.0663	$756.49
31254	Revision of ethmoid sinus	Y	A2	23.8889	$1,000.30
31255	Removal of ethmoid sinus	Y	A2	25.0699	$1,049.75
31256	Exploration maxillary sinus	Y	A2	23.8889	$1,000.30
31267	Endoscopy, maxillary sinus	Y	A2	23.8889	$1,000.30
31276	Sinus endoscopy, surgical	Y	A2	23.8889	$1,000.30
31287	Nasal/sinus endoscopy, surg	Y	A2	23.8889	$1,000.30
31288	Nasal/sinus endoscopy, surg	Y	A2	23.8889	$1,000.30
31300	Removal of larynx lesion	Y	A2	21.9824	$920.47
31320	Diagnostic incision, larynx	Y	A2	33.3501	$1,396.47
31400	Revision of larynx	Y	A2	33.3501	$1,396.47
31420	Removal of epiglottis	Y	A2	33.3501	$1,396.47
31500	Insert emergency airway	N	G2	2.3463	$98.25
31502	Change of windpipe airway	N	G2	1.3514	$56.59
31505	Diagnostic laryngoscopy	Y	P2	0.7651	$32.04
31510	Laryngoscopy with biopsy	Y	A2	18.0663	$756.49
31511	Remove foreign body, larynx	Y	A2	1.8133	$75.93
31512	Removal of larynx lesion	Y	A2	18.0663	$756.49
31513	Injection into vocal cord	Y	A2	1.8133	$75.93
31515	Laryngoscopy for aspiration	Y	A2	17.4217	$729.50
31520	Dx laryngoscopy, newborn	Y	G2	1.7607	$73.73
31525	Dx laryngoscopy excl nb	Y	A2	17.4217	$729.50
31526	Dx laryngoscopy w/oper scope	Y	A2	18.0663	$756.49

31527	Laryngoscopy for treatment	Y	A2	22.8789	$958.01
31528	Laryngoscopy and dilation	Y	A2	18.0663	$756.49
31529	Laryngoscopy and dilation	Y	A2	18.0663	$756.49
31530	Laryngoscopy w/fb removal	Y	A2	18.0663	$756.49
31531	Laryngoscopy w/fb & op scope	Y	A2	18.4314	$771.78
31535	Laryngoscopy w/biopsy	Y	A2	18.0663	$756.49
31536	Laryngoscopy w/bx & op scope	Y	A2	18.4314	$771.78
31540	Laryngoscopy w/exc of tumor	Y	A2	18.4314	$771.78
31541	Larynscop w/tumr exc + scope	Y	A2	19.1161	$800.45
31545	Remove vc lesion w/scope	Y	A2	24.5736	$1,028.97
31546	Remove vc lesion scope/graft	Y	A2	24.5736	$1,028.97
31560	Laryngoscop w/arytenoidectom	Y	A2	25.0699	$1,049.75
31561	Larynscop, remve cart + scop	Y	A2	25.0699	$1,049.75
31570	Laryngoscope w/vc inj	Y	A2	18.0663	$756.49
31571	Laryngoscop w/vc inj + scope	Y	A2	23.5238	$985.01
31575	Diagnostic laryngoscopy	Y	P3		$64.58
31576	Laryngoscopy with biopsy	Y	A2	18.0663	$756.49
31577	Remove foreign body, larynx	Y	A2	4.511	$188.89
31578	Removal of larynx lesion	Y	A2	23.5238	$985.01
31579	Diagnostic laryngoscopy	Y	P3		$114.37
31580	Revision of larynx	Y	A2	34.8965	$1,461.22
31582	Revision of larynx	Y	A2	34.8965	$1,461.22
31588	Revision of larynx	Y	A2	34.8965	$1,461.22
31590	Reinnervate larynx	Y	A2	34.8965	$1,461.22
31595	Larynx nerve surgery	Y	A2	33.3501	$1,396.47
31603	Incision of windpipe	Y	A2	7.3608	$308.22
31605	Incision of windpipe	Y	G2	7.2813	$304.89
31611	Surgery/speech prosthesis	Y	A2	20.8012	$871.01
31612	Puncture/clear windpipe	Y	A2	19.7915	$828.73
31613	Repair windpipe opening	Y	A2	20.4361	$855.72
31614	Repair windpipe opening	Y	A2	33.3501	$1,396.47

31615	Visualization of windpipe	Y	A2	7.3608	$308.22
31620	Endobronchial us add-on	N	N1		
31622	Dx bronchoscope/wash	Y	A2	9.3325	$390.78
31623	Dx bronchoscope/brush	Y	A2	9.9773	$417.78
31624	Dx bronchoscope/lavage	Y	A2	9.9773	$417.78
31625	Bronchoscopy w/biopsy(s)	Y	A2	9.9773	$417.78
31626	Bronchoscopy w/markers	Y	G2	9.9102	$414.97
31627	Navigational bronchoscopy	N	N1		
31628	Bronchoscopy/lung bx, each	Y	A2	9.9773	$417.78
31629	Bronchoscopy/needle bx, each	Y	A2	9.9773	$417.78
31630	Bronchoscopy dilate/fx repr	Y	A2	21.1088	$883.89
31631	Bronchoscopy, dilate w/stent	Y	A2	21.1088	$883.89
31632	Bronchoscopy/lung bx, addl	Y	G2	9.9102	$414.97
31633	Bronchoscopy/needle bx addl	Y	G2	9.9102	$414.97
31635	Bronchoscopy w/fb removal	Y	A2	9.9773	$417.78
31636	Bronchoscopy, bronch stents	Y	A2	21.1088	$883.89
31637	Bronchoscopy, stent add-on	Y	A2	9.3325	$390.78
31638	Bronchoscopy, revise stent	Y	A2	21.1088	$883.89
31640	Bronchoscopy w/tumor excise	Y	A2	21.1088	$883.89
31641	Bronchoscopy, treat blockage	Y	A2	21.1088	$883.89
31643	Diag bronchoscope/catheter	Y	A2	9.9773	$417.78
31645	Bronchoscopy, clear airways	Y	A2	9.3325	$390.78
31646	Bronchoscopy, reclear airway	Y	A2	9.3325	$390.78
31656	Bronchoscopy, inj for x-ray	Y	A2	9.3325	$390.78
31715	Injection for bronchus x-ray	N	N1		
31717	Bronchial brush biopsy	Y	A2	4.511	$188.89
31720	Clearance of airways	N	A2	0.5607	$23.48
31730	Intro, windpipe wire/tube	Y	A2	4.511	$188.89
31750	Repair of windpipe	Y	A2	34.8965	$1,461.22
31755	Repair of windpipe	Y	A2	33.3501	$1,396.47
31820	Closure of windpipe lesion	Y	A2	19.7915	$828.73
31825	Repair of windpipe defect	Y	A2	20.4361	$855.72
31830	Revise windpipe scar	Y	A2	20.4361	$855.72
32400	Needle biopsy chest lining	Y	A2	8.8279	$369.65
32405	Biopsy, lung or mediastinum	Y	A2	8.8279	$369.65
32420	Puncture/clear lung	Y	A2	5.2502	$219.84
32421	Thoracentesis for aspiration	Y	A2	5.2502	$219.84
32422	Thoracentesis w/tube insert	Y	G2	5.3056	$222.16
32550	Insert pleural cath	Y	G2	29.1078	$1,218.83
32552	Remove lung catheter	N	G2	1.3514	$56.59
32553	Ins mark thor for rt perq	N	G2	13.1468	$550.50
32960	Therapeutic pneumothorax	Y	G2	5.3056	$222.16
32998	Perq rf ablate tx, pul tumor	Y	G2	49.0813	$2,055.18
33010	Drainage of heart sac	Y	A2	5.2502	$219.84
33011	Repeat drainage of heart sac	Y	A2	5.2502	$219.84
33206	Insertion of heart pacemaker	Y	J8	169.0755	$7,079.70
33207	Insertion of heart pacemaker	Y	J8	169.0755	$7,079.70
33208	Insertion of heart pacemaker	Y	J8	205.0128	$8,584.50
33210	Insertion of heart electrode	Y	G2	46.7633	$1,958.12
33211	Insertion of heart electrode	Y	G2	46.7633	$1,958.12
33212	Insertion of pulse generator	Y	H8	138.2268	$5,787.97
33213	Insertion of pulse generator	Y	H8	152.3459	$6,379.18
33214	Upgrade of pacemaker system	Y	J8	205.0128	$8,584.50
33215	Reposition pacing-defib lead	Y	G2	21.9226	$917.97
33216	Insert 1 electrode pm-defib	Y	G2	46.7633	$1,958.12
33217	Insert 2 electrode pm-defib	Y	G2	46.7633	$1,958.12
33218	Repair lead pace-defib, one	Y	G2	21.9226	$917.97
33220	Repair lead pace-defib, dual	Y	G2	21.9226	$917.97
33222	Revise pocket, pacemaker	Y	A2	14.0506	$588.34
33223	Revise pocket for defib	Y	A2	14.0506	$588.34
33224	Insert pacing lead & connect	Y	J8	302.8118	$12,679.64
33225	L ventric pacing lead add-on	Y	J8	302.8118	$12,679.64

33226	Reposition l ventric lead	Y	G2	21.9226	$917.97
33233	Removal of pacemaker system	Y	A2	18.9867	$795.03
33234	Removal of pacemaker system	Y	G2	21.9226	$917.97
33235	Removal pacemaker electrode	Y	G2	21.9226	$917.97
33240	Insert pulse generator	Y	J8	499.7939	$20,927.87
33241	Remove pulse generator	Y	G2	21.9226	$917.97
33249	Eltrd/insert pace-defib	Y	J8	630.748	$26,411.31
33282	Implant pat-active ht record	N	J8	111.5846	$4,672.38
33284	Remove pat-active ht record	Y	G2	7.8386	$328.23
33508	Endoscopic vein harvest	N	N1		
34490	Removal of vein clot	Y	G2	39.0843	$1,636.58
35188	Repair blood vessel lesion	Y	A2	32.9076	$1,377.94
35207	Repair blood vessel lesion	Y	A2	32.9076	$1,377.94
35460	Repair venous blockage	Y	G2	48.4307	$2,027.94
35473	Repair arterial blockage	Y	G2	48.4307	$2,027.94
35475	Repair arterial blockage	Y	G2	48.4307	$2,027.94
35476	Repair venous blockage	Y	G2	48.4307	$2,027.94
35492	Atherectomy, percutaneous	Y	G2	89.1808	$3,734.27
35572	Harvest femoropopliteal vein	N	N1		
35761	Exploration of artery/vein	Y	G2	34.0164	$1,424.37
35875	Removal of clot in graft	Y	A2	36.9527	$1,547.32
35876	Removal of clot in graft	Y	A2	36.9527	$1,547.32
36000	Place needle in vein	N	N1		
36002	Pseudoaneurysm injection trt	N	G2	2.1984	$92.05
36005	Injection ext venography	N	N1		
36010	Place catheter in vein	N	N1		
36011	Place catheter in vein	N	N1		
36012	Place catheter in vein	N	N1		
36013	Place catheter in artery	N	N1		
36014	Place catheter in artery	N	N1		
36015	Place catheter in artery	N	N1		

36100	Establish access to artery	N	N1		
36120	Establish access to artery	N	N1		
36140	Establish access to artery	N	N1		
36145	Artery to vein shunt	N	D5		
36147	Access av dial grft for eval	Y	P2	2.289	$95.85
36148	Access av dial grft for proc	N	N1		
36160	Establish access to aorta	N	N1		
36200	Place catheter in aorta	N	N1		
36215	Place catheter in artery	N	N1		
36216	Place catheter in artery	N	N1		
36217	Place catheter in artery	N	N1		
36218	Place catheter in artery	N	N1		
36245	Place catheter in artery	N	N1		
36246	Place catheter in artery	N	N1		
36247	Place catheter in artery	N	N1		
36248	Place catheter in artery	N	N1		
36260	Insertion of infusion pump	Y	A2	24.726	$1,035.35
36261	Revision of infusion pump	Y	A2	18.9867	$795.03
36262	Removal of infusion pump	Y	A2	18.3419	$768.03
36400	Bl draw < 3 yrs fem/jugular	N	N1		
36405	Bl draw < 3 yrs scalp vein	N	N1		
36406	Bl draw < 3 yrs other vein	N	N1		
36410	Non-routine bl draw > 3 yrs	N	N1		
36416	Capillary blood draw	N	N1		
36420	Vein access cutdown < 1 yr	N	R2	0.2217	$9.28
36425	Vein access cutdown > 1 yr	N	R2	0.2217	$9.28
36430	Blood transfusion service	N	P3		$32.83
36440	Bl push transfuse, 2 yr or <	N	R2	3.2308	$135.28
36450	Bl exchange/transfuse, nb	N	R2	3.2308	$135.28
36455	Bl exchange/transfuse non-nb	N	G2	3.2308	$135.28
36468	Injection(s), spider veins	Y	R2	0.8399	$35.17

36469	Injection(s), spider veins	Y	R2	0.8399	$35.17
36470	Injection therapy of vein	Y	P2	0.8399	$35.17
36471	Injection therapy of veins	Y	P2	0.8399	$35.17
36475	Endovenous rf, 1st vein	Y	A2	39.9119	$1,671.23
36476	Endovenous rf, vein add-on	Y	A2	26.6831	$1,117.30
36478	Endovenous laser, 1st vein	Y	A2	26.6831	$1,117.30
36479	Endovenous laser vein addon	Y	A2	26.6831	$1,117.30
36481	Insertion of catheter, vein	N	N1		
36500	Insertion of catheter, vein	N	N1		
36510	Insertion of catheter, vein	N	N1		
36511	Apheresis wbc	N	G2	11.4122	$477.86
36512	Apheresis rbc	N	G2	11.4122	$477.86
36513	Apheresis platelets	N	G2	11.4122	$477.86
36514	Apheresis plasma	N	G2	11.4122	$477.86
36515	Apheresis, adsorp/reinfuse	N	P2	31.8412	$1,333.29
36516	Apheresis, selective	N	P2	31.8412	$1,333.29
36522	Photopheresis	N	G2	31.8412	$1,333.29
36555	Insert non-tunnel cv cath	Y	A2	9.9026	$414.65
36556	Insert non-tunnel cv cath	Y	A2	9.9026	$414.65
36557	Insert tunneled cv cath	Y	A2	20.7019	$866.85
36558	Insert tunneled cv cath	Y	A2	20.7019	$866.85
36560	Insert tunneled cv cath	Y	A2	24.726	$1,035.35
36561	Insert tunneled cv cath	Y	A2	24.726	$1,035.35
36563	Insert tunneled cv cath	Y	A2	24.726	$1,035.35
36565	Insert tunneled cv cath	Y	A2	24.726	$1,035.35
36566	Insert tunneled cv cath	Y	A2	24.726	$1,035.35
36568	Insert picc cath	Y	A2	9.9026	$414.65
36569	Insert picc cath	Y	A2	9.9026	$414.65
36570	Insert picvad cath	Y	A2	21.067	$882.14
36571	Insert picvad cath	Y	A2	21.067	$882.14
36575	Repair tunneled cv cath	Y	A2	7.1129	$297.84

36576	Repair tunneled cv cath	Y	A2	10.5471	$441.64
36578	Replace tunneled cv cath	Y	A2	20.7019	$866.85
36580	Replace cvad cath	Y	A2	9.9026	$414.65
36581	Replace tunneled cv cath	Y	A2	20.7019	$866.85
36582	Replace tunneled cv cath	Y	A2	24.726	$1,035.35
36583	Replace tunneled cv cath	Y	A2	24.726	$1,035.35
36584	Replace picc cath	Y	A2	9.9026	$414.65
36585	Replace picvad cath	Y	A2	21.067	$882.14
36589	Removal tunneled cv cath	Y	A2	6.4684	$270.85
36590	Removal tunneled cv cath	Y	A2	9.9026	$414.65
36591	Draw blood off venous device	N	N1		
36592	Collect blood from picc	N	N1		
36593	Declot vascular device	Y	P3		$25.62
36595	Mech remov tunneled cv cath	Y	G2	24.2096	$1,013.73
36596	Mech remov tunneled cv cath	Y	G2	10.6702	$446.79
36597	Reposition venous catheter	Y	G2	10.6702	$446.79
36598	Inj w/fluor, eval cv device	Y	P3		$80.82
36600	Withdrawal of arterial blood	N	N1		
36620	Insertion catheter, artery	N	N1		
36625	Insertion catheter, artery	N	N1		
36640	Insertion catheter, artery	Y	A2	23.716	$993.06
36680	Insert needle, bone cavity	Y	G2	1.444	$60.46
36800	Insertion of cannula	Y	A2	25.1121	$1,051.52
36810	Insertion of cannula	Y	A2	25.1121	$1,051.52
36815	Insertion of cannula	Y	A2	25.1121	$1,051.52
36818	Av fuse, uppr arm, cephalic	Y	A2	32.2229	$1,349.27
36819	Av fuse, uppr arm, basilic	Y	A2	32.2229	$1,349.27
36820	Av fusion/forearm vein	Y	A2	32.2229	$1,349.27
36821	Av fusion direct any site	Y	A2	32.2229	$1,349.27
36825	Artery-vein autograft	Y	A2	32.9076	$1,377.94
36830	Artery-vein nonautograft	Y	A2	32.9076	$1,377.94

36831	Open thrombect av fistula	Y	A2	36.9527	$1,547.32
36832	Av fistula revision, open	Y	A2	32.9076	$1,377.94
36833	Av fistula revision	Y	A2	32.9076	$1,377.94
36834	Repair A-V aneurysm	N	D5		
36835	Artery to vein shunt	Y	A2	25.7966	$1,080.18
36860	External cannula declotting	Y	A2	2.4436	$102.32
36861	Cannula declotting	Y	A2	25.1121	$1,051.52
36870	Percut thrombect av fistula	Y	A2	41.1009	$1,721.02
37184	Prim art mech thrombectomy	Y	G2	39.0843	$1,636.58
37185	Prim art m-thrombect add-on	Y	G2	39.0843	$1,636.58
37186	Sec art m-thrombect add-on	Y	G2	39.0843	$1,636.58
37187	Venous mech thrombectomy	Y	G2	39.0843	$1,636.58
37188	Venous m-thrombectomy add-on	Y	G2	39.0843	$1,636.58
37200	Transcatheter biopsy	Y	G2	29.0881	$1,218.01
37203	Transcatheter retrieval	Y	G2	29.0881	$1,218.01
37250	Iv us first vessel add-on	N	N1		
37251	Iv us each add vessel add-on	N	N1		
37500	Endoscopy ligate perf veins	Y	A2	35.1821	$1,473.18
37607	Ligation of a-v fistula	Y	A2	21.9533	$919.25
37609	Temporal artery procedure	Y	A2	15.0849	$631.65
37650	Revision of major vein	Y	A2	21.5881	$903.96
37700	Revise leg vein	Y	A2	21.5881	$903.96
37718	Ligate/strip short leg vein	Y	A2	21.9533	$919.25
37722	Ligate/strip long leg vein	Y	A2	35.1821	$1,473.18
37735	Removal of leg veins/lesion	Y	A2	35.1821	$1,473.18
37760	Ligate leg veins radical	Y	A2	21.9533	$919.25
37761*	Ligate leg veins open	Y	R2	25.3915	$1,063.22
37765	Phleb veins - extrem - to 20	Y	R2	25.3915	$1,063.22
37766	Phleb veins - extrem 20+	Y	R2	25.3915	$1,063.22
37780	Revision of leg vein	Y	A2	21.9533	$919.25
37785	Ligate/divide/excise vein	Y	A2	21.9533	$919.25

37790	Penile venous occlusion	Y	A2	27.9111	$1,168.72
38200	Injection for spleen x-ray	N	N1		
38204	Bl donor search management	N	N1		
38206	Harvest auto stem cells	N	G2	11.4122	$477.86
38220	Bone marrow aspiration	Y	P3		$103.19
38221	Bone marrow biopsy	Y	P3		$107.52
38230	Bone marrow collection	N	G2	31.8412	$1,333.29
38241	Bone marrow/stem transplant	N	G2	31.8412	$1,333.29
38242	Lymphocyte infuse transplant	N	R2	11.4122	$477.86
38300	Drainage, lymph node lesion	Y	A2	10.9457	$458.33
38305	Drainage, lymph node lesion	Y	A2	16.4531	$688.94
38308	Incision of lymph channels	Y	A2	20.186	$845.25
38500	Biopsy/removal, lymph nodes	Y	A2	20.186	$845.25
38505	Needle biopsy, lymph nodes	Y	A2	6.9699	$291.85
38510	Biopsy/removal, lymph nodes	Y	A2	20.186	$845.25
38520	Biopsy/removal, lymph nodes	Y	A2	20.186	$845.25
38525	Biopsy/removal, lymph nodes	Y	A2	20.186	$845.25
38530	Biopsy/removal, lymph nodes	Y	A2	20.186	$845.25
38542	Explore deep node(s), neck	Y	A2	37.4879	$1,569.73
38550	Removal, neck/armpit lesion	Y	A2	20.5512	$860.54
38555	Removal, neck/armpit lesion	Y	A2	21.2356	$889.20
38570	Laparoscopy, lymph node biop	Y	A2	41.2096	$1,725.57
38571	Laparoscopy, lymphadenectomy	Y	A2	59.9286	$2,509.39
38572	Laparoscopy, lymphadenectomy	Y	A2	41.2096	$1,725.57
38700	Removal of lymph nodes, neck	Y	G2	23.5217	$984.92
38740	Remove armpit lymph nodes	Y	A2	37.4879	$1,569.73
38745	Remove armpit lymph nodes	Y	A2	38.5377	$1,613.69
38760	Remove groin lymph nodes	Y	A2	20.186	$845.25
38790	Inject for lymphatic x-ray	N	N1		
38792	Identify sentinel node	N	N1		
38794	Access thoracic lymph duct	N	N1		

40490	Biopsy of lip	Y	P3		$72.16
40500	Partial excision of lip	Y	A2	14.863	$622.36
40510	Partial excision of lip	Y	A2	20.4361	$855.72
40520	Partial excision of lip	Y	A2	14.863	$622.36
40525	Reconstruct lip with flap	Y	A2	20.4361	$855.72
40527	Reconstruct lip with flap	Y	A2	20.4361	$855.72
40530	Partial removal of lip	Y	A2	20.4361	$855.72
40650	Repair lip	Y	A2	8.109	$339.55
40652	Repair lip	Y	A2	8.109	$339.55
40654	Repair lip	Y	A2	8.109	$339.55
40700	Repair cleft lip/nasal	Y	A2	36.4825	$1,527.63
40701	Repair cleft lip/nasal	Y	A2	36.4825	$1,527.63
40702	Repair cleft lip/nasal	Y	R2	41.0743	$1,719.90
40720	Repair cleft lip/nasal	Y	A2	36.4825	$1,527.63
40761	Repair cleft lip/nasal	Y	A2	33.7153	$1,411.76
40800	Drainage of mouth lesion	Y	P2	1.3911	$58.25
40801	Drainage of mouth lesion	Y	A2	8.0056	$335.22
40804	Removal, foreign body, mouth	N	P2	0.6396	$26.78
40805	Removal, foreign body, mouth	Y	P3		$183.28
40806	Incision of lip fold	Y	P3		$81.90
40808	Biopsy of mouth lesion	Y	P3		$125.56
40810	Excision of mouth lesion	Y	P3		$130.25
40812	Excise/repair mouth lesion	Y	P3		$164.52
40814	Excise/repair mouth lesion	Y	A2	14.863	$622.36
40816	Excision of mouth lesion	Y	A2	20.4361	$855.72
40818	Excise oral mucosa for graft	Y	A2	3.3145	$138.79
40819	Excise lip or cheek fold	Y	A2	7.3608	$308.22
40820	Treatment of mouth lesion	Y	P3		$185.45
40830	Repair mouth laceration	Y	G2	3.2729	$137.05
40831	Repair mouth laceration	Y	A2	7.3608	$308.22
40840	Reconstruction of mouth	Y	A2	20.4361	$855.72

40842	Reconstruction of mouth	Y	A2	20.8012	$871.01
40843	Reconstruction of mouth	Y	A2	20.8012	$871.01
40844	Reconstruction of mouth	Y	A2	34.8965	$1,461.22
40845	Reconstruction of mouth	Y	A2	34.8965	$1,461.22
41000	Drainage of mouth lesion	Y	P3		$93.44
41005	Drainage of mouth lesion	Y	A2	3.3145	$138.79
41006	Drainage of mouth lesion	Y	A2	19.7915	$828.73
41007	Drainage of mouth lesion	Y	A2	14.2185	$595.37
41008	Drainage of mouth lesion	Y	A2	14.2185	$595.37
41009	Drainage of mouth lesion	Y	A2	3.3145	$138.79
41010	Incision of tongue fold	Y	A2	7.3608	$308.22
41015	Drainage of mouth lesion	Y	A2	3.3145	$138.79
41016	Drainage of mouth lesion	Y	A2	7.3608	$308.22
41017	Drainage of mouth lesion	Y	A2	7.3608	$308.22
41018	Drainage of mouth lesion	Y	A2	7.3608	$308.22
41019	Place needles h&n for rt	Y	G2	23.8553	$998.89
41100	Biopsy of tongue	Y	P3		$98.14
41105	Biopsy of tongue	Y	P3		$97.41
41108	Biopsy of floor of mouth	Y	P3		$90.20
41110	Excision of tongue lesion	Y	P3		$130.61
41112	Excision of tongue lesion	Y	A2	14.863	$622.36
41113	Excision of tongue lesion	Y	A2	14.863	$622.36
41114	Excision of tongue lesion	Y	A2	20.4361	$855.72
41115	Excision of tongue fold	Y	P3		$151.17
41116	Excision of mouth lesion	Y	A2	14.2185	$595.37
41120	Partial removal of tongue	Y	A2	21.9824	$920.47
41250	Repair tongue laceration	Y	A2	1.6858	$70.59
41251	Repair tongue laceration	Y	A2	3.3145	$138.79
41252	Repair tongue laceration	Y	A2	8.0056	$335.22
41500	Fixation of tongue	Y	A2	19.7915	$828.73
41510	Tongue to lip surgery	Y	A2	14.2185	$595.37

41512	Tongue suspension	Y	G2	7.2813	$304.89
41520	Reconstruction, tongue fold	Y	A2	8.0056	$335.22
41530	Tongue base vol reduction	Y	G2	23.8553	$998.89
41800	Drainage of gum lesion	Y	A2	1.5478	$64.81
41805	Removal foreign body, gum	Y	P3		$167.77
41806	Removal foreign body,jawbone	Y	P3		$201.68
41820	Excision, gum, each quadrant	Y	R2	7.2813	$304.89
41821	Excision of gum flap	Y	G2	7.2813	$304.89
41822	Excision of gum lesion	Y	P3		$165.96
41823	Excision of gum lesion	Y	P3		$240.65
41825	Excision of gum lesion	Y	P3		$132.41
41826	Excision of gum lesion	Y	P3		$172.10
41827	Excision of gum lesion	Y	A2	20.4361	$855.72
41828	Excision of gum lesion	Y	P3		$152.98
41830	Removal of gum tissue	Y	P3		$215.75
41850	Treatment of gum lesion	Y	R2	16.4248	$687.76
41870	Gum graft	Y	G2	23.8553	$998.89
41872	Repair gum	Y	P3		$212.87
41874	Repair tooth socket	Y	P3		$207.82
42000	Drainage mouth roof lesion	Y	A2	3.3145	$138.79
42100	Biopsy roof of mouth	Y	P3		$83.70
42104	Excision lesion, mouth roof	Y	P3		$125.56
42106	Excision lesion, mouth roof	Y	P3		$157.30
42107	Excision lesion, mouth roof	Y	A2	20.4361	$855.72
42120	Remove palate/lesion	Y	A2	34.4	$1,440.43
42140	Excision of uvula	Y	A2	8.0056	$335.22
42145	Repair palate, pharynx/uvula	Y	A2	21.9824	$920.47
42160	Treatment mouth roof lesion	Y	P3		$145.40
42180	Repair palate	Y	A2	3.3145	$138.79
42182	Repair palate	Y	A2	33.3501	$1,396.47
42200	Reconstruct cleft palate	Y	A2	34.8965	$1,461.22

42205	Reconstruct cleft palate	Y	A2	34.8965	$1,461.22
42210	Reconstruct cleft palate	Y	A2	34.8965	$1,461.22
42215	Reconstruct cleft palate	Y	A2	36.4825	$1,527.63
42220	Reconstruct cleft palate	Y	A2	34.8965	$1,461.22
42225	Reconstruct cleft palate	Y	G2	41.0743	$1,719.90
42226	Lengthening of palate	Y	A2	34.8965	$1,461.22
42227	Lengthening of palate	Y	G2	41.0743	$1,719.90
42235	Repair palate	Y	A2	16.4091	$687.10
42260	Repair nose to lip fistula	Y	A2	21.4859	$899.68
42280	Preparation, palate mold	Y	P3		$82.98
42281	Insertion, palate prosthesis	Y	G2	16.4248	$687.76
42300	Drainage of salivary gland	Y	A2	14.2185	$595.37
42305	Drainage of salivary gland	Y	A2	14.863	$622.36
42310	Drainage of salivary gland	Y	A2	3.3145	$138.79
42320	Drainage of salivary gland	Y	A2	3.3145	$138.79
42330	Removal of salivary stone	Y	P3		$126.28
42335	Removal of salivary stone	Y	P3		$209.62
42340	Removal of salivary stone	Y	A2	14.863	$622.36
42400	Biopsy of salivary gland	Y	P3		$69.99
42405	Biopsy of salivary gland	Y	A2	20.4361	$855.72
42408	Excision of salivary cyst	Y	A2	15.2282	$637.65
42409	Drainage of salivary cyst	Y	A2	15.2282	$637.65
42410	Excise parotid gland/lesion	Y	A2	33.7153	$1,411.76
42415	Excise parotid gland/lesion	Y	A2	36.4825	$1,527.63
42420	Excise parotid gland/lesion	Y	A2	36.4825	$1,527.63
42425	Excise parotid gland/lesion	Y	A2	36.4825	$1,527.63
42440	Excise submaxillary gland	Y	A2	33.7153	$1,411.76
42450	Excise sublingual gland	Y	A2	20.4361	$855.72
42500	Repair salivary duct	Y	A2	20.8012	$871.01
42505	Repair salivary duct	Y	A2	34.4	$1,440.43
42507	Parotid duct diversion	Y	A2	33.7153	$1,411.76

42508	Parotid duct diversion	Y	A2	34.4	$1,440.43
42509	Parotid duct diversion	Y	A2	34.4	$1,440.43
42510	Parotid duct diversion	Y	A2	34.4	$1,440.43
42550	Injection for salivary x-ray	N	N1		
42600	Closure of salivary fistula	Y	A2	14.2185	$595.37
42650	Dilation of salivary duct	Y	P3		$46.54
42660	Dilation of salivary duct	Y	P3		$54.84
42665	Ligation of salivary duct	Y	A2	23.5684	$986.88
42700	Drainage of tonsil abscess	Y	A2	3.3145	$138.79
42720	Drainage of throat abscess	Y	A2	14.2185	$595.37
42725	Drainage of throat abscess	Y	A2	33.3501	$1,396.47
42800	Biopsy of throat	Y	P3		$89.84
42802	Biopsy of throat	Y	A2	14.2185	$595.37
42804	Biopsy of upper nose/throat	Y	A2	14.2185	$595.37
42806	Biopsy of upper nose/throat	Y	A2	20.4361	$855.72
42808	Excise pharynx lesion	Y	A2	20.4361	$855.72
42809	Remove pharynx foreign body	N	G2	0.6396	$26.78
42810	Excision of neck cyst	Y	A2	20.8012	$871.01
42815	Excision of neck cyst	Y	A2	34.8965	$1,461.22
42820	Remove tonsils and adenoids	Y	A2	20.8012	$871.01
42821	Remove tonsils and adenoids	Y	A2	21.9824	$920.47
42825	Removal of tonsils	Y	A2	21.4859	$899.68
42826	Removal of tonsils	Y	A2	21.4859	$899.68
42830	Removal of adenoids	Y	A2	21.4859	$899.68
42831	Removal of adenoids	Y	A2	21.4859	$899.68
42835	Removal of adenoids	Y	A2	21.4859	$899.68
42836	Removal of adenoids	Y	A2	21.4859	$899.68
42860	Excision of tonsil tags	Y	A2	20.8012	$871.01
42870	Excision of lingual tonsil	Y	A2	20.8012	$871.01
42890	Partial removal of pharynx	Y	A2	36.4825	$1,527.63
42892	Revision of pharyngeal walls	Y	A2	36.4825	$1,527.63

42900	Repair throat wound	Y	A2	7.3608	$308.22
42950	Reconstruction of throat	Y	A2	20.4361	$855.72
42955	Surgical opening of throat	Y	A2	20.4361	$855.72
42960	Control throat bleeding	Y	A2	1.2395	$51.90
42962	Control throat bleeding	Y	A2	33.3501	$1,396.47
42970	Control nose/throat bleeding	Y	R2	1.101	$46.10
42972	Control nose/throat bleeding	Y	A2	15.2282	$637.65
43030	Throat muscle surgery	Y	G2	16.4248	$687.76
43130	Removal of esophagus pouch	Y	G2	41.0743	$1,719.90
43200	Esophagus endoscopy	Y	A2	8.1683	$342.03
43201	Esoph scope w/submucous inj	Y	A2	8.1683	$342.03
43202	Esophagus endoscopy, biopsy	Y	A2	8.1683	$342.03
43204	Esoph scope w/sclerosis inj	Y	A2	8.1683	$342.03
43205	Esophagus endoscopy/ligation	Y	A2	8.1683	$342.03
43215	Esophagus endoscopy	Y	A2	8.1683	$342.03
43216	Esophagus endoscopy/lesion	Y	A2	8.1683	$342.03
43217	Esophagus endoscopy	Y	A2	8.1683	$342.03
43219	Esophagus endoscopy	Y	A2	20.8863	$874.57
43220	Esoph endoscopy, dilation	Y	A2	8.1683	$342.03
43226	Esoph endoscopy, dilation	Y	A2	8.1683	$342.03
43227	Esoph endoscopy, repair	Y	A2	8.8131	$369.03
43228	Esoph endoscopy, ablation	Y	A2	19.9391	$834.91
43231	Esoph endoscopy w/us exam	Y	A2	8.8131	$369.03
43232	Esoph endoscopy w/us fn bx	Y	A2	8.8131	$369.03
43234	Upper GI endoscopy, exam	Y	A2	8.1683	$342.03
43235	Uppr gi endoscopy, diagnosis	Y	A2	8.1683	$342.03
43236	Uppr gi scope w/submuc inj	Y	A2	8.8131	$369.03
43237	Endoscopic us exam, esoph	Y	A2	8.8131	$369.03
43238	Uppr gi endoscopy w/us fn bx	Y	A2	8.8131	$369.03
43239	Upper GI endoscopy, biopsy	Y	A2	8.8131	$369.03
43240	Esoph endoscope w/drain cyst	Y	A2	8.8131	$369.03

43241	Upper GI endoscopy with tube	Y	A2	8.8131	$369.03
43242	Uppr gi endoscopy w/us fn bx	Y	A2	8.8131	$369.03
43243	Upper gi endoscopy & inject	Y	A2	8.8131	$369.03
43244	Upper GI endoscopy/ligation	Y	A2	8.8131	$369.03
43245	Uppr gi scope dilate strictr	Y	A2	8.8131	$369.03
43246	Place gastrostomy tube	Y	A2	8.8131	$369.03
43247	Operative upper GI endoscopy	Y	A2	8.8131	$369.03
43248	Uppr gi endoscopy/guide wire	Y	A2	8.8131	$369.03
43249	Esoph endoscopy, dilation	Y	A2	8.8131	$369.03
43250	Upper GI endoscopy/tumor	Y	A2	8.8131	$369.03
43251	Operative upper GI endoscopy	Y	A2	8.8131	$369.03
43255	Operative upper GI endoscopy	Y	A2	8.8131	$369.03
43256	Uppr gi endoscopy w/stent	Y	A2	21.896	$916.85
43257	Uppr gi scope w/thrml txmnt	Y	A2	20.3043	$850.20
43258	Operative upper GI endoscopy	Y	A2	9.1782	$384.32
43259	Endoscopic ultrasound exam	Y	A2	9.1782	$384.32
43260	Endo cholangiopancreatograph	Y	A2	18.7498	$785.11
43261	Endo cholangiopancreatograph	Y	A2	18.7498	$785.11
43262	Endo cholangiopancreatograph	Y	A2	18.7498	$785.11
43263	Endo cholangiopancreatograph	Y	A2	18.7498	$785.11
43264	Endo cholangiopancreatograph	Y	A2	18.7498	$785.11
43265	Endo cholangiopancreatograph	Y	A2	18.7498	$785.11
43267	Endo cholangiopancreatograph	Y	A2	18.7498	$785.11
43268	Endo cholangiopancreatograph	Y	A2	21.5308	$901.56
43269	Endo cholangiopancreatograph	Y	A2	21.5308	$901.56
43271	Endo cholangiopancreatograph	Y	A2	18.7498	$785.11
43272	Endo cholangiopancreatograph	Y	A2	18.7498	$785.11
43273	Endoscopic pancreatoscopy	Y	G2	21.6072	$904.76
43450	Dilate esophagus	Y	A2	6.1732	$258.49
43453	Dilate esophagus	Y	A2	6.1732	$258.49
43456	Dilate esophagus	Y	A2	6.1868	$259.06

43458	Dilate esophagus	Y	A2	8.1821	$342.61
43600	Biopsy of stomach	Y	A2	8.1683	$342.03
43653	Laparoscopy, gastrostomy	Y	A2	41.2096	$1,725.57
43752	Nasal/orogastric w/stent	N	G2	1.2129	$50.79
43760	Change gastrostomy tube	Y	A2	2.5439	$106.52
43761	Reposition gastrostomy tube	Y	A2	8.1683	$342.03
43870	Repair stomach opening	Y	A2	8.1683	$342.03
43886	Revise gastric port, open	Y	G2	22.8691	$957.60
43887	Remove gastric port, open	Y	G2	4.2415	$177.60
43888	Change gastric port, open	Y	G2	22.8691	$957.60
44100	Biopsy of bowel	Y	A2	8.1683	$342.03
44312	Revision of ileostomy	Y	A2	19.0517	$797.75
44340	Revision of colostomy	Y	A2	20.0616	$840.04
44360	Small bowel endoscopy	Y	A2	9.6043	$402.16
44361	Small bowel endoscopy/biopsy	Y	A2	9.6043	$402.16
44363	Small bowel endoscopy	Y	A2	9.6043	$402.16
44364	Small bowel endoscopy	Y	A2	9.6043	$402.16
44365	Small bowel endoscopy	Y	A2	9.6043	$402.16
44366	Small bowel endoscopy	Y	A2	9.6043	$402.16
44369	Small bowel endoscopy	Y	A2	9.6043	$402.16
44370	Small bowel endoscopy/stent	Y	A2	26.6257	$1,114.90
44372	Small bowel endoscopy	Y	A2	9.6043	$402.16
44373	Small bowel endoscopy	Y	A2	9.6043	$402.16
44376	Small bowel endoscopy	Y	A2	9.6043	$402.16
44377	Small bowel endoscopy/biopsy	Y	A2	9.6043	$402.16
44378	Small bowel endoscopy	Y	A2	9.6043	$402.16
44379	S bowel endoscope w/stent	Y	A2	26.6257	$1,114.90
44380	Small bowel endoscopy	Y	A2	8.9597	$375.17
44382	Small bowel endoscopy	Y	A2	8.9597	$375.17
44383	Ileoscopy w/stent	Y	A2	26.6257	$1,114.90
44385	Endoscopy of bowel pouch	Y	A2	8.4255	$352.80

44386	Endoscopy, bowel pouch/biop	Y	A2	8.4255	$352.80
44388	Colonoscopy	Y	A2	8.4255	$352.80
44389	Colonoscopy with biopsy	Y	A2	8.4255	$352.80
44390	Colonoscopy for foreign body	Y	A2	8.4255	$352.80
44391	Colonoscopy for bleeding	Y	A2	8.4255	$352.80
44392	Colonoscopy & polypectomy	Y	A2	8.4255	$352.80
44393	Colonoscopy, lesion removal	Y	A2	8.4255	$352.80
44394	Colonoscopy w/snare	Y	A2	8.4255	$352.80
44397	Colonoscopy w/stent	Y	A2	20.8863	$874.57
44500	Intro, gastrointestinal tube	Y	G2	6.0912	$255.06
44701	Intraop colon lavage add-on	N	N1		
45000	Drainage of pelvic abscess	Y	A2	11.896	$498.12
45005	Drainage of rectal abscess	Y	A2	12.6602	$530.12
45020	Drainage of rectal abscess	Y	A2	12.6602	$530.12
45100	Biopsy of rectum	Y	A2	19.0796	$798.92
45108	Removal of anorectal lesion	Y	A2	19.7242	$825.91
45150	Excision of rectal stricture	Y	A2	19.7242	$825.91
45160	Excision of rectal lesion	Y	A2	19.7242	$825.91
45170	Excision of rectal lesion	N	D5		
45171	Exc rect tum transanal part	Y	G2	13.4873	$564.75
45172	Exc rect tum transanal full	Y	G2	22.906	$959.14
45190	Destruction, rectal tumor	Y	A2	24.8191	$1,039.25
45300	Proctosigmoidoscopy dx	Y	P3		$70.72
45303	Proctosigmoidoscopy dilate	Y	P2	8.8345	$369.93
45305	Proctosigmoidoscopy w/bx	Y	A2	8.5258	$357.00
45307	Proctosigmoidoscopy fb	Y	A2	18.2557	$764.42
45308	Proctosigmoidoscopy removal	Y	A2	8.5258	$357.00
45309	Proctosigmoidoscopy removal	Y	A2	8.5258	$357.00
45315	Proctosigmoidoscopy removal	Y	A2	8.5258	$357.00
45317	Proctosigmoidoscopy bleed	Y	A2	8.5258	$357.00
45320	Proctosigmoidoscopy ablate	Y	A2	18.2557	$764.42

45321	Proctosigmoidoscopy volvul	Y	A2	18.2557	$764.42
45327	Proctosigmoidoscopy w/stent	Y	A2	20.8863	$874.57
45330	Diagnostic sigmoidoscopy	Y	P3		$89.12
45331	Sigmoidoscopy and biopsy	Y	A2	5.8458	$244.78
45332	Sigmoidoscopy w/fb removal	Y	A2	5.8458	$244.78
45333	Sigmoidoscopy & polypectomy	Y	A2	8.5258	$357.00
45334	Sigmoidoscopy for bleeding	Y	A2	8.5258	$357.00
45335	Sigmoidoscopy w/submuc inj	Y	A2	5.8458	$244.78
45337	Sigmoidoscopy & decompress	Y	A2	5.8458	$244.78
45338	Sigmoidoscopy w/tumr remove	Y	A2	8.5258	$357.00
45339	Sigmoidoscopy w/ablate tumr	Y	A2	8.5258	$357.00
45340	Sig w/balloon dilation	Y	A2	8.5258	$357.00
45341	Sigmoidoscopy w/ultrasound	Y	A2	8.5258	$357.00
45342	Sigmoidoscopy w/us guide bx	Y	A2	8.5258	$357.00
45345	Sigmoidoscopy w/stent	Y	A2	20.8863	$874.57
45355	Surgical colonoscopy	Y	A2	8.4255	$352.80
45378	Diagnostic colonoscopy	Y	A2	9.0703	$379.80
45379	Colonoscopy w/fb removal	Y	A2	9.0703	$379.80
45380	Colonoscopy and biopsy	Y	A2	9.0703	$379.80
45381	Colonoscopy, submucous inj	Y	A2	9.0703	$379.80
45382	Colonoscopy/control bleeding	Y	A2	9.0703	$379.80
45383	Lesion removal colonoscopy	Y	A2	9.0703	$379.80
45384	Lesion remove colonoscopy	Y	A2	9.0703	$379.80
45385	Lesion removal colonoscopy	Y	A2	9.0703	$379.80
45386	Colonoscopy dilate stricture	Y	A2	9.0703	$379.80
45387	Colonoscopy w/stent	Y	A2	20.8863	$874.57
45391	Colonoscopy w/endoscope us	Y	A2	9.0703	$379.80
45392	Colonoscopy w/endoscopic fnb	Y	A2	9.0703	$379.80
45500	Repair of rectum	Y	A2	19.7242	$825.91
45505	Repair of rectum	Y	A2	25.6089	$1,072.32
45520	Treatment of rectal prolapse	Y	P2	0.8399	$35.17

45541	Correct rectal prolapse	Y	G2	30.7524	$1,287.70
45560	Repair of rectocele	Y	A2	25.6089	$1,072.32
45900	Reduction of rectal prolapse	Y	A2	5.6256	$235.56
45905	Dilation of anal sphincter	Y	A2	19.0796	$798.92
45910	Dilation of rectal narrowing	Y	A2	19.0796	$798.92
45915	Remove rectal obstruction	Y	A2	11.896	$498.12
45990	Surg dx exam, anorectal	Y	A2	18.9602	$793.92
46020	Placement of seton	Y	A2	20.0893	$841.20
46030	Removal of rectal marker	Y	A2	5.6256	$235.56
46040	Incision of rectal abscess	Y	A2	20.0893	$841.20
46045	Incision of rectal abscess	Y	A2	19.7242	$825.91
46050	Incision of anal abscess	Y	A2	11.896	$498.12
46060	Incision of rectal abscess	Y	A2	19.7242	$825.91
46070	Incision of anal septum	Y	G2	13.4873	$564.75
46080	Incision of anal sphincter	Y	A2	20.0893	$841.20
46083	Incise external hemorrhoid	Y	P2	1.9297	$80.80
46200	Removal of anal fissure	Y	A2	19.7242	$825.91
46210	Removal of anal crypt	N	D5		
46211	Removal of anal crypts	N	D5		
46220	Excise anal ext tag/papilla	Y	A2	12.0154	$503.12
46221	Ligation of hemorrhoid(s)	Y	P3		$133.49
46230	Removal of anal tags	Y	A2	19.0796	$798.92
46250	Remove ext hem groups = 2	Y	A2	20.0893	$841.20
46255	Remove int/ext hem 1 group	Y	A2	20.0893	$841.20
46257	Remove in/ex hem grp & fiss	Y	A2	20.0893	$841.20
46258	Remove in/ex hem grp w/fistu	Y	A2	20.0893	$841.20
46260	Remove in/ex hem groups = 2	Y	A2	20.0893	$841.20
46261	Remove in/ex hem grps & fiss	Y	A2	20.774	$869.87
46262	Remove in/ex hem grps w/fist	Y	A2	20.774	$869.87
46270	Remove anal fist subq	Y	A2	20.0893	$841.20
46275	Remove anal fist inter	Y	A2	20.0893	$841.20

46280	Remove anal fist complex	Y	A2	20.774	$869.87
46285	Remove anal fist 2 stage	Y	A2	19.0796	$798.92
46288	Repair anal fistula	Y	A2	20.774	$869.87
46320	Removal of hemorrhoid clot	Y	P3		$90.20
46500	Injection into hemorrhoid(s)	Y	P3		$125.92
46505	Chemodenervation anal musc	Y	G2	22.906	$959.14
46600	Diagnostic anoscopy	N	P2	0.6396	$26.78
46604	Anoscopy and dilation	Y	P2	8.8345	$369.93
46606	Anoscopy and biopsy	Y	P3		$143.96
46608	Anoscopy, remove for body	Y	A2	8.5258	$357.00
46610	Anoscopy, remove lesion	Y	A2	18.2557	$764.42
46611	Anoscopy	Y	A2	8.5258	$357.00
46612	Anoscopy, remove lesions	Y	A2	18.2557	$764.42
46614	Anoscopy, control bleeding	Y	P3		$75.04
46615	Anoscopy	Y	A2	18.9002	$791.41
46700	Repair of anal stricture	Y	A2	20.0893	$841.20
46706	Repr of anal fistula w/glue	Y	A2	24.9641	$1,045.32
46707	Repair anorectal fist w/plug	Y	G2	30.7524	$1,287.70
46750	Repair of anal sphincter	Y	A2	25.974	$1,087.61
46753	Reconstruction of anus	Y	A2	20.0893	$841.20
46754	Removal of suture from anus	Y	A2	19.7242	$825.91
46760	Repair of anal sphincter	Y	A2	25.6089	$1,072.32
46761	Repair of anal sphincter	Y	A2	25.974	$1,087.61
46762	Implant artificial sphincter	Y	A2	28.741	$1,203.47
46900	Destruction, anal lesion(s)	Y	P2	2.674	$111.97
46910	Destruction, anal lesion(s)	Y	P3		$139.63
46916	Cryosurgery, anal lesion(s)	Y	P2	1.4728	$61.67
46917	Laser surgery, anal lesions	Y	A2	17.1406	$717.73
46922	Excision of anal lesion(s)	Y	A2	17.1406	$717.73
46924	Destruction, anal lesion(s)	Y	A2	17.1406	$717.73
46930*	Destroy internal hemorrhoids	Y	P3		$127.36

46937	Cryotherapy of rectal lesion	N	D5		
46938	Cryotherapy of rectal lesion	N	D5		
46940	Treatment of anal fissure	Y	P3		$102.46
46942	Treatment of anal fissure	Y	P3		$100.30
46945	Remove by ligat int hem grp	Y	P3		$167.05
46946	Remove by ligat int hem grps	Y	A2	12.0154	$503.12
46947	Hemorrhoidopexy by stapling	Y	A2	28.741	$1,203.47
47000	Needle biopsy of liver	Y	A2	8.8279	$369.65
47001	Needle biopsy, liver add-on	N	N1		
47382	Percut ablate liver rf	Y	G2	49.0813	$2,055.18
47500	Injection for liver x-rays	N	N1		
47505	Injection for liver x-rays	N	N1		
47510	Insert catheter, bile duct	Y	A2	24.5779	$1,029.15
47511	Insert bile duct drain	Y	A2	29.1415	$1,220.24
47525	Change bile duct catheter	Y	A2	12.873	$539.03
47530	Revise/reinsert bile tube	Y	A2	12.873	$539.03
47552	Biliary endoscopy thru skin	Y	A2	24.5779	$1,029.15
47553	Biliary endoscopy thru skin	Y	A2	24.943	$1,044.44
47554	Biliary endoscopy thru skin	Y	A2	24.943	$1,044.44
47555	Biliary endoscopy thru skin	Y	A2	24.943	$1,044.44
47556	Biliary endoscopy thru skin	Y	A2	29.1415	$1,220.24
47560	Laparoscopy w/cholangio	Y	A2	30.1832	$1,263.86
47561	Laparo w/cholangio/biopsy	Y	A2	30.1832	$1,263.86
47562	Laparoscopic cholecystectomy	Y	G2	44.7603	$1,874.25
47563	Laparo cholecystectomy/graph	Y	G2	44.7603	$1,874.25
47564	Laparo cholecystectomy/explr	Y	G2	44.7603	$1,874.25
47630	Remove bile duct stone	Y	A2	24.943	$1,044.44
48102	Needle biopsy, pancreas	Y	A2	8.8279	$369.65
49080	Puncture, peritoneal cavity	Y	A2	5.2502	$219.84
49081	Removal of abdominal fluid	Y	A2	5.2502	$219.84
49180	Biopsy, abdominal mass	Y	A2	8.8279	$369.65

49250	Excision of umbilicus	Y	A2	23.0784	$966.36
49320	Diag laparo separate proc	Y	A2	30.1832	$1,263.86
49321	Laparoscopy, biopsy	Y	A2	30.8676	$1,292.52
49322	Laparoscopy, aspiration	Y	A2	30.8676	$1,292.52
49324	Lap insertion perm ip cath	Y	G2	36.3644	$1,522.69
49325	Lap revision perm ip cath	Y	G2	36.3644	$1,522.69
49326	Lap w/omentopexy add-on	Y	G2	36.3644	$1,522.69
49400	Air injection into abdomen	N	N1		
49402	Remove foreign body, adbomen	Y	A2	22.0285	$922.40
49411	Ins mark abd/pel for rt perq	N	P3		$356.10
49419	Insrt abdom cath for chemotx	Y	A2	24.1022	$1,009.23
49420	Insert abdom drain, temp	Y	A2	23.7308	$993.68
49421	Insert abdom drain, perm	Y	A2	23.7308	$993.68
49422	Remove perm cannula/catheter	Y	A2	18.3419	$768.03
49423	Exchange drainage catheter	Y	G2	14.6305	$612.62
49424	Assess cyst, contrast inject	N	N1		
49426	Revise abdomen-venous shunt	Y	A2	22.0285	$922.40
49427	Injection, abdominal shunt	N	N1		
49429	Removal of shunt	Y	G2	21.9226	$917.97
49435	Insert subq exten to ip cath	Y	G2	14.6305	$612.62
49436	Embedded ip cath exit-site	Y	G2	14.6305	$612.62
49440	Place gastrostomy tube perc	Y	G2	8.3579	$349.97
49441	Place duod/jej tube perc	Y	G2	8.3579	$349.97
49442	Place cecostomy tube perc	Y	G2	13.4873	$564.75
49446	Change g-tube to g-j perc	Y	G2	8.3579	$349.97
49450	Replace g/c tube perc	Y	G2	6.0912	$255.06
49451	Replace duod/jej tube perc	Y	G2	6.0912	$255.06
49452	Replace g-j tube perc	Y	G2	6.0912	$255.06
49460	Fix g/colon tube w/device	Y	G2	6.0912	$255.06
49465	Fluoro exam of g/colon tube	N	N1		
49495	Rpr ing hernia baby, reduc	Y	A2	26.5059	$1,109.88

49496	Rpr ing hernia baby, blocked	Y	A2	26.5059	$1,109.88
49500	Rpr ing hernia, init, reduce	Y	A2	26.5059	$1,109.88
49501	Rpr ing hernia, init blocked	Y	A2	30.551	$1,279.26
49505	Prp i/hern init reduc >5 yr	Y	A2	26.5059	$1,109.88
49507	Prp i/hern init block >5 yr	Y	A2	30.551	$1,279.26
49520	Rerepair ing hernia, reduce	Y	A2	28.5884	$1,197.08
49521	Rerepair ing hernia, blocked	Y	A2	30.551	$1,279.26
49525	Repair ing hernia, sliding	Y	A2	26.5059	$1,109.88
49540	Repair lumbar hernia	Y	A2	25.4563	$1,065.93
49550	Rpr rem hernia, init, reduce	Y	A2	27.0024	$1,130.67
49553	Rpr fem hernia, init blocked	Y	A2	30.551	$1,279.26
49555	Rerepair fem hernia, reduce	Y	A2	27.0024	$1,130.67
49557	Rerepair fem hernia, blocked	Y	A2	30.551	$1,279.26
49560	Rpr ventral hern init, reduc	Y	A2	26.5059	$1,109.88
49561	Rpr ventral hern init, block	Y	A2	30.551	$1,279.26
49565	Rerepair ventrl hern, reduce	Y	A2	26.5059	$1,109.88
49566	Rerepair ventrl hern, block	Y	A2	30.551	$1,279.26
49568	Hernia repair w/mesh	Y	A2	28.5884	$1,197.08
49570	Rpr epigastric hern, reduce	Y	A2	26.5059	$1,109.88
49572	Rpr epigastric hern, blocked	Y	A2	30.551	$1,279.26
49580	Rpr umbil hern, reduc < 5 yr	Y	A2	26.5059	$1,109.88
49582	Rpr umbil hern, block < 5 yr	Y	A2	30.551	$1,279.26
49585	Rpr umbil hern, reduc > 5 yr	Y	A2	26.5059	$1,109.88
49587	Rpr umbil hern, block > 5 yr	Y	A2	30.551	$1,279.26
49590	Repair spigelian hernia	Y	A2	25.8214	$1,081.22
49600	Repair umbilical lesion	Y	A2	26.5059	$1,109.88
49650	Lap ing hernia repair init	Y	A2	37.1645	$1,556.19
49651	Lap ing hernia repair recur	Y	A2	39.247	$1,643.39
49652	Lap vent/abd hernia repair	Y	G2	69.7189	$2,919.34
49653	Lap vent/abd hern proc comp	Y	G2	69.7189	$2,919.34
49654	Lap inc hernia repair	Y	G2	69.7189	$2,919.34
49655	Lap inc hern repair comp	Y	G2	69.7189	$2,919.34
49656	Lap inc hernia repair recur	Y	G2	69.7189	$2,919.34
49657	Lap inc hern recur comp	Y	G2	69.7189	$2,919.34
50080	Removal of kidney stone	Y	G2	44.6074	$1,867.85
50081	Removal of kidney stone	Y	G2	44.6074	$1,867.85
50200	Renal biopsy perq	Y	A2	8.8279	$369.65
50382	Change ureter stent, percut	Y	G2	24.3891	$1,021.24
50384	Remove ureter stent, percut	Y	G2	16.2781	$681.61
50385	Change stent via transureth	Y	G2	24.3891	$1,021.24
50386	Remove stent via transureth	Y	P2	6.8174	$285.46
50387	Change ext/int ureter stent	Y	G2	14.6305	$612.62
50389	Remove renal tube w/fluoro	Y	G2	6.8174	$285.46
50390	Drainage of kidney lesion	Y	A2	8.8279	$369.65
50391	Instll rx agnt into rnal tub	Y	P2	1.0471	$43.85
50392	Insert kidney drain	Y	A2	14.1084	$590.76
50393	Insert ureteral tube	Y	A2	20.1918	$845.49
50394	Injection for kidney x-ray	N	N1		
50395	Create passage to kidney	Y	A2	20.1918	$845.49
50396	Measure kidney pressure	Y	A2	2.1976	$92.02
50398	Change kidney tube	Y	A2	12.873	$539.03
50551	Kidney endoscopy	Y	A2	7.0131	$293.66
50553	Kidney endoscopy	Y	A2	20.1918	$845.49
50555	Kidney endoscopy & biopsy	Y	A2	7.0131	$293.66
50557	Kidney endoscopy & treatment	Y	A2	20.1918	$845.49
50561	Kidney endoscopy & treatment	Y	A2	20.1918	$845.49
50562	Renal scope w/tumor resect	Y	G2	6.8174	$285.46
50570	Kidney endoscopy	Y	G2	6.8174	$285.46
50572	Kidney endoscopy	Y	G2	6.8174	$285.46
50574	Kidney endoscopy & biopsy	Y	G2	6.8174	$285.46
50575	Kidney endoscopy	Y	G2	34.5936	$1,448.54
50576	Kidney endoscopy & treatment	Y	G2	16.2781	$681.61

50580	Kidney endoscopy & treatment	Y	G2	16.2781	$681.61
50590	Fragmenting of kidney stone	Y	G2	39.5261	$1,655.08
50592	Perc rf ablate renal tumor	Y	G2	49.0813	$2,055.18
50684	Injection for ureter x-ray	N	N1		
50686	Measure ureter pressure	Y	P2	1.0471	$43.85
50688	Change of ureter tube/stent	Y	A2	12.873	$539.03
50690	Injection for ureter x-ray	N	N1		
50727	Revise ureter	Y	G2	19.1352	$801.25
50947	Laparo new ureter/bladder	Y	A2	41.2096	$1,725.57
50948	Laparo new ureter/bladder	Y	A2	41.2096	$1,725.57
50951	Endoscopy of ureter	Y	A2	7.0131	$293.66
50953	Endoscopy of ureter	Y	A2	7.0131	$293.66
50955	Ureter endoscopy & biopsy	Y	A2	20.1918	$845.49
50957	Ureter endoscopy & treatment	Y	A2	20.1918	$845.49
50961	Ureter endoscopy & treatment	Y	A2	20.1918	$845.49
50970	Ureter endoscopy	Y	A2	7.0131	$293.66
50972	Ureter endoscopy & catheter	Y	A2	7.0131	$293.66
50974	Ureter endoscopy & biopsy	Y	A2	14.1084	$590.76
50976	Ureter endoscopy & treatment	Y	A2	14.1084	$590.76
50980	Ureter endoscopy & treatment	Y	A2	20.1918	$845.49
51020	Incise & treat bladder	Y	A2	21.8862	$916.44
51030	Incise & treat bladder	Y	A2	21.8862	$916.44
51040	Incise & drain bladder	Y	A2	21.8862	$916.44
51045	Incise bladder/drain ureter	Y	A2	7.3909	$309.48
51050	Removal of bladder stone	Y	A2	21.8862	$916.44
51065	Remove ureter calculus	Y	A2	21.8862	$916.44
51080	Drainage of bladder abscess	Y	A2	15.8083	$661.94
51100	Drain bladder by needle	Y	P3		$31.75
51101	Drain bladder by trocar/cath	Y	P2	1.0471	$43.85
51102	Drain bl w/cath insertion	Y	A2	16.2513	$680.49
51500	Removal of bladder cyst	Y	A2	26.5059	$1,109.88

51520	Removal of bladder lesion	Y	A2	21.8862	$916.44
51535	Repair of ureter lesion	Y	G2	24.3891	$1,021.24
51600	Injection for bladder x-ray	N	N1		
51605	Preparation for bladder xray	N	N1		
51610	Injection for bladder x-ray	N	N1		
51700	Irrigation of bladder	Y	P3		$52.68
51701	Insert bladder catheter	N	P2	0.6396	$26.78
51702	Insert temp bladder cath	N	P2	0.6396	$26.78
51703	Insert bladder cath, complex	Y	P2	1.0471	$43.85
51705	Change of bladder tube	Y	P3		$71.80
51710	Change of bladder tube	Y	A2	6.4684	$270.85
51715	Endoscopic injection/implant	Y	A2	25.3978	$1,063.48
51720	Treatment of bladder lesion	Y	P3		$57.73
51725	Simple cystometrogram	Y	P2	2.8872	$120.90
51726	Complex cystometrogram	Y	A2	3.3606	$140.72
51727	Cystometrogram w/up	Y	P2	2.8872	$120.90
51728	Cystometrogram w/vp	Y	P2	2.8872	$120.90
51729	Cystometrogram w/vp&up	Y	P2	2.8872	$120.90
51736	Urine flow measurement	Y	P3		$21.65
51741	Electro-uroflowmetry, first	Y	P3		$24.89
51772	Urethra pressure profile	N	D5		
51784	Anal/urinary muscle study	Y	P2	1.0471	$43.85
51785	Anal/urinary muscle study	Y	A2	1.8291	$76.59
51792	Urinary reflex study	Y	P2	1.0471	$43.85
51795	Urine voiding pressure study	N	D5		
51797	Intraabdominal pressure test	Y	P2	1.9297	$80.80
51798	Us urine capacity measure	N	P3		$18.40
51880	Repair of bladder opening	Y	A2	20.1918	$845.49
51992	Laparo sling operation	Y	A2	37.661	$1,576.98
52000	Cystoscopy	Y	A2	7.0131	$293.66
52001	Cystoscopy, removal of clots	Y	A2	14.4864	$606.59

52005	Cystoscopy & ureter catheter	Y	A2	20.8366	$872.49
52007	Cystoscopy and biopsy	Y	A2	20.8366	$872.49
52010	Cystoscopy & duct catheter	Y	A2	7.3909	$309.48
52204	Cystoscopy w/biopsy(s)	Y	A2	20.8366	$872.49
52214	Cystoscopy and treatment	Y	A2	20.8366	$872.49
52224	Cystoscopy and treatment	Y	A2	20.8366	$872.49
52234	Cystoscopy and treatment	Y	A2	20.8366	$872.49
52235	Cystoscopy and treatment	Y	A2	21.2017	$887.78
52240	Cystoscopy and treatment	Y	A2	21.2017	$887.78
52250	Cystoscopy and radiotracer	Y	A2	21.8862	$916.44
52260	Cystoscopy and treatment	Y	A2	14.7532	$617.76
52265	Cystoscopy and treatment	Y	P2	6.8174	$285.46
52270	Cystoscopy & revise urethra	Y	A2	14.7532	$617.76
52275	Cystoscopy & revise urethra	Y	A2	20.8366	$872.49
52276	Cystoscopy and treatment	Y	A2	21.2017	$887.78
52277	Cystoscopy and treatment	Y	A2	20.8366	$872.49
52281	Cystoscopy and treatment	Y	A2	14.7532	$617.76
52282	Cystoscopy, implant stent	Y	A2	33.5846	$1,406.29
52283	Cystoscopy and treatment	Y	A2	20.8366	$872.49
52285	Cystoscopy and treatment	Y	A2	14.7532	$617.76
52290	Cystoscopy and treatment	Y	A2	20.8366	$872.49
52300	Cystoscopy and treatment	Y	A2	20.8366	$872.49
52301	Cystoscopy and treatment	Y	A2	21.2017	$887.78
52305	Cystoscopy and treatment	Y	A2	20.8366	$872.49
52310	Cystoscopy and treatment	Y	A2	14.4864	$606.59
52315	Cystoscopy and treatment	Y	A2	20.8366	$872.49
52317	Remove bladder stone	Y	A2	20.1918	$845.49
52318	Remove bladder stone	Y	A2	20.8366	$872.49
52320	Cystoscopy and treatment	Y	A2	22.3827	$937.23
52325	Cystoscopy, stone removal	Y	A2	21.8862	$916.44
52327	Cystoscopy, inject material	Y	A2	28.4897	$1,192.95

52330	Cystoscopy and treatment	Y	A2	20.8366	$872.49
52332	Cystoscopy and treatment	Y	A2	20.8366	$872.49
52334	Create passage to kidney	Y	A2	21.2017	$887.78
52341	Cysto w/ureter stricture tx	Y	A2	21.2017	$887.78
52342	Cysto w/up stricture tx	Y	A2	21.2017	$887.78
52343	Cysto w/renal stricture tx	Y	A2	21.2017	$887.78
52344	Cysto/uretero, stricture tx	Y	A2	21.2017	$887.78
52345	Cysto/uretero w/up stricture	Y	A2	21.2017	$887.78
52346	Cystouretero w/renal strict	Y	A2	21.2017	$887.78
52351	Cystouretero & or pyeloscope	Y	A2	21.2017	$887.78
52352	Cystouretero w/stone remove	Y	A2	21.8862	$916.44
52353	Cystouretero w/lithotripsy	Y	A2	29.5396	$1,236.91
52354	Cystouretero w/biopsy	Y	A2	21.8862	$916.44
52355	Cystouretero w/excise tumor	Y	A2	21.8862	$916.44
52400	Cystouretero w/congen repr	Y	A2	21.2017	$887.78
52402	Cystourethro cut ejacul duct	Y	A2	21.2017	$887.78
52450	Incision of prostate	Y	A2	21.2017	$887.78
52500	Revision of bladder neck	Y	A2	21.2017	$887.78
52601	Prostatectomy (TURP)	Y	A2	29.5396	$1,236.91
52630	Remove prostate regrowth	Y	A2	28.4897	$1,192.95
52640	Relieve bladder contracture	Y	A2	20.8366	$872.49
52647	Laser surgery of prostate	Y	A2	41.095	$1,720.77
52648	Laser surgery of prostate	Y	A2	41.095	$1,720.77
52700	Drainage of prostate abscess	Y	A2	20.8366	$872.49
53000	Incision of urethra	Y	A2	16.4758	$689.89
53010	Incision of urethra	Y	A2	16.4758	$689.89
53020	Incision of urethra	Y	A2	16.4758	$689.89
53025	Incision of urethra	Y	R2	19.4344	$813.78
53040	Drainage of urethra abscess	Y	A2	17.1203	$716.88
53060	Drainage of urethra abscess	Y	P3		$74.32
53080	Drainage of urinary leakage	Y	A2	17.4855	$732.17

53085	Drainage of urinary leakage	Y	G2	19.4344	$813.78
53200	Biopsy of urethra	Y	A2	16.4758	$689.89
53210	Removal of urethra	Y	A2	26.5787	$1,112.93
53215	Removal of urethra	Y	A2	18.6667	$781.63
53220	Treatment of urethra lesion	Y	A2	25.0326	$1,048.19
53230	Removal of urethra lesion	Y	A2	25.0326	$1,048.19
53235	Removal of urethra lesion	Y	A2	17.4855	$732.17
53240	Surgery for urethra pouch	Y	A2	25.0326	$1,048.19
53250	Removal of urethra gland	Y	A2	17.1203	$716.88
53260	Treatment of urethra lesion	Y	A2	17.1203	$716.88
53265	Treatment of urethra lesion	Y	A2	17.1203	$716.88
53270	Removal of urethra gland	Y	A2	17.1203	$716.88
53275	Repair of urethra defect	Y	A2	17.1203	$716.88
53400	Revise urethra, stage 1	Y	A2	25.3978	$1,063.48
53405	Revise urethra, stage 2	Y	A2	25.0326	$1,048.19
53410	Reconstruction of urethra	Y	A2	25.0326	$1,048.19
53420	Reconstruct urethra, stage 1	Y	A2	25.3978	$1,063.48
53425	Reconstruct urethra, stage 2	Y	A2	25.0326	$1,048.19
53430	Reconstruction of urethra	Y	A2	25.0326	$1,048.19
53431	Reconstruct urethra/bladder	Y	A2	25.0326	$1,048.19
53440	Male sling procedure	N	H8	124.4902	$5,212.78
53442	Remove/revise male sling	Y	A2	24.3878	$1,021.19
53444	Insert tandem cuff	N	H8	124.4902	$5,212.78
53445	Insert uro/ves nck sphincter	N	H8	222.7139	$9,325.70
53446	Remove uro sphincter	Y	A2	24.3878	$1,021.19
53447	Remove/replace ur sphincter	N	H8	222.7139	$9,325.70
53449	Repair uro sphincter	Y	A2	24.3878	$1,021.19
53450	Revision of urethra	Y	A2	24.3878	$1,021.19
53460	Revision of urethra	Y	A2	16.4758	$689.89
53502	Repair of urethra injury	Y	A2	17.1203	$716.88
53505	Repair of urethra injury	Y	A2	25.0326	$1,048.19
53510	Repair of urethra injury	Y	A2	17.1203	$716.88
53515	Repair of urethra injury	Y	A2	25.0326	$1,048.19
53520	Repair of urethra defect	Y	A2	25.0326	$1,048.19
53600	Dilate urethra stricture	Y	P3		$40.41
53601	Dilate urethra stricture	Y	P2	1.0471	$43.85
53605	Dilate urethra stricture	Y	A2	14.7532	$617.76
53620	Dilate urethra stricture	Y	P3		$61.70
53621	Dilate urethra stricture	Y	P3		$64.58
53660	Dilation of urethra	Y	P2	1.0471	$43.85
53661	Dilation of urethra	Y	P2	1.0471	$43.85
53665	Dilation of urethra	Y	A2	16.4758	$689.89
53850	Prostatic microwave thermotx	Y	P2	44.6074	$1,867.85
53852	Prostatic rf thermotx	Y	P2	44.6074	$1,867.85
53855	Insert prost urethral stent	Y	P2	1.9297	$80.80
54000	Slitting of prepuce	Y	A2	17.1203	$716.88
54001	Slitting of prepuce	Y	A2	17.1203	$716.88
54015	Drain penis lesion	Y	A2	17.5029	$732.90
54050	Destruction, penis lesion(s)	Y	P2	0.8399	$35.17
54055	Destruction, penis lesion(s)	Y	P3		$67.47
54056	Cryosurgery, penis lesion(s)	Y	P2	0.8399	$35.17
54057	Laser surg, penis lesion(s)	Y	A2	17.1406	$717.73
54060	Excision of penis lesion(s)	Y	A2	17.1406	$717.73
54065	Destruction, penis lesion(s)	Y	A2	17.1406	$717.73
54100	Biopsy of penis	Y	A2	14.4403	$604.66
54105	Biopsy of penis	Y	A2	18.6621	$781.44
54110	Treatment of penis lesion	Y	A2	27.5459	$1,153.43
54111	Treat penis lesion, graft	Y	A2	27.5459	$1,153.43
54112	Treat penis lesion, graft	Y	A2	27.5459	$1,153.43
54115	Treatment of penis lesion	Y	A2	15.8083	$661.94
54120	Partial removal of penis	Y	A2	27.5459	$1,153.43
54150	Circumcision w/regionl block	Y	A2	18.5874	$778.31

54160	Circumcision, neonate	Y	A2	19.232	$805.30
54161	Circum 28 days or older	Y	A2	19.232	$805.30
54162	Lysis penil circumic lesion	Y	A2	19.232	$805.30
54163	Repair of circumcision	Y	A2	19.232	$805.30
54164	Frenulotomy of penis	Y	A2	19.232	$805.30
54200	Treatment of penis lesion	Y	P3		$68.55
54205	Treatment of penis lesion	Y	A2	28.5958	$1,197.39
54220	Treatment of penis lesion	Y	A2	2.1976	$92.02
54230	Prepare penis study	N	N1		
54231	Dynamic cavernosometry	Y	P3		$64.58
54235	Penile injection	Y	P3		$46.18
54240	Penis study	Y	P3		$32.83
54250	Penis study	Y	P3		$11.55
54300	Revision of penis	Y	A2	27.9111	$1,168.72
54304	Revision of penis	Y	A2	27.9111	$1,168.72
54308	Reconstruction of urethra	Y	A2	27.9111	$1,168.72
54312	Reconstruction of urethra	Y	A2	27.9111	$1,168.72
54316	Reconstruction of urethra	Y	A2	27.9111	$1,168.72
54318	Reconstruction of urethra	Y	A2	27.9111	$1,168.72
54322	Reconstruction of urethra	Y	A2	27.9111	$1,168.72
54324	Reconstruction of urethra	Y	A2	27.9111	$1,168.72
54326	Reconstruction of urethra	Y	A2	27.9111	$1,168.72
54328	Revise penis/urethra	Y	A2	27.9111	$1,168.72
54340	Secondary urethral surgery	Y	A2	27.9111	$1,168.72
54344	Secondary urethral surgery	Y	A2	27.9111	$1,168.72
54348	Secondary urethral surgery	Y	A2	27.9111	$1,168.72
54352	Reconstruct urethra/penis	Y	A2	27.9111	$1,168.72
54360	Penis plastic surgery	Y	A2	27.9111	$1,168.72
54380	Repair penis	Y	A2	27.9111	$1,168.72
54385	Repair penis	Y	A2	27.9111	$1,168.72
54400	Insert semi-rigid prosthesis	N	H8	124.8554	$5,228.07

54401	Insert self-contd prosthesis	N	H8	223.7236	$9,367.98
54405	Insert multi-comp penis pros	N	H8	223.7236	$9,367.98
54406	Remove muti-comp penis pros	Y	A2	27.9111	$1,168.72
54408	Repair multi-comp penis pros	Y	A2	27.9111	$1,168.72
54410	Remove/replace penis prosth	N	H8	223.7236	$9,367.98
54415	Remove self-contd penis pros	Y	A2	27.9111	$1,168.72
54416	Remv/repl penis contain pros	N	H8	223.7236	$9,367.98
54420	Revision of penis	Y	A2	28.5958	$1,197.39
54435	Revision of penis	Y	A2	28.5958	$1,197.39
54440	Repair of penis	Y	A2	28.5958	$1,197.39
54450	Preputial stretching	Y	A2	3.3606	$140.72
54500	Biopsy of testis	Y	A2	13.0089	$544.72
54505	Biopsy of testis	Y	A2	18.5874	$778.31
54512	Excise lesion testis	Y	A2	19.232	$805.30
54520	Removal of testis	Y	A2	19.5971	$820.59
54522	Orchiectomy, partial	Y	A2	19.5971	$820.59
54530	Removal of testis	Y	A2	26.5059	$1,109.88
54550	Exploration for testis	Y	A2	26.5059	$1,109.88
54560	Exploration for testis	Y	G2	22.25	$931.67
54600	Reduce testis torsion	Y	A2	20.2818	$849.26
54620	Suspension of testis	Y	A2	19.5971	$820.59
54640	Suspension of testis	Y	A2	26.5059	$1,109.88
54660	Revision of testis	Y	A2	19.232	$805.30
54670	Repair testis injury	Y	A2	19.5971	$820.59
54680	Relocation of testis(es)	Y	A2	19.5971	$820.59
54690	Laparoscopy, orchiectomy	Y	A2	41.2096	$1,725.57
54692	Laparoscopy, orchiopexy	Y	G2	69.7189	$2,919.34
54700	Drainage of scrotum	Y	A2	19.232	$805.30
54800	Biopsy of epididymis	Y	A2	4.0217	$168.40
54830	Remove epididymis lesion	Y	A2	19.5971	$820.59
54840	Remove epididymis lesion	Y	A2	20.2818	$849.26

54860	Removal of epididymis	Y	A2	19.5971	$820.59
54861	Removal of epididymis	Y	A2	20.2818	$849.26
54865	Explore epididymis	Y	A2	18.5874	$778.31
54900	Fusion of spermatic ducts	Y	A2	20.2818	$849.26
54901	Fusion of spermatic ducts	Y	A2	20.2818	$849.26
55000	Drainage of hydrocele	Y	P3		$66.75
55040	Removal of hydrocele	Y	A2	25.8214	$1,081.22
55041	Removal of hydroceles	Y	A2	27.0024	$1,130.67
55060	Repair of hydrocele	Y	A2	20.2818	$849.26
55100	Drainage of scrotum abscess	Y	A2	10.9457	$458.33
55110	Explore scrotum	Y	A2	19.232	$805.30
55120	Removal of scrotum lesion	Y	A2	19.232	$805.30
55150	Removal of scrotum	Y	A2	18.5874	$778.31
55175	Revision of scrotum	Y	A2	18.5874	$778.31
55180	Revision of scrotum	Y	A2	19.232	$805.30
55200	Incision of sperm duct	Y	A2	19.232	$805.30
55250	Removal of sperm duct(s)	Y	A2	19.232	$805.30
55300	Prepare, sperm duct x-ray	N	N1		
55400	Repair of sperm duct	Y	A2	18.5874	$778.31
55450	Ligation of sperm duct	Y	P3		$211.42
55500	Removal of hydrocele	Y	A2	19.5971	$820.59
55520	Removal of sperm cord lesion	Y	A2	20.2818	$849.26
55530	Revise spermatic cord veins	Y	A2	20.2818	$849.26
55535	Revise spermatic cord veins	Y	A2	26.5059	$1,109.88
55540	Revise hernia & sperm veins	Y	A2	27.0024	$1,130.67
55550	Laparo ligate spermatic vein	Y	A2	41.2096	$1,725.57
55600	Incise sperm duct pouch	Y	R2	22.25	$931.67
55680	Remove sperm pouch lesion	Y	A2	18.5874	$778.31
55700	Biopsy of prostate	Y	A2	10.8827	$455.69
55705	Biopsy of prostate	Y	A2	10.8827	$455.69
55706	Prostate saturation sampling	Y	G2	11.8794	$497.43

55720	Drainage of prostate abscess	Y	A2	20.1918	$845.49
55725	Drainage of prostate abscess	Y	A2	20.8366	$872.49
55860	Surgical exposure, prostate	Y	G2	19.1352	$801.25
55870	Electroejaculation	Y	P3		$80.10
55873	Cryoablate prostate	Y	H8	146.3234	$6,127.00
55875	Transperi needle place, pros	N	A2	33.5846	$1,406.29
55876	Place rt device/marker, pros	N	P3		$72.88
55920	Place needles pelvic for rt	Y	G2	25.9785	$1,087.80
56405	I & D of vulva/perineum	Y	P3		$45.10
56420	Drainage of gland abscess	Y	P2	1.4599	$61.13
56440	Surgery for vulva lesion	Y	A2	16.9109	$708.11
56441	Lysis of labial lesion(s)	Y	A2	16.2661	$681.11
56442	Hymenotomy	Y	A2	16.2661	$681.11
56501	Destroy, vulva lesions, sim	Y	P3		$61.33
56515	Destroy vulva lesion/s compl	Y	A2	18.1504	$760.01
56605	Biopsy of vulva/perineum	Y	P3		$35.36
56606	Biopsy of vulva/perineum	Y	P3		$14.43
56620	Partial removal of vulva	Y	A2	18.457	$772.85
56625	Complete removal of vulva	Y	A2	20.0432	$839.27
56700	Partial removal of hymen	Y	A2	16.2661	$681.11
56740	Remove vagina gland lesion	Y	A2	17.276	$723.40
56800	Repair of vagina	Y	A2	17.276	$723.40
56805	Repair clitoris	Y	G2	19.1552	$802.09
56810	Repair of perineum	Y	A2	18.457	$772.85
56820	Exam of vulva w/scope	Y	P3		$45.82
56821	Exam/biopsy of vulva w/scope	Y	P3		$59.17
57000	Exploration of vagina	Y	A2	16.2661	$681.11
57010	Drainage of pelvic abscess	Y	A2	16.9109	$708.11
57020	Drainage of pelvic fluid	Y	A2	7.2054	$301.71
57022	I & d vaginal hematoma, pp	Y	R2	12.0613	$505.04
57023	I & d vag hematoma, non-ob	Y	A2	15.8083	$661.94

57061	Destroy vag lesions, simple	Y	P3		$56.64
57065	Destroy vag lesions, complex	Y	A2	16.2661	$681.11
57100	Biopsy of vagina	Y	P3		$36.44
57105	Biopsy of vagina	Y	A2	16.9109	$708.11
57130	Remove vagina lesion	Y	A2	16.9109	$708.11
57135	Remove vagina lesion	Y	A2	16.9109	$708.11
57150	Treat vagina infection	Y	P3		$25.26
57155	Insert uteri tandems/ovoids	Y	A2	7.2054	$301.71
57160	Insert pessary/other device	Y	P3		$37.88
57170	Fitting of diaphragm/cap	Y	P2	0.1261	$5.28
57180	Treat vaginal bleeding	Y	A2	2.1107	$88.38
57200	Repair of vagina	Y	A2	16.2661	$681.11
57210	Repair vagina/perineum	Y	A2	16.9109	$708.11
57220	Revision of urethra	Y	A2	35.1537	$1,471.99
57230	Repair of urethral lesion	Y	A2	28.1852	$1,180.20
57240	Repair bladder & vagina	Y	A2	29.3662	$1,229.65
57250	Repair rectum & vagina	Y	A2	29.3662	$1,229.65
57260	Repair of vagina	Y	A2	29.3662	$1,229.65
57265	Extensive repair of vagina	Y	A2	37.9209	$1,587.86
57267	Insert mesh/pelvic flr addon	Y	A2	30.9524	$1,296.07
57268	Repair of bowel bulge	Y	A2	28.1852	$1,180.20
57287	Revise/remove sling repair	Y	G2	33.7008	$1,411.15
57288	Repair bladder defect	Y	A2	36.3346	$1,521.44
57289	Repair bladder & vagina	Y	A2	29.3662	$1,229.65
57291	Construction of vagina	Y	A2	29.3662	$1,229.65
57295	Revise vag graft via vagina	Y	G2	19.1552	$802.09
57300	Repair rectum-vagina fistula	Y	A2	28.1852	$1,180.20
57320	Repair bladder-vagina lesion	Y	G2	33.7008	$1,411.15
57400	Dilation of vagina	Y	A2	16.9109	$708.11
57410	Pelvic examination	Y	A2	16.9109	$708.11
57415	Remove vaginal foreign body	Y	A2	16.9109	$708.11

57420	Exam of vagina w/scope	Y	P3		$47.26
57421	Exam/biopsy of vag w/scope	Y	P3		$61.70
57426	Revise prosth vag graft lap	Y	G2	19.1552	$802.09
57452	Exam of cervix w/scope	Y	P3		$44.38
57454	Bx/curett of cervix w/scope	Y	P3		$54.84
57455	Biopsy of cervix w/scope	Y	P3		$57.73
57456	Endocerv curettage w/scope	Y	P3		$55.92
57460	Bx of cervix w/scope, leep	Y	P3		$165.96
57461	Conz of cervix w/scope, leep	Y	P3		$177.15
57500	Biopsy of cervix	Y	P3		$76.49
57505	Endocervical curettage	Y	P3		$49.43
57510	Cauterization of cervix	Y	P3		$50.87
57511	Cryocautery of cervix	Y	P2	1.4599	$61.13
57513	Laser surgery of cervix	Y	A2	16.9109	$708.11
57520	Conization of cervix	Y	A2	16.9109	$708.11
57522	Conization of cervix	Y	A2	16.9109	$708.11
57530	Removal of cervix	Y	A2	28.1852	$1,180.20
57550	Removal of residual cervix	Y	A2	28.1852	$1,180.20
57556	Remove cervix, repair bowel	Y	A2	36.3346	$1,521.44
57558	D&c of cervical stump	Y	A2	17.276	$723.40
57700	Revision of cervix	Y	A2	16.2661	$681.11
57720	Revision of cervix	Y	A2	17.276	$723.40
57800	Dilation of cervical canal	Y	P3		$26.70
58100	Biopsy of uterus lining	Y	P3		$44.02
58110	Bx done w/colposcopy add-on	N	N1		
58120	Dilation and curettage	Y	A2	16.9109	$708.11
58145	Myomectomy vag method	Y	A2	29.3662	$1,229.65
58301	Remove intrauterine device	Y	P3		$41.13
58321	Artificial insemination	Y	P3		$38.60
58322	Artificial insemination	Y	P3		$39.33
58323	Sperm washing	Y	P3		$8.30

58340	Catheter for hysterography	N	N1		
58345	Reopen fallopian tube	Y	R2	19.1552	$802.09
58346	Insert heyman uteri capsule	Y	A2	16.9109	$708.11
58350	Reopen fallopian tube	Y	A2	28.1852	$1,180.20
58353	Endometr ablate, thermal	Y	A2	30.9524	$1,296.07
58356	Endometrial cryoablation	Y	P3		$1,649.90
58545	Laparoscopic myomectomy	Y	A2	34.9127	$1,461.90
58546	Laparo-myomectomy, complex	Y	A2	41.2096	$1,725.57
58550	Laparo-asst vag hysterectomy	Y	A2	59.9286	$2,509.39
58552	Laparo-vag hyst incl t/o	Y	G2	44.7603	$1,874.25
58555	Hysteroscopy, dx, sep proc	Y	A2	18.0921	$757.57
58558	Hysteroscopy, biopsy	Y	A2	19.1018	$799.85
58559	Hysteroscopy, lysis	Y	A2	18.7367	$784.56
58560	Hysteroscopy, resect septum	Y	A2	29.5852	$1,238.82
58561	Hysteroscopy, remove myoma	Y	A2	29.5852	$1,238.82
58562	Hysteroscopy, remove fb	Y	A2	19.1018	$799.85
58563	Hysteroscopy, ablation	Y	A2	34.315	$1,436.87
58565	Hysteroscopy, sterilization	Y	A2	39.8835	$1,670.04
58600	Division of fallopian tube	Y	G2	33.7008	$1,411.15
58615	Occlude fallopian tube(s)	Y	G2	19.1552	$802.09
58660	Laparoscopy, lysis	Y	A2	37.661	$1,576.98
58661	Laparoscopy, remove adnexa	Y	A2	37.661	$1,576.98
58662	Laparoscopy, excise lesions	Y	A2	37.661	$1,576.98
58670	Laparoscopy, tubal cautery	Y	A2	36.4801	$1,527.53
58671	Laparoscopy, tubal block	Y	A2	36.4801	$1,527.53
58672	Laparoscopy, fimbrioplasty	Y	A2	37.661	$1,576.98
58673	Laparoscopy, salpingostomy	Y	A2	37.661	$1,576.98
58800	Drainage of ovarian cyst(s)	Y	A2	17.276	$723.40
58805	Drainage of ovarian cyst(s)	Y	G2	33.7008	$1,411.15
58820	Drain ovary abscess, open	Y	A2	28.1852	$1,180.20
58900	Biopsy of ovary(s)	Y	A2	17.276	$723.40

58970	Retrieval of oocyte	Y	A2	3.8459	$161.04
58974	Transfer of embryo	Y	A2	3.8459	$161.04
58976	Transfer of embryo	Y	A2	3.8459	$161.04
59000	Amniocentesis, diagnostic	Y	P3		$65.66
59001	Amniocentesis, therapeutic	Y	R2	6.4932	$271.89
59012	Fetal cord puncture,prenatal	Y	G2	3.2572	$136.39
59015	Chorion biopsy	Y	P3		$54.84
59020	Fetal contract stress test	Y	P3		$28.50
59025	Fetal non-stress test	Y	P3		$15.15
59070	Transabdom amnioinfus w/us	Y	G2	1.4599	$61.13
59072	Umbilical cord occlud w/us	Y	G2	3.2572	$136.39
59076	Fetal shunt placement, w/us	Y	G2	3.2572	$136.39
59100	Remove uterus lesion	Y	R2	33.7008	$1,411.15
59150	Treat ectopic pregnancy	Y	G2	44.7603	$1,874.25
59151	Treat ectopic pregnancy	Y	G2	44.7603	$1,874.25
59160	D & c after delivery	Y	A2	17.276	$723.40
59200	Insert cervical dilator	Y	P3		$36.08
59300	Episiotomy or vaginal repair	Y	P3		$79.73
59320	Revision of cervix	Y	A2	16.2661	$681.11
59412	Antepartum manipulation	Y	G2	19.1552	$802.09
59414	Deliver placenta	Y	G2	19.1552	$802.09
59812	Treatment of miscarriage	Y	A2	18.457	$772.85
59820	Care of miscarriage	Y	A2	18.457	$772.85
59821	Treatment of miscarriage	Y	A2	18.457	$772.85
59840	Abortion	Y	A2	18.457	$772.85
59841	Abortion	Y	A2	18.457	$772.85
59866	Abortion (mpr)	Y	G2	3.2572	$136.39
59870	Evacuate mole of uterus	Y	A2	18.457	$772.85
59871	Remove cerclage suture	Y	A2	18.457	$772.85
60000	Drain thyroid/tongue cyst	Y	A2	7.3608	$308.22
60100	Biopsy of thyroid	Y	P3		$48.71

60200	Remove thyroid lesion	Y	A2	37.4879	$1,569.73
60210	Partial thyroid excision	Y	G2	46.5913	$1,950.92
60212	Partial thyroid excision	Y	G2	46.5913	$1,950.92
60220	Partial removal of thyroid	Y	G2	46.5913	$1,950.92
60225	Partial removal of thyroid	Y	G2	46.5913	$1,950.92
60280	Remove thyroid duct lesion	Y	A2	38.5377	$1,613.69
60281	Remove thyroid duct lesion	Y	A2	38.5377	$1,613.69
60300	Aspir/inj thyroid cyst	Y	P3		$66.02
61000	Remove cranial cavity fluid	Y	R2	6.8805	$288.11
61001	Remove cranial cavity fluid	Y	R2	6.8805	$288.11
61020	Remove brain cavity fluid	Y	A2	6.209	$259.99
61026	Injection into brain canal	Y	A2	6.209	$259.99
61050	Remove brain canal fluid	Y	A2	6.209	$259.99
61055	Injection into brain canal	Y	A2	6.209	$259.99
61070	Brain canal shunt procedure	Y	A2	5.6172	$235.21
61215	Insert brain-fluid device	Y	A2	32.3151	$1,353.13
61330	Decompress eye socket	Y	G2	41.0743	$1,719.90
61334	Explore orbit/remove object	Y	G2	41.0743	$1,719.90
61770	Incise skull for treatment	Y	G2	35.6253	$1,491.74
61790	Treat trigeminal nerve	Y	A2	16.3263	$683.63
61791	Treat trigeminal tract	Y	A2	11.4998	$481.53
61795	Brain surgery using computer	N	N1		
61880	Revise/remove neuroelectrode	Y	G2	18.7662	$785.80
61885	Insrt/redo neurostim 1 array	N	H8	306.8087	$12,847.00
61886	Implant neurostim arrays	N	H8	415.2461	$17,387.60
61888	Revise/remove neuroreceiver	Y	A2	22.4431	$939.76
62160	Neuroendoscopy add-on	N	N1		
62194	Replace/irrigate catheter	Y	A2	7.0602	$295.63
62225	Replace/irrigate catheter	Y	A2	12.873	$539.03
62230	Replace/revise brain shunt	Y	A2	31.9499	$1,337.84
62252	Csf shunt reprogram	N	P3		$49.79

62263	Epidural lysis mult sessions	Y	A2	7.0602	$295.63
62264	Epidural lysis on single day	Y	A2	11.3918	$477.01
62267	Interdiscal perq aspir, dx	Y	G2	4.3949	$184.03
62268	Drain spinal cord cyst	Y	A2	6.209	$259.99
62269	Needle biopsy, spinal cord	Y	A2	8.8279	$369.65
62270	Spinal fluid tap, diagnostic	Y	A2	3.4607	$144.91
62272	Drain cerebro spinal fluid	Y	A2	3.4607	$144.91
62273	Inject epidural patch	Y	A2	4.5676	$191.26
62280	Treat spinal cord lesion	Y	A2	7.0602	$295.63
62281	Treat spinal cord lesion	Y	A2	7.0602	$295.63
62282	Treat spinal canal lesion	Y	A2	7.0602	$295.63
62284	Injection for myelogram	N	N1		
62287	Percutaneous diskectomy	Y	A2	34.3584	$1,438.69
62290	Inject for spine disk x-ray	N	N1		
62291	Inject for spine disk x-ray	N	N1		
62292	Injection into disk lesion	Y	R2	6.8805	$288.11
62294	Injection into spinal artery	Y	A2	6.209	$259.99
62310	Inject spine c/t	Y	A2	7.0602	$295.63
62311	Inject spine l/s (cd)	Y	A2	7.0602	$295.63
62318	Inject spine w/cath, c/t	Y	A2	7.0602	$295.63
62319	Inject spine w/cath l/s (cd)	Y	A2	7.0602	$295.63
62350	Implant spinal canal cath	Y	A2	31.9499	$1,337.84
62355	Remove spinal canal catheter	Y	A2	12.0364	$504.00
62360	Insert spine infusion device	Y	A2	31.9499	$1,337.84
62361	Implant spine infusion pump	Y	H8	290.962	$12,183.45
62362	Implant spine infusion pump	Y	H8	290.962	$12,183.45
62365	Remove spine infusion device	Y	A2	29.2635	$1,225.35
62367	Analyze spine infusion pump	N	P3		$18.76
62368	Analyze spine infusion pump	N	P3		$24.53
63600	Remove spinal cord lesion	Y	A2	15.9611	$668.34
63610	Stimulation of spinal cord	Y	A2	15.3166	$641.35

63615	Remove lesion of spinal cord	Y	R2	17.8888	$749.06
63650	Implant neuroelectrodes	N	H8	83.3143	$3,488.62
63655	Implant neuroelectrodes	N	J8	118.4379	$4,959.35
63660	Revise/remove neuroelectrode	N	D5		
63661	Remove spine eltrd perq aray	Y	G2	18.7662	$785.80
63662	Remove spine eltrd plate	Y	G2	18.7662	$785.80
63663	Revise spine eltrd perq aray	Y	G2	18.7662	$785.80
63664	Revise spine eltrd plate	Y	G2	18.7662	$785.80
63685	Insrt/redo spine n generator	N	H8	306.8087	$12,847.00
63688	Revise/remove neuroreceiver	Y	A2	22.4431	$939.76
63744	Revision of spinal shunt	Y	A2	32.3151	$1,353.13
63746	Removal of spinal shunt	Y	A2	12.0364	$504.00
64400	N block inj, trigeminal	Y	P3		$58.81
64402	N block inj, facial	Y	P3		$55.92
64405	N block inj, occipital	Y	P3		$48.35
64408	N block inj, vagus	Y	P3		$58.09
64410	N block inj, phrenic	Y	A2	7.0602	$295.63
64412	N block inj, spinal accessor	Y	P3		$87.67
64413	N block inj, cervical plexus	Y	P3		$54.12
64415	N block inj, brachial plexus	Y	A2	3.4607	$144.91
64416	N block cont infuse, b plex	Y	G2	6.8805	$288.11
64417	N block inj, axillary	Y	A2	3.4607	$144.91
64418	N block inj, suprascapular	Y	P3		$75.77
64420	N block inj, intercost, sng	Y	A2	3.4607	$144.91
64421	N block inj, intercost, mlt	Y	A2	7.0602	$295.63
64425	N block inj, ilio-ing/hypogi	Y	P3		$54.12
64430	N block inj, pudendal	Y	A2	5.9532	$249.28
64435	N block inj, paracervical	Y	P3		$75.41
64445	N block inj, sciatic, sng	Y	P3		$68.91
64446	N blk inj, sciatic, cont inf	Y	G2	6.8805	$288.11
64447	N block inj fem, single	Y	R2	3.5568	$148.93

64448	N block inj fem, cont inf	Y	G2	6.8805	$288.11
64449	N block inj, lumbar plexus	Y	G2	6.8805	$288.11
64450	N block, other peripheral	Y	P3		$47.26
64455*	N block inj, plantar digit	Y	P3		$19.84
64470	Inj paravertebral c/t	N	D5		
64472	Inj paravertebral c/t add-on	N	D5		
64475	Inj paravertebral l/s	N	D5		
64476	Inj paravertebral l/s add-on	N	D5		
64479	Inj foramen epidural c/t	Y	A2	7.0602	$295.63
64480	Inj foramen epidural add-on	Y	A2	4.5676	$191.26
64483	Inj foramen epidural l/s	Y	A2	7.0602	$295.63
64484	Inj foramen epidural add-on	Y	A2	4.5676	$191.26
64490	Inj paravert f jnt c/t 1 lev	Y	G2	6.8805	$288.11
64491	Inj paravert f jnt c/t 2 lev	Y	G2	2.4423	$102.27
64492	Inj paravert f jnt c/t 3 lev	Y	G2	2.4423	$102.27
64493	Inj paravert f jnt l/s 1 lev	Y	G2	6.8805	$288.11
64494	Inj paravert f jnt l/s 2 lev	Y	G2	2.4423	$102.27
64495	Inj paravert f jnt l/s 3 lev	Y	G2	2.4423	$102.27
64505	N block, spenopalatine gangl	Y	P3		$41.85
64508	N block, carotid sinus s/p	Y	P3		$94.89
64510	N block, stellate ganglion	Y	A2	7.0602	$295.63
64517	N block inj, hypogas plxs	Y	A2	5.9532	$249.28
64520	N block, lumbar/thoracic	Y	A2	7.0602	$295.63
64530	N block inj, celiac pelus	Y	A2	7.0602	$295.63
64553	Implant neuroelectrodes	N	H8	82.6695	$3,461.62
64555	Implant neuroelectrodes	N	J8	87.4193	$3,660.51
64560	Implant neuroelectrodes	N	J8	87.4193	$3,660.51
64561	Implant neuroelectrodes	N	H8	83.6795	$3,503.91
64565	Implant neuroelectrodes	N	J8	87.4193	$3,660.51
64573	Implant neuroelectrodes	N	H8	217.7062	$9,116.01
64575	Implant neuroelectrodes	N	H8	112.808	$4,723.61

64577	Implant neuroelectrodes	N	H8	112.808	$4,723.61
64580	Implant neuroelectrodes	N	H8	112.808	$4,723.61
64581	Implant neuroelectrodes	N	H8	113.818	$4,765.90
64585	Revise/remove neuroelectrode	Y	A2	15.9745	$668.90
64590	Insrt/redo pn/gastr stimul	N	H8	306.8087	$12,847.00
64595	Revise/rmv pn/gastr stimul	Y	A2	22.4431	$939.76
64600	Injection treatment of nerve	Y	A2	11.3918	$477.01
64605	Injection treatment of nerve	Y	A2	15.3166	$641.35
64610	Injection treatment of nerve	Y	A2	15.3166	$641.35
64612	Destroy nerve, face muscle	Y	P3		$69.63
64613	Destroy nerve, neck muscle	Y	P3		$66.02
64614	Destroy nerve, extrem musc	Y	P3		$75.04
64620	Injection treatment of nerve	Y	A2	7.0602	$295.63
64622	Destr paravertebrl nerve l/s	Y	A2	11.3918	$477.01
64623	Destr paravertebral n add-on	Y	A2	7.0602	$295.63
64626	Destr paravertebrl nerve c/t	Y	A2	7.0602	$295.63
64627	Destr paravertebral n add-on	Y	A2	3.7318	$156.26
64630	Injection treatment of nerve	Y	A2	7.1681	$300.15
64632*	N block inj, common digit	Y	P3		$36.08
64640	Injection treatment of nerve	Y	P3		$102.46
64650	Chemodenerv eccrine glands	Y	P3		$36.44
64653	Chemodenerv eccrine glands	Y	P3		$40.05
64680	Injection treatment of nerve	Y	A2	7.3907	$309.47
64681	Injection treatment of nerve	Y	A2	12.0364	$504.00
64702	Revise finger/toe nerve	Y	A2	15.3166	$641.35
64704	Revise hand/foot nerve	Y	A2	15.3166	$641.35
64708	Revise arm/leg nerve	Y	A2	15.9611	$668.34
64712	Revision of sciatic nerve	Y	A2	15.9611	$668.34
64713	Revision of arm nerve(s)	Y	A2	15.9611	$668.34
64714	Revise low back nerve(s)	Y	A2	15.9611	$668.34
64716	Revision of cranial nerve	Y	A2	16.3263	$683.63

64718	Revise ulnar nerve at elbow	Y	A2	15.9611	$668.34
64719	Revise ulnar nerve at wrist	Y	A2	15.9611	$668.34
64721	Carpal tunnel surgery	Y	A2	15.9611	$668.34
64722	Relieve pressure on nerve(s)	Y	A2	15.3166	$641.35
64726	Release foot/toe nerve	Y	A2	15.3166	$641.35
64727	Internal nerve revision	Y	A2	15.3166	$641.35
64732	Incision of brow nerve	Y	A2	15.9611	$668.34
64734	Incision of cheek nerve	Y	A2	15.9611	$668.34
64736	Incision of chin nerve	Y	A2	15.9611	$668.34
64738	Incision of jaw nerve	Y	A2	15.9611	$668.34
64740	Incision of tongue nerve	Y	A2	15.9611	$668.34
64742	Incision of facial nerve	Y	A2	15.9611	$668.34
64744	Incise nerve, back of head	Y	A2	15.9611	$668.34
64746	Incise diaphragm nerve	Y	A2	15.9611	$668.34
64761	Incision of pelvis nerve	Y	G2	17.8888	$749.06
64763	Incise hip/thigh nerve	Y	G2	17.8888	$749.06
64766	Incise hip/thigh nerve	Y	G2	35.6253	$1,491.74
64771	Sever cranial nerve	Y	A2	15.9611	$668.34
64772	Incision of spinal nerve	Y	A2	15.9611	$668.34
64774	Remove skin nerve lesion	Y	A2	15.9611	$668.34
64776	Remove digit nerve lesion	Y	A2	16.3263	$683.63
64778	Digit nerve surgery add-on	Y	A2	15.9611	$668.34
64782	Remove limb nerve lesion	Y	A2	16.3263	$683.63
64783	Limb nerve surgery add-on	Y	A2	15.9611	$668.34
64784	Remove nerve lesion	Y	A2	16.3263	$683.63
64786	Remove sciatic nerve lesion	Y	A2	29.6286	$1,240.64
64787	Implant nerve end	Y	A2	15.9611	$668.34
64788	Remove skin nerve lesion	Y	A2	16.3263	$683.63
64790	Removal of nerve lesion	Y	A2	16.3263	$683.63
64792	Removal of nerve lesion	Y	A2	29.6286	$1,240.64
64795	Biopsy of nerve	Y	A2	15.9611	$668.34

64802	Remove sympathetic nerves	Y	A2	15.9611	$668.34
64820	Remove sympathetic nerves	Y	G2	17.8888	$749.06
64821	Remove sympathetic nerves	Y	A2	23.8321	$997.92
64822	Remove sympathetic nerves	Y	G2	26.9839	$1,129.90
64823	Remove sympathetic nerves	Y	G2	26.9839	$1,129.90
64831	Repair of digit nerve	Y	A2	30.3133	$1,269.31
64832	Repair nerve add-on	Y	A2	28.6189	$1,198.36
64834	Repair of hand or foot nerve	Y	A2	29.2635	$1,225.35
64835	Repair of hand or foot nerve	Y	A2	29.6286	$1,240.64
64836	Repair of hand or foot nerve	Y	A2	29.6286	$1,240.64
64837	Repair nerve add-on	Y	A2	28.6189	$1,198.36
64840	Repair of leg nerve	Y	A2	29.2635	$1,225.35
64856	Repair/transpose nerve	Y	A2	29.2635	$1,225.35
64857	Repair arm/leg nerve	Y	A2	29.2635	$1,225.35
64858	Repair sciatic nerve	Y	A2	29.2635	$1,225.35
64859	Nerve surgery	Y	A2	28.6189	$1,198.36
64861	Repair of arm nerves	Y	A2	29.6286	$1,240.64
64862	Repair of low back nerves	Y	A2	29.6286	$1,240.64
64864	Repair of facial nerve	Y	A2	29.6286	$1,240.64
64865	Repair of facial nerve	Y	A2	30.3133	$1,269.31
64870	Fusion of facial/other nerve	Y	A2	30.3133	$1,269.31
64872	Subsequent repair of nerve	Y	A2	29.2635	$1,225.35
64874	Repair & revise nerve add-on	Y	A2	29.6286	$1,240.64
64876	Repair nerve/shorten bone	Y	A2	29.6286	$1,240.64
64885	Nerve graft, head or neck	Y	A2	29.2635	$1,225.35
64886	Nerve graft, head or neck	Y	A2	29.2635	$1,225.35
64890	Nerve graft, hand or foot	Y	A2	29.2635	$1,225.35
64891	Nerve graft, hand or foot	Y	A2	29.2635	$1,225.35
64892	Nerve graft, arm or leg	Y	A2	29.2635	$1,225.35
64893	Nerve graft, arm or leg	Y	A2	29.2635	$1,225.35
64895	Nerve graft, hand or foot	Y	A2	29.6286	$1,240.64

64896	Nerve graft, hand or foot	Y	A2	29.6286	$1,240.64
64897	Nerve graft, arm or leg	Y	A2	29.6286	$1,240.64
64898	Nerve graft, arm or leg	Y	A2	29.6286	$1,240.64
64901	Nerve graft add-on	Y	A2	29.2635	$1,225.35
64902	Nerve graft add-on	Y	A2	29.2635	$1,225.35
64905	Nerve pedicle transfer	Y	A2	29.2635	$1,225.35
64907	Nerve pedicle transfer	Y	A2	28.6189	$1,198.36
64910	Nerve repair w/allograft	Y	G2	35.6253	$1,491.74
65091	Revise eye	Y	A2	30.8693	$1,292.59
65093	Revise eye with implant	Y	A2	30.8693	$1,292.59
65101	Removal of eye	Y	A2	30.8693	$1,292.59
65103	Remove eye/insert implant	Y	A2	30.8693	$1,292.59
65105	Remove eye/attach implant	Y	A2	31.554	$1,321.26
65110	Removal of eye	Y	A2	32.0502	$1,342.04
65112	Remove eye/revise socket	Y	A2	33.6365	$1,408.46
65114	Remove eye/revise socket	Y	A2	33.6365	$1,408.46
65125	Revise ocular implant	Y	G2	25.6479	$1,073.95
65130	Insert ocular implant	Y	A2	22.1455	$927.30
65135	Insert ocular implant	Y	A2	21.7804	$912.01
65140	Attach ocular implant	Y	A2	30.8693	$1,292.59
65150	Revise ocular implant	Y	A2	21.7804	$912.01
65155	Reinsert ocular implant	Y	A2	30.8693	$1,292.59
65175	Removal of ocular implant	Y	A2	14.9137	$624.48
65205	Remove foreign body from eye	N	P3		$22.73
65210	Remove foreign body from eye	N	P3		$28.86
65220	Remove foreign body from eye	N	G2	0.9129	$38.23
65222	Remove foreign body from eye	N	P3		$31.75
65235	Remove foreign body from eye	Y	A2	14.1898	$594.17
65260	Remove foreign body from eye	Y	A2	7.1022	$297.39
65265	Remove foreign body from eye	Y	A2	18.4405	$772.16
65270	Repair of eye wound	Y	A2	15.5585	$651.48

65272	Repair of eye wound	Y	A2	20.0334	$838.86
65275	Repair of eye wound	Y	A2	21.0833	$882.82
65280	Repair of eye wound	Y	A2	18.4405	$772.16
65285	Repair of eye wound	Y	A2	32.2368	$1,349.85
65286	Repair of eye wound	Y	P2	4.3073	$180.36
65290	Repair of eye socket wound	Y	A2	19.7301	$826.16
65400	Removal of eye lesion	Y	A2	13.545	$567.17
65410	Biopsy of cornea	Y	A2	14.1898	$594.17
65420	Removal of eye lesion	Y	A2	14.1898	$594.17
65426	Removal of eye lesion	Y	A2	21.5798	$903.61
65430	Corneal smear	N	P2	0.9129	$38.23
65435	Curette/treat cornea	Y	P3		$35.00
65436	Curette/treat cornea	Y	P3		$155.14
65450	Treatment of corneal lesion	N	G2	1.8706	$78.33
65600	Revision of cornea	Y	P3		$180.40
65710	Corneal transplant	Y	A2	32.5809	$1,364.26
65730	Corneal transplant	Y	A2	32.5809	$1,364.26
65750	Corneal transplant	Y	A2	32.5809	$1,364.26
65755	Corneal transplant	Y	A2	32.5809	$1,364.26
65756	Corneal trnspl, endothelial	Y	G2	35.8721	$1,502.07
65757	Prep corneal endo allograft	N	N1		
65770	Revise cornea with implant	Y	H8	134.0489	$5,613.03
65772	Correction of astigmatism	Y	A2	15.2397	$638.13
65775	Correction of astigmatism	Y	A2	15.2397	$638.13
65780	Ocular reconst, transplant	Y	A2	30.9947	$1,297.84
65781	Ocular reconst, transplant	Y	A2	30.9947	$1,297.84
65782	Ocular reconst, transplant	Y	A2	30.9947	$1,297.84
65800	Drainage of eye	Y	A2	13.545	$567.17
65805	Drainage of eye	Y	A2	13.545	$567.17
65810	Drainage of eye	Y	A2	20.3986	$854.15
65815	Drainage of eye	Y	A2	20.0334	$838.86

65820	Relieve inner eye pressure	Y	A2	5.1303	$214.82
65850	Incision of eye	Y	A2	21.0833	$882.82
65855	Laser surgery of eye	Y	P3		$146.12
65860	Incise inner eye adhesions	Y	P3		$136.02
65865	Incise inner eye adhesions	Y	A2	13.545	$567.17
65870	Incise inner eye adhesions	Y	A2	21.0833	$882.82
65875	Incise inner eye adhesions	Y	A2	21.0833	$882.82
65880	Incise inner eye adhesions	Y	A2	15.2397	$638.13
65900	Remove eye lesion	Y	A2	15.7359	$658.91
65920	Remove implant of eye	Y	A2	23.1658	$970.02
65930	Remove blood clot from eye	Y	A2	21.5798	$903.61
66020	Injection treatment of eye	Y	A2	13.545	$567.17
66030	Injection treatment of eye	Y	A2	5.1303	$214.82
66130	Remove eye lesion	Y	A2	23.1658	$970.02
66150	Glaucoma surgery	Y	A2	21.0833	$882.82
66155	Glaucoma surgery	Y	A2	21.0833	$882.82
66160	Glaucoma surgery	Y	A2	20.0334	$838.86
66165	Glaucoma surgery	Y	A2	21.0833	$882.82
66170	Glaucoma surgery	Y	A2	21.0833	$882.82
66172	Incision of eye	Y	A2	21.0833	$882.82
66180	Implant eye shunt	Y	A2	34.1091	$1,428.25
66185	Revise eye shunt	Y	A2	20.0334	$838.86
66220	Repair eye lesion	Y	A2	31.5523	$1,321.19
66225	Repair/graft eye lesion	Y	A2	33.6126	$1,407.46
66250	Follow-up surgery of eye	Y	A2	14.1898	$594.17
66500	Incision of iris	Y	A2	5.1303	$214.82
66505	Incision of iris	Y	A2	5.1303	$214.82
66600	Remove iris and lesion	Y	A2	20.3986	$854.15
66605	Removal of iris	Y	A2	20.3986	$854.15
66625	Removal of iris	Y	A2	13.7731	$576.72
66630	Removal of iris	Y	A2	20.3986	$854.15

66635	Removal of iris	Y	A2	20.3986	$854.15
66680	Repair iris & ciliary body	Y	A2	20.3986	$854.15
66682	Repair iris & ciliary body	Y	A2	20.0334	$838.86
66700	Destruction, ciliary body	Y	A2	14.1898	$594.17
66710	Ciliary transsleral therapy	Y	A2	14.1898	$594.17
66711	Ciliary endoscopic ablation	Y	A2	14.1898	$594.17
66720	Destruction, ciliary body	Y	A2	14.1898	$594.17
66740	Destruction, ciliary body	Y	A2	20.0334	$838.86
66761	Revision of iris	Y	P3		$204.21
66762	Revision of iris	Y	P2	5.066	$212.13
66770	Removal of inner eye lesion	Y	P2	5.066	$212.13
66820	Incision, secondary cataract	Y	G2	4.3073	$180.36
66821	After cataract laser surgery	Y	A2	5.5824	$233.75
66825	Reposition intraocular lens	Y	A2	21.0833	$882.82
66830	Removal of lens lesion	Y	A2	5.3583	$224.37
66840	Removal of lens material	Y	A2	14.9244	$624.93
66850	Removal of lens material	Y	A2	27.4138	$1,147.90
66852	Removal of lens material	Y	A2	25.3314	$1,060.70
66920	Extraction of lens	Y	A2	25.3314	$1,060.70
66930	Extraction of lens	Y	A2	25.8276	$1,081.48
66940	Extraction of lens	Y	A2	15.4207	$645.71
66982	Cataract surgery, complex	Y	A2	22.9585	$961.34
66983	Cataract surg w/iol, 1 stage	Y	A2	22.9585	$961.34
66984	Cataract surg w/iol, 1 stage	Y	A2	22.9585	$961.34
66985	Insert lens prosthesis	Y	A2	22.1197	$926.22
66986	Exchange lens prosthesis	Y	A2	22.1197	$926.22
66990	Ophthalmic endoscope add-on	N	N1		
67005	Partial removal of eye fluid	Y	A2	18.4405	$772.16
67010	Partial removal of eye fluid	Y	A2	32.2368	$1,349.85
67015	Release of eye fluid	Y	A2	30.5424	$1,278.90
67025	Replace eye fluid	Y	A2	16.7461	$701.21

67027	Implant eye drug system	Y	A2	32.2368	$1,349.85
67028	Injection eye drug	Y	P3		$90.56
67030	Incise inner eye strands	Y	A2	16.7461	$701.21
67031	Laser surgery, eye strands	Y	A2	5.5824	$233.75
67036	Removal of inner eye fluid	Y	A2	32.2368	$1,349.85
67039	Laser treatment of retina	Y	A2	34.3193	$1,437.05
67040	Laser treatment of retina	Y	A2	34.3193	$1,437.05
67041	Vit for macular pucker	Y	G2	38.1899	$1,599.13
67042	Vit for macular hole	Y	G2	38.1899	$1,599.13
67043	Vit for membrane dissect	Y	G2	38.1899	$1,599.13
67101	Repair detached retina	Y	P3		$343.83
67105	Repair detached retina	Y	P2	5.066	$212.13
67107	Repair detached retina	Y	A2	32.7333	$1,370.64
67108	Repair detached retina	Y	A2	34.3193	$1,437.05
67110	Repair detached retina	Y	P3		$368.73
67112	Rerepair detached retina	Y	A2	34.3193	$1,437.05
67113	Repair retinal detach, cplx	Y	G2	38.1899	$1,599.13
67115	Release encircling material	Y	A2	17.3907	$728.20
67120	Remove eye implant material	Y	A2	17.3907	$728.20
67121	Remove eye implant material	Y	A2	17.3907	$728.20
67141	Treatment of retina	Y	A2	5.5718	$233.31
67145	Treatment of retina	Y	P2	5.066	$212.13
67208	Treatment of retinal lesion	Y	P2	5.5901	$234.07
67210	Treatment of retinal lesion	Y	P2	5.066	$212.13
67218	Treatment of retinal lesion	Y	A2	18.9368	$792.94
67220	Treatment of choroid lesion	Y	P2	5.5901	$234.07
67221	Ocular photodynamic ther	Y	P3		$127.36
67225	Eye photodynamic ther add-on	Y	P3		$9.02
67227	Treatment of retinal lesion	Y	A2	16.7461	$701.21
67228	Treatment of retinal lesion	Y	P2	5.066	$212.13
67229*	Tr retinal les preterm inf	Y	R2	5.066	$212.13

67250	Reinforce eye wall	Y	A2	15.9236	$666.77
67255	Reinforce/graft eye wall	Y	A2	17.7558	$743.49
67311	Revise eye muscle	Y	A2	19.7301	$826.16
67312	Revise two eye muscles	Y	A2	20.4148	$854.83
67314	Revise eye muscle	Y	A2	20.4148	$854.83
67316	Revise two eye muscles	Y	A2	20.4148	$854.83
67318	Revise eye muscle(s)	Y	A2	20.4148	$854.83
67320	Revise eye muscle(s) add-on	Y	A2	20.4148	$854.83
67331	Eye surgery follow-up add-on	Y	A2	20.4148	$854.83
67332	Rerevise eye muscles add-on	Y	A2	20.4148	$854.83
67334	Revise eye muscle w/suture	Y	A2	20.4148	$854.83
67335	Eye suture during surgery	Y	A2	20.4148	$854.83
67340	Revise eye muscle add-on	Y	A2	20.4148	$854.83
67343	Release eye tissue	Y	A2	22.4973	$942.03
67345	Destroy nerve of eye muscle	Y	P3		$90.92
67346	Biopsy, eye muscle	Y	A2	13.038	$545.94
67400	Explore/biopsy eye socket	Y	A2	15.9236	$666.77
67405	Explore/drain eye socket	Y	A2	22.8302	$955.97
67412	Explore/treat eye socket	Y	A2	17.1046	$716.22
67413	Explore/treat eye socket	Y	A2	23.3265	$976.75
67414	Explr/decompress eye socket	Y	G2	37.2794	$1,561.00
67415	Aspiration, orbital contents	Y	A2	14.9137	$624.48
67420	Explore/treat eye socket	Y	A2	32.0502	$1,342.04
67430	Explore/treat eye socket	Y	A2	32.0502	$1,342.04
67440	Explore/drain eye socket	Y	A2	32.0502	$1,342.04
67445	Explr/decompress eye socket	Y	A2	32.0502	$1,342.04
67450	Explore/biopsy eye socket	Y	A2	32.0502	$1,342.04
67500	Inject/treat eye socket	N	G2	1.8706	$78.33
67505	Inject/treat eye socket	Y	P3		$30.31
67515	Inject/treat eye socket	Y	P3		$31.03
67550	Insert eye socket implant	Y	A2	31.554	$1,321.26

67560	Revise eye socket implant	Y	A2	21.7804	$912.01
67570	Decompress optic nerve	Y	A2	31.554	$1,321.26
67700	Drainage of eyelid abscess	Y	P2	3.0834	$129.11
67710	Incision of eyelid	Y	P3		$151.89
67715	Incision of eyelid fold	Y	A2	14.9137	$624.48
67800	Remove eyelid lesion	Y	P3		$57.00
67801	Remove eyelid lesions	Y	P3		$69.27
67805	Remove eyelid lesions	Y	P3		$89.84
67808	Remove eyelid lesion(s)	Y	A2	15.5585	$651.48
67810	Biopsy of eyelid	Y	P2	3.0834	$129.11
67820	Revise eyelashes	N	P3		$18.76
67825	Revise eyelashes	Y	P3		$58.09
67830	Revise eyelashes	Y	A2	8.0216	$335.89
67835	Revise eyelashes	Y	A2	15.5585	$651.48
67840	Remove eyelid lesion	Y	P3		$160.91
67850	Treat eyelid lesion	Y	P3		$126.64
67875	Closure of eyelid by suture	Y	G2	7.3028	$305.79
67880	Revision of eyelid	Y	A2	14.555	$609.46
67882	Revision of eyelid	Y	A2	15.9236	$666.77
67900	Repair brow defect	Y	A2	22.8302	$955.97
67901	Repair eyelid defect	Y	A2	17.1046	$716.22
67902	Repair eyelid defect	Y	A2	23.3265	$976.75
67903	Repair eyelid defect	Y	A2	16.6081	$695.43
67904	Repair eyelid defect	Y	A2	16.6081	$695.43
67906	Repair eyelid defect	Y	A2	17.1046	$716.22
67908	Repair eyelid defect	Y	A2	16.6081	$695.43
67909	Revise eyelid defect	Y	A2	16.6081	$695.43
67911	Revise eyelid defect	Y	A2	15.9236	$666.77
67912	Correction eyelid w/implant	Y	A2	15.9236	$666.77
67914	Repair eyelid defect	Y	A2	15.9236	$666.77
67915	Repair eyelid defect	Y	P3		$180.03

67916	Repair eyelid defect	Y	A2	16.6081	$695.43
67917	Repair eyelid defect	Y	A2	16.6081	$695.43
67921	Repair eyelid defect	Y	A2	15.9236	$666.77
67922	Repair eyelid defect	Y	P3		$174.98
67923	Repair eyelid defect	Y	A2	16.6081	$695.43
67924	Repair eyelid defect	Y	A2	16.6081	$695.43
67930	Repair eyelid wound	Y	P3		$181.12
67935	Repair eyelid wound	Y	A2	15.5585	$651.48
67938	Remove eyelid foreign body	N	P2	1.8706	$78.33
67950	Revision of eyelid	Y	A2	15.5585	$651.48
67961	Revision of eyelid	Y	A2	15.9236	$666.77
67966	Revision of eyelid	Y	A2	15.9236	$666.77
67971	Reconstruction of eyelid	Y	A2	15.9236	$666.77
67973	Reconstruction of eyelid	Y	A2	22.1455	$927.30
67974	Reconstruction of eyelid	Y	A2	15.9236	$666.77
67975	Reconstruction of eyelid	Y	A2	15.9236	$666.77
68020	Incise/drain eyelid lining	Y	P3		$50.87
68040	Treatment of eyelid lesions	N	P3		$25.26
68100	Biopsy of eyelid lining	Y	P3		$97.05
68110	Remove eyelid lining lesion	Y	P3		$125.92
68115	Remove eyelid lining lesion	Y	A2	15.5585	$651.48
68130	Remove eyelid lining lesion	Y	A2	14.1898	$594.17
68135	Remove eyelid lining lesion	Y	P3		$65.30
68200	Treat eyelid by injection	N	P3		$18.40
68320	Revise/graft eyelid lining	Y	A2	22.8302	$955.97
68325	Revise/graft eyelid lining	Y	A2	22.8302	$955.97
68326	Revise/graft eyelid lining	Y	A2	16.6081	$695.43
68328	Revise/graft eyelid lining	Y	A2	22.8302	$955.97
68330	Revise eyelid lining	Y	A2	21.0833	$882.82
68335	Revise/graft eyelid lining	Y	A2	22.8302	$955.97
68340	Separate eyelid adhesions	Y	A2	16.6081	$695.43

68360	Revise eyelid lining	Y	A2	20.0334	$838.86
68362	Revise eyelid lining	Y	A2	20.0334	$838.86
68371	Harvest eye tissue, alograft	Y	A2	14.1898	$594.17
68400	Incise/drain tear gland	Y	P2	3.0834	$129.11
68420	Incise/drain tear sac	Y	P3		$187.61
68440	Incise tear duct opening	Y	P3		$54.84
68500	Removal of tear gland	Y	A2	22.1455	$927.30
68505	Partial removal, tear gland	Y	A2	22.1455	$927.30
68510	Biopsy of tear gland	Y	A2	14.9137	$624.48
68520	Removal of tear sac	Y	A2	22.1455	$927.30
68525	Biopsy of tear sac	Y	A2	14.9137	$624.48
68530	Clearance of tear duct	Y	P2	3.0834	$129.11
68540	Remove tear gland lesion	Y	A2	15.9236	$666.77
68550	Remove tear gland lesion	Y	A2	22.1455	$927.30
68700	Repair tear ducts	Y	A2	15.5585	$651.48
68705	Revise tear duct opening	Y	P2	3.0834	$129.11
68720	Create tear sac drain	Y	A2	22.8302	$955.97
68745	Create tear duct drain	Y	A2	22.8302	$955.97
68750	Create tear duct drain	Y	A2	22.8302	$955.97
68760	Close tear duct opening	Y	P3		$107.52
68761	Close tear duct opening	Y	P3		$74.68
68770	Close tear system fistula	Y	A2	22.8302	$955.97
68801	Dilate tear duct opening	N	P2	0.9129	$38.23
68810	Probe nasolacrimal duct	Y	A2	3.0647	$128.33
68811	Probe nasolacrimal duct	Y	A2	15.5585	$651.48
68815	Probe nasolacrimal duct	Y	A2	15.5585	$651.48
68816	Probe nl duct w/balloon	Y	G2	17.3518	$726.57
68840	Explore/irrigate tear ducts	N	P3		$59.89
68850	Injection for tear sac x-ray	N	N1		
69000	Drain external ear lesion	Y	P2	1.3911	$58.25
69005	Drain external ear lesion	Y	P3		$112.93

69020	Drain outer ear canal lesion	Y	P2	1.3911	$58.25
69100	Biopsy of external ear	Y	P3		$64.94
69105	Biopsy of external ear canal	Y	P3		$94.89
69110	Remove external ear, partial	Y	A2	14.4403	$604.66
69120	Removal of external ear	Y	A2	20.4361	$855.72
69140	Remove ear canal lesion(s)	Y	A2	20.4361	$855.72
69145	Remove ear canal lesion(s)	Y	A2	15.0849	$631.65
69150	Extensive ear canal surgery	Y	A2	8.109	$339.55
69200	Clear outer ear canal	N	P2	0.6396	$26.78
69205	Clear outer ear canal	Y	A2	18.6621	$781.44
69210	Remove impacted ear wax	N	P3		$22.73
69220	Clean out mastoid cavity	Y	P2	0.8399	$35.17
69222	Clean out mastoid cavity	Y	P3		$145.40
69300	Revise external ear	Y	A2	20.8012	$871.01
69310	Rebuild outer ear canal	Y	A2	33.7153	$1,411.76
69320	Rebuild outer ear canal	Y	A2	36.4825	$1,527.63
69400	Inflate middle ear canal	Y	P3		$98.86
69401	Inflate middle ear canal	Y	P3		$52.31
69405	Catheterize middle ear canal	Y	P3		$137.10
69420	Incision of eardrum	Y	P3		$121.59
69421	Incision of eardrum	Y	A2	15.2282	$637.65
69424	Remove ventilating tube	Y	P3		$84.79
69433	Create eardrum opening	Y	P3		$121.59
69436	Create eardrum opening	Y	A2	15.2282	$637.65
69440	Exploration of middle ear	Y	A2	20.8012	$871.01
69450	Eardrum revision	Y	A2	32.7056	$1,369.48
69501	Mastoidectomy	Y	A2	36.4825	$1,527.63
69502	Mastoidectomy	Y	A2	23.5684	$986.88
69505	Remove mastoid structures	Y	A2	36.4825	$1,527.63
69511	Extensive mastoid surgery	Y	A2	36.4825	$1,527.63
69530	Extensive mastoid surgery	Y	A2	36.4825	$1,527.63

69540	Remove ear lesion	Y	P3		$142.15
69550	Remove ear lesion	Y	A2	34.8965	$1,461.22
69552	Remove ear lesion	Y	A2	36.4825	$1,527.63
69601	Mastoid surgery revision	Y	A2	36.4825	$1,527.63
69602	Mastoid surgery revision	Y	A2	36.4825	$1,527.63
69603	Mastoid surgery revision	Y	A2	36.4825	$1,527.63
69604	Mastoid surgery revision	Y	A2	36.4825	$1,527.63
69605	Mastoid surgery revision	Y	A2	36.4825	$1,527.63
69610	Repair of eardrum	Y	P3		$191.22
69620	Repair of eardrum	Y	A2	20.4361	$855.72
69631	Repair eardrum structures	Y	A2	34.8965	$1,461.22
69632	Rebuild eardrum structures	Y	A2	34.8965	$1,461.22
69633	Rebuild eardrum structures	Y	A2	34.8965	$1,461.22
69635	Repair eardrum structures	Y	A2	36.4825	$1,527.63
69636	Rebuild eardrum structures	Y	A2	36.4825	$1,527.63
69637	Rebuild eardrum structures	Y	A2	36.4825	$1,527.63
69641	Revise middle ear & mastoid	Y	A2	36.4825	$1,527.63
69642	Revise middle ear & mastoid	Y	A2	36.4825	$1,527.63
69643	Revise middle ear & mastoid	Y	A2	36.4825	$1,527.63
69644	Revise middle ear & mastoid	Y	A2	36.4825	$1,527.63
69645	Revise middle ear & mastoid	Y	A2	36.4825	$1,527.63
69646	Revise middle ear & mastoid	Y	A2	36.4825	$1,527.63
69650	Release middle ear bone	Y	A2	23.5684	$986.88
69660	Revise middle ear bone	Y	A2	34.8965	$1,461.22
69661	Revise middle ear bone	Y	A2	34.8965	$1,461.22
69662	Revise middle ear bone	Y	A2	34.8965	$1,461.22
69666	Repair middle ear structures	Y	A2	34.4	$1,440.43
69667	Repair middle ear structures	Y	A2	34.4	$1,440.43
69670	Remove mastoid air cells	Y	A2	33.7153	$1,411.76
69676	Remove middle ear nerve	Y	A2	33.7153	$1,411.76
69700	Close mastoid fistula	Y	A2	33.7153	$1,411.76

69711	Remove/repair hearing aid	Y	A2	32.7056	$1,369.48
69714	Implant temple bone w/stimul	Y	H8	153.5323	$6,428.86
69715	Temple bne implnt w/stimulat	Y	H8	153.5323	$6,428.86
69717	Temple bone implant revision	Y	H8	153.5323	$6,428.86
69718	Revise temple bone implant	Y	H8	153.5323	$6,428.86
69720	Release facial nerve	Y	A2	34.8965	$1,461.22
69740	Repair facial nerve	Y	A2	34.8965	$1,461.22
69745	Repair facial nerve	Y	A2	34.8965	$1,461.22
69801	Incise inner ear	Y	A2	21.9824	$920.47
69802	Incise inner ear	Y	A2	23.5684	$986.88
69805	Explore inner ear	Y	A2	36.4825	$1,527.63
69806	Explore inner ear	Y	A2	36.4825	$1,527.63
69820	Establish inner ear window	Y	A2	34.8965	$1,461.22
69840	Revise inner ear window	Y	A2	34.8965	$1,461.22
69905	Remove inner ear	Y	A2	36.4825	$1,527.63
69910	Remove inner ear & mastoid	Y	A2	36.4825	$1,527.63
69915	Incise inner ear nerve	Y	A2	36.4825	$1,527.63
69930	Implant cochlear device	Y	H8	635.3299	$26,603.17
69990	Microsurgery add-on	N	N1		
C9716	Radiofrequency energy to anu	Y	G2	30.7524	$1,287.70
C9724	EPS gast cardia plic	Y	G2	23.1927	$971.15
C9725	Place endorectal app	Y	G2	5.1268	$214.67
C9726	Rxt breast appl place/remov	Y	G2	23.6526	$990.41
C9727	Insert palate implants	Y	G2	7.2813	$304.89
C9728	Place device/marker, non pro	N	R2	13.1468	$550.50
G0104	CA screen;flexi sigmoidscope	N	P3		$89.12
G0105	Colorectal scrn; hi risk ind	Y	A2	8.3436	$349.37
G0121	Colon ca scrn not hi rsk ind	Y	A2	8.3436	$349.37
G0127	Trim nail(s)	Y	P3		$12.99
G0186	Dstry eye lesn,fdr vssl tech	Y	R2	5.5901	$234.07
G0247	Routine footcare pt w lops	Y	P3		$23.45

G0259	Inject for sacroiliac joint	N	N1		
G0260	Inj for sacroiliac jt anesth	Y	A2	7.0602	$295.63
G0268	Removal of impacted wax md	N	N1		
G0269	Occlusive device in vein art	N	N1		
G0289	Arthro, loose body + chondro	N	N1		
G0364	Bone marrow aspirate &biopsy	N	P3		$5.77
G0392	AV fistula or graft arterial	N	D5		
G0393	AV fistula or graft venous	N	D5		

NOTE 1: The Medicare program payment is 80 percent of the total payment amount and beneficiary coinsurance is 20 percent of the total payment amount, except for screening flexible sigmoidoscopies and screening colonoscopies for which the program payment is 75 percent and the beneficiary coinsurance is 25 percent.

NOTE 2: Payment indicators for "office-based" procedures (P2, P3) are based on a comparison of the final rates according to the ASC standard ratesetting methodology and the MPFS. At the time that we compiled these addenda, the MPFS payment rates have a zero percent update through May 31, 2010. For discussion of those rates, we refer readers to the CY 2010 MPFS final rule and correction notice.

*: Asterisked codes(*) indicate that the procedure's "office-based," designation is temporary because we have insufficient claims data. We will reconsider this designation when new claims data become available.

Addendum B.-OPPS Payment by HCPCS Code for CY 2010 as Revised by the Affordable Care Act

HCPCS Code	Short Descriptor	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment	* Indicates a Change
00100	Anesth, salivary gland	N						
00102	Anesth, repair of cleft lip	N						
00103	Anesth, blepharoplasty	N						
00104	Anesth, electroshock	N						
00120	Anesth, ear surgery	N						
00124	Anesth, ear exam	N						
00126	Anesth, tympanotomy	N						
00140	Anesth, procedures on eye	N						
00142	Anesth, lens surgery	N						
00144	Anesth, corneal transplant	N						
00145	Anesth, vitreoretinal surg	N						
00147	Anesth, iridectomy	N						
00148	Anesth, eye exam	N						
00160	Anesth, nose/sinus surgery	N						
00162	Anesth, nose/sinus surgery	N						
00164	Anesth, biopsy of nose	N						
00170	Anesth, procedure on mouth	N						
00172	Anesth, cleft palate repair	N						
00174	Anesth, pharyngeal surgery	N						
00176	Anesth, pharyngeal surgery	C						
00190	Anesth, face/skull bone surg	N						
00192	Anesth, facial bone surgery	C						
00210	Anesth, cranial surg nos	N						
00211	Anesth, cran surg, hemotoma	C						
00212	Anesth, skull drainage	N						
00214	Anesth, skull drainage	C						
00215	Anesth, skull repair/fract	C						
00216	Anesth, head vessel surgery	N						
00218	Anesth, special head surgery	N						
00220	Anesth, intrcrn nerve	N						
00222	Anesth, head nerve surgery	N						
00300	Anesth, head/neck/ptrunk	N						
00320	Anesth, neck organ, 1 & over	N						
00322	Anesth, biopsy of thyroid	N						
00326	Anesth, larynx/trach, < 1 yr	N						
00350	Anesth, neck vessel surgery	N						
00352	Anesth, neck vessel surgery	N						
00400	Anesth, skin, ext/per/atrunk	N						
00402	Anesth, surgery of breast	N						
00404	Anesth, surgery of breast	N						
00406	Anesth, surgery of breast	N						
00410	Anesth, correct heart rhythm	N						
00450	Anesth, surgery of shoulder	N						
00452	Anesth, surgery of shoulder	C						
00454	Anesth, collar bone biopsy	N						
00470	Anesth, removal of rib	N						
00472	Anesth, chest wall repair	N						
00474	Anesth, surgery of rib(s)	C						
00500	Anesth, esophageal surgery	N						
00520	Anesth, chest procedure	N						
00522	Anesth, chest lining biopsy	N						
00524	Anesth, chest drainage	C						
00528	Anesth, chest partition view	N						
00529	Anesth, chest partition view	N						
00530	Anesth, pacemaker insertion	N						
00532	Anesth, vascular access	N						
00534	Anesth, cardioverter/defib	N						
00537	Anesth, cardiac electrophys	N						

00539	Anesth, trach-bronch reconst	N						
00540	Anesth, chest surgery	C						
00541	Anesth, one lung ventilation	N						
00542	Anesth, release of lung	C						
00546	Anesth, lung,chest wall surg	C						
00548	Anesth, trachea,bronchi surg	N						
00550	Anesth, sternal debridement	N						
00560	Anesth, heart surg w/o pump	C						
00561	Anesth, heart surg < age 1	C						
00562	Anesth hrt surg w/pmp age 1+	C						
00563	Anesth, heart surg w/arrest	N						
00566	Anesth, cabg w/o pump	N						
00567	Anesth, cabg w/pump	C						
00580	Anesth, heart/lung transplnt	C						
00600	Anesth, spine, cord surgery	N						
00604	Anesth, sitting procedure	C						
00620	Anesth, spine, cord surgery	N						
00622	Anesth, removal of nerves	C						
00625	Anes spine tranthor w/o vent	N						
00626	Anes, spine transthor w/vent	N						
00630	Anesth, spine, cord surgery	N						
00632	Anesth, removal of nerves	C						
00634	Anesth for chemonucleolysis	N						
00635	Anesth, lumbar puncture	N						
00640	Anesth, spine manipulation	N						
00670	Anesth, spine, cord surgery	C						
00700	Anesth, abdominal wall surg	N						
00702	Anesth, for liver biopsy	N						
00730	Anesth, abdominal wall surg	N						
00740	Anesth, upper gi visualize	N						
00750	Anesth, repair of hernia	N						

00752	Anesth, repair of hernia	N						
00754	Anesth, repair of hernia	N						
00756	Anesth, repair of hernia	N						
00770	Anesth, blood vessel repair	N						
00790	Anesth, surg upper abdomen	N						
00792	Anesth, hemorr/excise liver	C						
00794	Anesth, pancreas removal	C						
00796	Anesth, for liver transplant	C						
00797	Anesth, surgery for obesity	N						
00800	Anesth, abdominal wall surg	N						
00802	Anesth, fat layer removal	C						
00810	Anesth, low intestine scope	N						
00820	Anesth, abdominal wall surg	N						
00830	Anesth, repair of hernia	N						
00832	Anesth, repair of hernia	N						
00834	Anesth, hernia repair< 1 yr	N						
00836	Anesth hernia repair preemie	N						
00840	Anesth, surg lower abdomen	N						
00842	Anesth, amniocentesis	N						
00844	Anesth, pelvis surgery	C						
00846	Anesth, hysterectomy	C						
00848	Anesth, pelvic organ surg	C						
00851	Anesth, tubal ligation	N						
00860	Anesth, surgery of abdomen	N						
00862	Anesth, kidney/ureter surg	N						
00864	Anesth, removal of bladder	C						
00865	Anesth, removal of prostate	C						
00866	Anesth, removal of adrenal	C						
00868	Anesth, kidney transplant	C						
00870	Anesth, bladder stone surg	N						
00872	Anesth kidney stone destruct	N						

00873	Anesth kidney stone destruct	N						
00880	Anesth, abdomen vessel surg	N						
00882	Anesth, major vein ligation	C						
00902	Anesth, anorectal surgery	N						
00904	Anesth, perineal surgery	C						
00906	Anesth, removal of vulva	N						
00908	Anesth, removal of prostate	C						
00910	Anesth, bladder surgery	N						
00912	Anesth, bladder tumor surg	N						
00914	Anesth, removal of prostate	N						
00916	Anesth, bleeding control	N						
00918	Anesth, stone removal	N						
00920	Anesth, genitalia surgery	N						
00921	Anesth, vasectomy	N						
00922	Anesth, sperm duct surgery	N						
00924	Anesth, testis exploration	N						
00926	Anesth, removal of testis	N						
00928	Anesth, removal of testis	N						
00930	Anesth, testis suspension	N						
00932	Anesth, amputation of penis	C						
00934	Anesth, penis, nodes removal	C						
00936	Anesth, penis, nodes removal	C						
00938	Anesth, insert penis device	N						
00940	Anesth, vaginal procedures	N						
00942	Anesth, surg on vag/urethral	N						
00944	Anesth, vaginal hysterectomy	C						
00948	Anesth, repair of cervix	N						
00950	Anesth, vaginal endoscopy	N						
00952	Anesth, hysteroscope/graph	N						
01112	Anesth, bone aspirate/bx	N						
01120	Anesth, pelvis surgery	N						
01130	Anesth, body cast procedure	N						
01140	Anesth, amputation at pelvis	C						
01150	Anesth, pelvic tumor surgery	C						
01160	Anesth, pelvis procedure	N						
01170	Anesth, pelvis surgery	N						
01173	Anesth, fx repair, pelvis	N						
01180	Anesth, pelvis nerve removal	N						
01190	Anesth, pelvis nerve removal	N						
01200	Anesth, hip joint procedure	N						
01202	Anesth, arthroscopy of hip	N						
01210	Anesth, hip joint surgery	N						
01212	Anesth, hip disarticulation	C						
01214	Anesth, hip arthroplasty	C						
01215	Anesth, revise hip repair	N						
01220	Anesth, procedure on femur	N						
01230	Anesth, surgery of femur	N						
01232	Anesth, amputation of femur	C						
01234	Anesth, radical femur surg	C						
01250	Anesth, upper leg surgery	N						
01260	Anesth, upper leg veins surg	N						
01270	Anesth, thigh arteries surg	N						
01272	Anesth, femoral artery surg	C						
01274	Anesth, femoral embolectomy	C						
01320	Anesth, knee area surgery	N						
01340	Anesth, knee area procedure	N						
01360	Anesth, knee area surgery	N						
01380	Anesth, knee joint procedure	N						
01382	Anesth, dx knee arthroscopy	N						
01390	Anesth, knee area procedure	N						
01392	Anesth, knee area surgery	N						
01400	Anesth, knee joint surgery	N						

01402	Anesth, knee arthroplasty	C						
01404	Anesth, amputation at knee	C						
01420	Anesth, knee joint casting	N						
01430	Anesth, knee veins surgery	N						
01432	Anesth, knee vessel surg	N						
01440	Anesth, knee arteries surg	N						
01442	Anesth, knee artery surg	C						
01444	Anesth, knee artery repair	C						
01462	Anesth, lower leg procedure	N						
01464	Anesth, ankle/ft arthroscopy	N						
01470	Anesth, lower leg surgery	N						
01472	Anesth, achilles tendon surg	N						
01474	Anesth, lower leg surgery	N						
01480	Anesth, lower leg bone surg	N						
01482	Anesth, radical leg surgery	N						
01484	Anesth, lower leg revision	N						
01486	Anesth, ankle replacement	C						
01490	Anesth, lower leg casting	N						
01500	Anesth, leg arteries surg	N						
01502	Anesth, lwr leg embolectomy	C						
01520	Anesth, lower leg vein surg	N						
01522	Anesth, lower leg vein surg	N						
01610	Anesth, surgery of shoulder	N						
01620	Anesth, shoulder procedure	N						
01622	Anes dx shoulder arthroscopy	N						
01630	Anesth, surgery of shoulder	N						
01634	Anesth, shoulder joint amput	C						
01636	Anesth, forequarter amput	C						
01638	Anesth, shoulder replacement	C						
01650	Anesth, shoulder artery surg	N						
01652	Anesth, shoulder vessel surg	C						

01654	Anesth, shoulder vessel surg	C						
01656	Anesth, arm-leg vessel surg	C						
01670	Anesth, shoulder vein surg	N						
01680	Anesth, shoulder casting	N						
01682	Anesth, airplane cast	N						
01710	Anesth, elbow area surgery	N						
01712	Anesth, uppr arm tendon surg	N						
01714	Anesth, uppr arm tendon surg	N						
01716	Anesth, biceps tendon repair	N						
01730	Anesth, uppr arm procedure	N						
01732	Anesth, dx elbow arthroscopy	N						
01740	Anesth, upper arm surgery	N						
01742	Anesth, humerus surgery	N						
01744	Anesth, humerus repair	N						
01756	Anesth, radical humerus surg	C						
01758	Anesth, humeral lesion surg	N						
01760	Anesth, elbow replacement	N						
01770	Anesth, uppr arm artery surg	N						
01772	Anesth, uppr arm embolectomy	N						
01780	Anesth, upper arm vein surg	N						
01782	Anesth, uppr arm vein repair	N						
01810	Anesth, lower arm surgery	N						
01820	Anesth, lower arm procedure	N						
01829	Anesth, dx wrist arthroscopy	N						
01830	Anesth, lower arm surgery	N						
01832	Anesth, wrist replacement	N						
01840	Anesth, lwr arm artery surg	N						
01842	Anesth, lwr arm embolectomy	N						
01844	Anesth, vascular shunt surg	N						
01850	Anesth, lower arm vein surg	N						
01852	Anesth, lwr arm vein repair	N						

01860	Anesth, lower arm casting	N						
01916	Anesth, dx arteriography	N						
01920	Anesth, catheterize heart	N						
01922	Anesth, cat or MRI scan	N						
01924	Anes, ther interven rad, art	N						
01925	Anes, ther interven rad, car	N						
01926	Anes, tx interv rad hrt/cran	N						
01930	Anes, ther interven rad, vei	N						
01931	Anes, ther interven rad, tip	N						
01932	Anes, tx interv rad, th vein	N						
01933	Anes, tx interv rad, cran v	N						
01935	Anesth, perc img dx sp proc	N						
01936	Anesth, perc img tx sp proc	N						
01951	Anesth, burn, less 4 percent	N						
01952	Anesth, burn, 4-9 percent	N						
01953	Anesth, burn, each 9 percent	N						
01958	Anesth, antepartum manipul	N						
01960	Anesth, vaginal delivery	N						
01961	Anesth, cs delivery	N						
01962	Anesth, emer hysterectomy	N						
01963	Anesth, cs hysterectomy	N						
01965	Anesth, inc/missed ab proc	N						
01966	Anesth, induced ab procedure	N						
01967	Anesth/analg, vag delivery	N						
01968	Anes/analg cs deliver add-on	N						
01969	Anesth/analg cs hyst add-on	N						
01990	Support for organ donor	C						
01991	Anesth, nerve block/inj	N						
01992	Anesth, n block/inj, prone	N						
01996	Hosp manage cont drug admin	N						
01999	Unlisted anesth procedure	N						

10021	Fna w/o image	T	0002	1.5111	$101.61		$20.33	*
10022	Fna w/image	T	0004	4.5991	$309.25		$61.85	*
10040	Acne surgery	T	0013	0.8789	$59.10		$11.82	*
10060	Drainage of skin abscess	T	0006	1.4557	$97.88		$19.58	*
10061	Drainage of skin abscess	T	0006	1.4557	$97.88		$19.58	*
10080	Drainage of pilonidal cyst	T	0006	1.4557	$97.88		$19.58	*
10081	Drainage of pilonidal cyst	T	0007	12.6217	$848.70		$169.74	*
10120	Remove foreign body	T	0016	2.7982	$188.15		$37.63	*
10121	Remove foreign body	T	0021	17.4975	$1,176.55		$235.31	*
10140	Drainage of hematoma/fluid	T	0007	12.6217	$848.70		$169.74	*
10160	Puncture drainage of lesion	T	0006	1.4557	$97.88		$19.58	*
10180	Complex drainage, wound	T	0008	19.4063	$1,304.90		$260.98	*
11000	Debride infected skin	T	0015	1.5412	$103.63		$20.73	*
11001	Debride infected skin add-on	T	0013	0.8789	$59.10		$11.82	*
11004	Debride genitalia & perineum	C						
11005	Debride abdom wall	C						
11006	Debride genit/per/abdom wall	C						
11008	Remove mesh from abd wall	C						
11010	Debride skin, fx	T	0019	4.3625	$293.34	$64.35	$58.67	*
11011	Debride skin/muscle, fx	T	0019	4.3625	$293.34	$64.35	$58.67	*
11012	Debride skin/muscle/bone, fx	T	0019	4.3625	$293.34	$64.35	$58.67	*
11040	Debride skin, partial	T	0015	1.5412	$103.63		$20.73	*
11041	Debride skin, full	T	0015	1.5412	$103.63		$20.73	*
11042	Debride skin/tissue	T	0016	2.7982	$188.15		$37.63	*
11043	Debride tissue/muscle	T	0016	2.7982	$188.15		$37.63	*
11044	Debride tissue/muscle/bone	T	0020	8.2028	$551.56		$110.32	*
11055	Trim skin lesion	T	0013	0.8789	$59.10		$11.82	*
11056	Trim skin lesions, 2 to 4	T	0013	0.8789	$59.10		$11.82	*
11057	Trim skin lesions, over 4	T	0013	0.8789	$59.10		$11.82	*
11100	Biopsy, skin lesion	T	0015	1.5412	$103.63		$20.73	*
11101	Biopsy, skin add-on	T	0013	0.8789	$59.10		$11.82	*

11200	Removal of skin tags	T	0013	0.8789	$59.10		$11.82	*
11201	Remove skin tags add-on	T	0013	0.8789	$59.10		$11.82	*
11300	Shave skin lesion	T	0013	0.8789	$59.10		$11.82	*
11301	Shave skin lesion	T	0013	0.8789	$59.10		$11.82	*
11302	Shave skin lesion	T	0013	0.8789	$59.10		$11.82	*
11303	Shave skin lesion	T	0015	1.5412	$103.63		$20.73	*
11305	Shave skin lesion	T	0013	0.8789	$59.10		$11.82	*
11306	Shave skin lesion	T	0013	0.8789	$59.10		$11.82	*
11307	Shave skin lesion	T	0013	0.8789	$59.10		$11.82	*
11308	Shave skin lesion	T	0013	0.8789	$59.10		$11.82	*
11310	Shave skin lesion	T	0013	0.8789	$59.10		$11.82	*
11311	Shave skin lesion	T	0013	0.8789	$59.10		$11.82	*
11312	Shave skin lesion	T	0013	0.8789	$59.10		$11.82	*
11313	Shave skin lesion	T	0013	0.8789	$59.10		$11.82	*
11400	Exc tr-ext b9+marg 0.5 < cm	T	0019	4.3625	$293.34	$64.35	$58.67	*
11401	Exc tr-ext b9+marg 0.6-1 cm	T	0019	4.3625	$293.34	$64.35	$58.67	*
11402	Exc tr-ext b9+marg 1.1-2 cm	T	0019	4.3625	$293.34	$64.35	$58.67	*
11403	Exc tr-ext b9+marg 2.1-3 cm	T	0020	8.2028	$551.56		$110.32	*
11404	Exc tr-ext b9+marg 3.1-4 cm	T	0021	17.4975	$1,176.55		$235.31	*
11406	Exc tr-ext b9+marg > 4.0 cm	T	0021	17.4975	$1,176.55		$235.31	*
11420	Exc h-f-nk-sp b9+marg 0.5 <	T	0020	8.2028	$551.56		$110.32	*
11421	Exc h-f-nk-sp b9+marg 0.6-1	T	0020	8.2028	$551.56		$110.32	*
11422	Exc h-f-nk-sp b9+marg 1.1-2	T	0020	8.2028	$551.56		$110.32	*
11423	Exc h-f-nk-sp b9+marg 2.1-3	T	0021	17.4975	$1,176.55		$235.31	*
11424	Exc h-f-nk-sp b9+marg 3.1-4	T	0021	17.4975	$1,176.55		$235.31	*
11426	Exc h-f-nk-sp b9+marg > 4 cm	T	0022	23.388	$1,572.63	$354.45	$314.53	*
11440	Exc face-mm b9+marg 0.5 < cm	T	0019	4.3625	$293.34	$64.35	$58.67	*
11441	Exc face-mm b9+marg 0.6-1 cm	T	0019	4.3625	$293.34	$64.35	$58.67	*
11442	Exc face-mm b9+marg 1.1-2 cm	T	0020	8.2028	$551.56		$110.32	*
11443	Exc face-mm b9+marg 2.1-3 cm	T	0020	8.2028	$551.56		$110.32	*
11444	Exc face-mm b9+marg 3.1-4 cm	T	0020	8.2028	$551.56		$110.32	*
11446	Exc face-mm b9+marg > 4 cm	T	0022	23.388	$1,572.63	$354.45	$314.53	*
11450	Removal, sweat gland lesion	T	0022	23.388	$1,572.63	$354.45	$314.53	*
11451	Removal, sweat gland lesion	T	0022	23.388	$1,572.63	$354.45	$314.53	*
11462	Removal, sweat gland lesion	T	0022	23.388	$1,572.63	$354.45	$314.53	*
11463	Removal, sweat gland lesion	T	0022	23.388	$1,572.63	$354.45	$314.53	*
11470	Removal, sweat gland lesion	T	0022	23.388	$1,572.63	$354.45	$314.53	*
11471	Removal, sweat gland lesion	T	0022	23.388	$1,572.63	$354.45	$314.53	*
11600	Exc tr-ext mlg+marg 0.5 < cm	T	0020	8.2028	$551.56		$110.32	*
11601	Exc tr-ext mlg+marg 0.6-1 cm	T	0019	4.3625	$293.34	$64.35	$58.67	*
11602	Exc tr-ext mlg+marg 1.1-2 cm	T	0019	4.3625	$293.34	$64.35	$58.67	*
11603	Exc tr-ext mlg+marg 2.1-3 cm	T	0020	8.2028	$551.56		$110.32	*
11604	Exc tr-ext mlg+marg 3.1-4 cm	T	0020	8.2028	$551.56		$110.32	*
11606	Exc tr-ext mlg+marg > 4 cm	T	0021	17.4975	$1,176.55		$235.31	*
11620	Exc h-f-nk-sp mlg+marg 0.5 <	T	0020	8.2028	$551.56		$110.32	*
11621	Exc h-f-nk-sp mlg+marg 0.6-1	T	0019	4.3625	$293.34	$64.35	$58.67	*
11622	Exc h-f-nk-sp mlg+marg 1.1-2	T	0020	8.2028	$551.56		$110.32	*
11623	Exc h-f-nk-sp mlg+marg 2.1-3	T	0021	17.4975	$1,176.55		$235.31	*
11624	Exc h-f-nk-sp mlg+marg 3.1-4	T	0021	17.4975	$1,176.55		$235.31	*
11626	Exc h-f-nk-sp mlg+mar > 4 cm	T	0022	23.388	$1,572.63	$354.45	$314.53	*
11640	Exc face-mm malig+marg 0.5 <	T	0020	8.2028	$551.56		$110.32	*
11641	Exc face-mm malig+marg 0.6-1	T	0020	8.2028	$551.56		$110.32	*
11642	Exc face-mm malig+marg 1.1-2	T	0020	8.2028	$551.56		$110.32	*
11643	Exc face-mm malig+marg 2.1-3	T	0020	8.2028	$551.56		$110.32	*
11644	Exc face-mm malig+marg 3.1-4	T	0021	17.4975	$1,176.55		$235.31	*
11646	Exc face-mm mlg+marg > 4 cm	T	0022	23.388	$1,572.63	$354.45	$314.53	*
11719	Trim nail(s)	T	0012	0.4436	$29.83		$5.97	*
11720	Debride nail, 1-5	T	0013	0.8789	$59.10		$11.82	*
11721	Debride nail, 6 or more	T	0013	0.8789	$59.10		$11.82	*
11730	Removal of nail plate	T	0013	0.8789	$59.10		$11.82	*
11732	Remove nail plate, add-on	T	0013	0.8789	$59.10		$11.82	*
11740	Drain blood from under nail	T	0012	0.4436	$29.83		$5.97	*

11750	Removal of nail bed	T	0019	4.3625	$293.34	$64.35	$58.67	*
11752	Remove nail bed/finger tip	T	0022	23.388	$1,572.63	$354.45	$314.53	*
11755	Biopsy, nail unit	T	0019	4.3625	$293.34	$64.35	$58.67	*
11760	Repair of nail bed	T	0133	1.3542	$91.06	$25.67	$18.22	*
11762	Reconstruction of nail bed	T	0136	16.0542	$1,079.50		$215.90	*
11765	Excision of nail fold, toe	T	0013	0.8789	$59.10		$11.82	*
11770	Removal of pilonidal lesion	T	0022	23.388	$1,572.63	$354.45	$314.53	*
11771	Removal of pilonidal lesion	T	0022	23.388	$1,572.63	$354.45	$314.53	*
11772	Removal of pilonidal lesion	T	0022	23.388	$1,572.63	$354.45	$314.53	*
11900	Injection into skin lesions	T	0013	0.8789	$59.10		$11.82	*
11901	Added skin lesions injection	T	0013	0.8789	$59.10		$11.82	*
11920	Correct skin color defects	T	0134	3.1508	$211.86		$42.38	*
11921	Correct skin color defects	T	0134	3.1508	$211.86		$42.38	*
11922	Correct skin color defects	T	0134	3.1508	$211.86		$42.38	*
11950	Therapy for contour defects	T	0133	1.3542	$91.06	$25.67	$18.22	*
11951	Therapy for contour defects	T	0133	1.3542	$91.06	$25.67	$18.22	*
11952	Therapy for contour defects	T	0133	1.3542	$91.06	$25.67	$18.22	*
11954	Therapy for contour defects	T	0133	1.3542	$91.06	$25.67	$18.22	*
11960	Insert tissue expander(s)	T	0137	23.9317	$1,609.19		$321.84	*
11970	Replace tissue expander	T	0051	46.5786	$3,131.99		$626.40	*
11971	Remove tissue expander(s)	T	0022	23.388	$1,572.63	$354.45	$314.53	*
11975	Insert contraceptive cap	E						
11976	Removal of contraceptive cap	T	0019	4.3625	$293.34	$64.35	$58.67	*
11977	Removal/reinsert contra cap	E						
11980	Implant hormone pellet(s)	X	0340	0.6693	$45.00		$9.00	*
11981	Insert drug implant device	X	0340	0.6693	$45.00		$9.00	*
11982	Remove drug implant device	X	0340	0.6693	$45.00		$9.00	*
11983	Remove/insert drug implant	X	0340	0.6693	$45.00		$9.00	*
12001	Repair superficial wound(s)	T	0133	1.3542	$91.06	$25.67	$18.22	*
12002	Repair superficial wound(s)	T	0133	1.3542	$91.06	$25.67	$18.22	*
12004	Repair superficial wound(s)	T	0133	1.3542	$91.06	$25.67	$18.22	*
12005	Repair superficial wound(s)	T	0133	1.3542	$91.06	$25.67	$18.22	*
12006	Repair superficial wound(s)	T	0133	1.3542	$91.06	$25.67	$18.22	*
12007	Repair superficial wound(s)	T	0133	1.3542	$91.06	$25.67	$18.22	*
12011	Repair superficial wound(s)	T	0133	1.3542	$91.06	$25.67	$18.22	*
12013	Repair superficial wound(s)	T	0133	1.3542	$91.06	$25.67	$18.22	*
12014	Repair superficial wound(s)	T	0133	1.3542	$91.06	$25.67	$18.22	*
12015	Repair superficial wound(s)	T	0133	1.3542	$91.06	$25.67	$18.22	*
12016	Repair superficial wound(s)	T	0133	1.3542	$91.06	$25.67	$18.22	*
12017	Repair superficial wound(s)	T	0133	1.3542	$91.06	$25.67	$18.22	*
12018	Repair superficial wound(s)	T	0133	1.3542	$91.06	$25.67	$18.22	*
12020	Closure of split wound	T	0135	4.4386	$298.46		$59.70	*
12021	Closure of split wound	T	0134	3.1508	$211.86		$42.38	*
12031	Intmd wnd repair s/tr/ext	T	0133	1.3542	$91.06	$25.67	$18.22	*
12032	Intmd wnd repair s/tr/ext	T	0134	3.1508	$211.86		$42.38	*
12034	Intmd wnd repair s/tr/ext	T	0133	1.3542	$91.06	$25.67	$18.22	*
12035	Intmd wnd repair s/tr/ext	T	0133	1.3542	$91.06	$25.67	$18.22	*
12036	Intmd wnd repair s/tr/ext	T	0134	3.1508	$211.86		$42.38	*
12037	Intmd wnd repair s/tr/ext	T	0134	3.1508	$211.86		$42.38	*
12041	Intmd wnd repair n-hf/genit	T	0133	1.3542	$91.06	$25.67	$18.22	*
12042	Intmd wnd repair n-hg/genit	T	0133	1.3542	$91.06	$25.67	$18.22	*
12044	Intmd wnd repair n-hg/genit	T	0133	1.3542	$91.06	$25.67	$18.22	*
12045	Intmd wnd repair n-hg/genit	T	0134	3.1508	$211.86		$42.38	*
12046	Intmd wnd repair n-hg/genit	T	0134	3.1508	$211.86		$42.38	*
12047	Intmd wnd repair n-hg/genit	T	0134	3.1508	$211.86		$42.38	*
12051	Intmd wnd repair face/mm	T	0133	1.3542	$91.06	$25.67	$18.22	*
12052	Intmd wnd repair face/mm	T	0133	1.3542	$91.06	$25.67	$18.22	*
12053	Intmd wnd repair face/mm	T	0133	1.3542	$91.06	$25.67	$18.22	*
12054	Intmd wnd repair, face/mm	T	0133	1.3542	$91.06	$25.67	$18.22	*
12055	Intmd wnd repair face/mm	T	0134	3.1508	$211.86		$42.38	*
12056	Intmd wnd repair face/mm	T	0134	3.1508	$211.86		$42.38	*
12057	Intmd wnd repair face/mm	T	0134	3.1508	$211.86		$42.38	*

13100	Repair of wound or lesion	T	0135	4.4386	$298.46		$59.70	*
13101	Repair of wound or lesion	T	0135	4.4386	$298.46		$59.70	*
13102	Repair wound/lesion add-on	T	0135	4.4386	$298.46		$59.70	*
13120	Repair of wound or lesion	T	0134	3.1508	$211.86		$42.38	*
13121	Repair of wound or lesion	T	0134	3.1508	$211.86		$42.38	*
13122	Repair wound/lesion add-on	T	0133	1.3542	$91.06	$25.67	$18.22	*
13131	Repair of wound or lesion	T	0134	3.1508	$211.86		$42.38	*
13132	Repair of wound or lesion	T	0135	4.4386	$298.46		$59.70	*
13133	Repair wound/lesion add-on	T	0134	3.1508	$211.86		$42.38	*
13150	Repair of wound or lesion	T	0135	4.4386	$298.46		$59.70	*
13151	Repair of wound or lesion	T	0135	4.4386	$298.46		$59.70	*
13152	Repair of wound or lesion	T	0135	4.4386	$298.46		$59.70	*
13153	Repair wound/lesion add-on	T	0134	3.1508	$211.86		$42.38	*
13160	Late closure of wound	T	0137	23.9317	$1,609.19		$321.84	*
14000	Skin tissue rearrangement	T	0136	16.0542	$1,079.50		$215.90	*
14001	Skin tissue rearrangement	T	0136	16.0542	$1,079.50		$215.90	*
14020	Skin tissue rearrangement	T	0136	16.0542	$1,079.50		$215.90	*
14021	Skin tissue rearrangement	T	0136	16.0542	$1,079.50		$215.90	*
14040	Skin tissue rearrangement	T	0136	16.0542	$1,079.50		$215.90	*
14041	Skin tissue rearrangement	T	0136	16.0542	$1,079.50		$215.90	*
14060	Skin tissue rearrangement	T	0136	16.0542	$1,079.50		$215.90	*
14061	Skin tissue rearrangement	T	0136	16.0542	$1,079.50		$215.90	*
14301	Skin tissue rearrangement	T	0137	23.9317	$1,609.19		$321.84	*
14302	Skin tissue rearrange add-on	T	0137	23.9317	$1,609.19		$321.84	*
14350	Skin tissue rearrangement	T	0137	23.9317	$1,609.19		$321.84	*
15002	Wound prep, trk/arm/leg	T	0135	4.4386	$298.46		$59.70	*
15003	Wound prep, addl 100 cm	T	0135	4.4386	$298.46		$59.70	*
15004	Wound prep, f/n/hf/g	T	0135	4.4386	$298.46		$59.70	*
15005	Wnd prep, f/n/hf/g, addl cm	T	0135	4.4386	$298.46		$59.70	*
15040	Harvest cultured skin graft	T	0134	3.1508	$211.86		$42.38	*
15050	Skin pinch graft	T	0135	4.4386	$298.46		$59.70	*
15100	Skin splt grft, trnk/arm/leg	T	0137	23.9317	$1,609.19		$321.84	*
15101	Skin splt grft t/a/l, add-on	T	0137	23.9317	$1,609.19		$321.84	*
15110	Epidrm autogrft trnk/arm/leg	T	0135	4.4386	$298.46		$59.70	*
15111	Epidrm autogrft t/a/l add-on	T	0135	4.4386	$298.46		$59.70	*
15115	Epidrm a-grft face/nck/hf/g	T	0135	4.4386	$298.46		$59.70	*
15116	Epidrm a-grft f/n/hf/g addl	T	0135	4.4386	$298.46		$59.70	*
15120	Skn splt a-grft fac/nck/hf/g	T	0137	23.9317	$1,609.19		$321.84	*
15121	Skn splt a-grft f/n/hf/g add	T	0137	23.9317	$1,609.19		$321.84	*
15130	Derm autograft, trnk/arm/leg	T	0136	16.0542	$1,079.50		$215.90	*
15131	Derm autograft t/a/l add-on	T	0136	16.0542	$1,079.50		$215.90	*
15135	Derm autograft face/nck/hf/g	T	0136	16.0542	$1,079.50		$215.90	*
15136	Derm autograft, f/n/hf/g add	T	0136	16.0542	$1,079.50		$215.90	*
15150	Cult epiderm grft t/arm/leg	T	0135	4.4386	$298.46		$59.70	*
15151	Cult epiderm grft t/a/l addl	T	0135	4.4386	$298.46		$59.70	*
15152	Cult epiderm graft t/a/l +%	T	0135	4.4386	$298.46		$59.70	*
15155	Cult epiderm graft, f/n/hf/g	T	0135	4.4386	$298.46		$59.70	*
15156	Cult epidrm grft f/n/hfg add	T	0135	4.4386	$298.46		$59.70	*
15157	Cult epiderm grft f/n/hfg +%	T	0135	4.4386	$298.46		$59.70	*
15170	Acell graft trunk/arms/legs	T	0135	4.4386	$298.46		$59.70	*
15171	Acell graft t/arm/leg add-on	T	0134	3.1508	$211.86		$42.38	*
15175	Acellular graft, f/n/hf/g	T	0135	4.4386	$298.46		$59.70	*
15176	Acell graft, f/n/hf/g add-on	T	0135	4.4386	$298.46		$59.70	*
15200	Skin full graft, trunk	T	0136	16.0542	$1,079.50		$215.90	*
15201	Skin full graft trunk add-on	T	0136	16.0542	$1,079.50		$215.90	*
15220	Skin full graft sclp/arm/leg	T	0136	16.0542	$1,079.50		$215.90	*
15221	Skin full graft add-on	T	0135	4.4386	$298.46		$59.70	*
15240	Skin full grft face/genit/hf	T	0136	16.0542	$1,079.50		$215.90	*
15241	Skin full graft add-on	T	0135	4.4386	$298.46		$59.70	*
15260	Skin full graft een & lips	T	0136	16.0542	$1,079.50		$215.90	*
15261	Skin full graft add-on	T	0136	16.0542	$1,079.50		$215.90	*
15300	Apply skinallogrft, t/arm/lg	T	0135	4.4386	$298.46		$59.70	*

15301	Apply sknallogrft t/a/l addl	T	0135	4.4386	$298.46		$59.70	*
15320	Apply skin allogrft f/n/hf/g	T	0135	4.4386	$298.46		$59.70	*
15321	Aply sknallogrft f/n/hfg add	T	0135	4.4386	$298.46		$59.70	*
15330	Aply acell alogrft t/arm/leg	T	0135	4.4386	$298.46		$59.70	*
15331	Aply acell grft t/a/l add-on	T	0135	4.4386	$298.46		$59.70	*
15335	Apply acell graft, f/n/hf/g	T	0135	4.4386	$298.46		$59.70	*
15336	Aply acell grft f/n/hf/g add	T	0135	4.4386	$298.46		$59.70	*
15340	Apply cult skin substitute	T	0134	3.1508	$211.86		$42.38	*
15341	Apply cult skin sub add-on	T	0134	3.1508	$211.86		$42.38	*
15360	Apply cult derm sub, t/a/l	T	0134	3.1508	$211.86		$42.38	*
15361	Aply cult derm sub t/a/l add	T	0134	3.1508	$211.86		$42.38	*
15365	Apply cult derm sub f/n/hf/g	T	0134	3.1508	$211.86		$42.38	*
15366	Apply cult derm f/hf/g add	T	0134	3.1508	$211.86		$42.38	*
15400	Apply skin xenograft, t/a/l	T	0135	4.4386	$298.46		$59.70	*
15401	Apply skn xenogrft t/a/l add	T	0135	4.4386	$298.46		$59.70	*
15420	Apply skin xgraft, f/n/hf/g	T	0135	4.4386	$298.46		$59.70	*
15421	Apply skn xgrft f/n/hf/g add	T	0135	4.4386	$298.46		$59.70	*
15430	Apply acellular xenograft	T	0135	4.4386	$298.46		$59.70	*
15431	Apply acellular xgraft add	T	0135	4.4386	$298.46		$59.70	*
15570	Form skin pedicle flap	T	0137	23.9317	$1,609.19		$321.84	*
15572	Form skin pedicle flap	T	0137	23.9317	$1,609.19		$321.84	*
15574	Form skin pedicle flap	T	0137	23.9317	$1,609.19		$321.84	*
15576	Form skin pedicle flap	T	0137	23.9317	$1,609.19		$321.84	*
15600	Skin graft	T	0137	23.9317	$1,609.19		$321.84	*
15610	Skin graft	T	0137	23.9317	$1,609.19		$321.84	*
15620	Skin graft	T	0137	23.9317	$1,609.19		$321.84	*
15630	Skin graft	T	0137	23.9317	$1,609.19		$321.84	*
15650	Transfer skin pedicle flap	T	0137	23.9317	$1,609.19		$321.84	*
15731	Forehead flap w/vasc pedicle	T	0137	23.9317	$1,609.19		$321.84	*
15732	Muscle-skin graft, head/neck	T	0137	23.9317	$1,609.19		$321.84	*
15734	Muscle-skin graft, trunk	T	0137	23.9317	$1,609.19		$321.84	*
15736	Muscle-skin graft, arm	T	0137	23.9317	$1,609.19		$321.84	*
15738	Muscle-skin graft, leg	T	0137	23.9317	$1,609.19		$321.84	*
15740	Island pedicle flap graft	T	0136	16.0542	$1,079.50		$215.90	*
15750	Neurovascular pedicle graft	T	0137	23.9317	$1,609.19		$321.84	*
15756	Free myo/skin flap microvasc	C						
15757	Free skin flap, microvasc	C						
15758	Free fascial flap, microvasc	C						
15760	Composite skin graft	T	0137	23.9317	$1,609.19		$321.84	*
15770	Derma-fat-fascia graft	T	0137	23.9317	$1,609.19		$321.84	*
15775	Hair transplant punch grafts	T	0133	1.3542	$91.06	$25.67	$18.22	*
15776	Hair transplant punch grafts	T	0133	1.3542	$91.06	$25.67	$18.22	*
15780	Abrasion treatment of skin	T	0022	23.388	$1,572.63	$354.45	$314.53	*
15781	Abrasion treatment of skin	T	0019	4.3625	$293.34	$64.35	$58.67	*
15782	Abrasion treatment of skin	T	0019	4.3625	$293.34	$64.35	$58.67	*
15783	Abrasion treatment of skin	T	0016	2.7982	$188.15		$37.63	*
15786	Abrasion, lesion, single	T	0013	0.8789	$59.10		$11.82	*
15787	Abrasion, lesions, add-on	T	0013	0.8789	$59.10		$11.82	*
15788	Chemical peel, face, epiderm	T	0013	0.8789	$59.10		$11.82	*
15789	Chemical peel, face, dermal	T	0015	1.5412	$103.63		$20.73	*
15792	Chemical peel, nonfacial	T	0015	1.5412	$103.63		$20.73	*
15793	Chemical peel, nonfacial	T	0013	0.8789	$59.10		$11.82	*
15819	Plastic surgery, neck	T	0134	3.1508	$211.86		$42.38	*
15820	Revision of lower eyelid	T	0137	23.9317	$1,609.19		$321.84	*
15821	Revision of lower eyelid	T	0137	23.9317	$1,609.19		$321.84	*
15822	Revision of upper eyelid	T	0137	23.9317	$1,609.19		$321.84	*
15823	Revision of upper eyelid	T	0137	23.9317	$1,609.19		$321.84	*
15824	Removal of forehead wrinkles	T	0137	23.9317	$1,609.19		$321.84	*
15825	Removal of neck wrinkles	T	0137	23.9317	$1,609.19		$321.84	*
15826	Removal of brow wrinkles	T	0137	23.9317	$1,609.19		$321.84	*
15828	Removal of face wrinkles	T	0137	23.9317	$1,609.19		$321.84	*
15829	Removal of skin wrinkles	T	0137	23.9317	$1,609.19		$321.84	*

15830	Exc skin abd	T	0022	23.388	$1,572.63	$354.45	$314.53	*
15832	Excise excessive skin tissue	T	0022	23.388	$1,572.63	$354.45	$314.53	*
15833	Excise excessive skin tissue	T	0022	23.388	$1,572.63	$354.45	$314.53	*
15834	Excise excessive skin tissue	T	0022	23.388	$1,572.63	$354.45	$314.53	*
15835	Excise excessive skin tissue	T	0022	23.388	$1,572.63	$354.45	$314.53	*
15836	Excise excessive skin tissue	T	0021	17.4975	$1,176.55		$235.31	*
15837	Excise excessive skin tissue	T	0021	17.4975	$1,176.55		$235.31	*
15838	Excise excessive skin tissue	T	0021	17.4975	$1,176.55		$235.31	*
15839	Excise excessive skin tissue	T	0021	17.4975	$1,176.55		$235.31	*
15840	Graft for face nerve palsy	T	0137	23.9317	$1,609.19		$321.84	*
15841	Graft for face nerve palsy	T	0137	23.9317	$1,609.19		$321.84	*
15842	Flap for face nerve palsy	T	0137	23.9317	$1,609.19		$321.84	*
15845	Skin and muscle repair, face	T	0137	23.9317	$1,609.19		$321.84	*
15847	Exc skin abd add-on	T	0022	23.388	$1,572.63	$354.45	$314.53	*
15850	Removal of sutures	T	0016	2.7982	$188.15		$37.63	*
15851	Removal of sutures	T	0016	2.7982	$188.15		$37.63	*
15852	Dressing change not for burn	X	0340	0.6693	$45.00		$9.00	*
15860	Test for blood flow in graft	X	0340	0.6693	$45.00		$9.00	*
15876	Suction assisted lipectomy	T	0137	23.9317	$1,609.19		$321.84	*
15877	Suction assisted lipectomy	T	0137	23.9317	$1,609.19		$321.84	*
15878	Suction assisted lipectomy	T	0137	23.9317	$1,609.19		$321.84	*
15879	Suction assisted lipectomy	T	0137	23.9317	$1,609.19		$321.84	*
15920	Removal of tail bone ulcer	T	0019	4.3625	$293.34	$64.35	$58.67	*
15922	Removal of tail bone ulcer	T	0137	23.9317	$1,609.19		$321.84	*
15931	Remove sacrum pressure sore	T	0022	23.388	$1,572.63	$354.45	$314.53	*
15933	Remove sacrum pressure sore	T	0022	23.388	$1,572.63	$354.45	$314.53	*
15934	Remove sacrum pressure sore	T	0137	23.9317	$1,609.19		$321.84	*
15935	Remove sacrum pressure sore	T	0137	23.9317	$1,609.19		$321.84	*
15936	Remove sacrum pressure sore	T	0136	16.0542	$1,079.50		$215.90	*
15937	Remove sacrum pressure sore	T	0137	23.9317	$1,609.19		$321.84	*
15940	Remove hip pressure sore	T	0022	23.388	$1,572.63	$354.45	$314.53	*
15941	Remove hip pressure sore	T	0022	23.388	$1,572.63	$354.45	$314.53	*
15944	Remove hip pressure sore	T	0137	23.9317	$1,609.19		$321.84	*
15945	Remove hip pressure sore	T	0137	23.9317	$1,609.19		$321.84	*
15946	Remove hip pressure sore	T	0137	23.9317	$1,609.19		$321.84	*
15950	Remove thigh pressure sore	T	0022	23.388	$1,572.63	$354.45	$314.53	*
15951	Remove thigh pressure sore	T	0022	23.388	$1,572.63	$354.45	$314.53	*
15952	Remove thigh pressure sore	T	0136	16.0542	$1,079.50		$215.90	*
15953	Remove thigh pressure sore	T	0136	16.0542	$1,079.50		$215.90	*
15956	Remove thigh pressure sore	T	0136	16.0542	$1,079.50		$215.90	*
15958	Remove thigh pressure sore	T	0136	16.0542	$1,079.50		$215.90	*
15999	Removal of pressure sore	T	0019	4.3625	$293.34	$64.35	$58.67	*
16000	Initial treatment of burn(s)	T	0013	0.8789	$59.10		$11.82	*
16020	Dress/debrid p-thick burn, s	T	0015	1.5412	$103.63		$20.73	*
16025	Dress/debrid p-thick burn, m	T	0015	1.5412	$103.63		$20.73	*
16030	Dress/debrid p-thick burn, l	T	0015	1.5412	$103.63		$20.73	*
16035	Incision of burn scab, initi	T	0015	1.5412	$103.63		$20.73	*
16036	Escharotomy; addl incision	C						
17000	Destruct premalg lesion	T	0013	0.8789	$59.10		$11.82	*
17003	Destruct premalg les, 2-14	T	0012	0.4436	$29.83		$5.97	*
17004	Destroy premlg lesions 15+	T	0016	2.7982	$188.15		$37.63	*
17106	Destruction of skin lesions	T	0016	2.7982	$188.15		$37.63	*
17107	Destruction of skin lesions	T	0016	2.7982	$188.15		$37.63	*
17108	Destruction of skin lesions	T	0016	2.7982	$188.15		$37.63	*
17110	Destruct b9 lesion, 1-14	T	0013	0.8789	$59.10		$11.82	*
17111	Destruct lesion, 15 or more	T	0015	1.5412	$103.63		$20.73	*
17250	Chemical cautery, tissue	T	0015	1.5412	$103.63		$20.73	*
17260	Destruction of skin lesions	T	0015	1.5412	$103.63		$20.73	*
17261	Destruction of skin lesions	T	0015	1.5412	$103.63		$20.73	*
17262	Destruction of skin lesions	T	0015	1.5412	$103.63		$20.73	*
17263	Destruction of skin lesions	T	0015	1.5412	$103.63		$20.73	*
17264	Destruction of skin lesions	T	0015	1.5412	$103.63		$20.73	*

17266	Destruction of skin lesions	T	0016	2.7982	$188.15		$37.63	*
17270	Destruction of skin lesions	T	0015	1.5412	$103.63		$20.73	*
17271	Destruction of skin lesions	T	0015	1.5412	$103.63		$20.73	*
17272	Destruction of skin lesions	T	0015	1.5412	$103.63		$20.73	*
17273	Destruction of skin lesions	T	0016	2.7982	$188.15		$37.63	*
17274	Destruction of skin lesions	T	0016	2.7982	$188.15		$37.63	*
17276	Destruction of skin lesions	T	0016	2.7982	$188.15		$37.63	*
17280	Destruction of skin lesions	T	0015	1.5412	$103.63		$20.73	*
17281	Destruction of skin lesions	T	0016	2.7982	$188.15		$37.63	*
17282	Destruction of skin lesions	T	0016	2.7982	$188.15		$37.63	*
17283	Destruction of skin lesions	T	0016	2.7982	$188.15		$37.63	*
17284	Destruction of skin lesions	T	0016	2.7982	$188.15		$37.63	*
17286	Destruction of skin lesions	T	0016	2.7982	$188.15		$37.63	*
17311	Mohs, 1 stage, h/n/hf/g	T	0694	4.9337	$331.75	$91.69	$66.35	*
17312	Mohs addl stage	T	0694	4.9337	$331.75	$91.69	$66.35	*
17313	Mohs, 1 stage, t/a/l	T	0694	4.9337	$331.75	$91.69	$66.35	*
17314	Mohs, addl stage, t/a/l	T	0694	4.9337	$331.75	$91.69	$66.35	*
17315	Mohs surg, addl block	T	0694	4.9337	$331.75	$91.69	$66.35	*
17340	Cryotherapy of skin	T	0013	0.8789	$59.10		$11.82	*
17360	Skin peel therapy	T	0013	0.8789	$59.10		$11.82	*
17380	Hair removal by electrolysis	T	0013	0.8789	$59.10		$11.82	*
17999	Skin tissue procedure	T	0012	0.4436	$29.83		$5.97	*
19000	Drainage of breast lesion	T	0004	4.5991	$309.25		$61.85	*
19001	Drain breast lesion add-on	T	0002	1.5111	$101.61		$20.33	*
19020	Incision of breast lesion	T	0008	19.4063	$1,304.90		$260.98	*
19030	Injection for breast x-ray	N						
19100	Bx breast percut w/o image	T	0004	4.5991	$309.25		$61.85	*
19101	Biopsy of breast, open	T	0028	24.7516	$1,664.32		$332.87	*
19102	Bx breast percut w/image	T	0005	7.8145	$525.45		$105.09	*
19103	Bx breast percut w/device	T	0037	15.5003	$1,042.26	$228.76	$208.46	*
19105	Cryosurg ablate fa, each	T	0029	34.1654	$2,297.32	$581.52	$459.47	*
19110	Nipple exploration	T	0028	24.7516	$1,664.32		$332.87	*
19112	Excise breast duct fistula	T	0028	24.7516	$1,664.32		$332.87	*
19120	Removal of breast lesion	T	0028	24.7516	$1,664.32		$332.87	*
19125	Excision, breast lesion	T	0028	24.7516	$1,664.32		$332.87	*
19126	Excision, addl breast lesion	T	0028	24.7516	$1,664.32		$332.87	*
19260	Removal of chest wall lesion	T	0021	17.4975	$1,176.55		$235.31	*
19271	Revision of chest wall	C						
19272	Extensive chest wall surgery	C						
19290	Place needle wire, breast	N						
19291	Place needle wire, breast	N						
19295	Place breast clip, percut	N						
19296	Place po breast cath for rad	T	0648	58.2278	$3,915.30		$783.06	*
19297	Place breast cath for rad	T	0648	58.2278	$3,915.30		$783.06	*
19298	Place breast rad tube/caths	T	0648	58.2278	$3,915.30		$783.06	*
19300	Removal of breast tissue	T	0028	24.7516	$1,664.32		$332.87	*
19301	Partical mastectomy	T	0028	24.7516	$1,664.32		$332.87	*
19302	P-mastectomy w/ln removal	T	0030	41.9997	$2,824.10	$747.07	$564.82	*
19303	Mast, simple, complete	T	0029	34.1654	$2,297.32	$581.52	$459.47	*
19304	Mast, subq	T	0029	34.1654	$2,297.32	$581.52	$459.47	*
19305	Mast, radical	C						
19306	Mast, rad, urban type	C						
19307	Mast, mod rad	T	0030	41.9997	$2,824.10	$747.07	$564.82	*
19316	Suspension of breast	T	0029	34.1654	$2,297.32	$581.52	$459.47	*
19318	Reduction of large breast	T	0030	41.9997	$2,824.10	$747.07	$564.82	*
19324	Enlarge breast	T	0030	41.9997	$2,824.10	$747.07	$564.82	*
19325	Enlarge breast with implant	T	0648	58.2278	$3,915.30		$783.06	*
19328	Removal of breast implant	T	0029	34.1654	$2,297.32	$581.52	$459.47	*
19330	Removal of implant material	T	0029	34.1654	$2,297.32	$581.52	$459.47	*
19340	Immediate breast prosthesis	T	0030	41.9997	$2,824.10	$747.07	$564.82	*
19342	Delayed breast prosthesis	T	0648	58.2278	$3,915.30		$783.06	*
19350	Breast reconstruction	T	0028	24.7516	$1,664.32		$332.87	*

19355	Correct inverted nipple(s)	T	0029	34.1654	$2,297.32	$581.52	$459.47	*
19357	Breast reconstruction	T	0648	58.2278	$3,915.30		$783.06	*
19361	Breast reconstr w/lat flap	C						
19364	Breast reconstruction	C						
19366	Breast reconstruction	T	0029	34.1654	$2,297.32	$581.52	$459.47	*
19367	Breast reconstruction	C						
19368	Breast reconstruction	C						
19369	Breast reconstruction	C						
19370	Surgery of breast capsule	T	0029	34.1654	$2,297.32	$581.52	$459.47	*
19371	Removal of breast capsule	T	0029	34.1654	$2,297.32	$581.52	$459.47	*
19380	Revise breast reconstruction	T	0030	41.9997	$2,824.10	$747.07	$564.82	*
19396	Design custom breast implant	T	0029	34.1654	$2,297.32	$581.52	$459.47	*
19499	Breast surgery procedure	T	0028	24.7516	$1,664.32		$332.87	*
20000	Incision of abscess	T	0006	1.4557	$97.88		$19.58	*
20005	Incision of deep abscess	T	0049	22.0149	$1,480.30		$296.06	*
20100	Explore wound, neck	T	0252	7.6196	$512.35	$109.16	$102.47	*
20101	Explore wound, chest	T	0137	23.9317	$1,609.19		$321.84	*
20102	Explore wound, abdomen	T	0137	23.9317	$1,609.19		$321.84	*
20103	Explore wound, extremity	T	0007	12.6217	$848.70		$169.74	*
20150	Excise epiphyseal bar	T	0051	46.5786	$3,131.99		$626.40	*
20200	Muscle biopsy	T	0021	17.4975	$1,176.55		$235.31	*
20205	Deep muscle biopsy	T	0021	17.4975	$1,176.55		$235.31	*
20206	Needle biopsy, muscle	T	0005	7.8145	$525.45		$105.09	*
20220	Bone biopsy, trocar/needle	T	0020	8.2028	$551.56		$110.32	*
20225	Bone biopsy, trocar/needle	T	0021	17.4975	$1,176.55		$235.31	*
20240	Bone biopsy, excisional	T	0022	23.388	$1,572.63	$354.45	$314.53	*
20245	Bone biopsy, excisional	T	0022	23.388	$1,572.63	$354.45	$314.53	*
20250	Open bone biopsy	T	0049	22.0149	$1,480.30		$296.06	*
20251	Open bone biopsy	T	0049	22.0149	$1,480.30		$296.06	*
20500	Injection of sinus tract	T	0252	7.6196	$512.35	$109.16	$102.47	*
20501	Inject sinus tract for x-ray	N						
20520	Removal of foreign body	T	0019	4.3625	$293.34	$64.35	$58.67	*
20525	Removal of foreign body	T	0022	23.388	$1,572.63	$354.45	$314.53	*
20526	Ther injection, carp tunnel	T	0204	2.5558	$171.85	$40.13	$34.37	*
20550	Inj tendon sheath/ligament	T	0204	2.5558	$171.85	$40.13	$34.37	*
20551	Inj tendon origin/insertion	T	0204	2.5558	$171.85	$40.13	$34.37	*
20552	Inj trigger point, 1/2 muscl	T	0204	2.5558	$171.85	$40.13	$34.37	*
20553	Inject trigger points, =/> 3	T	0204	2.5558	$171.85	$40.13	$34.37	*
20555	Place ndl musc/tis for rt	T	0050	31.7717	$2,136.36		$427.28	*
20600	Drain/inject, joint/bursa	T	0204	2.5558	$171.85	$40.13	$34.37	*
20605	Drain/inject, joint/bursa	T	0204	2.5558	$171.85	$40.13	$34.37	*
20610	Drain/inject, joint/bursa	T	0204	2.5558	$171.85	$40.13	$34.37	*
20612	Aspirate/inj ganglion cyst	T	0204	2.5558	$171.85	$40.13	$34.37	*
20615	Treatment of bone cyst	T	0004	4.5991	$309.25		$61.85	*
20650	Insert and remove bone pin	T	0049	22.0149	$1,480.30		$296.06	*
20660	Apply, rem fixation device	T	0138	4.7946	$322.39		$64.48	*
20661	Application of head brace	C						
20662	Application of pelvis brace	T	0049	22.0149	$1,480.30		$296.06	*
20663	Application of thigh brace	T	0049	22.0149	$1,480.30		$296.06	*
20664	Halo brace application	C						
20665	Removal of fixation device	X	0340	0.6693	$45.00		$9.00	*
20670	Removal of support implant	T	0021	17.4975	$1,176.55		$235.31	*
20680	Removal of support implant	T	0022	23.388	$1,572.63	$354.45	$314.53	*
20690	Apply bone fixation device	T	0050	31.7717	$2,136.36		$427.28	*
20692	Apply bone fixation device	T	0050	31.7717	$2,136.36		$427.28	*
20693	Adjust bone fixation device	T	0049	22.0149	$1,480.30		$296.06	*
20694	Remove bone fixation device	T	0049	22.0149	$1,480.30		$296.06	*
20696	Comp multiplane ext fixation	T	0050	31.7717	$2,136.36		$427.28	*
20697	Comp ext fixate strut change	T	0139	18.3962	$1,236.98		$247.40	*
20802	Replantation, arm, complete	C						
20805	Replant forearm, complete	C						
20808	Replantation hand, complete	C						

20816	Replantation digit, complete	C						
20822	Replantation digit, complete	T	0054	28.2376	$1,898.72		$379.75	*
20824	Replantation thumb, complete	C						
20827	Replantation thumb, complete	C						
20838	Replantation foot, complete	C						
20900	Removal of bone for graft	T	0050	31.7717	$2,136.36		$427.28	*
20902	Removal of bone for graft	T	0050	31.7717	$2,136.36		$427.28	*
20910	Remove cartilage for graft	T	0137	23.9317	$1,609.19		$321.84	*
20912	Remove cartilage for graft	T	0137	23.9317	$1,609.19		$321.84	*
20920	Removal of fascia for graft	T	0136	16.0542	$1,079.50		$215.90	*
20922	Removal of fascia for graft	T	0136	16.0542	$1,079.50		$215.90	*
20924	Removal of tendon for graft	T	0050	31.7717	$2,136.36		$427.28	*
20926	Removal of tissue for graft	T	0135	4.4386	$298.46		$59.70	*
20930	Sp bone algrft morsel add-on	C						
20931	Sp bone algrft struct add-on	C						
20936	Sp bone agrft local add-on	C						
20937	Sp bone agrft morsel add-on	C						
20938	Sp bone agrft struct add-on	C						
20950	Fluid pressure, muscle	T	0006	1.4557	$97.88		$19.58	*
20955	Fibula bone graft, microvasc	C						
20956	Iliac bone graft, microvasc	C						
20957	Mt bone graft, microvasc	C						
20962	Other bone graft, microvasc	C						
20969	Bone/skin graft, microvasc	C						
20970	Bone/skin graft, iliac crest	C						
20972	Bone/skin graft, metatarsal	T	0056	52.5258	$3,531.89		$706.38	*
20973	Bone/skin graft, great toe	T	0056	52.5258	$3,531.89		$706.38	*
20974	Electrical bone stimulation	A						
20975	Electrical bone stimulation	N						
20979	Us bone stimulation	X	0340	0.6693	$45.00		$9.00	*
20982	Ablate, bone tumor(s) perq	T	0051	46.5786	$3,131.99		$626.40	*
20985	Cptr-asst dir ms px	N						
20999	Musculoskeletal surgery	T	0049	22.0149	$1,480.30		$296.06	*
21010	Incision of jaw joint	T	0254	24.9637	$1,678.58		$335.72	*
21011	Exc face les sc < 2 cm	T	0020	8.2028	$551.56		$110.32	*
21012	Exc face les sc = 2 cm	T	0020	8.2028	$551.56		$110.32	*
21013	Exc face tum deep < 2 cm	T	0020	8.2028	$551.56		$110.32	*
21014	Exc face tum deep = 2 cm	T	0020	8.2028	$551.56		$110.32	*
21015	Resect face tum < 2 cm	T	0021	17.4975	$1,176.55		$235.31	*
21016	Resect face tum = 2 cm	T	0022	23.388	$1,572.63	$354.45	$314.53	*
21025	Excision of bone, lower jaw	T	0256	42.9827	$2,890.20		$578.04	*
21026	Excision of facial bone(s)	T	0256	42.9827	$2,890.20		$578.04	*
21029	Contour of face bone lesion	T	0256	42.9827	$2,890.20		$578.04	*
21030	Excise max/zygoma b9 tumor	T	0254	24.9637	$1,678.58		$335.72	*
21031	Remove exostosis, mandible	T	0254	24.9637	$1,678.58		$335.72	*
21032	Remove exostosis, maxilla	T	0254	24.9637	$1,678.58		$335.72	*
21034	Excise max/zygoma mlg tumor	T	0256	42.9827	$2,890.20		$578.04	*
21040	Excise mandible lesion	T	0254	24.9637	$1,678.58		$335.72	*
21044	Removal of jaw bone lesion	T	0256	42.9827	$2,890.20		$578.04	*
21045	Extensive jaw surgery	C						
21046	Remove mandible cyst complex	T	0256	42.9827	$2,890.20		$578.04	*
21047	Excise lwr jaw cyst w/repair	T	0256	42.9827	$2,890.20		$578.04	*
21048	Remove maxilla cyst complex	T	0256	42.9827	$2,890.20		$578.04	*
21049	Excis uppr jaw cyst w/repair	T	0256	42.9827	$2,890.20		$578.04	*
21050	Removal of jaw joint	T	0256	42.9827	$2,890.20		$578.04	*
21060	Remove jaw joint cartilage	T	0256	42.9827	$2,890.20		$578.04	*
21070	Remove coronoid process	T	0256	42.9827	$2,890.20		$578.04	*
21073	Mnpj of tmj w/anesth	T	0252	7.6196	$512.35	$109.16	$102.47	*
21076	Prepare face/oral prosthesis	T	0254	24.9637	$1,678.58		$335.72	*
21077	Prepare face/oral prosthesis	T	0256	42.9827	$2,890.20		$578.04	*
21079	Prepare face/oral prosthesis	T	0256	42.9827	$2,890.20		$578.04	*
21080	Prepare face/oral prosthesis	T	0256	42.9827	$2,890.20		$578.04	*

21081	Prepare face/oral prosthesis	T	0256	42.9827	$2,890.20		$578.04	*
21082	Prepare face/oral prosthesis	T	0256	42.9827	$2,890.20		$578.04	*
21083	Prepare face/oral prosthesis	T	0256	42.9827	$2,890.20		$578.04	*
21084	Prepare face/oral prosthesis	T	0256	42.9827	$2,890.20		$578.04	*
21085	Prepare face/oral prosthesis	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
21086	Prepare face/oral prosthesis	T	0256	42.9827	$2,890.20		$578.04	*
21087	Prepare face/oral prosthesis	T	0256	42.9827	$2,890.20		$578.04	*
21088	Prepare face/oral prosthesis	T	0256	42.9827	$2,890.20		$578.04	*
21089	Prepare face/oral prosthesis	T	0250	1.1522	$77.48	$25.10	$15.50	*
21100	Maxillofacial fixation	T	0256	42.9827	$2,890.20		$578.04	*
21110	Interdental fixation	T	0252	7.6196	$512.35	$109.16	$102.47	*
21116	Injection, jaw joint x-ray	N						
21120	Reconstruction of chin	T	0254	24.9637	$1,678.58		$335.72	*
21121	Reconstruction of chin	T	0254	24.9637	$1,678.58		$335.72	*
21122	Reconstruction of chin	T	0254	24.9637	$1,678.58		$335.72	*
21123	Reconstruction of chin	T	0254	24.9637	$1,678.58		$335.72	*
21125	Augmentation, lower jaw bone	T	0254	24.9637	$1,678.58		$335.72	*
21127	Augmentation, lower jaw bone	T	0256	42.9827	$2,890.20		$578.04	*
21137	Reduction of forehead	T	0254	24.9637	$1,678.58		$335.72	*
21138	Reduction of forehead	T	0256	42.9827	$2,890.20		$578.04	*
21139	Reduction of forehead	T	0256	42.9827	$2,890.20		$578.04	*
21141	Reconstruct midface, lefort	C						
21142	Reconstruct midface, lefort	C						
21143	Reconstruct midface, lefort	C						
21145	Reconstruct midface, lefort	C						
21146	Reconstruct midface, lefort	C						
21147	Reconstruct midface, lefort	C						
21150	Reconstruct midface, lefort	T	0256	42.9827	$2,890.20		$578.04	*
21151	Reconstruct midface, lefort	C						
21154	Reconstruct midface, lefort	C						
21155	Reconstruct midface, lefort	C						
21159	Reconstruct midface, lefort	C						
21160	Reconstruct midface, lefort	C						
21172	Reconstruct orbit/forehead	T	0256	42.9827	$2,890.20		$578.04	*
21175	Reconstruct orbit/forehead	T	0256	42.9827	$2,890.20		$578.04	*
21179	Reconstruct entire forehead	C						
21180	Reconstruct entire forehead	C						
21181	Contour cranial bone lesion	T	0254	24.9637	$1,678.58		$335.72	*
21182	Reconstruct cranial bone	C						
21183	Reconstruct cranial bone	C						
21184	Reconstruct cranial bone	C						
21188	Reconstruction of midface	C						
21193	Reconst lwr jaw w/o graft	C						
21194	Reconst lwr jaw w/graft	C						
21195	Reconst lwr jaw w/o fixation	T	0256	42.9827	$2,890.20		$578.04	*
21196	Reconst lwr jaw w/fixation	C						
21198	Reconstr lwr jaw segment	T	0256	42.9827	$2,890.20		$578.04	*
21199	Reconstr lwr jaw w/advance	T	0256	42.9827	$2,890.20		$578.04	*
21206	Reconstruct upper jaw bone	T	0256	42.9827	$2,890.20		$578.04	*
21208	Augmentation of facial bones	T	0256	42.9827	$2,890.20		$578.04	*
21209	Reduction of facial bones	T	0256	42.9827	$2,890.20		$578.04	*
21210	Face bone graft	T	0256	42.9827	$2,890.20		$578.04	*
21215	Lower jaw bone graft	T	0256	42.9827	$2,890.20		$578.04	*
21230	Rib cartilage graft	T	0256	42.9827	$2,890.20		$578.04	*
21235	Ear cartilage graft	T	0254	24.9637	$1,678.58		$335.72	*
21240	Reconstruction of jaw joint	T	0256	42.9827	$2,890.20		$578.04	*
21242	Reconstruction of jaw joint	T	0256	42.9827	$2,890.20		$578.04	*
21243	Reconstruction of jaw joint	T	0256	42.9827	$2,890.20		$578.04	*
21244	Reconstruction of lower jaw	T	0256	42.9827	$2,890.20		$578.04	*
21245	Reconstruction of jaw	T	0256	42.9827	$2,890.20		$578.04	*
21246	Reconstruction of jaw	T	0256	42.9827	$2,890.20		$578.04	*
21247	Reconstruct lower jaw bone	C						

21248	Reconstruction of jaw	T	0256	42.9827	$2,890.20		$578.04	*
21249	Reconstruction of jaw	T	0256	42.9827	$2,890.20		$578.04	*
21255	Reconstruct lower jaw bone	C						
21256	Reconstruction of orbit	T	0256	42.9827	$2,890.20		$578.04	*
21260	Revise eye sockets	T	0256	42.9827	$2,890.20		$578.04	*
21261	Revise eye sockets	T	0256	42.9827	$2,890.20		$578.04	*
21263	Revise eye sockets	T	0256	42.9827	$2,890.20		$578.04	*
21267	Revise eye sockets	T	0256	42.9827	$2,890.20		$578.04	*
21268	Revise eye sockets	C						
21270	Augmentation, cheek bone	T	0256	42.9827	$2,890.20		$578.04	*
21275	Revision, orbitofacial bones	T	0256	42.9827	$2,890.20		$578.04	*
21280	Revision of eyelid	T	0256	42.9827	$2,890.20		$578.04	*
21282	Revision of eyelid	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
21295	Revision of jaw muscle/bone	T	0252	7.6196	$512.35	$109.16	$102.47	*
21296	Revision of jaw muscle/bone	T	0254	24.9637	$1,678.58		$335.72	*
21299	Cranio/maxillofacial surgery	T	0250	1.1522	$77.48	$25.10	$15.50	*
21310	Treatment of nose fracture	T	0250	1.1522	$77.48	$25.10	$15.50	*
21315	Treatment of nose fracture	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
21320	Treatment of nose fracture	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
21325	Treatment of nose fracture	T	0254	24.9637	$1,678.58		$335.72	*
21330	Treatment of nose fracture	T	0254	24.9637	$1,678.58		$335.72	*
21335	Treatment of nose fracture	T	0254	24.9637	$1,678.58		$335.72	*
21336	Treat nasal septal fracture	T	0062	25.8446	$1,737.82	$372.87	$347.57	*
21337	Treat nasal septal fracture	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
21338	Treat nasoethmoid fracture	T	0254	24.9637	$1,678.58		$335.72	*
21339	Treat nasoethmoid fracture	T	0254	24.9637	$1,678.58		$335.72	*
21340	Treatment of nose fracture	T	0256	42.9827	$2,890.20		$578.04	*
21343	Treatment of sinus fracture	C						
21344	Treatment of sinus fracture	C						
21345	Treat nose/jaw fracture	T	0254	24.9637	$1,678.58		$335.72	*
21346	Treat nose/jaw fracture	C						
21347	Treat nose/jaw fracture	C						
21348	Treat nose/jaw fracture	C						
21355	Treat cheek bone fracture	T	0256	42.9827	$2,890.20		$578.04	*
21356	Treat cheek bone fracture	T	0254	24.9637	$1,678.58		$335.72	*
21360	Treat cheek bone fracture	T	0254	24.9637	$1,678.58		$335.72	*
21365	Treat cheek bone fracture	T	0256	42.9827	$2,890.20		$578.04	*
21366	Treat cheek bone fracture	C						
21385	Treat eye socket fracture	T	0256	42.9827	$2,890.20		$578.04	*
21386	Treat eye socket fracture	T	0256	42.9827	$2,890.20		$578.04	*
21387	Treat eye socket fracture	T	0256	42.9827	$2,890.20		$578.04	*
21390	Treat eye socket fracture	T	0256	42.9827	$2,890.20		$578.04	*
21395	Treat eye socket fracture	C						
21400	Treat eye socket fracture	T	0252	7.6196	$512.35	$109.16	$102.47	*
21401	Treat eye socket fracture	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
21406	Treat eye socket fracture	T	0256	42.9827	$2,890.20		$578.04	*
21407	Treat eye socket fracture	T	0256	42.9827	$2,890.20		$578.04	*
21408	Treat eye socket fracture	T	0256	42.9827	$2,890.20		$578.04	*
21421	Treat mouth roof fracture	T	0254	24.9637	$1,678.58		$335.72	*
21422	Treat mouth roof fracture	C						
21423	Treat mouth roof fracture	C						
21431	Treat craniofacial fracture	C						
21432	Treat craniofacial fracture	C						
21433	Treat craniofacial fracture	C						
21435	Treat craniofacial fracture	C						
21436	Treat craniofacial fracture	C						
21440	Treat dental ridge fracture	T	0254	24.9637	$1,678.58		$335.72	*
21445	Treat dental ridge fracture	T	0254	24.9637	$1,678.58		$335.72	*
21450	Treat lower jaw fracture	T	0251	3.425	$230.30		$46.06	*
21451	Treat lower jaw fracture	T	0252	7.6196	$512.35	$109.16	$102.47	*
21452	Treat lower jaw fracture	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
21453	Treat lower jaw fracture	T	0256	42.9827	$2,890.20		$578.04	*

21454	Treat lower jaw fracture	T	0254	24.9637	$1,678.58		$335.72	*
21461	Treat lower jaw fracture	T	0256	42.9827	$2,890.20		$578.04	*
21462	Treat lower jaw fracture	T	0256	42.9827	$2,890.20		$578.04	*
21465	Treat lower jaw fracture	T	0256	42.9827	$2,890.20		$578.04	*
21470	Treat lower jaw fracture	T	0256	42.9827	$2,890.20		$578.04	*
21480	Reset dislocated jaw	T	0250	1.1522	$77.48	$25.10	$15.50	*
21485	Reset dislocated jaw	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
21490	Repair dislocated jaw	T	0256	42.9827	$2,890.20		$578.04	*
21495	Treat hyoid bone fracture	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
21497	Interdental wiring	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
21499	Head surgery procedure	T	0250	1.1522	$77.48	$25.10	$15.50	*
21501	Drain neck/chest lesion	T	0008	19.4063	$1,304.90		$260.98	*
21502	Drain chest lesion	T	0049	22.0149	$1,480.30		$296.06	*
21510	Drainage of bone lesion	C						
21550	Biopsy of neck/chest	T	0021	17.4975	$1,176.55		$235.31	*
21552	Exc neck les sc = 3 cm	T	0022	23.388	$1,572.63	$354.45	$314.53	*
21554	Exc neck tum deep = 5 cm	T	0022	23.388	$1,572.63	$354.45	$314.53	*
21555	Exc neck les sc < 3 cm	T	0021	17.4975	$1,176.55		$235.31	*
21556	Exc neck tum deep < 5 cm	T	0022	23.388	$1,572.63	$354.45	$314.53	*
21557	Resect neck tum < 5 cm	T	0021	17.4975	$1,176.55		$235.31	*
21558	Resect neck tum = 5 cm	T	0022	23.388	$1,572.63	$354.45	$314.53	*
21600	Partial removal of rib	T	0050	31.7717	$2,136.36		$427.28	*
21610	Partial removal of rib	T	0050	31.7717	$2,136.36		$427.28	*
21615	Removal of rib	C						
21616	Removal of rib and nerves	C						
21620	Partial removal of sternum	C						
21627	Sternal debridement	C						
21630	Extensive sternum surgery	C						
21632	Extensive sternum surgery	C						
21685	Hyoid myotomy & suspension	T	0252	7.6196	$512.35	$109.16	$102.47	*
21700	Revision of neck muscle	T	0049	22.0149	$1,480.30		$296.06	*
21705	Revision of neck muscle/rib	C						
21720	Revision of neck muscle	T	0049	22.0149	$1,480.30		$296.06	*
21725	Revision of neck muscle	T	0006	1.4557	$97.88		$19.58	*
21740	Reconstruction of sternum	C						
21742	Repair stern/nuss w/o scope	T	0051	46.5786	$3,131.99		$626.40	*
21743	Repair sternum/nuss w/scope	T	0051	46.5786	$3,131.99		$626.40	*
21750	Repair of sternum separation	C						
21800	Treatment of rib fracture	T	0129	1.6576	$111.46		$22.30	*
21805	Treatment of rib fracture	T	0062	25.8446	$1,737.82	$372.87	$347.57	*
21810	Treatment of rib fracture(s)	C						
21820	Treat sternum fracture	T	0129	1.6576	$111.46		$22.30	*
21825	Treat sternum fracture	C						
21899	Neck/chest surgery procedure	T	0250	1.1522	$77.48	$25.10	$15.50	*
21920	Biopsy soft tissue of back	T	0020	8.2028	$551.56		$110.32	*
21925	Biopsy soft tissue of back	T	0022	23.388	$1,572.63	$354.45	$314.53	*
21930	Exc back les sc < 3 cm	T	0021	17.4975	$1,176.55		$235.31	*
21931	Exc back les sc = 3 cm	T	0022	23.388	$1,572.63	$354.45	$314.53	*
21932	Exc back tum deep < 5 cm	T	0021	17.4975	$1,176.55		$235.31	*
21933	Exc back tum deep = 5 cm	T	0022	23.388	$1,572.63	$354.45	$314.53	*
21935	Resect back tum < 5 cm	T	0021	17.4975	$1,176.55		$235.31	*
21936	Resect back tum = 5 cm	T	0022	23.388	$1,572.63	$354.45	$314.53	*
22010	I&d, p-spine, c/t/cerv-thor	C						
22015	I&d, p-spine, l/s/ls	C						
22100	Remove part of neck vertebra	T	0208	49.2256	$3,309.98		$662.00	*
22101	Remove part, thorax vertebra	T	0208	49.2256	$3,309.98		$662.00	*
22102	Remove part, lumbar vertebra	T	0208	49.2256	$3,309.98		$662.00	*
22103	Remove extra spine segment	T	0208	49.2256	$3,309.98		$662.00	*
22110	Remove part of neck vertebra	C						
22112	Remove part, thorax vertebra	C						
22114	Remove part, lumbar vertebra	C						
22116	Remove extra spine segment	C						

22206	Cut spine 3 col, thor	C						
22207	Cut spine 3 col, lumb	C						
22208	Cut spine 3 col, addl seg	C						
22210	Revision of neck spine	C						
22212	Revision of thorax spine	C						
22214	Revision of lumbar spine	C						
22216	Revise, extra spine segment	C						
22220	Revision of neck spine	C						
22222	Revision of thorax spine	T	0208	49.2256	$3,309.98		$662.00	*
22224	Revision of lumbar spine	C						
22226	Revise, extra spine segment	C						
22305	Treat spine process fracture	T	0129	1.6576	$111.46		$22.30	*
22310	Treat spine fracture	T	0138	4.7946	$322.39		$64.48	*
22315	Treat spine fracture	T	0139	18.3962	$1,236.98		$247.40	*
22318	Treat odontoid fx w/o graft	C						
22319	Treat odontoid fx w/graft	C						
22325	Treat spine fracture	C						
22326	Treat neck spine fracture	C						
22327	Treat thorax spine fracture	C						
22328	Treat each add spine fx	C						
22505	Manipulation of spine	T	0045	15.2922	$1,028.26	$268.44	$205.66	*
22520	Percut vertebroplasty thor	T	0050	31.7717	$2,136.36		$427.28	*
22521	Percut vertebroplasty lumb	T	0050	31.7717	$2,136.36		$427.28	*
22522	Percut vertebroplasty addl	T	0050	31.7717	$2,136.36		$427.28	*
22523	Percut kyphoplasty, thor	T	0052	88.6521	$5,961.06		$1,192.22	*
22524	Percut kyphoplasty, lumbar	T	0052	88.6521	$5,961.06		$1,192.22	*
22525	Percut kyphoplasty, add-on	T	0052	88.6521	$5,961.06		$1,192.22	*
22526	Idet, single level	E						
22527	Idet, 1 or more levels	E						
22532	Lat thorax spine fusion	C						
22533	Lat lumbar spine fusion	C						
22534	Lat thor/lumb, addl seg	C						
22548	Neck spine fusion	C						
22554	Neck spine fusion	C						
22556	Thorax spine fusion	C						
22558	Lumbar spine fusion	C						
22585	Additional spinal fusion	C						
22590	Spine & skull spinal fusion	C						
22595	Neck spinal fusion	C						
22600	Neck spine fusion	C						
22610	Thorax spine fusion	C						
22612	Lumbar spine fusion	T	0208	49.2256	$3,309.98		$662.00	*
22614	Spine fusion, extra segment	T	0208	49.2256	$3,309.98		$662.00	*
22630	Lumbar spine fusion	C						
22632	Spine fusion, extra segment	C						
22800	Fusion of spine	C						
22802	Fusion of spine	C						
22804	Fusion of spine	C						
22808	Fusion of spine	C						
22810	Fusion of spine	C						
22812	Fusion of spine	C						
22818	Kyphectomy, 1-2 segments	C						
22819	Kyphectomy, 3 or more	C						
22830	Exploration of spinal fusion	C						
22840	Insert spine fixation device	C						
22841	Insert spine fixation device	C						
22842	Insert spine fixation device	C						
22843	Insert spine fixation device	C						
22844	Insert spine fixation device	C						
22845	Insert spine fixation device	C						
22846	Insert spine fixation device	C						
22847	Insert spine fixation device	C						

22848	Insert pelv fixation device	C						
22849	Reinsert spinal fixation	C						
22850	Remove spine fixation device	C						
22851	Apply spine prosth device	T	0049	22.0149	$1,480.30		$296.06	*
22852	Remove spine fixation device	C						
22855	Remove spine fixation device	C						
22856	Cerv artific diskectomy	C						
22857	Lumbar artif diskectomy	C						
22861	Revise cerv artific disc	C						
22862	Revise lumbar artif disc	C						
22864	Remove cerv artif disc	C						
22865	Remove lumb artif disc	C						
22899	Spine surgery procedure	T	0049	22.0149	$1,480.30		$296.06	*
22900	Exc back tum deep < 5 cm	T	0022	23.388	$1,572.63	$354.45	$314.53	*
22901	Exc back tum deep = 5 cm	T	0022	23.388	$1,572.63	$354.45	$314.53	*
22902	Exc abd les sc < 3 cm	T	0021	17.4975	$1,176.55		$235.31	*
22903	Exc abd les sc > 3 cm	T	0022	23.388	$1,572.63	$354.45	$314.53	*
22904	Resect abd tum < 5 cm	T	0021	17.4975	$1,176.55		$235.31	*
22905	Resect abd tum > 5 cm	T	0022	23.388	$1,572.63	$354.45	$314.53	*
22999	Abdomen surgery procedure	T	0049	22.0149	$1,480.30		$296.06	*
23000	Removal of calcium deposits	T	0021	17.4975	$1,176.55		$235.31	*
23020	Release shoulder joint	T	0051	46.5786	$3,131.99		$626.40	*
23030	Drain shoulder lesion	T	0008	19.4063	$1,304.90		$260.98	*
23031	Drain shoulder bursa	T	0008	19.4063	$1,304.90		$260.98	*
23035	Drain shoulder bone lesion	T	0049	22.0149	$1,480.30		$296.06	*
23040	Exploratory shoulder surgery	T	0050	31.7717	$2,136.36		$427.28	*
23044	Exploratory shoulder surgery	T	0050	31.7717	$2,136.36		$427.28	*
23065	Biopsy shoulder tissues	T	0020	8.2028	$551.56		$110.32	*
23066	Biopsy shoulder tissues	T	0022	23.388	$1,572.63	$354.45	$314.53	*
23071	Exc shoulder les sc > 3 cm	T	0022	23.388	$1,572.63	$354.45	$314.53	*
23073	Exc shoulder tum deep > 5 cm	T	0022	23.388	$1,572.63	$354.45	$314.53	*
23075	Exc shoulder les sc < 3 cm	T	0021	17.4975	$1,176.55		$235.31	*
23076	Exc shoulder tum deep < 5 cm	T	0021	17.4975	$1,176.55		$235.31	*
23077	Resect shoulder tum < 5 cm	T	0021	17.4975	$1,176.55		$235.31	*
23078	Resect shoulder tum > 5 cm	T	0022	23.388	$1,572.63	$354.45	$314.53	*
23100	Biopsy of shoulder joint	T	0049	22.0149	$1,480.30		$296.06	*
23101	Shoulder joint surgery	T	0050	31.7717	$2,136.36		$427.28	*
23105	Remove shoulder joint lining	T	0050	31.7717	$2,136.36		$427.28	*
23106	Incision of collarbone joint	T	0050	31.7717	$2,136.36		$427.28	*
23107	Explore treat shoulder joint	T	0050	31.7717	$2,136.36		$427.28	*
23120	Partial removal, collar bone	T	0050	31.7717	$2,136.36		$427.28	*
23125	Removal of collar bone	T	0050	31.7717	$2,136.36		$427.28	*
23130	Remove shoulder bone, part	T	0051	46.5786	$3,131.99		$626.40	*
23140	Removal of bone lesion	T	0049	22.0149	$1,480.30		$296.06	*
23145	Removal of bone lesion	T	0050	31.7717	$2,136.36		$427.28	*
23146	Removal of bone lesion	T	0050	31.7717	$2,136.36		$427.28	*
23150	Removal of humerus lesion	T	0050	31.7717	$2,136.36		$427.28	*
23155	Removal of humerus lesion	T	0050	31.7717	$2,136.36		$427.28	*
23156	Removal of humerus lesion	T	0050	31.7717	$2,136.36		$427.28	*
23170	Remove collar bone lesion	T	0050	31.7717	$2,136.36		$427.28	*
23172	Remove shoulder blade lesion	T	0050	31.7717	$2,136.36		$427.28	*
23174	Remove humerus lesion	T	0050	31.7717	$2,136.36		$427.28	*
23180	Remove collar bone lesion	T	0050	31.7717	$2,136.36		$427.28	*
23182	Remove shoulder blade lesion	T	0050	31.7717	$2,136.36		$427.28	*
23184	Remove humerus lesion	T	0050	31.7717	$2,136.36		$427.28	*
23190	Partial removal of scapula	T	0050	31.7717	$2,136.36		$427.28	*
23195	Removal of head of humerus	T	0050	31.7717	$2,136.36		$427.28	*
23200	Resect clavicle tumor	C						
23210	Resect scapula tumor	C						
23220	Resect prox humerus tumor	C						
23330	Remove shoulder foreign body	T	0020	8.2028	$551.56		$110.32	*
23331	Remove shoulder foreign body	T	0022	23.388	$1,572.63	$354.45	$314.53	*

23332	Remove shoulder foreign body	C						
23350	Injection for shoulder x-ray	N						
23395	Muscle transfer,shoulder/arm	T	0051	46.5786	$3,131.99		$626.40	*
23397	Muscle transfers	T	0052	88.6521	$5,961.06		$1,192.22	*
23400	Fixation of shoulder blade	T	0050	31.7717	$2,136.36		$427.28	*
23405	Incision of tendon & muscle	T	0050	31.7717	$2,136.36		$427.28	*
23406	Incise tendon(s) & muscle(s)	T	0050	31.7717	$2,136.36		$427.28	*
23410	Repair rotator cuff, acute	T	0051	46.5786	$3,131.99		$626.40	*
23412	Repair rotator cuff, chronic	T	0051	46.5786	$3,131.99		$626.40	*
23415	Release of shoulder ligament	T	0051	46.5786	$3,131.99		$626.40	*
23420	Repair of shoulder	T	0051	46.5786	$3,131.99		$626.40	*
23430	Repair biceps tendon	T	0051	46.5786	$3,131.99		$626.40	*
23440	Remove/transplant tendon	T	0051	46.5786	$3,131.99		$626.40	*
23450	Repair shoulder capsule	T	0052	88.6521	$5,961.06		$1,192.22	*
23455	Repair shoulder capsule	T	0052	88.6521	$5,961.06		$1,192.22	*
23460	Repair shoulder capsule	T	0052	88.6521	$5,961.06		$1,192.22	*
23462	Repair shoulder capsule	T	0051	46.5786	$3,131.99		$626.40	*
23465	Repair shoulder capsule	T	0052	88.6521	$5,961.06		$1,192.22	*
23466	Repair shoulder capsule	T	0051	46.5786	$3,131.99		$626.40	*
23470	Reconstruct shoulder joint	T	0425	118.767	$7,986.01		$1,597.21	*
23472	Reconstruct shoulder joint	C						
23480	Revision of collar bone	T	0051	46.5786	$3,131.99		$626.40	*
23485	Revision of collar bone	T	0052	88.6521	$5,961.06		$1,192.22	*
23490	Reinforce clavicle	T	0051	46.5786	$3,131.99		$626.40	*
23491	Reinforce shoulder bones	T	0052	88.6521	$5,961.06		$1,192.22	*
23500	Treat clavicle fracture	T	0129	1.6576	$111.46		$22.30	*
23505	Treat clavicle fracture	T	0139	18.3962	$1,236.98		$247.40	*
23515	Treat clavicle fracture	T	0064	65.4752	$4,402.62		$880.53	*
23520	Treat clavicle dislocation	T	0138	4.7946	$322.39		$64.48	*
23525	Treat clavicle dislocation	T	0138	4.7946	$322.39		$64.48	*
23530	Treat clavicle dislocation	T	0063	45.4678	$3,057.30		$611.46	*
23532	Treat clavicle dislocation	T	0062	25.8446	$1,737.82	$372.87	$347.57	*
23540	Treat clavicle dislocation	T	0129	1.6576	$111.46		$22.30	*
23545	Treat clavicle dislocation	T	0138	4.7946	$322.39		$64.48	*
23550	Treat clavicle dislocation	T	0063	45.4678	$3,057.30		$611.46	*
23552	Treat clavicle dislocation	T	0063	45.4678	$3,057.30		$611.46	*
23570	Treat shoulder blade fx	T	0129	1.6576	$111.46		$22.30	*
23575	Treat shoulder blade fx	T	0138	4.7946	$322.39		$64.48	*
23585	Treat scapula fracture	T	0064	65.4752	$4,402.62		$880.53	*
23600	Treat humerus fracture	T	0129	1.6576	$111.46		$22.30	*
23605	Treat humerus fracture	T	0139	18.3962	$1,236.98		$247.40	*
23615	Treat humerus fracture	T	0064	65.4752	$4,402.62		$880.53	*
23616	Treat humerus fracture	T	0064	65.4752	$4,402.62		$880.53	*
23620	Treat humerus fracture	T	0129	1.6576	$111.46		$22.30	*
23625	Treat humerus fracture	T	0139	18.3962	$1,236.98		$247.40	*
23630	Treat humerus fracture	T	0064	65.4752	$4,402.62		$880.53	*
23650	Treat shoulder dislocation	T	0129	1.6576	$111.46		$22.30	*
23655	Treat shoulder dislocation	T	0045	15.2922	$1,028.26	$268.44	$205.66	*
23660	Treat shoulder dislocation	T	0063	45.4678	$3,057.30		$611.46	*
23665	Treat dislocation/fracture	T	0138	4.7946	$322.39		$64.48	*
23670	Treat dislocation/fracture	T	0064	65.4752	$4,402.62		$880.53	*
23675	Treat dislocation/fracture	T	0129	1.6576	$111.46		$22.30	*
23680	Treat dislocation/fracture	T	0063	45.4678	$3,057.30		$611.46	*
23700	Fixation of shoulder	T	0045	15.2922	$1,028.26	$268.44	$205.66	*
23800	Fusion of shoulder joint	T	0052	88.6521	$5,961.06		$1,192.22	*
23802	Fusion of shoulder joint	T	0051	46.5786	$3,131.99		$626.40	*
23900	Amputation of arm & girdle	C						
23920	Amputation at shoulder joint	C						
23921	Amputation follow-up surgery	T	0136	16.0542	$1,079.50		$215.90	*
23929	Shoulder surgery procedure	T	0129	1.6576	$111.46		$22.30	*
23930	Drainage of arm lesion	T	0008	19.4063	$1,304.90		$260.98	*
23931	Drainage of arm bursa	T	0008	19.4063	$1,304.90		$260.98	*

23935	Drain arm/elbow bone lesion	T	0049	22.0149	$1,480.30		$296.06	*
24000	Exploratory elbow surgery	T	0050	31.7717	$2,136.36		$427.28	*
24006	Release elbow joint	T	0050	31.7717	$2,136.36		$427.28	*
24065	Biopsy arm/elbow soft tissue	T	0021	17.4975	$1,176.55		$235.31	*
24066	Biopsy arm/elbow soft tissue	T	0021	17.4975	$1,176.55		$235.31	*
24071	Exc arm/elbow les sc = 3 cm	T	0022	23.388	$1,572.63	$354.45	$314.53	*
24073	Ex arm/elbow tum deep > 5 cm	T	0022	23.388	$1,572.63	$354.45	$314.53	*
24075	Exc arm/elbow les sc < 3 cm	T	0021	17.4975	$1,176.55		$235.31	*
24076	Ex arm/elbow tum deep < 5 cm	T	0021	17.4975	$1,176.55		$235.31	*
24077	Resect arm/elbow tum < 5 cm	T	0021	17.4975	$1,176.55		$235.31	*
24079	Resect arm/elbow tum > 5 cm	T	0022	23.388	$1,572.63	$354.45	$314.53	*
24100	Biopsy elbow joint lining	T	0049	22.0149	$1,480.30		$296.06	*
24101	Explore/treat elbow joint	T	0050	31.7717	$2,136.36		$427.28	*
24102	Remove elbow joint lining	T	0050	31.7717	$2,136.36		$427.28	*
24105	Removal of elbow bursa	T	0049	22.0149	$1,480.30		$296.06	*
24110	Remove humerus lesion	T	0049	22.0149	$1,480.30		$296.06	*
24115	Remove/graft bone lesion	T	0050	31.7717	$2,136.36		$427.28	*
24116	Remove/graft bone lesion	T	0050	31.7717	$2,136.36		$427.28	*
24120	Remove elbow lesion	T	0049	22.0149	$1,480.30		$296.06	*
24125	Remove/graft bone lesion	T	0050	31.7717	$2,136.36		$427.28	*
24126	Remove/graft bone lesion	T	0050	31.7717	$2,136.36		$427.28	*
24130	Removal of head of radius	T	0050	31.7717	$2,136.36		$427.28	*
24134	Removal of arm bone lesion	T	0050	31.7717	$2,136.36		$427.28	*
24136	Remove radius bone lesion	T	0050	31.7717	$2,136.36		$427.28	*
24138	Remove elbow bone lesion	T	0050	31.7717	$2,136.36		$427.28	*
24140	Partial removal of arm bone	T	0050	31.7717	$2,136.36		$427.28	*
24145	Partial removal of radius	T	0050	31.7717	$2,136.36		$427.28	*
24147	Partial removal of elbow	T	0050	31.7717	$2,136.36		$427.28	*
24149	Radical resection of elbow	T	0050	31.7717	$2,136.36		$427.28	*
24150	Resect distal humerus tumor	T	0051	46.5786	$3,131.99		$626.40	*
24152	Resect radius tumor	T	0051	46.5786	$3,131.99		$626.40	*
24155	Removal of elbow joint	T	0051	46.5786	$3,131.99		$626.40	*
24160	Remove elbow joint implant	T	0050	31.7717	$2,136.36		$427.28	*
24164	Remove radius head implant	T	0050	31.7717	$2,136.36		$427.28	*
24200	Removal of arm foreign body	T	0019	4.3625	$293.34	$64.35	$58.67	*
24201	Removal of arm foreign body	T	0021	17.4975	$1,176.55		$235.31	*
24220	Injection for elbow x-ray	N						
24300	Manipulate elbow w/anesth	T	0045	15.2922	$1,028.26	$268.44	$205.66	*
24301	Muscle/tendon transfer	T	0050	31.7717	$2,136.36		$427.28	*
24305	Arm tendon lengthening	T	0050	31.7717	$2,136.36		$427.28	*
24310	Revision of arm tendon	T	0049	22.0149	$1,480.30		$296.06	*
24320	Repair of arm tendon	T	0051	46.5786	$3,131.99		$626.40	*
24330	Revision of arm muscles	T	0052	88.6521	$5,961.06		$1,192.22	*
24331	Revision of arm muscles	T	0051	46.5786	$3,131.99		$626.40	*
24332	Tenolysis, triceps	T	0049	22.0149	$1,480.30		$296.06	*
24340	Repair of biceps tendon	T	0051	46.5786	$3,131.99		$626.40	*
24341	Repair arm tendon/muscle	T	0051	46.5786	$3,131.99		$626.40	*
24342	Repair of ruptured tendon	T	0051	46.5786	$3,131.99		$626.40	*
24343	Repr elbow lat ligmnt w/tiss	T	0050	31.7717	$2,136.36		$427.28	*
24344	Reconstruct elbow lat ligmnt	T	0052	88.6521	$5,961.06		$1,192.22	*
24345	Repr elbw med ligmnt w/tissu	T	0050	31.7717	$2,136.36		$427.28	*
24346	Reconstruct elbow med ligmnt	T	0051	46.5786	$3,131.99		$626.40	*
24357	Repair elbow, perc	T	0050	31.7717	$2,136.36		$427.28	*
24358	Repair elbow w/deb, open	T	0050	31.7717	$2,136.36		$427.28	*
24359	Repair elbow deb/attch open	T	0050	31.7717	$2,136.36		$427.28	*
24360	Reconstruct elbow joint	T	0047	39.8877	$2,682.09	$537.03	$536.42	*
24361	Reconstruct elbow joint	T	0425	118.767	$7,986.01		$1,597.21	*
24362	Reconstruct elbow joint	T	0048	58.0838	$3,905.61		$781.13	*
24363	Replace elbow joint	T	0425	118.767	$7,986.01		$1,597.21	*
24365	Reconstruct head of radius	T	0047	39.8877	$2,682.09	$537.03	$536.42	*
24366	Reconstruct head of radius	T	0425	118.767	$7,986.01		$1,597.21	*
24400	Revision of humerus	T	0051	46.5786	$3,131.99		$626.40	*

24410	Revision of humerus	T	0051	46.5786	$3,131.99		$626.40	*
24420	Revision of humerus	T	0051	46.5786	$3,131.99		$626.40	*
24430	Repair of humerus	T	0052	88.6521	$5,961.06		$1,192.22	*
24435	Repair humerus with graft	T	0052	88.6521	$5,961.06		$1,192.22	*
24470	Revision of elbow joint	T	0051	46.5786	$3,131.99		$626.40	*
24495	Decompression of forearm	T	0050	31.7717	$2,136.36		$427.28	*
24498	Reinforce humerus	T	0052	88.6521	$5,961.06		$1,192.22	*
24500	Treat humerus fracture	T	0129	1.6576	$111.46		$22.30	*
24505	Treat humerus fracture	T	0129	1.6576	$111.46		$22.30	*
24515	Treat humerus fracture	T	0064	65.4752	$4,402.62		$880.53	*
24516	Treat humerus fracture	T	0064	65.4752	$4,402.62		$880.53	*
24530	Treat humerus fracture	T	0129	1.6576	$111.46		$22.30	*
24535	Treat humerus fracture	T	0138	4.7946	$322.39		$64.48	*
24538	Treat humerus fracture	T	0062	25.8446	$1,737.82	$372.87	$347.57	*
24545	Treat humerus fracture	T	0064	65.4752	$4,402.62		$880.53	*
24546	Treat humerus fracture	T	0064	65.4752	$4,402.62		$880.53	*
24560	Treat humerus fracture	T	0129	1.6576	$111.46		$22.30	*
24565	Treat humerus fracture	T	0129	1.6576	$111.46		$22.30	*
24566	Treat humerus fracture	T	0062	25.8446	$1,737.82	$372.87	$347.57	*
24575	Treat humerus fracture	T	0064	65.4752	$4,402.62		$880.53	*
24576	Treat humerus fracture	T	0129	1.6576	$111.46		$22.30	*
24577	Treat humerus fracture	T	0138	4.7946	$322.39		$64.48	*
24579	Treat humerus fracture	T	0064	65.4752	$4,402.62		$880.53	*
24582	Treat humerus fracture	T	0062	25.8446	$1,737.82	$372.87	$347.57	*
24586	Treat elbow fracture	T	0064	65.4752	$4,402.62		$880.53	*
24587	Treat elbow fracture	T	0064	65.4752	$4,402.62		$880.53	*
24600	Treat elbow dislocation	T	0129	1.6576	$111.46		$22.30	*
24605	Treat elbow dislocation	T	0045	15.2922	$1,028.26	$268.44	$205.66	*
24615	Treat elbow dislocation	T	0064	65.4752	$4,402.62		$880.53	*
24620	Treat elbow fracture	T	0139	18.3962	$1,236.98		$247.40	*
24635	Treat elbow fracture	T	0064	65.4752	$4,402.62		$880.53	*
24640	Treat elbow dislocation	T	0129	1.6576	$111.46		$22.30	*
24650	Treat radius fracture	T	0129	1.6576	$111.46		$22.30	*
24655	Treat radius fracture	T	0138	4.7946	$322.39		$64.48	*
24665	Treat radius fracture	T	0063	45.4678	$3,057.30		$611.46	*
24666	Treat radius fracture	T	0064	65.4752	$4,402.62		$880.53	*
24670	Treat ulnar fracture	T	0129	1.6576	$111.46		$22.30	*
24675	Treat ulnar fracture	T	0129	1.6576	$111.46		$22.30	*
24685	Treat ulnar fracture	T	0063	45.4678	$3,057.30		$611.46	*
24800	Fusion of elbow joint	T	0051	46.5786	$3,131.99		$626.40	*
24802	Fusion/graft of elbow joint	T	0051	46.5786	$3,131.99		$626.40	*
24900	Amputation of upper arm	C						
24920	Amputation of upper arm	C						
24925	Amputation follow-up surgery	T	0049	22.0149	$1,480.30		$296.06	*
24930	Amputation follow-up surgery	C						
24931	Amputate upper arm & implant	C						
24935	Revision of amputation	T	0052	88.6521	$5,961.06		$1,192.22	*
24940	Revision of upper arm	C						
24999	Upper arm/elbow surgery	T	0129	1.6576	$111.46		$22.30	*
25000	Incision of tendon sheath	T	0049	22.0149	$1,480.30		$296.06	*
25001	Incise flexor carpi radialis	T	0049	22.0149	$1,480.30		$296.06	*
25020	Decompress forearm 1 space	T	0050	31.7717	$2,136.36		$427.28	*
25023	Decompress forearm 1 space	T	0050	31.7717	$2,136.36		$427.28	*
25024	Decompress forearm 2 spaces	T	0050	31.7717	$2,136.36		$427.28	*
25025	Decompress forearm 2 spaces	T	0050	31.7717	$2,136.36		$427.28	*
25028	Drainage of forearm lesion	T	0049	22.0149	$1,480.30		$296.06	*
25031	Drainage of forearm bursa	T	0049	22.0149	$1,480.30		$296.06	*
25035	Treat forearm bone lesion	T	0049	22.0149	$1,480.30		$296.06	*
25040	Explore/treat wrist joint	T	0050	31.7717	$2,136.36		$427.28	*
25065	Biopsy forearm soft tissues	T	0020	8.2028	$551.56		$110.32	*
25066	Biopsy forearm soft tissues	T	0022	23.388	$1,572.63	$354.45	$314.53	*
25071	Exc forearm les sc > 3 cm	T	0022	23.388	$1,572.63	$354.45	$314.53	*

25073	Exc forearm tum deep = 3 cm	T	0022	23.388	$1,572.63	$354.45	$314.53	*
25075	Exc forearm les sc < 3 cm	T	0021	17.4975	$1,176.55		$235.31	*
25076	Exc forearm tum deep < 3 cm	T	0021	17.4975	$1,176.55		$235.31	*
25077	Resect forearm/wrist tum<3cm	T	0021	17.4975	$1,176.55		$235.31	*
25078	Resect forearm/wrist tum=3cm	T	0022	23.388	$1,572.63	$354.45	$314.53	*
25085	Incision of wrist capsule	T	0049	22.0149	$1,480.30		$296.06	*
25100	Biopsy of wrist joint	T	0049	22.0149	$1,480.30		$296.06	*
25101	Explore/treat wrist joint	T	0050	31.7717	$2,136.36		$427.28	*
25105	Remove wrist joint lining	T	0050	31.7717	$2,136.36		$427.28	*
25107	Remove wrist joint cartilage	T	0050	31.7717	$2,136.36		$427.28	*
25109	Excise tendon forearm/wrist	T	0049	22.0149	$1,480.30		$296.06	*
25110	Remove wrist tendon lesion	T	0049	22.0149	$1,480.30		$296.06	*
25111	Remove wrist tendon lesion	T	0049	22.0149	$1,480.30		$296.06	*
25112	Reremove wrist tendon lesion	T	0049	22.0149	$1,480.30		$296.06	*
25115	Remove wrist/forearm lesion	T	0049	22.0149	$1,480.30		$296.06	*
25116	Remove wrist/forearm lesion	T	0049	22.0149	$1,480.30		$296.06	*
25118	Excise wrist tendon sheath	T	0050	31.7717	$2,136.36		$427.28	*
25119	Partial removal of ulna	T	0050	31.7717	$2,136.36		$427.28	*
25120	Removal of forearm lesion	T	0050	31.7717	$2,136.36		$427.28	*
25125	Remove/graft forearm lesion	T	0050	31.7717	$2,136.36		$427.28	*
25126	Remove/graft forearm lesion	T	0050	31.7717	$2,136.36		$427.28	*
25130	Removal of wrist lesion	T	0050	31.7717	$2,136.36		$427.28	*
25135	Remove & graft wrist lesion	T	0050	31.7717	$2,136.36		$427.28	*
25136	Remove & graft wrist lesion	T	0050	31.7717	$2,136.36		$427.28	*
25145	Remove forearm bone lesion	T	0050	31.7717	$2,136.36		$427.28	*
25150	Partial removal of ulna	T	0050	31.7717	$2,136.36		$427.28	*
25151	Partial removal of radius	T	0050	31.7717	$2,136.36		$427.28	*
25170	Resect radius/ulnar tumor	T	0051	46.5786	$3,131.99		$626.40	*
25210	Removal of wrist bone	T	0050	31.7717	$2,136.36		$427.28	*
25215	Removal of wrist bones	T	0050	31.7717	$2,136.36		$427.28	*
25230	Partial removal of radius	T	0050	31.7717	$2,136.36		$427.28	*
25240	Partial removal of ulna	T	0050	31.7717	$2,136.36		$427.28	*
25246	Injection for wrist x-ray	N						
25248	Remove forearm foreign body	T	0049	22.0149	$1,480.30		$296.06	*
25250	Removal of wrist prosthesis	T	0050	31.7717	$2,136.36		$427.28	*
25251	Removal of wrist prosthesis	T	0050	31.7717	$2,136.36		$427.28	*
25259	Manipulate wrist w/anesthes	T	0139	18.3962	$1,236.98		$247.40	*
25260	Repair forearm tendon/muscle	T	0050	31.7717	$2,136.36		$427.28	*
25263	Repair forearm tendon/muscle	T	0050	31.7717	$2,136.36		$427.28	*
25265	Repair forearm tendon/muscle	T	0050	31.7717	$2,136.36		$427.28	*
25270	Repair forearm tendon/muscle	T	0050	31.7717	$2,136.36		$427.28	*
25272	Repair forearm tendon/muscle	T	0050	31.7717	$2,136.36		$427.28	*
25274	Repair forearm tendon/muscle	T	0050	31.7717	$2,136.36		$427.28	*
25275	Repair forearm tendon sheath	T	0050	31.7717	$2,136.36		$427.28	*
25280	Revise wrist/forearm tendon	T	0050	31.7717	$2,136.36		$427.28	*
25290	Incise wrist/forearm tendon	T	0050	31.7717	$2,136.36		$427.28	*
25295	Release wrist/forearm tendon	T	0049	22.0149	$1,480.30		$296.06	*
25300	Fusion of tendons at wrist	T	0050	31.7717	$2,136.36		$427.28	*
25301	Fusion of tendons at wrist	T	0050	31.7717	$2,136.36		$427.28	*
25310	Transplant forearm tendon	T	0051	46.5786	$3,131.99		$626.40	*
25312	Transplant forearm tendon	T	0051	46.5786	$3,131.99		$626.40	*
25315	Revise palsy hand tendon(s)	T	0051	46.5786	$3,131.99		$626.40	*
25316	Revise palsy hand tendon(s)	T	0052	88.6521	$5,961.06		$1,192.22	*
25320	Repair/revise wrist joint	T	0051	46.5786	$3,131.99		$626.40	*
25332	Revise wrist joint	T	0047	39.8877	$2,682.09	$537.03	$536.42	*
25335	Realignment of hand	T	0051	46.5786	$3,131.99		$626.40	*
25337	Reconstruct ulna/radioulnar	T	0051	46.5786	$3,131.99		$626.40	*
25350	Revision of radius	T	0051	46.5786	$3,131.99		$626.40	*
25355	Revision of radius	T	0051	46.5786	$3,131.99		$626.40	*
25360	Revision of ulna	T	0051	46.5786	$3,131.99		$626.40	*
25365	Revise radius & ulna	T	0051	46.5786	$3,131.99		$626.40	*
25370	Revise radius or ulna	T	0051	46.5786	$3,131.99		$626.40	*

25375	Revise radius & ulna	T	0051	46.5786	$3,131.99		$626.40	*
25390	Shorten radius or ulna	T	0051	46.5786	$3,131.99		$626.40	*
25391	Lengthen radius or ulna	T	0051	46.5786	$3,131.99		$626.40	*
25392	Shorten radius & ulna	T	0050	31.7717	$2,136.36		$427.28	*
25393	Lengthen radius & ulna	T	0051	46.5786	$3,131.99		$626.40	*
25394	Repair carpal bone, shorten	T	0051	46.5786	$3,131.99		$626.40	*
25400	Repair radius or ulna	T	0051	46.5786	$3,131.99		$626.40	*
25405	Repair/graft radius or ulna	T	0052	88.6521	$5,961.06		$1,192.22	*
25415	Repair radius & ulna	T	0052	88.6521	$5,961.06		$1,192.22	*
25420	Repair/graft radius & ulna	T	0052	88.6521	$5,961.06		$1,192.22	*
25425	Repair/graft radius or ulna	T	0051	46.5786	$3,131.99		$626.40	*
25426	Repair/graft radius & ulna	T	0051	46.5786	$3,131.99		$626.40	*
25430	Vasc graft into carpal bone	T	0051	46.5786	$3,131.99		$626.40	*
25431	Repair nonunion carpal bone	T	0051	46.5786	$3,131.99		$626.40	*
25440	Repair/graft wrist bone	T	0052	88.6521	$5,961.06		$1,192.22	*
25441	Reconstruct wrist joint	T	0425	118.767	$7,986.01		$1,597.21	*
25442	Reconstruct wrist joint	T	0425	118.767	$7,986.01		$1,597.21	*
25443	Reconstruct wrist joint	T	0048	58.0838	$3,905.61		$781.13	*
25444	Reconstruct wrist joint	T	0048	58.0838	$3,905.61		$781.13	*
25445	Reconstruct wrist joint	T	0048	58.0838	$3,905.61		$781.13	*
25446	Wrist replacement	T	0425	118.767	$7,986.01		$1,597.21	*
25447	Repair wrist joint(s)	T	0047	39.8877	$2,682.09	$537.03	$536.42	*
25449	Remove wrist joint implant	T	0047	39.8877	$2,682.09	$537.03	$536.42	*
25450	Revision of wrist joint	T	0051	46.5786	$3,131.99		$626.40	*
25455	Revision of wrist joint	T	0051	46.5786	$3,131.99		$626.40	*
25490	Reinforce radius	T	0051	46.5786	$3,131.99		$626.40	*
25491	Reinforce ulna	T	0051	46.5786	$3,131.99		$626.40	*
25492	Reinforce radius and ulna	T	0051	46.5786	$3,131.99		$626.40	*
25500	Treat fracture of radius	T	0129	1.6576	$111.46		$22.30	*
25505	Treat fracture of radius	T	0138	4.7946	$322.39		$64.48	*
25515	Treat fracture of radius	T	0063	45.4678	$3,057.30		$611.46	*
25520	Treat fracture of radius	T	0138	4.7946	$322.39		$64.48	*
25525	Treat fracture of radius	T	0063	45.4678	$3,057.30		$611.46	*
25526	Treat fracture of radius	T	0063	45.4678	$3,057.30		$611.46	*
25530	Treat fracture of ulna	T	0129	1.6576	$111.46		$22.30	*
25535	Treat fracture of ulna	T	0129	1.6576	$111.46		$22.30	*
25545	Treat fracture of ulna	T	0063	45.4678	$3,057.30		$611.46	*
25560	Treat fracture radius & ulna	T	0129	1.6576	$111.46		$22.30	*
25565	Treat fracture radius & ulna	T	0138	4.7946	$322.39		$64.48	*
25574	Treat fracture radius & ulna	T	0064	65.4752	$4,402.62		$880.53	*
25575	Treat fracture radius/ulna	T	0064	65.4752	$4,402.62		$880.53	*
25600	Treat fracture radius/ulna	T	0129	1.6576	$111.46		$22.30	*
25605	Treat fracture radius/ulna	T	0138	4.7946	$322.39		$64.48	*
25606	Treat fx distal radial	T	0062	25.8446	$1,737.82	$372.87	$347.57	*
25607	Treat fx rad extra-articul	T	0064	65.4752	$4,402.62		$880.53	*
25608	Treat fx rad intra-articul	T	0064	65.4752	$4,402.62		$880.53	*
25609	Treat fx radial 3+ frag	T	0064	65.4752	$4,402.62		$880.53	*
25622	Treat wrist bone fracture	T	0129	1.6576	$111.46		$22.30	*
25624	Treat wrist bone fracture	T	0138	4.7946	$322.39		$64.48	*
25628	Treat wrist bone fracture	T	0063	45.4678	$3,057.30		$611.46	*
25630	Treat wrist bone fracture	T	0129	1.6576	$111.46		$22.30	*
25635	Treat wrist bone fracture	T	0138	4.7946	$322.39		$64.48	*
25645	Treat wrist bone fracture	T	0063	45.4678	$3,057.30		$611.46	*
25650	Treat wrist bone fracture	T	0129	1.6576	$111.46		$22.30	*
25651	Pin ulnar styloid fracture	T	0062	25.8446	$1,737.82	$372.87	$347.57	*
25652	Treat fracture ulnar styloid	T	0063	45.4678	$3,057.30		$611.46	*
25660	Treat wrist dislocation	T	0129	1.6576	$111.46		$22.30	*
25670	Treat wrist dislocation	T	0062	25.8446	$1,737.82	$372.87	$347.57	*
25671	Pin radioulnar dislocation	T	0062	25.8446	$1,737.82	$372.87	$347.57	*
25675	Treat wrist dislocation	T	0129	1.6576	$111.46		$22.30	*
25676	Treat wrist dislocation	T	0062	25.8446	$1,737.82	$372.87	$347.57	*
25680	Treat wrist fracture	T	0129	1.6576	$111.46		$22.30	*

25685	Treat wrist fracture	T	0062	25.8446	$1,737.82	$372.87	$347.57	*
25690	Treat wrist dislocation	T	0139	18.3962	$1,236.98		$247.40	*
25695	Treat wrist dislocation	T	0062	25.8446	$1,737.82	$372.87	$347.57	*
25800	Fusion of wrist joint	T	0052	88.6521	$5,961.06		$1,192.22	*
25805	Fusion/graft of wrist joint	T	0051	46.5786	$3,131.99		$626.40	*
25810	Fusion/graft of wrist joint	T	0052	88.6521	$5,961.06		$1,192.22	*
25820	Fusion of hand bones	T	0051	46.5786	$3,131.99		$626.40	*
25825	Fuse hand bones with graft	T	0052	88.6521	$5,961.06		$1,192.22	*
25830	Fusion, radioulnar jnt/ulna	T	0052	88.6521	$5,961.06		$1,192.22	*
25900	Amputation of forearm	C						
25905	Amputation of forearm	C						
25907	Amputation follow-up surgery	T	0049	22.0149	$1,480.30		$296.06	*
25909	Amputation follow-up surgery	C						
25915	Amputation of forearm	C						
25920	Amputate hand at wrist	C						
25922	Amputate hand at wrist	T	0049	22.0149	$1,480.30		$296.06	*
25924	Amputation follow-up surgery	C						
25927	Amputation of hand	C						
25929	Amputation follow-up surgery	T	0136	16.0542	$1,079.50		$215.90	*
25931	Amputation follow-up surgery	T	0049	22.0149	$1,480.30		$296.06	*
25999	Forearm or wrist surgery	T	0129	1.6576	$111.46		$22.30	*
26010	Drainage of finger abscess	T	0006	1.4557	$97.88		$19.58	*
26011	Drainage of finger abscess	T	0007	12.6217	$848.70		$169.74	*
26020	Drain hand tendon sheath	T	0053	17.042	$1,145.92	$253.49	$229.19	*
26025	Drainage of palm bursa	T	0053	17.042	$1,145.92	$253.49	$229.19	*
26030	Drainage of palm bursa(s)	T	0053	17.042	$1,145.92	$253.49	$229.19	*
26034	Treat hand bone lesion	T	0053	17.042	$1,145.92	$253.49	$229.19	*
26035	Decompress fingers/hand	T	0053	17.042	$1,145.92	$253.49	$229.19	*
26037	Decompress fingers/hand	T	0053	17.042	$1,145.92	$253.49	$229.19	*
26040	Release palm contracture	T	0054	28.2376	$1,898.72		$379.75	*
26045	Release palm contracture	T	0054	28.2376	$1,898.72		$379.75	*
26055	Incise finger tendon sheath	T	0053	17.042	$1,145.92	$253.49	$229.19	*
26060	Incision of finger tendon	T	0053	17.042	$1,145.92	$253.49	$229.19	*
26070	Explore/treat hand joint	T	0053	17.042	$1,145.92	$253.49	$229.19	*
26075	Explore/treat finger joint	T	0053	17.042	$1,145.92	$253.49	$229.19	*
26080	Explore/treat finger joint	T	0053	17.042	$1,145.92	$253.49	$229.19	*
26100	Biopsy hand joint lining	T	0053	17.042	$1,145.92	$253.49	$229.19	*
26105	Biopsy finger joint lining	T	0053	17.042	$1,145.92	$253.49	$229.19	*
26110	Biopsy finger joint lining	T	0053	17.042	$1,145.92	$253.49	$229.19	*
26111	Exc hand les sc > 1.5 cm	T	0022	23.388	$1,572.63	$354.45	$314.53	*
26113	Exc hand tum deep > 1.5 cm	T	0022	23.388	$1,572.63	$354.45	$314.53	*
26115	Exc hand les sc < 1.5 cm	T	0021	17.4975	$1,176.55		$235.31	*
26116	Exc hand tum deep < 1.5 cm	T	0021	17.4975	$1,176.55		$235.31	*
26117	Exc hand tum ra < 3 cm	T	0021	17.4975	$1,176.55		$235.31	*
26118	Exc hand tum ra > 3 cm	T	0022	23.388	$1,572.63	$354.45	$314.53	*
26121	Release palm contracture	T	0054	28.2376	$1,898.72		$379.75	*
26123	Release palm contracture	T	0054	28.2376	$1,898.72		$379.75	*
26125	Release palm contracture	T	0053	17.042	$1,145.92	$253.49	$229.19	*
26130	Remove wrist joint lining	T	0053	17.042	$1,145.92	$253.49	$229.19	*
26135	Revise finger joint, each	T	0054	28.2376	$1,898.72		$379.75	*
26140	Revise finger joint, each	T	0053	17.042	$1,145.92	$253.49	$229.19	*
26145	Tendon excision, palm/finger	T	0053	17.042	$1,145.92	$253.49	$229.19	*
26160	Remove tendon sheath lesion	T	0053	17.042	$1,145.92	$253.49	$229.19	*
26170	Removal of palm tendon, each	T	0053	17.042	$1,145.92	$253.49	$229.19	*
26180	Removal of finger tendon	T	0053	17.042	$1,145.92	$253.49	$229.19	*
26185	Remove finger bone	T	0053	17.042	$1,145.92	$253.49	$229.19	*
26200	Remove hand bone lesion	T	0053	17.042	$1,145.92	$253.49	$229.19	*
26205	Remove/graft bone lesion	T	0054	28.2376	$1,898.72		$379.75	*
26210	Removal of finger lesion	T	0053	17.042	$1,145.92	$253.49	$229.19	*
26215	Remove/graft finger lesion	T	0053	17.042	$1,145.92	$253.49	$229.19	*
26230	Partial removal of hand bone	T	0053	17.042	$1,145.92	$253.49	$229.19	*
26235	Partial removal, finger bone	T	0053	17.042	$1,145.92	$253.49	$229.19	*

26236	Partial removal, finger bone	T	0053	17.042	$1,145.92	$253.49	$229.19	*
26250	Extensive hand surgery	T	0053	17.042	$1,145.92	$253.49	$229.19	*
26260	Resect prox finger tumor	T	0053	17.042	$1,145.92	$253.49	$229.19	*
26262	Resect distal finger tumor	T	0053	17.042	$1,145.92	$253.49	$229.19	*
26320	Removal of implant from hand	T	0021	17.4975	$1,176.55		$235.31	*
26340	Manipulate finger w/anesth	T	0138	4.7946	$322.39		$64.48	*
26350	Repair finger/hand tendon	T	0054	28.2376	$1,898.72		$379.75	*
26352	Repair/graft hand tendon	T	0054	28.2376	$1,898.72		$379.75	*
26356	Repair finger/hand tendon	T	0054	28.2376	$1,898.72		$379.75	*
26357	Repair finger/hand tendon	T	0054	28.2376	$1,898.72		$379.75	*
26358	Repair/graft hand tendon	T	0054	28.2376	$1,898.72		$379.75	*
26370	Repair finger/hand tendon	T	0054	28.2376	$1,898.72		$379.75	*
26372	Repair/graft hand tendon	T	0054	28.2376	$1,898.72		$379.75	*
26373	Repair finger/hand tendon	T	0054	28.2376	$1,898.72		$379.75	*
26390	Revise hand/finger tendon	T	0054	28.2376	$1,898.72		$379.75	*
26392	Repair/graft hand tendon	T	0054	28.2376	$1,898.72		$379.75	*
26410	Repair hand tendon	T	0053	17.042	$1,145.92	$253.49	$229.19	*
26412	Repair/graft hand tendon	T	0054	28.2376	$1,898.72		$379.75	*
26415	Excision, hand/finger tendon	T	0054	28.2376	$1,898.72		$379.75	*
26416	Graft hand or finger tendon	T	0054	28.2376	$1,898.72		$379.75	*
26418	Repair finger tendon	T	0053	17.042	$1,145.92	$253.49	$229.19	*
26420	Repair/graft finger tendon	T	0054	28.2376	$1,898.72		$379.75	*
26426	Repair finger/hand tendon	T	0054	28.2376	$1,898.72		$379.75	*
26428	Repair/graft finger tendon	T	0054	28.2376	$1,898.72		$379.75	*
26432	Repair finger tendon	T	0053	17.042	$1,145.92	$253.49	$229.19	*
26433	Repair finger tendon	T	0053	17.042	$1,145.92	$253.49	$229.19	*
26434	Repair/graft finger tendon	T	0054	28.2376	$1,898.72		$379.75	*
26437	Realignment of tendons	T	0053	17.042	$1,145.92	$253.49	$229.19	*
26440	Release palm/finger tendon	T	0053	17.042	$1,145.92	$253.49	$229.19	*
26442	Release palm & finger tendon	T	0054	28.2376	$1,898.72		$379.75	*
26445	Release hand/finger tendon	T	0053	17.042	$1,145.92	$253.49	$229.19	*
26449	Release forearm/hand tendon	T	0054	28.2376	$1,898.72		$379.75	*
26450	Incision of palm tendon	T	0053	17.042	$1,145.92	$253.49	$229.19	*
26455	Incision of finger tendon	T	0053	17.042	$1,145.92	$253.49	$229.19	*
26460	Incise hand/finger tendon	T	0053	17.042	$1,145.92	$253.49	$229.19	*
26471	Fusion of finger tendons	T	0053	17.042	$1,145.92	$253.49	$229.19	*
26474	Fusion of finger tendons	T	0053	17.042	$1,145.92	$253.49	$229.19	*
26476	Tendon lengthening	T	0053	17.042	$1,145.92	$253.49	$229.19	*
26477	Tendon shortening	T	0053	17.042	$1,145.92	$253.49	$229.19	*
26478	Lengthening of hand tendon	T	0053	17.042	$1,145.92	$253.49	$229.19	*
26479	Shortening of hand tendon	T	0053	17.042	$1,145.92	$253.49	$229.19	*
26480	Transplant hand tendon	T	0054	28.2376	$1,898.72		$379.75	*
26483	Transplant/graft hand tendon	T	0054	28.2376	$1,898.72		$379.75	*
26485	Transplant palm tendon	T	0054	28.2376	$1,898.72		$379.75	*
26489	Transplant/graft palm tendon	T	0054	28.2376	$1,898.72		$379.75	*
26490	Revise thumb tendon	T	0054	28.2376	$1,898.72		$379.75	*
26492	Tendon transfer with graft	T	0054	28.2376	$1,898.72		$379.75	*
26494	Hand tendon/muscle transfer	T	0054	28.2376	$1,898.72		$379.75	*
26496	Revise thumb tendon	T	0054	28.2376	$1,898.72		$379.75	*
26497	Finger tendon transfer	T	0054	28.2376	$1,898.72		$379.75	*
26498	Finger tendon transfer	T	0054	28.2376	$1,898.72		$379.75	*
26499	Revision of finger	T	0054	28.2376	$1,898.72		$379.75	*
26500	Hand tendon reconstruction	T	0053	17.042	$1,145.92	$253.49	$229.19	*
26502	Hand tendon reconstruction	T	0054	28.2376	$1,898.72		$379.75	*
26508	Release thumb contracture	T	0053	17.042	$1,145.92	$253.49	$229.19	*
26510	Thumb tendon transfer	T	0054	28.2376	$1,898.72		$379.75	*
26516	Fusion of knuckle joint	T	0054	28.2376	$1,898.72		$379.75	*
26517	Fusion of knuckle joints	T	0054	28.2376	$1,898.72		$379.75	*
26518	Fusion of knuckle joints	T	0054	28.2376	$1,898.72		$379.75	*
26520	Release knuckle contracture	T	0053	17.042	$1,145.92	$253.49	$229.19	*
26525	Release finger contracture	T	0053	17.042	$1,145.92	$253.49	$229.19	*
26530	Revise knuckle joint	T	0047	39.8877	$2,682.09	$537.03	$536.42	*

26531	Revise knuckle with implant	T	0048	58.0838	$3,905.61		$781.13	*
26535	Revise finger joint	T	0047	39.8877	$2,682.09	$537.03	$536.42	*
26536	Revise/implant finger joint	T	0048	58.0838	$3,905.61		$781.13	*
26540	Repair hand joint	T	0053	17.042	$1,145.92	$253.49	$229.19	*
26541	Repair hand joint with graft	T	0054	28.2376	$1,898.72		$379.75	*
26542	Repair hand joint with graft	T	0053	17.042	$1,145.92	$253.49	$229.19	*
26545	Reconstruct finger joint	T	0054	28.2376	$1,898.72		$379.75	*
26546	Repair nonunion hand	T	0054	28.2376	$1,898.72		$379.75	*
26548	Reconstruct finger joint	T	0054	28.2376	$1,898.72		$379.75	*
26550	Construct thumb replacement	T	0054	28.2376	$1,898.72		$379.75	*
26551	Great toe-hand transfer	C						
26553	Single transfer, toe-hand	C						
26554	Double transfer, toe-hand	C						
26555	Positional change of finger	T	0054	28.2376	$1,898.72		$379.75	*
26556	Toe joint transfer	C						
26560	Repair of web finger	T	0053	17.042	$1,145.92	$253.49	$229.19	*
26561	Repair of web finger	T	0054	28.2376	$1,898.72		$379.75	*
26562	Repair of web finger	T	0054	28.2376	$1,898.72		$379.75	*
26565	Correct metacarpal flaw	T	0054	28.2376	$1,898.72		$379.75	*
26567	Correct finger deformity	T	0054	28.2376	$1,898.72		$379.75	*
26568	Lengthen metacarpal/finger	T	0054	28.2376	$1,898.72		$379.75	*
26580	Repair hand deformity	T	0053	17.042	$1,145.92	$253.49	$229.19	*
26587	Reconstruct extra finger	T	0053	17.042	$1,145.92	$253.49	$229.19	*
26590	Repair finger deformity	T	0053	17.042	$1,145.92	$253.49	$229.19	*
26591	Repair muscles of hand	T	0054	28.2376	$1,898.72		$379.75	*
26593	Release muscles of hand	T	0053	17.042	$1,145.92	$253.49	$229.19	*
26596	Excision constricting tissue	T	0053	17.042	$1,145.92	$253.49	$229.19	*
26600	Treat metacarpal fracture	T	0129	1.6576	$111.46		$22.30	*
26605	Treat metacarpal fracture	T	0129	1.6576	$111.46		$22.30	*
26607	Treat metacarpal fracture	T	0139	18.3962	$1,236.98		$247.40	*
26608	Treat metacarpal fracture	T	0062	25.8446	$1,737.82	$372.87	$347.57	*
26615	Treat metacarpal fracture	T	0063	45.4678	$3,057.30		$611.46	*
26641	Treat thumb dislocation	T	0129	1.6576	$111.46		$22.30	*
26645	Treat thumb fracture	T	0138	4.7946	$322.39		$64.48	*
26650	Treat thumb fracture	T	0062	25.8446	$1,737.82	$372.87	$347.57	*
26665	Treat thumb fracture	T	0063	45.4678	$3,057.30		$611.46	*
26670	Treat hand dislocation	T	0129	1.6576	$111.46		$22.30	*
26675	Treat hand dislocation	T	0138	4.7946	$322.39		$64.48	*
26676	Pin hand dislocation	T	0062	25.8446	$1,737.82	$372.87	$347.57	*
26685	Treat hand dislocation	T	0062	25.8446	$1,737.82	$372.87	$347.57	*
26686	Treat hand dislocation	T	0064	65.4752	$4,402.62		$880.53	*
26700	Treat knuckle dislocation	T	0129	1.6576	$111.46		$22.30	*
26705	Treat knuckle dislocation	T	0129	1.6576	$111.46		$22.30	*
26706	Pin knuckle dislocation	T	0139	18.3962	$1,236.98		$247.40	*
26715	Treat knuckle dislocation	T	0062	25.8446	$1,737.82	$372.87	$347.57	*
26720	Treat finger fracture, each	T	0129	1.6576	$111.46		$22.30	*
26725	Treat finger fracture, each	T	0129	1.6576	$111.46		$22.30	*
26727	Treat finger fracture, each	T	0062	25.8446	$1,737.82	$372.87	$347.57	*
26735	Treat finger fracture, each	T	0062	25.8446	$1,737.82	$372.87	$347.57	*
26740	Treat finger fracture, each	T	0129	1.6576	$111.46		$22.30	*
26742	Treat finger fracture, each	T	0129	1.6576	$111.46		$22.30	*
26746	Treat finger fracture, each	T	0062	25.8446	$1,737.82	$372.87	$347.57	*
26750	Treat finger fracture, each	T	0129	1.6576	$111.46		$22.30	*
26755	Treat finger fracture, each	T	0129	1.6576	$111.46		$22.30	*
26756	Pin finger fracture, each	T	0062	25.8446	$1,737.82	$372.87	$347.57	*
26765	Treat finger fracture, each	T	0062	25.8446	$1,737.82	$372.87	$347.57	*
26770	Treat finger dislocation	T	0129	1.6576	$111.46		$22.30	*
26775	Treat finger dislocation	T	0045	15.2922	$1,028.26	$268.44	$205.66	*
26776	Pin finger dislocation	T	0062	25.8446	$1,737.82	$372.87	$347.57	*
26785	Treat finger dislocation	T	0062	25.8446	$1,737.82	$372.87	$347.57	*
26820	Thumb fusion with graft	T	0054	28.2376	$1,898.72		$379.75	*
26841	Fusion of thumb	T	0054	28.2376	$1,898.72		$379.75	*

26842	Thumb fusion with graft	T	0054	28.2376	$1,898.72		$379.75	*
26843	Fusion of hand joint	T	0054	28.2376	$1,898.72		$379.75	*
26844	Fusion/graft of hand joint	T	0054	28.2376	$1,898.72		$379.75	*
26850	Fusion of knuckle	T	0054	28.2376	$1,898.72		$379.75	*
26852	Fusion of knuckle with graft	T	0054	28.2376	$1,898.72		$379.75	*
26860	Fusion of finger joint	T	0054	28.2376	$1,898.72		$379.75	*
26861	Fusion of finger jnt, add-on	T	0054	28.2376	$1,898.72		$379.75	*
26862	Fusion/graft of finger joint	T	0054	28.2376	$1,898.72		$379.75	*
26863	Fuse/graft added joint	T	0054	28.2376	$1,898.72		$379.75	*
26910	Amputate metacarpal bone	T	0054	28.2376	$1,898.72		$379.75	*
26951	Amputation of finger/thumb	T	0053	17.042	$1,145.92	$253.49	$229.19	*
26952	Amputation of finger/thumb	T	0053	17.042	$1,145.92	$253.49	$229.19	*
26989	Hand/finger surgery	T	0129	1.6576	$111.46		$22.30	*
26990	Drainage of pelvis lesion	T	0049	22.0149	$1,480.30		$296.06	*
26991	Drainage of pelvis bursa	T	0049	22.0149	$1,480.30		$296.06	*
26992	Drainage of bone lesion	C						
27000	Incision of hip tendon	T	0049	22.0149	$1,480.30		$296.06	*
27001	Incision of hip tendon	T	0050	31.7717	$2,136.36		$427.28	*
27003	Incision of hip tendon	T	0050	31.7717	$2,136.36		$427.28	*
27005	Incision of hip tendon	C						
27006	Incision of hip tendons	T	0050	31.7717	$2,136.36		$427.28	*
27025	Incision of hip/thigh fascia	C						
27027	Buttock fasciotomy	T	0049	22.0149	$1,480.30		$296.06	*
27030	Drainage of hip joint	C						
27033	Exploration of hip joint	T	0051	46.5786	$3,131.99		$626.40	*
27035	Denervation of hip joint	T	0051	46.5786	$3,131.99		$626.40	*
27036	Excision of hip joint/muscle	C						
27040	Biopsy of soft tissues	T	0020	8.2028	$551.56		$110.32	*
27041	Biopsy of soft tissues	T	0020	8.2028	$551.56		$110.32	*
27043	Exc hip pelvis les sc > 3 cm	T	0022	23.388	$1,572.63	$354.45	$314.53	*
27045	Exc hip/pelv tum deep > 5 cm	T	0022	23.388	$1,572.63	$354.45	$314.53	*
27047	Exc hip/pelvis les sc < 3 cm	T	0021	17.4975	$1,176.55		$235.31	*
27048	Exc hip/pelv tum deep < 5 cm	T	0021	17.4975	$1,176.55		$235.31	*
27049	Resect hip/pelv tum < 5 cm	T	0021	17.4975	$1,176.55		$235.31	*
27050	Biopsy of sacroiliac joint	T	0049	22.0149	$1,480.30		$296.06	*
27052	Biopsy of hip joint	T	0049	22.0149	$1,480.30		$296.06	*
27054	Removal of hip joint lining	C						
27057	Buttock fasciotomy w/dbrdmt	T	0049	22.0149	$1,480.30		$296.06	*
27059	Resect hip/pelv tum > 5 cm	T	0022	23.388	$1,572.63	$354.45	$314.53	*
27060	Removal of ischial bursa	T	0049	22.0149	$1,480.30		$296.06	*
27062	Remove femur lesion/bursa	T	0049	22.0149	$1,480.30		$296.06	*
27065	Removal of hip bone lesion	T	0049	22.0149	$1,480.30		$296.06	*
27066	Removal of hip bone lesion	T	0050	31.7717	$2,136.36		$427.28	*
27067	Remove/graft hip bone lesion	T	0050	31.7717	$2,136.36		$427.28	*
27070	Partial removal of hip bone	C						
27071	Partial removal of hip bone	C						
27075	Resect hip tumor	C						
27076	Resect hip tum incl acetabul	C						
27077	Resect hip tum w/innom bone	C						
27078	Rsect hip tum incl femur	C						
27080	Removal of tail bone	T	0050	31.7717	$2,136.36		$427.28	*
27086	Remove hip foreign body	T	0020	8.2028	$551.56		$110.32	*
27087	Remove hip foreign body	T	0049	22.0149	$1,480.30		$296.06	*
27090	Removal of hip prosthesis	C						
27091	Removal of hip prosthesis	C						
27093	Injection for hip x-ray	N						
27095	Injection for hip x-ray	N						
27096	Inject sacroiliac joint	B						
27097	Revision of hip tendon	T	0050	31.7717	$2,136.36		$427.28	*
27098	Transfer tendon to pelvis	T	0050	31.7717	$2,136.36		$427.28	*
27100	Transfer of abdominal muscle	T	0051	46.5786	$3,131.99		$626.40	*
27105	Transfer of spinal muscle	T	0051	46.5786	$3,131.99		$626.40	*

27110	Transfer of iliopsoas muscle	T	0051	46.5786	$3,131.99		$626.40	*
27111	Transfer of iliopsoas muscle	T	0051	46.5786	$3,131.99		$626.40	*
27120	Reconstruction of hip socket	C						
27122	Reconstruction of hip socket	C						
27125	Partial hip replacement	C						
27130	Total hip arthroplasty	C						
27132	Total hip arthroplasty	C						
27134	Revise hip joint replacement	C						
27137	Revise hip joint replacement	C						
27138	Revise hip joint replacement	C						
27140	Transplant femur ridge	C						
27146	Incision of hip bone	C						
27147	Revision of hip bone	C						
27151	Incision of hip bones	C						
27156	Revision of hip bones	C						
27158	Revision of pelvis	C						
27161	Incision of neck of femur	C						
27165	Incision/fixation of femur	C						
27170	Repair/graft femur head/neck	C						
27175	Treat slipped epiphysis	C						
27176	Treat slipped epiphysis	C						
27177	Treat slipped epiphysis	C						
27178	Treat slipped epiphysis	C						
27179	Revise head/neck of femur	T	0052	88.6521	$5,961.06		$1,192.22	*
27181	Treat slipped epiphysis	C						
27185	Revision of femur epiphysis	C						
27187	Reinforce hip bones	C						
27193	Treat pelvic ring fracture	T	0129	1.6576	$111.46		$22.30	*
27194	Treat pelvic ring fracture	T	0045	15.2922	$1,028.26	$268.44	$205.66	*
27200	Treat tail bone fracture	T	0129	1.6576	$111.46		$22.30	*
27202	Treat tail bone fracture	T	0063	45.4678	$3,057.30		$611.46	*
27215	Treat pelvic fracture(s)	E						
27216	Treat pelvic ring fracture	E						
27217	Treat pelvic ring fracture	E						
27218	Treat pelvic ring fracture	E						
27220	Treat hip socket fracture	T	0129	1.6576	$111.46		$22.30	*
27222	Treat hip socket fracture	C						
27226	Treat hip wall fracture	C						
27227	Treat hip fracture(s)	C						
27228	Treat hip fracture(s)	C						
27230	Treat thigh fracture	T	0129	1.6576	$111.46		$22.30	*
27232	Treat thigh fracture	C						
27235	Treat thigh fracture	T	0050	31.7717	$2,136.36		$427.28	*
27236	Treat thigh fracture	C						
27238	Treat thigh fracture	T	0138	4.7946	$322.39		$64.48	*
27240	Treat thigh fracture	C						
27244	Treat thigh fracture	C						
27245	Treat thigh fracture	C						
27246	Treat thigh fracture	T	0138	4.7946	$322.39		$64.48	*
27248	Treat thigh fracture	C						
27250	Treat hip dislocation	T	0129	1.6576	$111.46		$22.30	*
27252	Treat hip dislocation	T	0045	15.2922	$1,028.26	$268.44	$205.66	*
27253	Treat hip dislocation	C						
27254	Treat hip dislocation	C						
27256	Treat hip dislocation	T	0129	1.6576	$111.46		$22.30	*
27257	Treat hip dislocation	T	0045	15.2922	$1,028.26	$268.44	$205.66	*
27258	Treat hip dislocation	C						
27259	Treat hip dislocation	C						
27265	Treat hip dislocation	T	0129	1.6576	$111.46		$22.30	*
27266	Treat hip dislocation	T	0045	15.2922	$1,028.26	$268.44	$205.66	*
27267	Cltx thigh fx	T	0129	1.6576	$111.46		$22.30	*
27268	Cltx thigh fx w/mnpj	C						

27269	Optx thigh fx	C						
27275	Manipulation of hip joint	T	0045	15.2922	$1,028.26	$268.44	$205.66	*
27280	Fusion of sacroiliac joint	C						
27282	Fusion of pubic bones	C						
27284	Fusion of hip joint	C						
27286	Fusion of hip joint	C						
27290	Amputation of leg at hip	C						
27295	Amputation of leg at hip	C						
27299	Pelvis/hip joint surgery	T	0129	1.6576	$111.46		$22.30	*
27301	Drain thigh/knee lesion	T	0008	19.4063	$1,304.90		$260.98	*
27303	Drainage of bone lesion	C						
27305	Incise thigh tendon & fascia	T	0049	22.0149	$1,480.30		$296.06	*
27306	Incision of thigh tendon	T	0049	22.0149	$1,480.30		$296.06	*
27307	Incision of thigh tendons	T	0049	22.0149	$1,480.30		$296.06	*
27310	Exploration of knee joint	T	0050	31.7717	$2,136.36		$427.28	*
27323	Biopsy, thigh soft tissues	T	0020	8.2028	$551.56		$110.32	*
27324	Biopsy, thigh soft tissues	T	0022	23.388	$1,572.63	$354.45	$314.53	*
27325	Neurectomy, hamstring	T	0220	18.72	$1,258.75		$251.75	*
27326	Neurectomy, popliteal	T	0220	18.72	$1,258.75		$251.75	*
27327	Exc thigh/knee les sc < 3 cm	T	0022	23.388	$1,572.63	$354.45	$314.53	*
27328	Exc thigh/knee tum deep <5cm	T	0021	17.4975	$1,176.55		$235.31	*
27329	Resect thigh/knee tum < 5 cm	T	0021	17.4975	$1,176.55		$235.31	*
27330	Biopsy, knee joint lining	T	0050	31.7717	$2,136.36		$427.28	*
27331	Explore/treat knee joint	T	0050	31.7717	$2,136.36		$427.28	*
27332	Removal of knee cartilage	T	0050	31.7717	$2,136.36		$427.28	*
27333	Removal of knee cartilage	T	0050	31.7717	$2,136.36		$427.28	*
27334	Remove knee joint lining	T	0050	31.7717	$2,136.36		$427.28	*
27335	Remove knee joint lining	T	0050	31.7717	$2,136.36		$427.28	*
27337	Exc thigh/knee les sc > 3 cm	T	0022	23.388	$1,572.63	$354.45	$314.53	*
27339	Exc thigh/knee tum deep >5cm	T	0022	23.388	$1,572.63	$354.45	$314.53	*
27340	Removal of kneecap bursa	T	0049	22.0149	$1,480.30		$296.06	*
27345	Removal of knee cyst	T	0049	22.0149	$1,480.30		$296.06	*
27347	Remove knee cyst	T	0049	22.0149	$1,480.30		$296.06	*
27350	Removal of kneecap	T	0050	31.7717	$2,136.36		$427.28	*
27355	Remove femur lesion	T	0050	31.7717	$2,136.36		$427.28	*
27356	Remove femur lesion/graft	T	0050	31.7717	$2,136.36		$427.28	*
27357	Remove femur lesion/graft	T	0050	31.7717	$2,136.36		$427.28	*
27358	Remove femur lesion/fixation	T	0050	31.7717	$2,136.36		$427.28	*
27360	Partial removal, leg bone(s)	T	0050	31.7717	$2,136.36		$427.28	*
27364	Resect thigh/knee tum >5 cm	T	0022	23.388	$1,572.63	$354.45	$314.53	*
27365	Resect femur/knee tumor	C						
27370	Injection for knee x-ray	N						
27372	Removal of foreign body	T	0022	23.388	$1,572.63	$354.45	$314.53	*
27380	Repair of kneecap tendon	T	0049	22.0149	$1,480.30		$296.06	*
27381	Repair/graft kneecap tendon	T	0049	22.0149	$1,480.30		$296.06	*
27385	Repair of thigh muscle	T	0049	22.0149	$1,480.30		$296.06	*
27386	Repair/graft of thigh muscle	T	0049	22.0149	$1,480.30		$296.06	*
27390	Incision of thigh tendon	T	0049	22.0149	$1,480.30		$296.06	*
27391	Incision of thigh tendons	T	0049	22.0149	$1,480.30		$296.06	*
27392	Incision of thigh tendons	T	0049	22.0149	$1,480.30		$296.06	*
27393	Lengthening of thigh tendon	T	0050	31.7717	$2,136.36		$427.28	*
27394	Lengthening of thigh tendons	T	0050	31.7717	$2,136.36		$427.28	*
27395	Lengthening of thigh tendons	T	0051	46.5786	$3,131.99		$626.40	*
27396	Transplant of thigh tendon	T	0050	31.7717	$2,136.36		$427.28	*
27397	Transplants of thigh tendons	T	0051	46.5786	$3,131.99		$626.40	*
27400	Revise thigh muscles/tendons	T	0051	46.5786	$3,131.99		$626.40	*
27403	Repair of knee cartilage	T	0050	31.7717	$2,136.36		$427.28	*
27405	Repair of knee ligament	T	0051	46.5786	$3,131.99		$626.40	*
27407	Repair of knee ligament	T	0052	88.6521	$5,961.06		$1,192.22	*
27409	Repair of knee ligaments	T	0051	46.5786	$3,131.99		$626.40	*
27412	Autochondrocyte implant knee	T	0052	88.6521	$5,961.06		$1,192.22	*
27415	Osteochondral knee allograft	T	0052	88.6521	$5,961.06		$1,192.22	*

27416	Osteochondral knee autograft	T	0051	46.5786	$3,131.99		$626.40	*
27418	Repair degenerated kneecap	T	0051	46.5786	$3,131.99		$626.40	*
27420	Revision of unstable kneecap	T	0051	46.5786	$3,131.99		$626.40	*
27422	Revision of unstable kneecap	T	0051	46.5786	$3,131.99		$626.40	*
27424	Revision/removal of kneecap	T	0051	46.5786	$3,131.99		$626.40	*
27425	Lat retinacular release open	T	0050	31.7717	$2,136.36		$427.28	*
27427	Reconstruction, knee	T	0051	46.5786	$3,131.99		$626.40	*
27428	Reconstruction, knee	T	0052	88.6521	$5,961.06		$1,192.22	*
27429	Reconstruction, knee	T	0052	88.6521	$5,961.06		$1,192.22	*
27430	Revision of thigh muscles	T	0051	46.5786	$3,131.99		$626.40	*
27435	Incision of knee joint	T	0051	46.5786	$3,131.99		$626.40	*
27437	Revise kneecap	T	0047	39.8877	$2,682.09	$537.03	$536.42	*
27438	Revise kneecap with implant	T	0048	58.0838	$3,905.61		$781.13	*
27440	Revision of knee joint	T	0047	39.8877	$2,682.09	$537.03	$536.42	*
27441	Revision of knee joint	T	0047	39.8877	$2,682.09	$537.03	$536.42	*
27442	Revision of knee joint	T	0047	39.8877	$2,682.09	$537.03	$536.42	*
27443	Revision of knee joint	T	0047	39.8877	$2,682.09	$537.03	$536.42	*
27445	Revision of knee joint	C						
27446	Revision of knee joint	T	0425	118.767	$7,986.01		$1,597.21	*
27447	Total knee arthroplasty	C						
27448	Incision of thigh	C						
27450	Incision of thigh	C						
27454	Realignment of thigh bone	C						
27455	Realignment of knee	C						
27457	Realignment of knee	C						
27465	Shortening of thigh bone	C						
27466	Lengthening of thigh bone	C						
27468	Shorten/lengthen thighs	C						
27470	Repair of thigh	C						
27472	Repair/graft of thigh	C						
27475	Surgery to stop leg growth	T	0050	31.7717	$2,136.36		$427.28	*
27477	Surgery to stop leg growth	C						
27479	Surgery to stop leg growth	T	0050	31.7717	$2,136.36		$427.28	*
27485	Surgery to stop leg growth	C						
27486	Revise/replace knee joint	C						
27487	Revise/replace knee joint	C						
27488	Removal of knee prosthesis	C						
27495	Reinforce thigh	C						
27496	Decompression of thigh/knee	T	0050	31.7717	$2,136.36		$427.28	*
27497	Decompression of thigh/knee	T	0049	22.0149	$1,480.30		$296.06	*
27498	Decompression of thigh/knee	T	0050	31.7717	$2,136.36		$427.28	*
27499	Decompression of thigh/knee	T	0050	31.7717	$2,136.36		$427.28	*
27500	Treatment of thigh fracture	T	0138	4.7946	$322.39		$64.48	*
27501	Treatment of thigh fracture	T	0129	1.6576	$111.46		$22.30	*
27502	Treatment of thigh fracture	T	0139	18.3962	$1,236.98		$247.40	*
27503	Treatment of thigh fracture	T	0129	1.6576	$111.46		$22.30	*
27506	Treatment of thigh fracture	C						
27507	Treatment of thigh fracture	C						
27508	Treatment of thigh fracture	T	0129	1.6576	$111.46		$22.30	*
27509	Treatment of thigh fracture	T	0062	25.8446	$1,737.82	$372.87	$347.57	*
27510	Treatment of thigh fracture	T	0138	4.7946	$322.39		$64.48	*
27511	Treatment of thigh fracture	C						
27513	Treatment of thigh fracture	C						
27514	Treatment of thigh fracture	C						
27516	Treat thigh fx growth plate	T	0129	1.6576	$111.46		$22.30	*
27517	Treat thigh fx growth plate	T	0129	1.6576	$111.46		$22.30	*
27519	Treat thigh fx growth plate	C						
27520	Treat kneecap fracture	T	0129	1.6576	$111.46		$22.30	*
27524	Treat kneecap fracture	T	0063	45.4678	$3,057.30		$611.46	*
27530	Treat knee fracture	T	0129	1.6576	$111.46		$22.30	*
27532	Treat knee fracture	T	0139	18.3962	$1,236.98		$247.40	*
27535	Treat knee fracture	C						

27536	Treat knee fracture	C						
27538	Treat knee fracture(s)	T	0129	1.6576	$111.46		$22.30	*
27540	Treat knee fracture	C						
27550	Treat knee dislocation	T	0129	1.6576	$111.46		$22.30	*
27552	Treat knee dislocation	T	0045	15.2922	$1,028.26	$268.44	$205.66	*
27556	Treat knee dislocation	C						
27557	Treat knee dislocation	C						
27558	Treat knee dislocation	C						
27560	Treat kneecap dislocation	T	0129	1.6576	$111.46		$22.30	*
27562	Treat kneecap dislocation	T	0045	15.2922	$1,028.26	$268.44	$205.66	*
27566	Treat kneecap dislocation	T	0063	45.4678	$3,057.30		$611.46	*
27570	Fixation of knee joint	T	0045	15.2922	$1,028.26	$268.44	$205.66	*
27580	Fusion of knee	C						
27590	Amputate leg at thigh	C						
27591	Amputate leg at thigh	C						
27592	Amputate leg at thigh	C						
27594	Amputation follow-up surgery	T	0049	22.0149	$1,480.30		$296.06	*
27596	Amputation follow-up surgery	C						
27598	Amputate lower leg at knee	C						
27599	Leg surgery procedure	T	0129	1.6576	$111.46		$22.30	*
27600	Decompression of lower leg	T	0049	22.0149	$1,480.30		$296.06	*
27601	Decompression of lower leg	T	0049	22.0149	$1,480.30		$296.06	*
27602	Decompression of lower leg	T	0049	22.0149	$1,480.30		$296.06	*
27603	Drain lower leg lesion	T	0008	19.4063	$1,304.90		$260.98	*
27604	Drain lower leg bursa	T	0049	22.0149	$1,480.30		$296.06	*
27605	Incision of achilles tendon	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
27606	Incision of achilles tendon	T	0049	22.0149	$1,480.30		$296.06	*
27607	Treat lower leg bone lesion	T	0049	22.0149	$1,480.30		$296.06	*
27610	Explore/treat ankle joint	T	0050	31.7717	$2,136.36		$427.28	*
27612	Exploration of ankle joint	T	0050	31.7717	$2,136.36		$427.28	*
27613	Biopsy lower leg soft tissue	T	0020	8.2028	$551.56		$110.32	*
27614	Biopsy lower leg soft tissue	T	0022	23.388	$1,572.63	$354.45	$314.53	*
27615	Resect leg/ankle tum < 5 cm	T	0021	17.4975	$1,176.55		$235.31	*
27616	Resect leg/ankle tum > 5 cm	T	0022	23.388	$1,572.63	$354.45	$314.53	*
27618	Exc leg/ankle tum < 3 cm	T	0021	17.4975	$1,176.55		$235.31	*
27619	Exc leg/ankle tum deep <5 cm	T	0021	17.4975	$1,176.55		$235.31	*
27620	Explore/treat ankle joint	T	0050	31.7717	$2,136.36		$427.28	*
27625	Remove ankle joint lining	T	0050	31.7717	$2,136.36		$427.28	*
27626	Remove ankle joint lining	T	0050	31.7717	$2,136.36		$427.28	*
27630	Removal of tendon lesion	T	0049	22.0149	$1,480.30		$296.06	*
27632	Exc leg/ankle les sc > 3 cm	T	0022	23.388	$1,572.63	$354.45	$314.53	*
27634	Exc leg/ankle tum deep >5 cm	T	0022	23.388	$1,572.63	$354.45	$314.53	*
27635	Remove lower leg bone lesion	T	0050	31.7717	$2,136.36		$427.28	*
27637	Remove/graft leg bone lesion	T	0050	31.7717	$2,136.36		$427.28	*
27638	Remove/graft leg bone lesion	T	0050	31.7717	$2,136.36		$427.28	*
27640	Partial removal of tibia	T	0051	46.5786	$3,131.99		$626.40	*
27641	Partial removal of fibula	T	0050	31.7717	$2,136.36		$427.28	*
27645	Resect tibia tumor	C						
27646	Resect fibula tumor	C						
27647	Resect talus/calcaneus tum	T	0051	46.5786	$3,131.99		$626.40	*
27648	Injection for ankle x-ray	N						
27650	Repair achilles tendon	T	0051	46.5786	$3,131.99		$626.40	*
27652	Repair/graft achilles tendon	T	0052	88.6521	$5,961.06		$1,192.22	*
27654	Repair of achilles tendon	T	0051	46.5786	$3,131.99		$626.40	*
27656	Repair leg fascia defect	T	0049	22.0149	$1,480.30		$296.06	*
27658	Repair of leg tendon, each	T	0049	22.0149	$1,480.30		$296.06	*
27659	Repair of leg tendon, each	T	0049	22.0149	$1,480.30		$296.06	*
27664	Repair of leg tendon, each	T	0050	31.7717	$2,136.36		$427.28	*
27665	Repair of leg tendon, each	T	0050	31.7717	$2,136.36		$427.28	*
27675	Repair lower leg tendons	T	0049	22.0149	$1,480.30		$296.06	*
27676	Repair lower leg tendons	T	0050	31.7717	$2,136.36		$427.28	*
27680	Release of lower leg tendon	T	0050	31.7717	$2,136.36		$427.28	*

27681	Release of lower leg tendons	T	0050	31.7717	$2,136.36		$427.28	*
27685	Revision of lower leg tendon	T	0050	31.7717	$2,136.36		$427.28	*
27686	Revise lower leg tendons	T	0050	31.7717	$2,136.36		$427.28	*
27687	Revision of calf tendon	T	0050	31.7717	$2,136.36		$427.28	*
27690	Revise lower leg tendon	T	0051	46.5786	$3,131.99		$626.40	*
27691	Revise lower leg tendon	T	0051	46.5786	$3,131.99		$626.40	*
27692	Revise additional leg tendon	T	0051	46.5786	$3,131.99		$626.40	*
27695	Repair of ankle ligament	T	0050	31.7717	$2,136.36		$427.28	*
27696	Repair of ankle ligaments	T	0050	31.7717	$2,136.36		$427.28	*
27698	Repair of ankle ligament	T	0050	31.7717	$2,136.36		$427.28	*
27700	Revision of ankle joint	T	0047	39.8877	$2,682.09	$537.03	$536.42	*
27702	Reconstruct ankle joint	C						
27703	Reconstruction, ankle joint	C						
27704	Removal of ankle implant	T	0049	22.0149	$1,480.30		$296.06	*
27705	Incision of tibia	T	0051	46.5786	$3,131.99		$626.40	*
27707	Incision of fibula	T	0049	22.0149	$1,480.30		$296.06	*
27709	Incision of tibia & fibula	T	0050	31.7717	$2,136.36		$427.28	*
27712	Realignment of lower leg	C						
27715	Revision of lower leg	C						
27720	Repair of tibia	T	0063	45.4678	$3,057.30		$611.46	*
27722	Repair/graft of tibia	T	0064	65.4752	$4,402.62		$880.53	*
27724	Repair/graft of tibia	C						
27725	Repair of lower leg	C						
27726	Repair fibula nonunion	T	0063	45.4678	$3,057.30		$611.46	*
27727	Repair of lower leg	C						
27730	Repair of tibia epiphysis	T	0050	31.7717	$2,136.36		$427.28	*
27732	Repair of fibula epiphysis	T	0050	31.7717	$2,136.36		$427.28	*
27734	Repair lower leg epiphyses	T	0050	31.7717	$2,136.36		$427.28	*
27740	Repair of leg epiphyses	T	0050	31.7717	$2,136.36		$427.28	*
27742	Repair of leg epiphyses	T	0051	46.5786	$3,131.99		$626.40	*
27745	Reinforce tibia	T	0052	88.6521	$5,961.06		$1,192.22	*

27750	Treatment of tibia fracture	T	0129	1.6576	$111.46		$22.30	*
27752	Treatment of tibia fracture	T	0139	18.3962	$1,236.98		$247.40	*
27756	Treatment of tibia fracture	T	0062	25.8446	$1,737.82	$372.87	$347.57	*
27758	Treatment of tibia fracture	T	0063	45.4678	$3,057.30		$611.46	*
27759	Treatment of tibia fracture	T	0064	65.4752	$4,402.62		$880.53	*
27760	Cltx medial ankle fx	T	0129	1.6576	$111.46		$22.30	*
27762	Cltx med ankle fx w/mnpj	T	0139	18.3962	$1,236.98		$247.40	*
27766	Optx medial ankle fx	T	0063	45.4678	$3,057.30		$611.46	*
27767	Cltx post ankle fx	T	0129	1.6576	$111.46		$22.30	*
27768	Cltx post ankle fx w/mnpj	T	0129	1.6576	$111.46		$22.30	*
27769	Optx post ankle fx	T	0063	45.4678	$3,057.30		$611.46	*
27780	Treatment of fibula fracture	T	0129	1.6576	$111.46		$22.30	*
27781	Treatment of fibula fracture	T	0139	18.3962	$1,236.98		$247.40	*
27784	Treatment of fibula fracture	T	0063	45.4678	$3,057.30		$611.46	*
27786	Treatment of ankle fracture	T	0129	1.6576	$111.46		$22.30	*
27788	Treatment of ankle fracture	T	0129	1.6576	$111.46		$22.30	*
27792	Treatment of ankle fracture	T	0063	45.4678	$3,057.30		$611.46	*
27808	Treatment of ankle fracture	T	0129	1.6576	$111.46		$22.30	*
27810	Treatment of ankle fracture	T	0138	4.7946	$322.39		$64.48	*
27814	Treatment of ankle fracture	T	0063	45.4678	$3,057.30		$611.46	*
27816	Treatment of ankle fracture	T	0129	1.6576	$111.46		$22.30	*
27818	Treatment of ankle fracture	T	0138	4.7946	$322.39		$64.48	*
27822	Treatment of ankle fracture	T	0063	45.4678	$3,057.30		$611.46	*
27823	Treatment of ankle fracture	T	0064	65.4752	$4,402.62		$880.53	*
27824	Treat lower leg fracture	T	0129	1.6576	$111.46		$22.30	*
27825	Treat lower leg fracture	T	0139	18.3962	$1,236.98		$247.40	*
27826	Treat lower leg fracture	T	0063	45.4678	$3,057.30		$611.46	*
27827	Treat lower leg fracture	T	0064	65.4752	$4,402.62		$880.53	*
27828	Treat lower leg fracture	T	0064	65.4752	$4,402.62		$880.53	*
27829	Treat lower leg joint	T	0063	45.4678	$3,057.30		$611.46	*
27830	Treat lower leg dislocation	T	0129	1.6576	$111.46		$22.30	*

27831	Treat lower leg dislocation	T	0139	18.3962	$1,236.98		$247.40	*
27832	Treat lower leg dislocation	T	0063	45.4678	$3,057.30		$611.46	*
27840	Treat ankle dislocation	T	0138	4.7946	$322.39		$64.48	*
27842	Treat ankle dislocation	T	0045	15.2922	$1,028.26	$268.44	$205.66	*
27846	Treat ankle dislocation	T	0063	45.4678	$3,057.30		$611.46	*
27848	Treat ankle dislocation	T	0063	45.4678	$3,057.30		$611.46	*
27860	Fixation of ankle joint	T	0045	15.2922	$1,028.26	$268.44	$205.66	*
27870	Fusion of ankle joint, open	T	0052	88.6521	$5,961.06		$1,192.22	*
27871	Fusion of tibiofibular joint	T	0052	88.6521	$5,961.06		$1,192.22	*
27880	Amputation of lower leg	C						
27881	Amputation of lower leg	C						
27882	Amputation of lower leg	C						
27884	Amputation follow-up surgery	T	0049	22.0149	$1,480.30		$296.06	*
27886	Amputation follow-up surgery	C						
27888	Amputation of foot at ankle	C						
27889	Amputation of foot at ankle	T	0050	31.7717	$2,136.36		$427.28	*
27892	Decompression of leg	T	0050	31.7717	$2,136.36		$427.28	*
27893	Decompression of leg	T	0050	31.7717	$2,136.36		$427.28	*
27894	Decompression of leg	T	0050	31.7717	$2,136.36		$427.28	*
27899	Leg/ankle surgery procedure	T	0129	1.6576	$111.46		$22.30	*
28001	Drainage of bursa of foot	T	0007	12.6217	$848.70		$169.74	*
28002	Treatment of foot infection	T	0049	22.0149	$1,480.30		$296.06	*
28003	Treatment of foot infection	T	0049	22.0149	$1,480.30		$296.06	*
28005	Treat foot bone lesion	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28008	Incision of foot fascia	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28010	Incision of toe tendon	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28011	Incision of toe tendons	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28020	Exploration of foot joint	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28022	Exploration of foot joint	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28024	Exploration of toe joint	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28035	Decompression of tibia nerve	T	0220	18.72	$1,258.75		$251.75	*
28039	Exc foot/toe tum sc > 1.5 cm	T	0022	23.388	$1,572.63	$354.45	$314.53	*
28041	Exc foot/toe tum deep >1.5cm	T	0022	23.388	$1,572.63	$354.45	$314.53	*
28043	Exc foot/toe tum sc < 1.5 cm	T	0021	17.4975	$1,176.55		$235.31	*
28045	Exc foot/toe tum deep <1.5cm	T	0021	17.4975	$1,176.55		$235.31	*
28046	Resect foot/toe tumor < 3 cm	T	0021	17.4975	$1,176.55		$235.31	*
28047	Resect foot/toe tumor > 3 cm	T	0022	23.388	$1,572.63	$354.45	$314.53	*
28050	Biopsy of foot joint lining	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28052	Biopsy of foot joint lining	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28054	Biopsy of toe joint lining	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28055	Neurectomy, foot	T	0220	18.72	$1,258.75		$251.75	*
28060	Partial removal, foot fascia	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28062	Removal of foot fascia	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28070	Removal of foot joint lining	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28072	Removal of foot joint lining	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28080	Removal of foot lesion	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28086	Excise foot tendon sheath	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28088	Excise foot tendon sheath	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28090	Removal of foot lesion	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28092	Removal of toe lesions	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28100	Removal of ankle/heel lesion	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28102	Remove/graft foot lesion	T	0056	52.5258	$3,531.89		$706.38	*
28103	Remove/graft foot lesion	T	0056	52.5258	$3,531.89		$706.38	*
28104	Removal of foot lesion	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28106	Remove/graft foot lesion	T	0056	52.5258	$3,531.89		$706.38	*
28107	Remove/graft foot lesion	T	0056	52.5258	$3,531.89		$706.38	*
28108	Removal of toe lesions	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28110	Part removal of metatarsal	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28111	Part removal of metatarsal	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28112	Part removal of metatarsal	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28113	Part removal of metatarsal	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28114	Removal of metatarsal heads	T	0055	21.8439	$1,468.81	$355.34	$293.77	*

28116	Revision of foot	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28118	Removal of heel bone	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28119	Removal of heel spur	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28120	Part removal of ankle/heel	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28122	Partial removal of foot bone	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28124	Partial removal of toe	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28126	Partial removal of toe	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28130	Removal of ankle bone	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28140	Removal of metatarsal	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28150	Removal of toe	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28153	Partial removal of toe	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28160	Partial removal of toe	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28171	Resect tarsal tumor	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28173	Resect metatarsal tumor	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28175	Resect phalanx of toe tumor	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28190	Removal of foot foreign body	T	0020	8.2028	$551.56		$110.32	*
28192	Removal of foot foreign body	T	0021	17.4975	$1,176.55		$235.31	*
28193	Removal of foot foreign body	T	0020	8.2028	$551.56		$110.32	*
28200	Repair of foot tendon	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28202	Repair/graft of foot tendon	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28208	Repair of foot tendon	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28210	Repair/graft of foot tendon	T	0056	52.5258	$3,531.89		$706.38	*
28220	Release of foot tendon	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28222	Release of foot tendons	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28225	Release of foot tendon	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28226	Release of foot tendons	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28230	Incision of foot tendon(s)	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28232	Incision of toe tendon	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28234	Incision of foot tendon	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28238	Revision of foot tendon	T	0056	52.5258	$3,531.89		$706.38	*
28240	Release of big toe	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28250	Revision of foot fascia	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28260	Release of midfoot joint	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28261	Revision of foot tendon	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28262	Revision of foot and ankle	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28264	Release of midfoot joint	T	0056	52.5258	$3,531.89		$706.38	*
28270	Release of foot contracture	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28272	Release of toe joint, each	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28280	Fusion of toes	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28285	Repair of hammertoe	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28286	Repair of hammertoe	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28288	Partial removal of foot bone	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28289	Repair hallux rigidus	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28290	Correction of bunion	T	0057	31.5534	$2,121.68	$475.91	$424.34	*
28292	Correction of bunion	T	0057	31.5534	$2,121.68	$475.91	$424.34	*
28293	Correction of bunion	T	0057	31.5534	$2,121.68	$475.91	$424.34	*
28294	Correction of bunion	T	0057	31.5534	$2,121.68	$475.91	$424.34	*
28296	Correction of bunion	T	0057	31.5534	$2,121.68	$475.91	$424.34	*
28297	Correction of bunion	T	0057	31.5534	$2,121.68	$475.91	$424.34	*
28298	Correction of bunion	T	0057	31.5534	$2,121.68	$475.91	$424.34	*
28299	Correction of bunion	T	0057	31.5534	$2,121.68	$475.91	$424.34	*
28300	Incision of heel bone	T	0056	52.5258	$3,531.89		$706.38	*
28302	Incision of ankle bone	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28304	Incision of midfoot bones	T	0056	52.5258	$3,531.89		$706.38	*
28305	Incise/graft midfoot bones	T	0056	52.5258	$3,531.89		$706.38	*
28306	Incision of metatarsal	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28307	Incision of metatarsal	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28308	Incision of metatarsal	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28309	Incision of metatarsals	T	0056	52.5258	$3,531.89		$706.38	*
28310	Revision of big toe	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28312	Revision of toe	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28313	Repair deformity of toe	T	0055	21.8439	$1,468.81	$355.34	$293.77	*

28315	Removal of sesamoid bone	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28320	Repair of foot bones	T	0056	52.5258	$3,531.89		$706.38	*
28322	Repair of metatarsals	T	0056	52.5258	$3,531.89		$706.38	*
28340	Resect enlarged toe tissue	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28341	Resect enlarged toe	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28344	Repair extra toe(s)	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28345	Repair webbed toe(s)	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28360	Reconstruct cleft foot	T	0056	52.5258	$3,531.89		$706.38	*
28400	Treatment of heel fracture	T	0129	1.6576	$111.46		$22.30	*
28405	Treatment of heel fracture	T	0139	18.3962	$1,236.98		$247.40	*
28406	Treatment of heel fracture	T	0062	25.8446	$1,737.82	$372.87	$347.57	*
28415	Treat heel fracture	T	0064	65.4752	$4,402.62		$880.53	*
28420	Treat/graft heel fracture	T	0063	45.4678	$3,057.30		$611.46	*
28430	Treatment of ankle fracture	T	0129	1.6576	$111.46		$22.30	*
28435	Treatment of ankle fracture	T	0129	1.6576	$111.46		$22.30	*
28436	Treatment of ankle fracture	T	0062	25.8446	$1,737.82	$372.87	$347.57	*
28445	Treat ankle fracture	T	0063	45.4678	$3,057.30		$611.46	*
28446	Osteochondral talus autogrft	T	0056	52.5258	$3,531.89		$706.38	*
28450	Treat midfoot fracture, each	T	0129	1.6576	$111.46		$22.30	*
28455	Treat midfoot fracture, each	T	0129	1.6576	$111.46		$22.30	*
28456	Treat midfoot fracture	T	0062	25.8446	$1,737.82	$372.87	$347.57	*
28465	Treat midfoot fracture, each	T	0063	45.4678	$3,057.30		$611.46	*
28470	Treat metatarsal fracture	T	0129	1.6576	$111.46		$22.30	*
28475	Treat metatarsal fracture	T	0129	1.6576	$111.46		$22.30	*
28476	Treat metatarsal fracture	T	0062	25.8446	$1,737.82	$372.87	$347.57	*
28485	Treat metatarsal fracture	T	0063	45.4678	$3,057.30		$611.46	*
28490	Treat big toe fracture	T	0129	1.6576	$111.46		$22.30	*
28495	Treat big toe fracture	T	0129	1.6576	$111.46		$22.30	*
28496	Treat big toe fracture	T	0062	25.8446	$1,737.82	$372.87	$347.57	*
28505	Treat big toe fracture	T	0062	25.8446	$1,737.82	$372.87	$347.57	*
28510	Treatment of toe fracture	T	0129	1.6576	$111.46		$22.30	*
28515	Treatment of toe fracture	T	0129	1.6576	$111.46		$22.30	*
28525	Treat toe fracture	T	0062	25.8446	$1,737.82	$372.87	$347.57	*
28530	Treat sesamoid bone fracture	T	0129	1.6576	$111.46		$22.30	*
28531	Treat sesamoid bone fracture	T	0062	25.8446	$1,737.82	$372.87	$347.57	*
28540	Treat foot dislocation	T	0129	1.6576	$111.46		$22.30	*
28545	Treat foot dislocation	T	0062	25.8446	$1,737.82	$372.87	$347.57	*
28546	Treat foot dislocation	T	0062	25.8446	$1,737.82	$372.87	$347.57	*
28555	Repair foot dislocation	T	0063	45.4678	$3,057.30		$611.46	*
28570	Treat foot dislocation	T	0138	4.7946	$322.39		$64.48	*
28575	Treat foot dislocation	T	0139	18.3962	$1,236.98		$247.40	*
28576	Treat foot dislocation	T	0062	25.8446	$1,737.82	$372.87	$347.57	*
28585	Repair foot dislocation	T	0062	25.8446	$1,737.82	$372.87	$347.57	*
28600	Treat foot dislocation	T	0129	1.6576	$111.46		$22.30	*
28605	Treat foot dislocation	T	0129	1.6576	$111.46		$22.30	*
28606	Treat foot dislocation	T	0062	25.8446	$1,737.82	$372.87	$347.57	*
28615	Repair foot dislocation	T	0063	45.4678	$3,057.30		$611.46	*
28630	Treat toe dislocation	T	0129	1.6576	$111.46		$22.30	*
28635	Treat toe dislocation	T	0045	15.2922	$1,028.26	$268.44	$205.66	*
28636	Treat toe dislocation	T	0062	25.8446	$1,737.82	$372.87	$347.57	*
28645	Repair toe dislocation	T	0062	25.8446	$1,737.82	$372.87	$347.57	*
28660	Treat toe dislocation	T	0129	1.6576	$111.46		$22.30	*
28665	Treat toe dislocation	T	0045	15.2922	$1,028.26	$268.44	$205.66	*
28666	Treat toe dislocation	T	0062	25.8446	$1,737.82	$372.87	$347.57	*
28675	Repair of toe dislocation	T	0062	25.8446	$1,737.82	$372.87	$347.57	*
28705	Fusion of foot bones	T	0056	52.5258	$3,531.89		$706.38	*
28715	Fusion of foot bones	T	0052	88.6521	$5,961.06		$1,192.22	*
28725	Fusion of foot bones	T	0056	52.5258	$3,531.89		$706.38	*
28730	Fusion of foot bones	T	0056	52.5258	$3,531.89		$706.38	*
28735	Fusion of foot bones	T	0056	52.5258	$3,531.89		$706.38	*
28737	Revision of foot bones	T	0056	52.5258	$3,531.89		$706.38	*
28740	Fusion of foot bones	T	0056	52.5258	$3,531.89		$706.38	*

28750	Fusion of big toe joint	T	0056	52.5258	$3,531.89		$706.38	*
28755	Fusion of big toe joint	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28760	Fusion of big toe joint	T	0056	52.5258	$3,531.89		$706.38	*
28800	Amputation of midfoot	C						
28805	Amputation thru metatarsal	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28810	Amputation toe & metatarsal	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28820	Amputation of toe	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28825	Partial amputation of toe	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
28890	High energy eswt, plantar f	T	0050	31.7717	$2,136.36		$427.28	*
28899	Foot/toes surgery procedure	T	0129	1.6576	$111.46		$22.30	*
29000	Application of body cast	S	0058	1.0537	$70.85		$14.17	*
29010	Application of body cast	S	0426	2.3457	$157.73		$31.55	*
29015	Application of body cast	S	0426	2.3457	$157.73		$31.55	*
29020	Application of body cast	S	0058	1.0537	$70.85		$14.17	*
29025	Application of body cast	S	0058	1.0537	$70.85		$14.17	*
29035	Application of body cast	S	0426	2.3457	$157.73		$31.55	*
29040	Application of body cast	S	0058	1.0537	$70.85		$14.17	*
29044	Application of body cast	S	0426	2.3457	$157.73		$31.55	*
29046	Application of body cast	S	0426	2.3457	$157.73		$31.55	*
29049	Application of figure eight	S	0058	1.0537	$70.85		$14.17	*
29055	Application of shoulder cast	S	0426	2.3457	$157.73		$31.55	*
29058	Application of shoulder cast	S	0058	1.0537	$70.85		$14.17	*
29065	Application of long arm cast	S	0426	2.3457	$157.73		$31.55	*
29075	Application of forearm cast	S	0426	2.3457	$157.73		$31.55	*
29085	Apply hand/wrist cast	S	0058	1.0537	$70.85		$14.17	*
29086	Apply finger cast	S	0058	1.0537	$70.85		$14.17	*
29105	Apply long arm splint	S	0058	1.0537	$70.85		$14.17	*
29125	Apply forearm splint	S	0058	1.0537	$70.85		$14.17	*
29126	Apply forearm splint	S	0058	1.0537	$70.85		$14.17	*
29130	Application of finger splint	S	0058	1.0537	$70.85		$14.17	*
29131	Application of finger splint	S	0058	1.0537	$70.85		$14.17	*
29200	Strapping of chest	S	0058	1.0537	$70.85		$14.17	*
29240	Strapping of shoulder	S	0058	1.0537	$70.85		$14.17	*
29260	Strapping of elbow or wrist	S	0058	1.0537	$70.85		$14.17	*
29280	Strapping of hand or finger	S	0058	1.0537	$70.85		$14.17	*
29305	Application of hip cast	S	0426	2.3457	$157.73		$31.55	*
29325	Application of hip casts	S	0426	2.3457	$157.73		$31.55	*
29345	Application of long leg cast	S	0426	2.3457	$157.73		$31.55	*
29355	Application of long leg cast	S	0426	2.3457	$157.73		$31.55	*
29358	Apply long leg cast brace	S	0426	2.3457	$157.73		$31.55	*
29365	Application of long leg cast	S	0426	2.3457	$157.73		$31.55	*
29405	Apply short leg cast	S	0426	2.3457	$157.73		$31.55	*
29425	Apply short leg cast	S	0426	2.3457	$157.73		$31.55	*
29435	Apply short leg cast	S	0426	2.3457	$157.73		$31.55	*
29440	Addition of walker to cast	S	0058	1.0537	$70.85		$14.17	*
29445	Apply rigid leg cast	S	0426	2.3457	$157.73		$31.55	*
29450	Application of leg cast	S	0058	1.0537	$70.85		$14.17	*
29505	Application, long leg splint	S	0058	1.0537	$70.85		$14.17	*
29515	Application lower leg splint	S	0058	1.0537	$70.85		$14.17	*
29520	Strapping of hip	S	0058	1.0537	$70.85		$14.17	*
29530	Strapping of knee	S	0058	1.0537	$70.85		$14.17	*
29540	Strapping of ankle and/or ft	S	0058	1.0537	$70.85		$14.17	*
29550	Strapping of toes	S	0058	1.0537	$70.85		$14.17	*
29580	Application of paste boot	S	0058	1.0537	$70.85		$14.17	*
29581	Apply multlay comprs lwr leg	S	0058	1.0537	$70.85		$14.17	*
29590	Application of foot splint	S	0058	1.0537	$70.85		$14.17	*
29700	Removal/revision of cast	S	0058	1.0537	$70.85		$14.17	*
29705	Removal/revision of cast	S	0058	1.0537	$70.85		$14.17	*
29710	Removal/revision of cast	S	0426	2.3457	$157.73		$31.55	*
29715	Removal/revision of cast	S	0058	1.0537	$70.85		$14.17	*
29720	Repair of body cast	S	0058	1.0537	$70.85		$14.17	*
29730	Windowing of cast	S	0058	1.0537	$70.85		$14.17	*

29740	Wedging of cast	S	0058	1.0537	$70.85		$14.17	*
29750	Wedging of clubfoot cast	S	0058	1.0537	$70.85		$14.17	*
29799	Casting/strapping procedure	S	0058	1.0537	$70.85		$14.17	*
29800	Jaw arthroscopy/surgery	T	0041	29.9198	$2,011.84		$402.37	*
29804	Jaw arthroscopy/surgery	T	0041	29.9198	$2,011.84		$402.37	*
29805	Shoulder arthroscopy, dx	T	0041	29.9198	$2,011.84		$402.37	*
29806	Shoulder arthroscopy/surgery	T	0042	48.8176	$3,282.54	$804.74	$656.51	*
29807	Shoulder arthroscopy/surgery	T	0042	48.8176	$3,282.54	$804.74	$656.51	*
29819	Shoulder arthroscopy/surgery	T	0042	48.8176	$3,282.54	$804.74	$656.51	*
29820	Shoulder arthroscopy/surgery	T	0042	48.8176	$3,282.54	$804.74	$656.51	*
29821	Shoulder arthroscopy/surgery	T	0042	48.8176	$3,282.54	$804.74	$656.51	*
29822	Shoulder arthroscopy/surgery	T	0041	29.9198	$2,011.84		$402.37	*
29823	Shoulder arthroscopy/surgery	T	0042	48.8176	$3,282.54	$804.74	$656.51	*
29824	Shoulder arthroscopy/surgery	T	0041	29.9198	$2,011.84		$402.37	*
29825	Shoulder arthroscopy/surgery	T	0042	48.8176	$3,282.54	$804.74	$656.51	*
29826	Shoulder arthroscopy/surgery	T	0042	48.8176	$3,282.54	$804.74	$656.51	*
29827	Arthroscop rotator cuff repr	T	0042	48.8176	$3,282.54	$804.74	$656.51	*
29828	Arthroscopy biceps tenodesis	T	0042	48.8176	$3,282.54	$804.74	$656.51	*
29830	Elbow arthroscopy	T	0041	29.9198	$2,011.84		$402.37	*
29834	Elbow arthroscopy/surgery	T	0041	29.9198	$2,011.84		$402.37	*
29835	Elbow arthroscopy/surgery	T	0041	29.9198	$2,011.84		$402.37	*
29836	Elbow arthroscopy/surgery	T	0041	29.9198	$2,011.84		$402.37	*
29837	Elbow arthroscopy/surgery	T	0041	29.9198	$2,011.84		$402.37	*
29838	Elbow arthroscopy/surgery	T	0041	29.9198	$2,011.84		$402.37	*
29840	Wrist arthroscopy	T	0041	29.9198	$2,011.84		$402.37	*
29843	Wrist arthroscopy/surgery	T	0041	29.9198	$2,011.84		$402.37	*
29844	Wrist arthroscopy/surgery	T	0041	29.9198	$2,011.84		$402.37	*
29845	Wrist arthroscopy/surgery	T	0041	29.9198	$2,011.84		$402.37	*
29846	Wrist arthroscopy/surgery	T	0041	29.9198	$2,011.84		$402.37	*
29847	Wrist arthroscopy/surgery	T	0042	48.8176	$3,282.54	$804.74	$656.51	*
29848	Wrist endoscopy/surgery	T	0041	29.9198	$2,011.84		$402.37	*
29850	Knee arthroscopy/surgery	T	0041	29.9198	$2,011.84		$402.37	*
29851	Knee arthroscopy/surgery	T	0042	48.8176	$3,282.54	$804.74	$656.51	*
29855	Tibial arthroscopy/surgery	T	0042	48.8176	$3,282.54	$804.74	$656.51	*
29856	Tibial arthroscopy/surgery	T	0042	48.8176	$3,282.54	$804.74	$656.51	*
29860	Hip arthroscopy, dx	T	0042	48.8176	$3,282.54	$804.74	$656.51	*
29861	Hip arthroscopy/surgery	T	0042	48.8176	$3,282.54	$804.74	$656.51	*
29862	Hip arthroscopy/surgery	T	0042	48.8176	$3,282.54	$804.74	$656.51	*
29863	Hip arthroscopy/surgery	T	0042	48.8176	$3,282.54	$804.74	$656.51	*
29866	Autgrft implnt, knee w/scope	T	0042	48.8176	$3,282.54	$804.74	$656.51	*
29867	Allgrft implnt, knee w/scope	T	0042	48.8176	$3,282.54	$804.74	$656.51	*
29868	Meniscal trnspl, knee w/scpe	T	0042	48.8176	$3,282.54	$804.74	$656.51	*
29870	Knee arthroscopy, dx	T	0041	29.9198	$2,011.84		$402.37	*
29871	Knee arthroscopy/drainage	T	0041	29.9198	$2,011.84		$402.37	*
29873	Knee arthroscopy/surgery	T	0041	29.9198	$2,011.84		$402.37	*
29874	Knee arthroscopy/surgery	T	0041	29.9198	$2,011.84		$402.37	*
29875	Knee arthroscopy/surgery	T	0041	29.9198	$2,011.84		$402.37	*
29876	Knee arthroscopy/surgery	T	0041	29.9198	$2,011.84		$402.37	*
29877	Knee arthroscopy/surgery	T	0041	29.9198	$2,011.84		$402.37	*
29879	Knee arthroscopy/surgery	T	0041	29.9198	$2,011.84		$402.37	*
29880	Knee arthroscopy/surgery	T	0041	29.9198	$2,011.84		$402.37	*
29881	Knee arthroscopy/surgery	T	0041	29.9198	$2,011.84		$402.37	*
29882	Knee arthroscopy/surgery	T	0041	29.9198	$2,011.84		$402.37	*
29883	Knee arthroscopy/surgery	T	0041	29.9198	$2,011.84		$402.37	*
29884	Knee arthroscopy/surgery	T	0041	29.9198	$2,011.84		$402.37	*
29885	Knee arthroscopy/surgery	T	0042	48.8176	$3,282.54	$804.74	$656.51	*
29886	Knee arthroscopy/surgery	T	0041	29.9198	$2,011.84		$402.37	*
29887	Knee arthroscopy/surgery	T	0041	29.9198	$2,011.84		$402.37	*
29888	Knee arthroscopy/surgery	T	0052	88.6521	$5,961.06		$1,192.22	*
29889	Knee arthroscopy/surgery	T	0052	88.6521	$5,961.06		$1,192.22	*
29891	Ankle arthroscopy/surgery	T	0042	48.8176	$3,282.54	$804.74	$656.51	*
29892	Ankle arthroscopy/surgery	T	0052	88.6521	$5,961.06		$1,192.22	*

29893	Scope, plantar fasciotomy	T	0055	21.8439	$1,468.81	$355.34	$293.77	*
29894	Ankle arthroscopy/surgery	T	0041	29.9198	$2,011.84		$402.37	*
29895	Ankle arthroscopy/surgery	T	0041	29.9198	$2,011.84		$402.37	*
29897	Ankle arthroscopy/surgery	T	0041	29.9198	$2,011.84		$402.37	*
29898	Ankle arthroscopy/surgery	T	0041	29.9198	$2,011.84		$402.37	*
29899	Ankle arthroscopy/surgery	T	0042	48.8176	$3,282.54	$804.74	$656.51	*
29900	Mcp joint arthroscopy, dx	T	0041	29.9198	$2,011.84		$402.37	*
29901	Mcp joint arthroscopy, surg	T	0041	29.9198	$2,011.84		$402.37	*
29902	Mcp joint arthroscopy, surg	T	0041	29.9198	$2,011.84		$402.37	*
29904	Subtalar arthro w/fb rmvl	T	0041	29.9198	$2,011.84		$402.37	*
29905	Subtalar arthro w/exc	T	0041	29.9198	$2,011.84		$402.37	*
29906	Subtalar arthro w/deb	T	0041	29.9198	$2,011.84		$402.37	*
29907	Subtalar arthro w/fusion	T	0042	48.8176	$3,282.54	$804.74	$656.51	*
29999	Arthroscopy of joint	T	0041	29.9198	$2,011.84		$402.37	*
30000	Drainage of nose lesion	T	0251	3.425	$230.30		$46.06	*
30020	Drainage of nose lesion	T	0251	3.425	$230.30		$46.06	*
30100	Intranasal biopsy	T	0252	7.6196	$512.35	$109.16	$102.47	*
30110	Removal of nose polyp(s)	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
30115	Removal of nose polyp(s)	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
30117	Removal of intranasal lesion	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
30118	Removal of intranasal lesion	T	0254	24.9637	$1,678.58		$335.72	*
30120	Revision of nose	T	0254	24.9637	$1,678.58		$335.72	*
30124	Removal of nose lesion	T	0252	7.6196	$512.35	$109.16	$102.47	*
30125	Removal of nose lesion	T	0256	42.9827	$2,890.20		$578.04	*
30130	Excise inferior turbinate	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
30140	Resect inferior turbinate	T	0254	24.9637	$1,678.58		$335.72	*
30150	Partial removal of nose	T	0256	42.9827	$2,890.20		$578.04	*
30160	Removal of nose	T	0256	42.9827	$2,890.20		$578.04	*
30200	Injection treatment of nose	T	0252	7.6196	$512.35	$109.16	$102.47	*
30210	Nasal sinus therapy	T	0252	7.6196	$512.35	$109.16	$102.47	*
30220	Insert nasal septal button	T	0252	7.6196	$512.35	$109.16	$102.47	*
30300	Remove nasal foreign body	X	0340	0.6693	$45.00		$9.00	*
30310	Remove nasal foreign body	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
30320	Remove nasal foreign body	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
30400	Reconstruction of nose	T	0256	42.9827	$2,890.20		$578.04	*
30410	Reconstruction of nose	T	0256	42.9827	$2,890.20		$578.04	*
30420	Reconstruction of nose	T	0256	42.9827	$2,890.20		$578.04	*
30430	Revision of nose	T	0254	24.9637	$1,678.58		$335.72	*
30435	Revision of nose	T	0256	42.9827	$2,890.20		$578.04	*
30450	Revision of nose	T	0256	42.9827	$2,890.20		$578.04	*
30460	Revision of nose	T	0256	42.9827	$2,890.20		$578.04	*
30462	Revision of nose	T	0256	42.9827	$2,890.20		$578.04	*
30465	Repair nasal stenosis	T	0256	42.9827	$2,890.20		$578.04	*
30520	Repair of nasal septum	T	0254	24.9637	$1,678.58		$335.72	*
30540	Repair nasal defect	T	0256	42.9827	$2,890.20		$578.04	*
30545	Repair nasal defect	T	0256	42.9827	$2,890.20		$578.04	*
30560	Release of nasal adhesions	T	0251	3.425	$230.30		$46.06	*
30580	Repair upper jaw fistula	T	0256	42.9827	$2,890.20		$578.04	*
30600	Repair mouth/nose fistula	T	0256	42.9827	$2,890.20		$578.04	*
30620	Intranasal reconstruction	T	0256	42.9827	$2,890.20		$578.04	*
30630	Repair nasal septum defect	T	0254	24.9637	$1,678.58		$335.72	*
30801	Ablate inf turbinate, superf	T	0252	7.6196	$512.35	$109.16	$102.47	*
30802	Ablate inf turbinate submuc	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
30901	Control of nosebleed	T	0250	1.1522	$77.48	$25.10	$15.50	*
30903	Control of nosebleed	T	0250	1.1522	$77.48	$25.10	$15.50	*
30905	Control of nosebleed	T	0250	1.1522	$77.48	$25.10	$15.50	*
30906	Repeat control of nosebleed	T	0250	1.1522	$77.48	$25.10	$15.50	*
30915	Ligation, nasal sinus artery	T	0092	26.5713	$1,786.68		$357.34	*
30920	Ligation, upper jaw artery	T	0092	26.5713	$1,786.68		$357.34	*
30930	Ther fx, nasal inf turbinate	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
30999	Nasal surgery procedure	T	0250	1.1522	$77.48	$25.10	$15.50	*
31000	Irrigation, maxillary sinus	T	0251	3.425	$230.30		$46.06	*

31002	Irrigation, sphenoid sinus	T	0252	7.6196	$512.35	$109.16	$102.47	*
31020	Exploration, maxillary sinus	T	0254	24.9637	$1,678.58		$335.72	*
31030	Exploration, maxillary sinus	T	0256	42.9827	$2,890.20		$578.04	*
31032	Explore sinus, remove polyps	T	0256	42.9827	$2,890.20		$578.04	*
31040	Exploration behind upper jaw	T	0254	24.9637	$1,678.58		$335.72	*
31050	Exploration, sphenoid sinus	T	0256	42.9827	$2,890.20		$578.04	*
31051	Sphenoid sinus surgery	T	0256	42.9827	$2,890.20		$578.04	*
31070	Exploration of frontal sinus	T	0254	24.9637	$1,678.58		$335.72	*
31075	Exploration of frontal sinus	T	0256	42.9827	$2,890.20		$578.04	*
31080	Removal of frontal sinus	T	0256	42.9827	$2,890.20		$578.04	*
31081	Removal of frontal sinus	T	0256	42.9827	$2,890.20		$578.04	*
31084	Removal of frontal sinus	T	0256	42.9827	$2,890.20		$578.04	*
31085	Removal of frontal sinus	T	0256	42.9827	$2,890.20		$578.04	*
31086	Removal of frontal sinus	T	0256	42.9827	$2,890.20		$578.04	*
31087	Removal of frontal sinus	T	0256	42.9827	$2,890.20		$578.04	*
31090	Exploration of sinuses	T	0256	42.9827	$2,890.20		$578.04	*
31200	Removal of ethmoid sinus	T	0256	42.9827	$2,890.20		$578.04	*
31201	Removal of ethmoid sinus	T	0256	42.9827	$2,890.20		$578.04	*
31205	Removal of ethmoid sinus	T	0256	42.9827	$2,890.20		$578.04	*
31225	Removal of upper jaw	C						
31230	Removal of upper jaw	C						
31231	Nasal endoscopy, dx	T	0072	1.8425	$123.89		$24.78	*
31233	Nasal/sinus endoscopy, dx	T	0072	1.8425	$123.89		$24.78	*
31235	Nasal/sinus endoscopy, dx	T	0074	21.6572	$1,456.25	$292.25	$291.25	*
31237	Nasal/sinus endoscopy, surg	T	0074	21.6572	$1,456.25	$292.25	$291.25	*
31238	Nasal/sinus endoscopy, surg	T	0074	21.6572	$1,456.25	$292.25	$291.25	*
31239	Nasal/sinus endoscopy, surg	T	0075	29.2718	$1,968.27	$445.92	$393.66	*
31240	Nasal/sinus endoscopy, surg	T	0074	21.6572	$1,456.25	$292.25	$291.25	*
31254	Revision of ethmoid sinus	T	0075	29.2718	$1,968.27	$445.92	$393.66	*
31255	Removal of ethmoid sinus	T	0075	29.2718	$1,968.27	$445.92	$393.66	*
31256	Exploration maxillary sinus	T	0075	29.2718	$1,968.27	$445.92	$393.66	*
31267	Endoscopy, maxillary sinus	T	0075	29.2718	$1,968.27	$445.92	$393.66	*
31276	Sinus endoscopy, surgical	T	0075	29.2718	$1,968.27	$445.92	$393.66	*
31287	Nasal/sinus endoscopy, surg	T	0075	29.2718	$1,968.27	$445.92	$393.66	*
31288	Nasal/sinus endoscopy, surg	T	0075	29.2718	$1,968.27	$445.92	$393.66	*
31290	Nasal/sinus endoscopy, surg	C						
31291	Nasal/sinus endoscopy, surg	C						
31292	Nasal/sinus endoscopy, surg	T	0075	29.2718	$1,968.27	$445.92	$393.66	*
31293	Nasal/sinus endoscopy, surg	T	0075	29.2718	$1,968.27	$445.92	$393.66	*
31294	Nasal/sinus endoscopy, surg	T	0075	29.2718	$1,968.27	$445.92	$393.66	*
31299	Sinus surgery procedure	T	0250	1.1522	$77.48	$25.10	$15.50	*
31300	Removal of larynx lesion	T	0254	24.9637	$1,678.58		$335.72	*
31320	Diagnostic incision, larynx	T	0256	42.9827	$2,890.20		$578.04	*
31360	Removal of larynx	C						
31365	Removal of larynx	C						
31367	Partial removal of larynx	C						
31368	Partial removal of larynx	C						
31370	Partial removal of larynx	C						
31375	Partial removal of larynx	C						
31380	Partial removal of larynx	C						
31382	Partial removal of larynx	C						
31390	Removal of larynx & pharynx	C						
31395	Reconstruct larynx & pharynx	C						
31400	Revision of larynx	T	0256	42.9827	$2,890.20		$578.04	*
31420	Removal of epiglottis	T	0256	42.9827	$2,890.20		$578.04	*
31500	Insert emergency airway	S	0094	2.4553	$165.10	$46.29	$33.02	*
31502	Change of windpipe airway	S	0078	1.4142	$95.09		$19.02	*
31505	Diagnostic laryngoscopy	T	0071	0.8007	$53.84	$11.11	$10.77	*
31510	Laryngoscopy with biopsy	T	0074	21.6572	$1,456.25	$292.25	$291.25	*
31511	Remove foreign body, larynx	T	0072	1.8425	$123.89		$24.78	*
31512	Removal of larynx lesion	T	0074	21.6572	$1,456.25	$292.25	$291.25	*
31513	Injection into vocal cord	T	0072	1.8425	$123.89		$24.78	*

31515	Laryngoscopy for aspiration	T	0074	21.6572	$1,456.25	$292.25	$291.25	*
31520	Dx laryngoscopy, newborn	T	0072	1.8425	$123.89		$24.78	*
31525	Dx laryngoscopy excl nb	T	0074	21.6572	$1,456.25	$292.25	$291.25	*
31526	Dx laryngoscopy w/oper scope	T	0074	21.6572	$1,456.25	$292.25	$291.25	*
31527	Laryngoscopy for treatment	T	0075	29.2718	$1,968.27	$445.92	$393.66	*
31528	Laryngoscopy and dilation	T	0074	21.6572	$1,456.25	$292.25	$291.25	*
31529	Laryngoscopy and dilation	T	0074	21.6572	$1,456.25	$292.25	$291.25	*
31530	Laryngoscopy w/fb removal	T	0074	21.6572	$1,456.25	$292.25	$291.25	*
31531	Laryngoscopy w/fb & op scope	T	0074	21.6572	$1,456.25	$292.25	$291.25	*
31535	Laryngoscopy w/biopsy	T	0074	21.6572	$1,456.25	$292.25	$291.25	*
31536	Laryngoscopy w/bx & op scope	T	0074	21.6572	$1,456.25	$292.25	$291.25	*
31540	Laryngoscopy w/exc of tumor	T	0074	21.6572	$1,456.25	$292.25	$291.25	*
31541	Larynscop w/tumr exc + scope	T	0074	21.6572	$1,456.25	$292.25	$291.25	*
31545	Remove vc lesion w/scope	T	0075	29.2718	$1,968.27	$445.92	$393.66	*
31546	Remove vc lesion scope/graft	T	0075	29.2718	$1,968.27	$445.92	$393.66	*
31560	Laryngoscop w/arytenoidectom	T	0075	29.2718	$1,968.27	$445.92	$393.66	*
31561	Larynscop, remve cart + scop	T	0075	29.2718	$1,968.27	$445.92	$393.66	*
31570	Laryngoscope w/vc inj	T	0074	21.6572	$1,456.25	$292.25	$291.25	*
31571	Laryngoscop w/vc inj + scope	T	0075	29.2718	$1,968.27	$445.92	$393.66	*
31575	Diagnostic laryngoscopy	T	0072	1.8425	$123.89		$24.78	*
31576	Laryngoscopy with biopsy	T	0074	21.6572	$1,456.25	$292.25	$291.25	*
31577	Remove foreign body, larynx	T	0073	4.4119	$296.66	$69.15	$59.34	*
31578	Removal of larynx lesion	T	0075	29.2718	$1,968.27	$445.92	$393.66	*
31579	Diagnostic laryngoscopy	T	0073	4.4119	$296.66	$69.15	$59.34	*
31580	Revision of larynx	T	0256	42.9827	$2,890.20		$578.04	*
31582	Revision of larynx	T	0256	42.9827	$2,890.20		$578.04	*
31584	Treat larynx fracture	C						
31587	Revision of larynx	C						
31588	Revision of larynx	T	0256	42.9827	$2,890.20		$578.04	*
31590	Reinnervate larynx	T	0256	42.9827	$2,890.20		$578.04	*
31595	Larynx nerve surgery	T	0256	42.9827	$2,890.20		$578.04	*
31599	Larynx surgery procedure	T	0250	1.1522	$77.48	$25.10	$15.50	*
31600	Incision of windpipe	T	0254	24.9637	$1,678.58		$335.72	*
31601	Incision of windpipe	T	0254	24.9637	$1,678.58		$335.72	*
31603	Incision of windpipe	T	0252	7.6196	$512.35	$109.16	$102.47	*
31605	Incision of windpipe	T	0252	7.6196	$512.35	$109.16	$102.47	*
31610	Incision of windpipe	T	0254	24.9637	$1,678.58		$335.72	*
31611	Surgery/speech prosthesis	T	0254	24.9637	$1,678.58		$335.72	*
31612	Puncture/clear windpipe	T	0254	24.9637	$1,678.58		$335.72	*
31613	Repair windpipe opening	T	0254	24.9637	$1,678.58		$335.72	*
31614	Repair windpipe opening	T	0256	42.9827	$2,890.20		$578.04	*
31615	Visualization of windpipe	T	0252	7.6196	$512.35	$109.16	$102.47	*
31620	Endobronchial us add-on	N						
31622	Dx bronchoscope/wash	T	0076	10.3707	$697.34	$189.82	$139.47	*
31623	Dx bronchoscope/brush	T	0076	10.3707	$697.34	$189.82	$139.47	*
31624	Dx bronchoscope/lavage	T	0076	10.3707	$697.34	$189.82	$139.47	*
31625	Bronchoscopy w/biopsy(s)	T	0076	10.3707	$697.34	$189.82	$139.47	*
31626	Bronchoscopy w/markers	T	0076	10.3707	$697.34	$189.82	$139.47	*
31627	Navigational bronchoscopy	N						
31628	Bronchoscopy/lung bx, each	T	0076	10.3707	$697.34	$189.82	$139.47	*
31629	Bronchoscopy/needle bx, each	T	0076	10.3707	$697.34	$189.82	$139.47	*
31630	Bronchoscopy dilate/fx repr	T	0415	25.9024	$1,741.70	$459.92	$348.34	*
31631	Bronchoscopy, dilate w/stent	T	0415	25.9024	$1,741.70	$459.92	$348.34	*
31632	Bronchoscopy/lung bx, addl	T	0076	10.3707	$697.34	$189.82	$139.47	*
31633	Bronchoscopy/needle bx addl	T	0076	10.3707	$697.34	$189.82	$139.47	*
31635	Bronchoscopy w/fb removal	T	0076	10.3707	$697.34	$189.82	$139.47	*
31636	Bronchoscopy, bronch stents	T	0415	25.9024	$1,741.70	$459.92	$348.34	*
31637	Bronchoscopy, stent add-on	T	0076	10.3707	$697.34	$189.82	$139.47	*
31638	Bronchoscopy, revise stent	T	0415	25.9024	$1,741.70	$459.92	$348.34	*
31640	Bronchoscopy w/tumor excise	T	0415	25.9024	$1,741.70	$459.92	$348.34	*
31641	Bronchoscopy, treat blockage	T	0415	25.9024	$1,741.70	$459.92	$348.34	*
31643	Diag bronchoscope/catheter	T	0076	10.3707	$697.34	$189.82	$139.47	*

31645	Bronchoscopy, clear airways	T	0076	10.3707	$697.34	$189.82	$139.47	*
31646	Bronchoscopy, reclear airway	T	0076	10.3707	$697.34	$189.82	$139.47	*
31656	Bronchoscopy, inj for x-ray	T	0076	10.3707	$697.34	$189.82	$139.47	*
31715	Injection for bronchus x-ray	N						
31717	Bronchial brush biopsy	T	0073	4.4119	$296.66	$69.15	$59.34	*
31720	Clearance of airways	S	0077	0.4058	$27.29	$7.74	$5.46	*
31725	Clearance of airways	C						
31730	Intro, windpipe wire/tube	T	0073	4.4119	$296.66	$69.15	$59.34	*
31750	Repair of windpipe	T	0256	42.9827	$2,890.20		$578.04	*
31755	Repair of windpipe	T	0256	42.9827	$2,890.20		$578.04	*
31760	Repair of windpipe	C						
31766	Reconstruction of windpipe	C						
31770	Repair/graft of bronchus	C						
31775	Reconstruct bronchus	C						
31780	Reconstruct windpipe	C						
31781	Reconstruct windpipe	C						
31785	Remove windpipe lesion	T	0254	24.9637	$1,678.58		$335.72	*
31786	Remove windpipe lesion	C						
31800	Repair of windpipe injury	C						
31805	Repair of windpipe injury	C						
31820	Closure of windpipe lesion	T	0254	24.9637	$1,678.58		$335.72	*
31825	Repair of windpipe defect	T	0254	24.9637	$1,678.58		$335.72	*
31830	Revise windpipe scar	T	0254	24.9637	$1,678.58		$335.72	*
31899	Airways surgical procedure	T	0076	10.3707	$697.34	$189.82	$139.47	*
32035	Exploration of chest	C						
32036	Exploration of chest	C						
32095	Biopsy through chest wall	C						
32100	Exploration/biopsy of chest	C						
32110	Explore/repair chest	C						
32120	Re-exploration of chest	C						
32124	Explore chest free adhesions	C						
32140	Removal of lung lesion(s)	C						
32141	Remove/treat lung lesions	C						
32150	Removal of lung lesion(s)	C						
32151	Remove lung foreign body	C						
32160	Open chest heart massage	C						
32200	Drain, open, lung lesion	C						
32201	Drain, percut, lung lesion	T	0070	5.5521	$373.33		$74.67	*
32215	Treat chest lining	C						
32220	Release of lung	C						
32225	Partial release of lung	C						
32310	Removal of chest lining	C						
32320	Free/remove chest lining	C						
32400	Needle biopsy chest lining	T	0685	9.6666	$649.99		$130.00	*
32402	Open biopsy chest lining	C						
32405	Biopsy, lung or mediastinum	T	0685	9.6666	$649.99		$130.00	*
32420	Puncture/clear lung	T	0070	5.5521	$373.33		$74.67	*
32421	Thoracentesis for aspiration	T	0070	5.5521	$373.33		$74.67	*
32422	Thoracentesis w/tube insert	T	0070	5.5521	$373.33		$74.67	*
32440	Removal of lung	C						
32442	Sleeve pneumonectomy	C						
32445	Removal of lung	C						
32480	Partial removal of lung	C						
32482	Bilobectomy	C						
32484	Segmentectomy	C						
32486	Sleeve lobectomy	C						
32488	Completion pneumonectomy	C						
32491	Lung volume reduction	C						
32500	Partial removal of lung	C						
32501	Repair bronchus add-on	C						
32503	Resect apical lung tumor	C						
32504	Resect apical lung tum/chest	C						

32540	Removal of lung lesion	C						
32550	Insert pleural cath	T	0652	30.4602	$2,048.17		$409.64	*
32551	Insertion of chest tube	T	0070	5.5521	$373.33		$74.67	*
32552	Remove lung catheter	S	0078	1.4142	$95.09		$19.02	*
32553	Ins mark thor for rt perq	X	0310	13.7576	$925.07	$325.27	$185.02	*
32560	Treat pleurodesis w/agent	T	0070	5.5521	$373.33		$74.67	*
32561	Lyse chest fibrin init day	T	0070	5.5521	$373.33		$74.67	*
32562	Lyse chest fibrin subq day	T	0070	5.5521	$373.33		$74.67	*
32601	Thoracoscopy, diagnostic	T	0069	34.0084	$2,286.76	$591.64	$457.36	*
32602	Thoracoscopy, diagnostic	T	0069	34.0084	$2,286.76	$591.64	$457.36	*
32603	Thoracoscopy, diagnostic	T	0069	34.0084	$2,286.76	$591.64	$457.36	*
32604	Thoracoscopy, diagnostic	T	0069	34.0084	$2,286.76	$591.64	$457.36	*
32605	Thoracoscopy, diagnostic	T	0069	34.0084	$2,286.76	$591.64	$457.36	*
32606	Thoracoscopy, diagnostic	T	0069	34.0084	$2,286.76	$591.64	$457.36	*
32650	Thoracoscopy, surgical	C						
32651	Thoracoscopy, surgical	C						
32652	Thoracoscopy, surgical	C						
32653	Thoracoscopy, surgical	C						
32654	Thoracoscopy, surgical	C						
32655	Thoracoscopy, surgical	C						
32656	Thoracoscopy, surgical	C						
32657	Thoracoscopy, surgical	C						
32658	Thoracoscopy, surgical	C						
32659	Thoracoscopy, surgical	C						
32660	Thoracoscopy, surgical	C						
32661	Thoracoscopy, surgical	C						
32662	Thoracoscopy, surgical	C						
32663	Thoracoscopy, surgical	C						
32664	Thoracoscopy, surgical	C						
32665	Thoracoscopy, surgical	C						
32800	Repair lung hernia	C						
32810	Close chest after drainage	C						
32815	Close bronchial fistula	C						
32820	Reconstruct injured chest	C						
32850	Donor pneumonectomy	C						
32851	Lung transplant, single	C						
32852	Lung transplant with bypass	C						
32853	Lung transplant, double	C						
32854	Lung transplant with bypass	C						
32855	Prepare donor lung, single	C						
32856	Prepare donor lung, double	C						
32900	Removal of rib(s)	C						
32905	Revise & repair chest wall	C						
32906	Revise & repair chest wall	C						
32940	Revision of lung	C						
32960	Therapeutic pneumothorax	T	0070	5.5521	$373.33		$74.67	*
32997	Total lung lavage	C						
32998	Perq rf ablate tx, pul tumor	T	0423	51.3618	$3,453.62		$690.73	*
32999	Chest surgery procedure	T	0070	5.5521	$373.33		$74.67	*
33010	Drainage of heart sac	T	0070	5.5521	$373.33		$74.67	*
33011	Repeat drainage of heart sac	T	0070	5.5521	$373.33		$74.67	*
33015	Incision of heart sac	C						
33020	Incision of heart sac	C						
33025	Incision of heart sac	C						
33030	Partial removal of heart sac	C						
33031	Partial removal of heart sac	C						
33050	Removal of heart sac lesion	C						
33120	Removal of heart lesion	C						
33130	Removal of heart lesion	C						
33140	Heart revascularize (tmr)	C						
33141	Heart tmr w/other procedure	C						
33202	Insert epicard eltrd, open	C						

33203	Insert epicard eltrd, endo	C						
33206	Insertion of heart pacemaker	T	0089	118.8826	$7,993.78	$1,682.28	$1,598.76	*
33207	Insertion of heart pacemaker	T	0089	118.8826	$7,993.78	$1,682.28	$1,598.76	*
33208	Insertion of heart pacemaker	T	0655	142.1623	$9,559.14		$1,911.83	*
33210	Insertion of heart electrode	T	0106	48.9361	$3,290.51		$658.11	*
33211	Insertion of heart electrode	T	0106	48.9361	$3,290.51		$658.11	*
33212	Insertion of pulse generator	T	0090	98.1576	$6,600.22	$1,597.43	$1,320.05	*
33213	Insertion of pulse generator	T	0654	108.1692	$7,273.41		$1,454.69	*
33214	Upgrade of pacemaker system	T	0655	142.1623	$9,559.14		$1,911.83	*
33215	Reposition pacing-defib lead	T	0105	22.9412	$1,542.59		$308.52	*
33216	Insert 1 electrode pm-defib	T	0106	48.9361	$3,290.51		$658.11	*
33217	Insert 2 electrode pm-defib	T	0106	48.9361	$3,290.51		$658.11	*
33218	Repair lead pace-defib, one	T	0105	22.9412	$1,542.59		$308.52	*
33220	Repair lead pace-defib, dual	T	0105	22.9412	$1,542.59		$308.52	*
33222	Revise pocket, pacemaker	T	0136	16.0542	$1,079.50		$215.90	*
33223	Revise pocket for defib	T	0136	16.0542	$1,079.50		$215.90	*
33224	Insert pacing lead & connect	T	0418	204.1256	$13,725.61		$2,745.13	*
33225	L ventric pacing lead add-on	T	0418	204.1256	$13,725.61		$2,745.13	*
33226	Reposition l ventric lead	T	0105	22.9412	$1,542.59		$308.52	*
33233	Removal of pacemaker system	T	0105	22.9412	$1,542.59		$308.52	*
33234	Removal of pacemaker system	T	0105	22.9412	$1,542.59		$308.52	*
33235	Removal pacemaker electrode	T	0105	22.9412	$1,542.59		$308.52	*
33236	Remove electrode/thoracotomy	C						
33237	Remove electrode/thoracotomy	C						
33238	Remove electrode/thoracotomy	C						
33240	Insert pulse generator	T	0107	325.8288	$21,909.05		$4,381.81	*
33241	Remove pulse generator	T	0105	22.9412	$1,542.59		$308.52	*
33243	Remove eltrd/thoracotomy	C						
33244	Remove eltrd, transven	T	0105	22.9412	$1,542.59		$308.52	*
33249	Eltrd/insert pace-defib	T	0108	412.3722	$27,728.32		$5,545.67	*
33250	Ablate heart dysrhythm focus	C						
33251	Ablate heart dysrhythm focus	C						
33254	Ablate atria, lmtd	C						
33255	Ablate atria w/o bypass, ext	C						
33256	Ablate atria w/bypass, exten	C						
33257	Ablate atria, lmtd, add-on	C						
33258	Ablate atria, x10sv, add-on	C						
33259	Ablate atria w/bypass add-on	C						
33261	Ablate heart dysrhythm focus	C						
33265	Ablate atria, lmtd, endo	C						
33266	Ablate atria, x10sv, endo	C						
33282	Implant pat-active ht record	S	0680	78.0661	$5,249.24		$1,049.85	*
33284	Remove pat-active ht record	T	0020	8.2028	$551.56		$110.32	*
33300	Repair of heart wound	C						
33305	Repair of heart wound	C						
33310	Exploratory heart surgery	C						
33315	Exploratory heart surgery	C						
33320	Repair major blood vessel(s)	C						
33321	Repair major vessel	C						
33322	Repair major blood vessel(s)	C						
33330	Insert major vessel graft	C						
33332	Insert major vessel graft	C						
33335	Insert major vessel graft	C						
33400	Repair of aortic valve	C						
33401	Valvuloplasty, open	C						
33403	Valvuloplasty, w/cp bypass	C						
33404	Prepare heart-aorta conduit	C						
33405	Replacement of aortic valve	C						
33406	Replacement of aortic valve	C						
33410	Replacement of aortic valve	C						
33411	Replacement of aortic valve	C						
33412	Replacement of aortic valve	C						

33413	Replacement of aortic valve	C						
33414	Repair of aortic valve	C						
33415	Revision, subvalvular tissue	C						
33416	Revise ventricle muscle	C						
33417	Repair of aortic valve	C						
33420	Revision of mitral valve	C						
33422	Revision of mitral valve	C						
33425	Repair of mitral valve	C						
33426	Repair of mitral valve	C						
33427	Repair of mitral valve	C						
33430	Replacement of mitral valve	C						
33460	Revision of tricuspid valve	C						
33463	Valvuloplasty, tricuspid	C						
33464	Valvuloplasty, tricuspid	C						
33465	Replace tricuspid valve	C						
33468	Revision of tricuspid valve	C						
33470	Revision of pulmonary valve	C						
33471	Valvotomy, pulmonary valve	C						
33472	Revision of pulmonary valve	C						
33474	Revision of pulmonary valve	C						
33475	Replacement, pulmonary valve	C						
33476	Revision of heart chamber	C						
33478	Revision of heart chamber	C						
33496	Repair, prosth valve clot	C						
33500	Repair heart vessel fistula	C						
33501	Repair heart vessel fistula	C						
33502	Coronary artery correction	C						
33503	Coronary artery graft	C						
33504	Coronary artery graft	C						
33505	Repair artery w/tunnel	C						
33506	Repair artery, translocation	C						
33507	Repair art, intramural	C						
33508	Endoscopic vein harvest	N						
33510	CABG, vein, single	C						
33511	CABG, vein, two	C						
33512	CABG, vein, three	C						
33513	CABG, vein, four	C						
33514	CABG, vein, five	C						
33516	Cabg, vein, six or more	C						
33517	CABG, artery-vein, single	C						
33518	CABG, artery-vein, two	C						
33519	CABG, artery-vein, three	C						
33521	CABG, artery-vein, four	C						
33522	CABG, artery-vein, five	C						
33523	Cabg, art-vein, six or more	C						
33530	Coronary artery, bypass/reop	C						
33533	CABG, arterial, single	C						
33534	CABG, arterial, two	C						
33535	CABG, arterial, three	C						
33536	Cabg, arterial, four or more	C						
33542	Removal of heart lesion	C						
33545	Repair of heart damage	C						
33548	Restore/remodel, ventricle	C						
33572	Open coronary endarterectomy	C						
33600	Closure of valve	C						
33602	Closure of valve	C						
33606	Anastomosis/artery-aorta	C						
33608	Repair anomaly w/conduit	C						
33610	Repair by enlargement	C						
33611	Repair double ventricle	C						
33612	Repair double ventricle	C						
33615	Repair, modified fontan	C						

33617	Repair single ventricle	C						
33619	Repair single ventricle	C						
33641	Repair heart septum defect	C						
33645	Revision of heart veins	C						
33647	Repair heart septum defects	C						
33660	Repair of heart defects	C						
33665	Repair of heart defects	C						
33670	Repair of heart chambers	C						
33675	Close mult vsd	C						
33676	Close mult vsd w/resection	C						
33677	Cl mult vsd w/rem pul band	C						
33681	Repair heart septum defect	C						
33684	Repair heart septum defect	C						
33688	Repair heart septum defect	C						
33690	Reinforce pulmonary artery	C						
33692	Repair of heart defects	C						
33694	Repair of heart defects	C						
33697	Repair of heart defects	C						
33702	Repair of heart defects	C						
33710	Repair of heart defects	C						
33720	Repair of heart defect	C						
33722	Repair of heart defect	C						
33724	Repair venous anomaly	C						
33726	Repair pul venous stenosis	C						
33730	Repair heart-vein defect(s)	C						
33732	Repair heart-vein defect	C						
33735	Revision of heart chamber	C						
33736	Revision of heart chamber	C						
33737	Revision of heart chamber	C						
33750	Major vessel shunt	C						
33755	Major vessel shunt	C						
33762	Major vessel shunt	C						
33764	Major vessel shunt & graft	C						
33766	Major vessel shunt	C						
33767	Major vessel shunt	C						
33768	Cavopulmonary shunting	C						
33770	Repair great vessels defect	C						
33771	Repair great vessels defect	C						
33774	Repair great vessels defect	C						
33775	Repair great vessels defect	C						
33776	Repair great vessels defect	C						
33777	Repair great vessels defect	C						
33778	Repair great vessels defect	C						
33779	Repair great vessels defect	C						
33780	Repair great vessels defect	C						
33781	Repair great vessels defect	C						
33782	Nikaidoh proc	C						
33783	Nikaidoh proc w/ostia implt	C						
33786	Repair arterial trunk	C						
33788	Revision of pulmonary artery	C						
33800	Aortic suspension	C						
33802	Repair vessel defect	C						
33803	Repair vessel defect	C						
33813	Repair septal defect	C						
33814	Repair septal defect	C						
33820	Revise major vessel	C						
33822	Revise major vessel	C						
33824	Revise major vessel	C						
33840	Remove aorta constriction	C						
33845	Remove aorta constriction	C						
33851	Remove aorta constriction	C						
33852	Repair septal defect	C						

33853	Repair septal defect	C						
33860	Ascending aortic graft	C						
33861	Ascending aortic graft	C						
33863	Ascending aortic graft	C						
33864	Ascending aortic graft	C						
33870	Transverse aortic arch graft	C						
33875	Thoracic aortic graft	C						
33877	Thoracoabdominal graft	C						
33880	Endovasc taa repr incl subcl	C						
33881	Endovasc taa repr w/o subcl	C						
33883	Insert endovasc prosth, taa	C						
33884	Endovasc prosth, taa, add-on	C						
33886	Endovasc prosth, delayed	C						
33889	Artery transpose/endovas taa	C						
33891	Car-car bp grft/endovas taa	C						
33910	Remove lung artery emboli	C						
33915	Remove lung artery emboli	C						
33916	Surgery of great vessel	C						
33917	Repair pulmonary artery	C						
33920	Repair pulmonary atresia	C						
33922	Transect pulmonary artery	C						
33924	Remove pulmonary shunt	C						
33925	Rpr pul art unifocal w/o cpb	C						
33926	Repr pul art, unifocal w/cpb	C						
33930	Removal of donor heart/lung	C						
33933	Prepare donor heart/lung	C						
33935	Transplantation, heart/lung	C						
33940	Removal of donor heart	C						
33944	Prepare donor heart	C						
33945	Transplantation of heart	C						
33960	External circulation assist	C						
33961	External circulation assist	C						
33967	Insert ia percut device	C						
33968	Remove aortic assist device	C						
33970	Aortic circulation assist	C						
33971	Aortic circulation assist	C						
33973	Insert balloon device	C						
33974	Remove intra-aortic balloon	C						
33975	Implant ventricular device	C						
33976	Implant ventricular device	C						
33977	Remove ventricular device	C						
33978	Remove ventricular device	C						
33979	Insert intracorporeal device	C						
33980	Remove intracorporeal device	C						
33981	Replace vad pump ext	C						
33982	Replace vad intra w/o bp	C						
33983	Replace vad intra w/bp	C						
33999	Cardiac surgery procedure	T	0070	5.5521	$373.33		$74.67	*
34001	Removal of artery clot	C						
34051	Removal of artery clot	C						
34101	Removal of artery clot	T	0088	40.9003	$2,750.18	$655.22	$550.04	*
34111	Removal of arm artery clot	T	0088	40.9003	$2,750.18	$655.22	$550.04	*
34151	Removal of artery clot	C						
34201	Removal of artery clot	T	0088	40.9003	$2,750.18	$655.22	$550.04	*
34203	Removal of leg artery clot	T	0088	40.9003	$2,750.18	$655.22	$550.04	*
34401	Removal of vein clot	C						
34421	Removal of vein clot	T	0088	40.9003	$2,750.18	$655.22	$550.04	*
34451	Removal of vein clot	C						
34471	Removal of vein clot	T	0088	40.9003	$2,750.18	$655.22	$550.04	*
34490	Removal of vein clot	T	0088	40.9003	$2,750.18	$655.22	$550.04	*
34501	Repair valve, femoral vein	T	0088	40.9003	$2,750.18	$655.22	$550.04	*
34502	Reconstruct vena cava	C						

34510	Transposition of vein valve	T	0088	40.9003	$2,750.18	$655.22	$550.04	*
34520	Cross-over vein graft	T	0088	40.9003	$2,750.18	$655.22	$550.04	*
34530	Leg vein fusion	T	0088	40.9003	$2,750.18	$655.22	$550.04	*
34800	Endovas aaa repr w/sm tube	C						
34802	Endovas aaa repr w/2-p part	C						
34803	Endovas aaa repr w/3-p part	C						
34804	Endovas aaa repr w/1-p part	C						
34805	Endovas aaa repr w/long tube	C						
34806	Aneurysm press sensor add-on	C						
34808	Endovas iliac a device addon	C						
34812	Xpose for endoprosth, femorl	C						
34813	Femoral endovas graft add-on	C						
34820	Xpose for endoprosth, iliac	C						
34825	Endovasc extend prosth, init	C						
34826	Endovasc exten prosth, addl	C						
34830	Open aortic tube prosth repr	C						
34831	Open aortoiliac prosth repr	C						
34832	Open aortofemor prosth repr	C						
34833	Xpose for endoprosth, iliac	C						
34834	Xpose, endoprosth, brachial	C						
34900	Endovasc iliac repr w/graft	C						
35001	Repair defect of artery	C						
35002	Repair artery rupture, neck	C						
35005	Repair defect of artery	C						
35011	Repair defect of artery	T	0653	46.6883	$3,139.37		$627.88	*
35013	Repair artery rupture, arm	C						
35021	Repair defect of artery	C						
35022	Repair artery rupture, chest	C						
35045	Repair defect of arm artery	C						
35081	Repair defect of artery	C						
35082	Repair artery rupture, aorta	C						
35091	Repair defect of artery	C						
35092	Repair artery rupture, aorta	C						
35102	Repair defect of artery	C						
35103	Repair artery rupture, groin	C						
35111	Repair defect of artery	C						
35112	Repair artery rupture,spleen	C						
35121	Repair defect of artery	C						
35122	Repair artery rupture, belly	C						
35131	Repair defect of artery	C						
35132	Repair artery rupture, groin	C						
35141	Repair defect of artery	C						
35142	Repair artery rupture, thigh	C						
35151	Repair defect of artery	C						
35152	Repair artery rupture, knee	C						
35180	Repair blood vessel lesion	T	0093	35.5969	$2,393.57		$478.72	*
35182	Repair blood vessel lesion	C						
35184	Repair blood vessel lesion	T	0093	35.5969	$2,393.57		$478.72	*
35188	Repair blood vessel lesion	T	0088	40.9003	$2,750.18	$655.22	$550.04	*
35189	Repair blood vessel lesion	C						
35190	Repair blood vessel lesion	T	0093	35.5969	$2,393.57		$478.72	*
35201	Repair blood vessel lesion	T	0093	35.5969	$2,393.57		$478.72	*
35206	Repair blood vessel lesion	T	0093	35.5969	$2,393.57		$478.72	*
35207	Repair blood vessel lesion	T	0088	40.9003	$2,750.18	$655.22	$550.04	*
35211	Repair blood vessel lesion	C						
35216	Repair blood vessel lesion	C						
35221	Repair blood vessel lesion	C						
35226	Repair blood vessel lesion	T	0020	8.2028	$551.56		$110.32	*
35231	Repair blood vessel lesion	T	0093	35.5969	$2,393.57		$478.72	*
35236	Repair blood vessel lesion	T	0093	35.5969	$2,393.57		$478.72	*
35241	Repair blood vessel lesion	C						
35246	Repair blood vessel lesion	C						

35251	Repair blood vessel lesion	C						
35256	Repair blood vessel lesion	T	0093	35.5969	$2,393.57		$478.72	*
35261	Repair blood vessel lesion	T	0653	46.6883	$3,139.37		$627.88	*
35266	Repair blood vessel lesion	T	0653	46.6883	$3,139.37		$627.88	*
35271	Repair blood vessel lesion	C						
35276	Repair blood vessel lesion	C						
35281	Repair blood vessel lesion	C						
35286	Repair blood vessel lesion	T	0653	46.6883	$3,139.37		$627.88	*
35301	Rechanneling of artery	C						
35302	Rechanneling of artery	C						
35303	Rechanneling of artery	C						
35304	Rechanneling of artery	C						
35305	Rechanneling of artery	C						
35306	Rechanneling of artery	C						
35311	Rechanneling of artery	C						
35321	Rechanneling of artery	T	0093	35.5969	$2,393.57		$478.72	*
35331	Rechanneling of artery	C						
35341	Rechanneling of artery	C						
35351	Rechanneling of artery	C						
35355	Rechanneling of artery	C						
35361	Rechanneling of artery	C						
35363	Rechanneling of artery	C						
35371	Rechanneling of artery	C						
35372	Rechanneling of artery	C						
35390	Reoperation, carotid add-on	C						
35400	Angioscopy	C						
35450	Repair arterial blockage	C						
35452	Repair arterial blockage	C						
35454	Repair arterial blockage	C						
35456	Repair arterial blockage	C						
35458	Repair arterial blockage	T	0083	50.6809	$3,407.83		$681.57	*
35459	Repair arterial blockage	T	0083	50.6809	$3,407.83		$681.57	*
35460	Repair venous blockage	T	0083	50.6809	$3,407.83		$681.57	*
35470	Repair arterial blockage	T	0083	50.6809	$3,407.83		$681.57	*
35471	Repair arterial blockage	T	0083	50.6809	$3,407.83		$681.57	*
35472	Repair arterial blockage	T	0083	50.6809	$3,407.83		$681.57	*
35473	Repair arterial blockage	T	0083	50.6809	$3,407.83		$681.57	*
35474	Repair arterial blockage	T	0083	50.6809	$3,407.83		$681.57	*
35475	Repair arterial blockage	T	0083	50.6809	$3,407.83		$681.57	*
35476	Repair venous blockage	T	0083	50.6809	$3,407.83		$681.57	*
35480	Atherectomy, open	C						
35481	Atherectomy, open	C						
35482	Atherectomy, open	C						
35483	Atherectomy, open	C						
35484	Atherectomy, open	T	0082	93.3244	$6,275.23		$1,255.05	*
35485	Atherectomy, open	T	0082	93.3244	$6,275.23		$1,255.05	*
35490	Atherectomy, percutaneous	T	0082	93.3244	$6,275.23		$1,255.05	*
35491	Atherectomy, percutaneous	T	0082	93.3244	$6,275.23		$1,255.05	*
35492	Atherectomy, percutaneous	T	0082	93.3244	$6,275.23		$1,255.05	*
35493	Atherectomy, percutaneous	T	0082	93.3244	$6,275.23		$1,255.05	*
35494	Atherectomy, percutaneous	T	0082	93.3244	$6,275.23		$1,255.05	*
35495	Atherectomy, percutaneous	T	0082	93.3244	$6,275.23		$1,255.05	*
35500	Harvest vein for bypass	T	0103	17.8436	$1,199.82		$239.97	*
35501	Artery bypass graft	C						
35506	Artery bypass graft	C						
35508	Artery bypass graft	C						
35509	Artery bypass graft	C						
35510	Artery bypass graft	C						
35511	Artery bypass graft	C						
35512	Artery bypass graft	C						
35515	Artery bypass graft	C						
35516	Artery bypass graft	C						

35518	Artery bypass graft	C						
35521	Artery bypass graft	C						
35522	Artery bypass graft	C						
35523	Artery bypass graft	C						
35525	Artery bypass graft	C						
35526	Artery bypass graft	C						
35531	Artery bypass graft	C						
35533	Artery bypass graft	C						
35535	Artery bypass graft	C						
35536	Artery bypass graft	C						
35537	Artery bypass graft	C						
35538	Artery bypass graft	C						
35539	Artery bypass graft	C						
35540	Artery bypass graft	C						
35548	Artery bypass graft	C						
35549	Artery bypass graft	C						
35551	Artery bypass graft	C						
35556	Artery bypass graft	C						
35558	Artery bypass graft	C						
35560	Artery bypass graft	C						
35563	Artery bypass graft	C						
35565	Artery bypass graft	C						
35566	Artery bypass graft	C						
35570	Artery bypass graft	C						
35571	Artery bypass graft	C						
35572	Harvest femoropopliteal vein	N						
35583	Vein bypass graft	C						
35585	Vein bypass graft	C						
35587	Vein bypass graft	C						
35600	Harvest art for cabg add-on	C						
35601	Artery bypass graft	C						

35606	Artery bypass graft	C						
35612	Artery bypass graft	C						
35616	Artery bypass graft	C						
35621	Artery bypass graft	C						
35623	Bypass graft, not vein	C						
35626	Artery bypass graft	C						
35631	Artery bypass graft	C						
35632	Artery bypass graft	C						
35633	Artery bypass graft	C						
35634	Artery bypass graft	C						
35636	Artery bypass graft	C						
35637	Artery bypass graft	C						
35638	Artery bypass graft	C						
35638	Artery bypass graft	C						
35642	Artery bypass graft	C						
35645	Artery bypass graft	C						
35646	Artery bypass graft	C						
35647	Artery bypass graft	C						
35650	Artery bypass graft	C						
35651	Artery bypass graft	C						
35654	Artery bypass graft	C						
35656	Artery bypass graft	C						
35661	Artery bypass graft	C						
35663	Artery bypass graft	C						
35665	Artery bypass graft	C						
35666	Artery bypass graft	C						
35671	Artery bypass graft	C						
35681	Composite bypass graft	C						
35682	Composite bypass graft	C						
35683	Composite bypass graft	C						
35685	Bypass graft patency/patch	T	0093	35.5969	$2,393.57		$478.72	*

35686	Bypass graft/av fist patency	T	0093	35.5969	$2,393.57		$478.72	*
35691	Arterial transposition	C						
35693	Arterial transposition	C						
35694	Arterial transposition	C						
35695	Arterial transposition	C						
35697	Reimplant artery each	C						
35700	Reoperation, bypass graft	C						
35701	Exploration, carotid artery	C						
35721	Exploration, femoral artery	C						
35741	Exploration popliteal artery	C						
35761	Exploration of artery/vein	T	0093	35.5969	$2,393.57		$478.72	*
35800	Explore neck vessels	C						
35820	Explore chest vessels	C						
35840	Explore abdominal vessels	C						
35860	Explore limb vessels	T	0093	35.5969	$2,393.57		$478.72	*
35870	Repair vessel graft defect	C						
35875	Removal of clot in graft	T	0088	40.9003	$2,750.18	$655.22	$550.04	*
35876	Removal of clot in graft	T	0088	40.9003	$2,750.18	$655.22	$550.04	*
35879	Revise graft w/vein	T	0088	40.9003	$2,750.18	$655.22	$550.04	*
35881	Revise graft w/vein	T	0088	40.9003	$2,750.18	$655.22	$550.04	*
35883	Revise graft w/nonauto graft	T	0088	40.9003	$2,750.18	$655.22	$550.04	*
35884	Revise graft w/vein	T	0088	40.9003	$2,750.18	$655.22	$550.04	*
35901	Excision, graft, neck	C						
35903	Excision, graft, extremity	T	0093	35.5969	$2,393.57		$478.72	*
35905	Excision, graft, thorax	C						
35907	Excision, graft, abdomen	C						
36000	Place needle in vein	N						
36002	Pseudoaneurysm injection trt	S	0267	2.3005	$154.69	$60.50	$30.94	*
36005	Injection ext venography	N						
36010	Place catheter in vein	N						
36011	Place catheter in vein	N						
36012	Place catheter in vein	N						
36013	Place catheter in artery	N						
36014	Place catheter in artery	N						
36015	Place catheter in artery	N						
36100	Establish access to artery	N						
36120	Establish access to artery	N						
36140	Establish access to artery	N						
36147	Access av dial grft for eval	T	0676	2.3954	$161.07		$32.22	*
36148	Access av dial grft for proc	N						
36160	Establish access to aorta	N						
36200	Place catheter in aorta	N						
36215	Place catheter in artery	N						
36216	Place catheter in artery	N						
36217	Place catheter in artery	N						
36218	Place catheter in artery	N						
36245	Place catheter in artery	N						
36246	Place catheter in artery	N						
36247	Place catheter in artery	N						
36248	Place catheter in artery	N						
36260	Insertion of infusion pump	T	0623	30.4396	$2,046.79		$409.36	*
36261	Revision of infusion pump	T	0105	22.9412	$1,542.59		$308.52	*
36262	Removal of infusion pump	T	0105	22.9412	$1,542.59		$308.52	*
36299	Vessel injection procedure	N						
36400	Bl draw < 3 yrs fem/jugular	N						
36405	Bl draw < 3 yrs scalp vein	N						
36406	Bl draw < 3 yrs other vein	N						
36410	Non-routine bl draw > 3 yrs	N						
36415	Routine venipuncture	A						
36416	Capillary blood draw	N						
36420	Vein access cutdown < 1 yr	X	0035	0.232	$15.60		$3.12	*
36425	Vein access cutdown > 1 yr	X	0035	0.232	$15.60		$3.12	*

36430	Blood transfusion service	S	0110	3.3809	$227.34		$45.47	*
36440	Bl push transfuse, 2 yr or <	S	0110	3.3809	$227.34		$45.47	*
36450	Bl exchange/transfuse, nb	S	0110	3.3809	$227.34		$45.47	*
36455	Bl exchange/transfuse non-nb	S	0110	3.3809	$227.34		$45.47	*
36460	Transfusion service, fetal	S	0110	3.3809	$227.34		$45.47	*
36468	Injection(s), spider veins	T	0013	0.8789	$59.10		$11.82	*
36469	Injection(s), spider veins	T	0013	0.8789	$59.10		$11.82	*
36470	Injection therapy of vein	T	0013	0.8789	$59.10		$11.82	*
36471	Injection therapy of veins	T	0013	0.8789	$59.10		$11.82	*
36475	Endovenous rf, 1st vein	T	0091	45.0292	$3,027.81		$605.57	*
36476	Endovenous rf, vein add-on	T	0092	26.5713	$1,786.68		$357.34	*
36478	Endovenous laser, 1st vein	T	0092	26.5713	$1,786.68		$357.34	*
36479	Endovenous laser vein addon	T	0092	26.5713	$1,786.68		$357.34	*
36481	Insertion of catheter, vein	N						
36500	Insertion of catheter, vein	N						
36510	Insertion of catheter, vein	N						
36511	Apheresis wbc	S	0111	11.9424	$803.02	$198.40	$160.61	*
36512	Apheresis rbc	S	0111	11.9424	$803.02	$198.40	$160.61	*
36513	Apheresis platelets	S	0111	11.9424	$803.02	$198.40	$160.61	*
36514	Apheresis plasma	S	0111	11.9424	$803.02	$198.40	$160.61	*
36515	Apheresis, adsorp/reinfuse	S	0112	33.3206	$2,240.51		$448.11	*
36516	Apheresis, selective	S	0112	33.3206	$2,240.51		$448.11	*
36522	Photopheresis	S	0112	33.3206	$2,240.51		$448.11	*
36555	Insert non-tunnel cv cath	T	0621	11.166	$750.81		$150.17	*
36556	Insert non-tunnel cv cath	T	0621	11.166	$750.81		$150.17	*
36557	Insert tunneled cv cath	T	0622	25.3344	$1,703.51		$340.71	*
36558	Insert tunneled cv cath	T	0622	25.3344	$1,703.51		$340.71	*
36560	Insert tunneled cv cath	T	0623	30.4396	$2,046.79		$409.36	*
36561	Insert tunneled cv cath	T	0623	30.4396	$2,046.79		$409.36	*
36563	Insert tunneled cv cath	T	0623	30.4396	$2,046.79		$409.36	*
36565	Insert tunneled cv cath	T	0623	30.4396	$2,046.79		$409.36	*
36566	Insert tunneled cv cath	T	0623	30.4396	$2,046.79		$409.36	*
36568	Insert picc cath	T	0621	11.166	$750.81		$150.17	*
36569	Insert picc cath	T	0621	11.166	$750.81		$150.17	*
36570	Insert picvad cath	T	0622	25.3344	$1,703.51		$340.71	*
36571	Insert picvad cath	T	0622	25.3344	$1,703.51		$340.71	*
36575	Repair tunneled cv cath	T	0121	6.3742	$428.61		$85.73	*
36576	Repair tunneled cv cath	T	0621	11.166	$750.81		$150.17	*
36578	Replace tunneled cv cath	T	0622	25.3344	$1,703.51		$340.71	*
36580	Replace cvad cath	T	0621	11.166	$750.81		$150.17	*
36581	Replace tunneled cv cath	T	0622	25.3344	$1,703.51		$340.71	*
36582	Replace tunneled cv cath	T	0623	30.4396	$2,046.79		$409.36	*
36583	Replace tunneled cv cath	T	0623	30.4396	$2,046.79		$409.36	*
36584	Replace picc cath	T	0621	11.166	$750.81		$150.17	*
36585	Replace picvad cath	T	0622	25.3344	$1,703.51		$340.71	*
36589	Removal tunneled cv cath	T	0121	6.3742	$428.61		$85.73	*
36590	Removal tunneled cv cath	T	0621	11.166	$750.81		$150.17	*
36591	Draw blood off venous device	Q1	0624	0.6132	$41.23	$12.65	$8.25	*
36592	Collect blood from picc	Q1	0624	0.6132	$41.23	$12.65	$8.25	*
36593	Declot vascular device	T	0676	2.3954	$161.07		$32.22	*
36595	Mech remov tunneled cv cath	T	0622	25.3344	$1,703.51		$340.71	*
36596	Mech remov tunneled cv cath	T	0621	11.166	$750.81		$150.17	*
36597	Reposition venous catheter	T	0621	11.166	$750.81		$150.17	*
36598	Inj w/fluor, eval cv device	T	0676	2.3954	$161.07		$32.22	*
36600	Withdrawal of arterial blood	Q1	0035	0.232	$15.60		$3.12	*
36620	Insertion catheter, artery	N						
36625	Insertion catheter, artery	N						
36640	Insertion catheter, artery	T	0623	30.4396	$2,046.79		$409.36	*
36660	Insertion catheter, artery	C						
36680	Insert needle, bone cavity	T	0002	1.5111	$101.61		$20.33	*
36800	Insertion of cannula	T	0115	30.9784	$2,083.02		$416.61	*
36810	Insertion of cannula	T	0115	30.9784	$2,083.02		$416.61	*

36815	Insertion of cannula	T	0115	30.9784	$2,083.02		$416.61	*
36818	Av fuse, uppr arm, cephalic	T	0088	40.9003	$2,750.18	$655.22	$550.04	*
36819	Av fuse, uppr arm, basilic	T	0088	40.9003	$2,750.18	$655.22	$550.04	*
36820	Av fusion/forearm vein	T	0088	40.9003	$2,750.18	$655.22	$550.04	*
36821	Av fusion direct any site	T	0088	40.9003	$2,750.18	$655.22	$550.04	*
36822	Insertion of cannula(s)	C						
36823	Insertion of cannula(s)	C						
36825	Artery-vein autograft	T	0088	40.9003	$2,750.18	$655.22	$550.04	*
36830	Artery-vein nonautograft	T	0088	40.9003	$2,750.18	$655.22	$550.04	*
36831	Open thrombect av fistula	T	0088	40.9003	$2,750.18	$655.22	$550.04	*
36832	Av fistula revision, open	T	0088	40.9003	$2,750.18	$655.22	$550.04	*
36833	Av fistula revision	T	0088	40.9003	$2,750.18	$655.22	$550.04	*
36835	Artery to vein shunt	T	0115	30.9784	$2,083.02		$416.61	*
36838	Dist revas ligation, hemo	T	0088	40.9003	$2,750.18	$655.22	$550.04	*
36860	External cannula declotting	T	0676	2.3954	$161.07		$32.22	*
36861	Cannula declotting	T	0115	30.9784	$2,083.02		$416.61	*
36870	Percut thrombect av fistula	T	0653	46.6883	$3,139.37		$627.88	*
37140	Revision of circulation	C						
37145	Revision of circulation	C						
37160	Revision of circulation	C						
37180	Revision of circulation	C						
37181	Splice spleen/kidney veins	C						
37182	Insert hepatic shunt (tips)	C						
37183	Remove hepatic shunt (tips)	T	0229	97.291	$6,541.94		$1,308.39	*
37184	Prim art mech thrombectomy	T	0088	40.9003	$2,750.18	$655.22	$550.04	*
37185	Prim art m-thrombect add-on	T	0088	40.9003	$2,750.18	$655.22	$550.04	*
37186	Sec art m-thrombect add-on	T	0088	40.9003	$2,750.18	$655.22	$550.04	*
37187	Venous mech thrombectomy	T	0088	40.9003	$2,750.18	$655.22	$550.04	*
37188	Venous m-thrombectomy add-on	T	0088	40.9003	$2,750.18	$655.22	$550.04	*
37195	Thrombolytic therapy, stroke	T	0676	2.3954	$161.07		$32.22	*
37200	Transcatheter biopsy	T	0623	30.4396	$2,046.79		$409.36	*
37201	Transcatheter therapy infuse	T	0103	17.8436	$1,199.82		$239.97	*
37202	Transcatheter therapy infuse	T	0103	17.8436	$1,199.82		$239.97	*
37203	Transcatheter retrieval	T	0623	30.4396	$2,046.79		$409.36	*
37204	Transcatheter occlusion	T	0082	93.3244	$6,275.23		$1,255.05	*
37205	Transcath iv stent, percut	T	0229	97.291	$6,541.94		$1,308.39	*
37206	Transcath iv stent/perc addl	T	0229	97.291	$6,541.94		$1,308.39	*
37207	Transcath iv stent, open	T	0229	97.291	$6,541.94		$1,308.39	*
37208	Transcath iv stent/open addl	T	0229	97.291	$6,541.94		$1,308.39	*
37209	Change iv cath at thromb tx	T	0623	30.4396	$2,046.79		$409.36	*
37210	Embolization uterine fibroid	T	0229	97.291	$6,541.94		$1,308.39	*
37215	Transcath stent, cca w/eps	C						
37216	Transcath stent, cca w/o eps	E						
37250	Iv us first vessel add-on	N						
37251	Iv us each add vessel add-on	N						
37500	Endoscopy ligate perf veins	T	0091	45.0292	$3,027.81		$605.57	*
37501	Vascular endoscopy procedure	T	0092	26.5713	$1,786.68		$357.34	*
37565	Ligation of neck vein	T	0093	35.5969	$2,393.57		$478.72	*
37600	Ligation of neck artery	T	0093	35.5969	$2,393.57		$478.72	*
37605	Ligation of neck artery	T	0091	45.0292	$3,027.81		$605.57	*
37606	Ligation of neck artery	T	0092	26.5713	$1,786.68		$357.34	*
37607	Ligation of a-v fistula	T	0092	26.5713	$1,786.68		$357.34	*
37609	Temporal artery procedure	T	0021	17.4975	$1,176.55		$235.31	*
37615	Ligation of neck artery	T	0092	26.5713	$1,786.68		$357.34	*
37616	Ligation of chest artery	C						
37617	Ligation of abdomen artery	C						
37618	Ligation of extremity artery	C						
37620	Revision of major vein	T	0091	45.0292	$3,027.81		$605.57	*
37650	Revision of major vein	T	0092	26.5713	$1,786.68		$357.34	*
37660	Revision of major vein	C						
37700	Revise leg vein	T	0092	26.5713	$1,786.68		$357.34	*
37718	Ligate/strip short leg vein	T	0092	26.5713	$1,786.68		$357.34	*

37722	Ligate/strip long leg vein	T	0091	45.0292	$3,027.81		$605.57	*
37735	Removal of leg veins/lesion	T	0091	45.0292	$3,027.81		$605.57	*
37760	Ligate leg veins radical	T	0092	26.5713	$1,786.68		$357.34	*
37761	Ligate leg veins open	T	0092	26.5713	$1,786.68		$357.34	*
37765	Phleb veins - extrem - to 20	T	0092	26.5713	$1,786.68		$357.34	*
37766	Phleb veins - extrem 20+	T	0092	26.5713	$1,786.68		$357.34	*
37780	Revision of leg vein	T	0092	26.5713	$1,786.68		$357.34	*
37785	Ligate/divide/excise vein	T	0092	26.5713	$1,786.68		$357.34	*
37788	Revascularization, penis	C						
37790	Penile venous occlusion	T	0181	34.8837	$2,345.61	$620.84	$469.13	*
37799	Vascular surgery procedure	X	0624	0.6132	$41.23	$12.65	$8.25	*
38100	Removal of spleen, total	C						
38101	Removal of spleen, partial	C						
38102	Removal of spleen, total	C						
38115	Repair of ruptured spleen	C						
38120	Laparoscopy, splenectomy	T	0131	46.84	$3,149.57	$1,001.89	$629.92	*
38129	Laparoscope proc, spleen	T	0130	38.054	$2,558.79	$659.53	$511.76	*
38200	Injection for spleen x-ray	N						
38204	Bl donor search management	N						
38205	Harvest allogenic stem cells	B						
38206	Harvest auto stem cells	S	0111	11.9424	$803.02	$198.40	$160.61	*
38207	Cryopreserve stem cells	S	0110	3.3809	$227.34		$45.47	*
38208	Thaw preserved stem cells	S	0110	3.3809	$227.34		$45.47	*
38209	Wash harvest stem cells	S	0110	3.3809	$227.34		$45.47	*
38210	T-cell depletion of harvest	S	0393	5.7873	$389.14	$79.77	$77.83	*
38211	Tumor cell deplete of harvst	S	0393	5.7873	$389.14	$79.77	$77.83	*
38212	Rbc depletion of harvest	S	0393	5.7873	$389.14	$79.77	$77.83	*
38213	Platelet deplete of harvest	S	0393	5.7873	$389.14	$79.77	$77.83	*
38214	Volume deplete of harvest	S	0393	5.7873	$389.14	$79.77	$77.83	*
38215	Harvest stem cell concentrte	S	0393	5.7873	$389.14	$79.77	$77.83	*
38220	Bone marrow aspiration	T	0003	3.0998	$208.43		$41.69	*
38221	Bone marrow biopsy	T	0003	3.0998	$208.43		$41.69	*
38230	Bone marrow collection	S	0112	33.3206	$2,240.51		$448.11	*
38240	Bone marrow/stem transplant	S	0112	33.3206	$2,240.51		$448.11	*
38241	Bone marrow/stem transplant	S	0112	33.3206	$2,240.51		$448.11	*
38242	Lymphocyte infuse transplant	S	0111	11.9424	$803.02	$198.40	$160.61	*
38300	Drainage, lymph node lesion	T	0007	12.6217	$848.70		$169.74	*
38305	Drainage, lymph node lesion	T	0008	19.4063	$1,304.90		$260.98	*
38308	Incision of lymph channels	T	0113	24.6146	$1,655.11		$331.03	*
38380	Thoracic duct procedure	C						
38381	Thoracic duct procedure	C						
38382	Thoracic duct procedure	C						
38500	Biopsy/removal, lymph nodes	T	0113	24.6146	$1,655.11		$331.03	*
38505	Needle biopsy, lymph nodes	T	0005	7.8145	$525.45		$105.09	*
38510	Biopsy/removal, lymph nodes	T	0113	24.6146	$1,655.11		$331.03	*
38520	Biopsy/removal, lymph nodes	T	0113	24.6146	$1,655.11		$331.03	*
38525	Biopsy/removal, lymph nodes	T	0113	24.6146	$1,655.11		$331.03	*
38530	Biopsy/removal, lymph nodes	T	0113	24.6146	$1,655.11		$331.03	*
38542	Explore deep node(s), neck	T	0114	48.7561	$3,278.41		$655.69	*
38550	Removal, neck/armpit lesion	T	0113	24.6146	$1,655.11		$331.03	*
38555	Removal, neck/armpit lesion	T	0113	24.6146	$1,655.11		$331.03	*
38562	Removal, pelvic lymph nodes	C						
38564	Removal, abdomen lymph nodes	C						
38570	Laparoscopy, lymph node biop	T	0131	46.84	$3,149.57	$1,001.89	$629.92	*
38571	Laparoscopy, lymphadenectomy	T	0132	72.9582	$4,905.78	$1,239.22	$981.16	*
38572	Laparoscopy, lymphadenectomy	T	0131	46.84	$3,149.57	$1,001.89	$629.92	*
38589	Laparoscope proc, lymphatic	T	0130	38.054	$2,558.79	$659.53	$511.76	*
38700	Removal of lymph nodes, neck	T	0113	24.6146	$1,655.11		$331.03	*
38720	Removal of lymph nodes, neck	T	0113	24.6146	$1,655.11		$331.03	*
38724	Removal of lymph nodes, neck	C						
38740	Remove armpit lymph nodes	T	0114	48.7561	$3,278.41		$655.69	*
38745	Remove armpit lymph nodes	T	0114	48.7561	$3,278.41		$655.69	*

38746	Remove thoracic lymph nodes	C						
38747	Remove abdominal lymph nodes	C						
38760	Remove groin lymph nodes	T	0113	24.6146	$1,655.11		$331.03	*
38765	Remove groin lymph nodes	C						
38770	Remove pelvis lymph nodes	C						
38780	Remove abdomen lymph nodes	C						
38790	Inject for lymphatic x-ray	N						
38792	Identify sentinel node	Q1	0392	2.6817	$180.32	$43.95	$36.07	*
38794	Access thoracic lymph duct	N						
38999	Blood/lymph system procedure	S	0110	3.3809	$227.34		$45.47	*
39000	Exploration of chest	C						
39010	Exploration of chest	C						
39200	Removal chest lesion	C						
39220	Removal chest lesion	C						
39400	Visualization of chest	T	0069	34.0084	$2,286.76	$591.64	$457.36	*
39499	Chest procedure	C						
39501	Repair diaphragm laceration	C						
39502	Repair paraesophageal hernia	C						
39503	Repair of diaphragm hernia	C						
39520	Repair of diaphragm hernia	C						
39530	Repair of diaphragm hernia	C						
39531	Repair of diaphragm hernia	C						
39540	Repair of diaphragm hernia	C						
39541	Repair of diaphragm hernia	C						
39545	Revision of diaphragm	C						
39560	Resect diaphragm, simple	C						
39561	Resect diaphragm, complex	C						
39599	Diaphragm surgery procedure	C						
40490	Biopsy of lip	T	0251	3.425	$230.30		$46.06	*
40500	Partial excision of lip	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
40510	Partial excision of lip	T	0254	24.9637	$1,678.58		$335.72	*
40520	Partial excision of lip	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
40525	Reconstruct lip with flap	T	0254	24.9637	$1,678.58		$335.72	*
40527	Reconstruct lip with flap	T	0254	24.9637	$1,678.58		$335.72	*
40530	Partial removal of lip	T	0254	24.9637	$1,678.58		$335.72	*
40650	Repair lip	T	0252	7.6196	$512.35	$109.16	$102.47	*
40652	Repair lip	T	0252	7.6196	$512.35	$109.16	$102.47	*
40654	Repair lip	T	0252	7.6196	$512.35	$109.16	$102.47	*
40700	Repair cleft lip/nasal	T	0256	42.9827	$2,890.20		$578.04	*
40701	Repair cleft lip/nasal	T	0256	42.9827	$2,890.20		$578.04	*
40702	Repair cleft lip/nasal	T	0256	42.9827	$2,890.20		$578.04	*
40720	Repair cleft lip/nasal	T	0256	42.9827	$2,890.20		$578.04	*
40761	Repair cleft lip/nasal	T	0256	42.9827	$2,890.20		$578.04	*
40799	Lip surgery procedure	T	0250	1.1522	$77.48	$25.10	$15.50	*
40800	Drainage of mouth lesion	T	0006	1.4557	$97.88		$19.58	*
40801	Drainage of mouth lesion	T	0252	7.6196	$512.35	$109.16	$102.47	*
40804	Removal, foreign body, mouth	X	0340	0.6693	$45.00		$9.00	*
40805	Removal, foreign body, mouth	T	0252	7.6196	$512.35	$109.16	$102.47	*
40806	Incision of lip fold	T	0251	3.425	$230.30		$46.06	*
40808	Biopsy of mouth lesion	T	0251	3.425	$230.30		$46.06	*
40810	Excision of mouth lesion	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
40812	Excise/repair mouth lesion	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
40814	Excise/repair mouth lesion	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
40816	Excision of mouth lesion	T	0254	24.9637	$1,678.58		$335.72	*
40818	Excise oral mucosa for graft	T	0251	3.425	$230.30		$46.06	*
40819	Excise lip or cheek fold	T	0252	7.6196	$512.35	$109.16	$102.47	*
40820	Treatment of mouth lesion	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
40830	Repair mouth laceration	T	0251	3.425	$230.30		$46.06	*
40831	Repair mouth laceration	T	0252	7.6196	$512.35	$109.16	$102.47	*
40840	Reconstruction of mouth	T	0254	24.9637	$1,678.58		$335.72	*
40842	Reconstruction of mouth	T	0254	24.9637	$1,678.58		$335.72	*
40843	Reconstruction of mouth	T	0254	24.9637	$1,678.58		$335.72	*

40844	Reconstruction of mouth	T	0256	42.9827	$2,890.20		$578.04	*
40845	Reconstruction of mouth	T	0256	42.9827	$2,890.20		$578.04	*
40899	Mouth surgery procedure	T	0250	1.1522	$77.48	$25.10	$15.50	*
41000	Drainage of mouth lesion	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
41005	Drainage of mouth lesion	T	0251	3.425	$230.30		$46.06	*
41006	Drainage of mouth lesion	T	0254	24.9637	$1,678.58		$335.72	*
41007	Drainage of mouth lesion	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
41008	Drainage of mouth lesion	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
41009	Drainage of mouth lesion	T	0251	3.425	$230.30		$46.06	*
41010	Incision of tongue fold	T	0252	7.6196	$512.35	$109.16	$102.47	*
41015	Drainage of mouth lesion	T	0251	3.425	$230.30		$46.06	*
41016	Drainage of mouth lesion	T	0252	7.6196	$512.35	$109.16	$102.47	*
41017	Drainage of mouth lesion	T	0252	7.6196	$512.35	$109.16	$102.47	*
41018	Drainage of mouth lesion	T	0252	7.6196	$512.35	$109.16	$102.47	*
41019	Place needles h&n for rt	T	0254	24.9637	$1,678.58		$335.72	*
41100	Biopsy of tongue	T	0252	7.6196	$512.35	$109.16	$102.47	*
41105	Biopsy of tongue	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
41108	Biopsy of floor of mouth	T	0019	4.3625	$293.34	$64.35	$58.67	*
41110	Excision of tongue lesion	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
41112	Excision of tongue lesion	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
41113	Excision of tongue lesion	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
41114	Excision of tongue lesion	T	0254	24.9637	$1,678.58		$335.72	*
41115	Excision of tongue fold	T	0252	7.6196	$512.35	$109.16	$102.47	*
41116	Excision of mouth lesion	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
41120	Partial removal of tongue	T	0254	24.9637	$1,678.58		$335.72	*
41130	Partial removal of tongue	C						
41135	Tongue and neck surgery	C						
41140	Removal of tongue	C						
41145	Tongue removal, neck surgery	C						
41150	Tongue, mouth, jaw surgery	C						
41153	Tongue, mouth, neck surgery	C						
41155	Tongue, jaw, & neck surgery	C						
41250	Repair tongue laceration	T	0250	1.1522	$77.48	$25.10	$15.50	*
41251	Repair tongue laceration	T	0251	3.425	$230.30		$46.06	*
41252	Repair tongue laceration	T	0252	7.6196	$512.35	$109.16	$102.47	*
41500	Fixation of tongue	T	0254	24.9637	$1,678.58		$335.72	*
41510	Tongue to lip surgery	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
41512	Tongue suspension	T	0252	7.6196	$512.35	$109.16	$102.47	*
41520	Reconstruction, tongue fold	T	0252	7.6196	$512.35	$109.16	$102.47	*
41530	Tongue base vol reduction	T	0254	24.9637	$1,678.58		$335.72	*
41599	Tongue and mouth surgery	T	0250	1.1522	$77.48	$25.10	$15.50	*
41800	Drainage of gum lesion	T	0006	1.4557	$97.88		$19.58	*
41805	Removal foreign body, gum	T	0254	24.9637	$1,678.58		$335.72	*
41806	Removal foreign body,jawbone	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
41820	Excision, gum, each quadrant	T	0252	7.6196	$512.35	$109.16	$102.47	*
41821	Excision of gum flap	T	0252	7.6196	$512.35	$109.16	$102.47	*
41822	Excision of gum lesion	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
41823	Excision of gum lesion	T	0254	24.9637	$1,678.58		$335.72	*
41825	Excision of gum lesion	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
41826	Excision of gum lesion	T	0254	24.9637	$1,678.58		$335.72	*
41827	Excision of gum lesion	T	0254	24.9637	$1,678.58		$335.72	*
41828	Excision of gum lesion	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
41830	Removal of gum tissue	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
41850	Treatment of gum lesion	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
41870	Gum graft	T	0254	24.9637	$1,678.58		$335.72	*
41872	Repair gum	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
41874	Repair tooth socket	T	0254	24.9637	$1,678.58		$335.72	*
41899	Dental surgery procedure	T	0250	1.1522	$77.48	$25.10	$15.50	*
42000	Drainage mouth roof lesion	T	0251	3.425	$230.30		$46.06	*
42100	Biopsy roof of mouth	T	0252	7.6196	$512.35	$109.16	$102.47	*
42104	Excision lesion, mouth roof	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
42106	Excision lesion, mouth roof	T	0253	17.1879	$1,155.73	$282.29	$231.15	*

42107	Excision lesion, mouth roof	T	0254	24.9637	$1,678.58		$335.72	*
42120	Remove palate/lesion	T	0256	42.9827	$2,890.20		$578.04	*
42140	Excision of uvula	T	0252	7.6196	$512.35	$109.16	$102.47	*
42145	Repair palate, pharynx/uvula	T	0254	24.9637	$1,678.58		$335.72	*
42160	Treatment mouth roof lesion	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
42180	Repair palate	T	0251	3.425	$230.30		$46.06	*
42182	Repair palate	T	0256	42.9827	$2,890.20		$578.04	*
42200	Reconstruct cleft palate	T	0256	42.9827	$2,890.20		$578.04	*
42205	Reconstruct cleft palate	T	0256	42.9827	$2,890.20		$578.04	*
42210	Reconstruct cleft palate	T	0256	42.9827	$2,890.20		$578.04	*
42215	Reconstruct cleft palate	T	0256	42.9827	$2,890.20		$578.04	*
42220	Reconstruct cleft palate	T	0256	42.9827	$2,890.20		$578.04	*
42225	Reconstruct cleft palate	T	0256	42.9827	$2,890.20		$578.04	*
42226	Lengthening of palate	T	0256	42.9827	$2,890.20		$578.04	*
42227	Lengthening of palate	T	0256	42.9827	$2,890.20		$578.04	*
42235	Repair palate	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
42260	Repair nose to lip fistula	T	0254	24.9637	$1,678.58		$335.72	*
42280	Preparation, palate mold	T	0251	3.425	$230.30		$46.06	*
42281	Insertion, palate prosthesis	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
42299	Palate/uvula surgery	T	0250	1.1522	$77.48	$25.10	$15.50	*
42300	Drainage of salivary gland	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
42305	Drainage of salivary gland	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
42310	Drainage of salivary gland	T	0251	3.425	$230.30		$46.06	*
42320	Drainage of salivary gland	T	0251	3.425	$230.30		$46.06	*
42330	Removal of salivary stone	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
42335	Removal of salivary stone	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
42340	Removal of salivary stone	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
42400	Biopsy of salivary gland	T	0005	7.8145	$525.45		$105.09	*
42405	Biopsy of salivary gland	T	0254	24.9637	$1,678.58		$335.72	*
42408	Excision of salivary cyst	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
42409	Drainage of salivary cyst	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
42410	Excise parotid gland/lesion	T	0256	42.9827	$2,890.20		$578.04	*
42415	Excise parotid gland/lesion	T	0256	42.9827	$2,890.20		$578.04	*
42420	Excise parotid gland/lesion	T	0256	42.9827	$2,890.20		$578.04	*
42425	Excise parotid gland/lesion	T	0256	42.9827	$2,890.20		$578.04	*
42426	Excise parotid gland/lesion	C						
42440	Excise submaxillary gland	T	0256	42.9827	$2,890.20		$578.04	*
42450	Excise sublingual gland	T	0254	24.9637	$1,678.58		$335.72	*
42500	Repair salivary duct	T	0254	24.9637	$1,678.58		$335.72	*
42505	Repair salivary duct	T	0256	42.9827	$2,890.20		$578.04	*
42507	Parotid duct diversion	T	0256	42.9827	$2,890.20		$578.04	*
42508	Parotid duct diversion	T	0256	42.9827	$2,890.20		$578.04	*
42509	Parotid duct diversion	T	0256	42.9827	$2,890.20		$578.04	*
42510	Parotid duct diversion	T	0256	42.9827	$2,890.20		$578.04	*
42550	Injection for salivary x-ray	N						
42600	Closure of salivary fistula	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
42650	Dilation of salivary duct	T	0252	7.6196	$512.35	$109.16	$102.47	*
42660	Dilation of salivary duct	T	0251	3.425	$230.30		$46.06	*
42665	Ligation of salivary duct	T	0254	24.9637	$1,678.58		$335.72	*
42699	Salivary surgery procedure	T	0250	1.1522	$77.48	$25.10	$15.50	*
42700	Drainage of tonsil abscess	T	0251	3.425	$230.30		$46.06	*
42720	Drainage of throat abscess	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
42725	Drainage of throat abscess	T	0256	42.9827	$2,890.20		$578.04	*
42800	Biopsy of throat	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
42802	Biopsy of throat	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
42804	Biopsy of upper nose/throat	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
42806	Biopsy of upper nose/throat	T	0254	24.9637	$1,678.58		$335.72	*
42808	Excise pharynx lesion	T	0254	24.9637	$1,678.58		$335.72	*
42809	Remove pharynx foreign body	X	0340	0.6693	$45.00		$9.00	*
42810	Excision of neck cyst	T	0254	24.9637	$1,678.58		$335.72	*
42815	Excision of neck cyst	T	0256	42.9827	$2,890.20		$578.04	*
42820	Remove tonsils and adenoids	T	0254	24.9637	$1,678.58		$335.72	*

42821	Remove tonsils and adenoids	T	0254	24.9637	$1,678.58		$335.72	*
42825	Removal of tonsils	T	0254	24.9637	$1,678.58		$335.72	*
42826	Removal of tonsils	T	0254	24.9637	$1,678.58		$335.72	*
42830	Removal of adenoids	T	0254	24.9637	$1,678.58		$335.72	*
42831	Removal of adenoids	T	0254	24.9637	$1,678.58		$335.72	*
42835	Removal of adenoids	T	0254	24.9637	$1,678.58		$335.72	*
42836	Removal of adenoids	T	0254	24.9637	$1,678.58		$335.72	*
42842	Extensive surgery of throat	T	0254	24.9637	$1,678.58		$335.72	*
42844	Extensive surgery of throat	T	0256	42.9827	$2,890.20		$578.04	*
42845	Extensive surgery of throat	C						
42860	Excision of tonsil tags	T	0254	24.9637	$1,678.58		$335.72	*
42870	Excision of lingual tonsil	T	0254	24.9637	$1,678.58		$335.72	*
42890	Partial removal of pharynx	T	0256	42.9827	$2,890.20		$578.04	*
42892	Revision of pharyngeal walls	T	0256	42.9827	$2,890.20		$578.04	*
42894	Revision of pharyngeal walls	C						
42900	Repair throat wound	T	0252	7.6196	$512.35	$109.16	$102.47	*
42950	Reconstruction of throat	T	0254	24.9637	$1,678.58		$335.72	*
42953	Repair throat, esophagus	C						
42955	Surgical opening of throat	T	0254	24.9637	$1,678.58		$335.72	*
42960	Control throat bleeding	T	0250	1.1522	$77.48	$25.10	$15.50	*
42961	Control throat bleeding	C						
42962	Control throat bleeding	T	0256	42.9827	$2,890.20		$578.04	*
42970	Control nose/throat bleeding	T	0250	1.1522	$77.48	$25.10	$15.50	*
42971	Control nose/throat bleeding	C						
42972	Control nose/throat bleeding	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
42999	Throat surgery procedure	T	0250	1.1522	$77.48	$25.10	$15.50	*
43020	Incision of esophagus	T	0252	7.6196	$512.35	$109.16	$102.47	*
43030	Throat muscle surgery	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
43045	Incision of esophagus	C						
43100	Excision of esophagus lesion	C						
43101	Excision of esophagus lesion	C						
43107	Removal of esophagus	C						
43108	Removal of esophagus	C						
43112	Removal of esophagus	C						
43113	Removal of esophagus	C						
43116	Partial removal of esophagus	C						
43117	Partial removal of esophagus	C						
43118	Partial removal of esophagus	C						
43121	Partial removal of esophagus	C						
43122	Partial removal of esophagus	C						
43123	Partial removal of esophagus	C						
43124	Removal of esophagus	C						
43130	Removal of esophagus pouch	T	0256	42.9827	$2,890.20		$578.04	*
43135	Removal of esophagus pouch	C						
43200	Esophagus endoscopy	T	0141	8.7462	$588.10	$143.38	$117.62	*
43201	Esoph scope w/submucous inj	T	0141	8.7462	$588.10	$143.38	$117.62	*
43202	Esophagus endoscopy, biopsy	T	0141	8.7462	$588.10	$143.38	$117.62	*
43204	Esoph scope w/sclerosis inj	T	0141	8.7462	$588.10	$143.38	$117.62	*
43205	Esophagus endoscopy/ligation	T	0141	8.7462	$588.10	$143.38	$117.62	*
43215	Esophagus endoscopy	T	0141	8.7462	$588.10	$143.38	$117.62	*
43216	Esophagus endoscopy/lesion	T	0141	8.7462	$588.10	$143.38	$117.62	*
43217	Esophagus endoscopy	T	0141	8.7462	$588.10	$143.38	$117.62	*
43219	Esophagus endoscopy	T	0384	26.4913	$1,781.30		$356.26	*
43220	Esoph endoscopy, dilation	T	0141	8.7462	$588.10	$143.38	$117.62	*
43226	Esoph endoscopy, dilation	T	0141	8.7462	$588.10	$143.38	$117.62	*
43227	Esoph endoscopy, repair	T	0141	8.7462	$588.10	$143.38	$117.62	*
43228	Esoph endoscopy, ablation	T	0422	24.2703	$1,631.96	$436.89	$326.40	*
43231	Esoph endoscopy w/us exam	T	0141	8.7462	$588.10	$143.38	$117.62	*
43232	Esoph endoscopy w/us fn bx	T	0141	8.7462	$588.10	$143.38	$117.62	*
43234	Upper GI endoscopy, exam	T	0141	8.7462	$588.10	$143.38	$117.62	*
43235	Uppr gi endoscopy, diagnosis	T	0141	8.7462	$588.10	$143.38	$117.62	*
43236	Uppr gi scope w/submuc inj	T	0141	8.7462	$588.10	$143.38	$117.62	*

43237	Endoscopic us exam, esoph	T	0141	8.7462	$588.10	$143.38	$117.62	*
43238	Uppr gi endoscopy w/us fn bx	T	0141	8.7462	$588.10	$143.38	$117.62	*
43239	Upper GI endoscopy, biopsy	T	0141	8.7462	$588.10	$143.38	$117.62	*
43240	Esoph endoscope w/drain cyst	T	0141	8.7462	$588.10	$143.38	$117.62	*
43241	Upper GI endoscopy with tube	T	0141	8.7462	$588.10	$143.38	$117.62	*
43242	Uppr gi endoscopy w/us fn bx	T	0141	8.7462	$588.10	$143.38	$117.62	*
43243	Upper gi endoscopy & inject	T	0141	8.7462	$588.10	$143.38	$117.62	*
43244	Upper GI endoscopy/ligation	T	0141	8.7462	$588.10	$143.38	$117.62	*
43245	Uppr gi scope dilate strictr	T	0141	8.7462	$588.10	$143.38	$117.62	*
43246	Place gastrostomy tube	T	0141	8.7462	$588.10	$143.38	$117.62	*
43247	Operative upper GI endoscopy	T	0141	8.7462	$588.10	$143.38	$117.62	*
43248	Uppr gi endoscopy/guide wire	T	0141	8.7462	$588.10	$143.38	$117.62	*
43249	Esoph endoscopy, dilation	T	0141	8.7462	$588.10	$143.38	$117.62	*
43250	Upper GI endoscopy/tumor	T	0141	8.7462	$588.10	$143.38	$117.62	*
43251	Operative upper GI endoscopy	T	0141	8.7462	$588.10	$143.38	$117.62	*
43255	Operative upper GI endoscopy	T	0141	8.7462	$588.10	$143.38	$117.62	*
43256	Uppr gi endoscopy w/stent	T	0384	26.4913	$1,781.30		$356.26	*
43257	Uppr gi scope w/thrml txmnt	T	0422	24.2703	$1,631.96	$436.89	$326.40	*
43258	Operative upper GI endoscopy	T	0141	8.7462	$588.10	$143.38	$117.62	*
43259	Endoscopic ultrasound exam	T	0141	8.7462	$588.10	$143.38	$117.62	*
43260	Endo cholangiopancreatograph	T	0151	22.6111	$1,520.39		$304.08	*
43261	Endo cholangiopancreatograph	T	0151	22.6111	$1,520.39		$304.08	*
43262	Endo cholangiopancreatograph	T	0151	22.6111	$1,520.39		$304.08	*
43263	Endo cholangiopancreatograph	T	0151	22.6111	$1,520.39		$304.08	*
43264	Endo cholangiopancreatograph	T	0151	22.6111	$1,520.39		$304.08	*
43265	Endo cholangiopancreatograph	T	0151	22.6111	$1,520.39		$304.08	*
43267	Endo cholangiopancreatograph	T	0151	22.6111	$1,520.39		$304.08	*
43268	Endo cholangiopancreatograph	T	0384	26.4913	$1,781.30		$356.26	*
43269	Endo cholangiopancreatograph	T	0384	26.4913	$1,781.30		$356.26	*
43271	Endo cholangiopancreatograph	T	0151	22.6111	$1,520.39		$304.08	*
43272	Endo cholangiopancreatograph	T	0151	22.6111	$1,520.39		$304.08	*
43273	Endoscopic pancreatoscopy	T	0151	22.6111	$1,520.39		$304.08	*
43279	Lap myotomy, heller	C						
43280	Laparoscopy, fundoplasty	T	0132	72.9582	$4,905.78	$1,239.22	$981.16	*
43281	Lap paraesophag hern repair	C						
43282	Lap paraesoph her rpr w/mesh	C						
43289	Laparoscope proc, esoph	T	0130	38.054	$2,558.79	$659.53	$511.76	*
43300	Repair of esophagus	C						
43305	Repair esophagus and fistula	C						
43310	Repair of esophagus	C						
43312	Repair esophagus and fistula	C						
43313	Esophagoplasty congenital	C						
43314	Tracheo-esophagoplasty cong	C						
43320	Fuse esophagus & stomach	C						
43324	Revise esophagus & stomach	C						
43325	Revise esophagus & stomach	C						
43326	Revise esophagus & stomach	C						
43330	Repair of esophagus	C						
43331	Repair of esophagus	C						
43340	Fuse esophagus & intestine	C						
43341	Fuse esophagus & intestine	C						
43350	Surgical opening, esophagus	C						
43351	Surgical opening, esophagus	C						
43352	Surgical opening, esophagus	C						
43360	Gastrointestinal repair	C						
43361	Gastrointestinal repair	C						
43400	Ligate esophagus veins	C						
43401	Esophagus surgery for veins	C						
43405	Ligate/staple esophagus	C						
43410	Repair esophagus wound	C						
43415	Repair esophagus wound	C						
43420	Repair esophagus opening	T	0254	24.9637	$1,678.58		$335.72	*

43425	Repair esophagus opening	C						
43450	Dilate esophagus	T	0140	5.9622	$400.90	$84.58	$80.18	*
43453	Dilate esophagus	T	0140	5.9622	$400.90	$84.58	$80.18	*
43456	Dilate esophagus	T	0140	5.9622	$400.90	$84.58	$80.18	*
43458	Dilate esophagus	T	0141	8.7462	$588.10	$143.38	$117.62	*
43460	Pressure treatment esophagus	C						
43496	Free jejunum flap, microvasc	C						
43499	Esophagus surgery procedure	T	0141	8.7462	$588.10	$143.38	$117.62	*
43500	Surgical opening of stomach	C						
43501	Surgical repair of stomach	C						
43502	Surgical repair of stomach	C						
43510	Surgical opening of stomach	T	0141	8.7462	$588.10	$143.38	$117.62	*
43520	Incision of pyloric muscle	C						
43600	Biopsy of stomach	T	0141	8.7462	$588.10	$143.38	$117.62	*
43605	Biopsy of stomach	C						
43610	Excision of stomach lesion	C						
43611	Excision of stomach lesion	C						
43620	Removal of stomach	C						
43621	Removal of stomach	C						
43622	Removal of stomach	C						
43631	Removal of stomach, partial	C						
43632	Removal of stomach, partial	C						
43633	Removal of stomach, partial	C						
43634	Removal of stomach, partial	C						
43635	Removal of stomach, partial	C						
43640	Vagotomy & pylorus repair	C						
43641	Vagotomy & pylorus repair	C						
43644	Lap gastric bypass/roux-en-y	C						
43645	Lap gastr bypass incl smll i	C						
43647	Lap impl electrode, antrum	S	0061	86.5171	$5,817.50		$1,163.50	*
43648	Lap revise/remv eltrd antrum	T	0130	38.054	$2,558.79	$659.53	$511.76	*
43651	Laparoscopy, vagus nerve	T	0132	72.9582	$4,905.78	$1,239.22	$981.16	*
43652	Laparoscopy, vagus nerve	T	0132	72.9582	$4,905.78	$1,239.22	$981.16	*
43653	Laparoscopy, gastrostomy	T	0131	46.84	$3,149.57	$1,001.89	$629.92	*
43659	Laparoscope proc, stom	T	0130	38.054	$2,558.79	$659.53	$511.76	*
43752	Nasal/orogastric w/stent	X	0272	1.2693	$85.35	$31.15	$17.07	*
43760	Change gastrostomy tube	T	0676	2.3954	$161.07		$32.22	*
43761	Reposition gastrostomy tube	T	0141	8.7462	$588.10	$143.38	$117.62	*
43770	Lap place gastr adj device	C						
43771	Lap revise gastr adj device	C						
43772	Lap rmvl gastr adj device	C						
43773	Lap replace gastr adj device	C						
43774	Lap rmvl gastr adj all parts	C						
43775	Lap sleeve gastrectomy	C						
43800	Reconstruction of pylorus	C						
43810	Fusion of stomach and bowel	C						
43820	Fusion of stomach and bowel	C						
43825	Fusion of stomach and bowel	C						
43830	Place gastrostomy tube	T	0422	24.2703	$1,631.96	$436.89	$326.40	*
43831	Place gastrostomy tube	T	0141	8.7462	$588.10	$143.38	$117.62	*
43832	Place gastrostomy tube	C						
43840	Repair of stomach lesion	C						
43842	V-band gastroplasty	E						
43843	Gastroplasty w/o v-band	C						
43845	Gastroplasty duodenal switch	C						
43846	Gastric bypass for obesity	C						
43847	Gastric bypass incl small i	C						
43848	Revision gastroplasty	C						
43850	Revise stomach-bowel fusion	C						
43855	Revise stomach-bowel fusion	C						
43860	Revise stomach-bowel fusion	C						
43865	Revise stomach-bowel fusion	C						

43870	Repair stomach opening	T	0141	8.7462	$588.10	$143.38	$117.62	*
43880	Repair stomach-bowel fistula	C						
43881	Impl/redo electrd, antrum	C						
43882	Revise/remove electrd antrum	C						
43886	Revise gastric port, open	T	0137	23.9317	$1,609.19		$321.84	*
43887	Remove gastric port, open	T	0135	4.4386	$298.46		$59.70	*
43888	Change gastric port, open	T	0137	23.9317	$1,609.19		$321.84	*
43999	Stomach surgery procedure	T	0141	8.7462	$588.10	$143.38	$117.62	*
44005	Freeing of bowel adhesion	C						
44010	Incision of small bowel	C						
44015	Insert needle cath bowel	C						
44020	Explore small intestine	C						
44021	Decompress small bowel	C						
44025	Incision of large bowel	C						
44050	Reduce bowel obstruction	C						
44055	Correct malrotation of bowel	C						
44100	Biopsy of bowel	T	0141	8.7462	$588.10	$143.38	$117.62	*
44110	Excise intestine lesion(s)	C						
44111	Excision of bowel lesion(s)	C						
44120	Removal of small intestine	C						
44121	Removal of small intestine	C						
44125	Removal of small intestine	C						
44126	Enterectomy w/o taper, cong	C						
44127	Enterectomy w/taper, cong	C						
44128	Enterectomy cong, add-on	C						
44130	Bowel to bowel fusion	C						
44132	Enterectomy, cadaver donor	C						
44133	Enterectomy, live donor	C						
44135	Intestine transplnt, cadaver	C						
44136	Intestine transplant, live	C						
44137	Remove intestinal allograft	C						
44139	Mobilization of colon	C						
44140	Partial removal of colon	C						
44141	Partial removal of colon	C						
44143	Partial removal of colon	C						
44144	Partial removal of colon	C						
44145	Partial removal of colon	C						
44146	Partial removal of colon	C						
44147	Partial removal of colon	C						
44150	Removal of colon	C						
44151	Removal of colon/ileostomy	C						
44155	Removal of colon/ileostomy	C						
44156	Removal of colon/ileostomy	C						
44157	Colectomy w/ileoanal anast	C						
44158	Colectomy w/neo-rectum pouch	C						
44160	Removal of colon	C						
44180	Lap, enterolysis	T	0131	46.84	$3,149.57	$1,001.89	$629.92	*
44186	Lap, jejunostomy	T	0131	46.84	$3,149.57	$1,001.89	$629.92	*
44187	Lap, ileo/jejuno-stomy	C						
44188	Lap, colostomy	C						
44202	Lap, enterectomy	C						
44203	Lap resect s/intestine, addl	C						
44204	Laparo partial colectomy	C						
44205	Lap colectomy part w/ileum	C						
44206	Lap part colectomy w/stoma	T	0132	72.9582	$4,905.78	$1,239.22	$981.16	*
44207	L colectomy/coloproctostomy	T	0132	72.9582	$4,905.78	$1,239.22	$981.16	*
44208	L colectomy/coloproctostomy	T	0132	72.9582	$4,905.78	$1,239.22	$981.16	*
44210	Laparo total proctocolectomy	C						
44211	Lap colectomy w/proctectomy	C						
44212	Laparo total proctocolectomy	C						
44213	Lap, mobil splenic fl add-on	T	0130	38.054	$2,558.79	$659.53	$511.76	*
44227	Lap, close enterostomy	C						

44238	Laparoscope proc, intestine	T	0130	38.054	$2,558.79	$659.53	$511.76	*
44300	Open bowel to skin	C						
44310	Ileostomy/jejunostomy	C						
44312	Revision of ileostomy	T	0137	23.9317	$1,609.19		$321.84	*
44314	Revision of ileostomy	C						
44316	Devise bowel pouch	C						
44320	Colostomy	C						
44322	Colostomy with biopsies	C						
44340	Revision of colostomy	T	0137	23.9317	$1,609.19		$321.84	*
44345	Revision of colostomy	C						
44346	Revision of colostomy	C						
44360	Small bowel endoscopy	T	0142	9.8503	$662.34	$152.78	$132.47	*
44361	Small bowel endoscopy/biopsy	T	0142	9.8503	$662.34	$152.78	$132.47	*
44363	Small bowel endoscopy	T	0142	9.8503	$662.34	$152.78	$132.47	*
44364	Small bowel endoscopy	T	0142	9.8503	$662.34	$152.78	$132.47	*
44365	Small bowel endoscopy	T	0142	9.8503	$662.34	$152.78	$132.47	*
44366	Small bowel endoscopy	T	0142	9.8503	$662.34	$152.78	$132.47	*
44369	Small bowel endoscopy	T	0142	9.8503	$662.34	$152.78	$132.47	*
44370	Small bowel endoscopy/stent	T	0384	26.4913	$1,781.30		$356.26	*
44372	Small bowel endoscopy	T	0142	9.8503	$662.34	$152.78	$132.47	*
44373	Small bowel endoscopy	T	0142	9.8503	$662.34	$152.78	$132.47	*
44376	Small bowel endoscopy	T	0142	9.8503	$662.34	$152.78	$132.47	*
44377	Small bowel endoscopy/biopsy	T	0142	9.8503	$662.34	$152.78	$132.47	*
44378	Small bowel endoscopy	T	0142	9.8503	$662.34	$152.78	$132.47	*
44379	S bowel endoscope w/stent	T	0384	26.4913	$1,781.30		$356.26	*
44380	Small bowel endoscopy	T	0142	9.8503	$662.34	$152.78	$132.47	*
44382	Small bowel endoscopy	T	0142	9.8503	$662.34	$152.78	$132.47	*
44383	Ileoscopy w/stent	T	0384	26.4913	$1,781.30		$356.26	*
44385	Endoscopy of bowel pouch	T	0143	9.1051	$612.24	$186.06	$122.45	*
44386	Endoscopy, bowel pouch/biop	T	0143	9.1051	$612.24	$186.06	$122.45	*
44388	Colonoscopy	T	0143	9.1051	$612.24	$186.06	$122.45	*
44389	Colonoscopy with biopsy	T	0143	9.1051	$612.24	$186.06	$122.45	*
44390	Colonoscopy for foreign body	T	0143	9.1051	$612.24	$186.06	$122.45	*
44391	Colonoscopy for bleeding	T	0143	9.1051	$612.24	$186.06	$122.45	*
44392	Colonoscopy & polypectomy	T	0143	9.1051	$612.24	$186.06	$122.45	*
44393	Colonoscopy, lesion removal	T	0143	9.1051	$612.24	$186.06	$122.45	*
44394	Colonoscopy w/snare	T	0143	9.1051	$612.24	$186.06	$122.45	*
44397	Colonoscopy w/stent	T	0384	26.4913	$1,781.30		$356.26	*
44500	Intro, gastrointestinal tube	T	0121	6.3742	$428.61		$85.73	*
44602	Suture, small intestine	C						
44603	Suture, small intestine	C						
44604	Suture, large intestine	C						
44605	Repair of bowel lesion	C						
44615	Intestinal stricturoplasty	C						
44620	Repair bowel opening	C						
44625	Repair bowel opening	C						
44626	Repair bowel opening	C						
44640	Repair bowel-skin fistula	C						
44650	Repair bowel fistula	C						
44660	Repair bowel-bladder fistula	C						
44661	Repair bowel-bladder fistula	C						
44680	Surgical revision, intestine	C						
44700	Suspend bowel w/prosthesis	C						
44701	Intraop colon lavage add-on	N						
44715	Prepare donor intestine	C						
44720	Prep donor intestine/venous	C						
44721	Prep donor intestine/artery	C						
44799	Unlisted procedure intestine	T	0153	27.1855	$1,827.98	$376.05	$365.60	*
44800	Excision of bowel pouch	C						
44820	Excision of mesentery lesion	C						
44850	Repair of mesentery	C						
44899	Bowel surgery procedure	C						

44900	Drain app abscess, open	C						
44901	Drain app abscess, percut	T	0037	15.5003	$1,042.26	$228.76	$208.46	*
44950	Appendectomy	T	0153	27.1855	$1,827.98	$376.05	$365.60	*
44955	Appendectomy add-on	T	0153	27.1855	$1,827.98	$376.05	$365.60	*
44960	Appendectomy	C						
44970	Laparoscopy, appendectomy	T	0131	46.84	$3,149.57	$1,001.89	$629.92	*
44979	Laparoscope proc, app	T	0130	38.054	$2,558.79	$659.53	$511.76	*
45000	Drainage of pelvic abscess	T	0155	14.114	$949.04		$189.81	*
45005	Drainage of rectal abscess	T	0155	14.114	$949.04		$189.81	*
45020	Drainage of rectal abscess	T	0155	14.114	$949.04		$189.81	*
45100	Biopsy of rectum	T	0149	23.9703	$1,611.79		$322.36	*
45108	Removal of anorectal lesion	T	0149	23.9703	$1,611.79		$322.36	*
45110	Removal of rectum	C						
45111	Partial removal of rectum	C						
45112	Removal of rectum	C						
45113	Partial proctectomy	C						
45114	Partial removal of rectum	C						
45116	Partial removal of rectum	C						
45119	Remove rectum w/reservoir	C						
45120	Removal of rectum	C						
45121	Removal of rectum and colon	C						
45123	Partial proctectomy	C						
45126	Pelvic exenteration	C						
45130	Excision of rectal prolapse	C						
45135	Excision of rectal prolapse	C						
45136	Excise ileoanal reservior	C						
45150	Excision of rectal stricture	T	0149	23.9703	$1,611.79		$322.36	*
45160	Excision of rectal lesion	T	0149	23.9703	$1,611.79		$322.36	*
45171	Exc rect tum transanal part	T	0155	14.114	$949.04		$189.81	*
45172	Exc rect tum transanal full	T	0149	23.9703	$1,611.79		$322.36	*
45190	Destruction, rectal tumor	T	0149	23.9703	$1,611.79		$322.36	*
45300	Proctosigmoidoscopy dx	T	0146	5.7747	$388.30		$77.66	*
45303	Proctosigmoidoscopy dilate	T	0147	9.245	$621.64		$124.33	*
45305	Proctosigmoidoscopy w/bx	T	0147	9.245	$621.64		$124.33	*
45307	Proctosigmoidoscopy fb	T	0428	22.8208	$1,534.49		$306.90	*
45308	Proctosigmoidoscopy removal	T	0147	9.245	$621.64		$124.33	*
45309	Proctosigmoidoscopy removal	T	0147	9.245	$621.64		$124.33	*
45315	Proctosigmoidoscopy removal	T	0147	9.245	$621.64		$124.33	*
45317	Proctosigmoidoscopy bleed	T	0147	9.245	$621.64		$124.33	*
45320	Proctosigmoidoscopy ablate	T	0428	22.8208	$1,534.49		$306.90	*
45321	Proctosigmoidoscopy volvul	T	0428	22.8208	$1,534.49		$306.90	*
45327	Proctosigmoidoscopy w/stent	T	0384	26.4913	$1,781.30		$356.26	*
45330	Diagnostic sigmoidoscopy	T	0146	5.7747	$388.30		$77.66	*
45331	Sigmoidoscopy and biopsy	T	0146	5.7747	$388.30		$77.66	*
45332	Sigmoidoscopy w/fb removal	T	0146	5.7747	$388.30		$77.66	*
45333	Sigmoidoscopy & polypectomy	T	0147	9.245	$621.64		$124.33	*
45334	Sigmoidoscopy for bleeding	T	0147	9.245	$621.64		$124.33	*
45335	Sigmoidoscopy w/submuc inj	T	0146	5.7747	$388.30		$77.66	*
45337	Sigmoidoscopy & decompress	T	0146	5.7747	$388.30		$77.66	*
45338	Sigmoidoscopy w/tumr remove	T	0147	9.245	$621.64		$124.33	*
45339	Sigmoidoscopy w/ablate tumr	T	0147	9.245	$621.64		$124.33	*
45340	Sig w/balloon dilation	T	0147	9.245	$621.64		$124.33	*
45341	Sigmoidoscopy w/ultrasound	T	0147	9.245	$621.64		$124.33	*
45342	Sigmoidoscopy w/us guide bx	T	0147	9.245	$621.64		$124.33	*
45345	Sigmoidoscopy w/stent	T	0384	26.4913	$1,781.30		$356.26	*
45355	Surgical colonoscopy	T	0143	9.1051	$612.24	$186.06	$122.45	*
45378	Diagnostic colonoscopy	T	0143	9.1051	$612.24	$186.06	$122.45	*
45379	Colonoscopy w/fb removal	T	0143	9.1051	$612.24	$186.06	$122.45	*
45380	Colonoscopy and biopsy	T	0143	9.1051	$612.24	$186.06	$122.45	*
45381	Colonoscopy, submucous inj	T	0143	9.1051	$612.24	$186.06	$122.45	*
45382	Colonoscopy/control bleeding	T	0143	9.1051	$612.24	$186.06	$122.45	*
45383	Lesion removal colonoscopy	T	0143	9.1051	$612.24	$186.06	$122.45	*

45384	Lesion remove colonoscopy	T	0143	9.1051	$612.24	$186.06	$122.45	*
45385	Lesion removal colonoscopy	T	0143	9.1051	$612.24	$186.06	$122.45	*
45386	Colonoscopy dilate stricture	T	0143	9.1051	$612.24	$186.06	$122.45	*
45387	Colonoscopy w/stent	T	0384	26.4913	$1,781.30		$356.26	*
45391	Colonoscopy w/endoscope us	T	0143	9.1051	$612.24	$186.06	$122.45	*
45392	Colonoscopy w/endoscopic fnb	T	0143	9.1051	$612.24	$186.06	$122.45	*
45395	Lap, removal of rectum	C						
45397	Lap, remove rectum w/pouch	C						
45400	Laparoscopic proc	C						
45402	Lap proctopexy w/sig resect	C						
45499	Laparoscope proc, rectum	T	0130	38.054	$2,558.79	$659.53	$511.76	*
45500	Repair of rectum	T	0149	23.9703	$1,611.79		$322.36	*
45505	Repair of rectum	T	0150	32.1812	$2,163.90	$437.12	$432.78	*
45520	Treatment of rectal prolapse	T	0013	0.8789	$59.10		$11.82	*
45540	Correct rectal prolapse	C						
45541	Correct rectal prolapse	T	0150	32.1812	$2,163.90	$437.12	$432.78	*
45550	Repair rectum/remove sigmoid	C						
45560	Repair of rectocele	T	0150	32.1812	$2,163.90	$437.12	$432.78	*
45562	Exploration/repair of rectum	C						
45563	Exploration/repair of rectum	C						
45800	Repair rect/bladder fistula	C						
45805	Repair fistula w/colostomy	C						
45820	Repair rectourethral fistula	C						
45825	Repair fistula w/colostomy	C						
45900	Reduction of rectal prolapse	T	0148	5.365	$360.75		$72.15	*
45905	Dilation of anal sphincter	T	0149	23.9703	$1,611.79		$322.36	*
45910	Dilation of rectal narrowing	T	0149	23.9703	$1,611.79		$322.36	*
45915	Remove rectal obstruction	T	0155	14.114	$949.04		$189.81	*
45990	Surg dx exam, anorectal	T	0149	23.9703	$1,611.79		$322.36	*
45999	Rectum surgery procedure	T	0148	5.365	$360.75		$72.15	*
46020	Placement of seton	T	0149	23.9703	$1,611.79		$322.36	*
46030	Removal of rectal marker	T	0148	5.365	$360.75		$72.15	*
46040	Incision of rectal abscess	T	0149	23.9703	$1,611.79		$322.36	*
46045	Incision of rectal abscess	T	0149	23.9703	$1,611.79		$322.36	*
46050	Incision of anal abscess	T	0155	14.114	$949.04		$189.81	*
46060	Incision of rectal abscess	T	0149	23.9703	$1,611.79		$322.36	*
46070	Incision of anal septum	T	0155	14.114	$949.04		$189.81	*
46080	Incision of anal sphincter	T	0149	23.9703	$1,611.79		$322.36	*
46083	Incise external hemorrhoid	T	0164	2.0194	$135.79		$27.16	*
46200	Removal of anal fissure	T	0149	23.9703	$1,611.79		$322.36	*
46220	Excise anal ext tag/papilla	T	0155	14.114	$949.04		$189.81	*
46221	Ligation of hemorrhoid(s)	T	0148	5.365	$360.75		$72.15	*
46230	Removal of anal tags	T	0149	23.9703	$1,611.79		$322.36	*
46250	Remove ext hem groups = 2	T	0149	23.9703	$1,611.79		$322.36	*
46255	Remove int/ext hem 1 group	T	0149	23.9703	$1,611.79		$322.36	*
46257	Remove in/ex hem grp & fiss	T	0149	23.9703	$1,611.79		$322.36	*
46258	Remove in/ex hem grp w/fistu	T	0149	23.9703	$1,611.79		$322.36	*
46260	Remove in/ex hem groups = 2	T	0149	23.9703	$1,611.79		$322.36	*
46261	Remove in/ex hem grps & fiss	T	0149	23.9703	$1,611.79		$322.36	*
46262	Remove in/ex hem grps w/fist	T	0149	23.9703	$1,611.79		$322.36	*
46270	Remove anal fist subq	T	0149	23.9703	$1,611.79		$322.36	*
46275	Remove anal fist inter	T	0149	23.9703	$1,611.79		$322.36	*
46280	Remove anal fist complex	T	0149	23.9703	$1,611.79		$322.36	*
46285	Remove anal fist 2 stage	T	0149	23.9703	$1,611.79		$322.36	*
46288	Repair anal fistula	T	0149	23.9703	$1,611.79		$322.36	*
46320	Removal of hemorrhoid clot	T	0149	23.9703	$1,611.79		$322.36	*
46500	Injection into hemorrhoid(s)	T	0155	14.114	$949.04		$189.81	*
46505	Chemodenervation anal musc	T	0149	23.9703	$1,611.79		$322.36	*
46600	Diagnostic anoscopy	X	0340	0.6693	$45.00		$9.00	*
46604	Anoscopy and dilation	T	0147	9.245	$621.64		$124.33	*
46606	Anoscopy and biopsy	T	0146	5.7747	$388.30		$77.66	*
46608	Anoscopy, remove for body	T	0147	9.245	$621.64		$124.33	*

46610	Anoscopy, remove lesion	T	0428	22.8208	$1,534.49		$306.90	*
46611	Anoscopy	T	0147	9.245	$621.64		$124.33	*
46612	Anoscopy, remove lesions	T	0428	22.8208	$1,534.49		$306.90	*
46614	Anoscopy, control bleeding	T	0146	5.7747	$388.30		$77.66	*
46615	Anoscopy	T	0428	22.8208	$1,534.49		$306.90	*
46700	Repair of anal stricture	T	0149	23.9703	$1,611.79		$322.36	*
46705	Repair of anal stricture	C						
46706	Repr of anal fistula w/glue	T	0150	32.1812	$2,163.90	$437.12	$432.78	*
46707	Repair anorectal fist w/plug	T	0150	32.1812	$2,163.90	$437.12	$432.78	*
46710	Repr per/vag pouch sngl proc	C						
46712	Repr per/vag pouch dbl proc	C						
46715	Rep perf anoper fistu	C						
46716	Rep perf anoper/vestib fistu	C						
46730	Construction of absent anus	C						
46735	Construction of absent anus	C						
46740	Construction of absent anus	C						
46742	Repair of imperforated anus	C						
46744	Repair of cloacal anomaly	C						
46746	Repair of cloacal anomaly	C						
46748	Repair of cloacal anomaly	C						
46750	Repair of anal sphincter	T	0150	32.1812	$2,163.90	$437.12	$432.78	*
46751	Repair of anal sphincter	C						
46753	Reconstruction of anus	T	0149	23.9703	$1,611.79		$322.36	*
46754	Removal of suture from anus	T	0149	23.9703	$1,611.79		$322.36	*
46760	Repair of anal sphincter	T	0150	32.1812	$2,163.90	$437.12	$432.78	*
46761	Repair of anal sphincter	T	0150	32.1812	$2,163.90	$437.12	$432.78	*
46762	Implant artificial sphincter	T	0150	32.1812	$2,163.90	$437.12	$432.78	*
46900	Destruction, anal lesion(s)	T	0016	2.7982	$188.15		$37.63	*
46910	Destruction, anal lesion(s)	T	0017	21.2653	$1,429.90		$285.98	*
46916	Cryosurgery, anal lesion(s)	T	0015	1.5412	$103.63		$20.73	*
46917	Laser surgery, anal lesions	T	0017	21.2653	$1,429.90		$285.98	*
46922	Excision of anal lesion(s)	T	0017	21.2653	$1,429.90		$285.98	*
46924	Destruction, anal lesion(s)	T	0017	21.2653	$1,429.90		$285.98	*
46930	Destroy internal hemorrhoids	T	0148	5.365	$360.75		$72.15	*
46940	Treatment of anal fissure	T	0149	23.9703	$1,611.79		$322.36	*
46942	Treatment of anal fissure	T	0148	5.365	$360.75		$72.15	*
46945	Remove by ligat int hem grp	T	0155	14.114	$949.04		$189.81	*
46946	Remove by ligat int hem grps	T	0155	14.114	$949.04		$189.81	*
46947	Hemorrhoidopexy by stapling	T	0150	32.1812	$2,163.90	$437.12	$432.78	*
46999	Anus surgery procedure	T	0148	5.365	$360.75		$72.15	*
47000	Needle biopsy of liver	T	0685	9.6666	$649.99		$130.00	*
47001	Needle biopsy, liver add-on	N						
47010	Open drainage, liver lesion	C						
47011	Percut drain, liver lesion	T	0037	15.5003	$1,042.26	$228.76	$208.46	*
47015	Inject/aspirate liver cyst	C						
47100	Wedge biopsy of liver	C						
47120	Partial removal of liver	C						
47122	Extensive removal of liver	C						
47125	Partial removal of liver	C						
47130	Partial removal of liver	C						
47133	Removal of donor liver	C						
47135	Transplantation of liver	C						
47136	Transplantation of liver	C						
47140	Partial removal, donor liver	C						
47141	Partial removal, donor liver	C						
47142	Partial removal, donor liver	C						
47143	Prep donor liver, whole	C						
47144	Prep donor liver, 3-segment	C						
47145	Prep donor liver, lobe split	C						
47146	Prep donor liver/venous	C						
47147	Prep donor liver/arterial	C						
47300	Surgery for liver lesion	C						

47350	Repair liver wound	C						
47360	Repair liver wound	C						
47361	Repair liver wound	C						
47362	Repair liver wound	C						
47370	Laparo ablate liver tumor rf	T	0174	109.9237	$7,391.38	$2,064.24	$1,478.28	*
47371	Laparo ablate liver cryosurg	T	0174	109.9237	$7,391.38	$2,064.24	$1,478.28	*
47379	Laparoscope procedure, liver	T	0130	38.054	$2,558.79	$659.53	$511.76	*
47380	Open ablate liver tumor rf	C						
47381	Open ablate liver tumor cryo	C						
47382	Percut ablate liver rf	T	0423	51.3618	$3,453.62		$690.73	*
47399	Liver surgery procedure	T	0004	4.5991	$309.25		$61.85	*
47400	Incision of liver duct	C						
47420	Incision of bile duct	C						
47425	Incision of bile duct	C						
47460	Incise bile duct sphincter	C						
47480	Incision of gallbladder	C						
47490	Incision of gallbladder	T	0152	30.743	$2,067.19		$413.44	*
47500	Injection for liver x-rays	N						
47505	Injection for liver x-rays	N						
47510	Insert catheter, bile duct	T	0152	30.743	$2,067.19		$413.44	*
47511	Insert bile duct drain	T	0152	30.743	$2,067.19		$413.44	*
47525	Change bile duct catheter	T	0427	15.3103	$1,029.48		$205.90	*
47530	Revise/reinsert bile tube	T	0427	15.3103	$1,029.48		$205.90	*
47550	Bile duct endoscopy add-on	C						
47552	Biliary endoscopy thru skin	T	0152	30.743	$2,067.19		$413.44	*
47553	Biliary endoscopy thru skin	T	0152	30.743	$2,067.19		$413.44	*
47554	Biliary endoscopy thru skin	T	0152	30.743	$2,067.19		$413.44	*
47555	Biliary endoscopy thru skin	T	0152	30.743	$2,067.19		$413.44	*
47556	Biliary endoscopy thru skin	T	0152	30.743	$2,067.19		$413.44	*
47560	Laparoscopy w/cholangio	T	0130	38.054	$2,558.79	$659.53	$511.76	*
47561	Laparo w/cholangio/biopsy	T	0130	38.054	$2,558.79	$659.53	$511.76	*
47562	Laparoscopic cholecystectomy	T	0131	46.84	$3,149.57	$1,001.89	$629.92	*
47563	Laparo cholecystectomy/graph	T	0131	46.84	$3,149.57	$1,001.89	$629.92	*
47564	Laparo cholecystectomy/explr	T	0131	46.84	$3,149.57	$1,001.89	$629.92	*
47570	Laparo cholecystoenterostomy	C						
47579	Laparoscope proc, biliary	T	0130	38.054	$2,558.79	$659.53	$511.76	*
47600	Removal of gallbladder	C						
47605	Removal of gallbladder	C						
47610	Removal of gallbladder	C						
47612	Removal of gallbladder	C						
47620	Removal of gallbladder	C						
47630	Remove bile duct stone	T	0152	30.743	$2,067.19		$413.44	*
47700	Exploration of bile ducts	C						
47701	Bile duct revision	C						
47711	Excision of bile duct tumor	C						
47712	Excision of bile duct tumor	C						
47715	Excision of bile duct cyst	C						
47720	Fuse gallbladder & bowel	C						
47721	Fuse upper gi structures	C						
47740	Fuse gallbladder & bowel	C						
47741	Fuse gallbladder & bowel	C						
47760	Fuse bile ducts and bowel	C						
47765	Fuse liver ducts & bowel	C						
47780	Fuse bile ducts and bowel	C						
47785	Fuse bile ducts and bowel	C						
47800	Reconstruction of bile ducts	C						
47801	Placement, bile duct support	C						
47802	Fuse liver duct & intestine	C						
47900	Suture bile duct injury	C						
47999	Bile tract surgery procedure	T	0152	30.743	$2,067.19		$413.44	*
48000	Drainage of abdomen	C						
48001	Placement of drain, pancreas	C						

48020	Removal of pancreatic stone	C						
48100	Biopsy of pancreas, open	C						
48102	Needle biopsy, pancreas	T	0685	9.6666	$649.99		$130.00	*
48105	Resect/debride pancreas	C						
48120	Removal of pancreas lesion	C						
48140	Partial removal of pancreas	C						
48145	Partial removal of pancreas	C						
48146	Pancreatectomy	C						
48148	Removal of pancreatic duct	C						
48150	Partial removal of pancreas	C						
48152	Pancreatectomy	C						
48153	Pancreatectomy	C						
48154	Pancreatectomy	C						
48155	Removal of pancreas	C						
48160	Pancreas removal/transplant	E						
48400	Injection, intraop add-on	C						
48500	Surgery of pancreatic cyst	C						
48510	Drain pancreatic pseudocyst	C						
48511	Drain pancreatic pseudocyst	T	0037	15.5003	$1,042.26	$228.76	$208.46	*
48520	Fuse pancreas cyst and bowel	C						
48540	Fuse pancreas cyst and bowel	C						
48545	Pancreatorrhaphy	C						
48547	Duodenal exclusion	C						
48548	Fuse pancreas and bowel	C						
48550	Donor pancreatectomy	E						
48551	Prep donor pancreas	C						
48552	Prep donor pancreas/venous	C						
48554	Transpl allograft pancreas	C						
48556	Removal, allograft pancreas	C						
48999	Pancreas surgery procedure	T	0004	4.5991	$309.25		$61.85	*
49000	Exploration of abdomen	C						
49002	Reopening of abdomen	C						
49010	Exploration behind abdomen	C						
49020	Drain abdominal abscess	C						
49021	Drain abdominal abscess	T	0037	15.5003	$1,042.26	$228.76	$208.46	*
49040	Drain, open, abdom abscess	C						
49041	Drain, percut, abdom abscess	T	0037	15.5003	$1,042.26	$228.76	$208.46	*
49060	Drain, open, retrop abscess	C						
49061	Drain, percut, retroper absc	T	0037	15.5003	$1,042.26	$228.76	$208.46	*
49062	Drain to peritoneal cavity	C						
49080	Puncture, peritoneal cavity	T	0070	5.5521	$373.33		$74.67	*
49081	Removal of abdominal fluid	T	0070	5.5521	$373.33		$74.67	*
49180	Biopsy, abdominal mass	T	0685	9.6666	$649.99		$130.00	*
49203	Exc abd tum 5 cm or less	C						
49204	Exc abd tum over 5 cm	C						
49205	Exc abd tum over 10 cm	C						
49215	Excise sacral spine tumor	C						
49220	Multiple surgery, abdomen	C						
49250	Excision of umbilicus	T	0153	27.1855	$1,827.98	$376.05	$365.60	*
49255	Removal of omentum	C						
49320	Diag laparo separate proc	T	0130	38.054	$2,558.79	$659.53	$511.76	*
49321	Laparoscopy, biopsy	T	0130	38.054	$2,558.79	$659.53	$511.76	*
49322	Laparoscopy, aspiration	T	0130	38.054	$2,558.79	$659.53	$511.76	*
49323	Laparo drain lymphocele	T	0130	38.054	$2,558.79	$659.53	$511.76	*
49324	Lap insertion perm ip cath	T	0130	38.054	$2,558.79	$659.53	$511.76	*
49325	Lap revision perm ip cath	T	0130	38.054	$2,558.79	$659.53	$511.76	*
49326	Lap w/omentopexy add-on	T	0130	38.054	$2,558.79	$659.53	$511.76	*
49329	Laparo proc, abdm/per/oment	T	0130	38.054	$2,558.79	$659.53	$511.76	*
49400	Air injection into abdomen	N						
49402	Remove foreign body, adbomen	T	0153	27.1855	$1,827.98	$376.05	$365.60	*
49411	Ins mark abd/pel for rt perq	X	0310	13.7576	$925.07	$325.27	$185.02	*
49419	Insrt abdom cath for chemotx	T	0115	30.9784	$2,083.02		$416.61	*

49420	Insert abdom drain, temp	T	0652	30.4602	$2,048.17		$409.64	*
49421	Insert abdom drain, perm	T	0652	30.4602	$2,048.17		$409.64	*
49422	Remove perm cannula/catheter	T	0105	22.9412	$1,542.59		$308.52	*
49423	Exchange drainage catheter	T	0427	15.3103	$1,029.48		$205.90	*
49424	Assess cyst, contrast inject	N						
49425	Insert abdomen-venous drain	C						
49426	Revise abdomen-venous shunt	T	0153	27.1855	$1,827.98	$376.05	$365.60	*
49427	Injection, abdominal shunt	N						
49428	Ligation of shunt	C						
49429	Removal of shunt	T	0105	22.9412	$1,542.59		$308.52	*
49435	Insert subq exten to ip cath	T	0427	15.3103	$1,029.48		$205.90	*
49436	Embedded ip cath exit-site	T	0427	15.3103	$1,029.48		$205.90	*
49440	Place gastrostomy tube perc	T	0141	8.7462	$588.10	$143.38	$117.62	*
49441	Place duod/jej tube perc	T	0141	8.7462	$588.10	$143.38	$117.62	*
49442	Place cecostomy tube perc	T	0155	14.114	$949.04		$189.81	*
49446	Change g-tube to g-j perc	T	0141	8.7462	$588.10	$143.38	$117.62	*
49450	Replace g/c tube perc	T	0121	6.3742	$428.61		$85.73	*
49451	Replace duod/jej tube perc	T	0121	6.3742	$428.61		$85.73	*
49452	Replace g-j tube perc	T	0121	6.3742	$428.61		$85.73	*
49460	Fix g/colon tube w/device	T	0121	6.3742	$428.61		$85.73	*
49465	Fluoro exam of g/colon tube	Q1	0276	1.2985	$87.31	$34.66	$17.47	*
49491	Rpr hern preemie reduc	T	0154	31.9682	$2,149.57	$464.85	$429.92	*
49492	Rpr ing hern premie, blocked	T	0154	31.9682	$2,149.57	$464.85	$429.92	*
49495	Rpr ing hernia baby, reduc	T	0154	31.9682	$2,149.57	$464.85	$429.92	*
49496	Rpr ing hernia baby, blocked	T	0154	31.9682	$2,149.57	$464.85	$429.92	*
49500	Rpr ing hernia, init, reduce	T	0154	31.9682	$2,149.57	$464.85	$429.92	*
49501	Rpr ing hernia, init blocked	T	0154	31.9682	$2,149.57	$464.85	$429.92	*
49505	Prp i/hern init reduc >5 yr	T	0154	31.9682	$2,149.57	$464.85	$429.92	*
49507	Prp i/hern init block >5 yr	T	0154	31.9682	$2,149.57	$464.85	$429.92	*
49520	Rerepair ing hernia, reduce	T	0154	31.9682	$2,149.57	$464.85	$429.92	*
49521	Rerepair ing hernia, blocked	T	0154	31.9682	$2,149.57	$464.85	$429.92	*
49525	Repair ing hernia, sliding	T	0154	31.9682	$2,149.57	$464.85	$429.92	*
49540	Repair lumbar hernia	T	0154	31.9682	$2,149.57	$464.85	$429.92	*
49550	Rpr rem hernia, init, reduce	T	0154	31.9682	$2,149.57	$464.85	$429.92	*
49553	Rpr fem hernia, init blocked	T	0154	31.9682	$2,149.57	$464.85	$429.92	*
49555	Rerepair fem hernia, reduce	T	0154	31.9682	$2,149.57	$464.85	$429.92	*
49557	Rerepair fem hernia, blocked	T	0154	31.9682	$2,149.57	$464.85	$429.92	*
49560	Rpr ventral hern init, reduc	T	0154	31.9682	$2,149.57	$464.85	$429.92	*
49561	Rpr ventral hern init, block	T	0154	31.9682	$2,149.57	$464.85	$429.92	*
49565	Rerepair ventrl hern, reduce	T	0154	31.9682	$2,149.57	$464.85	$429.92	*
49566	Rerepair ventrl hern, block	T	0154	31.9682	$2,149.57	$464.85	$429.92	*
49568	Hernia repair w/mesh	T	0154	31.9682	$2,149.57	$464.85	$429.92	*
49570	Rpr epigastric hern, reduce	T	0154	31.9682	$2,149.57	$464.85	$429.92	*
49572	Rpr epigastric hern, blocked	T	0154	31.9682	$2,149.57	$464.85	$429.92	*
49580	Rpr umbil hern, reduc < 5 yr	T	0154	31.9682	$2,149.57	$464.85	$429.92	*
49582	Rpr umbil hern, block < 5 yr	T	0154	31.9682	$2,149.57	$464.85	$429.92	*
49585	Rpr umbil hern, reduc > 5 yr	T	0154	31.9682	$2,149.57	$464.85	$429.92	*
49587	Rpr umbil hern, block > 5 yr	T	0154	31.9682	$2,149.57	$464.85	$429.92	*
49590	Repair spigelian hernia	T	0154	31.9682	$2,149.57	$464.85	$429.92	*
49600	Repair umbilical lesion	T	0154	31.9682	$2,149.57	$464.85	$429.92	*
49605	Repair umbilical lesion	C						
49606	Repair umbilical lesion	C						
49610	Repair umbilical lesion	C						
49611	Repair umbilical lesion	C						
49650	Lap ing hernia repair init	T	0131	46.84	$3,149.57	$1,001.89	$629.92	*
49651	Lap ing hernia repair recur	T	0131	46.84	$3,149.57	$1,001.89	$629.92	*
49652	Lap vent/abd hernia repair	T	0132	72.9582	$4,905.78	$1,239.22	$981.16	*
49653	Lap vent/abd hern proc comp	T	0132	72.9582	$4,905.78	$1,239.22	$981.16	*
49654	Lap inc hernia repair	T	0132	72.9582	$4,905.78	$1,239.22	$981.16	*
49655	Lap inc hern repair comp	T	0132	72.9582	$4,905.78	$1,239.22	$981.16	*
49656	Lap inc hernia repair recur	T	0132	72.9582	$4,905.78	$1,239.22	$981.16	*
49657	Lap inc hern recur comp	T	0132	72.9582	$4,905.78	$1,239.22	$981.16	*

49659	Laparo proc, hernia repair	T	0130	38.054	$2,558.79	$659.53	$511.76	*
49900	Repair of abdominal wall	C						
49904	Omental flap, extra-abdom	C						
49905	Omental flap, intra-abdom	C						
49906	Free omental flap, microvasc	C						
49999	Abdomen surgery procedure	T	0153	27.1855	$1,827.98	$376.05	$365.60	*
50010	Exploration of kidney	C						
50020	Renal abscess, open drain	T	0162	25.5223	$1,716.14		$343.23	*
50021	Renal abscess, percut drain	T	0037	15.5003	$1,042.26	$228.76	$208.46	*
50040	Drainage of kidney	C						
50045	Exploration of kidney	C						
50060	Removal of kidney stone	C						
50065	Incision of kidney	C						
50070	Incision of kidney	C						
50075	Removal of kidney stone	C						
50080	Removal of kidney stone	T	0429	46.68	$3,138.81		$627.77	*
50081	Removal of kidney stone	T	0429	46.68	$3,138.81		$627.77	*
50100	Revise kidney blood vessels	C						
50120	Exploration of kidney	C						
50125	Explore and drain kidney	C						
50130	Removal of kidney stone	C						
50135	Exploration of kidney	C						
50200	Renal biopsy perq	T	0685	9.6666	$649.99		$130.00	*
50205	Renal biopsy open	C						
50220	Remove kidney, open	C						
50225	Removal kidney open, complex	C						
50230	Removal kidney open, radical	C						
50234	Removal of kidney & ureter	C						
50236	Removal of kidney & ureter	C						
50240	Partial removal of kidney	C						
50250	Cryoablate renal mass open	C						
50280	Removal of kidney lesion	C						
50290	Removal of kidney lesion	C						
50300	Remove cadaver donor kidney	C						
50320	Remove kidney, living donor	C						
50323	Prep cadaver renal allograft	C						
50325	Prep donor renal graft	C						
50327	Prep renal graft/venous	C						
50328	Prep renal graft/arterial	C						
50329	Prep renal graft/ureteral	C						
50340	Removal of kidney	C						
50360	Transplantation of kidney	C						
50365	Transplantation of kidney	C						
50370	Remove transplanted kidney	C						
50380	Reimplantation of kidney	C						
50382	Change ureter stent, percut	T	0162	25.5223	$1,716.14		$343.23	*
50384	Remove ureter stent, percut	T	0161	17.0344	$1,145.41		$229.09	*
50385	Change stent via transureth	T	0162	25.5223	$1,716.14		$343.23	*
50386	Remove stent via transureth	T	0160	7.1342	$479.71		$95.95	*
50387	Change ext/int ureter stent	T	0427	15.3103	$1,029.48		$205.90	*
50389	Remove renal tube w/fluoro	T	0160	7.1342	$479.71		$95.95	*
50390	Drainage of kidney lesion	T	0685	9.6666	$649.99		$130.00	*
50391	Instll rx agnt into rnal tub	T	0126	1.0958	$73.68	$16.21	$14.74	*
50392	Insert kidney drain	T	0161	17.0344	$1,145.41		$229.09	*
50393	Insert ureteral tube	T	0162	25.5223	$1,716.14		$343.23	*
50394	Injection for kidney x-ray	N						
50395	Create passage to kidney	T	0162	25.5223	$1,716.14		$343.23	*
50396	Measure kidney pressure	T	0164	2.0194	$135.79		$27.16	*
50398	Change kidney tube	T	0427	15.3103	$1,029.48		$205.90	*
50400	Revision of kidney/ureter	C						
50405	Revision of kidney/ureter	C						
50500	Repair of kidney wound	C						

50520	Close kidney-skin fistula	C						
50525	Repair renal-abdomen fistula	C						
50526	Repair renal-abdomen fistula	C						
50540	Revision of horseshoe kidney	C						
50541	Laparo ablate renal cyst	T	0130	38.054	$2,558.79	$659.53	$511.76	*
50542	Laparo ablate renal mass	T	0174	109.9237	$7,391.38	$2,064.24	$1,478.28	*
50543	Laparo partial nephrectomy	T	0131	46.84	$3,149.57	$1,001.89	$629.92	*
50544	Laparoscopy, pyeloplasty	T	0130	38.054	$2,558.79	$659.53	$511.76	*
50545	Laparo radical nephrectomy	C						
50546	Laparoscopic nephrectomy	C						
50547	Laparo removal donor kidney	C						
50548	Laparo remove w/ureter	C						
50549	Laparoscope proc, renal	T	0130	38.054	$2,558.79	$659.53	$511.76	*
50551	Kidney endoscopy	T	0160	7.1342	$479.71		$95.95	*
50553	Kidney endoscopy	T	0162	25.5223	$1,716.14		$343.23	*
50555	Kidney endoscopy & biopsy	T	0160	7.1342	$479.71		$95.95	*
50557	Kidney endoscopy & treatment	T	0162	25.5223	$1,716.14		$343.23	*
50561	Kidney endoscopy & treatment	T	0162	25.5223	$1,716.14		$343.23	*
50562	Renal scope w/tumor resect	T	0160	7.1342	$479.71		$95.95	*
50570	Kidney endoscopy	T	0160	7.1342	$479.71		$95.95	*
50572	Kidney endoscopy	T	0160	7.1342	$479.71		$95.95	*
50574	Kidney endoscopy & biopsy	T	0160	7.1342	$479.71		$95.95	*
50575	Kidney endoscopy	T	0163	36.2009	$2,434.18		$486.84	*
50576	Kidney endoscopy & treatment	T	0161	17.0344	$1,145.41		$229.09	*
50580	Kidney endoscopy & treatment	T	0161	17.0344	$1,145.41		$229.09	*
50590	Fragmenting of kidney stone	T	0169	41.3626	$2,781.26	$997.74	$556.26	*
50592	Perc rf ablate renal tumor	T	0423	51.3618	$3,453.62		$690.73	*
50593	Perc cryo ablate renal tum	T	0423	51.3618	$3,453.62		$690.73	*
50600	Exploration of ureter	C						
50605	Insert ureteral support	C						
50610	Removal of ureter stone	C						
50620	Removal of ureter stone	C						
50630	Removal of ureter stone	C						
50650	Removal of ureter	C						
50660	Removal of ureter	C						
50684	Injection for ureter x-ray	N						
50686	Measure ureter pressure	T	0126	1.0958	$73.68	$16.21	$14.74	*
50688	Change of ureter tube/stent	T	0427	15.3103	$1,029.48		$205.90	*
50690	Injection for ureter x-ray	N						
50700	Revision of ureter	C						
50715	Release of ureter	C						
50722	Release of ureter	C						
50725	Release/revise ureter	C						
50727	Revise ureter	T	0165	20.0243	$1,346.45		$269.29	*
50728	Revise ureter	C						
50740	Fusion of ureter & kidney	C						
50750	Fusion of ureter & kidney	C						
50760	Fusion of ureters	C						
50770	Splicing of ureters	C						
50780	Reimplant ureter in bladder	C						
50782	Reimplant ureter in bladder	C						
50783	Reimplant ureter in bladder	C						
50785	Reimplant ureter in bladder	C						
50800	Implant ureter in bowel	C						
50810	Fusion of ureter & bowel	C						
50815	Urine shunt to intestine	C						
50820	Construct bowel bladder	C						
50825	Construct bowel bladder	C						
50830	Revise urine flow	C						
50840	Replace ureter by bowel	C						
50845	Appendico-vesicostomy	C						
50860	Transplant ureter to skin	C						

50900	Repair of ureter	C						
50920	Closure ureter/skin fistula	C						
50930	Closure ureter/bowel fistula	C						
50940	Release of ureter	C						
50945	Laparoscopy ureterolithotomy	T	0131	46.84	$3,149.57	$1,001.89	$629.92	*
50947	Laparo new ureter/bladder	T	0131	46.84	$3,149.57	$1,001.89	$629.92	*
50948	Laparo new ureter/bladder	T	0131	46.84	$3,149.57	$1,001.89	$629.92	*
50949	Laparoscope proc, ureter	T	0130	38.054	$2,558.79	$659.53	$511.76	*
50951	Endoscopy of ureter	T	0160	7.1342	$479.71		$95.95	*
50953	Endoscopy of ureter	T	0160	7.1342	$479.71		$95.95	*
50955	Ureter endoscopy & biopsy	T	0162	25.5223	$1,716.14		$343.23	*
50957	Ureter endoscopy & treatment	T	0162	25.5223	$1,716.14		$343.23	*
50961	Ureter endoscopy & treatment	T	0162	25.5223	$1,716.14		$343.23	*
50970	Ureter endoscopy	T	0160	7.1342	$479.71		$95.95	*
50972	Ureter endoscopy & catheter	T	0160	7.1342	$479.71		$95.95	*
50974	Ureter endoscopy & biopsy	T	0161	17.0344	$1,145.41		$229.09	*
50976	Ureter endoscopy & treatment	T	0161	17.0344	$1,145.41		$229.09	*
50980	Ureter endoscopy & treatment	T	0162	25.5223	$1,716.14		$343.23	*
51020	Incise & treat bladder	T	0162	25.5223	$1,716.14		$343.23	*
51030	Incise & treat bladder	T	0162	25.5223	$1,716.14		$343.23	*
51040	Incise & drain bladder	T	0162	25.5223	$1,716.14		$343.23	*
51045	Incise bladder/drain ureter	T	0160	7.1342	$479.71		$95.95	*
51050	Removal of bladder stone	T	0162	25.5223	$1,716.14		$343.23	*
51060	Removal of ureter stone	T	0163	36.2009	$2,434.18		$486.84	*
51065	Remove ureter calculus	T	0162	25.5223	$1,716.14		$343.23	*
51080	Drainage of bladder abscess	T	0008	19.4063	$1,304.90		$260.98	*
51100	Drain bladder by needle	T	0164	2.0194	$135.79		$27.16	*
51101	Drain bladder by trocar/cath	T	0126	1.0958	$73.68	$16.21	$14.74	*
51102	Drain bl w/cath insertion	T	0165	20.0243	$1,346.45		$269.29	*
51500	Removal of bladder cyst	T	0154	31.9682	$2,149.57	$464.85	$429.92	*
51520	Removal of bladder lesion	T	0162	25.5223	$1,716.14		$343.23	*
51525	Removal of bladder lesion	C						
51530	Removal of bladder lesion	C						
51535	Repair of ureter lesion	T	0162	25.5223	$1,716.14		$343.23	*
51550	Partial removal of bladder	C						
51555	Partial removal of bladder	C						
51565	Revise bladder & ureter(s)	C						
51570	Removal of bladder	C						
51575	Removal of bladder & nodes	C						
51580	Remove bladder/revise tract	C						
51585	Removal of bladder & nodes	C						
51590	Remove bladder/revise tract	C						
51595	Remove bladder/revise tract	C						
51596	Remove bladder/create pouch	C						
51597	Removal of pelvic structures	C						
51600	Injection for bladder x-ray	N						
51605	Preparation for bladder xray	N						
51610	Injection for bladder x-ray	N						
51700	Irrigation of bladder	T	0164	2.0194	$135.79		$27.16	*
51701	Insert bladder catheter	X	0340	0.6693	$45.00		$9.00	*
51702	Insert temp bladder cath	X	0340	0.6693	$45.00		$9.00	*
51703	Insert bladder cath, complex	T	0126	1.0958	$73.68	$16.21	$14.74	*
51705	Change of bladder tube	T	0164	2.0194	$135.79		$27.16	*
51710	Change of bladder tube	T	0121	6.3742	$428.61		$85.73	*
51715	Endoscopic injection/implant	T	0168	31.377	$2,109.82		$421.97	*
51720	Treatment of bladder lesion	T	0156	3.0214	$203.16		$40.64	*
51725	Simple cystometrogram	T	0156	3.0214	$203.16		$40.64	*
51726	Complex cystometrogram	T	0156	3.0214	$203.16		$40.64	*
51727	Cystometrogram w/up	T	0156	3.0214	$203.16		$40.64	*
51728	Cystometrogram w/vp	T	0156	3.0214	$203.16		$40.64	*
51729	Cystometrogram w/vp&up	T	0156	3.0214	$203.16		$40.64	*
51736	Urine flow measurement	T	0126	1.0958	$73.68	$16.21	$14.74	*

51741	Electro-uroflowmetry, first	T	0126	1.0958	$73.68	$16.21	$14.74	*
51784	Anal/urinary muscle study	T	0126	1.0958	$73.68	$16.21	$14.74	*
51785	Anal/urinary muscle study	T	0164	2.0194	$135.79		$27.16	*
51792	Urinary reflex study	T	0126	1.0958	$73.68	$16.21	$14.74	*
51797	Intraabdominal pressure test	T	0164	2.0194	$135.79		$27.16	*
51798	Us urine capacity measure	X	0340	0.6693	$45.00		$9.00	*
51800	Revision of bladder/urethra	C						
51820	Revision of urinary tract	C						
51840	Attach bladder/urethra	C						
51841	Attach bladder/urethra	C						
51845	Repair bladder neck	T	0202	44.9894	$3,025.13	$981.50	$605.03	*
51860	Repair of bladder wound	T	0162	25.5223	$1,716.14		$343.23	*
51865	Repair of bladder wound	C						
51880	Repair of bladder opening	T	0162	25.5223	$1,716.14		$343.23	*
51900	Repair bladder/vagina lesion	C						
51920	Close bladder-uterus fistula	C						
51925	Hysterectomy/bladder repair	C						
51940	Correction of bladder defect	C						
51960	Revision of bladder & bowel	C						
51980	Construct bladder opening	C						
51990	Laparo urethral suspension	T	0131	46.84	$3,149.57	$1,001.89	$629.92	*
51992	Laparo sling operation	T	0131	46.84	$3,149.57	$1,001.89	$629.92	*
51999	Laparoscope proc, bla	T	0130	38.054	$2,558.79	$659.53	$511.76	*
52000	Cystoscopy	T	0160	7.1342	$479.71		$95.95	*
52001	Cystoscopy, removal of clots	T	0161	17.0344	$1,145.41		$229.09	*
52005	Cystoscopy & ureter catheter	T	0162	25.5223	$1,716.14		$343.23	*
52007	Cystoscopy and biopsy	T	0162	25.5223	$1,716.14		$343.23	*
52010	Cystoscopy & duct catheter	T	0160	7.1342	$479.71		$95.95	*
52204	Cystoscopy w/biopsy(s)	T	0162	25.5223	$1,716.14		$343.23	*
52214	Cystoscopy and treatment	T	0162	25.5223	$1,716.14		$343.23	*
52224	Cystoscopy and treatment	T	0162	25.5223	$1,716.14		$343.23	*
52234	Cystoscopy and treatment	T	0162	25.5223	$1,716.14		$343.23	*
52235	Cystoscopy and treatment	T	0162	25.5223	$1,716.14		$343.23	*
52240	Cystoscopy and treatment	T	0162	25.5223	$1,716.14		$343.23	*
52250	Cystoscopy and radiotracer	T	0162	25.5223	$1,716.14		$343.23	*
52260	Cystoscopy and treatment	T	0161	17.0344	$1,145.41		$229.09	*
52265	Cystoscopy and treatment	T	0160	7.1342	$479.71		$95.95	*
52270	Cystoscopy & revise urethra	T	0161	17.0344	$1,145.41		$229.09	*
52275	Cystoscopy & revise urethra	T	0162	25.5223	$1,716.14		$343.23	*
52276	Cystoscopy and treatment	T	0162	25.5223	$1,716.14		$343.23	*
52277	Cystoscopy and treatment	T	0162	25.5223	$1,716.14		$343.23	*
52281	Cystoscopy and treatment	T	0161	17.0344	$1,145.41		$229.09	*
52282	Cystoscopy, implant stent	T	0163	36.2009	$2,434.18		$486.84	*
52283	Cystoscopy and treatment	T	0162	25.5223	$1,716.14		$343.23	*
52285	Cystoscopy and treatment	T	0161	17.0344	$1,145.41		$229.09	*
52290	Cystoscopy and treatment	T	0162	25.5223	$1,716.14		$343.23	*
52300	Cystoscopy and treatment	T	0162	25.5223	$1,716.14		$343.23	*
52301	Cystoscopy and treatment	T	0162	25.5223	$1,716.14		$343.23	*
52305	Cystoscopy and treatment	T	0162	25.5223	$1,716.14		$343.23	*
52310	Cystoscopy and treatment	T	0161	17.0344	$1,145.41		$229.09	*
52315	Cystoscopy and treatment	T	0162	25.5223	$1,716.14		$343.23	*
52317	Remove bladder stone	T	0162	25.5223	$1,716.14		$343.23	*
52318	Remove bladder stone	T	0162	25.5223	$1,716.14		$343.23	*
52320	Cystoscopy and treatment	T	0162	25.5223	$1,716.14		$343.23	*
52325	Cystoscopy, stone removal	T	0162	25.5223	$1,716.14		$343.23	*
52327	Cystoscopy, inject material	T	0163	36.2009	$2,434.18		$486.84	*
52330	Cystoscopy and treatment	T	0162	25.5223	$1,716.14		$343.23	*
52332	Cystoscopy and treatment	T	0162	25.5223	$1,716.14		$343.23	*
52334	Create passage to kidney	T	0162	25.5223	$1,716.14		$343.23	*
52341	Cysto w/ureter stricture tx	T	0162	25.5223	$1,716.14		$343.23	*
52342	Cysto w/up stricture tx	T	0162	25.5223	$1,716.14		$343.23	*
52343	Cysto w/renal stricture tx	T	0162	25.5223	$1,716.14		$343.23	*

52344	Cysto/uretero, stricture tx	T	0162	25.5223	$1,716.14		$343.23	*
52345	Cysto/uretero w/up stricture	T	0162	25.5223	$1,716.14		$343.23	*
52346	Cystouretero w/renal strict	T	0162	25.5223	$1,716.14		$343.23	*
52351	Cystouretero & or pyeloscope	T	0162	25.5223	$1,716.14		$343.23	*
52352	Cystouretero w/stone remove	T	0162	25.5223	$1,716.14		$343.23	*
52353	Cystouretero w/lithotripsy	T	0163	36.2009	$2,434.18		$486.84	*
52354	Cystouretero w/biopsy	T	0162	25.5223	$1,716.14		$343.23	*
52355	Cystouretero w/excise tumor	T	0162	25.5223	$1,716.14		$343.23	*
52400	Cystouretero w/congen repr	T	0162	25.5223	$1,716.14		$343.23	*
52402	Cystourethro cut ejacul duct	T	0162	25.5223	$1,716.14		$343.23	*
52450	Incision of prostate	T	0162	25.5223	$1,716.14		$343.23	*
52500	Revision of bladder neck	T	0162	25.5223	$1,716.14		$343.23	*
52601	Prostatectomy (TURP)	T	0163	36.2009	$2,434.18		$486.84	*
52630	Remove prostate regrowth	T	0163	36.2009	$2,434.18		$486.84	*
52640	Relieve bladder contracture	T	0162	25.5223	$1,716.14		$343.23	*
52647	Laser surgery of prostate	T	0429	46.68	$3,138.81		$627.77	*
52648	Laser surgery of prostate	T	0429	46.68	$3,138.81		$627.77	*
52649	Prostate laser enucleation	T	0429	46.68	$3,138.81		$627.77	*
52700	Drainage of prostate abscess	T	0162	25.5223	$1,716.14		$343.23	*
53000	Incision of urethra	T	0166	20.3374	$1,367.51		$273.51	*
53010	Incision of urethra	T	0166	20.3374	$1,367.51		$273.51	*
53020	Incision of urethra	T	0166	20.3374	$1,367.51		$273.51	*
53025	Incision of urethra	T	0166	20.3374	$1,367.51		$273.51	*
53040	Drainage of urethra abscess	T	0166	20.3374	$1,367.51		$273.51	*
53060	Drainage of urethra abscess	T	0166	20.3374	$1,367.51		$273.51	*
53080	Drainage of urinary leakage	T	0166	20.3374	$1,367.51		$273.51	*
53085	Drainage of urinary leakage	T	0166	20.3374	$1,367.51		$273.51	*
53200	Biopsy of urethra	T	0166	20.3374	$1,367.51		$273.51	*
53210	Removal of urethra	T	0168	31.377	$2,109.82		$421.97	*
53215	Removal of urethra	T	0166	20.3374	$1,367.51		$273.51	*
53220	Treatment of urethra lesion	T	0168	31.377	$2,109.82		$421.97	*
53230	Removal of urethra lesion	T	0168	31.377	$2,109.82		$421.97	*
53235	Removal of urethra lesion	T	0166	20.3374	$1,367.51		$273.51	*
53240	Surgery for urethra pouch	T	0168	31.377	$2,109.82		$421.97	*
53250	Removal of urethra gland	T	0166	20.3374	$1,367.51		$273.51	*
53260	Treatment of urethra lesion	T	0166	20.3374	$1,367.51		$273.51	*
53265	Treatment of urethra lesion	T	0166	20.3374	$1,367.51		$273.51	*
53270	Removal of urethra gland	T	0166	20.3374	$1,367.51		$273.51	*
53275	Repair of urethra defect	T	0166	20.3374	$1,367.51		$273.51	*
53400	Revise urethra, stage 1	T	0168	31.377	$2,109.82		$421.97	*
53405	Revise urethra, stage 2	T	0168	31.377	$2,109.82		$421.97	*
53410	Reconstruction of urethra	T	0168	31.377	$2,109.82		$421.97	*
53415	Reconstruction of urethra	C						
53420	Reconstruct urethra, stage 1	T	0168	31.377	$2,109.82		$421.97	*
53425	Reconstruct urethra, stage 2	T	0168	31.377	$2,109.82		$421.97	*
53430	Reconstruction of urethra	T	0168	31.377	$2,109.82		$421.97	*
53431	Reconstruct urethra/bladder	T	0168	31.377	$2,109.82		$421.97	*
53440	Male sling procedure	S	0385	98.0867	$6,595.45		$1,319.09	*
53442	Remove/revise male sling	T	0168	31.377	$2,109.82		$421.97	*
53444	Insert tandem cuff	S	0385	98.0867	$6,595.45		$1,319.09	*
53445	Insert uro/ves nck sphincter	S	0386	164.32	$11,049.04		$2,209.81	*
53446	Remove uro sphincter	T	0168	31.377	$2,109.82		$421.97	*
53447	Remove/replace ur sphincter	S	0386	164.32	$11,049.04		$2,209.81	*
53448	Remov/replc ur sphinctr comp	C						
53449	Repair uro sphincter	T	0168	31.377	$2,109.82		$421.97	*
53450	Revision of urethra	T	0168	31.377	$2,109.82		$421.97	*
53460	Revision of urethra	T	0166	20.3374	$1,367.51		$273.51	*
53500	Urethrlys, transvag w/ scope	T	0168	31.377	$2,109.82		$421.97	*
53502	Repair of urethra injury	T	0166	20.3374	$1,367.51		$273.51	*
53505	Repair of urethra injury	T	0168	31.377	$2,109.82		$421.97	*
53510	Repair of urethra injury	T	0166	20.3374	$1,367.51		$273.51	*
53515	Repair of urethra injury	T	0168	31.377	$2,109.82		$421.97	*

53520	Repair of urethra defect	T	0168	31.377	$2,109.82		$421.97	*
53600	Dilate urethra stricture	T	0156	3.0214	$203.16		$40.64	*
53601	Dilate urethra stricture	T	0126	1.0958	$73.68	$16.21	$14.74	*
53605	Dilate urethra stricture	T	0161	17.0344	$1,145.41		$229.09	*
53620	Dilate urethra stricture	T	0165	20.0243	$1,346.45		$269.29	*
53621	Dilate urethra stricture	T	0164	2.0194	$135.79		$27.16	*
53660	Dilation of urethra	T	0126	1.0958	$73.68	$16.21	$14.74	*
53661	Dilation of urethra	T	0126	1.0958	$73.68	$16.21	$14.74	*
53665	Dilation of urethra	T	0166	20.3374	$1,367.51		$273.51	*
53850	Prostatic microwave thermotx	T	0429	46.68	$3,138.81		$627.77	*
53852	Prostatic rf thermotx	T	0429	46.68	$3,138.81		$627.77	*
53855	Insert prost urethral stent	T	0164	2.0194	$135.79		$27.16	*
53899	Urology surgery procedure	T	0126	1.0958	$73.68	$16.21	$14.74	*
54000	Slitting of prepuce	T	0166	20.3374	$1,367.51		$273.51	*
54001	Slitting of prepuce	T	0166	20.3374	$1,367.51		$273.51	*
54015	Drain penis lesion	T	0008	19.4063	$1,304.90		$260.98	*
54050	Destruction, penis lesion(s)	T	0013	0.8789	$59.10		$11.82	*
54055	Destruction, penis lesion(s)	T	0017	21.2653	$1,429.90		$285.98	*
54056	Cryosurgery, penis lesion(s)	T	0013	0.8789	$59.10		$11.82	*
54057	Laser surg, penis lesion(s)	T	0017	21.2653	$1,429.90		$285.98	*
54060	Excision of penis lesion(s)	T	0017	21.2653	$1,429.90		$285.98	*
54065	Destruction, penis lesion(s)	T	0017	21.2653	$1,429.90		$285.98	*
54100	Biopsy of penis	T	0021	17.4975	$1,176.55		$235.31	*
54105	Biopsy of penis	T	0022	23.388	$1,572.63	$354.45	$314.53	*
54110	Treatment of penis lesion	T	0181	34.8837	$2,345.61	$620.84	$469.13	*
54111	Treat penis lesion, graft	T	0181	34.8837	$2,345.61	$620.84	$469.13	*
54112	Treat penis lesion, graft	T	0181	34.8837	$2,345.61	$620.84	$469.13	*
54115	Treatment of penis lesion	T	0008	19.4063	$1,304.90		$260.98	*
54120	Partial removal of penis	T	0181	34.8837	$2,345.61	$620.84	$469.13	*
54125	Removal of penis	C						
54130	Remove penis & nodes	C						
54135	Remove penis & nodes	C						
54150	Circumcision w/regionl block	T	0183	23.2838	$1,565.63		$313.13	*
54160	Circumcision, neonate	T	0183	23.2838	$1,565.63		$313.13	*
54161	Circum 28 days or older	T	0183	23.2838	$1,565.63		$313.13	*
54162	Lysis penil circumic lesion	T	0183	23.2838	$1,565.63		$313.13	*
54163	Repair of circumcision	T	0183	23.2838	$1,565.63		$313.13	*
54164	Frenulotomy of penis	T	0183	23.2838	$1,565.63		$313.13	*
54200	Treatment of penis lesion	T	0164	2.0194	$135.79		$27.16	*
54205	Treatment of penis lesion	T	0181	34.8837	$2,345.61	$620.84	$469.13	*
54220	Treatment of penis lesion	T	0164	2.0194	$135.79		$27.16	*
54230	Prepare penis study	N						
54231	Dynamic cavernosometry	T	0165	20.0243	$1,346.45		$269.29	*
54235	Penile injection	T	0164	2.0194	$135.79		$27.16	*
54240	Penis study	T	0126	1.0958	$73.68	$16.21	$14.74	*
54250	Penis study	T	0164	2.0194	$135.79		$27.16	*
54300	Revision of penis	T	0181	34.8837	$2,345.61	$620.84	$469.13	*
54304	Revision of penis	T	0181	34.8837	$2,345.61	$620.84	$469.13	*
54308	Reconstruction of urethra	T	0181	34.8837	$2,345.61	$620.84	$469.13	*
54312	Reconstruction of urethra	T	0181	34.8837	$2,345.61	$620.84	$469.13	*
54316	Reconstruction of urethra	T	0181	34.8837	$2,345.61	$620.84	$469.13	*
54318	Reconstruction of urethra	T	0181	34.8837	$2,345.61	$620.84	$469.13	*
54322	Reconstruction of urethra	T	0181	34.8837	$2,345.61	$620.84	$469.13	*
54324	Reconstruction of urethra	T	0181	34.8837	$2,345.61	$620.84	$469.13	*
54326	Reconstruction of urethra	T	0181	34.8837	$2,345.61	$620.84	$469.13	*
54328	Revise penis/urethra	T	0181	34.8837	$2,345.61	$620.84	$469.13	*
54332	Revise penis/urethra	T	0181	34.8837	$2,345.61	$620.84	$469.13	*
54336	Revise penis/urethra	T	0181	34.8837	$2,345.61	$620.84	$469.13	*
54340	Secondary urethral surgery	T	0181	34.8837	$2,345.61	$620.84	$469.13	*
54344	Secondary urethral surgery	T	0181	34.8837	$2,345.61	$620.84	$469.13	*
54348	Secondary urethral surgery	T	0181	34.8837	$2,345.61	$620.84	$469.13	*
54352	Reconstruct urethra/penis	T	0181	34.8837	$2,345.61	$620.84	$469.13	*

54360	Penis plastic surgery	T	0181	34.8837	$2,345.61	$620.84	$469.13	*
54380	Repair penis	T	0181	34.8837	$2,345.61	$620.84	$469.13	*
54385	Repair penis	T	0181	34.8837	$2,345.61	$620.84	$469.13	*
54390	Repair penis and bladder	C						
54400	Insert semi-rigid prosthesis	S	0385	98.0867	$6,595.45		$1,319.09	*
54401	Insert self-contd prosthesis	S	0386	164.32	$11,049.04		$2,209.81	*
54405	Insert multi-comp penis pros	S	0386	164.32	$11,049.04		$2,209.81	*
54406	Remove muti-comp penis pros	T	0181	34.8837	$2,345.61	$620.84	$469.13	*
54408	Repair multi-comp penis pros	T	0181	34.8837	$2,345.61	$620.84	$469.13	*
54410	Remove/replace penis prosth	S	0386	164.32	$11,049.04		$2,209.81	*
54411	Remov/replc penis pros, comp	C						
54415	Remove self-contd penis pros	T	0181	34.8837	$2,345.61	$620.84	$469.13	*
54416	Remv/repl penis contain pros	S	0386	164.32	$11,049.04		$2,209.81	*
54417	Remv/replc penis pros, compl	C						
54420	Revision of penis	T	0181	34.8837	$2,345.61	$620.84	$469.13	*
54430	Revision of penis	C						
54435	Revision of penis	T	0181	34.8837	$2,345.61	$620.84	$469.13	*
54440	Repair of penis	T	0181	34.8837	$2,345.61	$620.84	$469.13	*
54450	Preputial stretching	T	0156	3.0214	$203.16		$40.64	*
54500	Biopsy of testis	T	0037	15.5003	$1,042.26	$228.76	$208.46	*
54505	Biopsy of testis	T	0183	23.2838	$1,565.63		$313.13	*
54512	Excise lesion testis	T	0183	23.2838	$1,565.63		$313.13	*
54520	Removal of testis	T	0183	23.2838	$1,565.63		$313.13	*
54522	Orchiectomy, partial	T	0183	23.2838	$1,565.63		$313.13	*
54530	Removal of testis	T	0154	31.9682	$2,149.57	$464.85	$429.92	*
54535	Extensive testis surgery	T	0181	34.8837	$2,345.61	$620.84	$469.13	*
54550	Exploration for testis	T	0154	31.9682	$2,149.57	$464.85	$429.92	*
54560	Exploration for testis	T	0183	23.2838	$1,565.63		$313.13	*
54600	Reduce testis torsion	T	0183	23.2838	$1,565.63		$313.13	*
54620	Suspension of testis	T	0183	23.2838	$1,565.63		$313.13	*
54640	Suspension of testis	T	0154	31.9682	$2,149.57	$464.85	$429.92	*
54650	Orchiopexy (Fowler-Stephens)	C						
54660	Revision of testis	T	0183	23.2838	$1,565.63		$313.13	*
54670	Repair testis injury	T	0183	23.2838	$1,565.63		$313.13	*
54680	Relocation of testis(es)	T	0183	23.2838	$1,565.63		$313.13	*
54690	Laparoscopy, orchiectomy	T	0131	46.84	$3,149.57	$1,001.89	$629.92	*
54692	Laparoscopy, orchiopexy	T	0132	72.9582	$4,905.78	$1,239.22	$981.16	*
54699	Laparoscope proc, testis	T	0130	38.054	$2,558.79	$659.53	$511.76	*
54700	Drainage of scrotum	T	0183	23.2838	$1,565.63		$313.13	*
54800	Biopsy of epididymis	T	0004	4.5991	$309.25		$61.85	*
54830	Remove epididymis lesion	T	0183	23.2838	$1,565.63		$313.13	*
54840	Remove epididymis lesion	T	0183	23.2838	$1,565.63		$313.13	*
54860	Removal of epididymis	T	0183	23.2838	$1,565.63		$313.13	*
54861	Removal of epididymis	T	0183	23.2838	$1,565.63		$313.13	*
54865	Explore epididymis	T	0183	23.2838	$1,565.63		$313.13	*
54900	Fusion of spermatic ducts	T	0183	23.2838	$1,565.63		$313.13	*
54901	Fusion of spermatic ducts	T	0183	23.2838	$1,565.63		$313.13	*
55000	Drainage of hydrocele	T	0004	4.5991	$309.25		$61.85	*
55040	Removal of hydrocele	T	0154	31.9682	$2,149.57	$464.85	$429.92	*
55041	Removal of hydroceles	T	0154	31.9682	$2,149.57	$464.85	$429.92	*
55060	Repair of hydrocele	T	0183	23.2838	$1,565.63		$313.13	*
55100	Drainage of scrotum abscess	T	0007	12.6217	$848.70		$169.74	*
55110	Explore scrotum	T	0183	23.2838	$1,565.63		$313.13	*
55120	Removal of scrotum lesion	T	0183	23.2838	$1,565.63		$313.13	*
55150	Removal of scrotum	T	0183	23.2838	$1,565.63		$313.13	*
55175	Revision of scrotum	T	0183	23.2838	$1,565.63		$313.13	*
55180	Revision of scrotum	T	0183	23.2838	$1,565.63		$313.13	*
55200	Incision of sperm duct	T	0183	23.2838	$1,565.63		$313.13	*
55250	Removal of sperm duct(s)	T	0183	23.2838	$1,565.63		$313.13	*
55300	Prepare, sperm duct x-ray	N						
55400	Repair of sperm duct	T	0183	23.2838	$1,565.63		$313.13	*
55450	Ligation of sperm duct	T	0183	23.2838	$1,565.63		$313.13	*

55500	Removal of hydrocele	T	0183	23.2838	$1,565.63		$313.13	*
55520	Removal of sperm cord lesion	T	0183	23.2838	$1,565.63		$313.13	*
55530	Revise spermatic cord veins	T	0183	23.2838	$1,565.63		$313.13	*
55535	Revise spermatic cord veins	T	0154	31.9682	$2,149.57	$464.85	$429.92	*
55540	Revise hernia & sperm veins	T	0154	31.9682	$2,149.57	$464.85	$429.92	*
55550	Laparo ligate spermatic vein	T	0131	46.84	$3,149.57	$1,001.89	$629.92	*
55559	Laparo proc, spermatic cord	T	0130	38.054	$2,558.79	$659.53	$511.76	*
55600	Incise sperm duct pouch	T	0183	23.2838	$1,565.63		$313.13	*
55605	Incise sperm duct pouch	C						
55650	Remove sperm duct pouch	C						
55680	Remove sperm pouch lesion	T	0183	23.2838	$1,565.63		$313.13	*
55700	Biopsy of prostate	T	0184	12.4313	$835.89		$167.18	*
55705	Biopsy of prostate	T	0184	12.4313	$835.89		$167.18	*
55706	Prostate saturation sampling	T	0184	12.4313	$835.89		$167.18	*
55720	Drainage of prostate abscess	T	0162	25.5223	$1,716.14		$343.23	*
55725	Drainage of prostate abscess	T	0162	25.5223	$1,716.14		$343.23	*
55801	Removal of prostate	C						
55810	Extensive prostate surgery	C						
55812	Extensive prostate surgery	C						
55815	Extensive prostate surgery	C						
55821	Removal of prostate	C						
55831	Removal of prostate	C						
55840	Extensive prostate surgery	C						
55842	Extensive prostate surgery	C						
55845	Extensive prostate surgery	C						
55860	Surgical exposure, prostate	T	0165	20.0243	$1,346.45		$269.29	*
55862	Extensive prostate surgery	C						
55865	Extensive prostate surgery	C						
55866	Laparo radical prostatectomy	C						
55870	Electroejaculation	T	0189	3.4085	$229.19		$45.84	*
55873	Cryoablate prostate	T	0674	113.8626	$7,656.24		$1,531.25	*

55875	Transperi needle place, pros	Q3	0163	36.2009	$2,434.18		$486.84	*
55876	Place rt device/marker, pros	X	0310	13.7576	$925.07	$325.27	$185.02	*
55899	Genital surgery procedure	T	0126	1.0958	$73.68	$16.21	$14.74	*
55920	Place needles pelvic for rt	T	0153	27.1855	$1,827.98	$376.05	$365.60	*
55970	Sex transformation, M to F	E						
55980	Sex transformation, F to M	E						
56405	I & D of vulva/perineum	T	0188	1.5277	$102.72		$20.55	*
56420	Drainage of gland abscess	T	0188	1.5277	$102.72		$20.55	*
56440	Surgery for vulva lesion	T	0193	20.0452	$1,347.86		$269.58	*
56441	Lysis of labial lesion(s)	T	0193	20.0452	$1,347.86		$269.58	*
56442	Hymenotomy	T	0193	20.0452	$1,347.86		$269.58	*
56501	Destroy, vulva lesions, sim	T	0017	21.2653	$1,429.90		$285.98	*
56515	Destroy vulva lesion/s compl	T	0017	21.2653	$1,429.90		$285.98	*
56605	Biopsy of vulva/perineum	T	0189	3.4085	$229.19		$45.84	*
56606	Biopsy of vulva/perineum	T	0188	1.5277	$102.72		$20.55	*
56620	Partial removal of vulva	T	0193	20.0452	$1,347.86		$269.58	*
56625	Complete removal of vulva	T	0193	20.0452	$1,347.86		$269.58	*
56630	Extensive vulva surgery	C						
56631	Extensive vulva surgery	C						
56632	Extensive vulva surgery	C						
56633	Extensive vulva surgery	C						
56634	Extensive vulva surgery	C						
56637	Extensive vulva surgery	C						
56640	Extensive vulva surgery	C						
56700	Partial removal of hymen	T	0193	20.0452	$1,347.86		$269.58	*
56740	Remove vagina gland lesion	T	0193	20.0452	$1,347.86		$269.58	*
56800	Repair of vagina	T	0193	20.0452	$1,347.86		$269.58	*
56805	Repair clitoris	T	0193	20.0452	$1,347.86		$269.58	*
56810	Repair of perineum	T	0193	20.0452	$1,347.86		$269.58	*
56820	Exam of vulva w/scope	T	0188	1.5277	$102.72		$20.55	*
56821	Exam/biopsy of vulva w/scope	T	0188	1.5277	$102.72		$20.55	*

57000	Exploration of vagina	T	0193	20.0452	$1,347.86		$269.58	*
57010	Drainage of pelvic abscess	T	0193	20.0452	$1,347.86		$269.58	*
57020	Drainage of pelvic fluid	T	0192	6.7949	$456.90		$91.38	*
57022	I & d vaginal hematoma, pp	T	0007	12.6217	$848.70		$169.74	*
57023	I & d vag hematoma, non-ob	T	0008	19.4063	$1,304.90		$260.98	*
57061	Destroy vag lesions, simple	T	0193	20.0452	$1,347.86		$269.58	*
57065	Destroy vag lesions, complex	T	0193	20.0452	$1,347.86		$269.58	*
57100	Biopsy of vagina	T	0192	6.7949	$456.90		$91.38	*
57105	Biopsy of vagina	T	0193	20.0452	$1,347.86		$269.58	*
57106	Remove vagina wall, partial	T	0193	20.0452	$1,347.86		$269.58	*
57107	Remove vagina tissue, part	T	0195	35.2666	$2,371.36	$483.80	$474.28	*
57109	Vaginectomy partial w/nodes	T	0195	35.2666	$2,371.36	$483.80	$474.28	*
57110	Remove vagina wall, complete	C						
57111	Remove vagina tissue, compl	C						
57112	Vaginectomy w/nodes, compl	C						
57120	Closure of vagina	T	0195	35.2666	$2,371.36	$483.80	$474.28	*
57130	Remove vagina lesion	T	0193	20.0452	$1,347.86		$269.58	*
57135	Remove vagina lesion	T	0193	20.0452	$1,347.86		$269.58	*
57150	Treat vagina infection	T	0188	1.5277	$102.72		$20.55	*
57155	Insert uteri tandems/ovoids	T	0192	6.7949	$456.90		$91.38	*
57160	Insert pessary/other device	T	0188	1.5277	$102.72		$20.55	*
57170	Fitting of diaphragm/cap	T	0191	0.132	$8.88	$2.08	$1.78	*
57180	Treat vaginal bleeding	T	0188	1.5277	$102.72		$20.55	*
57200	Repair of vagina	T	0193	20.0452	$1,347.86		$269.58	*
57210	Repair vagina/perineum	T	0193	20.0452	$1,347.86		$269.58	*
57220	Revision of urethra	T	0202	44.9894	$3,025.13	$981.50	$605.03	*
57230	Repair of urethral lesion	T	0195	35.2666	$2,371.36	$483.80	$474.28	*
57240	Repair bladder & vagina	T	0195	35.2666	$2,371.36	$483.80	$474.28	*
57250	Repair rectum & vagina	T	0195	35.2666	$2,371.36	$483.80	$474.28	*
57260	Repair of vagina	T	0195	35.2666	$2,371.36	$483.80	$474.28	*
57265	Extensive repair of vagina	T	0202	44.9894	$3,025.13	$981.50	$605.03	*
57267	Insert mesh/pelvic flr addon	T	0195	35.2666	$2,371.36	$483.80	$474.28	*
57268	Repair of bowel bulge	T	0195	35.2666	$2,371.36	$483.80	$474.28	*
57270	Repair of bowel pouch	C						
57280	Suspension of vagina	C						
57282	Colpopexy, extraperitoneal	T	0202	44.9894	$3,025.13	$981.50	$605.03	*
57283	Colpopexy, intraperitoneal	T	0202	44.9894	$3,025.13	$981.50	$605.03	*
57284	Repair paravag defect, open	T	0202	44.9894	$3,025.13	$981.50	$605.03	*
57285	Repair paravag defect, vag	T	0202	44.9894	$3,025.13	$981.50	$605.03	*
57287	Revise/remove sling repair	T	0195	35.2666	$2,371.36	$483.80	$474.28	*
57288	Repair bladder defect	T	0202	44.9894	$3,025.13	$981.50	$605.03	*
57289	Repair bladder & vagina	T	0195	35.2666	$2,371.36	$483.80	$474.28	*
57291	Construction of vagina	T	0195	35.2666	$2,371.36	$483.80	$474.28	*
57292	Construct vagina with graft	T	0195	35.2666	$2,371.36	$483.80	$474.28	*
57295	Revise vag graft via vagina	T	0193	20.0452	$1,347.86		$269.58	*
57296	Revise vag graft, open abd	C						
57300	Repair rectum-vagina fistula	T	0195	35.2666	$2,371.36	$483.80	$474.28	*
57305	Repair rectum-vagina fistula	C						
57307	Fistula repair & colostomy	C						
57308	Fistula repair, transperine	C						
57310	Repair urethrovaginal lesion	T	0202	44.9894	$3,025.13	$981.50	$605.03	*
57311	Repair urethrovaginal lesion	C						
57320	Repair bladder-vagina lesion	T	0195	35.2666	$2,371.36	$483.80	$474.28	*
57330	Repair bladder-vagina lesion	T	0195	35.2666	$2,371.36	$483.80	$474.28	*
57335	Repair vagina	T	0195	35.2666	$2,371.36	$483.80	$474.28	*
57400	Dilation of vagina	T	0193	20.0452	$1,347.86		$269.58	*
57410	Pelvic examination	T	0193	20.0452	$1,347.86		$269.58	*
57415	Remove vaginal foreign body	T	0193	20.0452	$1,347.86		$269.58	*
57420	Exam of vagina w/scope	T	0189	3.4085	$229.19		$45.84	*
57421	Exam/biopsy of vag w/scope	T	0189	3.4085	$229.19		$45.84	*
57423	Repair paravag defect, lap	T	0202	44.9894	$3,025.13	$981.50	$605.03	*
57425	Laparoscopy, surg, colpopexy	T	0130	38.054	$2,558.79	$659.53	$511.76	*

57426	Revise prosth vag graft lap	T	0193	20.0452	$1,347.86		$269.58	*
57452	Exam of cervix w/scope	T	0188	1.5277	$102.72		$20.55	*
57454	Bx/curett of cervix w/scope	T	0189	3.4085	$229.19		$45.84	*
57455	Biopsy of cervix w/scope	T	0189	3.4085	$229.19		$45.84	*
57456	Endocerv curettage w/scope	T	0189	3.4085	$229.19		$45.84	*
57460	Bx of cervix w/scope, leep	T	0193	20.0452	$1,347.86		$269.58	*
57461	Conz of cervix w/scope, leep	T	0193	20.0452	$1,347.86		$269.58	*
57500	Biopsy of cervix	T	0192	6.7949	$456.90		$91.38	*
57505	Endocervical curettage	T	0192	6.7949	$456.90		$91.38	*
57510	Cauterization of cervix	T	0193	20.0452	$1,347.86		$269.58	*
57511	Cryocautery of cervix	T	0188	1.5277	$102.72		$20.55	*
57513	Laser surgery of cervix	T	0193	20.0452	$1,347.86		$269.58	*
57520	Conization of cervix	T	0193	20.0452	$1,347.86		$269.58	*
57522	Conization of cervix	T	0193	20.0452	$1,347.86		$269.58	*
57530	Removal of cervix	T	0195	35.2666	$2,371.36	$483.80	$474.28	*
57531	Removal of cervix, radical	C						
57540	Removal of residual cervix	C						
57545	Remove cervix/repair pelvis	C						
57550	Removal of residual cervix	T	0195	35.2666	$2,371.36	$483.80	$474.28	*
57555	Remove cervix/repair vagina	T	0195	35.2666	$2,371.36	$483.80	$474.28	*
57556	Remove cervix, repair bowel	T	0202	44.9894	$3,025.13	$981.50	$605.03	*
57558	D&c of cervical stump	T	0193	20.0452	$1,347.86		$269.58	*
57700	Revision of cervix	T	0193	20.0452	$1,347.86		$269.58	*
57720	Revision of cervix	T	0193	20.0452	$1,347.86		$269.58	*
57800	Dilation of cervical canal	T	0193	20.0452	$1,347.86		$269.58	*
58100	Biopsy of uterus lining	T	0188	1.5277	$102.72		$20.55	*
58110	Bx done w/colposcopy add-on	N						
58120	Dilation and curettage	T	0193	20.0452	$1,347.86		$269.58	*
58140	Myomectomy abdom method	C						
58145	Myomectomy vag method	T	0195	35.2666	$2,371.36	$483.80	$474.28	*
58146	Myomectomy abdom complex	C						
58150	Total hysterectomy	C						
58152	Total hysterectomy	C						
58180	Partial hysterectomy	C						
58200	Extensive hysterectomy	C						
58210	Extensive hysterectomy	C						
58240	Removal of pelvis contents	C						
58260	Vaginal hysterectomy	T	0195	35.2666	$2,371.36	$483.80	$474.28	*
58262	Vag hyst including t/o	T	0195	35.2666	$2,371.36	$483.80	$474.28	*
58263	Vag hyst w/t/o & vag repair	T	0195	35.2666	$2,371.36	$483.80	$474.28	*
58267	Vag hyst w/urinary repair	C						
58270	Vag hyst w/enterocele repair	T	0195	35.2666	$2,371.36	$483.80	$474.28	*
58275	Hysterectomy/revise vagina	C						
58280	Hysterectomy/revise vagina	C						
58285	Extensive hysterectomy	C						
58290	Vag hyst complex	T	0202	44.9894	$3,025.13	$981.50	$605.03	*
58291	Vag hyst incl t/o, complex	T	0202	44.9894	$3,025.13	$981.50	$605.03	*
58292	Vag hyst t/o & repair, compl	T	0202	44.9894	$3,025.13	$981.50	$605.03	*
58293	Vag hyst w/uro repair, compl	C						
58294	Vag hyst w/enterocele, compl	T	0202	44.9894	$3,025.13	$981.50	$605.03	*
58300	Insert intrauterine device	E						
58301	Remove intrauterine device	T	0188	1.5277	$102.72		$20.55	*
58321	Artificial insemination	T	0189	3.4085	$229.19		$45.84	*
58322	Artificial insemination	T	0189	3.4085	$229.19		$45.84	*
58323	Sperm washing	T	0189	3.4085	$229.19		$45.84	*
58340	Catheter for hysterography	N						
58345	Reopen fallopian tube	T	0193	20.0452	$1,347.86		$269.58	*
58346	Insert heyman uteri capsule	T	0193	20.0452	$1,347.86		$269.58	*
58350	Reopen fallopian tube	T	0195	35.2666	$2,371.36	$483.80	$474.28	*
58353	Endometr ablate, thermal	T	0195	35.2666	$2,371.36	$483.80	$474.28	*
58356	Endometrial cryoablation	T	0202	44.9894	$3,025.13	$981.50	$605.03	*
58400	Suspension of uterus	C						

58410	Suspension of uterus	C						
58520	Repair of ruptured uterus	C						
58540	Revision of uterus	C						
58541	Lsh, uterus 250 g or less	T	0132	72.9582	$4,905.78	$1,239.22	$981.16	*
58542	Lsh w/t/o ut 250 g or less	T	0132	72.9582	$4,905.78	$1,239.22	$981.16	*
58543	Lsh uterus above 250 g	T	0132	72.9582	$4,905.78	$1,239.22	$981.16	*
58544	Lsh w/t/o uterus above 250 g	T	0132	72.9582	$4,905.78	$1,239.22	$981.16	*
58545	Laparoscopic myomectomy	T	0130	38.054	$2,558.79	$659.53	$511.76	*
58546	Laparo-myomectomy, complex	T	0131	46.84	$3,149.57	$1,001.89	$629.92	*
58548	Lap radical hyst	C						
58550	Laparo-asst vag hysterectomy	T	0132	72.9582	$4,905.78	$1,239.22	$981.16	*
58552	Laparo-vag hyst incl t/o	T	0131	46.84	$3,149.57	$1,001.89	$629.92	*
58553	Laparo-vag hyst, complex	T	0131	46.84	$3,149.57	$1,001.89	$629.92	*
58554	Laparo-vag hyst w/t/o, compl	T	0131	46.84	$3,149.57	$1,001.89	$629.92	*
58555	Hysteroscopy, dx, sep proc	T	0190	22.5926	$1,519.15	$424.28	$303.83	*
58558	Hysteroscopy, biopsy	T	0190	22.5926	$1,519.15	$424.28	$303.83	*
58559	Hysteroscopy, lysis	T	0190	22.5926	$1,519.15	$424.28	$303.83	*
58560	Hysteroscopy, resect septum	T	0387	37.2199	$2,502.70	$655.55	$500.54	*
58561	Hysteroscopy, remove myoma	T	0387	37.2199	$2,502.70	$655.55	$500.54	*
58562	Hysteroscopy, remove fb	T	0190	22.5926	$1,519.15	$424.28	$303.83	*
58563	Hysteroscopy, ablation	T	0387	37.2199	$2,502.70	$655.55	$500.54	*
58565	Hysteroscopy, sterilization	T	0202	44.9894	$3,025.13	$981.50	$605.03	*
58570	Tlh, uterus 250 g or less	T	0131	46.84	$3,149.57	$1,001.89	$629.92	*
58571	Tlh w/t/o 250 g or less	T	0131	46.84	$3,149.57	$1,001.89	$629.92	*
58572	Tlh, uterus over 250 g	T	0131	46.84	$3,149.57	$1,001.89	$629.92	*
58573	Tlh w/t/o uterus over 250 g	T	0131	46.84	$3,149.57	$1,001.89	$629.92	*
58578	Laparo proc, uterus	T	0130	38.054	$2,558.79	$659.53	$511.76	*
58579	Hysteroscope procedure	T	0190	22.5926	$1,519.15	$424.28	$303.83	*
58600	Division of fallopian tube	T	0195	35.2666	$2,371.36	$483.80	$474.28	*
58605	Division of fallopian tube	C						
58611	Ligate oviduct(s) add-on	C						
58615	Occlude fallopian tube(s)	T	0193	20.0452	$1,347.86		$269.58	*
58660	Laparoscopy, lysis	T	0131	46.84	$3,149.57	$1,001.89	$629.92	*
58661	Laparoscopy, remove adnexa	T	0131	46.84	$3,149.57	$1,001.89	$629.92	*
58662	Laparoscopy, excise lesions	T	0131	46.84	$3,149.57	$1,001.89	$629.92	*
58670	Laparoscopy, tubal cautery	T	0131	46.84	$3,149.57	$1,001.89	$629.92	*
58671	Laparoscopy, tubal block	T	0131	46.84	$3,149.57	$1,001.89	$629.92	*
58672	Laparoscopy, fimbrioplasty	T	0131	46.84	$3,149.57	$1,001.89	$629.92	*
58673	Laparoscopy, salpingostomy	T	0131	46.84	$3,149.57	$1,001.89	$629.92	*
58679	Laparo proc, oviduct-ovary	T	0130	38.054	$2,558.79	$659.53	$511.76	*
58700	Removal of fallopian tube	C						
58720	Removal of ovary/tube(s)	C						
58740	Adhesiolysis tube, ovary	C						
58750	Repair oviduct	C						
58752	Revise ovarian tube(s)	C						
58760	Fimbrioplasty	C						
58770	Create new tubal opening	T	0195	35.2666	$2,371.36	$483.80	$474.28	*
58800	Drainage of ovarian cyst(s)	T	0193	20.0452	$1,347.86		$269.58	*
58805	Drainage of ovarian cyst(s)	T	0195	35.2666	$2,371.36	$483.80	$474.28	*
58820	Drain ovary abscess, open	T	0195	35.2666	$2,371.36	$483.80	$474.28	*
58822	Drain ovary abscess, percut	C						
58823	Drain pelvic abscess, percut	T	0193	20.0452	$1,347.86		$269.58	*
58825	Transposition, ovary(s)	C						
58900	Biopsy of ovary(s)	T	0193	20.0452	$1,347.86		$269.58	*
58920	Partial removal of ovary(s)	T	0195	35.2666	$2,371.36	$483.80	$474.28	*
58925	Removal of ovarian cyst(s)	T	0195	35.2666	$2,371.36	$483.80	$474.28	*
58940	Removal of ovary(s)	C						
58943	Removal of ovary(s)	C						
58950	Resect ovarian malignancy	C						
58951	Resect ovarian malignancy	C						
58952	Resect ovarian malignancy	C						
58953	Tah, rad dissect for debulk	C						

58954	Tah rad debulk/lymph remove	C						
58956	Bso, omentectomy w/tah	C						
58957	Resect recurrent gyn mal	C						
58958	Resect recur gyn mal w/lym	C						
58960	Exploration of abdomen	C						
58970	Retrieval of oocyte	T	0189	3.4085	$229.19		$45.84	*
58974	Transfer of embryo	T	0189	3.4085	$229.19		$45.84	*
58976	Transfer of embryo	T	0189	3.4085	$229.19		$45.84	*
58999	Genital surgery procedure	T	0191	0.132	$8.88	$2.08	$1.78	*
59000	Amniocentesis, diagnostic	T	0189	3.4085	$229.19		$45.84	*
59001	Amniocentesis, therapeutic	T	0192	6.7949	$456.90		$91.38	*
59012	Fetal cord puncture,prenatal	T	0189	3.4085	$229.19		$45.84	*
59015	Chorion biopsy	T	0189	3.4085	$229.19		$45.84	*
59020	Fetal contract stress test	T	0188	1.5277	$102.72		$20.55	*
59025	Fetal non-stress test	T	0188	1.5277	$102.72		$20.55	*
59030	Fetal scalp blood sample	T	0189	3.4085	$229.19		$45.84	*
59050	Fetal monitor w/report	M						
59051	Fetal monitor/interpret only	B						
59070	Transabdom amnioinfus w/us	T	0188	1.5277	$102.72		$20.55	*
59072	Umbilical cord occlud w/us	T	0189	3.4085	$229.19		$45.84	*
59074	Fetal fluid drainage w/us	T	0189	3.4085	$229.19		$45.84	*
59076	Fetal shunt placement, w/us	T	0189	3.4085	$229.19		$45.84	*
59100	Remove uterus lesion	T	0195	35.2666	$2,371.36	$483.80	$474.28	*
59120	Treat ectopic pregnancy	C						
59121	Treat ectopic pregnancy	C						
59130	Treat ectopic pregnancy	C						
59135	Treat ectopic pregnancy	C						
59136	Treat ectopic pregnancy	C						
59140	Treat ectopic pregnancy	C						
59150	Treat ectopic pregnancy	T	0131	46.84	$3,149.57	$1,001.89	$629.92	*
59151	Treat ectopic pregnancy	T	0131	46.84	$3,149.57	$1,001.89	$629.92	*
59160	D & c after delivery	T	0193	20.0452	$1,347.86		$269.58	*
59200	Insert cervical dilator	T	0188	1.5277	$102.72		$20.55	*
59300	Episiotomy or vaginal repair	T	0193	20.0452	$1,347.86		$269.58	*
59320	Revision of cervix	T	0193	20.0452	$1,347.86		$269.58	*
59325	Revision of cervix	C						
59350	Repair of uterus	C						
59400	Obstetrical care	B						
59409	Obstetrical care	T	0193	20.0452	$1,347.86		$269.58	*
59410	Obstetrical care	B						
59412	Antepartum manipulation	T	0193	20.0452	$1,347.86		$269.58	*
59414	Deliver placenta	T	0193	20.0452	$1,347.86		$269.58	*
59425	Antepartum care only	B						
59426	Antepartum care only	B						
59430	Care after delivery	B						
59510	Cesarean delivery	B						
59514	Cesarean delivery only	C						
59515	Cesarean delivery	B						
59525	Remove uterus after cesarean	C						
59610	Vbac delivery	B						
59612	Vbac delivery only	T	0193	20.0452	$1,347.86		$269.58	*
59614	Vbac care after delivery	B						
59618	Attempted vbac delivery	B						
59620	Attempted vbac delivery only	C						
59622	Attempted vbac after care	B						
59812	Treatment of miscarriage	T	0193	20.0452	$1,347.86		$269.58	*
59820	Care of miscarriage	T	0193	20.0452	$1,347.86		$269.58	*
59821	Treatment of miscarriage	T	0193	20.0452	$1,347.86		$269.58	*
59830	Treat uterus infection	C						
59840	Abortion	T	0193	20.0452	$1,347.86		$269.58	*
59841	Abortion	T	0193	20.0452	$1,347.86		$269.58	*
59850	Abortion	C						

59851	Abortion	C						
59852	Abortion	C						
59855	Abortion	C						
59856	Abortion	C						
59857	Abortion	C						
59866	Abortion (mpr)	T	0189	3.4085	$229.19		$45.84	*
59870	Evacuate mole of uterus	T	0193	20.0452	$1,347.86		$269.58	*
59871	Remove cerclage suture	T	0193	20.0452	$1,347.86		$269.58	*
59897	Fetal invas px w/us	T	0191	0.132	$8.88	$2.08	$1.78	*
59898	Laparo proc, ob care/deliver	T	0130	38.054	$2,558.79	$659.53	$511.76	*
59899	Maternity care procedure	T	0191	0.132	$8.88	$2.08	$1.78	*
60000	Drain thyroid/tongue cyst	T	0252	7.6196	$512.35	$109.16	$102.47	*
60100	Biopsy of thyroid	T	0004	4.5991	$309.25		$61.85	*
60200	Remove thyroid lesion	T	0114	48.7561	$3,278.41		$655.69	*
60210	Partial thyroid excision	T	0114	48.7561	$3,278.41		$655.69	*
60212	Partial thyroid excision	T	0114	48.7561	$3,278.41		$655.69	*
60220	Partial removal of thyroid	T	0114	48.7561	$3,278.41		$655.69	*
60225	Partial removal of thyroid	T	0114	48.7561	$3,278.41		$655.69	*
60240	Removal of thyroid	T	0114	48.7561	$3,278.41		$655.69	*
60252	Removal of thyroid	T	0256	42.9827	$2,890.20		$578.04	*
60254	Extensive thyroid surgery	C						
60260	Repeat thyroid surgery	T	0256	42.9827	$2,890.20		$578.04	*
60270	Removal of thyroid	C						
60271	Removal of thyroid	T	0256	42.9827	$2,890.20		$578.04	*
60280	Remove thyroid duct lesion	T	0114	48.7561	$3,278.41		$655.69	*
60281	Remove thyroid duct lesion	T	0114	48.7561	$3,278.41		$655.69	*
60300	Aspir/inj thyroid cyst	T	0004	4.5991	$309.25		$61.85	*
60500	Explore parathyroid glands	T	0256	42.9827	$2,890.20		$578.04	*
60502	Re-explore parathyroids	T	0256	42.9827	$2,890.20		$578.04	*
60505	Explore parathyroid glands	C						
60512	Autotransplant parathyroid	T	0022	23.388	$1,572.63	$354.45	$314.53	*

60520	Removal of thymus gland	T	0256	42.9827	$2,890.20		$578.04	*
60521	Removal of thymus gland	C						
60522	Removal of thymus gland	C						
60540	Explore adrenal gland	C						
60545	Explore adrenal gland	C						
60600	Remove carotid body lesion	C						
60605	Remove carotid body lesion	C						
60650	Laparoscopy adrenalectomy	C						
60659	Laparo proc, endocrine	T	0130	38.054	$2,558.79	$659.53	$511.76	*
60699	Endocrine surgery procedure	T	0114	48.7561	$3,278.41		$655.69	*
61000	Remove cranial cavity fluid	T	0207	7.2002	$484.15		$96.83	*
61001	Remove cranial cavity fluid	T	0207	7.2002	$484.15		$96.83	*
61020	Remove brain cavity fluid	T	0207	7.2002	$484.15		$96.83	*
61026	Injection into brain canal	T	0207	7.2002	$484.15		$96.83	*
61050	Remove brain canal fluid	T	0207	7.2002	$484.15		$96.83	*
61055	Injection into brain canal	T	0207	7.2002	$484.15		$96.83	*
61070	Brain canal shunt procedure	T	0121	6.3742	$428.61		$85.73	*
61105	Twist drill hole	C						
61107	Drill skull for implantation	C						
61108	Drill skull for drainage	C						
61120	Burr hole for puncture	C						
61140	Pierce skull for biopsy	C						
61150	Pierce skull for drainage	C						
61151	Pierce skull for drainage	C						
61154	Pierce skull & remove clot	C						
61156	Pierce skull for drainage	C						
61210	Pierce skull, implant device	C						
61215	Insert brain-fluid device	T	0224	41.0288	$2,758.82		$551.77	*
61250	Pierce skull & explore	C						
61253	Pierce skull & explore	C						
61304	Open skull for exploration	C						

61305	Open skull for exploration	C						
61312	Open skull for drainage	C						
61313	Open skull for drainage	C						
61314	Open skull for drainage	C						
61315	Open skull for drainage	C						
61316	Implt cran bone flap to abdo	C						
61320	Open skull for drainage	C						
61321	Open skull for drainage	C						
61322	Decompressive craniotomy	C						
61323	Decompressive lobectomy	C						
61330	Decompress eye socket	T	0256	42.9827	$2,890.20		$578.04	*
61332	Explore/biopsy eye socket	C						
61333	Explore orbit/remove lesion	C						
61334	Explore orbit/remove object	T	0256	42.9827	$2,890.20		$578.04	*
61340	Subtemporal decompression	C						
61343	Incise skull (press relief)	C						
61345	Relieve cranial pressure	C						
61440	Incise skull for surgery	C						
61450	Incise skull for surgery	C						
61458	Incise skull for brain wound	C						
61460	Incise skull for surgery	C						
61470	Incise skull for surgery	C						
61480	Incise skull for surgery	C						
61490	Incise skull for surgery	C						
61500	Removal of skull lesion	C						
61501	Remove infected skull bone	C						
61510	Removal of brain lesion	C						
61512	Remove brain lining lesion	C						
61514	Removal of brain abscess	C						
61516	Removal of brain lesion	C						
61517	Implt brain chemotx add-on	C						
61518	Removal of brain lesion	C						
61519	Remove brain lining lesion	C						
61520	Removal of brain lesion	C						
61521	Removal of brain lesion	C						
61522	Removal of brain abscess	C						
61524	Removal of brain lesion	C						
61526	Removal of brain lesion	C						
61530	Removal of brain lesion	C						
61531	Implant brain electrodes	C						
61533	Implant brain electrodes	C						
61534	Removal of brain lesion	C						
61535	Remove brain electrodes	C						
61536	Removal of brain lesion	C						
61537	Removal of brain tissue	C						
61538	Removal of brain tissue	C						
61539	Removal of brain tissue	C						
61540	Removal of brain tissue	C						
61541	Incision of brain tissue	C						
61542	Removal of brain tissue	C						
61543	Removal of brain tissue	C						
61544	Remove & treat brain lesion	C						
61545	Excision of brain tumor	C						
61546	Removal of pituitary gland	C						
61548	Removal of pituitary gland	C						
61550	Release of skull seams	C						
61552	Release of skull seams	C						
61556	Incise skull/sutures	C						
61557	Incise skull/sutures	C						
61558	Excision of skull/sutures	C						
61559	Excision of skull/sutures	C						
61563	Excision of skull tumor	C						

61564	Excision of skull tumor	C						
61566	Removal of brain tissue	C						
61567	Incision of brain tissue	C						
61570	Remove foreign body, brain	C						
61571	Incise skull for brain wound	C						
61575	Skull base/brainstem surgery	C						
61576	Skull base/brainstem surgery	C						
61580	Craniofacial approach, skull	C						
61581	Craniofacial approach, skull	C						
61582	Craniofacial approach, skull	C						
61583	Craniofacial approach, skull	C						
61584	Orbitocranial approach/skull	C						
61585	Orbitocranial approach/skull	C						
61586	Resect nasopharynx, skull	C						
61590	Infratemporal approach/skull	C						
61591	Infratemporal approach/skull	C						
61592	Orbitocranial approach/skull	C						
61595	Transtemporal approach/skull	C						
61596	Transcochlear approach/skull	C						
61597	Transcondylar approach/skull	C						
61598	Transpetrosal approach/skull	C						
61600	Resect/excise cranial lesion	C						
61601	Resect/excise cranial lesion	C						
61605	Resect/excise cranial lesion	C						
61606	Resect/excise cranial lesion	C						
61607	Resect/excise cranial lesion	C						
61608	Resect/excise cranial lesion	C						
61609	Transect artery, sinus	C						
61610	Transect artery, sinus	C						
61611	Transect artery, sinus	C						
61612	Transect artery, sinus	C						
61613	Remove aneurysm, sinus	C						
61615	Resect/excise lesion, skull	C						
61616	Resect/excise lesion, skull	C						
61618	Repair dura	C						
61619	Repair dura	C						
61623	Endovasc tempory vessel occl	T	0082	93.3244	$6,275.23		$1,255.05	*
61624	Transcath occlusion, cns	C						
61626	Transcath occlusion, non-cns	T	0082	93.3244	$6,275.23		$1,255.05	*
61630	Intracranial angioplasty	C						
61635	Intracran angioplsty w/stent	C						
61640	Dilate ic vasospasm, init	E						
61641	Dilate ic vasospasm add-on	E						
61642	Dilate ic vasospasm add-on	E						
61680	Intracranial vessel surgery	C						
61682	Intracranial vessel surgery	C						
61684	Intracranial vessel surgery	C						
61686	Intracranial vessel surgery	C						
61690	Intracranial vessel surgery	C						
61692	Intracranial vessel surgery	C						
61697	Brain aneurysm repr, complx	C						
61698	Brain aneurysm repr, complx	C						
61700	Brain aneurysm repr, simple	C						
61702	Inner skull vessel surgery	C						
61703	Clamp neck artery	C						
61705	Revise circulation to head	C						
61708	Revise circulation to head	C						
61710	Revise circulation to head	C						
61711	Fusion of skull arteries	C						
61720	Incise skull/brain surgery	T	0221	37.2806	$2,506.78		$501.36	*
61735	Incise skull/brain surgery	C						
61750	Incise skull/brain biopsy	C						

61751	Brain biopsy w/ct/mr guide	C						
61760	Implant brain electrodes	C						
61770	Incise skull for treatment	T	0221	37.2806	$2,506.78		$501.36	*
61790	Treat trigeminal nerve	T	0220	18.72	$1,258.75		$251.75	*
61791	Treat trigeminal tract	T	0203	13.2439	$890.53	$225.43	$178.11	*
61795	Brain surgery using computer	N						
61796	Srs, cranial lesion simple	B						
61797	Srs, cran les simple, addl	B						
61798	Srs, cranial lesion complex	B						
61799	Srs, cran les complex, addl	B						
61800	Apply srs headframe add-on	B						
61850	Implant neuroelectrodes	C						
61860	Implant neuroelectrodes	C						
61863	Implant neuroelectrode	C						
61864	Implant neuroelectrde, addl	C						
61867	Implant neuroelectrode	C						
61868	Implant neuroelectrde, addl	C						
61870	Implant neuroelectrodes	C						
61875	Implant neuroelectrodes	C						
61880	Revise/remove neuroelectrode	T	0687	19.6381	$1,320.49	$397.37	$264.10	*
61885	Insrt/redo neurostim 1 array	S	0039	206.1011	$13,858.44		$2,771.69	*
61886	Implant neurostim arrays	S	0315	274.7397	$18,473.77		$3,694.76	*
61888	Revise/remove neuroreceiver	T	0688	28.6636	$1,927.37	$768.94	$385.48	*
62000	Treat skull fracture	T	0254	24.9637	$1,678.58		$335.72	*
62005	Treat skull fracture	C						
62010	Treatment of head injury	C						
62100	Repair brain fluid leakage	C						
62115	Reduction of skull defect	C						
62116	Reduction of skull defect	C						
62117	Reduction of skull defect	C						
62120	Repair skull cavity lesion	C						
62121	Incise skull repair	C						
62140	Repair of skull defect	C						
62141	Repair of skull defect	C						
62142	Remove skull plate/flap	C						
62143	Replace skull plate/flap	C						
62145	Repair of skull & brain	C						
62146	Repair of skull with graft	C						
62147	Repair of skull with graft	C						
62148	Retr bone flap to fix skull	C						
62160	Neuroendoscopy add-on	N						
62161	Dissect brain w/scope	C						
62162	Remove colloid cyst w/scope	C						
62163	Neuroendoscopy w/fb removal	C						
62164	Remove brain tumor w/scope	C						
62165	Remove pituit tumor w/scope	C						
62180	Establish brain cavity shunt	C						
62190	Establish brain cavity shunt	C						
62192	Establish brain cavity shunt	C						
62194	Replace/irrigate catheter	T	0207	7.2002	$484.15		$96.83	*
62200	Establish brain cavity shunt	C						
62201	Brain cavity shunt w/scope	C						
62220	Establish brain cavity shunt	C						
62223	Establish brain cavity shunt	C						
62225	Replace/irrigate catheter	T	0427	15.3103	$1,029.48		$205.90	*
62230	Replace/revise brain shunt	T	0224	41.0288	$2,758.82		$551.77	*
62252	Csf shunt reprogram	S	0691	2.5406	$170.83	$50.49	$34.17	*
62256	Remove brain cavity shunt	C						
62258	Replace brain cavity shunt	C						
62263	Epidural lysis mult sessions	T	0207	7.2002	$484.15		$96.83	*
62264	Epidural lysis on single day	T	0203	13.2439	$890.53	$225.43	$178.11	*
62267	Interdiscal perq aspir, dx	T	0004	4.5991	$309.25		$61.85	*

62268	Drain spinal cord cyst	T	0207	7.2002	$484.15		$96.83	*
62269	Needle biopsy, spinal cord	T	0685	9.6666	$649.99		$130.00	*
62270	Spinal fluid tap, diagnostic	T	0206	3.7221	$250.28	$51.76	$50.06	*
62272	Drain cerebro spinal fluid	T	0206	3.7221	$250.28	$51.76	$50.06	*
62273	Inject epidural patch	T	0206	3.7221	$250.28	$51.76	$50.06	*
62280	Treat spinal cord lesion	T	0207	7.2002	$484.15		$96.83	*
62281	Treat spinal cord lesion	T	0207	7.2002	$484.15		$96.83	*
62282	Treat spinal canal lesion	T	0207	7.2002	$484.15		$96.83	*
62284	Injection for myelogram	N						
62287	Percutaneous diskectomy	T	0221	37.2806	$2,506.78		$501.36	*
62290	Inject for spine disk x-ray	N						
62291	Inject for spine disk x-ray	N						
62292	Injection into disk lesion	T	0207	7.2002	$484.15		$96.83	*
62294	Injection into spinal artery	T	0207	7.2002	$484.15		$96.83	*
62310	Inject spine c/t	T	0207	7.2002	$484.15		$96.83	*
62311	Inject spine l/s (cd)	T	0207	7.2002	$484.15		$96.83	*
62318	Inject spine w/cath, c/t	T	0207	7.2002	$484.15		$96.83	*
62319	Inject spine w/cath l/s (cd)	T	0207	7.2002	$484.15		$96.83	*
62350	Implant spinal canal cath	T	0224	41.0288	$2,758.82		$551.77	*
62351	Implant spinal canal cath	T	0208	49.2256	$3,309.98		$662.00	*
62355	Remove spinal canal catheter	T	0203	13.2439	$890.53	$225.43	$178.11	*
62360	Insert spine infusion device	T	0224	41.0288	$2,758.82		$551.77	*
62361	Implant spine infusion pump	T	0227	198.6572	$13,357.91		$2,671.59	*
62362	Implant spine infusion pump	T	0227	198.6572	$13,357.91		$2,671.59	*
62365	Remove spine infusion device	T	0221	37.2806	$2,506.78		$501.36	*
62367	Analyze spine infusion pump	S	0691	2.5406	$170.83	$50.49	$34.17	*
62368	Analyze spine infusion pump	S	0691	2.5406	$170.83	$50.49	$34.17	*
63001	Removal of spinal lamina	T	0208	49.2256	$3,309.98		$662.00	*
63003	Removal of spinal lamina	T	0208	49.2256	$3,309.98		$662.00	*
63005	Removal of spinal lamina	T	0208	49.2256	$3,309.98		$662.00	*
63011	Removal of spinal lamina	T	0208	49.2256	$3,309.98		$662.00	*
63012	Removal of spinal lamina	T	0208	49.2256	$3,309.98		$662.00	*
63015	Removal of spinal lamina	T	0208	49.2256	$3,309.98		$662.00	*
63016	Removal of spinal lamina	T	0208	49.2256	$3,309.98		$662.00	*
63017	Removal of spinal lamina	T	0208	49.2256	$3,309.98		$662.00	*
63020	Neck spine disk surgery	T	0208	49.2256	$3,309.98		$662.00	*
63030	Low back disk surgery	T	0208	49.2256	$3,309.98		$662.00	*
63035	Spinal disk surgery add-on	T	0208	49.2256	$3,309.98		$662.00	*
63040	Laminotomy, single cervical	T	0208	49.2256	$3,309.98		$662.00	*
63042	Laminotomy, single lumbar	T	0208	49.2256	$3,309.98		$662.00	*
63043	Laminotomy, addl cervical	C						
63044	Laminotomy, addl lumbar	C						
63045	Removal of spinal lamina	T	0208	49.2256	$3,309.98		$662.00	*
63046	Removal of spinal lamina	T	0208	49.2256	$3,309.98		$662.00	*
63047	Removal of spinal lamina	T	0208	49.2256	$3,309.98		$662.00	*
63048	Remove spinal lamina add-on	T	0208	49.2256	$3,309.98		$662.00	*
63050	Cervical laminoplasty	C						
63051	C-laminoplasty w/graft/plate	C						
63055	Decompress spinal cord	T	0208	49.2256	$3,309.98		$662.00	*
63056	Decompress spinal cord	T	0208	49.2256	$3,309.98		$662.00	*
63057	Decompress spine cord add-on	T	0208	49.2256	$3,309.98		$662.00	*
63064	Decompress spinal cord	T	0208	49.2256	$3,309.98		$662.00	*
63066	Decompress spine cord add-on	T	0208	49.2256	$3,309.98		$662.00	*
63075	Neck spine disk surgery	T	0208	49.2256	$3,309.98		$662.00	*
63076	Neck spine disk surgery	T	0208	49.2256	$3,309.98		$662.00	*
63077	Spine disk surgery, thorax	C						
63078	Spine disk surgery, thorax	C						
63081	Removal of vertebral body	C						
63082	Remove vertebral body add-on	C						
63085	Removal of vertebral body	C						
63086	Remove vertebral body add-on	C						
63087	Removal of vertebral body	C						

63088	Remove vertebral body add-on	C						
63090	Removal of vertebral body	C						
63091	Remove vertebral body add-on	C						
63101	Removal of vertebral body	C						
63102	Removal of vertebral body	C						
63103	Remove vertebral body add-on	C						
63170	Incise spinal cord tract(s)	C						
63172	Drainage of spinal cyst	C						
63173	Drainage of spinal cyst	C						
63180	Revise spinal cord ligaments	C						
63182	Revise spinal cord ligaments	C						
63185	Incise spinal column/nerves	C						
63190	Incise spinal column/nerves	C						
63191	Incise spinal column/nerves	C						
63194	Incise spinal column & cord	C						
63195	Incise spinal column & cord	C						
63196	Incise spinal column & cord	C						
63197	Incise spinal column & cord	C						
63198	Incise spinal column & cord	C						
63199	Incise spinal column & cord	C						
63200	Release of spinal cord	C						
63250	Revise spinal cord vessels	C						
63251	Revise spinal cord vessels	C						
63252	Revise spinal cord vessels	C						
63265	Excise intraspinal lesion	C						
63266	Excise intraspinal lesion	C						
63267	Excise intraspinal lesion	C						
63268	Excise intraspinal lesion	C						
63270	Excise intraspinal lesion	C						
63271	Excise intraspinal lesion	C						
63272	Excise intraspinal lesion	C						
63273	Excise intraspinal lesion	C						
63275	Biopsy/excise spinal tumor	C						
63276	Biopsy/excise spinal tumor	C						
63277	Biopsy/excise spinal tumor	C						
63278	Biopsy/excise spinal tumor	C						
63280	Biopsy/excise spinal tumor	C						
63281	Biopsy/excise spinal tumor	C						
63282	Biopsy/excise spinal tumor	C						
63283	Biopsy/excise spinal tumor	C						
63285	Biopsy/excise spinal tumor	C						
63286	Biopsy/excise spinal tumor	C						
63287	Biopsy/excise spinal tumor	C						
63290	Biopsy/excise spinal tumor	C						
63295	Repair of laminectomy defect	C						
63300	Removal of vertebral body	C						
63301	Removal of vertebral body	C						
63302	Removal of vertebral body	C						
63303	Removal of vertebral body	C						
63304	Removal of vertebral body	C						
63305	Removal of vertebral body	C						
63306	Removal of vertebral body	C						
63307	Removal of vertebral body	C						
63308	Remove vertebral body add-on	C						
63600	Remove spinal cord lesion	T	0220	18.72	$1,258.75		$251.75	*
63610	Stimulation of spinal cord	T	0220	18.72	$1,258.75		$251.75	*
63615	Remove lesion of spinal cord	T	0220	18.72	$1,258.75		$251.75	*
63620	Srs, spinal lesion	B						
63621	Srs, spinal lesion, addl	B						
63650	Implant neuroelectrodes	S	0040	65.7095	$4,418.37		$883.68	*
63655	Implant neuroelectrodes	S	0061	86.5171	$5,817.50		$1,163.50	*
63661	Remove spine eltrd perq aray	T	0687	19.6381	$1,320.49	$397.37	$264.10	*

63662	Remove spine eltrd plate	T	0687	19.6381	$1,320.49	$397.37	$264.10	*
63663	Revise spine eltrd perq aray	T	0687	19.6381	$1,320.49	$397.37	$264.10	*
63664	Revise spine eltrd plate	T	0687	19.6381	$1,320.49	$397.37	$264.10	*
63685	Insrt/redo spine n generator	S	0039	206.1011	$13,858.44		$2,771.69	*
63688	Revise/remove neuroreceiver	T	0688	28.6636	$1,927.37	$768.94	$385.48	*
63700	Repair of spinal herniation	C						
63702	Repair of spinal herniation	C						
63704	Repair of spinal herniation	C						
63706	Repair of spinal herniation	C						
63707	Repair spinal fluid leakage	C						
63709	Repair spinal fluid leakage	C						
63710	Graft repair of spine defect	C						
63740	Install spinal shunt	C						
63741	Install spinal shunt	T	0224	41.0288	$2,758.82		$551.77	*
63744	Revision of spinal shunt	T	0224	41.0288	$2,758.82		$551.77	*
63746	Removal of spinal shunt	T	0203	13.2439	$890.53	$225.43	$178.11	*
64400	N block inj, trigeminal	T	0204	2.5558	$171.85	$40.13	$34.37	*
64402	N block inj, facial	T	0204	2.5558	$171.85	$40.13	$34.37	*
64405	N block inj, occipital	T	0206	3.7221	$250.28	$51.76	$50.06	*
64408	N block inj, vagus	T	0207	7.2002	$484.15		$96.83	*
64410	N block inj, phrenic	T	0207	7.2002	$484.15		$96.83	*
64412	N block inj, spinal accessor	T	0207	7.2002	$484.15		$96.83	*
64413	N block inj, cervical plexus	T	0206	3.7221	$250.28	$51.76	$50.06	*
64415	N block inj, brachial plexus	T	0206	3.7221	$250.28	$51.76	$50.06	*
64416	N block cont infuse, b plex	T	0207	7.2002	$484.15		$96.83	*
64417	N block inj, axillary	T	0206	3.7221	$250.28	$51.76	$50.06	*
64418	N block inj, suprascapular	T	0206	3.7221	$250.28	$51.76	$50.06	*
64420	N block inj, intercost, sng	T	0206	3.7221	$250.28	$51.76	$50.06	*
64421	N block inj, intercost, mlt	T	0207	7.2002	$484.15		$96.83	*
64425	N block inj, ilio-ing/hypogi	T	0206	3.7221	$250.28	$51.76	$50.06	*
64430	N block inj, pudendal	T	0207	7.2002	$484.15		$96.83	*
64435	N block inj, paracervical	T	0206	3.7221	$250.28	$51.76	$50.06	*
64445	N block inj, sciatic, sng	T	0207	7.2002	$484.15		$96.83	*
64446	N blk inj, sciatic, cont inf	T	0207	7.2002	$484.15		$96.83	*
64447	N block inj fem, single	T	0206	3.7221	$250.28	$51.76	$50.06	*
64448	N block inj fem, cont inf	T	0207	7.2002	$484.15		$96.83	*
64449	N block inj, lumbar plexus	T	0207	7.2002	$484.15		$96.83	*
64450	N block, other peripheral	T	0206	3.7221	$250.28	$51.76	$50.06	*
64455	N block inj, plantar digit	T	0204	2.5558	$171.85	$40.13	$34.37	*
64479	Inj foramen epidural c/t	T	0207	7.2002	$484.15		$96.83	*
64480	Inj foramen epidural add-on	T	0206	3.7221	$250.28	$51.76	$50.06	*
64483	Inj foramen epidural l/s	T	0207	7.2002	$484.15		$96.83	*
64484	Inj foramen epidural add-on	T	0206	3.7221	$250.28	$51.76	$50.06	*
64490	Inj paravert f jnt c/t 1 lev	T	0207	7.2002	$484.15		$96.83	*
64491	Inj paravert f jnt c/t 2 lev	T	0204	2.5558	$171.85	$40.13	$34.37	*
64492	Inj paravert f jnt c/t 3 lev	T	0204	2.5558	$171.85	$40.13	$34.37	*
64493	Inj paravert f jnt l/s 1 lev	T	0207	7.2002	$484.15		$96.83	*
64494	Inj paravert f jnt l/s 2 lev	T	0204	2.5558	$171.85	$40.13	$34.37	*
64495	Inj paravert f jnt l/s 3 lev	T	0204	2.5558	$171.85	$40.13	$34.37	*
64505	N block, spenopalatine gangl	T	0204	2.5558	$171.85	$40.13	$34.37	*
64508	N block, carotid sinus s/p	T	0204	2.5558	$171.85	$40.13	$34.37	*
64510	N block, stellate ganglion	T	0207	7.2002	$484.15		$96.83	*
64517	N block inj, hypogas plxs	T	0207	7.2002	$484.15		$96.83	*
64520	N block, lumbar/thoracic	T	0207	7.2002	$484.15		$96.83	*
64530	N block inj, celiac pelus	T	0207	7.2002	$484.15		$96.83	*
64550	Apply neurostimulator	A						
64553	Implant neuroelectrodes	S	0040	65.7095	$4,418.37		$883.68	*
64555	Implant neuroelectrodes	S	0040	65.7095	$4,418.37		$883.68	*
64560	Implant neuroelectrodes	S	0040	65.7095	$4,418.37		$883.68	*
64561	Implant neuroelectrodes	S	0040	65.7095	$4,418.37		$883.68	*
64565	Implant neuroelectrodes	S	0040	65.7095	$4,418.37		$883.68	*
64573	Implant neuroelectrodes	S	0225	157.939	$10,619.98		$2,124.00	*

64575	Implant neuroelectrodes	S	0061	86.5171	$5,817.50		$1,163.50	*
64577	Implant neuroelectrodes	S	0061	86.5171	$5,817.50		$1,163.50	*
64580	Implant neuroelectrodes	S	0061	86.5171	$5,817.50		$1,163.50	*
64581	Implant neuroelectrodes	S	0061	86.5171	$5,817.50		$1,163.50	*
64585	Revise/remove neuroelectrode	T	0687	19.6381	$1,320.49	$397.37	$264.10	*
64590	Insrt/redo pn/gastr stimul	S	0039	206.1011	$13,858.44		$2,771.69	*
64595	Revise/rmv pn/gastr stimul	T	0688	28.6636	$1,927.37	$768.94	$385.48	*
64600	Injection treatment of nerve	T	0203	13.2439	$890.53	$225.43	$178.11	*
64605	Injection treatment of nerve	T	0220	18.72	$1,258.75		$251.75	*
64610	Injection treatment of nerve	T	0220	18.72	$1,258.75		$251.75	*
64612	Destroy nerve, face muscle	T	0204	2.5558	$171.85	$40.13	$34.37	*
64613	Destroy nerve, neck muscle	T	0206	3.7221	$250.28	$51.76	$50.06	*
64614	Destroy nerve, extrem musc	T	0206	3.7221	$250.28	$51.76	$50.06	*
64620	Injection treatment of nerve	T	0207	7.2002	$484.15		$96.83	*
64622	Destr paravertebrl nerve l/s	T	0203	13.2439	$890.53	$225.43	$178.11	*
64623	Destr paravertebral n add-on	T	0207	7.2002	$484.15		$96.83	*
64626	Destr paravertebrl nerve c/t	T	0207	7.2002	$484.15		$96.83	*
64627	Destr paravertebral n add-on	T	0204	2.5558	$171.85	$40.13	$34.37	*
64630	Injection treatment of nerve	T	0207	7.2002	$484.15		$96.83	*
64632	N block inj, common digit	T	0204	2.5558	$171.85	$40.13	$34.37	*
64640	Injection treatment of nerve	T	0207	7.2002	$484.15		$96.83	*
64650	Chemodenerv eccrine glands	T	0204	2.5558	$171.85	$40.13	$34.37	*
64653	Chemodenerv eccrine glands	T	0204	2.5558	$171.85	$40.13	$34.37	*
64680	Injection treatment of nerve	T	0207	7.2002	$484.15		$96.83	*
64681	Injection treatment of nerve	T	0203	13.2439	$890.53	$225.43	$178.11	*
64702	Revise finger/toe nerve	T	0220	18.72	$1,258.75		$251.75	*
64704	Revise hand/foot nerve	T	0220	18.72	$1,258.75		$251.75	*
64708	Revise arm/leg nerve	T	0220	18.72	$1,258.75		$251.75	*
64712	Revision of sciatic nerve	T	0220	18.72	$1,258.75		$251.75	*
64713	Revision of arm nerve(s)	T	0220	18.72	$1,258.75		$251.75	*
64714	Revise low back nerve(s)	T	0220	18.72	$1,258.75		$251.75	*
64716	Revision of cranial nerve	T	0220	18.72	$1,258.75		$251.75	*
64718	Revise ulnar nerve at elbow	T	0220	18.72	$1,258.75		$251.75	*
64719	Revise ulnar nerve at wrist	T	0220	18.72	$1,258.75		$251.75	*
64721	Carpal tunnel surgery	T	0220	18.72	$1,258.75		$251.75	*
64722	Relieve pressure on nerve(s)	T	0220	18.72	$1,258.75		$251.75	*
64726	Release foot/toe nerve	T	0220	18.72	$1,258.75		$251.75	*
64727	Internal nerve revision	T	0220	18.72	$1,258.75		$251.75	*
64732	Incision of brow nerve	T	0220	18.72	$1,258.75		$251.75	*
64734	Incision of cheek nerve	T	0220	18.72	$1,258.75		$251.75	*
64736	Incision of chin nerve	T	0220	18.72	$1,258.75		$251.75	*
64738	Incision of jaw nerve	T	0220	18.72	$1,258.75		$251.75	*
64740	Incision of tongue nerve	T	0220	18.72	$1,258.75		$251.75	*
64742	Incision of facial nerve	T	0220	18.72	$1,258.75		$251.75	*
64744	Incise nerve, back of head	T	0220	18.72	$1,258.75		$251.75	*
64746	Incise diaphragm nerve	T	0220	18.72	$1,258.75		$251.75	*
64752	Incision of vagus nerve	C						
64755	Incision of stomach nerves	C						
64760	Incision of vagus nerve	C						
64761	Incision of pelvis nerve	T	0220	18.72	$1,258.75		$251.75	*
64763	Incise hip/thigh nerve	T	0220	18.72	$1,258.75		$251.75	*
64766	Incise hip/thigh nerve	T	0221	37.2806	$2,506.78		$501.36	*
64771	Sever cranial nerve	T	0220	18.72	$1,258.75		$251.75	*
64772	Incision of spinal nerve	T	0220	18.72	$1,258.75		$251.75	*
64774	Remove skin nerve lesion	T	0220	18.72	$1,258.75		$251.75	*
64776	Remove digit nerve lesion	T	0220	18.72	$1,258.75		$251.75	*
64778	Digit nerve surgery add-on	T	0220	18.72	$1,258.75		$251.75	*
64782	Remove limb nerve lesion	T	0220	18.72	$1,258.75		$251.75	*
64783	Limb nerve surgery add-on	T	0220	18.72	$1,258.75		$251.75	*
64784	Remove nerve lesion	T	0220	18.72	$1,258.75		$251.75	*
64786	Remove sciatic nerve lesion	T	0221	37.2806	$2,506.78		$501.36	*
64787	Implant nerve end	T	0220	18.72	$1,258.75		$251.75	*

64788	Remove skin nerve lesion	T	0220	18.72	$1,258.75		$251.75	*
64790	Removal of nerve lesion	T	0220	18.72	$1,258.75		$251.75	*
64792	Removal of nerve lesion	T	0221	37.2806	$2,506.78		$501.36	*
64795	Biopsy of nerve	T	0220	18.72	$1,258.75		$251.75	*
64802	Remove sympathetic nerves	T	0220	18.72	$1,258.75		$251.75	*
64804	Remove sympathetic nerves	T	0220	18.72	$1,258.75		$251.75	*
64809	Remove sympathetic nerves	C						
64818	Remove sympathetic nerves	C						
64820	Remove sympathetic nerves	T	0220	18.72	$1,258.75		$251.75	*
64821	Remove sympathetic nerves	T	0054	28.2376	$1,898.72		$379.75	*
64822	Remove sympathetic nerves	T	0054	28.2376	$1,898.72		$379.75	*
64823	Remove sympathetic nerves	T	0054	28.2376	$1,898.72		$379.75	*
64831	Repair of digit nerve	T	0221	37.2806	$2,506.78		$501.36	*
64832	Repair nerve add-on	T	0221	37.2806	$2,506.78		$501.36	*
64834	Repair of hand or foot nerve	T	0221	37.2806	$2,506.78		$501.36	*
64835	Repair of hand or foot nerve	T	0221	37.2806	$2,506.78		$501.36	*
64836	Repair of hand or foot nerve	T	0221	37.2806	$2,506.78		$501.36	*
64837	Repair nerve add-on	T	0221	37.2806	$2,506.78		$501.36	*
64840	Repair of leg nerve	T	0221	37.2806	$2,506.78		$501.36	*
64856	Repair/transpose nerve	T	0221	37.2806	$2,506.78		$501.36	*
64857	Repair arm/leg nerve	T	0221	37.2806	$2,506.78		$501.36	*
64858	Repair sciatic nerve	T	0221	37.2806	$2,506.78		$501.36	*
64859	Nerve surgery	T	0221	37.2806	$2,506.78		$501.36	*
64861	Repair of arm nerves	T	0221	37.2806	$2,506.78		$501.36	*
64862	Repair of low back nerves	T	0221	37.2806	$2,506.78		$501.36	*
64864	Repair of facial nerve	T	0221	37.2806	$2,506.78		$501.36	*
64865	Repair of facial nerve	T	0221	37.2806	$2,506.78		$501.36	*
64866	Fusion of facial/other nerve	C						
64868	Fusion of facial/other nerve	C						
64870	Fusion of facial/other nerve	T	0221	37.2806	$2,506.78		$501.36	*
64872	Subsequent repair of nerve	T	0221	37.2806	$2,506.78		$501.36	*
64874	Repair & revise nerve add-on	T	0221	37.2806	$2,506.78		$501.36	*
64876	Repair nerve/shorten bone	T	0221	37.2806	$2,506.78		$501.36	*
64885	Nerve graft, head or neck	T	0221	37.2806	$2,506.78		$501.36	*
64886	Nerve graft, head or neck	T	0221	37.2806	$2,506.78		$501.36	*
64890	Nerve graft, hand or foot	T	0221	37.2806	$2,506.78		$501.36	*
64891	Nerve graft, hand or foot	T	0221	37.2806	$2,506.78		$501.36	*
64892	Nerve graft, arm or leg	T	0221	37.2806	$2,506.78		$501.36	*
64893	Nerve graft, arm or leg	T	0221	37.2806	$2,506.78		$501.36	*
64895	Nerve graft, hand or foot	T	0221	37.2806	$2,506.78		$501.36	*
64896	Nerve graft, hand or foot	T	0221	37.2806	$2,506.78		$501.36	*
64897	Nerve graft, arm or leg	T	0221	37.2806	$2,506.78		$501.36	*
64898	Nerve graft, arm or leg	T	0221	37.2806	$2,506.78		$501.36	*
64901	Nerve graft add-on	T	0221	37.2806	$2,506.78		$501.36	*
64902	Nerve graft add-on	T	0221	37.2806	$2,506.78		$501.36	*
64905	Nerve pedicle transfer	T	0221	37.2806	$2,506.78		$501.36	*
64907	Nerve pedicle transfer	T	0221	37.2806	$2,506.78		$501.36	*
64910	Nerve repair w/allograft	T	0221	37.2806	$2,506.78		$501.36	*
64911	Neurorraphy w/vein autograft	T	0221	37.2806	$2,506.78		$501.36	*
64999	Nervous system surgery	T	0204	2.5558	$171.85	$40.13	$34.37	*
65091	Revise eye	T	0242	39.0115	$2,623.17	$597.36	$524.64	*
65093	Revise eye with implant	T	0242	39.0115	$2,623.17	$597.36	$524.64	*
65101	Removal of eye	T	0242	39.0115	$2,623.17	$597.36	$524.64	*
65103	Remove eye/insert implant	T	0242	39.0115	$2,623.17	$597.36	$524.64	*
65105	Remove eye/attach implant	T	0242	39.0115	$2,623.17	$597.36	$524.64	*
65110	Removal of eye	T	0242	39.0115	$2,623.17	$597.36	$524.64	*
65112	Remove eye/revise socket	T	0242	39.0115	$2,623.17	$597.36	$524.64	*
65114	Remove eye/revise socket	T	0242	39.0115	$2,623.17	$597.36	$524.64	*
65125	Revise ocular implant	T	0241	26.8396	$1,804.72	$383.45	$360.95	*
65130	Insert ocular implant	T	0241	26.8396	$1,804.72	$383.45	$360.95	*
65135	Insert ocular implant	T	0241	26.8396	$1,804.72	$383.45	$360.95	*
65140	Attach ocular implant	T	0242	39.0115	$2,623.17	$597.36	$524.64	*

65150	Revise ocular implant	T	0241	26.8396	$1,804.72	$383.45	$360.95	*
65155	Reinsert ocular implant	T	0242	39.0115	$2,623.17	$597.36	$524.64	*
65175	Removal of ocular implant	T	0240	18.158	$1,220.96	$296.20	$244.20	*
65205	Remove foreign body from eye	S	0698	0.9553	$64.24		$12.85	*
65210	Remove foreign body from eye	S	0698	0.9553	$64.24		$12.85	*
65220	Remove foreign body from eye	S	0698	0.9553	$64.24		$12.85	*
65222	Remove foreign body from eye	S	0698	0.9553	$64.24		$12.85	*
65235	Remove foreign body from eye	T	0233	16.2485	$1,092.57	$263.12	$218.52	*
65260	Remove foreign body from eye	T	0235	5.8498	$393.35		$78.67	*
65265	Remove foreign body from eye	T	0237	20.7145	$1,392.86		$278.58	*
65270	Repair of eye wound	T	0240	18.158	$1,220.96	$296.20	$244.20	*
65272	Repair of eye wound	T	0234	24.4021	$1,640.82	$511.31	$328.17	*
65273	Repair of eye wound	C						
65275	Repair of eye wound	T	0234	24.4021	$1,640.82	$511.31	$328.17	*
65280	Repair of eye wound	T	0237	20.7145	$1,392.86		$278.58	*
65285	Repair of eye wound	T	0672	39.9643	$2,687.24		$537.45	*
65286	Repair of eye wound	T	0232	4.5074	$303.08	$75.93	$60.62	*
65290	Repair of eye socket wound	T	0243	23.4694	$1,578.11	$416.98	$315.63	*
65400	Removal of eye lesion	T	0233	16.2485	$1,092.57	$263.12	$218.52	*
65410	Biopsy of cornea	T	0233	16.2485	$1,092.57	$263.12	$218.52	*
65420	Removal of eye lesion	T	0233	16.2485	$1,092.57	$263.12	$218.52	*
65426	Removal of eye lesion	T	0234	24.4021	$1,640.82	$511.31	$328.17	*
65430	Corneal smear	S	0698	0.9553	$64.24		$12.85	*
65435	Curette/treat cornea	T	0239	7.6421	$513.86		$102.78	*
65436	Curette/treat cornea	T	0233	16.2485	$1,092.57	$263.12	$218.52	*
65450	Treatment of corneal lesion	S	0231	1.9575	$131.62		$26.33	*
65600	Revision of cornea	T	0240	18.158	$1,220.96	$296.20	$244.20	*
65710	Corneal transplant	T	0244	37.5388	$2,524.15	$803.26	$504.83	*
65730	Corneal transplant	T	0244	37.5388	$2,524.15	$803.26	$504.83	*
65750	Corneal transplant	T	0244	37.5388	$2,524.15	$803.26	$504.83	*
65755	Corneal transplant	T	0244	37.5388	$2,524.15	$803.26	$504.83	*
65756	Corneal trnspl, endothelial	T	0244	37.5388	$2,524.15	$803.26	$504.83	*
65757	Prep corneal endo allograft	N						
65760	Revision of cornea	E						
65765	Revision of cornea	E						
65767	Corneal tissue transplant	E						
65770	Revise cornea with implant	T	0293	101.0161	$6,792.42		$1,358.49	*
65771	Radial keratotomy	E						
65772	Correction of astigmatism	T	0233	16.2485	$1,092.57	$263.12	$218.52	*
65775	Correction of astigmatism	T	0233	16.2485	$1,092.57	$263.12	$218.52	*
65780	Ocular reconst, transplant	T	0244	37.5388	$2,524.15	$803.26	$504.83	*
65781	Ocular reconst, transplant	T	0244	37.5388	$2,524.15	$803.26	$504.83	*
65782	Ocular reconst, transplant	T	0244	37.5388	$2,524.15	$803.26	$504.83	*
65800	Drainage of eye	T	0233	16.2485	$1,092.57	$263.12	$218.52	*
65805	Drainage of eye	T	0233	16.2485	$1,092.57	$263.12	$218.52	*
65810	Drainage of eye	T	0234	24.4021	$1,640.82	$511.31	$328.17	*
65815	Drainage of eye	T	0234	24.4021	$1,640.82	$511.31	$328.17	*
65820	Relieve inner eye pressure	T	0232	4.5074	$303.08	$75.93	$60.62	*
65850	Incision of eye	T	0234	24.4021	$1,640.82	$511.31	$328.17	*
65855	Laser surgery of eye	T	0247	5.3014	$356.47	$104.31	$71.30	*
65860	Incise inner eye adhesions	T	0247	5.3014	$356.47	$104.31	$71.30	*
65865	Incise inner eye adhesions	T	0233	16.2485	$1,092.57	$263.12	$218.52	*
65870	Incise inner eye adhesions	T	0234	24.4021	$1,640.82	$511.31	$328.17	*
65875	Incise inner eye adhesions	T	0234	24.4021	$1,640.82	$511.31	$328.17	*
65880	Incise inner eye adhesions	T	0233	16.2485	$1,092.57	$263.12	$218.52	*
65900	Remove eye lesion	T	0233	16.2485	$1,092.57	$263.12	$218.52	*
65920	Remove implant of eye	T	0234	24.4021	$1,640.82	$511.31	$328.17	*
65930	Remove blood clot from eye	T	0234	24.4021	$1,640.82	$511.31	$328.17	*
66020	Injection treatment of eye	T	0233	16.2485	$1,092.57	$263.12	$218.52	*
66030	Injection treatment of eye	T	0232	4.5074	$303.08	$75.93	$60.62	*
66130	Remove eye lesion	T	0234	24.4021	$1,640.82	$511.31	$328.17	*
66150	Glaucoma surgery	T	0234	24.4021	$1,640.82	$511.31	$328.17	*

66155	Glaucoma surgery	T	0234	24.4021	$1,640.82	$511.31	$328.17	*
66160	Glaucoma surgery	T	0234	24.4021	$1,640.82	$511.31	$328.17	*
66165	Glaucoma surgery	T	0234	24.4021	$1,640.82	$511.31	$328.17	*
66170	Glaucoma surgery	T	0234	24.4021	$1,640.82	$511.31	$328.17	*
66172	Incision of eye	T	0234	24.4021	$1,640.82	$511.31	$328.17	*
66180	Implant eye shunt	T	0673	41.884	$2,816.32	$649.56	$563.27	*
66185	Revise eye shunt	T	0234	24.4021	$1,640.82	$511.31	$328.17	*
66220	Repair eye lesion	T	0672	39.9643	$2,687.24		$537.45	*
66225	Repair/graft eye lesion	T	0673	41.884	$2,816.32	$649.56	$563.27	*
66250	Follow-up surgery of eye	T	0233	16.2485	$1,092.57	$263.12	$218.52	*
66500	Incision of iris	T	0232	4.5074	$303.08	$75.93	$60.62	*
66505	Incision of iris	T	0232	4.5074	$303.08	$75.93	$60.62	*
66600	Remove iris and lesion	T	0234	24.4021	$1,640.82	$511.31	$328.17	*
66605	Removal of iris	T	0234	24.4021	$1,640.82	$511.31	$328.17	*
66625	Removal of iris	T	0233	16.2485	$1,092.57	$263.12	$218.52	*
66630	Removal of iris	T	0234	24.4021	$1,640.82	$511.31	$328.17	*
66635	Removal of iris	T	0234	24.4021	$1,640.82	$511.31	$328.17	*
66680	Repair iris & ciliary body	T	0234	24.4021	$1,640.82	$511.31	$328.17	*
66682	Repair iris & ciliary body	T	0234	24.4021	$1,640.82	$511.31	$328.17	*
66700	Destruction, ciliary body	T	0233	16.2485	$1,092.57	$263.12	$218.52	*
66710	Ciliary transscleral therapy	T	0233	16.2485	$1,092.57	$263.12	$218.52	*
66711	Ciliary endoscopic ablation	T	0233	16.2485	$1,092.57	$263.12	$218.52	*
66720	Destruction, ciliary body	T	0233	16.2485	$1,092.57	$263.12	$218.52	*
66740	Destruction, ciliary body	T	0234	24.4021	$1,640.82	$511.31	$328.17	*
66761	Revision of iris	T	0247	5.3014	$356.47	$104.31	$71.30	*
66762	Revision of iris	T	0247	5.3014	$356.47	$104.31	$71.30	*
66770	Removal of inner eye lesion	T	0247	5.3014	$356.47	$104.31	$71.30	*
66820	Incision, secondary cataract	T	0232	4.5074	$303.08	$75.93	$60.62	*
66821	After cataract laser surgery	T	0247	5.3014	$356.47	$104.31	$71.30	*
66825	Reposition intraocular lens	T	0234	24.4021	$1,640.82	$511.31	$328.17	*
66830	Removal of lens lesion	T	0232	4.5074	$303.08	$75.93	$60.62	*
66840	Removal of lens material	T	0245	15.8085	$1,062.98	$214.11	$212.60	*
66850	Removal of lens material	T	0249	30.3293	$2,039.37	$516.99	$407.88	*
66852	Removal of lens material	T	0249	30.3293	$2,039.37	$516.99	$407.88	*
66920	Extraction of lens	T	0249	30.3293	$2,039.37	$516.99	$407.88	*
66930	Extraction of lens	T	0249	30.3293	$2,039.37	$516.99	$407.88	*
66940	Extraction of lens	T	0245	15.8085	$1,062.98	$214.11	$212.60	*
66982	Cataract surgery, complex	T	0246	24.2879	$1,633.14	$495.96	$326.63	*
66983	Cataract surg w/iol, 1 stage	T	0246	24.2879	$1,633.14	$495.96	$326.63	*
66984	Cataract surg w/iol, 1 stage	T	0246	24.2879	$1,633.14	$495.96	$326.63	*
66985	Insert lens prosthesis	T	0246	24.2879	$1,633.14	$495.96	$326.63	*
66986	Exchange lens prosthesis	T	0246	24.2879	$1,633.14	$495.96	$326.63	*
66990	Ophthalmic endoscope add-on	N						
66999	Eye surgery procedure	T	0232	4.5074	$303.08	$75.93	$60.62	*
67005	Partial removal of eye fluid	T	0237	20.7145	$1,392.86		$278.58	*
67010	Partial removal of eye fluid	T	0672	39.9643	$2,687.24		$537.45	*
67015	Release of eye fluid	T	0672	39.9643	$2,687.24		$537.45	*
67025	Replace eye fluid	T	0237	20.7145	$1,392.86		$278.58	*
67027	Implant eye drug system	T	0672	39.9643	$2,687.24		$537.45	*
67028	Injection eye drug	T	0238	3.2267	$216.97		$43.40	*
67030	Incise inner eye strands	T	0237	20.7145	$1,392.86		$278.58	*
67031	Laser surgery, eye strands	T	0247	5.3014	$356.47	$104.31	$71.30	*
67036	Removal of inner eye fluid	T	0672	39.9643	$2,687.24		$537.45	*
67039	Laser treatment of retina	T	0672	39.9643	$2,687.24		$537.45	*
67040	Laser treatment of retina	T	0672	39.9643	$2,687.24		$537.45	*
67041	Vit for macular pucker	T	0672	39.9643	$2,687.24		$537.45	*
67042	Vit for macular hole	T	0672	39.9643	$2,687.24		$537.45	*
67043	Vit for membrane dissect	T	0672	39.9643	$2,687.24		$537.45	*
67101	Repair detached retina	T	0237	20.7145	$1,392.86		$278.58	*
67105	Repair detached retina	T	0247	5.3014	$356.47	$104.31	$71.30	*
67107	Repair detached retina	T	0672	39.9643	$2,687.24		$537.45	*
67108	Repair detached retina	T	0672	39.9643	$2,687.24		$537.45	*

67110	Repair detached retina	T	0237	20.7145	$1,392.86		$278.58	*
67112	Rerepair detached retina	T	0672	39.9643	$2,687.24		$537.45	*
67113	Repair retinal detach, cplx	T	0672	39.9643	$2,687.24		$537.45	*
67115	Release encircling material	T	0237	20.7145	$1,392.86		$278.58	*
67120	Remove eye implant material	T	0237	20.7145	$1,392.86		$278.58	*
67121	Remove eye implant material	T	0237	20.7145	$1,392.86		$278.58	*
67141	Treatment of retina	T	0235	5.8498	$393.35		$78.67	*
67145	Treatment of retina	T	0247	5.3014	$356.47	$104.31	$71.30	*
67208	Treatment of retinal lesion	T	0235	5.8498	$393.35		$78.67	*
67210	Treatment of retinal lesion	T	0247	5.3014	$356.47	$104.31	$71.30	*
67218	Treatment of retinal lesion	T	0237	20.7145	$1,392.86		$278.58	*
67220	Treatment of choroid lesion	T	0235	5.8498	$393.35		$78.67	*
67221	Ocular photodynamic ther	T	0235	5.8498	$393.35		$78.67	*
67225	Eye photodynamic ther add-on	T	0235	5.8498	$393.35		$78.67	*
67227	Treatment of retinal lesion	T	0237	20.7145	$1,392.86		$278.58	*
67228	Treatment of retinal lesion	T	0247	5.3014	$356.47	$104.31	$71.30	*
67229	Tr retinal les preterm inf	T	0247	5.3014	$356.47	$104.31	$71.30	*
67250	Reinforce eye wall	T	0240	18.158	$1,220.96	$296.20	$244.20	*
67255	Reinforce/graft eye wall	T	0237	20.7145	$1,392.86		$278.58	*
67299	Eye surgery procedure	T	0235	5.8498	$393.35		$78.67	*
67311	Revise eye muscle	T	0243	23.4694	$1,578.11	$416.98	$315.63	*
67312	Revise two eye muscles	T	0243	23.4694	$1,578.11	$416.98	$315.63	*
67314	Revise eye muscle	T	0243	23.4694	$1,578.11	$416.98	$315.63	*
67316	Revise two eye muscles	T	0243	23.4694	$1,578.11	$416.98	$315.63	*
67318	Revise eye muscle(s)	T	0243	23.4694	$1,578.11	$416.98	$315.63	*
67320	Revise eye muscle(s) add-on	T	0243	23.4694	$1,578.11	$416.98	$315.63	*
67331	Eye surgery follow-up add-on	T	0243	23.4694	$1,578.11	$416.98	$315.63	*
67332	Rerevise eye muscles add-on	T	0243	23.4694	$1,578.11	$416.98	$315.63	*
67334	Revise eye muscle w/suture	T	0243	23.4694	$1,578.11	$416.98	$315.63	*
67335	Eye suture during surgery	T	0243	23.4694	$1,578.11	$416.98	$315.63	*
67340	Revise eye muscle add-on	T	0243	23.4694	$1,578.11	$416.98	$315.63	*
67343	Release eye tissue	T	0243	23.4694	$1,578.11	$416.98	$315.63	*
67345	Destroy nerve of eye muscle	T	0238	3.2267	$216.97		$43.40	*
67346	Biopsy, eye muscle	T	0699	15.5407	$1,044.97		$209.00	*
67399	Eye muscle surgery procedure	T	0243	23.4694	$1,578.11	$416.98	$315.63	*
67400	Explore/biopsy eye socket	T	0240	18.158	$1,220.96	$296.20	$244.20	*
67405	Explore/drain eye socket	T	0241	26.8396	$1,804.72	$383.45	$360.95	*
67412	Explore/treat eye socket	T	0240	18.158	$1,220.96	$296.20	$244.20	*
67413	Explore/treat eye socket	T	0241	26.8396	$1,804.72	$383.45	$360.95	*
67414	Explr/decompress eye socket	T	0242	39.0115	$2,623.17	$597.36	$524.64	*
67415	Aspiration, orbital contents	T	0240	18.158	$1,220.96	$296.20	$244.20	*
67420	Explore/treat eye socket	T	0242	39.0115	$2,623.17	$597.36	$524.64	*
67430	Explore/treat eye socket	T	0242	39.0115	$2,623.17	$597.36	$524.64	*
67440	Explore/drain eye socket	T	0242	39.0115	$2,623.17	$597.36	$524.64	*
67445	Explr/decompress eye socket	T	0242	39.0115	$2,623.17	$597.36	$524.64	*
67450	Explore/biopsy eye socket	T	0242	39.0115	$2,623.17	$597.36	$524.64	*
67500	Inject/treat eye socket	S	0231	1.9575	$131.62		$26.33	*
67505	Inject/treat eye socket	T	0238	3.2267	$216.97		$43.40	*
67515	Inject/treat eye socket	T	0238	3.2267	$216.97		$43.40	*
67550	Insert eye socket implant	T	0242	39.0115	$2,623.17	$597.36	$524.64	*
67560	Revise eye socket implant	T	0241	26.8396	$1,804.72	$383.45	$360.95	*
67570	Decompress optic nerve	T	0242	39.0115	$2,623.17	$597.36	$524.64	*
67599	Orbit surgery procedure	T	0238	3.2267	$216.97		$43.40	*
67700	Drainage of eyelid abscess	T	0238	3.2267	$216.97		$43.40	*
67710	Incision of eyelid	T	0239	7.6421	$513.86		$102.78	*
67715	Incision of eyelid fold	T	0240	18.158	$1,220.96	$296.20	$244.20	*
67800	Remove eyelid lesion	T	0238	3.2267	$216.97		$43.40	*
67801	Remove eyelid lesions	T	0239	7.6421	$513.86		$102.78	*
67805	Remove eyelid lesions	T	0238	3.2267	$216.97		$43.40	*
67808	Remove eyelid lesion(s)	T	0240	18.158	$1,220.96	$296.20	$244.20	*
67810	Biopsy of eyelid	T	0238	3.2267	$216.97		$43.40	*
67820	Revise eyelashes	S	0698	0.9553	$64.24		$12.85	*

67825	Revise eyelashes	T	0238	3.2267	$216.97		$43.40	*
67830	Revise eyelashes	T	0239	7.6421	$513.86		$102.78	*
67835	Revise eyelashes	T	0240	18.158	$1,220.96	$296.20	$244.20	*
67840	Remove eyelid lesion	T	0239	7.6421	$513.86		$102.78	*
67850	Treat eyelid lesion	T	0239	7.6421	$513.86		$102.78	*
67875	Closure of eyelid by suture	T	0239	7.6421	$513.86		$102.78	*
67880	Revision of eyelid	T	0233	16.2485	$1,092.57	$263.12	$218.52	*
67882	Revision of eyelid	T	0240	18.158	$1,220.96	$296.20	$244.20	*
67900	Repair brow defect	T	0241	26.8396	$1,804.72	$383.45	$360.95	*
67901	Repair eyelid defect	T	0240	18.158	$1,220.96	$296.20	$244.20	*
67902	Repair eyelid defect	T	0241	26.8396	$1,804.72	$383.45	$360.95	*
67903	Repair eyelid defect	T	0240	18.158	$1,220.96	$296.20	$244.20	*
67904	Repair eyelid defect	T	0240	18.158	$1,220.96	$296.20	$244.20	*
67906	Repair eyelid defect	T	0240	18.158	$1,220.96	$296.20	$244.20	*
67908	Repair eyelid defect	T	0240	18.158	$1,220.96	$296.20	$244.20	*
67909	Revise eyelid defect	T	0240	18.158	$1,220.96	$296.20	$244.20	*
67911	Revise eyelid defect	T	0240	18.158	$1,220.96	$296.20	$244.20	*
67912	Correction eyelid w/implant	T	0240	18.158	$1,220.96	$296.20	$244.20	*
67914	Repair eyelid defect	T	0240	18.158	$1,220.96	$296.20	$244.20	*
67915	Repair eyelid defect	T	0240	18.158	$1,220.96	$296.20	$244.20	*
67916	Repair eyelid defect	T	0240	18.158	$1,220.96	$296.20	$244.20	*
67917	Repair eyelid defect	T	0240	18.158	$1,220.96	$296.20	$244.20	*
67921	Repair eyelid defect	T	0240	18.158	$1,220.96	$296.20	$244.20	*
67922	Repair eyelid defect	T	0240	18.158	$1,220.96	$296.20	$244.20	*
67923	Repair eyelid defect	T	0240	18.158	$1,220.96	$296.20	$244.20	*
67924	Repair eyelid defect	T	0240	18.158	$1,220.96	$296.20	$244.20	*
67930	Repair eyelid wound	T	0240	18.158	$1,220.96	$296.20	$244.20	*
67935	Repair eyelid wound	T	0240	18.158	$1,220.96	$296.20	$244.20	*
67938	Remove eyelid foreign body	S	0231	1.9575	$131.62		$26.33	*
67950	Revision of eyelid	T	0240	18.158	$1,220.96	$296.20	$244.20	*
67961	Revision of eyelid	T	0240	18.158	$1,220.96	$296.20	$244.20	*
67966	Revision of eyelid	T	0240	18.158	$1,220.96	$296.20	$244.20	*
67971	Reconstruction of eyelid	T	0240	18.158	$1,220.96	$296.20	$244.20	*
67973	Reconstruction of eyelid	T	0241	26.8396	$1,804.72	$383.45	$360.95	*
67974	Reconstruction of eyelid	T	0240	18.158	$1,220.96	$296.20	$244.20	*
975	Reconstruction of eyelid	T	0240	18.158	$1,220.96	$296.20	$244.20	*
67999	Revision of eyelid	T	0238	3.2267	$216.97		$43.40	*
68020	Incise/drain eyelid lining	T	0238	3.2267	$216.97		$43.40	*
68040	Treatment of eyelid lesions	S	0698	0.9553	$64.24		$12.85	*
68100	Biopsy of eyelid lining	T	0232	4.5074	$303.08	$75.93	$60.62	*
68110	Remove eyelid lining lesion	T	0699	15.5407	$1,044.97		$209.00	*
68115	Remove eyelid lining lesion	T	0240	18.158	$1,220.96	$296.20	$244.20	*
68130	Remove eyelid lining lesion	T	0233	16.2485	$1,092.57	$263.12	$218.52	*
68135	Remove eyelid lining lesion	T	0239	7.6421	$513.86		$102.78	*
68200	Treat eyelid by injection	S	0698	0.9553	$64.24		$12.85	*
68320	Revise/graft eyelid lining	T	0241	26.8396	$1,804.72	$383.45	$360.95	*
68325	Revise/graft eyelid lining	T	0241	26.8396	$1,804.72	$383.45	$360.95	*
68326	Revise/graft eyelid lining	T	0240	18.158	$1,220.96	$296.20	$244.20	*
68328	Revise/graft eyelid lining	T	0241	26.8396	$1,804.72	$383.45	$360.95	*
68330	Revise eyelid lining	T	0234	24.4021	$1,640.82	$511.31	$328.17	*
68335	Revise/graft eyelid lining	T	0241	26.8396	$1,804.72	$383.45	$360.95	*
68340	Separate eyelid adhesions	T	0240	18.158	$1,220.96	$296.20	$244.20	*
68360	Revise eyelid lining	T	0234	24.4021	$1,640.82	$511.31	$328.17	*
68362	Revise eyelid lining	T	0234	24.4021	$1,640.82	$511.31	$328.17	*
68371	Harvest eye tissue, alograft	T	0233	16.2485	$1,092.57	$263.12	$218.52	*
68399	Eyelid lining surgery	T	0238	3.2267	$216.97		$43.40	*
68400	Incise/drain tear gland	T	0238	3.2267	$216.97		$43.40	*
68420	Incise/drain tear sac	T	0240	18.158	$1,220.96	$296.20	$244.20	*
68440	Incise tear duct opening	T	0238	3.2267	$216.97		$43.40	*
68500	Removal of tear gland	T	0241	26.8396	$1,804.72	$383.45	$360.95	*
68505	Partial removal, tear gland	T	0241	26.8396	$1,804.72	$383.45	$360.95	*
68510	Biopsy of tear gland	T	0240	18.158	$1,220.96	$296.20	$244.20	*

68520	Removal of tear sac	T	0241	26.8396	$1,804.72	$383.45	$360.95	*
68525	Biopsy of tear sac	T	0240	18.158	$1,220.96	$296.20	$244.20	*
68530	Clearance of tear duct	T	0238	3.2267	$216.97		$43.40	*
68540	Remove tear gland lesion	T	0240	18.158	$1,220.96	$296.20	$244.20	*
68550	Remove tear gland lesion	T	0241	26.8396	$1,804.72	$383.45	$360.95	*
68700	Repair tear ducts	T	0240	18.158	$1,220.96	$296.20	$244.20	*
68705	Revise tear duct opening	T	0238	3.2267	$216.97		$43.40	*
68720	Create tear sac drain	T	0241	26.8396	$1,804.72	$383.45	$360.95	*
68745	Create tear duct drain	T	0241	26.8396	$1,804.72	$383.45	$360.95	*
68750	Create tear duct drain	T	0241	26.8396	$1,804.72	$383.45	$360.95	*
68760	Close tear duct opening	T	0238	3.2267	$216.97		$43.40	*
68761	Close tear duct opening	T	0238	3.2267	$216.97		$43.40	*
68770	Close tear system fistula	T	0241	26.8396	$1,804.72	$383.45	$360.95	*
68801	Dilate tear duct opening	S	0698	0.9553	$64.24		$12.85	*
68810	Probe nasolacrimal duct	T	0238	3.2267	$216.97		$43.40	*
68811	Probe nasolacrimal duct	T	0240	18.158	$1,220.96	$296.20	$244.20	*
68815	Probe nasolacrimal duct	T	0240	18.158	$1,220.96	$296.20	$244.20	*
68816	Probe nl duct w/balloon	T	0240	18.158	$1,220.96	$296.20	$244.20	*
68840	Explore/irrigate tear ducts	S	0231	1.9575	$131.62		$26.33	*
68850	Injection for tear sac x-ray	N						
68899	Tear duct system surgery	T	0238	3.2267	$216.97		$43.40	*
69000	Drain external ear lesion	T	0006	1.4557	$97.88		$19.58	*
69005	Drain external ear lesion	T	0008	19.4063	$1,304.90		$260.98	*
69020	Drain outer ear canal lesion	T	0006	1.4557	$97.88		$19.58	*
69090	Pierce earlobes	E						
69100	Biopsy of external ear	T	0251	3.425	$230.30		$46.06	*
69105	Biopsy of external ear canal	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
69110	Remove external ear, partial	T	0021	17.4975	$1,176.55		$235.31	*
69120	Removal of external ear	T	0254	24.9637	$1,678.58		$335.72	*
69140	Remove ear canal lesion(s)	T	0254	24.9637	$1,678.58		$335.72	*
69145	Remove ear canal lesion(s)	T	0021	17.4975	$1,176.55		$235.31	*
69150	Extensive ear canal surgery	T	0252	7.6196	$512.35	$109.16	$102.47	*
69155	Extensive ear/neck surgery	C						
69200	Clear outer ear canal	X	0340	0.6693	$45.00		$9.00	*
69205	Clear outer ear canal	T	0022	23.388	$1,572.63	$354.45	$314.53	*
69210	Remove impacted ear wax	X	0340	0.6693	$45.00		$9.00	*
69220	Clean out mastoid cavity	T	0013	0.8789	$59.10		$11.82	*
69222	Clean out mastoid cavity	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
69300	Revise external ear	T	0254	24.9637	$1,678.58		$335.72	*
69310	Rebuild outer ear canal	T	0256	42.9827	$2,890.20		$578.04	*
69320	Rebuild outer ear canal	T	0256	42.9827	$2,890.20		$578.04	*
69399	Outer ear surgery procedure	T	0250	1.1522	$77.48	$25.10	$15.50	*
69400	Inflate middle ear canal	T	0251	3.425	$230.30		$46.06	*
69401	Inflate middle ear canal	T	0251	3.425	$230.30		$46.06	*
69405	Catheterize middle ear canal	T	0252	7.6196	$512.35	$109.16	$102.47	*
69420	Incision of eardrum	T	0251	3.425	$230.30		$46.06	*
69421	Incision of eardrum	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
69424	Remove ventilating tube	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
69433	Create eardrum opening	T	0252	7.6196	$512.35	$109.16	$102.47	*
69436	Create eardrum opening	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
69440	Exploration of middle ear	T	0254	24.9637	$1,678.58		$335.72	*
69450	Eardrum revision	T	0256	42.9827	$2,890.20		$578.04	*
69501	Mastoidectomy	T	0256	42.9827	$2,890.20		$578.04	*
69502	Mastoidectomy	T	0254	24.9637	$1,678.58		$335.72	*
69505	Remove mastoid structures	T	0256	42.9827	$2,890.20		$578.04	*
69511	Extensive mastoid surgery	T	0256	42.9827	$2,890.20		$578.04	*
69530	Extensive mastoid surgery	T	0256	42.9827	$2,890.20		$578.04	*
69535	Remove part of temporal bone	C						
69540	Remove ear lesion	T	0253	17.1879	$1,155.73	$282.29	$231.15	*
69550	Remove ear lesion	T	0256	42.9827	$2,890.20		$578.04	*
69552	Remove ear lesion	T	0256	42.9827	$2,890.20		$578.04	*
69554	Remove ear lesion	C						

69601	Mastoid surgery revision	T	0256	42.9827	$2,890.20		$578.04	*
69602	Mastoid surgery revision	T	0256	42.9827	$2,890.20		$578.04	*
69603	Mastoid surgery revision	T	0256	42.9827	$2,890.20		$578.04	*
69604	Mastoid surgery revision	T	0256	42.9827	$2,890.20		$578.04	*
69605	Mastoid surgery revision	T	0256	42.9827	$2,890.20		$578.04	*
69610	Repair of eardrum	T	0254	24.9637	$1,678.58		$335.72	*
69620	Repair of eardrum	T	0254	24.9637	$1,678.58		$335.72	*
69631	Repair eardrum structures	T	0256	42.9827	$2,890.20		$578.04	*
69632	Rebuild eardrum structures	T	0256	42.9827	$2,890.20		$578.04	*
69633	Rebuild eardrum structures	T	0256	42.9827	$2,890.20		$578.04	*
69635	Repair eardrum structures	T	0256	42.9827	$2,890.20		$578.04	*
69636	Rebuild eardrum structures	T	0256	42.9827	$2,890.20		$578.04	*
69637	Rebuild eardrum structures	T	0256	42.9827	$2,890.20		$578.04	*
69641	Revise middle ear & mastoid	T	0256	42.9827	$2,890.20		$578.04	*
69642	Revise middle ear & mastoid	T	0256	42.9827	$2,890.20		$578.04	*
69643	Revise middle ear & mastoid	T	0256	42.9827	$2,890.20		$578.04	*
69644	Revise middle ear & mastoid	T	0256	42.9827	$2,890.20		$578.04	*
69645	Revise middle ear & mastoid	T	0256	42.9827	$2,890.20		$578.04	*
69646	Revise middle ear & mastoid	T	0256	42.9827	$2,890.20		$578.04	*
69650	Release middle ear bone	T	0254	24.9637	$1,678.58		$335.72	*
69660	Revise middle ear bone	T	0256	42.9827	$2,890.20		$578.04	*
69661	Revise middle ear bone	T	0256	42.9827	$2,890.20		$578.04	*
69662	Revise middle ear bone	T	0256	42.9827	$2,890.20		$578.04	*
69666	Repair middle ear structures	T	0256	42.9827	$2,890.20		$578.04	*
69667	Repair middle ear structures	T	0256	42.9827	$2,890.20		$578.04	*
69670	Remove mastoid air cells	T	0256	42.9827	$2,890.20		$578.04	*
69676	Remove middle ear nerve	T	0256	42.9827	$2,890.20		$578.04	*
69700	Close mastoid fistula	T	0256	42.9827	$2,890.20		$578.04	*
69710	Implant/replace hearing aid	E						
69711	Remove/repair hearing aid	T	0256	42.9827	$2,890.20		$578.04	*
69714	Implant temple bone w/stimul	T	0425	118.767	$7,986.01		$1,597.21	*
69715	Temple bne implnt w/stimulat	T	0425	118.767	$7,986.01		$1,597.21	*
69717	Temple bone implant revision	T	0425	118.767	$7,986.01		$1,597.21	*
69718	Revise temple bone implant	T	0425	118.767	$7,986.01		$1,597.21	*
69720	Release facial nerve	T	0256	42.9827	$2,890.20		$578.04	*
69725	Release facial nerve	T	0256	42.9827	$2,890.20		$578.04	*
69740	Repair facial nerve	T	0256	42.9827	$2,890.20		$578.04	*
69745	Repair facial nerve	T	0256	42.9827	$2,890.20		$578.04	*
69799	Middle ear surgery procedure	T	0250	1.1522	$77.48	$25.10	$15.50	*
69801	Incise inner ear	T	0254	24.9637	$1,678.58		$335.72	*
69802	Incise inner ear	T	0254	24.9637	$1,678.58		$335.72	*
69805	Explore inner ear	T	0256	42.9827	$2,890.20		$578.04	*
69806	Explore inner ear	T	0256	42.9827	$2,890.20		$578.04	*
69820	Establish inner ear window	T	0256	42.9827	$2,890.20		$578.04	*
69840	Revise inner ear window	T	0256	42.9827	$2,890.20		$578.04	*
69905	Remove inner ear	T	0256	42.9827	$2,890.20		$578.04	*
69910	Remove inner ear & mastoid	T	0256	42.9827	$2,890.20		$578.04	*
69915	Incise inner ear nerve	T	0256	42.9827	$2,890.20		$578.04	*
69930	Implant cochlear device	T	0259	428.8363	$28,835.38	$8,543.66	$5,767.08	*
69949	Inner ear surgery procedure	T	0250	1.1522	$77.48	$25.10	$15.50	*
69950	Incise inner ear nerve	C						
69955	Release facial nerve	T	0256	42.9827	$2,890.20		$578.04	*
69960	Release inner ear canal	T	0256	42.9827	$2,890.20		$578.04	*
69970	Remove inner ear lesion	T	0256	42.9827	$2,890.20		$578.04	*
69979	Temporal bone surgery	T	0250	1.1522	$77.48	$25.10	$15.50	*
69990	Microsurgery add-on	N						
70010	Contrast x-ray of brain	Q2	0274	7.226	$485.88		$97.18	*
70015	Contrast x-ray of brain	Q2	0274	7.226	$485.88		$97.18	*
70030	X-ray eye for foreign body	X	0260	0.6661	$44.79		$8.96	*
70100	X-ray exam of jaw	X	0260	0.6661	$44.79		$8.96	*
70110	X-ray exam of jaw	X	0260	0.6661	$44.79		$8.96	*
70120	X-ray exam of mastoids	X	0260	0.6661	$44.79		$8.96	*

70130	X-ray exam of mastoids	X	0260	0.6661	$44.79		$8.96	*
70134	X-ray exam of middle ear	X	0261	1.1161	$75.05		$15.01	*
70140	X-ray exam of facial bones	X	0260	0.6661	$44.79		$8.96	*
70150	X-ray exam of facial bones	X	0260	0.6661	$44.79		$8.96	*
70160	X-ray exam of nasal bones	X	0260	0.6661	$44.79		$8.96	*
70170	X-ray exam of tear duct	Q2	0263	3.1192	$209.74		$41.95	*
70190	X-ray exam of eye sockets	X	0260	0.6661	$44.79		$8.96	*
70200	X-ray exam of eye sockets	X	0260	0.6661	$44.79		$8.96	*
70210	X-ray exam of sinuses	X	0260	0.6661	$44.79		$8.96	*
70220	X-ray exam of sinuses	X	0260	0.6661	$44.79		$8.96	*
70240	X-ray exam, pituitary saddle	X	0260	0.6661	$44.79		$8.96	*
70250	X-ray exam of skull	X	0260	0.6661	$44.79		$8.96	*
70260	X-ray exam of skull	X	0261	1.1161	$75.05		$15.01	*
70300	X-ray exam of teeth	X	0262	0.4469	$30.05		$6.01	*
70310	X-ray exam of teeth	X	0262	0.4469	$30.05		$6.01	*
70320	Full mouth x-ray of teeth	X	0262	0.4469	$30.05		$6.01	*
70328	X-ray exam of jaw joint	X	0260	0.6661	$44.79		$8.96	*
70330	X-ray exam of jaw joints	X	0260	0.6661	$44.79		$8.96	*
70332	X-ray exam of jaw joint	Q2	0275	3.9361	$264.67	$68.90	$52.94	*
70336	Magnetic image, jaw joint	Q3	0336	5.1855	$348.68	$137.40	$69.74	*
70350	X-ray head for orthodontia	X	0260	0.6661	$44.79		$8.96	*
70355	Panoramic x-ray of jaws	X	0260	0.6661	$44.79		$8.96	*
70360	X-ray exam of neck	X	0260	0.6661	$44.79		$8.96	*
70370	Throat x-ray & fluoroscopy	X	0272	1.2693	$85.35	$31.15	$17.07	*
70371	Speech evaluation, complex	X	0272	1.2693	$85.35	$31.15	$17.07	*
70373	Contrast x-ray of larynx	Q2	0263	3.1192	$209.74		$41.95	*
70380	X-ray exam of salivary gland	X	0260	0.6661	$44.79		$8.96	*
70390	X-ray exam of salivary duct	Q2	0263	3.1192	$209.74		$41.95	*
70450	Ct head/brain w/o dye	Q3	0332	2.894	$194.60	$75.24	$38.92	*
70460	Ct head/brain w/dye	Q3	0283	4.4066	$296.30	$96.62	$59.26	*
70470	Ct head/brain w/o & w/dye	Q3	0333	4.9479	$332.70	$116.13	$66.54	*
70480	Ct orbit/ear/fossa w/o dye	Q3	0332	2.894	$194.60	$75.24	$38.92	*
70481	Ct orbit/ear/fossa w/dye	Q3	0283	4.4066	$296.30	$96.62	$59.26	*
70482	Ct orbit/ear/fossa w/o&w/dye	Q3	0333	4.9479	$332.70	$116.13	$66.54	*
70486	Ct maxillofacial w/o dye	Q3	0332	2.894	$194.60	$75.24	$38.92	*
70487	Ct maxillofacial w/dye	Q3	0283	4.4066	$296.30	$96.62	$59.26	*
70488	Ct maxillofacial w/o & w/dye	Q3	0333	4.9479	$332.70	$116.13	$66.54	*
70490	Ct soft tissue neck w/o dye	Q3	0332	2.894	$194.60	$75.24	$38.92	*
70491	Ct soft tissue neck w/dye	Q3	0283	4.4066	$296.30	$96.62	$59.26	*
70492	Ct sft tsue nck w/o & w/dye	Q3	0333	4.9479	$332.70	$116.13	$66.54	*
70496	Ct angiography, head	Q3	0662	5.0511	$339.64	$114.75	$67.93	*
70498	Ct angiography, neck	Q3	0662	5.0511	$339.64	$114.75	$67.93	*
70540	Mri orbit/face/neck w/o dye	Q3	0336	5.1855	$348.68	$137.40	$69.74	*
70542	Mri orbit/face/neck w/dye	Q3	0284	6.2901	$422.95	$146.85	$84.59	*
70543	Mri orbt/fac/nck w/o & w/dye	Q3	0337	7.9432	$534.11	$197.83	$106.83	*
70544	Mr angiography head w/o dye	Q3	0336	5.1855	$348.68	$137.40	$69.74	*
70545	Mr angiography head w/dye	Q3	0284	6.2901	$422.95	$146.85	$84.59	*
70546	Mr angiograph head w/o&w/dye	Q3	0337	7.9432	$534.11	$197.83	$106.83	*
70547	Mr angiography neck w/o dye	Q3	0336	5.1855	$348.68	$137.40	$69.74	*
70548	Mr angiography neck w/dye	Q3	0284	6.2901	$422.95	$146.85	$84.59	*
70549	Mr angiograph neck w/o&w/dye	Q3	0337	7.9432	$534.11	$197.83	$106.83	*
70551	Mri brain w/o dye	Q3	0336	5.1855	$348.68	$137.40	$69.74	*
70552	Mri brain w/dye	Q3	0284	6.2901	$422.95	$146.85	$84.59	*
70553	Mri brain w/o & w/dye	Q3	0337	7.9432	$534.11	$197.83	$106.83	*
70554	Fmri brain by tech	Q3	0336	5.1855	$348.68	$137.40	$69.74	*
70555	Fmri brain by phys/psych	S	0336	5.1855	$348.68	$137.40	$69.74	*
70557	Mri brain w/o dye	S	0336	5.1855	$348.68	$137.40	$69.74	*
70558	Mri brain w/dye	S	0284	6.2901	$422.95	$146.85	$84.59	*
70559	Mri brain w/o & w/dye	S	0337	7.9432	$534.11	$197.83	$106.83	*
71010	Chest x-ray	X	0260	0.6661	$44.79		$8.96	*
71015	Chest x-ray	X	0260	0.6661	$44.79		$8.96	*
71020	Chest x-ray	X	0260	0.6661	$44.79		$8.96	*

71021	Chest x-ray	X	0260	0.6661	$44.79		$8.96	*
71022	Chest x-ray	X	0260	0.6661	$44.79		$8.96	*
71023	Chest x-ray and fluoroscopy	X	0272	1.2693	$85.35	$31.15	$17.07	*
71030	Chest x-ray	X	0260	0.6661	$44.79		$8.96	*
71034	Chest x-ray and fluoroscopy	X	0272	1.2693	$85.35	$31.15	$17.07	*
71035	Chest x-ray	X	0260	0.6661	$44.79		$8.96	*
71040	Contrast x-ray of bronchi	Q2	0263	3.1192	$209.74		$41.95	*
71060	Contrast x-ray of bronchi	Q2	0263	3.1192	$209.74		$41.95	*
71090	X-ray & pacemaker insertion	N						
71100	X-ray exam of ribs	X	0260	0.6661	$44.79		$8.96	*
71101	X-ray exam of ribs/chest	X	0260	0.6661	$44.79		$8.96	*
71110	X-ray exam of ribs	X	0260	0.6661	$44.79		$8.96	*
71111	X-ray exam of ribs/chest	X	0261	1.1161	$75.05		$15.01	*
71120	X-ray exam of breastbone	X	0260	0.6661	$44.79		$8.96	*
71130	X-ray exam of breastbone	X	0260	0.6661	$44.79		$8.96	*
71250	Ct thorax w/o dye	Q3	0332	2.894	$194.60	$75.24	$38.92	*
71260	Ct thorax w/dye	Q3	0283	4.4066	$296.30	$96.62	$59.26	*
71270	Ct thorax w/o & w/dye	Q3	0333	4.9479	$332.70	$116.13	$66.54	*
71275	Ct angiography, chest	Q3	0662	5.0511	$339.64	$114.75	$67.93	*
71550	Mri chest w/o dye	Q3	0336	5.1855	$348.68	$137.40	$69.74	*
71551	Mri chest w/dye	Q3	0284	6.2901	$422.95	$146.85	$84.59	*
71552	Mri chest w/o & w/dye	Q3	0337	7.9432	$534.11	$197.83	$106.83	*
71555	Mri angio chest w or w/o dye	B						
72010	X-ray exam of spine	X	0261	1.1161	$75.05		$15.01	*
72020	X-ray exam of spine	X	0260	0.6661	$44.79		$8.96	*
72040	X-ray exam of neck spine	X	0260	0.6661	$44.79		$8.96	*
72050	X-ray exam of neck spine	X	0261	1.1161	$75.05		$15.01	*
72052	X-ray exam of neck spine	X	0261	1.1161	$75.05		$15.01	*
72069	X-ray exam of trunk spine	X	0260	0.6661	$44.79		$8.96	*
72070	X-ray exam of thoracic spine	X	0260	0.6661	$44.79		$8.96	*
72072	X-ray exam of thoracic spine	X	0260	0.6661	$44.79		$8.96	*
72074	X-ray exam of thoracic spine	X	0260	0.6661	$44.79		$8.96	*
72080	X-ray exam of trunk spine	X	0260	0.6661	$44.79		$8.96	*
72090	X-ray exam of trunk spine	X	0261	1.1161	$75.05		$15.01	*
72100	X-ray exam of lower spine	X	0260	0.6661	$44.79		$8.96	*
72110	X-ray exam of lower spine	X	0261	1.1161	$75.05		$15.01	*
72114	X-ray exam of lower spine	X	0261	1.1161	$75.05		$15.01	*
72120	X-ray exam of lower spine	X	0261	1.1161	$75.05		$15.01	*
72125	Ct neck spine w/o dye	Q3	0332	2.894	$194.60	$75.24	$38.92	*
72126	Ct neck spine w/dye	Q3	0283	4.4066	$296.30	$96.62	$59.26	*
72127	Ct neck spine w/o & w/dye	Q3	0333	4.9479	$332.70	$116.13	$66.54	*
72128	Ct chest spine w/o dye	Q3	0332	2.894	$194.60	$75.24	$38.92	*
72129	Ct chest spine w/dye	Q3	0283	4.4066	$296.30	$96.62	$59.26	*
72130	Ct chest spine w/o & w/dye	Q3	0333	4.9479	$332.70	$116.13	$66.54	*
72131	Ct lumbar spine w/o dye	Q3	0332	2.894	$194.60	$75.24	$38.92	*
72132	Ct lumbar spine w/dye	Q3	0283	4.4066	$296.30	$96.62	$59.26	*
72133	Ct lumbar spine w/o & w/dye	Q3	0333	4.9479	$332.70	$116.13	$66.54	*
72141	Mri neck spine w/o dye	Q3	0336	5.1855	$348.68	$137.40	$69.74	*
72142	Mri neck spine w/dye	Q3	0284	6.2901	$422.95	$146.85	$84.59	*
72146	Mri chest spine w/o dye	Q3	0336	5.1855	$348.68	$137.40	$69.74	*
72147	Mri chest spine w/dye	Q3	0284	6.2901	$422.95	$146.85	$84.59	*
72148	Mri lumbar spine w/o dye	Q3	0336	5.1855	$348.68	$137.40	$69.74	*
72149	Mri lumbar spine w/dye	Q3	0284	6.2901	$422.95	$146.85	$84.59	*
72156	Mri neck spine w/o & w/dye	Q3	0337	7.9432	$534.11	$197.83	$106.83	*
72157	Mri chest spine w/o & w/dye	Q3	0337	7.9432	$534.11	$197.83	$106.83	*
72158	Mri lumbar spine w/o & w/dye	Q3	0337	7.9432	$534.11	$197.83	$106.83	*
72159	Mr angio spine w/o&w/dye	E						
72170	X-ray exam of pelvis	X	0260	0.6661	$44.79		$8.96	*
72190	X-ray exam of pelvis	X	0260	0.6661	$44.79		$8.96	*
72191	Ct angiograph pelv w/o&w/dye	Q3	0662	5.0511	$339.64	$114.75	$67.93	*
72192	Ct pelvis w/o dye	Q3	0332	2.894	$194.60	$75.24	$38.92	*
72193	Ct pelvis w/dye	Q3	0283	4.4066	$296.30	$96.62	$59.26	*

72194	Ct pelvis w/o & w/dye	Q3	0333	4.9479	$332.70	$116.13	$66.54	*
72195	Mri pelvis w/o dye	Q3	0336	5.1855	$348.68	$137.40	$69.74	*
72196	Mri pelvis w/dye	Q3	0284	6.2901	$422.95	$146.85	$84.59	*
72197	Mri pelvis w/o & w/dye	Q3	0337	7.9432	$534.11	$197.83	$106.83	*
72198	Mr angio pelvis w/o & w/dye	B						
72200	X-ray exam sacroiliac joints	X	0260	0.6661	$44.79		$8.96	*
72202	X-ray exam sacroiliac joints	X	0260	0.6661	$44.79		$8.96	*
72220	X-ray exam of tailbone	X	0260	0.6661	$44.79		$8.96	*
72240	Contrast x-ray of neck spine	Q2	0274	7.226	$485.88		$97.18	*
72255	Contrast x-ray, thorax spine	Q2	0274	7.226	$485.88		$97.18	*
72265	Contrast x-ray, lower spine	Q2	0274	7.226	$485.88		$97.18	*
72270	Contrast x-ray, spine	Q2	0274	7.226	$485.88		$97.18	*
72275	Epidurography	N						
72285	X-ray c/t spine disk	Q2	0388	25.8604	$1,738.88		$347.78	*
72291	Perq verte/sacroplsty, fluor	N						
72292	Perq verte/sacroplsty, ct	N						
72295	X-ray of lower spine disk	Q2	0388	25.8604	$1,738.88		$347.78	*
73000	X-ray exam of collar bone	X	0260	0.6661	$44.79		$8.96	*
73010	X-ray exam of shoulder blade	X	0260	0.6661	$44.79		$8.96	*
73020	X-ray exam of shoulder	X	0260	0.6661	$44.79		$8.96	*
73030	X-ray exam of shoulder	X	0260	0.6661	$44.79		$8.96	*
73040	Contrast x-ray of shoulder	Q2	0275	3.9361	$264.67	$68.90	$52.94	*
73050	X-ray exam of shoulders	X	0260	0.6661	$44.79		$8.96	*
73060	X-ray exam of humerus	X	0260	0.6661	$44.79		$8.96	*
73070	X-ray exam of elbow	X	0260	0.6661	$44.79		$8.96	*
73080	X-ray exam of elbow	X	0260	0.6661	$44.79		$8.96	*
73085	Contrast x-ray of elbow	Q2	0275	3.9361	$264.67	$68.90	$52.94	*
73090	X-ray exam of forearm	X	0260	0.6661	$44.79		$8.96	*
73092	X-ray exam of arm, infant	X	0260	0.6661	$44.79		$8.96	*
73100	X-ray exam of wrist	X	0260	0.6661	$44.79		$8.96	*
73110	X-ray exam of wrist	X	0260	0.6661	$44.79		$8.96	*
73115	Contrast x-ray of wrist	Q2	0275	3.9361	$264.67	$68.90	$52.94	*
73120	X-ray exam of hand	X	0260	0.6661	$44.79		$8.96	*
73130	X-ray exam of hand	X	0260	0.6661	$44.79		$8.96	*
73140	X-ray exam of finger(s)	X	0260	0.6661	$44.79		$8.96	*
73200	Ct upper extremity w/o dye	Q3	0332	2.894	$194.60	$75.24	$38.92	*
73201	Ct upper extremity w/dye	Q3	0283	4.4066	$296.30	$96.62	$59.26	*
73202	Ct uppr extremity w/o&w/dye	Q3	0333	4.9479	$332.70	$116.13	$66.54	*
73206	Ct angio upr extrm w/o&w/dye	Q3	0662	5.0511	$339.64	$114.75	$67.93	*
73218	Mri upper extremity w/o dye	Q3	0336	5.1855	$348.68	$137.40	$69.74	*
73219	Mri upper extremity w/dye	Q3	0284	6.2901	$422.95	$146.85	$84.59	*
73220	Mri uppr extremity w/o&w/dye	Q3	0337	7.9432	$534.11	$197.83	$106.83	*
73221	Mri joint upr extrem w/o dye	Q3	0336	5.1855	$348.68	$137.40	$69.74	*
73222	Mri joint upr extrem w/dye	Q3	0284	6.2901	$422.95	$146.85	$84.59	*
73223	Mri joint upr extr w/o&w/dye	Q3	0337	7.9432	$534.11	$197.83	$106.83	*
73225	Mr angio upr extr w/o&w/dye	E						
73500	X-ray exam of hip	X	0260	0.6661	$44.79		$8.96	*
73510	X-ray exam of hip	X	0260	0.6661	$44.79		$8.96	*
73520	X-ray exam of hips	X	0261	1.1161	$75.05		$15.01	*
73525	Contrast x-ray of hip	Q2	0275	3.9361	$264.67	$68.90	$52.94	*
73530	X-ray exam of hip	N						
73540	X-ray exam of pelvis & hips	X	0260	0.6661	$44.79		$8.96	*
73542	X-ray exam, sacroiliac joint	Q2	0275	3.9361	$264.67	$68.90	$52.94	*
73550	X-ray exam of thigh	X	0260	0.6661	$44.79		$8.96	*
73560	X-ray exam of knee, 1 or 2	X	0260	0.6661	$44.79		$8.96	*
73562	X-ray exam of knee, 3	X	0260	0.6661	$44.79		$8.96	*
73564	X-ray exam, knee, 4 or more	X	0260	0.6661	$44.79		$8.96	*
73565	X-ray exam of knees	X	0260	0.6661	$44.79		$8.96	*
73580	Contrast x-ray of knee joint	Q2	0275	3.9361	$264.67	$68.90	$52.94	*
73590	X-ray exam of lower leg	X	0260	0.6661	$44.79		$8.96	*
73592	X-ray exam of leg, infant	X	0260	0.6661	$44.79		$8.96	*
73600	X-ray exam of ankle	X	0260	0.6661	$44.79		$8.96	*

73610	X-ray exam of ankle	X	0260	0.6661	$44.79		$8.96	*
73615	Contrast x-ray of ankle	Q2	0275	3.9361	$264.67	$68.90	$52.94	*
73620	X-ray exam of foot	X	0260	0.6661	$44.79		$8.96	*
73630	X-ray exam of foot	X	0260	0.6661	$44.79		$8.96	*
73650	X-ray exam of heel	X	0260	0.6661	$44.79		$8.96	*
73660	X-ray exam of toe(s)	X	0260	0.6661	$44.79		$8.96	*
73700	Ct lower extremity w/o dye	Q3	0332	2.894	$194.60	$75.24	$38.92	*
73701	Ct lower extremity w/dye	Q3	0283	4.4066	$296.30	$96.62	$59.26	*
73702	Ct lwr extremity w/o&w/dye	Q3	0333	4.9479	$332.70	$116.13	$66.54	*
73706	Ct angio lwr extr w/o&w/dye	Q3	0662	5.0511	$339.64	$114.75	$67.93	*
73718	Mri lower extremity w/o dye	Q3	0336	5.1855	$348.68	$137.40	$69.74	*
73719	Mri lower extremity w/dye	Q3	0284	6.2901	$422.95	$146.85	$84.59	*
73720	Mri lwr extremity w/o&w/dye	Q3	0337	7.9432	$534.11	$197.83	$106.83	*
73721	Mri jnt of lwr extre w/o dye	Q3	0336	5.1855	$348.68	$137.40	$69.74	*
73722	Mri joint of lwr extr w/dye	Q3	0284	6.2901	$422.95	$146.85	$84.59	*
73723	Mri joint lwr extr w/o&w/dye	Q3	0337	7.9432	$534.11	$197.83	$106.83	*
73725	Mr ang lwr ext w or w/o dye	B						
74000	X-ray exam of abdomen	X	0260	0.6661	$44.79		$8.96	*
74010	X-ray exam of abdomen	X	0260	0.6661	$44.79		$8.96	*
74020	X-ray exam of abdomen	X	0260	0.6661	$44.79		$8.96	*
74022	X-ray exam series, abdomen	X	0261	1.1161	$75.05		$15.01	*
74150	Ct abdomen w/o dye	Q3	0332	2.894	$194.60	$75.24	$38.92	*
74160	Ct abdomen w/dye	Q3	0283	4.4066	$296.30	$96.62	$59.26	*
74170	Ct abdomen w/o & w/dye	Q3	0333	4.9479	$332.70	$116.13	$66.54	*
74175	Ct angio abdom w/o & w/dye	Q3	0662	5.0511	$339.64	$114.75	$67.93	*
74181	Mri abdomen w/o dye	Q3	0336	5.1855	$348.68	$137.40	$69.74	*
74182	Mri abdomen w/dye	Q3	0284	6.2901	$422.95	$146.85	$84.59	*
74183	Mri abdomen w/o & w/dye	Q3	0337	7.9432	$534.11	$197.83	$106.83	*
74185	Mri angio, abdom w orw/o dye	B						
74190	X-ray exam of peritoneum	Q2	0263	3.1192	$209.74		$41.95	*
74210	Contrst x-ray exam of throat	S	0276	1.2985	$87.31	$34.66	$17.47	*
74220	Contrast x-ray, esophagus	S	0276	1.2985	$87.31	$34.66	$17.47	*
74230	Cine/vid x-ray, throat/esoph	S	0276	1.2985	$87.31	$34.66	$17.47	*
74235	Remove esophagus obstruction	N						
74240	X-ray exam, upper gi tract	S	0276	1.2985	$87.31	$34.66	$17.47	*
74241	X-ray exam, upper gi tract	S	0276	1.2985	$87.31	$34.66	$17.47	*
74245	X-ray exam, upper gi tract	S	0277	2.1001	$141.21	$53.90	$28.25	*
74246	Contrst x-ray uppr gi tract	S	0276	1.2985	$87.31	$34.66	$17.47	*
74247	Contrst x-ray uppr gi tract	S	0276	1.2985	$87.31	$34.66	$17.47	*
74249	Contrst x-ray uppr gi tract	S	0277	2.1001	$141.21	$53.90	$28.25	*
74250	X-ray exam of small bowel	S	0276	1.2985	$87.31	$34.66	$17.47	*
74251	X-ray exam of small bowel	S	0277	2.1001	$141.21	$53.90	$28.25	*
74260	X-ray exam of small bowel	S	0276	1.2985	$87.31	$34.66	$17.47	*
74261	Ct colonography, w/o dye	Q3	0332	2.894	$194.60	$75.24	$38.92	*
74262	Ct colonography, w/dye	Q3	0283	4.4066	$296.30	$96.62	$59.26	*
74263	Ct colonography, screen	E						
74270	Contrast x-ray exam of colon	S	0276	1.2985	$87.31	$34.66	$17.47	*
74280	Contrast x-ray exam of colon	S	0277	2.1001	$141.21	$53.90	$28.25	*
74283	Contrast x-ray exam of colon	S	0276	1.2985	$87.31	$34.66	$17.47	*
74290	Contrast x-ray, gallbladder	S	0276	1.2985	$87.31	$34.66	$17.47	*
74291	Contrast x-rays, gallbladder	S	0276	1.2985	$87.31	$34.66	$17.47	*
74300	X-ray bile ducts/pancreas	N						
74301	X-rays at surgery add-on	N						
74305	X-ray bile ducts/pancreas	Q2	0263	3.1192	$209.74		$41.95	*
74320	Contrast x-ray of bile ducts	Q2	0317	5.6012	$376.63		$75.33	*
74327	X-ray bile stone removal	N						
74328	X-ray bile duct endoscopy	N						
74329	X-ray for pancreas endoscopy	N						
74330	X-ray bile/panc endoscopy	N						
74340	X-ray guide for GI tube	N						
74355	X-ray guide, intestinal tube	N						
74360	X-ray guide, GI dilation	N						

74363	X-ray, bile duct dilation	N						
74400	Contrst x-ray, urinary tract	S	0278	2.546	$171.20	$58.44	$34.24	*
74410	Contrst x-ray, urinary tract	S	0278	2.546	$171.20	$58.44	$34.24	*
74415	Contrst x-ray, urinary tract	S	0278	2.546	$171.20	$58.44	$34.24	*
74420	Contrst x-ray, urinary tract	S	0278	2.546	$171.20	$58.44	$34.24	*
74425	Contrst x-ray, urinary tract	Q2	0278	2.546	$171.20	$58.44	$34.24	*
74430	Contrast x-ray, bladder	Q2	0278	2.546	$171.20	$58.44	$34.24	*
74440	X-ray, male genital tract	Q2	0278	2.546	$171.20	$58.44	$34.24	*
74445	X-ray exam of penis	Q2	0278	2.546	$171.20	$58.44	$34.24	*
74450	X-ray, urethra/bladder	Q2	0278	2.546	$171.20	$58.44	$34.24	*
74455	X-ray, urethra/bladder	Q2	0278	2.546	$171.20	$58.44	$34.24	*
74470	X-ray exam of kidney lesion	Q2	0263	3.1192	$209.74		$41.95	*
74475	X-ray control, cath insert	Q2	0161	17.0344	$1,145.41		$229.09	*
74480	X-ray control, cath insert	Q2	0161	17.0344	$1,145.41		$229.09	*
74485	X-ray guide, GU dilation	Q2	0161	17.0344	$1,145.41		$229.09	*
74710	X-ray measurement of pelvis	X	0261	1.1161	$75.05		$15.01	*
74740	X-ray, female genital tract	Q2	0263	3.1192	$209.74		$41.95	*
74742	X-ray, fallopian tube	N						
74775	X-ray exam of perineum	S	0278	2.546	$171.20	$58.44	$34.24	*
75557	Cardiac mri for morph	Q3	0336	5.1855	$348.68	$137.40	$69.74	*
75559	Cardiac mri w/stress img	Q3	0336	5.1855	$348.68	$137.40	$69.74	*
75561	Cardiac mri for morph w/dye	Q3	0337	7.9432	$534.11	$197.83	$106.83	*
75563	Card mri w/stress img & dye	Q3	0337	7.9432	$534.11	$197.83	$106.83	*
75565	Card mri vel flw map add-on	N						
75571	Ct hrt w/o dye w/ca test	X	0340	0.6693	$45.00		$9.00	*
75572	Ct hrt w/3d image	S	0383	3.9929	$268.49		$53.70	*
75573	Ct hrt w/3d image, congen	S	0383	3.9929	$268.49		$53.70	*
75574	Ct angio hrt w/3d image	S	0383	3.9929	$268.49		$53.70	*
75600	Contrast x-ray exam of aorta	Q2	0279	29.1126	$1,957.56		$391.52	*
75605	Contrast x-ray exam of aorta	Q2	0279	29.1126	$1,957.56		$391.52	*
75625	Contrast x-ray exam of aorta	Q2	0279	29.1126	$1,957.56		$391.52	*
75630	X-ray aorta, leg arteries	Q2	0279	29.1126	$1,957.56		$391.52	*
75635	Ct angio abdominal arteries	Q2	0662	5.0511	$339.64	$114.75	$67.93	*
75650	Artery x-rays, head & neck	Q2	0280	45.8793	$3,084.97		$617.00	*
75658	Artery x-rays, arm	Q2	0279	29.1126	$1,957.56		$391.52	*
75660	Artery x-rays, head & neck	Q2	0280	45.8793	$3,084.97		$617.00	*
75662	Artery x-rays, head & neck	Q2	0280	45.8793	$3,084.97		$617.00	*
75665	Artery x-rays, head & neck	Q2	0279	29.1126	$1,957.56		$391.52	*
75671	Artery x-rays, head & neck	Q2	0280	45.8793	$3,084.97		$617.00	*
75676	Artery x-rays, neck	Q2	0279	29.1126	$1,957.56		$391.52	*
75680	Artery x-rays, neck	Q2	0279	29.1126	$1,957.56		$391.52	*
75685	Artery x-rays, spine	Q2	0279	29.1126	$1,957.56		$391.52	*
75705	Artery x-rays, spine	Q2	0279	29.1126	$1,957.56		$391.52	*
75710	Artery x-rays, arm/leg	Q2	0279	29.1126	$1,957.56		$391.52	*
75716	Artery x-rays, arms/legs	Q2	0279	29.1126	$1,957.56		$391.52	*
75722	Artery x-rays, kidney	Q2	0279	29.1126	$1,957.56		$391.52	*
75724	Artery x-rays, kidneys	Q2	0279	29.1126	$1,957.56		$391.52	*
75726	Artery x-rays, abdomen	Q2	0279	29.1126	$1,957.56		$391.52	*
75731	Artery x-rays, adrenal gland	Q2	0279	29.1126	$1,957.56		$391.52	*
75733	Artery x-rays, adrenals	Q2	0279	29.1126	$1,957.56		$391.52	*
75736	Artery x-rays, pelvis	Q2	0279	29.1126	$1,957.56		$391.52	*
75741	Artery x-rays, lung	Q2	0279	29.1126	$1,957.56		$391.52	*
75743	Artery x-rays, lungs	Q2	0279	29.1126	$1,957.56		$391.52	*
75746	Artery x-rays, lung	Q2	0668	10.2978	$692.43		$138.49	*
75756	Artery x-rays, chest	Q2	0668	10.2978	$692.43		$138.49	*
75774	Artery x-ray, each vessel	N						
75791	Av dialysis shunt imaging	Q2	0676	2.3954	$161.07		$32.22	*
75801	Lymph vessel x-ray, arm/leg	Q2	0317	5.6012	$376.63		$75.33	*
75803	Lymph vessel x-ray,arms/legs	Q2	0317	5.6012	$376.63		$75.33	*
75805	Lymph vessel x-ray, trunk	Q2	0317	5.6012	$376.63		$75.33	*
75807	Lymph vessel x-ray, trunk	Q2	0317	5.6012	$376.63		$75.33	*
75809	Nonvascular shunt, x-ray	Q2	0261	1.1161	$75.05		$15.01	*

75810	Vein x-ray, spleen/liver	Q2	0279	29.1126	$1,957.56		$391.52	*
75820	Vein x-ray, arm/leg	Q2	0668	10.2978	$692.43		$138.49	*
75822	Vein x-ray, arms/legs	Q2	0668	10.2978	$692.43		$138.49	*
75825	Vein x-ray, trunk	Q2	0279	29.1126	$1,957.56		$391.52	*
75827	Vein x-ray, chest	Q2	0668	10.2978	$692.43		$138.49	*
75831	Vein x-ray, kidney	Q2	0279	29.1126	$1,957.56		$391.52	*
75833	Vein x-ray, kidneys	Q2	0279	29.1126	$1,957.56		$391.52	*
75840	Vein x-ray, adrenal gland	Q2	0279	29.1126	$1,957.56		$391.52	*
75842	Vein x-ray, adrenal glands	Q2	0279	29.1126	$1,957.56		$391.52	*
75860	Vein x-ray, neck	Q2	0668	10.2978	$692.43		$138.49	*
75870	Vein x-ray, skull	Q2	0668	10.2978	$692.43		$138.49	*
75872	Vein x-ray, skull	Q2	0668	10.2978	$692.43		$138.49	*
75880	Vein x-ray, eye socket	Q2	0668	10.2978	$692.43		$138.49	*
75885	Vein x-ray, liver	Q2	0279	29.1126	$1,957.56		$391.52	*
75887	Vein x-ray, liver	Q2	0668	10.2978	$692.43		$138.49	*
75889	Vein x-ray, liver	Q2	0279	29.1126	$1,957.56		$391.52	*
75891	Vein x-ray, liver	Q2	0279	29.1126	$1,957.56		$391.52	*
75893	Venous sampling by catheter	Q2	0279	29.1126	$1,957.56		$391.52	*
75894	X-rays, transcath therapy	N						
75896	X-rays, transcath therapy	N						
75898	Follow-up angiography	Q1	0261	1.1161	$75.05		$15.01	*
75900	Intravascular cath exchange	C						
75901	Remove cva device obstruct	N						
75902	Remove cva lumen obstruct	N						
75940	X-ray placement, vein filter	N						
75945	Intravascular us	Q2	0267	2.3005	$154.69	$60.50	$30.94	*
75946	Intravascular us add-on	N						
75952	Endovasc repair abdom aorta	C						
75953	Abdom aneurysm endovas rpr	C						
75954	Iliac aneurysm endovas rpr	C						
75956	Xray, endovasc thor ao repr	C						
75957	Xray, endovasc thor ao repr	C						
75958	Xray, place prox ext thor ao	C						
75959	Xray, place dist ext thor ao	C						
75960	Transcath iv stent rs&i	N						
75961	Retrieval, broken catheter	N						
75962	Repair arterial blockage	Q2	0083	50.6809	$3,407.83		$681.57	*
75964	Repair artery blockage, each	N						
75966	Repair arterial blockage	Q2	0083	50.6809	$3,407.83		$681.57	*
75968	Repair artery blockage, each	N						
75970	Vascular biopsy	N						
75978	Repair venous blockage	Q2	0093	35.5969	$2,393.57		$478.72	*
75980	Contrast xray exam bile duct	N						
75982	Contrast xray exam bile duct	N						
75984	Xray control catheter change	N						
75989	Abscess drainage under x-ray	N						
75992	Atherectomy, x-ray exam	N						
75993	Atherectomy, x-ray exam	N						
75994	Atherectomy, x-ray exam	N						
75995	Atherectomy, x-ray exam	N						
75996	Atherectomy, x-ray exam	N						
76000	Fluoroscope examination	Q1	0272	1.2693	$85.35	$31.15	$17.07	*
76001	Fluoroscope exam, extensive	N						
76010	X-ray, nose to rectum	X	0260	0.6661	$44.79		$8.96	*
76080	X-ray exam of fistula	Q2	0263	3.1192	$209.74		$41.95	*
76098	X-ray exam, breast specimen	Q2	0317	5.6012	$376.63		$75.33	*
76100	X-ray exam of body section	X	0261	1.1161	$75.05		$15.01	*
76101	Complex body section x-ray	X	0263	3.1192	$209.74		$41.95	*
76102	Complex body section x-rays	X	0263	3.1192	$209.74		$41.95	*
76120	Cine/video x-rays	X	0272	1.2693	$85.35	$31.15	$17.07	*
76125	Cine/video x-rays add-on	N						
76140	X-ray consultation	E						

76150	X-ray exam, dry process	X	0260	0.6661	$44.79		$8.96	*
76350	Special x-ray contrast study	N						
76376	3d render w/o postprocess	N						
76377	3d rendering w/postprocess	N						
76380	CAT scan follow-up study	S	0282	1.6291	$109.54	$37.81	$21.91	*
76390	Mr spectroscopy	E						
76496	Fluoroscopic procedure	X	0272	1.2693	$85.35	$31.15	$17.07	*
76497	Ct procedure	S	0282	1.6291	$109.54	$37.81	$21.91	*
76498	Mri procedure	S	0336	5.1855	$348.68	$137.40	$69.74	*
76499	Radiographic procedure	X	0260	0.6661	$44.79		$8.96	*
76506	Echo exam of head	S	0265	0.9267	$62.31	$22.28	$12.47	*
76510	Ophth us, b & quant a	T	0232	4.5074	$303.08	$75.93	$60.62	*
76511	Ophth us, quant a only	S	0266	1.4434	$97.06	$37.53	$19.42	*
76512	Ophth us, b w/non-quant a	S	0266	1.4434	$97.06	$37.53	$19.42	*
76513	Echo exam of eye, water bath	S	0266	1.4434	$97.06	$37.53	$19.42	*
76514	Echo exam of eye, thickness	X	0035	0.232	$15.60		$3.12	*
76516	Echo exam of eye	S	0265	0.9267	$62.31	$22.28	$12.47	*
76519	Echo exam of eye	S	0266	1.4434	$97.06	$37.53	$19.42	*
76529	Echo exam of eye	S	0265	0.9267	$62.31	$22.28	$12.47	*
76536	Us exam of head and neck	S	0266	1.4434	$97.06	$37.53	$19.42	*
76604	Us exam, chest	Q3	0265	0.9267	$62.31	$22.28	$12.47	*
76645	Us exam, breast(s)	S	0265	0.9267	$62.31	$22.28	$12.47	*
76700	Us exam, abdom, complete	Q3	0266	1.4434	$97.06	$37.53	$19.42	*
76705	Echo exam of abdomen	Q3	0266	1.4434	$97.06	$37.53	$19.42	*
76770	Us exam abdo back wall, comp	Q3	0266	1.4434	$97.06	$37.53	$19.42	*
76775	Us exam abdo back wall, lim	Q3	0266	1.4434	$97.06	$37.53	$19.42	*
76776	Us exam k transpl w/doppler	Q3	0266	1.4434	$97.06	$37.53	$19.42	*
76800	Us exam, spinal canal	S	0266	1.4434	$97.06	$37.53	$19.42	*
76801	Ob us < 14 wks, single fetus	S	0266	1.4434	$97.06	$37.53	$19.42	*
76802	Ob us < 14 wks, addl fetus	S	0265	0.9267	$62.31	$22.28	$12.47	*
76805	Ob us >/= 14 wks, sngl fetus	S	0266	1.4434	$97.06	$37.53	$19.42	*
76810	Ob us >/= 14 wks, addl fetus	S	0266	1.4434	$97.06	$37.53	$19.42	*
76811	Ob us, detailed, sngl fetus	S	0267	2.3005	$154.69	$60.50	$30.94	*
76812	Ob us, detailed, addl fetus	S	0265	0.9267	$62.31	$22.28	$12.47	*
76813	Ob us nuchal meas, 1 gest	S	0265	0.9267	$62.31	$22.28	$12.47	*
76814	Ob us nuchal meas, add-on	S	0265	0.9267	$62.31	$22.28	$12.47	*
76815	Ob us, limited, fetus(s)	S	0265	0.9267	$62.31	$22.28	$12.47	*
76816	Ob us, follow-up, per fetus	S	0265	0.9267	$62.31	$22.28	$12.47	*
76817	Transvaginal us, obstetric	S	0265	0.9267	$62.31	$22.28	$12.47	*
76818	Fetal biophys profile w/nst	S	0266	1.4434	$97.06	$37.53	$19.42	*
76819	Fetal biophys profil w/o nst	S	0266	1.4434	$97.06	$37.53	$19.42	*
76820	Umbilical artery echo	S	0265	0.9267	$62.31	$22.28	$12.47	*
76821	Middle cerebral artery echo	S	0265	0.9267	$62.31	$22.28	$12.47	*
76825	Echo exam of fetal heart	S	0270	8.8425	$594.58	$141.32	$118.92	*
76826	Echo exam of fetal heart	S	0269	6.6903	$449.86		$89.98	*
76827	Echo exam of fetal heart	S	0265	0.9267	$62.31	$22.28	$12.47	*
76828	Echo exam of fetal heart	S	0265	0.9267	$62.31	$22.28	$12.47	*
76830	Transvaginal us, non-ob	S	0266	1.4434	$97.06	$37.53	$19.42	*
76831	Echo exam, uterus	Q3	0267	2.3005	$154.69	$60.50	$30.94	*
76856	Us exam, pelvic, complete	Q3	0266	1.4434	$97.06	$37.53	$19.42	*
76857	Us exam, pelvic, limited	Q3	0265	0.9267	$62.31	$22.28	$12.47	*
76870	Us exam, scrotum	Q3	0266	1.4434	$97.06	$37.53	$19.42	*
76872	Us, transrectal	S	0266	1.4434	$97.06	$37.53	$19.42	*
76873	Echograp trans r, pros study	S	0266	1.4434	$97.06	$37.53	$19.42	*
76880	Us exam, extremity	S	0266	1.4434	$97.06	$37.53	$19.42	*
76885	Us exam infant hips, dynamic	S	0265	0.9267	$62.31	$22.28	$12.47	*
76886	Us exam infant hips, static	S	0265	0.9267	$62.31	$22.28	$12.47	*
76930	Echo guide, cardiocentesis	N						
76932	Echo guide for heart biopsy	N						
76936	Echo guide for artery repair	S	0096	1.6075	$108.09	$37.42	$21.62	*
76937	Us guide, vascular access	N						
76940	Us guide, tissue ablation	N						

76941	Echo guide for transfusion	N						
76942	Echo guide for biopsy	N						
76945	Echo guide, villus sampling	N						
76946	Echo guide for amniocentesis	N						
76948	Echo guide, ova aspiration	N						
76950	Echo guidance radiotherapy	N						
76965	Echo guidance radiotherapy	N						
76970	Ultrasound exam follow-up	S	0265	0.9267	$62.31	$22.28	$12.47	*
76975	GI endoscopic ultrasound	Q2	0267	2.3005	$154.69	$60.50	$30.94	*
76977	Us bone density measure	X	0340	0.6693	$45.00		$9.00	*
76998	Us guide, intraop	N						
76999	Echo examination procedure	S	0265	0.9267	$62.31	$22.28	$12.47	*
77001	Fluoroguide for vein device	N						
77002	Needle localization by xray	N						
77003	Fluoroguide for spine inject	N						
77011	Ct scan for localization	N						
77012	Ct scan for needle biopsy	N						
77013	Ct guide for tissue ablation	N						
77014	Ct scan for therapy guide	N						
77021	Mr guidance for needle place	N						
77022	Mri for tissue ablation	N						
77031	Stereotact guide for brst bx	N						
77032	Guidance for needle, breast	N						
77051	Computer dx mammogram add-on	A						
77052	Comp screen mammogram add-on	A						
77053	X-ray of mammary duct	Q2	0263	3.1192	$209.74		$41.95	*
77054	X-ray of mammary ducts	Q2	0263	3.1192	$209.74		$41.95	*
77055	Mammogram, one breast	A						
77056	Mammogram, both breasts	A						
77057	Mammogram, screening	A						

77058	Mri, one breast	B						
77059	Mri, both breasts	B						
77071	X-ray stress view	X	0260	0.6661	$44.79		$8.96	*
77072	X-rays for bone age	X	0260	0.6661	$44.79		$8.96	*
77073	X-rays, bone length studies	X	0260	0.6661	$44.79		$8.96	*
77074	X-rays, bone survey, limited	X	0261	1.1161	$75.05		$15.01	*
77075	X-rays, bone survey complete	X	0261	1.1161	$75.05		$15.01	*
77076	X-rays, bone survey, infant	X	0261	1.1161	$75.05		$15.01	*
77077	Joint survey, single view	X	0260	0.6661	$44.79		$8.96	*
77078	Ct bone density, axial	S	0288	1.0755	$72.32	$28.66	$14.47	*
77079	Ct bone density, peripheral	S	0282	1.6291	$109.54	$37.81	$21.91	*
77080	Dxa bone density, axial	S	0288	1.0755	$72.32	$28.66	$14.47	*
77081	Dxa bone density/peripheral	S	0665	0.4318	$29.03	$11.60	$5.81	*
77082	Dxa bone density, vert fx	X	0260	0.6661	$44.79		$8.96	*
77083	Radiographic absorptiometry	X	0261	1.1161	$75.05		$15.01	*
77084	Magnetic image, bone marrow	S	0336	5.1855	$348.68	$137.40	$69.74	*
77261	Radiation therapy planning	B						
77262	Radiation therapy planning	B						
77263	Radiation therapy planning	B						
77280	Set radiation therapy field	X	0304	1.5271	$102.68	$34.63	$20.54	*
77285	Set radiation therapy field	X	0305	3.951	$265.67	$91.38	$53.14	*
77290	Set radiation therapy field	X	0305	3.951	$265.67	$91.38	$53.14	*
77295	Set radiation therapy field	X	0310	13.7576	$925.07	$325.27	$185.02	*
77299	Radiation therapy planning	X	0304	1.5271	$102.68	$34.63	$20.54	*
77300	Radiation therapy dose plan	X	0304	1.5271	$102.68	$34.63	$20.54	*
77301	Radiotherapy dose plan, imrt	X	0310	13.7576	$925.07	$325.27	$185.02	*
77305	Teletx isodose plan simple	X	0304	1.5271	$102.68	$34.63	$20.54	*
77310	Teletx isodose plan intermed	X	0304	1.5271	$102.68	$34.63	$20.54	*
77315	Teletx isodose plan complex	X	0305	3.951	$265.67	$91.38	$53.14	*
77321	Special teletx port plan	X	0305	3.951	$265.67	$91.38	$53.14	*
77326	Brachytx isodose calc simp	X	0304	1.5271	$102.68	$34.63	$20.54	*

77327	Brachytx isodose calc interm	X	0305	3.951	$265.67	$91.38	$53.14	*
77328	Brachytx isodose plan compl	X	0305	3.951	$265.67	$91.38	$53.14	*
77331	Special radiation dosimetry	X	0304	1.5271	$102.68	$34.63	$20.54	*
77332	Radiation treatment aid(s)	X	0303	2.8279	$190.15	$66.95	$38.03	*
77333	Radiation treatment aid(s)	X	0303	2.8279	$190.15	$66.95	$38.03	*
77334	Radiation treatment aid(s)	X	0303	2.8279	$190.15	$66.95	$38.03	*
77336	Radiation physics consult	X	0304	1.5271	$102.68	$34.63	$20.54	*
77338	Design mlc device for imrt	X	0303	2.8279	$190.15	$66.95	$38.03	*
77370	Radiation physics consult	X	0304	1.5271	$102.68	$34.63	$20.54	*
77371	Srs, multisource	S	0127	108.9558	$7,326.30		$1,465.26	*
77372	Srs, linear based	B						
77373	Sbrt delivery	B						
77399	External radiation dosimetry	X	0304	1.5271	$102.68	$34.63	$20.54	*
77401	Radiation treatment delivery	S	0300	1.3764	$92.55		$18.51	*
77402	Radiation treatment delivery	S	0300	1.3764	$92.55		$18.51	*
77403	Radiation treatment delivery	S	0300	1.3764	$92.55		$18.51	*
77404	Radiation treatment delivery	S	0300	1.3764	$92.55		$18.51	*
77406	Radiation treatment delivery	S	0301	2.303	$154.86		$30.98	*
77407	Radiation treatment delivery	S	0300	1.3764	$92.55		$18.51	*
77408	Radiation treatment delivery	S	0300	1.3764	$92.55		$18.51	*
77409	Radiation treatment delivery	S	0300	1.3764	$92.55		$18.51	*
77411	Radiation treatment delivery	S	0301	2.303	$154.86		$30.98	*
77412	Radiation treatment delivery	S	0301	2.303	$154.86		$30.98	*
77413	Radiation treatment delivery	S	0301	2.303	$154.86		$30.98	*
77414	Radiation treatment delivery	S	0301	2.303	$154.86		$30.98	*
77416	Radiation treatment delivery	S	0301	2.303	$154.86		$30.98	*
77417	Radiology port film(s)	N						
77418	Radiation tx delivery, imrt	S	0412	6.249	$420.19		$84.04	*
77421	Stereoscopic x-ray guidance	N						
77422	Neutron beam tx, simple	S	0301	2.303	$154.86		$30.98	*
77423	Neutron beam tx, complex	S	0301	2.303	$154.86		$30.98	*
77427	Radiation tx management, x5	B						
77431	Radiation therapy management	B						
77432	Stereotactic radiation trmt	B						
77435	Sbrt management	N						
77470	Special radiation treatment	S	0299	5.6461	$379.65		$75.93	*
77499	Radiation therapy management	B						
77520	Proton trmt, simple w/o comp	S	0664	13.9796	$940.00		$188.00	*
77522	Proton trmt, simple w/comp	S	0664	13.9796	$940.00		$188.00	*
77523	Proton trmt, intermediate	S	0667	18.2873	$1,229.66		$245.94	*
77525	Proton treatment, complex	S	0667	18.2873	$1,229.66		$245.94	*
77600	Hyperthermia treatment	S	0299	5.6461	$379.65		$75.93	*
77605	Hyperthermia treatment	S	0299	5.6461	$379.65		$75.93	*
77610	Hyperthermia treatment	S	0299	5.6461	$379.65		$75.93	*
77615	Hyperthermia treatment	S	0299	5.6461	$379.65		$75.93	*
77620	Hyperthermia treatment	S	0299	5.6461	$379.65		$75.93	*
77750	Infuse radioactive materials	S	0301	2.303	$154.86		$30.98	*
77761	Apply intrcav radiat simple	S	0312	4.4846	$301.55		$60.31	*
77762	Apply intrcav radiat interm	S	0312	4.4846	$301.55		$60.31	*
77763	Apply intrcav radiat compl	S	0312	4.4846	$301.55		$60.31	*
77776	Apply interstit radiat simpl	S	0312	4.4846	$301.55		$60.31	*
77777	Apply interstit radiat inter	S	0312	4.4846	$301.55		$60.31	*
77778	Apply interstit radiat compl	Q3	0651	13.2555	$891.31		$178.27	*
77785	Hdr brachytx, 1 channel	S	0313	11.5353	$775.65	$293.30	$155.13	*
77786	Hdr brachytx, 2-12 channel	S	0313	11.5353	$775.65	$293.30	$155.13	*
77787	Hdr brachytx over 12 chan	S	0313	11.5353	$775.65	$293.30	$155.13	*
77789	Apply surface radiation	S	0300	1.3764	$92.55		$18.51	*
77790	Radiation handling	N						
77799	Radium/radioisotope therapy	S	0312	4.4846	$301.55		$60.31	*
78000	Thyroid, single uptake	S	0389	1.6695	$112.26	$29.94	$22.46	*
78001	Thyroid, multiple uptakes	S	0389	1.6695	$112.26	$29.94	$22.46	*
78003	Thyroid suppress/stimul	S	0389	1.6695	$112.26	$29.94	$22.46	*

78006	Thyroid imaging with uptake	S	0391	3.2894	$221.18	$65.96	$44.24	*
78007	Thyroid image, mult uptakes	S	0391	3.2894	$221.18	$65.96	$44.24	*
78010	Thyroid imaging	S	0390	2.1595	$145.21	$52.15	$29.05	*
78011	Thyroid imaging with flow	S	0390	2.1595	$145.21	$52.15	$29.05	*
78015	Thyroid met imaging	S	0406	4.3034	$289.36	$88.01	$57.88	*
78016	Thyroid met imaging/studies	S	0406	4.3034	$289.36	$88.01	$57.88	*
78018	Thyroid met imaging, body	S	0406	4.3034	$289.36	$88.01	$57.88	*
78020	Thyroid met uptake	N						
78070	Parathyroid nuclear imaging	S	0391	3.2894	$221.18	$65.96	$44.24	*
78075	Adrenal nuclear imaging	S	0408	14.2874	$960.70		$192.14	*
78099	Endocrine nuclear procedure	S	0390	2.1595	$145.21	$52.15	$29.05	*
78102	Bone marrow imaging, ltd	S	0400	3.8342	$257.82	$91.52	$51.57	*
78103	Bone marrow imaging, mult	S	0400	3.8342	$257.82	$91.52	$51.57	*
78104	Bone marrow imaging, body	S	0400	3.8342	$257.82	$91.52	$51.57	*
78110	Plasma volume, single	S	0393	5.7873	$389.14	$79.77	$77.83	*
78111	Plasma volume, multiple	S	0393	5.7873	$389.14	$79.77	$77.83	*
78120	Red cell mass, single	S	0393	5.7873	$389.14	$79.77	$77.83	*
78121	Red cell mass, multiple	S	0393	5.7873	$389.14	$79.77	$77.83	*
78122	Blood volume	S	0393	5.7873	$389.14	$79.77	$77.83	*
78130	Red cell survival study	S	0393	5.7873	$389.14	$79.77	$77.83	*
78135	Red cell survival kinetics	S	0393	5.7873	$389.14	$79.77	$77.83	*
78140	Red cell sequestration	S	0393	5.7873	$389.14	$79.77	$77.83	*
78185	Spleen imaging	S	0400	3.8342	$257.82	$91.52	$51.57	*
78190	Platelet survival, kinetics	S	0392	2.6817	$180.32	$43.95	$36.07	*
78191	Platelet survival	S	0392	2.6817	$180.32	$43.95	$36.07	*
78195	Lymph system imaging	S	0400	3.8342	$257.82	$91.52	$51.57	*
78199	Blood/lymph nuclear exam	S	0400	3.8342	$257.82	$91.52	$51.57	*
78201	Liver imaging	S	0394	4.3139	$290.07	$99.32	$58.02	*
78202	Liver imaging with flow	S	0394	4.3139	$290.07	$99.32	$58.02	*
78205	Liver imaging (3D)	S	0394	4.3139	$290.07	$99.32	$58.02	*
78206	Liver image (3d) with flow	S	0394	4.3139	$290.07	$99.32	$58.02	*
78215	Liver and spleen imaging	S	0394	4.3139	$290.07	$99.32	$58.02	*
78216	Liver & spleen image/flow	S	0394	4.3139	$290.07	$99.32	$58.02	*
78220	Liver function study	S	0394	4.3139	$290.07	$99.32	$58.02	*
78223	Hepatobiliary imaging	S	0394	4.3139	$290.07	$99.32	$58.02	*
78230	Salivary gland imaging	S	0395	3.6702	$246.79	$89.73	$49.36	*
78231	Serial salivary imaging	S	0395	3.6702	$246.79	$89.73	$49.36	*
78232	Salivary gland function exam	S	0395	3.6702	$246.79	$89.73	$49.36	*
78258	Esophageal motility study	S	0395	3.6702	$246.79	$89.73	$49.36	*
78261	Gastric mucosa imaging	S	0395	3.6702	$246.79	$89.73	$49.36	*
78262	Gastroesophageal reflux exam	S	0395	3.6702	$246.79	$89.73	$49.36	*
78264	Gastric emptying study	S	0395	3.6702	$246.79	$89.73	$49.36	*
78267	Breath tst attain/anal c-14	A						
78268	Breath test analysis, c-14	A						
78270	Vit B-12 absorption exam	S	0392	2.6817	$180.32	$43.95	$36.07	*
78271	Vit b-12 absrp exam, int fac	S	0392	2.6817	$180.32	$43.95	$36.07	*
78272	Vit B-12 absorp, combined	S	0392	2.6817	$180.32	$43.95	$36.07	*
78278	Acute GI blood loss imaging	S	0395	3.6702	$246.79	$89.73	$49.36	*
78282	GI protein loss exam	S	0395	3.6702	$246.79	$89.73	$49.36	*
78290	Meckels divert exam	S	0395	3.6702	$246.79	$89.73	$49.36	*
78291	Leveen/shunt patency exam	S	0395	3.6702	$246.79	$89.73	$49.36	*
78299	GI nuclear procedure	S	0395	3.6702	$246.79	$89.73	$49.36	*
78300	Bone imaging, limited area	S	0396	3.6707	$246.82	$95.02	$49.37	*
78305	Bone imaging, multiple areas	S	0396	3.6707	$246.82	$95.02	$49.37	*
78306	Bone imaging, whole body	S	0396	3.6707	$246.82	$95.02	$49.37	*
78315	Bone imaging, 3 phase	S	0396	3.6707	$246.82	$95.02	$49.37	*
78320	Bone imaging (3D)	S	0396	3.6707	$246.82	$95.02	$49.37	*
78350	Bone mineral, single photon	E						
78351	Bone mineral, dual photon	E						
78399	Musculoskeletal nuclear exam	S	0396	3.6707	$246.82	$95.02	$49.37	*
78414	Non-imaging heart function	S	0398	4.5366	$305.05	$97.71	$61.01	*
78428	Cardiac shunt imaging	S	0398	4.5366	$305.05	$97.71	$61.01	*

78445	Vascular flow imaging	S	0397	2.9679	$199.56	$46.29	$39.92	*
78451	Ht muscle image spect, sing	S	0377	11.4989	$773.20		$154.64	*
78452	Ht muscle image spect, mult	S	0377	11.4989	$773.20		$154.64	*
78453	Ht muscle image,planar,sing	S	0377	11.4989	$773.20		$154.64	*
78454	Ht musc image, planar, mult	S	0377	11.4989	$773.20		$154.64	*
78456	Acute venous thrombus image	S	0397	2.9679	$199.56	$46.29	$39.92	*
78457	Venous thrombosis imaging	S	0397	2.9679	$199.56	$46.29	$39.92	*
78458	Ven thrombosis images, bilat	S	0397	2.9679	$199.56	$46.29	$39.92	*
78459	Heart muscle imaging (PET)	S	0307	21.2573	$1,429.36		$285.88	*
78466	Heart infarct image	S	0398	4.5366	$305.05	$97.71	$61.01	*
78468	Heart infarct image (ef)	S	0398	4.5366	$305.05	$97.71	$61.01	*
78469	Heart infarct image (3D)	S	0398	4.5366	$305.05	$97.71	$61.01	*
78472	Gated heart, planar, single	S	0398	4.5366	$305.05	$97.71	$61.01	*
78473	Gated heart, multiple	S	0398	4.5366	$305.05	$97.71	$61.01	*
78481	Heart first pass, single	S	0398	4.5366	$305.05	$97.71	$61.01	*
78483	Heart first pass, multiple	S	0398	4.5366	$305.05	$97.71	$61.01	*
78491	Heart image (pet), single	S	0307	21.2573	$1,429.36		$285.88	*
78492	Heart image (pet), multiple	S	0307	21.2573	$1,429.36		$285.88	*
78494	Heart image, spect	S	0398	4.5366	$305.05	$97.71	$61.01	*
78496	Heart first pass add-on	N						
78499	Cardiovascular nuclear exam	S	0398	4.5366	$305.05	$97.71	$61.01	*
78580	Lung perfusion imaging	S	0401	3.0625	$205.93	$74.45	$41.19	*
78584	Lung V/Q image single breath	S	0378	4.8032	$322.97	$124.64	$64.60	*
78585	Lung V/Q imaging	S	0378	4.8032	$322.97	$124.64	$64.60	*
78586	Aerosol lung image, single	S	0401	3.0625	$205.93	$74.45	$41.19	*
78587	Aerosol lung image, multiple	S	0401	3.0625	$205.93	$74.45	$41.19	*
78588	Perfusion lung image	S	0378	4.8032	$322.97	$124.64	$64.60	*
78591	Vent image, 1 breath, 1 proj	S	0401	3.0625	$205.93	$74.45	$41.19	*
78593	Vent image, 1 proj, gas	S	0401	3.0625	$205.93	$74.45	$41.19	*
78594	Vent image, mult proj, gas	S	0401	3.0625	$205.93	$74.45	$41.19	*
78596	Lung differential function	S	0378	4.8032	$322.97	$124.64	$64.60	*
78599	Respiratory nuclear exam	S	0401	3.0625	$205.93	$74.45	$41.19	*
78600	Brain image < 4 views	S	0403	2.9181	$196.22	$72.42	$39.25	*
78601	Brain image w/flow < 4 views	S	0402	8.5845	$577.23		$115.45	*
78605	Brain image 4+ views	S	0403	2.9181	$196.22	$72.42	$39.25	*
78606	Brain image w/flow 4 + views	S	0402	8.5845	$577.23		$115.45	*
78607	Brain imaging (3D)	S	0402	8.5845	$577.23		$115.45	*
78608	Brain imaging (PET)	S	0308	15.3895	$1,034.81		$206.97	*
78609	Brain imaging (PET)	E						
78610	Brain flow imaging only	S	0403	2.9181	$196.22	$72.42	$39.25	*
78630	Cerebrospinal fluid scan	S	0402	8.5845	$577.23		$115.45	*
78635	CSF ventriculography	S	0402	8.5845	$577.23		$115.45	*
78645	CSF shunt evaluation	S	0403	2.9181	$196.22	$72.42	$39.25	*
78647	Cerebrospinal fluid scan	S	0402	8.5845	$577.23		$115.45	*
78650	CSF leakage imaging	S	0402	8.5845	$577.23		$115.45	*
78660	Nuclear exam of tear flow	S	0403	2.9181	$196.22	$72.42	$39.25	*
78699	Nervous system nuclear exam	S	0403	2.9181	$196.22	$72.42	$39.25	*
78700	Kidney imaging, morphol	S	0404	4.8221	$324.24	$82.90	$64.85	*
78701	Kidney imaging with flow	S	0404	4.8221	$324.24	$82.90	$64.85	*
78707	K flow/funct image w/o drug	S	0404	4.8221	$324.24	$82.90	$64.85	*
78708	K flow/funct image w/drug	S	0404	4.8221	$324.24	$82.90	$64.85	*
78709	K flow/funct image, multiple	S	0404	4.8221	$324.24	$82.90	$64.85	*
78710	Kidney imaging (3D)	S	0404	4.8221	$324.24	$82.90	$64.85	*
78725	Kidney function study	S	0392	2.6817	$180.32	$43.95	$36.07	*
78730	Urinary bladder retention	S	0389	1.6695	$112.26	$29.94	$22.46	*
78740	Ureteral reflux study	S	0404	4.8221	$324.24	$82.90	$64.85	*
78761	Testicular imaging w/flow	S	0404	4.8221	$324.24	$82.90	$64.85	*
78799	Genitourinary nuclear exam	S	0404	4.8221	$324.24	$82.90	$64.85	*
78800	Tumor imaging, limited area	S	0406	4.3034	$289.36	$88.01	$57.88	*
78801	Tumor imaging, mult areas	S	0414	7.5722	$509.16		$101.84	*
78802	Tumor imaging, whole body	S	0414	7.5722	$509.16		$101.84	*
78803	Tumor imaging (3D)	S	0414	7.5722	$509.16		$101.84	*

78804	Tumor imaging, whole body	S	0408	14.2874	$960.70		$192.14	*
78805	Abscess imaging, ltd area	S	0414	7.5722	$509.16		$101.84	*
78806	Abscess imaging, whole body	S	0414	7.5722	$509.16		$101.84	*
78807	Nuclear localization/abscess	S	0406	4.3034	$289.36	$88.01	$57.88	*
78808	Iv inj ra drug dx study	Q1	0392	2.6817	$180.32	$43.95	$36.07	*
78811	Pet image, ltd area	S	0308	15.3895	$1,034.81		$206.97	*
78812	Pet image, skull-thigh	S	0308	15.3895	$1,034.81		$206.97	*
78813	Pet image, full body	S	0308	15.3895	$1,034.81		$206.97	*
78814	Pet image w/ct, lmtd	S	0308	15.3895	$1,034.81		$206.97	*
78815	Pet image w/ct, skull-thigh	S	0308	15.3895	$1,034.81		$206.97	*
78816	Pet image w/ct, full body	S	0308	15.3895	$1,034.81		$206.97	*
78999	Nuclear diagnostic exam	S	0389	1.6695	$112.26	$29.94	$22.46	*
79005	Nuclear rx, oral admin	S	0407	3.2356	$217.56	$78.13	$43.52	*
79101	Nuclear rx, iv admin	S	0407	3.2356	$217.56	$78.13	$43.52	*
79200	Nuclear rx, intracav admin	S	0413	5.2007	$349.70		$69.94	*
79300	Nuclr rx, interstit colloid	S	0407	3.2356	$217.56	$78.13	$43.52	*
79403	Hematopoietic nuclear tx	S	0413	5.2007	$349.70		$69.94	*
79440	Nuclear rx, intra-articular	S	0413	5.2007	$349.70		$69.94	*
79445	Nuclear rx, intra-arterial	S	0407	3.2356	$217.56	$78.13	$43.52	*
79999	Nuclear medicine therapy	S	0407	3.2356	$217.56	$78.13	$43.52	*
80047	Metabolic panel ionized ca	A						
80048	Metabolic panel total ca	A						
80050	General health panel	E						
80051	Electrolyte panel	A						
80053	Comprehen metabolic panel	A						
80055	Obstetric panel	E						
80061	Lipid panel	A						
80069	Renal function panel	A						
80074	Acute hepatitis panel	A						
80076	Hepatic function panel	A						
80100	Drug screen, qualitate/multi	A						
80101	Drug screen, single	A						
80102	Drug confirmation	A						
80103	Drug analysis, tissue prep	N						
80150	Assay of amikacin	A						
80152	Assay of amitriptyline	A						
80154	Assay of benzodiazepines	A						
80156	Assay, carbamazepine, total	A						
80157	Assay, carbamazepine, free	A						
80158	Assay of cyclosporine	A						
80160	Assay of desipramine	A						
80162	Assay of digoxin	A						
80164	Assay, dipropylacetic acid	A						
80166	Assay of doxepin	A						
80168	Assay of ethosuximide	A						
80170	Assay of gentamicin	A						
80172	Assay of gold	A						
80173	Assay of haloperidol	A						
80174	Assay of imipramine	A						
80176	Assay of lidocaine	A						
80178	Assay of lithium	A						
80182	Assay of nortriptyline	A						
80184	Assay of phenobarbital	A						
80185	Assay of phenytoin, total	A						
80186	Assay of phenytoin, free	A						
80188	Assay of primidone	A						
80190	Assay of procainamide	A						
80192	Assay of procainamide	A						
80194	Assay of quinidine	A						
80195	Assay of sirolimus	A						
80196	Assay of salicylate	A						
80197	Assay of tacrolimus	A						

80198	Assay of theophylline	A						
80200	Assay of tobramycin	A						
80201	Assay of topiramate	A						
80202	Assay of vancomycin	A						
80299	Quantitative assay, drug	A						
80400	Acth stimulation panel	A						
80402	Acth stimulation panel	A						
80406	Acth stimulation panel	A						
80408	Aldosterone suppression eval	A						
80410	Calcitonin stimul panel	A						
80412	CRH stimulation panel	A						
80414	Testosterone response	A						
80415	Estradiol response panel	A						
80416	Renin stimulation panel	A						
80417	Renin stimulation panel	A						
80418	Pituitary evaluation panel	A						
80420	Dexamethasone panel	A						
80422	Glucagon tolerance panel	A						
80424	Glucagon tolerance panel	A						
80426	Gonadotropin hormone panel	A						
80428	Growth hormone panel	A						
80430	Growth hormone panel	A						
80432	Insulin suppression panel	A						
80434	Insulin tolerance panel	A						
80435	Insulin tolerance panel	A						
80436	Metyrapone panel	A						
80438	TRH stimulation panel	A						
80439	TRH stimulation panel	A						
80440	TRH stimulation panel	A						
80500	Lab pathology consultation	X	0433	0.2482	$16.69	$5.17	$3.34	*
80502	Lab pathology consultation	X	0342	0.1546	$10.40		$2.08	*

81000	Urinalysis, nonauto w/scope	A						
81001	Urinalysis, auto w/scope	A						
81002	Urinalysis nonauto w/o scope	A						
81003	Urinalysis, auto, w/o scope	A						
81005	Urinalysis	A						
81007	Urine screen for bacteria	A						
81015	Microscopic exam of urine	A						
81020	Urinalysis, glass test	A						
81025	Urine pregnancy test	A						
81050	Urinalysis, volume measure	A						
81099	Urinalysis test procedure	A						
82000	Assay of blood acetaldehyde	A						
82003	Assay of acetaminophen	A						
82009	Test for acetone/ketones	A						
82010	Acetone assay	A						
82013	Acetylcholinesterase assay	A						
82016	Acylcarnitines, qual	A						
82017	Acylcarnitines, quant	A						
82024	Assay of acth	A						
82030	Assay of adp & amp	A						
82040	Assay of serum albumin	A						
82042	Assay of urine albumin	A						
82043	Microalbumin, quantitative	A						
82044	Microalbumin, semiquant	A						
82045	Albumin, ischemia modified	A						
82055	Assay of ethanol	A						
82075	Assay of breath ethanol	A						
82085	Assay of aldolase	A						
82088	Assay of aldosterone	A						
82101	Assay of urine alkaloids	A						
82103	Alpha-1-antitrypsin, total	A						

82104	Alpha-1-antitrypsin, pheno	A						
82105	Alpha-fetoprotein, serum	A						
82106	Alpha-fetoprotein, amniotic	A						
82107	Alpha-fetoprotein l3	A						
82108	Assay of aluminum	A						
82120	Amines, vaginal fluid qual	A						
82127	Amino acid, single qual	A						
82128	Amino acids, mult qual	A						
82131	Amino acids, single quant	A						
82135	Assay, aminolevulinic acid	A						
82136	Amino acids, quant, 2-5	A						
82139	Amino acids, quan, 6 or more	A						
82140	Assay of ammonia	A						
82143	Amniotic fluid scan	A						
82145	Assay of amphetamines	A						
82150	Assay of amylase	A						
82154	Androstanediol glucuronide	A						
82157	Assay of androstenedione	A						
82160	Assay of androsterone	A						
82163	Assay of angiotensin II	A						
82164	Angiotensin I enzyme test	A						
82172	Assay of apolipoprotein	A						
82175	Assay of arsenic	A						
82180	Assay of ascorbic acid	A						
82190	Atomic absorption	A						
82205	Assay of barbiturates	A						
82232	Assay of beta-2 protein	A						
82239	Bile acids, total	A						
82240	Bile acids, cholylglycine	A						
82247	Bilirubin, total	A						
82248	Bilirubin, direct	A						
82252	Fecal bilirubin test	A						
82261	Assay of biotinidase	A						
82270	Occult blood, feces	A						
82271	Occult blood, other sources	A						
82272	Occult bld feces, 1-3 tests	A						
82274	Assay test for blood, fecal	A						
82286	Assay of bradykinin	A						
82300	Assay of cadmium	A						
82306	Vitamin d, 25 hydroxy	A						
82308	Assay of calcitonin	A						
82310	Assay of calcium	A						
82330	Assay of calcium	A						
82331	Calcium infusion test	A						
82340	Assay of calcium in urine	A						
82355	Calculus analysis, qual	A						
82360	Calculus assay, quant	A						
82365	Calculus spectroscopy	A						
82370	X-ray assay, calculus	A						
82373	Assay, c-d transfer measure	A						
82374	Assay, blood carbon dioxide	A						
82375	Assay, carboxyhb, quant	A						
82376	Assay, carboxyhb, qual	A						
82378	Carcinoembryonic antigen	A						
82379	Assay of carnitine	A						
82380	Assay of carotene	A						
82382	Assay, urine catecholamines	A						
82383	Assay, blood catecholamines	A						
82384	Assay, three catecholamines	A						
82387	Assay of cathepsin-d	A						
82390	Assay of ceruloplasmin	A						
82397	Chemiluminescent assay	A						

82415	Assay of chloramphenicol	A						
82435	Assay of blood chloride	A						
82436	Assay of urine chloride	A						
82438	Assay, other fluid chlorides	A						
82441	Test for chlorohydrocarbons	A						
82465	Assay, bld/serum cholesterol	A						
82480	Assay, serum cholinesterase	A						
82482	Assay, rbc cholinesterase	A						
82485	Assay, chondroitin sulfate	A						
82486	Gas/liquid chromatography	A						
82487	Paper chromatography	A						
82488	Paper chromatography	A						
82489	Thin layer chromatography	A						
82491	Chromotography, quant, sing	A						
82492	Chromotography, quant, mult	A						
82495	Assay of chromium	A						
82507	Assay of citrate	A						
82520	Assay of cocaine	A						
82523	Collagen crosslinks	A						
82525	Assay of copper	A						
82528	Assay of corticosterone	A						
82530	Cortisol, free	A						
82533	Total cortisol	A						
82540	Assay of creatine	A						
82541	Column chromotography, qual	A						
82542	Column chromotography, quant	A						
82543	Column chromotograph/isotope	A						
82544	Column chromotograph/isotope	A						
82550	Assay of ck (cpk)	A						
82552	Assay of cpk in blood	A						
82553	Creatine, MB fraction	A						

82554	Creatine, isoforms	A						
82565	Assay of creatinine	A						
82570	Assay of urine creatinine	A						
82575	Creatinine clearance test	A						
82585	Assay of cryofibrinogen	A						
82595	Assay of cryoglobulin	A						
82600	Assay of cyanide	A						
82607	Vitamin B-12	A						
82608	B-12 binding capacity	A						
82610	Cystatin c	A						
82615	Test for urine cystines	A						
82626	Dehydroepiandrosterone	A						
82627	Dehydroepiandrosterone	A						
82633	Desoxycorticosterone	A						
82634	Deoxycortisol	A						
82638	Assay of dibucaine number	A						
82646	Assay of dihydrocodeinone	A						
82649	Assay of dihydromorphinone	A						
82651	Assay of dihydrotestosterone	A						
82652	Vit d 1, 25-dihydroxy	A						
82654	Assay of dimethadione	A						
82656	Pancreatic elastase, fecal	A						
82657	Enzyme cell activity	A						
82658	Enzyme cell activity, ra	A						
82664	Electrophoretic test	A						
82666	Assay of epiandrosterone	A						
82668	Assay of erythropoietin	A						
82670	Assay of estradiol	A						
82671	Assay of estrogens	A						
82672	Assay of estrogen	A						
82677	Assay of estriol	A						

82679	Assay of estrone	A						
82690	Assay of ethchlorvynol	A						
82693	Assay of ethylene glycol	A						
82696	Assay of etiocholanolone	A						
82705	Fats/lipids, feces, qual	A						
82710	Fats/lipids, feces, quant	A						
82715	Assay of fecal fat	A						
82725	Assay of blood fatty acids	A						
82726	Long chain fatty acids	A						
82728	Assay of ferritin	A						
82731	Assay of fetal fibronectin	A						
82735	Assay of fluoride	A						
82742	Assay of flurazepam	A						
82746	Blood folic acid serum	A						
82747	Assay of folic acid, rbc	A						
82757	Assay of semen fructose	A						
82759	Assay of rbc galactokinase	A						
82760	Assay of galactose	A						
82775	Assay galactose transferase	A						
82776	Galactose transferase test	A						
82784	Assay, iga/igd/igg/igm each	A						
82785	Assay of ige	A						
82787	Igg 1, 2, 3 or 4, each	A						
82800	Blood pH	A						
82803	Blood gases: pH, pO2 & pCO2	A						
82805	Blood gases w/02 saturation	A						
82810	Blood gases, O2 sat only	A						
82820	Hemoglobin-oxygen affinity	A						
82926	Assay of gastric acid	A						
82928	Assay of gastric acid	A						
82938	Gastrin test	A						

82941	Assay of gastrin	A						
82943	Assay of glucagon	A						
82945	Glucose other fluid	A						
82946	Glucagon tolerance test	A						
82947	Assay, glucose, blood quant	A						
82948	Reagent strip/blood glucose	A						
82950	Glucose test	A						
82951	Glucose tolerance test (GTT)	A						
82952	GTT-added samples	A						
82953	Glucose-tolbutamide test	A						
82955	Assay of g6pd enzyme	A						
82960	Test for G6PD enzyme	A						
82962	Glucose blood test	A						
82963	Assay of glucosidase	A						
82965	Assay of gdh enzyme	A						
82975	Assay of glutamine	A						
82977	Assay of GGT	A						
82978	Assay of glutathione	A						
82979	Assay, rbc glutathione	A						
82980	Assay of glutethimide	A						
82985	Glycated protein	A						
83001	Gonadotropin (FSH)	A						
83002	Gonadotropin (LH)	A						
83003	Assay, growth hormone (hgh)	A						
83008	Assay of guanosine	A						
83009	H pylori (c-13), blood	A						
83010	Assay of haptoglobin, quant	A						
83012	Assay of haptoglobins	A						
83013	H pylori (c-13), breath	A						
83014	H pylori drug admin	A						
83015	Heavy metal screen	A						

83018	Quantitative screen, metals	A						
83020	Hemoglobin electrophoresis	A						
83021	Hemoglobin chromotography	A						
83026	Hemoglobin, copper sulfate	A						
83030	Fetal hemoglobin, chemical	A						
83033	Fetal hemoglobin assay, qual	A						
83036	Glycosylated hemoglobin test	A						
83037	Glycosylated hb, home device	A						
83045	Blood methemoglobin test	A						
83050	Blood methemoglobin assay	A						
83051	Assay of plasma hemoglobin	A						
83055	Blood sulfhemoglobin test	A						
83060	Blood sulfhemoglobin assay	A						
83065	Assay of hemoglobin heat	A						
83068	Hemoglobin stability screen	A						
83069	Assay of urine hemoglobin	A						
83070	Assay of hemosiderin, qual	A						
83071	Assay of hemosiderin, quant	A						
83080	Assay of b hexosaminidase	A						
83088	Assay of histamine	A						
83090	Assay of homocystine	A						
83150	Assay of for hva	A						
83491	Assay of corticosteroids	A						
83497	Assay of 5-hiaa	A						
83498	Assay of progesterone	A						
83499	Assay of progesterone	A						
83500	Assay, free hydroxyproline	A						
83505	Assay, total hydroxyproline	A						
83516	Immunoassay, nonantibody	A						
83518	Immunoassay, dipstick	A						
83519	Ria nonantibody	A						

83520	Immunoassay quant nos nonab	A						
83525	Assay of insulin	A						
83527	Assay of insulin	A						
83528	Assay of intrinsic factor	A						
83540	Assay of iron	A						
83550	Iron binding test	A						
83570	Assay of idh enzyme	A						
83582	Assay of ketogenic steroids	A						
83586	Assay 17- ketosteroids	A						
83593	Fractionation, ketosteroids	A						
83605	Assay of lactic acid	A						
83615	Lactate (LD) (LDH) enzyme	A						
83625	Assay of ldh enzymes	A						
83630	Lactoferrin, fecal (qual)	A						
83631	Lactoferrin, fecal (quant)	A						
83632	Placental lactogen	A						
83633	Test urine for lactose	A						
83634	Assay of urine for lactose	A						
83655	Assay of lead	A						
83661	L/s ratio, fetal lung	A						
83662	Foam stability, fetal lung	A						
83663	Fluoro polarize, fetal lung	A						
83664	Lamellar bdy, fetal lung	A						
83670	Assay of lap enzyme	A						
83690	Assay of lipase	A						
83695	Assay of lipoprotein(a)	A						
83698	Assay lipoprotein pla2	A						
83700	Lipopro bld, electrophoretic	A						
83701	Lipoprotein bld, hr fraction	A						
83704	Lipoprotein, bld, by nmr	A						
83718	Assay of lipoprotein	A						

83719	Assay of blood lipoprotein	A						
83721	Assay of blood lipoprotein	A						
83727	Assay of lrh hormone	A						
83735	Assay of magnesium	A						
83775	Assay of md enzyme	A						
83785	Assay of manganese	A						
83788	Mass spectrometry qual	A						
83789	Mass spectrometry quant	A						
83805	Assay of meprobamate	A						
83825	Assay of mercury	A						
83835	Assay of metanephrines	A						
83840	Assay of methadone	A						
83857	Assay of methemalbumin	A						
83858	Assay of methsuximide	A						
83864	Mucopolysaccharides	A						
83866	Mucopolysaccharides screen	A						
83872	Assay synovial fluid mucin	A						
83873	Assay of csf protein	A						
83874	Assay of myoglobin	A						
83876	Assay, myeloperoxidase	A						
83880	Natriuretic peptide	A						
83883	Assay, nephelometry not spec	A						
83885	Assay of nickel	A						
83887	Assay of nicotine	A						
83890	Molecule isolate	A						
83891	Molecule isolate nucleic	A						
83892	Molecular diagnostics	A						
83893	Molecule dot/slot/blot	A						
83894	Molecule gel electrophor	A						
83896	Molecular diagnostics	A						
83897	Molecule nucleic transfer	A						

83898	Molecule nucleic ampli, each	A						
83900	Molecule nucleic ampli 2 seq	A						
83901	Molecule nucleic ampli addon	A						
83902	Molecular diagnostics	A						
83903	Molecule mutation scan	A						
83904	Molecule mutation identify	A						
83905	Molecule mutation identify	A						
83906	Molecule mutation identify	A						
83907	Lyse cells for nucleic ext	A						
83908	Nucleic acid, signal ampli	A						
83909	Nucleic acid, high resolute	A						
83912	Genetic examination	A						
83913	Molecular, rna stabilization	A						
83914	Mutation ident ola/sbce/aspe	A						
83915	Assay of nucleotidase	A						
83916	Oligoclonal bands	A						
83918	Organic acids, total, quant	A						
83919	Organic acids, qual, each	A						
83921	Organic acid, single, quant	A						
83925	Assay of opiates	A						
83930	Assay of blood osmolality	A						
83935	Assay of urine osmolality	A						
83937	Assay of osteocalcin	A						
83945	Assay of oxalate	A						
83950	Oncoprotein, her-2/neu	A						
83951	Oncoprotein, dcp	A						
83970	Assay of parathormone	A						
83986	Assay ph body fluid nos	A						
83987	Exhaled breath condensate	A						
83992	Assay for phencyclidine	A						
83993	Assay for calprotectin fecal	A						

84022	Assay of phenothiazine	A						
84030	Assay of blood pku	A						
84035	Assay of phenylketones	A						
84060	Assay acid phosphatase	A						
84061	Phosphatase, forensic exam	A						
84066	Assay prostate phosphatase	A						
84075	Assay alkaline phosphatase	A						
84078	Assay alkaline phosphatase	A						
84080	Assay alkaline phosphatases	A						
84081	Amniotic fluid enzyme test	A						
84085	Assay of rbc pg6d enzyme	A						
84087	Assay phosphohexose enzymes	A						
84100	Assay of phosphorus	A						
84105	Assay of urine phosphorus	A						
84106	Test for porphobilinogen	A						
84110	Assay of porphobilinogen	A						
84119	Test urine for porphyrins	A						
84120	Assay of urine porphyrins	A						
84126	Assay of feces porphyrins	A						
84127	Assay of feces porphyrins	A						
84132	Assay of serum potassium	A						
84133	Assay of urine potassium	A						
84134	Assay of prealbumin	A						
84135	Assay of pregnanediol	A						
84138	Assay of pregnanetriol	A						
84140	Assay of pregnenolone	A						
84143	Assay of 17-hydroxypregneno	A						
84144	Assay of progesterone	A						
84145	Procalcitonin (pct)	A						
84146	Assay of prolactin	A						
84150	Assay of prostaglandin	A						

84152	Assay of psa, complexed	A						
84153	Assay of psa, total	A						
84154	Assay of psa, free	A						
84155	Assay of protein, serum	A						
84156	Assay of protein, urine	A						
84157	Assay of protein, other	A						
84160	Assay of protein, any source	A						
84163	Pappa, serum	A						
84165	Protein e-phoresis, serum	A						
84166	Protein e-phoresis/urine/csf	A						
84181	Western blot test	A						
84182	Protein, western blot test	A						
84202	Assay RBC protoporphyrin	A						
84203	Test RBC protoporphyrin	A						
84206	Assay of proinsulin	A						
84207	Assay of vitamin b-6	A						
84210	Assay of pyruvate	A						
84220	Assay of pyruvate kinase	A						
84228	Assay of quinine	A						
84233	Assay of estrogen	A						
84234	Assay of progesterone	A						
84235	Assay of endocrine hormone	A						
84238	Assay, nonendocrine receptor	A						
84244	Assay of renin	A						
84252	Assay of vitamin b-2	A						
84255	Assay of selenium	A						
84260	Assay of serotonin	A						
84270	Assay of sex hormone globul	A						
84275	Assay of sialic acid	A						
84285	Assay of silica	A						
84295	Assay of serum sodium	A						

84300	Assay of urine sodium	A						
84302	Assay of sweat sodium	A						
84305	Assay of somatomedin	A						
84307	Assay of somatostatin	A						
84311	Spectrophotometry	A						
84315	Body fluid specific gravity	A						
84375	Chromatogram assay, sugars	A						
84376	Sugars, single, qual	A						
84377	Sugars, multiple, qual	A						
84378	Sugars, single, quant	A						
84379	Sugars multiple quant	A						
84392	Assay of urine sulfate	A						
84402	Assay of testosterone	A						
84403	Assay of total testosterone	A						
84425	Assay of vitamin b-1	A						
84430	Assay of thiocyanate	A						
84431	Thromboxane, urine	A						
84432	Assay of thyroglobulin	A						
84436	Assay of total thyroxine	A						
84437	Assay of neonatal thyroxine	A						
84439	Assay of free thyroxine	A						
84442	Assay of thyroid activity	A						
84443	Assay thyroid stim hormone	A						
84445	Assay of tsi	A						
84446	Assay of vitamin e	A						
84449	Assay of transcortin	A						
84450	Transferase (AST) (SGOT)	A						
84460	Alanine amino (ALT) (SGPT)	A						
84466	Assay of transferrin	A						
84478	Assay of triglycerides	A						
84479	Assay of thyroid (t3 or t4)	A						
84480	Assay, triiodothyronine (t3)	A						
84481	Free assay (FT-3)	A						
84482	T3 reverse	A						
84484	Assay of troponin, quant	A						
84485	Assay duodenal fluid trypsin	A						
84488	Test feces for trypsin	A						
84490	Assay of feces for trypsin	A						
84510	Assay of tyrosine	A						
84512	Assay of troponin, qual	A						
84520	Assay of urea nitrogen	A						
84525	Urea nitrogen semi-quant	A						
84540	Assay of urine/urea-n	A						
84545	Urea-N clearance test	A						
84550	Assay of blood/uric acid	A						
84560	Assay of urine/uric acid	A						
84577	Assay of feces/urobilinogen	A						
84578	Test urine urobilinogen	A						
84580	Assay of urine urobilinogen	A						
84583	Assay of urine urobilinogen	A						
84585	Assay of urine vma	A						
84586	Assay of vip	A						
84588	Assay of vasopressin	A						
84590	Assay of vitamin a	A						
84591	Assay of nos vitamin	A						
84597	Assay of vitamin k	A						
84600	Assay of volatiles	A						
84620	Xylose tolerance test	A						
84630	Assay of zinc	A						
84681	Assay of c-peptide	A						
84702	Chorionic gonadotropin test	A						
84703	Chorionic gonadotropin assay	A						

84704	Hcg, free betachain test	A						
84830	Ovulation tests	A						
84999	Clinical chemistry test	A						
85002	Bleeding time test	A						
85004	Automated diff wbc count	A						
85007	Bl smear w/diff wbc count	A						
85008	Bl smear w/o diff wbc count	A						
85009	Manual diff wbc count b-coat	A						
85013	Spun microhematocrit	A						
85014	Hematocrit	A						
85018	Hemoglobin	A						
85025	Complete cbc w/auto diff wbc	A						
85027	Complete cbc, automated	A						
85032	Manual cell count, each	A						
85041	Automated rbc count	A						
85044	Manual reticulocyte count	A						
85045	Automated reticulocyte count	A						
85046	Reticyte/hgb concentrate	A						
85048	Automated leukocyte count	A						
85049	Automated platelet count	A						
85055	Reticulated platelet assay	A						
85060	Blood smear interpretation	B						
85097	Bone marrow interpretation	X	0343	0.5301	$35.64	$10.84	$7.13	*
85130	Chromogenic substrate assay	A						
85170	Blood clot retraction	A						
85175	Blood clot lysis time	A						
85210	Blood clot factor II test	A						
85220	Blood clot factor V test	A						
85230	Blood clot factor VII test	A						
85240	Blood clot factor VIII test	A						
85244	Blood clot factor VIII test	A						
85245	Blood clot factor VIII test	A						
85246	Blood clot factor VIII test	A						
85247	Blood clot factor VIII test	A						
85250	Blood clot factor IX test	A						
85260	Blood clot factor X test	A						
85270	Blood clot factor XI test	A						
85280	Blood clot factor XII test	A						
85290	Blood clot factor XIII test	A						
85291	Blood clot factor XIII test	A						
85292	Blood clot factor assay	A						
85293	Blood clot factor assay	A						
85300	Antithrombin III test	A						
85301	Antithrombin III test	A						
85302	Blood clot inhibitor antigen	A						
85303	Blood clot inhibitor test	A						
85305	Blood clot inhibitor assay	A						
85306	Blood clot inhibitor test	A						
85307	Assay activated protein c	A						
85335	Factor inhibitor test	A						
85337	Thrombomodulin	A						
85345	Coagulation time	A						
85347	Coagulation time	A						
85348	Coagulation time	A						
85360	Euglobulin lysis	A						
85362	Fibrin degradation products	A						
85366	Fibrinogen test	A						
85370	Fibrinogen test	A						
85378	Fibrin degrade, semiquant	A						
85379	Fibrin degradation, quant	A						
85380	Fibrin degradation, vte	A						
85384	Fibrinogen	A						

85385	Fibrinogen	A						
85390	Fibrinolysins screen	A						
85396	Clotting assay, whole blood	N						
85397	Clotting funct activity	A						
85400	Fibrinolytic plasmin	A						
85410	Fibrinolytic antiplasmin	A						
85415	Fibrinolytic plasminogen	A						
85420	Fibrinolytic plasminogen	A						
85421	Fibrinolytic plasminogen	A						
85441	Heinz bodies, direct	A						
85445	Heinz bodies, induced	A						
85460	Hemoglobin, fetal	A						
85461	Hemoglobin, fetal	A						
85475	Hemolysin	A						
85520	Heparin assay	A						
85525	Heparin neutralization	A						
85530	Heparin-protamine tolerance	A						
85536	Iron stain peripheral blood	A						
85540	Wbc alkaline phosphatase	A						
85547	RBC mechanical fragility	A						
85549	Muramidase	A						
85555	RBC osmotic fragility	A						
85557	RBC osmotic fragility	A						
85576	Blood platelet aggregation	A						
85597	Platelet neutralization	A						
85610	Prothrombin time	A						
85611	Prothrombin test	A						
85612	Viper venom prothrombin time	A						
85613	Russell viper venom, diluted	A						
85635	Reptilase test	A						
85651	Rbc sed rate, nonautomated	A						
85652	Rbc sed rate, automated	A						
85660	RBC sickle cell test	A						
85670	Thrombin time, plasma	A						
85675	Thrombin time, titer	A						
85705	Thromboplastin inhibition	A						
85730	Thromboplastin time, partial	A						
85732	Thromboplastin time, partial	A						
85810	Blood viscosity examination	A						
85999	Hematology procedure	A						
86000	Agglutinins, febrile	A						
86001	Allergen specific igg	A						
86003	Allergen specific IgE	A						
86005	Allergen specific IgE	A						
86021	WBC antibody identification	A						
86022	Platelet antibodies	A						
86023	Immunoglobulin assay	A						
86038	Antinuclear antibodies	A						
86039	Antinuclear antibodies (ANA)	A						
86060	Antistreptolysin o, titer	A						
86063	Antistreptolysin o, screen	A						
86077	Physician blood bank service	X	0433	0.2482	$16.69	$5.17	$3.34	*
86078	Physician blood bank service	X	0343	0.5301	$35.64	$10.84	$7.13	*
86079	Physician blood bank service	X	0433	0.2482	$16.69	$5.17	$3.34	*
86140	C-reactive protein	A						
86141	C-reactive protein, hs	A						
86146	Glycoprotein antibody	A						
86147	Cardiolipin antibody	A						
86148	Phospholipid antibody	A						
86155	Chemotaxis assay	A						
86156	Cold agglutinin, screen	A						
86157	Cold agglutinin, titer	A						

86160	Complement, antigen	A						
86161	Complement/function activity	A						
86162	Complement, total (CH50)	A						
86171	Complement fixation, each	A						
86185	Counterimmunoelectrophoresis	A						
86200	Ccp antibody	A						
86215	Deoxyribonuclease, antibody	A						
86225	DNA antibody	A						
86226	DNA antibody, single strand	A						
86235	Nuclear antigen antibody	A						
86243	Fc receptor	A						
86255	Fluorescent antibody, screen	A						
86256	Fluorescent antibody, titer	A						
86277	Growth hormone antibody	A						
86280	Hemagglutination inhibition	A						
86294	Immunoassay, tumor, qual	A						
86300	Immunoassay, tumor, ca 15-3	A						
86301	Immunoassay, tumor, ca 19-9	A						
86304	Immunoassay, tumor, ca 125	A						
86305	Human epididymis protein 4	A						
86308	Heterophile antibodies	A						
86309	Heterophile antibodies	A						
86310	Heterophile antibodies	A						
86316	Immunoassay, tumor other	A						
86317	Immunoassay,infectious agent	A						
86318	Immunoassay,infectious agent	A						
86320	Serum immunoelectrophoresis	A						
86325	Other immunoelectrophoresis	A						
86327	Immunoelectrophoresis assay	A						
86329	Immunodiffusion	A						
86331	Immunodiffusion ouchterlony	A						
86332	Immune complex assay	A						
86334	Immunofix e-phoresis, serum	A						
86335	Immunfix e-phorsis/urine/csf	A						
86336	Inhibin A	A						
86337	Insulin antibodies	A						
86340	Intrinsic factor antibody	A						
86341	Islet cell antibody	A						
86343	Leukocyte histamine release	A						
86344	Leukocyte phagocytosis	A						
86352	Cell function assay w/stim	A						
86353	Lymphocyte transformation	A						
86355	B cells, total count	A						
86356	Mononuclear cell antigen	A						
86357	Nk cells, total count	A						
86359	T cells, total count	A						
86360	T cell, absolute count/ratio	A						
86361	T cell, absolute count	A						
86367	Stem cells, total count	A						
86376	Microsomal antibody	A						
86378	Migration inhibitory factor	A						
86382	Neutralization test, viral	A						
86384	Nitroblue tetrazolium dye	A						
86403	Particle agglutination test	A						
86406	Particle agglutination test	A						
86430	Rheumatoid factor test	A						
86431	Rheumatoid factor, quant	A						
86480	Tb test, cell immun measure	A						
86485	Skin test, candida	X	0341	0.0799	$5.37	$2.09	$1.08	*
86486	Skin test, nos antigen	X	0341	0.0799	$5.37	$2.09	$1.08	*
86490	Coccidioidomycosis skin test	X	0341	0.0799	$5.37	$2.09	$1.08	*
86510	Histoplasmosis skin test	X	0341	0.0799	$5.37	$2.09	$1.08	*

86580	TB intradermal test	X	0341	0.0799	$5.37	$2.09	$1.08	*
86590	Streptokinase, antibody	A						
86592	Syphilis test non-trep qual	A						
86593	Syphilis test non-trep quant	A						
86602	Antinomyces antibody	A						
86603	Adenovirus antibody	A						
86606	Aspergillus antibody	A						
86609	Bacterium antibody	A						
86611	Bartonella antibody	A						
86612	Blastomyces antibody	A						
86615	Bordetella antibody	A						
86617	Lyme disease antibody	A						
86618	Lyme disease antibody	A						
86619	Borrelia antibody	A						
86622	Brucella antibody	A						
86625	Campylobacter antibody	A						
86628	Candida antibody	A						
86631	Chlamydia antibody	A						
86632	Chlamydia igm antibody	A						
86635	Coccidioides antibody	A						
86638	Q fever antibody	A						
86641	Cryptococcus antibody	A						
86644	CMV antibody	A						
86645	CMV antibody, IgM	A						
86648	Diphtheria antibody	A						
86651	Encephalitis antibody	A						
86652	Encephalitis antibody	A						
86653	Encephalitis antibody	A						
86654	Encephalitis antibody	A						
86658	Enterovirus antibody	A						
86663	Epstein-barr antibody	A						
86664	Epstein-barr antibody	A						
86665	Epstein-barr antibody	A						
86666	Ehrlichia antibody	A						
86668	Francisella tularensis	A						
86671	Fungus antibody	A						
86674	Giardia lamblia antibody	A						
86677	Helicobacter pylori	A						
86682	Helminth antibody	A						
86684	Hemophilus influenza	A						
86687	Htlv-i antibody	A						
86688	Htlv-ii antibody	A						
86689	HTLV/HIV confirmatory test	A						
86692	Hepatitis, delta agent	A						
86694	Herpes simplex test	A						
86695	Herpes simplex test	A						
86696	Herpes simplex type 2	A						
86698	Histoplasma	A						
86701	HIV-1	A						
86702	HIV-2	A						
86703	HIV-1/HIV-2, single assay	A						
86704	Hep b core antibody, total	A						
86705	Hep b core antibody, igm	A						
86706	Hep b surface antibody	A						
86707	Hep be antibody	A						
86708	Hep a antibody, total	A						
86709	Hep a antibody, igm	A						
86710	Influenza virus antibody	A						
86713	Legionella antibody	A						
86717	Leishmania antibody	A						
86720	Leptospira antibody	A						
86723	Listeria monocytogenes ab	A						

86727	Lymph choriomeningitis ab	A						
86729	Lympho venereum antibody	A						
86732	Mucormycosis antibody	A						
86735	Mumps antibody	A						
86738	Mycoplasma antibody	A						
86741	Neisseria meningitidis	A						
86744	Nocardia antibody	A						
86747	Parvovirus antibody	A						
86750	Malaria antibody	A						
86753	Protozoa antibody nos	A						
86756	Respiratory virus antibody	A						
86757	Rickettsia antibody	A						
86759	Rotavirus antibody	A						
86762	Rubella antibody	A						
86765	Rubeola antibody	A						
86768	Salmonella antibody	A						
86771	Shigella antibody	A						
86774	Tetanus antibody	A						
86777	Toxoplasma antibody	A						
86778	Toxoplasma antibody, igm	A						
86780	Treponema pallidum	A						
86784	Trichinella antibody	A						
86787	Varicella-zoster antibody	A						
86788	West nile virus ab, igm	A						
86789	West nile virus antibody	A						
86790	Virus antibody nos	A						
86793	Yersinia antibody	A						
86800	Thyroglobulin antibody	A						
86803	Hepatitis c ab test	A						
86804	Hep c ab test, confirm	A						
86805	Lymphocytotoxicity assay	A						

86806	Lymphocytotoxicity assay	A						
86807	Cytotoxic antibody screening	A						
86808	Cytotoxic antibody screening	A						
86812	HLA typing, A, B, or C	A						
86813	HLA typing, A, B, or C	A						
86816	HLA typing, DR/DQ	A						
86817	HLA typing, DR/DQ	A						
86821	Lymphocyte culture, mixed	A						
86822	Lymphocyte culture, primed	A						
86825	Hla x-match, non-cytotoxic	A						
86826	Hla x-match, non-cyt add-on	A						
86849	Immunology procedure	A						
86850	RBC antibody screen	X	0345	0.2195	$14.76		$2.96	*
86860	RBC antibody elution	X	0346	0.3734	$25.11		$5.03	*
86870	RBC antibody identification	X	0346	0.3734	$25.11		$5.03	*
86880	Coombs test, direct	X	0409	0.1161	$7.81	$2.20	$1.57	*
86885	Coombs test, indirect, qual	X	0409	0.1161	$7.81	$2.20	$1.57	*
86886	Coombs test, indirect, titer	X	0409	0.1161	$7.81	$2.20	$1.57	*
86890	Autologous blood process	X	0347	0.7384	$49.65	$9.94	$9.93	*
86891	Autologous blood, op salvage	X	0345	0.2195	$14.76		$2.96	*
86900	Blood typing, ABO	X	0409	0.1161	$7.81	$2.20	$1.57	*
86901	Blood typing, Rh (D)	X	0409	0.1161	$7.81	$2.20	$1.57	*
86903	Blood typing, antigen screen	X	0345	0.2195	$14.76		$2.96	*
86904	Blood typing, patient serum	X	0345	0.2195	$14.76		$2.96	*
86905	Blood typing, RBC antigens	X	0345	0.2195	$14.76		$2.96	*
86906	Blood typing, Rh phenotype	X	0345	0.2195	$14.76		$2.96	*
86910	Blood typing, paternity test	E						
86911	Blood typing, antigen system	E						
86920	Compatibility test, spin	X	0345	0.2195	$14.76		$2.96	*
86921	Compatibility test, incubate	X	0345	0.2195	$14.76		$2.96	*
86922	Compatibility test, antiglob	X	0346	0.3734	$25.11		$5.03	*

86923	Compatibility test, electric	X	0345	0.2195	$14.76		$2.96	*
86927	Plasma, fresh frozen	X	0345	0.2195	$14.76		$2.96	*
86930	Frozen blood prep	X	0347	0.7384	$49.65	$9.94	$9.93	*
86931	Frozen blood thaw	X	0347	0.7384	$49.65	$9.94	$9.93	*
86932	Frozen blood freeze/thaw	X	0347	0.7384	$49.65	$9.94	$9.93	*
86940	Hemolysins/agglutinins, auto	A						
86941	Hemolysins/agglutinins	A						
86945	Blood product/irradiation	X	0345	0.2195	$14.76		$2.96	*
86950	Leukacyte transfusion	X	0345	0.2195	$14.76		$2.96	*
86960	Vol reduction of blood/prod	X	0345	0.2195	$14.76		$2.96	*
86965	Pooling blood platelets	X	0346	0.3734	$25.11		$5.03	*
86970	RBC pretreatment	X	0345	0.2195	$14.76		$2.96	*
86971	RBC pretreatment	X	0345	0.2195	$14.76		$2.96	*
86972	RBC pretreatment	X	0345	0.2195	$14.76		$2.96	*
86975	RBC pretreatment, serum	X	0346	0.3734	$25.11		$5.03	*
86976	RBC pretreatment, serum	X	0345	0.2195	$14.76		$2.96	*
86977	RBC pretreatment, serum	X	0347	0.7384	$49.65	$9.94	$9.93	*
86978	RBC pretreatment, serum	X	0346	0.3734	$25.11		$5.03	*
86985	Split blood or products	X	0345	0.2195	$14.76		$2.96	*
86999	Transfusion procedure	X	0345	0.2195	$14.76		$2.96	*
87001	Small animal inoculation	A						
87003	Small animal inoculation	A						
87015	Specimen concentration	A						
87040	Blood culture for bacteria	A						
87045	Feces culture, bacteria	A						
87046	Stool cultr, bacteria, each	A						
87070	Culture, bacteria, other	A						
87071	Culture bacteri aerobic othr	A						
87073	Culture bacteria anaerobic	A						
87075	Cultr bacteria, except blood	A						
87076	Culture anaerobe ident, each	A						
87077	Culture aerobic identify	A						
87081	Culture screen only	A						
87084	Culture of specimen by kit	A						
87086	Urine culture/colony count	A						
87088	Urine bacteria culture	A						
87101	Skin fungi culture	A						
87102	Fungus isolation culture	A						
87103	Blood fungus culture	A						
87106	Fungi identification, yeast	A						
87107	Fungi identification, mold	A						
87109	Mycoplasma	A						
87110	Chlamydia culture	A						
87116	Mycobacteria culture	A						
87118	Mycobacteric identification	A						
87140	Culture type immunofluoresc	A						
87143	Culture typing, glc/hplc	A						
87147	Culture type, immunologic	A						
87149	Dna/rna direct probe	A						
87150	Dna/rna, amplified probe	A						
87152	Culture type pulse field gel	A						
87153	Dna/rna sequencing	A						
87158	Culture typing, added method	A						
87164	Dark field examination	A						
87166	Dark field examination	A						
87168	Macroscopic exam arthropod	A						
87169	Macroscopic exam parasite	A						
87172	Pinworm exam	A						
87176	Tissue homogenization, cultr	A						
87177	Ova and parasites smears	A						
87181	Microbe susceptible, diffuse	A						
87184	Microbe susceptible, disk	A						

87185	Microbe susceptible, enzyme	A						
87186	Microbe susceptible, mic	A						
87187	Microbe susceptible, mlc	A						
87188	Microbe suscept, macrobroth	A						
87190	Microbe suscept, mycobacteri	A						
87197	Bactericidal level, serum	A						
87205	Smear, gram stain	A						
87206	Smear, fluorescent/acid stai	A						
87207	Smear, special stain	A						
87209	Smear, complex stain	A						
87210	Smear, wet mount, saline/ink	A						
87220	Tissue exam for fungi	A						
87230	Assay, toxin or antitoxin	A						
87250	Virus inoculate, eggs/animal	A						
87252	Virus inoculation, tissue	A						
87253	Virus inoculate tissue, addl	A						
87254	Virus inoculation, shell via	A						
87255	Genet virus isolate, hsv	A						
87260	Adenovirus ag, if	A						
87265	Pertussis ag, if	A						
87267	Enterovirus antibody, dfa	A						
87269	Giardia ag, if	A						
87270	Chlamydia trachomatis ag, if	A						
87271	Cytomegalovirus dfa	A						
87272	Cryptosporidium ag, if	A						
87273	Herpes simplex 2, ag, if	A						
87274	Herpes simplex 1, ag, if	A						
87275	Influenza b, ag, if	A						
87276	Influenza a, ag, if	A						
87277	Legionella micdadei, ag, if	A						
87278	Legion pneumophilia ag, if	A						
87279	Parainfluenza, ag, if	A						
87280	Respiratory syncytial ag, if	A						
87281	Pneumocystis carinii, ag, if	A						
87283	Rubeola, ag, if	A						
87285	Treponema pallidum, ag, if	A						
87290	Varicella zoster, ag, if	A						
87299	Antibody detection, nos, if	A						
87300	Ag detection, polyval, if	A						
87301	Adenovirus ag, eia	A						
87305	Aspergillus ag, eia	A						
87320	Chylmd trach ag, eia	A						
87324	Clostridium ag, eia	A						
87327	Cryptococcus neoform ag, eia	A						
87328	Cryptosporidium ag, eia	A						
87329	Giardia ag, eia	A						
87332	Cytomegalovirus ag, eia	A						
87335	E coli 0157 ag, eia	A						
87336	Entamoeb hist dispr, ag, eia	A						
87337	Entamoeb hist group, ag, eia	A						
87338	Hpylori, stool, eia	A						
87339	H pylori ag, eia	A						
87340	Hepatitis b surface ag, eia	A						
87341	Hepatitis b surface, ag, eia	A						
87350	Hepatitis be ag, eia	A						
87380	Hepatitis delta ag, eia	A						
87385	Histoplasma capsul ag, eia	A						
87390	Hiv-1 ag, eia	A						
87391	Hiv-2 ag, eia	A						
87400	Influenza a/b, ag, eia	A						
87420	Resp syncytial ag, eia	A						
87425	Rotavirus ag, eia	A						

87427	Shiga-like toxin ag, eia	A						
87430	Strep a ag, eia	A						
87449	Ag detect nos, eia, mult	A						
87450	Ag detect nos, eia, single	A						
87451	Ag detect polyval, eia, mult	A						
87470	Bartonella, dna, dir probe	A						
87471	Bartonella, dna, amp probe	A						
87472	Bartonella, dna, quant	A						
87475	Lyme dis, dna, dir probe	A						
87476	Lyme dis, dna, amp probe	A						
87477	Lyme dis, dna, quant	A						
87480	Candida, dna, dir probe	A						
87481	Candida, dna, amp probe	A						
87482	Candida, dna, quant	A						
87485	Chylmd pneum, dna, dir probe	A						
87486	Chylmd pneum, dna, amp probe	A						
87487	Chylmd pneum, dna, quant	A						
87490	Chylmd trach, dna, dir probe	A						
87491	Chylmd trach, dna, amp probe	A						
87492	Chylmd trach, dna, quant	A						
87493	C diff amplified probe	A						
87495	Cytomeg, dna, dir probe	A						
87496	Cytomeg, dna, amp probe	A						
87497	Cytomeg, dna, quant	A						
87498	Enterovirus, dna, amp probe	A						
87500	Vanomycin, dna, amp probe	A						
87510	Gardner vag, dna, dir probe	A						
87511	Gardner vag, dna, amp probe	A						
87512	Gardner vag, dna, quant	A						
87515	Hepatitis b, dna, dir probe	A						
87516	Hepatitis b, dna, amp probe	A						
87517	Hepatitis b, dna, quant	A						
87520	Hepatitis c, rna, dir probe	A						
87521	Hepatitis c, rna, amp probe	A						
87522	Hepatitis c, rna, quant	A						
87525	Hepatitis g, dna, dir probe	A						
87526	Hepatitis g, dna, amp probe	A						
87527	Hepatitis g, dna, quant	A						
87528	Hsv, dna, dir probe	A						
87529	Hsv, dna, amp probe	A						
87530	Hsv, dna, quant	A						
87531	Hhv-6, dna, dir probe	A						
87532	Hhv-6, dna, amp probe	A						
87533	Hhv-6, dna, quant	A						
87534	Hiv-1, dna, dir probe	A						
87535	Hiv-1, dna, amp probe	A						
87536	Hiv-1, dna, quant	A						
87537	Hiv-2, dna, dir probe	A						
87538	Hiv-2, dna, amp probe	A						
87539	Hiv-2, dna, quant	A						
87540	Legion pneumo, dna, dir prob	A						
87541	Legion pneumo, dna, amp prob	A						
87542	Legion pneumo, dna, quant	A						
87550	Mycobacteria, dna, dir probe	A						
87551	Mycobacteria, dna, amp probe	A						
87552	Mycobacteria, dna, quant	A						
87555	M.tuberculo, dna, dir probe	A						
87556	M.tuberculo, dna, amp probe	A						
87557	M.tuberculo, dna, quant	A						
87560	M.avium-intra, dna, dir prob	A						
87561	M.avium-intra, dna, amp prob	A						
87562	M.avium-intra, dna, quant	A						

87580	M.pneumon, dna, dir probe	A						
87581	M.pneumon, dna, amp probe	A						
87582	M.pneumon, dna, quant	A						
87590	N.gonorrhoeae, dna, dir prob	A						
87591	N.gonorrhoeae, dna, amp prob	A						
87592	N.gonorrhoeae, dna, quant	A						
87620	Hpv, dna, dir probe	A						
87621	Hpv, dna, amp probe	A						
87622	Hpv, dna, quant	A						
87640	Staph a, dna, amp probe	A						
87641	Mr-staph, dna, amp probe	A						
87650	Strep a, dna, dir probe	A						
87651	Strep a, dna, amp probe	A						
87652	Strep a, dna, quant	A						
87653	Strep b, dna, amp probe	A						
87660	Trichomonas vagin, dir probe	A						
87797	Detect agent nos, dna, dir	A						
87798	Detect agent nos, dna, amp	A						
87799	Detect agent nos, dna, quant	A						
87800	Detect agnt mult, dna, direc	A						
87801	Detect agnt mult, dna, ampli	A						
87802	Strep b assay w/optic	A						
87803	Clostridium toxin a w/optic	A						
87804	Influenza assay w/optic	A						
87807	Rsv assay w/optic	A						
87808	Trichomonas assay w/optic	A						
87809	Adenovirus assay w/optic	A						
87810	Chylmd trach assay w/optic	A						
87850	N. gonorrhoeae assay w/optic	A						
87880	Strep a assay w/optic	A						
87899	Agent nos assay w/optic	A						
87900	Phenotype, infect agent drug	A						
87901	Genotype, dna, hiv reverse t	A						
87902	Genotype, dna, hepatitis C	A						
87903	Phenotype, dna hiv w/culture	A						
87904	Phenotype, dna hiv w/clt add	A						
87905	Sialidase enzyme assay	A						
87999	Microbiology procedure	A						
88000	Autopsy (necropsy), gross	E						
88005	Autopsy (necropsy), gross	E						
88007	Autopsy (necropsy), gross	E						
88012	Autopsy (necropsy), gross	E						
88014	Autopsy (necropsy), gross	E						
88016	Autopsy (necropsy), gross	E						
88020	Autopsy (necropsy), complete	E						
88025	Autopsy (necropsy), complete	E						
88027	Autopsy (necropsy), complete	E						
88028	Autopsy (necropsy), complete	E						
88029	Autopsy (necropsy), complete	E						
88036	Limited autopsy	E						
88037	Limited autopsy	E						
88040	Forensic autopsy (necropsy)	E						
88045	Coroners autopsy (necropsy)	E						
88099	Necropsy (autopsy) procedure	E						
88104	Cytopath fl nongyn, smears	X	0433	0.2482	$16.69	$5.17	$3.34	*
88106	Cytopath fl nongyn, filter	X	0433	0.2482	$16.69	$5.17	$3.34	*
88107	Cytopath fl nongyn, sm/fltr	X	0343	0.5301	$35.64	$10.84	$7.13	*
88108	Cytopath, concentrate tech	X	0433	0.2482	$16.69	$5.17	$3.34	*
88112	Cytopath, cell enhance tech	X	0343	0.5301	$35.64	$10.84	$7.13	*
88125	Forensic cytopathology	X	0433	0.2482	$16.69	$5.17	$3.34	*
88130	Sex chromatin identification	A						
88140	Sex chromatin identification	A						

88141	Cytopath, c/v, interpret	N						
88142	Cytopath, c/v, thin layer	A						
88143	Cytopath c/v thin layer redo	A						
88147	Cytopath, c/v, automated	A						
88148	Cytopath, c/v, auto rescreen	A						
88150	Cytopath, c/v, manual	A						
88152	Cytopath, c/v, auto redo	A						
88153	Cytopath, c/v, redo	A						
88154	Cytopath, c/v, select	A						
88155	Cytopath, c/v, index add-on	A						
88160	Cytopath smear, other source	X	0433	0.2482	$16.69	$5.17	$3.34	*
88161	Cytopath smear, other source	X	0433	0.2482	$16.69	$5.17	$3.34	*
88162	Cytopath smear, other source	X	0343	0.5301	$35.64	$10.84	$7.13	*
88164	Cytopath tbs, c/v, manual	A						
88165	Cytopath tbs, c/v, redo	A						
88166	Cytopath tbs, c/v, auto redo	A						
88167	Cytopath tbs, c/v, select	A						
88172	Cytopathology eval of fna	X	0343	0.5301	$35.64	$10.84	$7.13	*
88173	Cytopath eval, fna, report	X	0343	0.5301	$35.64	$10.84	$7.13	*
88174	Cytopath, c/v auto, in fluid	A						
88175	Cytopath c/v auto fluid redo	A						
88182	Cell marker study	X	0343	0.5301	$35.64	$10.84	$7.13	*
88184	Flowcytometry/ tc, 1 marker	X	0433	0.2482	$16.69	$5.17	$3.34	*
88185	Flowcytometry/tc, add-on	X	0433	0.2482	$16.69	$5.17	$3.34	*
88187	Flowcytometry/read, 2-8	X	0342	0.1546	$10.40		$2.08	*
88188	Flowcytometry/read, 9-15	X	0343	0.5301	$35.64	$10.84	$7.13	*
88189	Flowcytometry/read, 16 & >	X	0343	0.5301	$35.64	$10.84	$7.13	*
88199	Cytopathology procedure	X	0342	0.1546	$10.40		$2.08	*
88230	Tissue culture, lymphocyte	A						
88233	Tissue culture, skin/biopsy	A						
88235	Tissue culture, placenta	A						
88237	Tissue culture, bone marrow	A						
88239	Tissue culture, tumor	A						
88240	Cell cryopreserve/storage	A						
88241	Frozen cell preparation	A						
88245	Chromosome analysis, 20-25	A						
88248	Chromosome analysis, 50-100	A						
88249	Chromosome analysis, 100	A						
88261	Chromosome analysis, 5	A						
88262	Chromosome analysis, 15-20	A						
88263	Chromosome analysis, 45	A						
88264	Chromosome analysis, 20-25	A						
88267	Chromosome analys, placenta	A						
88269	Chromosome analys, amniotic	A						
88271	Cytogenetics, dna probe	A						
88272	Cytogenetics, 3-5	A						
88273	Cytogenetics, 10-30	A						
88274	Cytogenetics, 25-99	A						
88275	Cytogenetics, 100-300	A						
88280	Chromosome karyotype study	A						
88283	Chromosome banding study	A						
88285	Chromosome count, additional	A						
88289	Chromosome study, additional	A						
88291	Cyto/molecular report	M						
88299	Cytogenetic study	X	0342	0.1546	$10.40		$2.08	*
88300	Surgical path, gross	X	0433	0.2482	$16.69	$5.17	$3.34	*
88302	Tissue exam by pathologist	X	0433	0.2482	$16.69	$5.17	$3.34	*
88304	Tissue exam by pathologist	X	0343	0.5301	$35.64	$10.84	$7.13	*
88305	Tissue exam by pathologist	X	0343	0.5301	$35.64	$10.84	$7.13	*
88307	Tissue exam by pathologist	X	0344	0.8028	$53.98	$15.56	$10.80	*
88309	Tissue exam by pathologist	X	0344	0.8028	$53.98	$15.56	$10.80	*
88311	Decalcify tissue	X	0342	0.1546	$10.40		$2.08	*

88312	Special stains group 1	X	0433	0.2482	$16.69	$5.17	$3.34	*
88313	Special stains group 2	X	0433	0.2482	$16.69	$5.17	$3.34	*
88314	Histochemical stain add-on	X	0433	0.2482	$16.69	$5.17	$3.34	*
88318	Chemical histochemistry	X	0433	0.2482	$16.69	$5.17	$3.34	*
88319	Enzyme histochemistry	X	0344	0.8028	$53.98	$15.56	$10.80	*
88321	Microslide consultation	X	0433	0.2482	$16.69	$5.17	$3.34	*
88323	Microslide consultation	X	0343	0.5301	$35.64	$10.84	$7.13	*
88325	Comprehensive review of data	X	0344	0.8028	$53.98	$15.56	$10.80	*
88329	Path consult introp	X	0433	0.2482	$16.69	$5.17	$3.34	*
88331	Path consult intraop, 1 bloc	X	0343	0.5301	$35.64	$10.84	$7.13	*
88332	Path consult intraop, addl	X	0433	0.2482	$16.69	$5.17	$3.34	*
88333	Intraop cyto path consult, 1	X	0433	0.2482	$16.69	$5.17	$3.34	*
88334	Intraop cyto path consult, 2	X	0433	0.2482	$16.69	$5.17	$3.34	*
88342	Immunohistochemistry	X	0343	0.5301	$35.64	$10.84	$7.13	*
88346	Immunofluorescent study	X	0343	0.5301	$35.64	$10.84	$7.13	*
88347	Immunofluorescent study	X	0343	0.5301	$35.64	$10.84	$7.13	*
88348	Electron microscopy	X	0661	2.445	$164.40	$57.69	$32.88	*
88349	Scanning electron microscopy	X	0661	2.445	$164.40	$57.69	$32.88	*
88355	Analysis, skeletal muscle	X	0343	0.5301	$35.64	$10.84	$7.13	*
88356	Analysis, nerve	X	0344	0.8028	$53.98	$15.56	$10.80	*
88358	Analysis, tumor	X	0343	0.5301	$35.64	$10.84	$7.13	*
88360	Tumor immunohistochem/manual	X	0343	0.5301	$35.64	$10.84	$7.13	*
88361	Tumor immunohistochem/comput	X	0344	0.8028	$53.98	$15.56	$10.80	*
88362	Nerve teasing preparations	X	0344	0.8028	$53.98	$15.56	$10.80	*
88365	Insitu hybridization (fish)	X	0344	0.8028	$53.98	$15.56	$10.80	*
88367	Insitu hybridization, auto	X	0344	0.8028	$53.98	$15.56	$10.80	*
88368	Insitu hybridization, manual	X	0344	0.8028	$53.98	$15.56	$10.80	*
88371	Protein, western blot tissue	A						
88372	Protein analysis w/probe	A						
88380	Microdissection, laser	N						
88381	Microdissection, manual	N						

88384	Eval molecular probes, 11-50	X	0433	0.2482	$16.69	$5.17	$3.34	*
88385	Eval molecul probes, 51-250	X	0343	0.5301	$35.64	$10.84	$7.13	*
88386	Eval molecul probes, 251-500	X	0344	0.8028	$53.98	$15.56	$10.80	*
88387	Tiss exam molecular study	N						
88388	Tiss ex molecul study add-on	N						
88399	Surgical pathology procedure	X	0342	0.1546	$10.40		$2.08	*
88720	Bilirubin total transcut	A						
88738	Hgb quant transcutaneous	A						
88740	Transcutaneous carboxyhb	A						
88741	Transcutaneous methb	A						
89049	Chct for mal hyperthermia	X	0342	0.1546	$10.40		$2.08	*
89050	Body fluid cell count	A						
89051	Body fluid cell count	A						
89055	Leukocyte assessment, fecal	A						
89060	Exam,synovial fluid crystals	A						
89100	Sample intestinal contents	X	0360	1.5203	$102.23	$33.88	$20.45	*
89105	Sample intestinal contents	X	0360	1.5203	$102.23	$33.88	$20.45	*
89125	Specimen fat stain	A						
89130	Sample stomach contents	X	0360	1.5203	$102.23	$33.88	$20.45	*
89132	Sample stomach contents	X	0360	1.5203	$102.23	$33.88	$20.45	*
89135	Sample stomach contents	X	0360	1.5203	$102.23	$33.88	$20.45	*
89136	Sample stomach contents	X	0360	1.5203	$102.23	$33.88	$20.45	*
89140	Sample stomach contents	X	0360	1.5203	$102.23	$33.88	$20.45	*
89141	Sample stomach contents	X	0360	1.5203	$102.23	$33.88	$20.45	*
89160	Exam feces for meat fibers	A						
89190	Nasal smear for eosinophils	A						
89220	Sputum specimen collection	X	0433	0.2482	$16.69	$5.17	$3.34	*
89225	Starch granules, feces	A						
89230	Collect sweat for test	X	0343	0.5301	$35.64	$10.84	$7.13	*
89235	Water load test	A						
89240	Pathology lab procedure	X	0342	0.1546	$10.40		$2.08	*

89250	Cultr oocyte/embryo <4 days	X	0344	0.8028	$53.98	$15.56	$10.80	*
89251	Cultr oocyte/embryo <4 days	X	0344	0.8028	$53.98	$15.56	$10.80	*
89253	Embryo hatching	X	0344	0.8028	$53.98	$15.56	$10.80	*
89254	Oocyte identification	X	0344	0.8028	$53.98	$15.56	$10.80	*
89255	Prepare embryo for transfer	X	0344	0.8028	$53.98	$15.56	$10.80	*
89257	Sperm identification	X	0344	0.8028	$53.98	$15.56	$10.80	*
89258	Cryopreservation; embryo(s)	X	0344	0.8028	$53.98	$15.56	$10.80	*
89259	Cryopreservation, sperm	X	0344	0.8028	$53.98	$15.56	$10.80	*
89260	Sperm isolation, simple	X	0344	0.8028	$53.98	$15.56	$10.80	*
89261	Sperm isolation, complex	X	0344	0.8028	$53.98	$15.56	$10.80	*
89264	Identify sperm tissue	X	0344	0.8028	$53.98	$15.56	$10.80	*
89268	Insemination of oocytes	X	0344	0.8028	$53.98	$15.56	$10.80	*
89272	Extended culture of oocytes	X	0344	0.8028	$53.98	$15.56	$10.80	*
89280	Assist oocyte fertilization	X	0344	0.8028	$53.98	$15.56	$10.80	*
89281	Assist oocyte fertilization	X	0344	0.8028	$53.98	$15.56	$10.80	*
89290	Biopsy, oocyte polar body	X	0344	0.8028	$53.98	$15.56	$10.80	*
89291	Biopsy, oocyte polar body	X	0344	0.8028	$53.98	$15.56	$10.80	*
89300	Semen analysis w/huhner	A						
89310	Semen analysis w/count	A						
89320	Semen anal vol/count/mot	A						
89321	Semen anal, sperm detection	A						
89322	Semen anal, strict criteria	A						
89325	Sperm antibody test	A						
89329	Sperm evaluation test	A						
89330	Evaluation, cervical mucus	A						
89331	Retrograde ejaculation anal	A						
89335	Cryopreserve testicular tiss	X	0344	0.8028	$53.98	$15.56	$10.80	*
89342	Storage/year; embryo(s)	X	0344	0.8028	$53.98	$15.56	$10.80	*
89343	Storage/year; sperm/semen	X	0344	0.8028	$53.98	$15.56	$10.80	*
89344	Storage/year; reprod tissue	X	0344	0.8028	$53.98	$15.56	$10.80	*
89346	Storage/year; oocyte(s)	X	0344	0.8028	$53.98	$15.56	$10.80	*
89352	Thawing cryopresrved; embryo	X	0344	0.8028	$53.98	$15.56	$10.80	*
89353	Thawing cryopresrved; sperm	X	0344	0.8028	$53.98	$15.56	$10.80	*
89354	Thaw cryoprsvrd; reprod tiss	X	0344	0.8028	$53.98	$15.56	$10.80	*
89356	Thawing cryopresrved; oocyte	X	0344	0.8028	$53.98	$15.56	$10.80	*
89398	Unlisted reprod med lab proc	X	0342	0.1546	$10.40		$2.08	*
90281	Human ig, im	E						
90283	Human ig, iv	E						
90284	Human ig, sc	E						
90287	Botulinum antitoxin	E						
90288	Botulism ig, iv	E						
90291	Cmv ig, iv	E						
90296	Diphtheria antitoxin	E						
90371	Hep b ig, im	K	1630		$114.20		$22.84	
90375	Rabies ig, im/sc	K	9133		$150.91		$30.18	
90376	Rabies ig, heat treated	K	9134		$140.06		$28.01	
90378	Rsv, mab, im, 50mg	K	9003		$634.00		$126.80	
90384	Rh ig, full-dose, im	E						
90385	Rh ig, minidose, im	N						
90386	Rh ig, iv	E						
90389	Tetanus ig, im	E						
90393	Vaccina ig, im	E						
90396	Varicella-zoster ig, im	K	9135		$147.58		$29.52	
90399	Immune globulin	E						
90465	Immune admin 1 inj, < 8 yrs	B						
90466	Immune admin addl inj, < 8 y	B						
90467	Immune admin o or n, < 8 yrs	B						
90468	Immune admin o/n, addl < 8 y	B						
90470	Immune admin H1N1 im/nasal	E						
90471	Immunization admin	S	0436	0.3809	$25.61		$5.13	*
90472	Immunization admin, each add	S	0436	0.3809	$25.61		$5.13	*
90473	Immune admin oral/nasal	S	0436	0.3809	$25.61		$5.13	*

90474	Immune admin oral/nasal addl	S	0436	0.3809	$25.61		$5.13	*
90476	Adenovirus vaccine, type 4	K	1254		$72.17		$14.43	
90477	Adenovirus vaccine, type 7	E						
90581	Anthrax vaccine, sc	E						
90585	Bcg vaccine, percut	K	9137		$108.14		$21.63	
90586	Bcg vaccine, intravesical	B						
90632	Hep a vaccine, adult im	N						
90633	Hep a vacc, ped/adol, 2 dose	N						
90634	Hep a vacc, ped/adol, 3 dose	N						
90636	Hep a/hep b vacc, adult im	N						
90644	HIB/men/tt vaccine, im	E						
90645	Hib vaccine, hboc, im	N						
90646	Hib vaccine, prp-d, im	N						
90647	Hib vaccine, prp-omp, im	N						
90648	Hib vaccine, prp-t, im	N						
90649	Hpv vaccine 4 valent, im	M						
90650	Hpv vaccine 2 valent, im	M						
90655	Flu vaccine no preserv 6-35m	L						
90656	Flu vaccine no preserv 3 & >	L						
90657	Flu vaccine, 3 yrs, im	L						
90658	Flu vaccine, 3 yrs & >, im	L						
90660	Flu vaccine, nasal	L						
90661	Flu vacc cell cult prsv free	E						
90662	Flu vacc prsv free inc antig	E						
90663	Flu vacc pandemic H1N1	E						
90665	Lyme disease vaccine, im	K	1216		$0.93		$0.19	
90669	Pneumococcal vacc, 7 val im	L						
90670	Pneumococcal vacc, 13 val im	E						
90675	Rabies vaccine, im	K	9139		$173.25		$34.65	
90676	Rabies vaccine, id	K	9140		$96.27		$19.25	
90680	Rotovirus vacc 3 dose, oral	K	1255		$72.37		$14.47	
90681	Rotavirus vacc 2 dose oral	K	1239		$106.60		$21.32	
90690	Typhoid vaccine, oral	N						
90691	Typhoid vaccine, im	N						
90692	Typhoid vaccine, h-p, sc/id	N						
90693	Typhoid vaccine, akd, sc	B						
90696	Dtap-ipv vacc 4-6 yr im	N						
90698	Dtap-hib-ip vaccine, im	N						
90700	Dtap vaccine, < 7 yrs, im	N						
90701	Dtp vaccine, im	N						
90702	Dt vaccine < 7, im	N						
90703	Tetanus vaccine, im	N						
90704	Mumps vaccine, sc	N						
90705	Measles vaccine, sc	N						
90706	Rubella vaccine, sc	N						
90707	Mmr vaccine, sc	N						
90708	Measles-rubella vaccine, sc	N						
90710	Mmrv vaccine, sc	N						
90712	Oral poliovirus vaccine	N						
90713	Poliovirus, ipv, sc/im	N						
90714	Td vaccine no prsrv >/= 7 im	N						
90715	Tdap vaccine >7 im	N						
90716	Chicken pox vaccine, sc	M						
90717	Yellow fever vaccine, sc	N						
90718	Td vaccine > 7, im	N						
90719	Diphtheria vaccine, im	N						
90720	Dtp/hib vaccine, im	N						
90721	Dtap/hib vaccine, im	N						
90723	Dtap-hep b-ipv vaccine, im	E						
90725	Cholera vaccine, injectable	K	1271		$103.90		$20.78	
90727	Plague vaccine, im	E						
90732	Pneumococcal vaccine	L						

90733	Meningococcal vaccine, sc	K	9143		$98.54		$19.71	
90734	Meningococcal vaccine, im	K	9145		$102.46		$20.50	
90735	Encephalitis vaccine, sc	K	9144		$100.15		$20.03	
90736	Zoster vacc, sc	M						
90738	Inactivated je vacc im	M						
90740	Hepb vacc, ill pat 3 dose im	F						
90743	Hep b vacc, adol, 2 dose, im	F						
90744	Hepb vacc ped/adol 3 dose im	F						
90746	Hep b vaccine, adult, im	F						
90747	Hepb vacc, ill pat 4 dose im	F						
90748	Hep b/hib vaccine, im	E						
90749	Vaccine toxoid	N						
90801	Psy dx interview	Q3	0323	1.669	$112.23		$22.45	*
90802	Intac psy dx interview	Q3	0323	1.669	$112.23		$22.45	*
90804	Psytx, office, 20-30 min	Q3	0322	1.1958	$80.41		$16.09	*
90805	Psytx, off, 20-30 min w/e&m	Q3	0322	1.1958	$80.41		$16.09	*
90806	Psytx, off, 45-50 min	Q3	0323	1.669	$112.23		$22.45	*
90807	Psytx, off, 45-50 min w/e&m	Q3	0323	1.669	$112.23		$22.45	*
90808	Psytx, office, 75-80 min	Q3	0323	1.669	$112.23		$22.45	*
90809	Psytx, off, 75-80, w/e&m	Q3	0323	1.669	$112.23		$22.45	*
90810	Intac psytx, off, 20-30 min	Q3	0322	1.1958	$80.41		$16.09	*
90811	Intac psytx, 20-30, w/e&m	Q3	0322	1.1958	$80.41		$16.09	*
90812	Intac psytx, off, 45-50 min	Q3	0323	1.669	$112.23		$22.45	*
90813	Intac psytx, 45-50 min w/e&m	Q3	0323	1.669	$112.23		$22.45	*
90814	Intac psytx, off, 75-80 min	Q3	0323	1.669	$112.23		$22.45	*
90815	Intac psytx, 75-80 w/e&m	Q3	0323	1.669	$112.23		$22.45	*
90816	Psytx, hosp, 20-30 min	P						
90817	Psytx, hosp, 20-30 min w/e&m	P						
90818	Psytx, hosp, 45-50 min	P						
90819	Psytx, hosp, 45-50 min w/e&m	P						
90821	Psytx, hosp, 75-80 min	P						
90822	Psytx, hosp, 75-80 min w/e&m	P						
90823	Intac psytx, hosp, 20-30 min	P						
90824	Intac psytx, hsp 20-30 w/e&m	P						
90826	Intac psytx, hosp, 45-50 min	P						
90827	Intac psytx, hsp 45-50 w/e&m	P						
90828	Intac psytx, hosp, 75-80 min	P						
90829	Intac psytx, hsp 75-80 w/e&m	P						
90845	Psychoanalysis	Q3	0323	1.669	$112.23		$22.45	*
90846	Family psytx w/o patient	Q3	0324	2.2103	$148.62		$29.73	*
90847	Family psytx w/patient	Q3	0324	2.2103	$148.62		$29.73	*
90849	Multiple family group psytx	Q3	0325	0.8905	$59.88	$12.77	$11.98	*
90853	Group psychotherapy	Q3	0325	0.8905	$59.88	$12.77	$11.98	*
90857	Intac group psytx	Q3	0325	0.8905	$59.88	$12.77	$11.98	*
90862	Medication management	Q3	0606	1.3222	$88.91		$17.79	*
90865	Narcosynthesis	Q3	0323	1.669	$112.23		$22.45	*
90870	Electroconvulsive therapy	S	0320	5.862	$394.17	$80.06	$78.84	*
90875	Psychophysiological therapy	E						
90876	Psychophysiological therapy	E						
90880	Hypnotherapy	Q3	0323	1.669	$112.23		$22.45	*
90882	Environmental manipulation	E						
90885	Psy evaluation of records	N						
90887	Consultation with family	N						
90889	Preparation of report	N						
90899	Psychiatric service/therapy	Q3	0322	1.1958	$80.41		$16.09	*
90901	Biofeedback train, any meth	A						
90911	Biofeedback peri/uro/rectal	T	0126	1.0958	$73.68	$16.21	$14.74	*
90935	Hemodialysis, one evaluation	S	0170	6.8212	$458.66		$91.74	*
90937	Hemodialysis, repeated eval	B						
90940	Hemodialysis access study	N						
90945	Dialysis, one evaluation	V	0608	2.4853	$167.11		$33.43	*
90947	Dialysis, repeated eval	B						

90951	Esrd serv, 4 visits p mo, <2	M						
90952	Esrd serv, 2-3 vsts p mo, <2	M						
90953	Esrd serv, 1 visit p mo, <2	M						
90954	Esrd serv, 4 vsts p mo, 2-11	M						
90955	Esrd srv 2-3 vsts p mo, 2-11	M						
90956	Esrd srv, 1 visit p mo, 2-11	M						
90957	Esrd srv, 4 vsts p mo, 12-19	M						
90958	Esrd srv 2-3 vsts p mo 12-19	M						
90959	Esrd serv, 1 vst p mo, 12-19	M						
90960	Esrd srv, 4 visits p mo, 20+	M						
90961	Esrd srv, 2-3 vsts p mo, 20+	M						
90962	Esrd serv, 1 visit p mo, 20+	M						
90963	Esrd home pt, serv p mo, <2	M						
90964	Esrd home pt serv p mo, 2-11	M						
90965	Esrd home pt serv p mo 12-19	M						
90966	Esrd home pt, serv p mo, 20+	M						
90967	Esrd home pt serv p day, <2	M						
90968	Esrd home pt srv p day, 2-11	M						
90969	Esrd home pt srv p day 12-19	M						
90970	Esrd home pt serv p day, 20+	M						
90989	Dialysis training, complete	B						
90993	Dialysis training, incompl	B						
90997	Hemoperfusion	B						
90999	Dialysis procedure	B						
91000	Esophageal intubation	X	0361	4.0839	$274.61	$83.23	$54.93	*
91010	Esophagus motility study	X	0361	4.0839	$274.61	$83.23	$54.93	*
91011	Esophagus motility study	X	0361	4.0839	$274.61	$83.23	$54.93	*
91012	Esophagus motility study	X	0361	4.0839	$274.61	$83.23	$54.93	*
91020	Gastric motility studies	X	0361	4.0839	$274.61	$83.23	$54.93	*
91022	Duodenal motility study	X	0361	4.0839	$274.61	$83.23	$54.93	*
91030	Acid perfusion of esophagus	X	0361	4.0839	$274.61	$83.23	$54.93	*
91034	Gastroesophageal reflux test	X	0361	4.0839	$274.61	$83.23	$54.93	*
91035	G-esoph reflx tst w/electrod	X	0361	4.0839	$274.61	$83.23	$54.93	*
91037	Esoph imped function test	X	0361	4.0839	$274.61	$83.23	$54.93	*
91038	Esoph imped funct test > 1h	X	0361	4.0839	$274.61	$83.23	$54.93	*
91040	Esoph balloon distension tst	X	0360	1.5203	$102.23	$33.88	$20.45	*
91052	Gastric analysis test	X	0361	4.0839	$274.61	$83.23	$54.93	*
91055	Gastric intubation for smear	X	0360	1.5203	$102.23	$33.88	$20.45	*
91065	Breath hydrogen test	X	0360	1.5203	$102.23	$33.88	$20.45	*
91105	Gastric intubation treatment	X	0360	1.5203	$102.23	$33.88	$20.45	*
91110	Gi tract capsule endoscopy	T	0142	9.8503	$662.34	$152.78	$132.47	*
91111	Esophageal capsule endoscopy	T	0141	8.7462	$588.10	$143.38	$117.62	*
91120	Rectal sensation test	T	0126	1.0958	$73.68	$16.21	$14.74	*
91122	Anal pressure record	T	0156	3.0214	$203.16		$40.64	*
91123	Irrigate fecal impaction	N						
91132	Electrogastrography	X	0360	1.5203	$102.23	$33.88	$20.45	*
91133	Electrogastrography w/test	X	0360	1.5203	$102.23	$33.88	$20.45	*
91299	Gastroenterology procedure	X	0360	1.5203	$102.23	$33.88	$20.45	*
92002	Eye exam, new patient	V	0606	1.3222	$88.91		$17.79	*
92004	Eye exam, new patient	V	0606	1.3222	$88.91		$17.79	*
92012	Eye exam established pat	V	0604	0.8593	$57.78		$11.56	*
92014	Eye exam & treatment	V	0605	1.0337	$69.51		$13.91	*
92015	Refraction	E						
92018	New eye exam & treatment	T	0699	15.5407	$1,044.97		$209.00	*
92019	Eye exam & treatment	T	0699	15.5407	$1,044.97		$209.00	*
92020	Special eye evaluation	S	0230	0.5945	$39.97		$8.00	*
92025	Corneal topography	S	0698	0.9553	$64.24		$12.85	*
92060	Special eye evaluation	S	0698	0.9553	$64.24		$12.85	*
92065	Orthoptic/pleoptic training	S	0698	0.9553	$64.24		$12.85	*
92070	Fitting of contact lens	N						
92081	Visual field examination(s)	S	0230	0.5945	$39.97		$8.00	*
92082	Visual field examination(s)	S	0698	0.9553	$64.24		$12.85	*

92083	Visual field examination(s)	S	0698	0.9553	$64.24		$12.85	*
92100	Serial tonometry exam(s)	N						
92120	Tonography & eye evaluation	S	0698	0.9553	$64.24		$12.85	*
92130	Water provocation tonography	S	0230	0.5945	$39.97		$8.00	*
92135	Ophth dx imaging post seg	S	0230	0.5945	$39.97		$8.00	*
92136	Ophthalmic biometry	S	0698	0.9553	$64.24		$12.85	*
92140	Glaucoma provocative tests	S	0230	0.5945	$39.97		$8.00	*
92225	Special eye exam, initial	S	0230	0.5945	$39.97		$8.00	*
92226	Special eye exam, subsequent	S	0698	0.9553	$64.24		$12.85	*
92230	Eye exam with photos	S	0231	1.9575	$131.62		$26.33	*
92235	Eye exam with photos	S	0231	1.9575	$131.62		$26.33	*
92240	Icg angiography	S	0231	1.9575	$131.62		$26.33	*
92250	Eye exam with photos	S	0698	0.9553	$64.24		$12.85	*
92260	Ophthalmoscopy/dynamometry	S	0230	0.5945	$39.97		$8.00	*
92265	Eye muscle evaluation	S	0698	0.9553	$64.24		$12.85	*
92270	Electro-oculography	S	0230	0.5945	$39.97		$8.00	*
92275	Electroretinography	S	0231	1.9575	$131.62		$26.33	*
92283	Color vision examination	S	0230	0.5945	$39.97		$8.00	*
92284	Dark adaptation eye exam	S	0698	0.9553	$64.24		$12.85	*
92285	Eye photography	S	0698	0.9553	$64.24		$12.85	*
92286	Internal eye photography	S	0231	1.9575	$131.62		$26.33	*
92287	Internal eye photography	S	0231	1.9575	$131.62		$26.33	*
92310	Contact lens fitting	E						
92311	Contact lens fitting	S	0698	0.9553	$64.24		$12.85	*
92312	Contact lens fitting	S	0698	0.9553	$64.24		$12.85	*
92313	Contact lens fitting	S	0230	0.5945	$39.97		$8.00	*
92314	Prescription of contact lens	E						
92315	Prescription of contact lens	S	0230	0.5945	$39.97		$8.00	*
92316	Prescription of contact lens	S	0698	0.9553	$64.24		$12.85	*
92317	Prescription of contact lens	S	0230	0.5945	$39.97		$8.00	*
92325	Modification of contact lens	S	0230	0.5945	$39.97		$8.00	*
92326	Replacement of contact lens	S	0698	0.9553	$64.24		$12.85	*
92340	Fitting of spectacles	E						
92341	Fitting of spectacles	E						
92342	Fitting of spectacles	E						
92352	Special spectacles fitting	S	0698	0.9553	$64.24		$12.85	*
92353	Special spectacles fitting	S	0230	0.5945	$39.97		$8.00	*
92354	Special spectacles fitting	S	0230	0.5945	$39.97		$8.00	*
92355	Special spectacles fitting	S	0230	0.5945	$39.97		$8.00	*
92358	Eye prosthesis service	S	0230	0.5945	$39.97		$8.00	*
92370	Repair & adjust spectacles	E						
92371	Repair & adjust spectacles	S	0230	0.5945	$39.97		$8.00	*
92499	Eye service or procedure	S	0230	0.5945	$39.97		$8.00	*
92502	Ear and throat examination	T	0251	3.425	$230.30		$46.06	*
92504	Ear microscopy examination	N						
92506	Speech/hearing evaluation	A						
92507	Speech/hearing therapy	A						
92508	Speech/hearing therapy	A						
92511	Nasopharyngoscopy	T	0071	0.8007	$53.84	$11.11	$10.77	*
92512	Nasal function studies	X	0363	0.9061	$60.93	$17.10	$12.19	*
92516	Facial nerve function test	X	0660	1.5019	$100.99	$27.10	$20.20	*
92520	Laryngeal function studies	X	0660	1.5019	$100.99	$27.10	$20.20	*
92526	Oral function therapy	A						
92531	Spontaneous nystagmus study	N						
92532	Positional nystagmus test	N						
92533	Caloric vestibular test	N						
92534	Optokinetic nystagmus test	N						
92540	Basic vestibular evaluation	X	0660	1.5019	$100.99	$27.10	$20.20	*
92541	Spontaneous nystagmus test	X	0363	0.9061	$60.93	$17.10	$12.19	*
92542	Positional nystagmus test	X	0363	0.9061	$60.93	$17.10	$12.19	*
92543	Caloric vestibular test	X	0660	1.5019	$100.99	$27.10	$20.20	*
92544	Optokinetic nystagmus test	X	0363	0.9061	$60.93	$17.10	$12.19	*

92545	Oscillating tracking test	X	0363	0.9061	$60.93	$17.10	$12.19	*
92546	Sinusoidal rotational test	X	0660	1.5019	$100.99	$27.10	$20.20	*
92547	Supplemental electrical test	N						
92548	Posturography	X	0660	1.5019	$100.99	$27.10	$20.20	*
92550	Tympanometry & reflex thresh	X	0364	0.47	$31.60	$7.06	$6.32	*
92551	Pure tone hearing test, air	E						
92552	Pure tone audiometry, air	X	0364	0.47	$31.60	$7.06	$6.32	*
92553	Audiometry, air & bone	X	0365	1.2675	$85.23	$18.52	$17.05	*
92555	Speech threshold audiometry	X	0364	0.47	$31.60	$7.06	$6.32	*
92556	Speech audiometry, complete	X	0364	0.47	$31.60	$7.06	$6.32	*
92557	Comprehensive hearing test	X	0365	1.2675	$85.23	$18.52	$17.05	*
92559	Group audiometric testing	E						
92560	Bekesy audiometry, screen	E						
92561	Bekesy audiometry, diagnosis	X	0364	0.47	$31.60	$7.06	$6.32	*
92562	Loudness balance test	X	0364	0.47	$31.60	$7.06	$6.32	*
92563	Tone decay hearing test	X	0364	0.47	$31.60	$7.06	$6.32	*
92564	Sisi hearing test	X	0364	0.47	$31.60	$7.06	$6.32	*
92565	Stenger test, pure tone	X	0364	0.47	$31.60	$7.06	$6.32	*
92567	Tympanometry	X	0364	0.47	$31.60	$7.06	$6.32	*
92568	Acoustic refl threshold tst	X	0364	0.47	$31.60	$7.06	$6.32	*
92570	Acoustic immittance testing	X	0364	0.47	$31.60	$7.06	$6.32	*
92571	Filtered speech hearing test	X	0364	0.47	$31.60	$7.06	$6.32	*
92572	Staggered spondaic word test	X	0366	1.6243	$109.22	$24.94	$21.85	*
92575	Sensorineural acuity test	X	0364	0.47	$31.60	$7.06	$6.32	*
92576	Synthetic sentence test	X	0364	0.47	$31.60	$7.06	$6.32	*
92577	Stenger test, speech	X	0366	1.6243	$109.22	$24.94	$21.85	*
92579	Visual audiometry (vra)	X	0365	1.2675	$85.23	$18.52	$17.05	*
92582	Conditioning play audiometry	X	0365	1.2675	$85.23	$18.52	$17.05	*
92583	Select picture audiometry	X	0364	0.47	$31.60	$7.06	$6.32	*
92584	Electrocochleography	S	0216	2.6831	$180.41		$36.09	*
92585	Auditor evoke potent, compre	S	0216	2.6831	$180.41		$36.09	*
92586	Auditor evoke potent, limit	S	0218	1.1965	$80.45		$16.09	*
92587	Evoked auditory test	X	0363	0.9061	$60.93	$17.10	$12.19	*
92588	Evoked auditory test	X	0363	0.9061	$60.93	$17.10	$12.19	*
92590	Hearing aid exam, one ear	E						
92591	Hearing aid exam, both ears	E						
92592	Hearing aid check, one ear	E						
92593	Hearing aid check, both ears	E						
92594	Electro hearng aid test, one	E						
92595	Electro hearng aid tst, both	E						
92596	Ear protector evaluation	X	0364	0.47	$31.60	$7.06	$6.32	*
92597	Oral speech device eval	A						
92601	Cochlear implt f/up exam < 7	X	0366	1.6243	$109.22	$24.94	$21.85	*
92602	Reprogram cochlear implt < 7	X	0366	1.6243	$109.22	$24.94	$21.85	*
92603	Cochlear implt f/up exam 7 >	X	0366	1.6243	$109.22	$24.94	$21.85	*
92604	Reprogram cochlear implt 7 >	X	0366	1.6243	$109.22	$24.94	$21.85	*
92605	Eval for nonspeech device rx	A						
92606	Non-speech device service	A						
92607	Ex for speech device rx, 1hr	A						
92608	Ex for speech device rx addl	A						
92609	Use of speech device service	A						
92610	Evaluate swallowing function	A						
92611	Motion fluoroscopy/swallow	A						
92612	Endoscopy swallow tst (fees)	A						
92613	Endoscopy swallow tst (fees)	B						
92614	Laryngoscopic sensory test	A						
92615	Eval laryngoscopy sense tst	E						
92616	Fees w/laryngeal sense test	A						
92617	Interprt fees/laryngeal test	E						
92620	Auditory function, 60 min	X	0365	1.2675	$85.23	$18.52	$17.05	*
92621	Auditory function, + 15 min	N						
92625	Tinnitus assessment	X	0365	1.2675	$85.23	$18.52	$17.05	*

92626	Eval aud rehab status	X	0366	1.6243	$109.22	$24.94	$21.85	*
92627	Eval aud status rehab add-on	N						
92630	Aud rehab pre-ling hear loss	E						
92633	Aud rehab postling hear loss	E						
92640	Aud brainstem implt programg	X	0365	1.2675	$85.23	$18.52	$17.05	*
92700	Ent procedure/service	X	0364	0.47	$31.60	$7.06	$6.32	*
92950	Heart/lung resuscitation cpr	S	0094	2.4553	$165.10	$46.29	$33.02	*
92953	Temporary external pacing	S	0094	2.4553	$165.10	$46.29	$33.02	*
92960	Cardioversion electric, ext	S	0679	5.5047	$370.14	$95.30	$74.03	*
92961	Cardioversion, electric, int	S	0679	5.5047	$370.14	$95.30	$74.03	*
92970	Cardioassist, internal	C						
92971	Cardioassist, external	C						
92973	Percut coronary thrombectomy	T	0088	40.9003	$2,750.18	$655.22	$550.04	*
92974	Cath place, cardio brachytx	T	0103	17.8436	$1,199.82		$239.97	*
92975	Dissolve clot, heart vessel	C						
92977	Dissolve clot, heart vessel	T	0676	2.3954	$161.07		$32.22	*
92978	Intravasc us, heart add-on	N						
92979	Intravasc us, heart add-on	N						
92980	Insert intracoronary stent	T	0104	84.7773	$5,700.51		$1,140.11	*
92981	Insert intracoronary stent	T	0104	84.7773	$5,700.51		$1,140.11	*
92982	Coronary artery dilation	T	0083	50.6809	$3,407.83		$681.57	*
92984	Coronary artery dilation	T	0083	50.6809	$3,407.83		$681.57	*
92986	Revision of aortic valve	T	0083	50.6809	$3,407.83		$681.57	*
92987	Revision of mitral valve	T	0083	50.6809	$3,407.83		$681.57	*
92990	Revision of pulmonary valve	T	0083	50.6809	$3,407.83		$681.57	*
92992	Revision of heart chamber	C						
92993	Revision of heart chamber	C						
92995	Coronary atherectomy	T	0082	93.3244	$6,275.23		$1,255.05	*
92996	Coronary atherectomy add-on	T	0082	93.3244	$6,275.23		$1,255.05	*
92997	Pul art balloon repr, percut	T	0083	50.6809	$3,407.83		$681.57	*
92998	Pul art balloon repr, percut	T	0083	50.6809	$3,407.83		$681.57	*

93000	Electrocardiogram, complete	M						
93005	Electrocardiogram, tracing	S	0099	0.394	$26.49		$5.30	*
93010	Electrocardiogram report	B						
93012	Transmission of ecg	N						
93014	Report on transmitted ecg	B						
93015	Cardiovascular stress test	B						
93016	Cardiovascular stress test	B						
93017	Cardiovascular stress test	X	0100	2.6136	$175.74	$41.44	$35.15	*
93018	Cardiovascular stress test	B						
93024	Cardiac drug stress test	X	0100	2.6136	$175.74	$41.44	$35.15	*
93025	Microvolt t-wave assess	X	0100	2.6136	$175.74	$41.44	$35.15	*
93040	Rhythm ECG with report	B						
93041	Rhythm ECG, tracing	X	0035	0.232	$15.60		$3.12	*
93042	Rhythm ECG, report	B						
93224	ECG monitor/report, 24 hrs	M						
93225	ECG monitor/record, 24 hrs	S	0097	0.9848	$66.22	$23.79	$13.25	*
93226	ECG monitor/report, 24 hrs	S	0097	0.9848	$66.22	$23.79	$13.25	*
93227	ECG monitor/review, 24 hrs	M						
93228	Remote 30 day ecg rev/report	M						
93229	Remote 30 day ecg tech supp	S	0209	11.4315	$768.67	$268.73	$153.74	*
93230	ECG monitor/report, 24 hrs	M						
93231	Ecg monitor/record, 24 hrs	S	0097	0.9848	$66.22	$23.79	$13.25	*
93232	ECG monitor/report, 24 hrs	S	0097	0.9848	$66.22	$23.79	$13.25	*
93233	ECG monitor/review, 24 hrs	M						
93235	ECG monitor/report, 24 hrs	M						
93236	ECG monitor/report, 24 hrs	S	0097	0.9848	$66.22	$23.79	$13.25	*
93237	ECG monitor/review, 24 hrs	M						
93268	ECG record/review	M						
93270	ECG recording	S	0097	0.9848	$66.22	$23.79	$13.25	*
93271	Ecg/monitoring and analysis	S	0692	1.6	$107.59		$21.52	*
93272	Ecg/review, interpret only	M						

93278	ECG/signal-averaged	X	0035	0.232	$15.60		$3.12	*
93279	Pm device progr eval, sngl	S	0690	0.3506	$23.57	$8.67	$4.72	*
93280	Pm device progr eval, dual	S	0690	0.3506	$23.57	$8.67	$4.72	*
93281	Pm device progr eval, multi	S	0690	0.3506	$23.57	$8.67	$4.72	*
93282	Icd device prog eval, 1 sngl	S	0689	0.568	$38.19		$7.64	*
93283	Icd device progr eval, dual	S	0689	0.568	$38.19		$7.64	*
93284	Icd device progr eval, mult	S	0689	0.568	$38.19		$7.64	*
93285	Ilr device eval progr	S	0690	0.3506	$23.57	$8.67	$4.72	*
93286	Pre-op pm device eval	N						
93287	Pre-op icd device eval	N						
93288	Pm device eval in person	S	0690	0.3506	$23.57	$8.67	$4.72	*
93289	Icd device interrogate	S	0689	0.568	$38.19		$7.64	*
93290	Icm device eval	S	0690	0.3506	$23.57	$8.67	$4.72	*
93291	Ilr device interrogate	S	0690	0.3506	$23.57	$8.67	$4.72	*
93292	Wcd device interrogate	S	0689	0.568	$38.19		$7.64	*
93293	Pm phone r-strip device eval	S	0689	0.568	$38.19		$7.64	*
93294	Pm device interrogate remote	M						
93295	Icd device interrogat remote	M						
93296	Pm/icd remote tech serv	S	0689	0.568	$38.19		$7.64	*
93297	Icm device interrogat remote	M						
93298	Ilr device interrogat remote	M						
93299	Icm/ilr remote tech serv	S	0689	0.568	$38.19		$7.64	*
93303	Echo transthoracic	S	0270	8.8425	$594.58	$141.32	$118.92	*
93304	Echo transthoracic	S	0269	6.6903	$449.86		$89.98	*
93306	Tte w/doppler, complete	S	0269	6.6903	$449.86		$89.98	*
93307	Tte w/o doppler, complete	S	0697	3.9223	$263.74		$52.75	*
93308	Tte, f-up or lmtd	S	0697	3.9223	$263.74		$52.75	*
93312	Echo transesophageal	S	0270	8.8425	$594.58	$141.32	$118.92	*
93313	Echo transesophageal	S	0269	6.6903	$449.86		$89.98	*
93314	Echo transesophageal	N						
93315	Echo transesophageal	S	0270	8.8425	$594.58	$141.32	$118.92	*
93316	Echo transesophageal	S	0270	8.8425	$594.58	$141.32	$118.92	*
93317	Echo transesophageal	N						
93318	Echo transesophageal intraop	S	0270	8.8425	$594.58	$141.32	$118.92	*
93320	Doppler echo exam, heart	N						
93321	Doppler echo exam, heart	N						
93325	Doppler color flow add-on	N						
93350	Stress tte only	S	0269	6.6903	$449.86		$89.98	*
93351	Stress tte complete	S	0270	8.8425	$594.58	$141.32	$118.92	*
93352	Admin ecg contrast agent	M						
93501	Right heart catheterization	T	0080	39.8099	$2,676.86	$838.92	$535.38	*
93503	Insert/place heart catheter	T	0103	17.8436	$1,199.82		$239.97	*
93505	Biopsy of heart lining	T	0103	17.8436	$1,199.82		$239.97	*
93508	Cath placement, angiography	T	0080	39.8099	$2,676.86	$838.92	$535.38	*
93510	Left heart catheterization	T	0080	39.8099	$2,676.86	$838.92	$535.38	*
93511	Left heart catheterization	T	0080	39.8099	$2,676.86	$838.92	$535.38	*
93514	Left heart catheterization	T	0080	39.8099	$2,676.86	$838.92	$535.38	*
93524	Left heart catheterization	T	0080	39.8099	$2,676.86	$838.92	$535.38	*
93526	Rt & Lt heart catheters	T	0080	39.8099	$2,676.86	$838.92	$535.38	*
93527	Rt & Lt heart catheters	T	0080	39.8099	$2,676.86	$838.92	$535.38	*
93528	Rt & Lt heart catheters	T	0080	39.8099	$2,676.86	$838.92	$535.38	*
93529	Rt, lt heart catheterization	T	0080	39.8099	$2,676.86	$838.92	$535.38	*
93530	Rt heart cath, congenital	T	0080	39.8099	$2,676.86	$838.92	$535.38	*
93531	R & l heart cath, congenital	T	0080	39.8099	$2,676.86	$838.92	$535.38	*
93532	R & l heart cath, congenital	T	0080	39.8099	$2,676.86	$838.92	$535.38	*
93533	R & l heart cath, congenital	T	0080	39.8099	$2,676.86	$838.92	$535.38	*
93539	Injection, cardiac cath	N						
93540	Injection, cardiac cath	N						
93541	Injection for lung angiogram	N						
93542	Injection for heart x-rays	N						
93543	Injection for heart x-rays	N						
93544	Injection for aortography	N						

93545	Inject for coronary x-rays	N						
93555	Imaging, cardiac cath	N						
93556	Imaging, cardiac cath	N						
93561	Cardiac output measurement	N						
93562	Cardiac output measurement	N						
93571	Heart flow reserve measure	N						
93572	Heart flow reserve measure	N						
93580	Transcath closure of asd	T	0434	147.3728	$9,909.49		$1,981.90	*
93581	Transcath closure of vsd	T	0434	147.3728	$9,909.49		$1,981.90	*
93600	Bundle of His recording	S	0084	10.811	$726.94		$145.39	*
93602	Intra-atrial recording	S	0084	10.811	$726.94		$145.39	*
93603	Right ventricular recording	S	0084	10.811	$726.94		$145.39	*
93609	Map tachycardia, add-on	N						
93610	Intra-atrial pacing	S	0084	10.811	$726.94		$145.39	*
93612	Intraventricular pacing	S	0084	10.811	$726.94		$145.39	*
93613	Electrophys map 3d, add-on	N						
93615	Esophageal recording	S	0084	10.811	$726.94		$145.39	*
93616	Esophageal recording	S	0084	10.811	$726.94		$145.39	*
93618	Heart rhythm pacing	S	0084	10.811	$726.94		$145.39	*
93619	Electrophysiology evaluation	Q3	0085	52.3882	$3,522.63		$704.53	*
93620	Electrophysiology evaluation	Q3	0085	52.3882	$3,522.63		$704.53	*
93621	Electrophysiology evaluation	N						
93622	Electrophysiology evaluation	N						
93623	Stimulation, pacing heart	N						
93624	Electrophysiologic study	T	0085	52.3882	$3,522.63		$704.53	*
93631	Heart pacing, mapping	N						
93640	Evaluation heart device	N						
93641	Electrophysiology evaluation	N						
93642	Electrophysiology evaluation	S	0084	10.811	$726.94		$145.39	*
93650	Ablate heart dysrhythm focus	Q3	0085	52.3882	$3,522.63		$704.53	*
93651	Ablate heart dysrhythm focus	Q3	0086	106.9978	$7,194.64		$1,438.93	*
93652	Ablate heart dysrhythm focus	Q3	0086	106.9978	$7,194.64		$1,438.93	*
93660	Tilt table evaluation	S	0101	4.3705	$293.88	$100.24	$58.78	*
93662	Intracardiac ecg (ice)	N						
93668	Peripheral vascular rehab	E						
93701	Bioimpedance, cv analysis	S	0099	0.394	$26.49		$5.30	*
93720	Total body plethysmography	B						
93721	Plethysmography tracing	X	0368	0.8495	$57.12	$20.93	$11.43	*
93722	Plethysmography report	B						
93724	Analyze pacemaker system	S	0690	0.3506	$23.57	$8.67	$4.72	*
93740	Temperature gradient studies	X	0368	0.8495	$57.12	$20.93	$11.43	*
93745	Set-up cardiovert-defibrill	S	0689	0.568	$38.19		$7.64	*
93750	Interrogation vad, in person	S	0692	1.6	$107.59		$21.52	*
93770	Measure venous pressure	N						
93784	Ambulatory BP monitoring	E						
93786	Ambulatory BP recording	S	0097	0.9848	$66.22	$23.79	$13.25	*
93788	Ambulatory BP analysis	S	0097	0.9848	$66.22	$23.79	$13.25	*
93790	Review/report BP recording	M						
93797	Cardiac rehab	S	0095	0.5691	$38.27	$13.86	$7.66	*
93798	Cardiac rehab/monitor	S	0095	0.5691	$38.27	$13.86	$7.66	*
93799	Cardiovascular procedure	S	0097	0.9848	$66.22	$23.79	$13.25	*
93875	Extracranial study	S	0096	1.6075	$108.09	$37.42	$21.62	*
93880	Extracranial study	S	0267	2.3005	$154.69	$60.50	$30.94	*
93882	Extracranial study	S	0267	2.3005	$154.69	$60.50	$30.94	*
93886	Intracranial study	S	0267	2.3005	$154.69	$60.50	$30.94	*
93888	Intracranial study	S	0265	0.9267	$62.31	$22.28	$12.47	*
93890	Tcd, vasoreactivity study	S	0266	1.4434	$97.06	$37.53	$19.42	*
93892	Tcd, emboli detect w/o inj	S	0266	1.4434	$97.06	$37.53	$19.42	*
93893	Tcd, emboli detect w/inj	S	0266	1.4434	$97.06	$37.53	$19.42	*
93922	Extremity study	S	0097	0.9848	$66.22	$23.79	$13.25	*
93923	Extremity study	S	0096	1.6075	$108.09	$37.42	$21.62	*
93924	Extremity study	S	0096	1.6075	$108.09	$37.42	$21.62	*

93925	Lower extremity study	S	0267	2.3005	$154.69	$60.50	$30.94	*
93926	Lower extremity study	S	0266	1.4434	$97.06	$37.53	$19.42	*
93930	Upper extremity study	S	0267	2.3005	$154.69	$60.50	$30.94	*
93931	Upper extremity study	S	0266	1.4434	$97.06	$37.53	$19.42	*
93965	Extremity study	S	0096	1.6075	$108.09	$37.42	$21.62	*
93970	Extremity study	S	0267	2.3005	$154.69	$60.50	$30.94	*
93971	Extremity study	S	0266	1.4434	$97.06	$37.53	$19.42	*
93975	Vascular study	S	0267	2.3005	$154.69	$60.50	$30.94	*
93976	Vascular study	S	0267	2.3005	$154.69	$60.50	$30.94	*
93978	Vascular study	S	0267	2.3005	$154.69	$60.50	$30.94	*
93979	Vascular study	S	0266	1.4434	$97.06	$37.53	$19.42	*
93980	Penile vascular study	S	0267	2.3005	$154.69	$60.50	$30.94	*
93981	Penile vascular study	S	0267	2.3005	$154.69	$60.50	$30.94	*
93982	Aneurysm pressure sens study	S	0097	0.9848	$66.22	$23.79	$13.25	*
93990	Doppler flow testing	S	0266	1.4434	$97.06	$37.53	$19.42	*
94002	Vent mgmt inpat, init day	S	0079	3.0865	$207.54		$41.51	*
94003	Vent mgmt inpat, subq day	S	0079	3.0865	$207.54		$41.51	*
94004	Vent mgmt nf per day	B						
94005	Home vent mgmt supervision	M						
94010	Breathing capacity test	X	0368	0.8495	$57.12	$20.93	$11.43	*
94011	Up to 2 yrs old, spirometry	X	0368	0.8495	$57.12	$20.93	$11.43	*
94012	= 2 yrs, spiromtry w/dilator	X	0368	0.8495	$57.12	$20.93	$11.43	*
94013	= 2 yrs, lung volumes	X	0369	2.6228	$176.36	$42.19	$35.28	*
94014	Patient recorded spirometry	X	0367	0.5968	$40.13	$13.76	$8.03	*
94015	Patient recorded spirometry	X	0367	0.5968	$40.13	$13.76	$8.03	*
94016	Review patient spirometry	A						
94060	Evaluation of wheezing	S	0078	1.4142	$95.09		$19.02	*
94070	Evaluation of wheezing	X	0369	2.6228	$176.36	$42.19	$35.28	*
94150	Vital capacity test	X	0367	0.5968	$40.13	$13.76	$8.03	*
94200	Lung function test (MBC/MVV)	X	0367	0.5968	$40.13	$13.76	$8.03	*
94240	Residual lung capacity	X	0368	0.8495	$57.12	$20.93	$11.43	*
94250	Expired gas collection	X	0368	0.8495	$57.12	$20.93	$11.43	*
94260	Thoracic gas volume	X	0368	0.8495	$57.12	$20.93	$11.43	*
94350	Lung nitrogen washout curve	X	0368	0.8495	$57.12	$20.93	$11.43	*
94360	Measure airflow resistance	X	0367	0.5968	$40.13	$13.76	$8.03	*
94370	Breath airway closing volume	X	0035	0.232	$15.60		$3.12	*
94375	Respiratory flow volume loop	X	0368	0.8495	$57.12	$20.93	$11.43	*
94400	CO2 breathing response curve	X	0367	0.5968	$40.13	$13.76	$8.03	*
94450	Hypoxia response curve	X	0368	0.8495	$57.12	$20.93	$11.43	*
94452	Hast w/report	X	0368	0.8495	$57.12	$20.93	$11.43	*
94453	Hast w/oxygen titrate	X	0368	0.8495	$57.12	$20.93	$11.43	*
94610	Surfactant admin thru tube	S	0077	0.4058	$27.29	$7.74	$5.46	*
94620	Pulmonary stress test/simple	X	0368	0.8495	$57.12	$20.93	$11.43	*
94621	Pulm stress test/complex	X	0369	2.6228	$176.36	$42.19	$35.28	*
94640	Airway inhalation treatment	S	0077	0.4058	$27.29	$7.74	$5.46	*
94642	Aerosol inhalation treatment	S	0078	1.4142	$95.09		$19.02	*
94644	Cbt, 1st hour	X	0340	0.6693	$45.00		$9.00	*
94645	Cbt, each addl hour	X	0340	0.6693	$45.00		$9.00	*
94660	Pos airway pressure, CPAP	S	0078	1.4142	$95.09		$19.02	*
94662	Neg press ventilation, cnp	S	0079	3.0865	$207.54		$41.51	*
94664	Evaluate pt use of inhaler	S	0077	0.4058	$27.29	$7.74	$5.46	*
94667	Chest wall manipulation	S	0077	0.4058	$27.29	$7.74	$5.46	*
94668	Chest wall manipulation	S	0077	0.4058	$27.29	$7.74	$5.46	*
94680	Exhaled air analysis, o2	X	0369	2.6228	$176.36	$42.19	$35.28	*
94681	Exhaled air analysis, o2/co2	X	0368	0.8495	$57.12	$20.93	$11.43	*
94690	Exhaled air analysis	X	0367	0.5968	$40.13	$13.76	$8.03	*
94720	Monoxide diffusing capacity	X	0368	0.8495	$57.12	$20.93	$11.43	*
94725	Membrane diffusion capacity	X	0368	0.8495	$57.12	$20.93	$11.43	*
94750	Pulmonary compliance study	X	0367	0.5968	$40.13	$13.76	$8.03	*
94760	Measure blood oxygen level	N						
94761	Measure blood oxygen level	N						
94762	Measure blood oxygen level	Q1	0097	0.9848	$66.22	$23.79	$13.25	*

94770	Exhaled carbon dioxide test	X	0367	0.5968	$40.13	$13.76	$8.03	*
94772	Breath recording, infant	X	0369	2.6228	$176.36	$42.19	$35.28	*
94774	Ped home apnea rec, compl	B						
94775	Ped home apnea rec, hk-up	S	0097	0.9848	$66.22	$23.79	$13.25	*
94776	Ped home apnea rec, downld	S	0097	0.9848	$66.22	$23.79	$13.25	*
94777	Ped home apnea rec, report	B						
94799	Pulmonary service/procedure	X	0367	0.5968	$40.13	$13.76	$8.03	*
95004	Percut allergy skin tests	X	0381	0.4312	$28.99		$5.80	*
95010	Percut allergy titrate test	X	0381	0.4312	$28.99		$5.80	*
95012	Exhaled nitric oxide meas	X	0367	0.5968	$40.13	$13.76	$8.03	*
95015	Id allergy titrate-drug/bug	X	0381	0.4312	$28.99		$5.80	*
95024	Id allergy test, drug/bug	X	0381	0.4312	$28.99		$5.80	*
95027	Id allergy titrate-airborne	X	0381	0.4312	$28.99		$5.80	*
95028	Id allergy test-delayed type	X	0381	0.4312	$28.99		$5.80	*
95044	Allergy patch tests	X	0381	0.4312	$28.99		$5.80	*
95052	Photo patch test	X	0381	0.4312	$28.99		$5.80	*
95056	Photosensitivity tests	X	0370	1.4598	$98.16		$19.64	*
95060	Eye allergy tests	X	0370	1.4598	$98.16		$19.64	*
95065	Nose allergy test	X	0381	0.4312	$28.99		$5.80	*
95070	Bronchial allergy tests	X	0369	2.6228	$176.36	$42.19	$35.28	*
95071	Bronchial allergy tests	X	0369	2.6228	$176.36	$42.19	$35.28	*
95075	Ingestion challenge test	X	0361	4.0839	$274.61	$83.23	$54.93	*
95115	Immunotherapy, one injection	S	0436	0.3809	$25.61		$5.13	*
95117	Immunotherapy injections	S	0436	0.3809	$25.61		$5.13	*
95120	Immunotherapy, one injection	E						
95125	Immunotherapy, many antigens	E						
95130	Immunotherapy, insect venom	E						
95131	Immunotherapy, insect venoms	E						
95132	Immunotherapy, insect venoms	E						
95133	Immunotherapy, insect venoms	E						
95134	Immunotherapy, insect venoms	E						
95144	Antigen therapy services	S	0437	0.5555	$37.35		$7.47	*
95145	Antigen therapy services	S	0437	0.5555	$37.35		$7.47	*
95146	Antigen therapy services	S	0438	1.1229	$75.50		$15.10	*
95147	Antigen therapy services	S	0438	1.1229	$75.50		$15.10	*
95148	Antigen therapy services	S	0437	0.5555	$37.35		$7.47	*
95149	Antigen therapy services	S	0437	0.5555	$37.35		$7.47	*
95165	Antigen therapy services	S	0436	0.3809	$25.61		$5.13	*
95170	Antigen therapy services	S	0437	0.5555	$37.35		$7.47	*
95180	Rapid desensitization	X	0370	1.4598	$98.16		$19.64	*
95199	Allergy immunology services	X	0381	0.4312	$28.99		$5.80	*
95250	Glucose monitoring, cont	V	0607	1.683	$113.17		$22.64	*
95251	Gluc monitor, cont, phys i&r	B						
95803	Actigraphy testing	S	0218	1.1965	$80.45		$16.09	*
95805	Multiple sleep latency test	S	0209	11.4315	$768.67	$268.73	$153.74	*
95806	Sleep study unatt&resp efft	S	0213	2.4043	$161.67	$53.58	$32.34	*
95807	Sleep study, attended	S	0209	11.4315	$768.67	$268.73	$153.74	*
95808	Polysomnography, 1-3	S	0209	11.4315	$768.67	$268.73	$153.74	*
95810	Polysomnography, 4 or more	S	0209	11.4315	$768.67	$268.73	$153.74	*
95811	Polysomnography w/cpap	S	0209	11.4315	$768.67	$268.73	$153.74	*
95812	Eeg, 41-60 minutes	S	0213	2.4043	$161.67	$53.58	$32.34	*
95813	Eeg, over 1 hour	S	0213	2.4043	$161.67	$53.58	$32.34	*
95816	Eeg, awake and drowsy	S	0213	2.4043	$161.67	$53.58	$32.34	*
95819	Eeg, awake and asleep	S	0213	2.4043	$161.67	$53.58	$32.34	*
95822	Eeg, coma or sleep only	S	0213	2.4043	$161.67	$53.58	$32.34	*
95824	Eeg, cerebral death only	S	0216	2.6831	$180.41		$36.09	*
95827	Eeg, all night recording	S	0213	2.4043	$161.67	$53.58	$32.34	*
95829	Surgery electrocorticogram	N						
95830	Insert electrodes for EEG	B						
95831	Limb muscle testing, manual	A						
95832	Hand muscle testing, manual	A						
95833	Body muscle testing, manual	A						

95834	Body muscle testing, manual	A						
95851	Range of motion measurements	A						
95852	Range of motion measurements	A						
95857	Tensilon test	S	0218	1.1965	$80.45		$16.09	*
95860	Muscle test, one limb	S	0218	1.1965	$80.45		$16.09	*
95861	Muscle test, 2 limbs	S	0218	1.1965	$80.45		$16.09	*
95863	Muscle test, 3 limbs	S	0218	1.1965	$80.45		$16.09	*
95864	Muscle test, 4 limbs	S	0218	1.1965	$80.45		$16.09	*
95865	Muscle test, larynx	S	0218	1.1965	$80.45		$16.09	*
95866	Muscle test, hemidiaphragm	S	0218	1.1965	$80.45		$16.09	*
95867	Muscle test cran nerv unilat	S	0218	1.1965	$80.45		$16.09	*
95868	Muscle test cran nerve bilat	S	0218	1.1965	$80.45		$16.09	*
95869	Muscle test, thor paraspinal	S	0215	0.6135	$41.25		$8.25	*
95870	Muscle test, nonparaspinal	S	0215	0.6135	$41.25		$8.25	*
95872	Muscle test, one fiber	S	0218	1.1965	$80.45		$16.09	*
95873	Guide nerv destr, elec stim	N						
95874	Guide nerv destr, needle emg	N						
95875	Limb exercise test	S	0215	0.6135	$41.25		$8.25	*
95900	Motor nerve conduction test	S	0215	0.6135	$41.25		$8.25	*
95903	Motor nerve conduction test	S	0215	0.6135	$41.25		$8.25	*
95904	Sense nerve conduction test	S	0215	0.6135	$41.25		$8.25	*
95905	Motor/sens nrve conduct test	S	0215	0.6135	$41.25		$8.25	*
95920	Intraop nerve test add-on	N						
95921	Autonomic nerv function test	S	0218	1.1965	$80.45		$16.09	*
95922	Autonomic nerv function test	S	0215	0.6135	$41.25		$8.25	*
95923	Autonomic nerv function test	S	0218	1.1965	$80.45		$16.09	*
95925	Somatosensory testing	S	0216	2.6831	$180.41		$36.09	*
95926	Somatosensory testing	S	0216	2.6831	$180.41		$36.09	*
95927	Somatosensory testing	S	0216	2.6831	$180.41		$36.09	*
95928	C motor evoked, uppr limbs	S	0218	1.1965	$80.45		$16.09	*
95929	C motor evoked, lwr limbs	S	0218	1.1965	$80.45		$16.09	*
95930	Visual evoked potential test	S	0216	2.6831	$180.41		$36.09	*
95933	Blink reflex test	S	0215	0.6135	$41.25		$8.25	*
95934	H-reflex test	S	0215	0.6135	$41.25		$8.25	*
95936	H-reflex test	S	0215	0.6135	$41.25		$8.25	*
95937	Neuromuscular junction test	S	0218	1.1965	$80.45		$16.09	*
95950	Ambulatory eeg monitoring	S	0209	11.4315	$768.67	$268.73	$153.74	*
95951	EEG monitoring/videorecord	S	0209	11.4315	$768.67	$268.73	$153.74	*
95953	EEG monitoring/computer	S	0209	11.4315	$768.67	$268.73	$153.74	*
95954	EEG monitoring/giving drugs	S	0218	1.1965	$80.45		$16.09	*
95955	EEG during surgery	N						
95956	Eeg monitoring, cable/radio	S	0209	11.4315	$768.67	$268.73	$153.74	*
95957	EEG digital analysis	N						
95958	EEG monitoring/function test	S	0213	2.4043	$161.67	$53.58	$32.34	*
95961	Electrode stimulation, brain	S	0216	2.6831	$180.41		$36.09	*
95962	Electrode stim, brain add-on	S	0216	2.6831	$180.41		$36.09	*
95965	Meg, spontaneous	S	0067	52.9891	$3,563.04		$712.61	*
95966	Meg, evoked, single	S	0065	14.2808	$960.26		$192.06	*
95967	Meg, evoked, each addl	S	0065	14.2808	$960.26		$192.06	*
95970	Analyze neurostim, no prog	S	0218	1.1965	$80.45		$16.09	*
95971	Analyze neurostim, simple	S	0692	1.6	$107.59		$21.52	*
95972	Analyze neurostim, complex	S	0692	1.6	$107.59		$21.52	*
95973	Analyze neurostim, complex	S	0692	1.6	$107.59		$21.52	*
95974	Cranial neurostim, complex	S	0692	1.6	$107.59		$21.52	*
95975	Cranial neurostim, complex	S	0692	1.6	$107.59		$21.52	*
95978	Analyze neurostim brain/1h	S	0692	1.6	$107.59		$21.52	*
95979	Analyz neurostim brain addon	S	0692	1.6	$107.59		$21.52	*
95980	Io anal gast n-stim init	N						
95981	Io anal gast n-stim subsq	S	0218	1.1965	$80.45		$16.09	*
95982	Io ga n-stim subsq w/reprog	S	0692	1.6	$107.59		$21.52	*
95990	Spin/brain pump refil & main	S	0439	1.8808	$126.47		$25.30	*
95991	Spin/brain pump refil & main	S	0439	1.8808	$126.47		$25.30	*

95992	Canalith repositioning proc	E						
95999	Neurological procedure	S	0215	0.6135	$41.25		$8.25	*
96000	Motion analysis, video/3d	S	0216	2.6831	$180.41		$36.09	*
96001	Motion test w/ft press meas	S	0216	2.6831	$180.41		$36.09	*
96002	Dynamic surface emg	S	0218	1.1965	$80.45		$16.09	*
96003	Dynamic fine wire emg	S	0215	0.6135	$41.25		$8.25	*
96004	Phys review of motion tests	B						
96020	Functional brain mapping	N						
96040	Genetic counseling, 30 min	B						
96101	Psycho testing by psych/phys	Q3	0382	2.6683	$179.42		$35.89	*
96102	Psycho testing by technician	Q3	0382	2.6683	$179.42		$35.89	*
96103	Psycho testing admin by comp	Q3	0373	0.9758	$65.61		$13.13	*
96105	Assessment of aphasia	A						
96110	Developmental test, lim	Q3	0373	0.9758	$65.61		$13.13	*
96111	Developmental test, extend	Q3	0373	0.9758	$65.61		$13.13	*
96116	Neurobehavioral status exam	Q3	0382	2.6683	$179.42		$35.89	*
96118	Neuropsych tst by psych/phys	Q3	0382	2.6683	$179.42		$35.89	*
96119	Neuropsych testing by tec	Q3	0382	2.6683	$179.42		$35.89	*
96120	Neuropsych tst admin w/comp	Q3	0382	2.6683	$179.42		$35.89	*
96125	Cognitive test by hc pro	A						
96150	Assess hlth/behave, init	Q3	0432	0.6013	$40.43		$8.09	*
96151	Assess hlth/behave, subseq	Q3	0432	0.6013	$40.43		$8.09	*
96152	Intervene hlth/behave, indiv	Q3	0432	0.6013	$40.43		$8.09	*
96153	Intervene hlth/behave, group	Q3	0432	0.6013	$40.43		$8.09	*
96154	Interv hlth/behav, fam w/pt	Q3	0432	0.6013	$40.43		$8.09	*
96155	Interv hlth/behav fam no pt	E						
96360	Hydration iv infusion, init	S	0438	1.1229	$75.50		$15.10	*
96361	Hydrate iv infusion, add-on	S	0436	0.3809	$25.61		$5.13	*
96361	Hydrate iv infusion, add-on	S	0436	0.3809	$25.61		$5.13	*
96365	Ther/proph/diag iv inf, init	S	0439	1.8808	$126.47		$25.30	*
96366	Ther/proph/diag iv inf addon	S	0436	0.3809	$25.61		$5.13	*
96367	Tx/proph/dg addl seq iv inf	S	0437	0.5555	$37.35		$7.47	*
96368	Ther/diag concurrent inf	N						
96369	Sc ther infusion, up to 1 hr	S	0439	1.8808	$126.47		$25.30	*
96370	Sc ther infusion, addl hr	S	0437	0.5555	$37.35		$7.47	*
96371	Sc ther infusion, reset pump	S	0436	0.3809	$25.61		$5.13	*
96372	Ther/proph/diag inj, sc/im	S	0436	0.3809	$25.61		$5.13	*
96373	Ther/proph/diag inj, ia	S	0437	0.5555	$37.35		$7.47	*
96374	Ther/proph/diag inj, iv push	S	0437	0.5555	$37.35		$7.47	*
96375	Tx/pro/dx inj new drug addon	S	0437	0.5555	$37.35		$7.47	*
96376	Tx/pro/dx inj new drug adon	N						
96379	Ther/prop/diag inj/inf proc	S	0436	0.3809	$25.61		$5.13	*
96401	Chemo, anti-neopl, sq/im	S	0437	0.5555	$37.35		$7.47	*
96402	Chemo hormon antineopl sq/im	S	0437	0.5555	$37.35		$7.47	*
96405	Chemo intralesional, up to 7	S	0437	0.5555	$37.35		$7.47	*
96406	Chemo intralesional over 7	S	0439	1.8808	$126.47		$25.30	*
96409	Chemo, iv push, sngl drug	S	0439	1.8808	$126.47		$25.30	*
96411	Chemo, iv push, addl drug	S	0438	1.1229	$75.50		$15.10	*
96413	Chemo, iv infusion, 1 hr	S	0440	3.2632	$219.42		$43.89	*
96415	Chemo, iv infusion, addl hr	S	0437	0.5555	$37.35		$7.47	*
96416	Chemo prolong infuse w/pump	S	0440	3.2632	$219.42		$43.89	*
96417	Chemo iv infus each addl seq	S	0438	1.1229	$75.50		$15.10	*
96420	Chemo, ia, push tecnique	S	0438	1.1229	$75.50		$15.10	*
96422	Chemo ia infusion up to 1 hr	S	0440	3.2632	$219.42		$43.89	*
96423	Chemo ia infuse each addl hr	S	0438	1.1229	$75.50		$15.10	*
96425	Chemotherapy,infusion method	S	0440	3.2632	$219.42		$43.89	*
96440	Chemotherapy, intracavitary	S	0439	1.8808	$126.47		$25.30	*
96445	Chemotherapy, intracavitary	S	0440	3.2632	$219.42		$43.89	*
96450	Chemotherapy, into CNS	S	0440	3.2632	$219.42		$43.89	*
96521	Refill/maint, portable pump	S	0439	1.8808	$126.47		$25.30	*
96522	Refill/maint pump/resvr syst	S	0439	1.8808	$126.47		$25.30	*
96523	Irrig drug delivery device	Q1	0624	0.6132	$41.23	$12.65	$8.25	*

96542	Chemotherapy injection	S	0438	1.1229	$75.50		$15.10	*
96549	Chemotherapy, unspecified	S	0436	0.3809	$25.61		$5.13	*
96567	Photodynamic tx, skin	T	0016	2.7982	$188.15		$37.63	*
96570	Photodynmc tx, 30 min add-on	T	0015	1.5412	$103.63		$20.73	*
96571	Photodynamic tx, addl 15 min	T	0015	1.5412	$103.63		$20.73	*
96900	Ultraviolet light therapy	S	0001	0.5302	$35.65		$7.13	*
96902	Trichogram	N						
96904	Whole body photography	N						
96910	Photochemotherapy with UV-B	S	0001	0.5302	$35.65		$7.13	*
96912	Photochemotherapy with UV-A	S	0001	0.5302	$35.65		$7.13	*
96913	Photochemotherapy, UV-A or B	S	0683	2.679	$180.14		$36.03	*
96920	Laser tx, skin < 250 sq cm	T	0015	1.5412	$103.63		$20.73	*
96921	Laser tx, skin 250-500 sq cm	T	0015	1.5412	$103.63		$20.73	*
96922	Laser tx, skin > 500 sq cm	T	0015	1.5412	$103.63		$20.73	*
96999	Dermatological procedure	T	0012	0.4436	$29.83		$5.97	*
97001	Pt evaluation	A						
97002	Pt re-evaluation	A						
97003	Ot evaluation	A						
97004	Ot re-evaluation	A						
97005	Athletic train eval	E						
97006	Athletic train reeval	E						
97010	Hot or cold packs therapy	A						
97012	Mechanical traction therapy	A						
97014	Electric stimulation therapy	E						
97016	Vasopneumatic device therapy	A						
97018	Paraffin bath therapy	A						
97022	Whirlpool therapy	A						
97024	Diathermy eg, microwave	A						
97026	Infrared therapy	A						
97028	Ultraviolet therapy	A						
97032	Electrical stimulation	A						
97033	Electric current therapy	A						
97034	Contrast bath therapy	A						
97035	Ultrasound therapy	A						
97036	Hydrotherapy	A						
97039	Physical therapy treatment	A						
97110	Therapeutic exercises	A						
97112	Neuromuscular reeducation	A						
97113	Aquatic therapy/exercises	A						
97116	Gait training therapy	A						
97124	Massage therapy	A						
97139	Physical medicine procedure	A						
97140	Manual therapy	A						
97150	Group therapeutic procedures	A						
97530	Therapeutic activities	A						
97532	Cognitive skills development	A						
97533	Sensory integration	A						
97535	Self care mngment training	A						
97537	Community/work reintegration	A						
97542	Wheelchair mngment training	A						
97545	Work hardening	A						
97546	Work hardening add-on	A						
97597	Active wound care/20 cm or <	T	0015	1.5412	$103.63		$20.73	*
97598	Active wound care > 20 cm	T	0015	1.5412	$103.63		$20.73	*
97602	Wound(s) care non-selective	T	0013	0.8789	$59.10		$11.82	*
97605	Neg press wound tx, < 50 cm	T	0013	0.8789	$59.10		$11.82	*
97606	Neg press wound tx, > 50 cm	T	0015	1.5412	$103.63		$20.73	*
97750	Physical performance test	A						
97755	Assistive technology assess	A						
97760	Orthotic mgmt and training	A						
97761	Prosthetic training	A						
97762	C/o for orthotic/prosth use	A						

97799	Physical medicine procedure	A						
97802	Medical nutrition, indiv, in	A						
97803	Med nutrition, indiv, subseq	A						
97804	Medical nutrition, group	A						
97810	Acupunct w/o stimul 15 min	E						
97811	Acupunct w/o stimul addl 15m	E						
97813	Acupunct w/stimul 15 min	E						
97814	Acupunct w/stimul addl 15m	E						
98925	Osteopathic manipulation	S	0060	0.3808	$25.61		$5.13	*
98926	Osteopathic manipulation	S	0060	0.3808	$25.61		$5.13	*
98927	Osteopathic manipulation	S	0060	0.3808	$25.61		$5.13	*
98928	Osteopathic manipulation	S	0060	0.3808	$25.61		$5.13	*
98929	Osteopathic manipulation	S	0060	0.3808	$25.61		$5.13	*
98940	Chiropractic manipulation	S	0060	0.3808	$25.61		$5.13	*
98941	Chiropractic manipulation	S	0060	0.3808	$25.61		$5.13	*
98942	Chiropractic manipulation	S	0060	0.3808	$25.61		$5.13	*
98943	Chiropractic manipulation	E						
98960	Self-mgmt educ & train, 1 pt	E						
98961	Self-mgmt educ/train, 2-4 pt	E						
98962	Self-mgmt educ/train, 5-8 pt	E						
98966	Hc pro phone call 5-10 min	E						
98967	Hc pro phone call 11-20 min	E						
98968	Hc pro phone call 21-30 min	E						
98969	Online service by hc pro	E						
99000	Specimen handling	E						
99001	Specimen handling	E						
99002	Device handling	B						
99024	Postop follow-up visit	B						
99026	In-hospital on call service	E						
99027	Out-of-hosp on call service	E						
99050	Medical services after hrs	B						
99051	Med serv, eve/wkend/holiday	B						
99053	Med serv 10pm-8am, 24 hr fac	B						
99056	Med service out of office	B						
99058	Office emergency care	B						
99060	Out of office emerg med serv	B						
99070	Special supplies	B						
99071	Patient education materials	B						
99075	Medical testimony	E						
99078	Group health education	N						
99080	Special reports or forms	B						
99082	Unusual physician travel	B						
99090	Computer data analysis	B						
99091	Collect/review data from pt	N						
99100	Special anesthesia service	B						
99116	Anesthesia with hypothermia	B						
99135	Special anesthesia procedure	B						
99140	Emergency anesthesia	B						
99143	Mod cs by same phys, < 5 yrs	N						
99144	Mod cs by same phys, 5 yrs +	N						
99145	Mod cs by same phys add-on	N						
99148	Mod cs diff phys < 5 yrs	N						
99149	Mod cs diff phys 5 yrs +	N						
99150	Mod cs diff phys add-on	N						
99170	Anogenital exam, child	T	0191	0.132	$8.88	$2.08	$1.78	*
99172	Ocular function screen	E						
99173	Visual acuity screen	E						
99174	Ocular photoscreening	E						
99175	Induction of vomiting	N						
99183	Hyperbaric oxygen therapy	B						
99190	Special pump services	C						
99191	Special pump services	C						

99192	Special pump services	C						
99195	Phlebotomy	X	0624	0.6132	$41.23	$12.65	$8.25	*
99199	Special service/proc/report	B						
99201	Office/outpatient visit, new	V	0604	0.8593	$57.78		$11.56	*
99202	Office/outpatient visit, new	V	0605	1.0337	$69.51		$13.91	*
99203	Office/outpatient visit, new	V	0606	1.3222	$88.91		$17.79	*
99204	Office/outpatient visit, new	V	0607	1.683	$113.17		$22.64	*
99205	Office/outpatient visit, new	Q3	0608	2.4853	$167.11		$33.43	*
99211	Office/outpatient visit, est	V	0604	0.8593	$57.78		$11.56	*
99212	Office/outpatient visit, est	V	0605	1.0337	$69.51		$13.91	*
99213	Office/outpatient visit, est	V	0605	1.0337	$69.51		$13.91	*
99214	Office/outpatient visit, est	V	0606	1.3222	$88.91		$17.79	*
99215	Office/outpatient visit, est	Q3	0607	1.683	$113.17		$22.64	*
99217	Observation care discharge	B						
99218	Observation care	B						
99219	Observation care	B						
99220	Observation care	B						
99221	Initial hospital care	B						
99222	Initial hospital care	B						
99223	Initial hospital care	B						
99231	Subsequent hospital care	B						
99232	Subsequent hospital care	B						
99233	Subsequent hospital care	B						
99234	Observ/hosp same date	B						
99235	Observ/hosp same date	B						
99236	Observ/hosp same date	B						
99238	Hospital discharge day	B						
99239	Hospital discharge day	B						
99241	Office consultation	E						
99242	Office consultation	E						
99243	Office consultation	E						
99244	Office consultation	E						
99245	Office consultation	E						
99251	Inpatient consultation	E						
99252	Inpatient consultation	E						
99253	Inpatient consultation	E						
99254	Inpatient consultation	E						
99255	Inpatient consultation	E						
99281	Emergency dept visit	V	0609	0.7886	$53.03	$12.70	$10.61	*
99282	Emergency dept visit	V	0613	1.3033	$87.64	$21.06	$17.53	*
99283	Emergency dept visit	V	0614	2.0796	$139.83	$34.50	$27.97	*
99284	Emergency dept visit	Q3	0615	3.3109	$222.63	$48.49	$44.53	*
99285	Emergency dept visit	Q3	0616	4.8917	$328.92	$72.86	$65.79	*
99288	Direct advanced life support	B						
99291	Critical care, first hour	Q3	0617	7.3492	$494.17	$111.59	$98.84	*
99292	Critical care, addl 30 min	N						
99304	Nursing facility care, init	B						
99305	Nursing facility care, init	B						
99306	Nursing facility care, init	B						
99307	Nursing fac care, subseq	B						
99308	Nursing fac care, subseq	B						
99309	Nursing fac care, subseq	B						
99310	Nursing fac care, subseq	B						
99315	Nursing fac discharge day	B						
99316	Nursing fac discharge day	B						
99318	Annual nursing fac assessmnt	B						
99324	Domicil/r-home visit new pat	B						
99325	Domicil/r-home visit new pat	B						
99326	Domicil/r-home visit new pat	B						
99327	Domicil/r-home visit new pat	B						
99328	Domicil/r-home visit new pat	B						
99334	Domicil/r-home visit est pat	B						

99335	Domicil/r-home visit est pat	B						
99336	Domicil/r-home visit est pat	B						
99337	Domicil/r-home visit est pat	B						
99339	Domicil/r-home care supervis	B						
99340	Domicil/r-home care supervis	B						
99341	Home visit, new patient	B						
99342	Home visit, new patient	B						
99343	Home visit, new patient	B						
99344	Home visit, new patient	B						
99345	Home visit, new patient	B						
99347	Home visit, est patient	B						
99348	Home visit, est patient	B						
99349	Home visit, est patient	B						
99350	Home visit, est patient	B						
99354	Prolonged service, office	N						
99355	Prolonged service, office	N						
99356	Prolonged service, inpatient	C						
99357	Prolonged service, inpatient	C						
99358	Prolong service w/o contact	N						
99359	Prolong serv w/o contact add	N						
99360	Physician standby services	B						
99363	Anticoag mgmt, init	B						
99364	Anticoag mgmt, subseq	B						
99366	Team conf w/pat by hc pro	N						
99367	Team conf w/o pat by phys	N						
99368	Team conf w/o pat by hc pro	N						
99374	Home health care supervision	B						
99375	Home health care supervision	E						
99377	Hospice care supervision	B						
99378	Hospice care supervision	E						
99379	Nursing fac care supervision	B						
99380	Nursing fac care supervision	B						
99381	Init pm e/m, new pat, inf	E						
99382	Init pm e/m, new pat 1-4 yrs	E						
99383	Prev visit, new, age 5-11	E						
99384	Prev visit, new, age 12-17	E						
99385	Prev visit, new, age 18-39	E						
99386	Prev visit, new, age 40-64	E						
99387	Init pm e/m, new pat 65+ yrs	E						
99391	Per pm reeval, est pat, inf	E						
99392	Prev visit, est, age 1-4	E						
99393	Prev visit, est, age 5-11	E						
99394	Prev visit, est, age 12-17	E						
99395	Prev visit, est, age 18-39	E						
99396	Prev visit, est, age 40-64	E						
99397	Per pm reeval est pat 65+ yr	E						
99401	Preventive counseling, indiv	E						
99402	Preventive counseling, indiv	E						
99403	Preventive counseling, indiv	E						
99404	Preventive counseling, indiv	E						
99406	Behav chng smoking 3-10 min	X	0031	0.3448	$23.18		$4.64	*
99407	Behav chng smoking > 10 min	X	0031	0.3448	$23.18		$4.64	*
99408	Audit/dast, 15-30 min	E						
99409	Audit/dast, over 30 min	E						
99411	Preventive counseling, group	E						
99412	Preventive counseling, group	E						
99420	Health risk assessment test	E						
99429	Unlisted preventive service	E						
99441	Phone e/m by phys 5-10 min	E						
99442	Phone e/m by phys 11-20 min	E						
99443	Phone e/m by phys 21-30 min	E						
99444	Online e/m by phys	E						

99450	Basic life disability exam	E						
99455	Work related disability exam	B						
99456	Disability examination	B						
99460	Init nb em per day, hosp	V	0605	1.0337	$69.51		$13.91	*
99461	Init nb em per day, non-fac	M						
99462	Sbsq nb em per day, hosp	C						
99463	Same day nb discharge	V	0605	1.0337	$69.51		$13.91	*
99464	Attendance at delivery	N						
99465	Nb resuscitation	S	0094	2.4553	$165.10	$46.29	$33.02	*
99466	Ped crit care transport	N						
99467	Ped crit care transport addl	N						
99468	Neonate crit care, initial	C						
99469	Neonate crit care, subsq	C						
99471	Ped critical care, initial	C						
99472	Ped critical care, subsq	C						
99475	Ped crit care age 2-5, init	C						
99476	Ped crit care age 2-5, subsq	C						
99477	Init day hosp neonate care	C						
99478	Ic, lbw inf < 1500 gm subsq	C						
99479	Ic lbw inf 1500-2500 g subsq	C						
99480	Ic inf pbw 2501-5000 g subsq	C						
99499	Unlisted e&m service	B						
99500	Home visit, prenatal	E						
99501	Home visit, postnatal	E						
99502	Home visit, nb care	E						
99503	Home visit, resp therapy	E						
99504	Home visit mech ventilator	E						
99505	Home visit, stoma care	E						
99506	Home visit, im injection	E						
99507	Home visit, cath maintain	E						
99509	Home visit day life activity	E						
99510	Home visit, sing/m/fam couns	E						
99511	Home visit, fecal/enema mgmt	E						
99512	Home visit for hemodialysis	E						
99600	Home visit nos	E						
99601	Home infusion/visit, 2 hrs	E						
99602	Home infusion, each addtl hr	E						
99605	Mtms by pharm, np, 15 min	E						
99606	Mtms by pharm, est, 15 min	E						
99607	Mtms by pharm, addl 15 min	E						
0001F	Heart failure composite	M						
0005F	Osteoarthritis composite	M						
0012F	Cap bacterial assess	M						
0014F	Comp preop assess cat surg	M						
0015F	Melan follow-up complete	M						
0016T	Thermotx choroid vasc lesion	T	0235	5.8498	$393.35		$78.67	*
0017T	Photocoagulat macular drusen	T	0235	5.8498	$393.35		$78.67	*
0019T	Extracorp shock wv tx,ms nos	A						
0030T	Antiprothrombin antibody	A						
0042T	Ct perfusion w/contrast, cbf	N						
0048T	Implant ventricular device	C						
0050T	Removal circulation assist	C						
0051T	Implant total heart system	C						
0052T	Replace component heart syst	C						
0053T	Replace component heart syst	C						
0054T	Bone surgery using computer	N						
0055T	Bone surgery using computer	N						
0071T	U/s leiomyomata ablate <200	S	0067	52.9891	$3,563.04		$712.61	*
0072T	U/s leiomyomata ablate >200	S	0067	52.9891	$3,563.04		$712.61	*
0073T	Delivery, comp imrt	S	0412	6.249	$420.19		$84.04	*
0075T	Perq stent/chest vert art	C						
0076T	S&i stent/chest vert art	C						

0078T	Endovasc aort repr w/device	C						
0079T	Endovasc visc extnsn repr	C						
0080T	Endovasc aort repr rad s&i	C						
0081T	Endovasc visc extnsn s&i	C						
0085T	Breath test heart reject	E						
0092T	Artific disc addl	C						
0095T	Artific diskectomy addl	C						
0098T	Rev artific disc addl	C						
0099T	Implant corneal ring	T	0233	16.2485	$1,092.57	$263.12	$218.52	*
0100T	Prosth retina receive&gen	T	0672	39.9643	$2,687.24		$537.45	*
0101T	Extracorp shockwv tx,hi enrg	T	0050	31.7717	$2,136.36		$427.28	*
0102T	Extracorp shockwv tx,anesth	T	0050	31.7717	$2,136.36		$427.28	*
0103T	Holotranscobalamin	A						
0104T	At rest cardio gas rebreathe	A						
0105T	Exerc cardio gas rebreathe	A						
0106T	Touch quant sensory test	X	0341	0.0799	$5.37	$2.09	$1.08	*
0107T	Vibrate quant sensory test	X	0341	0.0799	$5.37	$2.09	$1.08	*
0108T	Cool quant sensory test	X	0341	0.0799	$5.37	$2.09	$1.08	*
0109T	Heat quant sensory test	X	0341	0.0799	$5.37	$2.09	$1.08	*
0110T	Nos quant sensory test	X	0341	0.0799	$5.37	$2.09	$1.08	*
0111T	Rbc membranes fatty acids	A						
0123T	Scleral fistulization	T	0234	24.4021	$1,640.82	$511.31	$328.17	*
0124T	Conjunctival drug placement	T	0232	4.5074	$303.08	$75.93	$60.62	*
0126T	Chd risk imt study	Q1	0340	0.6693	$45.00		$9.00	*
0130T	Chron care drug investigatn	B						
0140T	Exhaled breath condensate ph	A						
0141T	Perq islet transplant	E						
0142T	Open islet transplant	E						
0143T	Laparoscopic islet transplnt	E						
0155T	Lap impl gast curve electrd	T	0130	38.054	$2,558.79	$659.53	$511.76	*
0156T	Lap remv gast curve electrd	T	0130	38.054	$2,558.79	$659.53	$511.76	*
0157T	Open impl gast curve electrd	C						
0158T	Open remv gast curve electrd	C						
0159T	Cad breast mri	N						
0160T	Tcranial magn stim tx plan	S	0216	2.6831	$180.41		$36.09	*
0161T	Tcranial magn stim tx deliv	S	0216	2.6831	$180.41		$36.09	*
0163T	Lumb artif diskectomy addl	C						
0164T	Remove lumb artif disc addl	C						
0165T	Revise lumb artif disc addl	C						
0166T	Tcath vsd close w/o bypass	C						
0167T	Tcath vsd close w bypass	C						
0168T	Rhinophototx light app bilat	T	0251	3.425	$230.30		$46.06	*
0169T	Place stereo cath brain	C						
0171T	Lumbar spine proces distract	T	0052	88.6521	$5,961.06		$1,192.22	*
0172T	Lumbar spine process addl	T	0052	88.6521	$5,961.06		$1,192.22	*
0173T	Iop monit io pressure	N						
0174T	Cad cxr with interp	N						
0175T	Cad cxr remote	N						
0176T	Aqu canal dilat w/o retent	T	0673	41.884	$2,816.32	$649.56	$563.27	*
0177T	Aqu canal dilat w retent	T	0673	41.884	$2,816.32	$649.56	$563.27	*
0178T	64 lead ecg w i&r	B						
0179T	64 lead ecg w tracing	X	0100	2.6136	$175.74	$41.44	$35.15	*
0180T	64 lead ecg w i&r only	B						
0181T	Corneal hysteresis	S	0230	0.5945	$39.97		$8.00	*
0182T	Hdr elect brachytherapy	S	0313	11.5353	$775.65	$293.30	$155.13	*
0183T	Wound ultrasound	T	0013	0.8789	$59.10		$11.82	*
0184T	Exc rectal tumor endoscopic	C						
0185T	Comptr probability analysis	N						
0186T	Suprachoroidal drug delivery	T	0237	20.7145	$1,392.86		$278.58	*
0187T	Ophthalmic dx image anterior	S	0230	0.5945	$39.97		$8.00	*
0188T	Videoconf crit care 74 min	M						
0189T	Videoconf crit care addl 30	M						

0190T	Place intraoc radiation src	T	0237	20.7145	$1,392.86		$278.58	*
0191T	Insert ant segment drain int	T	0234	24.4021	$1,640.82	$511.31	$328.17	*
0192T	Insert ant segment drain ext	T	0673	41.884	$2,816.32	$649.56	$563.27	*
0193T	Rf bladder neck microremodel	T	0165	20.0243	$1,346.45		$269.29	*
0195T	Arthrod presac interbody	C						
0196T	Arthrod presac interbody eac	C						
0197T	Intrafraction track motion	N						
0198T	Ocular blood flow measure	S	0230	0.5945	$39.97		$8.00	*
0199T	Physiologic tremor record	S	0215	0.6135	$41.25		$8.25	*
0200T	Perq sacral augmt unilat inj	T	0049	22.0149	$1,480.30		$296.06	*
0201T	Perq sacral augmt bilat inj	T	0050	31.7717	$2,136.36		$427.28	*
0202T	Post vert arthrplst 1 lumbar	C						
0203T	Unattend sleep study w/time	S	0213	2.4043	$161.67	$53.58	$32.34	*
0204T	Unattended sleep study	S	0213	2.4043	$161.67	$53.58	$32.34	*
0205T	Inirs each vessel add-on	N						
0206T	Remote algorithm analys ecg	Q1	0340	0.6693	$45.00		$9.00	*
0207T	Clear eyelid gland w/heat	S	0230	0.5945	$39.97		$8.00	*
0208T	Automated audiometry air	X	0035	0.232	$15.60		$3.12	*
0209T	Auto audiometry air/bone	X	0035	0.232	$15.60		$3.12	*
0210T	Auto audiometry sp thresh	X	0035	0.232	$15.60		$3.12	*
0211T	Auto audiometry sp thresh	X	0035	0.232	$15.60		$3.12	*
0212T	Comprehen auto audiometry	X	0364	0.47	$31.60	$7.06	$6.32	*
0213T	Us facet jt inj cerv/t 1 lev	T	0207	7.2002	$484.15		$96.83	*
0214T	Us facet jt inj cerv/t 2 lev	T	0204	2.5558	$171.85	$40.13	$34.37	*
0215T	Us facet jt inj cerv/t 3 lev	T	0204	2.5558	$171.85	$40.13	$34.37	*
0216T	Us facet jt inj ls 1 level	T	0207	7.2002	$484.15		$96.83	*
0217T	Us facet jt inj ls 2 level	T	0204	2.5558	$171.85	$40.13	$34.37	*
0218T	Us facet jt inj ls 3 level	T	0204	2.5558	$171.85	$40.13	$34.37	*
0219T	Fuse spine facet jt cerv	C						
0220T	Fuse spine facet jt thor	C						
0221T	Fuse spine facet jt lumbar	T	0050	31.7717	$2,136.36		$427.28	*

0222T	Fuse spine facet jt add seg	T	0050	31.7717	$2,136.36		$427.28	*
0500F	Initial prenatal care visit	M						
0501F	Prenatal flow sheet	M						
0502F	Subsequent prenatal care	M						
0503F	Postpartum care visit	M						
0505F	Hemodialysis plan docd	M						
0507F	Periton dialysis plan docd	M						
0509F	Urine incon plan docd	M						
0513F	Elev bp plan of care docd	M						
0514F	Care plan hgb docd esa pt	M						
0516F	Anemia plan of care docd	M						
0517F	Glaucoma plan of care docd	M						
0518F	Fall plan of care docd	M						
0519F	Pland chemo docd b/4 txmnt	M						
0520F	Rad dos limts b/4 3d rad	M						
0521F	Plan of care 4 pain docd	M						
0525F	Initial visit for episode	M						
0526F	Subs visit for episode	M						
0528F	Rcmnd flw-up 10 yrs docd	E						
0529F	Intrvl 3+yrs pts clnscp docd	M						
0535F	Dyspnea mngmnt plan docd	E						
0540F	Gluco mngmnt plan docd	M						
0545F	Follow up care plan mdd docd	E						
0575F	HIV rna plan care docd	M						
1000F	Tobacco use assessed	M						
1002F	Assess anginal symptom/level	M						
1003F	Level of activity assess	M						
1004F	Clin symp vol ovrld assess	M						
1005F	Asthma symptoms evaluate	M						
1006F	Osteoarthritis assess	M						
1007F	Anti-inflm/anlgsc otc assess	M						

1008F	Gi/renal risk assess	M						
1015F	Copd symptoms assess	M						
1018F	Assess dyspnea not present	M						
1019F	Assess dyspnea present	M						
1022F	Pneumo imm status assess	M						
1026F	Co-morbid condition assess	M						
1030F	Influenza imm status assess	M						
1034F	Current tobacco smoker	M						
1035F	Smokeless tobacco user	M						
1036F	Tobacco non-user	M						
1038F	Persistent asthma	M						
1039F	Intermittent asthma	M						
1040F	Dsm-ivtm info mdd docd	M						
1050F	History of mole changes	M						
1055F	Visual funct status assess	M						
1060F	Doc perm/cont/parox atr fib	M						
1061F	Doc lack perm+cont+parox fib	M						
1065F	Ischm stroke symp lt3 hrsb/4	M						
1066F	Ischm stroke symp ge3 hrsb/4	M						
1070F	Alarm symp assessed-absent	M						
1071F	Alarm symp assessed-1+ prsnt	M						
1090F	Pres/absn urine incon assess	M						
1091F	Urine incon characterized	M						
1100F	Ptfalls assess-docd ge2+/yr	M						
1101F	Pt falls assess-docd le1/yr	M						
1110F	Pt lft inpt fac w/in 60 days	M						
1111F	Dschrg med/current med merge	M						
1116F	Auric/peri pain assessed	M						
1118F	GERD symps assessed 12 month	M						
1119F	Init eval for condition	M						
1121F	Subs eval for condition	M						

1123F	Acp discuss/dscn mkr docd	M						
1124F	Acp discuss-no dscnmkr docd	M						
1125F	Amnt pain noted pain prsnt	M						
1126F	Amnt pain noted none prsnt	M						
1130F	Bk pain + fxn assessed	M						
1134F	Epsd bk pain for =< 6 wks	M						
1135F	Epsd bk pain for > 6 wks	M						
1136F	Epsd bk pain for <= 12 wks	M						
1137F	Epsd bk pain for > 12 wks	M						
1150F	Doc pt rsk death w/in 1yr	E						
1151F	Doc no pt rsk death w/in 1yr	E						
1152F	Doc advncd dis comfort 1st	E						
1153F	Doc advncd dis cmfrt not 1st	E						
1157F	Advnc care plan in rcrd	E						
1158F	Advnc care plan tlk docd	M						
1159F	Med list docd in rcrd	E						
1160F	Rvw meds by rx/dr in rcrd	E						
1170F	Fxnl status assessed	M						
1180F	Thromboemb risk assessed	E						
1200F	Seizure type(s)+ frq docd	E						
1205F	EPI etiol synd rvwd and docd	E						
1220F	Pt screened for depression	M						
2000F	Blood pressure measure	M						
2001F	Weight record	M						
2002F	Clin sign vol ovrld assess	M						
2004F	Initial exam involved joints	M						
2010F	Vital signs recorded	M						
2014F	Mental status assess	M						
2018F	Hydration status assess	M						
2019F	Dilated macul exam done	M						
2020F	Dilated fundus eval done	M						

2021F	Dilat macul+ exam done	M						
2022F	Dil retina exam interp rev	M						
2024F	7 field photo interp doc rev	M						
2026F	Eye image valid to dx rev	M						
2027F	Optic nerve head eval done	M						
2028F	Foot exam performed	M						
2029F	Complete phys skin exam done	M						
2030F	H2o stat docd, normal	M						
2031F	H2o stat docd, dehydrated	M						
2035F	Tymp memb motion examd	M						
2040F	Bk pn xm on init visit date	M						
2044F	Doc mntl tst b/4 bk trxmnt	M						
2050F	Wound char size etc docd	E						
2060F	Pt talk eval hlthwkr re mdd	E						
3006F	Cxr doc rev	M						
3008F	Body mass index docd	E						
3011F	Lipid panel doc rev	M						
3014F	Screen mammo doc rev	M						
3015F	Cerv cancer screen docd	E						
3016F	Pt scrnd unhlthy OH use	M						
3017F	Colorectal ca screen doc rev	M						
3018F	Pre-prxd rsk et al docd	E						
3020F	Lvf assess	M						
3021F	Lvef mod/sever deprs syst	M						
3022F	Lvef >=40% systolic	M						
3023F	Spirom doc rev	M						
3025F	Spirom fev/fvc<70% w copd	M						
3027F	Spirom fev/fvc>=70%/w/o copd	M						
3028F	O2 saturation doc rev	M						
3035F	O2 saturation<=88% /pao<=55	M						
3037F	O2 saturation> 88% /pao>55	M						

3038F	Pulm fx w/in 12 mon b/4 surg	E						
3040F	Fev<40% predicted value	M						
3042F	Fev>=40% predicted value	M						
3044F	Hg a1c level lt 7.0%	M						
3045F	Hg a1c level 7.0-9.0%	M						
3046F	Hemoglobin a1c level > 9.0%	M						
3048F	Ldl-c <100 mg/dl	M						
3049F	Ldl-c 100-129 mg/dl	M						
3050F	Ldl-c >= 130 mg/dl	M						
3060F	Pos microalbuminuria rev	M						
3061F	Neg microalbuminuria rev	M						
3062F	Pos macroalbuminuria rev	M						
3066F	Nephropathy doc tx	M						
3072F	Low risk for retinopathy	M						
3073F	Pre-surg eye measures docd	M						
3074F	Syst bp lt 130 mm hg	M						
3075F	Syst bp ge 130 - 139mm hg	M						
3077F	Syst bp >= 140 mm hg6 it	M						
3078F	Diast bp < 80 mm hg	M						
3079F	Diast bp 80-89 mm hg	M						
3080F	Diast bp >= 90 mm hg	M						
3082F	Kt/v lt1.2	M						
3083F	Kt/v ge 1.2 and <1.7	M						
3084F	Kt/v ge 1.7	M						
3085F	Suicide risk assessed	M						
3088F	MDD, mild	M						
3089F	MDD, moderate	M						
3090F	MDD, severe; w/o psych	M						
3091F	Mdd, severe; w/ psych	M						
3092F	MDD, in remission	M						
3093F	Doc new diag 1st/addl mdd	M						

3095F	Central dexa results docd	M						
3096F	Central dexa ordered	M						
3100F	Image test ref carot diam	M						
3110F	Doc pres/absn hmrhg/lesion	M						
3111F	Ct/mri brain done w/in 24hrs	M						
3112F	Ct/Mri brain done gt 24 hrs	M						
3120F	12-lead ecg performed	M						
3130F	Upper gi endoscopy performed	M						
3132F	Doc ref upper gi endoscopy	M						
3140F	Upper gi endo shows barrtts	M						
3141F	Upper gi endo not barrtts	M						
3142F	Barium swallow test ordered	M						
3150F	Forceps esoph biopsy done	M						
3155F	Cytogen test marrow b/4 tx	M						
3160F	Doc fe+ stores b/4 epo thx	M						
3170F	Flow cyto done b/4 tx	M						
3200F	Barium swallow test not req	M						
3210F	Grp a strep test performed	M						
3215F	Pt immunity to hep a docd	M						
3216F	Pt immunity to hep b docd	M						
3218F	Rna tstng hep c docd-done	M						
3220F	Hep c quant rna tstng docd	M						
3230F	Note hring tst w/in 6 mon	M						
3250F	Nonprim loc anat bx site tum	M						
3260F	Pt cat/pn cat/hist grd docd	M						
3265F	Rna tstng hepc vir ord/docd	M						
3266F	Hepc gn tstng docd b/4txmnt	M						
3268F	Psa/t/glsc docd b/4 txmnt	M						
3269F	Bone scn b/4 txmnt/aftr Dx	M						
3270F	No bone scn b/4 txmnt/aftrDx	M						
3271F	Low risk prostate cancer	M						

3272F	Med risk prostate cancer	M						
3273F	High risk prostate cancer	M						
3274F	Prost Cncr rsk not lw/md/hgh	M						
3278F	Serum lvls CA/iPTH/lpd ord	M						
3279F	Hgb lvl >/= 13 g/dl	M						
3280F	Hgb lvl 11-12.9 g/dL	M						
3281F	Hgb lvl < 11 g/dl	M						
3284F	IOP down>=15% of pre-svc lvl	M						
3285F	IOP down <15% of pre-svc lvl	M						
3288F	Fall risk assessment docd	M						
3290F	Pt=D(Rh)- and unsensitized	M						
3291F	Pt=d(rh)+ or sensitized	M						
3292F	Hiv tstng asked/docd/revwd	M						
3293F	Abo rh blood typing docd	E						
3294F	Grp b strep screening docd	E						
3300F	AJCC stage docd b/4 thxpy	M						
3301F	Cancer stage docd metast	M						
3315F	Er+ or pr+ breast cancer	M						
3316F	ER- or PR- breast cancer	M						
3317F	Path rpt malig cancer docd	M						
3318F	Path rpt malig cancer docd	M						
3319F	X-ray/ct/ultrsnd et al ord	M						
3320F	No xray/ct/ et al ordd	M						
3321F	AJCC cncr 0/IA melan docd	E						
3322F	Melan >AJCC stage 0 or IA	E						
3323F	Clin node stgng docdb/4 surg	M						
3324F	Mri ct scan ord rvwd rqstd	E						
3325F	Preop asses 4 cataract surg	M						
3328F	Prfrmnc docd 2 wks b/4 surg	E						
3330F	Imaging study ordered (bkp)	M						
3331F	Bk imaging tst not ordered	M						

3340F	Mammo assess inc xray docd	M						
3341F	Mammo assess negative docd	M						
3342F	Mammo assess bengn docd	M						
3343F	Mammo probably bengn docd	M						
3344F	Mammo assess susp, docd	M						
3345F	Mammo assess hghlymalig doc	M						
3350F	Mammo bx proven malig docd	M						
3351F	Neg scrn dep symp by deptool	E						
3352F	No sig dep symp by dep tool	E						
3353F	Mild-mod dep symp by deptool	E						
3354F	Clin sig dep sym by dep tool	E						
3370F	AJCC brst cncr stage 0 docd	M						
3372F	Ajcc brst cncr stage 1+docd	M						
3374F	Ajcc brst cncr stage 1+docd	M						
3376F	AJCC brstcncr stage 2 docd	M						
3378F	AJCC brstcncr stage 3 docd	M						
3380F	AJCC brstcncr stage 4 docd	M						
3382F	AJCC cln cncr stage 0 docd	M						
3384F	AJCC cln cncr stage 1 docd	M						
3386F	AJCC cln cncr stage 2 docd	M						
3388F	AJCC cln cncr stage 3 docd	M						
3390F	AJCC cln cncr stage 4 docd	M						
3450F	Dyspnea scrnd, no-mild dysp	E						
3451F	Dyspnea scrnd mod-high dysp	E						
3452F	Dyspnea not screened	E						
3455F	TB scrng done-interpd 6mon	M						
3470F	RA disease activity, low	M						
3471F	RA disease activity, mod	M						
3472F	RA disease activity, high	M						
3475F	Disease progn RA poor docd	M						
3476F	Disease progn RA good docd	M						

3490F	History - AIDS-defining cond	M						
3491F	HIV unsure baby of HIV+moms	E						
3492F	History cd4+ cell count <350	M						
3493F	No hist cd4+cell cnt<350	M						
3494F	CD4+cell count <200cells/mm3	M						
3495F	Cd4+cell cnt 200-499 cells	M						
3496F	Cd4+ cell count =500 cells	M						
3497F	CD4+ cell percentage <15%	E						
3498F	CD4+ cell percentage >=15%	E						
3500F	Cd4+cell cnt/% docd as done	M						
3502F	HIV rna vrl ld <lmts quantif	M						
3503F	HIV rna vrl ldnot<lmts quntf	M						
3510F	Doc tb scrng-rslts interpd	E						
3511F	Chlmyd/gonrh tsts docd done	M						
3512F	Syph scrng docd as done	M						
3513F	Hep B scrng docd as done	E						
3514F	Hep C scrng docd as done	E						
3515F	Pt has docd immun to hep C	E						
3550F	Low rsk thromboembolism	E						
3551F	Intrmed rsk thromboembolism	E						
3552F	Hgh risk for thromboembolism	E						
3555F	Pt inr measurement performed	E						
3570F	Rprt bone scint xref w xray	M						
3572F	Pt consid poss risk fx	E						
3573F	Pt not consid poss risk fx	E						
3650F	Eeg ordered rvwd reqstd	E						
4000F	Tobacco use txmnt counseling	M						
4001F	Tobacco use txmnt, pharmacol	M						
4002F	Statin therapy, rx	M						
4003F	Pt ed write/oral, pts w/ hf	M						
4004F	Pt tobacco use done rcvd tlk	E						

4005F	Pharm thx for op rxd	M						
4006F	Beta-blocker therapy rx	M						
4009F	Ace/arb inhibitor therapy rx	M						
4011F	Oral antiplatelet therapy rx	M						
4012F	Warfarin therapy rx	M						
4014F	Written discharge instr prvd	M						
4015F	Persist asthma medicine ctrl	M						
4016F	Anti-inflm/anlgsc agent rx	M						
4017F	Gi prophylaxis for nsaid rx	M						
4018F	Therapy exercise joint rx	M						
4019F	Doc recpt counsl vit d/calc+	M						
4025F	Inhaled bronchodilator rx	M						
4030F	Oxygen therapy rx	M						
4033F	Pulmonary rehab rec	M						
4035F	Influenza imm rec	M						
4037F	Influenza imm order/admin	M						
4040F	Pneumoc vac/admin/rcvd	M						
4041F	Doc order cefazolin/cefurox	M						
4042F	Doc antibio not given	M						
4043F	Doc order given stop antibio	M						
4044F	Doc order given vte prophylx	M						
4045F	Empiric antibiotic rx	M						
4046F	Doc antibio given b/4 surg	M						
4047F	Doc antibio given b/4 surg	M						
4048F	Doc antibio given b/4 surg	M						
4049F	Doc order given stop antibio	M						
4050F	Ht care plan doc	M						
4051F	Referred for an AV fistula	M						
4052F	Hemodialysis via AV fistula	M						
4053F	Hemodialysis via AV graft	M						
4054F	Hemodialysis via catheter	M						

4055F	Pt rcvng periton dialysis	M						
4056F	Approp oral rehyd recommd	M						
4058F	Ped gastro ed given, caregvr	M						
4060F	Psych svcs provided	M						
4062F	Pt referral psych docd	M						
4063F	Antidepres rxthxpy not rxd	E						
4064F	Antidepressant rx	M						
4065F	Antipsychotic rx	M						
4066F	ECT provided	M						
4067F	Pt referral for ect docd	M						
4070F	Dvt prophylx recvd day 2	M						
4073F	Oral antiplat thx rx dischrg	M						
4075F	Anticoag thx rx at dischrg	M						
4077F	Doc t-pa admin considered	M						
4079F	Doc rehab svcs considered	M						
4084F	Aspirin recvd w/in 24 hrs	M						
4090F	Pt rcvng epo thxpy	M						
4095F	Pt not rcvng epo thxpy	M						
4100F	Biphos thxpy vein ord/recvd	M						
4110F	Int mam art used for cabg	M						
4115F	Beta blckr admin w/in 24 hrs	M						
4120F	Antibiot rxd/given	M						
4124F	Antibiot not rxd/given	M						
4130F	Topical prep rx aoe	M						
4131F	Syst antimicrobial thx rx	M						
4132F	No syst antimicrobial thx rx	M						
4133F	Antihist/decong rx/recom	M						
4134F	No antihist/decong rx/recom	M						
4135F	Systemic corticosteroids rx	M						
4136F	Syst corticosteroids not rx	M						
4148F	Hep A vac injxn admin/recvd	M						

4149F	Hep B vac injxn admin/recvd	M						
4150F	Pt recvng antivir txmnt hepc	M						
4151F	Pt not recvng antiv hep c	M						
4153F	Combo pegintf/rib rx	M						
4155F	Hep A vac series prev recvd	M						
4157F	Hep B vac series prev recvd	M						
4158F	Pt edu re alcoh drnkng done	M						
4159F	Contrcp talk b/4 antiv txmnt	M						
4163F	Pt couns 4 txmnt opt prost	M						
4164F	Adjv hrmnl thxpy rxd	M						
4165F	3d-crt/imrt) received	M						
4167F	Hd bed tilted 1st day vent	M						
4168F	Pt care icu&vent w/in 24hrs	M						
4169F	No pt care ICU/vent in 24hrs	M						
4171F	Pt rcvng esa thxpy	M						
4172F	Pt not rcvng esa thxpy	M						
4174F	Couns potent glauc impct	M						
4175F	Vis of >= 20/40 w/in 90 days	M						
4176F	Talk re uv light pt/crgvr	M						
4177F	Talk pt/crgvr re areds prev	M						
4178F	Antid glbln rcvd w/in 26wks	M						
4179F	Tamoxifen/AI prescribed	M						
4180F	Adjv thxpyrxd/rcvd stg3a-c	M						
4181F	Conformal radn thxpy rcvd	M						
4182F	No conformal radn thxpy	M						
4185F	Continuous ppi or h2ra rcvd	M						
4186F	No cont ppi or h2ra rcvd	M						
4187F	Anti rheum drugthxpyrxd/gvn	M						
4188F	Approp ACE/ARB tstng done	M						
4189F	Approp digoxin tstng done	M						
4190F	Approp diuretic tstng done	M						

4191F	Approp anticonvuls tstng	M						
4192F	Pt not rcvng glucoco thxpy	M						
4193F	Pt rcvng<10mg daily predniso	M						
4194F	Pt rec>=10mg prednison qd	M						
4195F	Pt rcvng anti-rheum thxpy RA	M						
4196F	Ptnot rcvng anti-rhm thxpyRA	M						
4200F	External beam to prost only	M						
4201F	Extrnl beam other than prost	M						
4210F	ACE/ARB thxpy for >= 6 mons	M						
4220F	Digoxin thxpy for >= 6 mons	M						
4221F	Diuretic thxpy for >= 6 mons	M						
4230F	Anticonv thxpy for >= 6 mons	M						
4240F	Instr xrcz 4bk pn >12 weeks	M						
4242F	Sprvsd xrcz bk pn >12 weeks	M						
4245F	Pt instr nrml lifest	M						
4248F	Pt instr-no bd rest>= 4 days	M						
4250F	Wrmng 4 surg - normothermia	M						
4255F	Anesth >= 60 min as docd	M						
4256F	Anesth < 60 min as docd	M						
4260F	Wound srfc culturetech used	E						
4261F	Tech other than surfc cultr	E						
4265F	Wet-dry dressings Rx-recmd	E						
4266F	No wet-dry drssings Rx-recmd	E						
4267F	Comprssion thxpy prescribed	M						
4268F	Pt ed re comp thxpy rcvd	E						
4269F	Appropos mthd offloading Rxd	E						
4270F	Pt rcvng anti r-viral thxpy	M						
4271F	Pt rcvng anti r-viral thxpy	M						
4274F	Flu immuno admind rcvd	M						
4275F	Hep b vac inj admin/ rcvd	E						
4276F	Potent antivir thxpy Rxd	M						

4279F	PCP prophylaxis Rxd	E						
4280F	PCP prophylax Rxd 3mon low %	M						
4290F	Pt scrned for inj drug use	M						
4293F	Pt scrnd - hgh-rsk sex behav	M						
4300F	Pt rcvng warf thxpy	E						
4301F	Pt not rcvng warf thxpy	E						
4305F	Pt ed re ft care inspct rcvd	E						
4306F	Pt tlk psych & Rx opd addic	E						
4320F	Pt talk psychsoc+rx oh dpnd	E						
4330F	Cnslng epi spec sfty issues	E						
4340F	Cnslng chldbrng+ women epi	E						
5005F	Pt counsld on exam for moles	M						
5010F	Macul+ fndngs to dr mng dm	M						
5015F	Doc fx & test/txmnt for op	M						
5020F	Txmnts 2 main Dr by 1 mon	E						
5050F	Plan 2 main dr by 1 month	M						
5060F	Fndngs mammo 2pt w/in 3 days	M						
5062F	Doc f2fmammo fndng in 5 days	M						
5100F	Rsk fx ref w/n 24 hrs x-ray	E						
5200F	Eval appros surg thxpy epi	E						
6005F	Care level rationale doc	M						
6010F	Dysphag test done b/4 eating	M						
6015F	Dysphag test done b/4 eating	M						
6020F	Npo (nothing-mouth) ordered	M						
6030F	Max sterile barriers follwd	M						
6040F	Appro rad ds dvcs techs docd	M						
6045F	Radxps in end rprt4fluro pxd	M						
6070F	Pt asked/cnsld aed effects	E						
7010F	Pt info into recall system	M						
7020F	Mammo assess cat in dbase	M						
7025F	Pt infosys alarm 4 nxt mammo	M						

A0021	Outside state ambulance serv	E						
A0080	Noninterest escort in non er	E						
A0090	Interest escort in non er	E						
A0100	Nonemergency transport taxi	E						
A0110	Nonemergency transport bus	E						
A0120	Noner transport mini-bus	E						
A0130	Noner transport wheelch van	E						
A0140	Nonemergency transport air	E						
A0160	Noner transport case worker	E						
A0170	Transport parking fees/tolls	E						
A0180	Noner transport lodgng recip	E						
A0190	Noner transport meals recip	E						
A0200	Noner transport lodgng escrt	E						
A0210	Noner transport meals escort	E						
A0225	Neonatal emergency transport	E						
A0380	Basic life support mileage	E						
A0382	Basic support routine suppls	A						
A0384	Bls defibrillation supplies	A						
A0390	Advanced life support mileag	E						
A0392	Als defibrillation supplies	A						
A0394	Als IV drug therapy supplies	A						
A0396	Als esophageal intub suppls	A						
A0398	Als routine disposble suppls	A						
A0420	Ambulance waiting 1/2 hr	A						
A0422	Ambulance 02 life sustaining	A						
A0424	Extra ambulance attendant	A						
A0425	Ground mileage	A						
A0426	Als 1	A						
A0427	ALS1-emergency	A						
A0428	bls	A						
A0429	BLS-emergency	A						

A0430	Fixed wing air transport	A						
A0431	Rotary wing air transport	A						
A0432	PI volunteer ambulance co	A						
A0433	als 2	A						
A0434	Specialty care transport	A						
A0435	Fixed wing air mileage	A						
A0436	Rotary wing air mileage	A						
A0888	Noncovered ambulance mileage	E						
A0998	Ambulance response/treatment	E						
A0999	Unlisted ambulance service	A						
A4206	1 CC sterile syringe&needle	E						
A4207	2 CC sterile syringe&needle	E						
A4208	3 CC sterile syringe&needle	E						
A4209	5+ CC sterile syringe&needle	E						
A4210	Nonneedle injection device	E						
A4211	Supp for self-adm injections	E						
A4212	Non coring needle or stylet	B						
A4213	20+ CC syringe only	E						
A4215	Sterile needle	E						
A4216	Sterile water/saline, 10 ml	A						
A4217	Sterile water/saline, 500 ml	A						
A4218	Sterile saline or water	N						
A4220	Infusion pump refill kit	N						
A4221	Maint drug infus cath per wk	Y						
A4222	Infusion supplies with pump	Y						
A4223	Infusion supplies w/o pump	E						
A4230	Infus insulin pump non needl	N						
A4231	Infusion insulin pump needle	N						
A4232	Syringe w/needle insulin 3cc	E						
A4233	Alkalin batt for glucose mon	Y						
A4234	J-cell batt for glucose mon	Y						

A4235	Lithium batt for glucose mon	Y						
A4236	Silvr oxide batt glucose mon	Y						
A4244	Alcohol or peroxide per pint	E						
A4245	Alcohol wipes per box	E						
A4246	Betadine/phisohex solution	E						
A4247	Betadine/iodine swabs/wipes	E						
A4248	Chlorhexidine antisept	N						
A4250	Urine reagent strips/tablets	E						
A4252	Blood ketone test or strip	E						
A4253	Blood glucose/reagent strips	Y						
A4255	Glucose monitor platforms	Y						
A4256	Calibrator solution/chips	Y						
A4257	Replace Lensshield Cartridge	Y						
A4258	Lancet device each	Y						
A4259	Lancets per box	Y						
A4261	Cervical cap contraceptive	E						
A4262	Temporary tear duct plug	N						
A4263	Permanent tear duct plug	N						
A4264	Intratubal occlusion device	E						
A4265	Paraffin	Y						
A4266	Diaphragm	E						
A4267	Male condom	E						
A4268	Female condom	E						
A4269	Spermicide	E						
A4270	Disposable endoscope sheath	N						
A4280	Brst prsths adhsv attchmnt	A						
A4281	Replacement breastpump tube	E						
A4282	Replacement breastpump adpt	E						
A4283	Replacement breastpump cap	E						
A4284	Replcmnt breast pump shield	E						
A4285	Replcmnt breast pump bottle	E						

A4286	Replcmnt breastpump lok ring	E						
A4290	Sacral nerve stim test lead	B						
A4300	Cath impl vasc access portal	N						
A4301	Implantable access syst perc	N						
A4305	Drug delivery system >=50 ML	N						
A4306	Drug delivery system <=50 ml	N						
A4310	Insert tray w/o bag/cath	A						
A4311	Catheter w/o bag 2-way latex	A						
A4312	Cath w/o bag 2-way silicone	A						
A4313	Catheter w/bag 3-way	A						
A4314	Cath w/drainage 2-way latex	A						
A4315	Cath w/drainage 2-way silcne	A						
A4316	Cath w/drainage 3-way	A						
A4320	Irrigation tray	A						
A4321	Cath therapeutic irrig agent	A						
A4322	Irrigation syringe	A						
A4326	Male external catheter	A						
A4327	Fem urinary collect dev cup	A						
A4328	Fem urinary collect pouch	A						
A4330	Stool collection pouch	A						
A4331	Extension drainage tubing	A						
A4332	Lube sterile packet	A						
A4333	Urinary cath anchor device	A						
A4334	Urinary cath leg strap	A						
A4335	Incontinence supply	A						
A4336	Urethral insert	A						
A4338	Indwelling catheter latex	A						
A4340	Indwelling catheter special	A						
A4344	Cath indw foley 2 way silicn	A						
A4346	Cath indw foley 3 way	A						
A4349	Disposable male external cat	A						

A4351	Straight tip urine catheter	A						
A4352	Coude tip urinary catheter	A						
A4353	Intermittent urinary cath	A						
A4354	Cath insertion tray w/bag	A						
A4355	Bladder irrigation tubing	A						
A4356	Ext ureth clmp or compr dvc	A						
A4357	Bedside drainage bag	A						
A4358	Urinary leg or abdomen bag	A						
A4360	Disposable ext urethral dev	A						
A4361	Ostomy face plate	A						
A4362	Solid skin barrier	A						
A4363	Ostomy clamp, replacement	A						
A4364	Adhesive, liquid or equal	A						
A4366	Ostomy vent	A						
A4367	Ostomy belt	A						
A4368	Ostomy filter	A						
A4369	Skin barrier liquid per oz	A						
A4371	Skin barrier powder per oz	A						
A4372	Skin barrier solid 4x4 equiv	A						
A4373	Skin barrier with flange	A						
A4375	Drainable plastic pch w fcpl	A						
A4376	Drainable rubber pch w fcplt	A						
A4377	Drainable plstic pch w/o fp	A						
A4378	Drainable rubber pch w/o fp	A						
A4379	Urinary plastic pouch w fcpl	A						
A4380	Urinary rubber pouch w fcplt	A						
A4381	Urinary plastic pouch w/o fp	A						
A4382	Urinary hvy plstc pch w/o fp	A						
A4383	Urinary rubber pouch w/o fp	A						
A4384	Ostomy faceplt/silicone ring	A						
A4385	Ost skn barrier sld ext wear	A						

A4387	Ost clsd pouch w att st barr	A						
A4388	Drainable pch w ex wear barr	A						
A4389	Drainable pch w st wear barr	A						
A4390	Drainable pch ex wear convex	A						
A4391	Urinary pouch w ex wear barr	A						
A4392	Urinary pouch w st wear barr	A						
A4393	Urine pch w ex wear bar conv	A						
A4394	Ostomy pouch liq deodorant	A						
A4395	Ostomy pouch solid deodorant	A						
A4396	Peristomal hernia supprt blt	A						
A4397	Irrigation supply sleeve	A						
A4398	Ostomy irrigation bag	A						
A4399	Ostomy irrig cone/cath w brs	A						
A4400	Ostomy irrigation set	A						
A4402	Lubricant per ounce	A						
A4404	Ostomy ring each	A						
A4405	Nonpectin based ostomy paste	A						
A4406	Pectin based ostomy paste	A						
A4407	Ext wear ost skn barr <=4sq"	A						
A4408	Ext wear ost skn barr >4sq"	A						
A4409	Ost skn barr convex <=4 sq i	A						
A4410	Ost skn barr extnd >4 sq	A						
A4411	Ost skn barr extnd =4sq	A						
A4412	Ost pouch drain high output	A						
A4413	2 pc drainable ost pouch	A						
A4414	Ost sknbar w/o conv<=4 sq in	A						
A4415	Ost skn barr w/o conv >4 sqi	A						
A4416	Ost pch clsd w barrier/filtr	A						
A4417	Ost pch w bar/bltinconv/fltr	A						
A4418	Ost pch clsd w/o bar w filtr	A						
A4419	Ost pch for bar w flange/flt	A						
A4420	Ost pch clsd for bar w lk fl	A						
A4421	Ostomy supply misc	E						
A4422	Ost pouch absorbent material	A						
A4423	Ost pch for bar w lk fl/fltr	A						
A4424	Ost pch drain w bar & filter	A						
A4425	Ost pch drain for barrier fl	A						
A4426	Ost pch drain 2 piece system	A						
A4427	Ost pch drain/barr lk flng/f	A						
A4428	Urine ost pouch w faucet/tap	A						
A4429	Urine ost pouch w bltinconv	A						
A4430	Ost urine pch w b/bltin conv	A						
A4431	Ost pch urine w barrier/tapv	A						
A4432	Os pch urine w bar/fange/tap	A						
A4433	Urine ost pch bar w lock fln	A						
A4434	Ost pch urine w lock flng/ft	A						
A4450	Non-waterproof tape	A						
A4452	Waterproof tape	A						
A4455	Adhesive remover per ounce	A						
A4456	Adhesive remover, wipes	A						
A4458	Reusable enema bag	E						
A4461	Surgicl dress hold non-reuse	A						
A4463	Surgical dress holder reuse	A						
A4465	Non-elastic extremity binder	N						
A4466	Elastic garment/covering	E						
A4470	Gravlee jet washer	N						
A4480	Vabra aspirator	N						
A4481	Tracheostoma filter	A						
A4483	Moisture exchanger	A						
A4490	Above knee surgical stocking	E						
A4495	Thigh length surg stocking	E						
A4500	Below knee surgical stocking	E						

A4510	Full length surg stocking	E						
A4520	Incontinence garment anytype	E						
A4550	Surgical trays	B						
A4554	Disposable underpads	E						
A4556	Electrodes, pair	Y						
A4557	Lead wires, pair	Y						
A4558	Conductive gel or paste	Y						
A4559	Coupling gel or paste	Y						
A4561	Pessary rubber, any type	N						
A4562	Pessary, non rubber,any type	N						
A4565	Slings	N						
A4570	Splint	E						
A4575	Hyperbaric o2 chamber disps	E						
A4580	Cast supplies (plaster)	E						
A4590	Special casting material	E						
A4595	TENS suppl 2 lead per month	Y						
A4600	Sleeve, inter limb comp dev	Y						
A4601	Lith ion batt, non-pros use	Y						
A4604	Tubing with heating element	Y						
A4605	Trach suction cath close sys	Y						
A4606	Oxygen probe used w oximeter	A						
A4608	Transtracheal oxygen cath	Y						
A4611	Heavy duty battery	Y						
A4612	Battery cables	Y						
A4613	Battery charger	Y						
A4614	Hand-held PEFR meter	Y						
A4615	Cannula nasal	Y						
A4616	Tubing (oxygen) per foot	Y						
A4617	Mouth piece	Y						
A4618	Breathing circuits	Y						
A4619	Face tent	Y						

A4620	Variable concentration mask	Y						
A4623	Tracheostomy inner cannula	A						
A4624	Tracheal suction tube	Y						
A4625	Trach care kit for new trach	A						
A4626	Tracheostomy cleaning brush	A						
A4627	Spacer bag/reservoir	E						
A4628	Oropharyngeal suction cath	Y						
A4629	Tracheostomy care kit	A						
A4630	Repl bat t.e.n.s. own by pt	Y						
A4633	Uvl replacement bulb	Y						
A4634	Replacement bulb th lightbox	A						
A4635	Underarm crutch pad	Y						
A4636	Handgrip for cane etc	Y						
A4637	Repl tip cane/crutch/walker	Y						
A4638	Repl batt pulse gen sys	Y						
A4639	Infrared ht sys replcmnt pad	Y						
A4640	Alternating pressure pad	Y						
A4641	Radiopharm dx agent noc	N						
A4642	In111 satumomab	N						
A4648	Implantable tissue marker	N						
A4649	Surgical supplies	N						
A4650	Implant radiation dosimeter	N						
A4651	Calibrated microcap tube	A						
A4652	Microcapillary tube sealant	A						
A4653	PD catheter anchor belt	A						
A4657	Syringe w/wo needle	N						
A4660	Sphyg/bp app w cuff and stet	N						
A4663	Dialysis blood pressure cuff	N						
A4670	Automatic bp monitor, dial	E						
A4671	Disposable cycler set	B						
A4672	Drainage ext line, dialysis	B						

A4673	Ext line w easy lock connect	B						
A4674	Chem/antisept solution, 8oz	B						
A4680	Activated carbon filter, ea	N						
A4690	Dialyzer, each	N						
A4706	Bicarbonate conc sol per gal	N						
A4707	Bicarbonate conc pow per pac	N						
A4708	Acetate conc sol per gallon	N						
A4709	Acid conc sol per gallon	N						
A4714	Treated water per gallon	N						
A4719	"Y set" tubing	N						
A4720	Dialysat sol fld vol > 249cc	N						
A4721	Dialysat sol fld vol > 999cc	N						
A4722	Dialys sol fld vol > 1999cc	N						
A4723	Dialys sol fld vol > 2999cc	N						
A4724	Dialys sol fld vol > 3999cc	N						
A4725	Dialys sol fld vol > 4999cc	N						
A4726	Dialys sol fld vol > 5999cc	N						
A4728	Dialysate solution, non-dex	B						
A4730	Fistula cannulation set, ea	N						
A4736	Topical anesthetic, per gram	N						
A4737	Inj anesthetic per 10 ml	N						
A4740	Shunt accessory	N						
A4750	Art or venous blood tubing	N						
A4755	Comb art/venous blood tubing	N						
A4760	Dialysate sol test kit, each	N						
A4765	Dialysate conc pow per pack	N						
A4766	Dialysate conc sol add 10 ml	N						
A4770	Blood collection tube/vacuum	N						
A4771	Serum clotting time tube	N						
A4772	Blood glucose test strips	N						
A4773	Occult blood test strips	N						

A4774	Ammonia test strips	N						
A4802	Protamine sulfate per 50 mg	N						
A4860	Disposable catheter tips	N						
A4870	Plumb/elec wk hm hemo equip	N						
A4890	Repair/maint cont hemo equip	N						
A4911	Drain bag/bottle	N						
A4913	Misc dialysis supplies noc	N						
A4918	Venous pressure clamp	N						
A4927	Non-sterile gloves	N						
A4928	Surgical mask	N						
A4929	Tourniquet for dialysis, ea	N						
A4930	Sterile, gloves per pair	N						
A4931	Reusable oral thermometer	N						
A4932	Reusable rectal thermometer	E						
A5051	Pouch clsd w barr attached	A						
A5052	Clsd ostomy pouch w/o barr	A						
A5053	Clsd ostomy pouch faceplate	A						
A5054	Clsd ostomy pouch w/flange	A						
A5055	Stoma cap	A						
A5061	Pouch drainable w barrier at	A						
A5062	Drnble ostomy pouch w/o barr	A						
A5063	Drain ostomy pouch w/flange	A						
A5071	Urinary pouch w/barrier	A						
A5072	Urinary pouch w/o barrier	A						
A5073	Urinary pouch on barr w/flng	A						
A5081	Continent stoma plug	A						
A5082	Continent stoma catheter	A						
A5083	Stoma absorptive cover	A						
A5093	Ostomy accessory convex inse	A						
A5102	Bedside drain btl w/wo tube	A						
A5105	Urinary suspensory	A						

A5112	Urinary leg bag	A						
A5113	Latex leg strap	A						
A5114	Foam/fabric leg strap	A						
A5120	Skin barrier, wipe or swab	A						
A5121	Solid skin barrier 6x6	A						
A5122	Solid skin barrier 8x8	A						
A5126	Disk/foam pad +or- adhesive	A						
A5131	Appliance cleaner	A						
A5200	Percutaneous catheter anchor	A						
A5500	Diab shoe for density insert	Y						
A5501	Diabetic custom molded shoe	Y						
A5503	Diabetic shoe w/roller/rockr	Y						
A5504	Diabetic shoe with wedge	Y						
A5505	Diab shoe w/metatarsal bar	Y						
A5506	Diabetic shoe w/off set heel	Y						
A5507	Modification diabetic shoe	Y						
A5508	Diabetic deluxe shoe	Y						
A5510	Compression form shoe insert	E						
A5512	Multi den insert direct form	Y						
A5513	Multi den insert custom mold	Y						
A6000	Wound warming wound cover	E						
A6010	Collagen based wound filler	A						
A6011	Collagen gel/paste wound fil	A						
A6021	Collagen dressing <=16 sq in	A						
A6022	Collagen drsg>16<=48 sq in	A						
A6023	Collagen dressing >48 sq in	A						
A6024	Collagen dsg wound filler	A						
A6025	Silicone gel sheet, each	E						
A6154	Wound pouch each	A						
A6196	Alginate dressing <=16 sq in	A						
A6197	Alginate drsg >16 <=48 sq in	A						

A6198	alginate dressing > 48 sq in	A						
A6199	Alginate drsg wound filler	A						
A6203	Composite drsg <= 16 sq in	A						
A6204	Composite drsg >16<=48 sq in	A						
A6205	Composite drsg > 48 sq in	A						
A6206	Contact layer <= 16 sq in	A						
A6207	Contact layer >16<= 48 sq in	A						
A6208	Contact layer > 48 sq in	A						
A6209	Foam drsg <=16 sq in w/o bdr	A						
A6210	Foam drg >16<=48 sq in w/o b	A						
A6211	Foam drg > 48 sq in w/o brdr	A						
A6212	Foam drg <=16 sq in w/border	A						
A6213	Foam drg >16<=48 sq in w/bdr	A						
A6214	Foam drg > 48 sq in w/border	A						
A6215	Foam dressing wound filler	A						
A6216	Non-sterile gauze<=16 sq in	A						
A6217	Non-sterile gauze>16<=48 sq	A						
A6218	Non-sterile gauze > 48 sq in	A						
A6219	Gauze <= 16 sq in w/border	A						
A6220	Gauze >16 <=48 sq in w/bordr	A						
A6221	Gauze > 48 sq in w/border	A						
A6222	Gauze <=16 in no w/sal w/o b	A						
A6223	Gauze >16<=48 no w/sal w/o b	A						
A6224	Gauze > 48 in no w/sal w/o b	A						
A6228	Gauze <= 16 sq in water/sal	A						
A6229	Gauze >16<=48 sq in watr/sal	A						
A6230	Gauze > 48 sq in water/salne	A						
A6231	Hydrogel dsg<=16 sq in	A						
A6232	Hydrogel dsg>16<=48 sq in	A						
A6233	Hydrogel dressing >48 sq in	A						
A6234	Hydrocolld drg <=16 w/o bdr	A						

A6235	Hydrocolld drg >16<=48 w/o b	A						
A6236	Hydrocolld drg > 48 in w/o b	A						
A6237	Hydrocolld drg <=16 in w/bdr	A						
A6238	Hydrocolld drg >16<=48 w/bdr	A						
A6239	Hydrocolld drg > 48 in w/bdr	A						
A6240	Hydrocolld drg filler paste	A						
A6241	Hydrocolloid drg filler dry	A						
A6242	Hydrogel drg <=16 in w/o bdr	A						
A6243	Hydrogel drg >16<=48 w/o bdr	A						
A6244	Hydrogel drg >48 in w/o bdr	A						
A6245	Hydrogel drg <= 16 in w/bdr	A						
A6246	Hydrogel drg >16<=48 in w/b	A						
A6247	Hydrogel drg > 48 sq in w/b	A						
A6248	Hydrogel drsg gel filler	A						
A6250	Skin seal protect moisturizr	A						
A6251	Absorpt drg <=16 sq in w/o b	A						
A6252	Absorpt drg >16 <=48 w/o bdr	A						
A6253	Absorpt drg > 48 sq in w/o b	A						
A6254	Absorpt drg <=16 sq in w/bdr	A						
A6255	Absorpt drg >16<=48 in w/bdr	A						
A6256	Absorpt drg > 48 sq in w/bdr	A						
A6257	Transparent film <= 16 sq in	A						
A6258	Transparent film >16<=48 in	A						
A6259	Transparent film > 48 sq in	A						
A6260	Wound cleanser any type/size	A						
A6261	Wound filler gel/paste /oz	A						
A6262	Wound filler dry form / gram	A						
A6266	Impreg gauze no h20/sal/yard	A						
A6402	Sterile gauze <= 16 sq in	A						
A6403	Sterile gauze>16 <= 48 sq in	A						
A6404	Sterile gauze > 48 sq in	A						

A6407	Packing strips, non-impreg	A						
A6410	Sterile eye pad	A						
A6411	Non-sterile eye pad	A						
A6412	Occlusive eye patch	E						
A6413	Adhesive bandage, first-aid	E						
A6441	Pad band w>=3" <5"/yd	A						
A6442	Conform band n/s w<3"/yd	A						
A6443	Conform band n/s w>=3"<5"/yd	A						
A6444	Conform band n/s w>=5"/yd	A						
A6445	Conform band s w <3"/yd	A						
A6446	Conform band s w>=3" <5"/yd	A						
A6447	Conform band s w >=5"/yd	A						
A6448	Lt compres band <3"/yd	A						
A6449	Lt compres band >=3" <5"/yd	A						
A6450	Lt compres band >=5"/yd	A						
A6451	Mod compres band w>=3"<5"/yd	A						
A6452	High compres band w>=3"<5"yd	A						
A6453	Self-adher band w <3"/yd	A						
A6454	Self-adher band w>=3" <5"/yd	A						
A6455	Self-adher band >=5"/yd	A						
A6456	Zinc paste band w >=3"<5"/yd	A						
A6457	Tubular dressing	A						
A6501	Compres burngarment bodysuit	A						
A6502	Compres burngarment chinstrp	A						
A6503	Compres burngarment facehood	A						
A6504	Cmprsburngarment glove-wrist	A						
A6505	Cmprsburngarment glove-elbow	A						
A6506	Cmprsburngrmnt glove-axilla	A						
A6507	Cmprs burngarment foot-knee	A						
A6508	Cmprs burngarment foot-thigh	A						
A6509	Compres burn garment jacket	A						

A6510	Compres burn garment leotard	A						
A6511	Compres burn garment panty	A						
A6512	Compres burn garment, noc	A						
A6513	Compress burn mask face/neck	B						
A6530	Compression stocking BK18-30	E						
A6531	Compression stocking BK30-40	A						
A6532	Compression stocking BK40-50	A						
A6533	Gc stocking thighlngth 18-30	E						
A6534	Gc stocking thighlngth 30-40	E						
A6535	Gc stocking thighlngth 40-50	E						
A6536	Gc stocking full lngth 18-30	E						
A6537	Gc stocking full lngth 30-40	E						
A6538	Gc stocking full lngth 40-50	E						
A6539	Gc stocking waistlngth 18-30	E						
A6540	Gc stocking waistlngth 30-40	E						
A6541	Gc stocking waistlngth 40-50	E						
A6544	Gc stocking garter belt	E						
A6545	Grad comp non-elastic BK	A						
A6549	G compression stocking	E						
A6550	Neg pres wound ther drsg set	Y						
A7000	Disposable canister for pump	Y						
A7001	Nondisposable pump canister	Y						
A7002	Tubing used w suction pump	Y						
A7003	Nebulizer administration set	Y						
A7004	Disposable nebulizer sml vol	Y						
A7005	Nondisposable nebulizer set	Y						
A7006	Filtered nebulizer admin set	Y						
A7007	Lg vol nebulizer disposable	Y						
A7008	Disposable nebulizer prefill	Y						
A7009	Nebulizer reservoir bottle	Y						
A7010	Disposable corrugated tubing	Y						
A7011	Nondispos corrugated tubing	Y						
A7012	Nebulizer water collec devic	Y						
A7013	Disposable compressor filter	Y						
A7014	Compressor nondispos filter	Y						
A7015	Aerosol mask used w nebulize	Y						
A7016	Nebulizer dome & mouthpiece	Y						
A7017	Nebulizer not used w oxygen	Y						
A7018	Water distilled w/nebulizer	Y						
A7025	Replace chest compress vest	Y						
A7026	Replace chst cmprss sys hose	Y						
A7027	Combination oral/nasal mask	Y						
A7028	Repl oral cushion combo mask	Y						
A7029	Repl nasal pillow comb mask	Y						
A7030	CPAP full face mask	Y						
A7031	Replacement facemask interfa	Y						
A7032	Replacement nasal cushion	Y						
A7033	Replacement nasal pillows	Y						
A7034	Nasal application device	Y						
A7035	Pos airway press headgear	Y						
A7036	Pos airway press chinstrap	Y						
A7037	Pos airway pressure tubing	Y						
A7038	Pos airway pressure filter	Y						
A7039	Filter, non disposable w pap	Y						
A7040	One way chest drain valve	A						
A7041	Water seal drain container	A						
A7042	Implanted pleural catheter	N						
A7043	Vacuum drainagebottle/tubing	A						
A7044	PAP oral interface	Y						
A7045	Repl exhalation port for PAP	Y						
A7046	Repl water chamber, PAP dev	Y						
A7501	Tracheostoma valve w diaphra	A						

A7502	Replacement diaphragm/fplate	A						
A7503	HMES filter holder or cap	A						
A7504	Tracheostoma HMES filter	A						
A7505	HMES or trach valve housing	A						
A7506	HMES/trachvalve adhesivedisk	A						
A7507	Integrated filter & holder	A						
A7508	Housing & Integrated Adhesiv	A						
A7509	Heat & moisture exchange sys	A						
A7520	Trach/laryn tube non-cuffed	A						
A7521	Trach/laryn tube cuffed	A						
A7522	Trach/laryn tube stainless	A						
A7523	Tracheostomy shower protect	A						
A7524	Tracheostoma stent/stud/bttn	A						
A7525	Tracheostomy mask	A						
A7526	Tracheostomy tube collar	A						
A7527	Trach/laryn tube plug/stop	A						
A8000	Soft protect helmet prefab	Y						
A8001	Hard protect helmet prefab	Y						
A8002	Soft protect helmet custom	Y						
A8003	Hard protect helmet custom	Y						
A8004	Repl soft interface, helmet	Y						
A9150	Misc/exper non-prescript dru	B						
A9152	Single vitamin nos	E						
A9153	Multi-vitamin nos	E						
A9155	Artificial saliva	B						
A9180	Lice treatment, topical	E						
A9270	Non-covered item or service	E						
A9274	Ext amb insulin delivery sys	E						
A9275	Disp home glucose monitor	E						
A9276	Disposable sensor, CGM sys	E						
A9277	External transmitter, CGM	E						
A9278	External receiver, CGM sys	E						
A9279	Monitoring feature/deviceNOC	E						
A9280	Alert device, noc	E						
A9281	Reaching/grabbing device	E						
A9282	Wig any type	E						
A9283	Foot press off load supp dev	E						
A9284	Non-electronic spirometer	N						
A9300	Exercise equipment	E						
A9500	Tc99m sestamibi	N						
A9501	Technetium TC-99m teboroxime	N						
A9502	Tc99m tetrofosmin	N						
A9503	Tc99m medronate	N						
A9504	Tc99m apcitide	N						
A9505	TL201 thallium	N						
A9507	In111 capromab	N						
A9508	I131 iodobenguate, dx	N						
A9509	Iodine I-123 sod iodide mil	N						
A9510	Tc99m disofenin	N						
A9512	Tc99m pertechnetate	N						
A9516	Iodine I-123 sod iodide mic	N						
A9517	I131 iodide cap, rx	K	1064		$16.51		$3.30	
A9521	Tc99m exametazime	N						
A9524	I131 serum albumin, dx	N						
A9526	Nitrogen N-13 ammonia	N						
A9527	Iodine I-125 sodium iodide	U	2632	0.5626	$37.83		$7.57	*
A9528	Iodine I-131 iodide cap, dx	N						
A9529	I131 iodide sol, dx	N						
A9530	I131 iodide sol, rx	K	1150		$11.02		$2.20	
A9531	I131 max 100uCi	N						
A9532	I125 serum albumin, dx	N						
A9536	Tc99m depreotide	N						

A9537	Tc99m mebrofenin	N						
A9538	Tc99m pyrophosphate	N						
A9539	Tc99m pentetate	N						
A9540	Tc99m MAA	N						
A9541	Tc99m sulfur colloid	N						
A9542	In111 ibritumomab, dx	N						
A9543	Y90 ibritumomab, rx	K	1643		$30,110.81		$6,022.16	
A9544	I131 tositumomab, dx	N						
A9545	I131 tositumomab, rx	K	1645		$22,693.52		$4,538.70	
A9546	Co57/58	N						
A9547	In111 oxyquinoline	N						
A9548	In111 pentetate	N						
A9550	Tc99m gluceptate	N						
A9551	Tc99m succimer	N						
A9552	F18 fdg	N						
A9553	Cr51 chromate	N						
A9554	I125 iothalamate, dx	N						
A9555	Rb82 rubidium	N						
A9556	Ga67 gallium	N						
A9557	Tc99m bicisate	N						
A9558	Xe133 xenon 10mci	N						
A9559	Co57 cyano	N						
A9560	Tc99m labeled rbc	N						
A9561	Tc99m oxidronate	N						
A9562	Tc99m mertiatide	N						
A9563	P32 Na phosphate	K	1675		$196.49		$39.30	
A9564	P32 chromic phosphate	K	1676		$113.44		$22.69	
A9566	Tc99m fanolesomab	N						
A9567	Technetium TC-99m aerosol	N						
A9568	Technetium tc99m arcitumomab	N						
A9569	Technetium TC-99m auto WBC	N						
A9570	Indium In-111 auto WBC	N						
A9571	Indium IN-111 auto platelet	N						
A9572	Indium In-111 pentetreotide	N						
A9576	Inj prohance multipack	N						
A9577	Inj multihance	N						
A9578	Inj multihance multipack	N						
A9579	Gad-base MR contrast NOS,1ml	N						
A9580	Sodium fluoride F-18	N						
A9581	Gadoxetate disodium inj	G	9246		$13.50			*
A9582	Iodine I-123 iobenguane	G	9247		$2,284.77			*
A9583	Gadofosveset trisodium inj	G	1299		$12.89			*
A9600	Sr89 strontium	K	0701		$778.98		$155.80	
A9604	Sm 153 lexidronam	K	1295		$5,504.70		$1,100.94	
A9698	Non-rad contrast materialNOC	N						
A9699	Radiopharm rx agent noc	N						
A9700	Echocardiography Contrast	B						
A9900	Supply/accessory/service	Y						
A9901	Delivery/set up/dispensing	A						
A9999	DME supply or accessory, nos	Y						
B4034	Enter feed supkit syr by day	Y						
B4035	Enteral feed supp pump per d	Y						
B4036	Enteral feed sup kit grav by	Y						
B4081	Enteral ng tubing w/ stylet	Y						
B4082	Enteral ng tubing w/o stylet	Y						
B4083	Enteral stomach tube levine	Y						
B4087	Gastro/jejuno tube, std	A						
B4088	Gastro/jejuno tube, low-pro	A						
B4100	Food thickener oral	E						
B4102	EF adult fluids and electro	Y						
B4103	EF ped fluid and electrolyte	Y						
B4104	Additive for enteral formula	E						

B4149	EF blenderized foods	Y						
B4150	EF complet w/intact nutrient	Y						
B4152	EF calorie dense>/=1.5Kcal	Y						
B4153	EF hydrolyzed/amino acids	Y						
B4154	EF spec metabolic noninherit	Y						
B4155	EF incomplete/modular	Y						
B4157	EF special metabolic inherit	Y						
B4158	EF ped complete intact nut	Y						
B4159	EF ped complete soy based	Y						
B4160	EF ped caloric dense>/=0.7kc	Y						
B4161	EF ped hydrolyzed/amino acid	Y						
B4162	EF ped specmetabolic inherit	Y						
B4164	Parenteral 50% dextrose solu	Y						
B4168	Parenteral sol amino acid 3.	Y						
B4172	Parenteral sol amino acid 5.	Y						
B4176	Parenteral sol amino acid 7-	Y						
B4178	Parenteral sol amino acid >	Y						
B4180	Parenteral sol carb > 50%	Y						
B4185	Parenteral sol 10 gm lipids	B						
B4189	Parenteral sol amino acid &	Y						
B4193	Parenteral sol 52-73 gm prot	Y						
B4197	Parenteral sol 74-100 gm pro	Y						
B4199	Parenteral sol > 100gm prote	Y						
B4216	Parenteral nutrition additiv	Y						
B4220	Parenteral supply kit premix	Y						
B4222	Parenteral supply kit homemi	Y						
B4224	Parenteral administration ki	Y						
B5000	Parenteral sol renal-amirosy	Y						
B5100	Parenteral sol hepatic-fream	Y						
B5200	Parenteral sol stres-brnch c	Y						
B9000	Enter infusion pump w/o alrm	Y						
B9002	Enteral infusion pump w/ ala	Y						
B9004	Parenteral infus pump portab	Y						
B9006	Parenteral infus pump statio	Y						
B9998	Enteral supp not otherwise c	Y						
B9999	Parenteral supp not othrws c	Y						
C1300	HYPERBARIC Oxygen	S	0659	1.588	$106.78		$21.36	*
C1713	Anchor/screw bn/bn,tis/bn	N						
C1714	Cath, trans atherectomy, dir	N						
C1715	Brachytherapy needle	N						
C1716	Brachytx, non-str, Gold-198	U	1716	0.6357	$42.75		$8.55	*
C1717	Brachytx, non-str,HDR Ir-192	U	1717	3.4326	$230.81		$46.17	*
C1719	Brachytx, NS, Non-HDRIr-192	U	1719	0.9497	$63.86		$12.78	*
C1721	AICD, dual chamber	N						
C1722	AICD, single chamber	N						
C1724	Cath, trans atherec,rotation	N						
C1725	Cath, translumin non-laser	N						
C1726	Cath, bal dil, non-vascular	N						
C1727	Cath, bal tis dis, non-vas	N						
C1728	Cath, brachytx seed adm	N						
C1729	Cath, drainage	N						
C1730	Cath, EP, 19 or few elect	N						
C1731	Cath, EP, 20 or more elec	N						
C1732	Cath, EP, diag/abl, 3D/vect	N						
C1733	Cath, EP, othr than cool-tip	N						
C1750	Cath, hemodialysis,long-term	N						
C1751	Cath, inf, per/cent/midline	N						
C1752	Cath,hemodialysis,short-term	N						
C1753	Cath, intravas ultrasound	N						
C1754	Catheter, intradiscal	N						
C1755	Catheter, intraspinal	N						
C1756	Cath, pacing, transesoph	N						

C1757	Cath, thrombectomy/embolect	N						
C1758	Catheter, ureteral	N						
C1759	Cath, intra echocardiography	N						
C1760	Closure dev, vasc	N						
C1762	Conn tiss, human(inc fascia)	N						
C1763	Conn tiss, non-human	N						
C1764	Event recorder, cardiac	N						
C1765	Adhesion barrier	N						
C1766	Intro/sheath,strble,non-peel	N						
C1767	Generator, neuro non-recharg	N						
C1768	Graft, vascular	N						
C1769	Guide wire	N						
C1770	Imaging coil, MR, insertable	N						
C1771	Rep dev, urinary, w/sling	N						
C1772	Infusion pump, programmable	N						
C1773	Ret dev, insertable	N						
C1776	Joint device (implantable)	N						
C1777	Lead, AICD, endo single coil	N						
C1778	Lead, neurostimulator	N						
C1779	Lead, pmkr, transvenous VDD	N						
C1780	Lens, intraocular (new tech)	N						
C1781	Mesh (implantable)	N						
C1782	Morcellator	N						
C1783	Ocular imp, aqueous drain de	N						
C1784	Ocular dev, intraop, det ret	N						
C1785	Pmkr, dual, rate-resp	N						
C1786	Pmkr, single, rate-resp	N						
C1787	Patient progr, neurostim	N						
C1788	Port, indwelling, imp	N						
C1789	Prosthesis, breast, imp	N						
C1813	Prosthesis, penile, inflatab	N						

C1814	Retinal tamp, silicone oil	N						
C1815	Pros, urinary sph, imp	N						
C1816	Receiver/transmitter, neuro	N						
C1817	Septal defect imp sys	N						
C1818	Integrated keratoprosthesis	N						
C1819	Tissue localization-excision	N						
C1820	Generator neuro rechg bat sy	N						
C1821	Interspinous implant	N						
C1874	Stent, coated/cov w/del sys	N						
C1875	Stent, coated/cov w/o del sy	N						
C1876	Stent, non-coa/non-cov w/del	N						
C1877	Stent, non-coat/cov w/o del	N						
C1878	Matrl for vocal cord	N						
C1879	Tissue marker, implantable	N						
C1880	Vena cava filter	N						
C1881	Dialysis access system	N						
C1882	AICD, other than sing/dual	N						
C1883	Adapt/ext, pacing/neuro lead	N						
C1884	Embolization Protect syst	N						
C1885	Cath, translumin angio laser	N						
C1887	Catheter, guiding	N						
C1888	Endovas non-cardiac abl cath	N						
C1891	Infusion pump,non-prog, perm	N						
C1892	Intro/sheath,fixed,peel-away	N						
C1893	Intro/sheath, fixed,non-peel	N						
C1894	Intro/sheath, non-laser	N						
C1895	Lead, AICD, endo dual coil	N						
C1896	Lead, AICD, non sing/dual	N						
C1897	Lead, neurostim test kit	N						
C1898	Lead, pmkr, other than trans	N						
C1899	Lead, pmkr/AICD combination	N						

C1900	Lead, coronary venous	N						
C2614	Probe, perc lumb disc	N						
C2615	Sealant, pulmonary, liquid	N						
C2616	Brachytx, non-str,Yttrium-90	U	2616	234.0942	$15,740.73		$3,148.15	*
C2617	Stent, non-cor, tem w/o del	N						
C2618	Probe, cryoablation	N						
C2619	Pmkr, dual, non rate-resp	N						
C2620	Pmkr, single, non rate-resp	N						
C2621	Pmkr, other than sing/dual	N						
C2622	Prosthesis, penile, non-inf	N						
C2625	Stent, non-cor, tem w/del sy	N						
C2626	Infusion pump, non-prog,temp	N						
C2627	Cath, suprapubic/cystoscopic	N						
C2628	Catheter, occlusion	N						
C2629	Intro/sheath, laser	N						
C2630	Cath, EP, cool-tip	N						
C2631	Rep dev, urinary, w/o sling	N						
C2634	Brachytx, non-str, HA, I-125	U	2634	0.8871	$59.65		$11.93	*
C2635	Brachytx, non-str, HA, P-103	U	2635	0.4242	$28.52		$5.71	*
C2636	Brachy linear, non-str,P-103	U	2636	0.2873	$19.32		$3.87	*
C2637	Brachy,non-str,Ytterbium-169	B						
C2638	Brachytx, stranded, I-125	U	2638	0.6302	$42.38		$8.48	*
C2639	Brachytx, non-stranded,I-125	U	2639	0.5368	$36.09		$7.22	*
C2640	Brachytx, stranded, P-103	U	2640	0.8955	$60.21		$12.05	*
C2641	Brachytx, non-stranded,P-103	U	2641	0.8474	$56.98		$11.40	*
C2642	Brachytx, stranded, C-131	U	2642	1.6295	$109.57		$21.92	*
C2643	Brachytx, non-stranded,C-131	U	2643	0.9805	$65.93		$13.19	*
C2698	Brachytx, stranded, NOS	U	2698	0.6302	$42.38		$8.48	*
C2699	Brachytx, non-stranded, NOS	U	2699	0.4242	$28.52		$5.71	*
C8900	MRA w/cont, abd	Q3	0284	6.2901	$422.95	$146.85	$84.59	*
C8901	MRA w/o cont, abd	Q3	0336	5.1855	$348.68	$137.40	$69.74	*
C8902	MRA w/o fol w/cont, abd	Q3	0337	7.9432	$534.11	$197.83	$106.83	*
C8903	MRI w/cont, breast, uni	Q3	0284	6.2901	$422.95	$146.85	$84.59	*
C8904	MRI w/o cont, breast, uni	Q3	0336	5.1855	$348.68	$137.40	$69.74	*
C8905	MRI w/o fol w/cont, brst, un	Q3	0337	7.9432	$534.11	$197.83	$106.83	*
C8906	MRI w/cont, breast, bi	Q3	0284	6.2901	$422.95	$146.85	$84.59	*
C8907	MRI w/o cont, breast, bi	Q3	0336	5.1855	$348.68	$137.40	$69.74	*
C8908	MRI w/o fol w/cont, breast,	Q3	0337	7.9432	$534.11	$197.83	$106.83	*
C8909	MRA w/cont, chest	Q3	0284	6.2901	$422.95	$146.85	$84.59	*
C8910	MRA w/o cont, chest	Q3	0336	5.1855	$348.68	$137.40	$69.74	*
C8911	MRA w/o fol w/cont, chest	Q3	0337	7.9432	$534.11	$197.83	$106.83	*
C8912	MRA w/cont, lwr ext	Q3	0284	6.2901	$422.95	$146.85	$84.59	*
C8913	MRA w/o cont, lwr ext	Q3	0336	5.1855	$348.68	$137.40	$69.74	*
C8914	MRA w/o fol w/cont, lwr ext	Q3	0337	7.9432	$534.11	$197.83	$106.83	*
C8918	MRA w/cont, pelvis	Q3	0284	6.2901	$422.95	$146.85	$84.59	*
C8919	MRA w/o cont, pelvis	Q3	0336	5.1855	$348.68	$137.40	$69.74	*
C8920	MRA w/o fol w/cont, pelvis	Q3	0337	7.9432	$534.11	$197.83	$106.83	*
C8921	TTE w or w/o fol w/cont, com	S	0128	9.6604	$649.57	$216.29	$129.92	*
C8922	TTE w or w/o fol w/cont, f/u	S	0128	9.6604	$649.57	$216.29	$129.92	*
C8923	2D TTE w or w/o fol w/con,co	S	0128	9.6604	$649.57	$216.29	$129.92	*
C8924	2D TTE w or w/o fol w/con,fu	S	0128	9.6604	$649.57	$216.29	$129.92	*
C8925	2D TEE w or w/o fol w/con,in	S	0128	9.6604	$649.57	$216.29	$129.92	*
C8926	TEE w or w/o fol w/cont,cong	S	0128	9.6604	$649.57	$216.29	$129.92	*
C8927	TEE w or w/o fol w/cont, mon	S	0128	9.6604	$649.57	$216.29	$129.92	*
C8928	TTE w or w/o fol w/con,stres	S	0128	9.6604	$649.57	$216.29	$129.92	*
C8929	TTE w or wo fol wcon,Doppler	S	0128	9.6604	$649.57	$216.29	$129.92	*
C8930	TTE w or w/o contr, cont ECG	S	0128	9.6604	$649.57	$216.29	$129.92	*
C8957	Prolonged IV inf, req pump	S	0440	3.2632	$219.42		$43.89	*
C9113	Inj pantoprazole sodium, via	N						
C9121	Injection, argatroban	K	9121		$17.87		$3.57	
C9248	Inj, clevidipine butyrate	G	9248		$3.10		$0.61	
C9250	Artiss fibrin sealant	G	9250		$135.36		$26.56	

C9254	Injection, lacosamide	K	9254		$0.18		$0.04	
C9255	Paliperidone palmitate inj	G	9255		$6.71		$1.32	
C9256	Dexamethasone intravitreal	G	9256		$196.10		$38.48	
C9257	Bevacizumab injection	K	1281		$1.41		$0.28	
C9352	Neuragen nerve guide, per cm	N						
C9353	Neurawrap nerve protector,cm	N						
C9354	Veritas collagen matrix, cm2	N						
C9355	Neuromatrix nerve cuff, cm	N						
C9356	TenoGlide tendon prot, cm2	G	9356		$26.37			*
C9358	SurgiMend, fetal	G	9358		$10.64		$2.09	
C9359	Implnt,bon void filler-putty	G	9359		$61.47			*
C9360	SurgiMend, neonatal	G	9360		$11.14		$2.19	
C9361	NeuroMend nerve wrap	G	9361		$250.53			*
C9362	Implnt,bon void filler-strip	G	9362		$63.60			
C9363	Integra Meshed Bil Wound Mat	G	9363		$28.30		$5.55	
C9364	Porcine implant, Permacol	G	9364		$18.09			*
C9399	Unclassified drugs or biolog	A						
C9716	Radiofrequency energy to anu	T	0150	32.1812	$2,163.90	$437.12	$432.78	*
C9724	EPS gast cardia plic	T	0422	24.2703	$1,631.96	$436.89	$326.40	*
C9725	Place endorectal app	T	0148	5.365	$360.75		$72.15	*
C9726	Rxt breast appl place/remov	T	0028	24.7516	$1,664.32		$332.87	*
C9727	Insert palate implants	T	0252	7.6196	$512.35	$109.16	$102.47	*
C9728	Place device/marker, non pro	X	0310	13.7576	$925.07	$325.27	$185.02	*
C9898	Inpnt stay radiolabeled item	N						
C9899	Inpt implant pros dev,no cov	A						
D0120	Periodic oral evaluation	E						
D0140	Limit oral eval problm focus	E						
D0145	Oral evaluation, pt < 3yrs	E						
D0150	Comprehensve oral evaluation	S	0330	10.3227	$694.11		$138.83	*
D0160	Extensv oral eval prob focus	E						
D0170	Re-eval,est pt,problem focus	E						
D0180	Comp periodontal evaluation	E						
D0210	Intraor complete film series	E						
D0220	Intraoral periapical first f	E						
D0230	Intraoral periapical ea add	E						
D0240	Intraoral occlusal film	S	0330	10.3227	$694.11		$138.83	*
D0250	Extraoral first film	S	0330	10.3227	$694.11		$138.83	*
D0260	Extraoral ea additional film	S	0330	10.3227	$694.11		$138.83	*
D0270	Dental bitewing single film	S	0330	10.3227	$694.11		$138.83	*
D0272	Dental bitewings two films	S	0330	10.3227	$694.11		$138.83	*
D0273	Bitewings - three films	E						
D0274	Dental bitewings four films	S	0330	10.3227	$694.11		$138.83	*
D0277	Vert bitewings-sev to eight	S	0330	10.3227	$694.11		$138.83	*
D0290	Dental film skull/facial bon	E						
D0310	Dental saliography	E						
D0320	Dental tmj arthrogram incl i	E						
D0321	Dental other tmj films	E						
D0322	Dental tomographic survey	E						
D0330	Dental panoramic film	E						
D0340	Dental cephalometric film	E						
D0350	Oral/facial photo images	E						
D0360	Cone beam ct	E						
D0362	Cone beam, two dimensional	E						
D0363	Cone beam, three dimensional	E						
D0415	Collection of microorganisms	E						
D0416	Viral culture	B						
D0417	Collect & prep saliva sample	E						
D0418	Analysis of saliva sample	E						
D0421	Gen tst suscept oral disease	B						
D0425	Caries susceptibility test	E						
D0431	Diag tst detect mucos abnorm	B						
D0460	Pulp vitality test	S	0330	10.3227	$694.11		$138.83	*

D0470	Diagnostic casts	E						
D0472	Gross exam, prep & report	B						
D0473	Micro exam, prep & report	B						
D0474	Micro w exam of surg margins	B						
D0475	Decalcification procedure	B						
D0476	Spec stains for microorganis	B						
D0477	Spec stains not for microorg	B						
D0478	Immunohistochemical stains	B						
D0479	Tissue in-situ hybridization	B						
D0480	Cytopath smear prep & report	B						
D0481	Electron microscopy diagnost	B						
D0482	Direct immunofluorescence	B						
D0483	Indirect immunofluorescence	B						
D0484	Consult slides prep elsewher	B						
D0485	Consult inc prep of slides	B						
D0486	Accession of brush biopsy	E						
D0502	Other oral pathology procedu	B						
D0999	Unspecified diagnostic proce	B						
D1110	Dental prophylaxis adult	E						
D1120	Dental prophylaxis child	E						
D1203	Topical app fluoride child	E						
D1204	Topical app fluoride adult	E						
D1206	Topical fluoride varnish	E						
D1310	Nutri counsel-control caries	E						
D1320	Tobacco counseling	E						
D1330	Oral hygiene instruction	E						
D1351	Dental sealant per tooth	E						
D1510	Space maintainer fxd unilat	S	0330	10.3227	$694.11		$138.83	*
D1515	Fixed bilat space maintainer	S	0330	10.3227	$694.11		$138.83	*
D1520	Remove unilat space maintain	S	0330	10.3227	$694.11		$138.83	*
D1525	Remove bilat space maintain	S	0330	10.3227	$694.11		$138.83	*
D1550	Recement space maintainer	S	0330	10.3227	$694.11		$138.83	*
D1555	Remove fix space maintainer	E						
D2140	Amalgam one surface permanen	E						
D2150	Amalgam two surfaces permane	E						
D2160	Amalgam three surfaces perma	E						
D2161	Amalgam 4 or > surfaces perm	E						
D2330	Resin one surface-anterior	E						
D2331	Resin two surfaces-anterior	E						
D2332	Resin three surfaces-anterio	E						
D2335	Resin 4/> surf or w incis an	E						
D2390	Ant resin-based cmpst crown	E						
D2391	Post 1 srfc resinbased cmpst	E						
D2392	Post 2 srfc resinbased cmpst	E						
D2393	Post 3 srfc resinbased cmpst	E						
D2394	Post >=4srfc resinbase cmpst	E						
D2410	Dental gold foil one surface	E						
D2420	Dental gold foil two surface	E						
D2430	Dental gold foil three surfa	E						
D2510	Dental inlay metalic 1 surf	E						
D2520	Dental inlay metallic 2 surf	E						
D2530	Dental inlay metl 3/more sur	E						
D2542	Dental onlay metallic 2 surf	E						
D2543	Dental onlay metallic 3 surf	E						
D2544	Dental onlay metl 4/more sur	E						
D2610	Inlay porcelain/ceramic 1 su	E						
D2620	Inlay porcelain/ceramic 2 su	E						
D2630	Dental onlay porc 3/more sur	E						
D2642	Dental onlay porcelin 2 surf	E						
D2643	Dental onlay porcelin 3 surf	E						
D2644	Dental onlay porc 4/more sur	E						
D2650	Inlay composite/resin one su	E						

D2651	Inlay composite/resin two su	E						
D2652	Dental inlay resin 3/mre sur	E						
D2662	Dental onlay resin 2 surface	E						
D2663	Dental onlay resin 3 surface	E						
D2664	Dental onlay resin 4/mre sur	E						
D2710	Crown resin-based indirect	E						
D2712	Crown 3/4 resin-based compos	E						
D2720	Crown resin w/ high noble me	E						
D2721	Crown resin w/ base metal	E						
D2722	Crown resin w/ noble metal	E						
D2740	Crown porcelain/ceramic subs	E						
D2750	Crown porcelain w/ h noble m	E						
D2751	Crown porcelain fused base m	E						
D2752	Crown porcelain w/ noble met	E						
D2780	Crown 3/4 cast hi noble met	E						
D2781	Crown 3/4 cast base metal	E						
D2782	Crown 3/4 cast noble metal	E						
D2783	Crown 3/4 porcelain/ceramic	E						
D2790	Crown full cast high noble m	E						
D2791	Crown full cast base metal	E						
D2792	Crown full cast noble metal	E						
D2794	Crown-titanium	E						
D2799	Provisional crown	E						
D2910	Recement inlay onlay or part	E						
D2915	Recement cast or prefab post	E						
D2920	Dental recement crown	E						
D2930	Prefab stnlss steel crwn pri	E						
D2931	Prefab stnlss steel crown pe	E						
D2932	Prefabricated resin crown	E						
D2933	Prefab stainless steel crown	E						
D2934	Prefab steel crown primary	E						
D2940	Dental sedative filling	E						
D2950	Core build-up incl any pins	E						
D2951	Tooth pin retention	E						
D2952	Post and core cast + crown	E						
D2953	Each addtnl cast post	E						
D2954	Prefab post/core + crown	E						
D2955	Post removal	E						
D2957	Each addtnl prefab post	E						
D2960	Laminate labial veneer	E						
D2961	Lab labial veneer resin	E						
D2962	Lab labial veneer porcelain	E						
D2970	Temp crown (fractured tooth)	E						
D2971	Add proc construct new crown	E						
D2975	Coping	E						
D2980	Crown repair	E						
D2999	Dental unspec restorative pr	S	0330	10.3227	$694.11		$138.83	*
D3110	Pulp cap direct	E						
D3120	Pulp cap indirect	E						
D3220	Therapeutic pulpotomy	E						
D3221	Gross pulpal debridement	E						
D3222	Part pulp for apexogenesis	E						
D3230	Pulpal therapy anterior prim	E						
D3240	Pulpal therapy posterior pri	E						
D3310	End thxpy, anterior tooth	E						
D3320	End thxpy, bicuspid tooth	E						
D3330	End thxpy, molar	E						
D3331	Non-surg tx root canal obs	E						
D3332	Incomplete endodontic tx	E						
D3333	Internal root repair	E						
D3346	Retreat root canal anterior	E						
D3347	Retreat root canal bicuspid	E						

D3348	Retreat root canal molar	E						
D3351	Apexification/recalc initial	E						
D3352	Apexification/recalc interim	E						
D3353	Apexification/recalc final	E						
D3410	Apicoect/perirad surg anter	E						
D3421	Root surgery bicuspid	E						
D3425	Root surgery molar	E						
D3426	Root surgery ea add root	E						
D3430	Retrograde filling	E						
D3450	Root amputation	E						
D3460	Endodontic endosseous implan	S	0330	10.3227	$694.11		$138.83	*
D3470	Intentional replantation	E						
D3910	Isolation- tooth w rubb dam	E						
D3920	Tooth splitting	E						
D3950	Canal prep/fitting of dowel	E						
D3999	Endodontic procedure	S	0330	10.3227	$694.11		$138.83	*
D4210	Gingivectomy/plasty per quad	E						
D4211	Gingivectomy/plasty per toot	E						
D4230	Ana crown exp 4 or> per quad	E						
D4231	Ana crown exp 1-3 per quad	E						
D4240	Gingival flap proc w/ planin	E						
D4241	Gngvl flap w rootplan 1-3 th	E						
D4245	Apically positioned flap	E						
D4249	Crown lengthen hard tissue	E						
D4260	Osseous surgery per quadrant	S	0330	10.3227	$694.11		$138.83	*
D4261	Osseous surgl-3teethperquad	E						
D4263	Bone replce graft first site	S	0330	10.3227	$694.11		$138.83	*
D4264	Bone replce graft each add	S	0330	10.3227	$694.11		$138.83	*
D4265	Bio mtrls to aid soft/os reg	E						
D4266	Guided tiss regen resorble	E						
D4267	Guided tiss regen nonresorb	E						
D4268	Surgical revision procedure	S	0330	10.3227	$694.11		$138.83	*
D4270	Pedicle soft tissue graft pr	S	0330	10.3227	$694.11		$138.83	*
D4271	Free soft tissue graft proc	S	0330	10.3227	$694.11		$138.83	*
D4273	Subepithelial tissue graft	S	0330	10.3227	$694.11		$138.83	*
D4274	Distal/proximal wedge proc	E						
D4275	Soft tissue allograft	E						
D4276	Con tissue w dble ped graft	E						
D4320	Provision splnt intracoronal	E						
D4321	Provisional splint extracoro	E						
D4341	Periodontal scaling & root	E						
D4342	Periodontal scaling 1-3teeth	E						
D4355	Full mouth debridement	S	0330	10.3227	$694.11		$138.83	*
D4381	Localized delivery antimicro	S	0330	10.3227	$694.11		$138.83	*
D4910	Periodontal maint procedures	E						
D4920	Unscheduled dressing change	E						
D4999	Unspecified periodontal proc	E						
D5110	Dentures complete maxillary	E						
D5120	Dentures complete mandible	E						
D5130	Dentures immediat maxillary	E						
D5140	Dentures immediat mandible	E						
D5211	Dentures maxill part resin	E						
D5212	Dentures mand part resin	E						
D5213	Dentures maxill part metal	E						
D5214	Dentures mandibl part metal	E						
D5225	Maxillary part denture flex	E						
D5226	Mandibular part denture flex	E						
D5281	Removable partial denture	E						
D5410	Dentures adjust cmplt maxil	E						
D5411	Dentures adjust cmplt mand	E						
D5421	Dentures adjust part maxill	E						
D5422	Dentures adjust part mandbl	E						

D5510	Dentur repr broken compl bas	E						
D5520	Replace denture teeth complt	E						
D5610	Dentures repair resin base	E						
D5620	Rep part denture cast frame	E						
D5630	Rep partial denture clasp	E						
D5640	Replace part denture teeth	E						
D5650	Add tooth to partial denture	E						
D5660	Add clasp to partial denture	E						
D5670	Replc tth&acrlc on mtl frmwk	E						
D5671	Replc tth&acrlc mandibular	E						
D5710	Dentures rebase cmplt maxil	E						
D5711	Dentures rebase cmplt mand	E						
D5720	Dentures rebase part maxill	E						
D5721	Dentures rebase part mandbl	E						
D5730	Denture reln cmplt maxil ch	E						
D5731	Denture reln cmplt mand chr	E						
D5740	Denture reln part maxil chr	E						
D5741	Denture reln part mand chr	E						
D5750	Denture reln cmplt max lab	E						
D5751	Denture reln cmplt mand lab	E						
D5760	Denture reln part maxil lab	E						
D5761	Denture reln part mand lab	E						
D5810	Denture interm cmplt maxill	E						
D5811	Denture interm cmplt mandbl	E						
D5820	Denture interm part maxill	E						
D5821	Denture interm part mandbl	E						
D5850	Denture tiss conditn maxill	E						
D5851	Denture tiss condtin mandbl	E						
D5860	Overdenture complete	E						
D5861	Overdenture partial	E						
D5862	Precision attachment	E						

D5867	Replacement of precision att	E						
D5875	Prosthesis modification	E						
D5899	Removable prosthodontic proc	E						
D5911	Facial moulage sectional	S	0330	10.3227	$694.11		$138.83	*
D5912	Facial moulage complete	S	0330	10.3227	$694.11		$138.83	*
D5913	Nasal prosthesis	E						
D5914	Auricular prosthesis	E						
D5915	Orbital prosthesis	E						
D5916	Ocular prosthesis	E						
D5919	Facial prosthesis	E						
D5922	Nasal septal prosthesis	E						
D5923	Ocular prosthesis interim	E						
D5924	Cranial prosthesis	E						
D5925	Facial augmentation implant	E						
D5926	Replacement nasal prosthesis	E						
D5927	Auricular replacement	E						
D5928	Orbital replacement	E						
D5929	Facial replacement	E						
D5931	Surgical obturator	E						
D5932	Postsurgical obturator	E						
D5933	Refitting of obturator	E						
D5934	Mandibular flange prosthesis	E						
D5935	Mandibular denture prosth	E						
D5936	Temp obturator prosthesis	E						
D5937	Trismus appliance	E						
D5951	Feeding aid	E						
D5952	Pediatric speech aid	E						
D5953	Adult speech aid	E						
D5954	Superimposed prosthesis	E						
D5955	Palatal lift prosthesis	E						
D5958	Intraoral con def inter plt	E						

D5959	Intraoral con def mod palat	E						
D5960	Modify speech aid prosthesis	E						
D5982	Surgical stent	E						
D5983	Radiation applicator	S	0330	10.3227	$694.11		$138.83	*
D5984	Radiation shield	S	0330	10.3227	$694.11		$138.83	*
D5985	Radiation cone locator	S	0330	10.3227	$694.11		$138.83	*
D5986	Fluoride applicator	E						
D5987	Commissure splint	S	0330	10.3227	$694.11		$138.83	*
D5988	Surgical splint	E						
D5991	Topical medicament carrier	E						
D5999	Maxillofacial prosthesis	E						
D6010	Odontics endosteal implant	E						
D6012	Endosteal implant	E						
D6040	Odontics eposteal implant	E						
D6050	Odontics transosteal implnt	E						
D6053	Implnt/abtmnt spprt remv dnt	E						
D6054	Implnt/abtmnt spprt remvprtl	E						
D6055	Implant connecting bar	E						
D6056	Prefabricated abutment	E						
D6057	Custom abutment	E						
D6058	Abutment supported crown	E						
D6059	Abutment supported mtl crown	E						
D6060	Abutment supported mtl crown	E						
D6061	Abutment supported mtl crown	E						
D6062	Abutment supported mtl crown	E						
D6063	Abutment supported mtl crown	E						
D6064	Abutment supported mtl crown	E						
D6065	Implant supported crown	E						
D6066	Implant supported mtl crown	E						
D6067	Implant supported mtl crown	E						
D6068	Abutment supported retainer	E						

D6069	Abutment supported retainer	E						
D6070	Abutment supported retainer	E						
D6071	Abutment supported retainer	E						
D6072	Abutment supported retainer	E						
D6073	Abutment supported retainer	E						
D6074	Abutment supported retainer	E						
D6075	Implant supported retainer	E						
D6076	Implant supported retainer	E						
D6077	Implant supported retainer	E						
D6078	Implnt/abut suprtd fixd dent	E						
D6079	Implnt/abut suprtd fixd dent	E						
D6080	Implant maintenance	E						
D6090	Repair implant	E						
D6091	Repl semi/precision attach	E						
D6092	Recement supp crown	E						
D6093	Recement supp part denture	E						
D6094	Abut support crown titanium	E						
D6095	Odontics repr abutment	E						
D6100	Removal of implant	E						
D6190	Radio/surgical implant index	E						
D6194	Abut support retainer titani	E						
D6199	Implant procedure	E						
D6205	Pontic-indirect resin based	E						
D6210	Prosthodont high noble metal	E						
D6211	Bridge base metal cast	E						
D6212	Bridge noble metal cast	E						
D6214	Pontic titanium	E						
D6240	Bridge porcelain high noble	E						
D6241	Bridge porcelain base metal	E						
D6242	Bridge porcelain nobel metal	E						
D6245	Bridge porcelain/ceramic	E						

D6250	Bridge resin w/high noble	E						
D6251	Bridge resin base metal	E						
D6252	Bridge resin w/noble metal	E						
D6253	Provisional pontic	E						
D6545	Dental retainr cast metl	E						
D6548	Porcelain/ceramic retainer	E						
D6600	Porcelain/ceramic inlay 2srf	E						
D6601	Porc/ceram inlay >= 3 surfac	E						
D6602	Cst hgh nble mtl inlay 2 srf	E						
D6603	Cst hgh nble mtl inlay >=3sr	E						
D6604	Cst bse mtl inlay 2 surfaces	E						
D6605	Cst bse mtl inlay >= 3 surfa	E						
D6606	Cast noble metal inlay 2 sur	E						
D6607	Cst noble mtl inlay >=3 surf	E						
D6608	Onlay porc/crmc 2 surfaces	E						
D6609	Onlay porc/crmc >=3 surfaces	E						
D6610	Onlay cst hgh nbl mtl 2 srfc	E						
D6611	Onlay cst hgh nbl mtl >=3srf	E						
D6612	Onlay cst base mtl 2 surface	E						
D6613	Onlay cst base mtl >=3 surfa	E						
D6614	Onlay cst nbl mtl 2 surfaces	E						
D6615	Onlay cst nbl mtl >=3 surfac	E						
D6624	Inlay titanium	E						
D6634	Onlay titanium	E						
D6710	Crown-indirect resin based	E						
D6720	Retain crown resin w hi nble	E						
D6721	Crown resin w/base metal	E						
D6722	Crown resin w/noble metal	E						
D6740	Crown porcelain/ceramic	E						
D6750	Crown porcelain high noble	E						
D6751	Crown porcelain base metal	E						
D6752	Crown porcelain noble metal	E						
D6780	Crown 3/4 high noble metal	E						
D6781	Crown 3/4 cast based metal	E						
D6782	Crown 3/4 cast noble metal	E						
D6783	Crown 3/4 porcelain/ceramic	E						
D6790	Crown full high noble metal	E						
D6791	Crown full base metal cast	E						
D6792	Crown full noble metal cast	E						
D6793	Provisional retainer crown	E						
D6794	Crown titanium	E						
D6920	Dental connector bar	S	0330	10.3227	$694.11		$138.83	*
D6930	Dental recement bridge	E						
D6940	Stress breaker	E						
D6950	Precision attachment	E						
D6970	Post & core plus retainer	E						
D6972	Prefab post & core plus reta	E						
D6973	Core build up for retainer	E						
D6975	Coping metal	E						
D6976	Each addtnl cast post	E						
D6977	Each addtl prefab post	E						
D6980	Bridge repair	E						
D6985	Pediatric partial denture fx	E						
D6999	Fixed prosthodontic proc	E						
D7111	Extraction coronal remnants	S	0330	10.3227	$694.11		$138.83	*
D7140	Extraction erupted tooth/exr	S	0330	10.3227	$694.11		$138.83	*
D7210	Rem imp tooth w mucoper flp	S	0330	10.3227	$694.11		$138.83	*
D7220	Impact tooth remov soft tiss	S	0330	10.3227	$694.11		$138.83	*
D7230	Impact tooth remov part bony	S	0330	10.3227	$694.11		$138.83	*
D7240	Impact tooth remov comp bony	S	0330	10.3227	$694.11		$138.83	*
D7241	Impact tooth rem bony w/comp	S	0330	10.3227	$694.11		$138.83	*
D7250	Tooth root removal	S	0330	10.3227	$694.11		$138.83	*

D7260	Oral antral fistula closure	S	0330	10.3227	$694.11		$138.83	*
D7261	Primary closure sinus perf	S	0330	10.3227	$694.11		$138.83	*
D7270	Tooth reimplantation	E						
D7272	Tooth transplantation	E						
D7280	Exposure impact tooth orthod	E						
D7282	Mobilize erupted/malpos toot	E						
D7283	Place device impacted tooth	B						
D7285	Biopsy of oral tissue hard	E						
D7286	Biopsy of oral tissue soft	E						
D7287	Exfoliative cytolog collect	E						
D7288	Brush biopsy	B						
D7290	Repositioning of teeth	E						
D7291	Transseptal fiberotomy	S	0330	10.3227	$694.11		$138.83	*
D7292	Screw retained plate	E						
D7293	Temp anchorage dev w flap	E						
D7294	Temp anchorage dev w/o flap	E						
D7310	Alveoplasty w/ extraction	E						
D7311	Alveoloplasty w/extract 1-3	E						
D7320	Alveoplasty w/o extraction	E						
D7321	Alveoloplasty not w/extracts	B						
D7340	Vestibuloplasty ridge extens	E						
D7350	Vestibuloplasty exten graft	E						
D7410	Rad exc lesion up to 1.25 cm	E						
D7411	Excision benign lesion>1.25c	E						
D7412	Excision benign lesion compl	E						
D7413	Excision malig lesion<=1.25c	E						
D7414	Excision malig lesion>1.25cm	E						
D7415	Excision malig les complicat	E						
D7440	Malig tumor exc to 1.25 cm	E						
D7441	Malig tumor > 1.25 cm	E						
D7450	Rem odontogen cyst to 1.25cm	E						
D7451	Rem odontogen cyst > 1.25 cm	E						
D7460	Rem nonodonto cyst to 1.25cm	E						
D7461	Rem nonodonto cyst > 1.25 cm	E						
D7465	Lesion destruction	E						
D7471	Rem exostosis any site	E						
D7472	Removal of torus palatinus	E						
D7473	Remove torus mandibularis	E						
D7485	Surg reduct osseoustuberosit	E						
D7490	Maxilla or mandible resectio	E						
D7510	I&d absc intraoral soft tiss	E						
D7511	Incision/drain abscess intra	B						
D7520	I&d abscess extraoral	E						
D7521	Incision/drain abscess extra	B						
D7530	Removal fb skin/areolar tiss	E						
D7540	Removal of fb reaction	E						
D7550	Removal of sloughed off bone	E						
D7560	Maxillary sinusotomy	E						
D7610	Maxilla open reduct simple	E						
D7620	Clsd reduct simpl maxilla fx	E						
D7630	Open red simpl mandible fx	E						
D7640	Clsd red simpl mandible fx	E						
D7650	Open red simp malar/zygom fx	E						
D7660	Clsd red simp malar/zygom fx	E						
D7670	Closd rductn splint alveolus	E						
D7671	Alveolus open reduction	E						
D7680	Reduct simple facial bone fx	E						
D7710	Maxilla open reduct compound	E						
D7720	Clsd reduct compd maxilla fx	E						
D7730	Open reduct compd mandble fx	E						
D7740	Clsd reduct compd mandble fx	E						
D7750	Open red comp malar/zygma fx	E						

D7760	Clsd red comp malar/zygma fx	E						
D7770	Open reduc compd alveolus fx	E						
D7771	Alveolus clsd reduc stblz te	E						
D7780	Reduct compnd facial bone fx	E						
D7810	Tmj open reduct-dislocation	E						
D7820	Closed tmp manipulation	E						
D7830	Tmj manipulation under anest	E						
D7840	Removal of tmj condyle	E						
D7850	Tmj meniscectomy	E						
D7852	Tmj repair of joint disc	E						
D7854	Tmj excisn of joint membrane	E						
D7856	Tmj cutting of a muscle	E						
D7858	Tmj reconstruction	E						
D7860	Tmj cutting into joint	E						
D7865	Tmj reshaping components	E						
D7870	Tmj aspiration joint fluid	E						
D7871	Lysis + lavage w catheters	E						
D7872	Tmj diagnostic arthroscopy	E						
D7873	Tmj arthroscopy lysis adhesn	E						
D7874	Tmj arthroscopy disc reposit	E						
D7875	Tmj arthroscopy synovectomy	E						
D7876	Tmj arthroscopy discectomy	E						
D7877	Tmj arthroscopy debridement	E						
D7880	Occlusal orthotic appliance	E						
D7899	Tmj unspecified therapy	E						
D7910	Dent sutur recent wnd to 5cm	E						
D7911	Dental suture wound to 5 cm	E						
D7912	Suture complicate wnd > 5 cm	E						
D7920	Dental skin graft	E						
D7940	Reshaping bone orthognathic	S	0330	10.3227	$694.11		$138.83	*
D7941	Bone cutting ramus closed	E						

D7943	Cutting ramus open w/graft	E						
D7944	Bone cutting segmented	E						
D7945	Bone cutting body mandible	E						
D7946	Reconstruction maxilla total	E						
D7947	Reconstruct maxilla segment	E						
D7948	Reconstruct midface no graft	E						
D7949	Reconstruct midface w/graft	E						
D7950	Mandible graft	E						
D7951	Sinus aug w bone/bone sup	E						
D7953	Bone replacement graft	E						
D7955	Repair maxillofacial defects	E						
D7960	Frenulectomy/frenulotomy	E						
D7963	Frenuloplasty	E						
D7970	Excision hyperplastic tissue	E						
D7971	Excision pericoronal gingiva	E						
D7972	Surg redct fibrous tuberosit	E						
D7980	Sialolithotomy	E						
D7981	Excision of salivary gland	E						
D7982	Sialodochoplasty	E						
D7983	Closure of salivary fistula	E						
D7990	Emergency tracheotomy	E						
D7991	Dental coronoidectomy	E						
D7995	Synthetic graft facial bones	E						
D7996	Implant mandible for augment	E						
D7997	Appliance removal	E						
D7998	Intraoral place of fix dev	E						
D7999	Oral surgery procedure	E						
D8010	Limited dental tx primary	E						
D8020	Limited dental tx transition	E						
D8030	Limited dental tx adolescent	E						
D8040	Limited dental tx adult	E						

D8050	Intercep dental tx primary	E						
D8060	Intercep dental tx transitn	E						
D8070	Compre dental tx transition	E						
D8080	Compre dental tx adolescent	E						
D8090	Compre dental tx adult	E						
D8210	Orthodontic rem appliance tx	E						
D8220	Fixed appliance therapy habt	E						
D8660	Preorthodontic tx visit	E						
D8670	Periodic orthodontc tx visit	E						
D8680	Orthodontic retention	E						
D8690	Orthodontic treatment	E						
D8691	Repair ortho appliance	E						
D8692	Replacement retainer	E						
D8693	Rebond/cement/repair retain	E						
D8999	Orthodontic procedure	E						
D9110	Tx dental pain minor proc	N						
D9120	Fix partial denture section	E						
D9210	Dent anesthesia w/o surgery	E						
D9211	Regional block anesthesia	E						
D9212	Trigeminal block anesthesia	E						
D9215	Local anesthesia	E						
D9220	General anesthesia	E						
D9221	General anesthesia ea ad 15m	E						
D9230	Analgesia	N						
D9241	Intravenous sedation	E						
D9242	IV sedation ea ad 30 m	E						
D9248	Sedation (non-iv)	N						
D9310	Dental consultation	E						
D9410	Dental house call	E						
D9420	Hospital call	E						
D9430	Office visit during hours	E						
D9440	Office visit after hours	E						
D9450	Case presentation tx plan	E						
D9610	Dent therapeutic drug inject	E						
D9612	Thera par drugs 2 or > admin	E						
D9630	Other drugs/medicaments	S	0330	10.3227	$694.11		$138.83	*
D9910	Dent appl desensitizing med	E						
D9911	Appl desensitizing resin	E						
D9920	Behavior management	E						
D9930	Treatment of complications	S	0330	10.3227	$694.11		$138.83	*
D9940	Dental occlusal guard	S	0330	10.3227	$694.11		$138.83	*
D9941	Fabrication athletic guard	E						
D9942	Repair/reline occlusal guard	E						
D9950	Occlusion analysis	S	0330	10.3227	$694.11		$138.83	*
D9951	Limited occlusal adjustment	S	0330	10.3227	$694.11		$138.83	*
D9952	Complete occlusal adjustment	S	0330	10.3227	$694.11		$138.83	*
D9970	Enamel microabrasion	E						
D9971	Odontoplasty 1-2 teeth	E						
D9972	Extrnl bleaching per arch	E						
D9973	Extrnl bleaching per tooth	E						
D9974	Intrnl bleaching per tooth	E						
D9999	Adjunctive procedure	E						
E0100	Cane adjust/fixed with tip	Y						
E0105	Cane adjust/fixed quad/3 pro	Y						
E0110	Crutch forearm pair	Y						
E0111	Crutch forearm each	Y						
E0112	Crutch underarm pair wood	Y						
E0113	Crutch underarm each wood	Y						
E0114	Crutch underarm pair no wood	Y						
E0116	Crutch underarm each no wood	Y						
E0117	Underarm springassist crutch	Y						
E0118	Crutch substitute	E						

E0130	Walker rigid adjust/fixed ht	Y						
E0135	Walker folding adjust/fixed	Y						
E0140	Walker w trunk support	Y						
E0141	Rigid wheeled walker adj/fix	Y						
E0143	Walker folding wheeled w/o s	Y						
E0144	Enclosed walker w rear seat	Y						
E0147	Walker variable wheel resist	Y						
E0148	Heavyduty walker no wheels	Y						
E0149	Heavy duty wheeled walker	Y						
E0153	Forearm crutch platform atta	Y						
E0154	Walker platform attachment	Y						
E0155	Walker wheel attachment,pair	Y						
E0156	Walker seat attachment	Y						
E0157	Walker crutch attachment	Y						
E0158	Walker leg extenders set of4	Y						
E0159	Brake for wheeled walker	Y						
E0160	Sitz type bath or equipment	Y						
E0161	Sitz bath/equipment w/faucet	Y						
E0162	Sitz bath chair	Y						
E0163	Commode chair with fixed arm	Y						
E0165	Commode chair with detacharm	Y						
E0167	Commode chair pail or pan	Y						
E0168	Heavyduty/wide commode chair	Y						
E0170	Commode chair electric	Y						
E0171	Commode chair non-electric	Y						
E0172	Seat lift mechanism toilet	E						
E0175	Commode chair foot rest	Y						
E0181	Press pad alternating w/ pum	Y						
E0182	Replace pump, alt press pad	Y						
E0184	Dry pressure mattress	Y						
E0185	Gel pressure mattress pad	Y						

E0186	Air pressure mattress	Y						
E0187	Water pressure mattress	Y						
E0188	Synthetic sheepskin pad	Y						
E0189	Lambswool sheepskin pad	Y						
E0190	Positioning cushion	E						
E0191	Protector heel or elbow	Y						
E0193	Powered air flotation bed	Y						
E0194	Air fluidized bed	Y						
E0196	Gel pressure mattress	Y						
E0197	Air pressure pad for mattres	Y						
E0198	Water pressure pad for mattr	Y						
E0199	Dry pressure pad for mattres	Y						
E0200	Heat lamp without stand	Y						
E0202	Phototherapy light w/ photom	Y						
E0203	Therapeutic lightbox tabletp	E						
E0205	Heat lamp with stand	Y						
E0210	Electric heat pad standard	Y						
E0215	Electric heat pad moist	Y						
E0217	Water circ heat pad w pump	Y						
E0218	Water circ cold pad w pump	Y						
E0220	Hot water bottle	Y						
E0221	Infrared heating pad system	Y						
E0225	Hydrocollator unit	Y						
E0230	Ice cap or collar	Y						
E0231	Wound warming device	E						
E0232	Warming card for NWT	E						
E0235	Paraffin bath unit portable	Y						
E0236	Pump for water circulating p	Y						
E0238	Heat pad non-electric moist	Y						
E0239	Hydrocollator unit portable	Y						
E0240	Bath/shower chair	E						

E0241	Bath tub wall rail	E						
E0242	Bath tub rail floor	E						
E0243	Toilet rail	E						
E0244	Toilet seat raised	E						
E0245	Tub stool or bench	E						
E0246	Transfer tub rail attachment	E						
E0247	Trans bench w/wo comm open	E						
E0248	HDtrans bench w/wo comm open	E						
E0249	Pad water circulating heat u	Y						
E0250	Hosp bed fixed ht w/ mattres	Y						
E0251	Hosp bed fixd ht w/o mattres	Y						
E0255	Hospital bed var ht w/ mattr	Y						
E0256	Hospital bed var ht w/o matt	Y						
E0260	Hosp bed semi-electr w/ matt	Y						
E0261	Hosp bed semi-electr w/o mat	Y						
E0265	Hosp bed total electr w/ mat	Y						
E0266	Hosp bed total elec w/o matt	Y						
E0270	Hospital bed institutional t	E						
E0271	Mattress innerspring	Y						
E0272	Mattress foam rubber	Y						
E0273	Bed board	E						
E0274	Over-bed table	E						
E0275	Bed pan standard	Y						
E0276	Bed pan fracture	Y						
E0277	Powered pres-redu air mattrs	Y						
E0280	Bed cradle	Y						
E0290	Hosp bed fx ht w/o rails w/m	Y						
E0291	Hosp bed fx ht w/o rail w/o	Y						
E0292	Hosp bed var ht w/o rail w/o	Y						
E0293	Hosp bed var ht w/o rail w/	Y						
E0294	Hosp bed semi-elect w/ mattr	Y						
E0295	Hosp bed semi-elect w/o matt	Y						
E0296	Hosp bed total elect w/ matt	Y						
E0297	Hosp bed total elect w/o mat	Y						
E0300	Enclosed ped crib hosp grade	Y						
E0301	HD hosp bed, 350-600 lbs	Y						
E0302	Ex hd hosp bed > 600 lbs	Y						
E0303	Hosp bed hvy dty xtra wide	Y						
E0304	Hosp bed xtra hvy dty x wide	Y						
E0305	Rails bed side half length	Y						
E0310	Rails bed side full length	Y						
E0315	Bed accessory brd/tbl/supprt	E						
E0316	Bed safety enclosure	Y						
E0325	Urinal male jug-type	Y						
E0326	Urinal female jug-type	Y						
E0328	Ped hospital bed, manual	Y						
E0329	Ped hospital bed semi/elect	Y						
E0350	Control unit bowel system	E						
E0352	Disposable pack w/bowel syst	E						
E0370	Air elevator for heel	E						
E0371	Nonpower mattress overlay	Y						
E0372	Powered air mattress overlay	Y						
E0373	Nonpowered pressure mattress	Y						
E0424	Stationary compressed gas 02	Y						
E0425	Gas system stationary compre	E						
E0430	Oxygen system gas portable	E						
E0431	Portable gaseous 02	Y						
E0433	Portable liquid oxygen sys	Y						
E0434	Portable liquid 02	Y						
E0435	Oxygen system liquid portabl	E						
E0439	Stationary liquid 02	Y						
E0440	Oxygen system liquid station	E						

E0441	Stationary O2 contents, gas	Y						
E0442	Stationary O2 contents, liq	Y						
E0443	Portable 02 contents, gas	Y						
E0444	Portable 02 contents, liquid	Y						
E0445	Oximeter non-invasive	N						
E0450	Vol control vent invasiv int	Y						
E0455	Oxygen tent excl croup/ped t	Y						
E0457	Chest shell	Y						
E0459	Chest wrap	Y						
E0460	Neg press vent portabl/statn	Y						
E0461	Vol control vent noninv int	Y						
E0462	Rocking bed w/ or w/o side r	Y						
E0463	Press supp vent invasive int	Y						
E0464	Press supp vent noninv int	Y						
E0470	RAD w/o backup non-inv intfc	Y						
E0471	RAD w/backup non inv intrfc	Y						
E0472	RAD w backup invasive intrfc	Y						
E0480	Percussor elect/pneum home m	Y						
E0481	Intrpulmnry percuss vent sys	E						
E0482	Cough stimulating device	Y						
E0483	Chest compression gen system	Y						
E0484	Non-elec oscillatory pep dvc	Y						
E0485	Oral device/appliance prefab	Y						
E0486	Oral device/appliance cusfab	Y						
E0487	Electronic spirometer	N						
E0500	Ippb all types	Y						
E0550	Humidif extens supple w ippb	Y						
E0555	Humidifier for use w/ regula	Y						
E0560	Humidifier supplemental w/ i	Y						
E0561	Humidifier nonheated w PAP	Y						
E0562	Humidifier heated used w PAP	Y						

E0565	Compressor air power source	Y						
E0570	Nebulizer with compression	Y						
E0571	Aerosol compressor for svneb	Y						
E0572	Aerosol compressor adjust pr	Y						
E0574	Ultrasonic generator w svneb	Y						
E0575	Nebulizer ultrasonic	Y						
E0580	Nebulizer for use w/ regulat	Y						
E0585	Nebulizer w/ compressor & he	Y						
E0600	Suction pump portab hom modl	Y						
E0601	Cont airway pressure device	Y						
E0602	Manual breast pump	Y						
E0603	Electric breast pump	N						
E0604	Hosp grade elec breast pump	A						
E0605	Vaporizer room type	Y						
E0606	Drainage board postural	Y						
E0607	Blood glucose monitor home	Y						
E0610	Pacemaker monitr audible/vis	Y						
E0615	Pacemaker monitr digital/vis	Y						
E0616	Cardiac event recorder	N						
E0617	Automatic ext defibrillator	Y						
E0618	Apnea monitor	Y						
E0619	Apnea monitor w recorder	Y						
E0620	Cap bld skin piercing laser	Y						
E0621	Patient lift sling or seat	Y						
E0625	Patient lift bathroom or toi	E						
E0627	Seat lift incorp lift-chair	Y						
E0628	Seat lift for pt furn-electr	Y						
E0629	Seat lift for pt furn-non-el	Y						
E0630	Patient lift hydraulic	Y						
E0635	Patient lift electric	Y						
E0636	PT support & positioning sys	Y						

E0637	Combination sit to stand sys	E						
E0638	Standing frame sys	E						
E0639	Moveable patient lift system	E						
E0640	Fixed patient lift system	E						
E0641	Multi-position stnd fram sys	E						
E0642	Dynamic standing frame	E						
E0650	Pneuma compresor non-segment	Y						
E0651	Pneum compressor segmental	Y						
E0652	Pneum compres w/cal pressure	Y						
E0655	Pneumatic appliance half arm	Y						
E0656	Segmental pneumatic trunk	Y						
E0657	Segmental pneumatic chest	Y						
E0660	Pneumatic appliance full leg	Y						
E0665	Pneumatic appliance full arm	Y						
E0666	Pneumatic appliance half leg	Y						
E0667	Seg pneumatic appl full leg	Y						
E0668	Seg pneumatic appl full arm	Y						
E0669	Seg pneumatic appli half leg	Y						
E0671	Pressure pneum appl full leg	Y						
E0672	Pressure pneum appl full arm	Y						
E0673	Pressure pneum appl half leg	Y						
E0675	Pneumatic compression device	Y						
E0676	Inter limb compress dev NOS	Y						
E0691	Uvl pnl 2 sq ft or less	Y						
E0692	Uvl sys panel 4 ft	Y						
E0693	Uvl sys panel 6 ft	Y						
E0694	Uvl md cabinet sys 6 ft	Y						
E0700	Safety equipment	E						
E0705	Transfer device	B						
E0710	Restraints any type	E						
E0720	Tens two lead	Y						

E0730	Tens four lead	Y						
E0731	Conductive garment for tens/	Y						
E0740	Incontinence treatment systm	Y						
E0744	Neuromuscular stim for scoli	Y						
E0745	Neuromuscular stim for shock	Y						
E0746	Electromyograph biofeedback	N						
E0747	Elec osteogen stim not spine	Y						
E0748	Elec osteogen stim spinal	Y						
E0749	Elec osteogen stim implanted	N						
E0755	Electronic salivary reflex s	E						
E0760	Osteogen ultrasound stimltor	Y						
E0761	Nontherm electromgntc device	E						
E0762	Trans elec jt stim dev sys	B						
E0764	Functional neuromuscularstim	Y						
E0765	Nerve stimulator for tx n&v	Y						
E0769	Electric wound treatment dev	B						
E0770	Functional electric stim NOS	Y						
E0776	Iv pole	Y						
E0779	Amb infusion pump mechanical	Y						
E0780	Mech amb infusion pump <8hrs	Y						
E0781	External ambulatory infus pu	Y						
E0782	Non-programble infusion pump	N						
E0783	Programmable infusion pump	N						
E0784	Ext amb infusn pump insulin	Y						
E0785	Replacement impl pump cathet	N						
E0786	Implantable pump replacement	N						
E0791	Parenteral infusion pump sta	Y						
E0830	Ambulatory traction device	N						
E0840	Tract frame attach headboard	Y						
E0849	Cervical pneum trac equip	Y						
E0850	Traction stand free standing	Y						

E0855	Cervical traction equipment	Y						
E0856	Cervic collar w air bladder	Y						
E0860	Tract equip cervical tract	Y						
E0870	Tract frame attach footboard	Y						
E0880	Trac stand free stand extrem	Y						
E0890	Traction frame attach pelvic	Y						
E0900	Trac stand free stand pelvic	Y						
E0910	Trapeze bar attached to bed	Y						
E0911	HD trapeze bar attach to bed	Y						
E0912	HD trapeze bar free standing	Y						
E0920	Fracture frame attached to b	Y						
E0930	Fracture frame free standing	Y						
E0935	Cont pas motion exercise dev	Y						
E0936	CPM device, other than knee	E						
E0940	Trapeze bar free standing	Y						
E0941	Gravity assisted traction de	Y						
E0942	Cervical head harness/halter	Y						
E0944	Pelvic belt/harness/boot	Y						
E0945	Belt/harness extremity	Y						
E0946	Fracture frame dual w cross	Y						
E0947	Fracture frame attachmnts pe	Y						
E0948	Fracture frame attachmnts ce	Y						
E0950	Tray	Y						
E0951	Loop heel	Y						
E0952	Toe loop/holder, each	Y						
E0955	Cushioned headrest	Y						
E0956	W/c lateral trunk/hip suppor	Y						
E0957	W/c medial thigh support	Y						
E0958	Whlchr att- conv 1 arm drive	Y						
E0959	Amputee adapter	B						
E0960	W/c shoulder harness/straps	Y						

E0961	Wheelchair brake extension	B						
E0966	Wheelchair head rest extensi	B						
E0967	Manual wc hand rim w project	Y						
E0968	Wheelchair commode seat	Y						
E0969	Wheelchair narrowing device	Y						
E0970	Wheelchair no. 2 footplates	E						
E0971	Wheelchair anti-tipping devi	B						
E0973	W/Ch access det adj armrest	B						
E0974	W/Ch access anti-rollback	B						
E0978	W/C acc,saf belt pelv strap	B						
E0980	Wheelchair safety vest	Y						
E0981	Seat upholstery, replacement	Y						
E0982	Back upholstery, replacement	Y						
E0983	Add pwr joystick	Y						
E0984	Add pwr tiller	Y						
E0985	W/c seat lift mechanism	Y						
E0986	Man w/c push-rim pow assist	Y						
E0990	Wheelchair elevating leg res	B						
E0992	Wheelchair solid seat insert	B						
E0994	Wheelchair arm rest	Y						
E0995	Wheelchair calf rest	B						
E1002	Pwr seat tilt	Y						
E1003	Pwr seat recline	Y						
E1004	Pwr seat recline mech	Y						
E1005	Pwr seat recline pwr	Y						
E1006	Pwr seat combo w/o shear	Y						
E1007	Pwr seat combo w/shear	Y						
E1008	Pwr seat combo pwr shear	Y						
E1009	Add mech leg elevation	Y						
E1010	Add pwr leg elevation	Y						
E1011	Ped wc modify width adjustm	Y						

E1014	Reclining back add ped w/c	Y						
E1015	Shock absorber for man w/c	Y						
E1016	Shock absorber for power w/c	Y						
E1017	HD shck absrbr for hd man wc	Y						
E1018	HD shck absrber for hd powwc	Y						
E1020	Residual limb support system	Y						
E1028	W/c manual swingaway	Y						
E1029	W/c vent tray fixed	Y						
E1030	W/c vent tray gimbaled	Y						
E1031	Rollabout chair with casters	Y						
E1035	Patient transfer system <300	Y						
E1036	Patient transfer system >300	Y						
E1037	Transport chair, ped size	Y						
E1038	Transport chair pt wt<=300lb	Y						
E1039	Transport chair pt wt >300lb	Y						
E1050	Whelchr fxd full length arms	Y						
E1060	Wheelchair detachable arms	Y						
E1070	Wheelchair detachable foot r	Y						
E1083	Hemi-wheelchair fixed arms	Y						
E1084	Hemi-wheelchair detachable a	Y						
E1085	Hemi-wheelchair fixed arms	E						
E1086	Hemi-wheelchair detachable a	E						
E1087	Wheelchair lightwt fixed arm	Y						
E1088	Wheelchair lightweight det a	Y						
E1089	Wheelchair lightwt fixed arm	E						
E1090	Wheelchair lightweight det a	E						
E1092	Wheelchair wide w/ leg rests	Y						
E1093	Wheelchair wide w/ foot rest	Y						
E1100	Whchr s-recl fxd arm leg res	Y						
E1110	Wheelchair semi-recl detach	Y						
E1130	Whlchr stand fxd arm ft rest	E						

E1140	Wheelchair standard detach a	E						
E1150	Wheelchair standard w/ leg r	Y						
E1160	Wheelchair fixed arms	Y						
E1161	Manual adult wc w tiltinspac	Y						
E1170	Whlchr ampu fxd arm leg rest	Y						
E1171	Wheelchair amputee w/o leg r	Y						
E1172	Wheelchair amputee detach ar	Y						
E1180	Wheelchair amputee w/ foot r	Y						
E1190	Wheelchair amputee w/ leg re	Y						
E1195	Wheelchair amputee heavy dut	Y						
E1200	Wheelchair amputee fixed arm	Y						
E1220	Whlchr special size/constrc	Y						
E1221	Wheelchair spec size w foot	Y						
E1222	Wheelchair spec size w/ leg	Y						
E1223	Wheelchair spec size w foot	Y						
E1224	Wheelchair spec size w/ leg	Y						
E1225	Manual semi-reclining back	Y						
E1226	Manual fully reclining back	B						
E1227	Wheelchair spec sz spec ht a	Y						
E1228	Wheelchair spec sz spec ht b	Y						
E1229	Pediatric wheelchair NOS	Y						
E1230	Power operated vehicle	Y						
E1231	Rigid ped w/c tilt-in-space	Y						
E1232	Folding ped wc tilt-in-space	Y						
E1233	Rig ped wc tltnspc w/o seat	Y						
E1234	Fld ped wc tltnspc w/o seat	Y						
E1235	Rigid ped wc adjustable	Y						
E1236	Folding ped wc adjustable	Y						
E1237	Rgd ped wc adjstabl w/o seat	Y						
E1238	Fld ped wc adjstabl w/o seat	Y						
E1239	Ped power wheelchair NOS	Y						

E1240	Whchr litwt det arm leg rest	Y						
E1250	Wheelchair lightwt fixed arm	E						
E1260	Wheelchair lightwt foot rest	E						
E1270	Wheelchair lightweight leg r	Y						
E1280	Whchr h-duty det arm leg res	Y						
E1285	Wheelchair heavy duty fixed	E						
E1290	Wheelchair hvy duty detach a	E						
E1295	Wheelchair heavy duty fixed	Y						
E1296	Wheelchair special seat heig	Y						
E1297	Wheelchair special seat dept	Y						
E1298	Wheelchair spec seat depth/w	Y						
E1300	Whirlpool portable	E						
E1310	Whirlpool non-portable	Y						
E1353	Oxygen supplies regulator	Y						
E1354	Wheeled cart, port cyl/conc	Y						
E1355	Oxygen supplies stand/rack	Y						
E1356	Batt pack/cart, port conc	Y						
E1357	Battery charger, port conc	Y						
E1358	DC power adapter, port conc	Y						
E1372	Oxy suppl heater for nebuliz	Y						
E1390	Oxygen concentrator	Y						
E1391	Oxygen concentrator, dual	Y						
E1392	Portable oxygen concentrator	Y						
E1399	Durable medical equipment mi	Y						
E1405	O2/water vapor enrich w/heat	Y						
E1406	O2/water vapor enrich w/o he	Y						
E1500	Centrifuge	A						
E1510	Kidney dialysate delivry sys	A						
E1520	Heparin infusion pump	A						
E1530	Replacement air bubble detec	A						
E1540	Replacement pressure alarm	A						
E1550	Bath conductivity meter	A						
E1560	Replace blood leak detector	A						
E1570	Adjustable chair for esrd pt	A						
E1575	Transducer protect/fld bar	A						
E1580	Unipuncture control system	A						
E1590	Hemodialysis machine	A						
E1592	Auto interm peritoneal dialy	A						
E1594	Cycler dialysis machine	A						
E1600	Deli/install chrg hemo equip	A						
E1610	Reverse osmosis h2o puri sys	A						
E1615	Deionizer H2O puri system	A						
E1620	Replacement blood pump	A						
E1625	Water softening system	A						
E1630	Reciprocating peritoneal dia	A						
E1632	Wearable artificial kidney	A						
E1634	Peritoneal dialysis clamp	B						
E1635	Compact travel hemodialyzer	A						
E1636	Sorbent cartridges per 10	A						
E1637	Hemostats for dialysis, each	A						
E1639	Dialysis scale	A						
E1699	Dialysis equipment noc	A						
E1700	Jaw motion rehab system	Y						
E1701	Repl cushions for jaw motion	Y						
E1702	Repl measr scales jaw motion	Y						
E1800	Adjust elbow ext/flex device	Y						
E1801	SPS elbow device	Y						
E1802	Adjst forearm pro/sup device	Y						
E1805	Adjust wrist ext/flex device	Y						
E1806	SPS wrist device	Y						
E1810	Adjust knee ext/flex device	Y						
E1811	SPS knee device	Y						

E1812	Knee ext/flex w act res ctrl	Y						
E1815	Adjust ankle ext/flex device	Y						
E1816	SPS ankle device	Y						
E1818	SPS forearm device	Y						
E1820	Soft interface material	Y						
E1821	Replacement interface SPSD	Y						
E1825	Adjust finger ext/flex devc	Y						
E1830	Adjust toe ext/flex device	Y						
E1840	Adj shoulder ext/flex device	Y						
E1841	Static str shldr dev rom adj	Y						
E1902	AAC non-electronic board	Y						
E2000	Gastric suction pump hme mdl	Y						
E2100	Bld glucose monitor w voice	Y						
E2101	Bld glucose monitor w lance	Y						
E2120	Pulse gen sys tx endolymp fl	Y						
E2201	Man w/ch acc seat w>=20"<24"	Y						
E2202	Seat width 24-27 in	Y						
E2203	Frame depth less than 22 in	Y						
E2204	Frame depth 22 to 25 in	Y						
E2205	Manual wc accessory, handrim	Y						
E2206	Complete wheel lock assembly	Y						
E2207	Crutch and cane holder	Y						
E2208	Cylinder tank carrier	Y						
E2209	Arm trough each	Y						
E2210	Wheelchair bearings	Y						
E2211	Pneumatic propulsion tire	Y						
E2212	Pneumatic prop tire tube	Y						
E2213	Pneumatic prop tire insert	Y						
E2214	Pneumatic caster tire each	Y						
E2215	Pneumatic caster tire tube	Y						
E2216	Foam filled propulsion tire	Y						
E2217	Foam filled caster tire each	Y						
E2218	Foam propulsion tire each	Y						
E2219	Foam caster tire any size ea	Y						
E2220	Solid propulsion tire each	Y						
E2221	Solid caster tire each	Y						
E2222	Solid caster integrated whl	Y						
E2224	Propulsion whl excludes tire	Y						
E2225	Caster wheel excludes tire	Y						
E2226	Caster fork replacement only	Y						
E2227	Gear reduction drive wheel	Y						
E2228	Mwc acc, wheelchair brake	Y						
E2230	Manual standing system	E						
E2231	Solid seat support base	Y						
E2291	Planar back for ped size wc	Y						
E2292	Planar seat for ped size wc	Y						
E2293	Contour back for ped size wc	Y						
E2294	Contour seat for ped size wc	Y						
E2295	Ped dynamic seating frame	Y						
E2300	Pwr seat elevation sys	Y						
E2301	Pwr standing	Y						
E2310	Electro connect btw control	Y						
E2311	Electro connect btw 2 sys	Y						
E2312	Mini-prop remote joystick	Y						
E2313	PWC harness, expand control	Y						
E2321	Hand interface joystick	Y						
E2322	Mult mech switches	Y						
E2323	Special joystick handle	Y						
E2324	Chin cup interface	Y						
E2325	Sip and puff interface	Y						
E2326	Breath tube kit	Y						
E2327	Head control interface mech	Y						

E2328	Head/extremity control inter	Y						
E2329	Head control nonproportional	Y						
E2330	Head control proximity switc	Y						
E2331	Attendant control	Y						
E2340	W/c wdth 20-23 in seat frame	Y						
E2341	W/c wdth 24-27 in seat frame	Y						
E2342	W/c dpth 20-21 in seat frame	Y						
E2343	W/c dpth 22-25 in seat frame	Y						
E2351	Electronic SGD interface	Y						
E2360	22nf nonsealed leadacid	Y						
E2361	22nf sealed leadacid battery	Y						
E2362	Gr24 nonsealed leadacid	Y						
E2363	Gr24 sealed leadacid battery	Y						
E2364	U1nonsealed leadacid battery	Y						
E2365	U1 sealed leadacid battery	Y						
E2366	Battery charger, single mode	Y						
E2367	Battery charger, dual mode	Y						
E2368	Power wc motor replacement	Y						
E2369	Pwr wc gear box replacement	Y						
E2370	Pwr wc motor/gear box combo	Y						
E2371	Gr27 sealed leadacid battery	Y						
E2372	Gr27 non-sealed leadacid	Y						
E2373	Hand/chin ctrl spec joystick	Y						
E2374	Hand/chin ctrl std joystick	Y						
E2375	Non-expandable controller	Y						
E2376	Expandable controller, repl	Y						
E2377	Expandable controller, initl	Y						
E2381	Pneum drive wheel tire	Y						
E2382	Tube, pneum wheel drive tire	Y						
E2383	Insert, pneum wheel drive	Y						
E2384	Pneumatic caster tire	Y						

E2385	Tube, pneumatic caster tire	Y						
E2386	Foam filled drive wheel tire	Y						
E2387	Foam filled caster tire	Y						
E2388	Foam drive wheel tire	Y						
E2389	Foam caster tire	Y						
E2390	Solid drive wheel tire	Y						
E2391	Solid caster tire	Y						
E2392	Solid caster tire, integrate	Y						
E2394	Drive wheel excludes tire	Y						
E2395	Caster wheel excludes tire	Y						
E2396	Caster fork	Y						
E2397	Pwc acc, lith-based battery	Y						
E2402	Neg press wound therapy pump	Y						
E2500	SGD digitized pre-rec <=8min	Y						
E2502	SGD prerec msg >8min <=20min	Y						
E2504	SGD prerec msg>20min <=40min	Y						
E2506	SGD prerec msg > 40 min	Y						
E2508	SGD spelling phys contact	Y						
E2510	SGD w multi methods msg/accs	Y						
E2511	SGD sftwre prgrm for PC/PDA	Y						
E2512	SGD accessory, mounting sys	Y						
E2599	SGD accessory noc	Y						
E2601	Gen w/c cushion wdth < 22 in	Y						
E2602	Gen w/c cushion wdth >=22 in	Y						
E2603	Skin protect wc cus wd <22in	Y						
E2604	Skin protect wc cus wd>=22in	Y						
E2605	Position wc cush wdth <22 in	Y						
E2606	Position wc cush wdth>=22 in	Y						
E2607	Skin pro/pos wc cus wd <22in	Y						
E2608	Skin pro/pos wc cus wd>=22in	Y						
E2609	Custom fabricate w/c cushion	Y						

E2610	Powered w/c cushion	B						
E2611	Gen use back cush wdth <22in	Y						
E2612	Gen use back cush wdth>=22in	Y						
E2613	Position back cush wd <22in	Y						
E2614	Position back cush wd>=22in	Y						
E2615	Pos back post/lat wdth <22in	Y						
E2616	Pos back post/lat wdth>=22in	Y						
E2617	Custom fab w/c back cushion	Y						
E2619	Replace cover w/c seat cush	Y						
E2620	WC planar back cush wd <22in	Y						
E2621	WC planar back cush wd>=22in	Y						
E8000	Posterior gait trainer	E						
E8001	Upright gait trainer	E						
E8002	Anterior gait trainer	E						
G0008	Admin influenza virus vac	S	0350	0.3809	$25.61			*
G0009	Admin pneumococcal vaccine	S	0350	0.3809	$25.61			*
G0010	Admin hepatitis b vaccine	B						
G0027	Semen analysis	A						
G0101	CA screen;pelvic/breast exam	V	0604	0.8593	$57.78		$11.56	*
G0102	Prostate ca screening; dre	N						
G0103	PSA screening	A						
G0104	CA screen;flexi sigmoidscope	S	0159	3.7227	$250.32		$62.58	*
G0105	Colorectal scrn; hi risk ind	T	0158	8.0912	$544.06		$136.02	*
G0106	Colon CA screen;barium enema	S	0157	1.2511	$84.13		$16.83	*
G0108	Diab manage trn per indiv	A						
G0109	Diab manage trn ind/group	A						
G0117	Glaucoma scrn hgh risk direc	S	0698	0.9553	$64.24		$12.85	*
G0118	Glaucoma scrn hgh risk direc	S	0230	0.5945	$39.97		$8.00	*
G0120	Colon ca scrn; barium enema	S	0157	1.2511	$84.13		$16.83	*
G0121	Colon ca scrn not hi rsk ind	T	0158	8.0912	$544.06		$136.02	*
G0122	Colon ca scrn; barium enema	E						
G0123	Screen cerv/vag thin layer	A						
G0124	Screen c/v thin layer by MD	B						
G0127	Trim nail(s)	T	0012	0.4436	$29.83		$5.97	*
G0128	CORF skilled nursing service	B						
G0129	Partial hosp prog service	P						
G0130	Single energy x-ray study	X	0260	0.6661	$44.79		$8.96	*
G0141	Scr c/v cyto,autosys and md	B						
G0143	Scr c/v cyto,thinlayer,rescr	A						
G0144	Scr c/v cyto,thinlayer,rescr	A						
G0145	Scr c/v cyto,thinlayer,rescr	A						
G0147	Scr c/v cyto, automated sys	A						
G0148	Scr c/v cyto, autosys, rescr	A						
G0151	HHCP-serv of pt,ea 15 min	B						
G0152	HHCP-serv of ot,ea 15 min	B						
G0153	HHCP-svs of s/l path,ea 15mn	B						
G0154	HHCP-svs of rn,ea 15 min	B						
G0155	HHCP-svs of csw,ea 15 min	B						
G0156	HHCP-svs of aide,ea 15 min	B						
G0166	Extrnl counterpulse, per tx	T	0678	1.5463	$103.97		$20.80	*
G0168	Wound closure by adhesive	B						
G0173	Linear acc stereo radsur com	S	0067	52.9891	$3,563.04		$712.61	*
G0175	OPPS Service,sched team conf	V	0607	1.683	$113.17		$22.64	*
G0176	OPPS/PHP;activity therapy	P						
G0177	OPPS/PHP; train & educ serv	N						
G0179	MD recertification HHA PT	M						
G0180	MD certification HHA patient	M						
G0181	Home health care supervision	M						
G0182	Hospice care supervision	M						
G0186	Dstry eye lesn,fdr vssl tech	T	0235	5.8498	$393.35		$78.67	*
G0202	Screeningmammographydigital	A						
G0204	Diagnosticmammographydigital	A						

G0206	Diagnosticmammographydigital	A						
G0219	PET img wholbod melano nonco	E						
G0235	PET not otherwise specified	E						
G0237	Therapeutic procd strg endur	S	0077	0.4058	$27.29	$7.74	$5.46	*
G0238	Oth resp proc, indiv	S	0077	0.4058	$27.29	$7.74	$5.46	*
G0239	Oth resp proc, group	S	0077	0.4058	$27.29	$7.74	$5.46	*
G0245	Initial foot exam pt lops	V	0604	0.8593	$57.78		$11.56	*
G0246	Followup eval of foot pt lop	V	0605	1.0337	$69.51		$13.91	*
G0247	Routine footcare pt w lops	T	0013	0.8789	$59.10		$11.82	*
G0248	Demonstrate use home inr mon	V	0607	1.683	$113.17		$22.64	*
G0249	Provide INR test mater/equip	V	0607	1.683	$113.17		$22.64	*
G0250	MD INR test revie inter mgmt	M						
G0251	Linear acc based stero radio	S	0065	14.2808	$960.26		$192.06	*
G0252	PET imaging initial dx	E						
G0255	Current percep threshold tst	E						
G0257	Unsched dialysis ESRD pt hos	S	0170	6.8212	$458.66		$91.74	*
G0259	Inject for sacroiliac joint	N						
G0260	Inj for sacroiliac jt anesth	T	0207	7.2002	$484.15		$96.83	*
G0268	Removal of impacted wax md	N						
G0269	Occlusive device in vein art	N						
G0270	MNT subs tx for change dx	A						
G0271	Group MNT 2 or more 30 mins	A						
G0275	Renal angio, cardiac cath	N						
G0278	Iliac art angio,cardiac cath	N						
G0281	Elec stim unattend for press	A						
G0282	Elect stim wound care not pd	E						
G0283	Elec stim other than wound	A						
G0288	Recon, CTA for surg plan	N						
G0289	Arthro, loose body + chondro	N						
G0290	Drug-eluting stents, single	T	0656	110.787	$7,449.43		$1,489.89	*
G0291	Drug-eluting stents,each add	T	0656	110.787	$7,449.43		$1,489.89	*
G0293	Non-cov surg proc,clin trial	X	0340	0.6693	$45.00		$9.00	*
G0294	Non-cov proc, clinical trial	X	0340	0.6693	$45.00		$9.00	*
G0295	Electromagnetic therapy onc	E						
G0302	Pre-op service LVRS complete	S	0209	11.4315	$768.67	$268.73	$153.74	*
G0303	Pre-op service LVRS 10-15dos	S	0209	11.4315	$768.67	$268.73	$153.74	*
G0304	Pre-op service LVRS 1-9 dos	S	0213	2.4043	$161.67	$53.58	$32.34	*
G0305	Post op service LVRS min 6	S	0213	2.4043	$161.67	$53.58	$32.34	*
G0306	CBC/diffwbc w/o platelet	A						
G0307	CBC without platelet	A						
G0328	Fecal blood scrn immunoassay	A						
G0329	Electromagntic tx for ulcers	A						
G0333	Dispense fee initial 30 day	M						
G0337	Hospice evaluation preelecti	B						
G0339	Robot lin-radsurg com, first	S	0067	52.9891	$3,563.04		$712.61	*
G0340	Robt lin-radsurg fractx 2-5	S	0066	36.9119	$2,481.99		$496.40	*
G0341	Percutaneous islet celltrans	C						
G0342	Laparoscopy islet cell trans	C						
G0343	Laparotomy islet cell transp	C						
G0364	Bone marrow aspirate &biopsy	X	0340	0.6693	$45.00		$9.00	*
G0365	Vessel mapping hemo access	S	0267	2.3005	$154.69	$60.50	$30.94	*
G0372	MD service required for PMD	M						
G0378	Hospital observation per hr	N						
G0379	Direct refer hospital observ	Q3	0604	0.8593	$57.78		$11.56	*
G0380	Lev 1 hosp type B ED visit	V	0626	0.6796	$45.70		$9.14	*
G0381	Lev 2 hosp type B ED visit	V	0627	0.9229	$62.06		$12.42	*
G0382	Lev 3 hosp type B ED visit	V	0628	1.4572	$97.98		$19.60	*
G0383	Lev 4 hosp type B ED visit	V	0629	2.1041	$141.48		$28.30	*
G0384	Lev 5 hosp type B ED visit	Q3	0630	3.4466	$231.75	$52.13	$46.35	*
G0389	Ultrasound exam AAA screen	S	0266	1.4434	$97.06	$37.53	$19.42	*
G0390	Trauma Respons w/hosp criti	S	0618	12.3717	$831.89		$166.38	*
G0396	Alcohol/subs interv 15-30mn	S	0432	0.6013	$40.43		$8.09	*

G0397	Alcohol/subs interv >30 min	S	0432	0.6013	$40.43		$8.09	*
G0398	Home sleep test/type 2 Porta	S	0213	2.4043	$161.67	$53.58	$32.34	*
G0399	Home sleep test/type 3 Porta	S	0213	2.4043	$161.67	$53.58	$32.34	*
G0400	Home sleep test/type 4 Porta	S	0213	2.4043	$161.67	$53.58	$32.34	*
G0402	Initial preventive exam	V	0607	1.683	$113.17		$22.64	*
G0403	EKG for initial prevent exam	M						
G0404	EKG tracing for initial prev	S	0099	0.394	$26.49		$5.30	*
G0405	EKG interpret & report preve	B						
G0406	Telhealth inpt consult 15min	C						
G0407	Telheath inpt consult 25min	C						
G0408	Telhealth inpt consult 35min	C						
G0409	CORF related serv 15 mins ea	M						
G0410	Grp psych partial hosp 45-50	P						
G0411	Inter active grp psych parti	P						
G0412	Open tx iliac spine uni/bil	C						
G0413	Pelvic ring fracture uni/bil	T	0050	31.7717	$2,136.36		$427.28	*
G0414	Pelvic ring fx treat int fix	C						
G0415	Open tx post pelvic fxcture	C						
G0416	Sat biopsy prostate 1-20 spc	S	1505		$350.00		$70.00	
G0417	Sat biopsy prostate 21-40	S	1507		$550.00		$110.00	
G0418	Sat biopsy prostate 41-60	S	1511		$950.00		$190.00	
G0419	Sat biopsy prostate: >60	S	1513		$1,150.00		$230.00	
G0420	Ed svc CKD ind per session	A						
G0421	Ed svc CKD grp per session	A						
G0422	Intens cardiac rehab w/exerc	S	0095	0.5691	$38.27	$13.86	$7.66	*
G0423	Intens cardiac rehab no exer	S	0095	0.5691	$38.27	$13.86	$7.66	*
G0424	Pulmonary rehab w exer	S	0102	0.7486	$50.34		$10.07	*
G0425	Inpt telehealth consult 30m	C						
G0426	Inpt telehealth consult 50m	C						
G0427	Inpt telehealth con 70/>m	C						
G0430	Drug screen multi class	A						
G0431	Drug screen single class	A						
G3001	Admin + supply, tositumomab	S	0442	25.7674	$1,732.63		$346.53	*
G8006	AMI pt recd aspirin at arriv	M						
G8007	AMI pt did not receiv aspiri	M						
G8008	AMI pt ineligible for aspiri	M						
G8009	AMI pt recd Bblock at arr	M						
G8010	AMI pt did not rec bblock	M						
G8011	AMI pt inelig Bbloc at arriv	M						
G8012	Pneum pt recv antibiotic 4 h	M						
G8013	Pneum pt w/o antibiotic 4 hr	M						
G8014	Pneum pt not elig antibiotic	M						
G8015	Diabetic pt w/ HBA1c>9%	M						
G8016	Diabetic pt w/ HBA1c<or=9%	M						
G8017	DM pt inelig for HBA1c measu	M						
G8018	Care not provided for HbA1c	M						
G8019	Diabetic pt w/LDL>= 100mg/dl	M						
G8020	Diab pt w/LDL< 100mg/dl	M						
G8021	Diab pt inelig for LDL meas	M						
G8022	Care not provided for LDL	M						
G8023	DM pt w BP>=140/80	M						
G8024	Diabetic pt wBP<140/80	M						
G8025	Diabetic pt inelig for BP me	M						
G8026	Diabet pt w no care re BP me	M						
G8027	HF p w/LVSD on ACE-I/ARB	M						
G8028	HF pt w/LVSD not on ACE-I/AR	M						
G8029	HF pt not elig for ACE-I/ARB	M						
G8030	HF pt w/LVSD on Bblocker	M						
G8031	HF pt w/LVSD not on Bblocker	M						
G8032	HF pt not elig for Bblocker	M						
G8033	PMI-CAD pt on Bblocker	M						
G8034	PMI-CAD pt not on Bblocker	M						

G8035	PMI-CAD pt inelig Bblocker	M						
G8036	AMI-CAD pt doc on antiplatel	M						
G8037	AMI-CAD pt not docu on antip	M						
G8038	AMI-CAD inelig antiplate mea	M						
G8039	CAD pt w/LDL>100mg/dl	M						
G8040	CAD pt w/LDL<or=100mg/dl	M						
G8041	CAD pt not eligible for LDL	M						
G8051	Osteoporosis assess	M						
G8052	Osteopor pt not assess	M						
G8053	Pt inelig for osteopor meas	M						
G8054	Falls assess not docum 12 mo	M						
G8055	Falls assess w/ 12 mon	M						
G8056	Not elig for falls assessmen	M						
G8057	Hearing assess receive	M						
G8058	Pt w/o hearing assess	M						
G8059	Pt inelig for hearing assess	M						
G8060	Urinary incont pt assess	M						
G8061	Pt not assess for urinary in	M						
G8062	Pt not elig for urinary inco	M						
G8075	ESRD pt w/ dialy of URR>=65%	M						
G8076	ESRD pt w/ dialy of URR<65%	M						
G8077	ESRD pt not elig for URR/KtV	M						
G8078	ESRD pt w/Hct>or=33	M						
G8079	ESRD pt w/Hct<33	M						
G8080	ESRD pt inelig for HCT/Hgb	M						
G8081	ESRD pt w/ auto AV fistula	M						
G8082	ESRD pt w other fistula	M						
G8085	ESRD PT inelig auto AV FISTU	M						
G8093	COPD pt rec smoking cessat	M						
G8094	COPD pt w/o smoke cessat int	M						
G8099	Osteopo pt given Ca+VitD sup	M						
G8100	Osteop pt inelig for Ca+VitD	M						
G8103	New dx osteo pt w/antiresorp	M						
G8104	Osteo pt inelig for antireso	M						
G8106	Bone dens meas test perf	M						
G8107	Bone dens meas test inelig	M						
G8108	Pt receiv influenza vacc	M						
G8109	Pt w/o influenza vacc	M						
G8110	Pt inelig for influenza vacc	M						
G8111	Pt receiv mammogram	M						
G8112	Pt not doc mammogram	M						
G8113	Pt ineligible mammography	M						
G8114	Care not provided for mamogr	M						
G8115	Pt receiv pneumo vacc	M						
G8116	Pt did not rec pneumo vacc	M						
G8117	Pt was inelig for pneumo vac	M						
G8126	Pt treat w/antidepress12wks	M						
G8127	Pt not treat w/antidepres12w	M						
G8128	Pt inelig for antidepres med	M						
G8129	Pt treat w/antidepres for 6m	M						
G8130	Pt not treat w/antidepres 6m	M						
G8131	Pt inelig for antidepres med	M						
G8152	Pt w/AB 1 hr prior to incisi	M						
G8153	Pt not doc for AB 1 hr prior	M						
G8154	Pt ineligi for AB therapy	M						
G8155	Pt recd thromboemb prophylax	M						
G8156	Pt did not rec thromboembo	M						
G8157	Pt ineligi for thrombolism	M						
G8159	Pt w/CABG w/o IMA	M						
G8162	Iso CABG pt w/o preop Bblock	M						
G8164	Iso CABG pt w/prolng intub	M						
G8165	Iso CABG pt w/o prolng intub	M						

G8166	Iso CABG req surg rexpo	M						
G8167	Iso CABG w/o surg explo	M						
G8170	CEA/ext bypass pt on aspirin	M						
G8171	Pt w/carot endarct/ext bypas	M						
G8172	CEA/ext bypass pt not on asp	M						
G8182	CAD pt care not prov LDL	M						
G8183	HF/atrial fib pt on warfarin	M						
G8184	HF/atrial fib pt inelig warf	M						
G8185	Osteoarth pt w/ assess pain	M						
G8186	Osteoarth pt inelig assess	M						
G8193	Antibio not doc prior surg	M						
G8196	Antibio not docum prior surg	M						
G8200	Cefazolin not docum prophy	M						
G8204	MD not doc order to d/c anti	M						
G8209	Clinician did not doc	M						
G8214	Clini not doc order VTE	M						
G8217	Pt not received DVT proph	M						
G8219	Received DVT proph day 2	M						
G8220	Pt not rec DVT proph day 2	M						
G8221	Pt inelig for DVT proph	M						
G8223	Pt not doc for presc antipla	M						
G8226	Pt no prescr anticoa at D/C	M						
G8231	Pt not doc for admin t-PA	M						
G8234	Pt not doc dysphagia screen	M						
G8238	Pt not doc to rec rehab serv	M						
G8240	Inter carotid stenosis30-99%	M						
G8243	Pt not doc MRI/CT w/o lesion	M						
G8246	Pt inelig hx w new/chg mole	M						
G8248	Pt w/one alarm symp not doc	M						
G8251	Pt not doc w/Barretts, endo	M						
G8254	Pt w/no doc order for barium	M						
G8257	Pt not doc rev meds D/C	M						
G8260	Pt not doc to have dec maker	M						
G8263	Pt not doc assess urinary in	M						
G8266	Pt not doc charc urin incon	M						
G8268	Pt not doc rec care urin inc	M						
G8271	Pt no doc screen fall	M						
G8274	Clini not doc pres/abs alarm	M						
G8276	Pt not doc mole change	M						
G8279	Pt not doc rec PE	M						
G8282	Pt not doc to rec couns	M						
G8285	Pt did not rec pres osteo	M						
G8289	Pt not doc rec Ca/Vit D	M						
G8293	COPD pt w/o spir results	M						
G8296	COPD pt not doc bronch ther	M						
G8298	Pt doc optic nerve eval	M						
G8299	Pt not doc optic nerv eval	M						
G8302	Pt doc w/ target IOP	M						
G8303	Pt not doc w/ IOP	M						
G8304	Clin doc pt inelig IOP	M						
G8305	Clin not prov care POAG	M						
G8306	POAG w/ IOP rec care plan	M						
G8307	POAG w/ IOP no care plan	M						
G8308	POAG w/ IOP not doc plan	M						
G8310	Pt not doc rec antiox	M						
G8314	Pt not doc to rec mac exam	M						
G8318	Pt doc not have visual func	M						
G8322	Pt not doc pre axial leng	M						
G8326	Pt not doc rec fundus exam	M						
G8330	Pt not doc rec dilated mac	M						
G8334	Doc of macular not giv MD	M						
G8338	Clin not doc pt test osteo	M						

G8341	Pt not doc for DEXA	M						
G8345	Pt not doc have DEXA	M						
G8351	Pt not doc ECG	M						
G8354	Pt not rec aspirin prior ER	M						
G8357	Pt not doc to have ECG	M						
G8360	Pt not doc vital signs recor	M						
G8362	Pt not doc 02 SAT assess	M						
G8365	Pt not doc mental status	M						
G8367	Pt not doc have empiric AB	M						
G8370	Asthma pt w survey not docum	M						
G8371	Chemother not rec stg3 colon	M						
G8372	Chemother rec stg3 colon ca	M						
G8373	Chemo plan documen prior che	M						
G8374	Chemo plan not doc prior che	M						
G8375	CLL pt w/o doc flow cytometr	M						
G8376	Brst ca pt inelig tamoxifen	M						
G8377	MD doc colon ca pt inelig ch	M						
G8378	MD doc pt inelig radiation	M						
G8379	Doc radiat tx recom 12mo ov	M						
G8380	Pt w stgIC-3Brst ca not rec	M						
G8381	Pt w stgIC-3Brst ca rec tam	M						
G8382	MM pt w/o doc IV bisphophon	M						
G8383	No doc radiation rec 12mo ov	M						
G8384	Base cytogen test MDS notper	M						
G8385	Diabet pt no do Hgb A1c 12m	M						
G8386	Diabet pt nodoc LDLiprotei	M						
G8387	ESRD pt w Hct/Hgb not docume	M						
G8388	ESRD pt w URR/Ktv notdoc eli	M						
G8389	MDS pt no doc FE st prio EPO	M						
G8390	Diabetic w/o document BP 12m	M						
G8391	Pt w asthma no doc med or tx	M						

G8395	LVEF>=40% doc normal or mild	M						
G8396	LVEF not performed	M						
G8397	Dil macula/fundus exam/w doc	M						
G8398	Dil macular/fundus not perfo	M						
G8399	Pt w/DXA document or order	M						
G8400	Pt w/DXA no document or orde	M						
G8401	Pt inelig osteo screen measu	M						
G8402	Smoke preven interven counse	M						
G8403	Smoke preven nocounsel	M						
G8404	Low extemity neur exam docum	M						
G8405	Low extemity neur not perfor	M						
G8406	Pt inelig lower extrem neuro	M						
G8407	ABI documented	M						
G8408	ABI not documented	M						
G8409	Pt inelig for ABI measure	M						
G8410	Eval on foot documented	M						
G8415	Eval on foot not performed	M						
G8416	Pt inelig footwear evaluatio	M						
G8417	Calc BMI abv up param f/u	M						
G8418	Calc BMI blw low param f/u	M						
G8419	Calc BMI out nrm param nof/u	M						
G8420	Calc BMI norm parameters	M						
G8421	BMI not calculated	M						
G8422	Pt inelig BMI calculation	M						
G8423	Pt screen flu vac & counsel	M						
G8424	Flu vaccine not screen	M						
G8425	Flu vaccine screen not curre	M						
G8426	Pt not approp screen & counc	M						
G8427	Doc meds verified w/pt or re	M						
G8428	Meds document w/o verifica	M						
G8429	Incomplete doc pt on meds	M						

G8430	Pt inelig med check	M						
G8431	Pos clin depres scrn f/u doc	M						
G8432	Clin depression screen not d	M						
G8433	Pt inelig; scrn clin dep	M						
G8434	Cognitive impairment screen	M						
G8435	Cognitive screen not documen	M						
G8436	Pt inelig for cognitive impa	M						
G8437	Care plan develop & document	M						
G8438	Pt inelig for devlp care pln	M						
G8439	Care plan develp & not docum	M						
G8440	Pain assess f/u pln document	M						
G8441	No document of pain assess	M						
G8442	Pt inelig pain assessment	M						
G8443	Prescription by E-Prescrib s	M						
G8445	Prescrip not gen at encounte	M						
G8446	Some prescrib print or call	M						
G8447	Pt vis doc use CCHIT cer EHR	M						
G8448	Pt vis doc w/non-CCHIT EHR	M						
G8449	Pt not doc w/EMR due to syst	M						
G8450	Beta-bloc rx pt w/abn lvef	M						
G8451	Pt w/abn lvef inelig b-bloc	M						
G8452	Pt w/abn lvef b-bloc no rx	M						
G8453	Tob use cess int counsel	M						
G8454	Tob use cess int no counsel	M						
G8455	Current tobacco smoker	M						
G8456	Current smkless tobacco user	M						
G8457	Cur tobacco non-user	M						
G8458	Pt inelig geno no antvir tx	M						
G8459	Doc pt rec antivir treat	M						
G8460	Pt inelig RNA no antvir tx	M						
G8461	Pt rec antivir treat hep c	M						

G8462	Pt inelig couns no antvir tx	M						
G8463	Pt rec antiviral treat doc	M						
G8464	Pt inelig; lo to no dter rsk	M						
G8465	High risk recurrence pro ca	M						
G8466	Pt inelig suic; MDD remis	M						
G8467	New dx init/rec episode MDD	M						
G8468	ACE/ARB rx pt w/abn lvef	M						
G8469	Pt w/abn lvef inelig ACE/ARB	M						
G8470	Pt w/ normal lvef	M						
G8471	LVEF not performed/doc	M						
G8472	ACE/ARB no rx pt w/abn lvef	M						
G8473	ACE/ARB thxpy rx'd	M						
G8474	ACE/ARB not rx'd; doc reas	M						
G8475	ACE/ARB thxpy not rx'd	M						
G8476	BP sys <130 and dias <80	M						
G8477	BP sys>=130 and/or dias >=80	M						
G8478	BP not performed/doc	M						
G8479	MD rx'd ACE/ARB thxpy	M						
G8480	Pt inelig ACE/ARB thxpy	M						
G8481	MD not rx'd ACE/ARB thxpy	M						
G8482	Flu immunize order/admin	M						
G8483	Flu imm no ord/admin doc rea	M						
G8484	Flu immunize no order/admin	M						
G8485	Report, Diabetes measures	M						
G8486	Report, Prev Care Measures	M						
G8487	Report CKD Measures	M						
G8488	Report ESRD Measures	M						
G8489	CAD measures grp	M						
G8490	RA measures grp	M						
G8491	HIV/AIDS measures grp	M						
G8492	Periop Care measures grp	M						

G8493	Back pain measures grp	M						
G8494	DM meas qual act perform	M						
G8495	CKD meas qual act perform	M						
G8496	Prev Care MG qual act perfrm	M						
G8497	CABG meas qual act perform	M						
G8498	CAD meas qual act perform	M						
G8499	RA meas qual act perform	M						
G8500	HIV meas qual act perform	M						
G8501	Perio meas qual act perform	M						
G8502	Back Pain MG qual act perfrm	M						
G8506	Pt rec ACE/ARB	M						
G8507	Pt inelig pt verif meds	M						
G8508	Pt inelig; pain asses no f/u	M						
G8509	Pain assess no f/u pln doc	M						
G8510	Pt inelig neg scrn depres	M						
G8511	Clin depres scrn no f/u doc	M						
G8518	Clin stg b/f lun/eso ca surg	M						
G8519	Pt in; clin ca stg b/f surg	M						
G8520	Clin stg b/f surg not doc	M						
G8524	Patch closure conv CEA	M						
G8525	No patch closure CEA	M						
G8526	No patch closure conv CEA	M						
G8530	Auto AV fistula recd	M						
G8531	Pt inelig; auto AV fistula	M						
G8532	No auto AV fistula; no reas	M						
G8534	Doc elder mal scrn f/u plan	M						
G8535	Pt inelig no eld mal scrn	M						
G8536	No doc elder mal scrn	M						
G8537	Pt inelig eldmal scrn no f/u	M						
G8538	Eld mal scrn no f/u pln	M						
G8539	Cur funct assess & care pln	M						
G8540	Pt inelig funct assess	M						
G8541	No doc cur funct assess	M						
G8542	Pt inelig func asses no pln	M						
G8543	Cur funct asses; no care pln	M						
G8544	CABG measures grp	M						
G8545	HepC measures grp	M						
G8546	CAP measures grp	M						
G8547	IVD measures grp	M						
G8548	HF measures grp	M						
G8549	HepC MG qual act perform	M						
G8550	CAP MG qual act perform	M						
G8551	HF MG qual act perform	M						
G8552	IVD MG qual act perform	M						
G8553	1 Rx via qualified eRx sys	M						
G8556	Ref to doc otolog eval	M						
G8557	Pt inelig ref otolog eval	M						
G8558	No ref to doc otolog eval	M						
G8559	Pt ref doc oto eval	M						
G8560	Pt hx act drain prev 90 days	M						
G8561	Pt inelig for ref oto eval	M						
G8562	Pt no hx act drain 90 d	M						
G8563	Pt no ref oto reas no spec	M						
G8564	Pt ref oto eval	M						
G8565	Ver doc hear loss	M						
G8566	Pt inelig ref oto eval	M						
G8567	Pt no doc hear loss	M						
G8568	Pt no ref otolo no spec	M						
G8569	Prol intubation req	M						
G8570	No prol intub req	M						
G8571	Ster wd ifx 30 d postop	M						
G8572	No ster wd ifx	M						

G8573	Stk/CVA CABG	M						
G8574	No strk/CVA CABG	M						
G8575	Postop ren insuf	M						
G8576	No postop ren insuf	M						
G8577	Reop req bld grft oth	M						
G8578	No reop req bld grft oth	M						
G8579	Antplt med disch	M						
G8580	Antplt med contraind	M						
G8581	no antplt med disch	M						
G8582	Bblock disch	M						
G8583	Bblock contraind	M						
G8584	No bblock disch	M						
G8585	Antilipid treat disch	M						
G8586	Antlip disch contra	M						
G8587	No antlipid treat disch	M						
G8588	Sys BP <140	M						
G8589	Sys BP >= 140	M						
G8590	Dia BP < 90	M						
G8591	Dia BP >= 90	M						
G8592	No BP measure	M						
G8593	Lipid pn results	M						
G8594	No lipid prof perf	M						
G8595	Ldl < 100	M						
G8596	No LDL perf	M						
G8597	Ldl >= 100	M						
G8598	Asp therp used	M						
G8599	No asp therp used	M						
G8600	tPA initi w/in 3 hrs	M						
G8601	No elig tPA init w/in 3 hrs	M						
G8602	No tPA init w/in 3 hrs	M						
G8603	Spok lang comp score	M						
G8604	No high score spok lang	M						
G8605	No spok lang comp score	M						
G8606	Attention score	M						
G8607	No high score attention	M						
G8608	No attention score	M						
G8609	Memory score	M						
G8610	No high score memory	M						
G8611	No memory score	M						
G8612	Moto speech score	M						
G8613	No high score moto speech	M						
G8614	No moto speech score	M						
G8615	Reading score	M						
G8616	No high score reading	M						
G8617	No reading score	M						
G8618	Spok lang exp score	M						
G8619	No high score spok lang exp	M						
G8620	No spok lang exp score	M						
G8621	Writing score	M						
G8622	No high score writing	M						
G8623	No writing score	M						
G8624	Swallowing score	M						
G8625	No high score swallowing	M						
G8626	No swallowing score	M						
G8627	Surg proc w/in 30 days	M						
G8628	No surg proc w/in 30 days	M						
G9001	MCCD, initial rate	B						
G9002	MCCD,maintenance rate	B						
G9003	MCCD, risk adj hi, initial	B						
G9004	MCCD, risk adj lo, initial	B						
G9005	MCCD, risk adj, maintenance	B						
G9006	MCCD, Home monitoring	B						

G9007	MCCD, sch team conf	B						
G9008	Mccd,phys coor-care ovrsght	B						
G9009	MCCD, risk adj, level 3	B						
G9010	MCCD, risk adj, level 4	B						
G9011	MCCD, risk adj, level 5	B						
G9012	Other Specified Case Mgmt	B						
G9013	ESRD demo bundle level I	E						
G9014	ESRD demo bundle-level II	E						
G9016	Demo-smoking cessation coun	E						
G9017	Amantadine HCL 100mg oral	A						
G9018	Zanamivir,inhalation pwd 10m	A						
G9019	Oseltamivir phosphate 75mg	A						
G9020	Rimantadine HCL 100mg oral	A						
G9033	Amantadine HCL oral brand	A						
G9034	Zanamivir, inh pwdr, brand	A						
G9035	Oseltamivir phosp, brand	A						
G9036	Rimantadine HCL, brand	A						
G9041	Low vision rehab occupationa	A						
G9042	Low vision rehab orient/mobi	A						
G9043	Low vision lowvision therapi	A						
G9044	Low vision rehabilate teache	A						
G9050	Oncology work-up evaluation	E						
G9051	Oncology tx decision-mgmt	E						
G9052	Onc surveillance for disease	E						
G9053	Onc expectant management pt	E						
G9054	Onc supervision palliative	E						
G9055	Onc visit unspecified NOS	E						
G9056	Onc prac mgmt adheres guide	E						
G9057	Onc pract mgmt differs trial	E						
G9058	Onc prac mgmt disagree w/gui	E						
G9059	Onc prac mgmt pt opt alterna	E						
G9060	Onc prac mgmt dif pt comorb	E						
G9061	Onc prac cond noadd by guide	E						
G9062	Onc prac guide differs nos	E						
G9063	Onc dx nsclc stgI no progres	M						
G9064	Onc dx nsclc stg2 no progres	M						
G9065	Onc dx nsclc stg3A no progre	M						
G9066	Onc dx nsclc stg3B-4 metasta	M						
G9067	Onc dx nsclc dx unknown nos	M						
G9068	Onc dx sclc/nsclc limited	M						
G9069	Onc dx sclc/nsclc ext at dx	M						
G9070	Onc dx sclc/nsclc ext unknwn	M						
G9071	Onc dx brst stg1-2B HR,nopro	M						
G9072	Onc dx brst stg1-2 noprogres	M						
G9073	Onc dx brst stg3-HR, no pro	M						
G9074	Onc dx brst stg3-noprogress	M						
G9075	Onc dx brst metastic/ recur	M						
G9077	Onc dx prostate T1no progres	M						
G9078	Onc dx prostate T2no progres	M						
G9079	Onc dx prostate T3b-T4noprog	M						
G9080	Onc dx prostate w/rise PSA	M						
G9083	Onc dx prostate unknwn nos	M						
G9084	Onc dx colon t1-3,n1-2,no pr	M						
G9085	Onc dx colon T4, N0 w/o prog	M						
G9086	Onc dx colon T1-4 no dx prog	M						
G9087	Onc dx colon metas evid dx	M						
G9088	Onc dx colon metas noevid dx	M						
G9089	Onc dx colon extent unknown	M						
G9090	Onc dx rectal T1-2 no progr	M						
G9091	Onc dx rectal T3 N0 no prog	M						
G9092	Onc dx rectal T1-3,N1-2noprg	M						
G9093	Onc dx rectal T4,N,M0 no prg	M						

G9094	Onc dx rectal M1 w/mets prog	M						
G9095	Onc dx rectal extent unknwn	M						
G9096	Onc dx esophag T1-T3 noprog	M						
G9097	Onc dx esophageal T4 no prog	M						
G9098	Onc dx esophageal mets recur	M						
G9099	Onc dx esophageal unknown	M						
G9100	Onc dx gastric no recurrence	M						
G9101	Onc dx gastric p R1-R2noprog	M						
G9102	Onc dx gastric unresectable	M						
G9103	Onc dx gastric recurrent	M						
G9104	Onc dx gastric unknown NOS	M						
G9105	Onc dx pancreatc p R0 res no	M						
G9106	Onc dx pancreatc p R1/R2 no	M						
G9107	Onc dx pancreatic unresectab	M						
G9108	Onc dx pancreatic unknwn NOS	M						
G9109	Onc dx head/neck T1-T2no prg	M						
G9110	Onc dx head/neck T3-4 noprog	M						
G9111	Onc dx head/neck M1 mets rec	M						
G9112	Onc dx head/neck ext unknown	M						
G9113	Onc dx ovarian stg1A-B no pr	M						
G9114	Onc dx ovarian stg1A-B or 2	M						
G9115	Onc dx ovarian stg3/4 noprog	M						
G9116	Onc dx ovarian recurrence	M						
G9117	Onc dx ovarian unknown NOS	M						
G9123	Onc dx CML chronic phase	M						
G9124	Onc dx CML acceler phase	M						
G9125	Onc dx CML blast phase	M						
G9126	Onc dx CML remission	M						
G9128	Onc dx multi myeloma stage I	M						
G9129	Onc dx mult myeloma stg2 hig	M						
G9130	Onc dx multi myeloma unknown	M						
G9131	Onc dx brst unknown NOS	M						
G9132	Onc dx prostate mets no cast	M						
G9133	Onc dx prostate clinical met	M						
G9134	Onc NHLstg 1-2 no relap no	M						
G9135	Onc dx NHL stg 3-4 not relap	M						
G9136	Onc dx NHL trans to lg Bcell	M						
G9137	Onc dx NHL relapse/refractor	M						
G9138	Onc dx NHL stg unknown	M						
G9139	Onc dx CML dx status unknown	M						
G9140	Frontier extended stay demo	A						
G9141	Influenza A H1N1,admin w cou	S	0350	0.3809	$25.61			*
G9142	Influenza A H1N1, vaccine	E						
G9143	Warfarin respon genetic test	M						
J0120	Tetracyclin injection	N						
J0128	Abarelix injection	E						
J0129	Abatacept injection	K	9230		$19.15		$3.83	
J0130	Abciximab injection	K	1605		$454.71		$90.94	
J0132	Acetylcysteine injection	K	1272		$2.33		$0.47	
J0133	Acyclovir injection	N						
J0135	Adalimumab injection	K	1083		$359.89		$71.98	
J0150	Injection adenosine 6 MG	K	0379		$10.01		$2.00	
J0152	Adenosine injection	K	0917		$79.40		$15.88	
J0170	Adrenalin epinephrin inject	N						
J0180	Agalsidase beta injection	K	9208		$133.68		$26.74	
J0190	Inj biperiden lactate/5 mg	N						
J0200	Alatrofloxacin mesylate	N						
J0205	Alglucerase injection	K	0900		$41.20		$8.24	
J0207	Amifostine	K	7000		$333.69		$66.74	
J0210	Methyldopate hcl injection	K	2210		$32.60		$6.52	
J0215	Alefacept	K	1633		$30.14		$6.03	
J0220	Alglucosidase alfa injection	K	9234		$124.69		$24.94	

J0256	Alpha 1 proteinase inhibitor	K	0901		$3.67		$0.73	
J0270	Alprostadil for injection	B						
J0275	Alprostadil urethral suppos	B						
J0278	Amikacin sulfate injection	N						
J0280	Aminophyllin 250 MG inj	N						
J0282	Amiodarone HCl	N						
J0285	Amphotericin B	N						
J0287	Amphotericin b lipid complex	K	9024		$9.47		$1.89	
J0288	Ampho b cholesteryl sulfate	K	0735		$13.74		$2.75	
J0289	Amphotericin b liposome inj	K	0736		$15.51		$3.10	
J0290	Ampicillin 500 MG inj	N						
J0295	Ampicillin sodium per 1.5 gm	N						
J0300	Amobarbital 125 MG inj	N						
J0330	Succinycholine chloride inj	N						
J0348	Anidulafungin injection	K	0760		$1.22		$0.24	
J0350	Injection anistreplase 30 u	E						
J0360	Hydralazine hcl injection	N						
J0364	Apomorphine hydrochloride	N						
J0365	Aprotonin, 10,000 kiu	K	1682		$2.60		$0.52	
J0380	Inj metaraminol bitartrate	N						
J0390	Chloroquine injection	N						
J0395	Arbutamine hcl injection	E						
J0400	Aripiprazole injection	N						
J0456	Azithromycin	N						
J0461	Atropine sulfate injection	N						
J0470	Dimecaprol injection	K	1273		$26.88		$5.38	
J0475	Baclofen 10 MG injection	K	9032		$199.42		$39.88	
J0476	Baclofen intrathecal trial	K	1631		$73.00		$14.60	
J0480	Basiliximab	K	1683		$1,696.29		$339.26	
J0500	Dicyclomine injection	N						
J0515	Inj benztropine mesylate	N						

J0520	Bethanechol chloride inject	N						
J0559	PenG benzathine/procaine inj	N						
J0560	Penicillin g benzathine inj	N						
J0570	Penicillin g benzathine inj	N						
J0580	Penicillin g benzathine inj	N						
J0583	Bivalirudin	K	3041		$2.41		$0.48	
J0585	Injection,onabotulinumtoxinA	K	0902		$5.40		$1.08	
J0586	AbobotulinumtoxinA	K	1289		$7.93		$1.59	
J0587	Inj, rimabotulinumtoxinB	K	9018		$10.38		$2.08	
J0592	Buprenorphine hydrochloride	N						
J0594	Busulfan injection	K	1178		$14.18		$2.84	
J0595	Butorphanol tartrate 1 mg	N						
J0598	C1 esterase inhibitor inj	G	9251		$41.40		$8.12	
J0600	Edetate calcium disodium inj	K	1274		$78.86		$15.78	
J0610	Calcium gluconate injection	N						
J0620	Calcium glycer & lact/10 ML	N						
J0630	Calcitonin salmon injection	K	1220		$48.34		$9.67	
J0636	Inj calcitriol per 0.1 mcg	N						
J0637	Caspofungin acetate	K	9019		$11.54		$2.31	
J0640	Leucovorin calcium injection	N						
J0641	Levoleucovorin injection	G	1236		$1.36		$0.27	
J0670	Inj mepivacaine HCL/10 ml	N						
J0690	Cefazolin sodium injection	N						
J0692	Cefepime HCl for injection	N						
J0694	Cefoxitin sodium injection	N						
J0696	Ceftriaxone sodium injection	N						
J0697	Sterile cefuroxime injection	N						
J0698	Cefotaxime sodium injection	N						
J0702	Betamethasone acet&sod phosp	N						
J0704	Betamethasone sod phosp/4 MG	N						
J0706	Caffeine citrate injection	N						

J0710	Cephapirin sodium injection	N						
J0713	Inj ceftazidime per 500 mg	N						
J0715	Ceftizoxime sodium / 500 MG	N						
J0718	Certolizumab pegol inj	G	9249		$3.72		$0.73	
J0720	Chloramphenicol sodium injec	N						
J0725	Chorionic gonadotropin/1000u	N						
J0735	Clonidine hydrochloride	K	0935		$110.46		$22.09	
J0740	Cidofovir injection	K	9033		$746.87		$149.37	
J0743	Cilastatin sodium injection	N						
J0744	Ciprofloxacin iv	N						
J0745	Inj codeine phosphate /30 MG	N						
J0760	Colchicine injection	N						
J0770	Colistimethate sodium inj	N						
J0780	Prochlorperazine injection	N						
J0795	Corticorelin ovine triflutal	K	1684		$4.22		$0.84	
J0800	Corticotropin injection	K	1280		$2,394.31		$478.86	
J0833	Cosyntropin injection NOS	K	0835		$64.19		$12.84	
J0834	Cosyntropin cortrosyn inj	K	1298		$89.48		$17.90	
J0850	Cytomegalovirus imm IV /vial	K	0903		$862.24		$172.45	
J0878	Daptomycin injection	K	9124		$0.42		$0.08	
J0881	Darbepoetin alfa, non-esrd	K	1685		$2.78		$0.56	
J0882	Darbepoetin alfa, esrd use	A						
J0885	Epoetin alfa, non-esrd	K	1686		$9.36		$1.87	
J0886	Epoetin alfa 1000 units ESRD	A						
J0894	Decitabine injection	K	9231		$28.68		$5.74	
J0895	Deferoxamine mesylate inj	N						
J0900	Testosterone enanthate inj	N						
J0945	Brompheniramine maleate inj	K	1256		$9.24		$1.85	
J0970	Estradiol valerate injection	N						
J1000	Depo-estradiol cypionate inj	N						
J1020	Methylprednisolone 20 MG inj	N						
J1030	Methylprednisolone 40 MG inj	N						
J1040	Methylprednisolone 80 MG inj	N						
J1051	Medroxyprogesterone inj	N						
J1055	Medrxyprogester acetate inj	E						
J1056	MA/EC contraceptiveinjection	E						
J1060	Testosterone cypionate 1 ML	N						
J1070	Testosterone cypionat 100 MG	N						
J1080	Testosterone cypionat 200 MG	N						
J1094	Inj dexamethasone acetate	N						
J1100	Dexamethasone sodium phos	N						
J1110	Inj dihydroergotamine mesylt	N						
J1120	Acetazolamid sodium injectio	N						
J1160	Digoxin injection	N						
J1162	Digoxin immune fab (ovine)	K	1687		$467.59		$93.52	
J1165	Phenytoin sodium injection	N						
J1170	Hydromorphone injection	N						
J1180	Dyphylline injection	N						
J1190	Dexrazoxane HCl injection	K	0726		$367.10		$73.42	
J1200	Diphenhydramine hcl injectio	N						
J1205	Chlorothiazide sodium inj	K	0747		$304.91		$60.98	
J1212	Dimethyl sulfoxide 50% 50 ML	K	1221		$68.40		$13.68	
J1230	Methadone injection	N						
J1240	Dimenhydrinate injection	N						
J1245	Dipyridamole injection	N						
J1250	Inj dobutamine HCL/250 mg	N						
J1260	Dolasetron mesylate	N						
J1265	Dopamine injection	N						
J1267	Doripenem injection	G	9241		$0.55		$0.11	
J1270	Injection, doxercalciferol	N						
J1300	Eculizumab injection	K	9236		$177.56		$35.51	
J1320	Amitriptyline injection	N						

J1324	Enfuvirtide injection	K	1257		$0.48		$0.10	
J1325	Epoprostenol injection	N						
J1327	Eptifibatide injection	K	1607		$18.50		$3.70	
J1330	Ergonovine maleate injection	N						
J1335	Ertapenem injection	N						
J1364	Erythro lactobionate /500 MG	N						
J1380	Estradiol valerate 10 MG inj	N						
J1390	Estradiol valerate 20 MG inj	N						
J1410	Inj estrogen conjugate 25 MG	K	9038		$87.05		$17.41	
J1430	Ethanolamine oleate 100 mg	K	1688		$147.14		$29.43	
J1435	Injection estrone per 1 MG	N						
J1436	Etidronate disodium inj	K	1436		$25.02		$5.00	
J1438	Etanercept injection	K	1608		$188.41		$37.68	
J1440	Filgrastim 300 mcg injection	K	0728		$215.57		$43.11	
J1441	Filgrastim 480 mcg injection	K	7049		$336.26		$67.25	
J1450	Fluconazole	N						
J1451	Fomepizole, 15 mg	K	1689		$7.56		$1.51	
J1452	Intraocular Fomivirsen na	E						
J1453	Fosaprepitant injection	G	9242		$1.57		$0.31	
J1455	Foscarnet sodium injection	N						
J1457	Gallium nitrate injection	K	0878		$1.97		$0.39	
J1458	Galsulfase injection	K	9224		$334.14		$66.83	
J1459	Inj IVIG privigen 500 mg	G	1214		$35.14		$6.89	
J1460	Gamma globulin 1 CC inj	K	3043		$15.85		$3.17	
J1470	Gamma globulin 2 CC inj	K	1282		$31.70		$6.34	
J1480	Gamma globulin 3 CC inj	K	1283		$47.53		$9.51	
J1490	Gamma globulin 4 CC inj	K	0904		$63.39		$12.68	
J1500	Gamma globulin 5 CC inj	K	1284		$79.24		$15.85	
J1510	Gamma globulin 6 CC inj	K	0920		$95.12		$19.02	
J1520	Gamma globulin 7 CC inj	K	0921		$110.86		$22.17	
J1530	Gamma globulin 8 CC inj	K	0922		$126.78		$25.36	
J1540	Gamma globulin 9 CC inj	K	0923		$158.48		$31.70	
J1550	Gamma globulin 10 CC inj	K	0924		$158.48		$31.70	
J1560	Gamma globulin > 10 CC inj	K	0933		$158.48		$31.70	
J1561	Gamunex injection	K	0948		$36.91		$7.38	
J1562	Vivaglobin, inj	K	1275		$7.04		$1.41	
J1566	Immune globulin, powder	K	2731		$29.90		$5.98	
J1568	Octagam injection	K	0943		$37.00		$7.40	
J1569	Gammagard liquid injection	K	0944		$37.81		$7.56	
J1570	Ganciclovir sodium injection	N						
J1571	Hepagam b im injection	G	0946		$50.22		$9.85	
J1572	Flebogamma injection	K	0947		$36.42		$7.28	
J1573	Hepagam b intravenous, inj	G	1138		$50.22		$9.85	
J1580	Garamycin gentamicin inj	N						
J1590	Gatifloxacin injection	N						
J1595	Injection glatiramer acetate	K	1015		$81.34		$16.27	
J1600	Gold sodium thiomaleate inj	N						
J1610	Glucagon hydrochloride/1 MG	K	9042		$82.64		$16.53	
J1620	Gonadorelin hydroch/ 100 mcg	K	7005		$32.12		$6.42	
J1626	Granisetron hcl injection	N						
J1630	Haloperidol injection	N						
J1631	Haloperidol decanoate inj	N						
J1640	Hemin, 1 mg	K	1690		$7.98		$1.60	
J1642	Inj heparin sodium per 10 u	N						
J1644	Inj heparin sodium per 1000u	N						
J1645	Dalteparin sodium	N						
J1650	Inj enoxaparin sodium	N						
J1652	Fondaparinux sodium	K	1276		$6.04		$1.21	
J1655	Tinzaparin sodium injection	N						
J1670	Tetanus immune globulin inj	K	1670		$207.82		$41.56	
J1675	Histrelin acetate	B						
J1680	Human fibrinogen conc inj	G	1290		$0.24		$0.05	

J1700	Hydrocortisone acetate inj	N						
J1710	Hydrocortisone sodium ph inj	N						
J1720	Hydrocortisone sodium succ i	N						
J1730	Diazoxide injection	K	1740		$112.16		$22.44	
J1740	Ibandronate sodium injection	K	9229		$138.94		$27.79	
J1742	Ibutilide fumarate injection	K	9044		$395.62		$79.12	
J1743	Idursulfase injection	K	9232		$446.44		$89.29	
J1745	Infliximab injection	K	7043		$57.56		$11.51	
J1750	Inj iron dextran	K	1237		$12.69		$2.54	
J1756	Iron sucrose injection	K	9046		$0.37		$0.08	
J1785	Injection imiglucerase /unit	K	0916		$4.12		$0.83	
J1790	Droperidol injection	N						
J1800	Propranolol injection	N						
J1810	Droperidol/fentanyl inj	E						
J1815	Insulin injection	N						
J1817	Insulin for insulin pump use	K	1277		$3.37		$0.67	
J1825	Interferon beta-1a	E						
J1830	Interferon beta-1b / .25 MG	K	0910		$175.51		$35.10	
J1835	Itraconazole injection	N						
J1840	Kanamycin sulfate 500 MG inj	N						
J1850	Kanamycin sulfate 75 MG inj	N						
J1885	Ketorolac tromethamine inj	N						
J1890	Cephalothin sodium injection	N						
J1930	Lanreotide injection	K	9237		$26.62		$5.32	
J1931	Laronidase injection	K	9209		$25.08		$5.02	
J1940	Furosemide injection	N						
J1945	Lepirudin	K	1693		$226.90		$45.38	
J1950	Leuprolide acetate /3.75 MG	K	0800		$483.41		$96.68	
J1953	Levetiracetam injection	G	9238		$0.46		$0.09	
J1955	Inj levocarnitine per 1 gm	B						
J1956	Levofloxacin injection	N						
J1960	Levorphanol tartrate inj	N						
J1980	Hyoscyamine sulfate inj	N						
J1990	Chlordiazepoxide injection	N						
J2001	Lidocaine injection	N						
J2010	Lincomycin injection	N						
J2020	Linezolid injection	K	9001		$30.94		$6.19	
J2060	Lorazepam injection	N						
J2150	Mannitol injection	N						
J2170	Mecasermin injection	N						
J2175	Meperidine hydrochl /100 MG	N						
J2180	Meperidine/promethazine inj	N						
J2185	Meropenem	N						
J2210	Methylergonovin maleate inj	N						
J2248	Micafungin sodium injection	K	9227		$1.11		$0.22	
J2250	Inj midazolam hydrochloride	N						
J2260	Inj milrinone lactate / 5 MG	N						
J2270	Morphine sulfate injection	N						
J2271	Morphine so4 injection 100mg	N						
J2275	Morphine sulfate injection	N						
J2278	Ziconotide injection	K	1694		$6.38		$1.28	
J2280	Inj, moxifloxacin 100 mg	N						
J2300	Inj nalbuphine hydrochloride	N						
J2310	Inj naloxone hydrochloride	N						
J2315	Naltrexone, depot form	K	0759		$2.10		$0.42	
J2320	Nandrolone decanoate 50 MG	K	1285		$7.00		$1.40	
J2321	Nandrolone decanoate 100 MG	K	1260		$7.00		$1.40	
J2322	Nandrolone decanoate 200 MG	K	1286		$14.73		$2.95	
J2323	Natalizumab injection	K	9126		$8.08		$1.62	
J2325	Nesiritide injection	K	1695		$37.25		$7.45	
J2353	Octreotide injection, depot	K	1207		$106.19		$21.24	
J2354	Octreotide inj, non-depot	N						

J2355	Oprelvekin injection	K	7011		$241.17		$48.23	
J2357	Omalizumab injection	K	9300		$18.86		$3.78	
J2360	Orphenadrine injection	N						
J2370	Phenylephrine hcl injection	N						
J2400	Chloroprocaine hcl injection	N						
J2405	Ondansetron hcl injection	N						
J2410	Oxymorphone hcl injection	N						
J2425	Palifermin injection	K	1696		$11.11		$2.22	
J2430	Pamidronate disodium /30 MG	K	0730		$19.98		$4.00	
J2440	Papaverin hcl injection	N						
J2460	Oxytetracycline injection	E						
J2469	Palonosetron hcl	K	9210		$17.18		$3.44	
J2501	Paricalcitol	N						
J2503	Pegaptanib sodium injection	K	1697		$1,014.11		$202.83	
J2504	Pegademase bovine, 25 iu	K	1739		$242.67		$48.54	
J2505	Injection, pegfilgrastim 6mg	K	9119		$2,320.08		$464.02	
J2510	Penicillin g procaine inj	N						
J2513	Pentastarch 10% solution	K	1222		$158.77		$31.75	
J2515	Pentobarbital sodium inj	N						
J2540	Penicillin g potassium inj	N						
J2543	Piperacillin/tazobactam	N						
J2545	Pentamidine non-comp unit	B						
J2550	Promethazine hcl injection	N						
J2560	Phenobarbital sodium inj	N						
J2562	Plerixafor injection	G	9252		$268.72		$52.73	
J2590	Oxytocin injection	N						
J2597	Inj desmopressin acetate	N						
J2650	Prednisolone acetate inj	N						
J2670	Totazoline hcl injection	N						
J2675	Inj progesterone per 50 MG	N						
J2680	Fluphenazine decanoate 25 MG	N						
J2690	Procainamide hcl injection	N						
J2700	Oxacillin sodium injeciton	N						
J2710	Neostigmine methylslfte inj	N						
J2720	Inj protamine sulfate/10 MG	N						
J2724	Protein c concentrate	K	1139		$11.96		$2.40	
J2725	Inj protirelin per 250 mcg	N						
J2730	Pralidoxime chloride inj	K	1023		$89.08		$17.82	
J2760	Phentolaine mesylate inj	N						
J2765	Metoclopramide hcl injection	N						
J2770	Quinupristin/dalfopristin	K	2770		$144.34		$28.87	
J2778	Ranibizumab injection	K	9233		$397.01		$79.40	
J2780	Ranitidine hydrochloride inj	N						
J2783	Rasburicase	K	0738		$169.23		$33.85	
J2785	Regadenoson injection	G	9244		$50.85		$9.98	
J2788	Rho d immune globulin 50 mcg	K	9023		$25.47		$5.09	
J2790	Rho d immune globulin inj	K	0884		$84.51		$16.90	
J2791	Rhophylac injection	K	0945		$5.12		$1.02	
J2792	Rho(D) immune globulin h, sd	K	1609		$18.22		$3.64	
J2793	Rilonacept injection	K	1291		$23.64		$4.73	
J2794	Risperidone, long acting	K	9125		$4.94		$0.99	
J2795	Ropivacaine HCl injection	N						
J2796	Romiplostim injection	G	9245		$43.60		$8.55	
J2800	Methocarbamol injection	N						
J2805	Sincalide injection	N						
J2810	Inj theophylline per 40 MG	N						
J2820	Sargramostim injection	K	0731		$23.81		$4.76	
J2850	Inj secretin synthetic human	K	1700		$19.93		$3.99	
J2910	Aurothioglucose injeciton	N						
J2916	Na ferric gluconate complex	N						
J2920	Methylprednisolone injection	N						
J2930	Methylprednisolone injection	N						

J2940	Somatrem injection	K	1225		$4.89		$0.98	
J2941	Somatropin injection	K	7034		$54.38		$10.88	
J2950	Promazine hcl injection	N						
J2993	Reteplase injection	K	9005		$1,258.72		$251.74	
J2995	Inj streptokinase /250000 IU	K	1226		$78.00		$15.60	
J2997	Alteplase recombinant	K	7048		$36.23		$7.25	
J3000	Streptomycin injection	N						
J3010	Fentanyl citrate injeciton	N						
J3030	Sumatriptan succinate / 6 MG	K	3030		$42.72		$8.54	
J3070	Pentazocine injection	N						
J3101	Tenecteplase injection	K	9002		$41.84		$8.37	
J3105	Terbutaline sulfate inj	N						
J3110	Teriparatide injection	B						
J3120	Testosterone enanthate inj	N						
J3130	Testosterone enanthate inj	N						
J3140	Testosterone suspension inj	N						
J3150	Testosteron propionate inj	N						
J3230	Chlorpromazine hcl injection	N						
J3240	Thyrotropin injection	K	9108		$1,043.80		$208.76	
J3243	Tigecycline injection	K	9228		$1.15		$0.23	
J3246	Tirofiban HCl	K	7041		$7.74		$1.55	
J3250	Trimethobenzamide hcl inj	N						
J3260	Tobramycin sulfate injection	N						
J3265	Injection torsemide 10 mg/ml	N						
J3280	Thiethylperazine maleate inj	N						
J3285	Treprostinil injection	K	1701		$54.83		$10.97	
J3300	Triamcinolone A inj PRS-free	K	1253		$3.16		$0.63	
J3301	Triamcinolone acet inj NOS	N						
J3302	Triamcinolone diacetate inj	N						
J3303	Triamcinolone hexacetonl inj	N						
J3305	Inj trimetrexate glucoronate	K	7045		$146.89		$29.38	
J3310	Perphenazine injeciton	N						
J3315	Triptorelin pamoate	K	9122		$153.42		$30.68	
J3320	Spectinomycn di-hcl inj	N						
J3350	Urea injection	N						
J3355	Urofollitropin, 75 iu	K	1741		$57.43		$11.49	
J3360	Diazepam injection	N						
J3364	Urokinase 5000 IU injection	N						
J3365	Urokinase 250,000 IU inj	K	7036		$449.09		$89.82	
J3370	Vancomycin hcl injection	N						
J3396	Verteporfin injection	K	1203		$9.31		$1.87	
J3400	Triflupromazine hcl inj	N						
J3410	Hydroxyzine hcl injection	N						
J3411	Thiamine hcl 100 mg	N						
J3415	Pyridoxine hcl 100 mg	N						
J3420	Vitamin b12 injection	N						
J3430	Vitamin k phytonadione inj	N						
J3465	Injection, voriconazole	K	1052		$5.56		$1.11	
J3470	Hyaluronidase injection	N						
J3471	Ovine, up to 999 USP units	N						
J3472	Ovine, 1000 USP units	N						
J3473	Hyaluronidase recombinant	N						
J3475	Inj magnesium sulfate	N						
J3480	Inj potassium chloride	N						
J3485	Zidovudine	N						
J3486	Ziprasidone mesylate	N						
J3487	Zoledronic acid	K	9115		$215.25		$43.05	
J3488	Reclast injection	K	0951		$218.49		$43.70	
J3490	Drugs unclassified injection	N						
J3520	Edetate disodium per 150 mg	E						
J3530	Nasal vaccine inhalation	N						
J3535	Metered dose inhaler drug	E						

J3570	Laetrile amygdalin vit B17	E						
J3590	Unclassified biologics	N						
J7030	Normal saline solution infus	N						
J7040	Normal saline solution infus	N						
J7042	5% dextrose/normal saline	N						
J7050	Normal saline solution infus	N						
J7060	5% dextrose/water	N						
J7070	D5w infusion	N						
J7100	Dextran 40 infusion	N						
J7110	Dextran 75 infusion	N						
J7120	Ringers lactate infusion	N						
J7130	Hypertonic saline solution	N						
J7185	Xyntha inj	K	1268		$1.07		$0.21	
J7186	Antihemophilic viii/vwf comp	K	1213		$0.90		$0.18	
J7187	Humate-P, inj	K	1704		$0.86		$0.17	
J7189	Factor viia	K	1705		$1.30		$0.26	
J7190	Factor viii	K	0925		$0.85		$0.17	
J7191	Factor VIII (porcine)	K	1279		$8.21		$1.64	
J7192	Factor viii recombinant NOS	K	0927		$1.08		$0.22	
J7193	Factor IX non-recombinant	K	0931		$0.87		$0.17	
J7194	Factor ix complex	K	0928		$0.86		$0.17	
J7195	Factor IX recombinant	K	0932		$1.09		$0.22	
J7197	Antithrombin iii injection	K	1263		$2.28		$0.46	
J7198	Anti-inhibitor	K	0929		$1.52		$0.30	
J7199	Hemophilia clot factor noc	B						
J7300	Intraut copper contraceptive	E						
J7302	Levonorgestrel iu contracept	E						
J7303	Contraceptive vaginal ring	E						
J7304	Contraceptive hormone patch	E						
J7306	Levonorgestrel implant sys	E						
J7307	Etonogestrel implant system	E						
J7308	Aminolevulinic acid hcl top	K	7308		$127.08		$25.42	
J7310	Ganciclovir long act implant	K	0913		$16,640.00		$3,328.00	
J7311	Fluocinolone acetonide implt	K	9225		$18,980.00		$3,796.00	
J7321	Hyalgan/supartz inj per dose	K	0873		$90.54		$18.11	
J7323	Euflexxa inj per dose	K	0875		$111.88		$22.38	
J7324	Orthovisc inj per dose	K	0877		$172.73		$34.55	
J7325	Synvisc or Synvisc-One	K	0874		$11.52		$2.30	
J7330	Cultured chondrocytes implnt	B						
J7500	Azathioprine oral 50mg	N						
J7501	Azathioprine parenteral	K	0887		$93.84		$18.77	
J7502	Cyclosporine oral 100 mg	K	1292		$3.12		$0.62	
J7504	Lymphocyte immune globulin	K	0890		$456.47		$91.29	
J7505	Monoclonal antibodies	K	7038		$1,111.55		$222.31	
J7506	Prednisone oral	N						
J7507	Tacrolimus oral per 1 MG	K	0891		$3.57		$0.71	
J7509	Methylprednisolone oral	N						
J7510	Prednisolone oral per 5 mg	N						
J7511	Antithymocyte globuln rabbit	K	9104		$401.93		$80.39	
J7513	Daclizumab, parenteral	K	1612		$381.18		$76.24	
J7515	Cyclosporine oral 25 mg	K	1294		$0.81		$0.16	
J7516	Cyclosporin parenteral 250mg	K	1204		$23.37		$4.67	
J7517	Mycophenolate mofetil oral	K	9015		$2.55		$0.51	
J7518	Mycophenolic acid	N						
J7520	Sirolimus, oral	K	9020		$9.47		$1.89	
J7525	Tacrolimus injection	K	9006		$137.01		$27.40	
J7599	Immunosuppressive drug noc	N						
J7604	Acetylcysteine comp unit	M						
J7605	Arformoterol non-comp unit	M						
J7606	Formoterol fumarate, inh	M						
J7607	Levalbuterol comp con	M						
J7608	Acetylcysteine non-comp unit	M						

J7609	Albuterol comp unit	M						
J7610	Albuterol comp con	M						
J7611	Albuterol non-comp con	M						
J7612	Levalbuterol non-comp con	M						
J7613	Albuterol non-comp unit	M						
J7614	Levalbuterol non-comp unit	M						
J7615	Levalbuterol comp unit	M						
J7620	Albuterol ipratrop non-comp	M						
J7622	Beclomethasone comp unit	M						
J7624	Betamethasone comp unit	M						
J7626	Budesonide non-comp unit	M						
J7627	Budesonide comp unit	M						
J7628	Bitolterol mesylate comp con	M						
J7629	Bitolterol mesylate comp unt	M						
J7631	Cromolyn sodium noncomp unit	M						
J7632	Cromolyn sodium comp unit	M						
J7633	Budesonide non-comp con	M						
J7634	Budesonide comp con	M						
J7635	Atropine comp con	M						
J7636	Atropine comp unit	M						
J7637	Dexamethasone comp con	M						
J7638	Dexamethasone comp unit	M						
J7639	Dornase alfa non-comp unit	M						
J7640	Formoterol comp unit	E						
J7641	Flunisolide comp unit	M						
J7642	Glycopyrrolate comp con	M						
J7643	Glycopyrrolate comp unit	M						
J7644	Ipratropium bromide non-comp	M						
J7645	Ipratropium bromide comp	M						
J7647	Isoetharine comp con	M						
J7648	Isoetharine non-comp con	M						
J7649	Isoetharine non-comp unit	M						
J7650	Isoetharine comp unit	M						
J7657	Isoproterenol comp con	M						
J7658	Isoproterenol non-comp con	M						
J7659	Isoproterenol non-comp unit	M						
J7660	Isoproterenol comp unit	M						
J7667	Metaproterenol comp con	M						
J7668	Metaproterenol non-comp con	M						
J7669	Metaproterenol non-comp unit	M						
J7670	Metaproterenol comp unit	M						
J7674	Methacholine chloride, neb	N						
J7676	Pentamidine comp unit dose	M						
J7680	Terbutaline sulf comp con	M						
J7681	Terbutaline sulf comp unit	M						
J7682	Tobramycin non-comp unit	M						
J7683	Triamcinolone comp con	M						
J7684	Triamcinolone comp unit	M						
J7685	Tobramycin comp unit	M						
J7699	Inhalation solution for DME	M						
J7799	Non-inhalation drug for DME	N						
J8498	Antiemetic rectal/supp NOS	B						
J8499	Oral prescrip drug non chemo	E						
J8501	Oral aprepitant	K	0868		$5.42		$1.09	
J8510	Oral busulfan	N						
J8515	Cabergoline, oral 0.25mg	E						
J8520	Capecitabine, oral, 150 mg	K	7042		$6.11		$1.22	
J8521	Capecitabine, oral, 500 mg	K	0934		$20.04		$4.01	
J8530	Cyclophosphamide oral 25 MG	N						
J8540	Oral dexamethasone	N						
J8560	Etoposide oral 50 MG	K	0802		$29.69		$5.94	
J8565	Gefitinib oral	E						

J8597	Antiemetic drug oral NOS	N						
J8600	Melphalan oral 2 MG	N						
J8610	Methotrexate oral 2.5 MG	N						
J8650	Nabilone oral	N						
J8700	Temozolomide	K	1086		$8.63		$1.73	
J8705	Topotecan oral	G	1238		$73.00		$14.33	
J8999	Oral prescription drug chemo	B						
J9000	Doxorubicin hcl injection	N						
J9001	Doxorubicin hcl liposome inj	K	7046		$462.49		$92.50	
J9010	Alemtuzumab injection	K	9110		$555.50		$111.10	
J9015	Aldesleukin injection	K	0807		$830.93		$166.19	
J9017	Arsenic trioxide injection	K	9012		$36.83		$7.37	
J9020	Asparaginase injection	K	0814		$59.27		$11.85	
J9025	Azacitidine injection	K	1709		$4.79		$0.96	
J9027	Clofarabine injection	K	1710		$113.36		$22.67	
J9031	Bcg live intravesical vac	K	0809		$108.55		$21.71	
J9033	Bendamustine injection	G	9243		$18.51		$3.63	
J9035	Bevacizumab injection	K	9214		$56.37		$11.27	
J9040	Bleomycin sulfate injection	N						
J9041	Bortezomib injection	K	9207		$37.52		$7.50	
J9045	Carboplatin injection	N						
J9050	Carmustine injection	K	0812		$173.53		$34.71	
J9055	Cetuximab injection	K	9215		$48.79		$9.76	
J9060	Cisplatin 10 MG injection	N						
J9062	Cisplatin 50 MG injection	N						
J9065	Inj cladribine per 1 MG	K	0858		$23.52		$4.70	
J9070	Cyclophosphamide 100 MG inj	N						
J9080	Cyclophosphamide 200 MG inj	N						
J9090	Cyclophosphamide 500 MG inj	N						
J9091	Cyclophosphamide 1.0 grm inj	N						
J9092	Cyclophosphamide 2.0 grm inj	N						
J9093	Cyclophosphamide lyophilized	N						
J9094	Cyclophosphamide lyophilized	N						
J9095	Cyclophosphamide lyophilized	N						
J9096	Cyclophosphamide lyophilized	N						
J9097	Cyclophosphamide lyophilized	N						
J9098	Cytarabine liposome inj	K	1166		$480.16		$96.03	
J9100	Cytarabine hcl 100 MG inj	N						
J9110	Cytarabine hcl 500 MG inj	N						
J9120	Dactinomycin injection	K	0752		$556.34		$111.27	
J9130	Dacarbazine 100 mg inj	N						
J9140	Dacarbazine 200 MG inj	N						
J9150	Daunorubicin injection	K	0820		$16.65		$3.33	
J9151	Daunorubicin citrate inj	K	0821		$55.33		$11.07	
J9155	Degarelix injection	G	1296		$2.87		$0.56	
J9160	Denileukin diftitox inj	K	1084		$1,467.55		$293.51	
J9165	Diethylstilbestrol injection	K	1209		$3.83		$0.77	
J9171	Docetaxel injection	K	0823		$17.29		$3.46	
J9175	Elliotts b solution per ml	N						
J9178	Inj, epirubicin hcl, 2 mg	K	1167		$2.60		$0.52	
J9181	Etoposide injection	N						
J9185	Fludarabine phosphate inj	K	0842		$158.63		$31.73	
J9190	Fluorouracil injection	N						
J9200	Floxuridine injection	K	0827		$42.85		$8.57	
J9201	Gemcitabine hcl injection	K	0828		$142.20		$28.44	
J9202	Goserelin acetate implant	K	0810		$200.02		$40.00	
J9206	Irinotecan injection	K	0830		$6.81		$1.36	
J9207	Ixabepilone injection	G	9240		$63.74		$12.51	
J9208	Ifosfomide injection	K	0831		$29.51		$5.90	
J9209	Mesna injection	K	0732		$4.55		$0.91	
J9211	Idarubicin hcl injection	K	0832		$100.89		$20.18	
J9212	Interferon alfacon-1 inj	K	1266		$4.71		$0.94	

J9213	Interferon alfa-2a inj	K	0834		$10.60		$2.12	
J9214	Interferon alfa-2b inj	K	0836		$15.54		$3.11	
J9215	Interferon alfa-n3 inj	K	0865		$17.89		$3.58	
J9216	Interferon gamma 1-b inj	K	0838		$294.03		$58.81	
J9217	Leuprolide acetate suspnsion	K	9217		$202.62		$40.52	
J9218	Leuprolide acetate injeciton	K	0861		$4.68		$0.94	
J9219	Leuprolide acetate implant	K	7051		$4,728.88		$945.78	
J9225	Vantas implant	G	1711		$1,462.69		$287.02	
J9226	Supprelin LA implant	G	1142		$14,841.08		$2,912.21	
J9230	Mechlorethamine hcl inj	K	0751		$151.24		$30.25	
J9245	Inj melphalan hydrochl 50 MG	K	0840		$1,520.24		$304.05	
J9250	Methotrexate sodium inj	N						
J9260	Methotrexate sodium inj	N						
J9261	Nelarabine injection	K	0825		$101.35		$20.27	
J9263	Oxaliplatin	K	1738		$7.47		$1.49	
J9264	Paclitaxel protein bound	K	1712		$9.20		$1.84	
J9265	Paclitaxel injection	N						
J9266	Pegaspargase injection	K	0843		$2,695.46		$539.09	
J9268	Pentostatin injection	K	0844		$1,318.44		$263.69	
J9270	Plicamycin (mithramycin) inj	N						
J9280	Mitomycin 5 MG inj	K	1232		$16.83		$3.37	
J9290	Mitomycin 20 MG inj	K	1233		$67.30		$13.46	
J9291	Mitomycin 40 MG inj	K	1234		$134.60		$26.92	
J9293	Mitoxantrone hydrochl / 5 MG	K	0864		$46.87		$9.37	
J9300	Gemtuzumab ozogamicin inj	K	9004		$2,573.49		$514.70	
J9303	Panitumumab injection	K	9235		$85.35		$17.07	
J9305	Pemetrexed injection	K	9213		$49.63		$9.93	
J9310	Rituximab injection	K	0849		$553.12		$110.62	
J9320	Streptozocin injection	K	0850		$278.77		$55.75	
J9328	Temozolomide injection	G	9253		$4.90		$0.96	
J9330	Temsirolimus injection	K	1168		$48.90		$9.78	
J9340	Thiotepa injection	K	0851		$103.08		$20.62	
J9350	Topotecan injection	K	0852		$1,012.44		$202.49	
J9355	Trastuzumab injection	K	1613		$63.56		$12.71	
J9357	Valrubicin injection	K	1235		$933.57		$186.71	
J9360	Vinblastine sulfate inj	N						
J9370	Vincristine sulfate 1 MG inj	N						
J9375	Vincristine sulfate 2 MG inj	N						
J9380	Vincristine sulfate 5 MG inj	N						
J9390	Vinorelbine tartrate inj	N						
J9395	Injection, Fulvestrant	K	9120		$80.66		$16.13	
J9600	Porfimer sodium injection	K	0856		$2,748.96		$549.79	
J9999	Chemotherapy drug	N						
K0001	Standard wheelchair	Y						
K0002	Stnd hemi (low seat) whlchr	Y						
K0003	Lightweight wheelchair	Y						
K0004	High strength ltwt whlchr	Y						
K0005	Ultralightweight wheelchair	Y						
K0006	Heavy duty wheelchair	Y						
K0007	Extra heavy duty wheelchair	Y						
K0009	Other manual wheelchair/base	Y						
K0010	Stnd wt frame power whlchr	Y						
K0011	Stnd wt pwr whlchr w control	Y						
K0012	Ltwt portbl power whlchr	Y						
K0014	Other power whlchr base	Y						
K0015	Detach non-adjus hght armrst	Y						
K0017	Detach adjust armrest base	Y						
K0018	Detach adjust armrst upper	Y						
K0019	Arm pad each	Y						
K0020	Fixed adjust armrest pair	Y						
K0037	High mount flip-up footrest	Y						
K0038	Leg strap each	Y						

K0039	Leg strap h style each	Y						
K0040	Adjustable angle footplate	Y						
K0041	Large size footplate each	Y						
K0042	Standard size footplate each	Y						
K0043	Ftrst lower extension tube	Y						
K0044	Ftrst upper hanger bracket	Y						
K0045	Footrest complete assembly	Y						
K0046	Elevat legrst low extension	Y						
K0047	Elevat legrst up hangr brack	Y						
K0050	Ratchet assembly	Y						
K0051	Cam relese assem ftrst/lgrst	Y						
K0052	Swingaway detach footrest	Y						
K0053	Elevate footrest articulate	Y						
K0056	Seat ht <17 or >=21 ltwt wc	Y						
K0065	Spoke protectors	Y						
K0069	Rear whl complete solid tire	Y						
K0070	Rear whl compl pneum tire	Y						
K0071	Front castr compl pneum tire	Y						
K0072	Frnt cstr cmpl sem-pneum tir	Y						
K0073	Caster pin lock each	Y						
K0077	Front caster assem complete	Y						
K0098	Drive belt power wheelchair	Y						
K0105	Iv hanger	Y						
K0108	W/c component-accessory NOS	Y						
K0195	Elevating whlchair leg rests	Y						
K0455	Pump uninterrupted infusion	Y						
K0462	Temporary replacement eqpmnt	Y						
K0552	Supply/ext inf pump syr type	Y						
K0601	Repl batt silver oxide 1.5 v	Y						
K0602	Repl batt silver oxide 3 v	Y						
K0603	Repl batt alkaline 1.5 v	Y						
K0604	Repl batt lithium 3.6 v	Y						
K0605	Repl batt lithium 4.5 v	Y						
K0606	AED garment w elec analysis	Y						
K0607	Repl batt for AED	Y						
K0608	Repl garment for AED	Y						
K0609	Repl electrode for AED	Y						
K0669	Seat/back cus no sadmerc ver	Y						
K0672	Removable soft interface LE	A						
K0730	Ctrl dose inh drug deliv sys	Y						
K0733	12-24hr sealed lead acid	Y						
K0734	Adj skin pro w/c cus wd<22in	Y						
K0735	Adj skin pro wc cus wd>=22in	Y						
K0736	Adj skin pro/pos wc cus<22in	Y						
K0737	Adj skin pro/pos wc cus>=22"	Y						
K0738	Portable gas oxygen system	Y						
K0739	Repair/svc DME non-oxygen eq	Y						
K0740	Repair/svc oxygen equipment	E						
K0800	POV group 1 std up to 300lbs	Y						
K0801	POV group 1 hd 301-450 lbs	Y						
K0802	POV group 1 vhd 451-600 lbs	Y						
K0806	POV group 2 std up to 300lbs	Y						
K0807	POV group 2 hd 301-450 lbs	Y						
K0808	POV group 2 vhd 451-600 lbs	Y						
K0812	Power operated vehicle NOC	Y						
K0813	PWC gp 1 std port seat/back	Y						
K0814	PWC gp 1 std port cap chair	Y						
K0815	PWC gp 1 std seat/back	Y						
K0816	PWC gp 1 std cap chair	Y						
K0820	PWC gp 2 std port seat/back	Y						
K0821	PWC gp 2 std port cap chair	Y						
K0822	PWC gp 2 std seat/back	Y						

K0823	PWC gp 2 std cap chair	Y						
K0824	PWC gp 2 hd seat/back	Y						
K0825	PWC gp 2 hd cap chair	Y						
K0826	PWC gp 2 vhd seat/back	Y						
K0827	PWC gp vhd cap chair	Y						
K0828	PWC gp 2 xtra hd seat/back	Y						
K0829	PWC gp 2 xtra hd cap chair	Y						
K0830	PWC gp2 std seat elevate s/b	Y						
K0831	PWC gp2 std seat elevate cap	Y						
K0835	PWC gp2 std sing pow opt s/b	Y						
K0836	PWC gp2 std sing pow opt cap	Y						
K0837	PWC gp 2 hd sing pow opt s/b	Y						
K0838	PWC gp 2 hd sing pow opt cap	Y						
K0839	PWC gp2 vhd sing pow opt s/b	Y						
K0840	PWC gp2 xhd sing pow opt s/b	Y						
K0841	PWC gp2 std mult pow opt s/b	Y						
K0842	PWC gp2 std mult pow opt cap	Y						
K0843	PWC gp2 hd mult pow opt s/b	Y						
K0848	PWC gp 3 std seat/back	Y						
K0849	PWC gp 3 std cap chair	Y						
K0850	PWC gp 3 hd seat/back	Y						
K0851	PWC gp 3 hd cap chair	Y						
K0852	PWC gp 3 vhd seat/back	Y						
K0853	PWC gp 3 vhd cap chair	Y						
K0854	PWC gp 3 xhd seat/back	Y						
K0855	PWC gp 3 xhd cap chair	Y						
K0856	PWC gp3 std sing pow opt s/b	Y						
K0857	PWC gp3 std sing pow opt cap	Y						
K0858	PWC gp3 hd sing pow opt s/b	Y						
K0859	PWC gp3 hd sing pow opt cap	Y						
K0860	PWC gp3 vhd sing pow opt s/b	Y						
K0861	PWC gp3 std mult pow opt s/b	Y						
K0862	PWC gp3 hd mult pow opt s/b	Y						
K0863	PWC gp3 vhd mult pow opt s/b	Y						
K0864	PWC gp3 xhd mult pow opt s/b	Y						
K0868	PWC gp 4 std seat/back	Y						
K0869	PWC gp 4 std cap chair	Y						
K0870	PWC gp 4 hd seat/back	Y						
K0871	PWC gp 4 vhd seat/back	Y						
K0877	PWC gp4 std sing pow opt s/b	Y						
K0878	PWC gp4 std sing pow opt cap	Y						
K0879	PWC gp4 hd sing pow opt s/b	Y						
K0880	PWC gp4 vhd sing pow opt s/b	Y						
K0884	PWC gp4 std mult pow opt s/b	Y						
K0885	PWC gp4 std mult pow opt cap	Y						
K0886	PWC gp4 hd mult pow s/b	Y						
K0890	PWC gp5 ped sing pow opt s/b	Y						
K0891	PWC gp5 ped mult pow opt s/b	Y						
K0898	Power wheelchair NOC	Y						
K0899	Pow mobil dev no SADMERC	Y						
L0112	Cranial cervical orthosis	A						
L0113	Cranial cervical torticollis	A						
L0120	Cerv flexible non-adjustable	A						
L0130	Flex thermoplastic collar mo	A						
L0140	Cervical semi-rigid adjustab	A						
L0150	Cerv semi-rig adj molded chn	A						
L0160	Cerv semi-rig wire occ/mand	A						
L0170	Cervical collar molded to pt	A						
L0172	Cerv col thermplas foam 2 pi	A						
L0174	Cerv col foam 2 piece w thor	A						
L0180	Cer post col occ/man sup adj	A						
L0190	Cerv collar supp adj cerv ba	A						

L0200	Cerv col supp adj bar & thor	A						
L0220	Thor rib belt custom fabrica	A						
L0430	Dewall posture protector	A						
L0450	TLSO flex prefab thoracic	A						
L0452	tlso flex custom fab thoraci	A						
L0454	TLSO flex prefab sacrococ-T9	A						
L0456	TLSO flex prefab	A						
L0458	TLSO 2Mod symphis-xipho pre	A						
L0460	TLSO2Mod symphysis-stern pre	A						
L0462	TLSO 3Mod sacro-scap pre	A						
L0464	TLSO 4Mod sacro-scap pre	A						
L0466	TLSO rigid frame pre soft ap	A						
L0468	TLSO rigid frame prefab pelv	A						
L0470	TLSO rigid frame pre subclav	A						
L0472	TLSO rigid frame hyperex pre	A						
L0480	TLSO rigid plastic custom fa	A						
L0482	TLSO rigid lined custom fab	A						
L0484	TLSO rigid plastic cust fab	A						
L0486	TLSO rigidlined cust fab two	A						
L0488	TLSO rigid lined pre one pie	A						
L0490	TLSO rigid plastic pre one	A						
L0491	TLSO 2 piece rigid shell	A						
L0492	TLSO 3 piece rigid shell	A						
L0621	SIO flex pelvisacral prefab	A						
L0622	SIO flex pelvisacral custom	A						
L0623	SIO panel prefab	A						
L0624	SIO panel custom	A						
L0625	LO flexibl L1-below L5 pre	A						
L0626	LO sag stays/panels pre-fab	A						
L0627	LO sagitt rigid panel prefab	A						
L0628	LO flex w/o rigid stays pre	A						
L0629	LSO flex w/rigid stays cust	A						
L0630	LSO post rigid panel pre	A						
L0631	LSO sag-coro rigid frame pre	A						
L0632	LSO sag rigid frame cust	A						
L0633	LSO flexion control prefab	A						
L0634	LSO flexion control custom	A						
L0635	LSO sagit rigid panel prefab	A						
L0636	LSO sagittal rigid panel cus	A						
L0637	LSO sag-coronal panel prefab	A						
L0638	LSO sag-coronal panel custom	A						
L0639	LSO s/c shell/panel prefab	A						
L0640	LSO s/c shell/panel custom	A						
L0700	Ctlso a-p-l control molded	A						
L0710	Ctlso a-p-l control w/ inter	A						
L0810	Halo cervical into jckt vest	A						
L0820	Halo cervical into body jack	A						
L0830	Halo cerv into milwaukee typ	A						
L0859	MRI compatible system	A						
L0861	Halo repl liner/interface	A						
L0970	Tlso corset front	A						
L0972	Lso corset front	A						
L0974	Tlso full corset	A						
L0976	Lso full corset	A						
L0978	Axillary crutch extension	A						
L0980	Peroneal straps pair	A						
L0982	Stocking supp grips set of f	A						
L0984	Protective body sock each	A						
L0999	Add to spinal orthosis NOS	A						
L1000	Ctlso milwauke initial model	A						
L1001	CTLSO infant immobilizer	A						
L1005	Tension based scoliosis orth	A						

L1010	Ctlso axilla sling	A						
L1020	Kyphosis pad	A						
L1025	Kyphosis pad floating	A						
L1030	Lumbar bolster pad	A						
L1040	Lumbar or lumbar rib pad	A						
L1050	Sternal pad	A						
L1060	Thoracic pad	A						
L1070	Trapezius sling	A						
L1080	Outrigger	A						
L1085	Outrigger bil w/ vert extens	A						
L1090	Lumbar sling	A						
L1100	Ring flange plastic/leather	A						
L1110	Ring flange plas/leather mol	A						
L1120	Covers for upright each	A						
L1200	Furnsh initial orthosis only	A						
L1210	Lateral thoracic extension	A						
L1220	Anterior thoracic extension	A						
L1230	Milwaukee type superstructur	A						
L1240	Lumbar derotation pad	A						
L1250	Anterior asis pad	A						
L1260	Anterior thoracic derotation	A						
L1270	Abdominal pad	A						
L1280	Rib gusset (elastic) each	A						
L1290	Lateral trochanteric pad	A						
L1300	Body jacket mold to patient	A						
L1310	Post-operative body jacket	A						
L1499	Spinal orthosis NOS	A						
L1500	Thkao mobility frame	A						
L1510	Thkao standing frame	A						
L1520	Thkao swivel walker	A						
L1600	Abduct hip flex frejka w cvr	A						

L1610	Abduct hip flex frejka covr	A						
L1620	Abduct hip flex pavlik harne	A						
L1630	Abduct control hip semi-flex	A						
L1640	Pelv band/spread bar thigh c	A						
L1650	HO abduction hip adjustable	A						
L1652	HO bi thighcuffs w sprdr bar	A						
L1660	HO abduction static plastic	A						
L1680	Pelvic & hip control thigh c	A						
L1685	Post-op hip abduct custom fa	A						
L1686	HO post-op hip abduction	A						
L1690	Combination bilateral HO	A						
L1700	Leg perthes orth toronto typ	A						
L1710	Legg perthes orth newington	A						
L1720	Legg perthes orthosis trilat	A						
L1730	Legg perthes orth scottish r	A						
L1755	Legg perthes patten bottom t	A						
L1810	Ko elastic with joints	A						
L1820	Ko elas w/ condyle pads & jo	A						
L1830	Ko immobilizer canvas longit	A						
L1831	Knee orth pos locking joint	A						
L1832	KO adj jnt pos rigid support	A						
L1834	Ko w/0 joint rigid molded to	A						
L1836	Rigid KO wo joints	A						
L1840	Ko derot ant cruciate custom	A						
L1843	KO single upright custom fit	A						
L1844	Ko w/adj jt rot cntrl molded	A						
L1845	Ko w/ adj flex/ext rotat cus	A						
L1846	Ko w adj flex/ext rotat mold	A						
L1847	KO adjustable w air chambers	A						
L1850	Ko swedish type	A						
L1860	Ko supracondylar socket mold	A						

L1900	Afo sprng wir drsflx calf bd	A						
L1902	Afo ankle gauntlet	A						
L1904	Afo molded ankle gauntlet	A						
L1906	Afo multiligamentus ankle su	A						
L1907	AFO supramalleolar custom	A						
L1910	Afo sing bar clasp attach sh	A						
L1920	Afo sing upright w/ adjust s	A						
L1930	Afo plastic	A						
L1932	Afo rig ant tib prefab TCF/=	A						
L1940	Afo molded to patient plasti	A						
L1945	Afo molded plas rig ant tib	A						
L1950	Afo spiral molded to pt plas	A						
L1951	AFO spiral prefabricated	A						
L1960	Afo pos solid ank plastic mo	A						
L1970	Afo plastic molded w/ankle j	A						
L1971	AFO w/ankle joint, prefab	A						
L1980	Afo sing solid stirrup calf	A						
L1990	Afo doub solid stirrup calf	A						
L2000	Kafo sing fre stirr thi/calf	A						
L2005	KAFO sng/dbl mechanical act	A						
L2010	Kafo sng solid stirrup w/o j	A						
L2020	Kafo dbl solid stirrup band/	A						
L2030	Kafo dbl solid stirrup w/o j	A						
L2034	KAFO pla sin up w/wo k/a cus	A						
L2035	KAFO plastic pediatric size	A						
L2036	Kafo plas doub free knee mol	A						
L2037	Kafo plas sing free knee mol	A						
L2038	Kafo w/o joint multi-axis an	A						
L2040	Hkafo torsion bil rot straps	A						
L2050	Hkafo torsion cable hip pelv	A						
L2060	Hkafo torsion ball bearing j	A						

L2070	Hkafo torsion unilat rot str	A						
L2080	Hkafo unilat torsion cable	A						
L2090	Hkafo unilat torsion ball br	A						
L2106	Afo tib fx cast plaster mold	A						
L2108	Afo tib fx cast molded to pt	A						
L2112	Afo tibial fracture soft	A						
L2114	Afo tib fx semi-rigid	A						
L2116	Afo tibial fracture rigid	A						
L2126	Kafo fem fx cast thermoplas	A						
L2128	Kafo fem fx cast molded to p	A						
L2132	Kafo femoral fx cast soft	A						
L2134	Kafo fem fx cast semi-rigid	A						
L2136	Kafo femoral fx cast rigid	A						
L2180	Plas shoe insert w ank joint	A						
L2182	Drop lock knee	A						
L2184	Limited motion knee joint	A						
L2186	Adj motion knee jnt lerman t	A						
L2188	Quadrilateral brim	A						
L2190	Waist belt	A						
L2192	Pelvic band & belt thigh fla	A						
L2200	Limited ankle motion ea jnt	A						
L2210	Dorsiflexion assist each joi	A						
L2220	Dorsi & plantar flex ass/res	A						
L2230	Split flat caliper stirr & p	A						
L2232	Rocker bottom, contact AFO	A						
L2240	Round caliper and plate atta	A						
L2250	Foot plate molded stirrup at	A						
L2260	Reinforced solid stirrup	A						
L2265	Long tongue stirrup	A						
L2270	Varus/valgus strap padded/li	A						
L2275	Plastic mod low ext pad/line	A						

L2280	Molded inner boot	A						
L2300	Abduction bar jointed adjust	A						
L2310	Abduction bar-straight	A						
L2320	Non-molded lacer	A						
L2330	Lacer molded to patient mode	A						
L2335	Anterior swing band	A						
L2340	Pre-tibial shell molded to p	A						
L2350	Prosthetic type socket molde	A						
L2360	Extended steel shank	A						
L2370	Patten bottom	A						
L2375	Torsion ank & half solid sti	A						
L2380	Torsion straight knee joint	A						
L2385	Straight knee joint heavy du	A						
L2387	Add LE poly knee custom KAFO	A						
L2390	Offset knee joint each	A						
L2395	Offset knee joint heavy duty	A						
L2397	Suspension sleeve lower ext	A						
L2405	Knee joint drop lock ea jnt	A						
L2415	Knee joint cam lock each joi	A						
L2425	Knee disc/dial lock/adj flex	A						
L2430	Knee jnt ratchet lock ea jnt	A						
L2492	Knee lift loop drop lock rin	A						
L2500	Thi/glut/ischia wgt bearing	A						
L2510	Th/wght bear quad-lat brim m	A						
L2520	Th/wght bear quad-lat brim c	A						
L2525	Th/wght bear nar m-l brim mo	A						
L2526	Th/wght bear nar m-l brim cu	A						
L2530	Thigh/wght bear lacer non-mo	A						
L2540	Thigh/wght bear lacer molded	A						
L2550	Thigh/wght bear high roll cu	A						
L2570	Hip clevis type 2 posit jnt	A						
L2580	Pelvic control pelvic sling	A						
L2600	Hip clevis/thrust bearing fr	A						
L2610	Hip clevis/thrust bearing lo	A						
L2620	Pelvic control hip heavy dut	A						
L2622	Hip joint adjustable flexion	A						
L2624	Hip adj flex ext abduct cont	A						
L2627	Plastic mold recipro hip & c	A						
L2628	Metal frame recipro hip & ca	A						
L2630	Pelvic control band & belt u	A						
L2640	Pelvic control band & belt b	A						
L2650	Pelv & thor control gluteal	A						
L2660	Thoracic control thoracic ba	A						
L2670	Thorac cont paraspinal uprig	A						
L2680	Thorac cont lat support upri	A						
L2750	Plating chrome/nickel pr bar	A						
L2755	Carbon graphite lamination	A						
L2760	Extension per extension per	A						
L2768	Ortho sidebar disconnect	A						
L2780	Non-corrosive finish	A						
L2785	Drop lock retainer each	A						
L2795	Knee control full kneecap	A						
L2800	Knee cap medial or lateral p	A						
L2810	Knee control condylar pad	A						
L2820	Soft interface below knee se	A						
L2830	Soft interface above knee se	A						
L2840	Tibial length sock fx or equ	A						
L2850	Femoral lgth sock fx or equa	A						
L2861	Torsion mechanism knee/ankle	E						
L2999	Lower extremity orthosis NOS	A						
L3000	Ft insert ucb berkeley shell	A						
L3001	Foot insert remov molded spe	A						

L3002	Foot insert plastazote or eq	A						
L3003	Foot insert silicone gel eac	A						
L3010	Foot longitudinal arch suppo	A						
L3020	Foot longitud/metatarsal sup	A						
L3030	Foot arch support removprem	A						
L3031	Foot lamin/prepreg composite	A						
L3040	Ft arch suprt premold longit	A						
L3050	Foot arch supp premold metat	A						
L3060	Foot arch supp longitud/meta	A						
L3070	Arch suprt att to sho longit	A						
L3080	Arch supp att to shoe metata	A						
L3090	Arch supp att to shoe long/m	A						
L3100	Hallus-valgus nght dynamic s	A						
L3140	Abduction rotation bar shoe	A						
L3150	Abduct rotation bar w/o shoe	A						
L3160	Shoe styled positioning dev	A						
L3170	Foot plastic heel stabilizer	A						
L3201	Oxford w supinat/pronat inf	A						
L3202	Oxford w/ supinat/pronator c	A						
L3203	Oxford w/ supinator/pronator	A						
L3204	Hightop w/ supp/pronator inf	A						
L3206	Hightop w/ supp/pronator chi	A						
L3207	Hightop w/ supp/pronator jun	A						
L3208	Surgical boot each infant	A						
L3209	Surgical boot each child	A						
L3211	Surgical boot each junior	A						
L3212	Benesch boot pair infant	A						
L3213	Benesch boot pair child	A						
L3214	Benesch boot pair junior	A						
L3215	Orthopedic ftwear ladies oxf	E						
L3216	Orthoped ladies shoes dpth i	E						
L3217	Ladies shoes hightop depth i	E						
L3219	Orthopedic mens shoes oxford	E						
L3221	Orthopedic mens shoes dpth i	E						
L3222	Mens shoes hightop depth inl	E						
L3224	Woman's shoe oxford brace	A						
L3225	Man's shoe oxford brace	A						
L3230	Custom shoes depth inlay	A						
L3250	Custom mold shoe removprost	A						
L3251	Shoe molded to pt silicone s	A						
L3252	Shoe molded plastazote cust	A						
L3253	Shoe molded plastazote cust	A						
L3254	Orth foot non-stndard size/w	A						
L3255	Orth foot non-standard size/	A						
L3257	Orth foot add charge split s	A						
L3260	Ambulatory surgical boot eac	E						
L3265	Plastazote sandal each	A						
L3300	Sho lift taper to metatarsal	A						
L3310	Shoe lift elev heel/sole neo	A						
L3320	Shoe lift elev heel/sole cor	A						
L3330	Lifts elevation metal extens	A						
L3332	Shoe lifts tapered to one-ha	A						
L3334	Shoe lifts elevation heel /i	A						
L3340	Shoe wedge sach	A						
L3350	Shoe heel wedge	A						
L3360	Shoe sole wedge outside sole	A						
L3370	Shoe sole wedge between sole	A						
L3380	Shoe clubfoot wedge	A						
L3390	Shoe outflare wedge	A						
L3400	Shoe metatarsal bar wedge ro	A						
L3410	Shoe metatarsal bar between	A						
L3420	Full sole/heel wedge btween	A						

L3430	Sho heel count plast reinfor	A						
L3440	Heel leather reinforced	A						
L3450	Shoe heel sach cushion type	A						
L3455	Shoe heel new leather standa	A						
L3460	Shoe heel new rubber standar	A						
L3465	Shoe heel thomas with wedge	A						
L3470	Shoe heel thomas extend to b	A						
L3480	Shoe heel pad & depress for	A						
L3485	Shoe heel pad removable for	A						
L3500	Ortho shoe add leather insol	A						
L3510	Orthopedic shoe add rub insl	A						
L3520	O shoe add felt w leath insl	A						
L3530	Ortho shoe add half sole	A						
L3540	Ortho shoe add full sole	A						
L3550	O shoe add standard toe tap	A						
L3560	O shoe add horseshoe toe tap	A						
L3570	O shoe add instep extension	A						
L3580	O shoe add instep velcro clo	A						
L3590	O shoe convert to sof counte	A						
L3595	Ortho shoe add march bar	A						
L3600	Trans shoe calip plate exist	A						
L3610	Trans shoe caliper plate new	A						
L3620	Trans shoe solid stirrup exi	A						
L3630	Trans shoe solid stirrup new	A						
L3640	Shoe dennis browne splint bo	A						
L3649	Orthopedic shoe modifica NOS	A						
L3650	Shlder fig 8 abduct restrain	A						
L3660	Abduct restrainer canvas&web	A						
L3670	Acromio/clavicular canvas&we	A						
L3671	SO cap design w/o jnts CF	A						
L3672	SO airplane w/o jnts CF	A						
L3673	SO airplane w/joint CF	A						
L3675	Canvas vest SO	A						
L3677	SO hard plastic stabilizer	E						
L3702	EO w/o joints CF	A						
L3710	Elbow elastic with metal joi	A						
L3720	Forearm/arm cuffs free motio	A						
L3730	Forearm/arm cuffs ext/flex a	A						
L3740	Cuffs adj lock w/ active con	A						
L3760	EO withjoint, Prefabricated	A						
L3762	Rigid EO wo joints	A						
L3763	EWHO rigid w/o jnts CF	A						
L3764	EWHO w/joint(s) CF	A						
L3765	EWHFO rigid w/o jnts CF	A						
L3766	EWHFO w/joint(s) CF	A						
L3806	WHFO w/joint(s) custom fab	A						
L3807	WHFO,no joint, prefabricated	A						
L3808	WHFO, rigid w/o joints	A						
L3891	Torsion mechanism wrist/elbo	E						
L3900	Hinge extension/flex wrist/f	A						
L3901	Hinge ext/flex wrist finger	A						
L3904	Whfo electric custom fitted	A						
L3905	WHO w/nontorsion jnt(s) CF	A						
L3906	WHO w/o joints CF	A						
L3908	Wrist cock-up non-molded	A						
L3912	Flex glove w/elastic finger	A						
L3913	HFO w/o joints CF	A						
L3915	WHO w nontor jnt(s) prefab	A						
L3917	Prefab metacarpl fx orthosis	A						
L3919	HO w/o joints CF	A						
L3921	HFO w/joint(s) CF	A						
L3923	HFO w/o joints PF	A						

L3925	FO pip/dip with joint/spring	A						
L3927	FO pip/dip w/o joint/spring	A						
L3929	HFO nontorsion joint, prefab	A						
L3931	WHFO nontorsion joint prefab	A						
L3933	FO w/o joints CF	A						
L3935	FO nontorsion joint CF	A						
L3956	Add joint upper ext orthosis	A						
L3960	Sewho airplan desig abdu pos	A						
L3961	SEWHO cap design w/o jnts CF	A						
L3962	Sewho erbs palsey design abd	A						
L3964	Seo mobile arm sup att to wc	Y						
L3965	Arm supp att to wc rancho ty	Y						
L3966	Mobile arm supports reclinin	Y						
L3967	SEWHO airplane w/o jnts CF	A						
L3968	Friction dampening arm supp	Y						
L3969	Monosuspension arm/hand supp	Y						
L3970	Elevat proximal arm support	Y						
L3971	SEWHO cap design w/jnt(s) CF	A						
L3972	Offset/lat rocker arm w/ ela	Y						
L3973	SEWHO airplane w/jnt(s) CF	A						
L3974	Mobile arm support supinator	Y						
L3975	SEWHFO cap design w/o jnt CF	A						
L3976	SEWHFO airplane w/o jnts CF	A						
L3977	SEWHFO cap desgn w/jnt(s) CF	A						
L3978	SEWHFO airplane w/jnt(s) CF	A						
L3980	Upp ext fx orthosis humeral	A						
L3982	Upper ext fx orthosis rad/ul	A						
L3984	Upper ext fx orthosis wrist	A						
L3995	Sock fracture or equal each	A						
L3999	Upper limb orthosis NOS	A						
L4000	Repl girdle milwaukee orth	A						

L4002	Replace strap, any orthosis	A						
L4010	Replace trilateral socket br	A						
L4020	Replace quadlat socket brim	A						
L4030	Replace socket brim cust fit	A						
L4040	Replace molded thigh lacer	A						
L4045	Replace non-molded thigh lac	A						
L4050	Replace molded calf lacer	A						
L4055	Replace non-molded calf lace	A						
L4060	Replace high roll cuff	A						
L4070	Replace prox & dist upright	A						
L4080	Repl met band kafo-afo prox	A						
L4090	Repl met band kafo-afo calf/	A						
L4100	Repl leath cuff kafo prox th	A						
L4110	Repl leath cuff kafo-afo cal	A						
L4130	Replace pretibial shell	A						
L4205	Ortho dvc repair per 15 min	A						
L4210	Orth dev repair/repl minor p	A						
L4350	Ankle control orthosi prefab	A						
L4360	Pneumati walking boot prefab	A						
L4370	Pneumatic full leg splint	A						
L4380	Pneumatic knee splint	A						
L4386	Non-pneum walk boot prefab	A						
L4392	Replace AFO soft interface	A						
L4394	Replace foot drop spint	A						
L4396	Static AFO	A						
L4398	Foot drop splint recumbent	A						
L5000	Sho insert w arch toe filler	A						
L5010	Mold socket ank hgt w/ toe f	A						
L5020	Tibial tubercle hgt w/ toe f	A						
L5050	Ank symes mold sckt sach ft	A						
L5060	Symes met fr leath socket ar	A						

L5100	Molded socket shin sach foot	A						
L5105	Plast socket jts/thgh lacer	A						
L5150	Mold sckt ext knee shin sach	A						
L5160	Mold socket bent knee shin s	A						
L5200	Kne sing axis fric shin sach	A						
L5210	No knee/ankle joints w/ ft b	A						
L5220	No knee joint with artic ali	A						
L5230	Fem focal defic constant fri	A						
L5250	Hip canad sing axi cons fric	A						
L5270	Tilt table locking hip sing	A						
L5280	Hemipelvect canad sing axis	A						
L5301	BK mold socket SACH ft endo	A						
L5311	Knee disart, SACH ft, endo	A						
L5321	AK open end SACH	A						
L5331	Hip disart canadian SACH ft	A						
L5341	Hemipelvectomy canadian SACH	A						
L5400	Postop dress & 1 cast chg bk	A						
L5410	Postop dsg bk ea add cast ch	A						
L5420	Postop dsg & 1 cast chg ak/d	A						
L5430	Postop dsg ak ea add cast ch	A						
L5450	Postop app non-wgt bear dsg	A						
L5460	Postop app non-wgt bear dsg	A						
L5500	Init bk ptb plaster direct	A						
L5505	Init ak ischal plstr direct	A						
L5510	Prep BK ptb plaster molded	A						
L5520	Perp BK ptb thermopls direct	A						
L5530	Prep BK ptb thermopls molded	A						
L5535	Prep BK ptb open end socket	A						
L5540	Prep BK ptb laminated socket	A						
L5560	Prep AK ischial plast molded	A						
L5570	Prep AK ischial direct form	A						
L5580	Prep AK ischial thermo mold	A						
L5585	Prep AK ischial open end	A						
L5590	Prep AK ischial laminated	A						
L5595	Hip disartic sach thermopls	A						
L5600	Hip disart sach laminat mold	A						
L5610	Above knee hydracadence	A						
L5611	Ak 4 bar link w/fric swing	A						
L5613	Ak 4 bar ling w/hydraul swig	A						
L5614	4-bar link above knee w/swng	A						
L5616	Ak univ multiplex sys frict	A						
L5617	AK/BK self-aligning unit ea	A						
L5618	Test socket symes	A						
L5620	Test socket below knee	A						
L5622	Test socket knee disarticula	A						
L5624	Test socket above knee	A						
L5626	Test socket hip disarticulat	A						
L5628	Test socket hemipelvectomy	A						
L5629	Below knee acrylic socket	A						
L5630	Syme typ expandabl wall sckt	A						
L5631	Ak/knee disartic acrylic soc	A						
L5632	Symes type ptb brim design s	A						
L5634	Symes type poster opening so	A						
L5636	Symes type medial opening so	A						
L5637	Below knee total contact	A						
L5638	Below knee leather socket	A						
L5639	Below knee wood socket	A						
L5640	Knee disarticulat leather so	A						
L5642	Above knee leather socket	A						
L5643	Hip flex inner socket ext fr	A						
L5644	Above knee wood socket	A						
L5645	Bk flex inner socket ext fra	A						

L5646	Below knee cushion socket	A						
L5647	Below knee suction socket	A						
L5648	Above knee cushion socket	A						
L5649	Isch containmt/narrow m-l so	A						
L5650	Tot contact ak/knee disart s	A						
L5651	Ak flex inner socket ext fra	A						
L5652	Suction susp ak/knee disart	A						
L5653	Knee disart expand wall sock	A						
L5654	Socket insert symes	A						
L5655	Socket insert below knee	A						
L5656	Socket insert knee articulat	A						
L5658	Socket insert above knee	A						
L5661	Multi-durometer symes	A						
L5665	Multi-durometer below knee	A						
L5666	Below knee cuff suspension	A						
L5668	Socket insert w/o lock lower	A						
L5670	Bk molded supracondylar susp	A						
L5671	BK/AK locking mechanism	A						
L5672	Bk removable medial brim sus	A						
L5673	Socket insert w lock mech	A						
L5676	Bk knee joints single axis p	A						
L5677	Bk knee joints polycentric p	A						
L5678	Bk joint covers pair	A						
L5679	Socket insert w/o lock mech	A						
L5680	Bk thigh lacer non-molded	A						
L5681	Intl custm cong/latyp insert	A						
L5682	Bk thigh lacer glut/ischia m	A						
L5683	Initial custom socket insert	A						
L5684	Bk fork strap	A						
L5685	Below knee sus/seal sleeve	A						
L5686	Bk back check	A						

L5688	Bk waist belt webbing	A						
L5690	Bk waist belt padded and lin	A						
L5692	Ak pelvic control belt light	A						
L5694	Ak pelvic control belt pad/l	A						
L5695	Ak sleeve susp neoprene/equa	A						
L5696	Ak/knee disartic pelvic join	A						
L5697	Ak/knee disartic pelvic band	A						
L5698	Ak/knee disartic silesian ba	A						
L5699	Shoulder harness	A						
L5700	Replace socket below knee	A						
L5701	Replace socket above knee	A						
L5702	Replace socket hip	A						
L5703	Symes ankle w/o (SACH) foot	A						
L5704	Custom shape cover BK	A						
L5705	Custom shape cover AK	A						
L5706	Custom shape cvr knee disart	A						
L5707	Custom shape cvr hip disart	A						
L5710	Kne-shin exo sng axi mnl loc	A						
L5711	Knee-shin exo mnl lock ultra	A						
L5712	Knee-shin exo frict swg & st	A						
L5714	Knee-shin exo variable frict	A						
L5716	Knee-shin exo mech stance ph	A						
L5718	Knee-shin exo frct swg & sta	A						
L5722	Knee-shin pneum swg frct exo	A						
L5724	Knee-shin exo fluid swing ph	A						
L5726	Knee-shin ext jnts fld swg e	A						
L5728	Knee-shin fluid swg & stance	A						
L5780	Knee-shin pneum/hydra pneum	A						
L5781	Lower limb pros vacuum pump	A						
L5782	HD low limb pros vacuum pump	A						
L5785	Exoskeletal bk ultralt mater	A						

L5790	Exoskeletal ak ultra-light m	A						
L5795	Exoskel hip ultra-light mate	A						
L5810	Endoskel knee-shin mnl lock	A						
L5811	Endo knee-shin mnl lck ultra	A						
L5812	Endo knee-shin frct swg & st	A						
L5814	Endo knee-shin hydral swg ph	A						
L5816	Endo knee-shin polyc mch sta	A						
L5818	Endo knee-shin frct swg & st	A						
L5822	Endo knee-shin pneum swg frc	A						
L5824	Endo knee-shin fluid swing p	A						
L5826	Miniature knee joint	A						
L5828	Endo knee-shin fluid swg/sta	A						
L5830	Endo knee-shin pneum/swg pha	A						
L5840	Multi-axial knee/shin system	A						
L5845	Knee-shin sys stance flexion	A						
L5848	Knee-shin sys hydraul stance	A						
L5850	Endo ak/hip knee extens assi	A						
L5855	Mech hip extension assist	A						
L5856	Elec knee-shin swing/stance	A						
L5857	Elec knee-shin swing only	A						
L5858	Stance phase only	A						
L5910	Endo below knee alignable sy	A						
L5920	Endo ak/hip alignable system	A						
L5925	Above knee manual lock	A						
L5930	High activity knee frame	A						
L5940	Endo bk ultra-light material	A						
L5950	Endo ak ultra-light material	A						
L5960	Endo hip ultra-light materia	A						
L5962	Below knee flex cover system	A						
L5964	Above knee flex cover system	A						
L5966	Hip flexible cover system	A						

L5968	Multiaxial ankle w dorsiflex	A						
L5970	Foot external keel sach foot	A						
L5971	SACH foot, replacement	A						
L5972	Flexible keel foot	A						
L5973	Ank-foot sys dors-plant flex	A						
L5974	Foot single axis ankle/foot	A						
L5975	Combo ankle/foot prosthesis	A						
L5976	Energy storing foot	A						
L5978	Ft prosth multiaxial ankl/ft	A						
L5979	Multi-axial ankle/ft prosth	A						
L5980	Flex foot system	A						
L5981	Flex-walk sys low ext prosth	A						
L5982	Exoskeletal axial rotation u	A						
L5984	Endoskeletal axial rotation	A						
L5985	Lwr ext dynamic prosth pylon	A						
L5986	Multi-axial rotation unit	A						
L5987	Shank ft w vert load pylon	A						
L5988	Vertical shock reducing pylo	A						
L5990	User adjustable heel height	A						
L5999	Lowr extremity prosthes NOS	A						
L6000	Par hand robin-aids thum rem	A						
L6010	Hand robin-aids little/ring	A						
L6020	Part hand robin-aids no fing	A						
L6025	Part hand disart myoelectric	A						
L6050	Wrst MLd sck flx hng tri pad	A						
L6055	Wrst mold sock w/exp interfa	A						
L6100	Elb mold sock flex hinge pad	A						
L6110	Elbow mold sock suspension t	A						
L6120	Elbow mold doub splt soc ste	A						
L6130	Elbow stump activated lock h	A						
L6200	Elbow mold outsid lock hinge	A						

L6205	Elbow molded w/ expand inter	A						
L6250	Elbow inter loc elbow forarm	A						
L6300	Shlder disart int lock elbow	A						
L6310	Shoulder passive restor comp	A						
L6320	Shoulder passive restor cap	A						
L6350	Thoracic intern lock elbow	A						
L6360	Thoracic passive restor comp	A						
L6370	Thoracic passive restor cap	A						
L6380	Postop dsg cast chg wrst/elb	A						
L6382	Postop dsg cast chg elb dis/	A						
L6384	Postop dsg cast chg shlder/t	A						
L6386	Postop ea cast chg & realign	A						
L6388	Postop applicat rigid dsg on	A						
L6400	Below elbow prosth tiss shap	A						
L6450	Elb disart prosth tiss shap	A						
L6500	Above elbow prosth tiss shap	A						
L6550	Shldr disar prosth tiss shap	A						
L6570	Scap thorac prosth tiss shap	A						
L6580	Wrist/elbow bowden cable mol	A						
L6582	Wrist/elbow bowden cbl dir f	A						
L6584	Elbow fair lead cable molded	A						
L6586	Elbow fair lead cable dir fo	A						
L6588	Shdr fair lead cable molded	A						
L6590	Shdr fair lead cable direct	A						
L6600	Polycentric hinge pair	A						
L6605	Single pivot hinge pair	A						
L6610	Flexible metal hinge pair	A						
L6611	Additional switch, ext power	A						
L6615	Disconnect locking wrist uni	A						
L6616	Disconnect insert locking wr	A						
L6620	Flexion/extension wrist unit	A						

L6621	Flex/ext wrist w/wo friction	A						
L6623	Spring-ass rot wrst w/ latch	A						
L6624	Flex/ext/rotation wrist unit	A						
L6625	Rotation wrst w/ cable lock	A						
L6628	Quick disconn hook adapter o	A						
L6629	Lamination collar w/ couplin	A						
L6630	Stainless steel any wrist	A						
L6632	Latex suspension sleeve each	A						
L6635	Lift assist for elbow	A						
L6637	Nudge control elbow lock	A						
L6638	Elec lock on manual pw elbow	A						
L6640	Shoulder abduction joint pai	A						
L6641	Excursion amplifier pulley t	A						
L6642	Excursion amplifier lever ty	A						
L6645	Shoulder flexion-abduction j	A						
L6646	Multipo locking shoulder jnt	A						
L6647	Shoulder lock actuator	A						
L6648	Ext pwrd shlder lock/unlock	A						
L6650	Shoulder universal joint	A						
L6655	Standard control cable extra	A						
L6660	Heavy duty control cable	A						
L6665	Teflon or equal cable lining	A						
L6670	Hook to hand cable adapter	A						
L6672	Harness chest/shlder saddle	A						
L6675	Harness figure of 8 sing con	A						
L6676	Harness figure of 8 dual con	A						
L6677	UE triple control harness	A						
L6680	Test sock wrist disart/bel e	A						
L6682	Test sock elbw disart/above	A						
L6684	Test socket shldr disart/tho	A						
L6686	Suction socket	A						

L6687	Frame typ socket bel elbow/w	A						
L6688	Frame typ sock above elb/dis	A						
L6689	Frame typ socket shoulder di	A						
L6690	Frame typ sock interscap-tho	A						
L6691	Removable insert each	A						
L6692	Silicone gel insert or equal	A						
L6693	Lockingelbow forearm cntrbal	A						
L6694	Elbow socket ins use w/lock	A						
L6695	Elbow socket ins use w/o lck	A						
L6696	Cus elbo skt in for con/atyp	A						
L6697	Cus elbo skt in not con/atyp	A						
L6698	Below/above elbow lock mech	A						
L6703	Term dev, passive hand mitt	A						
L6704	Term dev, sport/rec/work att	A						
L6706	Term dev mech hook vol open	A						
L6707	Term dev mech hook vol close	A						
L6708	Term dev mech hand vol open	A						
L6709	Term dev mech hand vol close	A						
L6711	Ped term dev, hook, vol open	A						
L6712	Ped term dev, hook, vol clos	A						
L6713	Ped term dev, hand, vol open	A						
L6714	Ped term dev, hand, vol clos	A						
L6721	Hook/hand, hvy dty, vol open	A						
L6722	Hook/hand, hvy dty, vol clos	A						
L6805	Term dev modifier wrist unit	A						
L6810	Term dev precision pinch dev	A						
L6881	Term dev auto grasp feature	A						
L6882	Microprocessor control uplmb	A						
L6883	Replc sockt below e/w disa	A						
L6884	Replc sockt above elbow disa	A						
L6885	Replc sockt shldr dis/interc	A						

L6890	Prefab glove for term device	A						
L6895	Custom glove for term device	A						
L6900	Hand restorat thumb/1 finger	A						
L6905	Hand restoration multiple fi	A						
L6910	Hand restoration no fingers	A						
L6915	Hand restoration replacmnt g	A						
L6920	Wrist disarticul switch ctrl	A						
L6925	Wrist disart myoelectronic c	A						
L6930	Below elbow switch control	A						
L6935	Below elbow myoelectronic ct	A						
L6940	Elbow disarticulation switch	A						
L6945	Elbow disart myoelectronic c	A						
L6950	Above elbow switch control	A						
L6955	Above elbow myoelectronic ct	A						
L6960	Shldr disartic switch contro	A						
L6965	Shldr disartic myoelectronic	A						
L6970	Interscapular-thor switch ct	A						
L6975	Interscap-thor myoelectronic	A						
L7007	Adult electric hand	A						
L7008	Pediatric electric hand	A						
L7009	Adult electric hook	A						
L7040	Prehensile actuator	A						
L7045	Pediatric electric hook	A						
L7170	Electronic elbow hosmer swit	A						
L7180	Electronic elbow sequential	A						
L7181	Electronic elbo simultaneous	A						
L7185	Electron elbow adolescent sw	A						
L7186	Electron elbow child switch	A						
L7190	Elbow adolescent myoelectron	A						
L7191	Elbow child myoelectronic ct	A						
L7260	Electron wrist rotator otto	A						

L7261	Electron wrist rotator utah	A						
L7266	Servo control steeper or equ	A						
L7272	Analogue control unb or equa	A						
L7274	Proportional ctl 12 volt uta	A						
L7360	Six volt bat otto bock/eq ea	A						
L7362	Battery chrgr six volt otto	A						
L7364	Twelve volt battery utah/equ	A						
L7366	Battery chrgr 12 volt utah/e	A						
L7367	Replacemnt lithium ionbatter	A						
L7368	Lithium ion battery charger	A						
L7400	Add UE prost be/wd, ultlite	A						
L7401	Add UE prost a/e ultlite mat	A						
L7402	Add UE prost s/d ultlite mat	A						
L7403	Add UE prost b/e acrylic	A						
L7404	Add UE prost a/e acrylic	A						
L7405	Add UE prost s/d acrylic	A						
L7499	Upper extremity prosthes NOS	A						
L7500	Prosthetic dvc repair hourly	A						
L7510	Prosthetic device repair rep	A						
L7520	Repair prosthesis per 15 min	A						
L7600	Prosthetic donning sleeve	E						
L7900	Male vacuum erection system	A						
L8000	Mastectomy bra	A						
L8001	Breast prosthesis bra & form	A						
L8002	Brst prsth bra & bilat form	A						
L8010	Mastectomy sleeve	A						
L8015	Ext breastprosthesis garment	A						
L8020	Mastectomy form	A						
L8030	Breast prosthes w/o adhesive	A						
L8031	Breast prosthesis w adhesive	A						
L8032	Reusable nipple prosthesis	A						

L8035	Custom breast prosthesis	A						
L8039	Breast prosthesis NOS	A						
L8040	Nasal prosthesis	A						
L8041	Midfacial prosthesis	A						
L8042	Orbital prosthesis	A						
L8043	Upper facial prosthesis	A						
L8044	Hemi-facial prosthesis	A						
L8045	Auricular prosthesis	A						
L8046	Partial facial prosthesis	A						
L8047	Nasal septal prosthesis	A						
L8048	Unspec maxillofacial prosth	A						
L8049	Repair maxillofacial prosth	A						
L8300	Truss single w/ standard pad	A						
L8310	Truss double w/ standard pad	A						
L8320	Truss addition to std pad wa	A						
L8330	Truss add to std pad scrotal	A						
L8400	Sheath below knee	A						
L8410	Sheath above knee	A						
L8415	Sheath upper limb	A						
L8417	Pros sheath/sock w gel cushn	A						
L8420	Prosthetic sock multi ply BK	A						
L8430	Prosthetic sock multi ply AK	A						
L8435	Pros sock multi ply upper lm	A						
L8440	Shrinker below knee	A						
L8460	Shrinker above knee	A						
L8465	Shrinker upper limb	A						
L8470	Pros sock single ply BK	A						
L8480	Pros sock single ply AK	A						
L8485	Pros sock single ply upper l	A						
L8499	Unlisted misc prosthetic ser	A						
L8500	Artificial larynx	A						

L8501	Tracheostomy speaking valve	A						
L8505	Artificial larynx, accessory	A						
L8507	Trach-esoph voice pros pt in	A						
L8509	Trach-esoph voice pros md in	A						
L8510	Voice amplifier	A						
L8511	Indwelling trach insert	A						
L8512	Gel cap for trach voice pros	A						
L8513	Trach pros cleaning device	A						
L8514	Repl trach puncture dilator	A						
L8515	Gel cap app device for trach	A						
L8600	Implant breast silicone/eq	N						
L8603	Collagen imp urinary 2.5 ml	N						
L8604	Dextranomer/hyaluronic acid	N						
L8606	Synthetic implnt urinary 1ml	N						
L8609	Artificial cornea	N						
L8610	Ocular implant	N						
L8612	Aqueous shunt prosthesis	N						
L8613	Ossicular implant	N						
L8614	Cochlear device	N						
L8615	Coch implant headset replace	A						
L8616	Coch implant microphone repl	A						
L8617	Coch implant trans coil repl	A						
L8618	Coch implant tran cable repl	A						
L8619	Coch imp ext proc/contr rplc	A						
L8621	Repl zinc air battery	A						
L8622	Repl alkaline battery	A						
L8623	Lith ion batt CID,non-earlvl	A						
L8624	Lith ion batt CID, ear level	A						
L8627	CID ext speech process repl	A						
L8628	CID ext controller repl	A						
L8629	CID transmit coil and cable	A						
L8630	Metacarpophalangeal implant	N						
L8631	MCP joint repl 2 pc or more	N						
L8641	Metatarsal joint implant	N						
L8642	Hallux implant	N						
L8658	Interphalangeal joint spacer	N						
L8659	Interphalangeal joint repl	N						
L8670	Vascular graft, synthetic	N						
L8680	Implt neurostim elctr each	N						
L8681	Pt prgrm for implt neurostim	A						
L8682	Implt neurostim radiofq rec	N						
L8683	Radiofq trsmtr for implt neu	A						
L8684	Radiof trsmtr implt scrl neu	A						
L8685	Implt nrostm pls gen sng rec	N						
L8686	Implt nrostm pls gen sng non	N						
L8687	Implt nrostm pls gen dua rec	N						
L8688	Implt nrostm pls gen dua non	N						
L8689	External recharg sys intern	A						
L8690	Aud osseo dev, int/ext comp	N						
L8691	Osseointegrated snd proc rpl	A						
L8692	Non-osseointegrated snd proc	E						
L8695	External recharg sys extern	A						
L8699	Prosthetic implant NOS	N						
L9900	O&P supply/accessory/service	N						
M0064	Visit for drug monitoring	Q3	0607	1.683	$113.17		$22.64	*
M0075	Cellular therapy	E						
M0076	Prolotherapy	E						
M0100	Intragastric hypothermia	E						
M0300	IV chelationtherapy	E						
M0301	Fabric wrapping of aneurysm	E						
P2028	Cephalin floculation test	A						
P2029	Congo red blood test	A						

P2031	Hair analysis	E						
P2033	Blood thymol turbidity	A						
P2038	Blood mucoprotein	A						
P3000	Screen pap by tech w md supv	A						
P3001	Screening pap smear by phys	B						
P7001	Culture bacterial urine	E						
P9010	Whole blood for transfusion	R	0950	3.0598	$205.74		$41.15	*
P9011	Blood split unit	R	0967	1.2965	$87.18		$17.44	*
P9012	Cryoprecipitate each unit	R	0952	0.691	$46.46		$9.30	*
P9016	RBC leukocytes reduced	R	0954	2.7703	$186.28		$37.26	*
P9017	Plasma 1 donor frz w/in 8 hr	R	9508	1.1278	$75.83		$15.17	*
P9019	Platelets, each unit	R	0957	0.9882	$66.45		$13.29	*
P9020	Plaelet rich plasma unit	R	0958	2.0294	$136.46		$27.30	*
P9021	Red blood cells unit	R	0959	2.1027	$141.39		$28.28	*
P9022	Washed red blood cells unit	R	0960	3.6495	$245.40		$49.08	*
P9023	Frozen plasma, pooled, sd	R	0949	0.7589	$51.03		$10.21	*
P9031	Platelets leukocytes reduced	R	1013	1.5541	$104.50		$20.90	*
P9032	Platelets, irradiated	R	9500	2.232	$150.08		$30.02	*
P9033	Platelets leukoreduced irrad	R	0968	1.9576	$131.63		$26.33	*
P9034	Platelets, pheresis	R	9507	6.9594	$467.96		$93.60	*
P9035	Platelet pheres leukoreduced	R	9501	7.5974	$510.86		$102.18	*
P9036	Platelet pheresis irradiated	R	9502	5.3105	$357.08		$71.42	*
P9037	Plate pheres leukoredu irrad	R	1019	10.0373	$674.92		$134.99	*
P9038	RBC irradiated	R	9505	3.3499	$225.25		$45.05	*
P9039	RBC deglycerolized	R	9504	5.3988	$363.02		$72.61	*
P9040	RBC leukoreduced irradiated	R	0969	3.635	$244.42		$48.89	*
P9041	Albumin (human),5%, 50ml	K	0961		$16.89		$3.38	
P9043	Plasma protein fract,5%,50ml	R	0956	0.9754	$65.59		$13.12	*
P9044	Cryoprecipitatereducedplasma	R	1009	1.4035	$94.37		$18.88	*
P9045	Albumin (human), 5%, 250 ml	K	0963		$60.58		$12.12	
P9046	Albumin (human), 25%, 20 ml	K	0964		$25.67		$5.13	
P9047	Albumin (human), 25%, 50ml	K	0965		$62.05		$12.41	
P9048	Plasmaprotein fract,5%,250ml	R	0966	1.6017	$107.70		$21.54	*
P9050	Granulocytes, pheresis unit	R	9506	0.6664	$44.81		$8.97	*
P9051	Blood, l/r, cmv-neg	R	1010	2.0076	$134.99		$27.00	*
P9052	Platelets, hla-m, l/r, unit	R	1011	10.929	$734.88		$146.98	*
P9053	Plt, pher, l/r cmv-neg, irr	R	1020	9.7428	$655.12		$131.03	*
P9054	Blood, l/r, froz/degly/wash	R	1016	1.5373	$103.37		$20.68	*
P9055	Plt, aph/pher, l/r, cmv-neg	R	1017	6.2195	$418.21		$83.65	*
P9056	Blood, l/r, irradiated	R	1018	2.4502	$164.75		$32.95	*
P9057	RBC, frz/deg/wsh, l/r, irrad	R	1021	5.3858	$362.15		$72.43	*
P9058	RBC, l/r, cmv-neg, irrad	R	1022	4.3604	$293.20		$58.64	*
P9059	Plasma, frz between 8-24hour	R	0955	1.1491	$77.27		$15.46	*
P9060	Fr frz plasma donor retested	R	9503	1.0664	$71.71		$14.35	*
P9603	One-way allow prorated miles	A						
P9604	One-way allow prorated trip	A						
P9612	Catheterize for urine spec	A						
P9615	Urine specimen collect mult	N						
Q0035	Cardiokymography	X	0100	2.6136	$175.74	$41.44	$35.15	*
Q0081	Infusion ther other than che	B						
Q0083	Chemo by other than infusion	B						
Q0084	Chemotherapy by infusion	B						
Q0085	Chemo by both infusion and o	B						
Q0091	Obtaining screen pap smear	T	0191	0.132	$8.88	$2.08	$1.78	*
Q0092	Set up port xray equipment	N						
Q0111	Wet mounts/ w preparations	A						
Q0112	Potassium hydroxide preps	A						
Q0113	Pinworm examinations	A						
Q0114	Fern test	A						
Q0115	Post-coital mucous exam	A						
Q0138	Ferumoxytol, non-esrd	G	1297		$0.82		$0.16	
Q0139	Ferumoxytol, esrd use	A						

Q0144	Azithromycin dihydrate, oral	E						
Q0163	Diphenhydramine HCl 50mg	N						
Q0164	Prochlorperazine maleate 5mg	N						
Q0165	Prochlorperazine maleate10mg	N						
Q0166	Granisetron hcl 1 mg oral	N						
Q0167	Dronabinol 2.5mg oral	N						
Q0168	Dronabinol 5mg oral	N						
Q0169	Promethazine HCl 12.5mg oral	N						
Q0170	Promethazine HCl 25 mg oral	N						
Q0171	Chlorpromazine HCl 10mg oral	N						
Q0172	Chlorpromazine HCl 25mg oral	N						
Q0173	Trimethobenzamide HCl 250mg	N						
Q0174	Thiethylperazine maleate10mg	N						
Q0175	Perphenazine 4mg oral	N						
Q0176	Perphenazine 8mg oral	N						
Q0177	Hydroxyzine pamoate 25mg	N						
Q0178	Hydroxyzine pamoate 50mg	N						
Q0179	Ondansetron hcl 8 mg oral	N						
Q0180	Dolasetron mesylate oral	N						
Q0181	Unspecified oral anti-emetic	E						
Q0480	Driver pneumatic vad, rep	A						
Q0481	Microprcsr cu elec vad, rep	A						
Q0482	Microprcsr cu combo vad, rep	A						
Q0483	Monitor elec vad, rep	A						
Q0484	Monitor elec or comb vad rep	A						
Q0485	Monitor cable elec vad, rep	A						
Q0486	Mon cable elec/pneum vad rep	A						
Q0487	Leads any type vad, rep only	A						
Q0488	Pwr pack base elec vad, rep	A						
Q0489	Pwr pck base combo vad, rep	A						
Q0490	Emr pwr source elec vad, rep	A						
Q0491	Emr pwr source combo vad rep	A						
Q0492	Emr pwr cbl elec vad, rep	A						
Q0493	Emr pwr cbl combo vad, rep	A						
Q0494	Emr hd pmp elec/combo, rep	A						
Q0495	Charger elec/combo vad, rep	A						
Q0496	Battery elec/combo vad, rep	A						
Q0497	Bat clps elec/comb vad, rep	A						
Q0498	Holster elec/combo vad, rep	A						
Q0499	Belt/vest elec/combo vad rep	A						
Q0500	Filters elec/combo vad, rep	A						
Q0501	Shwr cov elec/combo vad, rep	A						
Q0502	Mobility cart pneum vad, rep	A						
Q0503	Battery pneum vad replacemnt	A						
Q0504	Pwr adpt pneum vad, rep veh	A						
Q0505	Miscl supply/accessory vad	A						
Q0506	Lith-ion batt elec/pneum VAD	A						
Q0510	Dispens fee immunosupressive	B						
Q0511	Sup fee antiem,antica,immuno	B						
Q0512	Px sup fee anti-can sub pres	B						
Q0513	Disp fee inhal drugs/30 days	B						
Q0514	Disp fee inhal drugs/90 days	B						
Q0515	Sermorelin acetate injection	K	3050		$1.77		$0.36	
Q1003	Ntiol category 3	N						
Q1004	Ntiol category 4	E						
Q1005	Ntiol category 5	E						
Q2004	Bladder calculi irrig sol	K	1293		$5.11		$1.02	
Q2009	Fosphenytoin inj PE	N						
Q2017	Teniposide, 50 mg	K	7035		$319.21		$63.84	
Q3001	Brachytherapy Radioelements	B						
Q3014	Telehealth facility fee	A						
Q3025	IM inj interferon beta 1-a	K	9022		$187.31		$37.46	

Q3026	Subc inj interferon beta-1a	E						
Q3031	Collagen skin test	N						
Q4001	Cast sup body cast plaster	B						
Q4002	Cast sup body cast fiberglas	B						
Q4003	Cast sup shoulder cast plstr	B						
Q4004	Cast sup shoulder cast fbrgl	B						
Q4005	Cast sup long arm adult plst	B						
Q4006	Cast sup long arm adult fbrg	B						
Q4007	Cast sup long arm ped plster	B						
Q4008	Cast sup long arm ped fbrgls	B						
Q4009	Cast sup sht arm adult plstr	B						
Q4010	Cast sup sht arm adult fbrgl	B						
Q4011	Cast sup sht arm ped plaster	B						
Q4012	Cast sup sht arm ped fbrglas	B						
Q4013	Cast sup gauntlet plaster	B						
Q4014	Cast sup gauntlet fiberglass	B						
Q4015	Cast sup gauntlet ped plster	B						
Q4016	Cast sup gauntlet ped fbrgls	B						
Q4017	Cast sup lng arm splint plst	B						
Q4018	Cast sup lng arm splint fbrg	B						
Q4019	Cast sup lng arm splnt ped p	B						
Q4020	Cast sup lng arm splnt ped f	B						
Q4021	Cast sup sht arm splint plst	B						
Q4022	Cast sup sht arm splint fbrg	B						
Q4023	Cast sup sht arm splnt ped p	B						
Q4024	Cast sup sht arm splnt ped f	B						
Q4025	Cast sup hip spica plaster	B						
Q4026	Cast sup hip spica fiberglas	B						
Q4027	Cast sup hip spica ped plstr	B						
Q4028	Cast sup hip spica ped fbrgl	B						
Q4029	Cast sup long leg plaster	B						
Q4030	Cast sup long leg fiberglass	B						
Q4031	Cast sup lng leg ped plaster	B						
Q4032	Cast sup lng leg ped fbrgls	B						
Q4033	Cast sup lng leg cylinder pl	B						
Q4034	Cast sup lng leg cylinder fb	B						
Q4035	Cast sup lngleg cylndr ped p	B						
Q4036	Cast sup lngleg cylndr ped f	B						
Q4037	Cast sup shrt leg plaster	B						
Q4038	Cast sup shrt leg fiberglass	B						
Q4039	Cast sup shrt leg ped plster	B						
Q4040	Cast sup shrt leg ped fbrgls	B						
Q4041	Cast sup lng leg splnt plstr	B						
Q4042	Cast sup lng leg splnt fbrgl	B						
Q4043	Cast sup lng leg splnt ped p	B						
Q4044	Cast sup lng leg splnt ped f	B						
Q4045	Cast sup sht leg splnt plstr	B						
Q4046	Cast sup sht leg splnt fbrgl	B						
Q4047	Cast sup sht leg splnt ped p	B						
Q4048	Cast sup sht leg splnt ped f	B						
Q4049	Finger splint, static	B						
Q4050	Cast supplies unlisted	B						
Q4051	Splint supplies misc	B						
Q4074	Iloprost non-comp unit dose	Y						
Q4081	Epoetin alfa, 100 units ESRD	A						
Q4082	Drug/bio NOC part B drug CAP	B						
Q4100	Skin substitute, NOS	N						
Q4101	Apligraf skin sub	K	1240		$32.10		$6.42	
Q4102	Oasis wound matrix skin sub	K	1241		$4.30		$0.86	
Q4103	Oasis burn matrix skin sub	K	1242		$4.30		$0.86	
Q4104	Integra BMWD skin sub	K	1243		$14.65		$2.93	
Q4105	Integra DRT skin sub	K	1244		$10.57		$2.11	

Q4106	Dermagraft skin sub	K	1245		$39.37		$7.87	
Q4107	Graftjacket skin sub	K	1246		$89.87		$17.97	
Q4108	Integra matrix skin sub	K	1247		$18.78		$3.76	
Q4109	Tissuemend skin sub	N						
Q4110	Primatrix skin sub	K	1248		$35.09		$7.02	
Q4111	Gammagraft skin sub	K	1252		$7.64		$1.53	
Q4112	Cymetra allograft	K	1249		$338.32		$67.66	
Q4113	Graftjacket express allograf	K	1250		$338.32		$67.66	
Q4114	Integra flowable wound matri	G	1251		$910.19		$178.60	
Q4115	Alloskin skin sub	K	1287		$9.36		$1.88	
Q4116	Alloderm skin sub	K	1270		$31.78		$6.36	
Q5001	Hospice in patient home	B						
Q5002	Hospice in assisted living	B						
Q5003	Hospice in LT/non-skilled NF	B						
Q5004	Hospice in SNF	B						
Q5005	Hospice, inpatient hospital	B						
Q5006	Hospice in hospice facility	B						
Q5007	Hospice in LTCH	B						
Q5008	Hospice in inpatient psych	B						
Q5009	Hospice care, NOS	B						
Q9951	LOCM >= 400 mg/ml iodine,1ml	N						
Q9953	Inj Fe-based MR contrast,1ml	N						
Q9954	Oral MR contrast, 100 ml	N						
Q9955	Inj perflexane lip micros,ml	N						
Q9956	Inj octafluoropropane mic,ml	N						
Q9957	Inj perflutren lip micros,ml	N						
Q9958	HOCM <=149 mg/ml iodine, 1ml	N						
Q9959	HOCM 150-199mg/ml iodine,1ml	N						
Q9960	HOCM 200-249mg/ml iodine,1ml	N						
Q9961	HOCM 250-299mg/ml iodine,1ml	N						
Q9962	HOCM 300-349mg/ml iodine,1ml	N						
Q9963	HOCM 350-399mg/ml iodine,1ml	N						
Q9964	HOCM>= 400mg/ml iodine, 1ml	N						
Q9965	LOCM 100-199mg/ml iodine,1ml	N						
Q9966	LOCM 200-299mg/ml iodine,1ml	N						
Q9967	LOCM 300-399mg/ml iodine,1ml	N						
Q9968	Visualization adjunct	K	1288		$2.46		$0.49	
R0070	Transport portable x-ray	B						
R0075	Transport port x-ray multipl	B						
R0076	Transport portable EKG	B						
V2020	Vision svcs frames purchases	A						
V2025	Eyeglasses delux frames	E						
V2100	Lens spher single plano 4.00	A						
V2101	Single visn sphere 4.12-7.00	A						
V2102	Singl visn sphere 7.12-20.00	A						
V2103	Spherocylindr 4.00d/12-2.00d	A						
V2104	Spherocylindr 4.00d/2.12-4d	A						
V2105	Spherocylinder 4.00d/4.25-6d	A						
V2106	Spherocylinder 4.00d/>6.00d	A						
V2107	Spherocylinder 4.25d/12-2d	A						
V2108	Spherocylinder 4.25d/2.12-4d	A						
V2109	Spherocylinder 4.25d/4.25-6d	A						
V2110	Spherocylinder 4.25d/over 6d	A						
V2111	Spherocylindr 7.25d/.25-2.25	A						
V2112	Spherocylindr 7.25d/2.25-4d	A						
V2113	Spherocylindr 7.25d/4.25-6d	A						
V2114	Spherocylinder over 12.00d	A						
V2115	Lens lenticular bifocal	A						
V2118	Lens aniseikonic single	A						
V2121	Lenticular lens, single	A						
V2199	Lens single vision not oth c	A						
V2200	Lens spher bifoc plano 4.00d	A						

V2201	Lens sphere bifocal 4.12-7.0	A						
V2202	Lens sphere bifocal 7.12-20.	A						
V2203	Lens sphcyl bifocal 4.00d/.1	A						
V2204	Lens sphcy bifocal 4.00d/2.1	A						
V2205	Lens sphcy bifocal 4.00d/4.2	A						
V2206	Lens sphcy bifocal 4.00d/ove	A						
V2207	Lens sphcy bifocal 4.25-7d/.	A						
V2208	Lens sphcy bifocal 4.25-7/2.	A						
V2209	Lens sphcy bifocal 4.25-7/4.	A						
V2210	Lens sphcy bifocal 4.25-7/ov	A						
V2211	Lens sphcy bifo 7.25-12/.25-	A						
V2212	Lens sphcyl bifo 7.25-12/2.2	A						
V2213	Lens sphcyl bifo 7.25-12/4.2	A						
V2214	Lens sphcyl bifocal over 12.	A						
V2215	Lens lenticular bifocal	A						
V2218	Lens aniseikonic bifocal	A						
V2219	Lens bifocal seg width over	A						
V2220	Lens bifocal add over 3.25d	A						
V2221	Lenticular lens, bifocal	A						
V2299	Lens bifocal speciality	A						
V2300	Lens sphere trifocal 4.00d	A						
V2301	Lens sphere trifocal 4.12-7.	A						
V2302	Lens sphere trifocal 7.12-20	A						
V2303	Lens sphcy trifocal 4.0/.12-	A						
V2304	Lens sphcy trifocal 4.0/2.25	A						
V2305	Lens sphcy trifocal 4.0/4.25	A						
V2306	Lens sphcyl trifocal 4.00/>6	A						
V2307	Lens sphcy trifocal 4.25-7/.	A						
V2308	Lens sphc trifocal 4.25-7/2.	A						
V2309	Lens sphc trifocal 4.25-7/4.	A						
V2310	Lens sphc trifocal 4.25-7/>6	A						

V2311	Lens sphc trifo 7.25-12/.25-	A						
V2312	Lens sphc trifo 7.25-12/2.25	A						
V2313	Lens sphc trifo 7.25-12/4.25	A						
V2314	Lens sphcyl trifocal over 12	A						
V2315	Lens lenticular trifocal	A						
V2318	Lens aniseikonic trifocal	A						
V2319	Lens trifocal seg width > 28	A						
V2320	Lens trifocal add over 3.25d	A						
V2321	Lenticular lens, trifocal	A						
V2399	Lens trifocal speciality	A						
V2410	Lens variab asphericity sing	A						
V2430	Lens variable asphericity bi	A						
V2499	Variable asphericity lens	A						
V2500	Contact lens pmma spherical	A						
V2501	Cntct lens pmma-toric/prism	A						
V2502	Contact lens pmma bifocal	A						
V2503	Cntct lens pmma color vision	A						
V2510	Cntct gas permeable sphericl	A						
V2511	Cntct toric prism ballast	A						
V2512	Cntct lens gas permbl bifocl	A						
V2513	Contact lens extended wear	A						
V2520	Contact lens hydrophilic	A						
V2521	Cntct lens hydrophilic toric	A						
V2522	Cntct lens hydrophil bifocl	A						
V2523	Cntct lens hydrophil extend	A						
V2530	Contact lens gas impermeable	A						
V2531	Contact lens gas permeable	A						
V2599	Contact lens/es other type	A						
V2600	Hand held low vision aids	A						
V2610	Single lens spectacle mount	A						
V2615	Telescop/othr compound lens	A						

V2623	Plastic eye prosth custom	A						
V2624	Polishing artifical eye	A						
V2625	Enlargemnt of eye prosthesis	A						
V2626	Reduction of eye prosthesis	A						
V2627	Scleral cover shell	A						
V2628	Fabrication & fitting	A						
V2629	Prosthetic eye other type	A						
V2630	Anter chamber intraocul lens	N						
V2631	Iris support intraoclr lens	N						
V2632	Post chmbr intraocular lens	N						
V2700	Balance lens	A						
V2702	Deluxe lens feature		E					
V2710	Glass/plastic slab off prism		A					
V2715	Prism lens/es		A					
V2718	Fresnell prism press-on lens		A					
V2730	Special base curve		A					
V2744	Tint photochromatic lens/es		A					
V2745	Tint, any color/solid/grad		A					
V2750	Anti-reflective coating		A					
V2755	UV lens/es		A					
V2756	Eye glass case		E					
V2760	Scratch resistant coating		A					
V2761	Mirror coating		B					
V2762	Polarization, any lens		A					
V2770	Occluder lens/es		A					
V2780	Oversize lens/es		A					
V2781	Progressive lens per lens		B					
V2782	Lens, 1.54-1.65 p/1.60-1.79g		A					
V2783	Lens, >= 1.66 p/>=1.80 g		A					
V2784	Lens polycarb or equal		A					
V2785	Corneal tissue processing		F					
V2786	Occupational multifocal lens		A					
V2787	Astigmatism-correct function		E					
V2788	Presbyopia-correct function		E					
V2790	Amniotic membrane		N					
V2797	Vis item/svc in other code		A					
V2799	Miscellaneous vision service		A					
V5008	Hearing screening		E					
V5010	Assessment for hearing aid		E					
V5011	Hearing aid fitting/checking		E					
V5014	Hearing aid repair/modifying		E					
V5020	Conformity evaluation		E					
V5030	Body-worn hearing aid air		E					
V5040	Body-worn hearing aid bone		E					
V5050	Hearing aid monaural in ear		E					
V5060	Behind ear hearing aid		E					
V5070	Glasses air conduction		E					
V5080	Glasses bone conduction		E					
V5090	Hearing aid dispensing fee		E					
V5095	Implant mid ear hearing pros		E					
V5100	Body-worn bilat hearing aid		E					
V5110	Hearing aid dispensing fee		E					
V5120	Body-worn binaur hearing aid		E					
V5130	In ear binaural hearing aid		E					
V5140	Behind ear binaur hearing ai		E					
V5150	Glasses binaural hearing aid		E					
V5160	Dispensing fee binaural		E					
V5170	Within ear cros hearing aid		E					
V5180	Behind ear cros hearing aid		E					
V5190	Glasses cros hearing aid		E					
V5200	Cros hearing aid dispens fee		E					
V5210	In ear bicros hearing aid		E					

V5220	Behind ear bicros hearing ai	E					
V5230	Glasses bicros hearing aid	E					
V5240	Dispensing fee bicros	E					
V5241	Dispensing fee, monaural	E					
V5242	Hearing aid, monaural, cic	E					
V5243	Hearing aid, monaural, itc	E					
V5244	Hearing aid, prog, mon, cic	E					
V5245	Hearing aid, prog, mon, itc	E					
V5246	Hearing aid, prog, mon, ite	E					
V5247	Hearing aid, prog, mon, bte	E					
V5248	Hearing aid, binaural, cic	E					
V5249	Hearing aid, binaural, itc	E					
V5250	Hearing aid, prog, bin, cic	E					
V5251	Hearing aid, prog, bin, itc	E					
V5252	Hearing aid, prog, bin, ite	E					
V5253	Hearing aid, prog, bin, bte	E					
V5254	Hearing id, digit, mon, cic	E					
V5255	Hearing aid, digit, mon, itc	E					
V5256	Hearing aid, digit, mon, ite	E					
V5257	Hearing aid, digit, mon, bte	E					
V5258	Hearing aid, digit, bin, cic	E					
V5259	Hearing aid, digit, bin, itc	E					
V5260	Hearing aid, digit, bin, ite	E					
V5261	Hearing aid, digit, bin, bte	E					
V5262	Hearing aid, disp, monaural	E					
V5263	Hearing aid, disp, binaural	E					
V5264	Ear mold/insert	E					
V5265	Ear mold/insert, disp	E					
V5266	Battery for hearing device	E					
V5267	Hearing aid supply/accessory	E					
V5268	ALD Telephone Amplifier	E					

V5269	Alerting device, any type	E					
V5270	ALD, TV amplifier, any type	E					
V5271	ALD, TV caption decoder	E					
V5272	Tdd	E					
V5273	ALD for cochlear implant	E					
V5274	ALD unspecified	E					
V5275	Ear impression	E					
V5298	Hearing aid noc	E					
V5299	Hearing service	B					
V5336	Repair communication device	E					
V5362	Speech screening	E					
V5363	Language screening	E					
V5364	Dysphagia screening	E					

Addendum BB -- Revised Final ASC Covered Ancillary Services Integral to Covered Surgical Procedures for CY 2010 (Including Ancillary Services for Which Payment is Packaged) to Reflect Retroactive Provisions of the Affordable Care Act

HCPCS Code	Short Descriptor	CY 2010 Payment Indicator	CY 2010 Third Year Transition Payment Weight	CY 2010 Third Year Transition Payment
0042T	Ct perfusion w/contrast, cbf	N1		
0067T	Ct colonography;dx	D5		
0073T	Delivery, comp imrt	Z2	5.9715	$250.04
0126T	Chd risk imt study	N1		
0144T	CT heart wo dye; qual calc	D5		
0145T	CT heart w/wo dye funct	D5		
0146T	CCTA w/wo dye	D5		
0147T	CCTA w/wo, quan calcium	D5		
0148T	CCTA w/wo, strxr	D5		
0149T	CCTA w/wo, strxr quan calc	D5		
0150T	CCTA w/wo, disease strxr	D5		
0151T	CT heart funct add-on	D5		
0159T	Cad breast mri	N1		
0174T	Cad cxr with interp	N1		
0175T	Cad cxr remote	N1		
0182T	Hdr elect brachytherapy	Z2	11.0231	$461.57
0185T	Comptr probability analysis	N1		
70010	Contrast x-ray of brain	N1		
70015	Contrast x-ray of brain	N1		
70030	X-ray eye for foreign body	Z3		$18.40
70100	X-ray exam of jaw	Z3		$20.57
70110	X-ray exam of jaw	Z3		$24.89
70120	X-ray exam of mastoids	Z3		$23.09
70130	X-ray exam of mastoids	Z2	0.6365	$26.65
70134	X-ray exam of middle ear	Z3		$27.06
70140	X-ray exam of facial bones	Z3		$18.40
70150	X-ray exam of facial bones	Z2	0.6365	$26.65
70160	X-ray exam of nasal bones	Z3		$22.01
70170	X-ray exam of tear duct	N1		
70190	X-ray exam of eye sockets	Z3		$23.09
70200	X-ray exam of eye sockets	Z2	0.6365	$26.65
70210	X-ray exam of sinuses	Z3		$19.84
70220	X-ray exam of sinuses	Z3		$24.53
70240	X-ray exam, pituitary saddle	Z3		$18.40
70250	X-ray exam of skull	Z3		$22.37
70260	X-ray exam of skull	Z3		$28.14
70300	X-ray exam of teeth	Z3		$7.94
70310	X-ray exam of teeth	Z2	0.4271	$17.88
70320	Full mouth x-ray of teeth	Z2	0.4271	$17.88
70328	X-ray exam of jaw joint	Z3		$19.48
70330	X-ray exam of jaw joints	Z2	0.6365	$26.65
70332	X-ray exam of jaw joint	N1		
70336	Magnetic image, jaw joint	Z2	4.9553	$207.49
70350	X-ray head for orthodontia	Z3		$10.82
70355	Panoramic x-ray of jaws	Z3		$10.46
70360	X-ray exam of neck	Z3		$17.32
70370	Throat x-ray & fluoroscopy	Z2	1.2129	$50.79
70371	Speech evaluation, complex	Z2	1.2129	$50.79
70373	Contrast x-ray of larynx	N1		
70380	X-ray exam of salivary gland	Z2	0.6365	$26.65
70390	X-ray exam of salivary duct	N1		
70450	Ct head/brain w/o dye	Z2	2.7655	$115.80
70460	Ct head/brain w/dye	Z2	4.2109	$176.32
70470	Ct head/brain w/o & w/dye	Z2	4.7282	$197.98
70480	Ct orbit/ear/fossa w/o dye	Z2	2.7655	$115.80
70481	Ct orbit/ear/fossa w/dye	Z2	4.2109	$176.32
70482	Ct orbit/ear/fossa w/o&w/dye	Z2	4.7282	$197.98
70486	Ct maxillofacial w/o dye	Z2	2.7655	$115.80
70487	Ct maxillofacial w/dye	Z2	4.2109	$176.32
70488	Ct maxillofacial w/o & w/dye	Z2	4.7282	$197.98
70490	Ct soft tissue neck w/o dye	Z2	2.7655	$115.80
70491	Ct soft tissue neck w/dye	Z2	4.2109	$176.32
70492	Ct sft tsue nck w/o & w/dye	Z2	4.7282	$197.98
70496	Ct angiography, head	Z2	4.8268	$202.11
70498	Ct angiography, neck	Z2	4.8268	$202.11
70540	Mri orbit/face/neck w/o dye	Z2	4.9553	$207.49
70542	Mri orbit/face/neck w/dye	Z2	6.0108	$251.69

70543	Mri orbt/fac/nck w/o & w/dye	Z2	7.5905	$317.84			
70544	Mr angiography head w/o dye	Z2	4.9553	$207.49			
70545	Mr angiography head w/dye	Z2	6.0108	$251.69			
70546	Mr angiograph head w/o&w/dye	Z2	7.5905	$317.84			
70547	Mr angiography neck w/o dye	Z2	4.9553	$207.49			
70548	Mr angiography neck w/dye	Z2	6.0108	$251.69			
70549	Mr angiograph neck w/o&w/dye	Z2	7.5905	$317.84			
70551	Mri brain w/o dye	Z2	4.9553	$207.49			
70552	Mri brain w/dye	Z2	6.0108	$251.69			
70553	Mri brain w/o & w/dye	Z2	7.5905	$317.84			
70554	Fmri brain by tech	Z2	4.9553	$207.49			
70555	Fmri brain by phys/psych	Z2	4.9553	$207.49			
70557	Mri brain w/o dye	Z2	4.9553	$207.49			
70558	Mri brain w/dye	Z2	6.0108	$251.69			
70559	Mri brain w/o & w/dye	Z2	7.5905	$317.84			
71010	Chest x-ray	Z3		$13.71			
71015	Chest x-ray	Z3		$18.04			
71020	Chest x-ray	Z3		$18.76			
71021	Chest x-ray	Z3		$22.73			
71022	Chest x-ray	Z2	0.6365	$26.65			
71023	Chest x-ray and fluoroscopy	Z3		$45.10			
71030	Chest x-ray	Z2	0.6365	$26.65			
71034	Chest x-ray and fluoroscopy	Z2	1.2129	$50.79			
71035	Chest x-ray	Z3		$23.81			
71040	Contrast x-ray of bronchi	N1					
71060	Contrast x-ray of bronchi	N1					
71090	X-ray & pacemaker insertion	N1					
71100	X-ray exam of ribs	Z3		$19.84			
71101	X-ray exam of ribs/chest	Z3		$23.81			
71110	X-ray exam of ribs	Z3		$24.89			
71111	X-ray exam of ribs/chest	Z3		$33.55			
71120	X-ray exam of breastbone	Z3		$20.57			
71130	X-ray exam of breastbone	Z3		$24.17			
71250	Ct thorax w/o dye	Z2	2.7655	$115.80			
71260	Ct thorax w/dye	Z2	4.2109	$176.32			

71270	Ct thorax w/o & w/dye	Z2	4.7282	$197.98			
71275	Ct angiography, chest	Z2	4.8268	$202.11			
71550	Mri chest w/o dye	Z2	4.9553	$207.49			
71551	Mri chest w/dye	Z2	6.0108	$251.69			
71552	Mri chest w/o & w/dye	Z2	7.5905	$317.84			
72010	X-ray exam of spine	Z2	1.0665	$44.66			
72020	X-ray exam of spine	Z3		$14.79			
72040	X-ray exam of neck spine	Z3		$24.17			
72050	X-ray exam of neck spine	Z3		$33.91			
72052	X-ray exam of neck spine	Z2	1.0665	$44.66			
72069	X-ray exam of trunk spine	Z3		$22.73			
72070	X-ray exam of thoracic spine	Z3		$20.57			
72072	X-ray exam of thoracic spine	Z3		$24.89			
72074	X-ray exam of thoracic spine	Z2	0.6365	$26.65			
72080	X-ray exam of trunk spine	Z3		$22.37			
72090	X-ray exam of trunk spine	Z3		$30.67			
72100	X-ray exam of lower spine	Z3		$25.98			
72110	X-ray exam of lower spine	Z3		$35.72			
72114	X-ray exam of lower spine	Z2	1.0665	$44.66			
72120	X-ray exam of lower spine	Z3		$35.36			
72125	Ct neck spine w/o dye	Z2	2.7655	$115.80			
72126	Ct neck spine w/dye	Z2	4.2109	$176.32			
72127	Ct neck spine w/o & w/dye	Z2	4.7282	$197.98			
72128	Ct chest spine w/o dye	Z2	2.7655	$115.80			
72129	Ct chest spine w/dye	Z2	4.2109	$176.32			
72130	Ct chest spine w/o & w/dye	Z2	4.7282	$197.98			
72131	Ct lumbar spine w/o dye	Z2	2.7655	$115.80			
72132	Ct lumbar spine w/dye	Z2	4.2109	$176.32			
72133	Ct lumbar spine w/o & w/dye	Z2	4.7282	$197.98			
72141	Mri neck spine w/o dye	Z2	4.9553	$207.49			
72142	Mri neck spine w/dye	Z2	6.0108	$251.69			
72146	Mri chest spine w/o dye	Z2	4.9553	$207.49			
72147	Mri chest spine w/dye	Z2	6.0108	$251.69			
72148	Mri lumbar spine w/o dye	Z2	4.9553	$207.49			
72149	Mri lumbar spine w/dye	Z2	6.0108	$251.69			

72156	Mri neck spine w/o & w/dye	Z2	7.5905	$317.84			
72157	Mri chest spine w/o & w/dye	Z2	7.5905	$317.84			
72158	Mri lumbar spine w/o & w/dye	Z2	7.5905	$317.84			
72170	X-ray exam of pelvis	Z3		$16.24			
72190	X-ray exam of pelvis	Z2	0.6365	$26.65			
72191	Ct angiograph pelv w/o&w/dye	Z2	4.8268	$202.11			
72192	Ct pelvis w/o dye	Z2	2.7655	$115.80			
72193	Ct pelvis w/dye	Z2	4.2109	$176.32			
72194	Ct pelvis w/o & w/dye	Z2	4.7282	$197.98			
72195	Mri pelvis w/o dye	Z2	4.9553	$207.49			
72196	Mri pelvis w/dye	Z2	6.0108	$251.69			
72197	Mri pelvis w/o & w/dye	Z2	7.5905	$317.84			
72200	X-ray exam sacroiliac joints	Z3		$19.12			
72202	X-ray exam sacroiliac joints	Z3		$23.09			
72220	X-ray exam of tailbone	Z3		$18.76			
72240	Contrast x-ray of neck spine	N1					
72255	Contrast x-ray, thorax spine	N1					
72265	Contrast x-ray, lower spine	N1					
72270	Contrast x-ray, spine	N1					
72275	Epidurography	N1					
72285	X-ray c/t spine disk	N1					
72291	Perq verte/sacroplsty, fluor	N1					
72292	Perq verte/sacroplsty, ct	N1					
72295	X-ray of lower spine disk	N1					
73000	X-ray exam of collar bone	Z3		$18.04			
73010	X-ray exam of shoulder blade	Z3		$18.76			
73020	X-ray exam of shoulder	Z3		$14.79			
73030	X-ray exam of shoulder	Z3		$18.76			
73040	Contrast x-ray of shoulder	N1					
73050	X-ray exam of shoulders	Z3		$24.17			
73060	X-ray exam of humerus	Z3		$18.76			
73070	X-ray exam of elbow	Z3		$18.40			
73080	X-ray exam of elbow	Z3		$24.17			
73085	Contrast x-ray of elbow	N1					
73090	X-ray exam of forearm	Z3		$18.04			

73092	X-ray exam of arm, infant	Z3		$19.12			
73100	X-ray exam of wrist	Z3		$19.48			
73110	X-ray exam of wrist	Z3		$24.53			
73115	Contrast x-ray of wrist	N1					
73120	X-ray exam of hand	Z3		$17.68			
73130	X-ray exam of hand	Z3		$20.93			
73140	X-ray exam of finger(s)	Z3		$21.29			
73200	Ct upper extremity w/o dye	Z2	2.7655	$115.80			
73201	Ct upper extremity w/dye	Z2	4.2109	$176.32			
73202	Ct uppr extremity w/o&w/dye	Z2	4.7282	$197.98			
73206	Ct angio upr extrm w/o&w/dye	Z2	4.8268	$202.11			
73218	Mri upper extremity w/o dye	Z2	4.9553	$207.49			
73219	Mri upper extremity w/dye	Z2	6.0108	$251.69			
73220	Mri uppr extremity w/o&w/dye	Z2	7.5905	$317.84			
73221	Mri joint upr extrem w/o dye	Z2	4.9553	$207.49			
73222	Mri joint upr extrem w/dye	Z2	6.0108	$251.69			
73223	Mri joint upr extr w/o&w/dye	Z2	7.5905	$317.84			
73500	X-ray exam of hip	Z3		$15.51			
73510	X-ray exam of hip	Z3		$24.17			
73520	X-ray exam of hips	Z3		$24.53			
73525	Contrast x-ray of hip	N1					
73530	X-ray exam of hip	N1					
73540	X-ray exam of pelvis & hips	Z3		$25.98			
73542	X-ray exam, sacroiliac joint	N1					
73550	X-ray exam of thigh	Z3		$17.68			
73560	X-ray exam of knee, 1 or 2	Z3		$18.76			
73562	X-ray exam of knee, 3	Z3		$23.45			
73564	X-ray exam, knee, 4 or more	Z2	0.6365	$26.65			
73565	X-ray exam of knees	Z3		$20.93			
73580	Contrast x-ray of knee joint	N1					
73590	X-ray exam of lower leg	Z3		$17.32			
73592	X-ray exam of leg, infant	Z3		$19.48			
73600	X-ray exam of ankle	Z3		$18.04			
73610	X-ray exam of ankle	Z3		$21.29			
73615	Contrast x-ray of ankle	N1					

73620	X-ray exam of foot	Z3		$17.32			
73630	X-ray exam of foot	Z3		$20.93			
73650	X-ray exam of heel	Z3		$17.68			
73660	X-ray exam of toe(s)	Z3		$19.84			
73700	Ct lower extremity w/o dye	Z2	2.7655	$115.80			
73701	Ct lower extremity w/dye	Z2	4.2109	$176.32			
73702	Ct lwr extremity w/o&w/dye	Z2	4.7282	$197.98			
73706	Ct angio lwr extr w/o&w/dye	Z2	4.8268	$202.11			
73718	Mri lower extremity w/o dye	Z2	4.9553	$207.49			
73719	Mri lower extremity w/dye	Z2	6.0108	$251.69			
73720	Mri lwr extremity w/o&w/dye	Z2	7.5905	$317.84			
73721	Mri jnt of lwr extre w/o dye	Z2	4.9553	$207.49			
73722	Mri joint of lwr extr w/dye	Z2	6.0108	$251.69			
73723	Mri joint lwr extr w/o&w/dye	Z2	7.5905	$317.84			
74000	X-ray exam of abdomen	Z3		$15.15			
74010	X-ray exam of abdomen	Z3		$24.17			
74020	X-ray exam of abdomen	Z3		$24.53			
74022	X-ray exam series, abdomen	Z3		$29.58			
74150	Ct abdomen w/o dye	Z2	2.7655	$115.80			
74160	Ct abdomen w/dye	Z2	4.2109	$176.32			
74170	Ct abdomen w/o & w/dye	Z2	4.7282	$197.98			
74175	Ct angio abdom w/o & w/dye	Z2	4.8268	$202.11			
74181	Mri abdomen w/o dye	Z2	4.9553	$207.49			
74182	Mri abdomen w/dye	Z2	6.0108	$251.69			
74183	Mri abdomen w/o & w/dye	Z2	7.5905	$317.84			
74190	X-ray exam of peritoneum	N1					
74210	Contrst x-ray exam of throat	Z2	1.2408	$51.96			
74220	Contrast x-ray, esophagus	Z2	1.2408	$51.96			
74230	Cine/vid x-ray, throat/esoph	Z2	1.2408	$51.96			
74235	Remove esophagus obstruction	N1					
74240	X-ray exam, upper gi tract	Z2	1.2408	$51.96			
74241	X-ray exam, upper gi tract	Z2	1.2408	$51.96			
74245	X-ray exam, upper gi tract	Z2	2.0069	$84.03			
74246	Contrst x-ray uppr gi tract	Z2	1.2408	$51.96			
74247	Contrst x-ray uppr gi tract	Z2	1.2408	$51.96			

74249	Contrst x-ray uppr gi tract	Z2	2.0069	$84.03			
74250	X-ray exam of small bowel	Z2	1.2408	$51.96			
74251	X-ray exam of small bowel	Z2	2.0069	$84.03			
74260	X-ray exam of small bowel	Z2	1.2408	$51.96			
74261	Ct colonography, w/o dye	Z2	2.7655	$115.80			
74262	Ct colonography, w/dye	Z2	4.2109	$176.32			
74270	Contrast x-ray exam of colon	Z2	1.2408	$51.96			
74280	Contrast x-ray exam of colon	Z2	2.0069	$84.03			
74283	Contrast x-ray exam of colon	Z2	1.2408	$51.96			
74290	Contrast x-ray, gallbladder	Z3		$46.90			
74291	Contrast x-rays, gallbladder	Z3		$46.18			
74300	X-ray bile ducts/pancreas	N1					
74301	X-rays at surgery add-on	N1					
74305	X-ray bile ducts/pancreas	N1					
74320	Contrast x-ray of bile ducts	N1					
74327	X-ray bile stone removal	N1					
74328	X-ray bile duct endoscopy	N1					
74329	X-ray for pancreas endoscopy	N1					
74330	X-ray bile/panc endoscopy	N1					
74340	X-ray guide for GI tube	N1					
74355	X-ray guide, intestinal tube	N1					
74360	X-ray guide, GI dilation	N1					
74363	X-ray, bile duct dilation	N1					
74400	Contrst x-ray, urinary tract	Z3		$79.73			
74410	Contrst x-ray, urinary tract	Z3		$83.70			
74415	Contrst x-ray, urinary tract	Z2	2.433	$101.88			
74420	Contrst x-ray, urinary tract	Z2	2.433	$101.88			
74425	Contrst x-ray, urinary tract	N1					
74430	Contrast x-ray, bladder	N1					
74440	X-ray, male genital tract	N1					
74445	X-ray exam of penis	N1					
74450	X-ray, urethra/bladder	N1					
74455	X-ray, urethra/bladder	N1					
74470	X-ray exam of kidney lesion	N1					
74475	X-ray control, cath insert	N1					

74480	X-ray control, cath insert	N1					
74485	X-ray guide, GU dilation	N1					
74710	X-ray measurement of pelvis	Z3		$22.37			
74740	X-ray, female genital tract	N1					
74742	X-ray, fallopian tube	N1					
74775	X-ray exam of perineum	Z2	2.433	$101.88			
75557	Cardiac mri for morph	Z2	4.9553	$207.49			
75559	Cardiac mri w/stress img	Z2	4.9553	$207.49			
75561	Cardiac mri for morph w/dye	Z2	7.5905	$317.84			
75563	Card mri w/stress img & dye	Z2	7.5905	$317.84			
75565	Card mri vel flw map add-on	N1					
75571	Ct hrt w/o dye w/ca test	Z2	0.6396	$26.78			
75572	Ct hrt w/3d image	Z2	3.8156	$159.77			
75573	Ct hrt w/3d image, congen	Z2	3.8156	$159.77			
75574	Ct angio hrt w/3d image	Z2	3.8156	$159.77			
75600	Contrast x-ray exam of aorta	N1					
75605	Contrast x-ray exam of aorta	N1					
75625	Contrast x-ray exam of aorta	N1					
75630	X-ray aorta, leg arteries	N1					
75635	Ct angio abdominal arteries	N1					
75650	Artery x-rays, head & neck	N1					
75658	Artery x-rays, arm	N1					
75660	Artery x-rays, head & neck	N1					
75662	Artery x-rays, head & neck	N1					
75665	Artery x-rays, head & neck	N1					
75671	Artery x-rays, head & neck	N1					
75676	Artery x-rays, neck	N1					
75680	Artery x-rays, neck	N1					
75685	Artery x-rays, spine	N1					
75705	Artery x-rays, spine	N1					
75710	Artery x-rays, arm/leg	N1					
75716	Artery x-rays, arms/legs	N1					
75722	Artery x-rays, kidney	N1					
75724	Artery x-rays, kidneys	N1					
75726	Artery x-rays, abdomen	N1					

75731	Artery x-rays, adrenal gland	N1					
75733	Artery x-rays, adrenals	N1					
75736	Artery x-rays, pelvis	N1					
75741	Artery x-rays, lung	N1					
75743	Artery x-rays, lungs	N1					
75746	Artery x-rays, lung	N1					
75756	Artery x-rays, chest	N1					
75774	Artery x-ray, each vessel	N1					
75790	Visualize A-V shunt	D5					
75791	Av dialysis shunt imaging	N1					
75801	Lymph vessel x-ray, arm/leg	N1					
75803	Lymph vessel x-ray,arms/legs	N1					
75805	Lymph vessel x-ray, trunk	N1					
75807	Lymph vessel x-ray, trunk	N1					
75809	Nonvascular shunt, x-ray	N1					
75810	Vein x-ray, spleen/liver	N1					
75820	Vein x-ray, arm/leg	N1					
75822	Vein x-ray, arms/legs	N1					
75825	Vein x-ray, trunk	N1					
75827	Vein x-ray, chest	N1					
75831	Vein x-ray, kidney	N1					
75833	Vein x-ray, kidneys	N1					
75840	Vein x-ray, adrenal gland	N1					
75842	Vein x-ray, adrenal glands	N1					
75860	Vein x-ray, neck	N1					
75870	Vein x-ray, skull	N1					
75872	Vein x-ray, skull	N1					
75880	Vein x-ray, eye socket	N1					
75885	Vein x-ray, liver	N1					
75887	Vein x-ray, liver	N1					
75889	Vein x-ray, liver	N1					
75891	Vein x-ray, liver	N1					
75893	Venous sampling by catheter	N1					
75894	X-rays, transcath therapy	N1					
75896	X-rays, transcath therapy	N1					

75898	Follow-up angiography	N1					
75901	Remove cva device obstruct	N1					
75902	Remove cva lumen obstruct	N1					
75940	X-ray placement, vein filter	N1					
75945	Intravascular us	N1					
75946	Intravascular us add-on	N1					
75960	Transcath iv stent rs&i	N1					
75961	Retrieval, broken catheter	N1					
75962	Repair arterial blockage	N1					
75964	Repair artery blockage, each	N1					
75966	Repair arterial blockage	N1					
75968	Repair artery blockage, each	N1					
75970	Vascular biopsy	N1					
75978	Repair venous blockage	N1					
75980	Contrast xray exam bile duct	N1					
75982	Contrast xray exam bile duct	N1					
75984	Xray control catheter change	N1					
75989	Abscess drainage under x-ray	N1					
75992	Atherectomy, x-ray exam	N1					
75993	Atherectomy, x-ray exam	N1					
75994	Atherectomy, x-ray exam	N1					
75995	Atherectomy, x-ray exam	N1					
75996	Atherectomy, x-ray exam	N1					
76000	Fluoroscope examination	N1					
76001	Fluoroscope exam, extensive	N1					
76010	X-ray, nose to rectum	Z3			$17.32		
76080	X-ray exam of fistula	N1					
76098	X-ray exam, breast specimen	N1					
76100	X-ray exam of body section	Z2	1.0665		$44.66		
76101	Complex body section x-ray	Z2	2.9807		$124.81		
76102	Complex body section x-rays	Z2	2.9807		$124.81		
76120	Cine/video x-rays	Z2	1.2129		$50.79		
76125	Cine/video x-rays add-on	N1					
76150	X-ray exam, dry process	Z3			$18.40		
76350	Special x-ray contrast study	N1					

76376	3d render w/o postprocess	N1					
76377	3d rendering w/postprocess	N1					
76380	CAT scan follow-up study	Z2	1.5568		$65.19		
76496	Fluoroscopic procedure	Z2	1.2129		$50.79		
76497	Ct procedure	Z2	1.5568		$65.19		
76498	Mri procedure	Z2	4.9553		$207.49		
76499	Radiographic procedure	Z2	0.6365		$26.65		
76506	Echo exam of head	Z2	0.8856		$37.08		
76510	Ophth us, b & quant a	Z3			$66.39		
76511	Ophth us, quant a only	Z3			$44.74		
76512	Ophth us, b w/non-quant a	Z3			$37.52		
76513	Echo exam of eye, water bath	Z3			$47.99		
76514	Echo exam of eye, thickness	Z3			$3.61		
76516	Echo exam of eye	Z2	0.8856		$37.08		
76519	Echo exam of eye	Z3			$42.21		
76529	Echo exam of eye	Z2	0.8856		$37.08		
76536	Us exam of head and neck	Z2	1.3793		$57.76		
76604	Us exam, chest	Z2	0.8856		$37.08		
76645	Us exam, breast(s)	Z2	0.8856		$37.08		
76700	Us exam, abdom, complete	Z2	1.3793		$57.76		
76705	Echo exam of abdomen	Z2	1.3793		$57.76		
76770	Us exam abdo back wall, comp	Z2	1.3793		$57.76		
76775	Us exam abdo back wall, lim	Z2	1.3793		$57.76		
76776	Us exam k transpl w/doppler	Z2	1.3793		$57.76		
76800	Us exam, spinal canal	Z2	1.3793		$57.76		
76801	Ob us < 14 wks, single fetus	Z2	1.3793		$57.76		
76802	Ob us < 14 wks, addl fetus	Z3			$27.42		
76805	Ob us >/= 14 wks, sngl fetus	Z2	1.3793		$57.76		
76810	Ob us >/= 14 wks, addl fetus	Z3			$45.10		
76811	Ob us, detailed, sngl fetus	Z2	2.1984		$92.05		
76812	Ob us, detailed, addl fetus	Z2	0.8856		$37.08		
76813	Ob us nuchal meas, 1 gest	Z2	0.8856		$37.08		
76814	Ob us nuchal meas, add-on	Z3			$29.95		
76815	Ob us, limited, fetus(s)	Z2	0.8856		$37.08		
76816	Ob us, follow-up, per fetus	Z2	0.8856		$37.08		

76817	Transvaginal us, obstetric	Z2	0.8856	$37.08			
76818	Fetal biophys profile w/nst	Z2	1.3793	$57.76			
76819	Fetal biophys profil w/o nst	Z3		$50.15			
76820	Umbilical artery echo	Z3		$22.73			
76821	Middle cerebral artery echo	Z2	0.8856	$37.08			
76825	Echo exam of fetal heart	Z3		$121.95			
76826	Echo exam of fetal heart	Z3		$74.32			
76827	Echo exam of fetal heart	Z2	0.8856	$37.08			
76828	Echo exam of fetal heart	Z3		$20.93			
76830	Transvaginal us, non-ob	Z2	1.3793	$57.76			
76831	Echo exam, uterus	Z3		$81.18			
76856	Us exam, pelvic, complete	Z2	1.3793	$57.76			
76857	Us exam, pelvic, limited	Z2	0.8856	$37.08			
76870	Us exam, scrotum	Z2	1.3793	$57.76			
76872	Us, transrectal	Z2	1.3793	$57.76			
76873	Echograp trans r, pros study	Z2	1.3793	$57.76			
76880	Us exam, extremity	Z2	1.3793	$57.76			
76885	Us exam infant hips, dynamic	Z2	0.8856	$37.08			
76886	Us exam infant hips, static	Z2	0.8856	$37.08			
76930	Echo guide, cardiocentesis	N1					
76932	Echo guide for heart biopsy	N1					
76936	Echo guide for artery repair	Z2	1.5361	$64.32			
76937	Us guide, vascular access	N1					
76940	Us guide, tissue ablation	N1					
76941	Echo guide for transfusion	N1					
76942	Echo guide for biopsy	N1					
76945	Echo guide, villus sampling	N1					
76946	Echo guide for amniocentesis	N1					
76948	Echo guide, ova aspiration	N1					
76950	Echo guidance radiotherapy	N1					
76965	Echo guidance radiotherapy	N1					
76970	Ultrasound exam follow-up	Z2	0.8856	$37.08			
76975	GI endoscopic ultrasound	N1					
76977	Us bone density measure	Z3		$8.30			
76998	Us guide, intraop	N1					

76999	Echo examination procedure	Z2	0.8856	$37.08			
77001	Fluoroguide for vein device	N1					
77002	Needle localization by xray	N1					
77003	Fluoroguide for spine inject	N1					
77011	Ct scan for localization	N1					
77012	Ct scan for needle biopsy	N1					
77013	Ct guide for tissue ablation	N1					
77014	Ct scan for therapy guide	N1					
77021	Mr guidance for needle place	N1					
77022	Mri for tissue ablation	N1					
77031	Stereotact guide for brst bx	N1					
77032	Guidance for needle, breast	N1					
77053	X-ray of mammary duct	N1					
77054	X-ray of mammary ducts	N1					
77071	X-ray stress view	Z3		$24.89			
77072	X-rays for bone age	Z3		$12.63			
77073	X-rays, bone length studies	Z3		$22.01			
77074	X-rays, bone survey, limited	Z3		$42.93			
77075	X-rays, bone survey complete	Z2	1.0665	$44.66			
77076	X-rays, bone survey, infant	Z2	1.0665	$44.66			
77077	Joint survey, single view	Z3		$23.81			
77078	Ct bone density, axial	Z2	1.0277	$43.03			
77079	Ct bone density, peripheral	Z3		$40.77			
77080	Dxa bone density, axial	Z2	1.0277	$43.03			
77081	Dxa bone density/peripheral	Z2	0.4126	$17.28			
77082	Dxa bone density, vert fx	Z3		$19.84			
77083	Radiographic absorptiometry	Z3		$14.43			
77084	Magnetic image, bone marrow	Z2	4.9553	$207.49			
77280	Set radiation therapy field	Z2	1.4593	$61.11			
77285	Set radiation therapy field	Z2	3.7756	$158.10			
77290	Set radiation therapy field	Z2	3.7756	$158.10			
77295	Set radiation therapy field	Z3		$361.15			
77299	Radiation therapy planning	Z2	1.4593	$61.11			
77300	Radiation therapy dose plan	Z3		$36.80			
77301	Radiotherapy dose plan, imrt	Z2	13.1468	$550.50			

77305	Teletx isodose plan simple	Z3		$31.75			
77310	Teletx isodose plan intermed	Z3		$41.85			
77315	Teletx isodose plan complex	Z3		$63.14			
77321	Special teletx port plan	Z3		$61.70			
77326	Brachytx isodose calc simp	Z2	1.4593	$61.11			
77327	Brachytx isodose calc interm	Z3		$127.00			
77328	Brachytx isodose plan compl	Z2	3.7756	$158.10			
77331	Special radiation dosimetry	Z3		$18.04			
77332	Radiation treatment aid(s)	Z3		$47.99			
77333	Radiation treatment aid(s)	Z3		$19.84			
77334	Radiation treatment aid(s)	Z3		$88.03			
77336	Radiation physics consult	Z3		$53.04			
77338	Design mlc device for imrt	Z2	2.7023	$113.15			
77370	Radiation physics consult	Z2	1.4593	$61.11			
77371	Srs, multisource	Z2	104.1182	$4,359.74			
77399	External radiation dosimetry	Z2	1.4593	$61.11			
77401	Radiation treatment delivery	Z3		$25.62			
77402	Radiation treatment delivery	Z2	1.3153	$55.08			
77403	Radiation treatment delivery	Z2	1.3153	$55.08			
77404	Radiation treatment delivery	Z2	1.3153	$55.08			
77406	Radiation treatment delivery	Z2	2.2007	$92.15			
77407	Radiation treatment delivery	Z2	1.3153	$55.08			
77408	Radiation treatment delivery	Z2	1.3153	$55.08			
77409	Radiation treatment delivery	Z2	1.3153	$55.08			
77411	Radiation treatment delivery	Z2	2.2007	$92.15			
77412	Radiation treatment delivery	Z2	2.2007	$92.15			
77413	Radiation treatment delivery	Z2	2.2007	$92.15			
77414	Radiation treatment delivery	Z2	2.2007	$92.15			
77416	Radiation treatment delivery	Z2	2.2007	$92.15			
77417	Radiology port film(s)	N1					
77418	Radiation tx delivery, imrt	Z2	5.9715	$250.04			
77421	Stereoscopic x-ray guidance	N1					
77422	Neutron beam tx, simple	Z2	2.2007	$92.15			
77423	Neutron beam tx, complex	Z2	2.2007	$92.15			
77435	Sbrt management	N1					

77470	Special radiation treatment	Z3		$111.85			
77520	Proton trmt, simple w/o comp	Z2	13.3589	$559.38			
77522	Proton trmt, simple w/comp	Z2	13.3589	$559.38			
77523	Proton trmt, intermediate	Z2	17.4753	$731.74			
77525	Proton treatment, complex	Z2	17.4753	$731.74			
77600	Hyperthermia treatment	Z2	5.3954	$225.92			
77605	Hyperthermia treatment	Z2	5.3954	$225.92			
77610	Hyperthermia treatment	Z2	5.3954	$225.92			
77615	Hyperthermia treatment	Z2	5.3954	$225.92			
77620	Hyperthermia treatment	Z2	5.3954	$225.92			
77750	Infuse radioactive materials	Z2	2.2007	$92.15			
77761	Apply intrcav radiat simple	Z3		$160.91			
77762	Apply intrcav radiat interm	Z2	4.2855	$179.45			
77763	Apply intrcav radiat compl	Z2	4.2855	$179.45			
77776	Apply interstit radiat simpl	Z3		$172.82			
77777	Apply interstit radiat inter	Z2	4.2855	$179.45			
77778	Apply interstit radiat compl	Z3		$251.11			
77785	Hdr brachytx, 1 channel	Z3		$124.47			
77786	Hdr brachytx, 2-12 channel	Z3		$384.96			
77787	Hdr brachytx over 12 chan	Z2	11.0231	$461.57			
77789	Apply surface radiation	Z3		$48.35			
77790	Radiation handling	N1					
77799	Radium/radioisotope therapy	Z2	4.2855	$179.45			
78000	Thyroid, single uptake	Z3		$56.28			
78001	Thyroid, multiple uptakes	Z2	1.5954	$66.80			
78003	Thyroid suppress/stimul	Z3		$57.37			
78006	Thyroid imaging with uptake	Z2	3.1434	$131.62			
78007	Thyroid image, mult uptakes	Z3		$126.28			
78010	Thyroid imaging	Z2	2.0636	$86.41			
78011	Thyroid imaging with flow	Z2	2.0636	$86.41			
78015	Thyroid met imaging	Z3		$162.72			
78016	Thyroid met imaging/studies	Z2	4.1123	$172.19			
78018	Thyroid met imaging, body	Z2	4.1123	$172.19			
78020	Thyroid met uptake	N1					
78070	Parathyroid nuclear imaging	Z3		$118.70			

78075	Adrenal nuclear imaging	Z3		$352.49			
78099	Endocrine nuclear procedure	Z2	2.0636	$86.41			
78102	Bone marrow imaging, ltd	Z3		$125.92			
78103	Bone marrow imaging, mult	Z2	3.664	$153.42			
78104	Bone marrow imaging, body	Z2	3.664	$153.42			
78110	Plasma volume, single	Z3		$64.94			
78111	Plasma volume, multiple	Z3		$75.04			
78120	Red cell mass, single	Z3		$68.55			
78121	Red cell mass, multiple	Z3		$76.13			
78122	Blood volume	Z3		$90.20			
78130	Red cell survival study	Z3		$113.29			
78135	Red cell survival kinetics	Z2	5.5303	$231.57			
78140	Red cell sequestration	Z3		$103.19			
78185	Spleen imaging	Z2	3.664	$153.42			
78190	Platelet survival, kinetics	Z2	2.5626	$107.30			
78191	Platelet survival	Z2	2.5626	$107.30			
78195	Lymph system imaging	Z2	3.664	$153.42			
78199	Blood/lymph nuclear exam	Z2	3.664	$153.42			
78201	Liver imaging	Z3		$145.76			
78202	Liver imaging with flow	Z3		$163.44			
78205	Liver imaging (3D)	Z2	4.1224	$172.62			
78206	Liver image (3d) with flow	Z2	4.1224	$172.62			
78215	Liver and spleen imaging	Z3		$151.17			
78216	Liver & spleen image/flow	Z3		$97.77			
78220	Liver function study	Z3		$106.79			
78223	Hepatobiliary imaging	Z2	4.1224	$172.62			
78230	Salivary gland imaging	Z3		$128.08			
78231	Serial salivary imaging	Z3		$96.33			
78232	Salivary gland function exam	Z3		$95.25			
78258	Esophageal motility study	Z2	3.5072	$146.86			
78261	Gastric mucosa imaging	Z2	3.5072	$146.86			
78262	Gastroesophageal reflux exam	Z2	3.5072	$146.86			
78264	Gastric emptying study	Z2	3.5072	$146.86			
78270	Vit B-12 absorption exam	Z3		$64.22			
78271	Vit b-12 absrp exam, int fac	Z3		$67.83			

78272	Vit B-12 absorp, combined	Z3		$71.08			
78278	Acute GI blood loss imaging	Z2	3.5072	$146.86			
78282	GI protein loss exam	Z2	3.5072	$146.86			
78290	Meckels divert exam	Z2	3.5072	$146.86			
78291	Leveen/shunt patency exam	Z2	3.5072	$146.86			
78299	GI nuclear procedure	Z2	3.5072	$146.86			
78300	Bone imaging, limited area	Z3		$130.25			
78305	Bone imaging, multiple areas	Z2	3.5077	$146.88			
78306	Bone imaging, whole body	Z2	3.5077	$146.88			
78315	Bone imaging, 3 phase	Z2	3.5077	$146.88			
78320	Bone imaging (3D)	Z2	3.5077	$146.88			
78399	Musculoskeletal nuclear exam	Z2	3.5077	$146.88			
78414	Non-imaging heart function	Z2	4.3352	$181.53			
78428	Cardiac shunt imaging	Z3		$145.04			
78445	Vascular flow imaging	Z2	2.8361	$118.76			
78451	Ht muscle image spect, sing	Z3		$246.06			
78452	Ht muscle image spect, mult	Z3		$360.07			
78453	Ht muscle image,planar,sing	Z3		$220.44			
78454	Ht musc image, planar, mult	Z3		$317.50			
78456	Acute venous thrombus image	Z2	2.8361	$118.76			
78457	Venous thrombosis imaging	Z2	2.8361	$118.76			
78458	Ven thrombosis images, bilat	Z2	2.8361	$118.76			
78459	Heart muscle imaging (PET)	Z2	20.3135	$850.59			
78460	Heart muscle blood, single	D5					
78461	Heart muscle blood, multiple	D5					
78464	Heart image (3d), single	D5					
78465	Heart image (3d), multiple	D5					
78466	Heart infarct image	Z3		$133.49			
78468	Heart infarct image (ef)	Z3		$167.77			
78469	Heart infarct image (3D)	Z2	4.3352	$181.53			
78472	Gated heart, planar, single	Z2	4.3352	$181.53			
78473	Gated heart, multiple	Z2	4.3352	$181.53			
78478	Heart wall motion add-on	D5					
78480	Heart function add-on	D5					
78481	Heart first pass, single	Z3		$155.14			

78483	Heart first pass, multiple	Z2	4.3352	$181.53			
78491	Heart image (pet), single	Z2	20.3135	$850.59			
78492	Heart image (pet), multiple	Z2	20.3135	$850.59			
78494	Heart image, spect	Z2	4.3352	$181.53			
78496	Heart first pass add-on	N1					
78499	Cardiovascular nuclear exam	Z2	4.3352	$181.53			
78580	Lung perfusion imaging	Z2	2.9265	$122.54			
78584	Lung V/Q image single breath	Z3		$96.33			
78585	Lung V/Q imaging	Z2	4.5899	$192.19			
78586	Aerosol lung image, single	Z2	2.9265	$122.54			
78587	Aerosol lung image, multiple	Z2	2.9265	$122.54			
78588	Perfusion lung image	Z2	4.5899	$192.19			
78591	Vent image, 1 breath, 1 proj	Z2	2.9265	$122.54			
78593	Vent image, 1 proj, gas	Z2	2.9265	$122.54			
78594	Vent image, mult proj, gas	Z2	2.9265	$122.54			
78596	Lung differential function	Z2	4.5899	$192.19			
78599	Respiratory nuclear exam	Z2	2.9265	$122.54			
78600	Brain image < 4 views	Z2	2.7885	$116.76			
78601	Brain image w/flow < 4 views	Z3		$169.57			
78605	Brain image 4+ views	Z2	2.7885	$116.76			
78606	Brain image w/flow 4 + views	Z3		$261.93			
78607	Brain imaging (3D)	Z3		$277.09			
78608	Brain imaging (PET)	Z2	14.7062	$615.79			
78610	Brain flow imaging only	Z2	2.7885	$116.76			
78630	Cerebrospinal fluid scan	Z3		$272.04			
78635	CSF ventriculography	Z3		$255.80			
78645	CSF shunt evaluation	Z2	2.7885	$116.76			
78647	Cerebrospinal fluid scan	Z3		$261.93			
78650	CSF leakage imaging	Z3		$267.71			
78660	Nuclear exam of tear flow	Z2	2.7885	$116.76			
78699	Nervous system nuclear exam	Z2	2.7885	$116.76			
78700	Kidney imaging, morphol	Z3		$138.54			
78701	Kidney imaging with flow	Z3		$170.65			
78707	K flow/funct image w/o drug	Z3		$175.34			
78708	K flow/funct image w/drug	Z3		$115.81			

78709	K flow/funct image, multiple	Z2	4.608	$192.95			
78710	Kidney imaging (3D)	Z3		$179.67			
78725	Kidney function study	Z3		$75.77			
78730	Urinary bladder retention	Z3		$61.70			
78740	Ureteral reflux study	Z3		$169.93			
78761	Testicular imaging w/flow	Z3		$158.75			
78799	Genitourinary nuclear exam	Z2	4.608	$192.95			
78800	Tumor imaging, limited area	Z3		$140.71			
78801	Tumor imaging, mult areas	Z3		$191.94			
78802	Tumor imaging, whole body	Z3		$259.05			
78803	Tumor imaging (3D)	Z3		$275.28			
78804	Tumor imaging, whole body	Z3		$484.18			
78805	Abscess imaging, ltd area	Z3		$135.30			
78806	Abscess imaging, whole body	Z3		$271.31			
78807	Nuclear localization/abscess	Z2	4.1123	$172.19			
78808	Iv inj ra drug dx study	N1					
78811	Pet image, ltd area	Z2	14.7062	$615.79			
78812	Pet image, skull-thigh	Z2	14.7062	$615.79			
78813	Pet image, full body	Z2	14.7062	$615.79			
78814	Pet image w/ct, lmtd	Z2	14.7062	$615.79			
78815	Pet image w/ct, skull-thigh	Z2	14.7062	$615.79			
78816	Pet image w/ct, full body	Z2	14.7062	$615.79			
78999	Nuclear diagnostic exam	Z2	1.5954	$66.80			
79005	Nuclear rx, oral admin	Z3		$53.76			
79101	Nuclear rx, iv admin	Z3		$58.45			
79200	Nuclear rx, intracav admin	Z3		$64.94			
79300	Nuclr rx, interstit colloid	Z2	3.0919	$129.47			
79403	Hematopoietic nuclear tx	Z3		$90.92			
79440	Nuclear rx, intra-articular	Z3		$51.23			
79445	Nuclear rx, intra-arterial	Z2	3.0919	$129.47			
79999	Nuclear medicine therapy	Z2	3.0919	$129.47			
90371	Hep b ig, im	K2		$114.20			
90375	Rabies ig, im/sc	K2		$150.91			
90376	Rabies ig, heat treated	K2		$140.06			
90378	Rsv, mab, im, 50mg	K2		$634.00			

90385	Rh ig, minidose, im	N1					
90396	Varicella-zoster ig, im	K2		$147.58			
90476	Adenovirus vaccine, type 4	K2		$72.17			
90585	Bcg vaccine, percut	K2		$108.14			
90632	Hep a vaccine, adult im	N1					
90633	Hep a vacc, ped/adol, 2 dose	N1					
90634	Hep a vacc, ped/adol, 3 dose	N1					
90636	Hep a/hep b vacc, adult im	N1					
90645	Hib vaccine, hboc, im	N1					
90646	Hib vaccine, prp-d, im	N1					
90647	Hib vaccine, prp-omp, im	N1					
90648	Hib vaccine, prp-t, im	N1					
90655	Flu vaccine no preserv 6-35m	L1					
90656	Flu vaccine no preserv 3 & >	L1					
90657	Flu vaccine, 3 yrs, im	L1					
90658	Flu vaccine, 3 yrs & >, im	L1					
90660	Flu vaccine, nasal	L1					
90665	Lyme disease vaccine, im	K2		$0.93			
90669	Pneumococcal vacc, 7 val im	L1					
90675	Rabies vaccine, im	K2		$173.25			
90676	Rabies vaccine, id	K2		$96.27			
90680	Rotovirus vacc 3 dose, oral	K2		$72.37			
90681	Rotavirus vacc 2 dose oral	K2		$106.60			
90690	Typhoid vaccine, oral	N1					
90691	Typhoid vaccine, im	N1					
90692	Typhoid vaccine, h-p, sc/id	N1					
90696	Dtap-ipv vacc 4-6 yr im	N1					
90698	Dtap-hib-ip vaccine, im	N1					
90700	Dtap vaccine, < 7 yrs, im	N1					
90701	Dtp vaccine, im	N1					
90702	Dt vaccine < 7, im	N1					
90703	Tetanus vaccine, im	N1					
90704	Mumps vaccine, sc	N1					
90705	Measles vaccine, sc	N1					
90706	Rubella vaccine, sc	N1					

90707	Mmr vaccine, sc	N1					
90708	Measles-rubella vaccine, sc	N1					
90710	Mmrv vaccine, sc	N1					
90712	Oral poliovirus vaccine	N1					
90713	Poliovirus, ipv, sc/im	N1					
90714	Td vaccine no prsrv >/= 7 im	N1					
90715	Tdap vaccine >7 im	N1					
90717	Yellow fever vaccine, sc	N1					
90718	Td vaccine > 7, im	N1					
90719	Diphtheria vaccine, im	N1					
90720	Dtp/hib vaccine, im	N1					
90721	Dtap/hib vaccine, im	N1					
90725	Cholera vaccine, injectable	K2		$103.90			
90732	Pneumococcal vaccine	L1					
90733	Meningococcal vaccine, sc	K2		$98.54			
90734	Meningococcal vaccine, im	K2		$102.46			
90735	Encephalitis vaccine, sc	K2		$100.15			
90740	Hepb vacc, ill pat 3 dose im	F4					
90743	Hep b vacc, adol, 2 dose, im	F4					
90744	Hepb vacc ped/adol 3 dose im	F4					
90746	Hep b vaccine, adult, im	F4					
90747	Hepb vacc, ill pat 4 dose im	F4					
90749	Vaccine toxoid	N1					
A4218	Sterile saline or water	N1					
A4220	Infusion pump refill kit	N1					
A4248	Chlorhexidine antisept	N1					
A4262	Temporary tear duct plug	N1					
A4263	Permanent tear duct plug	N1					
A4270	Disposable endoscope sheath	N1					
A4300	Cath impl vasc access portal	N1					
A4301	Implantable access syst perc	N1					
A4305	Drug delivery system >=50 ML	N1					
A4306	Drug delivery system <=50 ml	N1					
A4641	Radiopharm dx agent noc	N1					
A4642	In111 satumomab	N1					

A4648	Implantable tissue marker	N1					
A4650	Implant radiation dosimeter	N1					
A9500	Tc99m sestamibi	N1					
A9501	Technetium TC-99m teboroxime	N1					
A9502	Tc99m tetrofosmin	N1					
A9503	Tc99m medronate	N1					
A9504	Tc99m apcitide	N1					
A9505	TL201 thallium	N1					
A9507	In111 capromab	N1					
A9508	I131 iodobenguate, dx	N1					
A9509	Iodine I-123 sod iodide mil	N1					
A9510	Tc99m disofenin	N1					
A9512	Tc99m pertechnetate	N1					
A9516	Iodine I-123 sod iodide mic	N1					
A9521	Tc99m exametazime	N1					
A9524	I131 serum albumin, dx	N1					
A9526	Nitrogen N-13 ammonia	N1					
A9527	Iodine I-125 sodium iodide	H2			$37.83		
A9528	Iodine I-131 iodide cap, dx	N1					
A9529	I131 iodide sol, dx	N1					
A9531	I131 max 100uCi	N1					
A9532	I125 serum albumin, dx	N1					
A9535	Injection, methylene blue	D5					
A9536	Tc99m depreotide	N1					
A9537	Tc99m mebrofenin	N1					
A9538	Tc99m pyrophosphate	N1					
A9539	Tc99m pentetate	N1					
A9540	Tc99m MAA	N1					
A9541	Tc99m sulfur colloid	N1					
A9542	In111 ibritumomab, dx	N1					
A9544	I131 tositumomab, dx	N1					
A9546	Co57/58	N1					
A9547	In111 oxyquinoline	N1					
A9548	In111 pentetate	N1					
A9550	Tc99m gluceptate	N1					

A9551	Tc99m succimer	N1					
A9552	F18 fdg	N1					
A9553	Cr51 chromate	N1					
A9554	I125 iothalamate, dx	N1					
A9555	Rb82 rubidium	N1					
A9556	Ga67 gallium	N1					
A9557	Tc99m bicisate	N1					
A9558	Xe133 xenon 10mci	N1					
A9559	Co57 cyano	N1					
A9560	Tc99m labeled rbc	N1					
A9561	Tc99m oxidronate	N1					
A9562	Tc99m mertiatide	N1					
A9566	Tc99m fanolesomab	N1					
A9567	Technetium TC-99m aerosol	N1					
A9568	Technetium tc99m arcitumomab	N1					
A9569	Technetium TC-99m auto WBC	N1					
A9570	Indium In-111 auto WBC	N1					
A9571	Indium IN-111 auto platelet	N1					
A9572	Indium In-111 pentetreotide	N1					
A9576	Inj prohance multipack	N1					
A9577	Inj multihance	N1					
A9578	Inj multihance multipack	N1					
A9579	Gad-base MR contrast NOS,1ml	N1					
A9580	Sodium fluoride F-18	N1					
A9581	Gadoxetate disodium inj	K2			$13.50		
A9582	Iodine I-123 iobenguane	K2			$2,284.77		
A9583	Gadofosveset trisodium inj	K2			$12.89		
A9698	Non-rad contrast materialNOC	N1					
C1713	Anchor/screw bn/bn,tis/bn	N1					
C1714	Cath, trans atherectomy, dir	N1					
C1715	Brachytherapy needle	N1					
C1716	Brachytx, non-str, Gold-198	H2			$42.75		
C1717	Brachytx, non-str,HDR Ir-192	H2			$230.81		
C1719	Brachytx, NS, Non-HDRIr-192	H2			$63.86		
C1721	AICD, dual chamber	N1					

C1722	AICD, single chamber	N1					
C1724	Cath, trans atherec,rotation	N1					
C1725	Cath, translumin non-laser	N1					
C1726	Cath, bal dil, non-vascular	N1					
C1727	Cath, bal tis dis, non-vas	N1					
C1728	Cath, brachytx seed adm	N1					
C1729	Cath, drainage	N1					
C1730	Cath, EP, 19 or few elect	N1					
C1731	Cath, EP, 20 or more elec	N1					
C1732	Cath, EP, diag/abl, 3D/vect	N1					
C1733	Cath, EP, othr than cool-tip	N1					
C1750	Cath, hemodialysis,long-term	N1					
C1751	Cath, inf, per/cent/midline	N1					
C1752	Cath,hemodialysis,short-term	N1					
C1753	Cath, intravas ultrasound	N1					
C1754	Catheter, intradiscal	N1					
C1755	Catheter, intraspinal	N1					
C1756	Cath, pacing, transesoph	N1					
C1757	Cath, thrombectomy/embolect	N1					
C1758	Catheter, ureteral	N1					
C1759	Cath, intra echocardiography	N1					
C1760	Closure dev, vasc	N1					
C1762	Conn tiss, human(inc fascia)	N1					
C1763	Conn tiss, non-human	N1					
C1764	Event recorder, cardiac	N1					
C1765	Adhesion barrier	N1					
C1766	Intro/sheath,strble,non-peel	N1					
C1767	Generator, neuro non-recharg	N1					
C1768	Graft, vascular	N1					
C1769	Guide wire	N1					
C1770	Imaging coil, MR, insertable	N1					
C1771	Rep dev, urinary, w/sling	N1					
C1772	Infusion pump, programmable	N1					
C1773	Ret dev, insertable	N1					
C1776	Joint device (implantable)	N1					

C1777	Lead, AICD, endo single coil	N1					
C1778	Lead, neurostimulator	N1					
C1779	Lead, pmkr, transvenous VDD	N1					
C1780	Lens, intraocular (new tech)	N1					
C1781	Mesh (implantable)	N1					
C1782	Morcellator	N1					
C1783	Ocular imp, aqueous drain de	N1					
C1784	Ocular dev, intraop, det ret	N1					
C1785	Pmkr, dual, rate-resp	N1					
C1786	Pmkr, single, rate-resp	N1					
C1787	Patient progr, neurostim	N1					
C1788	Port, indwelling, imp	N1					
C1789	Prosthesis, breast, imp	N1					
C1813	Prosthesis, penile, inflatab	N1					
C1814	Retinal tamp, silicone oil	N1					
C1815	Pros, urinary sph, imp	N1					
C1816	Receiver/transmitter, neuro	N1					
C1817	Septal defect imp sys	N1					
C1818	Integrated keratoprosthesis	N1					
C1819	Tissue localization-excision	N1					
C1820	Generator neuro rechg bat sy	N1					
C1821	Interspinous implant	N1					
C1874	Stent, coated/cov w/del sys	N1					
C1875	Stent, coated/cov w/o del sy	N1					
C1876	Stent, non-coa/non-cov w/del	N1					
C1877	Stent, non-coat/cov w/o del	N1					
C1878	Matrl for vocal cord	N1					
C1879	Tissue marker, implantable	N1					
C1880	Vena cava filter	N1					
C1881	Dialysis access system	N1					
C1882	AICD, other than sing/dual	N1					
C1883	Adapt/ext, pacing/neuro lead	N1					
C1884	Embolization Protect syst	N1					
C1885	Cath, translumin angio laser	N1					
C1887	Catheter, guiding	N1					

C1888	Endovas non-cardiac abl cath	N1					
C1891	Infusion pump,non-prog, perm	N1					
C1892	Intro/sheath,fixed,peel-away	N1					
C1893	Intro/sheath, fixed,non-peel	N1					
C1894	Intro/sheath, non-laser	N1					
C1895	Lead, AICD, endo dual coil	N1					
C1896	Lead, AICD, non sing/dual	N1					
C1897	Lead, neurostim test kit	N1					
C1898	Lead, pmkr, other than trans	N1					
C1899	Lead, pmkr/AICD combination	N1					
C1900	Lead, coronary venous	N1					
C2614	Probe, perc lumb disc	N1					
C2615	Sealant, pulmonary, liquid	N1					
C2616	Brachytx, non-str,Yttrium-90	H2		$15,740.73			
C2617	Stent, non-cor, tem w/o del	N1					
C2618	Probe, cryoablation	N1					
C2619	Pmkr, dual, non rate-resp	N1					
C2620	Pmkr, single, non rate-resp	N1					
C2621	Pmkr, other than sing/dual	N1					
C2622	Prosthesis, penile, non-inf	N1					
C2625	Stent, non-cor, tem w/del sy	N1					
C2626	Infusion pump, non-prog,temp	N1					
C2627	Cath, suprapubic/cystoscopic	N1					
C2628	Catheter, occlusion	N1					
C2629	Intro/sheath, laser	N1					
C2630	Cath, EP, cool-tip	N1					
C2631	Rep dev, urinary, w/o sling	N1					
C2634	Brachytx, non-str, HA, I-125	H2		$59.65			
C2635	Brachytx, non-str, HA, P-103	H2		$28.52			
C2636	Brachy linear, non-str,P-103	H2		$19.32			
C2638	Brachytx, stranded, I-125	H2		$42.38			
C2639	Brachytx, non-stranded,I-125	H2		$36.09			
C2640	Brachytx, stranded, P-103	H2		$60.21			
C2641	Brachytx, non-stranded,P-103	H2		$56.98			
C2642	Brachytx, stranded, C-131	H2		$109.57			
C2643	Brachytx, non-stranded,C-131	H2		$65.93			
C2698	Brachytx, stranded, NOS	H2		$42.38			
C2699	Brachytx, non-stranded, NOS	H2		$28.52			
C8900	MRA w/cont, abd	Z2	6.0108	$251.69			
C8901	MRA w/o cont, abd	Z2	4.9553	$207.49			
C8902	MRA w/o fol w/cont, abd	Z2	7.5905	$317.84			
C8903	MRI w/cont, breast, uni	Z2	6.0108	$251.69			
C8904	MRI w/o cont, breast, uni	Z2	4.9553	$207.49			
C8905	MRI w/o fol w/cont, brst, un	Z2	7.5905	$317.84			
C8906	MRI w/cont, breast, bi	Z2	6.0108	$251.69			
C8907	MRI w/o cont, breast, bi	Z2	4.9553	$207.49			
C8908	MRI w/o fol w/cont, breast,	Z2	7.5905	$317.84			
C8909	MRA w/cont, chest	Z2	6.0108	$251.69			
C8910	MRA w/o cont, chest	Z2	4.9553	$207.49			
C8911	MRA w/o fol w/cont, chest	Z2	7.5905	$317.84			
C8912	MRA w/cont, lwr ext	Z2	6.0108	$251.69			
C8913	MRA w/o cont, lwr ext	Z2	4.9553	$207.49			
C8914	MRA w/o fol w/cont, lwr ext	Z2	7.5905	$317.84			
C8918	MRA w/cont, pelvis	Z2	6.0108	$251.69			
C8919	MRA w/o cont, pelvis	Z2	4.9553	$207.49			
C8920	MRA w/o fol w/cont, pelvis	Z2	7.5905	$317.84			
C9113	Inj pantoprazole sodium, via	N1					
C9121	Injection, argatroban	K2		$17.87			
C9245	Injection, romiplostim	D5					
C9246	Inj, gadoxetate disodium	D5					
C9247	Inj, iobenguane, I-123, dx	D5					
C9248	Inj, clevidipine butyrate	K2		$3.10			
C9249	Inj, certolizumab pegol	D5					
C9250	Artiss fibrin sealant	K2		$135.36			
C9251	Inj, C1 esterase inhibitor	D5					
C9252	Injection, plerixafor	D5					
C9253	Injection, temozolomide	D5					
C9254	Injection, lacosamide	K2		$0.18			
C9255	Paliperidone palmitate inj	K2		$6.71			
C9256	Dexamethasone intravitreal	K2		$196.10			

C9257	Bevacizumab injection	K2		$1.41			
C9352	Neuragen nerve guide, per cm	N1					
C9353	Neurawrap nerve protector,cm	N1					
C9354	Veritas collagen matrix, cm2	N1					
C9355	Neuromatrix nerve cuff, cm	N1					
C9356	TenoGlide tendon prot, cm2	K2		$26.37			
C9358	SurgiMend, fetal	K2		$10.64			
C9359	Implnt,bon void filler-putty	K2		$61.47			
C9360	SurgiMend, neonatal	K2		$11.14			
C9361	NeuroMend nerve wrap	K2		$250.53			
C9362	Implnt,bon void filler-strip	K2		$63.60			
C9363	Integra Meshed Bil Wound Mat	K2		$28.30			
C9364	Porcine implant, Permacol	K2		$18.09			
C9399	Unclassified drugs or biolog	K7					
E0616	Cardiac event recorder	N1					
E0749	Elec osteogen stim implanted	N1					
E0782	Non-programble infusion pump	N1					
E0783	Programmable infusion pump	N1					
E0785	Replacement impl pump cathet	N1					
E0786	Implantable pump replacement	N1					
G0130	Single energy x-ray study	Z3		$20.20			
G0173	Linear acc stereo radsur com	Z2	50.6364	$2,120.30			
G0251	Linear acc based stero radio	Z2	13.6467	$571.43			
G0288	Recon, CTA for surg plan	N1					
G0339	Robot lin-radsurg com, first	Z2	50.6364	$2,120.30			
G0340	Robt lin-radsurg fractx 2-5	Z2	35.273	$1,476.99			
J0120	Tetracyclin injection	N1					
J0129	Abatacept injection	K2		$19.15			
J0130	Abciximab injection	K2		$454.71			
J0132	Acetylcysteine injection	K2		$2.33			
J0133	Acyclovir injection	N1					
J0135	Adalimumab injection	K2		$359.89			
J0150	Injection adenosine 6 MG	K2		$10.01			
J0152	Adenosine injection	K2		$79.40			
J0170	Adrenalin epinephrin inject	N1					

J0180	Agalsidase beta injection	K2		$133.68			
J0190	Inj biperiden lactate/5 mg	N1					
J0200	Alatrofloxacin mesylate	N1					
J0205	Alglucerase injection	K2		$41.20			
J0207	Amifostine	K2		$333.69			
J0210	Methyldopate hcl injection	K2		$32.60			
J0215	Alefacept	K2		$30.14			
J0220	Alglucosidase alfa injection	K2		$124.69			
J0256	Alpha 1 proteinase inhibitor	K2		$3.67			
J0278	Amikacin sulfate injection	N1					
J0280	Aminophyllin 250 MG inj	N1					
J0282	Amiodarone HCl	N1					
J0285	Amphotericin B	N1					
J0287	Amphotericin b lipid complex	K2		$9.47			
J0288	Ampho b cholesteryl sulfate	K2		$13.74			
J0289	Amphotericin b liposome inj	K2		$15.51			
J0290	Ampicillin 500 MG inj	N1					
J0295	Ampicillin sodium per 1.5 gm	N1					
J0300	Amobarbital 125 MG inj	N1					
J0330	Succinycholine chloride inj	N1					
J0348	Anidulafungin injection	K2		$1.22			
J0360	Hydralazine hcl injection	N1					
J0364	Apomorphine hydrochloride	N1					
J0365	Aprotonin, 10,000 kiu	K2		$2.60			
J0380	Inj metaraminol bitartrate	N1					
J0390	Chloroquine injection	N1					
J0400	Aripiprazole injection	N1					
J0456	Azithromycin	N1					
J0460	Atropine sulfate injection	D5					
J0461	Atropine sulfate injection	N1					
J0470	Dimecaprol injection	K2		$26.88			
J0475	Baclofen 10 MG injection	K2		$199.42			
J0476	Baclofen intrathecal trial	K2		$73.00			
J0480	Basiliximab	K2		$1,696.29			
J0500	Dicyclomine injection	N1					

J0515	Inj benztropine mesylate	N1					
J0520	Bethanechol chloride inject	N1					
J0530	Penicillin g benzathine inj	D5					
J0540	Penicillin g benzathine inj	D5					
J0550	Penicillin g benzathine inj	D5					
J0559	PenG benzathine/procaine inj	N1					
J0560	Penicillin g benzathine inj	N1					
J0570	Penicillin g benzathine inj	N1					
J0580	Penicillin g benzathine inj	N1					
J0583	Bivalirudin	K2		$2.41			
J0585	Injection,onabotulinumtoxinA	K2		$5.40			
J0586	AbobotulinumtoxintypeA	K2		$7.93			
J0587	Inj, rimabotulinumtoxinB	K2		$10.38			
J0592	Buprenorphine hydrochloride	N1					
J0594	Busulfan injection	K2		$14.18			
J0595	Butorphanol tartrate 1 mg	N1					
J0598	C1 esterase inhibitor inj	K2		$41.40			
J0600	Edetate calcium disodium inj	K2		$78.86			
J0610	Calcium gluconate injection	N1					
J0620	Calcium glycer & lact/10 ML	N1					
J0630	Calcitonin salmon injection	K2		$48.34			
J0636	Inj calcitriol per 0.1 mcg	N1					
J0637	Caspofungin acetate	K2		$11.54			
J0640	Leucovorin calcium injection	N1					
J0641	Levoleucovorin injection	K2		$1.36			
J0670	Inj mepivacaine HCL/10 ml	N1					
J0690	Cefazolin sodium injection	N1					
J0692	Cefepime HCl for injection	N1					
J0694	Cefoxitin sodium injection	N1					
J0696	Ceftriaxone sodium injection	N1					
J0697	Sterile cefuroxime injection	N1					
J0698	Cefotaxime sodium injection	N1					
J0702	Betamethasone acet&sod phosp	N1					
J0704	Betamethasone sod phosp/4 MG	N1					
J0706	Caffeine citrate injection	N1					

J0710	Cephapirin sodium injection	N1					
J0713	Inj ceftazidime per 500 mg	N1					
J0715	Ceftizoxime sodium / 500 MG	N1					
J0718	Certolizumab pegol inj	K2		$3.72			
J0720	Chloramphenicol sodium injec	N1					
J0725	Chorionic gonadotropin/1000u	N1					
J0735	Clonidine hydrochloride	K2		$110.46			
J0740	Cidofovir injection	K2		$746.87			
J0743	Cilastatin sodium injection	N1					
J0744	Ciprofloxacin iv	N1					
J0745	Inj codeine phosphate /30 MG	N1					
J0760	Colchicine injection	N1					
J0770	Colistimethate sodium inj	N1					
J0780	Prochlorperazine injection	N1					
J0795	Corticorelin ovine triflutal	K2		$4.22			
J0800	Corticotropin injection	K2		$2,394.31			
J0833	Cosyntropin injection NOS	K2		$64.19			
J0834	Cosyntropin cortrosyn inj	K2		$89.48			
J0835	Inj cosyntropin per 0.25 MG	D5					
J0850	Cytomegalovirus imm IV /vial	K2		$862.24			
J0878	Daptomycin injection	K2		$0.42			
J0881	Darbepoetin alfa, non-esrd	K2		$2.78			
J0885	Epoetin alfa, non-esrd	K2		$9.36			
J0894	Decitabine injection	K2		$28.68			
J0895	Deferoxamine mesylate inj	N1					
J0900	Testosterone enanthate inj	N1					
J0945	Brompheniramine maleate inj	K2		$9.24			
J0970	Estradiol valerate injection	N1					
J1000	Depo-estradiol cypionate inj	N1					
J1020	Methylprednisolone 20 MG inj	N1					
J1030	Methylprednisolone 40 MG inj	N1					
J1040	Methylprednisolone 80 MG inj	N1					
J1051	Medroxyprogesterone inj	N1					
J1060	Testosterone cypionate 1 ML	N1					
J1070	Testosterone cypionat 100 MG	N1					

J1080	Testosterone cypionat 200 MG	N1					
J1094	Inj dexamethasone acetate	N1					
J1100	Dexamethasone sodium phos	N1					
J1110	Inj dihydroergotamine mesylt	N1					
J1120	Acetazolamid sodium injectio	N1					
J1160	Digoxin injection	N1					
J1162	Digoxin immune fab (ovine)	K2		$467.59			
J1165	Phenytoin sodium injection	N1					
J1170	Hydromorphone injection	N1					
J1180	Dyphylline injection	N1					
J1190	Dexrazoxane HCl injection	K2		$367.10			
J1200	Diphenhydramine hcl injectio	N1					
J1205	Chlorothiazide sodium inj	K2		$304.91			
J1212	Dimethyl sulfoxide 50% 50 ML	K2		$68.40			
J1230	Methadone injection	N1					
J1240	Dimenhydrinate injection	N1					
J1245	Dipyridamole injection	N1					
J1250	Inj dobutamine HCL/250 mg	N1					
J1260	Dolasetron mesylate	N1					
J1265	Dopamine injection	N1					
J1267	Doripenem injection	K2		$0.55			
J1270	Injection, doxercalciferol	N1					
J1300	Eculizumab injection	K2		$177.56			
J1320	Amitriptyline injection	N1					
J1324	Enfuvirtide injection	K2		$0.48			
J1325	Epoprostenol injection	N1					
J1327	Eptifibatide injection	K2		$18.50			
J1330	Ergonovine maleate injection	N1					
J1335	Ertapenem injection	N1					
J1364	Erythro lactobionate /500 MG	N1					
J1380	Estradiol valerate 10 MG inj	N1					
J1390	Estradiol valerate 20 MG inj	N1					
J1410	Inj estrogen conjugate 25 MG	K2		$87.05			
J1430	Ethanolamine oleate 100 mg	K2		$147.14			
J1435	Injection estrone per 1 MG	N1					

J1436	Etidronate disodium inj	K2		$25.02			
J1438	Etanercept injection	K2		$188.41			
J1440	Filgrastim 300 mcg injection	K2		$215.57			
J1441	Filgrastim 480 mcg injection	K2		$336.26			
J1450	Fluconazole	N1					
J1451	Fomepizole, 15 mg	K2		$7.56			
J1453	Fosaprepitant injection	K2		$1.57			
J1455	Foscarnet sodium injection	N1					
J1457	Gallium nitrate injection	K2		$1.97			
J1458	Galsulfase injection	K2		$334.14			
J1459	Inj IVIG privigen 500 mg	K2		$35.14			
J1460	Gamma globulin 1 CC inj	K2		$15.85			
J1470	Gamma globulin 2 CC inj	K2		$31.70			
J1480	Gamma globulin 3 CC inj	K2		$47.53			
J1490	Gamma globulin 4 CC inj	K2		$63.39			
J1500	Gamma globulin 5 CC inj	K2		$79.24			
J1510	Gamma globulin 6 CC inj	K2		$95.12			
J1520	Gamma globulin 7 CC inj	K2		$110.86			
J1530	Gamma globulin 8 CC inj	K2		$126.78			
J1540	Gamma globulin 9 CC inj	K2		$158.48			
J1550	Gamma globulin 10 CC inj	K2		$158.48			
J1560	Gamma globulin > 10 CC inj	K2		$158.48			
J1561	Gamunex injection	K2		$36.91			
J1562	Vivaglobin, inj	K2		$7.04			
J1565	RSV-ivig	D5					
J1566	Immune globulin, powder	K2		$29.90			
J1568	Octagam injection	K2		$37.00			
J1569	Gammagard liquid injection	K2		$37.81			
J1570	Ganciclovir sodium injection	N1					
J1571	Hepagam b im injection	K2		$50.22			
J1572	Flebogamma injection	K2		$36.42			
J1573	Hepagam b intravenous, inj	K2		$50.22			
J1580	Garamycin gentamicin inj	N1					
J1590	Gatifloxacin injection	N1					
J1595	Injection glatiramer acetate	K2		$81.34			

J1600	Gold sodium thiomaleate inj	N1					
J1610	Glucagon hydrochloride/1 MG	K2		$82.64			
J1620	Gonadorelin hydroch/ 100 mcg	K2		$32.12			
J1626	Granisetron hcl injection	N1					
J1630	Haloperidol injection	N1					
J1631	Haloperidol decanoate inj	N1					
J1640	Hemin, 1 mg	K2		$7.98			
J1642	Inj heparin sodium per 10 u	N1					
J1644	Inj heparin sodium per 1000u	N1					
J1645	Dalteparin sodium	N1					
J1650	Inj enoxaparin sodium	N1					
J1652	Fondaparinux sodium	K2		$6.04			
J1655	Tinzaparin sodium injection	N1					
J1670	Tetanus immune globulin inj	K2		$207.82			
J1680	Human fibrinogen conc inj	K2		$0.24			
J1700	Hydrocortisone acetate inj	N1					
J1710	Hydrocortisone sodium ph inj	N1					
J1720	Hydrocortisone sodium succ i	N1					
J1730	Diazoxide injection	K2		$112.16			
J1740	Ibandronate sodium injection	K2		$138.94			
J1742	Ibutilide fumarate injection	K2		$395.62			
J1743	Idursulfase injection	K2		$446.44			
J1745	Infliximab injection	K2		$57.56			
J1750	Inj iron dextran	K2		$12.69			
J1756	Iron sucrose injection	K2		$0.37			
J1785	Injection imiglucerase /unit	K2		$4.12			
J1790	Droperidol injection	N1					
J1800	Propranolol injection	N1					
J1815	Insulin injection	N1					
J1817	Insulin for insulin pump use	K2		$3.37			
J1830	Interferon beta-1b / .25 MG	K2		$175.51			
J1835	Itraconazole injection	N1					
J1840	Kanamycin sulfate 500 MG inj	N1					
J1850	Kanamycin sulfate 75 MG inj	N1					
J1885	Ketorolac tromethamine inj	N1					

J1890	Cephalothin sodium injection	N1					
J1930	Lanreotide injection	K2		$26.62			
J1931	Laronidase injection	K2		$25.08			
J1940	Furosemide injection	N1					
J1945	Lepirudin	K2		$226.90			
J1950	Leuprolide acetate /3.75 MG	K2		$483.41			
J1953	Levetiracetam injection	K2		$0.46			
J1956	Levofloxacin injection	N1					
J1960	Levorphanol tartrate inj	N1					
J1980	Hyoscyamine sulfate inj	N1					
J1990	Chlordiazepoxide injection	N1					
J2001	Lidocaine injection	N1					
J2010	Lincomycin injection	N1					
J2020	Linezolid injection	K2		$30.94			
J2060	Lorazepam injection	N1					
J2150	Mannitol injection	N1					
J2170	Mecasermin injection	N1					
J2175	Meperidine hydrochl /100 MG	N1					
J2180	Meperidine/promethazine inj	N1					
J2185	Meropenem	N1					
J2210	Methylergonovin maleate inj	N1					
J2248	Micafungin sodium injection	K2		$1.11			
J2250	Inj midazolam hydrochloride	N1					
J2260	Inj milrinone lactate / 5 MG	N1					
J2270	Morphine sulfate injection	N1					
J2271	Morphine so4 injection 100mg	N1					
J2275	Morphine sulfate injection	N1					
J2278	Ziconotide injection	K2		$6.38			
J2280	Inj, moxifloxacin 100 mg	N1					
J2300	Inj nalbuphine hydrochloride	N1					
J2310	Inj naloxone hydrochloride	N1					
J2315	Naltrexone, depot form	K2		$2.10			
J2320	Nandrolone decanoate 50 MG	K2		$7.00			
J2321	Nandrolone decanoate 100 MG	K2		$7.00			
J2322	Nandrolone decanoate 200 MG	K2		$14.73			

J2323	Natalizumab injection	K2		$8.08			
J2325	Nesiritide injection	K2		$37.25			
J2353	Octreotide injection, depot	K2		$106.19			
J2354	Octreotide inj, non-depot	N1					
J2355	Oprelvekin injection	K2		$241.17			
J2357	Omalizumab injection	K2		$18.86			
J2360	Orphenadrine injection	N1					
J2370	Phenylephrine hcl injection	N1					
J2400	Chloroprocaine hcl injection	N1					
J2405	Ondansetron hcl injection	N1					
J2410	Oxymorphone hcl injection	N1					
J2425	Palifermin injection	K2		$11.11			
J2430	Pamidronate disodium /30 MG	K2		$19.98			
J2440	Papaverin hcl injection	N1					
J2469	Palonosetron hcl	K2		$17.18			
J2501	Paricalcitol	N1					
J2503	Pegaptanib sodium injection	K2		$1,014.11			
J2504	Pegademase bovine, 25 iu	K2		$242.67			
J2505	Injection, pegfilgrastim 6mg	K2		$2,320.08			
J2510	Penicillin g procaine inj	N1					
J2513	Pentastarch 10% solution	K2		$158.77			
J2515	Pentobarbital sodium inj	N1					
J2540	Penicillin g potassium inj	N1					
J2543	Piperacillin/tazobactam	N1					
J2550	Promethazine hcl injection	N1					
J2560	Phenobarbital sodium inj	N1					
J2562	Plerixafor injection	K2		$268.72			
J2590	Oxytocin injection	N1					
J2597	Inj desmopressin acetate	N1					
J2650	Prednisolone acetate inj	N1					
J2670	Totazoline hcl injection	N1					
J2675	Inj progesterone per 50 MG	N1					
J2680	Fluphenazine decanoate 25 MG	N1					
J2690	Procainamide hcl injection	N1					
J2700	Oxacillin sodium injeciton	N1					

J2710	Neostigmine methylslfte inj	N1					
J2720	Inj protamine sulfate/10 MG	N1					
J2724	Protein c concentrate	K2		$11.96			
J2725	Inj protirelin per 250 mcg	N1					
J2730	Pralidoxime chloride inj	K2		$89.08			
J2760	Phentolaine mesylate inj	N1					
J2765	Metoclopramide hcl injection	N1					
J2770	Quinupristin/dalfopristin	K2		$144.34			
J2778	Ranibizumab injection	K2		$397.01			
J2780	Ranitidine hydrochloride inj	N1					
J2783	Rasburicase	K2		$169.23			
J2785	Regadenoson injection	K2		$50.85			
J2788	Rho d immune globulin 50 mcg	K2		$25.47			
J2790	Rho d immune globulin inj	K2		$84.51			
J2791	Rhophylac injection	K2		$5.12			
J2792	Rho(D) immune globulin h, sd	K2		$18.22			
J2793	Rilonacept injection	K2		$23.64			
J2794	Risperidone, long acting	K2		$4.94			
J2795	Ropivacaine HCl injection	N1					
J2796	Romiplostim injection	K2		$43.60			
J2800	Methocarbamol injection	N1					
J2805	Sincalide injection	N1					
J2810	Inj theophylline per 40 MG	N1					
J2820	Sargramostim injection	K2		$23.81			
J2850	Inj secretin synthetic human	K2		$19.93			
J2910	Aurothioglucose injeciton	N1					
J2916	Na ferric gluconate complex	N1					
J2920	Methylprednisolone injection	N1					
J2930	Methylprednisolone injection	N1					
J2940	Somatrem injection	K2		$4.89			
J2941	Somatropin injection	K2		$54.38			
J2950	Promazine hcl injection	N1					
J2993	Reteplase injection	K2		$1,258.72			
J2995	Inj streptokinase /250000 IU	K2		$78.00			
J2997	Alteplase recombinant	K2		$36.23			

J3000	Streptomycin injection	N1					
J3010	Fentanyl citrate injeciton	N1					
J3030	Sumatriptan succinate / 6 MG	K2		$42.72			
J3070	Pentazocine injection	N1					
J3101	Tenecteplase injection	K2		$41.84			
J3105	Terbutaline sulfate inj	N1					
J3120	Testosterone enanthate inj	N1					
J3130	Testosterone enanthate inj	N1					
J3140	Testosterone suspension inj	N1					
J3150	Testosteron propionate inj	N1					
J3230	Chlorpromazine hcl injection	N1					
J3240	Thyrotropin injection	K2		$1,043.80			
J3243	Tigecycline injection	K2		$1.15			
J3246	Tirofiban HCl	K2		$7.74			
J3250	Trimethobenzamide hcl inj	N1					
J3260	Tobramycin sulfate injection	N1					
J3265	Injection torsemide 10 mg/ml	N1					
J3280	Thiethylperazine maleate inj	N1					
J3285	Treprostinil injection	K2		$54.83			
J3300	Triamcinolone A inj PRS-free	K2		$3.16			
J3301	Triamcinolone acet inj NOS	N1					
J3302	Triamcinolone diacetate inj	N1					
J3303	Triamcinolone hexacetonl inj	N1					
J3305	Inj trimetrexate glucoronate	K2		$146.89			
J3310	Perphenazine injeciton	N1					
J3315	Triptorelin pamoate	K2		$153.42			
J3320	Spectinomycn di-hcl inj	N1					
J3350	Urea injection	N1					
J3355	Urofollitropin, 75 iu	K2		$57.43			
J3360	Diazepam injection	N1					
J3364	Urokinase 5000 IU injection	N1					
J3365	Urokinase 250,000 IU inj	K2		$449.09			
J3370	Vancomycin hcl injection	N1					
J3396	Verteporfin injection	K2		$9.31			
J3400	Triflupromazine hcl inj	N1					

J3410	Hydroxyzine hcl injection	N1					
J3411	Thiamine hcl 100 mg	N1					
J3415	Pyridoxine hcl 100 mg	N1					
J3420	Vitamin b12 injection	N1					
J3430	Vitamin k phytonadione inj	N1					
J3465	Injection, voriconazole	K2		$5.56			
J3470	Hyaluronidase injection	N1					
J3471	Ovine, up to 999 USP units	N1					
J3472	Ovine, 1000 USP units	N1					
J3473	Hyaluronidase recombinant	N1					
J3475	Inj magnesium sulfate	N1					
J3480	Inj potassium chloride	N1					
J3485	Zidovudine	N1					
J3486	Ziprasidone mesylate	N1					
J3487	Zoledronic acid	K2		$215.25			
J3488	Reclast injection	K2		$218.49			
J3490	Drugs unclassified injection	N1					
J3530	Nasal vaccine inhalation	N1					
J3590	Unclassified biologics	N1					
J7030	Normal saline solution infus	N1					
J7040	Normal saline solution infus	N1					
J7042	5% dextrose/normal saline	N1					
J7050	Normal saline solution infus	N1					
J7060	5% dextrose/water	N1					
J7070	D5w infusion	N1					
J7100	Dextran 40 infusion	N1					
J7110	Dextran 75 infusion	N1					
J7120	Ringers lactate infusion	N1					
J7130	Hypertonic saline solution	N1					
J7185	Xyntha inj	K2		$1.07			
J7186	Antihemophilic viii/vwf comp	K2		$0.90			
J7187	Humate-P, inj	K2		$0.86			
J7189	Factor viia	K2		$1.30			
J7190	Factor viii	K2		$0.85			
J7191	Factor VIII (porcine)	K2		$8.21			

J7192	Factor viii recombinant NOS	K2		$1.08			
J7193	Factor IX non-recombinant	K2		$0.87			
J7194	Factor ix complex	K2		$0.86			
J7195	Factor IX recombinant	K2		$1.09			
J7197	Antithrombin iii injection	K2		$2.28			
J7198	Anti-inhibitor	K2		$1.52			
J7308	Aminolevulinic acid hcl top	K2		$127.08			
J7310	Ganciclovir long act implant	K2		$16,640.00			
J7311	Fluocinolone acetonide implt	K2		$18,980.00			
J7321	Hyalgan/supartz inj per dose	K2		$90.54			
J7322	Synvisc inj per dose	D5					
J7323	Euflexxa inj per dose	K2		$111.88			
J7324	Orthovisc inj per dose	K2		$172.73			
J7325	Synvisc or Synvisc-One	K2		$11.52			
J7500	Azathioprine oral 50mg	N1					
J7501	Azathioprine parenteral	K2		$93.84			
J7502	Cyclosporine oral 100 mg	K2		$3.12			
J7504	Lymphocyte immune globulin	K2		$456.47			
J7505	Monoclonal antibodies	K2		$1,111.55			
J7506	Prednisone oral	N1					
J7507	Tacrolimus oral per 1 MG	K2		$3.57			
J7509	Methylprednisolone oral	N1					
J7510	Prednisolone oral per 5 mg	N1					
J7511	Antithymocyte globuln rabbit	K2		$401.93			
J7513	Daclizumab, parenteral	K2		$381.18			
J7515	Cyclosporine oral 25 mg	K2		$0.81			
J7516	Cyclosporin parenteral 250mg	K2		$23.37			
J7517	Mycophenolate mofetil oral	K2		$2.55			
J7518	Mycophenolic acid	N1					
J7520	Sirolimus, oral	K2		$9.47			
J7525	Tacrolimus injection	K2		$137.01			
J7599	Immunosuppressive drug noc	N1					
J7674	Methacholine chloride, neb	N1					
J7799	Non-inhalation drug for DME	N1					
J8501	Oral aprepitant	K2		$5.42			

J8510	Oral busulfan	N1					
J8520	Capecitabine, oral, 150 mg	K2		$6.11			
J8521	Capecitabine, oral, 500 mg	K2		$20.04			
J8530	Cyclophosphamide oral 25 MG	N1					
J8540	Oral dexamethasone	N1					
J8560	Etoposide oral 50 MG	K2		$29.69			
J8597	Antiemetic drug oral NOS	N1					
J8600	Melphalan oral 2 MG	N1					
J8610	Methotrexate oral 2.5 MG	N1					
J8650	Nabilone oral	N1					
J8700	Temozolomide	K2		$8.63			
J8705	Topotecan oral	K2		$73.00			
J9000	Doxorubicin hcl injection	N1					
J9001	Doxorubicin hcl liposome inj	K2		$462.49			
J9010	Alemtuzumab injection	K2		$555.50			
J9015	Aldesleukin injection	K2		$830.93			
J9017	Arsenic trioxide injection	K2		$36.83			
J9020	Asparaginase injection	K2		$59.27			
J9025	Azacitidine injection	K2		$4.79			
J9027	Clofarabine injection	K2		$113.36			
J9031	Bcg live intravesical vac	K2		$108.55			
J9033	Bendamustine injection	K2		$18.51			
J9035	Bevacizumab injection	K2		$56.37			
J9040	Bleomycin sulfate injection	N1					
J9041	Bortezomib injection	K2		$37.52			
J9045	Carboplatin injection	N1					
J9050	Carmustine injection	K2		$173.53			
J9055	Cetuximab injection	K2		$48.79			
J9060	Cisplatin 10 MG injection	N1					
J9062	Cisplatin 50 MG injection	N1					
J9065	Inj cladribine per 1 MG	K2		$23.52			
J9070	Cyclophosphamide 100 MG inj	N1					
J9080	Cyclophosphamide 200 MG inj	N1					
J9090	Cyclophosphamide 500 MG inj	N1					
J9091	Cyclophosphamide 1.0 grm inj	N1					

J9092	Cyclophosphamide 2.0 grm inj	N1					
J9093	Cyclophosphamide lyophilized	N1					
J9094	Cyclophosphamide lyophilized	N1					
J9095	Cyclophosphamide lyophilized	N1					
J9096	Cyclophosphamide lyophilized	N1					
J9097	Cyclophosphamide lyophilized	N1					
J9098	Cytarabine liposome inj	K2		$480.16			
J9100	Cytarabine hcl 100 MG inj	N1					
J9110	Cytarabine hcl 500 MG inj	N1					
J9120	Dactinomycin injection	K2		$556.34			
J9130	Dacarbazine 100 mg inj	N1					
J9140	Dacarbazine 200 MG inj	N1					
J9150	Daunorubicin injection	K2		$16.65			
J9151	Daunorubicin citrate inj	K2		$55.33			
J9155	Degarelix injection	K2		$2.87			
J9160	Denileukin diftitox inj	K2		$1,467.55			
J9165	Diethylstilbestrol injection	K2		$3.83			
J9170	Docetaxel injection	D5					
J9171	Docetaxel injection	K2		$17.29			
J9175	Elliotts b solution per ml	N1					
J9178	Inj, epirubicin hcl, 2 mg	K2		$2.60			
J9181	Etoposide injection	N1					
J9185	Fludarabine phosphate inj	K2		$158.63			
J9190	Fluorouracil injection	N1					
J9200	Floxuridine injection	K2		$42.85			
J9201	Gemcitabine hcl injection	K2		$142.20			
J9202	Goserelin acetate implant	K2		$200.02			
J9206	Irinotecan injection	K2		$6.81			
J9207	Ixabepilone injection	K2		$63.74			
J9208	Ifosfomide injection	K2		$29.51			
J9209	Mesna injection	K2		$4.55			
J9211	Idarubicin hcl injection	K2		$100.89			
J9212	Interferon alfacon-1 inj	K2		$4.71			
J9213	Interferon alfa-2a inj	K2		$10.60			
J9214	Interferon alfa-2b inj	K2		$15.54			

J9215	Interferon alfa-n3 inj	K2		$17.89			
J9216	Interferon gamma 1-b inj	K2		$294.03			
J9217	Leuprolide acetate suspnsion	K2		$202.62			
J9218	Leuprolide acetate injeciton	K2		$4.68			
J9219	Leuprolide acetate implant	K2		$4,728.88			
J9225	Vantas implant	K2		$1,462.69			
J9226	Supprelin LA implant	K2		$14,841.08			
J9230	Mechlorethamine hcl inj	K2		$151.24			
J9245	Inj melphalan hydrochl 50 MG	K2		$1,520.24			
J9250	Methotrexate sodium inj	N1					
J9260	Methotrexate sodium inj	N1					
J9261	Nelarabine injection	K2		$101.35			
J9263	Oxaliplatin	K2		$7.47			
J9264	Paclitaxel protein bound	K2		$9.20			
J9265	Paclitaxel injection	N1					
J9266	Pegaspargase injection	K2		$2,695.46			
J9268	Pentostatin injection	K2		$1,318.44			
J9270	Plicamycin (mithramycin) inj	N1					
J9280	Mitomycin 5 MG inj	K2		$16.83			
J9290	Mitomycin 20 MG inj	K2		$67.30			
J9291	Mitomycin 40 MG inj	K2		$134.60			
J9293	Mitoxantrone hydrochl / 5 MG	K2		$46.87			
J9300	Gemtuzumab ozogamicin inj	K2		$2,573.49			
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P9041	Albumin (human),5%, 50ml	K2		$16.89			
P9045	Albumin (human), 5%, 250 ml	K2		$60.58			
P9046	Albumin (human), 25%, 20 ml	K2		$25.67			
P9047	Albumin (human), 25%, 50ml	K2		$62.05			
Q0138	Ferumoxytol, non-esrd	K2		$0.82			
Q0163	Diphenhydramine HCl 50mg	N1					
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Q0167	Dronabinol 2.5mg oral	N1					
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Q2009	Fosphenytoin inj PE	N1					
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Q4114	Integra flowable wound matri	K2		$910.19			
Q4115	Alloskin skin sub	K2		$9.36			
Q4116	Alloderm skin sub	K2		$31.78			
Q9951	LOCM >= 400 mg/ml iodine,1ml	N1					
Q9953	Inj Fe-based MR contrast,1ml	N1					
Q9954	Oral MR contrast, 100 ml	N1					

Q9955	Inj perflexane lip micros,ml	N1					
Q9956	Inj octafluoropropane mic,ml	N1					
Q9957	Inj perflutren lip micros,ml	N1					
Q9958	HOCM <=149 mg/ml iodine, 1ml	N1					
Q9959	HOCM 150-199mg/ml iodine,1ml	N1					
Q9960	HOCM 200-249mg/ml iodine,1ml	N1					
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Q9966	LOCM 200-299mg/ml iodine,1ml	N1					
Q9967	LOCM 300-399mg/ml iodine,1ml	N1					
Q9968	Visualization adjunct	K2			$2.46		
V2630	Anter chamber intraocul lens	N1					
V2631	Iris support intraoclr lens	N1					
V2632	Post chmbr intraocular lens	N1					
V2785	Corneal tissue processing	F4					
V2790	Amniotic membrane	N1					
NOTE 1: The Medicare program payment is 80 percent of the total payment amount and beneficiary coinsurance is 20 percent of the total payment amount, except for screening flexible sigmoidoscopies and screening colonoscopies for which the program payment is 75 percent and the beneficiary coinsurance is 25 percent.							
NOTE 2: Payment indicators for ancillary radiology services (Z2, Z3) are based on a comparison of the final rates according to the ASC standard ratesetting methodology and the MPFS. At the time that we compiled these addenda, the MPFS payment rates have a zero percent update through May 31, 2010. For discussion of those rates, we refer readers to the CY 2010 MPFS final rule and correction notice.							

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program; No. 93.773 Medicare—Hospital Insurance Program; and No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: June 18, 2010.

Marilyn Tavenner,

Acting Administrator and Chief Operating Officer, Centers for Medicare & Medicaid Services.

Approved: June 30, 2010.

Kathleen Sebelius,

Secretary.

[FR Doc. 2010–16400 Filed 7–2–10; 2:30 pm]

BILLING CODE 4120–01–C

Federal Register

Tuesday,
August 3, 2010

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Part II—Continued

Department of Health and Human Services

Centers for Medicare and Medicaid

42 CFR Parts 410, 416 and 419

Medicare Program: Changes to the Hospital Outpatient Prospective Payment System and CY 2010 Payment Rates; Changes to the Ambulatory Surgical Center Payment System and CY 2010 Payment Rates; Corrections; Final Rule, Notice, and Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 410, 411, 412, 413, 416, 419, 482, and 489

[CMS–1504–P]

RIN 0938–AP82

Medicare Program; Proposed Changes to the Hospital Outpatient Prospective Payment System and CY 2011 Payment Rates; Proposed Changes to the Ambulatory Surgical Center Payment System and CY 2011 Payment Rates; Proposed Changes to Payments to Hospitals for Certain Inpatient Hospital Services and for Graduate Medical Education Costs; and Proposed Changes to Physician Self-Referral Rules and Related Changes to Provider Agreement Regulations

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

ACTION: Proposed rule.

SUMMARY: This proposed rule would revise the Medicare hospital outpatient prospective payment system (OPPS) to implement applicable statutory requirements and changes arising from our continuing experience with this system and to implement certain provisions of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (Affordable Care Act). In this proposed rule, we describe the proposed changes to the amounts and factors used to determine the payment rates for Medicare hospital outpatient services paid under the prospective payment system. These proposed changes would be applicable to services furnished on or after January 1, 2011.

In addition, this proposed rule would update the revised Medicare ambulatory surgical center (ASC) payment system to implement applicable statutory requirements and changes arising from our continuing experience with this system and to implement certain provisions of the Affordable Care Act. In this proposed rule, we set forth the proposed applicable relative payment weights and amounts for services furnished in ASCs, specific HCPCS codes to which these proposed changes would apply, and other pertinent ratesetting information for the CY 2011 ASC payment system. These proposed changes would be applicable to services furnished on or after January 1, 2011.

This proposed rule also includes proposals to implement provisions of the Affordable Care Act relating to payments to hospitals for direct graduate medical education (GME) and indirect medical education (IME) costs; and new limitations on certain physician referrals to hospitals in which they have an ownership or investment interest.

DATES: To be assured consideration, comments on all sections of this proposed rule must be received at one of the addresses provided in the **ADDRESSES** section no later than 5 p.m. EST on August 31, 2010.

ADDRESSES: In commenting, please refer to file code CMS–1504–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

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

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

2. *By regular mail.* You may mail written comments to the following address ONLY:

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1504–P, P.O. Box 8013, Baltimore, MD 21244–1850.

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

3. *By express or overnight mail.* You may send written comments to the following address ONLY:

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1504–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

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

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

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

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

If you intend to deliver your comments to the Baltimore address, please call the telephone number (410) 786–7195 in advance to schedule your arrival with one of our staff members.

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

Submission of comments on paperwork requirements. You may submit comments on this document's paperwork requirements by following the instructions at the end of the "Collection of Information Requirements" section in this document.

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

FOR FURTHER INFORMATION CONTACT:

Alberta Dwivedi, (410) 786–0378, Hospital outpatient prospective payment issues.

Paula Smith, (410) 786–0378, Ambulatory surgical center issues.

Michele Franklin, (410) 786–4533, and Jana Lindquist, (410) 786–4533, Partial hospitalization and community mental health center issues.

James Poyer, (410) 786–2261, Reporting of quality data issues.

Tzvi Hefter, (410) 786–4487, and Ing-Jye Cheng, (410) 786–4548, Hospital preadmission services and direct graduate medical education and indirect medical education payments issues.

Jacqueline Proctor, (410) 786–8852, Physician ownership and investment in hospitals issues.

SUPPLEMENTARY INFORMATION:

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

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, on Monday through Friday of each week from 8:30

a.m. to 4 p.m. EST. To schedule an appointment to view public comments, phone 1–800–743–3951.

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Alphabetical List of Acronyms Appearing in This Proposed Rule

ACEP American College of Emergency Physicians
AHA American Hospital Association
AHIMA American Health Information Management Association
AMA American Medical Association
AMP Average manufacturer price
AOA American Osteopathic Association
APC Ambulatory payment classification
ASC Ambulatory Surgical Center
ASP Average sales price
AWP Average wholesale price
BBA Balanced Budget Act of 1997, Public Law 105–33
BBRA Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999, Public Law 106–113
BCA Blue Cross Association
BCBSA Blue Cross and Blue Shield Association
BIPA Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Public Law 106–554
CAH Critical access hospital
CAP Competitive Acquisition Program
CBSA Core-Based Statistical Area
CCR Cost-to-charge ratio
CERT Comprehensive Error Rate Testing
CMHC Community mental health center
CMS Centers for Medicare & Medicaid Services
CoP Conditions of Participation
CORF Comprehensive outpatient rehabilitation facility
CPT [Physicians'] Current Procedural Terminology, Fourth Edition, 2009, copyrighted by the American Medical Association
CY Calendar year
DMEPOS Durable medical equipment, prosthetics, orthotics, and supplies
DMERC Durable medical equipment regional carrier
DRA Deficit Reduction Act of 2005, Public Law 109–171
DSH Disproportionate share hospital
EACH Essential Access Community Hospital
E/M Evaluation and management
EPO Erythropoietin
ESRD End-stage renal disease
FACA Federal Advisory Committee Act, Public Law 92–463
FAR Federal Acquisition Regulations
FDA Food and Drug Administration
FFS Fee-for-service
FSS Federal Supply Schedule
FTE Full-time equivalent
FY Federal fiscal year
GAO Government Accountability Office
GME Graduate medical education
HCERA Health Care and Education Reconciliation Act of 2010, Public Law 111–152
HCPCS Healthcare Common Procedure Coding System
HCRIS Hospital Cost Report Information System
HHA Home health agency
HIPAA Health Insurance Portability and Accountability Act of 1996, Public Law 104–191
HOPD Hospital outpatient department
HOP QDRP Hospital Outpatient Quality Data Reporting Program
ICD–9–CM International Classification of Diseases, Ninth Edition, Clinical Modification
ICD–10–CM International Classification of Diseases, Tenth Revision, Clinical Modification
ICD–10–PCS International Classification of Diseases, Tenth Revision, Procedure Coding System
IDE Investigational device exemption
IHS Indian Health Service
IME Indirect medical education
I/OCE Integrated Outpatient Code Editor
IOL Intraocular lens
IPPE Initial preventive physical examination
IPPS [Hospital] Inpatient prospective payment system
IVIG Intravenous immune globulin
MAC Medicare Administrative Contractor
MedPAC Medicare Payment Advisory Commission
MDH Medicare-dependent, small rural hospital
MIEA–TRHCA Medicare Improvements and Extension Act under Division B, Title I of the Tax Relief Health Care Act of 2006, Public Law 109–432
MIPPA Medicare Improvements for Patients and Providers Act of 2008, Public Law 110–275
MMA Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108–173
MMSEA Medicare, Medicaid, and SCHIP Extension Act of 2007, Public Law 110–173
MPFS Medicare Physician Fee Schedule
MSA Metropolitan Statistical Area
NCCI National Correct Coding Initiative
NCD National Coverage Determination
NTIOL New technology intraocular lens
OIG [HHS] Office of the Inspector General
OMB Office of Management and Budget
OPD [Hospital] Outpatient department
OPPS [Hospital] Outpatient prospective payment system
PHP Partial hospitalization program
PM Program memorandum
PPACA Patient Protection and Affordable Care Act, Public Law 111–148
PPI Producer Price Index
PPPS Personalized preventive plan services
PPS Prospective payment system
PR Pulmonary rehabilitation
PRA Paperwork Reduction Act
QAPI Quality Assessment and Performance Improvement
QIO Quality Improvement Organization
RAC Recovery Audit Contractor
RFA Regulatory Flexibility Act
RHQDAPU Reporting Hospital Quality Data for Annual Payment Update [Program]
RHHI Regional home health intermediary
SBA Small Business Administration
SCH Sole community hospital
SDP Single Drug Pricer
SI Status indicator
TEFRA Tax Equity and Fiscal Responsibility Act of 1982, Public Law 97–248
TOPS Transitional outpatient payments
USPDI United States Pharmacopoeia Drug Information
USPSTF United States Preventive Services Task Force
WAC Wholesale acquisition cost

In this document, we address two payment systems under the Medicare program: The hospital outpatient prospective payment system (OPPS) and the revised ambulatory surgical center (ASC) payment system. In addition, we are addressing provisions of the Affordable Care Act, relating to payments to hospitals for direct graduate medical education (GME) and indirect medical education (IME) costs; we are also addressing provisions relating to new limitations on certain physician referrals to hospitals in which they have an ownership or investment interest and proposing related changes to provider agreement regulations. The provisions relating to the OPPS are included in sections I. through XIV., XVI, and XIX. through XXII. of this proposed rule and in Addenda A, B, C (Addendum C is available on the Internet only; we refer readers to section XIX.A. of this proposed rule), D1, D2, E, L, and M to this proposed rule. The provisions related to the revised ASC payment system are included in sections XV., XVI., and XIX. through XXII. of this proposed rule and in Addenda AA, BB, DD1, DD2, and EE to this proposed rule. (Addendum EE is available on the Internet only; we refer readers to section XIX.B. of this proposed rule.) The provisions related to payments to hospitals for direct graduate medical education (GME) and indirect medical education (IME) costs are included in section XVII. of this proposed rule. The provisions relating to the new limitations on certain physician referrals to hospitals in which

they have an ownership or investment interest and proposed related changes to provider agreement regulations are included in section XVIII. of this proposed rule.

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I. Background and Summary of the CY 2011 OPPS/ASC Proposed Rule

A. Legislative and Regulatory Authority for the Hospital Outpatient Prospective Payment System

When Title XVIII of the Social Security Act (the Act) was enacted, Medicare payment for hospital outpatient services was based on hospital-specific costs. In an effort to ensure that Medicare and its beneficiaries pay appropriately for services and to encourage more efficient delivery of care, the Congress mandated replacement of the reasonable cost-based payment methodology with a prospective payment system (PPS). The Balanced Budget Act (BBA) of 1997 (Pub. L. 105–33) added section 1833(t) to the Act authorizing implementation of a PPS for hospital outpatient services. The OPPS was first implemented for services furnished on or after August 1, 2000. Implementing regulations for the OPPS are located at 42 CFR part 419.

The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act (BBRA) of 1999 (Pub. L. 106–113) made major changes in the hospital outpatient prospective payment system (OPPS). The following Acts made additional changes to the OPPS: the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 (Pub. L. 106–554); the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 (Pub. L. 108–173); the Deficit Reduction Act (DRA) of 2005 (Pub. L. 109–171), enacted on February 8, 2006; the Medicare Improvements and Extension Act under Division B of Title I of the Tax Relief and Health Care Act (MIEA–TRHCA) of 2006 (Pub. L. 109–432), enacted on December 20, 2006; the Medicare, Medicaid, and SCHIP Extension Act (MMSEA) of 2007 (Pub. L. 110–173), enacted on December 29, 2007; the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 (Pub. L. 110–275), enacted on July 15, 2008; and most recently the Patient Protection and Affordable Care Act (Pub. L. 111–148), enacted on March 23, 2010, as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152), enacted on March 30, 2010. We refer readers to section I.D. of this proposed rule for a summary of the provisions of Public Law 111–148, as amended by Public Law 111–152, that we are proposing to implement in this proposed rule.

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

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

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

For new technology items and services, special payments under the OPPS may be made in one of two ways. Section 1833(t)(6) of the Act provides for temporary additional payments, which we refer to as "transitional pass-through payments," for at least 2 but not more than 3 years for certain drugs, biological agents, brachytherapy devices used for the treatment of cancer, and categories of other medical devices. For new technology services that are not eligible for transitional pass-through payments, and for which we lack sufficient data to appropriately assign them to a clinical APC group, we have established special APC groups based on costs, which we refer to as New Technology APCs. These New

Technology APCs are designated by cost bands which allow us to provide appropriate and consistent payment for designated new procedures that are not yet reflected in our claims data. Similar to pass-through payments, an assignment to a New Technology APC is temporary; that is, we retain a service within a New Technology APC until we acquire sufficient data to assign it to a clinically appropriate APC group.

B. Excluded OPPS Services and Hospitals

Section 1833(t)(1)(B)(i) of the Act authorizes the Secretary to designate the hospital outpatient services that are paid under the OPPS. While most hospital outpatient services are payable under the OPPS, section 1833(t)(1)(B)(iv) of the Act excludes payment for ambulance, physical and occupational therapy, and speech-language pathology services, for which payment is made under a fee schedule. It also excludes screening mammography, diagnostic mammography, and effective January 1, 2011, an annual wellness visit providing personalized prevention plan services. The Secretary exercised the authority granted under the statute to also exclude from the OPPS those services that are paid under fee schedules or other payment systems. Such excluded services include, for example, the professional services of physicians and nonphysician practitioners paid under the Medicare Physician Fee Schedule (MPFS); laboratory services paid under the clinical diagnostic laboratory fee schedule (CLFS); services for beneficiaries with end-stage renal disease (ESRD) that are paid under the ESRD composite rate; and services and procedures that require an inpatient stay that are paid under the hospital inpatient prospective payment system (IPPS). We set forth the services that are excluded from payment under the OPPS in § 419.22 of the regulations.

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

C. Prior Rulemaking

On April 7, 2000, we published in the **Federal Register** a final rule with comment period (65 FR 18434) to implement a prospective payment system for hospital outpatient services. The hospital OPPS was first implemented for services furnished on or after August 1, 2000. Section 1833(t)(9) of the Act requires the Secretary to review certain components of the OPPS, not less often than annually, and to revise the groups, relative payment weights, and other adjustments that take into account changes in medical practices, changes in technologies, and the addition of new services, new cost data, and other relevant information and factors.

Since initially implementing the OPPS, we have published final rules in the **Federal Register** annually to implement statutory requirements and changes arising from our continuing experience with this system. These rules can be viewed on the CMS Web site at: *http://www.cms.gov/HospitalOutpatientPPS/*. The CY 2010 OPPS/ASC final rule with comment period appears in the November 20, 2009 **Federal Register** (74 FR 60316). In that final rule with comment period, we revised the OPPS to update the payment weights and conversion factor for services payable under the CY 2010 OPPS on the basis of claims data from January 1, 2008, through December 31, 2008, and to implement certain provisions of Public Law 110–173 and Public Law 110–275. In addition, we responded to public comments received on the provisions of the November 18, 2008 final rule with comment period (73 FR 68502) pertaining to the APC assignment of HCPCS codes identified in Addendum B to that rule with the new interim ("NI") comment indicator, and public comments received on the July 20, 2009 OPPS/ASC proposed rule for CY 2010 (74 FR 35232).

D. Provisions of the Patient Protection and Affordable Care Act (Pub. L. 111–148), as Amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152)

On March 23, 2010, the Patient Protection and Affordable Care Act, Public Law 111–148, was enacted. Following the enactment of Public Law 111–148, the Health Care and Education Reconciliation Act of 2010, Public Law 111–152 (enacted on March 30, 2010), amended certain provisions of Public Law 111–148. (These two public laws are collectively known as the Affordable Care Act.) A number of the provisions of the Affordable Care Act affect the OPPS and the ASC payment system and the providers and suppliers addressed in this proposed rule. Listed below are the provisions of the Affordable Care Act that we are proposing to implement in this proposed rule. We note that, due to the timing of the passage of the legislation, we were unable to address some of the provisions of the Affordable Care Act that affect the IPPS and the LTCH PPS in the FY 2011 IPPS/LTCH PPS proposed rule published in the **Federal Register** on May 4, 2010. Therefore, we also are including some proposals to implement certain provisions relating to the IPPS and LTCH PPS in this proposed rule. In addition, we note that we have issued or plan to issue separate documents in the **Federal Register** addressing other provisions of the Affordable Care Act (75 FR 30756 and 75 FR 31118).

- Section 1301 of the Affordable Care Act amended sections 1861(ff)(3)(A) and (B) of the Act to establish new additional requirements for CMHCs applicable to items or services furnished to Medicare beneficiaries on or after the first day of the first calendar quarter that begins at least 12 months after the date of enactment of Public Law 111–152 (that is, beginning April 1, 2011). The new requirements specify that a CMHC provide at least 40 percent of its services to individuals who are not eligible for Medicare benefits under Title XVIII of the Act and that a partial hospitalization program must be a distinct and organized intensive ambulatory treatment service offering less than 24-hour daily care "other than an individual's home or in an inpatient or residential setting." This provision is addressed in section X. of this proposed rule.
- Section 3121(a) of the Affordable Care Act amended section 1833(t)(7)(D)(i) of the Act to extend hold harmless payment adjustments (called transitional corridor payments or transitional outpatient payments (TOPS)) to rural hospitals with 100 or fewer beds and that are not sole community hospitals for covered OPD services furnished on or after January 1, 2006 and before January 1, 2011. Section 3121(b) amended section 1833(t)(7)(D)(i)(III) of the Act to provide that, for SCHs, in the case of covered OPD services furnished on or after January 1, 2010, and before January 1, 2011, the hold harmless TOPS provisions shall be applied without regard to the 100-bed limitation. These provisions are addressed in section II.E. of this proposed rule.
- Section 3138 of the Affordable Care Act amended section 1833(t) of the Act to direct the Secretary to conduct a study to determine if costs incurred by cancer hospitals (described in section 1886(d)(1)(B)(v) of the Act) for outpatient hospital services with respect to APC groups exceed those costs

incurred by other hospitals furnishing these services. In so far as the Secretary determines that such costs exceed those costs incurred by other hospitals, the Secretary shall provide for an appropriate adjustment under the authority of section 1833(t)(2)(E) to reflect those higher costs effective for services furnished on or after January 1, 2011. This provision is addressed in section II.F. of this proposed rule.

• Section 3401(i) of the Affordable Care Act amended section 1833(t)(3) of the Act by, among other things, adding new paragraphs (C)(iv)(F) and (G) to reduce the OPD fee schedule increase factor by a productivity adjustment and an additional adjustment for payments to hospital OPDs beginning in various years from CY 2010 through CY 2019 as applicable. These hospital OPD provisions are addressed in section II.B.1. of this proposed rule. Section 3401(k) of the Affordable Care Act amended section 1833(i)(2)(D) of the Act by adding a new subsection (iv) to provide for a similar productivity adjustment for payment for ASC services. This ASC provision is addressed in section XV.H.2.b. of this proposed rule.

• Section 4103(a) of the Affordable Care Act amended section 1861(s)(2) of the Act by adding a new subsection (FF) to provide Medicare coverage of "personalized prevention plan services," beginning January 1, 2011. Section 4103(b) of the Affordable Care Act amended section 1861 of the Act by adding a new subsection (hhh) to define "personalized prevention plan services" (also cited as the "annual wellness visit"). Section 4103(c) of the Affordable Care Act excludes the annual wellness visit from payment under the OPPS and provides for the elimination of beneficiary coinsurance requirements for these preventive services in outpatient hospital settings and for waiver of application of the deductible for these services. These provisions are addressed in section XII.B. of this proposed rule.

• Section 4104(a) of the Affordable Care Act amended section 1861(ddd) of the Act to define "preventive services" under Medicare to include screening and preventive services described under subsection (ww)(2) of the Act (other than services under subparagraph (M)); an initial preventive physical examination as defined in subsection (ww) of the Act; and personalized prevention plan services as defined in subsection (hhh)(1) of the Act. Section 4104(b) of the Affordable Care Act amended section 1833(a)(1) of the Act, as amended by section 4103(c)(1) of the Affordable Care Act, to provide for the elimination of coinsurance for most preventive services, and section 4104(c) amended section 1833(b) of the Act to provide for the waiver of the application of the deductible for most preventive services and, specifically, for colorectal cancer screening tests that become diagnostic and any related services performed with that diagnostic colorectal cancer screening test performed in the same clinical encounter, effective for items and services furnished on or after January 1, 2011. These provisions are addressed in section XII.B. of this proposed rule.

• Sections 5503, 5504, 5505, and 5506 of the Affordable Care Act made a number of changes to various sections of the Act relating to payment for direct GME and IME costs to hospitals.

(1) Section 5503 amended the Act to add a provision to redistribute medical residency positions that have been unfilled during a prior cost reporting period to other hospitals and to direct slots for training primary care physicians beginning July 1, 2011.

(2) Section 5504 amended sections 1886(h)(4)(E) and 1886(d)(5)(B)(iv) of the Act to allow any time spent by residents training in a nonprovider setting to count toward direct GME and IME costs if the hospital incurs the costs of residents' salaries and fringe benefits, effective for cost reporting periods beginning on or after July 1, 2010, for direct GME, and for discharges occurring on or after July 1, 2010, for IME.

(3) Section 5505 amended section 1886(h) and section 1886(d)(5)(B) of the Act to add a provision to allow hospitals to count resident time spent in certain non-patient care activities while training in certain nonhospital settings for direct GME purposes, effective for cost reporting periods beginning on or after July 1, 2009; to allow hospitals to count resident time spent in certain non-patient care activities while training in certain hospital settings for IME purposes for cost reporting periods beginning on or after January 1, 1983; and to prohibit the counting of time spent by residents in research not associated with the treatment or diagnosis of a particular patient for IME purposes effective October 1, 2001 (with certain limitations).

(4) Section 5506 amended section 1886(h)(4)(H) and section 1886(d)(5)(B)(iv) of the Act to add a provision to allow for the redistribution to other hospitals in the same or contiguous areas of FTE resident positions from a hospital that closes (on or after the date that is 2 years before the date of enactment of Pub. L. 111–148). These provisions are addressed in section XVII.B. of this proposed rule.

• Section 6001 of the Affordable Care Act amended section 1877 of the Act to add provisions under new subsection (i) relating to the prohibition against referrals to a hospital by a physician who has an ownership or investment interest in the hospital. This provision is addressed in section XVIII. of this proposed rule.

• Section 10324(b) of the Affordable Care Act amended section 1833(t) of the Act by adding a new subsection (19) to provide for a floor on the area wage adjustment factor for hospital outpatient department services furnished on or after January 1, 2011, in a State in which at least 50 percent of the counties in the State are frontier counties, that is, a county in which the population per square mile is less than 6. This provision is addressed in section II.C. of this proposed rule.

E. Advisory Panel on Ambulatory Payment Classification (APC) Groups

1. Authority of the Advisory Panel on Ambulatory Payment Classification (APC) Groups (the APC Panel)

Section 1833(t)(9)(A) of the Act, as amended by section 201(h) of Public Law 106–113, and redesignated by section 202(a)(2) of Public Law 106–113, requires that we consult with an outside panel of experts to review the clinical integrity of the payment groups and their weights under the OPPS. The Act further specifies that the panel will act in an advisory capacity. The APC Panel, discussed under section I.E.2. of this proposed rule, fulfills these requirements. The APC Panel is not restricted to using data compiled by CMS, and it may use data collected or developed by organizations outside the Department in conducting its review.

2. Establishment of the APC Panel

On November 21, 2000, the Secretary signed the initial charter establishing the APC Panel. This expert panel, which may be composed of up to 15 representatives of providers (currently employed full-time, not as consultants, in their respective areas of expertise) subject to the OPPS, reviews clinical data and advises CMS about the clinical integrity of the APC groups and their payment weights. The APC Panel is technical in nature, and it is governed by the provisions of the Federal Advisory Committee Act (FACA). Since its initial chartering, the Secretary has renewed the APC Panel's charter four times: on November 1, 2002; on November 1, 2004; on November 21, 2006; and on November 2, 2008. The

current charter specifies, among other requirements, that: the APC Panel continues to be technical in nature; is governed by the provisions of the FACA; may convene up to three meetings per year; has a Designated Federal Official (DFO); and is chaired by a Federal official designated by the Secretary.

The current APC Panel membership and other information pertaining to the APC Panel, including its charter, **Federal Register** notices, membership, meeting dates, agenda topics, and meeting reports, can be viewed on the CMS Web site at: *http://www.cms.hhs.gov/FACA/05_AdvisoryPanelonAmbulatoryPaymentClassificationGroups.asp#TopOfPage.*

3. APC Panel Meetings and Organizational Structure

The APC Panel first met on February 27 through March 1, 2001. Since the initial meeting, the APC Panel has held 17 meetings, with the last meeting taking place on February 17 and 18, 2010. Prior to each meeting, we publish a notice in the **Federal Register** to announce the meeting and, when necessary, to solicit nominations for APC Panel membership and to announce new members.

The APC Panel has established an operational structure that, in part, includes the use of three subcommittees to facilitate its required APC review process. The three current subcommittees are the Data Subcommittee, the Visits and Observation Subcommittee, and the Packaging Subcommittee. The Data Subcommittee is responsible for studying the data issues confronting the APC Panel and for recommending options for resolving them. The Visits and Observation Subcommittee reviews and makes recommendations to the APC Panel on all technical issues pertaining to observation services and hospital outpatient visits paid under the OPPS (for example, APC configurations and APC payment weights). The Packaging Subcommittee studies and makes recommendations on issues pertaining to services that are not separately payable under the OPPS, but whose payments are bundled or packaged into APC payments. Each of these subcommittees was established by a majority vote from the full APC Panel during a scheduled APC Panel meeting, and the APC Panel recommended that the subcommittees continue at the February 2010 APC Panel meeting. We accept those recommendations of the APC Panel. All subcommittee recommendations are discussed and voted upon by the full APC Panel.

Discussions of the other recommendations made by the APC Panel at the February 2010 meeting are included in the sections of this proposed rule that are specific to each recommendation. For discussions of earlier APC Panel meetings and recommendations, we refer readers to previously published hospital OPPS/ASC proposed and final rules, the CMS Web site mentioned earlier in this section, and the FACA database at: *http://fido.gov/facadatabase/public.asp*.

F. Summary of the Contents of This Proposed Rule

In this proposed rule, we set forth proposed changes to the Medicare hospital OPPS for CY 2011 to implement statutory requirements and changes arising from our continuing experience with the system and to implement certain provisions of Public Law 111–148, as amended by Public Law 111–152 (collectively known as the Affordable Care Act). In addition, we set forth proposed changes to the revised Medicare ASC payment system for CY 2011, including proposed updated payment weights, covered surgical procedures, and covered ancillary items and services based on the proposed OPPS update. We set forth proposed quality measures for the Hospital Outpatient Quality Data Reporting Program (HOP QDRP) for reporting quality data for annual payment rate updates for CY 2012 and subsequent calendar years, the proposed requirements for data collection and submission for the annual payment update, and a proposed reduction in the OPPS payment for hospitals that fail to meet the HOP QDRP requirements for the CY 2011 payment update, in accordance with the statutory requirement. We also set forth proposed changes to implement provisions of the Affordable Care Act relating to payments to hospitals for direct GME and IME costs and the rules relating to physician self-referrals to hospitals in which they have an ownership or investment interest. In addition, we are setting forth proposals affecting certain payments under the Medicare IPPS. The following is a summary of the major proposed changes that we are proposing to make:

1. Proposed Updates Affecting OPPS Payments

In section II. of this proposed rule, we set forth—

- The methodology used to recalibrate the proposed APC relative payment weights.
- The proposed changes to packaged services.
- The proposed update to the conversion factor used to determine payment rates under the OPPS. In this section, we set forth proposed changes in the amounts and factors for calculating the full annual update increase to the conversion factor.
- The proposed retention of our current policy to use the IPPS wage indices to adjust, for geographic wage differences, the portion of the OPPS payment rate and the copayment standardized amount attributable to labor-related cost. This proposal addresses the provisions of section 10324 of the Affordable Care Act relating to the establishment of a floor for the area wage adjustment factor for OPD services furnished in frontier States.
- The proposed update of statewide average default CCRs.
- The proposed application of hold harmless transitional outpatient payments (TOPs) for certain small rural hospitals, extended by section 3121 of the Affordable Care Act.
- The proposed payment adjustment for rural SCHs.
- The proposed calculation of the hospital outpatient outlier payment.
- The calculation of the proposed national unadjusted Medicare OPPS payment.
- The proposed beneficiary copayments for OPPS services.

2. Proposed OPPS Ambulatory Payment Classification (APC) Group Policies

In section III. of this proposed rule, we discuss—

- The proposed additions of new HCPCS codes to APCs.
- The proposed establishment of a number of new APCs.
- Our analyses of Medicare claims data and certain recommendations of the APC Panel.
- The application of the 2 times rule and proposed exceptions to it.
- The proposed changes to specific APCs.
- The proposed movement of procedures from New Technology APCs to clinical APCs.

3. Proposed OPPS Payment for Devices

In section IV. of this proposed rule, we discuss the proposed pass-through payment for specific categories of devices and the proposed adjustment for devices furnished at no cost or with partial or full credit.

4. Proposed OPPS Payment Changes for Drugs, Biologicals, and Radiopharmaceuticals

In section V. of this proposed rule, we discuss the proposed CY 2011 OPPS

payment for drugs, biologicals, and radiopharmaceuticals, including the proposed payment for drugs, biologicals, and radiopharmaceuticals with and without pass-through status.

5. Proposed Estimate of OPPS Transitional Pass-Through Spending for Drugs, Biologicals, Radiopharmaceuticals, and Devices

In section VI. of this proposed rule, we discuss the estimate of CY 2011 OPPS transitional pass-through spending for drugs, biologicals, and devices.

6. Proposed OPPS Payment for Brachytherapy Sources

In section VII. of this proposed rule, we discuss our proposal for payment for brachytherapy sources.

7. Proposed OPPS Payment for Drug Administration Services

In section VIII. of this proposed rule, we set forth our proposed policy concerning coding and payment for drug administration services.

8. Proposed OPPS Payment for Hospital Outpatient Visits

In section IX. of this proposed rule, we set forth our proposed policies for the payment of clinic and emergency department visits and critical care services based on claims data.

9. Proposed Payment for Partial Hospitalization Services

In section X. of this proposed rule, we set forth our proposed payment for partial hospitalization services, including the proposed separate threshold for outlier payments for CMHCs. We also set for our proposals to implement the new requirements for CMHCs established by section 1301 of the Affordable Care Act.

10. Proposed Procedures That Would Be Paid Only as Inpatient Procedures

In section XI. of this proposed rule, we discuss the procedures that we are proposing to remove from the inpatient list and assign to APCs for payment under the OPPS.

11. Proposed OPPS Nonrecurring Technical and Policy Changes and Clarifications

In section XII. of this proposed rule, we discuss nonrecurring technical issues and proposed policy changes relating to physician supervision of OPD services in hospitals, including CAHs. We also are proposing to implement the provisions of sections 4103 and 4104 of the Affordable Care Act relating to payment for preventive services, including personalized prevention plan services, and the waiver of beneficiary coinsurance and deductibles.

12. Proposed OPPS Payment Status and Comment Indicators

In section XIII. of this proposed rule, we discuss our proposed changes to the definitions of status indicators assigned to APCs and present our proposed comment indicators for the final rule with comment period.

13. OPPS Policy and Payment Recommendations

In section XIV. of this proposed rule, we address recommendations made by the Medicare Payment Advisory Commission (MedPAC) in its March 2010 report to Congress, by the Office of Inspector General (OIG), and by the APC Panel regarding the OPPS for CY 2011.

14. Proposed Updates to the Ambulatory Surgical Center (ASC) Payment System

In section XV. of this proposed rule, we discuss the proposed updates of the revised ASC payment system and payment rates for CY 2011.

15. Reporting Quality Data for Annual Payment Rate Updates

In section XVI. of this proposed rule, we discuss the proposed quality measures for reporting hospital outpatient (HOP) quality data for the annual payment update factor for CY 2012 and subsequent calendar years; set forth the requirements for data collection and submission for the annual payment update; and discuss the reduction in the OPPS payment for hospitals that fail to meet the HOP Quality Data Reporting Program (QDRP) requirements for CY 2011.

16. Bundling of Payments for Inpatient and Outpatient Services and Payments to Hospitals for Direct GME and IME Costs

In section XVII. of this proposed rule, we discuss our proposed implementation of the provisions of section 5503, 5504, 5505, and 5506 of the Affordable Care Act relating to redistribution of FTE resident slots of closed hospitals and policy changes for the counting of FTE residents in determining payments to hospitals for direct GME and IME costs.

17. Physician Self-Referrals to Hospitals

In section XVIII. of this preamble, we discuss our proposal to implement the changes made by section 6001 of the Affordable Care Act relating to the rules governing the prohibition on referrals to a hospital by a physician who has an ownership or investment interest in the hospital.

18. Regulatory Impact Analysis

In section XXII. of this proposed rule, we set forth an analysis of the impact that the proposed changes would have on affected entities and beneficiaries.

II. Proposed Updates Affecting OPPS Payments

A. Proposed Recalibration of APC Relative Weights

1. Database Construction

a. Database Source and Methodology

Section 1833(t)(9)(A) of the Act requires that the Secretary review and revise the relative payment weights for APCs at least annually. In the April 7, 2000 OPPS final rule with comment period (65 FR 18482), we explained in detail how we calculated the relative payment weights that were implemented on August 1, 2000 for each APC group.

For CY 2011, we are proposing to use the same basic methodology that we described in the November 20, 2009 OPPS final rule with comment period to recalibrate the APC relative payment weights for services furnished on or after January 1, 2011, and before January 1, 2012 (CY 2011). That is, we are proposing to recalibrate the relative payment weights for each APC based on claims and cost report data for hospital outpatient department (HOPD) services. We are proposing to use the most recent available data to construct the database for calculating APC group weights. Therefore, for the purpose of recalibrating the proposed APC relative payment weights for CY 2011, we used approximately 133 million final action claims for hospital outpatient department services furnished on or after January 1, 2009, and before January 1, 2010. (For exact counts of claims used, we refer readers to the claims accounting narrative under supporting documentation for this proposed rule on the CMS Web site at: *http://www.cms.gov/HospitalOutpatientPPS/HORD/*.)

Of the 133 million final action claims for services provided in hospital outpatient settings used to calculate the CY 2011 OPPS payment rates for this proposed rule, approximately 102 million claims were the type of bill potentially appropriate for use in setting rates for OPPS services (but did not necessarily contain services payable under the OPPS). Of the 102 million claims, approximately 4 million claims were not for services paid under the OPPS or were excluded as not

appropriate for use (for example, erroneous cost-to-charge ratios (CCRs) or no HCPCS codes reported on the claim). From the remaining 98 million claims, we created approximately 95 million single records, of which approximately 64 million were "pseudo" single or "single session" claims (created from 24 million multiple procedure claims using the process we discuss later in this section). Approximately 696,000 claims were trimmed out on cost or units in excess of +/− 3 standard deviations from the geometric mean, yielding approximately 95 million single bills for median setting. As described in section II.A.2. of this proposed rule, our data development process is designed with the goal of using appropriate cost information in setting the APC relative weights. The bypass process is described in section II.A.1.b. of this proposed rule. This section discusses how we develop "pseudo" single procedure claims, with the intention of using more appropriate data from the available claims. In some cases, the bypass process allows us to use some portion of the submitted claim for cost estimation purposes, while the remaining information on the claim continues to be unusable. Consistent with the goal of using appropriate information in our data development process, we only use claims (or portions of each claim) that are appropriate for ratesetting purposes. Ultimately, we were able to use for CY 2011 ratesetting some portion of 95 percent of the CY 2009 claims containing services payable under the OPPS.

The proposed APC relative weights and payments for CY 2011 in Addenda A and B to this proposed rule were calculated using claims from CY 2009 that were processed before January 1, 2010, and continue to be based on the median hospital costs for services in the APC groups. We selected claims for services paid under the OPPS and matched these claims to the most recent cost report filed by the individual hospitals represented in our claims data. We continue to believe that it is appropriate to use the most current full calendar year claims data and the most recently submitted cost reports to calculate the median costs underpinning the APC relative payment weights and the CY 2011 payment rates.

b. Proposed Use of Single and Multiple Procedure Claims

For CY 2011, in general, we are proposing to continue to use single procedure claims to set the medians on which the APC relative payment weights would be based, with some exceptions as discussed below in this section. We generally use single procedure claims to set the median costs for APCs because we believe that the OPPS relative weights on which payment rates are based should be derived from the costs of furnishing one unit of one procedure and because, in many circumstances, we are unable to ensure that packaged costs can be appropriately allocated across multiple procedures performed on the same date of service.

We agree that, optimally, it is desirable to use the data from as many claims as possible to recalibrate the APC relative payment weights, including those claims for multiple procedures. As we have for several years, we continued to use date of service stratification and a list of codes to be bypassed to convert multiple procedure claims to "pseudo" single procedure claims. Through bypassing specified codes that we believe do not have significant packaged costs, we are able to use more data from multiple procedure claims. In many cases, this enables us to create multiple "pseudo" single procedure claims from claims that were submitted as multiple procedure claims spanning multiple dates of service, or claims that contained numerous separately paid procedures reported on the same date on one claim. We refer to these newly created single procedure claims as "pseudo" single procedure claims. The history of our use of a bypass list to generate "pseudo" single procedure claims is well documented, most recently in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60324 through 60342). In addition, for CY 2008, we increased packaging and created the first composite APCs. We have continued our packaging policies and the creation of composite APCs for CY 2009 and 2010, and we are proposing to continue them for CY 2011. This also increased the number of bills that we were able to use for median calculation by enabling us to use claims that contained multiple major procedures that previously would not have been usable. Further, for CY 2009, we expanded the composite APC model to one additional clinical area, multiple imaging services (73 FR 68559 through 68569), which also increased the number of bills we were able to use to calculate APC median costs. We have continued the composite APCs for multiple imaging services for CY 2010, and we are proposing to continue to create them for CY 2011. We refer readers to section II.A.2.e. of this proposed rule for discussion of the use of claims to establish median costs for composite APCs.

We are proposing to continue to apply these processes to enable us to use as much claims data as possible for ratesetting for the CY 2011 OPPS. This methodology enabled us to create, for this proposed rule, approximately 64 million "pseudo" single procedure claims, including multiple imaging composite "single session" bills (we refer readers to section II.A.2.e.(5) of this proposed rule for further discussion), to add to the approximately 31 million "natural" single procedure claims. For this proposed rule, "pseudo" single procedure and "single session" procedure bills represent approximately 67 percent of all single procedure bills used to calculate median costs.

For CY 2011, we are proposing to bypass 448 HCPCS codes for CY 2011 that are identified in Table 1 of this proposed rule. Since the inception of the bypass list, we have calculated the percent of "natural" single bills that contained packaging for each HCPCS code and the amount of packaging on each "natural" single bill for each code. Each year, we generally retain the codes on the previous year's bypass list and use the update year's data (for CY 2011, data available for the February 2010 APC Panel meeting from CY 2009 claims processed through September 30, 2009, and CY 2008 claims data processed through June 30, 2009, used to model the payment rates for CY 2010) to determine whether it would be appropriate to propose to add additional codes to the previous year's bypass list. For CY 2011, we are proposing to continue to bypass all of the HCPCS codes on the CY 2010 OPPS bypass list. We updated HCPCS codes on the CY 2010 bypass list that were mapped to new HCPCS codes for CY 2011 ratesetting by adding the new replacement codes and also removing the deleted codes, which are listed in Table 2. None of these deleted codes were "overlap bypass codes" (those HCPCS codes that are both on the bypass list and are members of the multiple imaging composite APCs). We also are proposing to add to the bypass list for CY 2011 all HCPCS codes not on the CY 2010 bypass list that, using both CY 2010 final rule data (CY 2008 claims) and February 2010 APC Panel data (first 9 months of CY 2009 claims), met the same previously established empirical criteria for the bypass list that are summarized below. The entire list proposed for CY 2011 (including the codes that remain on the bypass list from prior years) is open to public comment. Because we must make some assumptions about packaging in the multiple procedure claims in order to

assess a HCPCS code for addition to the bypass list, we assume that the representation of packaging on "natural" single procedure claims for any given code is comparable to packaging for that code in the multiple procedure claims. The proposed criteria for the bypass list are:

- There are 100 or more "natural" single procedure claims for the code. This number of single procedure claims ensures that observed outcomes are sufficiently representative of packaging that might occur in the multiple claims.
- Five percent or fewer of the "natural" single procedure claims for the code have packaged costs on that single procedure claim for the code. This criterion results in limiting the amount of packaging being redistributed to the separately payable procedures remaining on the claim after the bypass code is removed and ensures that the costs associated with the bypass code represent the cost of the bypassed service.
- The median cost of packaging observed in the "natural" single procedure claims is equal to or less than $50. This criterion also limits the amount of error in redistributed costs. Throughout the bypass process, we do not know the dollar value of the packaged cost that should be appropriately attributed to the other procedures on the claim. Ensuring that redistributed costs associated with a bypass code are small in amount and volume protects the validity of cost estimates for low cost services billed with the bypassed service.

In response to comments to the CY 2010 OPPS/ASC proposed rule requesting that the packaged cost threshold be updated, we noted that we would consider whether it would be appropriate to update the $50 packaged cost threshold for inflation when examining potential bypass list additions (74 FR 60328). For the CY 2011 OPPS, based on CY 2009 claims data, we are proposing to apply the final market basket of 3.6 percent published in the CY 2009 OPPS/ASC final rule with comment period (73 FR 26584) to the $50 packaged cost threshold used in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60325) that we initially established in the CY 2005 OPPS final rule based on our analysis of the data (69 FR 65731), rounded to the nearest $5 increment. This calculation would lead us to a proposed packaged cost threshold for bypass list additions of $50 ($51.80 rounded to $50). We believe that applying the market basket from the year of claims data to the packaged cost threshold, rounded to the nearest $5 increment, would appropriately account for the effects of inflation when considering additions to the bypass list because the market basket increase percentage reflects the extent to which the cost of inputs for hospital services has increased compared to the cost of inputs for hospital services in the prior year. As discussed in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60328), the real value of this packaged cost threshold criterion has declined due to inflation, making the packaged cost threshold more restrictive over time when considering additions to the bypass list. Therefore, adjusting the threshold by the market basket would prevent continuing decline in the threshold's real value. The dollar threshold would not change for CY 2011 under this proposed policy, because when rounded to the nearest $5 increment after adjustment for the market basket increase, the threshold would for CY 2011 remain at $50. Therefore, we are not proposing to add any additional bypass codes for CY 2011 as a result of this proposed policy.

- The code is not a code for an unlisted service.

In addition, we are proposing to continue to include, on the bypass list, HCPCS codes that CMS medical advisors believe have minimal associated packaging based on their clinical assessment of the complete CY 2011 OPPS proposal. Some of these codes were identified by CMS medical advisors and some were identified in prior years by commenters with specialized knowledge of the packaging associated with specific services. We also are proposing to continue to include on the bypass list certain HCPCS codes in order to purposefully direct the assignment of packaged costs to a companion code where services always appear together and where there would otherwise be few single procedure claims available for ratesetting. For example, we have previously discussed our reasoning for adding HCPCS code G0390 (Trauma response team associated with hospital critical care service) and the CPT codes for additional hours of drug administration to the bypass list (73 FR 68513 and 71 FR 68117 through 68118).

As a result of the multiple imaging composite APCs that we established in CY 2009, the program logic for creating "pseudo" single procedure claims from bypassed codes that are also members of multiple imaging composite APCs changed. When creating the set of "pseudo" single procedure claims, claims that contain "overlap bypass codes" (those HCPCS codes that are both on the bypass list and are members of the multiple imaging composite APCs), were identified first. These HCPCS codes were then processed to create multiple imaging composite "single session" bills, that is, claims containing HCPCS codes from only one imaging family, thus suppressing the initial use of these codes as bypass codes. However, these "overlap bypass codes" were retained on the bypass list because, at the end of the "pseudo" single processing logic, we reassessed the claims without suppression of the "overlap bypass codes" under our longstanding "pseudo" single process to determine whether we could convert additional claims to "pseudo" single procedure claims. (We refer readers to section II.A.2.b. of this proposed rule for further discussion of the treatment of "overlap bypass codes.") This process also created multiple imaging composite "single session" bills that could be used for calculating composite APC median costs. "Overlap bypass codes" that are members of the proposed multiple imaging composite APCs are identified by asterisks (*) in Table 1 below.

Table 1 below includes the proposed list of bypass codes for CY 2011. The list of bypass codes contains codes that were reported on claims for services in CY 2009 and, therefore, includes codes that were in effect in 2009 and used for billing but were deleted for CY 2010. We retain these deleted bypass codes on the proposed CY 2011 bypass list because these codes existed in CY 2009 and were covered OPD services in that period. Since these bypass codes were deleted for billing in CY 2010, we will not need to retain them for the CY 2010 bypass list. Keeping these deleted bypass codes on the bypass list potentially allows us to create more "pseudo" single procedure claims for ratesetting purposes. "Overlap bypass codes" that are members of the proposed multiple imaging composite APCs are identified by asterisks (*) in the third column of Table 1 below. HCPCS codes that we are proposing to add for CY 2011 also are identified by asterisks (*) in the fourth column of Table 1. Table 2 contains the list of codes that we are proposing to remove from the CY 2011 bypass list because they were deleted from the HCPCS before CY 2009. None of these proposed deleted codes were "overlap bypass" codes.

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TABLE 1.—PROPOSED CY 2009 BYPASS CODES FOR CREATING "PSEUDO" SINGLE PROCEDURE CLAIMS FOR CALCULATING MEDIAN COSTS FOR CY 2011 OPPS

CY 2009 HCPCS Code	CY 2009 Short Descriptor	"Overlap Bypass Codes"	Proposed Additions
11056	Trim skin lesions, 2 to 4		
11057	Trim skin lesions, over 4		
11300	Shave skin lesion		
11301	Shave skin lesion		
11719	Trim nail(s)		
11720	Debride nail, 1-5		
11721	Debride nail, 6 or more		
11954	Therapy for contour defects		
17000	Destruct premalg lesion		
17003	Destruct premalg les, 2-14		
23600	Treat humerus fracture		*
29220	Strapping of low back		
29530	Strapping of knee		*
31231	Nasal endoscopy, dx		
31579	Diagnostic laryngoscopy		
51798	Us urine capacity measure		
53661	Dilation of urethra		
54240	Penis study		
56820	Exam of vulva w/scope		
57150	Treat vagina infection		
57452	Exam of cervix w/scope		*
57454	Bx/curett of cervix w/scope		*
67820	Revise eyelashes		
69210	Remove impacted ear wax		
69220	Clean out mastoid cavity		
70030	X-ray eye for foreign body		
70100	X-ray exam of jaw		
70110	X-ray exam of jaw		
70120	X-ray exam of mastoids		
70130	X-ray exam of mastoids		
70140	X-ray exam of facial bones		

CY 2009 HCPCS Code	CY 2009 Short Descriptor	"Overlap Bypass Codes"	Proposed Additions
70150	X-ray exam of facial bones		
70160	X-ray exam of nasal bones		
70200	X-ray exam of eye sockets		
70210	X-ray exam of sinuses		
70220	X-ray exam of sinuses		
70240	X-ray exam, pituitary saddle		*
70250	X-ray exam of skull		
70260	X-ray exam of skull		
70320	Full mouth x-ray of teeth		*
70328	X-ray exam of jaw joint		
70330	X-ray exam of jaw joints		
70336	Magnetic image, jaw joint	*	
70355	Panoramic x-ray of jaws		
70360	X-ray exam of neck		
70370	Throat x-ray & fluoroscopy		
70371	Speech evaluation, complex		
70450	Ct head/brain w/o dye	*	
70480	Ct orbit/ear/fossa w/o dye	*	
70486	Ct maxillofacial w/o dye	*	
70490	Ct soft tissue neck w/o dye	*	
70544	Mr angiography head w/o dye	*	
70547	Mr angiography neck w/o dye	*	*
70551	Mri brain w/o dye	*	
71010	Chest x-ray		
71015	Chest x-ray		
71020	Chest x-ray		
71021	Chest x-ray		
71022	Chest x-ray		
71023	Chest x-ray and fluoroscopy		
71030	Chest x-ray		
71034	Chest x-ray and fluoroscopy		
71035	Chest x-ray		
71100	X-ray exam of ribs		
71101	X-ray exam of ribs/chest		
71110	X-ray exam of ribs		
71111	X-ray exam of ribs/chest		

CY 2009 HCPCS Code	CY 2009 Short Descriptor	"Overlap Bypass Codes"	Proposed Additions
71120	X-ray exam of breastbone		
71130	X-ray exam of breastbone		
71250	Ct thorax w/o dye	*	
72010	X-ray exam of spine		
72020	X-ray exam of spine		
72040	X-ray exam of neck spine		
72050	X-ray exam of neck spine		
72052	X-ray exam of neck spine		
72069	X-ray exam of trunk spine		
72070	X-ray exam of thoracic spine		
72072	X-ray exam of thoracic spine		
72074	X-ray exam of thoracic spine		
72080	X-ray exam of trunk spine		
72090	X-ray exam of trunk spine		
72100	X-ray exam of lower spine		
72110	X-ray exam of lower spine		
72114	X-ray exam of lower spine		
72120	X-ray exam of lower spine		
72125	Ct neck spine w/o dye	*	
72128	Ct chest spine w/o dye	*	
72131	Ct lumbar spine w/o dye	*	
72141	Mri neck spine w/o dye	*	
72146	Mri chest spine w/o dye	*	
72148	Mri lumbar spine w/o dye	*	
72170	X-ray exam of pelvis		
72190	X-ray exam of pelvis		
72192	Ct pelvis w/o dye	*	
72202	X-ray exam sacroiliac joints		
72220	X-ray exam of tailbone		
73000	X-ray exam of collar bone		
73010	X-ray exam of shoulder blade		
73020	X-ray exam of shoulder		
73030	X-ray exam of shoulder		
73050	X-ray exam of shoulders		
73060	X-ray exam of humerus		
73070	X-ray exam of elbow		

CY 2009 HCPCS Code	CY 2009 Short Descriptor	"Overlap Bypass Codes"	Proposed Additions
73080	X-ray exam of elbow		
73090	X-ray exam of forearm		
73100	X-ray exam of wrist		
73110	X-ray exam of wrist		
73120	X-ray exam of hand		
73130	X-ray exam of hand		
73140	X-ray exam of finger(s)		
73200	Ct upper extremity w/o dye	*	
73218	Mri upper extremity w/o dye	*	
73221	Mri joint upr extrem w/o dye	*	
73510	X-ray exam of hip		
73520	X-ray exam of hips		
73540	X-ray exam of pelvis & hips		
73550	X-ray exam of thigh		
73560	X-ray exam of knee, 1 or 2		
73562	X-ray exam of knee, 3		
73564	X-ray exam, knee, 4 or more		
73565	X-ray exam of knees		
73590	X-ray exam of lower leg		
73600	X-ray exam of ankle		
73610	X-ray exam of ankle		
73620	X-ray exam of foot		
73630	X-ray exam of foot		
73650	X-ray exam of heel		
73660	X-ray exam of toe(s)		
73700	Ct lower extremity w/o dye	*	
73718	Mri lower extremity w/o dye	*	
73721	Mri jnt of lwr extre w/o dye	*	
74000	X-ray exam of abdomen		
74010	X-ray exam of abdomen		
74020	X-ray exam of abdomen		
74022	X-ray exam series, abdomen		
74150	Ct abdomen w/o dye	*	
74210	Contrst x-ray exam of throat		
74220	Contrast x-ray, esophagus		
74230	Cine/vid x-ray, throat/esoph		

CY 2009 HCPCS Code	CY 2009 Short Descriptor	"Overlap Bypass Codes"	Proposed Additions
74246	Contrst x-ray uppr gi tract		
74247	Contrst x-ray uppr gi tract		
74249	Contrst x-ray uppr gi tract		
76100	X-ray exam of body section		
76510	Ophth us, b & quant a		
76511	Ophth us, quant a only		
76512	Ophth us, b w/non-quant a		
76513	Echo exam of eye, water bath		
76514	Echo exam of eye, thickness		
76516	Echo exam of eye		
76519	Echo exam of eye		
76536	Us exam of head and neck		
76645	Us exam, breast(s)		
76700	Us exam, abdom, complete	*	
76705	Echo exam of abdomen	*	
76770	Us exam abdo back wall, comp	*	
76775	Us exam abdo back wall, lim	*	
76776	Us exam k transpl w/Doppler	*	
76801	Ob us < 14 wks, single fetus		
76805	Ob us >/= 14 wks, sngl fetus		
76811	Ob us, detailed, sngl fetus		
76816	Ob us, follow-up, per fetus		
76817	Transvaginal us, obstetric		
76830	Transvaginal us, non-ob		
76856	Us exam, pelvic, complete	*	
76857	Us exam, pelvic, limited	*	
76870	Us exam, scrotum	*	
76880	Us exam, extremity		
76970	Ultrasound exam follow-up		
76977	Us bone density measure		
77072	X-rays for bone age		
77073	X-rays, bone length studies		
77074	X-rays, bone survey, limited		
77075	X-rays, bone survey complete		
77076	X-rays, bone survey, infant		
77077	Joint survey, single view		

CY 2009 HCPCS Code	CY 2009 Short Descriptor	"Overlap Bypass Codes"	Proposed Additions
77078	Ct bone density, axial		
77079	Ct bone density, peripheral		
77080	Dxa bone density, axial		
77081	Dxa bone density/peripheral		
77082	Dxa bone density, vert fx		
77083	Radiographic absorptiometry		
77084	Magnetic image, bone marrow		
77300	Radiation therapy dose plan		
77301	Radiotherapy dose plan, imrt		
77315	Teletx isodose plan complex		
77327	Brachytx isodose calc interm		
77331	Special radiation dosimetry		
77336	Radiation physics consult		
77370	Radiation physics consult		
77401	Radiation treatment delivery		
77600	Hyperthermia treatment		
77605	Hyperthermia treatment		
77610	Hyperthermia treatment		
78350	Bone mineral, single photon		*
80500	Lab pathology consultation		
80502	Lab pathology consultation		
85097	Bone marrow interpretation		
86510	Histoplasmosis skin test		
86850	RBC antibody screen		
86870	RBC antibody identification		
86880	Coombs test, direct		
86885	Coombs test, indirect, qual		
86886	Coombs test, indirect, titer		
86890	Autologous blood process		
86900	Blood typing, ABO		
86901	Blood typing, Rh (D)		
86903	Blood typing, antigen screen		
86904	Blood typing, patient serum		
86905	Blood typing, RBC antigens		
86906	Blood typing, Rh phenotype		
86930	Frozen blood prep		

CY 2009 HCPCS Code	CY 2009 Short Descriptor	"Overlap Bypass Codes"	Proposed Additions
86970	RBC pretreatment		
86977	RBC pretreatment, serum		
88104	Cytopath fl nongyn, smears		
88106	Cytopath fl nongyn, filter		
88107	Cytopath fl nongyn, sm/fltr		
88108	Cytopath, concentrate tech		
88112	Cytopath, cell enhance tech		
88160	Cytopath smear, other source		
88161	Cytopath smear, other source		
88162	Cytopath smear, other source		
88172	Cytopathology eval of fna		
88173	Cytopath eval, fna, report		
88182	Cell marker study		
88184	Flowcytometry/ tc, 1 marker		
88185	Flowcytometry/tc, add-on		
88300	Surgical path, gross		
88302	Tissue exam by pathologist		
88304	Tissue exam by pathologist		
88305	Tissue exam by pathologist		
88307	Tissue exam by pathologist		
88311	Decalcify tissue		
88312	Special stains group 1		
88313	Special stains group 2		
88314	Histochemical stain add-on		*
88321	Microslide consultation		
88323	Microslide consultation		
88325	Comprehensive review of data		
88331	Path consult intraop, 1 bloc		
88342	Immunohistochemistry		
88346	Immunofluorescent study		
88347	Immunofluorescent study		
88348	Electron microscopy		
88358	Analysis, tumor		
88360	Tumor immunohistochem/manual		
88361	Tumor immunohistochem/comput		
88365	Insitu hybridization (fish)		

CY 2009 HCPCS Code	CY 2009 Short Descriptor	"Overlap Bypass Codes"	Proposed Additions
88368	Insitu hybridization, manual		
89049	Chct for mal hyperthermia		
89230	Collect sweat for test		
89240	Pathology lab procedure		
90472	Immunization admin, each add		
90474	Immune admin oral/nasal addl		
90801	Psy dx interview		
90802	Intac psy dx interview		
90804	Psytx, office, 20-30 min		
90805	Psytx, off, 20-30 min w/e&m		
90806	Psytx, off, 45-50 min		
90807	Psytx, off, 45-50 min w/e&m		
90808	Psytx, office, 75-80 min		
90809	Psytx, off, 75-80 min, w/e&m		
90810	Intac psytx, off, 20-30 min		
90811	Intac psytx, 20-30 min, w/e&m		
90812	Intac psytx, off, 45-50 min		
90816	Psytx, hosp, 20-30 min		
90818	Psytx, hosp, 45-50 min		
90826	Intac psytx, hosp, 45-50 min		
90845	Psychoanalysis		
90846	Family psytx w/o patient		
90847	Family psytx w/patient		
90853	Group psychotherapy		
90857	Intac group psytx		
90862	Medication management		
92002	Eye exam, new patient		
92004	Eye exam, new patient		
92012	Eye exam established pat		
92014	Eye exam & treatment		
92020	Special eye evaluation		
92025	Corneal topography		
92060	Special eye evaluation		*
92081	Visual field examination(s)		
92082	Visual field examination(s)		
92083	Visual field examination(s)		

CY 2009 HCPCS Code	CY 2009 Short Descriptor	"Overlap Bypass Codes"	Proposed Additions
92135	Ophth dx imaging post seg		
92136	Ophthalmic biometry		
92225	Special eye exam, initial		
92226	Special eye exam, subsequent		
92230	Eye exam with photos		
92240	Icg angiography		
92250	Eye exam with photos		
92275	Electroretinography		
92285	Eye photography		
92286	Internal eye photography		
92520	Laryngeal function studies		
92541	Spontaneous nystagmus test		
92542	Positional nystagmus test		*
92546	Sinusoidal rotational test		
92548	Posturography		
92552	Pure tone audiometry, air		
92553	Audiometry, air & bone		
92555	Speech threshold audiometry		
92556	Speech audiometry, complete		
92557	Comprehensive hearing test		
92567	Tympanometry		
92582	Conditioning play audiometry		
92585	Auditor evoke potent, compre		
92603	Cochlear implt f/up exam 7 >		
92604	Reprogram cochlear implt 7 >		
92626	Eval aud rehab status		
93005	Electrocardiogram, tracing		
93017	Cardiovascular stress test		
93225	ECG monitor/record, 24 hrs		
93226	ECG monitor/report, 24 hrs		
93231	Ecg monitor/record, 24 hrs		
93232	ECG monitor/report, 24 hrs		
93236	ECG monitor/report, 24 hrs		
93270	ECG recording		
93271	Ecg/monitoring and analysis		
93278	ECG/signal-averaged		

CY 2009 HCPCS Code	CY 2009 Short Descriptor	"Overlap Bypass Codes"	Proposed Additions
93279	Pm device progr eval, sngl		*
93280	Pm device progr eval, dual		*
93281	Pm device progr eval, multi		*
93282	Icd device progr eval, 1 sngl		*
93283	Icd device progr eval, dual		*
93284	Icd device progr eval, mult		*
93285	Ilr device eval progr		*
93288	Pm device eval in person		*
93289	Icd device interrogate		*
93290	Icm device eval		*
93291	Ilr device interrogate		*
93292	Wcd device interrogate		*
93293	Pm phone r-strip device eval		*
93296	Pm/icd remote tech serv		*
93306	Tte w/doppler, complete		*
93307	Tte w/o doppler, complete		*
93786	Ambulatory BP recording		
93788	Ambulatory BP analysis		
93797	Cardiac rehab		
93798	Cardiac rehab/monitor		
93875	Extracranial study		
93880	Extracranial study		
93882	Extracranial study		
93886	Intracranial study		
93888	Intracranial study		
93922	Extremity study		
93923	Extremity study		
93924	Extremity study		
93925	Lower extremity study		
93926	Lower extremity study		
93930	Upper extremity study		
93931	Upper extremity study		
93965	Extremity study		
93970	Extremity study		
93971	Extremity study		
93975	Vascular study		

CY 2009 HCPCS Code	CY 2009 Short Descriptor	"Overlap Bypass Codes"	Proposed Additions
93976	Vascular study		
93978	Vascular study		
93979	Vascular study		
93990	Doppler flow testing		
94015	Patient recorded spirometry		
94690	Exhaled air analysis		
95115	Immunotherapy, one injection		
95117	Immunotherapy injections		
95165	Antigen therapy services		
95250	Glucose monitoring, cont		
95805	Multiple sleep latency test		
95806	Sleep study unatt&resp efft		
95807	Sleep study, attended		
95808	Polysomnography, 1-3		
95812	Eeg, 41-60 minutes		
95813	Eeg, over 1 hour		
95816	Eeg, awake and drowsy		
95819	Eeg, awake and asleep		
95822	Eeg, coma or sleep only		
95869	Muscle test, thor paraspinal		
95872	Muscle test, one fiber		
95900	Motor nerve conduction test		
95921	Autonomic nerv function test		
95925	Somatosensory testing		
95926	Somatosensory testing		
95930	Visual evoked potential test		
95950	Ambulatory eeg monitoring		
95953	EEG monitoring/computer		
95970	Analyze neurostim, no prog		
95972	Analyze neurostim, complex		
95974	Cranial neurostim, complex		
95978	Analyze neurostim brain/1h		
96000	Motion analysis, video/3d		
96101	Psycho testing by psych/phys		
96111	Developmental test, extend		
96116	Neurobehavioral status exam		

CY 2009 HCPCS Code	CY 2009 Short Descriptor	"Overlap Bypass Codes"	Proposed Additions
96118	Neuropsych tst by psych/phys		
96119	Neuropsych testing by tec		
96150	Assess hlth/behave, init		
96151	Assess hlth/behave, subseq		
96152	Intervene hlth/behave, indiv		
96153	Intervene hlth/behave, group		
96361	Hydrate iv infusion, add-on		*
96366	Ther/proph/diag iv inf addon		*
96367	Tx/proph/dg addl seq iv inf		*
96370	Sc ther infusion, addl hr		*
96371	Sc ther infusion, reset pump		*
96375	Tx/pro/dx inj new drug addon		*
96402	Chemo hormon antineopl sq/im		
96411	Chemo, iv push, addl drug		
96415	Chemo, iv infusion, addl hr		
96417	Chemo iv infus each addl seq		
96423	Chemo ia infuse each addl hr		
96900	Ultraviolet light therapy		
96910	Photochemotherapy with UV-B		
96912	Photochemotherapy with UV-A		
96913	Photochemotherapy, UV-A or B		
96920	Laser tx, skin < 250 sq cm		
98925	Osteopathic manipulation		
98926	Osteopathic manipulation		
98927	Osteopathic manipulation		
98940	Chiropractic manipulation		
98941	Chiropractic manipulation		
98942	Chiropractic manipulation		
99203	Office/outpatient visit, new		*
99204	Office/outpatient visit, new		
99212	Office/outpatient visit, est		
99213	Office/outpatient visit, est		
99214	Office/outpatient visit, est		
99241	Office consultation		
99242	Office consultation		
99243	Office consultation		

CY 2009 HCPCS Code	CY 2009 Short Descriptor	"Overlap Bypass Codes"	Proposed Additions
99244	Office consultation		
99245	Office consultation		
99406	Behav chng smoking 3-10 min		*
99407	Behav chng smoking > 10 min		*
0144T	CT heart wo dye; qual calc		
G0008	Admin influenza virus vac		
G0101	CA screen;pelvic/breast exam		
G0127	Trim nail(s)		
G0130	Single energy x-ray study		
G0166	Extrnl counterpulse, per tx		
G0175	OPPS Service,sched team conf		
G0248	Demonstrate use home inr mon		*
G0249	Provide INR test mater/equip		*
G0340	Robt lin-radsurg fractx 2-5		
G0365	Vessel mapping hemo access		
G0389	Ultrasound exam AAA screen		
G0390	Trauma Respons w/hosp criti		
G0402	Initial preventive exam		*
G0404	EKG tracing for initial prev		*
M0064	Visit for drug monitoring		
Q0091	Obtaining screen pap smear		

TABLE 2.—HCPCS CODES PROPOSED TO BE REMOVED FROM THE CY 2011 BYPASS LIST BECAUSE THEY WERE DELETED PRIOR TO CY 2009

HCPCS Code	HCPCS Short Descriptor
90761	Hydrate iv infusion, add-on
90766	Ther/proph/dg iv inf, add-on
90767	Tx/proph/dg addl seq iv inf
90770	Sc ther infusion, addl hr
90771	Sc ther infusion, reset pump
90775	Tx/pro/dx inj new drug addon
93727	Analyze ilr system
93731	Analyze pacemaker system
93732	Analyze pacemaker system
93733	Telephone analy, pacemaker
93734	Analyze pacemaker system
93735	Analyze pacemaker system
93736	Telephonic analy, pacemaker
93741	Analyze ht pace device sngl
93742	Analyze ht pace device sngl
93743	Analyze ht pace device dual
93744	Analyze ht pace device dual
G0344	Initial preventive exam
G0367	EKG tracing for initial prev
G0376	Smoke/tobacco counseling >10

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c. Proposed Calculation and Use of Cost-to-Charge Ratios (CCRs)

For CY 2011, we are proposing to continue to use the hospital-specific overall ancillary and departmental CCRs to convert charges to estimated costs through application of a revenue code-to-cost center crosswalk. To calculate the APC median costs on which the proposed CY 2011 APC payment rates are based, we calculated hospital-specific overall ancillary CCRs and hospital-specific departmental CCRs for each hospital for which we had CY 2009 claims data from the most recent available hospital cost reports, in most cases, cost reports beginning in CY 2008. For the CY 2011 OPPS proposed rates, we used the set of claims processed during CY 2009. We applied the hospital-specific CCR to the hospital's charges at the most detailed level possible, based on a revenue code-to-cost center crosswalk that contains a hierarchy of CCRs used to estimate costs from charges for each revenue code. That crosswalk is available for review and continuous comment on the CMS Web site at: *http://www.cms.gov/HospitalOutpatientPPS/03_crosswalk.asp#TopOfPage.*

To ensure the completeness of the revenue code-to-cost center crosswalk, we reviewed changes to the list of revenue codes for CY 2009 (the year of the claims data we are using to calculate the CY 2011 OPPS proposed payment rates). For CY 2009, there were several changes to these revenue codes. The National Uniform Billing Committee (NUBC) is the organization that is responsible for the data specifications for the Uniform Bill (currently the UB–04). For CY 2009, the NUBC changed the title of revenue code series 076X from "Specialty Room—Treatment/Observation Room" to "Specialty Services" and changed the title of subclassification revenue code 0762 from "Observation Room" to "Observation Hours". We are not proposing to change the revenue code-to-cost center crosswalk as a result of this change because we believe that hospitals have historically reported charges for observation based on hours of care and that this change reflects existing practices. In addition, for CY 2009, NUBC removed a note that indicated that subcategory revenue codes 0912, Behavioral Health Treatment/Services (also see 091X, an extension of 090X), and 0913, Behavioral Health Treatment/Services—Extension of 090X, were designed as zero-billed revenue codes (that is, no dollar in the amount field). This change has no impact on the revenue code-to-cost center crosswalk. We note that the addition of revenue codes with effective dates in CY 2010 is not relevant to this process because the revenue codes were not applicable to claims for services furnished during CY 2009.

We calculated CCRs for the standard and nonstandard cost centers accepted by the electronic cost report database. In general, the most detailed level at which we calculated CCRs was the hospital-specific departmental level. For a discussion of the hospital-specific overall ancillary CCR calculation, we

refer readers to the CY 2007 OPPS/ASC final rule with comment period (71 FR 67983 through 67985). One longstanding exception to this general methodology for calculation of CCRs used for converting charges to costs on each claim is the calculation of median blood costs, as discussed in section II.A.2.d.(2) of this proposed rule and which has been our standard policy since the CY 2005 OPPS.

For the CCR calculation process, we used the same general approach that we used in developing the final APC rates for CY 2007 and thereafter, using the revised CCR calculation that excluded the costs of paramedical education programs and weighted the outpatient charges by the volume of outpatient services furnished by the hospital. We refer readers to the CY 2007 OPPS/ASC final rule with comment period for more information (71 FR 67983 through 67985). We first limited the population of cost reports to only those for hospitals that filed outpatient claims in CY 2009 before determining whether the CCRs for such hospitals were valid.

We then calculated the CCRs for each cost center and the overall ancillary CCR for each hospital for which we had claims data. We did this using hospital-specific data from the Hospital Cost Report Information System (HCRIS). We used the most recent available cost report data, in most cases, cost reports with cost reporting periods beginning in CY 2007. For this proposed rule, we used the most recently submitted cost reports to calculate the CCRs to be used to calculate median costs for the proposed CY 2011 OPPS payment rates. If the most recent available cost report was submitted but not settled, we looked at the last settled cost report to determine the ratio of submitted to settled cost using the overall ancillary CCR, and we then adjusted the most recent available submitted but not settled cost report using that ratio. We then calculated both an overall ancillary CCR and cost center-specific CCRs for each hospital. We used the overall ancillary CCR referenced in section II.A.1.c. of this proposed rule for all purposes that require use of an overall ancillary CCR.

Since the implementation of the OPPS, some commenters have raised concerns about potential bias in the OPPS cost-based weights due to "charge compression," which is the practice of applying a lower charge markup to higher-cost services and a higher charge markup to lower-cost services. As a result, the cost-based weights may reflect some aggregation bias, undervaluing high-cost items and overvaluing low-cost items when an estimate of average markup, embodied in a single CCR, is applied to items of widely varying costs in the same cost center.

To explore this issue, in August 2006 we awarded a contract to RTI International (RTI) to study the effects of charge compression in calculating the IPPS cost-based relative weights, particularly with regard to the impact on inpatient diagnosis-related group (DRG) payments, and to consider methods to better capture the variation in cost and charges for individual services when calculating costs for the IPPS relative weights across services in the same cost center. RTI issued a report in March 2007 with its findings on charge compression, which is available on the CMS Web site at: *http://www.cms.gov/reports/downloads/Dalton.pdf.* Although this report was focused largely on charge compression in the context of the IPPS cost-based relative weights, because several of the findings were relevant to the OPPS, we discussed that report in the CY 2008 OPPS/ASC proposed rule (72 FR 42641 through 42643) and reiterated them in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66599 through 66602).

In August 2007, we contracted with RTI to evaluate the cost estimation process for the OPPS relative weights because its 2007 report had concentrated on IPPS DRG cost-based relative weights. The results of RTI's analyses had implications for both the OPPS APC cost-based relative weights and the IPPS MS–DRG (Medicare severity) cost-based relative weights. The RTI final report can be found on RTI's Web site at: *http://www.rti.org/reports/cms/HHSM-500-2005-0029I/PDF/Refining_Cost_to_Charge_Ratios_200807_Final.pdf.* For a complete discussion of the RTI recommendations, public comments, and our responses, we refer readers to the CY 2009 OPPS/ASC final rule with comment period (73 FR 68519 through 68527).

We addressed the RTI finding that there was aggregation bias in both the IPPS and the OPPS cost estimation of expensive and inexpensive medical supplies in the FY 2009 IPPS final rule. Specifically, we finalized our proposal for both the OPPS and IPPS to create one cost center for "Medical Supplies Charged to Patients" and one cost center for "Implantable Devices Charged to Patients," essentially splitting the then current CCR for "Medical Supplies and Equipment" into one CCR for low-cost medical supplies and another CCR for high-cost implantable devices in order to mitigate some of the effects of charge compression. Accordingly, in Transmittal 20 of the Provider Reimbursement Manual, Part II (PRM–II), Chapter 36, Form CMS–2552–96, which was issued in July 2009, we created a new subscripted Line 55.01 on Worksheet A for the "Implantable Devices Charged to Patients" cost center. This new subscripted cost center, placed under the standard line for "Medical Supplies Charged to Patients," is available for use for cost reporting periods beginning on or after May 1, 2009. A subscripted cost center is the addition of a separate new cost center line and description which bears a logical relationship to the standard cost center line and is located immediately following a standard cost center line. Subscripting a cost center line adds flexibility and cost center expansion capability to the cost report. For example, Line 55 of Worksheet A on Form CMS 2552–96 (the Medicare hospital cost report) is "Medical Supplies Charged to Patients." The additional cost center, which isolates the costs of "Implantable Medical Supplies Charged to Patients", was created by adding subscripted Line 55.01 to Worksheet A.

Because there is approximately a 3-year lag in the availability of cost report data for IPPS and OPPS ratesetting purposes in a given calendar year, we believe we will be able to use data from the revised cost report form to estimate costs from charges for implantable devices for the CY 2013 OPPS relative weights. For a complete discussion of the rationale for the creation of the new cost center for "Implantable Devices Charged to Patients," public comments, and our responses, we refer readers to the FY 2009 IPPS final rule (73 FR 48458 through 45467).

In the CY 2009 OPPS/ASC final rule with comment period, we indicated that we would be making some OPPS-specific changes in response to the RTI report recommendations. Specifically, these changes included modifications to the cost reporting software and the addition of three new nonstandard cost centers. With regard to modifying the cost reporting preparation software in order to offer additional descriptions for nonstandard cost centers to improve the accuracy of reporting for nonstandard cost centers, we indicated that the change would be made for the next release of the cost report software. These changes have been made to the cost reporting software with the implementation of CMS Transmittal 21, under Chapter 36 of the Provider Reimbursement Manual—Part II, available online at *http://www.cms.hhs.gov/Manuals/PBM/,* which is effective for cost reporting

periods ending on or after October 1, 2009.

We also indicated that we intended to add new nonstandard cost centers for Cardiac Rehabilitation, Hyperbaric Oxygen Therapy, and Lithotripsy. We note that in January 2010, CMS issued Transmittal 21 which updated the PRM–II, Chapter 36, Form CMS–2552–96. One of the updates in this transmittal established nonstandard cost centers for Cardiac Rehabilitation, Hyperbaric Oxygen Therapy, and Lithotripsy for use on Worksheet A. These three new nonstandard cost centers are now available for cost reporting periods ending on or after October 1, 2009.

Furthermore, we noted in the FY 2010 IPPS/LTCH PPS final rule (74 FR 43781 through 43782) that we were updating the cost report form to eliminate outdated requirements, in conjunction with the Paperwork Reduction Act (PRA), and that we had proposed actual changes to the cost reporting form, the attending cost reporting software, and the cost report instructions in Chapters 36 and 40 of the PRM–II. The new draft hospital cost report Form CMS–2552–10 was published in the **Federal Register** on July 2, 2009, and was subject to a 60-day review and comment period, which ended on August 31, 2009. We received numerous comments on the draft hospital cost report Form CMS–2552–10, specifically regarding the creation of new cost centers from which data might be used in the OPPS cost-based relative weights calculation. We had proposed to create new standard cost centers for Computed Tomography (CT), Magnetic Resonance Imaging (MRI), and Cardiac Catheterization in Form CMS–2552–10. If these standard cost centers are finalized, when the data become available, we would analyze the cost and charge data to determine if it is appropriate to use those data to create distinct CCRs from these cost centers in setting the relative weights. For a discussion of these cost centers, we refer readers to the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 23878 through 23880). Comments will be addressed in detail in the **Federal Register** notice that will finalize Form CMS–2552–10. The revised draft of hospital cost report Form CMS–2552–10 went on public display on April 23, 2010, and appeared in the **Federal Register** on April 30, 2010 (75 FR 22810) with a 30-day public comment period. The public comment period ended on June 1, 2010.

We believe that improved cost report software, the incorporation of new standard and nonstandard cost centers, and the elimination of outdated requirements will improve the accuracy of the cost data contained in the electronic cost report data files and, therefore, the accuracy of our cost estimation processes for the OPPS relative weights. We will continue our standard practice of examining ways in which we can improve the accuracy of our cost estimation processes.

2. Proposed Data Development Process and Calculation of Median Costs

In this section of this proposed rule, we discuss the use of claims to calculate proposed OPPS payment rates for CY 2011. The hospital OPPS page on the CMS Web site on which this proposed rule is posted provides an accounting of claims used in the development of the proposed payment rates at: *http://www.cms.gov/HospitalOutpatientPPS*. The accounting of claims used in the development of this proposed rule is included on the CMS Web site under supplemental materials for the CY 2011 OPPS/ASC proposed rule. That accounting provides additional detail regarding the number of claims derived at each stage of the process. In addition, below in this section, we discuss the file of claims that comprises the data set that is available for purchase under a CMS data use agreement. Our CMS Web site, *http://www.cms.gov/HospitalOutpatientPPS*, includes information about purchasing the "OPPS Limited Data Set," which now includes the additional variables previously available only in the OPPS Identifiable Data Set, including ICD–9–CM diagnosis codes and revenue code payment amounts. This file is derived from the CY 2009 claims that were used to calculate the proposed payment rates for the CY 2011 OPPS.

We used the methodology described in sections II.A.2.a. through II.A.2.e. of this proposed rule to calculate the median costs we use to establish the relative weights used in calculating the proposed OPPS payment rates for CY 2011 shown in Addenda A and B to this proposed rule. We refer readers to section II.A.4. of this proposed rule for a discussion of the conversion of APC median costs to scaled payment weights.

a. Claims Preparation

We used the CY 2009 hospital outpatient claims processed before January 1, 2010 to calculate the median costs of APCs that underpin the proposed relative weights for CY 2011. To begin the calculation of the relative weights for CY 2011, we pulled all claims for outpatient services furnished in CY 2009 from the national claims history file. This is not the population of claims paid under the OPPS, but all outpatient claims (including, for example, critical access hospital (CAH) claims and hospital claims for clinical laboratory services for persons who are neither inpatients nor outpatients of the hospital).

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

We divided the remaining claims into the three groups shown below. Groups 2 and 3 comprise the 102 million claims that contain hospital bill types paid under the OPPS.

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

2. Claims that were bill types 12X, 13X or 14X. Claims with bill types 12X and 13X are hospital outpatient claims. Claims with bill type 14X are laboratory specimen claims, of which we use a subset for the limited number of services in these claims that are paid under the OPPS.

3. Claims that were bill type 76X (CMHC).

To convert charges on the claims to estimated cost, we multiplied the charges on each claim by the appropriate hospital specific CCR associated with the revenue code for the charge as discussed in section II.A.1.c. of this proposed rule. We then flagged and excluded CAH claims (which are not paid under the OPPS) and claims from hospitals with invalid CCRs. The latter included claims from hospitals without a CCR; those from hospitals paid an all-inclusive rate; those from hospitals with obviously erroneous CCRs (greater than 90 or less than .0001); and those from hospitals with overall ancillary CCRs that were identified as outliers (3 standard deviations from the geometric mean after removing error CCRs). In addition, we trimmed the CCRs at the cost center (that is, departmental) level by removing the CCRs for each cost center as outliers if they exceeded +/− 3 standard deviations from the geometric mean. We used a four-tiered hierarchy of cost

center CCRs, which is the revenue code-to-cost center crosswalk, to match a cost center to every possible revenue code appearing in the outpatient claims that is relevant to OPPS services, with the top tier being the most common cost center and the last tier being the default CCR. If a hospital's cost center CCR was deleted by trimming, we set the CCR for that cost center to "missing" so that another cost center CCR in the revenue center hierarchy could apply. If no other cost center CCR could apply to the revenue code on the claim, we used the hospital's overall ancillary CCR for the revenue code in question as the default CCR. For example, if a visit was reported under the clinic revenue code but the hospital did not have a clinic cost center, we mapped the hospital-specific overall ancillary CCR to the clinic revenue code. The revenue code-to-cost center crosswalk is available for inspection and comment on the CMS Web site: *http://www.cms.gov/HospitalOutpatientPPS*. Revenue codes that we do not use to set medians or to model impacts are identified with an "N" in the revenue code-to-cost center crosswalk.

At the February 17–18, 2010 APC Panel Meeting, the Panel recommended that CMS present to the Data Subcommittee an analysis of the effect of using a different lower-level threshold in the overall CCR error trim as part of the standard methodology. The Panel members were concerned that our current CCR trimming policy (excluding providers with an overall ancillary CCR greater than 90 or less than .0001 or above and then excluding remaining providers with overall ancillary CCRs beyond +/− 3 standard deviations from the geometric mean) could result in the exclusion of claims from providers that could otherwise be used for ratesetting and modeling. We are accepting this recommendation. We will study the issue and provide the relevant data to the Data Subcommittee at an upcoming meeting.

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

We identified claims with condition code 41 as partial hospitalization services of hospitals and moved them to another file. We note that the separate file containing partial hospitalization claims is included in the files that are available for purchase as discussed above.

We then excluded claims without a HCPCS code. We moved to another file claims that contained nothing but influenza and pneumococcal pneumonia (PPV) vaccines. Influenza and PPV vaccines are paid at reasonable cost and, therefore, these claims are not used to set OPPS rates.

We next copied line-item costs for drugs, blood, and brachytherapy sources (the lines stay on the claim, but are copied onto another file) to a separate file. No claims were deleted when we copied these lines onto another file. These line-items are used to calculate a per unit mean and median cost and a per day mean and median cost for drugs and nonimplantable biologicals, therapeutic radiopharmaceutical agents, and brachytherapy sources, as well as other information used to set payment rates, such as a unit-to-day ratio for drugs.

To implement our proposed policy to redistribute some portion of total cost for packaged drugs and biologicals to the separately payable drugs and biologicals as acquisition and pharmacy overhead and handling costs discussed in section V.B.3. of this proposed rule, we used the line-item cost data for drugs and biologicals for which we had a HCPCS code with ASP pricing information to calculate the ASP+X values, first for all drugs and biologicals, and then for separately payable drugs and biologicals and for packaged drugs and biologicals, respectively, by taking the ratio of total claim cost for each group relative to total ASP dollars (per unit of each drug or biological HCPCS code's April 2010 ASP amount multiplied by total units for each drug or biological in the CY 2009 claims data). These values are ASP+14 percent (for all drugs and biologicals with HCPCS codes, whether separately paid or packaged), ASP+0 percent (for drugs and biologicals that are separately paid), and ASP+283 percent (for drugs and biologicals that have HCPCS codes and that are packaged), respectively. As we discuss in section V.B.3. of this proposed rule, we are proposing a policy to redistribute $150 million of the total cost in our claims data for packaged drugs and biologicals that have an associated ASP from packaged drugs with an ASP to separately payable drugs and biologicals. We also are proposing a policy to redistribute an additional $50 million of the total cost in our claims data for drugs and biologicals lacking an ASP, largely for estimated costs associated with uncoded charges billed under pharmacy revenue code series 025X (Pharmacy (also see 063X, an extension of 025X)), 026X (IV Therapy), and 063X (Pharmacy—Extension of 025X). We observe about $623 million for drugs lacking an ASP in our CY 2009 claims data. This total excludes the cost of diagnostic and therapeutic radiopharmaceuticals because they are not reported under pharmacy revenue codes or under the pharmacy cost center on the hospital cost report.

Removing a total of $150 million in pharmacy overhead cost from packaged drugs and biologicals reduces the $593 million to $443 million, approximately a 25 percent reduction. Removing $50 million from the cost of drugs lacking an ASP reduces the $623 million to $573 million, approximately an 8 percent reduction. To implement our proposed CY 2011 policy to redistribute $150 million in claim cost from packaged drugs and biologicals with an ASP to separately payable drugs and biologicals and $50 million in claim cost from packaged drugs and biologicals lacking an ASP, including uncoded pharmacy revenue code charges, we multiplied the cost of each packaged drug or biological with a HCPCS code and ASP pricing information in our CY 2009 claims data by 0.75, and we multiplied all other packaged drug costs in our CY 2009 claims data, excluding those for diagnostic radiopharmaceuticals, by 0.92. We also added the redistributed $200 million to the total cost of separately payable drugs and biologicals in our CY 2009 claims data, which increased the relationship between the total cost for separately payable drugs and biologicals and ASP dollars for the same drugs and biologicals from ASP+0 percent to ASP+6 percent. We refer readers to section V.B.3. of this proposed rule for a complete discussion of our proposal to pay for separately paid drugs and biologicals and pharmacy overhead for CY 2011.

We then removed line-items that were not paid during claim processing, presumably for a line-item rejection or denial. We added this process to our median cost calculation methodology for the CY 2010 OPPS, as discussed in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60359). The number of edits for valid OPPS payment in the Integrated Outpatient Code Editor (I/OCE) and elsewhere has grown significantly in the past few years, especially with the implementation of the full spectrum of National Correct Coding Initiative (NCCI) edits. To ensure that we are using valid claims that represent the cost of payable services to set payment rates, we removed line-items with an OPPS status indicator for the claim year and a status indicator of "S," "T," "V," or "X" when separately paid under the prospective

year's payment system. This logic preserves charges for services that would not have been paid in the claim year but for which some estimate of cost is needed for the prospective year, such as services newly proposed to come off the inpatient list for CY 2010 that were assigned status indicator "C" in the claim year.

For CY 2011, we are proposing to expand the application of this trim to exclude line-item data for pass-through drugs and biologicals (status indicator "G" for CY 2009) and nonpass-through drugs and biologicals (status indicator "K" for CY 2009) where the charges reported on the claim for the line were either denied or rejected during claims processing. Removing lines that were eligible for payment but were not paid ensures that we are using appropriate data. The trim avoids using cost data on lines that we believe were defective or invalid because those rejected or denied lines did not meet the Medicare requirements for payment. For example, edits may reject a line for a separately paid drug because the number of units billed exceeded the number of units that would be reasonable and, therefore, is likely a billing error (for example, a line reporting 55 units of a drug for which 5 units is known to be a fatal dose). For approximately 90 percent of the codes with status indicators "G" and "K" in their claims year, to which the expansion of the trim would apply, between 0 and 10 percent of lines would be removed due to receiving zero payment. As with our trimming in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60359) of line items with a status indicator of "S," "T," "V," or "X", we believe that unpaid line-items represent services that are invalidly reported and, therefore, should not be used for ratesetting. We believe that removing lines with valid status indicators that were edited and not paid during claims processing increases the accuracy of the single bills used to determine the mean unit costs for use in the ASP+X calculation described in section V.B.3. of this proposed rule.

b. Splitting Claims and Creation of "Pseudo" Single Procedure Claims

(1) Splitting Claims

We then split the remaining claims into five groups: Single majors; multiple majors; single minors; multiple minors; and other claims. (Specific definitions of these groups follow below.) For CY 2011, we are proposing to continue our current policy of defining major procedures as any HCPCS code having a status indicator of "S," "T," "V," or "X;" defining minor procedures as any code having a status indicator of "F," "G," "H," "K," "L," "R," "U," or "N," and classifying "other" procedures as any code having a status indicator other than one that we have classified as major or minor. For CY 2011, we are proposing to continue assigning status indicator "R" to blood and blood products; status indicator "U" to brachytherapy sources; status indicator "Q1" to all "STVX-packaged codes;" status indicator "Q2" to all "T-packaged codes;" and status indicator "Q3" to all codes that may be paid through a composite APC based on composite-specific criteria or paid separately through single code APCs when the criteria are not met. As discussed in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68709), we established status indicators "Q1," "Q2," and "Q3" to facilitate identification of the different categories of codes. We are proposing to treat these codes in the same manner for data purposes for CY 2011 as we have treated them since CY 2008. Specifically, we are proposing to continue to evaluate whether the criteria for separate payment of codes with status indicator "Q1" or "Q2" are met in determining whether they are treated as major or minor codes. Codes with status indicator "Q1" or "Q2" are carried through the data either with status indicator "N" as packaged or, if they meet the criteria for separate payment, they are given the status indicator of the APC to which they are assigned and are considered as "pseudo" single procedure claims for major codes. Codes assigned status indicator "Q3" are paid under individual APCs unless they occur in the combinations that qualify for payment as composite APCs and, therefore, they carry the status indicator of the individual APC to which they are assigned through the data process and are treated as major codes during both the split and "pseudo" single creation process. The calculation of the median costs for composite APCs from multiple procedure major claims is discussed in section II.A.2.e. of this proposed rule.

Specifically, we divided the remaining claims into the following five groups:

1. *Single Procedure Major Claims:* Claims with a single separately payable procedure (that is, status indicator "S," "T," "V," or "X," which includes codes with status indicator "Q3"); claims with one unit of a status indicator "Q1" code ("STVX-packaged") where there was no code with status indicator "S," "T," "V," or "X" on the same claim on the same date; or claims with one unit of a status indicator "Q2" code ("T-packaged") where there was no code with a status indicator "T" on the same claim on the same date.

2. *Multiple Procedure Major Claims:* Claims with more than one separately payable procedure (that is, status indicator "S," "T," "V," or "X," which includes codes with status indicator "Q3"), or multiple units of one payable procedure. These claims include those codes with a status indicator "Q2" code ("T-packaged") where there was no procedure with a status indicator "T" on the same claim on the same date of service but where there was another separately paid procedure on the same claim with the same date of service (that is, another code with status indicator "S," "V," or "X"). We also include, in this set, claims that contained one unit of one code when the bilateral modifier was appended to the code and the code was conditionally or independently bilateral. In these cases, the claims represented more than one unit of the service described by the code, notwithstanding that only one unit was billed.

3. *Single Procedure Minor Claims:* Claims with a single HCPCS code that was assigned status indicator "F," "G," "H," "K," "L," "R," "U," or "N" and not status indicator "Q1" ("STVX-packaged") or status indicator "Q2" ("T-packaged") code.

4. *Multiple Procedure Minor Claims:* Claims with multiple HCPCS codes that are assigned status indicator "F," "G," "H," "K," "L," "R," "U," or "N;" claims that contain more than one code with status indicator "Q1" ("STVX-packaged") or more than one unit of a code with status indicator "Q1" but no codes with status indicator "S," "T," "V," or "X" on the same date of service; or claims that contain more than one code with status indicator "Q2" (T-packaged), or "Q2" and "Q1," or more than one unit of a code with status indicator "Q2" but no code with status indicator "T" on the same date of service.

5. *Non-OPPS Claims:* Claims that contain no services payable under the OPPS (that is, all status indicators other than those listed for major or minor status). These claims were excluded from the files used for the OPPS. Non-OPPS claims have codes paid under other fee schedules, for example, durable medical equipment or clinical laboratory tests, and do not contain a code for a separately payable or packaged OPPS service. Non-OPPS claims include claims for therapy services paid sometimes under the OPPS but billed, in these non-OPPS cases, with revenue codes indicating that the therapy services would be paid under the Medicare Physician Fee Schedule (MPFS).

The claims listed in numbers 1, 2, 3, and 4 above are included in the data file that can be purchased as described above. Claims that contain codes to which we have assigned status indicators "Q1" ("STVX-packaged") and "Q2" ("T-packaged") appear in the data for the single major file, the multiple major file, and the multiple minor file used in this proposed rule. Claims that contain codes to which we have assigned status indicator "Q3" (composite APC members) appear in both the data of the single and multiple major files used in this proposed rule, depending on the specific composite calculation.

(2) Creation of "Pseudo" Single Procedure Claims

To develop "pseudo" single procedure claims for this proposed rule, we examined both the multiple procedure major claims and the multiple procedure minor claims. We first examined the multiple major procedure claims for dates of service to determine if we could break them into "pseudo" single procedure claims using the dates of service for all lines on the claim. If we could create claims with single major procedures by using dates of service, we created a single procedure claim record for each separately payable procedure on a different date of service (that is, a "pseudo" single).

We also used the bypass codes listed earlier in Table 1 and discussed in section II.A.1.b. of this proposed rule to remove separately payable procedures that we determined contained limited or no packaged costs or that were otherwise suitable for inclusion on the bypass list from a multiple procedure bill. As discussed above, we ignore the "overlap bypass codes," that is, those HCPCS codes that are both on the bypass list and are members of the multiple imaging composite APCs, in this initial assessment for "pseudo" single procedure claims. The proposed CY 2011 "overlap bypass codes" are listed in Table 1 in section II.A.1.b. of this proposed rule. When one of the two separately payable procedures on a multiple procedure claim was on the bypass list, we split the claim into two "pseudo" single procedure claim records. The single procedure claim record that contained the bypass code did not retain packaged services. The single procedure claim record that contained the other separately payable procedure (but no bypass code) retained the packaged revenue code charges and the packaged HCPCS code charges. We also removed lines that contained multiple units of codes on the bypass list and treated them as "pseudo" single procedure claims by dividing the cost for the multiple units by the number of units on the line. Where one unit of a single, separately payable procedure code remained on the claim after removal of the multiple units of the bypass code, we created a "pseudo" single procedure claim from that residual claim record, which retained the costs of packaged revenue codes and packaged HCPCS codes. This enabled us to use claims that would otherwise be multiple procedure claims and could not be used.

We then assessed the claims to determine if the criteria for the multiple imaging composite APCs, discussed in section II.A.2.e.(5) of this proposed rule, were met. Where the criteria for the imaging composite APCs were met, we created a "single session" claim for the applicable imaging composite service and determined whether we could use the claim in ratesetting. For HCPCS codes that are both conditionally packaged and are members of a multiple imaging composite APC, we first assessed whether the code would be packaged and, if so, the code ceased to be available for further assessment as part of the composite APC. Because the packaged code would not be a separately payable procedure, we considered it to be unavailable for use in setting the composite APC median cost. Having identified "single session" claims for the imaging composite APCs, we reassessed the claim to determine if, after removal of all lines for bypass codes, including the "overlap bypass codes," a single unit of a single separately payable code remained on the claim. If so, we attributed the packaged costs on the claim to the single unit of the single remaining separately payable code other than the bypass code to create a "pseudo" single procedure claim. We also identified line-items of overlap bypass codes as a "pseudo" single procedure claim. This allowed us to use more claims data for ratesetting purposes.

We also examined the multiple procedure minor claims to determine whether we could create "pseudo" single procedure claims. Specifically, where the claim contained multiple codes with status indicator "Q1" ("STVX-packaged") on the same date of service or contained multiple units of a single code with status indicator "Q1," we selected the status indicator "Q1" HCPCS code that had the highest CY 2010 relative weight, set the units to one on that HCPCS code to reflect our policy of paying only one unit of a code with a status indicator of "Q1." We then packaged all costs for the following into a single cost for the "Q1" HCPCS code that had the highest CY 2010 relative weight to create a "pseudo" single procedure claim for that code: Additional units of the status indicator "Q1" HCPCS code with the highest CY 2010 relative weight; other codes with status indicator "Q1"; and all other packaged HCPCS codes and packaged revenue code costs. We changed the status indicator for selected codes from the data status indicator of "N" to the status indicator of the APC to which the selected procedure was assigned for further data processing and considered this claim as a major procedure claim. We used this claim in the calculation of the APC median cost for the status indicator "Q1" HCPCS code.

Similarly, where a multiple procedure minor claim contained multiple codes with status indicator "Q2" ("T-packaged") or multiple units of a single code with status indicator "Q2," we selected the status indicator "Q2" HCPCS code that had the highest CY 2010 relative weight, set the units to one on that HCPCS code to reflect our policy of paying only one unit of a code with a status indicator of "Q2." We then packaged all costs for the following into a single cost for the "Q2" HCPCS code that had the highest CY 2010 relative weight to create a "pseudo" single procedure claim for that code: Additional units of the status indicator "Q2" HCPCS code with the highest CY 2010 relative weight; other codes with status indicator "Q2;" and other packaged HCPCS codes and packaged revenue code costs. We changed the status indicator for the selected code from a data status indicator of "N" to the status indicator of the APC to which the selected code was assigned, and we considered this claim as a major procedure claim.

Lastly, where a multiple procedure minor claim contained multiple codes with status indicator "Q2" ("T-packaged") and status indicator "Q1" ("STVX-packaged"), we selected the status indicator "Q2" HCPCS code ("T-packaged") that had the highest relative weight for CY 2010 and set the units to one on that HCPCS code to reflect our policy of paying only one unit of a code with a status indicator of "Q2." We then packaged all costs for the following into a single cost for the selected ("T packaged") HCPCS code to create a "pseudo" single procedure claim for that code: Additional units of the status indicator "Q2" HCPCS code with the highest CY 2010 relative weight; other codes with status indicator "Q2;" codes with status indicator "Q1" ("STVX-packaged"); and other packaged HCPCS codes and packaged revenue code costs. We favor status indicator "Q2" over "Q1"

HCPCS codes because "Q2" HCPCS codes have higher CY 2010 relative weights. If a status indicator "Q1" HCPCS code had a higher CY 2010 relative weight, it would become the primary code for the simulated single bill process. We changed the status indicator for the selected status indicator "Q2" ("T-packaged") code from a data status indicator of "N" to the status indicator of the APC to which the selected code was assigned and we considered this claim as a major procedure claim.

In public comments received on the CY 2010 OPPS/ASC proposed rule, a public commenter suggested that CMS could use more claims data to develop medians for these conditionally packaged codes if CMS applied the "pseudo" single creation process to the conditionally packaged codes in the multiple major claims that still contained unusable data. We agree and, for this CY 2011 OPPS/ASC proposed rule, we are proposing to use the otherwise unusable multiple procedure claims data that remain after the standard pseudo single creation process is applied to them, in order to create more pseudo single procedure claims. We would do this by treating the conditionally packaged codes that do not meet the criteria for packaging as if they were separately payable major codes and applying the pseudo single process to the claims data to create single procedure claims from them if they meet the criteria for single procedure claims. Conditionally packaged codes are identified using status indicators "Q1" and "Q2," and are described in section XIII.A.1. of this proposed rule. Using the February 2010 APC Panel data, we estimate that the impact of adding this proposed additional step to the pseudo single creation process would result in a small increase in the number of claims usable for ratesetting in most cases, but with more significant increases of between 5 to 10 percent of claims for a few codes. For most of the codes affected by adding this proposed additional step to the "pseudo" single creation process, we found no significant changes to the APC medians. Some HCPCS codes do experience some fluctuations, with the impact of additional claims causing their APC median to decrease. We believe that this change is consistent with our goal of using more available data from within the existing set of claims information and results in a more accurate estimation of the APC median cost for conditionally packaged services.

We excluded those claims that we were not able to convert to single procedure claims even after applying all of the techniques for creation of "pseudo" single procedure claims to multiple procedure major and to multiple procedure minor claims. As has been our practice in recent years, we also excluded claims that contained codes that were viewed as independently or conditionally bilateral and that contained the bilateral modifier (Modifier 50 (Bilateral procedure)) because the line-item cost for the code represented the cost of two units of the procedure, notwithstanding that hospitals billed the code with a unit of one.

c. Completion of Claim Records and Median Cost Calculations

We then packaged the costs of packaged HCPCS codes (codes with status indicator "N" listed in Addendum B to this proposed rule and the costs of those lines for codes with status indicator "Q1" or "Q2" when they are not separately paid), and the costs of the services reported under packaged revenue codes in Table 3 that appeared on the claim without a HCPCS code into the cost of the single major procedure remaining on the claim.

As noted in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66606), for the CY 2008 OPPS, we adopted an APC Panel recommendation that CMS should review the final list of packaged revenue codes for consistency with OPPS policy and ensure that future versions of the I/OCE edit accordingly. As we have in the past, we will continue to compare the final list of packaged revenue codes that we adopt for CY 2011 to the revenue codes that the I/OCE will package for CY 2011 to ensure consistency.

In the CY 2009 OPPS/ASC final rule with comment period (73 FR 68531), we replaced the NUBC standard abbreviations for the revenue codes listed in Table 2 of the CY 2009 OPPS/ASC proposed rule with the most current NUBC descriptions of the revenue code categories and subcategories to better articulate the meanings of the revenue codes without changing the proposed list of revenue codes. In the CY 2010 OPPS/ASC final rule with comment period (74 FR 60362 through 60363), we finalized changes to the packaged revenue code list based on our examination of the updated NUBC codes and public comment to the CY 2010 proposed list of packaged revenue codes. For this CY 2011 OPPS proposed rule, we reviewed the changes to revenue codes that were effective during CY 2009 for purposes of determining the charges reported with revenue codes but without HCPCS codes that we would propose to package for the CY 2011 OPPS. As we discuss in the context of the revenue code-to-cost center crosswalk in section II.A.1.c. of this proposed rule, for CY 2009, the NUBC changed the title of revenue code series 076x from "Specialty Room—Treatment/Observation Room" to "Specialty Services" and changed the title of subclassification revenue code 0762 from "Observation Room" to "Observation Hours". In addition, the NUBC deleted an explanatory note following revenue code 0913, "Behavioral Health Treatment Services—Extension of 090x." We are proposing to revise the title for revenue code 076x, Observation Hours, in Table 3 to comport to the CY 2009 revenue code title for revenue code 076x. There is no need to revise the table as a result of the deletion of the explanatory note. We believe that the charges reported under the revenue codes listed in Table 3 continue to reflect ancillary and supportive services for which hospitals report charges without HCPCS codes. Therefore, we are proposing to continue to package the costs that we derive from the charges reported under the revenue codes displayed in Table 3 below for purposes of calculating the median costs on which the CY 2011 OPPS would be based.

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TABLE 3.—PROPOSED CY 2011 PACKAGED REVENUE CODES

Revenue Code	Description
0250	Pharmacy; General Classification
0251	Pharmacy; Generic Drugs
0252	Pharmacy; Non-Generic Drugs
0254	Pharmacy; Drugs Incident to Other Diagnostic Services
0255	Pharmacy; Drugs Incident to Radiology
0257	Pharmacy; Non-Prescription
0258	Pharmacy; IV Solutions
0259	Pharmacy; Other Pharmacy
0260	IV Therapy; General Classification
0261	IV Therapy; Infusion Pump
0262	IV Therapy; IV Therapy/Pharmacy Svcs
0263	IV Therapy; IV Therapy/Drug/Supply Delivery
0264	IV Therapy; IV Therapy/Supplies
0269	IV Therapy; Other IV Therapy
0270	Medical/Surgical Supplies and Devices; General Classification
0271	Medical/Surgical Supplies and Devices; Non-sterile Supply
0272	Medical/Surgical Supplies and Devices; Sterile Supply
0275	Medical/Surgical Supplies and Devices; Pacemaker
0276	Medical/Surgical Supplies and Devices; Intraocular Lens
0278	Medical/Surgical Supplies and Devices; Other Implants
0279	Medical/Surgical Supplies and Devices; Other Supplies/Devices
0280	Oncology; General Classification
0289	Oncology; Other Oncology
0343	Nuclear Medicine; Diagnostic Radiopharmaceuticals
0344	Nuclear Medicine; Therapeutic Radiopharmaceuticals
0370	Anesthesia; General Classification
0371	Anesthesia; Anesthesia Incident to Radiology
0372	Anesthesia; Anesthesia Incident to Other DX Services
0379	Anesthesia; Other Anesthesia
0390	Administration, Processing and Storage for Blood and Blood Components; General Classification
0392	Administration, Processing and Storage for Blood and Blood Components; Processing and Storage
0399	Administration, Processing and Storage for Blood and Blood Components; Other Blood Handling
0621	Medical Surgical Supplies – Extension of 027X; Supplies Incident to Radiology
0622	Medical Surgical Supplies – Extension of 027X; Supplies Incident to Other DX Services
0623	Medical Supplies – Extension of 027X, Surgical Dressings
0624	Medical Surgical Supplies – Extension of 027X; FDA Investigational Devices

Revenue Code	Description
0630	Pharmacy – Extension of 025X; Reserved
0631	Pharmacy – Extension of 025X; Single Source Drug
0632	Pharmacy – Extension of 025X; Multiple Source Drug
0633	Pharmacy – Extension of 025X; Restrictive Prescription
0681	Trauma Response; Level I Trauma
0682	Trauma Response; Level II Trauma
0683	Trauma Response; Level III Trauma
0684	Trauma Response; Level IV Trauma
0689	Trauma Response; Other
0700	Cast Room; General Classification
0710	Recovery Room; General Classification
0720	Labor Room/Delivery; General Classification
0721	Labor Room/Delivery; Labor
0732	EKG/ECG (Electrocardiogram); Telemetry
0762	Specialty services; Observation Hours
0801	Inpatient Renal Dialysis; Inpatient Hemodialysis
0802	Inpatient Renal Dialysis; Inpatient Peritoneal Dialysis (Non-CAPD)
0803	Inpatient Renal Dialysis; Inpatient Continuous Ambulatory Peritoneal Dialysis (CAPD)
0804	Inpatient Renal Dialysis; Inpatient Continuous Cycling Peritoneal Dialysis (CCPD)
0809	Inpatient Renal Dialysis; Other Inpatient Dialysis
0810	Acquisition of Body Components; General Classification
0819	Inpatient Renal Dialysis; Other Donor
0821	Hemodialysis-Outpatient or Home; Hemodialysis Composite or Other Rate
0824	Hemodialysis-Outpatient or Home; Maintenance – 100%
0825	Hemodialysis-Outpatient or Home; Support Services
0829	Hemodialysis-Outpatient or Home; Other OP Hemodialysis
0942	Other Therapeutic Services (also see 095X, an extension of 094x); Education/Training
0943	Other Therapeutic Services (also see 095X, an extension of 094X), Cardiac Rehabilitation
0948	Other Therapeutic Services (also see 095X, an extension of 094X), Pulmonary Rehabilitation

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In accordance with our longstanding policy, we are proposing to continue to exclude: (1) Claims that had zero costs after summing all costs on the claim; and (2) claims containing packaging flag number 3. Effective for services furnished on or after July 1, 2004, the I/OCE assigned packaging flag number 3 to claims on which hospitals submitted token charges less than $1.01 for a service with status indicator "S" or "T" (a major separately payable service under the OPPS) for which the fiscal intermediary or MAC was required to allocate the sum of charges for services with a status indicator equaling "S" or "T" based on the relative weight of the APC to which each code was assigned. We do not believe that these charges, which were token charges as submitted by the hospital, are valid reflections of hospital resources. Therefore, we deleted these claims. We also deleted claims for which the charges equaled the revenue center payment (that is, the Medicare payment) on the assumption that where the charge equaled the payment, to apply a CCR to the charge would not yield a valid estimate of relative provider cost. We are proposing to continue these processes for the CY 2011 OPPS.

For the remaining claims, we then standardized 60 percent of the costs of the claim (which we have previously determined to be the labor-related portion) for geographic differences in labor input costs. We made this adjustment by determining the wage index that applied to the hospital that furnished the service and dividing the cost for the separately paid HCPCS code furnished by the hospital by that wage index. As has been our policy since the inception of the OPPS, we are proposing to use the pre-reclassified wage indices for standardization because we believe that they better reflect the true costs of items and services in the area in which the hospital is located than the post-reclassification wage indices and, therefore, would result in the most accurate unadjusted median costs.

In accordance with our longstanding practice, we also excluded single and pseudo single procedure claims for

which the total cost on the claim was outside 3 standard deviations from the geometric mean of units for each HCPCS code on the bypass list (because, as discussed above, we used claims that contain multiple units of the bypass codes).

After removing claims for hospitals with error CCRs, claims without HCPCS codes, claims for immunizations not covered under the OPPS, and claims for services not paid under the OPPS, approximately 98 million claims were left. Using these 98 million claims, we created approximately 96 million single and "pseudo" single procedure claims, of which we used 95 million single bills (after trimming out approximately 696,000 claims as discussed above in this section) in the proposed CY 2011 median development and ratesetting.

We used these claims to calculate the proposed CY 2011 median costs for each separately payable HCPCS code and each APC. The comparison of HCPCS code-specific and APC medians determines the applicability of the 2 times rule. Section 1833(t)(2) of the Act provides that, subject to certain exceptions, the items and services within an APC group cannot be considered comparable with respect to the use of resources if the highest median (or mean cost, if elected by the Secretary) for an item or service in the group is more than 2 times greater than the lowest median cost for an item or service within the same group (the 2 times rule). Finally, we reviewed the median costs for the services for which we are proposing to pay separately under this proposed rule, and we reassigned HCPCS codes to different APCs where it was necessary to ensure clinical and resource homogeneity within the APCs. Section III. of this proposed rule includes a discussion of many of the HCPCS code assignment changes that resulted from examination of the median costs and for other reasons. The APC medians were recalculated after we reassigned the affected HCPCS codes. Both the HCPCS code-specific medians and the APC medians were weighted to account for the inclusion of multiple units of the bypass codes in the creation of "pseudo" single procedure claims.

As we discuss in sections II.A.2 d. and II.A.2.e. and in section X.B. of this proposed rule, in some cases, APC median costs are calculated using variations of the process outlined above. Specifically, section II.A.2.d. of this proposed rule addresses the proposed calculation of single APC criteria-based median costs. Section II.A.2.e. of this proposed rule discusses the proposed calculation of composite APC criteria-based median costs. Section X.B. of this proposed rule addresses the methodology for calculating the proposed median cost for partial hospitalization services.

At the February 2010 APC Panel Meeting, we provided the APC Panel a list of all APCs decreasing by more than 5 percent and increasing by more than 15 percent when comparing the proposed CY 2011 median costs based on data available for the February 2010 APC Panel meeting from CY 2009 claims processed through September 30, 2009, to those based on CY 2010 OPPS/ASC final rule data (CY 2008 claims). The APC Panel reviewed these fluctuations in the APC median costs but did not express particular concerns with the median cost changes.

As we stated earlier, at the February 2010 APC Panel Meeting, the APC Panel also recommended that the Data Subcommittee continue its work. We are proposing to accept that recommendation.

d. Proposed Calculation of Single Procedure APC Criteria-Based Median Costs

(1) Device-Dependent APCs

Device-dependent APCs are populated by HCPCS codes that usually, but not always, require that a device be implanted or used to perform the procedure. For a full history of how we have calculated payment rates for device-dependent APCs in previous years and a detailed discussion of how we developed the standard device-dependent APC ratesetting methodology, we refer readers to the CY 2008 OPPS/ASC final rule with comment period (72 FR 66739 through 66742). Overviews of the procedure-to-device edits and device-to-procedure edits used in ratesetting for device-dependent APCs are available in the CY 2005 OPPS final rule with comment period (69 FR 65761 through 65763) and the CY 2007 OPPS/ASC final rule with comment period (71 FR 68070 through 68071).

For CY 2011, we are proposing to continue to use the standard methodology for calculating median costs for device-dependent APCs that was finalized in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60365). This methodology utilizes claims data that generally represent the full cost of the required device. Specifically, we are proposing to calculate the median costs for device-dependent APCs for CY 2011 using only the subset of single procedure claims from CY 2009 claims data that pass the procedure-to-device and device-to-procedure edits; do not contain token charges (less than $1.01) for devices; do not contain the "FB" modifier signifying that the device was furnished without cost to the provider, supplier, or practitioner, or where a full credit was received; and do not contain the "FC" modifier signifying that the hospital received partial credit for the device. The "FC" modifier became effective January 1, 2008, and was present for the first time on claims that were used in OPPS ratesetting for CY 2010. We continue to believe the standard methodology for calculating median costs for device-dependent APCs gives us the most appropriate proposed median costs for device-dependent APCs in which the hospital incurs the full cost of the device.

The median costs for the majority of device-dependent APCs that are calculated using the CY 2011 proposed rule claims data are generally stable, with most median costs increasing moderately compared to the median costs upon which the CY 2010 OPPS payment rates were based. However, the median costs for APC 0225 (Implantation of Neurostimulator Electrodes, Cranial Nerve) and APC 0418 (Insertion of Left Ventricular Pacing Electrode) demonstrate significant fluctuation. Specifically, the proposed CY 2011 median cost for APC 0225 increased approximately 40 percent compared to its final CY 2010 median cost, while the proposed CY 2011 median cost for APC 0418, which had increased approximately 53 percent from CY 2009 to CY 2010, showed a decrease of approximately 27 percent based on the claims data available for this CY 2011 proposed rule. We believe the fluctuations in median costs for these two APCs are a consequence of the small number of single bills upon which the median costs are based and the small number of providers of these services. As we have stated in the past, some fluctuation in relative costs from year to year is to be expected in a prospective payment system for low volume device-dependent APCs, particularly where there are small numbers of single bills from a small number of providers. The additional single bills available for ratesetting in the CY 2011 final rule data and updated cost report data may result in less fluctuation in the median costs for these APCs for CY 2011.

Table 4 below lists the APCs for which we are proposing to use our standard device-dependent APC ratesetting methodology for CY 2011. We refer readers to Addendum A to this proposed rule for the proposed payment rates for these APCs.

TABLE 4.—PROPOSED CY 2011 DEVICE-DEPENDENT APCs

Proposed CY 2011 APC	Proposed CY 2011 Status Indicator	Proposed CY 2011 APC Title
0039	S	Level I Implantation of Neurostimulator Generator
0040	S	Percutaneous Implantation of Neurostimulator Electrodes
0061	S	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electrodes
0082	T	Coronary or Non-Coronary Atherectomy
0083	T	Coronary or Non-Coronary Angioplasty and Percutaneous Valvuloplasty
0084	S	Level I Electrophysiologic Procedures
0085	T	Level II Electrophysiologic Procedures
0086	T	Level III Electrophysiologic Procedures
0089	T	Insertion/Replacement of Permanent Pacemaker and Electrodes
0090	T	Insertion/Replacement of Pacemaker Pulse Generator
0104	T	Transcatheter Placement of Intracoronary Stents
0106	T	Insertion/Replacement of Pacemaker Leads and/or Electrodes
0107	T	Insertion of Cardioverter-Defibrillator
0108	T	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads
0115	T	Cannula/Access Device Procedures
0202	T	Level VII Female Reproductive Procedures
0225	S	Implantation of Neurostimulator Electrodes, Cranial Nerve
0227	T	Implantation of Drug Infusion Device
0229	T	Transcatheter Placement of Intravascular Shunts
0259	T	Level VII ENT Procedures
0293	T	Level V Anterior Segment Eye Procedures
0315	S	Level II Implantation of Neurostimulator Generator
0384	T	GI Procedures with Stents
0385	S	Level I Prosthetic Urological Procedures
0386	S	Level II Prosthetic Urological Procedures
0418	T	Insertion of Left Ventricular Pacing Electrode
0425	T	Level II Arthroplasty or Implantation with Prosthesis
0427	T	Level II Tube or Catheter Changes or Repositioning
0622	T	Level II Vascular Access Procedures
0623	T	Level III Vascular Access Procedures
0648	T	Level IV Breast Surgery
0652	T	Insertion of Intraperitoneal and Pleural Catheters
0653	T	Vascular Reconstruction/Fistula Repair with Device
0654	T	Insertion/Replacement of a Permanent Dual Chamber Pacemaker
0655	T	Insertion/Replacement/Conversion of a Permanent Dual Chamber Pacemaker
0656	T	Transcatheter Placement of Intracoronary Drug-Eluting Stents
0674	T	Prostate Cryoablation
0680	S	Insertion of Patient Activated Event Recorders

(2) Blood and Blood Products

Since the implementation of the OPPS in August 2000, we have made separate payments for blood and blood products through APCs rather than packaging payment for them into payments for the procedures with which they are administered. Hospital payments for the costs of blood and blood products, as well as for the costs of collecting, processing, and storing blood and blood products, are made through the OPPS payments for specific blood product APCs.

For CY 2011, we are proposing to continue to establish payment rates for blood and blood products using our blood-specific CCR methodology, which utilizes actual or simulated CCRs from the most recently available hospital cost reports to convert hospital charges for blood and blood products to costs. This methodology has been our standard ratesetting methodology for blood and blood products since CY 2005. It was developed in response to data analysis indicating that there was a significant difference in CCRs for those hospitals with and without blood-specific cost centers, and past comments indicating that the former OPPS policy of defaulting to the overall hospital CCR for hospitals not reporting a blood-specific cost center often resulted in an underestimation of the true hospital costs for blood and blood products. Specifically, in order to address the differences in CCRs and to better reflect hospitals' costs, we are proposing to continue to simulate blood CCRs for each hospital that does not report a blood cost center by calculating the ratio of the blood-specific CCRs to hospitals' overall CCRs for those hospitals that do report costs and charges for blood cost centers. We would then apply this mean ratio to the overall CCRs of hospitals not reporting costs and charges for blood cost centers on their cost reports in order to simulate blood-specific CCRs for those hospitals. We calculated the median costs upon which the proposed CY 2011 payment rates for blood and blood products are based using the actual blood-specific CCR for hospitals that reported costs and charges for a blood cost center and a hospital-specific simulated blood-specific CCR for hospitals that did not report costs and charges for a blood cost center.

We continue to believe the hospital-specific, blood-specific CCR methodology better responds to the absence of a blood-specific CCR for a hospital than alternative methodologies, such as defaulting to the overall hospital CCR or applying an average blood-specific CCR across hospitals. Because this methodology takes into account the unique charging and cost accounting structure of each provider, we believe that it yields more accurate estimated costs for these products. We believe that continuing with this methodology in CY 2011 would result in median costs for blood and blood products that appropriately reflect the relative estimated costs of these products for hospitals without blood cost centers and, therefore, for these blood products in general.

We refer readers to Addendum B to this proposed rule for the proposed CY 2011 payment rates for blood and blood products, which are identified with status indicator "R." For more detailed discussion of the blood-specific CCR methodology, we refer readers to the CY 2005 OPPS proposed rule (69 FR 50524 through 50525). For a full history of OPPS payment for blood and blood products, we refer readers to the CY 2008 OPPS/ASC final rule with comment period (72 FR 66807 through 66810).

(3) Single Allergy Tests

We are proposing to continue with our methodology of differentiating single allergy tests ("per test") from multiple allergy tests ("per visit") by assigning these services to two different APCs to provide accurate payments for these tests in CY 2011. Multiple allergy tests are currently assigned to APC 0370 (Allergy Tests), with a median cost calculated based on the standard OPPS methodology. We provided billing guidance in CY 2006 in Transmittal 804 (issued on January 3, 2006) specifically clarifying that hospitals should report charges for the CPT codes that describe single allergy tests to reflect charges "per test" rather than "per visit" and should bill the appropriate number of units (as defined in the CPT code descriptor) of these CPT codes to describe all of the tests provided. Our CY 2009 claims data available for this proposed rule for APC 0381 do not reflect improved and more consistent hospital billing practices of "per test" for single allergy tests. The median cost of APC 0381, calculated for this proposed rule according to the standard single claims OPPS methodology, is approximately $52, significantly higher than the CY 2010 median cost of APC 0381 of approximately $29 calculated according to the "per unit" methodology, and greater than we would expect for these procedures that are to be reported "per test" with the appropriate number of units. Some claims for single allergy tests still appear to provide charges that represent a "per visit" charge, rather than a "per test" charge. Therefore, consistent with our payment policy for single allergy tests since CY 2006, we are proposing to calculate a "per unit" median cost for APC 0381, based upon 595 claims containing multiple units or multiple occurrences of a single CPT code. The proposed CY 2011 median cost for APC 0381 using the "per unit" methodology is approximately $29. For a full discussion of this methodology, we refer readers to the CY 2008 OPPS/ASC final rule with comment period (72 FR 66737).

(4) Hyperbaric Oxygen Therapy (APC 0659)

Since the implementation of OPPS in August 2000, the OPPS has recognized HCPCS code C1300 (Hyperbaric oxygen under pressure, full body chamber, per 30 minute interval) for hyperbaric oxygen therapy (HBOT) provided in the hospital outpatient setting. In the CY 2005 final rule with comment period (69 FR 65758 through 65759), we finalized a "per unit" median cost calculation for APC 0659 (Hyperbaric Oxygen) using only claims with multiple units or multiple occurrences of HCPCS code C1300 because delivery of a typical HBOT service requires more than 30 minutes. We observed that claims with only a single occurrence of the code were anomalies, either because they reflected terminated sessions or because they were incorrectly coded with a single unit. In the same rule, we also established that HBOT would not generally be furnished with additional services that might be packaged under the standard OPPS APC median cost methodology. This enabled us to use claims with multiple units or multiple occurrences. Finally, we also used each hospital's overall CCR to estimate costs for HCPCS code C1300 from billed charges rather than the CCR for the respiratory therapy or other departmental cost centers. The public comments on the CY 2005 OPPS proposed rule effectively demonstrated that hospitals report the costs and charges for HBOT in a wide variety of cost centers. Since CY 2005, we have used this methodology to estimate the median cost for HBOT. The median costs of HBOT using this methodology have been relatively stable for the last 5 years. For CY 2011, we are proposing to continue using the same methodology to estimate a "per unit" median cost for HCPCS code C1300. This methodology results in a proposed APC median cost of approximately $109 using 328,960 claims with multiple units or multiple occurrences for HCPCS code C1300 for CY 2011.

(5) Payment for Ancillary Outpatient Services When Patient Expires (APC 0375)

In the November 1, 2002 final rule with comment period (67 FR 66798), we discussed the creation of the new HCPCS modifier –CA to address situations where a procedure on the OPPS inpatient list must be performed to resuscitate or stabilize a patient (whose status is that of an outpatient) with an emergent, life-threatening condition, and the patient dies before being admitted as an inpatient. HCPCS modifier –CA is defined as a procedure payable only in the inpatient setting when performed emergently on an outpatient who expires prior to admission. In Transmittal A–02–129, issued on January 3, 2003, we instructed hospitals on the use of this modifier. For a complete description of the history of the policy and the development of the payment methodology for these services, we refer readers to the CY 2007 OPPS/ASC final rule with comment period (71 FR 68157 through 68158).

For CY 2011, we are proposing to continue to use our established ratesetting methodology for calculating the median cost of APC 0375 (Ancillary Outpatient Services When Patient Expires) and to continue to make one payment under APC 0375 for the services that meet the specific conditions for using HCPCS modifier –CA. We are proposing to calculate the relative payment weight for APC 0375 by using all claims reporting a status indicator "C" (inpatient procedures) appended with HCPCS modifier –CA, using estimated costs from claims data for line-items with a HCPCS code assigned to status indicators "G," "H," "K," "N," "Q1," "Q2," "Q3," "R," "S," "T," "U," "V," and "X" and charges for packaged revenue codes without a HCPCS code (we refer readers to section XIII.A.1. of this proposed rule for a complete listing of status indicators). We continue to believe that this methodology results in the most appropriate aggregate median cost for the ancillary services provided in these unusual clinical situations.

We believe that hospitals are reporting the HCPCS modifier –CA according to the policy initially established in CY 2003. We note that the claims frequency for APC 0375 has been relatively stable over the past few years. Although the median cost for APC 0375 has increased, the median in the CY 2009 OPPS claims data used for development of proposed rates for CY 2011 was only slightly higher than that for CY 2010. Variation in the median cost for APC 0375 is expected because of the small number of claims and because the specific cases are grouped by the presence of the HCPCS modifier –CA appended to an inpatient procedure and not according to the standard APC criteria of clinical and resource homogeneity. Cost variation for APC 0375 from year to year is anticipated and acceptable as long as hospitals continue judicious reporting of the HCPCS modifier –CA. Table 5 below shows the number of claims and the final median costs for APC 0375 for CYs 2007, 2008, 2009, and 2010. For CY 2011, we are proposing a median cost of approximately $6,566 for APC 0375 based on 117 claims.

TABLE 5.--CLAIMS FOR ANCILLARY OUTPATIENT SERVICES WHEN PATIENT EXPIRES (–CA MODIFIER) FOR CYs 2007 THROUGH 2010

Prospective Payment Year	Number of Claims	APC Median Cost
CY 2007	260	$3,549
CY 2008	183	$4,945
CY 2009	168	$5,545
CY 2010	182	$5,911

(6) Pulmonary Rehabilitation

Section 144(a)(1) of Public Law 110–275 (MIPPA) added section 1861(fff) to the Act to provide Medicare Part B coverage and payment for a comprehensive program of pulmonary rehabilitation services furnished to beneficiaries with chronic obstructive pulmonary disease, effective January 1, 2010. Accordingly, in the CY 2010 OPPS/ASC final rule with comment period, we established a policy to pay for pulmonary rehabilitation (PR) services furnished as a part of the comprehensive PR program benefit (74 FR 60567). We created new HCPCS code G0424 (Pulmonary rehabilitation, including exercise (includes monitoring), one hour, per session, up to two sessions per day) and assigned it to new APC 0102 (Level II Pulmonary Treatment).

For CY 2011, we are proposing to continue to require hospitals to report PR services provided under the comprehensive PR benefit in section 1861(fff) of the Act using HCPCS code G0424. We also are proposing to continue to use the methodology described in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60567 through 60570) to calculate the median cost on which the proposed payment rate for CY 2011 is based. Specifically, we are proposing to continue to assign HCPCS code G0424 to APC 0102 and to calculate a median "per session" cost simulated from historical hospital claims data for similar pulmonary therapy services for the CY 2011 OPPS.

To simulate the proposed "per session" median cost of HCPCS code G0424 from claims data for existing services, we used only claims that contained at least one unit of HCPCS code G0239 (Therapeutic procedures to improve respiratory function or increase strength or endurance of respiratory muscles, two or more individuals (includes monitoring)), the group code that is without limitation on time duration, and one unit of HCPCS code G0237 (Therapeutic procedures to increase strength or endurance of respiratory muscles, face to face, one on one, each 15 minutes (includes monitoring)) or G0238 (Therapeutic procedures to improve respiratory function, other than described by G0237, one on one, face to face, per 15 minutes (includes monitoring)), the individual, face-to-face codes that report 15 minutes of service on the same date of service. We continue to believe that patients in a PR program would typically receive individual and group services in each session of

approximately 1 hour in duration. This proposal is consistent with public comments on the CY 2010 OPPS/ASC proposed rule that were addressed in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60569) that suggested that PR is often provided in group sessions in the HOPD, although patients commonly require additional one-on-one care in order to fully participate in the program. We note that our use of "per session" claims reporting one unit of HCPCS code G0237 or G0238 and one unit of HCPCS code G0239 in this simulation methodology is also consistent with our overall finding of approximately 2.4 service units of the HCPCS G-codes per day on a single date of service, usually consisting of both individual and group services, for patients receiving pulmonary therapy services in the HOPD based upon CY 2008 claims used for CY 2010 OPPS final rule ratesetting. We continue to believe that the typical session of PR is 1 hour based on public comments that indicated that a session of PR is typically 1 hour and based on our findings that the most commonly reported HCPCS code for pulmonary treatment is HCPCS code G0239, which has no time definition for this group service.

In the calculation of the proposed median cost for APC 0102, we included all costs of the related tests and assessment services, including CPT codes 94620 (Pulmonary stress testing, simple (e.g. 6-minute walk test, prolonged exercise test for bronchospasm with pre- and post-spirometry and oximetry)), 94664 (Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device), and 94667 (Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function; initial demonstration and/or evaluation and all the costs of all CPT codes for established patient clinic visits) on the same date of service as the HCPCS codes in the claims we used to simulate the median cost for HCPCS code G0424, which is the only HCPCS code in APC 0102. After identifying these "per session" claims, which we believe represent 1 hour of care, we summed the costs and calculated the median cost for the set of selected claims. In light of the cost and clinical similarities of PR and the existing services described by HCPCS codes G0237, G0238, and G0239 and the CPT codes for related assessments and tests, and the significant number of "per session" hospital claims we found, we are confident that the proposed simulated median cost for HCPCS code G0424 and APC 0102 of approximately $68 is a valid estimate of the expected hospital cost of a PR session. We note that this proposed median cost is higher than the CY 2010 final rule median cost for HCPCs code G0424 and APC 0102 of approximately $50 on which the CY 2010 payment is based.

e. Proposed Calculation of Composite APC Criteria-Based Median Costs

As discussed in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66613), we believe it is important that the OPPS enhance incentives for hospitals to provide only necessary, high quality care and to provide that care as efficiently as possible. For CY 2008, we developed composite APCs to provide a single payment for groups of services that are typically performed together during a single clinical encounter and that result in the provision of a complete service. Combining payment for multiple independent services into a single OPPS payment in this way enables hospitals to manage their resources with maximum flexibility by monitoring and adjusting the volume and efficiency of services themselves. An additional advantage to the composite APC model is that we can use data from correctly coded multiple procedure claims to calculate payment rates for the specified combinations of services, rather than relying upon single procedure claims which may be low in volume and/or incorrectly coded. Under the OPPS, we currently have composite APC policies for extended assessment and management services, low dose rate (LDR) prostate brachytherapy, cardiac electrophysiologic evaluation and ablation services, mental health services, and multiple imaging services. We refer readers to the CY 2008 OPPS/ASC final rule with comment period for a full discussion of the development of the composite APC methodology (72 FR 66611 through 66614 and 66650 through 66652).

At its February 2010 meeting, the APC Panel recommended that, in order to support stem cell transplantation, CMS consider creating a composite APC or custom APC that captures the costs of stem cell acquisition performed in conjunction with recipient transplantation and preparation of tissue. We are accepting this APC Panel recommendation to consider creating a composite APC or custom APC that captures the costs of stem cell acquisition performed in conjunction with recipient transplantation and preparation of tissue, and will report the results of our assessment to the APC Panel at a future meeting.

For CY 2011, we are proposing to continue our established composite APC policies for extended assessment and management, LDR prostate brachytherapy, cardiac electrophysiologic evaluation and ablation, mental health services, and multiple imaging services, as discussed in sections II.A.2.e.(1), II.A.2.e.(2), II.A.2.e.(3), II.A.2.e.(4), and II.A.2.e.(5), respectively, of this proposed rule.

(1) Extended Assessment and Management Composite APCs (APCs 8002 and 8003)

For CY 2011, we are proposing to continue to include composite APC 8002 (Level I Extended Assessment and Management Composite) and composite APC 8003 (Level II Extended Assessment and Management Composite) in the OPPS. For CY 2008, we created these two composite APCs to provide payment to hospitals in certain circumstances when extended assessment and management of a patient occur (an extended visit). In most circumstances, observation services are supportive and ancillary to the other services provided to a patient. In the circumstances when observation care is provided in conjunction with a high level visit or direct referral and is an integral part of a patient's extended encounter of care, payment is made for the entire care encounter through one of two composite APCs as appropriate.

As defined for the CY 2008 OPPS, composite APC 8002 describes an encounter for care provided to a patient that includes a high level (Level 5) clinic visit or direct referral for observation services in conjunction with observation services of substantial duration (72 FR 66648 through 66649). Composite APC 8003 describes an encounter for care provided to a patient that includes a high level (Level 4 or 5) Type A emergency department visit, a high level (Level 5) Type B emergency department visit, or critical care services in conjunction with observation services of substantial duration. HCPCS code G0378 (Observation services, per hour) is assigned status indicator "N," signifying that its payment is always packaged. As noted in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66648 through 66649), the Integrated Outpatient Code Editor (I/OCE) evaluates every claim received to determine if payment through a composite APC is appropriate. If payment through a composite APC is inappropriate, the I/OCE, in conjunction with the OPPS Pricer, determines the appropriate status indicator, APC, and

payment for every code on a claim. The specific criteria that must be met for the two extended assessment and management composite APCs to be paid are provided below in the description of the claims that were selected for the calculation of the proposed CY 2011 median costs for these composite APCs. We are not proposing to change these criteria for the CY 2011 OPPS.

When we created composite APCs 8002 and 8003 for CY 2008, we retained as general reporting requirements for all observation services those criteria related to physician order and evaluation, documentation, and observation beginning and ending time as listed in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66812). These are more general requirements that encourage hospitals to provide medically reasonable and necessary care and help to ensure the proper reporting of observation services on correctly coded hospital claims that reflect the full charges associated with all hospital resources utilized to provide the reported services. We also issued guidance clarifying the correct method for reporting the starting time for observation services sections 290.2.2 through 290.5 in the Medicare Claims Processing Manual (Pub. 100–4), Chapter 4, through Transmittal 1745, Change Request 6492, issued May 22, 2009 and implemented July 6, 2009. We are not proposing to change these reporting requirements for the CY 2011 OPPS.

For CY 2011, we are proposing to continue the extended assessment and management composite APC payment methodology for APCs 8002 and 8003. We continue to believe that the composite APCs 8002 and 8003 and related policies provide the most appropriate means of paying for these services. We are proposing to calculate the median costs for APCs 8002 and 8003 using all single and "pseudo" single procedure claims for CY 2009 that meet the criteria for payment of each composite APC.

Specifically, to calculate the proposed median costs for composite APCs 8002 and 8003, we selected single and "pseudo" single procedure claims that met each of the following criteria:

1. Did not contain a HCPCS code to which we have assigned status indicator "T" that is reported with a date of service 1 day earlier than the date of service associated with HCPCS code G0378. (By selecting these claims from single and "pseudo" single claims, we had already assured that they would not contain a code for a service with status indicator "T" on the same date of service.);

2. Contained 8 or more units of HCPCS code G0378; and

3. Contained one of the following codes:

- In the case of composite APC 8002, HCPCS code G0379 (Direct referral of patient for hospital observation care) on the same date of service as G0378; or CPT code 99205 (Office or other outpatient visit for the evaluation and management of a new patient (Level 5)); or CPT code 99215 (Office or other outpatient visit for the evaluation and management of an established patient (Level 5)) provided on the same date of service or one day before the date of service for HCPCS code G0378.
- In the case of composite APC 8003, CPT code 99284 (Emergency department visit for the evaluation and management of a patient (Level 4)); CPT code 99285 (Emergency department visit for the evaluation and management of a patient (Level 5)); CPT code 99291 (Critical care, evaluation and management of the critically ill or critically injured patient; first 30–74 minutes); or HCPCS code G0384 (Level 5 hospital emergency department visit provided in a Type B emergency department) provided on the same date of service or one day before the date of service for HCPCS code G0378. (As discussed in detail in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68684), we added HCPCS code G0384 to the eligibility criteria for composite APC 8003 for CY 2009.)

As discussed further in section IX. of this proposed rule, and consistent with our CY 2008, CY 2009, and CY 2010 final policies, when calculating the median costs for the clinic, Type A emergency department visit, Type B emergency department visit, and critical care APCs (0604 through 0617 and 0626 through 0630), we utilize our methodology that excludes those claims for visits that are eligible for payment through the two extended assessment and management composite APCs, that is APC 8002 or APC 8003. We believe that this approach results in the most accurate cost estimates for APCs 0604 through 0617 and 0626 through 0630 for CY 2011.

At its February 2010 meeting, the APC Panel recommended that CMS study the feasibility of expanding the extended assessment and management composite APC methodology to include services commonly furnished in conjunction with visits and observation services, such as drug infusion, electrocardiogram, and chest X-ray. We are accepting this recommendation, and we will share our assessment with the APC Panel at a future meeting.

In summary, for CY 2011, we are proposing to continue to include composite APCs 8002 and 8003 in the OPPS. We are proposing to continue the extended assessment and management composite APC payment methodology and criteria that we finalized for CYs 2009 and 2010. We also are proposing to calculate the median costs for APCs 8002 and 8003 using the same methodology that we used to calculate the medians for composite APCs 8002 and 8003 for the CY 2008 OPPS (72 FR 66649). That is, we used all single and "pseudo" single procedure claims from CY 2009 that met the criteria for payment of each composite APC and applied the standard packaging and trimming rules to the claims before calculating the proposed CY 2011 median costs. The proposed CY 2011 median cost resulting from this methodology for composite APC 8002 is approximately $401, which was calculated from 17,398 single and "pseudo" single bills that met the required criteria. The proposed CY 2011 median cost for composite APC 8003 is approximately $743, which was calculated from 201,189 single and "pseudo" single bills that met the required criteria.

(2) Low Dose Rate (LDR) Prostate Brachytherapy Composite APC (APC 8001)

LDR prostate brachytherapy is a treatment for prostate cancer in which hollow needles or catheters are inserted into the prostate, followed by permanent implantation of radioactive sources into the prostate through the needles/catheters. At least two CPT codes are used to report the composite treatment service because there are separate codes that describe placement of the needles/catheters and the application of the brachytherapy sources: CPT code 55875 (Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy) and CPT code 77778 (Interstitial radiation source application; complex). Generally, the component services represented by both codes are provided in the same operative session in the same hospital on the same date of service to the Medicare beneficiary being treated with LDR brachytherapy for prostate cancer. As discussed in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66653), OPPS payment rates for CPT code 77778, in particular, had fluctuated over the years. We were frequently informed by the public that reliance on single procedure claims to set the median costs for these services resulted in use of mainly

incorrectly coded claims for LDR prostate brachytherapy because a correctly coded claim should include, for the same date of service, CPT codes for both needle/catheter placement and application of radiation sources, as well as separately coded imaging and radiation therapy planning services (that is, a multiple procedure claim).

In order to base payment on claims for the most common clinical scenario, and to further our goal of providing payment under the OPPS for a larger bundle of component services provided in a single hospital encounter, beginning in CY 2008, we provide a single payment for LDR prostate brachytherapy when the composite service, reported as CPT codes 55875 and 77778, is furnished in a single hospital encounter. We base the payment for composite APC 8001 (LDR Prostate Brachytherapy Composite) on the median cost derived from claims for the same date of service that contain both CPT codes 55875 and 77778 and that do not contain other separately paid codes that are not on the bypass list. In uncommon occurrences in which the services are billed individually, hospitals continue to receive separate payments for the individual services. We refer readers to the CY 2008 OPPS/ASC final rule with comment period (72 FR 66652 through 66655) for a full history of OPPS payment for LDR prostate brachytherapy and a detailed description of how we developed the LDR prostate brachytherapy composite APC.

For CY 2011, we are proposing to continue paying for LDR prostate brachytherapy services using the composite APC methodology proposed and implemented for CYs 2008, 2009, and 2010. That is, we are proposing to use CY 2009 claims on which both CPT codes 55875 and 77778 were billed on the same date of service with no other separately paid procedure codes (other than those on the bypass list) to calculate the payment rate for composite APC 8001. Consistent with our CY 2008 through CY 2010 practice, we are proposing not to use the claims that meet these criteria in the calculation of the median costs for APCs 0163 (Level IV Cystourethroscopy and Other Genitourinary Procedures) and 0651 (Complex Interstitial Radiation Source Application), the APCs to which CPT codes 55875 and 77778 are assigned, respectively. The median costs for APCs 0163 and 0651 would continue to be calculated using single and "pseudo" single procedure claims. We continue to believe that this composite APC contributes to our goal of creating hospital incentives for efficiency and cost containment, while providing hospitals with the most flexibility to manage their resources. We also continue to believe that data from claims reporting both services required for LDR prostate brachytherapy provide the most accurate median cost upon which to base the composite APC payment rate.

Using partial year CY 2009 claims data available for this proposed rule, we were able to use 788 claims that contained both CPT codes and 55875 and 77778 to calculate the median cost upon which the proposed CY 2011 payment for composite APC 8001 is based. The proposed median cost for composite APC 8001 for CY 2011 is approximately $3,265. This is an increase compared to the CY 2010 OPPS/ASC final rule with comment period in which we calculated a final median cost for this composite APC of approximately $3,084 based on a full year of CY 2008 claims data. The proposed CY 2011 median cost for this composite APC is slightly less than $3,604, the sum of the proposed median costs for APCs 0163 and 0651 ($2,606 + $998), the APCs to which CPT codes 55875 and 77778 map if one service is billed on a claim without the other. We believe the proposed CY 2011 median cost for composite APC 8001 of approximately $3,265, calculated from claims we believe to be correctly coded, would result in a reasonable and appropriate payment rate for this service in CY 2011.

(3) Cardiac Electrophysiologic Evaluation and Ablation Composite APC (APC 8000)

Cardiac electrophysiologic evaluation and ablation services frequently are performed in varying combinations with one another during a single episode-of-care in the hospital outpatient setting. Therefore, correctly coded claims for these services often include multiple codes for component services that are reported with different CPT codes and that, prior to CY 2008, were always paid separately through different APCs (specifically, APC 0085 (Level II Electrophysiologic Evaluation), APC 0086 (Ablate Heart Dysrhythm Focus), and APC 0087 (Cardiac Electrophysiologic Recording/Mapping)). As a result, there would never be many single bills for cardiac electrophysiologic evaluation and ablation services, and those that are reported as single bills would often represent atypical cases or incorrectly coded claims. As described in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66655 through 66659), the APC Panel and the public expressed persistent concerns regarding the limited and reportedly unrepresentative single bills available for use in calculating the median costs for these services according to our standard OPPS methodology.

Effective January 1, 2008, we established APC 8000 (Cardiac Electrophysiologic Evaluation and Ablation Composite) to pay for a composite service made up of at least one specified electrophysiologic evaluation service and one specified electrophysiologic ablation service. Calculating a composite APC for these services allowed us to utilize many more claims than were available to establish the individual APC median costs for these services, and we also saw this composite APC as an opportunity to advance our stated goal of promoting hospital efficiency through larger payment bundles. In order to calculate the median cost upon which the payment rate for composite APC 8000 is based, we used multiple procedure claims that contained at least one CPT code from group A for evaluation services and at least one CPT code from group B for ablation services reported on the same date of service on an individual claim. Table 9 in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66656) identified the CPT codes that are assigned to groups A and B. For a full discussion of how we identified the group A and group B procedures and established the payment rate for the cardiac electrophysiologic evaluation and ablation composite APC, we refer readers to the CY 2008 OPPS/ASC final rule with comment period (72 FR 66655 through 66659). Where a service in group A is furnished on a date of service that is different from the date of service for a code in group B for the same beneficiary, payments are made under the appropriate single procedure APCs and the composite APC does not apply.

For CY 2011, we are proposing to continue to pay for cardiac electrophysiologic evaluation and ablation services using the composite APC methodology proposed and implemented for CY 2008, CY 2009, and CY 2010. Consistent with our CY 2008 through CY 2010 practice, we are proposing not to use the claims that meet the composite payment criteria in the calculation of the median costs for APC 0085 and APC 0086, to which the CPT codes in both groups A and B for composite APC 8000 are otherwise assigned. Median costs for APCs 0085 and 0086 would continue to be calculated using single procedure claims. We continue to believe that the composite APC methodology for cardiac electrophysiologic evaluation and

ablation services is the most efficient and effective way to use the claims data for the majority of these services and best represents the hospital resources associated with performing the common combinations of these services that are clinically typical. Furthermore, this approach creates incentives for efficiency by providing a single payment for a larger bundle of major procedures when they are performed together, in contrast to continued separate payment for each of the individual procedures.

Using partial year CY 2009 claims data available for this proposed rule, we were able to use 8,964 claims containing a combination of group A and group B codes and calculated a proposed median cost of approximately $10,834 for composite APC 8000. This is an increase compared to the CY 2010 OPPS/ASC final rule with comment period in which we calculated a final median cost for this composite APC of approximately $10,026 based on a full year of CY 2008 claims data. We believe the proposed median cost of $10,834 calculated from a high volume of correctly coded multiple procedure claims would result in an accurate and appropriate proposed payment for cardiac electrophysiologic evaluation and ablation services when at least one evaluation service is furnished during the same clinical encounter as at least one ablation service. Table 6 below list the groups of procedures upon which we are proposing to base composite APC 8000 for CY 2011.

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TABLE 6.—PROPOSED GROUPS OF CARDIAC ELECTROPHYSIOLOGIC EVALUATION AND ABLATION PROCEDURES UPON WHICH COMPOSITE APC 8000 IS BASED

Codes Used in Combinations: At Least One in Group A and One in Group B	CY 2010 CPT Code	Proposed Single Code CY 2011 APC	Proposed CY 2011 SI (Composite)
Group A			
Comprehensive electrophysiologic evaluation with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording, including insertion and repositioning of multiple electrode catheters, without induction or attempted induction of arrhythmia	93619	0085	Q3
Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording	93620	0085	Q3
Group B			
Intracardiac catheter ablation of atrioventricular node function, atrioventricular conduction for creation of complete heart block, with or without temporary pacemaker placement	93650	0085	Q3
Intracardiac catheter ablation of arrhythmogenic focus; for treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathways, accessory atrioventricular connections or other atrial foci, singly or in combination	93651	0086	Q3
Intracardiac catheter ablation of arrhythmogenic focus; for treatment of ventricular tachycardia	93652	0086	Q3

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(4) Mental Health Services Composite APC (APC 0034)

We are proposing to continue our longstanding policy of limiting the aggregate payment for specified less resource-intensive mental health services furnished on the same date to the payment for a day of partial hospitalization, which we consider to be the most resource-intensive of all outpatient mental health treatment for CY 2011. We refer readers to the April 7, 2000 OPPS final rule with comment period (65 FR 18452 through 18455) for the initial discussion of this longstanding policy. We continue to believe that the costs associated with administering a partial hospitalization program represent the most resource-intensive of all outpatient mental health treatment. Therefore, we do not believe that we should pay more for a day of individual mental health services under

the OPPS than the partial hospitalization per diem payment.

As discussed in detail in section X. of this proposed rule, for CY 2011, we are proposing to use a provider-specific two tiered payment approach for partial hospitalization services that distinguishes payment made for services furnished in a CMHC from payment made for services furnished in a hospital. Specifically, we are proposing one APC for partial hospitalization program days with three services furnished in a CMHC (APC 0172, Level I Partial Hospitalization (3 services) for CMHCs) and one APC for days with four or more services furnished in a CMHC (APC 0173, Level II Partial Hospitalization (4 or more services) for CMHCs). We are proposing that the payment rates for these two APCs be based upon the median per diem costs calculated using data only from CMHCs. Similarly, we are proposing one APC for partial hospitalization program days with three services furnished in a hospital (APC 0175, Level I Partial Hospitalization (3 services) for Hospital-Based PHPs), and one APC for days with four or more services furnished in a hospital (APC 0176, Level II Partial Hospitalization (4 or more services) for Hospital-Based PHPs). We are proposing that the payment rates for these two APCs be based on the median per diem costs calculated using data only from hospitals.

Because our longstanding policy of limiting the aggregate payment for specified less resource-intensive mental health services furnished on the same date to the payment rate for the most resource-intensive of all outpatient mental health treatment, we are proposing to set the CY 2011 payment rate for APC 0034 (Mental Health Services Composite) at the same rate as we are proposing for APC 0176, which is the maximum partial hospitalization per diem payment. We believe this APC payment rate would provide the most appropriate payment for composite APC 0034, taking into consideration the intensity of the mental health services and the differences in the HCPCS codes for mental health services that could be paid through this composite APC compared with the HCPCS codes that could be paid through partial hospitalization APC 0176. When the aggregate payment for specified mental health services provided by one hospital to a single beneficiary on one date of service based on the payment rates associated with the APCs for the individual services exceeds the maximum per diem partial hospitalization payment, we are proposing that those specified mental health services would be assigned to APC 0034. We are proposing that APC 0034 would have the same payment rate as APC 0176 and that the hospital would continue to be paid one unit of APC 0034. The I/OCE currently determines, and we are proposing for CY 2011 that it would continue to determine, whether to pay these specified mental health services individually or to make a single payment at the same rate as the APC 0176 per diem rate for partial hospitalization for all of the specified mental health services furnished by the hospital on that single date of service.

(5) Multiple Imaging Composite APCs (APCs 8004, 8005, 8006, 8007, and 8008)

Prior to CY 2009, hospitals received a full APC payment for each imaging service on a claim, regardless of how many procedures were performed during a single session using the same imaging modality. Based on extensive data analysis, we determined that this practice neither reflected nor promoted the efficiencies hospitals can achieve when performing multiple imaging procedures during a single session (73 FR 41448 through 41450). As a result of our data analysis, and in response to ongoing recommendations from MedPAC to improve payment accuracy for imaging services under the OPPS, we expanded the composite APC model developed in CY 2008 to multiple imaging services. Effective January 1, 2009, we provide a single payment each time a hospital bills more than one imaging procedure within an imaging family on the same date of service. We utilize three imaging families based on imaging modality for purposes of this methodology: (1) Ultrasound; (2) computed tomography (CT) and computed tomographic angiography (CTA); and (3) magnetic resonance imaging (MRI) and magnetic resonance angiography (MRA). The HCPCS codes subject to the multiple imaging composite policy, and their respective families, are listed in Table 13 of the CY 2010 OPPS/ASC final rule with comment period (74 FR 60403 through 60407).

While there are three imaging families, there are five multiple imaging composite APCs due to the statutory requirement at section 1833(t)(2)(G) of the Act that we differentiate payment for OPPS imaging services provided with and without contrast. While the ultrasound procedures included in the policy do not involve contrast, both CT/CTA and MRI/MRA scans can be provided either with or without contrast. The five multiple imaging composite APCs established in CY 2009 are:

- APC 8004 (Ultrasound Composite);
- APC 8005 (CT and CTA without Contrast Composite);
- APC 8006 (CT and CTA with Contrast Composite);
- APC 8007 (MRI and MRA without Contrast Composite); and
- APC 8008 (MRI and MRA with Contrast Composite).

We define the single imaging session for the "with contrast" composite APCs as having at least one or more imaging procedures from the same family performed with contrast on the same date of service. For example, if the hospital performs an MRI without contrast during the same session as at least one other MRI with contrast, the hospital will receive payment for APC 8008, the "with contrast" composite APC.

Hospitals continue to use the same HCPCS codes to report imaging procedures, and the I/OCE determines when combinations of imaging procedures qualify for composite APC payment or map to standard (sole service) APCs for payment. We make a single payment for those imaging procedures that qualify for composite APC payment, as well as any packaged services furnished on the same date of service. The standard (noncomposite) APC assignments continue to apply for single imaging procedures and multiple imaging procedures performed across families. For a full discussion of the development of the multiple imaging composite APC methodology, we refer readers to the CY 2009 OPPS/ASC final rule with comment period (73 FR 68559 through 68569).

At its February 2010 meeting, the APC Panel recommended that CMS continue providing analysis on an ongoing basis of the impact on beneficiaries of the multiple imaging composite APCs as data become available. We are accepting this recommendation and will provide the requested analysis to the APC Panel at a future meeting.

In summary, for CY 2011, we are proposing to continue paying for all multiple imaging procedures within an imaging family performed on the same date of service using the multiple imaging composite payment methodology. The proposed CY 2011 payment rates for the five multiple imaging composite APCs (APC 8004, APC 8005, APC 8006, APC 8007, and APC 8008) are based on median costs calculated from the partial year CY 2009 claims available for this proposed rule that would have qualified for composite payment under the current policy (that is, those claims with more than one

procedure within the same family on a single date of service). To calculate the proposed median costs, we used the same methodology that we used to calculate the final CY 2010 median costs for these composite APCs. That is, we removed any HCPCS codes in the OPPS imaging families that overlapped with codes on our bypass list ("overlap bypass codes") to avoid splitting claims with multiple units or multiple occurrences of codes in an OPPS imaging family into new "pseudo" single claims. The imaging HCPCS codes that we removed from the bypass list for purposes of calculating the proposed multiple imaging composite APC median costs appear in Table 8 of this proposed rule. (We note that, consistent with our proposal in section II.A.1.b. of this proposed rule to add CPT code 70547 (Magnetic resonance angiography, neck; without contrast material(s)) to the list of bypass codes for CY 2011, we also are proposing to add CPT code 70547 to the list of proposed OPPS imaging family services overlapping with HCPCS codes on the proposed CY 2010 bypass list.) We integrated the identification of imaging composite "single session" claims, that is, claims with multiple imaging procedures within the same family on the same date of service, into the creation of "pseudo" single procedure claims to ensure that claims were split in the "pseudo" single process into accurate reflections of either a composite "single session" imaging service or a standard sole imaging service resource cost. Like all single bills, the new composite "single session" claims were for the same date of service and contained no other separately paid services in order to isolate the session imaging costs. Our last step after processing all claims through the "pseudo" single process was to reassess the remaining multiple procedure claims using the full bypass list and bypass process in order to determine if we could make other "pseudo" single bills. That is, we assessed whether a single separately paid service remained on the claim after removing line-items for the "overlap bypass codes."

We were able to identify 1.7 million "single session" claims out of an estimated 2.7 million potential composite cases from our ratesetting claims data, or well over half of all eligible claims, to calculate the proposed CY 2011 median costs for the multiple imaging composite APCs. Table 7 below lists the HCPCS codes that would be subject to the proposed multiple imaging composite policy and their respective families for CY 2011.

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TABLE 7.—PROPOSED OPPS IMAGING FAMILIES AND MULTIPLE IMAGING PROCEDURE COMPOSITE APCs

Family 1 – Ultrasound	
Proposed CY 2011 APC 8004 (Ultrasound Composite)	**Proposed CY 2011 Approximate APC Median Cost = $197**
76604	Us exam, chest
76700	Us exam, abdom, complete
76705	Echo exam of abdomen
76770	Us exam abdo back wall, comp
76775	Us exam abdo back wall, lim
76776	Us exam k transpl w/Doppler
76831	Echo exam, uterus
76856	Us exam, pelvic, complete
76870	Us exam, scrotum
76857	Us exam, pelvic, limited
Family 2 - CT and CTA with and without Contrast	
Proposed CY 2011 APC 8005 (CT and CTA without Contrast Composite)*	**Proposed CY 2011 Approximate APC Median Cost = $431**
70450	Ct head/brain w/o dye
70480	Ct orbit/ear/fossa w/o dye
70486	Ct maxillofacial w/o dye
70490	Ct soft tissue neck w/o dye
71250	Ct thorax w/o dye
72125	Ct neck spine w/o dye
72128	Ct chest spine w/o dye
72131	Ct lumbar spine w/o dye
72192	Ct pelvis w/o dye
73200	Ct upper extremity w/o dye
73700	Ct lower extremity w/o dye
74150	Ct abdomen w/o dye
74261	Ct colonography, w/o dye
Proposed CY 2011 APC 8006 (CT and CTA with Contrast Composite)	**Proposed CY 2011 Approximate APC Median Cost = $649**
70487	Ct maxillofacial w/dye
70460	Ct head/brain w/dye
70470	Ct head/brain w/o & w/dye

70481	Ct orbit/ear/fossa w/dye
70482	Ct orbit/ear/fossa w/o&w/dye
70488	Ct maxillofacial w/o & w/dye
70491	Ct soft tissue neck w/dye
70492	Ct sft tsue nck w/o & w/dye
70496	Ct angiography, head
70498	Ct angiography, neck
71260	Ct thorax w/dye
71270	Ct thorax w/o & w/dye
71275	Ct angiography, chest
72126	Ct neck spine w/dye
72127	Ct neck spine w/o & w/dye
72129	Ct chest spine w/dye
72130	Ct chest spine w/o & w/dye
72132	Ct lumbar spine w/dye
72133	Ct lumbar spine w/o & w/dye
72191	Ct angiograph pelv w/o&w/dye
72193	Ct pelvis w/dye
72194	Ct pelvis w/o & w/dye
73201	Ct upper extremity w/dye
73202	Ct uppr extremity w/o&w/dye
73206	Ct angio upr extrm w/o&w/dye
73701	Ct lower extremity w/dye
73702	Ct lwr extremity w/o&w/dye
73706	Ct angio lwr extr w/o&w/dye
74160	Ct abdomen w/dye
74170	Ct abdomen w/o & w/dye
74175	Ct angio abdom w/o & w/dye
74262	Ct colonography, w/dye
75635	Ct angio abdominal arteries
* If a "without contrast" CT or CTA procedure is performed during the same session as a "with contrast" CT or CTA procedure, the I/OCE will assign APC 8006 rather than APC 8005.	
Family 3 - MRI and MRA with and without Contrast	
Proposed CY 2011 APC 8007 (MRI and MRA without Contrast Composite)*	**Proposed CY 2010 Approximate APC Median Cost = $732**
70336	Magnetic image, jaw joint
70540	Mri orbit/face/neck w/o dye

70544	Mr angiography head w/o dye
70547	Mr angiography neck w/o dye
70551	Mri brain w/o dye
70554	Fmri brain by tech
71550	Mri chest w/o dye
72141	Mri neck spine w/o dye
72146	Mri chest spine w/o dye
72148	Mri lumbar spine w/o dye
72195	Mri pelvis w/o dye
73218	Mri upper extremity w/o dye
73221	Mri joint upr extrem w/o dye
73718	Mri lower extremity w/o dye
73721	Mri jnt of lwr extre w/o dye
74181	Mri abdomen w/o dye
75557	Cardiac mri for morph
75559	Cardiac mri w/stress img
C8901	MRA w/o cont, abd
C8904	MRI w/o cont, breast, uni
C8907	MRI w/o cont, breast, bi
C8910	MRA w/o cont, chest
C8913	MRA w/o cont, lwr ext
C8919	MRA w/o cont, pelvis
Proposed CY 2011 APC 8008 (MRI and MRA with Contrast Composite)	**Proposed CY 2011 Approximate APC Median Cost = $1,028**
70549	Mr angiograph neck w/o&w/dye
70542	Mri orbit/face/neck w/dye
70543	Mri orbt/fac/nck w/o & w/dye
70545	Mr angiography head w/dye
70546	Mr angiograph head w/o&w/dye
70548	Mr angiography neck w/dye
70552	Mri brain w/dye
70553	Mri brain w/o & w/dye
71551	Mri chest w/dye
71552	Mri chest w/o & w/dye
72142	Mri neck spine w/dye
72147	Mri chest spine w/dye
72149	Mri lumbar spine w/dye
72156	Mri neck spine w/o & w/dye

72157	Mri chest spine w/o & w/dye
72158	Mri lumbar spine w/o & w/dye
72196	Mri pelvis w/dye
72197	Mri pelvis w/o & w/dye
73219	Mri upper extremity w/dye
73220	Mri uppr extremity w/o&w/dye
73222	Mri joint upr extrem w/dye
73223	Mri joint upr extr w/o&w/dye
73719	Mri lower extremity w/dye
73720	Mri lwr extremity w/o&w/dye
73722	Mri joint of lwr extr w/dye
73723	Mri joint lwr extr w/o&w/dye
74182	Mri abdomen w/dye
74183	Mri abdomen w/o & w/dye
75561	Cardiac mri for morph w/dye
75563	Card mri w/stress img & dye
C8900	MRA w/cont, abd
C8902	MRA w/o fol w/cont, abd
C8903	MRI w/cont, breast, uni
C8905	MRI w/o fol w/cont, brst, un
C8906	MRI w/cont, breast, bi
C8908	MRI w/o fol w/cont, breast,
C8909	MRA w/cont, chest
C8911	MRA w/o fol w/cont, chest
C8912	MRA w/cont, lwr ext
C8914	MRA w/o fol w/cont, lwr ext
C8918	MRA w/cont, pelvis
C8920	MRA w/o fol w/cont, pelvis
* If a "without contrast" MRI or MRA procedure is performed during the same session as a "with contrast" MRI or MRA procedure, the I/OCE will assign APC 8008 rather than 8007.	

TABLE 8.—PROPOSED OPPS IMAGING FAMILY SERVICES OVERLAPPING WITH HCPCS CODES ON THE PROPOSED CY 2011 BYPASS LIST

Family 1 – Ultrasound	
76700	Us exam, abdom, complete
76705	Echo exam of abdomen
76770	Us exam abdo back wall, comp
76775	Us exam abdo back wall, lim
76776	Us exam k transpl w/Doppler
76856	Us exam, pelvic, complete
76870	Us exam, scrotum
76857	Us exam, pelvic, limited
Family 2 - CT and CTA with and without Contrast	
70450	Ct head/brain w/o dye
70480	Ct orbit/ear/fossa w/o dye
70486	Ct maxillofacial w/o dye
70490	Ct soft tissue neck w/o dye
71250	Ct thorax w/o dye
72125	Ct neck spine w/o dye
72128	Ct chest spine w/o dye
72131	Ct lumbar spine w/o dye
72192	Ct pelvis w/o dye
73200	Ct upper extremity w/o dye
73700	Ct lower extremity w/o dye
74150	Ct abdomen w/o dye
Family 3 - MRI and MRA with and without Contrast	
70336	Magnetic image, jaw joint
70544	Mr angiography head w/o dye
70551	Mri brain w/o dye
72141	Mri neck spine w/o dye
72146	Mri chest spine w/o dye
72148	Mri lumbar spine w/o dye
73218	Mri upper extremity w/o dye
73221	Mri joint upr extrem w/o dye
73718	Mri lower extremity w/o dye
73721	Mri jnt of lwr extre w/o dye

76856	Us exam, pelvic, complete
76870	Us exam, scrotum
76857	Us exam, pelvic, limited
Family 2 - CT and CTA with and without Contrast	
70450	Ct head/brain w/o dye
70480	Ct orbit/ear/fossa w/o dye
70486	Ct maxillofacial w/o dye
70490	Ct soft tissue neck w/o dye
71250	Ct thorax w/o dye
72125	Ct neck spine w/o dye
72128	Ct chest spine w/o dye
72131	Ct lumbar spine w/o dye
72192	Ct pelvis w/o dye
73200	Ct upper extremity w/o dye
73700	Ct lower extremity w/o dye
74150	Ct abdomen w/o dye
Family 3 - MRI and MRA with and without Contrast	
70336	Magnetic image, jaw joint
70544	Mr angiography head w/o dye
70551	Mri brain w/o dye
72141	Mri neck spine w/o dye
72146	Mri chest spine w/o dye
72148	Mri lumbar spine w/o dye
73218	Mri upper extremity w/o dye
73221	Mri joint upr extrem w/o dye
73718	Mri lower extremity w/o dye
73721	Mri jnt of lwr extre w/o dye

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3. Proposed Changes to Packaged Services

a. Background

The OPPS, like other prospective payment systems, relies on the concept of averaging, where the payment may be more or less than the estimated cost of providing a service or bundle of services for a particular patient, but with the exception of outlier cases, the payment is adequate to ensure access to appropriate care. Packaging payment for multiple interrelated services into a single payment creates incentives for providers to furnish services in the most efficient way by enabling hospitals to manage their resources with maximum flexibility, thereby encouraging long-term cost containment. For example, where there are a variety of supplies that could be used to furnish a service, some of which are more expensive than others, packaging encourages hospitals to use the least expensive item that meets the patient's needs, rather than to routinely use a more expensive item. Packaging also encourages hospitals to negotiate carefully with manufacturers and suppliers to reduce the purchase price of items and services or to explore alternative group purchasing arrangements, thereby encouraging the most economical health care. Similarly, packaging encourages hospitals to establish protocols that ensure that necessary services are furnished, while carefully scrutinizing the services ordered by practitioners to maximize the efficient use of hospital resources. Packaging payments into larger payment bundles promotes the stability of payment for services over time. Finally, packaging also may reduce the importance of refining service-specific payment because there is more opportunity for hospitals to average payment across higher cost cases requiring many ancillary services and lower cost cases requiring fewer ancillary services. For these reasons, packaging payment for services that are typically ancillary and supportive to a primary service has been a fundamental part of the OPPS since its implementation in August 2000.

We assign status indicator "N" to those HCPCS codes that we believe are always integral to the performance of the primary modality; therefore, we always package their costs into the costs of the separately paid primary services with which they are billed. Services assigned status indicator "N" are unconditionally packaged.

We assign status indicator "Q1" ("STVX–Packaged Codes"), "Q2" ("T–Packaged Codes"), or "Q3" (Codes that may be paid through a composite APC) to each conditionally packaged HCPCS code. An "STVX-packaged code"

describes a HCPCS code whose payment is packaged when one or more separately paid primary services with the status indicator of "S," "T," "V," or "X" are furnished in the hospital outpatient encounter. A "T-packaged code" describes a code whose payment is packaged when one or more separately paid surgical procedures with the status indicator of "T" are provided during the hospital encounter. "STVX-packaged codes" and "T-packaged codes" are paid separately in those uncommon cases when they do not meet their respective criteria for packaged payment. "STVX-packaged codes" and "T-packaged codes" are conditionally packaged. We refer readers to section XIII.A.1. of this proposed rule for a complete listing of status indicators.

We use the term "dependent service" to refer to the HCPCS codes that represent services that are typically ancillary and supportive to a primary diagnostic or therapeutic modality. We use the term "independent service" to refer to the HCPCS codes that represent the primary therapeutic or diagnostic modality into which we package payment for the dependent service. In future years, as we consider the development of larger payment groups that more broadly reflect services provided in an encounter or episode-of-care, it is possible that we might propose to bundle payment for a service that we now refer to as "independent."

Hospitals include HCPCS codes and charges for packaged services on their claims, and the estimated costs associated with those packaged services are then added to the costs of separately payable procedures on the same claims in establishing payment rates for the separately payable services. We encourage hospitals to report all HCPCS codes that describe packaged services that were provided, unless the CPT Editorial Panel or CMS provide other guidance. The appropriateness of the OPPS payment rates depend on the quality and completeness of the claims data that hospitals submit for the services they furnish to our Medicare beneficiaries.

In the CY 2008 OPPS/ASC final rule with comment period (72 FR 66610 through 66659), we adopted the packaging of payment for items and services in seven categories into the payment for the primary diagnostic or therapeutic modality to which we believe these items and services are typically ancillary and supportive. The seven categories are: (1) Guidance services; (2) image processing services; (3) intraoperative services; (4) imaging supervision and interpretation services; (5) diagnostic radiopharmaceuticals; (6) contrast media; and (7) observation services. We specifically chose these categories of HCPCS codes for packaging because we believe that the items and services described by the codes in these categories are typically ancillary and supportive to a primary diagnostic or therapeutic modality and, in those cases, are an integral part of the primary service they support.

In addition, in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66650 through 66659), we finalized additional packaging for the CY 2008 OPPS, which included the establishment of new composite APCs for CY 2008, specifically APC 8000 (Cardiac Electrophysiologic Evaluation and Ablation Composite), APC 8001 (LDR Prostate Brachytherapy Composite), APC 8002 (Level I Extended Assessment & Management Composite), and APC 8003 (Level II Extended Assessment & Management Composite). In the CY 2009 OPPS/ASC final rule with comment period (73 FR 68559 through 68569), we expanded the composite APC model to one new clinical area—multiple imaging services. We created five multiple imaging composite APCs for payment in CY 2009 that incorporate statutory requirements to differentiate between imaging services provided with contrast and without contrast as required by section 1833(t)(2)(G) of the Act. The multiple imaging composite APCs are: APC 8004 (Ultrasound Composite); APC 8005 (CT and CTA without Contrast Composite); APC 8006 (CT and CTA with Contrast Composite); APC 8007 (MRI and MRA without Contrast Composite); and APC 8008 (MRI and MRA with Contrast Composite). We discuss composite APCs in more detail in section II.A.2.e. of this proposed rule.

We recognize that decisions about packaging and bundling payment involve a balance between ensuring that payment is adequate to enable the hospital to provide quality care and establishing incentives for efficiency through larger units of payment. Therefore we welcome public comments regarding our packaging proposals for calendar year (CY) 2011 OPPS.

b. Packaging Issues

(1) CMS Presentation of Findings Regarding Expanded Packaging at the February 2010 APC Panel Meeting

In deciding whether to package a service or pay for a code separately, we have historically considered a variety of factors, including whether the service is normally provided separately or in conjunction with other services; how likely it is for the costs of the packaged code to be appropriately mapped to the separately payable codes with which it was performed; and whether the expected cost of the service is relatively low.

As discussed in section I.E. of this proposed rule, the APC Panel advises CMS on the clinical integrity of payment groups and their weights, and the APC Panel has a Packaging Subcommittee that studies and makes recommendations on issues pertaining to services that are not separately payable under the OPPS, but whose payments are bundled or packaged into APC payments. The APC Panel has considered packaging issues at several earlier meetings. For discussions of earlier APC Panel meetings and recommendations, we refer readers to previously published hospital OPPS/ASC proposed and final rules on the CMS Web site at: *http://www.cms.gov/FACA/05_AdvisoryPanelonAmbulatoryPaymentClassificationGroups.asp#TopOfPage.*

During the August 5–6, 2009 meeting of the APC Panel, we agreed to continue to provide the Panel with information on the impact of increased packaging on Medicare beneficiaries building on the analyses we had presented at the February 2009 APC Panel meeting. We did not share additional packaging data with the APC Panel at the August 2009 meeting because we had already presented analysis comparing CY 2007 and CY 2008 claims data and believed the APC Panel's discussions would benefit from analyses of CY 2007 and CY 2009 claims data. We indicated that we planned to incorporate analysis of CY 2009 claims into the information we would bring to the APC Panel for its review at the winter 2010 meeting.

At the February 17–18, 2010 APC Panel meeting, we presented subsequent analyses that compared CY 2007 claims processed through September 30, 2007 to CY 2009 claims processed through September 30, 2009. Similar to the initial analysis that we presented to the APC Panel in 2009, the HCPCS codes that we compared are the ones that we identified in the CY 2008 OPPS final rule with comment period as fitting into one of the packaging categories, including HCPCS codes that became effective for CY 2009. As noted above, the seven packaging categories in our CY 2008 packaging proposal are guidance services, image processing services, intraoperative services, imaging supervision and interpretation services, diagnostic radiopharmaceuticals, contrast media, and observation services. We note that, similar to the initial analysis, we did not

make any adjustments for inflation, changes in the Medicare population, changes in payment due to APC recalibration, changes in frequency due to known changes in code definitions and coding practices, or changes in the population of hospitals paid under the OPPS. A summary of these data analyses is provided below.

Analysis of the diagnostic radiopharmaceuticals category showed that the diagnostic radiopharmaceuticals were billed 1 percent more often during the first 9 months of CY 2009 as compared to the first 9 months of CY 2007. We noticed very little change in the frequency of hospitals reporting one or more diagnostic radiopharmaceutical between CY 2007 and CY 2009. Beginning in CY 2008, we required reporting of a radiolabeled product (including diagnostic radiopharmaceuticals) when billing a nuclear medicine procedure, and we believe that the modest increases in frequency of reporting diagnostic radiopharmaceuticals and the percentage of reporting hospitals generally reflects hospitals adhering to our reporting requirements.

We also found that nuclear medicine procedures (into which diagnostic radiopharmaceuticals were packaged) and associated diagnostic radiopharmaceuticals were billed approximately 3 million times during the first 9 months of both CY 2007 and CY 2009. Further analysis revealed that we paid hospitals over $637 million for nuclear medicine procedures and diagnostic radiopharmaceuticals during the first 9 months of CY 2007, when diagnostic radiopharmaceuticals were separately payable, and approximately the same amount for nuclear medicine procedures and diagnostic radiopharmaceuticals during the first 9 months of CY 2009, when payment for diagnostic radiopharmaceuticals was packaged. This suggests that frequency and payment for nuclear medicine procedures remained fairly steady between the first 9 months of CY 2007 and the first 9 months of CY 2009.

We conducted the same analysis for guidance services that were packaged beginning in CY 2008. Analysis of the guidance category (which includes image-guided radiation therapy services) showed that guidance services were billed 8 percent more often during CY 2009 as compared to CY 2007 and that the number of hospitals reporting guidance services declined by 1 percent between CY 2007 and CY 2009.

We also analyzed the same data for all contrast services that were packaged beginning in CY 2008. Analysis of this category showed that contrast services were billed 9 percent more often during CY 2009 as compared to CY 2007 and that the number of hospitals reporting contrast media increased by 1 percent between CY 2007 and CY 2009.

Analysis of the data for image supervision and interpretation services showed that these services were billed 10 percent more often during CY 2009 as compared to CY 2007 and, similar to guidance services and contrast agents, the number of hospitals reporting image supervision and interpretation services declined by 1 percent between CY 2007 and CY 2009.

We also analyzed the first 9 months of CY 2007 and CY 2009 data related to all image processing services that were packaged beginning in the CY 2008 OPPS. This analysis was difficult because there were significant changes to the CPT codes in this category for CY 2009. For example, the intraoperative procedures described by CPT codes 93320 (which describes spectral Doppler) and 93325 (which describes color flow Doppler) are now reported using one comprehensive code, CPT 93306, which describes complete transthoracic echocardiogram with spectral and color flow Doppler. In an effort to isolate the effects of the changes to coding from our analysis, we removed the data for any codes experiencing significant modifications and observed a 7 percent decrease from CY 2007 to CY 2009 in the frequency of image processing services billed. However, as we pointed out to the APC panel, these numbers are not necessarily the majority of services in the category or reflective of behavioral changes for the services of interest. When we included the image processing services with the revised coding for CY 2009, the data showed a 61-percent decrease in the billing of these services between CY 2007 and CY 2009 and a 6-percent decrease in the number of hospitals reporting these services during the same timeframe.

Our analysis of changes in intraoperative services between CY 2007 and CY 2009 showed a 5-percent decrease in the billing of these services and a 5-percent decrease in the number of hospitals reporting these services during the same timeframe.

As we did for our presentation at the February 2009 APC Panel meeting, we also found that cardiac catheterization and other percutaneous vascular procedures that would typically be accompanied by Intravascular Ultrasound (IVUS), Intracardiac echocardiography (ICE), and Fractional flow reserve (FFR) (including IVUS, ICE, and FFR) were billed approximately 376,000 times in CY 2007 and approximately 473,000 times in CY 2009, representing an increase of 26 percent in the number of services and items billed between CY 2007 and CY 2009. IVUS, ICE, and FFR are intraoperative and image supervision and interpretation services that have received a lot of attention. Further analysis showed that the OPPS paid hospitals over $912 million for cardiac catheterizations, other related services, and IVUS, ICE, and FFR in CY 2007, when IVUS, ICE, and FFR were paid separately. In the first 9 months of CY 2009, the OPPS paid hospitals approximately $1.4 billion for cardiac catheterization and other percutaneous vascular procedures and IVUS, ICE, and FFR, when payments for IVUS, ICE, and FFR were packaged. This is a 58-percent increase in payment from CY 2007. Using the first 9 months of claims data for both CY 2007 and CY 2009, we calculated an average payment per service or item provided of $2,430 in CY 2007 and $3,048 in CY 2009 for cardiac catheterization and other related services, an increase of 25 percent in average payment per item or service. This observed increase in average payment per service is most likely attributable to the observed increase in the frequency of these cardiac catheterization and other percutaneous vascular procedures that would typically be accompanied by IVUS, ICE, and FFR (including IVUS, ICE, and FFR) billed in CY 2009.

We also cannot determine how much of the 58-percent increase in aggregate payment for these services may be due to the packaging of payment for IVUS, ICE, and FFR (and other services that were newly packaged for CY 2008) and how much may be due to annual APC recalibration and typical fluctuations in service frequency. However, we believe that all of these factors contributed to the notable increase in aggregate payment between CY 2007 and CY 2009.

We further analyzed the first 9 months of CY 2007 and CY 2009 claims data for radiation oncology services that would be accompanied by radiation oncology guidance. We found that radiation oncology services (including radiation oncology guidance services) were billed approximately 4 million times in CY 2007 and 3.8 million times in CY 2009, representing a decrease in frequency of approximately 6 percent between CY 2007 and CY 2009. These numbers represented each instance where a radiation oncology service or a radiation oncology guidance service was billed. Our analysis indicated that hospitals were paid over $811 million for radiation oncology services and

radiation oncology guidance services under the OPPS during the first 9 months of CY 2007, when radiation oncology guidance services were separately payable. During the first 9 months of CY 2009, when payments for radiation oncology guidance were packaged, hospitals were paid over $827 million for radiation oncology services under the OPPS. This $827 million included packaged payment for radiation oncology guidance services and represented a 2-percent increase in aggregate payment from CY 2007 to CY 2009. Using the first 9 months of claims data for both CY 2007 and CY 2009, we calculated an average payment per radiation oncology service or item billed of $199 in CY 2007 and $216 in CY 2009, representing a per service increase of 8 percent from CY 2007 to CY 2009.

At the February 2009 meeting, the APC panel also requested that CMS provide separate analyses of radiation oncology guidance, by type of radiation oncology service, specifically, intensity modulated radiation therapy (IMRT), stereotactic radiosurgery (SRS), brachytherapy, and conventional radiation therapy. The results from these analyses are discussed below:

We conducted these analyses on the specified categories using the first 9 months of claims and cost report data from CY 2007, before the expanded packaging went into effect, and the first 9 months of claims and cost report data from CY 2009—the second year of packaged payment for the radiation guidance services. We found that IMRT services were billed approximately 670 thousand times during the first 9 months of CY 2007. During this same timeframe, Medicare paid hospitals approximately $227 million for IMRT services. In comparison, during the first 9 months of CY 2009, IMRT services were billed 713 thousand times, representing an increase in frequency of 6 percent. Further, during the first 9 months of CY 2009, when payments for radiation oncology guidance were packaged into the payments for the separately paid IMRT procedures, we paid hospitals over $298 million, representing a 31-percent increase in payments from CY 2007 to CY 2009.

We further analyzed the data for SRS services and found that, for the first 9 months of CY 2007 and CY 2009, SRS services were billed approximately 9 thousand and 13 thousand times, respectively, representing an increase in frequency of 43 percent. Aggregate Medicare payments for these SRS services increased by 24 percent from $34 million in CY 2007 to $42 million in CY 2009.

Our review of the data for brachytherapy services revealed that, for the first 9 months of CY 2007 and CY 2009, these services were billed approximately 10 thousand and 11 thousand times, respectively, representing an increase in frequency of 8 percent. During this timeframe, aggregate Medicare payments for these brachytherapy services increased by 1 percent from $9.8 million in CY 2007 to $9.9 million in CY 2009.

Our review of the data for conventional radiation therapy services revealed that conventional radiation therapy services were billed 1.4 million times and 1.1 million times, in the first 9 months of CY 2007 and CY 2009, respectively, representing a decrease in frequency of 20 percent. During this timeframe, aggregate Medicare payments for these conventional radiation services decreased by 10 percent from $189 million in CY 2007 to $169 million in CY 2009.

In reviewing our early CY 2009 claims data, which reflect the second year of packaged payment for services in the packaged categories identified in the CY 2008 OPPS/ASC final rule with comment period, we generally observed increases in the billing and reporting of packaged services described by these categories, with the caveat that we are not able to untangle the various causes of declines in the image processing category, indicating steady beneficiary access to these categories of supporting and ancillary services. In aggregate, hospitals do not appear to have significantly changed their reporting patterns as a result of the expanded packaging policy nor do the analyses suggest that hospitals have stopped offering these supporting and ancillary services with the primary diagnostic and therapeutic modalities that they support.

(2) Packaging Recommendations of the APC Panel at Its February 2010 Meeting

During the February 2010 APC panel meeting, the APC Panel accepted the report of the Packaging Subcommittee, heard several presentations related to packaged services, discussed the deliberations of the Packaging Subcommittee, and made 6 recommendations. The Report of the February 2010 meeting of the APC Panel may be found at the Web site at: *http://www.cms.gov/FACA/05_AdvisoryPanelonAmbulatoryPaymentClassificationGroups.asp.*

To summarize, the APC Panel made the following recommendations regarding packaging of payment under the CY 2011 OPPS:

1. That CMS consider whether CPT code 31627 (Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with computer-assisted, image-guided navigation) (also known as electromagnetic navigational bronchoscopy (ENB)) should be packaged or paid separately; if it should be paid separately, CMS should investigate the appropriate APC assignment. The Panel suggests CMS use bronchoscopic ultrasonography (EBUS) as a clinical example for comparison. (Recommendation 1)

2. That CMS make CPT code 96368 (Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); concurrent infusion) and CPT code 96376 (Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular, each additional sequential intravenous push of the same substance/drug provided in the facility (List separately in addition to code for primary procedure)) separately payable in the CY 2011 OPPS/ASC final rule with comment period at an appropriate payment rate as determined by CMS. (Recommendation 2)

3. That CMS conditionally package payment for the guidance procedures that would accompany breast needle placement (specifically CPT code 19290 (Preoperative placement of needle localization wire, breast); CPT code 19291 (Preoperative placement of needle localization wire, breast; each additional lesion (List separately in addition to code for primary procedure)); CPT code 19295 (Image guided placement, metallic localization clip, percutaneous, during breast biopsy/aspiration (List separately in addition to code for primary procedure)); CPT code 77031 (Stereotactic localization guidance for breast biopsy or needle placement (*e.g.,* for wire localization or for injection)), each lesion, radiological supervision and interpretation); CPT code 77032 (Mammographic guidance for needle placement, breast (*e.g.,* for wire localization or for injection), each lesion, radiological supervision and interpretation); CPT code 76942 (Ultrasonic guidance for needle placement (*e.g.,* biopsy, aspiration, injection, localization device), imaging supervision and interpretation)) when these guidance services are performed separately. (Recommendation 3)

4. The Panel encourages the public to submit common clinical scenarios involving currently packaged HCPCS codes and recommendations of specific services or procedures for which

payment would be most appropriately packaged under the OPPS for review by the Packaging Subcommittee members. (Recommendation 4)

5. That CMS continue providing analysis on an ongoing basis of the impact on beneficiaries of the multiple imaging composite APCs as data become available. (Recommendation 5)

6. That the work of the Packaging Subcommittee continue. (Recommendation 6)

We address each of these recommendations in the discussion that follows:

Recommendation 1

At the APC Panel's February 2010 meeting, the manufacturer asserted that use of ENB technology during a bronchoscopy procedure enables access to distal lesions that are otherwise not accessible without use of the ENB technology. The manufacturer also argued that without separate payment for ENB, hospitals would likely not adopt the technology and the population that would likely benefit from ENB would not have access to this technology. In response to the manufacturer's assertion, the APC Panel asked CMS to consider whether CPT code 31627, which describes Electromagnetic Navigational Bronchoscopy (ENB), should be packaged or paid separately; and if it should be paid separately, the APC Panel asked CMS to investigate the appropriate APC assignment. CPT code 31627 is new for CY 2010, and we assigned it a new interim status indicator of "N" in our CY 2010 OPPS/ASC final rule with comment period based on our packaging policies (discussed in section II.A.3.a. of this proposed rule). We have considered the information available to us for CPT code 31627 and believe that the code describes a procedure that is supportive of and ancillary to the primary diagnostic or therapeutic modality, in this case, bronchoscopy procedures (for example, CPT code 31622 (Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed: diagnostic, with cell washing, when performed (separate procedure)). We currently package payment for CPT code 31627, and we continue to believe that this is the appropriate treatment of that code. Therefore, we are proposing to package payment for CPT code 31627. As we have discussed in past rules, in making our decision on whether to package a service or pay for it separately we consider a variety of factors, including whether the service is normally provided separately or in conjunction with other services because it supports those services. By proposing to packaging payment for this procedure, we would be treating it in the same manner as similar computer-assisted, navigational diagnostic procedures that are supportive of and ancillary to a primary diagnostic or therapeutic modality. In its recommendation regarding whether to make separate payment under an APC for CPT code 31627, the APC Panel suggested that we use bronchoscopic ultrasonography as a clinical example for comparison. We consider CPT code 31620 (Endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s) (List separately in addition to code for primary procedure)) to be a suitable comparison because it describes another bronchoscopic procedure in which a guidance technology (that is, ultrasonography) is used to achieve the therapeutic benefit of the procedure. Similar to our proposed payment for CPT code 31627, payment for CPT code 31620 is currently packaged into the primary modality with which it would be appropriately billed. In CY 2008, as part of our increased packaging proposal, we identified the EBUS procedure as an intraoperative ancillary service that would typically be reported in conjunction with an independent service. In addition, similar to CPT code 31627, CPT code 31620 is an add-on code that, per CPT reporting guidelines, would only be appropriately reported in conjunction with specified bronchoscopy procedures with which it would be performed. Based on these general comparisons of CPT code 31627 to the EBUS procedure described by CPT code 31620, we believe that our proposal to package payment for CPT code 31627 is consistent with the packaging approach that we have adopted in recent years. As we have stated in past rules with regard to EBUS, we also fully expect that, to the extent these services are billed appropriately, payment for the primary service would reflect the cost of the packaged ENB procedure. For example, in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68584), we discussed packaging of CPT code 31620; we state that we observed increased packaged costs associated with the services into which CPT code 31620 had been packaged, which increased the APC payment rates for bronchoscopy procedures.

In summary, we continue to believe that CPT code 31627 describes a procedure that is ancillary to and supportive of the primary service with which it is often billed. Therefore, for CY 2011, we are proposing to maintain CPT code 31627 as a packaged service.

Recommendation 2

We are not accepting the APC Panel's recommendation that CMS make CPT code 96368 and CPT code 96376 separately payable for the CY 2011 OPPS. We consider a variety of factors in making a decision whether to package a service or pay for it separately, including whether the service is normally provided separately or in conjunction with other services and how likely it is for the costs of the packaged code to be appropriately mapped to the separately payable codes with which it was performed. CPT codes 96376 and 96368 describe concurrent and sequential drug administration services that have always been packaged under the OPPS. From the inception of the OPPS through CY 2006, we paid for drug administration under the OPPS using HCPCS alphanumeric codes that packaged payment for concurrent infusions and administration of new drugs into the payment for the alphanumeric codes for drug administration. In CY 2007, we adopted CPT codes for drug administration services. The CY 2007 CPT codes did not separately recognize administration of new drugs during the same encounter with a separate CPT code. Therefore, administration of a new drug continued to be packaged into payment for the service of which it was a part. Moreover, for CY 2007, CPT code 90768 (Intravenous infusion, for therapy, prophylaxis, or diagnosis; concurrent infusion), which was replaced by CPT code 96368, was packaged under the OPPS, continuing the longstanding practice of not making separate payment for concurrent infusion. We also pointed out that, during our implementation of this new CPT code, while it was new for CY 2007, it represented the same procedures as described by the previous drug administration HCPCS code set, and, as a result, the payment data for these procedures would be captured in the claims that were available to us for ratesetting purposes.

Similarly, CPT codes 96368 and 96376, which were created by CPT in 2008, are replacement codes for those same procedures that were described by the previous drug administration code sets and their associated data would be captured in our claims database. The costs for these services, concurrent infusion and additional push of the same drug, would continue to be packaged into payment for the drug administration codes with which they

are reported. In making our decision whether to package a service or pay for it separately, we consider a variety of factors, including whether the service is normally provided separately or in conjunction with other services. CPT codes 96368 and 96376 describe concurrent and sequential drug administration services that, per CPT guidelines, are always provided in association with an initial drug administration service. Therefore, they continue to be appropriately packaged into the payment for the separately payable services that they usually accompany. For example, CPT code 96376 would be billed with CPT code 96374 (Therapeutic, prophylactic, or diagnostic injection; intravenous push, single or initial substance/drug), which describes an initial intravenous push code and, as a result, the cost for CPT code 96376 would be reflected in the total cost for CPT code 96374. Moreover, payment for these services has always been packaged into payment for the drug administration services without which they cannot be correctly reported.

These two codes each describe services that, by definition, are always provided in conjunction with an initial drug administration code. These services have been packaged since the inception of the OPPS, and we continue to believe they are appropriately packaged into the payment for the separately payable services without which, under CPT guidelines and definitions, they cannot be appropriately reported. Therefore, for CY 2011, we are proposing to make packaged payment for CPT code 96368 and CPT code 96376 and assign them a status indicator of "N."

Recommendation 3

We are not accepting the APC Panel's recommendation that we conditionally package CPT codes 19290, 19291, 19295, 77031, 77032, and 76942. During the APC Panel's February 2010 meeting, we shared with the Packaging Subcommittee our most recent claims data for the guidance procedures that would accompany breast needle placement, demonstrating that, for some of these services, the code was billed by itself up to 25 percent of the time. While the Packaging Subcommittee broadly discussed clinical scenarios in which these services may be billed separately, it remains unclear to us why these services are being performed separately and whether they should be paid separately. We believe that these services typically are performed in conjunction with surgical procedures involving the breast and, therefore, are appropriately packaged. Therefore, we are not accepting the APC panel's recommendation that we conditionally package payment for these guidance procedures when they are performed separately. For CY 2011, we are proposing to maintain the unconditional packaged payment status for these procedures. Specifically, we are proposing to package payment, indicated by a status indicator of "N," for CPT codes 19290, 19291, 19295, 77031, 77032, and 76942, into the primary modality with which they would be appropriately billed. However, observing such a sizable percentage of services that are the only service appearing on a claim for a packaged item, especially when these services do not receive separate payment, leads us to encourage the public to submit any clinical scenarios in their public comments involving these services that show the circumstances under which these services may be appropriately billed without a primary procedure that is furnished on the same date.

Recommendation 4

We are accepting the APC Panel's recommendation to continue to encourage submission of common clinical scenarios involving currently packaged HCPCS codes to the Packaging Subcommittee for its ongoing review. We also encourage recommendations from the public on specific services or procedures whose payment would be most appropriately packaged under the OPPS. Additional detailed suggestions for the Packaging Subcommittee should be submitted by e-mail to *APCPanel@cms.hhs.gov* with Packaging Subcommittee in the subject line.

Recommendation 5

We are accepting the APC Panel's recommendation that CMS provide information to the APC Panel on the impact of the creation of the imaging composite APCs on services to beneficiaries. Our proposal with regard to the imaging composite APCs is discussed in detail in section II.A.2.e.(5) of this proposed rule.

Recommendation 6

The Packaging Subcommittee of the APC Panel was established to review packaging issues. We are accepting the APC Panel's recommendation that the Packaging Subcommittee remain active until the next APC Panel meeting. We note that the APC Panel Packaging Subcommittee is currently active and that we will share additional issues and new data concerning the packaged status of codes with the APC Panel Packaging Subcommittee as that information becomes available.

4. Proposed Calculation of OPPS Scaled Payment Weights

Using the proposed APC median costs discussed in sections II.A.1. and II.A.2. of this proposed rule, we calculated the proposed relative payment weights for each APC for CY 2011 shown in Addenda A and B to this proposed rule. In years prior to CY 2007, we standardized all the relative payment weights to APC 0601 (Mid Level Clinic Visit) because mid-level clinic visits were among the most frequently performed services in the hospital outpatient setting. We assigned APC 0601 a relative payment weight of 1.00 and divided the median cost for each APC by the median cost for APC 0601 to derive the relative payment weight for each APC.

Beginning with the CY 2007 OPPS (71 FR 67990), we standardized all of the relative payment weights to APC 0606 (Level 3 Clinic Visits) because we deleted APC 0601 as part of the reconfiguration of the clinic visit APCs. We selected APC 0606 as the base because APC 0606 was the mid-level clinic visit APC (that is, Level 3 of five levels). Therefore, for CY 2011, to maintain consistency in using a median for calculating unscaled weights representing the median cost of some of the most frequently provided services, we are proposing to continue to use the median cost of the mid-level clinic visit APC (APC 0606) to calculate unscaled weights. Following our standard methodology, but using the proposed CY 2011 median cost for APC 0606, for CY 2011 we assigned APC 0606 a relative payment weight of 1.00 and divided the median cost of each APC by the proposed median cost for APC 0606 to derive the proposed unscaled relative payment weight for each APC. The choice of the APC on which to base the proposed relative weights for all other APCs does not affect the payments made under the OPPS because we scale the weights for budget neutrality.

Section 1833(t)(9)(B) of the Act requires that APC reclassification and recalibration changes, wage index changes, and other adjustments be made in a budget neutral manner. Budget neutrality ensures that the estimated aggregate weight under the OPPS for CY 2011 is neither greater than nor less than the estimated aggregate weight that would have been made without the changes. To comply with this requirement concerning the APC changes, we are proposing to compare the estimated aggregate weight using the CY 2010 scaled relative weights to the estimated aggregate weight using the proposed CY 2011 unscaled relative

weights. For CY 2010, we multiply the CY 2010 scaled APC relative weight applicable to a service paid under the OPPS by the volume of that service from CY 2009 claims to calculate the total weight for each service. We then add together the total weight for each of these services in order to calculate an estimated aggregate weight for the year. For CY 2011, we perform the same process using the proposed CY 2011 unscaled weights rather than scaled weights. We then calculate the weight scaler by dividing the CY 2010 estimated aggregate weight by the proposed CY 2011 estimated aggregate weight. The service-mix is the same in the current and prospective years because we use the same set of claims for service volume in calculating the aggregate weight for each year. For a detailed discussion of the weight scaler calculation, we refer readers to the OPPS claims accounting document available on the CMS Web site at: *http://www.cms.gov/HospitalOutpatientPPS/*. We included payments to CMHCs in our comparison of estimated unscaled weight in CY 2011 to estimated total weight in CY 2010 using CY 2009 claims data, holding all other components of the payment system constant to isolate changes in total weight. Based on this comparison, we adjusted the unscaled relative weights for purposes of budget neutrality. The proposed CY 2011 unscaled relative payment weights were adjusted by multiplying them by a proposed weight scaler of 1.3650 to ensure budget neutrality of the proposed CY 2011 relative weights.

Section 1833(t)(14) of the Act provides the payment rates for certain "specified covered outpatient drugs." That section states that "Additional expenditures resulting from this paragraph shall not be taken into account in establishing the conversion factor, weighting and other adjustment factors for 2004 and 2005 under paragraph (9) but shall be taken into account for subsequent years." Therefore, the cost of those specified covered outpatient drugs (as discussed in section V.B.3. of this proposed rule) was included in the proposed budget neutrality calculations for the CY 2011 OPPS.

The proposed scaled relative payment weights listed in Addenda A and B to this proposed rule incorporate the proposed recalibration adjustments discussed in sections II.A.1. and II.A.2. of this proposed rule.

B. Proposed Conversion Factor Update

Section 1833(t)(3)(C)(ii) of the Act requires us to update the conversion factor used to determine payment rates under the OPPS on an annual basis by applying the OPD fee schedule increase factor. Under the authority in section 1833(t)(3)(C)(iv) of the Act, for CY 2010, the OPD fee schedule increase factor is equal to the hospital inpatient market basket percentage increase applicable to hospital discharges under section 1886(b)(3)(B)(iii) of the Act. The proposed hospital market basket increase for FY 2011 published in the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24062) prior to changes required by the Affordable Care Act and the HCERA is 2.4 percent. New section 1833(t)(3)(F)(iii) and (G)(i) of the Act (as added by 3401(i) of the Affordable Care Act and as amended by 10319(g) of such Act and section 1105(e) of HCERA) require a .25 percentage point reduction to the CY 2011 OPD fee schedule increase factor, resulting in a proposed CY 2011 OPPS market basket update of 2.15 percent. To set the proposed OPPS conversion factor for CY 2011, we increased the CY 2010 conversion factor of $67.241 by 2.15 percent. We announced the CY 2010 OPPS conversion factor of $67.241 in the **Federal Register** Notice CMS 1504–N, entitled "Medicare Program; Changes to the Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System for CY 2010, and Extension of Part B Payment for Services Furnished by Hospitals or Clinics Operated by the Indian Health Service, Indian Tribes, or Tribal Organizations Made by the Affordable Care Act and ASC Changes Made By Previous Correction Notices," which is being published around the time of this proposed rule. Hospitals that fail to meet the reporting requirements of the Hospital Outpatient Quality Data Reporting Program (HOP QDRP) are subject to a reduction of 2.0 percentage points from the OPD fee schedule increase factor adjustment to the conversion factor. For a complete discussion of the HOP QDRP requirements and the payment reduction for hospitals that fail to meet those requirements, we refer readers to section XVI. of this proposed rule.

In accordance with section 1833(t)(9)(B) of the Act, we further adjusted the proposed conversion factor for CY 2011 to ensure that any revisions we are proposing to make to our updates for a revised wage index and rural adjustment are made on a budget neutral basis. We calculated a proposed overall budget neutrality factor of 1.0011 for wage index changes by comparing total payments from our simulation model using the FY 2011 IPPS proposed wage indices to those payments using the current (FY 2010) IPPS wage indices, as adopted on a calendar year basis for the OPPS, as indicated in the **Federal Register** notice announcing Affordable Care Act changes to the wage indices (*See* CMS 1504–N referenced above). For CY 2011, we are not proposing a change to our rural adjustment policy. Therefore, the proposed budget neutrality factor for the rural adjustment is 1.0000. In addition, to accommodate the proposed cancer hospital adjustment described in section II.F. of this preamble, we calculated an additional proposed budget neutrality factor of 0.9934 by comparing total payments from our simulation model for CY 2011 including the proposed adjustment for cancer hospitals to total payments from our simulation model for CY 2011 without the proposed adjustment for cancer hospitals.

For this proposed rule, we estimated that pass-through spending for both drugs and biologicals and devices for CY 2011 would equal approximately $86.9 million, which represents 0.20 percent of total projected CY 2011 OPPS spending. Therefore, the conversion factor would also be adjusted by the difference between the 0.14 percent estimate of pass-through spending for CY 2010 and the 0.20 percent estimate of CY 2011 pass-through spending. Finally, estimated payments for outliers remain at 1.0 percent of total OPPS payments for CY 2011.

The proposed OPD fee schedule increase factor of 2.15 percent for CY 2011, the required proposed wage index budget neutrality adjustment of approximately 1.0011, the proposed cancer hospital budget neutrality adjustment of 0.9934, and the proposed adjustment of 0.06 percent of projected OPPS spending for the difference in the pass-through spending resulted in a proposed conversion factor for CY 2011 of $68.267, which reflects the full proposed OPD fee schedule increase. To calculate the proposed CY 2011 reduced market basket conversion factor for those hospitals that fail to meet the requirements of the HOP QDRP for the full CY 2011 payment update, we made all other adjustments discussed above, but used a proposed reduced market basket increase update factor of 0.15 percent (that is, an unadjusted OPD fee schedule increase factor of 2.4 percent reduced by 0.25 percentage point as required by the Affordable Care Act and HCERA and further reduced by 2.0 percentage points as required by section 1833(t)(17)(A)(i) of the Act for failure to comply with the OPD quality reporting requirements). This resulted in a proposed reduced conversion factor for

CY 2011 of $66.930 for those hospitals that fail to meet the HOP QDRP requirements.

OPD Fee Schedule Increase Factor

In accordance with section 1833(t)(3)(C)(iv) of the Act, each year we update the OPPS conversion factor by an OPD fee schedule increase factor. For purposes of section 1833(t)(3)(C)(iv) of the Act, subject to 1833(t)(17) and 1833(t)(F), the OPD fee schedule increase factor is equal to the market basket percentage increase applicable under section 1886(b)(3)(B)(iii) to hospital discharges occurring during the fiscal year ending in such year, reduced by 1 percentage point for such factor for services furnished in each of 2000 and 2002. For hospitals that do not meet the HOP QDRP reporting requirements discussed in section XVI of this proposed rule, the update is equal to the OPD fee schedule increase factor less an additional 2.0 percentage points. In accordance with these statutory provisions, in the CY 2010 OPPS final rule (74 FR 60419), we finalized an OPD fee schedule increase factor equal to the IPPS full market basket update of 2.1 percent. Hospitals that failed to meet the HOP QDRP reporting requirements were subject to a reduced OPD fee schedule increase factor of 0.1 percent.

We note that section 1833(t)(3)(F)(ii) and (G)(i) of the Act as added by section 3401(i) of Public Law 111–148 (Affordable Care Act) and as amended by section 10319(g) of such Act and section 1105(e) of Public Law 111–152 (HCERA) require that after determining the OPD fee schedule increase factor, the Secretary shall reduce such factor for CY 2010 by 0.25 percentage point. Therefore, the reduction of 0.25 percentage point applied to the full IPPS hospital operating market basket increase factor of 2.1 percent results in a revised OPD fee schedule increase factor of 1.85 percent. For hospitals that do not meet the HOP QDRP reporting requirements, the update is equal to the OPD fee schedule increase factor, less the additional 0.25 percentage point required by section 1833(t)(F)(ii) and (G)(i) of the Act, minus 2.0 percentage points. New section 1833(t)(3)(F) of the Act further states the application of 1833(t)(3)(F) may result in the OPD fee schedule increase factor under 1833(t)(3)(C)(iv) of the Act being less than zero for a year. Thus, the CY 2010 OPD fee schedule increase factor was 1.85 percent (that is, 2.1 percent minus 0.25 percentage point) for hospitals that met the HOP QDRP reporting requirements and negative 0.15 percent (2.1 percent, less the 0.25 percentage point, minus the 2.0 percentage points) for hospitals failing to meet the HOP QDRP reporting requirements.

As with the CY 2010 OPD fee schedule increase factor, new section 1833(t)(3)(F)(ii) and (G)(i) of the Act requires that the CY 2011 OPD fee schedule increase factor be reduced by 0.25 percentage point, subject to the hospital submitting quality information under rules established by the Secretary in accordance with section 1833(t)(17) of the Act. For hospitals that do not meet the HOP QDRP reporting requirements, the update is equal to the OPD fee schedule increase factor minus 0.25 percentage point minus 2.0 percentage points. Section 1833(t)(3)(F) of the Act further states that this amendment may result in the applicable percentage increase being less than zero.

In the FY 2011 IPPS proposed rule, consistent with current law, based on IHS Global Insight, Inc.'s first quarter 2010 forecast, with historical data through the 2009 fourth quarter, we estimated that the FY 2011 IPPS market basket update would be 2.4 percent (75 FR 24016). However, consistent with the amendments to section 1833(t)(3)(F)(ii) and (G)(i) of the Act, we are required to reduce the OPD fee schedule increase factor by 0.25 percentage point. Therefore, the proposed market basket update to the CY 2011 OPD fee schedule increase factor is 2.15 percent (that is, the CY 2011 estimate of the OPD fee schedule increase factor of 2.4 percent minus 0.25 percentage point). For hospitals that do not meet the HOP QDRP reporting requirements, the proposed update to the OPPS conversion factor is 0.15 percent (that is, the adjusted CY 2011 estimate of the market basket rate-of increase of 2.15 percent minus 2.0 percentage points).

We are proposing to revise 42 CFR 419.32 to reflect the Affordable Care Act and HCERA requirements for 0.25 percentage point reductions to the OPPS fee schedule increase factor for CY 2010 and CY 2011 respectively in revised paragraph 42 CFR 419.32(b)(1)(iv).

C. Proposed Wage Index Changes

Section 1833(t)(2)(D) of the Act requires the Secretary to determine a wage adjustment factor to adjust, for geographic wage differences, the portion of the OPPS payment rate, which includes the copayment standardized amount, that is attributable to labor and labor-related cost. This adjustment must be made in a budget neutral manner and budget neutrality is discussed in section II.B. of this proposed rule.

The OPPS labor-related share is 60 percent of the national OPPS payment. This labor-related share is based on a regression analysis that determined that approximately 60 percent of the costs of services paid under the OPPS were attributable to wage costs. We confirmed that this labor-related share for outpatient services is still appropriate during our regression analysis for the payment adjustment for rural hospitals in the CY 2006 OPPS final rule with comment period (70 FR 68553). Therefore, we are not proposing to revise this policy for the CY 2011 OPPS. We refer readers to section II.H. of this proposed rule for a description and example of how the wage index for a particular hospital is used to determine the payment for the hospital.

As discussed in section II.A.2.c. of this proposed rule, for estimating national median APC costs, we standardize 60 percent of estimated claims costs for geographic area wage variation using the same FY 2011 pre-reclassified wage index that the IPPS uses to standardize costs. This standardization process removes the effects of differences in area wage levels from the determination of a national unadjusted OPPS payment rate and the copayment amount.

As published in the original OPPS April 7, 2000 final rule with comment period (65 FR 18545), the OPPS has consistently adopted the final IPPS wage index as the wage index for adjusting the OPPS standard payment amounts for labor market differences. Thus, the wage index that applies to a particular acute care short-stay hospital under the IPPS would also apply to that hospital under the OPPS. As initially explained in the September 8, 1998 OPPS proposed rule, we believed and continue to believe that using the IPPS wage index as the source of an adjustment factor for the OPPS is reasonable and logical, given the inseparable, subordinate status of the HOPD within the hospital overall. In accordance with section 1886(d)(3)(E) of the Act, the IPPS wage index is updated annually. Therefore, in accordance with our established policy, we are proposing to use the final FY 2011 version of the IPPS wage index used to pay IPPS hospitals to adjust the CY 2011 OPPS payment rates and copayment amounts for geographic differences in labor cost for all providers that participate in the OPPS, including providers that are not paid under the IPPS (referred to in this section as "non-IPPS" providers).

The Affordable Care Act contains a number of provisions affecting the FY 2011 IPPS wage index values, including revisions to the reclassification wage comparability criteria that were finalized in the FY 2009 IPPS final rule (73 FR 48568 through 48570), and the application of rural floor budget

neutrality on a national, rather than State-specific, basis through a uniform, national adjustment to the area wage index. These specific provisions are discussed in more detail in the supplemental FY 2011 IPPS/LTCH PPS proposed rule published June 2, 2010 in the **Federal Register** (75 FR 30920). The Affordable Care Act also required CMS to establish an adjustment to create a wage index floor of 1.00 for hospitals located in States determined to be frontier States (section 10324). We discuss this provision and how it applies to hospital outpatient departments in more detail below.

Section 10324 of the Affordable Care Act specifies that, for services furnished beginning CY 2011, the wage adjustment factor applicable to any hospital outpatient department that is located in a frontier State (as defined in section 1886(d)(3)(E)(iii)(II) of the Act) may not be less than 1.00. Further, section 10324 states that this adjustment to the wage index for these outpatient departments should not be made in a budget neutral manner. As such, for the CY 2011 OPPS, we are proposing to adjust the wage index for all HOPDs, including those providers that are not paid under the IPPS, which are identified as being located in a frontier State, in the manner specified in the Affordable Care Act. Specifically, we would adjust the FY 2011 wage index, as adopted on a calendar year basis for the OPPS, for all hospitals paid under the OPPS, including non-IPPS hospitals, located in a frontier State to 1.00 in instances where the assigned FY 2011 wage index (that reflects MGCRB reclassifications, application of the rural floor and rural floor budget neutrality adjustment) for these hospitals is less than 1.00. Similar to our current policy for HOPDs that are affiliated with multicampus hospital systems, we fully expect that the HOPD would receive a wage index based on the geographic location of the specific inpatient hospital with which it is associated. Therefore, if the associated hospital is located in a frontier state, then the wage index adjustment applicable for the hospital would also apply for the affiliated HOPD. We refer readers to the FY 2011 supplemental proposed rule published subsequent to the FY 2011 IPPS/LTCH proposed rule for detailed discussion regarding this provision, including our proposed methodology for identifying which areas meet the definition of frontier States as provided for in section 1886(d)(3)(E)(iii)(II)) of the Act.

In addition, we are proposing to revise § 419.43(c) of the regulations to incorporate the amendments made by section 10324 of the Affordable Care Act. Specifically, we would include a provision under a new paragraph (c)(2) to state that for services furnished beginning January 1, 2011, the wage adjustment factor referenced in the existing regulations applicable to any HOPD that is located in a frontier State, as defined in the statute and regulations, may not be less than 1.00. We also are proposing to add a new paragraph (c)(3) to § 419.43 to not consider these additional payments in budget neutrality.

In addition to the changes required by the Affordable Care Act, we note that the proposed FY 2011 IPPS wage indices continue to reflect a number of adjustments implemented over the past few years, including revised Office of Management and Budget (OMB) standards for defining geographic statistical areas (Core-Based Statistical Areas or CBSAs), reclassification of hospitals to different geographic areas, rural floor provisions, an adjustment for out-migration labor patterns, an adjustment for occupational mix, and a policy for allocating hourly wage data among campuses of multicampus hospital systems that cross CBSAs. We refer readers to the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 23936 through 23956) and the supplemental proposed rule (75 FR 30918) for a detailed discussion of all proposed changes, including changes required by the Affordable Care Act, to the FY 2011 IPPS wage indices. In addition, we refer readers to the CY 2005 OPPS final rule with comment period (69 FR 65842 through 65844) and subsequent OPPS rules for a detailed discussion of the history of these wage index adjustments as applied under the OPPS.

The IPPS wage index that we are proposing to adopt in this proposed rule includes all reclassifications that are approved by the Medicare Geographic Classification Review Board (MGCRB) for FY 2011. We note that reclassifications under section 508 of Public Law 108–173 and certain special exception wage indices that were extended by section 106(a) of Public Law 109–432 (MIEA–TRHCA) and section 117(a)(1) of Public Law 110–173 (MMSEA) were set to terminate September 30, 2008, but were further extended by section 124 of Public Law 110–275 (MIPPA) through September 30, 2009 and, most recently, by section 3137 as amended by section 10317 of Public Law 111–148 (Affordable Care Act) through September 30, 2010. We did not make any proposals related to these provisions for the CY 2010 OPPS wage index because Public Law 111–148 (Affordable Care Act) was enacted after issuance of the CY 2010 OPPS/ASC proposed and final rules. In accordance with section 10317 of Public Law 111–148, for CY 2010, we adopted all section 508 geographic reclassifications through September 30, 2010. Similar to our treatment of section 508 reclassifications extended under Public Law 110–173 (MMSEA) as described in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68586), hospitals with section 508 reclassifications will revert to their home area wage index, with out-migration adjustment if applicable, or a current MGCRB reclassification, from October 1, 2010 to December 31, 2010. In addition, as we did for CY 2009, we will recognize the revised wage index values for certain special exception hospitals from January 1, 2010 through December 31, 2010, under the OPPS, in order to give these hospitals the special exception wage indices under the OPPS for the same time period as under the IPPS. We refer readers to the FY 2010 section 508 reclassification **Federal Register** notice published on June 2, 2010 (75 FR 31118) for a detailed discussion of the changes to the wage indices as required by section 10317 of the Affordable Care Act. We also discuss the impact of the extension of reclassifications under section 508 and special exception wage indices in the **Federal Register** notice CMS–1504–N, entitled "Medicare Program; Changes to the Hospital Outpatient Prospective Payment System for CY 2010, Changes to the Ambulatory Surgical Center Payment System for CY 2010, and Extension of Payment under Part B for Services Furnished by Hospitals or Clinics Operated by the Indian Health Service or Tribal Organizations Made by the Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 and Changes to the Ambulatory Surgical Center Payment System for CY 2010 Made By Previous Correction Notices" that will be published around the same time as this proposed rule. Because the provisions of section 10317 of the Affordable Care Act expired in 2010 and are not applicable to FY 2011, we are not making any proposals related to those provisions for the OPPS wage indices for CY 2011. However, we note that Congress is currently considering legislation that may further extend section 508 reclassifications and wage indexes for special exception providers for FY 2011, which would be applicable for the CY 2011 OPPS. We will implement any extension occurring before or during the comment period for this proposed rule in our final rule.

For purposes of the OPPS, we are proposing to continue our policy in CY 2011 to allow non-IPPS hospitals paid under the OPPS to qualify for the out-migration adjustment if they are located in a section 505 out-migration county. We note that because non-IPPS hospitals cannot reclassify, they are eligible for the out-migration wage adjustment. Table 4J in the **Federal Register** for the supplemental FY 2011 IPPS proposed rule (75 FR 31049), identifies counties eligible for the out-migration adjustment and providers receiving the adjustment. As we have done in prior years, we are reprinting Table 4J as Addendum L to this proposed rule with the addition of non-IPPS hospitals that would receive the section 505 out-migration adjustment under the CY 2011 OPPS.

As stated earlier in this section, we continue to believe that using the IPPS wage index as the source of an adjustment factor for the OPPS is reasonable and logical, given the inseparable, subordinate status of the HOPD within the hospital overall. Therefore, we are proposing to use the final FY 2011 IPPS wage indices for calculating OPPS payments in CY 2011. With the exception of the out-migration wage adjustment table (Addendum L to this proposed rule), which includes non-IPPS hospitals paid under the OPPS, we are not reprinting the FY 2011 IPPS proposed wage indices referenced in this discussion of the wage index. We refer readers to the CMS Web site for the OPPS at: *http://www.cms.gov/HospitalOutpatientPPS/*. At this link, readers will find a link to the FY 2011 IPPS proposed wage index tables.

D. Proposed Statewide Average Default CCRs

In addition to using CCRs to estimate costs from charges on claims for ratesetting, CMS uses overall hospital-specific CCRs calculated from the hospital's most recent cost report to determine outlier payments, payments for pass-through devices, and monthly interim transitional corridor payments under the OPPS during the PPS year. Medicare contractors cannot calculate a CCR for some hospitals because there is no cost report available. For these hospitals, CMS uses the statewide average default CCRs to determine the payments mentioned above until a hospital's Medicare contractor is able to calculate the hospital's actual CCR from its most recently submitted Medicare cost report. These hospitals include, but are not limited to, hospitals that are new, have not accepted assignment of an existing hospital's provider agreement, and have not yet submitted a cost report. CMS also uses the statewide average default CCRs to determine payments for hospitals that appear to have a biased CCR (that is, the CCR falls outside the predetermined ceiling threshold for a valid CCR) or for hospitals whose most recent cost report reflects an all-inclusive rate status (Medicare Claims Processing Manual (Pub. 100–04), Chapter 4, Section 10.11). We are proposing to update the default ratios for CY 2011 using the most recent cost report data. We discuss our policy for using default CCRs, including setting the ceiling threshold for a valid CCR, in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68594 through 68599) in the context of our adoption of an outlier reconciliation policy for cost reports beginning on or after January 1, 2009.

For CY 2011, we are proposing to continue to use our standard methodology of calculating the statewide average default CCRs using the same hospital overall CCRs that we use to adjust charges to costs on claims data for setting the CY 2011 proposed OPPS relative weights. Table 9 below lists the proposed CY 2011 default urban and rural CCRs by State and compares them to last year's default CCRs. These proposed CCRs represent the ratio of total costs to total charges for those cost centers relevant to outpatient services from each hospital's most recently submitted cost report, weighted by Medicare Part B charges. We also adjusted ratios from submitted cost reports to reflect final settled status by applying the differential between settled to submitted overall CCR for the cost centers relevant to outpatient services from the most recent pair of final settled and submitted cost reports. We then weighted each hospital's CCR by the volume of separately paid line-items on hospital claims corresponding to the year of the majority of cost reports used to calculate the overall CCRs. We refer readers to the CY 2008 OPPS/ASC final rule with comment period (72 FR 66680 through 66682) and prior OPPS rules for a more detailed discussion of our established methodology for calculating the statewide average default CCRs, including the hospitals used in our calculations and our trimming criteria.

For this proposed rule, approximately 87 percent of the submitted cost reports utilized in the default ratio calculations represented data for cost reporting periods ending in CY 2008 and 12 percent were for cost reporting periods ending in CY 2007. For Maryland, we used an overall weighted average CCR for all hospitals in the nation as a substitute for Maryland CCRs. Few hospitals in Maryland are eligible to receive payment under the OPPS, which limits the data available to calculate an accurate and representative CCR. In general, observed changes in the statewide average default CCRs between CY 2010 and CY 2011 are modest and the few significant changes are associated with areas that have a small number of hospitals.

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TABLE 9.—PROPOSED CY 2011 STATEWIDE AVERAGE CCRs

State	Urban/Rural	Proposed CY 2011 Default CCR	Previous Default CCR (CY 2010 OPPS Final Rule)
ALASKA	RURAL	0.479	0.499
ALASKA	URBAN	0.336	0.328
ALABAMA	RURAL	0.217	0.220
ALABAMA	URBAN	0.193	0.193
ARKANSAS	RURAL	0.248	0.251
ARKANSAS	URBAN	0.251	0.263
ARIZONA	RURAL	0.256	0.251
ARIZONA	URBAN	0.212	0.217
CALIFORNIA	RURAL	0.198	0.208
CALIFORNIA	URBAN	0.209	0.210
COLORADO	RURAL	0.347	0.345
COLORADO	URBAN	0.248	0.255
CONNECTICUT	RURAL	0.372	0.375
CONNECTICUT	URBAN	0.317	0.319
DISTRICT OF COLUMBIA	URBAN	0.319	0.324
DELAWARE	RURAL	0.279	0.320
DELAWARE	URBAN	0.362	0.363
FLORIDA	RURAL	0.193	0.198
FLORIDA	URBAN	0.181	0.184
GEORGIA	RURAL	0.262	0.265
GEORGIA	URBAN	0.235	0.246
HAWAII	RURAL	0.359	0.359
HAWAII	URBAN	0.308	0.307
IOWA	RURAL	0.266	0.332
IOWA	URBAN	0.293	0.302
IDAHO	RURAL	0.507	0.507
IDAHO	URBAN	0.417	0.409
ILLINOIS	RURAL	0.256	0.273
ILLINOIS	URBAN	0.245	0.253
INDIANA	RURAL	0.307	0.299
INDIANA	URBAN	0.278	0.296
KANSAS	RURAL	0.285	0.291
KANSAS	URBAN	0.225	0.226
KENTUCKY	RURAL	0.224	0.223
KENTUCKY	URBAN	0.249	0.254
LOUISIANA	RURAL	0.265	0.271

State	Urban/Rural	Proposed CY 2011 Default CCR	Previous Default CCR (CY 2010 OPPS Final Rule)
LOUISIANA	URBAN	0.244	0.259
MARYLAND	RURAL	0.290	0.294
MARYLAND	URBAN	0.262	0.267
MASSACHUSETTS	URBAN	0.323	0.323
MAINE	RURAL	0.457	0.433
MAINE	URBAN	0.452	0.452
MICHIGAN	RURAL	0.313	0.318
MICHIGAN	URBAN	0.322	0.320
MINNESOTA	RURAL	0.498	0.502
MINNESOTA	URBAN	0.327	0.330
MISSOURI	RURAL	0.261	0.266
MISSOURI	URBAN	0.262	0.270
MISSISSIPPI	RURAL	0.241	0.244
MISSISSIPPI	URBAN	0.191	0.192
MONTANA	RURAL	0.428	0.438
MONTANA	URBAN	0.422	0.462
NORTH CAROLINA	RURAL	0.269	0.270
NORTH CAROLINA	URBAN	0.282	0.285
NORTH DAKOTA	RURAL	0.357	0.333
NORTH DAKOTA	URBAN	0.390	0.361
NEBRASKA	RURAL	0.335	0.340
NEBRASKA	URBAN	0.263	0.260
NEW HAMPSHIRE	RURAL	0.340	0.329
NEW HAMPSHIRE	URBAN	0.291	0.285
NEW JERSEY	URBAN	0.236	0.235
NEW MEXICO	RURAL	0.272	0.259
NEW MEXICO	URBAN	0.316	0.329
NEVADA	RURAL	0.280	0.296
NEVADA	URBAN	0.180	0.187
NEW YORK	RURAL	0.414	0.423
NEW YORK	URBAN	0.378	0.383
OHIO	RURAL	0.341	0.350
OHIO	URBAN	0.248	0.250
OKLAHOMA	RURAL	0.265	0.267
OKLAHOMA	URBAN	0.217	0.225
OREGON	RURAL	0.301	0.303
OREGON	URBAN	0.353	0.344
PENNSYLVANIA	RURAL	0.276	0.280
PENNSYLVANIA	URBAN	0.210	0.223

State	Urban/Rural	Proposed CY 2011 Default CCR	Previous Default CCR (CY 2010 OPPS Final Rule)
PUERTO RICO	URBAN	0.520	0.514
RHODE ISLAND	URBAN	0.299	0.299
SOUTH CAROLINA	RURAL	0.235	0.232
SOUTH CAROLINA	URBAN	0.235	0.242
SOUTH DAKOTA	RURAL	0.314	0.320
SOUTH DAKOTA	URBAN	0.256	0.261
TENNESSEE	RURAL	0.229	0.233
TENNESSEE	URBAN	0.211	0.214
TEXAS	RURAL	0.249	0.251
TEXAS	URBAN	0.218	0.222
UTAH	RURAL	0.397	0.397
UTAH	URBAN	0.385	0.400
VIRGINIA	RURAL	0.244	0.242
VIRGINIA	URBAN	0.257	0.255
VERMONT	RURAL	0.415	0.413
VERMONT	URBAN	0.397	0.397
WASHINGTON	RURAL	0.370	0.365
WASHINGTON	URBAN	0.335	0.340
WISCONSIN	RURAL	0.387	0.384
WISCONSIN	URBAN	0.337	0.329
WEST VIRGINIA	RURAL	0.292	0.283
WEST VIRGINIA	URBAN	0.336	0.339
WYOMING	RURAL	0.396	0.407
WYOMING	URBAN	0.300	0.315

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E. Proposed OPPS Payment to Certain Rural and Other Hospitals

1. Hold Harmless Transitional Payment Changes Made by Public Law 110–275 (MIPPA)

When the OPPS was implemented, every provider was eligible to receive an additional payment adjustment (called either transitional corridor payments or transitional outpatient payment (TOPs)) if the payments it received for covered OPD services under the OPPS were less than the payments it would have received for the same services under the prior reasonable cost-based system (referred to as the pre-BBA amount). Section 1833(t)(7) of the Act provides that the transitional corridor payments are temporary payments for most providers and were intended to ease their transition from the prior reasonable cost-based payment system to the OPPS system. There are two exceptions to this provision, cancer hospitals and children's hospitals, and those hospitals receive the transitional corridor payments on a permanent basis. Section 1833(t)(7)(D)(i) of the Act originally provided for transitional corridor payments to rural hospitals with 100 or fewer beds for covered OPD services furnished before January 1, 2004. However, section 411 of Public Law 108–173 amended section 1833(t)(7)(D)(i) of the Act to extend these payments through December 31, 2005, for rural hospitals with 100 or fewer beds. Section 411 also extended the transitional corridor payments to sole community hospitals (SCHs) located in rural areas for services furnished during the period that began with the provider's first cost reporting period beginning on or after January 1, 2004, and ended on December 31, 2005. Accordingly, the authority for making transitional corridor payments under section 1833(t)(7)(D)(i) of the Act, as amended by section 411 of Pub. L. 108–173, for rural hospitals having 100 or fewer beds and SCHs located in rural areas expired on December 31, 2005.

Section 5105 of Public Law 109–171 reinstituted the TOPs for covered OPD services furnished on or after January 1, 2006, and before January 1, 2009, for rural hospitals having 100 or fewer beds that are not SCHs. When the OPPS payment was less than the provider's pre-BBA amount, the amount of payment was increased by 95 percent of the amount of the difference between the two amounts for CY 2006, by 90 percent of the amount of that difference for CY 2007, and by 85 percent of the amount of that difference for CY 2008.

For CY 2006, we implemented section 5105 of Public Law 109–171 through Transmittal 877, issued on February 24, 2006. In the Transmittal, we did not specifically address whether TOPs apply to essential access community hospitals (EACHs), which are considered to be SCHs under section 1886(d)(5)(D)(iii)(III) of the Act. Accordingly, under the statute, EACHs are treated as SCHs. In the CY 2007 OPPS/ASC final rule with comment period (71 FR 68010), we stated that EACHs were not eligible for TOPs under Public Law 109–171. However, we stated they were eligible for the adjustment for rural SCHs. In the CY 2007 OPPS/ASC final rule with comment period (71 FR 68010 and 68228), we updated § 419.70(d) of our regulations to reflect the requirements of Public Law 109–171.

In the CY 2009 OPPS/ASC proposed rule (73 FR 41461), we stated that, effective for services provided on or after January 1, 2009, rural hospitals having 100 or fewer beds that are not SCHs would no longer be eligible for TOPs, in accordance with section 5105 of Public Law 109–171. However, subsequent to issuance of the CY 2009 OPPS/ASC proposed rule, section 147 of Public Law 110–275 amended section 1833(t)(7)(D)(i) of the Act by extending the period of TOPs to rural hospitals with 100 beds or fewer for 1 year, for services provided before January 1, 2010. Section 147 of Public Law 110–275 also extended TOPs to SCHs (including EACHs) with 100 or fewer beds for covered OPD services provided on or after January 1, 2009, and before January 1, 2010. In accordance with section 147 of Public Law 110–275, when the OPPS payment is less than the provider's pre-BBA amount, the amount of payment is increased by 85 percent of the amount of the difference between the two payment amounts for CY 2009.

For CY 2009, we revised our regulations at §§ 419.70(d)(2) and (d)(4) and added a new paragraph (d)(5) to incorporate the provisions of section 147 of Public Law 110–275. In addition, we made other technical changes to § 419.70(d)(2) to more precisely capture our existing policy and to correct an inaccurate cross-reference. We also made technical corrections to the cross-references in paragraphs (e), (g), and (i) of § 419.70.

For CY 2010, we made a technical correction to the heading of § 419.70(d)(5) to correctly identify the policy as described in the subsequent regulation text. The paragraph heading now indicates that the adjustment applies to small SCHs, rather than to rural SCHs.

In the CY 2010 OPPS/ASC final rule (74 FR 60425), we stated that, effective for services provided on or after January 1, 2010, rural hospitals and SCHs (including EACHs) having 100 or fewer beds would no longer be eligible for TOPs, in accordance with section 147 of Pub. L. 110–275. However, subsequent to issuance of the CY 2010 OPPS/ASC final rule, section 3121(a) of the Affordable Care Act, Public Law 111–148, amended section 1833(t)(7)(D)(i)(III) of the Act by extending the period of TOPs to rural hospitals that are not SCHs with 100 beds or fewer for 1 year, for services provided before January 1, 2011. Section 3121(a) of Public Law 111–148, amended section 1833(t)(7)(D)(i)(III) of the Act and extended the period of TOPs to SCHs (including EACHs) for 1 year, for services provided before January 1, 2011, with Section 3121(b) of Public Law 111–148 removing the 100-bed limitation applicable to such SCHs for covered OPD services furnished on and after January 1, 2010 and before January 1, 2011. In accordance with section 3121 of Public Law 111–148, when the OPPS payment is less than the provider's pre-BBA amount, the amount of payment is increased by 85 percent of the amount of the difference between the two payment amounts for CY 2010. Accordingly, we are proposing to update section 419.70(d) of the regulations to reflect the TOPs extensions and amendments described in section 3121 of Public Law 111–148.

Effective for services provided on or after January 1, 2011, rural hospitals having 100 or fewer beds that are not SCHs and SCHs (including EACHs) will no longer be eligible for hold harmless TOPs, in accordance with section 3121 of Public Law 111–148.

2. Proposed Adjustment for Rural SCHs Implemented in CY 2006 Related to Public Law 108–173 (MMA)

In the CY 2006 OPPS final rule with comment period (70 FR 68556), we finalized a payment increase for rural SCHs of 7.1 percent for all services and procedures paid under the OPPS, excluding drugs, biologicals, brachytherapy sources, and devices paid under the pass-through payment policy in accordance with section 1833(t)(13)(B) of the Act, as added by section 411 of Public Law 108–173. Section 411 gave the Secretary the authority to make an adjustment to OPPS payments for rural hospitals, effective January 1, 2006, if justified by a study of the difference in costs by APC between hospitals in rural areas and hospitals in urban areas. Our analysis showed a difference in costs for rural SCHs. Therefore, for the CY 2006 OPPS, we finalized a payment adjustment for rural SCHs of 7.1 percent for all services and procedures paid under the OPPS, excluding separately payable drugs and biologicals, brachytherapy sources, and devices paid under the pass-through payment policy, in accordance with section 1833(t)(13)(B) of the Act.

In CY 2007, we became aware that we did not specifically address whether the adjustment applies to EACHs, which are considered to be SCHs under section 1886(d)(5)(D)(iii)(III) of the Act. Thus, under the statute, EACHs are treated as SCHs. Therefore, in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68010 and 68227), for purposes of receiving this rural adjustment, we revised § 419.43(g) to clarify that EACHs are also eligible to receive the rural SCH adjustment, assuming these entities otherwise meet the rural adjustment criteria. Currently, fewer than 10 hospitals are classified as EACHs and as of CY 1998, under section 4201(c) of Public Law 105–33, a hospital can no longer become newly classified as an EACH.

This adjustment for rural SCHs is budget neutral and applied before calculating outliers and copayment. As stated in the CY 2006 OPPS final rule with comment period (70 FR 68560), we would not reestablish the adjustment amount on an annual basis, but we may review the adjustment in the future and, if appropriate, would revise the adjustment. We provided the same 7.1 percent adjustment to rural SCHs, including EACHs, again in CY 2008 and CY 2009. Further, in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68590), we updated the regulations at § 419.43(g)(4) to specify, in general terms, that items paid at charges adjusted to costs by application of a hospital-specific CCR are excluded from the 7.1 percent payment adjustment.

For the CY 2011 OPPS, we are proposing to continue our policy of a budget neutral 7.1 percent payment adjustment for rural SCHs, including EACHs, for all services and procedures paid under the OPPS, excluding separately payable drugs and biologicals, devices paid under the pass-through payment policy, and items paid at charges reduced to costs. We intend to reassess the 7.1 percent adjustment in the near future by examining differences between urban and rural hospitals' costs using updated claims, cost reports, and provider information.

F. Proposed OPPS Payments to Cancer Hospitals Described in Section 1886(d)(1)(B)(v) of the Act

1. Background

Since the inception of the hospital outpatient prospective payment system (OPPS), which was authorized by the Balanced Budget Act of 1997 (BBA), Medicare has paid cancer hospitals identified in section 1886(d)(1)(B)(v) of the Act (cancer hospitals) under the OPPS for covered outpatient hospital services. There are 11 cancer hospitals that meet the classification criteria in section 1886(d)(1)(B)(v) of the Act. These 11 cancer hospitals are exempted from payment under the inpatient prospective payment system (IPPS). With the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999, Congress created section 1833(t)(7) of the Act, "Transitional Adjustment to Limit Decline in Payment," to serve as a permanent payment floor by limiting cancer

hospitals' potential losses under the OPPS. Through 1833(t)(7)(D)(ii) of the Act, a cancer hospital receives the full amount of the difference between payments for covered outpatient services under the OPPS and a pre-BBA amount. That is, cancer hospitals are permanently held harmless to their "pre-BBA" amount, and they receive transitional outpatient payments (TOPs) to ensure that they do not receive a payment that is lower under the OPPS than the payment they would have received before implementation of the OPPS, as set forth in section 1833(t)(7)(F) of the Act. The pre-BBA payment amount is an amount equal to the product of the reasonable cost of the hospital for such services for the portions of the hospital's cost reporting period (or periods) occurring in the year and the base payment to cost ratio (base PCR) for the hospital. The pre-BBA amount, including the determination of the base PCR, are defined at 42 CFR 419.70(f). TOPs are calculated on Worksheet E Part B of the Hospital and Hospital Health Care Complex Cost Report (form CMS–2552–96) each year. Section 1833(t)(7)(I) of the Act exempts TOPs from budget neutrality calculations. Almost all of the 11 cancer hospitals receive TOPs each year. The volume weighted average payment to cost ratio (PCR) for the cancer hospitals is 0.83, or outpatient payment with TOPs to cancer hospitals is 83 percent of reasonable cost.

Section 3138 of the Affordable Care Act instructs the Secretary to conduct a study to determine if, under the OPPS, outpatient costs incurred by cancer hospitals described in section 1886(d)(1)(1)(v)(B) of the Act with respect to ambulatory classification groups exceed the costs incurred by other hospitals furnishing services under this subsection (section 1833(t) of the Act) as determined appropriate by the Secretary. In addition, section 3138 of the Affordable Care Act requires the Secretary to take into consideration the cost of drugs and biologicals incurred by such hospitals when studying cancer hospital costliness. Further, section 3138 of the Affordable Care Act states that if the cancer hospitals' costs are determined to be greater than the costs of other hospitals paid under the OPPS, the Secretary shall provide an appropriate adjustment to reflect these higher costs. Section 3138 of the Affordable Care Act also requires that this adjustment be budget neutral, and it would be effective for outpatient services provided at cancer hospitals on or after January 1, 2011. Cancer hospitals described in section 1886(d)(1)(B)(v) of the Act remain eligible for TOPs payment (which are not budget neutral) and outlier payments (which are budget neutral).

2. Study of Cancer Hospitals' Costs Relative to Other Hospitals

It has been our standard analytical approach to use a combination of explanatory and payment regression models to assess the costliness of a class of hospitals while controlling for other legitimate influences of costliness, such as ability to achieve economies of scale, to ensure that costliness is due to the type of hospital and to identify appropriate payment adjustments. We used this approach in our CY 2006 OPPS final rule with comment period to establish the 7.1 percent payment adjustment for rural sole community hospitals (70 FR 68556 through 68561). In our discussion for the CY 2006 OPPS proposed rule we stated that a simple comparison of unit costs would not be sufficient to assess the costliness of a class of hospitals because the costs faced by individual hospitals, whether urban or rural, are a function of many varying factors, including local labor supply and the complexity and volume of services provided (70 FR 42699).

In constructing our analysis of cancer hospitals' costs relative to other hospitals, we considered whether our standard analytical approach to use a combination of explanatory and payment regression models would lead to valid results for this particular study, or whether we should develop a different or modified analytic approach. We note that the analyses presented in the CY 2006 OPPS proposed and final rules were designed to establish an adjustment for a large class of rural hospitals. In contrast, section 3138 of the Affordable Care Act is specifically limited to identifying an adjustment for 11 cancer hospitals. With such a small sample size (11 out of approximately 4,000 hospitals paid under the OPPS), we are concerned that the standard explanatory and payment regression models used to establish the rural hospital adjustment would lead to imprecise estimates of payment adjustments for this small group of hospitals. Further, Section 3138 of the Affordable Care Act specifies explicitly that cost comparisons between classes of hospitals must include the cost of drugs and biologicals. In our CY 2006 analysis of rural hospitals, we excluded the cost of drugs and biologicals in our model because the extreme units associated with proper billing for some drugs and biologicals can bias the calculation of a service mix index, or volume weighted average APC relative weight, for each hospital (70 FR 42698). Therefore, we chose not to pursue our standard combination of explanatory and payment regression modeling to identify costliness and determine a cancer hospital adjustment.

While we chose not to use our standard models to calculate a proposed cancer hospital adjustment, we determined it still would be appropriate to construct our usual provider-level analytical dataset consisting of variables related to assessing costliness including average cost per unit for a hospital and the hospitals average APC relative weight as an indicator of the hospitals resource intensity, as measured by the APC relative weights. We used these variables to calculate univariate statistics that describe the costliness and related aspects of cancer hospitals and other hospitals paid under the OPPS. While descriptive statistics cannot control for the myriad factors that contribute to observed costs, we believe that we can assume that stark differences in cost between cancer hospitals and other hospitals paid under the OPPS that would be observable by examining descriptive univariate statistics would provide some indication of relative costliness. We began our analysis of the cancer hospitals as we did for the rural hospitals by creating an analytical dataset of hospitals billing under the OPPS for CY 2009 (a total of 3,933) that were included in our claims dataset for establishing the CY 2011 OPPS proposed APC relative weights (discussed in detail in section II.A. of this proposed rule). This analytical dataset includes the 3,933 OPPS hospitals' total estimated cost (including packaged cost), total lines, total discounted units as modeled for CY 2011 OPPS payment, and the average weight of their separately payable services (total APC weight divided by total units) as modeled for CY 2011 OPPS. We create this dataset from the hospital specific service utilization files that we use to model budget neutrality and to perform impact analyses after we complete estimating a median cost (or equivalent amount depending on unique APC methodologies as discussed in section II of this proposed rule) for each APC. Using the CY 2009 claims that we use to model the CY 2011 proposed OPPS, we use the utilization on those claims to model APC payment under the CY 2011 proposed payment policies, such as proposed payment for drugs and biologicals at ASP+6 percent and proposed reassignment of some HCPCS codes to different APCs. We then summarized this estimated

utilization and payment for each hospital ("hospital-level"). These files consist of hospital-level aggregate costs (including the cost of packaged items and services), total estimated discounted units under the modeled proposed CY 2011 OPPS, total estimated volume of number of occurrences of separately payable HCPCS codes under the modeled proposed CY 2011 OPPS, and total relative weight of separately payable services under the modeled proposed CY 2011 OPPS. The calculation of these summary files are discussed in Stage 6 of our claims accounting narrative available under supporting documentation for this proposed rule on the CMS Web site at: *http://www.cms.gov/HospitalOutpatientPPS/HORD/*. After summarizing modeled payment to the hospital-level, we removed 48 hospitals in Puerto Rico from our dataset, because we do not believe that their cost structure reflects the costs of most hospitals paid under the OPPS and because they could bias the calculation of hospital-weighted statistics. We then removed an additional 66 hospitals with a cost per unit of more than 3 standard deviations from the geometric mean (mean of the natural log) because including outliers in hospital-weighted descriptive statistics also could bias the those statistics. This resulted in a dataset with 11 cancer hospitals and 3,808 other hospitals.

We included the following standard hospital-level variables that describe hospital costliness in our analysis file: Outpatient cost per discounted unit under the modeled CY 2011 OPPS (substituting a cost per administration, rather than a cost per unit, for drugs and biologicals); each hospital's proposed CY 2011 wage index as a measure of relative labor cost; the service mix index, or volume-weighted average proposed CY 2011 APC relative weight (including a simulated weight for drugs and biologicals created by dividing the CY 2010 April ASP-based payment amount at ASP+6 percent appearing in Addendum A and B of this proposed rule by the proposed conversion factor of $68.267); outpatient volume based on number of occurrences of HCPCS codes in the CY 2009 claims data; and number of beds. We use these variables because they are key indicators of costliness under the modeled OPPS system, and they allow us to assess the relative costliness of classes of hospitals under the proposed CY 2011 OPPS. We further discuss these variables in our CY 2006 proposed rule analysis (70 FR 42698 through 42701). A hospital's service mix index is a measure of resource intensity of the services provided by the hospital as measured by the proposed CY 2011 OPPS relative weights, and standardizing the cost per discounted unit by the service mix index creates an adjusted cost per unit estimate that reflects the remaining relative costliness of a hospital remaining after receiving the estimated payments that we are proposing to make under the CY 2011 OPPS. In short, if a class of hospitals demonstrates higher cost per unit after standardization by service mix it is an early indication that the class of hospitals may be significantly more costly in the regression models. We used this data to calculate the descriptive univariate statistics for cancer hospitals appearing in Table 10 below. We note that because drugs and biologicals are such a significant portion of the services that the cancer hospitals provide, and because Section 3138 of the Affordable Care Act explicitly requires us to consider the cost of drugs and biologicals, we included the cost of these items in our total cost calculation for each hospital, counting each occurrence of a drug in the modeled proposed CY 2011 data (based on units in CY 2009 claims data). That is, we sought to treat each administration of a drug or biological as one unit.

In reviewing these descriptive statistics, we observe that cancer hospitals had a standardized cost per discounted unit of $150.12 compared to a standardized cost per discounted unit of $94.14 for all other hospitals. That is, cancer hospitals' average cost per discounted unit remains high even after accounting for payment under the modeled proposed CY 2011 payment system, which is not true for all other hospitals. Observing such differences in standardized cost per discounted unit lead us to conclude that cancer hospitals are more costly than other hospitals paid under the OPPS, even without the inferential statistical models that we typically employ.

Table 10. - Means and Standard Deviations for Key Variables by Cancer and Non-Cancer OPPS Hospitals

	Cancer Hospitals		Non-Cancer Hospitals	
Variable	Mean	Standard Deviation	Mean	Standard Deviation
Outpatient Cost per Unit*	$344.20	(64.68)	$264.11	(165.86)
Unit Cost Standardized by Service Mix Wage Indices	$150.12	(31.64)	$94.14	(81.19)
Wage Index	1.10	(0.13)	0.98	(0.16)
Service Mix Index *	2.19	(0.26)	3.18	(2.25)
Outpatient Volume	192,197	(186,063)	34,578	(43,094)
Beds	173	(162.33)	173	(171.46)
Number of Hospitals	11		3,808	

* Includes drugs and biologicals based on per administration rather than per unit

3. Proposed Adjustment for Certain Cancer Hospitals

Having reviewed the cost data from the standard analytic database and determined that cancer hospitals are more costly than other hospitals within the OPPS system, we decided to examine hospital cost report data from Worksheet E Part B (where TOPs are calculated on the Hospital and Hospital Health Care Complex Cost Report each year) in order to determine whether our findings were further supported by cost report data and to determine an appropriate proposed payment adjustment methodology. Analyses on our standard analytic database and descriptive statistics presented in Table 10 above, did not consider TOPs in assessing costliness of cancer hospitals relative to other hospitals furnishing services under section 1833(t) of the Act. This is because section 3138 of the Affordable Care Act requires that any cancer adjustment be made within the budget neutral system. In making a determination about a payment adjustment subject to budget neutrality, we believe it is appropriate to assess costliness and payments within the budget neutral payment system. We note that TOPs are based on reasonable cost and are not part of the budget neutral payment system. Further, TOPs have no associated relative weight that could be included in an assessment of APC-based payment. TOPs are paid at cost report settlement on an aggregate basis, not a per service basis, and we would have no way to break these payments down into a relative weight to incorporate these retrospective aggregate payments in the form of relative weight under the proposed modeled CY 2011 OPPS. The cost report data we selected for the analysis was limited to the OPPS-specific payment and cost data available on Worksheet E Part B, which is also where TOPs are calculated including aggregate OPPS payments, including outlier payments and the cost of medical and other health services. These aggregate measures of cost and payment also include the cost and payment for drugs and biologicals and other adjustments that we typically include in our regression modeling, including wage index adjustment and rural adjustment, if applicable. While this cost report data cannot provide an estimate of cost per unit after controlling for other potential factors that could influence cost per unit, we can use this aggregate cost and payment data to examine the cancer hospitals' OPPS PCR and OPPS PCR with TOPs, and compare these to the OPPS PCR for other hospitals.

PCRs calculated from the most recent cost report data also indicate that costs relative to payments at cancer hospitals are higher than those at other hospitals paid under the OPPS (that is, cancer hospitals have lower PCRs). In order to calculate PCRs for hospitals paid under the OPPS (including cancer hospitals), we used the same extract of cost report data from the Hospital Cost Report Information System (HCRIS), as discussed in section II.A. of this proposed rule, that we used to calculate the CCRs that we used to estimate median costs for this proposed CY 2011 OPPS. Using this cost report data, we included data from Worksheet E Part B for each hospital, keeping data from each hospital's most recent cost report, whether as submitted or settled. We then limited the data set to the hospitals with CY 2009 claims data that we used to model the CY 2011 proposed APC relative weights (3933 hospitals) because we used the claims from these hospitals to calculate the estimated costs we used for the descriptive statistics in our first analysis and because it is appropriate to use the same set of hospitals that we are using to calibrate the modeled proposed CY 2011 OPPS. The cancer hospitals in this data set largely had cost report data from cost reporting periods ending in FY 2008 and FY 2009. The cost report data for the other hospitals were from cost report periods with fiscal year ends ranging from 2005 to 2009. We then removed the cost report data for 48 hospitals from Puerto Rico from our data set because we do not believe that their cost structure reflects the costs of most hospitals paid under the OPPS and therefore may bias the results of the study. We also removed 301 hospitals with cost report data that was not complete (missing OPPS payments including outliers, missing aggregate cost data, or both) so that all cost reports in the study would have both the payment and cost data necessary to calculate a PCR for each hospital, leading to a final analytic file of 3584 hospitals with cost report data. We believe that the costs, PPS payments, and TOPs reported on Worksheet E part B for the hospitals included in our CY 2011 modeling should be sufficiently accurate for assessing hospitals' relative costliness because all of the key elements that we believe to be necessary for the analysis (payment, cost and TOPs) are contained on this worksheet.

Using this much smaller dataset of cost report data, we estimate that on average, the OPPS payments to the 11 cancer hospitals, not including TOPs, are approximately 62 percent of reasonable cost (that is, we calculate a PCR of 0.615 for the cancer hospitals), whereas, we estimate that, on average, the OPPS payments to other hospitals paid under the OPPS are approximately 87 percent of reasonable cost (resulting in a PCR of 0.868). Individual cancer hospitals' OPPS PCRs range from approximately 48 percent to approximately 82 percent. When TOPS are included in the calculation of the PCR, cancer hospitals, as a group, receive payments that are approximately 83 percent of reasonable cost, which is still lower than the average PCR of other OPPS hospitals of approximately 87 percent of reasonable cost. Considering this data, we find that the cancer hospitals are more costly than other hospitals paid under the OPPS. The dataset of hospital cost report data that we used to model this proposed adjustment is available under supporting documentation for this proposed rule on the CMS Web site at: *http://www.cms.gov/HospitalOutpatientPPS/HORD/.*

Based on our findings that cancer hospitals, as a class, have a significantly lower volume weighted average PCR than the volume weighted PCR of other hospitals paid under the OPPS and our findings above that the cancer hospitals cost per discounted unit standardized for service mix remains much higher than the standardized cost per discounted unit of all other hospitals, we are proposing an adjustment for cancer hospitals to reflect these higher costs effective January 1, 2011, as mandated by section 3138 of the Affordable Care Act. For purposes of calculating a proposed adjustment, we chose to rely on this straightforward assessment of payments and costs from the cost report data because of the concerns outlined above with respect to the small number of hospitals, and because of the challenges associated with accurately including drug and biological costs in our standard regression models. We believe that an appropriate adjustment would redistribute enough payments from other hospitals paid under the OPPS to the cancer hospitals to give cancer hospitals a PCR that is comparable to the average PCR for other hospitals paid under the OPPS. Therefore, we propose a hospital-specific payment adjustment determined as the percentage of additional payment needed to raise each cancer hospital's PCR to the weighted average PCR for all other hospitals paid under OPPS (0.868) in the CY 2011 dataset. This would be accomplished by adjusting each cancer hospital's OPPS payment by the percentage difference

between their individual PCR (without TOPs) and the weighted average PCR of the other hospitals paid under OPPS.

This proposed methodology would result in the proposed percentage payment adjustments for the 11 cancer hospitals appearing in Table 11. We propose that this hospital-specific adjustment would be applied to the wage adjusted payments for all items, except for items and services paid at charges adjusted to cost or devices receiving pass-through status defined in 42 CFR 419.66. The proposed cancer hospital adjustment would not be applied to items and services paid at charges adjusted to cost because these items and services are always paid the estimated full cost of the item or service. We are proposing to amend 42 CFR to add new section 419.43(i)(2) which would establish the amount of the adjustment to cancer hospitals. We also propose that this adjustment would be budget neutral as set forth in proposed new section 42 CFR 419.43(i)(3), consistent with section 3138 of the Affordable Care Act. We note that outlier payments would be appropriately assessed after application of the cancer adjustment and that TOPs would continue to apply. The changes made by section 3138 of the Affordable Care Act do not affect the existing statutory provisions that provide for outlier payment for all hospitals paid under the OPPS, including cancer hospitals and TOPs payments for cancer hospitals. Further, both outlier payments and TOPs serve as a safety net for hospitals, although outliers are budget neutral and TOPs are not, and TOPs are limited to certain hospitals. As a means of buffering the financial risk associated with a prospective payment system, both adjustments (outliers and TOPs) only should be assessed after final payments have been made. Because outlier payments are made within the budget neutrality, outlier payments should be assessed after all budget neutral payments for an individual service have been made, including the cancer adjustment. The TOPs payments would be assessed after all payments have been made for a cost reporting period. We note that the proposed adjustment for all cancer hospitals would result in an estimated aggregate increase in OPPS payments to cancer hospitals of 41.2 percent for CY 2011, based on cost report data.

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TABLE 11. – PROPOSED HOSPITAL-SPECIFIC ADJUSTMENT FOR CANCER HOSPITALS WITHOUT REGARD TO TOPs AND OUTLIER PAYMENTS

Provider Number	Hospital	Percent of Increase Without TOPs or Outlier Payment
050146	CITY OF HOPE HELFORD CLIN RESEARCH HOSP	5.9%
050660	USC KENNETH NORRIS JR CANCER HOSPITAL	11.5%
390196	HOSP OF THE FOX CHASE CANCER CENTER	13.6%
360242	JAMES CANCER HOSPITAL & SOLOVE RESEARCH INSTITUTE	15.7%
330354	ROSWELL PARK CANCER INSTITUTE	16.3%
100079	UNIV OF MIAMI HOSP & CLINIC	21.5%
100271	H LEE MOFFITT CANCER CENTER & RESEARCH INSTITUTE	29.4%
330154	MEM HOSP FOR CANCER AND ALLIED DISEASES	36.4%
220162	DANA-FARBER CANCER INSTITUTE	42.2%
500138	SEATTLE CANCER CARE ALLIANCE	47.6%
450076	UNIV OF TEXAS M D ANDERSON CANCER CENTER	82.6%
Proposed Aggregate Adjustment		41.2%

We propose to recalibrate the "other hospital" PCR target amount and the hospital-specific percentage adjustment for each cancer hospital periodically, but not every year, because we do not believe that these amounts will change

so drastically in any given year to warrant annual recalculation. In the event that a cancer hospital has a PCR that is higher than the volume weighted average PCR for all hospitals, we propose that the specific hospital would not be eligible for this adjustment. We believe that this would indicate that the hospital's costs do not exceed the costs incurred by other hospitals furnishing services under the OPPS and, therefore, an adjustment would not be required and would be unnecessary. We note that the TOPS provision remains in effect and that we will continue to make TOPS to cancer hospitals that continue to have all final OPPS payments (including but not limited to outlier payments, the wage adjustment, and this new cancer hospital adjustment), that are lower than their pre-BBA payment amount. If this proposed adjustment is finalized, we estimate that only one cancer hospital would continue to receive TOPS. We propose to update the hospital-specific cancer hospital payment adjustments in Table 11 using the more recent cost reports that become available for the CY 2011 OPPS/ASC final rule with comment period.

G. Proposed Hospital Outpatient Outlier Payments

1. Background

Currently, the OPPS pays outlier payments on a service-by-service basis. For CY 2010, the outlier threshold is met when the cost of furnishing a service or procedure by a hospital exceeds 1.75 times the APC payment amount and exceeds the APC payment rate plus a $2,175 fixed-dollar threshold. We introduced a fixed-dollar threshold in CY 2005 in addition to the traditional multiple threshold in order to better target outliers to those high cost and complex procedures where a very costly service could present a hospital with significant financial loss. If the cost of a service meets both of these conditions, the multiple threshold and the fixed-dollar threshold, the outlier payment is calculated as 50 percent of the amount by which the cost of furnishing the service exceeds 1.75 times the APC payment rate. Before CY 2009, this outlier payment had historically been considered a final payment by longstanding OPPS policy. We implemented a reconciliation process similar to the IPPS outlier reconciliation process for cost reports with cost reporting periods beginning on or after January 1, 2009 (73 FR 68594 through 68599).

It has been our policy for the past several years to report the actual amount of outlier payments as a percent of total spending in the claims being used to model the proposed OPPS. Our current estimate of total outlier payments as a percent of total CY 2009 OPPS payment, using available CY 2009 claims and the revised OPPS expenditure estimate for the President's Budget for FY 2011, is approximately 1.0 percent of the total aggregated OPPS payments. Therefore, for CY 2009, we estimate that we paid at the CY 2009 outlier target of 1.0 percent of total aggregated OPPS payments.

As explained in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60426 through 60427), we set our projected target for aggregate outlier payments at 1.0 percent of the aggregate total payments under the OPPS for CY 2010. The outlier thresholds were set so that estimated CY 2010 aggregate outlier payments would equal 1.0 percent of the total aggregated payments under the OPPS. Using CY 2009 claims data and CY 2010 payment rates, we currently estimate that the aggregate outlier payments for CY 2010 would be approximately 0.85 percent of the total CY 2010 OPPS payments. The difference between 1.0 percent and 0.85 percent is reflected in the regulatory impact analysis in section XXIII. of this proposed rule. We note that we provide estimated CY 2011 outlier payments for hospitals and CMHCs with claims included in the claims data that we used to model impacts in the Hospital-Specific Impacts—Provider-Specific Data file on the CMS Web site at: *http://www.cms.hhs.gov/HospitalOutpatientPPS/*.

2. Proposed Outlier Calculation

For CY 2011, we are proposing to continue our policy of estimating outlier payments to be 1.0 percent of the estimated aggregate total payments under the OPPS for outlier payments. We are proposing that a portion of that 1.0 percent, specifically 0.04 percent, would be allocated to CMHCs for PHP outlier payments. This is the amount of estimated outlier payments that would result from the proposed CMHC outlier threshold as a proportion of total estimated outlier payments. As discussed in section X.D. of this proposed rule, for CMHCs, we are proposing to continue a policy, that if a CMHC's cost for partial hospitalization services, paid under either APC 0172 (Level I Partial Hospitalization (3 services)) or APC 0173 (Level II Partial Hospitalization (4 or more services)), exceeds 3.40 times the payment for APC 0173, the outlier payment would be calculated as 50 percent of the amount by which the cost exceeds 3.40 times the APC 0173 payment rate. For further discussion of CMHC outlier payments, we refer readers to section X.D. of this proposed rule.

To ensure that the estimated CY 2011 aggregate outlier payments would equal 1.0 percent of estimated aggregate total payments under the OPPS, we are proposing that the hospital outlier threshold be set so that outlier payments would be triggered when the cost of furnishing a service or procedure by a hospital exceeds 1.75 times the APC payment amount and exceeds the APC payment rate plus a $2,025 fixed-dollar threshold. This proposed threshold reflects the methodology discussed below in this section, as well as the proposed APC recalibration for CY 2011.

We calculated the proposed fixed-dollar threshold for this proposed rule using largely the same methodology as we did in CY 2009 (73 FR 41462). For purposes of estimating outlier payments for this proposed rule, we used the hospital-specific overall ancillary CCRs available in the April 2010 update to the Outpatient Provider-Specific File (OPSF). The OPSF contains provider-specific data, such as the most current CCR, which are maintained by the Medicare contractors and used by the OPPS Pricer to pay claims. The claims that we use to model each OPPS update lag by 2 years. For this proposed rule, we used CY 2009 claims to model the CY 2011 OPPS. In order to estimate the proposed CY 2011 hospital outlier payments for this proposed rule, we inflated the charges on the CY 2009 claims using the same inflation factor of 1.1059 that we used to estimate the IPPS fixed-dollar outlier threshold for the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24068). We used an inflation factor of 1.0516 to estimate CY 2010 charges from the CY 2009 charges reported on CY 2009 claims. The methodology for determining this charge inflation factor was discussed in the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24068). As we stated in the CY 2005 OPPS final rule with comment period (69 FR 65845), we believe that the use of this charge inflation factor is appropriate for the OPPS because, with the exception of the inpatient routine service cost centers, hospitals use the same ancillary and outpatient cost centers to capture costs and charges for inpatient and outpatient services.

As noted in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68011), we are concerned that we could systematically overestimate the OPPS hospital outlier threshold if we did not apply a CCR inflation adjustment factor. Therefore, we are proposing to apply the same CCR inflation adjustment factor

that we proposed to apply for the FY 2011 IPPS outlier calculation to the CCRs used to simulate the proposed CY 2011 OPPS outlier payments that determine the fixed-dollar threshold. Specifically, for CY 2011, we are proposing to apply an adjustment of 0.9890 to the CCRs that were in the April 2010 OPSF to trend them forward from CY 2010 to CY 2011. The methodology for calculating this adjustment is discussed in the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24068 through 24070).

Therefore, to model hospital outlier payments for this proposed rule, we applied the overall CCRs from the April 2010 OPSF file after adjustment (using the proposed CCR inflation adjustment factor of 0.9890 to approximate CY 2011 CCRs) to charges on CY 2009 claims that were adjusted (using the proposed charge inflation factor of 1.1059 to approximate CY 2011 charges). We simulated aggregated CY 2011 hospital outlier payments using these costs for several different fixed-dollar thresholds, holding the 1.75 multiple threshold constant and assuming that outlier payment would continue to be made at 50 percent of the amount by which the cost of furnishing the service would exceed 1.75 times the APC payment amount, until the total outlier payments equaled 1.0 percent of aggregated estimated total CY 2011 OPPS payments. We estimated that a proposed fixed-dollar threshold of $2,025, combined with the proposed multiple threshold of 1.75 times the APC payment rate, would allocate 1.0 percent of aggregated total OPPS payments to outlier payments. We are proposing to continue to make an outlier payment that equals 50 percent of the amount by which the cost of furnishing the service exceeds 1.75 times the APC payment amount when both the 1.75 multiple threshold and the proposed fixed-dollar $2,025 threshold are met. For CMHCs, if a CMHC's cost for partial hospitalization services, paid under either APC 0172 or APC 0173, exceeds 3.40 times the payment for APC 0173, the outlier payment would be calculated as 50 percent of the amount by which the cost exceeds 3.40 times the APC 0173 payment rate.

Section 1833(t)(17)(A) of the Act, which applies to hospitals as defined under section 1886(d)(1)(B) of the Act, requires that hospitals that fail to report data required for the quality measures selected by the Secretary, in the form and manner required by the Secretary under 1833(t)(17)(B) of the Act, incur a 2.0 percentage point reduction to their OPD fee schedule increase factor, that is, the annual payment update factor. The application of a reduced OPD fee schedule increase factor results in reduced national unadjusted payment rates that will apply to certain outpatient items and services furnished by hospitals that are required to report outpatient quality data and that fail to meet the HOP QDRP requirements. For hospitals that fail to meet the HOP QDRP requirements, we are proposing to continue our policy that we implemented in CY 2009 that the hospitals' costs would be compared to the reduced payments for purposes of outlier eligibility and payment calculation. For more information on the HOP QDRP, we refer readers to section XVI. of this proposed rule.

In the CY 2009 OPPS/ASC final rule with comment period (73 CFR 68599), we adopted as final policy a process to reconcile hospital or CMHC outlier payments at cost report settlement for services furnished during cost reporting periods beginning in CY 2009. OPPS outlier reconciliation ensures accurate outlier payments for those facilities whose CCRs fluctuate significantly relative to the CCRs of other facilities, and who receive a significant amount of outlier payments. As under the IPPS, we do not adjust the fixed-dollar threshold or amount of total OPPS payment set aside for outlier payments for reconciliation activity because such action would be contrary to the prospective nature of the system. Our outlier threshold calculation assumes that overall ancillary CCRs accurately estimate hospital costs based on the information available to us at the time we set the prospective fixed-dollar outlier threshold. For these reasons, we are not incorporating any assumptions about the effects of reconciliation into our calculation of the proposed OPPS fixed-dollar outlier threshold.

H. Proposed Calculation of an Adjusted Medicare Payment From the National Unadjusted Medicare Payment

The basic methodology for determining prospective payment rates for HOPD services under the OPPS is set forth in existing regulations at 42 CFR part 419, subparts C and D. The payment rate for most services and procedures for which payment is made under the OPPS is the product of the conversion factor calculated in accordance with section II.B. of this proposed rule and the relative weight determined under section II.A. of this proposed rule. Therefore, the proposed national unadjusted payment rate for most APCs contained in Addendum A to this proposed rule and for most HCPCS codes to which separate payment under the OPPS has been assigned in Addendum B to this proposed rule was calculated by multiplying the proposed CY 2011 scaled weight for the APC by the proposed CY 2011 conversion factor.

We note that section 1833(t)(17) of the Act, which applies to hospitals as defined under section 1886(d)(1)(B) of the Act, requires that hospitals that fail to submit data required to be submitted on quality measures selected by the Secretary, in the form and manner and at a time specified by the Secretary, incur a 2.0 percentage point reduction to their OPD fee schedule increase factor, that is, the annual payment update factor. The application of a reduced OPD fee schedule increase factor results in reduced national unadjusted payment rates that apply to certain outpatient items and services provided by hospitals that are required to report outpatient quality data and that fail to meet the Hospital Outpatient Quality Data Reporting Program (HOP QDRP) requirements. For further discussion of the payment reduction for hospitals that fail to meet the requirements of the HOP QDRP, we refer readers to section XVII.D. of this proposed rule.

We demonstrate in the steps below how to determine the APC payments that would be made in a calendar year under the OPPS to a hospital that fulfills the HOP QDRP requirements and to a hospital that fails to meet the HOP QDRP requirements for a service that has any of the following status indicator assignments: "P," "Q1," "Q2," "Q3," "R," "S," "T," "U," "V," or "X" (as defined in Addendum D1 to this proposed rule), in a circumstance in which the multiple procedure discount does not apply, the procedure is not bilateral, and conditionally packaged services (status indicator of "Q1" and "Q2") qualify for separate payment. We note that although blood and blood products with status indicator "R" and brachytherapy sources with status indicator "U" are not subject to wage adjustment, they are subject to reduced payments when a hospital fails to meet the HOP QDRP requirements because the national unadjusted payment rates for these services are updated by the OPD fee schedule increase factor.

Individual providers interested in calculating the payment amount that they would receive for a specific service from the national unadjusted payment rates presented in Addenda A and B to this proposed rule should follow the formulas presented in the following steps. For purposes of the payment calculations below, we refer to the national unadjusted payment rate for hospitals that meet the requirements of

the HOP QDRP as the "full" national unadjusted payment rate. We refer to the national unadjusted payment rate for hospitals that fail to meet the requirements of the HOP QDRP as the "reduced" national unadjusted payment rate. The reduced national unadjusted payment rate is calculated by multiplying the reporting ratio of 0.980 times the "full" national unadjusted payment rate. The national unadjusted payment rate used in the calculations below is either the full national unadjusted payment rate or the reduced national unadjusted payment rate, depending on whether the hospital met its HOP QDRP requirements in order to receive the full CY 2011 OPPS increase factor.

Step 1. Calculate 60 percent (the labor-related portion) of the proposed national unadjusted payment rate. Since the initial implementation of the OPPS, we have used 60 percent to represent our estimate of that portion of costs attributable, on average, to labor. We refer readers to the April 7, 2000 OPPS final rule with comment period (65 FR 18496 through 18497) for a detailed discussion of how we derived this percentage. We confirmed that this labor-related share for hospital outpatient services is still appropriate during our regression analysis for the payment adjustment for rural hospitals in the CY 2006 OPPS final rule with comment period (70 FR 68553).

The formula below is a mathematical representation of Step 1 and identifies the labor-related portion of a specific payment rate for a specific service.

X is the labor-related portion of the national unadjusted payment rate.

X = .60 * (national unadjusted payment rate)

Step 2. Determine the wage index area in which the hospital is located and identify the wage index level that applies to the specific hospital. The wage index values assigned to each area reflect the geographic statistical areas (which are based upon OMB standards) to which hospitals are assigned for FY 2011 under the IPPS, reclassifications through the MGCRB, section 1886(d)(8)(B) "Lugar" hospitals, reclassifications under section 1886(d)(8)(E) of the Act, as defined in § 412.103 of the regulations, and hospitals designated as urban under section 601(g) of Public Law 98–21. We note that the reclassifications of hospitals under section 508 of Public Law 108–173, as extended by section 3137 of the Affordable Care Act, expires on September 30, 2010, and, therefore, are not applicable under the IPPS for FY 2011. Therefore, these reclassifications will not apply to the CY 2011 OPPS. (For further discussion of the changes to the FY 2011 IPPS wage indices, as applied to the CY 2011 OPPS, we refer readers to section II.C. of this proposed rule.) In section II.C. of this proposed rule, we also discuss our proposal to implement section 10324 of the Affordable Care Act, which establishes a wage index floor of 1.00 for frontier States, effective for services furnished on and after January 1, 2011.

Step 3. Adjust the wage index of hospitals located in certain qualifying counties that have a relatively high percentage of hospital employees who reside in the county, but who work in a different county with a higher wage index, in accordance with section 505 of Public Law 108–173. Addendum L to this proposed rule contains the qualifying counties and the associated proposed wage index increase developed for the FY 2011 IPPS and published as Table 4J in the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24182). This step is to be followed only if the hospital is not reclassified or redesignated under section 1886(d)(8) or section 1886(d)(10) of the Act.

Step 4. Multiply the applicable wage index determined under Steps 2 and 3 by the amount determined under Step 1 that represents the labor-related portion of the national unadjusted payment rate.

The formula below is a mathematical representation of Step 4 and adjusts the labor-related portion of the national payment rate for the specific service by the wage index.

X_a is the labor-related portion of the national unadjusted payment rate (wage adjusted).

X_a = .60 * (national unadjusted payment rate) * applicable wage index.

Step 5. Calculate 40 percent (the nonlabor-related portion) of the proposed national unadjusted payment rate and add that amount to the resulting product of Step 4. The result is the wage index adjusted payment rate for the relevant wage index area.

The formula below is a mathematical representation of Step 5 and calculates the remaining portion of the national payment rate, the amount not attributable to labor, and the adjusted payment for the specific service.

Y is the nonlabor-related portion of the national unadjusted payment rate.

Y = .40 * (national unadjusted payment rate)

Adjusted Medicare Payment = $Y + X_a$

Step 6. If a provider is a SCH, set forth in the regulations at § 412.92, or an EACH, which is considered to be a SCH under section 1886(d)(5)(D)(iii)(III) of the Act, and located in a rural area, as defined in § 412.64(b), or is treated as being located in a rural area under § 412.103, multiply the wage index adjusted payment rate by 1.071 to calculate the total payment.

The formula below is a mathematical representation of Step 6 and applies the rural adjustment for rural SCHs.

Adjusted Medicare Payment (SCH or EACH) = Adjusted Medicare Payment * 1.071

We have provided examples below of the calculation of both the proposed full and reduced national unadjusted payment rates that would apply to certain outpatient items and services performed by hospitals that meet and that fail to meet the HOP QDRP requirements, using the steps outlined above. For purposes of this example, we use a provider that is located in Brooklyn, New York that is assigned to CBSA 35644. This provider bills one service that is assigned to APC 0019 (Level I Excision/Biopsy). The proposed CY 2011 full national unadjusted payment rate for APC 0019 is $335.76. The proposed reduced national unadjusted payment rate for a hospital that fails to meet the HOP QDRP requirements is $329.04. This reduced rate is calculated by multiplying the reporting ratio of 0.980 by the full unadjusted payment rate for APC 0019.

The proposed FY 2011 wage index for a provider located in CBSA 35644 in New York is 1.3154. The proposed labor-related portion of the full national unadjusted payment is $264.99 (.60 * $335.76 * 1.3154). The proposed labor-related portion of the reduced national unadjusted payment is $259.69 (.60 * $329.04 * 1.3154). The proposed nonlabor-related portion of the full national unadjusted payment is $134.30 (.40 * $335.76). The proposed nonlabor-related portion of the reduced national unadjusted payment is $131.62 (.40 * $329.04). The sum of the labor-related and nonlabor-related portions of the full national adjusted payment is $399.29 ($264.99 + $134.30). The sum of the reduced national adjusted payment is $391.31 ($259.69 + $131.62).

I. Proposed Beneficiary Copayments

1. Background

Section 1833(t)(3)(B) of the Act requires the Secretary to set rules for determining the unadjusted copayment amounts to be paid by beneficiaries for covered OPD services. Section 1833(t)(8)(C)(ii) of the Act specifies that the Secretary must reduce the national unadjusted copayment amount for a covered OPD service (or group of such services) furnished in a year in a manner so that the effective copayment

rate (determined on a national unadjusted basis) for that service in the year does not exceed a specified percentage. As specified in section 1833(t)(8)(C)(ii)(V) of the Act, for all services paid under the OPPS in CY 2010, and in calendar years thereafter, the percentage is 40 percent of the APC payment rate.

Section 1833(t)(3)(B)(ii) of the Act provides that, for a covered OPD service (or group of such services) furnished in a year, the national unadjusted copayment amount cannot be less than 20 percent of the OPD fee schedule amount. Until CY 2011, sections 1834(d)(2)(C)(ii) and 1834(d)(3)(C)(ii) of the Act further require that the copayment for screening flexible sigmoidoscopies and screening colonoscopies be equal to 25 percent of the payment amount. Since the beginning of the OPPS, we have applied the 25 percent copayment to screening flexible sigmoidoscopies and screening colonoscopies. However, section 4104 of the Affordable Care Act eliminated the coinsurance (to which section 1833(t)(2)(B) refers as the "copayment") for preventive services that meet certain requirements, including flexible sigmoidoscopies and screening colonscopies, and waived the Part B deductible for screening colonoscopies that become diagnostic during the procedure. We discuss our proposal to implement this provision in section XII.B. of this proposed rule.

2. Proposed OPPS Copayment Policy

For CY 2011, we are proposing to determine copayment amounts for new and revised APCs using the same methodology that we implemented beginning in CY 2004. (We refer readers to the November 7, 2003 OPPS final rule with comment period (68 FR 63458).) In addition, we are proposing to use the same standard rounding principles that we have historically used in instances where the application of our standard copayment methodology would result in a copayment amount that is less than 20 percent and cannot be rounded, under standard rounding principles, to 20 percent. (We refer readers to the CY 2008 OPPS/ASC final rule with comment period (72 FR 66687) in which we discuss our rationale for applying these rounding principles.) The national unadjusted copayment amounts for services payable under the OPPS that would be effective January 1, 2011, are shown in Addenda A and B to this proposed rule. As discussed in section XVI.D. of this proposed rule, for CY 2011, the Medicare beneficiary's minimum unadjusted copayment and national unadjusted copayment for a service to which a reduced national unadjusted payment rate applies would equal the product of the reporting ratio and the national unadjusted copayment, or the product of the reporting ratio and the minimum unadjusted copayment, respectively, for the service.

3. Proposed Calculation of an Adjusted Copayment Amount for an APC Group

Individuals interested in calculating the national copayment liability for a Medicare beneficiary for a given service provided by a hospital that met or failed to meet its HOP QDRP requirements should follow the formulas presented in the following steps.

Step 1. Calculate the beneficiary payment percentage for the APC by dividing the APC's national unadjusted copayment by its payment rate. For example, using APC 0019, $67.16 is 20 percent of the full national unadjusted payment rate of $335.76. For APCs with only a minimum unadjusted copayment in Addendum A and B of this proposed rule, the beneficiary payment percentage is 20 percent.

The formula below is a mathematical representation of Step 1 and calculates national copayment as a percentage of national payment for a given service.

B is the beneficiary payment percentage.

B = National unadjusted copayment for APC/national unadjusted payment rate for APC

Step 2. Calculate the appropriate wage-adjusted payment rate for the APC for the provider in question, as indicated in Steps 2 through 4 under section II.H. of this proposed rule. Calculate the rural adjustment for eligible providers as indicated in Step 6 under section II.H. of this proposed rule.

Step 3. Multiply the percentage calculated in Step 1 by the payment rate calculated in Step 2. The result is the wage-adjusted copayment amount for the APC.

The formula below is a mathematical representation of Step 3 and applies the beneficiary percentage to the adjusted payment rate for a service calculated under section II.H. of this proposed rule, with and without the rural adjustment, to calculate the adjusted beneficiary copayment for a given service.

Wage-adjusted copayment amount for the APC = Adjusted Medicare Payment * B

Wage-adjusted copayment amount for the APC (SCH or EACH) = (Adjusted Medicare Payment * 1.071) * B

Step 4. For a hospital that failed to meet its HOP QDRP requirements, multiply the copayment calculated in Step 3 by the reporting ratio of 0.980.

The proposed unadjusted copayments for services payable under the OPPS that would be effective January 1, 2011, are shown in Addenda A and B to this proposed rule. We note that the national unadjusted payment rates and copayment rates shown in Addenda A and B to this proposed rule reflect the full market basket conversion factor increase, as discussed in section XVI.D. of this proposed rule.

III. Proposed OPPS Ambulatory Payment Classification (APC) Group Policies

A. Proposed OPPS Treatment of New HCPCS and CPT Codes

CPT and Level II HCPCS codes are used to report procedures, services, items, and supplies under the hospital OPPS. Specifically, CMS recognizes the following codes on OPPS claims: (1) Category I CPT codes, which describe medical services and procedures; (2) Category III CPT codes, which describe new and emerging technologies, services, and procedures; and (3) Level II HCPCS codes, which are used primarily to identify products, supplies, temporary procedures, and services not described by CPT codes. CPT codes are established by the American Medical Association (AMA) and the Level II HCPCS codes are established by the CMS HCPCS Workgroup. These codes are updated and changed throughout the year. CPT and HCPCS code changes that affect the OPPS are published both through the annual rulemaking cycle and through the OPPS quarterly update Change Requests (CRs). CMS releases new Level II HCPCS codes to the public or recognizes the release of new CPT codes by the AMA and makes these codes effective (that is, the codes can be reported on Medicare claims) outside of the formal rulemaking process via OPPS quarterly update CRs. This quarterly process offers hospitals access to codes that may more accurately describe items or services furnished and/or provides payment or more accurate payment for these items or services in a timelier manner than if CMS waited for the annual rulemaking process. We solicit comments on these new codes and finalize our proposals related to these codes through our annual rulemaking process. In Table 12 below, we summarize our proposed process for updating codes through our OPPS quarterly update CRs, seeking public comments, and finalizing their treatment under the OPPS.

TABLE 12.—COMMENT TIMEFRAME FOR NEW OR REVISED HCPCS CODES

OPPS Quarterly Update CR	Type of Code	Effective Date	Comments Sought	When Finalized
April 1, 2010	Level II HCPCS Codes	April 1, 2010	CY 2011 OPPS/ASC proposed rule	CY 2011 OPPS/ASC final rule with comment period
July 1, 2010	Level II HCPCS Codes	July 1, 2010	CY 2011 OPPS/ASC proposed rule	CY 2011 OPPS/ASC final rule with comment period
	Category I (certain vaccine codes) and III CPT codes	July 1, 2010	CY 2011 OPPS/ASC proposed rule	CY 2011 OPPS/ASC final rule with comment period
October 1, 2010	Level II HCPCS Codes	October 1, 2010	CY 2011 OPPS/ASC final rule with comment period	CY 2012 OPPS/ASC final rule with comment period
January 1, 2011	Level II HCPCS Codes	January 1, 2011	CY 2011 OPPS/ASC final rule with comment period	CY 2012 OPPS/ASC final rule with comment period
	Category I and III CPT Codes	January 1, 2011	CY 2011 OPPS/ASC final rule with comment period	CY 2012 OPPS/ASC final rule with comment period

This process is discussed in detail below and we have separated our discussion into two sections based on whether we are proposing to solicit public comments in this CY 2011 OPPS/ASC proposed rule on a specific group of the CPT and Level II HCPCS codes or whether we are proposing to solicit public comments on another specific group of the codes in the CY 2011 OPPS/ASC final rule with comment period. We note that we sought public comments in the CY 2010 OPPS/ASC final rule with comment period on the new CPT and Level II HCPCS codes that were effective January 1, 2010. We also sought public comments in the CY 2010 OPPS/ASC final rule with comment period on the new Level II HCPCS codes effective October 1, 2009. These new codes with an effective date of October 1, 2009, or January 1, 2010, were flagged with comment indicator "NI" (New code, interim APC assignment; comments will be accepted on the interim APC assignment for the new code) in Addendum B to the CY 2010 OPPS/ASC final rule with comment period to indicate that we were assigning them an interim payment status and an APC and payment rate, if applicable, which were subject to public comment following publication of the CY 2010 OPPS/ASC final rule with comment period. We will respond to public comments and finalize our proposed OPPS treatment of these codes in the CY 2011 OPPS/ASC final rule with comment period.

1. Proposed Treatment of New Level II HCPCS Codes and Category I CPT Vaccine Codes and Category III CPT Codes for Which We Are Soliciting Public Comments in This Proposed Rule

Effective April 1 and July 1 of CY 2010, we make effective a total of 22 new Level II HCPCS codes, 4 new Category I CPT vaccine codes, and 11 new Category III CPT codes that were not addressed in the CY 2010 OPPS/ASC final rule with comment period that updated the OPPS. Twenty-two new Level II HCPCS codes are effective for the April and July 2010 updates, and of the 22 new HCPCS codes, a total of 14 Level II HCPCS codes are newly recognized for separate payment under the OPPS.

Through the April 2010 OPPS quarterly update CR (Transmittal 1924, Change Request 6857, dated February 26, 2010), we allowed separate payment for a total of six of the 22 Level II HCPCS codes. Specifically, as displayed in Table 13 below, these included HCPCS code C9258 (Injection, telavancin, 10 mg), C9259 (Injection, pralatrexate, 1 mg), C9260 (Injection, ofatumumab, 10 mg), C9261 (Injection, ustekinumab, 1 mg), C9262 (Fludarabine phosphate, oral, 1 mg), and C9263 (Injection, ecallantide, 1 mg).

In addition to the six HCPCS C-codes, five new HCPCS G-codes were made effective on April 1, 2010. We did not recognize the five new HCPCS G-codes for separate payment under the OPPS because they were either paid under another Medicare payment system or were noncovered services under Medicare. Specifically, we assigned HCPCS G0432 (Infectious agent antigen detection by enzyme immunoassay (EIA) technique, qualitative or semi-quantitative, multiple-step method, HIV–1 or HIV–2, screening), G0433 (Infectious agent antigen detection by enzyme-linked immunosorbent assay

(ELISA) technique, antibody, HIV–1 or HIV–2, screening), G0435 (Infectious agent antigen detection by rapid antibody test of oral mucosa transudate, HIV–1 or HIV–2, screening), and G9143 (Warfarin responsiveness testing by genetic technique using any method, any number of specimen(s)), to status indicator "A" (Not paid under OPPS. Paid by fiscal intermediaries/MACs under a fee schedule or payment system other than OPPS) to indicate that these services are paid under the Medicare Clinical Laboratory Fee Schedule (CLFS). Further, we did not recognize for separate payment HCPCS G9147 (Outpatient Intravenous Insulin Treatment (OIVIT) and assigned it to status indicator "E" (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)) because this service is nationally a noncovered service under Medicare.

TABLE 13.—LEVEL II HCPCS CODES WITH A CHANGE IN OPPS STATUS INDICATOR OR NEWLY IMPLEMENTED IN APRIL 2010

CY 2010 HCPCS Code	CY 2010 Long Descriptor	Proposed CY 2011 Status Indicator	Proposed CY 2011 APC
C9258	Injection, telavancin, 10 mg	G	9258
C9259	Injection, pralatrexate, 1 mg	G	9259
C9260	Injection, ofatumumab, 10 mg	G	9260
C9261	Injection, ustekinumab, 1 mg	G	9261
C9262*	Fludarabine phosphate, oral, 1 mg	G	9262
C9263	Injection, ecallantide, 1 mg	G	9263
G0432	Infectious agent antibody detection by enzyme immunoassay (EIA) technique, qualitative or semiquantitative, multiple-step method, HIV-1 or HIV-2, screening	A	NA
G0433	Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique, antibody, HIV-1 or HIV-2, screening	A	NA
G0435	Infectious agent detection by rapid antibody test of oral mucosa transudate, HIV-1 or HIV-2, screening	A	NA
G9143	Warfarin responsiveness testing by genetic technique using any method, any number of specimen(s)	A	NA
G9147	Outpatient Intravenous Insulin Treatment (OIVIT) either pulsatile or continuous, by any means, guided by the results of measurements for: respiratory quotient; and/or, urine urea nitrogen (UUN); and/or, arterial, venous or capillary glucose; and/or potassium concentration	E	NA

*Level II HCPCS code C9262 was deleted June 30, 2010, and replaced with HCPCS code Q2025 effective July 1, 2010.

Through the July 2010 OPPS quarterly update CR (Transmittal 1980, Change Request 6996, dated June 4, 2010), which included HCPCS codes that were made effective July 1, 2010, we allowed separate payment for 8 of the 22 new Level II HCPCS codes. Specifically, as displayed in Table 14, we provided separate payment for HCPCS codes C9264 (Injection, tocilizumab, 1 mg), C9265 (Injection, romidepsin, 1 mg), C9266 (Injection, collagenase clostridium histolyticum, 0.1 mg), C9267 (Injection, von Willebrand factor complex (human), Wilate, per 100 IU VWF: RCO), C9268 (Capsaicin, patch, 10cm2), C9367 (Skin substitute, Endoform Dermal Template, per square centimeter), Q2025 (Fludarabine phosphate oral, 10mg), and C9800 (Dermal injection procedure(s) for facial lipodystrophy syndrome (LDS) and provision of Radiesse or Sculptra dermal filler, including all items and supplies).

We note that HCPCS code C9262 was made effective April 1, 2010, and deleted June 30, 2010, when it was replaced with HCPCS code Q2025. As discussed in section V.A.3. of this proposed rule, pass-through status began for this drug on April 1, 2010. Because HCPCS code Q2025 describes the same drug as HCPCS code C9262, we are continuing its pass-through status and assigning the HCPCS Q-code to the same APC and status indicator as its predecessor HCPCS C-code, as shown in Table 14. Specifically, HCPCS code Q2025 is assigned to APC 9262 and status indicator "G."

Of the 12 HCPCS codes that were made effective July 1, 2010, we did not recognize for separate payment four HCPCS codes. Specifically, we did not recognize HCPCS codes G0428 (Collagen Meniscus Implant procedure for filling meniscal defects (*e.g.,* CMI, collagen scaffold, Menaflex)), G0429 (Dermal filler injection(s) for the treatment of facial lipodystrophy syndrome (LDS) (*e.g.,* as a result of highly active antiretroviral therapy), Q2026 (Injection, Radiesse, 0.1 ml), and Q2027 (Injection, Sculptra, 0.1 ml). Under the hospital OPPS, we have assigned HCPCS code G0428 to status indicator "E" (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)) because this service is nationally noncovered by Medicare. Further, because HCPCS code C9800 describes both the injection procedure and the dermal filler supplies, we have assigned HCPCS codes G0429, Q2026, and Q2027 to status indicator "B" to indicate that these HCPCS codes are not recognized by OPPS when submitted on an outpatient hospital Part B bill type 12x and 13x. Specifically, hospitals must report HCPCS code C9800 to report the dermal filler supplies and the dermal filler injection procedure. Under the hospital OPPS, we have assigned HCPCS code C9800 to APC 0135 with a status indicator "T". We refer readers to Table 14 below for a complete list of the HCPCS codes that were made effective July 1, 2010.

TABLE 14.—NEW LEVEL II HCPCS CODES IMPLEMENTED IN JULY 2010

CY 2010 HCPCS Code	CY 2010 Long Descriptor	Proposed CY 2011 Status Indicator	Proposed CY 2011 APC	Proposed CY 2011 Payment Rate
C9264	Injection, tocilizumab, 1 mg	G	9264	$3.52
C9265	Injection, romidepsin, 1 mg	G	9265	$223.78
C9266	Injection, collagenase clostridium histolyticum, 0.1 mg	G	9266	$382.78
C9267	Injection, von Willebrand factor complex (human), Wilate, per 100 IU VWF: RCO	G	9267	$122.07
C9268	Capsaicin, patch, 10cm2	G	9268	$11.18
C9367	Skin substitute, Endoform Dermal Template, per square centimeter	G	9367	$4.35
C9800	Dermal injection procedure(s) for facial lipodystrophy syndrome (LDS) and provision of Radiesse or Sculptra dermal filler, including all items and supplies	T	0135	$298.46
G0428	Collagen Meniscus Implant procedure for filling meniscal defects (e.g., CMI, collagen scaffold, Menaflex)	E	NA	NA
G0429	Dermal Filler injection(s) for the treatment of facial lipodystrophy syndrome (LDS) (e.g., as a result of highly active antiretroviral therapy)	B	NA	NA
Q2025*	Fludarabine phosphate oral, 10mg	G	9262	$8.18
Q2026	Injection, Radiesse, 0.1 ml	B	NA	NA
Q2027	Injection, Sculptra, 0.1 ml	B	NA	NA

*Level II HCPCS code Q2025 was previously described under HCPCS code C9262.

For CY 2011, we are proposing to continue our established policy of recognizing Category I CPT vaccine codes for which FDA approval is imminent and Category III CPT codes that the AMA releases in January of each year for implementation in July through the OPPS quarterly update process. Under the OPPS, Category I vaccine codes and Category III CPT codes that are released on the AMA Web site in January are made effective in July of the same year through the July quarterly update CR, consistent with the AMA's implementation date for the codes. Through the July 2010 OPPS quarterly update CR, we allow separate payment for 10 of the 11 new Category III CPT codes effective July 1, 2010. Specifically, as displayed in Table 15 below, we allow separate payment for CPT codes 0223T (Acoustic cardiography, including automated analysis of combined acoustic and electrical intervals; single, with interpretation and report), 0224T (Multiple, including serial trended analysis and limited reprogramming of device parameter—AV or VV delays only, with interpretation and report), 0225T (Multiple, including serial trended analysis and limited reprogramming of device parameter—AV and VV delays, with interpretation and report), 0226T (Anoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); diagnostic, including collection of specimen(s) by brushing or washing when performed), 0227T (Anoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); with biopsy(ies)), 0228T (Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, cervical or thoracic; single level), 0229T (Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, cervical or thoracic; each additional level (List separately in addition to code for primary procedure)), 0230T (Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, lumbar or sacral; single level), 0231T (Injection(s),

anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, lumbar or sacral; each additional level (List separately in addition to code for primary procedure)), and 0232T (Injection(s), platelet rich plasma, any tissue, including image guidance, harvesting and preparation when performed). We note that CMS has issued a noncoverage determination (NCD) specifically for chronic, non-healing cutaneous wounds and acute surgical wounds when the autologous platelet rich plasma (PRP) is applied directly to the closed incision or for dehiscent wounds. Category III CPT code 0232T has been assigned to APC 0340 to provide a payment amount when payment is appropriate, both under the NCD provisions and any local coverage determinations. Under the hospital OPPS, Category III CPT code 0233T (Skin advanced glycation endproducts (AGE) measurement by multi-wavelength fluorescent spectroscopy) has been assigned to status indicator "A" and hospital payment for this test will be made under the MPFS.

Further, CMS does not recognize the four new H1N1 Category I CPT vaccine codes that are effective on July 1, 2010, for separate payment under the OPPS because we already recognize an existing HCPCS G-code for reporting the H1N1 vaccine, specifically HCPCS code G9142 (Influenza a (h1n1) vaccine, any route of administration), which is effective September 1, 2009. We have assigned HCPCS code G9142 to status indicator "E" under the OPPS because the vaccine is expected to be free. Consequently, Category I CPT vaccine codes 90664 (Influenza virus vaccine, pandemic formulation, live, for intranasal use), 90666 (Influenza virus vaccine, pandemic formulation, split virus, preservative free, for intramuscular use), 90667 (Influenza virus vaccine, pandemic formulation, split virus, adjuvanted, for intramuscular use), and 90668 (Influenza virus vaccine, pandemic formulation, split virus, for intramuscular use), are assigned to status indicator "E" (Not paid under OPPS or any other Medicare payment system). These codes and their status indicators are listed in Table 15 below.

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TABLE 15.—CATEGORY I VACCINE AND CATEGORY III CPT CODES IMPLEMENTED IN JULY 2010

CY 2010 CPT Code	CY 2010 Long Descriptor	Proposed CY 2011 Status Indicator	Proposed CY 2011 APC	Proposed CY 2011 Payment Rate
0223T	Acoustic cardiography, including automated analysis of combined acoustic and electrical intervals; single, with interpretation and report	S	0099	$26.49
0224T	Multiple, including serial trended analysis and limited reprogramming of device parameter - AV or VV delays only, with interpretation and report	S	0690	$23.57
0225T	Multiple, including serial trended analysis and limited reprogramming of device parameter - AV and VV delays, with interpretation and report	S	0690	$23.57
0226T	Anoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); diagnostic, including collection of specimen(s) by brushing or washing when performed	X	0340	$45.00
0227T	Anoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); with biopsy(ies)	T	0146	$388.30
0228T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, cervical or thoracic; single level	T	0207	$484.15
0229T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, cervical or thoracic; each additional level (List separately in addition to code for primary procedure)	T	0206	$250.28
0230T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, lumbar or sacral; single level	T	0207	$484.15
0231T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, lumbar or sacral; each additional level (List separately in addition to code for primary procedure)	T	0206	$250.28
0232T	Injection(s), platelet rich plasma, any tissue, including image guidance, harvesting and preparation when performed	X	0340	$45.00
0233T	Skin advanced glycation endproducts (AGE) measurement by multi-wavelength fluorescent spectroscopy	A	NA	NA
90664	Influenza virus vaccine, pandemic formulation, live, for intranasal use	E	NA	NA
90666	Influenza virus vaccine, pandemic formulation, split virus, preservative free, for intramuscular use	E	NA	NA
90667	Influenza virus vaccine, pandemic formulation, split virus, adjuvanted, for intramuscular use	E	NA	NA
90668	Influenza virus vaccine, pandemic formulation, split virus, for intramuscular use	E	NA	NA

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For CY 2011, we are soliciting public comments on the proposed status indicators and the proposed APC assignments and payment rates, if applicable, for the Level II HCPCS codes and the Category I vaccine codes and Category III CPT codes that are newly recognized in April or July 2010 through the respective OPPS quarterly update CRs. These codes are listed in Tables 13, 14, and 15 of this proposed rule. We are proposing to finalize their status indicators and their APC assignments and payment rates, if applicable, in the CY 2011 OPPS/ASC final rule with comment period. Because the July 2010 OPPS quarterly update CR is issued close to the publication of this proposed rule, the Level II HCPCS codes and the Category I vaccine and Category III CPT codes implemented through the July 2010 OPPS quarterly update CR could not be included in Addendum B to this proposed rule, but these codes are listed in Tables 14 and 15, respectively. We are proposing to incorporate them into Addendum B to the CY 2011 OPPS/ASC final rule with comment period, which is consistent with our annual OPPS update policy. The Level II HCPCS codes implemented or modified through the April 2010 OPPS update CR and displayed in Table 13 are included in Addendum B to this proposed rule, where their proposed CY 2011 payment rates also are shown.

2. Proposed Process for New Level II HCPCS Codes and Category I and Category III CPT Codes for Which We Will Be Soliciting Public Comments on the CY 2011 OPPS/ASC Final Rule With Comment Period

As has been our practice in the past, we incorporate those new Category I and III CPT codes and new Level II HCPCS codes that are effective January 1 in the final rule with comment period updating the OPPS for the following calendar year. These codes are released to the public via the CMS HCPCS (for Level II HCPCS codes) and AMA Web sites (for CPT codes), and also through the January OPPS quarterly update CRs. In the past, we also have released new Level II HCPCS codes that are effective October 1 through the October OPPS quarterly update CRs and incorporated these new codes in the final rule with comment period updating the OPPS for the following calendar year. All of these codes are flagged with comment indicator "NI" in Addendum B to the OPPS/ASC final rule with comment period to indicate that we are assigning them an interim payment status which is subject to public comment. Specifically, the status indicator and the APC assignment, and payment rate, if applicable, for all such codes flagged with comment indicator "NI" are open to public comment in the final rule with comment period, and we respond to these comments in the OPPS/ASC final rule with comment period for the next calendar year's OPPS/ASC update. We are proposing to continue this process for CY 2011. Specifically, for CY 2011, we are proposing to include in Addendum B to the CY 2011 OPPS/ASC final rule with comment period the new Category I and III CPT codes effective January 1, 2011 (including those Category I vaccine and Category III CPT codes that were released by the AMA in July 2010) that would be incorporated in the January 2011 OPPS quarterly update CR and the new Level II HCPCS codes, effective October 1, 2010, or January 1, 2011, that would be released by CMS in its October 2010 and January 2011 OPPS quarterly update CRs. These codes would be flagged with comment indicator "NI" in Addendum B to the CY 2011 OPPS/ASC final rule with comment period to indicate that we have assigned them an interim OPPS payment status. Their status indicators and their APC assignments and payment rates, if applicable, would be open to public comment in the CY 2011 OPPS/ASC final rule with comment period and would be finalized in the CY 2012 OPPS/ASC final rule with comment period.

B. Proposed OPPS Changes—Variations Within APCs

1. Background

Section 1833(t)(2)(A) of the Act requires the Secretary to develop a classification system for covered hospital outpatient department services. Section 1833(t)(2)(B) of the Act provides that the Secretary may establish groups of covered OPD services within this classification system, so that services classified within each group are comparable clinically and with respect to the use of resources (and so that an implantable item is classified to the group that includes the services to which the item relates). In accordance with these provisions, we developed a grouping classification system, referred to as APCs, as set forth in § 419.31 of the regulations. We use Level I and Level II HCPCS codes and descriptors to identify and group the services within each APC. The APCs are organized such that each group is homogeneous both clinically and in terms of resource use. Using this classification system, we have established distinct groups of similar services, as well as medical visits. We also have developed separate APC groups for certain medical devices, drugs, biologicals, therapeutic radiopharmaceuticals, and brachytherapy devices.

We have packaged into payment for each procedure or service within an APC group the costs associated with those items or services that are directly related to and supportive of performing the main independent procedures or furnishing the services. Therefore, we do not make separate payment for these packaged items or services. For example, packaged items and services include: (1) Use of an operating, treatment, or procedure room; (2) use of a recovery room; (3) observation services; (4) anesthesia; (5) medical/surgical supplies; (6) pharmaceuticals (other than those for which separate payment may be allowed under the provisions discussed in section V. of this proposed rule); (7) incidental services such as venipuncture; and (8) guidance services, image processing services, intraoperative services, imaging supervision and interpretation services, diagnostic radiopharmaceuticals, and contrast media. Further discussion of packaged services is included in section II.A.3. of this proposed rule.

In CY 2008, we implemented composite APCs to provide a single payment for groups of services that are typically performed together during a single clinical encounter and that result in the provision of a complete service (72 FR 66650 through 66652). Under CY 2010 OPPS policy, we provide composite APC payment for certain extended assessment and management services, low dose rate (LDR) prostate brachytherapy, cardiac electrophysiologic evaluation and ablation, mental health services, and multiple imaging services. Further discussion of composite APCs is included in section II.A.2.e. of this proposed rule.

Under the OPPS, we generally pay for hospital outpatient services on a rate-per-service basis, where the service may be reported with one or more HCPCS codes. Payment varies according to the APC group to which the independent service or combination of services is assigned. Each APC weight represents the hospital median cost of the services included in that APC relative to the hospital median cost of the services included in APC 0606 (Level 3 Hospital Clinic Visits). The APC weights are scaled to APC 0606 because it is the middle level hospital clinic visit APC (that is, where the Level 3 hospital clinic visit CPT code of five levels of hospital clinic visits is assigned), and because middle level hospital clinic visits are among the most frequently

furnished services in the hospital outpatient setting.

Section 1833(t)(9)(A) of the Act requires the Secretary to review not less often than annually and revise the groups, the relative payment weights, and the wage and other adjustments to take into account changes in medical practice, changes in technology, the addition of new services, new cost data, and other relevant information and factors. Section 1833(t)(9)(A) of the Act, as amended by section 201(h) of the BBRA, also requires the Secretary, beginning in CY 2001, to consult with an expert outside advisory panel composed of an appropriate selection of representatives of providers to review (and advise the Secretary concerning) the clinical integrity of the APC groups and the relative payment weights (the APC Panel recommendations for specific services for the CY 2011 OPPS and our responses to them are discussed in the relevant specific sections throughout this proposed rule).

Finally, section 1833(t)(2) of the Act provides that, subject to certain exceptions, the items and services within an APC group cannot be considered comparable with respect to the use of resources if the highest median cost (or mean cost as elected by the Secretary) for an item or service in the group is more than 2 times greater than the lowest median cost (or mean cost, if so elected) for an item or service within the same group (referred to as the "2 times rule"). We use the median cost of the item or service in implementing this provision. The statute authorizes the Secretary to make exceptions to the 2 times rule in unusual cases, such as low-volume items and services (but the Secretary may not make such an exception in the case of a drug or biological that has been designated as an orphan drug under section 526 of the Federal Food, Drug, and Cosmetic Act).

2. Application of the 2 Times Rule

In accordance with section 1833(t)(2) of the Act and § 419.31 of the regulations, we annually review the items and services within an APC group to determine, with respect to comparability of the use of resources, if the median cost of the highest cost item or service within an APC group is more than 2 times greater than the median of the lowest cost item or service within that same group. We are proposing to make exceptions to this limit on the variation of costs within each APC group in unusual cases, such as low-volume items and services for CY 2011.

During the APC Panel's February 2010 meeting, we presented median cost and utilization data for services furnished during the period of January 1, 2009 through September 30, 2009, about which we had concerns or about which the public had raised concerns regarding their APC assignments, status indicator assignments, or payment rates. The discussions of most service-specific issues, the APC Panel recommendations, if any, and our proposals for CY 2011 are contained mainly in sections III.C. and III.D. of this proposed rule.

In addition to the assignment of specific services to APCs that we discussed with the APC Panel, we also identified APCs with 2 times violations that were not specifically discussed with the APC Panel but for which we are proposing changes to their HCPCS codes' APC assignments in Addendum B to this proposed rule. In these cases, to eliminate a 2 times violation or to improve clinical and resource homogeneity, we are proposing to reassign the codes to APCs that contain services that are similar with regard to both their clinical and resource characteristics. We also are proposing to rename existing APCs or create new clinical APCs to complement proposed HCPCS code reassignments. In many cases, the proposed HCPCS code reassignments and associated APC reconfigurations for CY 2011 included in this proposed rule are related to changes in median costs of services that were observed in the CY 2009 claims data newly available for CY 2011 ratesetting. We also are proposing changes to the status indicators for some codes that are not specifically and separately discussed in this proposed rule. In these cases, we are proposing to change the status indicators for some codes because we believe that another status indicator would more accurately describe their payment status from an OPPS perspective based on the policies that we are proposing for CY 2011.

Addendum B to this proposed rule identifies with comment indicator "CH" those HCPCS codes for which we are proposing a change to the APC assignment or status indicator that were initially assigned in the April 2010 Addendum B update (via Transmittal 1924, Change Request 6857, dated February 26, 2010).

3. Proposed Exceptions to the 2 Times Rule

As discussed earlier, we may make exceptions to the 2 times limit on the variation of costs within each APC group in unusual cases such as low-volume items and services. Taking into account the APC changes that we are proposing for CY 2011 based on the APC Panel recommendations discussed mainly in sections III.C. and III.D. of this proposed rule, the other proposed changes to status indicators and APC assignments as identified in Addendum B to this proposed rule, and the use of CY 2009 claims data to calculate the median costs of procedures classified in the APCs, we reviewed all the APCs to determine which APCs would not satisfy the 2 times rule. We used the following criteria to decide whether to propose exceptions to the 2 times rule for affected APCs:

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

For a detailed discussion of these criteria, we refer readers to the April 7, 2000 OPPS final rule with comment period (65 FR 18457 and 18458).

Table 16 of this proposed rule lists 17 APCs that we are proposing to exempt from the 2 times rule for CY 2011 based on the criteria cited above. For cases in which a recommendation by the APC Panel appeared to result in or allow a violation of the 2 times rule, we generally accepted the APC Panel's recommendation because those recommendations were based on explicit consideration of resource use, clinical homogeneity, hospital specialization, and the quality of the CY 2009 claims data used to determine the APC payment rates that we are proposing for CY 2011. The median costs for hospital outpatient services for these and all other APCs that were used in the development of this proposed rule can be found on the CMS Web site at: *http://www.cms.gov/HospitalOutpatientPPS/01_overview.asp.*

TABLE 16.—PROPOSED APC EXCEPTIONS TO THE 2 TIMES RULE FOR CY 2011

Proposed CY 2011 APC	Proposed CY 2011 APC Title
0051	Level III Musculoskeletal Procedures Except Hand and Foot
0057	Bunion Procedures
0058	Level I Strapping and Cast Application
0080	Diagnostic Cardiac Catheterization
0105	Repair/Revision/Removal of Pacemakers, AICDs, or Vascular Devices
0138	Level II Closed Treatment Fracture Finger/Toe/Trunk
0142	Small Intestine Endoscopy
0173	Level II Partial Hospitalization (4 or more services)
0235	Level I Posterior Segment Eye Procedures
0245	Level I Cataract Procedures without IOL Insert
0303	Treatment Device Construction
0325	Group Psychotherapy
0340	Minor Ancillary Procedures
0344	Level IV Pathology
0432	Health and Behavior Services
0604	Level 1 Hospital Clinic Visits
0664	Level I Proton Beam Radiation Therapy

C. New Technology APCs

1. Background

In the November 30, 2001 final rule (66 FR 59903), we finalized changes to the time period a service was eligible for payment under a New Technology APC. Beginning in CY 2002, we retain services within New Technology APC groups until we gather sufficient claims data to enable us to assign the service to a clinically appropriate APC. This policy allows us to move a service from a New Technology APC in less than 2 years if sufficient data are available. It also allows us to retain a service in a New Technology APC for more than 2 years if sufficient data upon which to base a decision for reassignment have not been collected.

We note that the cost bands for New Technology APCs range from $0 to $50 in increments of $10, from $50 to $100 in increments of $50, from $100 through $2,000 in increments of $100, and from $2,000 through $10,000 in increments of $500. These cost bands identify the APCs to which new technology procedures and services with estimated service costs that fall within those cost bands are assigned under the OPPS. Payment for each APC is made at the mid-point of the APC's assigned cost band. For example, payment for New Technology APC 1507 (New Technology—Level VII ($500–$600)) is made at $550. Currently, there are 82 New Technology APCs, ranging from the lowest cost band assigned to APC 1491 (New Technology—Level IA ($0–$10)) through the highest cost band assigned to APC 1574 (New Technology—Level XXXVII ($9,500–$10,000). In CY 2004 (68 FR 63416), we last restructured the New Technology APCs to make the cost intervals more consistent across payment levels and refined the cost bands for these APCs to retain two parallel sets of New Technology APCs, one set with a status indicator of "S" (Significant Procedures, Not Discounted when Multiple. Paid under OPPS; separate APC payment) and the other set with a status indicator of "T" (Significant Procedure, Multiple Reduction Applies. Paid under OPPS; separate APC payment). These current New Technology APC configurations allow us to price new technology services more appropriately and consistently.

Every year we receive many requests for higher payment amounts under our New Technology APCs for specific procedures under the OPPS because they require the use of expensive equipment. We again are taking this opportunity to reiterate our response in general to the issue of hospitals' capital expenditures as they relate to the OPPS and Medicare.

Under the OPPS, one of our goals is to make payments that are appropriate for the services that are necessary for the treatment of Medicare beneficiaries. The OPPS, like other Medicare payment systems, is budget neutral and increases are limited to the hospital inpatient market basket. We believe that our payment rates generally reflect the costs that are associated with providing care to Medicare beneficiaries in cost-efficient settings, and we believe that our rates are adequate to ensure access to services.

For many emerging technologies there is a transitional period during which utilization may be low, often because providers are first learning about the techniques and their clinical utility. Quite often, parties request that Medicare make higher payment amounts under our New Technology APCs for new procedures in that transitional phase. These requests, and their accompanying estimates for expected total patient utilization, often reflect very low rates of patient use of expensive equipment, resulting in high per use costs for which requesters believe Medicare should make full payment. Medicare does not, and we believe should not, assume responsibility for more than its share of

the costs of procedures based on Medicare beneficiary projected utilization and does not set its payment rates based on initial projections of low utilization for services that require expensive capital equipment. For the OPPS, we rely on hospitals to make informed business decisions regarding the acquisition of high cost capital equipment, taking into consideration their knowledge about their entire patient base (Medicare beneficiaries included) and an understanding of Medicare's and other payers' payment policies.

We note that in a budget neutral environment, payments may not fully cover hospitals' costs in a particular circumstance, including those for the purchase and maintenance of capital equipment. We rely on providers to make their decisions regarding the acquisition of high cost equipment with the understanding that the Medicare program must be careful to establish its initial payment rates, including those made through New Technology APCS, for new services that lack hospital claims data based on realistic utilization projections for all such services delivered in cost-efficient hospital outpatient settings. As the OPPS acquires claims data regarding hospital costs associated with new procedures, we regularly examine the claims data and any available new information regarding the clinical aspects of new procedures to confirm that our OPPS payments remain appropriate for procedures as they transition into mainstream medical practice.

2. Proposed Movement of Procedures From New Technology APCs to Clinical APCs

As we explained in the November 30, 2001 final rule (66 FR 59902), we generally keep a procedure in the New Technology APC to which it is initially assigned until we have collected sufficient data to enable us to move the procedure to a clinically appropriate APC. However, in cases where we find that our original New Technology APC assignment was based on inaccurate or inadequate information (although it was the best information available at the time), or where the New Technology APCs are restructured, we may, based on more recent resource utilization information (including claims data) or the availability of refined New Technology APC cost bands, reassign the procedure or service to a different New Technology APC that most appropriately reflects its cost.

Consistent with our current policy, for CY 2011, we are proposing to retain services within New Technology APC groups until we gather sufficient data to enable us to assign the service to a clinically appropriate APC. The flexibility associated with this policy allows us to move a service from a New Technology APC in less than 2 years if sufficient data are available. It also allows us to retain a service in a New Technology APC for more than 2 years if sufficient data upon which to base a decision for reassignment have not been collected.

Table 17 below lists the HCPCS codes and associated status indicators that we are proposing to reassign from a New Technology APC to a clinically appropriate APC or to a different New Technology APC for CY 2011. For CY 2010, there are four services described by a HCPCS G-code receiving payment through a New Technology APC. Specifically, HCPCS code G0416 (Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 1–20 specimens), is assigned to New Technology APC 1505 (New Technology—Level V ($300–$400)); HCPCS code G0417 (Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 21–40 specimens), is assigned to New Technology APC 1507 (New Technology—Level VII ($500–$600)); G0418 (Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 41–60 specimens), is assigned to New Technology APC 1511 (New Technology—Level XI ($900—$1000)); and HCPCS code G0419 (Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, greater than 60 specimens), is assigned to New Technology APC 1513 (New Technology—Level XIII ($1100–$1200)). Based on the CY 2009 OPPS claims data available for this proposed rule, we believe that we have sufficient claims data to propose reassignment of HCPCS codes G0416 and G0417. Specifically, for HCPCS code G0416, our claims data show a median cost of approximately $113 based on 251 single claims out of 1,373 total claims for this service in CY 2009. For HCPCS code G0417, our claims data show a median cost of approximately $489 based on 5 single claims out of 135 total claims. We discuss our identification of single procedure claims, including "pseudo" single procedure claims, for ratesetting in section II.A.2. of this proposed rule. We believe we have sufficient claims data to propose the reassignment of HCPCS G-codes G0416 and G0417 to more appropriate APCs for CY 2011. Therefore, for CY 2011, we are proposing to reassign these procedures to more appropriate APCs. Specifically, we are proposing to reassign HCPCS G-code G0416 from New Technology APC 1505 to clinical APC 0661 (Level V Pathology), which has an APC median cost of approximately $165, and HCPCS G-code G0417 from New Technology APC 1507 (New Technology—Level VII ($500 to $600)) to New Technology APC 1506 (New Technology—Level VI ($400–$500)). We believe that HCPCS G-code G0416 is comparable clinically and with respect to the use of resources as other pathology services currently assigned to APC 0661. We also believe that HCPCS G-code G0417 would be more appropriately placed in New Technology APC 1506 in light of the median cost data available to us. Specifically, the HCPCS median cost of approximately $489 for HCPCS code G0417 closely aligns with the APC median cost of approximately $489 for APC 1506. We believe that HCPCS code G0417 would be more appropriately placed in APC 1506 based on clinical and resource considerations. These services and their proposed APC assignments are displayed in Table 17 below.

For CY 2011, we are proposing to continue the New Technology APC assignments for HCPCS G-codes G0418 and G0419, which is based on our understanding of the clinical and cost characteristics of the procedures described by these HCPCS codes. We do not believe we have enough claims data to assign these codes to a different APC. Specifically, our claims data show no single claims, out of 29 total claims, for HCPCS code G0418. Similarly, our data show no single claims, out of 3 total claims, for HCPCS code G0419. While we believe that these services always will be low volume, given the number of specimens being collected, we believe that we should continue their New Technology payments for another year to see if more claims data become available for HCPCS codes G0418 and G0419. Specifically, we are proposing to continue to assign HCPCS G-code G0418 to New Technology APC 1511 (New Technology—Level XI ($900–$1,000)) and HCPCS G-code G0419 to New Technology APC 1513 (New Technology—Level XIII ($1,100–$1,200)).

TABLE 17.—PROPOSED CY 2011 REASSIGNMENT OF NEW TECHNOLOGY PROCEDURES

CY 2010 HCPCS Code	CY 2010 Short Descriptor	CY 2010 SI	CY 2010 APC	Proposed CY 2011 SI	Proposed CY 2011 APC
G0416	Sat biopsy prostate 1-20 spc	S	1505	X	0661
G0417	Sat biopsy prostate 21-40	S	1507	S	1506

D. Proposed OPPS APC-Specific Policy: Skin Repair (APCs 0134 and 0135)

At the August 2009 APC Panel meeting, one public presenter requested that the APC Panel recommend that CMS reassign the Apligraf application CPT codes, specifically CPT codes 15340 (Tissue cultured allogeneic skin substitute; first 25 sq cm or less) and 15341 (Tissue cultured allogeneic skin substitute; each additional 25 sq cm, or part thereof), from APC 0134 (Level II Skin Repair) to APC 0135 (Level III Skin Repair). The same presenter requested that CMS continue to assign the Dermagraft application CPT codes, specifically CPT codes 15365 (Tissue cultured allogeneic dermal substitute, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children) and 15366 (Tissue cultured allogeneic dermal substitute, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof), to APC 0134. The public presenter believed that the CY 2010 proposal to continue to assign both the Apligraf and the Dermagraft application CPT codes to APC 0134 would create a financial incentive favoring the Dermagraft application. Specifically, the presenter explained that CPT instructions allow the separate reporting of the CPT codes for site preparation and debridement when Dermagraft is applied, while the CPT instructions for Apligraf application codes specify that site preparation and debridement cannot be separately reported. The presenter believed that this reporting difference and the resulting expected differences in the associated application procedure costs could be addressed by assigning the Apligraf application CPT codes to a higher paying APC than the Dermagraft application CPT codes, instead of the same APC as CMS proposed for CY 2010.

During the discussion, the APC Panel members were provided with the historical information on the coding and APC assignments for the skin substitute application procedures assigned to APCs 0134 and 0135. Specifically, the Apligraf application CPT codes 15340 and 15341, the Dermagraft application CPT codes 15365 and 15366, as well as the Oasis application CPT codes 15430 (Acellular xenograft implant; first 100 sq cm or less, or 1% of body area of infants and children) and 15431 (Acellular xenograft implant; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof), were at one time assigned to the same APC level (Level II Skin Repair). However, because of violations of the two times rule, CMS reconfigured the skin repair APCs and reassigned the Oasis application CPT codes 15430 and 15431 to APC 0135 (Level III Skin Repair) in CY 2008.

At the August 2009 APC Panel meeting, panel members debated whether the differences in sizes in each product's application CPT codes and the ability to bill separately for site preparation and debridement for Dermagraft application required different APC placement for any of the skin substitute application codes. We note that the long descriptors for the Apligraf application CPT codes 15340 and 15341 are scaled to "25 sq cm," whereas the Oasis application CPT codes 15430 and 15431 and the Dermagraft application CPT codes 15365 and 15366 are scaled to "100 sq cm." After review of median cost data from the CY 2008 hospital outpatient claims available at that time (those processed from January 1, 2008 through December 31, 2009), the APC Panel recommended that CMS continue to assign all six skin substitute application CPT codes to their existing APCs for CY 2010. In addition, because of the variable sizes associated with the skin repair application CPT codes, the Panel requested that CMS provide data at the next Panel meeting on the frequency of primary and add-on CPT codes billed for the Apligraf, Oasis, and Dermagraft applications in order to assess the variability in billing for the application of these products. In addition, because of the CPT instructions allowing site preparation and debridement to be reported separately only for the Dermagraft application, the Panel requested median cost data for site preparation and debridement.

We accepted the APC Panel's recommendation to continue to assign the skin repair CPT codes for the application of Apligraf, Oasis, and Dermagraft skin substitutes to the same procedural APCs for CY 2010 as their CY 2009 assignments. As a result, we continued to assign the Apligraf application CPT codes 15340 and 15341 and the Dermagraft application CPT codes 15365 and 15366 to APC 0134 and assigned the Oasis application CPT codes 15430 and 15431 to APC 0135 for CY 2010.

At the February 2010 APC Panel meeting, CMS presented the results of the data requested at the August 2009 meeting to the APC Panel. In response to data on the frequency of primary and add-on CPT codes, based on our analysis of the available CY 2009 hospital outpatient claims data on frequency of primary and add-on CPT codes billed for the Apligraf, Oasis, and Dermagraft applications (claims processed from January 1 through September 30, 2009), we found that hospitals report the application of Apligraf with only the primary code (CPT code 15340) on 77 percent of claims, while the add-on CPT code 15341 is billed in addition to the primary code on another 23 percent of claims. Specifically, our data showed that for the Apligraf application, there were a total of 8,614 claims with only the primary CPT code 15340 reported, and 2,545 claims with the add-on CPT code 15341 also reported on the same date of service. We note that each unit of the add-on CPT code is paid at 50 percent of the payment for the primary code in addition to the full payment for the primary code. We also found in our analysis that, on claims with the Dermagraft and Oasis application CPT codes, hospitals report the primary code only in approximately 98 to 99 percent of the cases. In addition, in response to the request for data for site preparation and debridement that may be reported

separately for the Dermagraft application, we found that approximately 87 percent of procedures for the application of Dermagraft were reported without debridement or site preparation on the same day. Similarly, we found that the Apligraf and Oasis procedures were rarely reported with the site preparation or debridement CPT procedure codes on the same day. Specifically, we found that the CPT procedure code for the application of Apligraf was reported without site preparation or debridement in approximately 94 percent of these cases, and that the CPT procedure code for application of Oasis was reported without site preparation or debridement in approximately 95 percent of these cases. Our data analysis also showed that the CPT median costs for the Apligraf application CPT code 15340 and the Dermagraft application CPT code 15365 are very similar. Specifically, the CPT code-specific median cost of CPT code 15340 is approximately $234 for the Apligraf application and approximately $237 for CPT code 15365 for the Dermagraft application. In contrast, the CPT median cost for the Oasis application primary CPT code 15430 of approximately $299 is higher.

At the February 2010 APC Panel meeting, a public presenter again requested that the APC Panel recommend that CMS reassign the Apligraf application CPT codes 15340 and 15341 from APC 0134 to APC 0135. The presenter indicated that the additional payment for site preparation and debridement procedures that may be reported separately with the Dermagraft application can significantly affect the total payment for the procedure. The presenter also provided data on the use of each product in relation to the size of the wounds treated, and concluded that the size of the wound treated does not affect the resources used. After further review of the available CY 2009 hospital outpatient claims data, the APC Panel recommended that CPT codes 15340 and 15341 remain in APC 0134.

We are accepting the recommendation of the APC Panel and are proposing to continue to assign the CPT skin repair codes for the application of Apligraf, Dermagraft, and Oasis skin substitutes to the same procedural APCs as their CY 2010 assignments for CY 2011. We also are proposing to continue to pay separately for the Apligraf, Dermagraft, and Oasis products themselves in CY 2011. Specifically, we are proposing to continue to assign the Apligraf application CPT codes 15340 and 15341 and the Dermagraft application CPT codes 15365 and 15366 to APC 0134, with a proposed APC median cost of approximately $222. We are proposing to continue to assign the Oasis application CPT codes 15430 and 15431 to APC 0135, with a proposed APC median cost of approximately $325.

For CY 2011, we also are proposing to create two new Level II HCPCS G-codes to report the application of Apligraf or Dermagraft specific to the lower extremities in order to provide appropriate and consistent payment for these services as they are commonly furnished, consistent with the CY 2011 proposal for the MPFS. (We refer readers to the CY 2011 MPFS proposed rule for additional information regarding the MPFS proposal.) The proposed HCPCS codes are: GXXX1 (Application of tissue cultured allogeneic skin substitute or dermal substitute; for use on lower limb, includes the site preparation and debridement if performed; first 25 sq cm or less); and GXXX2 (Application of tissue cultured allogeneic skin or dermal substitute; for use on lower limb, includes the site preparation and debridement if performed; each additional 25 sq cm). As indicated in the HCPCS G-code descriptors, these codes would not allow separate reporting of CPT codes for site preparation or debridement. We believe the descriptors of these proposed HCPCS G-codes more specifically reflect the characteristics of the application of Apligraf or Dermagraft to the lower limb so that reporting would result in more accurate cost data for OPPS ratesetting and, ultimately, more appropriate payment. Consistent with the proposed CY 2011 APC assignment for the Apligraf and Dermagraft application CPT codes, we are proposing to assign new HCPCS codes GXXX1 and GXXX2 to APC 0134, with a proposed APC median cost of approximately $222. We are specifically interested in public comment on the appropriateness of recognizing these proposed new HCPCS G-codes under the OPPS and their proposed APC assignments.

IV. Proposed OPPS Payment for Devices

A. Pass-Through Payments for Devices

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

Section 1833(t)(6)(B)(iii) of the Act requires that, under the OPPS, a category of devices be eligible for transitional pass-through payments for at least 2, but not more than 3, years. This pass-through payment eligibility period begins with the first date on which transitional pass-through payments may be made for any medical device that is described by the category. We may establish a new device category for pass-through payment in any quarter. Under our established policy, we base the pass-through status expiration dates for the category codes on the date on which a category is in effect. The date on which a category is in effect is the first date on which pass-through payment may be made for any medical device that is described by such category. We propose and finalize the dates for expiration of pass-through status for device categories as part of the OPPS annual update.

We also have an established policy to package the costs of the devices that are no longer eligible for pass-through payments into the costs of the procedures with which the devices are reported in the claims data used to set the payment rates (67 FR 66763). Brachytherapy sources, which are now separately paid in accordance with section 1833(t)(2)(H) of the Act, are an exception to this established policy.

There currently are no device categories eligible for pass-through payment, and there are no categories for which we would propose expiration of pass-through status in CY 2011. If we create new device categories for pass-through payment status during the remainder of CY 2010 or during CY 2011, we will propose future expiration dates in accordance with the statutory requirement that they be eligible for pass-through payments for at least 2, but not more than 3, years from the date on which pass-through payment for any medical device described by the category may first be made.

2. Proposed Provisions for Reducing Transitional Pass-Through Payments to Offset Costs Packaged Into APC Groups

a. Background

We have an established policy to estimate the portion of each APC payment rate that could reasonably be attributed to the cost of the associated devices that are eligible for pass-through payments (66 FR 59904). We deduct from the pass-through payments for identified device categories eligible for pass-through payments an amount that reflects the portion of the APC payment amount that we determine is associated with the cost of the device, defined as the device APC offset amount, as required by section 1833(t)(6)(D)(ii) of the Act. We have consistently employed an established methodology to estimate the portion of each APC payment rate that could reasonably be attributed to the cost of an associated device eligible for pass-through payment, using claims data from the period used for the most

recent recalibration of the APC rates (72 FR 66751 through 66752). We establish and update the applicable device APC offset amounts for eligible pass-through device categories through the transmittals that implement the quarterly OPPS updates.

We currently have published a list of all procedural APCs with the CY 2010 portions (both percentages and dollar amounts) of the APC payment amounts that we determine are associated with the cost of devices, on the CMS Web site at: *http://www.cms.gov/HospitalOutpatientPPS/01_overview.asp.* The dollar amounts are used as the device APC offset amounts. In addition, in accordance with our established practice, the device APC offset amounts in a related APC are used in order to evaluate whether the cost of a device in an application for a new device category for pass-through payment is not insignificant in relation to the APC payment amount for the service related to the category of devices, as specified in our regulations at § 419.66(d).

As of CY 2009, the costs of implantable biologicals without pass-through status are packaged into the payment for the procedures in which they are inserted or implanted because implantable biologicals without pass-through status are not separately paid (73 FR 68633 through 68636). For CY 2010, we finalized a new policy to specify that the pass-through evaluation process and pass-through payment methodology for implantable biologicals that are surgically inserted or implanted (through a surgical incision or a natural orifice) and that are newly approved for pass-through status beginning on or after January 1, 2010, be the device pass-through process and payment methodology only. As a result, for CY 2010, we included implantable biologicals in our calculation of the device APC offset amounts (74 FR 60476). We calculated and set the device APC offset amount for a newly established device pass-through category, which could include a newly eligible implantable biological, beginning in CY 2010 using the same methodology we have historically used to calculate and set device APC offset amounts for device categories eligible for pass-through payment (72 FR 66751 through 66752), with one modification. Because implantable biologicals are considered devices rather than drugs for purposes of pass-through evaluation and payment under our established policy, the device APC offset amounts include the costs of implantable biologicals. For CY 2010, we also finalized a policy to utilize the revised device APC offset amounts to evaluate whether the cost of an implantable biological in an application for a new device category for pass-through payment is not insignificant in relation to the APC payment amount for the service related to the category of devices. Further, for CY 2010, we also no longer used the "policy-packaged" drug APC offset amounts for evaluating the cost significance of implantable biological pass-through applications under review and for setting the APC offset amounts that would apply to pass-through payment for those implantable biologicals, effective for new pass-through status determinations beginning in CY 2010 (74 FR 60463).

b. Proposed Policy

For CY 2011, we are proposing to continue our policy that the pass-through evaluation process and pass-through payment methodology for implantable biologicals that are surgically inserted or implanted (through a surgical incision or a natural orifice) and that are newly approved for pass-through status beginning on or after January 1, 2010, be the device pass-through process and payment methodology only. The rationale for this policy is provided in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60471 through 60477). We also are proposing to continue our established policies for calculating and setting the device APC offset amounts for each device category eligible for pass-through payment. We also are proposing to continue to review each new device category on a case-by-case basis to determine whether device costs associated with the new category are already packaged into the existing APC structure. If device costs packaged into the existing APC structure are associated with the new category, we would deduct the device APC offset amount from the pass-through payment for the device category. As stated earlier, these device APC offset amounts also would be used in order to evaluate whether the cost of a device in an application for a new device category for pass-through payment is not insignificant in relation to the APC payment amount for the service related to the category of devices (§ 419.66(d)).

We also are proposing to continue our policy established in CY 2010 to include implantable biologicals in our calculation of the device APC offset amounts. In addition, we are proposing to continue to calculate and set any device APC offset amount for a new device pass-through category that includes a newly eligible implantable biological beginning in CY 2011 using the same methodology we have historically used to calculate and set device APC offset amounts for device categories eligible for pass-through payment, and to include the costs of implantable biologicals in the calculation of the device APC offset amounts, as we did for CY 2010.

In addition, we are proposing to update, on the CMS Web site at *http://www.cms.gov/HospitalOutpatientPPS,* the list of all procedural APCs with the final CY 2011 portions of the APC payment amounts that we determine are associated with the cost of devices so that this information is available for use by the public in developing potential CY 2011 device pass-through payment applications and by CMS in reviewing those applications.

In summary, for CY 2011, consistent with the policy established for CY 2010, we are proposing to continue the following policies related to pass-through payment for devices: (1) Treating implantable biologicals, that are surgically inserted or implanted (through a surgical incision or a natural orifice) and that are newly approved for pass-through status on or after January 1, 2010, as devices for purposes of the OPPS pass-through evaluation process and payment methodology; (2) including implantable biologicals in calculating the device APC offset amounts; (3) using the device APC offset amounts to evaluate whether the cost of a device (defined to include implantable biologicals) in an application for a new device category for pass-through payment is not insignificant in relation to the APC payment amount for the service related to the category of devices; and (4) reducing device pass-through payments based on device costs already included in the associated procedural APCs, when we determine that device costs associated with the new category are already packaged into the existing APC structure.

B. Proposed Adjustment to OPPS Payment for No Cost/Full Credit and Partial Credit Devices

1. Background

In recent years, there have been several field actions on and recalls of medical devices as a result of implantable device failures. In many of these cases, the manufacturers have offered devices without cost to the hospital or with credit for the device being replaced if the patient required a more expensive device. In order to ensure that payment rates for procedures involving devices reflect only the full costs of those devices, our

standard rate-setting methodology for device-dependent APCs uses only claims that contain the correct device code for the procedure, do not contain token charges, do not contain the "FB" modifier signifying that the device was furnished without cost or with a full credit, and do not contain the "FC" modifier signifying that the device was furnished with partial credit. As discussed in section II.A.2.d.(1) of this proposed rule, we are proposing to continue to use our standard rate-setting methodology for device-dependent APCs for CY 2011.

To ensure equitable payment when the hospital receives a device without cost or with full credit, in CY 2007 we implemented a policy to reduce the payment for specified device-dependent APCs by the estimated portion of the APC payment attributable to device costs (that is, the device offset) when the hospital receives a specified device at no cost or with full credit (71 FR 68071 through 68077). Hospitals are instructed to report no cost/full credit cases using the "FB" modifier on the line with the procedure code in which the no cost/full credit device is used. In cases in which the device is furnished without cost or with full credit, the hospital is instructed to report a token device charge of less than $1.01. In cases in which the device being inserted is an upgrade (either of the same type of device or to a different type of device) with a full credit for the device being replaced, the hospital is instructed to report as the device charge the difference between its usual charge for the device being implanted and its usual charge for the device for which it received full credit. In CY 2008, we expanded this payment adjustment policy to include cases in which hospitals receive partial credit of 50 percent or more of the cost of a specified device. Hospitals are instructed to append the "FC" modifier to the procedure code that reports the service provided to furnish the device when they receive a partial credit of 50 percent or more of the cost of the new device. We reduce the OPPS payment for the implantation procedure by 100 percent of the device offset for no cost/full credit cases when both a specified device code is present on the claim and the procedure code maps to a specified APC. Payment for the implantation procedure is reduced by 50 percent of the device offset for partial credit cases when both a specified device code is present on the claim and the procedure code maps to a specified APC. Beneficiary copayment is based on the reduced payment amount when either the "FB" or the "FC" modifier is billed and the procedure and device codes appear on the lists of procedures and devices to which this policy applies. We refer readers to the CY 2008 OPPS/ASC final rule with comment period for more background information on the "FB" and "FC" payment adjustment policies (72 FR 66743 through 66749).

2. Proposed APCs and Devices Subject to the Adjustment Policy

For CY 2011, we are proposing to continue to apply the existing policy of reducing OPPS payment for specified APCs by 100 percent of the device offset amount when a hospital furnishes a specified device without cost or with a full credit and by 50 percent of the device offset amount when the hospital receives partial credit in the amount of 50 percent or more of the cost for the specified device. Because the APC payments for the related services are specifically constructed to ensure that the full cost of the device is included in the payment, we continue to believe it is appropriate to reduce the APC payment in cases in which the hospital receives a device without cost, with full credit, or with partial credit, in order to provide equitable payment in these cases. (We refer readers to section II.A.2.d.(1) of this proposed rule for a description of our standard rate-setting methodology for device-dependent APCs.) Moreover, the payment for these devices comprises a large part of the APC payment on which the beneficiary copayment is based, and we continue to believe it is equitable that the beneficiary cost sharing reflects the reduced costs in these cases.

We also are proposing to continue using the three criteria established in the CY 2007 OPPS/ASC final rule with comment period for determining the APCs to which this policy applies (71 FR 68072 through 68077). Specifically, (1) all procedures assigned to the selected APCs must involve implantable devices that would be reported if device insertion procedures were performed; (2) the required devices must be surgically inserted or implanted devices that remain in the patient's body after the conclusion of the procedure (at least temporarily); and (3) the device offset amount must be significant, which, for purposes of this policy, is defined as exceeding 40 percent of the APC cost. We are proposing to continue to restrict the devices to which the APC payment adjustment would apply to a specific set of costly devices to ensure that the adjustment would not be triggered by the implantation of an inexpensive device whose cost would not constitute a significant proportion of the total payment rate for an APC. We continue to believe these criteria are appropriate because free devices and device credits are likely to be associated with particular cases only when the device must be reported on the claim and is of a type that is implanted and remains in the body when the beneficiary leaves the hospital. We believe that the reduction in payment is appropriate only when the cost of the device is a significant part of the total cost of the APC into which the device cost is packaged, and that the 40-percent threshold is a reasonable definition of a significant cost.

We examined the offset amounts calculated from the CY 2011 proposed rule data and the clinical characteristics of APCs to determine whether the APCs to which the no cost/full credit and partial credit device adjustment policy applies in CY 2010 continue to meet the criteria for CY 2011, and to determine whether other APCs to which the policy does not apply in CY 2010 would meet the criteria for CY 2011. Based on the CY 2009 claims data available for this proposed rule, we are not proposing any changes to the APCs and devices to which this policy applies. Table 18 below lists the proposed APCs to which the payment adjustment policy for no cost/full credit and partial credit devices would apply in CY 2011 and displays the proposed payment adjustment percentages for both no cost/full credit and partial credit circumstances. We are proposing that the no cost/full credit adjustment for each APC to which this policy would continue to apply would be the device offset percentage for the APC (the estimated percentage of the APC cost that is attributable to the device costs that are packaged into the APC). We also are proposing that the partial credit device adjustment for each APC would continue to be 50 percent of the no cost/full credit adjustment for the APC as shown in Table 18. Table 19 below lists the proposed devices to which this policy would apply in CY 2011. We will update the lists of APCs and devices to which the no cost/full credit and partial credit device adjustment policy would apply for CY 2011, consistent with the three selection criteria discussed earlier in this section, based on the final CY 2009 claims data available for the CY 2011 OPPS/ASC final rule with comment period.

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TABLE 18.—PROPOSED APCs TO WHICH THE NO COST/FULL CREDIT AND PARTIAL CREDIT DEVICE ADJUSTMENT POLICY WOULD APPLY

Proposed CY 2011 APC	Proposed CY 2011 APC Title	Proposed CY 2011 Device Offset Percentage for No Cost/ Full Credit Case	Proposed CY 2011 Device Offset Percentage for Partial Credit Case
0039	Level I Implantation of Neurostimulator Generator	85%	43%
0040	Percutaneous Implantation of Neurostimulator Electrodes	56%	28%
0061	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electrodes	63%	31%
0089	Insertion/Replacement of Permanent Pacemaker and Electrodes	70%	35%
0090	Insertion/Replacement of Pacemaker Pulse Generator	72%	36%
0106	Insertion/Replacement of Pacemaker Leads and/or Electrodes	46%	23%
0107	Insertion of Cardioverter-Defibrillator	88%	44%
0108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads	87%	44%
0225	Implantation of Neurostimulator Electrodes, Cranial Nerve	78%	39%
0227	Implantation of Drug Infusion Device	81%	41%
0259	Level VII ENT Procedures	86%	43%
0315	Level II Implantation of Neurostimulator Generator	88%	44%
0385	Level I Prosthetic Urological Procedures	61%	30%
0386	Level II Prosthetic Urological Procedures	71%	36%
0418	Insertion of Left Ventricular Pacing Elect.	72%	36%
0425	Level II Arthroplasty or Implantation with Prosthesis	59%	29%
0648	Level IV Breast Surgery	45%	23%
0654	Insertion/Replacement of a	73%	37%

Proposed CY 2011 APC	Proposed CY 2011 APC Title	Proposed CY 2011 Device Offset Percentage for No Cost/ Full Credit Case	Proposed CY 2011 Device Offset Percentage for Partial Credit Case
	permanent dual chamber pacemaker		
0655	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker	73%	37%
0680	Insertion of Patient Activated Event Recorders	71%	35%

TABLE 19.—PROPOSED DEVICES TO WHICH THE NO COST/FULL CREDIT AND PARTIAL CREDIT DEVICE ADJUSTMENT POLICY WOULD APPLY

CY 2010 Device HCPCS Code	CY 2010 Short Descriptor
C1721	AICD, dual chamber
C1722	AICD, single chamber
C1728	Cath, brachytx seed adm
C1764	Event recorder, cardiac
C1767	Generator, neurostim, imp
C1771	Rep dev, urinary, w/sling
C1772	Infusion pump, programmable
C1776	Joint device (implantable)
C1777	Lead, AICD, endo single coil
C1778	Lead, neurostimulator
C1779	Lead, pmkr, transvenous VDD
C1785	Pmkr, dual, rate-resp
C1786	Pmkr, single, rate-resp
C1789	Prosthesis, breast, imp
C1813	Prosthesis, penile, inflatab
C1815	Pros, urinary sph, imp
C1820	Generator, neuro rechg bat sys
C1881	Dialysis access system
C1882	AICD, other than sing/dual
C1891	Infusion pump, non-prog, perm
C1895	Lead, AICD, endo dual coil
C1896	Lead, AICD, non sing/dual
C1897	Lead, neurostim, test kit
C1898	Lead, pmkr, other than trans
C1899	Lead, pmkr/AICD combination
C1900	Lead coronary venous
C2619	Pmkr, dual, non rate-resp
C2620	Pmkr, single, non rate-resp
C2621	Pmkr, other than sing/dual
C2622	Prosthesis, penile, non-inf
C2626	Infusion pump, non-prog, temp
C2631	Rep dev, urinary, w/o sling
L8600	Implant breast silicone/eq
L8614	Cochlear device/system
L8680	Implt neurostim elctr each
L8685	Implt nrostm pls gen sng rec
L8686	Implt nrostm pls gen sng non
L8687	Implt nrostm pls gen dua rec
L8688	Implt nrostm pls gen dua non
L8690	Aud osseo dev, int/ext comp

<FNP>

V. Proposed OPPS Payment Changes for Drugs, Biologicals, and Radiopharmaceuticals

A. Proposed OPPS Transitional Pass-Through Payment for Additional Costs of Drugs, Biologicals, and Radiopharmaceuticals

1. Background

Section 1833(t)(6) of the Act provides for temporary additional payments or "transitional pass-through payments" for certain drugs and biological agents. As enacted by the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act (BBRA) of 1999 (Pub. L. 106–113), this provision requires the Secretary to make additional payments to hospitals for current orphan drugs, as designated under section 526 of the Federal Food, Drug, and Cosmetic Act (Pub. L. 107–186); current drugs and biological agents and brachytherapy sources used for the treatment of cancer; and current radiopharmaceutical drugs and biological products. For those drugs and biological agents referred to as "current," the transitional pass-through payment began on the first date the hospital OPPS was implemented.

Transitional pass-through payments also are provided for certain "new" drugs and biological agents that were not being paid for as an HOPD service as of December 31, 1996, and whose cost is "not insignificant" in relation to the OPPS payments for the procedures or services associated with the new drug or biological. For pass-through payment purposes, radiopharmaceuticals are included as "drugs." Under the statute, transitional pass-through payments for a drug or biological described in section 1833(t)(6)(C)(i)(II) of the Act can be made for at least 2 years but not more than 3 years after the product's first payment as a hospital outpatient service under Part B. Proposed CY 2011 pass-through drugs and biologicals and their designated APCs are assigned status indicator "G" in Addenda A and B to this proposed rule.

Section 1833(t)(6)(D)(i) of the Act specifies that the pass-through payment amount, in the case of a drug or biological, is the amount by which the amount determined under section 1842(o) of the Act for the drug or biological exceeds the portion of the otherwise applicable Medicare OPD fee schedule that the Secretary determines is associated with the drug or biological. If the drug or biological is covered under a competitive acquisition contract under section 1847B of the Act, the pass-through payment amount is determined by the Secretary to be equal to the average price for the drug or biological for all competitive acquisition areas and the year established under such section as calculated and adjusted by the Secretary.

This methodology for determining the pass-through payment amount is set forth in § 419.64 of the regulations, which specifies that the pass-through payment equals the amount determined under section 1842(o) of the Act minus the portion of the APC payment that CMS determines is associated with the drug or biological. Section 1847A of the Act establishes the use of the average sales price (ASP) methodology as the basis for payment for drugs and biologicals described in section 1842(o)(1)(C) of the Act that are furnished on or after January 1, 2005. The ASP methodology, as applied under the OPPS, uses several sources of data as a basis for payment, including the ASP, wholesale acquisition cost (WAC), and average wholesale price (AWP). In this proposed rule, the term "ASP methodology" and "ASP-based" are inclusive of all data sources and methodologies described therein. Additional information on the ASP methodology can be found on the CMS Web site at: *http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice.*

As noted above, section 1833(t)(6)(D)(i) of the Act also states that if a drug or biological is covered under a competitive acquisition contract under section 1847B of the Act, the payment rate is equal to the average price for the drug or biological for all competitive acquisition areas and the year established as calculated and adjusted by the Secretary. Section 1847B of the Act establishes the payment methodology for Medicare Part B drugs and biologicals under the competitive acquisition program (CAP). The Part B drug CAP was implemented on July 1, 2006, and included approximately 190 of the most common Part B drugs provided in the physician's office setting. As we noted in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68633), the Part B drug CAP program was suspended beginning in CY 2009 (Medicare Learning Network (MLN) Matters Special Edition 0833, available via the Web site: *http://www.medicare.gov*). Therefore, there is no effective Part B drug CAP rate for pass-through drugs and biologicals as of January 1, 2009. Consistent with what we indicated in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60466), if the program is reinstituted during CY 2011 and Part B drug CAP rates become available, we would again use the Part B drug CAP rate for pass-through drugs and biologicals if they are a part of the Part B drug CAP program. Otherwise, we would continue to use the rate that would be paid in the physician's office setting for drugs and biologicals with pass-through status.

For CYs 2005, 2006, and 2007, we estimated the OPPS pass-through payment amount for drugs and biologicals to be zero based on our interpretation that the "otherwise applicable Medicare OPD fee schedule" amount was equivalent to the amount to be paid for pass-through drugs and biologicals under section 1842(o) of the Act (or section 1847B of the Act, if the drug or biological is covered under a competitive acquisition contract). We concluded for those years that the resulting difference between these two rates would be zero. For CYs 2008 and 2009, we estimated the OPPS pass-through payment amount for drugs and biologicals to be $6.6 million and $23.3 million, respectively. For CY 2010, we estimated that the OPPS pass-through payment estimate for drugs and biologicals to be $35.5 million. Our proposed OPPS pass-through payment estimate for drugs and biologicals in CY 2011 is $15 million, which is discussed in section VI.B. of this proposed rule.

The pass-through application and review process for drugs and biologicals is explained on the CMS Web site at: *http://www.cms.hhs.gov/HospitalOutpatientPPS/04_passthrough_payment.asp.*

2. Proposed Drugs and Biologicals With Expiring Pass-Through Status in CY 2010

We are proposing that the pass-through status of 18 drugs and biologicals would expire on December 31, 2010, as listed in Table 20 of this proposed rule. All of these drugs and biologicals will have received OPPS pass-through payment for at least 2 years and no more than 3 years by December 31, 2010. These items were approved for pass-through status on or before January 1, 2009. With the exception of those groups of drugs and biologicals that are always packaged when they do not have pass-through status, specifically diagnostic radiopharmaceuticals, contrast agents, and implantable biologicals, our standard methodology for providing payment for drugs and biologicals with expiring pass-through status in an upcoming calendar year is to determine the product's estimated per day cost and compare it with the OPPS drug packaging threshold for that calendar year (which is proposed at $70 for CY 2011), as discussed further in section V.B.2 of this proposed rule. If the drug's or biological's estimated per day cost is

less than or equal to the applicable OPPS drug packaging threshold, we would package payment for the drug or biological into the payment for the associated procedure in the upcoming calendar year. If the estimated per day cost of the drug or biological is greater than the OPPS drug packaging threshold, we would provide separate payment at the applicable relative ASP-based payment amount (which is proposed at ASP+6 percent for CY 2011, as discussed further in section V.B.3. of this proposed rule). Section V.B.2.d. of this proposed rule discusses the packaging of all nonpass-through contrast agents, diagnostic radiopharmaceuticals, and implantable biologicals.

TABLE 20.—PROPOSED DRUGS AND BIOLOGICALS FOR WHICH PASS-THROUGH STATUS WOULD EXPIRE DECEMBER 31, 2010

CY 2010 HCPCS Code	CY 2010 Long Descriptor	Proposed CY 2011 SI	Proposed CY 2011 APC
A9581	Injection, gadoxetate disodium, 1 ml	N	N/A
C9248	Injection, clevidipien butyrate, 1 mg	K	9248
C9356	Tendon, porous matrix of cross-linked collagen and glycosaminoglycan matrix (TenoGlide Tendon Protector Sheet), per square centimeter	N	N/A
C9358	Dermal substitute, native, non-denatured collagen, fetal bovine origin (SurgiMend Collagen Matrix), per 0.5 square centimeters	K	9358
C9359	Porous purified collagen matrix bone void filler (Integra Mozaik Osteoconductive Scaffold Putty, Integra OS Osteoconductive Scaffold Putty), per 0.5 cc	N	N/A
J1267	Injection, doripenem, 10 mg	N	N/A
J1453	Injection, fosaprepitant, 1 mg	K	9242
J1459	Injection, immune globulin (privigen), intravenous, non-lyophilized (e.g. liquid), 500 mg	K	1214
J1571	Injection, hepatitis b immune globulin (hepagam b), intramuscular, 0.5 ml	K	0946
J1573	Injection, hepatitis B immune globulin (Hepagam B), intravenous, 0.5ml	K	1138
J1953	Injection, levetiracetam, 10 mg	N	N/A
J2785	Injection, regadenoson, 0.1 mg	K	9244
J2796	Injection,romiplostim, 10 micrograms	K	9245
J9033	Injection, bendamustine hcl, 1 mg	K	9243
J9207	Injection, ixabepilone, 1 mg	K	9240
J9225	Histrelin implant (vantas), 50 mg	K	1711
J9226	Histrelin implant (supprelin la), 50 mg	K	1142
Q4114	Dermal substitute, granulated cross-linked collagen and glycosaminoglycan matrix (Flowable Wound Matrix), 1 cc	K	1251

3. Proposed Drugs, Biologicals, and Radiopharmaceuticals With New or Continuing Pass-Through Status in CY 2011

We are proposing to continue pass-through status in CY 2011 for 31 drugs and biologicals. None of these products will have received OPPS pass-through payment for at least 2 years and no more than 3 years by December 31, 2010. These items, which were approved for pass-through status between April 1, 2009 and July 1, 2010, are listed in Table 21 below. The APCs and HCPCS codes for these drugs and biologicals were assigned status indicator "G" in Addenda A and B to this proposed rule.

Section 1833(t)(6)(D)(i) of the Act sets the amount of pass-through payment for pass-through drugs and biologicals (the pass-through payment amount) as the difference between the amount authorized under section 1842(o) of the Act (or, if the drug or biological is

covered under a CAP under section 1847B of the Act, an amount determined by the Secretary equal to the average price for the drug or biological for all competitive acquisition areas and the year established under such section as calculated and adjusted by the Secretary) and the portion of the otherwise applicable OPD fee schedule that the Secretary determines is associated with the drug or biological. Payment for drugs and biologicals with pass-through status under the OPPS is currently made at the physician's office payment rate of ASP+6 percent. We believe it is consistent with the statute to continue to provide payment for drugs and biologicals with pass-through status at a rate of ASP+6 percent in CY 2011, the amount that drugs and biologicals receive under section 1842(o) of the Act. Thus, for CY 2011, we are proposing to pay for pass-through drugs and biologicals at ASP+6 percent, equivalent to the rate these drugs and biologicals would receive in the physician's office setting in CY 2011. We are proposing that a $0.00 pass-through payment amount would be paid for most pass-through drugs and biologicals under the CY 2011 OPPS because the difference between the amount authorized under Section 1842(o) which is ASP+6 percent and the portion of the otherwise applicable OPD fee schedule that the Secretary determines is appropriate, proposed at ASP+6 percent is $0. In the case of pass-through contrast agents, diagnostic radiopharmaceuticals, and implantable biologicals, their pass-through payment amount would be equal to ASP+6 percent because, if not on pass-through status, payment for these products would be packaged into the associated procedures.

In addition, we are proposing to continue to update pass-through payment rates on a quarterly basis on the CMS Web site during CY 2011 if later quarter ASP submission (or more recent WAC or AWP information, as applicable) indicate that adjustments to the payment rates for these pass-through drugs or biologicals are necessary. For a full description of this policy, we refer readers to the CY 2006 OPPS/ASC final rule with comment period (70 FR 42722 and 42723). If the Part B drug CAP is reinstated during CY 2011, and a drug or biological that has been granted pass-through status for CY 2011 becomes covered under the Part B drug CAP, we are proposing to provide pass-though payment at the Part B drug CAP rate and to make the appropriate adjustments to the payment rates for these drugs and biologicals on a quarterly basis as appropriate. As is our standard methodology, we annually review new permanent HCPCS codes and delete temporary HCPCS C-codes if an alternate permanent HCPCS code is available for purposes of OPPS billing and payment.

In CY 2011, as is consistent with our CY 2010 policy for diagnostic radiopharmaceuticals, we are proposing to provide payment for both diagnostic and therapeutic radiopharmaceuticals that are granted pass-through status based on the ASP methodology. As stated above, for purposes of pass-through payment, we consider radiopharmaceuticals to be drugs under the OPPS and, therefore, if a diagnostic or therapeutic radiopharmaceutical receives pass-through status during CY 2011, we are proposing to follow the standard ASP methodology to determine its pass-through payment rate that drugs receive under section 1842(o) of the Act, that is, ASP+6 percent. If ASP data are not available for a radiopharmaceutical, we are proposing to provide pass-through payment at WAC+6 percent, the equivalent payment provided to pass-through drugs and biologicals without ASP information. If WAC information is also not available, we are proposing to provide payment for the pass-through radiopharmaceutical at 95 percent of its most recent AWP.

As discussed in more detail in section V.B.2.d. of this proposed rule, over the last 3 years, we implemented a policy whereby payment for all nonpass-through diagnostic radiopharmaceuticals, contrast agents, and implantable biologicals is packaged into payment for the associated procedure, and we are proposing to continue the packaging of these items, regardless of their per day cost, in CY 2011. As stated earlier, pass-through payment is the difference between the amount authorized under section 1842(o) of the Act (or, if the drug or biological is covered under a CAP under section 1847B of the Act, an amount determined by the Secretary equal to the average price for the drug or biological for all competitive acquisition areas and the year established under such section as calculated and adjusted by the Secretary) and the portion of the otherwise applicable OPD fee schedule that the Secretary determines is associated with the drug or biological. Because payment for a drug that is either a diagnostic radiopharmaceutical or a contrast agent (identified as a "policy-packaged" drug, first described in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68639)) or for an implantable biological (which we do consider to be a device for all payment purposes as discussed in sections V.A.4. and V.B.2.d. of the CY 2010 OPPS/ASC final rule with comment period (74 FR 60458)) would otherwise be packaged if the product did not have pass-through status, we believe the otherwise applicable OPPS payment amount would be equal to the "policy-packaged" drug or device APC offset amount for the associated clinical APC in which the drug or biological is utilized. The calculation of the "policy-packaged" drug and device APC offset amounts are described in more detail in sections IV.A.2. of this proposed rule. It follows that the copayment for the nonpass-through payment portion (the otherwise applicable fee schedule amount that we would also offset from payment for the drug or biological if a payment offset applies) of the total OPPS payment for those drugs and biologicals would, therefore, be accounted for in the copayment for the associated clinical APC in which the drug or biological is used. According to section 1833(t)(8)(E) of the Act, the amount of copayment associated with pass-through items is equal to the amount of copayment that would be applicable if the pass-through adjustment was not applied. Therefore, as we did in CY 2010, we are proposing to continue to set the associated copayment amount for pass-through diagnostic radiopharmaceuticals, contrast agents, and implantable biologicals that would otherwise be packaged if the item did not have pass-through status to zero for CY 2011. The separate OPPS payment to a hospital for the pass-through diagnostic radiopharmaceutical, contrast agent, or implantable biological, after taking into account any applicable payment offset for the item due to the device or "policy-packaged" APC offset policy, is the item's pass-through payment, which is not subject to a copayment according to the statute. Therefore, we are proposing to not publish a copayment amount for these items in Addenda A and B to the proposed rule.

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TABLE 21.—PROPOSED DRUGS AND BIOLOGICALS WITH PASS-THROUGH STATUS IN CY 2011

CY 2010 HCPCS Code	CY 2010 Long Descriptor	Proposed CY 2011 SI	Proposed CY 2011 APC
A9582	Iodine I-123 iobenguane, diagnostic, per study dose, up to 15 millicuries	G	9247
A9583	Injection, gadofosveset trisodium, 1 ml	G	1299
C9250	Human plasma fibrin sealant, vapor-heated, solvent-detergent (Artiss), 2ml	G	9250
C9255	Injection, paliperidone palmitate, 1 mg	G	9255
C9256	Injection, dexamethasone intravitreal implant, 0.1 mg	G	9256
C9258	Injection, telavancin, 10 mg	G	9258
C9259	Injection, pralatrexate, 1 mg	G	9259
C9260	Injection, ofatumumab, 10 mg	G	9260
C9261	Injection, ustekinumab, 1 mg	G	9261
C9263	Injection, ecallantide, 1 mg	G	9263
C9264	Injection, tocilizumab, 1 mg	G	9624
C9265	Injection, romidepsin, 1 mg	G	9625
C9266	Injection, collagenase clostridium histolyticum, 0.1 mg	G	9266
C9267	Injection, von Willebrand factor complex (human), Wilate, per 100 IU VWF: RCO	G	9267
C9268	Capsaicin, patch, 10cm2	G	9268
C9360	Dermal substitute, native, non-denatured collagen, neonatal bovine origin (SurgiMend Collagen Matrix), per 0.5 square centimeters	G	9360
C9361	Collagen matrix nerve wrap (NeuroMend Collagen Nerve Wrap), per 0.5 centimeter length	G	9361
C9362	Porous purified collagen matrix bone void filler (Integra Mozaik Osteoconductive Scaffold Strip), per 0.5 cc	G	9362
C9363	Skin substitute, Integra Meshed Bilayer Wound Matrix, per square centimeter	G	9363
C9364	Porcine implant, Permacol, per square centimeter	G	9364
C9367	Skin substitute, Endoform Dermal Template, per square centimeter	G	9367
J0598	Injection, C1 esterase inhibitor (human), 10 units	G	9251
J0641	Injection, levoleucovorin calcium, 0.5 mg	G	1236
J0718	Injection, certolizumab pegol, 1 mg	G	9249
J1680	Injection, human fibrinogen concentrate, 100 mg	G	1290
J2562	Injection, plerixafor, 1 mg	G	9252
J8705	Topotecan, oral, 0.25 mg	G	1238
J9155	Injection, degarelix, 1 mg	G	1296
J9328	Injection, temozolomide, 1 mg	G	9253
Q0138	Injection, Ferumoxytol, for treatment of iron deficiency anemia, 1 mg	G	1297
Q2025	Fludarabine phosphate, oral, 1 mg	G	9262

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4. Proposed Provisions for Reducing Transitional Pass-Through Payments for Diagnostic Radiopharmaceuticals and Contrast Agents to Offset Costs Packaged Into APC Groups

a. Background

Prior to CY 2008, diagnostic radiopharmaceuticals and contrast agents were paid separately under the OPPS if their mean per day costs were greater than the applicable year's drug packaging threshold. In CY 2008 (72 FR 66768), we began a policy of packaging payment for all nonpass-through diagnostic radiopharmaceuticals and contrast agents as ancillary and supportive items and services into their associated nuclear medicine procedures. Therefore, beginning in CY 2008, nonpass-through diagnostic radiopharmaceuticals and contrast agents were not subject to the annual OPPS drug packaging threshold to determine their packaged or separately payable payment status, and instead all nonpass-through diagnostic radiopharmaceuticals and contrast agents were packaged as a matter of policy. For CY 2011, we are proposing to continue to package payment for all nonpass-through diagnostic radiopharmaceuticals and contrast agents as discussed in section V.B.2.d. of this proposed rule.

b. Proposed Payment Offset Policy for Diagnostic Radiopharmaceuticals

As previously noted, radiopharmaceuticals are considered to be drugs for OPPS pass-through payment purposes. As described above, section 1833(t)(6)(D)(i) of the Act specifies that the transitional pass-through payment amount for pass-through drugs and biologicals is the difference between the amount paid under section 1842(o) (or the Part B drug CAP rate) and the otherwise applicable OPD fee schedule amount. There is currently one radiopharmaceutical with pass-through status under the OPPS, HCPCS code A9582 (Iobenguane, I–123, diagnostic, per study dose, up to 10 millicuries). HCPCS code A9582 was granted pass-through status beginning April 1, 2009 and will continue on pass-through status in CY 2011. We currently apply the established radiopharmaceutical payment offset policy to pass-through payment for this product. As described earlier in section V.A.3. of this proposed rule, new pass-through diagnostic radiopharmaceuticals will be paid at ASP+6 percent, while those without ASP information will be paid at WAC+6 percent or, if WAC is not available, payment will be based on 95 percent of the product's most recently published AWP.

As a payment offset is necessary in order to provide an appropriate transitional pass-through payment, we deduct from the payment for pass-through radiopharmaceuticals an amount that reflects the portion of the APC payment associated with predecessor radiopharmaceuticals in order to ensure no duplicate radiopharmaceutical payment is made. In CY 2009, we established a policy to estimate the portion of each APC payment rate that could reasonably be attributed to the cost of predecessor diagnostic radiopharmaceuticals when considering a new diagnostic radiopharmaceutical for pass-through payment (73 FR 68638 through 68641). Specifically, we utilize the "policy-packaged" drug offset fraction for APCs containing nuclear medicine procedures, calculated as 1 minus (the cost from single procedure claims in the APC after removing the cost for "policy-packaged" drugs divided by the cost from single procedure claims in the APC). In the CY 2010 OPPS/ASC final rule with comment period (74 FR 60480 through 60484), we finalized a policy to redefine "policy-packaged" drugs as only nonpass-through diagnostic radiopharmaceuticals and contrast agents, as a result of the policy discussed in sections V.A.4. and V.B.2.d. of the CY 2010 OPPS/ASC final rule with comment period (74 FR 60471 through 60477 and 60495 through 60499 respectively) that treats nonpass-through implantable biologicals that are surgically inserted or implanted (through a surgical incision or a natural orifice) and implantable biologicals that are surgically inserted or implanted (through a surgical incision or a natural orifice) with newly approved pass-through status beginning in CY 2010 or later as devices, rather than drugs. To determine the actual APC offset amount for pass-through diagnostic radiopharmaceuticals that takes into consideration the otherwise applicable OPPS payment amount, we multiply the "policy-packaged" drug offset fraction by the APC payment amount for the nuclear medicine procedure with which the pass-through diagnostic radiopharmaceutical is used and, accordingly, reduce the separate OPPS payment for the pass-through diagnostic radiopharmaceutical by this amount.

The Integrated Outpatient Code Editor processes claims for nuclear medicine procedures only when they are performed with a radiolabeled product. Therefore, the radiolabeled product edits in the Integrated Outpatient Code Editor require a hospital to report a diagnostic radiopharmaceutical with a nuclear medicine scan in order to receive payment for the nuclear medicine scan. We have received questions from hospitals on how to bill for a nuclear medicine scan when they receive a diagnostic radiopharmaceutical free of charge or with full credit. Currently, if a hospital receives a diagnostic radiopharmaceutical free of charge or with full credit and uses it to provide a nuclear medicine scan, the hospital could choose not to bill for both the nuclear medicine scan and the diagnostic radiopharmaceutical in order to bypass the radiolabeled product edits, but the hospital clearly would not receive OPPS payment for the scan or the diagnostic radiopharmaceutical. The hospital also could report the diagnostic radiopharmaceutical with the nuclear medicine scan and receive an APC payment that includes payment for the diagnostic radiopharmaceutical, but this would lead to inaccurate billing and incorrect payment. This is because the OPPS should not pay for a free item. We believe neither of the above alternatives is satisfactory.

In order to ensure that the OPPS is making appropriate and equitable payments under such circumstances and that a hospital can comply with the required radiolabeled product edits, we are proposing for CY 2011 to instruct hospitals to report the "FB" modifier on the line with the procedure code for the nuclear medicine scan in the APCs listed in Table E3 in which the no cost/full credit diagnostic radiopharmaceutical is used. Modifier -FB is "Item Provided Without Cost to Provider, Supplier or Practitioner, or Credit Received for Replacement Device (Examples, but not Limited to: Covered Under Warranty, Replaced Due to Defect, Free Samples)." Although this modifier is specific to devices, it captures the concept of the hospital receiving a key component of the service without cost. In cases in which the diagnostic radiopharmaceutical is furnished without cost or with full credit, we are proposing to instruct the hospital to report a token charge of less than $1.01. We refer readers to the CY 2008 OPPS/ASC final rule with comment period for more background information on the "FB" payment adjustment policies (72 FR 66743 through 66749). We are proposing that when a hospital bills an -FB with the nuclear medicine scan, the payment amount for procedures in the APCs listed in Table 20 would be reduced by the full "policy-packaged" offset amount appropriate for diagnostic

radiopharmaceuticals. As discussed in our CY 2009 OPPS/ASC final rule with comment period, the "policy packaged" offset amount that we calculate estimates the portion of each APC payment rate that could reasonably be attributed to the cost of predecessor diagnostic radiopharmaceuticals when considering a new diagnostic radiopharmaceutical for pass-through payment (73 FR 68638 through 68641). As in our offset policy, discussed below, we believe it is appropriate to remove the "policy packaged" offset amount from payment for a nuclear medicine scan with a diagnostic radiopharmaceutical received at no cost or full credit which is billed using one of the APCs appearing in Table 22 below because it represents the portion of the APC payment attributable to diagnostic radiopharmaceuticals used in the performance of a nuclear medicine scan. Using the -FB modifier with radiolabeled products will allow the hospital to bill accurately for a diagnostic radiopharmaceutical received free of charge and will allow the hospital to comply with the radiolabeled product edits to ensure appropriate payment.

At this time, we are not proposing to recognize modifier FC, which is defined as "Partial credit received for replaced device," because we were unsure of the circumstances in which hospitals would receive a diagnostic radiopharmaceutical at reduced cost to replace a previously provided diagnostic radiopharmaceutical. We invite public comment on when a diagnostic radiopharmaceutical is provided for a significantly reduced price and whether the "FC" modifier is appropriate for radiolabeled products.

We will continue to post annually on the CMS Web site at *http://www.cms.gov/HospitalOutpatientPPS,* a file that contains the APC offset amounts that would be used for that year for purposes of both evaluating cost significance for candidate pass-through device categories and drugs and biologicals, including diagnostic radiopharmaceuticals, and establishing any appropriate APC offset amounts. Specifically, the file will continue to provide, for every OPPS clinical APC, the amounts and percentages of APC payment associated with packaged implantable devices, including implantable biologicals; "policy-packaged" drugs, including diagnostic radiopharmaceuticals and contrast agents; and "threshold-packaged" drugs and biologicals, which are all other drugs, therapeutic radiopharmaceuticals, and nonimplantable biologicals.

Table 22 below displays the proposed APCs to which nuclear medicine procedures would be assigned in CY 2011 and for which we expect that an APC offset could be applicable in the case of new diagnostic radiopharmaceuticals with pass-through status.

TABLE 22.—PROPOSED APCs TO WHICH NUCLEAR MEDICINE PROCEDURES WOULD BE ASSIGNED FOR CY 2011

Proposed CY 2011 APC	Proposed CY 2011 APC Title
0307	Myocardial Positron Emission Tomography (PET) imaging.
0308	Non-Myocardial Positron Emission Tomography (PET) imaging.
0377	Level II Cardiac Imaging.
0378	Level II Pulmonary Imaging.
0389	Level I Non-imaging Nuclear Medicine.
0390	Level I Endocrine Imaging.
0391	Level II Endocrine Imaging.
0392	Level II Non-imaging Nuclear Medicine.
0393	Hematologic Processing & Studies.
0394	Hepatobiliary Imaging.
0395	GI Tract Imaging.
0396	Bone Imaging.
0397	Vascular Imaging.
0398	Level I Cardiac Imaging.
0400	Hematopoietic Imaging.
0401	Level I Pulmonary Imaging.
0402	Level II Nervous System Imaging.
0403	Level I Nervous System Imaging.
0404	Renal and Genitourinary Studies.
0406	Level I Tumor/Infection Imaging.
0408	Level II Tumor/Infection Imaging.
0414	Level II Tumor/Infection Imaging.

c. Proposed Payment Offset Policy for Contrast Agents

As described above, section 1833(t)(6)(D)(i) of the Act specifies that the transitional pass-through payment amount for pass-through drugs and biologicals is the difference between the amount paid under section 1842(o) (or the Part B drug CAP rate) and the otherwise applicable OPD fee schedule amount. There is currently one contrast agent with pass-through status under the OPPS, HCPCS code A9583 (Injection, gadoxetate disodium, per ml). HCPCS code A9583 was granted pass-through status beginning January 1, 2010, and will continue with pass-through status in CY 2011. As described earlier in section V.A.3. of this proposed rule, new pass-through contrast agents would be paid at ASP+6 percent, while those without ASP information would be paid at WAC+6 percent or, if WAC is not available, payment would be based on 95 percent of the product's most recently published AWP.

We believe that a payment offset is necessary in order to provide an appropriate transitional pass-through payment for contrast agents because all of these items are packaged when they do not have pass-through status. In accordance with our standard offset methodology, for CY 2011 we are proposing to deduct from the payment for pass-through contrast agents an amount that reflects the portion of the APC payment associated with predecessor contrast agents in order to ensure no duplicate contrast agent payment is made.

In CY 2010, we established a policy to estimate the portion of each APC payment rate that could reasonably be attributed to the cost of predecessor contrast agents when considering new contrast agents for pass-through payment (74 FR 60482 through 60484). For CY 2011, we are proposing to continue to apply this same policy to contrast agents. Specifically, we are proposing to utilize the "policy-packaged" drug offset fraction for clinical APCs calculated as 1 minus (the cost from single procedure claims in the APC after removing the cost for "policy-packaged" drugs divided by the cost from single procedure claims in the APC). As discussed above, in CY 2010, we finalized a policy to redefine "policy-packaged" drugs as only nonpass-through diagnostic radiopharmaceuticals and contrast agents (74 FR 60495 through 60499). To determine the actual APC offset amount for pass-through contrast agents that takes into consideration the otherwise applicable OPPS payment amount, we are proposing to multiply the "policy-packaged" drug offset fraction by the APC payment amount for the procedure with which the pass-through contrast agent is used and, accordingly, reduce the separate OPPS payment for the pass-through contrast agent by this amount.

We are proposing to continue to post annually on the CMS Web site at *http://www.cms.gov/HospitalOutpatientPPS,* a file that contains the APC offset amounts that would be used for that year for purposes of both evaluating cost significance for candidate pass-through device categories and drugs and biologicals, including contrast agents, and establishing any appropriate APC offset amounts. Specifically, the file will continue to provide, for every OPPS clinical APC, the amounts and percentages of APC payment associated with packaged implantable devices, "policy-packaged" drugs, and "threshold-packaged" drugs and biologicals.

Proposed procedural APCs for which we expect a contrast agent offset could be applicable in the case of a pass-through contrast agent have been identified as any procedural APC with a "policy-packaged" drug amount greater than $20 that is not a nuclear medicine APC identified in Table 20 above, and these APCs are displayed in Table 23 below. The methodology used to determine a proposed threshold cost for application of a contrast agent offset policy is described in detail in the CY 2010 OPPS/ASC final rule with comment period (70 FR 60483 through 60484). For CY 2011, we are proposing to continue to recognize that when a contrast agent with pass-through status is billed with any procedural APC listed in Table 23, a specific offset based on the procedural APC would be applied to payment for the contrast agent to ensure that duplicate payment is not made for the contrast agent.

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TABLE 23.--APCs TO WHICH A CONTRAST AGENT OFFSET MAY BE APPLICABLE FOR CY 2011

Proposed CY 2011 APC	Proposed CY 2011 APC Title
0080	Diagnostic Cardiac Catheterization.
0082	Coronary or Non-Coronary Atherectomy.
0083	Coronary or Non-Coronary Angioplasty and Percutaneous Valvulopasty.
0093	Vascular Reconstruction/Fistula Repair without Device.
0104	Transcathether Placement of Intracoronary Stents.
0128	Echocardiogram with Contrast.
0152	Level I Percutaneous Abdominal and Biliary Procedures.
0229	Transcathether Placement of Intravascular Shunts.
0278	Diagnostic Urography.
0279	Level II Angiography and Venography.
0280	Level III Angiography and Venography.
0283	Computed Tomography with Contrast.
0284	Magnetic Resonance Imaging and Magnetic Resonance Angiography with Contrast.
0333	Computed Tomography without Contrast followed by Contrast.
0337	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast followed by Contrast.
0375	Ancillary Outpatient Services When Patient Expires.
0383	Cardiac Computed Tomographic Imaging.
0388	Discography.
0418	Insertion of Left Ventricular Pacing Elect.
0442	Dosimetric Drug Administration.
0653	Vascular Reconstruction/Fistula Repair with Device.
0656	Transcatheter Placement of Intracoronary Drug-Eluting Stents.
0662	CT Angiography.
0668	Level I Angiography and Venography.
8006	CT and CTA with Contrast Composite.
8008	MRI and MRA with Contrast Composite.

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B. Proposed OPPS Payment for Drugs, Biologicals, and Radiopharmaceuticals Without Pass-Through Status

1. Background

Under the CY 2010 OPPS, we currently pay for drugs, biologicals, and radiopharmaceuticals that do not have pass-through status in one of two ways: Packaged payment into the payment for the associated service; or separate payment (individual APCs). We explained in the April 7, 2000 OPPS final rule with comment period (65 FR 18450) that we generally package the cost of drugs and radiopharmaceuticals into the APC payment rate for the procedure or treatment with which the products are usually furnished. Hospitals do not receive separate payment for packaged items and supplies, and hospitals may not bill beneficiaries separately for any packaged items and supplies whose costs are recognized and paid within the national OPPS payment rate for the associated procedure or service. (Transmittal A–01–133, issued on November 20, 2001, explains in greater detail the rules regarding separate payment for packaged services.)

Packaging costs into a single aggregate payment for a service, procedure, or episode-of-care is a fundamental principle that distinguishes a prospective payment system from a fee schedule. In general, packaging the costs of items and services into the payment for the primary procedure or service with which they are associated encourages hospital efficiencies and also enables hospitals to manage their resources with maximum flexibility.

Section 1833(t)(16)(B) of the Act, as added by section 621(a)(2) of Public Law 108–173, set the threshold for establishing separate APCs for drugs and biologicals at $50 per administration for CYs 2005 and 2006. Therefore, for CYs 2005 and 2006, we paid separately for drugs, biologicals, and radiopharmaceuticals whose per day cost exceeded $50 and packaged the costs of drugs, biologicals, and radiopharmaceuticals whose per day cost was equal to or less than $50 into the procedures with which they were billed. For CY 2007, the packaging threshold for drugs, biologicals, and radiopharmaceuticals that were not new and did not have pass-through status was established at $55. For CYs 2008 and 2009, the packaging threshold for drugs, biologicals, and radiopharmaceuticals that were not new and did not have pass-through status was established at $60. For CY 2010, the packaging threshold for drugs, biologicals, and radiopharmaceuticals that were not new and did not have pass-through status was established at $65. The methodology used to establish the $55 threshold for CY 2007, the $60 threshold for CYs 2008 and 2009, the $65 threshold for CY 2010, and our proposed approach for CY 2011 are discussed in more detail in section V.B.2.b. of this proposed rule.

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

a. Background

As indicated in section V.B.1. of this proposed rule, in accordance with section 1833(t)(16)(B) of the Act, the threshold for establishing separate APCs for payment of drugs and biologicals was set to $50 per administration during CYs 2005 and 2006. In CY 2007, we used the fourth quarter moving average Producer Price Index (PPI) levels for prescription preparations to trend the $50 threshold forward from the third quarter of CY 2005 (when the Pub. L. 108–173 mandated threshold became effective) to the third quarter of CY 2007. We then rounded the resulting dollar amount to the nearest $5 increment in order to determine the CY 2007 threshold amount of $55. Using the same methodology as that used in CY 2007 (which is discussed in more detail in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68085 through 68086)), we set the packaging threshold for establishing separate APCs for drugs and biologicals at $60 for CYs 2008 and 2009. For CY 2010 we set the packaging threshold at $65.

Following the CY 2007 methodology, for CY 2011, we used updated fourth quarter moving average PPI levels to trend the $50 threshold forward from the third quarter of CY 2005 to the third quarter of CY 2011 and again rounded the resulting dollar amount ($70.64) to the nearest $5 increment, which yielded a figure of $70. In performing this calculation, we used the most up-to-date forecasted, quarterly PPI estimates from CMS' Office of the Actuary (OACT). As actual inflation for past quarters replaced forecasted amounts, the PPI estimates for prior quarters have been revised (compared with those used in the CY 2007 OPPS/ASC final rule with comment period) and have been incorporated into our calculation. Based on the calculations described above, we are proposing a packaging threshold for CY 2011 of $70. (For a more detailed discussion of the OPPS drug packaging threshold and the use of the PPI for prescription drugs, we refer readers to the CY 2007 OPPS/ASC final rule with comment period (71 FR 68085 through 68086).)

b. Proposed Cost Threshold for Packaging of Payment for HCPCS Codes that Describe Certain Drugs, Nonimplantable Biologicals, and Therapeutic Radiopharmaceuticals ("Threshold-Packaged Drugs")

To determine their proposed CY 2011 packaging status, for this proposed rule, we calculated the per day cost of all drugs on a HCPCS code-specific basis (with the exception of those drugs and biologicals with multiple HCPCS codes that include different dosages as described in section V.B.2.c. of this proposed rule and excluding diagnostic radiopharmaceuticals, contrast agents, and implantable biologicals that we are proposing to continue to package in CY 2011 as discussed in section V.B.2.d. of this proposed rule), nonimplantable biologicals, and therapeutic radiopharmaceuticals (collectively called "threshold-packaged" drugs) that had a HCPCS code in CY 2009 and were paid (via packaged or separate payment) under the OPPS, using CY 2009 claims data processed before January 1, 2010. In order to calculate the per day costs for drugs, nonimplantable biologicals, and therapeutic radiopharmaceuticals to determine their proposed packaging status in CY 2011, we used the methodology that was described in detail in the CY 2006 OPPS proposed rule (70 FR 42723 through 42724) and finalized in the CY 2006 OPPS final rule with comment period (70 FR 68636 through 70 FR 68638).

To calculate the CY 2011 proposed rule per day costs, we used an estimated payment rate for each drug and nonimplantable biological HCPCS code of ASP+6 percent (which is the payment rate we are proposing for separately payable drugs and nonimplantable biologicals in CY 2011, as discussed in more detail in section V.B.3.b. of this proposed rule). We used the manufacturer submitted ASP data from the fourth quarter of CY 2009 (data that were used for payment purposes in the physician's office setting, effective April 1, 2010) to determine the proposed rule per day cost.

As is our standard methodology, for CY 2011, we are proposing to use payment rates based on the ASP data from the fourth quarter of CY 2009 for budget neutrality estimates, packaging determinations, impact analyses, and completion of Addenda A and B to this proposed rule because these are the most recent data available for use at the time of development of this proposed rule. These data are also the basis for drug payments in the physician's office

setting, effective April 1, 2010. For items that did not have an ASP-based payment rate, such as some therapeutic radiopharmaceuticals, we used their mean unit cost derived from the CY 2009 hospital claims data to determine their per day cost. We are proposing to package items with a per day cost less than or equal to $70 and identified items with a per day cost greater than $70 as separately payable. Consistent with our past practice, we crosswalked historical OPPS claims data from the CY 2009 HCPCS codes that were reported to the CY 2010 HCPCS codes that we displayed in Addendum B to this proposed rule for payment in CY 2011.

Our policy during previous cycles of the OPPS has been to use updated ASP and claims data to make final determinations of the packaging status of HCPCS codes for drugs, nonimplantable biologicals, and therapeutic radiopharmaceuticals for the final rule with comment period. We note that it is also our policy to make an annual packaging determination for a HCPCS code only when we develop the OPPS/ASC final rule for the update year. Only HCPCS codes that are identified as separately payable in the final rule with comment period are subject to quarterly updates. For our calculation of per day costs of HCPCS codes for drugs and nonimplantable biologicals in the CY 2011 OPPS/ASC final rule with comment period, we are proposing to use ASP data from the first quarter of CY 2010, which is the basis for calculating payment rates for drugs and biologicals in the physician's office setting using the ASP methodology, effective July 1, 2010, along with updated hospital claims data from CY 2009. We note that we also would use these data for budget neutrality estimates and impact analyses for the CY 2011 OPPS/ASC final rule with comment period. Payment rates for HCPCS codes for separately payable drugs and nonimplantable biologicals included in Addenda A and B to that final rule with comment period would be based on ASP data from the second quarter of CY 2010, which are the basis for calculating payment rates for drugs and biologicals in the physician's office setting using the ASP methodology, effective October 1, 2010. These rates would then be updated in the January 2011 OPPS update, based on the most recent ASP data to be used for physician's office and OPPS payment as of January 1, 2011. For items that do not currently have an ASP-based payment rate, we would recalculate their mean unit cost from all of the CY 2009 claims data and updated cost report information available for the CY 2011 final rule with comment period to determine their final per day cost.

Consequently, the packaging status of some HCPCS codes for drugs, nonimplantable biologicals, and therapeutic radiopharmaceuticals in the CY 2011 OPPS/ASC final rule with comment period using the updated data may be different from the same drug HCPCS code's packaging status determined based on the data used for this proposed rule. Under such circumstances, we are proposing to continue the established policies initially adopted for the CY 2005 OPPS (69 FR 65780) in order to more equitably pay for those drugs whose median cost fluctuates relative to the CY 2011 OPPS drug packaging threshold and the drug's payment status (packaged or separately payable) in CY 2010. Specifically, we are proposing for CY 2011 to apply the following policies to these HCPCS codes for drugs, nonimplantable biologicals, and therapeutic radiopharmaceuticals whose relationship to the $70 drug packaging threshold changes based on the final updated data:

- HCPCS codes for drugs and nonimplantable biologicals that were paid separately in CY 2010 and that were proposed for separate payment in CY 2011, and then have per day costs equal to or less than $70, based on the updated ASPs and hospital claims data used for the CY 2011 final rule with comment period, would continue to receive separate payment in CY 2011.
- HCPCS codes for drugs and nonimplantable biologicals that were packaged in CY 2010 and that were proposed for separate payment in CY 2011, and then have per day costs equal to or less than $70, based on the updated ASPs and hospital claims data used for the CY 2011 final rule with comment period, would remain packaged in CY 2011.
- HCPCS codes for drugs and nonimplantable biologicals for which we proposed packaged payment in CY 2011 but then have per day costs greater than $70, based on the updated ASPs and hospital claims data used for the CY 2011 final rule with comment period, would receive separate payment in CY 2011. In the CY 2010 OPPS/ASC final rule (74 FR 60485 through 60489), we implemented a policy to treat oral and injectable forms of 5–HT3 antiemetics comparable to all other threshold packaged drugs, nonimplantable biologicals, and therapeutic radiohpharmaceuticals under our standard packaging methodology of packaging drugs with a per day cost less than $70. For CY 2011, we are proposing to continue our policy of not exempting these 5–HT3 antiemetic products from our standard packaging methodology and to package payment for all of the 5–HT3 antiemetics except palonosetron hydrochloride, consistent with their estimated per day costs from the CY 2009 claims data.

c. Proposed Packaging Determination for HCPCS Codes That Describe the Same Drug or Biological But Different Dosages

In the CY 2008 OPPS/ASC final rule with comment period (72 FR 66776), we began recognizing, for OPPS payment purposes, multiple HCPCS codes reporting different dosages for the same covered Part B drugs or biologicals in order to reduce hospitals' administrative burden by permitting them to report all HCPCS codes for drugs and biologicals. In general, prior to CY 2008, the OPPS recognized for payment only the HCPCS code that described the lowest dosage of a drug or biological. We extended this recognition to multiple HCPCS codes for several other drugs under the CY 2009 OPPS (73 FR 68665). During CYs 2008 and 2009, we applied a policy that assigned the status indicator of the previously recognized HCPCS code to the associated newly recognized code(s), reflecting the new code(s)' packaged or separately payable status. In the CY 2008 OPPS/ASC final rule with comment period (72 FR 66775), we explained that once claims data were available for these previously unrecognized HCPCS codes, we would determine the packaging status and resulting status indicator for each HCPCS code according to the general, established HCPCS code-specific methodology for determining a code's packaging status for a given update year. However, we also stated that we planned to closely follow our claims data to ensure that our annual packaging determinations for the different HCPCS codes describing the same drug or biological did not create inappropriate payment incentives for hospitals to report certain HCPCS codes instead of others.

In the CY 2010 OPPS/ASC final rule with comment period (74 FR 60490 through 60491), we finalized a policy to make a single packaging determination for a drug, rather than an individual HCPCS code, when a drug has multiple HCPCS codes describing different dosages. We analyzed CY 2008 claims data for the HCPCS codes describing different dosages of the same drug or biological that were newly recognized in CY 2008 and found that our claims data would result in several different packaging determinations for different codes describing the same drug or biological. Furthermore, we found that

our claims data would include few units and days for a number of newly recognized HCPCS codes, resulting in our concern that these data reflected claims from only a small number of hospitals, even though the drug or biological itself may be reported by many other hospitals under the most common HCPCS code. Based on these findings from our first available claims data for the newly recognized HCPCS codes, we believed that adopting our standard HCPCS code-specific packaging determinations for these codes could lead to payment incentives for hospitals to report certain HCPCS codes instead of others, particularly because we do not currently require hospitals to report all drug and biological HCPCS codes under the OPPS in consideration of our previous policy that generally recognized only the lowest dosage HCPCS code for a drug or biological for OPPS payment. For CY 2011, we continue to believe that adopting the standard HCPCS code-specific packaging determinations for these codes could lead to payment incentives for hospitals to report certain HCPCS codes for drugs instead of others. Making packaging determinations on a drug-specific basis eliminates these incentives and allows hospitals flexibility in choosing to report all HCPCS codes for different dosages of the same drug or only the lowest dosage HCPCS code. Therefore, we are proposing to continue our policy to make packaging determinations on a drug-specific basis, rather than a HCPCS code-specific basis, for those HCPCS codes that describe the same drug or biological but different dosages in CY 2011.

For CY 2011, in order to propose a packaging determination that is consistent across all HCPCS codes that describe different dosages of the same drug or biological, we aggregated both our CY 2009 claims data and our pricing information at ASP+6 percent across all of the HCPCS codes that describe each distinct drug or biological in order to determine the mean units per day of the drug or biological in terms of the HCPCS code with the lowest dosage descriptor. HCPCS codes J9093 (cyclophosphamide, lyophilized, 100 mg), J9094 (cyclophosphamide, lyophilized, 200 mg), J9095 (cyclophosphamide, lyophilized, 500 mg), J9096 (cyclophosphamide, lyophilized, 1g), and J9097 (cyclophosphamide, lyophilized, 2g) did not have pricing information available for the ASP methodology and, as is our current policy for determining the packaging status of other drugs, we used the mean unit cost available from fourth quarter CY 2009 claims data to make the packaging determinations for these drugs. For all other drugs and biologicals that have HCPCS codes describing different dosages, we then multiplied the weighted average ASP+6 percent or mean unit cost payment amount across all dosage levels of a specific drug or biological by the estimated units per day for all HCPCS codes that describe each drug or biological from our claims data to determine the estimated per day cost of each drug or biological at less than or equal to $70 (whereupon all HCPCS codes for the same drug or biological would be packaged) or greater than $70 (whereupon all HCPCS codes for the same drug or biological would be separately payable). The proposed packaging status of each drug and biological HCPCS code to which this methodology would apply is displayed in Table 24.

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TABLE 24.—HCPCS CODES TO WHICH THE PROPOSED CY 2011 DRUG-SPECFIFIC PACKAGING DETERMINATION METHODOLOGY APPLIES

CY 2010 HCPCS Code	CY 2010 Long Descriptor	Proposed CY 2011 SI
C9257	Injection, bevacizumab, 0.25 mg	K
J9035	Injection, bevacizumab, 10 mg	K
J1380	Injection, estradiol valerate, up to 10 mg	N
J0970	Injection, estradiol valerate, up to 40 mg	N
J1390	Injection, estradiol valerate, up to 20 mg	N
J1020	Injection, methylprednisolone acetate, 20 mg	N
J1030	Injection, methylprednisolone acetate, 40 mg	N
J1040	Injection, methylprednisolone acetate, 80 mg	N
J1070	Injection, testosterone cypionate, up to 100 mg	N
J1080	Injection, testosterone cypionate, 1 cc, 200 mg	N
J1440	Injection, filgrastim (g-csf), 300 mcg	K
J1441	Injection, filgrastim (g-csf), 480 mcg	K
J1460	Injection, gamma globulin, intramuscular, 1 cc	K
J1470	Injection, gamma globulin, intramuscular 2 cc	K
J1480	Injection, gamma globulin, intramuscular 3 cc	K
J1490	Injection, gamma globulin, intramuscular 4 cc	K
J1500	Injection, gamma globulin, intramuscular 5 cc	K
J1510	Injection, gamma globulin, intramuscular 6 cc	K
J1520	Injection, gamma globulin, intramuscular 7 cc	K
J1530	Injection, gamma globulin, intramuscular 8 cc	K
J1540	Injection, gamma globulin, intramuscular 9 cc	K
J1550	Injection, gamma globulin, intramuscular 10 cc	K
J1560	Injection, gamma globulin, intramuscular over 10 cc	K
J1642	Injection, heparin sodium, (heparin lock flush), per 10 units	N
J1644	Injection, heparin sodium, per 1000 units	N
J1850	Injection, kanamycin sulfate, up to 75 mg	N
J1840	Injection, kanamycin sulfate, up to 500 mg	N
J2270	Injection, morphine sulfate, up to 10 mg	N
J2271	Injection, morphine sulfate, 100mg	N
J2320	Injection, nandrolone decanoate, up to 50 mg	K
J2321	Injection, nandrolone decanoate, up to 100 mg	K
J2322	Injection, nandrolone decanoate, up to 200 mg	K
J2788	Injection, rho d immune globulin, human, minidose, 50 micrograms (250 i.u.)	K
J2790	Injection, rho d immune globulin, human, full dose, 300 micrograms (1500 i.u.)	K
J2920	Injection, methylprednisolone sodium succinate, up to 40 mg	N
J2930	Injection, methylprednisolone sodium succinate, up to 125 mg	N
J3120	Injection, testosterone enanthate, up to 100 mg	N

CY 2010 HCPCS Code	CY 2010 Long Descriptor	Proposed CY 2011 SI
J3130	Injection, testosterone enanthate, up to 200 mg	N
J3471	Injection, hyaluronidase, ovine, preservative free, per 1 usp unit (up to 999 usp units)	N
J3472	Injection, hyaluronidase, ovine, preservative free, per 1000 usp units	N
J7050	Infusion, normal saline solution , 250 cc	N
J7040	Infusion, normal saline solution, sterile (500 ml=1 unit)	N
J7030	Infusion, normal saline solution , 1000 cc	N
J7515	Cyclosporine, oral, 25 mg	N
J7502	Cyclosporine, oral, 100 mg	N
J8520	Capecitabine, oral, 150 mg	K
J8521	Capecitabine, oral, 500 mg	K
J9060	Cisplatin, powder or solution, per 10 mg	N
J9062	Cisplatin, 50 mg	N
J9070	Cyclophosphamide, 100 mg	N
J9080	Cyclophosphamide, 200 mg	N
J9090	Cyclophosphamide, 500 mg	N
J9091	Injection, cyclophosphamide, 1.0 gram	N
J9092	Cyclophosphamide, 2.0 gram	N
J9093	Cyclophosphamide, lyophilized, 100 mg	N
J9094	Cyclophosphamide, lyophilized, 200 mg	N
J9095	Cyclophosphamide, lyophilized, 500 mg	N
J9096	Cyclophosphamide, lyophilized, 1g	N
J9097	Cyclophosphamide, lyophilized, 2g	N
J9100	Injection, cytarabine, 100 mg	N
J9110	Injection, cytarabine, 500 mg	N
J9130	Dacarbazine, 100 mg	N
J9140	Injection, dacarbazine, 200 mg	N
J9250	Methotrexate sodium, 5 mg	N
J9260	Methotrexate sodium, 50 mg	N
J9280	Mitomycin, 5 mg	K
J9290	Mitomycin, 20 mg	K
J9291	Mitomycin, 40 mg	K
J9370	Vincristine sulfate, 1 mg	N
J9375	Vincristine sulfate, 2 mg	N
J9380	Vincristine sulfate, 5 mg	N
Q0164	Prochlorperazine maleate, 5 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48-hour doseage regimen	N
Q0165	Prochlorperazine maleate, 10 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy	N

CY 2010 HCPCS Code	CY 2010 Long Descriptor	Proposed CY 2011 SI
	treatment, not to exceed a 48-hour doseage regimen	
Q0167	Dronabinol, 2.5 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anit0emetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen	N
Q0168	Dronabinol, 5 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anit0emetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen	N
Q0169	Promethazine hydrochloride, 12.5 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV antiemetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen	N
Q0170	Promethazine hydrochloride, 25 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV antiemetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen	N
Q0171	Chlorpromazine hydrochloride, 10 mg, oral, FDA approved prescription antiemetic, for use as a complete therapeutic substitute for an IV antiemetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen	N
Q0172	Chlorpromazine hydrochloride, 25 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotheapy treatment, not to exceed a 48-hour dosage regimen	N
Q0175	Perphenazine, 4 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen	N
Q0176	Perphenazine, 8 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen	N
Q0177	Hydroxyzine pamoate, 25 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen	N
Q0178	Hydroxyzine pamoate, 50 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exeed a 48-hour dosage regimen	N

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d. Proposed Packaging of Payment for Diagnostic Radiopharmaceuticals, Contrast Agents, and Implantable Biologicals ("Policy-Packaged" Drugs and Devices)

Prior to CY 2008, the methodology of calculating a product's estimated per day cost and comparing it to the annual OPPS drug packaging threshold was used to determine the packaging status of drugs, biologicals, and radiopharmaceuticals under the OPPS (except for our CYs 2005 through 2009 exemption for 5–HT3 antiemetics). However, as established in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66766 through 66768), we began packaging payment for all diagnostic radiopharmaceuticals and contrast agents into the payment for the associated procedure, regardless of their per day costs. In addition, in CY 2009 we adopted a policy that packaged the payment for nonpass-through implantable biologicals into payment for the associated surgical procedure on the claim (73 FR 68633 through 68636). We refer to diagnostic radiopharmaceuticals and contrast agents collectively as "policy-packaged" drugs and to implantable biologicals as devices because, in CY 2010, we began to treat implantable biologicals as devices for all OPPS payment purposes.

According to our regulations at § 419.2(b), as a prospective payment system, the OPPS establishes a national payment rate that includes operating and capital-related costs that are directly related and integral to performing a procedure or furnishing a service on an outpatient basis including, but not limited to, implantable prosthetics, implantable durable medical equipment, and medical and surgical supplies. Packaging costs into a single aggregate payment for a service, encounter, or episode-of-care is a fundamental principle that distinguishes a prospective payment system from a fee schedule. In general, packaging the costs of items and services into the payment for the primary procedure or service with which they are associated encourages hospital efficiencies and also enables hospitals to manage their resources with maximum flexibility.

Prior to CY 2008, we noted that the proportion of drugs, biologicals, and radiopharmaceuticals that were separately paid under the OPPS had increased in recent years, a pattern that we also observed for procedural services under the OPPS. Our final CY 2008 policy that packaged payment for all nonpass-through diagnostic radiopharmaceuticals and contrast agents, regardless of their per day costs, contributed significantly to expanding the size of the OPPS payment bundles and is consistent with the principles of a prospective payment system.

As discussed in more detail in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68645 through 68649), we presented several reasons supporting our initial policy to package payment of diagnostic radiopharmaceuticals and contrast agents into their associated procedures on a claim. Specifically, we stated that we believed packaging was appropriate because: (1) The statutory requirement that we must pay separately for drugs and biologicals for which the per day cost exceeds $50 under section 1833(t)(16)(B) of the Act has expired; (2) we believe that diagnostic radiopharmaceuticals and contrast agents function effectively as supplies that enable the provision of an independent service; and (3) section 1833(t)(14)(A)(iii) of the Act requires that payment for specified covered outpatient drugs (SCODs) be set prospectively based on a measure of average hospital acquisition cost. For these reasons, we believe it is appropriate to continue to treat diagnostic radiopharmaceuticals and contrast agents differently from other SCODs for CY 2011. Therefore, we are proposing to continue packaging payment for all contrast agents and diagnostic radiopharmaceuticals, collectively referred to as "policy-packaged" drugs, regardless of their per day costs, for CY 2011. We also are proposing to continue to package the payment for diagnostic radiopharmaceuticals into the payment for the associated nuclear medicine procedure and to package the payment for contrast agents into the payment of the associated echocardiography imaging procedure, regardless of whether the contrast agent met the OPPS drug packaging threshold. We refer readers to the CY 2010 OPPS/ASC final rule with comment period for a detailed discussion of nuclear medicine and echocardiography services (74 FR 35269 through 35277).

In CY 2009 (73 FR 68634), we began packaging the payment for all nonpass-through implantable biologicals into payment for the associated surgical procedure. Because implantable biologicals may sometimes substitute for nonbiological devices, we noted that if we were to provide separate payment for implantable biologicals without pass-through status, we would potentially be providing duplicate device payment, both through the packaged nonbiological device cost already included in the surgical procedure's payment and separate biological payment. We concluded that we saw no basis for treating implantable biological and nonbiological devices without pass-through status differently for OPPS payment purposes because both are integral to and supportive of the separately paid surgical procedures in which either may be used. Therefore, in CY 2009, we adopted a final policy to package payment for all nonpass-through implantable biologicals that are surgically inserted or implanted (through a surgical incision or a natural orifice), like our longstanding policy that packages payment for all implantable nonbiological devices without pass-through status. We finalized a policy in CY 2010 to package payment for nonpass-through implantable biologicals that are surgically inserted or implanted (through a surgical incision or a natural orifice) into the body, known as devices. For CY 2011, we are proposing to continue to package payment for nonpass-through implantable biologicals that are surgically inserted or implanted (through a surgical incision or a natural orifice) into the body, referred to as devices. In accordance with this proposal, two of the products with expiring pass-through status for CY 2011 are biologicals that are solely surgically implanted according to their FDA-approved indications. These products are described by HCPCS codes C9356 (Tendon, porous matrix of cross-linked collagen and glycosaminoglycan matrix (TenoGlide Tendon Protector Sheet), per square centimeter) and C9359 (Porous purified collagen matrix bone void filler (Integra Mozaik Osteoconductive Scaffold Putty, Integra OS Osteoconductive Scaffold Putty), per 0.5 cc). Like the two implantable biologicals with expiring pass-through status in CY 2010 that were discussed in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60459 through 60499), we believe that the two biologicals specified above with expiring pass-through status for CY 2011 differ from other biologicals paid under the OPPS in that they specifically function as surgically implanted devices. As a result of the CY 2010 packaged payment methodology for all nonpass-through implantable biologicals, we are proposing to package payment for HCPCS codes C9356 and C9359 and assign them status indicator "N" for CY 2011. In addition, any new biologicals without pass-through status that are surgically inserted or implanted (through a surgical incision or a natural orifice) would be packaged in CY 2011.

Moreover, for nonpass-through biologicals that may sometimes be used as implantable devices, we continue to instruct hospitals to not bill separately for the HCPCS codes for the products when used as implantable devices. This reporting ensures that the costs of these products that may be, but are not always, used as implanted biologicals are appropriately packaged into payment for the associated implantation procedures.

3. Proposed Payment for Drugs and Biologicals without Pass-Through Status That Are Not Packaged

a. Proposed Payment for Specified Covered Outpatient Drugs (SCODs) and Other Separately Payable and Packaged Drugs and Biologicals

Section 1833(t)(14) of the Act defines certain separately payable radiopharmaceuticals, drugs, and biologicals and mandates specific payments for these items. Under section 1833(t)(14)(B)(i) of the Act, a "specified covered outpatient drug" is a covered outpatient drug, as defined in section 1927(k)(2) of the Act, for which a separate APC has been established and that either is a radiopharmaceutical agent or is a drug or biological for which payment was made on a pass-through basis on or before December 31, 2002.

Under section 1833(t)(14)(B)(ii) of the Act, certain drugs and biologicals are designated as exceptions and are not included in the definition of "specified covered outpatient drugs," known as SCODs. These exceptions are—

- A drug or biological for which payment is first made on or after January 1, 2003, under the transitional pass-through payment provision in section 1833(t)(6) of the Act.
- A drug or biological for which a temporary HCPCS code has not been assigned.
- During CYs 2004 and 2005, an orphan drug (as designated by the Secretary).

Section 1833(t)(14)(A)(iii) of the Act requires that payment for SCODs in CY 2006 and subsequent years be equal to the average acquisition cost for the drug for that year as determined by the Secretary, subject to any adjustment for overhead costs and taking into account the hospital acquisition cost survey data collected by the Government Accountability Office (GAO) in CYs 2004 and 2005. If hospital acquisition cost data are not available, the law requires that payment be equal to payment rates established under the methodology described in section 1842(o), section 1847A, or section 1847B of the Act, as calculated and adjusted by the Secretary as necessary. Most physician Part B drugs are paid pursuant to ASP+6 percent pursuant to section 1842(o) of the Act and section 1847A of the Act.

Section 1833(t)(14)(E) of the Act provides for an adjustment in OPPS payment rates for overhead and related expenses, such as pharmacy services and handling costs. Section 1833(t)(14)(E)(i) of the Act required MedPAC to study pharmacy overhead and to make recommendations to the Secretary regarding whether, and if so how, a payment adjustment should be made to compensate hospitals for them. Section 1833(t)(14)(E)(ii) of the Act authorizes the Secretary to adjust the weights for ambulatory procedure classifications for SCODs to take into account the findings of the MedPAC study.

In the CY 2006 OPPS proposed rule (70 FR 42728), we discussed the June 2005 report by MedPAC regarding pharmacy overhead costs in HOPDs and summarized the findings of that study:

- Handling costs for drugs, biologicals, and radiopharmaceuticals administered in the HOPD are not insignificant;
- Little information is available about the magnitude of pharmacy overhead costs;
- Hospitals set charges for drugs, biologicals, and radiopharmaceuticals at levels that reflect their respective handling costs; and
- Hospitals vary considerably in their likelihood of providing services which utilize drugs, biologicals, or radiopharmaceuticals with different handling costs.

As a result of these findings, MedPAC developed seven drug categories for pharmacy and nuclear medicine handling costs based on the estimated level of hospital resources used to prepare the products (70 FR 42729). Associated with these categories were two recommendations for accurate payment of pharmacy overhead under the OPPS.

1. CMS should establish separate, budget neutral payments to cover the costs hospitals incur for handling separately payable drugs, biologicals, and radiopharmaceuticals.

2. CMS should define a set of handling fee APCs that group drugs, biologicals, and radiopharmaceuticals based on attributes of the products that affect handling costs; CMS should instruct hospitals to submit charges for these APCs and base payment rates for the handling fee APCs on submitted charges reduced to costs.

In response to the MedPAC findings, in the CY 2006 OPPS proposed rule (70 FR 42729), we discussed our belief that, because of the varied handling resources required to prepare different forms of drugs, it would be impossible to exclusively and appropriately assign a drug to a certain overhead category that would apply to all hospital outpatient uses of the drug. Therefore, our CY 2006 OPPS proposal included a proposal to establish three distinct Level II HCPCS C-codes and three corresponding APCs for drug handling categories to differentiate overhead costs for drugs and biologicals (70 FR 42730). We also proposed: (1) To combine several overhead categories recommended by MedPAC; (2) to establish three drug handling categories, as we believed that larger groups would minimize the number of drugs that may fit into more than one category and would lessen any undesirable payment policy incentives to utilize particular forms of drugs or specific preparation methods; (3) to collect hospital charges for these HCPCS C-codes for 2 years; and (4) to ultimately base payment for the corresponding drug handling APCs on CY 2006 claims data available for the CY 2008 OPPS.

In the CY 2006 OPPS final rule with comment period (70 FR 68659 through 68665), we discussed the public comments we received on our proposal regarding pharmacy overhead. The overwhelming majority of commenters did not support our proposal and urged us not to finalize this policy, as it would be administratively burdensome for hospitals to establish charges for HCPCS codes for pharmacy overhead and to report them. Therefore, we did not finalize this proposal for CY 2006. Instead, we established payment for separately payable drugs and biologicals at ASP+6 percent, which we calculated by comparing the estimated aggregate cost of separately payable drugs and biologicals in our claims data to the estimated aggregate ASP dollars for separately payable drugs and biologicals, using the ASP as a proxy for average acquisition cost (70 FR 68642). Hereinafter, we refer to this methodology as our standard drug payment methodology. We concluded that payment for drugs and biologicals and pharmacy overhead at a combined ASP+6 percent rate would serve as the best proxy for the combined acquisition and overhead costs of each of these products.

In the CY 2007 OPPS/ASC final rule with comment period (71 FR 68091), we finalized our proposed policy to provide a single payment of ASP+6 percent for the hospital's acquisition cost for the drug or biological and all associated pharmacy overhead and handling costs. The ASP+6 percent rate that we

finalized was higher than the equivalent average ASP-based amount calculated from claims of ASP+4 percent according to our standard drug payment methodology, but we adopted payment at ASP+6 percent for stability while we continued to examine the issue of the costs of pharmacy overhead in the HOPD.

In the CY 2008 OPPS/ASC proposed rule (72 FR 42735), in response to ongoing discussions with interested parties, we proposed to continue our methodology of providing a combined payment rate for drug and biological acquisition and pharmacy overhead costs. We also proposed to instruct hospitals to remove the pharmacy overhead charge for both packaged and separately payable drugs and biologicals from the charge for the drug or biological and report the pharmacy overhead charge on an uncoded revenue code line on the claim. We believed that this would provide us with an avenue for collecting pharmacy handling cost data specific to drugs in order to package the overhead costs of these items into the associated procedures, most likely drug administration services. Similar to the public response to our CY 2006 pharmacy overhead proposal, the overwhelming majority of commenters did not support our CY 2008 proposal and urged us to not finalize this policy (72 FR 66761). At its September 2007 meeting, the APC Panel recommended that hospitals not be required to separately report charges for pharmacy overhead and handling and that payment for overhead be included as part of drug payment. The APC Panel also recommended that CMS continue to evaluate alternative methods to standardize the capture of pharmacy overhead costs in a manner that is simple to implement at the organizational level (72 FR 66761). Because of concerns expressed by the APC Panel and public commenters, we did not finalize the proposal to instruct hospitals to separately report pharmacy overhead charges for CY 2008. Instead, in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66763), we finalized a policy of providing payment for separately payable drugs and biologicals and their pharmacy overhead at ASP+5 percent as a transition from their CY 2007 payment of ASP+6 percent to payment based on the equivalent average ASP-based payment rate calculated from hospital claims according to our standard drug payment methodology, which was ASP+3 percent for the CY 2008 OPPS/ASC final rule with comment period. Hospitals continued to include charges for pharmacy overhead costs in the line-item charges for the associated drugs reported on claims.

For CY 2009, we proposed to pay separately payable drugs and biologicals at ASP+4 percent, including both SCODs and other drugs without CY 2009 OPPS pass-through status, based on our standard drug payment methodology, and we also proposed to split the "Drugs Charged to Patients" cost center into two cost centers: One for drugs with high pharmacy overhead costs and one for drugs with low pharmacy overhead costs (73 FR 41492). We noted that we expected that CCRs from the proposed new cost centers would be available in 2 to 3 years to refine OPPS drug cost estimates by accounting for differential hospital markup practices for drugs with high and low overhead costs. After consideration of the public comments received and the APC Panel recommendations, we finalized a CY 2009 policy (73 FR 68659) to provide payment for separately payable nonpass-through drugs and biologicals based on costs calculated from hospital claims at a 1-year transitional rate of ASP+4 percent, in the context of an equivalent average ASP-based payment rate of ASP+2 percent calculated according to our standard drug payment methodology from the final rule claims and cost report data. We did not finalize our proposal to split the single standard "Drugs Charged to Patients" cost center into two cost centers largely due to concerns raised to us by hospitals about the associated administrative burden. Instead, we indicated in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68659) that we would continue to explore other potential approaches to improve our drug cost estimation methodology, thereby increasing payment accuracy for separately payable drugs and biologicals.

In response to the CMS proposals for the CY 2008 and CY 2009 OPPS, a group of pharmacy stakeholders (hereinafter referred to as the pharmacy stakeholders), including some cancer hospitals, some pharmaceutical manufacturers, and some hospital and professional associations, commented that CMS should pay an acquisition cost of ASP+6 percent for separately payable drugs, should substitute ASP+6 percent for the packaged cost of all packaged drugs and biologicals on procedure claims, and should redistribute the difference between the aggregate estimated packaged drug cost in claims and payment for all drugs, including packaged drugs at ASP+6 percent, as separate pharmacy overhead payments for separately payable drugs. They indicated that this approach would preserve the aggregate drug cost observed in the claims data, while significantly increasing payment accuracy for individual drugs and procedures by redistributing drug cost from packaged drugs. Their suggested approach would provide a separate overhead payment for each separately payable drug or biological at one of three different levels, depending on the pharmacy stakeholders' assessment of the complexity of pharmacy handling associated with each specific drug or biological (73 FR 68651 through 68652). Each separately payable drug or biological HCPCS code would be assigned to one of the three overhead categories, and the separate pharmacy overhead payment applicable to the category would be made when each of the separately payable drugs or biologicals was paid.

In the CY 2010 OPPS/ASC proposed rule (74 FR 35332), we proposed to redistribute between one-third and one-half of the estimated overhead cost associated with coded packaged drugs and biologicals with an ASP which resulted in our proposal to pay for the acquisition and pharmacy overhead costs of separately payable drugs and biologicals that did not have pass-through payment status at ASP+4 percent. We calculated estimated overhead cost for coded packaged drugs and biologicals by determining the difference between the aggregate claims cost for coded packaged drugs and biologicals with an ASP and the ASP dollars (ASP multiplied by the drug's or biological's units in the claims data) for those same coded drugs and biologicals; this difference was our estimated overhead cost for coded packaged drugs and biologicals. In our rationale described in the CY 2010 OPPS/ASC proposed rule (74 FR 35326 through 35333), we stated that we believed that approximately $150 million of the estimated $395 million total in pharmacy overhead cost included in our claims data for coded packaged drugs and biologicals with reported ASP data should be attributed to separately payable drugs and biologicals and that the $150 million serves as the adjustment for the pharmacy overhead costs of separately payable drugs and biologicals. As a result, we also proposed to reduce the cost of coded drugs and biologicals that is packaged into payment for procedural APCs to offset the $150 million adjustment to payment for separately payable drugs and biologicals. In addition, we proposed that any redistribution of

pharmacy overhead cost that may arise from CY 2010 final rule data would occur only from coded packaged drugs and biologicals with an ASP to separately payable drugs and biologicals, thereby maintaining the estimated total cost of drugs and biologicals.

Using our CY 2010 proposed rule data, and applying our longstanding methodology for calculating the total cost of separately payable drugs and biologicals in our claims compared to the ASP dollars for the same drugs and biologicals, without applying the proposed overhead cost redistribution, we determined that the estimated aggregate cost of separately payable drugs and biologicals (status indicators "K" and "G"), including acquisition and pharmacy overhead costs, was equivalent to ASP–2 percent. Therefore, under the standard methodology for establishing payment for separately payable drugs and biologicals, we would have paid for those drugs and biologicals at ASP–2 percent for CY 2010, their equivalent average ASP-based payment rate. We also determined that the estimated aggregate cost of coded packaged drugs and biologicals with an ASP (status indicator "N"), including acquisition and pharmacy overhead costs, was equivalent to ASP+247 percent.

While we had no way of assessing whether this current distribution of overhead cost to coded packaged drugs and biologicals with an ASP was appropriate, we acknowledged that the established method of converting billed charges to costs had the potential to "compress" the calculated costs to some degree. Further, we recognized that the attribution of pharmacy overhead costs to packaged or separately payable drugs and biologicals through our standard drug payment methodology of a combined payment for acquisition and pharmacy overhead costs depends, in part, on the treatment of all drugs and biologicals each year under our annual drug packaging threshold. Changes to the packaging threshold may result in changes to payment for the overhead cost of drugs and biologicals that do not reflect actual changes in hospital pharmacy overhead cost for those products. For these reasons, we stated that we believed some portion, but not all, of the total overhead cost that is associated with coded packaged drugs and biologicals (the difference between aggregate cost for those drugs on the claims and ASP for the same drugs), based on our standard drug payment methodology, should, at least for CY 2010, be attributed to separately payable drugs and biologicals.

We acknowledged that the observed combined payment for acquisition and pharmacy overhead costs of ASP–2 percent for separately payable drugs and biologicals may be too low and ASP+247 percent for coded packaged drugs and biologicals with reported ASP data in the CY 2010 claims data may be too high (74 FR 35328). We stated that a middle ground of approximately one-third to one-half of the total pharmacy overhead cost currently associated with coded packaged drugs and biologicals in the CY 2008 claims data would represent the most accurate redistribution of pharmacy overhead cost. We included a discussion of indirect overhead costs, such as administrative and general costs, capital costs, staff benefits, and other facility costs that do not vary across drugs, and direct overhead costs, including staff, supplies, and equipment that are directly attributable only to the storage, handling, preparation, and distribution of drugs and biologicals and which do vary, sometimes considerably, depending upon the drug being furnished. We presented analyses that modeled the redistribution of overhead costs in the packaged drugs to all drugs and biologicals based on overhead relative weights derived from industry and from MedPAC's recommended overhead relative weights and by assigning each drug, both packaged and separately paid, to a category of overhead complexity. Analyses relying on both sets of weights suggest that indirect costs are a sizable component of the overhead costs associated with all drugs and biologicals (74 FR 60505 to 60508).

Within the one-third to one-half parameters, we proposed that reallocating $150 million in drug and biological cost observed in the claims data from coded packaged drugs and biologicals with an ASP to separately payable drugs and biologicals for CY 2010 would more appropriately distribute pharmacy overhead cost among packaged and separately payable drugs and biologicals. Based on this redistribution, we proposed a payment rate for separately payable drugs and biologicals of ASP+4 percent. Thus, we proposed a pharmacy overhead adjustment for separately payable drugs and biologicals in CY 2010 that would result in their payment at ASP+4 percent. Redistributing $150 million represented a reduction in cost of coded packaged drug and biologicals with reported ASP data in the CY 2010 proposed rule claims data of 27 percent.

We also proposed that any redistribution of pharmacy overhead cost that may arise from CY 2010 final rule data would occur only from some drugs and biologicals to other drugs and biologicals, thereby maintaining the estimated total cost of drugs and biologicals in our claims data (no redistribution of cost would occur from other services to drugs and biologicals or vice versa). We further proposed that the claims data for 340B hospitals be included in the calculation of payment for drugs and biologicals under the CY 2010 OPPS and that 340B hospitals would be paid the same amounts for separately payable drugs and biologicals as hospitals that do not participate in the 340B program. Finally, we proposed that, in accordance with our standard drug payment methodology, the estimated payments for separately payable drugs and biologicals would be taken into account in the calculation of the weight scaler that would apply to the relative weights for all procedural services (but would not apply to separately payable drugs and biologicals) paid under the OPPS, as required by section 1833(t)(14)(H) of the Act.

In the CY 2010 OPPS final rule with comment period, we adopted a transitional payment rate of ASP+4 percent based on a pharmacy overhead adjustment methodology for CY 2010 that redistributed $200 million from packaged drug cost to separately payable drug cost. This $200 million included the proposed $150 million redistribution from the pharmacy overhead cost of coded packaged drugs and biologicals for which an ASP is reported and an additional $50 million dollars from the total uncoded drug and biological cost to separately payable drugs and biologicals as a conservative estimate of the pharmacy overhead cost of uncoded packaged drugs and biologicals that should be appropriately associated with the cost of separately payable drugs and biologicals (74 FR 60517). We noted that our final CY 2010 payment policy for separately payable drugs and biologicals at ASP+4 percent fell within the range of ASP–3 percent, that would have resulted from no pharmacy overhead cost redistribution from packaged to separately payable drugs and biologicals, to ASP+7 percent, that would have resulted from redistribution of pharmacy overhead cost based on expansive assumptions about the nature of uncoded packaged drug and biological cost. We acknowledged that, to some unknown extent, there are pharmacy overhead costs being attributed to the items and services reported under the pharmacy revenue code without HCPCS codes that are likely pharmacy overhead for

separately payable drugs. With regard to uncoded packaged drug costs, we redistributed $50 million and stated that we could not know the amount of overhead associated with these drugs without making significant further assumptions about the amount of pharmacy overhead cost associated with the drugs and biologicals captured by these uncoded packaged drug costs. We finalized a policy of redistributing pharmacy overhead cost from some drugs and biologicals to other drugs and biologicals, thereby maintaining the estimated total cost of drugs and biologicals in our claims data (no redistribution of cost would occur from other services to drugs and biologicals or vice versa).

b. Proposed Payment Policy

Section 1833(t)(14)(A)(iii) of the Act, as described above, continues to be applicable to determining payments for SCODs for CY 2011. This provision requires that payment for SCODs be equal to the average acquisition cost for the drug for that year as determined by the Secretary, subject to any adjustment for overhead costs and taking into account the hospital acquisition cost survey data collected by the GAO in CYs 2004 and 2005. If hospital acquisition cost data are not available, section 1833(t)(14)(A)(iii)(II) of the Act requires that payment be equal to payment rates established under the methodology described in section 1842(o) of the Act, section 1847A of the Act (ASP+6 percent as paid for physician Part B drugs), or section 1847B of the Act (CAP), as the case may be, as calculated and adjusted by the Secretary as necessary. In accordance with sections 1842(o) and 1847A, payment for most Medicare Part B drugs furnished on or after January 1, 2005, are paid based on the ASP methodology. Medicare Part B drugs generally fall into three categories: Physician drugs (drugs furnished incident to a physician's service), DME drugs (drugs furnished under the durable medical equipment benefit), and drugs specifically covered by statute (certain oral anti-cancer and immunosuppressive drugs). In addition, section 1833(t)(14)(E)(ii) of the Act authorizes, but does not require, the Secretary to adjust APC weights to take into account the 2005 MedPAC report relating to overhead and related expenses, such as pharmacy services and handling costs. As discussed in V.B.3.a. of this proposed rule, since CY 2006, we have used ASP data and costs estimated from charges on hospital claims data as a proxy for both the average hospital acquisition cost that the statute requires for payment of SCODs and the associated pharmacy overhead cost to establish a combined payment rate for acquisition cost and pharmacy overhead. Until CY 2010, we applied this methodology to payment for all separately payable drugs and biologicals without pass-through status, including both SCODs and other drugs and biologicals that do not meet the statutory definition of SCODs.

However, for the CY 2010 OPPS, we revised the standard methodology to include an adjustment for pharmacy overhead. We acknowledged that the established method of converting billed charges to costs had the potential to "compress" the calculated costs to some degree. We recognized that the attribution of pharmacy overhead costs to packaged or separately payable drugs and biologicals through our standard drug payment methodology of a combined payment for acquisition and pharmacy overhead costs depends, in part, on the treatment of all drugs and biologicals each year under our annual drug packaging threshold. To some unknown extent, we believe that some pharmacy overhead costs are being attributed to packaged drugs and biologicals that are likely pharmacy overhead costs for separately payable drugs.

For this CY 2011 OPPS/ASC proposed rule, using our standard methodology for determining the total cost of separately payable drugs in our CY 2009 claims data and comparing these costs to the ASP dollars (April 2010 ASP quarterly payment rates multiplied by units for the separately payable drugs and biologicals in the claims data) for the same drugs, we determined that the total payment for separately payable drugs (status indicators "K" and "G"), including acquisition and pharmacy overhead costs, is ASP+0 percent, which also would be the ASP-based payment rate under the standard methodology that we established in CY 2006. Additionally, we determined that the total aggregate cost for packaged drugs with a HCPCS code for which manufacturers report ASP data (status indicator "N"), including acquisition and pharmacy overhead costs, is equivalent to ASP+283 percent. Finally, we determined that the total cost for both packaged drugs with a HCPCS code and separately payable drugs (status indicators "N", "K" and "G") for which we also have ASP data, including acquisition and pharmacy overhead costs, is ASP+14 percent. Table 25 below displays our findings with regard to the percentage of ASP in comparison to the cost for packaged coded drugs and for separately payable coded drugs before application of the overhead adjustment methodology.

TABLE 25.—CY 2011 PROPOSED RULE DATA: ASP+X CALCULATION UNDER STANDARD METHODOLOGY

	Total ASP Dollars for Drugs and Biologicals in Claims Data (in millions)*	Total Cost of Drugs and Biologicals in Claims Data (in millions)**	Ratio of Cost to ASP (column C /column B)	ASP+X Percent
Uncoded packaged pharmacy revenue code costs	Unknown	$623	NA	NA
Coded Packaged Drugs and Biologicals with a reported ASP	$155	$593	3.83	ASP+283
Separately Payable Drugs and Biologicals with a reported ASP	$2,951	$2,939	1.00	ASP+0
All Coded Drugs and Biologicals with a reported ASP	$3,105	$3,532	1.14	ASP+14

*Total April 2010 ASP dollars (ASP multiplied by drug or biological units in CY 2009 claims) for drugs and biologicals with a HCPCS code and ASP information.

**Total cost in the CY 2009 claims data for drugs and biologicals.

We believe that the combined payment for average acquisition and pharmacy overhead costs under our standard methodology may understate the cost of separately payable drugs and biologicals and related pharmacy overhead for those drugs and biologicals. Specifically, we believe payment at ASP+0 percent for such costs may not be sufficient. We also acknowledge that ASP+283 percent may overstate the combined acquisition and pharmacy overhead cost of packaged drugs and biologicals. Therefore, for CY 2011, we are proposing to continue our CY 2010 pharmacy overhead adjustment methodology. We are proposing to redistribute $150 million from the pharmacy overhead cost of coded packaged drugs and biologicals with reported ASP data and to redistribute $50 million from the cost of uncoded packaged drugs and biologicals without an ASP, for a total redistribution of $200 million in drug cost from the cost of coded and uncoded packaged drugs to the cost of separately payable drugs, as we did for the CY 2010 final rule. We estimate the overhead cost for coded packaged drugs to be $438 million ($593 million in total cost for coded packaged drugs and biologicals with a reported ASP less $155 million in total ASP dollars for coded packaged drugs and biologicals with a reported ASP). Similar to the CY 2010 proposal, we are proposing that any redistribution of pharmacy overhead cost would occur only among drugs and biologicals in our claims data, that no redistribution of cost would occur from other services to drugs and biologicals or vice versa. We continue to believe that redistributing $200 million from packaged to separately payable drugs and biologicals is an appropriate redistribution of pharmacy overhead costs to address any charge compression in the standard methodology. This would result in a proposed CY 2011 payment rate for separately payable drugs and biologicals of ASP+6 percent. We emphasize that we are proposing a pharmacy overhead adjustment methodology based on a redistribution of overhead cost and that our proposal for payment at ASP+6 percent is a coincidental outcome of the proposed methodology to redistribute $200 million from packaged drugs to separately payable drugs. We are not proposing payment of ASP+6 percent for separately payable drugs as an alternative to payment of average acquisition costs based on a survey under section 1833(t)(14)(A)(iii)(I) of the Act. We continue to believe that the average sales price information collected under section 1847A (b)(1)(A) of the Act and our hospital claims data is a suitable proxy for the acquisition cost data. For a full explanation of our rationale for using ASP data and our hospital claims data as a suitable proxy for acquisition cost data we refer readers to the CY2010 OPPS/ASC final rule with comment period (74 FR 60515). We further note that, in past years, the proposed ASP+X amount decreased by at least 1 percentage point when we updated the ASP data, claims data, and cost report data between the proposed rule and the final rule with comment period, from ASP+5 to ASP+4 for example. Therefore, it is possible that this proposed methodology would result in an ASP+X amount that is different from ASP+6.

As indicated in Table 25 above, if we were to propose to establish payment for separately payable drugs and biologicals under the standard methodology established in CY 2006 without applying a pharmacy overhead adjustment, we would propose to pay for separately payable drugs and biologicals at ASP+0 percent. However, because we are concerned about underpaying separately payable drugs and biologicals, we believe a pharmacy overhead adjustment using a redistribution methodology for determining the amount of payment for drugs and biologicals as we did for CY 2010 is appropriate. We believe the observed ASP+0 percent reflects some amount of charge compression and variability attributable to choice of a packaging threshold.

We continue to believe that the methodology to redistribute $200 million in drug overhead cost from packaged coded and uncoded drugs to separately payable drugs, while keeping the total cost of drugs in the claims data constant, continues to be appropriate for the reasons set forth in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60501 through 60517). Therefore, we are proposing to redistribute $200 million in drug overhead costs from coded and uncoded packaged drugs to separately payable drugs while keeping the total cost of drugs in the claims data constant. Table 26 presents the ASP+X amount after redistribution of $150 million from the estimated overhead of $438 million for coded packaged drugs with reported ASP data to separately payable drugs and biologicals and $50 million from uncoded packaged drug cost for which an estimate of overhead cannot be calculated, resulting in a total redistribution of $200 million in cost from packaged drugs and biologicals to separately payable drugs and biologicals.

TABLE 26.— PROPOSED CY 2011 PHARMACY OVERHEAD ADJUSTMENT PAYMENT METHODOLOGY: ASP+X CALCULATION

	Total ASP Dollars for Drugs and Biologicals in Claims Data (in millions)*	Total Cost of Drugs and Biologicals in Claims Data *after Adjustment* (in millions)**	Ratio of Cost to ASP (column C /column B)	ASP+X Percent
Uncoded packaged pharmacy revenue code costs	Unknown	$548	NA	NA
Coded Packaged Drugs and Biologicals with a reported ASP	$155	$443	2.86	ASP+186
Separately Payable Drugs and Biologicals with a reported ASP	$2,951	$3,139	1.06	ASP+6
All Coded Drugs and Biologicals with a reported ASP	$3,105	$3,532	1.14	ASP+14

*Total April 2010 ASP dollars (ASP multiplied by drug or biological units in CY 2009 claims) for drugs and biologicals with a HCPCS code and ASP information.

**Total cost in the CY 2009 claims data for drugs and biologicals.

We generally received positive comments on our CY 2010 proposal to redistribute $150 million of drug cost from packaged drugs and biologicals to separately payable drugs and biologicals to establish their final combined payment level. The general comment we received on our pharmacy overhead adjustment methodology was that the amount of drug cost that should be redistributed should be greater, a sentiment reiterated at the February 2010 APC Panel meeting and discussed in greater detail below. Commenters and presenters to the APC Panel specifically argued that our CY 2010 proposal had not acknowledged the potential overhead cost available for redistribution in the uncoded packaged drugs.

We explain below our rationale for why we are not proposing to redistribute more cost from uncoded packaged drugs. Conversations with stakeholders and hospitals over the past year suggest that hospitals do not always report HCPCS codes for drugs for a variety of reasons including an internal practice not to code for packaged drugs, building the cost of the drugs into the associated procedure charge, lack of a HCPCS code for some drugs and biologicals, and purchased

vendor billing software functionality that removes codes. A key premise of our pharmacy overhead adjustment redistribution methodology was our assessment of the amount of drug cost in the claims data above aggregate ASP available as "overhead" for redistribution. Knowing the specific HCPCS codes for packaged drugs and their associated ASP allows us to assess the differential between aggregate ASP and claim cost for packaged drugs and to assess the intensity of pharmacy overhead associated with these drugs. The inability to know which drugs are captured by uncoded drug charges on a claim is challenging because we cannot know what is being charged or what the overhead complexity might be. Further, we understand that there is wide variation in how hospitals set charges for items and services in their chargemasters, sometimes charging separately for overhead (for example, paper cups, gloves, transportation, staff consultations) and sometimes including charges for those supplies in the charge for drugs. Therefore, we cannot be certain that the amount of uncoded pharmacy overhead cost is as high as the public has suggested or that hospitals mark up these uncoded drugs and biologicals in the same way as packaged drugs and biologicals with HCPCS codes.

In addition, at its February 2010 meeting, the APC Panel recommended that CMS reallocate a larger portion of the pharmacy overhead costs from packaged drugs to separately payable drugs for CY 2011. We do not accept the APC Panel's recommendation to redistribute a larger portion of the pharmacy overhead costs from packaged drugs to separately payable drugs because we also believe the analysis provided by the presenters at the February 2010 APC Panel meeting is insufficient to determine that it is appropriate to propose to redistribute more payment from uncoded packaged drugs and biologicals to separately paid drugs and biologicals. Although presenters at the APC Panel meeting acknowledged that CMS could not know the ASP for these uncoded drug costs, they provided analyses examining the proportion of estimated coded packaged drug cost relative to estimated uncoded packaged drug cost out of all packaged drug cost (both coded and uncoded) and concluded that uncoded and coded packaged drugs are probably the same drugs because hospitals tend to have roughly the same amount of estimated packaged drug cost in their claims data but wide variation on the proportion of coded packaged drugs. They also presented analyses stating that the relationship between pharmacy overhead and handling costs and the cost of drugs in the cost report data can be interpreted as providing a relationship between cost and overhead comparable to the ASP+X calculated for all drug cost in the claims data, if an aggregate ASP amount is assumed to be the same for uncoded drugs and biologicals as it is for coded packaged drugs. The presenters concluded that the uncoded packaged drug and biological cost accounts for exactly the same drugs and biologicals as those in the coded packaged drug and biological cost and that CMS could assume the same proportional amount of overhead cost that appears in the uncoded packaged drug and biological cost as observed in the coded packaged drug cost. They asked that CMS assume that uncoded packaged drugs and biologicals resemble coded packaged drugs and biologicals and treat them comparably for purposes of estimating "overhead." We reviewed the presenters' analyses, but we believe the information they provided is insufficient in order to enable us to isolate the portion of the uncoded packaged drug and biological cost that is pharmacy overhead cost. In order to isolate the portion of uncoded packaged drug and biological cost that is pharmacy overhead cost, we believe that we would need more drug-specific information reported to us by hospitals, either through more reporting of packaged drugs on claims or through more granular cost centers on the cost report. We note that we investigated uncoded drugs further. We evaluated the services with which uncoded packaged drug cost appears in the claims data in an effort to assess how much uncoded drugs resemble coded packaged drugs. We found that most uncoded packaged drug costs appear with surgical services and that most coded packaged drug costs appear with medical services. In light of this information, we are not confident that the drugs captured by uncoded drug cost are the same drugs captured by coded packaged drug cost. Therefore, we do not believe we can assume that they are the same drugs, with comparable overhead and handling costs. Without being able to calculate an ASP for these drugs and without being able to gauge the magnitude of the overhead complexity associated with these drugs, we do not believe we should assume that the same amount of proportional overhead is available for redistribution for this proposed rule. We are not convinced that the same proportionate amount of overhead cost should be redistributed from the packaged uncoded drugs as the amount of overhead cost that is appropriate to redistribute for packaged coded drugs. In addition, we remain committed to using hospital claims data reported to us by hospitals to set the OPPS payment rates because it provides more specificity about the provided drugs and biologicals and would allow us to assess an overhead amount for those drugs.and biologicals. Therefore, we continue to propose to redistribute a conservative estimate, $50 million, in cost from uncoded packaged drugs to separately payable drugs and biologicals.

Based on the reasons set forth above, and consistent with our rationale outlined in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60511 through 60512), we cannot be certain that we know what portion of the uncoded drugs and biologicals cost is acquisition cost versus pharmacy overhead costs, and we have no compelling reason to redistribute a greater amount of drug cost. Therefore, our proposal to redistribute $200 million in drug cost from packaged drugs to separately payable drugs, while maintaining the total cost of drugs in our claims data, consists of redistributing $150 million in "overhead" cost from packaged coded drugs and biologicals with reported ASP data to separately payable drugs and biologicals and redistributing $50 million in drug cost from uncoded packaged drugs and biologicals to separately payable drugs and biologicals as a conservative estimate of potential overhead cost appearing in uncoded packaged drugs that should have been associated with separately payable drugs and biologicals.

We have indicated that the basis for this CY 2011 proposal to redistribute $150 million dollars from packaged coded drugs and biologicals to separately payable drugs and biologicals as a pharmacy overhead adjustment is the same as our CY 2010 final policy. The CY 2010 policy was based on our assessment that between one-third and one-half of the overhead cost in coded packaged drugs could be attributable to charge compression due to our cost estimation methodology and our choice of a packaging threshold. We continue to believe that a precise amount of drug cost attributable to charge compression cannot be known precisely, but that $150 million is an appropriate adjustment. The current proposal for $150 million falls within the approximate one-third to one-half range established in CY 2010 with updated CY 2009 claim and cost report data, and we anticipate that the $150 million would

continue to roughly approximate one-third to one-half or thereabouts of overhead cost in the coded packaged drugs with updated ASP data, and claim and cost report data for the final rule. In order to redistribute the $150 million in pharmacy overhead from packaged costs of drugs and biologicals for which a HCPCS code was reported, we reduced the costs attributable to these items and services by multiplying the costs derived from the revenue center charges for packaged HCPCs codes by 0.75 (a 25 percent reduction).

To redistribute the $50 million in total cost from packaged costs of drugs and biologicals for which no HCPCS code was reported, we reduced the costs attributable to these items and services by multiplying the costs derived from revenue center charges for pharmacy by 0.92 (an 8 percent reduction). We note that for this CY 2011 OPPS/ASC proposed rule, the $50 million in drug overhead cost that we propose to redistribute from packaged uncoded drugs and biologicals to separately payable drugs and biologicals is 8 percent, comparable to the CY 2010 final rule amount. We note that $50 million as a percent of uncoded drug cost may be close to the 8 percent range or thereabouts of uncoded drug and biological cost in the final rule with updated claim and cost data. In addition, although we have arrived at a proposed payment rate of ASP+6 percent, we emphasize that the ASP+6 percent amount may change when ASP+X is recalculated using updated ASP data and claims and cost report data for the CY 2011 OPPS/ASC final rule with comment period.

We also note that, although it is CMS' longstanding policy under the OPPS to refrain from instructing hospitals on the appropriate revenue code to use to charge for specific services, we continue to encourage hospitals to bill all drugs and biologicals with HCPCS codes, regardless of whether they are separately payable or packaged. We believe that a practice of billing all drugs and biologicals with HCPCS codes under revenue code 0636 (Pharmacy—Extension of 025X; Drugs Requiring Detailed Coding) would be consistent with NUBC billing guidelines and would provide us with the most complete and detailed information for ratesetting. We note that we make packaging determinations for drugs annually based on cost information reported under HCPCS codes, and the OPPS ratesetting is best served when hospitals report charges for all items and services with HCPCS codes when they are available, whether or not Medicare makes separate payment for the items and services.

The APC Panel also recommended that CMS evaluate the impact of changes in its drug payment policy on hospitals (categorized by type and size) of such a reallocation and present this analysis to the APC Panel at its next meeting. We accept this recommendation and will present this analysis to the APC Panel at its next meeting.

The APC Panel also recommended that CMS continue to evaluate the impact of its drugs and biologicals overhead payment policy on hospitals. We accept this recommendation. We note that our regulatory impact analysis presented in section XXIII of this proposed rule includes some of the analysis requested in these last two recommendations.

In conclusion, we are proposing for CY 2011 to continue our CY 2010 redistribution methodology, to redistribute $150 million from the pharmacy overhead cost of coded packaged drugs and biologicals with an ASP and to redistribute $50 million from the cost of uncoded packaged drugs and biologicals for a total of $200 million from cost in coded and uncoded packaged drugs to separately payable drugs. We are proposing to redistribute pharmacy overhead cost among drugs and biologicals, thereby maintaining the estimated total cost of drugs and biologicals in our claims data (no redistribution of cost would occur from other services to drugs and biologicals or vice versa). The result of the proposed methodology when applied using April 2010 ASPs, data for claims for services furnished during CY 2009 and processed through the common working file before January 1, 2010, and the most current submitted cost reports as of January 1, 2010, is a proposed ASP+6 percent amount for CY 2011. We are further proposing to continue to include the claims data for 340B hospitals in the calculation of payment for drugs and biologicals under the CY 2011 OPPS because excluding data from hospitals that participate in the 340B program from our ASP+X calculation, but paying those hospitals at that derived payment amount, would effectively redistribute payment to drugs or biologicals from payment for other services under the OPPS, and we do not believe this redistribution would be appropriate (74 FR 35332). In addition, we are proposing that 340B hospitals continue to be paid the same amounts for separately payable drugs and biologicals as hospitals that do not participate in the 340B program for CY 2011 because commenters have generally opposed differential payment for hospitals based on their 340B participation status. In addition, we are proposing to include claims from 340B hospitals in our assessment of average acquisition cost under section 1833(t)(14)(A)(iii) of the Act. We are proposing that the estimated payments for separately payable drugs and biologicals be taken into account in the calculation of the weight scaler that would apply to the relative weights for all procedural services (but would not apply to separately payable drugs and biologicals) paid under the OPPS, as required by section 1833(t)(14)(H) of the Act.

Finally, we note that we continue to pursue the most appropriate methodology for establishing payment for drugs and biologicals under the OPPS and that we will continue to evaluate the appropriateness of this methodology in future years.

c. Proposed Payment Policy for Therapeutic Radiopharmaceuticals

From the implementation of the collection of ASP information in CY 2005, CMS exempted radiopharmaceutical manufacturers from reporting ASP data for all radiopharmaceuticals for payment purposes under the OPPS. (For more information, we refer readers to the CY 2005 OPPS final rule with comment period (69 FR 65811) and the CY 2006 OPPS final rule with comment period (70 FR 68655).) Consequently, we did not have ASP data for radiopharmaceuticals for consideration for OPPS ratesetting until we began collecting ASP for therapeutic radiopharmaceuticals for CY 2010. In accordance with section 1833(t)(14)(B)(i)(I) of the Act, we have classified radiopharmaceuticals under the OPPS as SCODs. As such, we have paid for radiopharmaceuticals at average acquisition cost as determined by the Secretary and subject to any adjustment for overhead costs. For CYs 2006 and 2007, we used mean unit cost data from hospital claims to determine each radiopharmaceutical's packaging status and implemented a temporary policy to pay for separately payable radiopharmaceuticals based on the hospital's charge for each radiopharmaceutical adjusted to cost using the hospital's overall CCR. The methodology of providing separate radiopharmaceutical payment based on charges adjusted to cost through application of an individual hospital's overall CCR for CYs 2006 and 2007 was finalized as an interim proxy for average acquisition cost.

In CY 2008, we packaged payment for all diagnostic radiopharmaceuticals and

we proposed and finalized a methodology to provide prospective payment for therapeutic radiopharmaceuticals (defined as those Level II HCPCS codes that include the term "therapeutic" along with a radiopharmaceutical in their long code descriptors) using mean costs derived from the CY 2006 claims data, where the costs were determined using our standard methodology of applying hospital-specific departmental CCRs to radiopharmaceutical charges, defaulting to hospital-specific overall CCRs only if appropriate departmental CCRs were unavailable (72 FR 66772). Following issuance of the CY 2009 OPPS/ASC proposed rule, section 142 of the Medicare Improvements for Patients and Providers Act of 2008 (Pub. L. 110–275) amended section 1833(t)(16)(C) of the Act, as amended by section 106(a) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Pub. L. 110–173), to further extend the payment period for therapeutic radiopharmaceuticals based on hospital's charges adjusted to cost through December 31, 2009. Therefore, for CY 2009, we finalized a policy to continue to pay hospitals for therapeutic radiopharmaceuticals at charges adjusted to cost through the end of CY 2009.

For CY 2010, we proposed and finalized a policy to pay for separately paid therapeutic radiopharmaceuticals under the ASP methodology adopted for separately payable drugs and biologicals. We allowed manufacturers to submit the ASP data in a patient-specific dose or patient-ready form in order to properly calculate the ASP amount for a given HCPCS code. This resulted in payment for therapeutic radiopharmaceuticals at ASP+4 percent for CY 2010 for products for which the manufacturer submitted ASP. We also finalized a policy to base therapeutic radiopharmaceutical payment on CY 2008 mean unit cost data derived from hospital claims if ASP information was unavailable.

We believe that the rationale outlined in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60524 through 60525) continues to be appropriate in for nonpass-through separately payable therapeutic radiopharmaceuticals in CY 2011. Therefore, we are proposing to continue to pay all nonpass-through, separately payable therapeutic radiopharmaceuticals under the ASP+X payment level established using the proposed pharmacy overhead adjustment based on a redistribution methodology to set payment for separately payable drugs and biologicals (as discussed in section V.B.3.b.) based on ASP information, if available, for a "patient ready" dose and updated on a quarterly basis for products for which manufacturers report ASP data. For a full discussion of how a "patient ready" dose is defined, we refer readers to the CY 2010 OPPS/ASC final rule with comment period, 74 FR 60520 through 60521. We also are proposing to rely on CY 2009 mean unit cost data derived from hospital claims data for payment rates for therapeutic radiopharmaceuticals for which ASP data are unavailable and to update the payment rates for separately payable therapeutic radiopharmaceuticals, according to our usual process for updating the payment rates for separately payable drugs and biologicals, on a quarterly basis if updated ASP information is available.

4. Proposed Payment for Blood Clotting Factors

For CY 2010, we provided payment for blood clotting factors under the same methodology as other nonpass-through separately payable drugs and biologicals under the OPPS and continued paying an updated furnishing fee. That is, for CY 2010, we provided payment for blood clotting factors under the OPPS at ASP+4 percent, plus an additional payment for the furnishing fee. We note that when blood clotting factors are provided in physicians' offices under Medicare Part B and in other Medicare settings, a furnishing fee is also applied to the payment. The CY 2010 updated furnishing fee is $0.170 per unit.

For CY 2011, we are proposing to pay for blood clotting factors at ASP+6 percent, consistent with our proposed payment policy for other nonpass-through separately payable drugs and biologicals, and to continue our policy for payment of the furnishing fee using an updated amount. Because the furnishing fee update is based on the percentage increase in the Consumer Price Index (CPI) for medical care for the 12-month period ending with June of the previous year and the Bureau of Labor Statistics releases the applicable CPI data after the MPFS and OPPS/ASC proposed rules are published, we are not able to include the actual updated furnishing fee in this proposed rule. Therefore, in accordance with our policy as finalized in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66765), we would announce the actual figure for the percent change in the applicable CPI and the updated furnishing fee calculated based on that figure through applicable program instructions and posting on the CMS Web site at: *http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/.*

5. Proposed Payment for Nonpass-Through Drugs, Biologicals, and Radiopharmaceuticals With HCPCS Codes, But Without OPPS Hospital Claims Data

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. 108–173) does not address the OPPS payment in CY 2005 and after for drugs, biologicals, and radiopharmaceuticals that have assigned HCPCS codes, but that do not have a reference AWP or approval for payment as pass-through drugs or biologicals. Because there is no statutory provision that dictated payment for such drugs, biologicals, and radiopharmaceuticals in CY 2005, and because we had no hospital claims data to use in establishing a payment rate for them, we investigated several payment options for CY 2005 and discussed them in detail in the CY 2005 OPPS final rule with comment period (69 FR 65797 through 65799).

For CYs 2005 to 2007, we implemented a policy to provide separate payment for new drugs, biologicals, and radiopharmaceuticals with HCPCS codes (specifically those new drug, biological, and radiopharmaceutical HCPCS codes in each of those calendar years that did not crosswalk to predecessor HCPCS codes) but which did not have pass-through status, at a rate that was equivalent to the payment they received in the physician's office setting, established in accordance with the ASP methodology for drugs and biologicals, and based on charges adjusted to cost for radiopharmaceuticals. For CYs 2008 and 2009, we finalized a policy to provide payment for new drugs (excluding contrast agents and diagnostic radiopharmaceuticals) and biologicals (excluding implantable biologicals for CY 2009) with HCPCS codes, but which did not have pass-through status and were without OPPS hospital claims data, at ASP+5 percent and ASP+4 percent, respectively, consistent with the final OPPS payment methodology for other separately payable drugs and biologicals. New therapeutic radiopharmaceuticals were paid at charges adjusted to cost based on the statutory requirement for CY 2008 and CY 2009 and payment for new diagnostic radiopharmaceuticals was packaged in both years. For CY 2010, we continued to provide payment for new drugs (excluding contrast agents), and nonimplantable biologicals with HCPCS codes that do not have pass-through status and are without OPPS hospital

claims data, at ASP+4 percent, consistent with the CY 2010 payment methodology for other separately payable nonpass-through drugs, and nonimplantable biologicals. We also finalized a policy to extend the CY 2009 payment methodology to new therapeutic radiopharmaceutical HCPCS codes, consistent with our final policy providing separate payment for therapeutic radiopharmaceuticals in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60581 through 60526), that do not crosswalk to CY 2009 HCPCS codes, do not have pass-through status, and are without OPPS hospital claims data, at ASP+4 percent.

For CY 2011, we are proposing to continue the CY 2010 payment methodology for new drugs (excluding contrast agents and diagnostic radiopharmaceuticals), nonimplantable biologicals, and therapeutic radiopharmaceuticals that meet the following conditions: those drugs, biologicals and therapeutic radiopharmaceuticals that have HCPCS codes that do not crosswalk to CY 2010 HCPCS codes, those that do not have pass-through status, and those that are without OPPS hospital claims data. We are proposing to provide payment for new CY 2011 drugs (excluding contrast agents and diagnostic radiopharmaceuticals), nonimplantable biologicals, and therapeutic radiopharmaceuticals, at ASP+6 percent, consistent with the proposed CY 2011 payment methodology for other separately payable nonpass-through drugs, nonimplantable biololgicals, and therapeutic radiopharmaceuticals. We believe this proposed policy would ensure that new nonpass-through drugs, nonimplantable biologicals, and therapeutic radiopharmaceuticals would be treated like other drugs, nonimplantable biologicals, and therapeutic radiopharmaceuticals under the OPPS, unless they are granted pass-through status. Only if they are pass-through drugs, nonimplantable biologicals, or therapeutic radiopharmaceuticals would they receive a different payment for CY 2011, generally equivalent to the payment these drug and biologicals would receive in the physician's office setting, consistent with the requirements of the statute.

We are proposing to continue our CY 2010 policy of packaging payment for all new nonpass-through diagnostic radiopharmaceuticals, contrast agents, and implantable biologicals with HCPCS codes but without claims data (those new CY 2011 diagnostic radiopharmaceutical, contrast agent, and implantable biological HCPCS codes that do not crosswalk to predecessor HCPCS codes), consistent with the proposed packaging of all existing nonpass-through diagnostic radiopharmaceuticals, contrast agents and implantable biologicals, as discussed in more detail in section V.B.2.d and IV.A.2. of this proposed rule.

In accordance with the OPPS ASP methodology, in the absence of ASP data, for CY 2011, we are proposing to continue the policy we implemented beginning in CY 2005 of using the WAC for the product to establish the initial payment rate for new nonpass-through drugs and biologicals with HCPCS codes, but which are without OPPS claims data. However, we note that if the WAC is also unavailable, we would make payment at 95 percent of the product's most recent AWP. We also are proposing to assign status indicator "K" to HCPCS codes for new drugs and nonimplantable biologicals without OPPS claims data and for which we have not granted pass-through status. We further note that, with respect to new items for which we do not have ASP data, once their ASP data become available in later quarter submissions, their payment rates under the OPPS would be adjusted so that the rates would be based on the ASP methodology and set to the finalized ASP-based amount (proposed for CY 2011 at ASP+6 percent) for items that have not been granted pass-through status. This proposed policy would ensure that new nonpass-through drugs, nonimplantable biologicals, and therapeutic radiopharmaceuticals would be treated like other drugs, nonimplantable biologicals, and therapeutic radiopharmaceuticals under the OPPS, unless they are granted pass-through status. Only if they are pass-through drugs, nonimplantable biologicals, or therapeutic radiopharmaceuticals would they receive a different payment for CY 2010, generally equivalent to the payment these drugs and biologicals would receive in the physician's office setting, consistent with the requirements of the statute.

We also are proposing to continue our CY 2010 policy to base payment for new therapeutic radiopharmaceuticals with HCPCS codes, but which do not have pass-through status and are without claims data, on the WACs for these products if ASP data for these therapeutic radiopharmaceuticals are not available. If the WACs are also unavailable, we are proposing to make payment for a new therapeutic radiopharmaceutical at 95 percent of the product's most recent AWP because we would not have mean costs from hospital claims data upon which to base payment. Analogous to new drugs and biologicals, we are proposing to continue our policy of assigning status indicator "K" to HCPCS codes for new therapeutic radiopharmaceuticals without OPPS claims data for which we have not granted pass-through status.

Consistent with other ASP-based payments, for CY 2011, we are proposing to announce any changes to the payment amounts for new drugs and biologicals in the CY 2011 OPPS/ASC final rule with comment period and also on a quarterly basis on the CMS Web site during CY 2011 if later quarter ASP submissions (or more recent WACs or AWPs) indicate that changes to the payment rates for these drugs and biologicals are necessary. The payment rates for new therapeutic radiopharmaceuticals would also be changed accordingly, based on later quarter ASP submissions. We note that the new CY 2011 HCPCS codes for drugs, biologicals, and therapeutic radiopharmaceuticals are not available at the time of development of this proposed rule. However, they will be included in Addendum B to the CY 2011 OPPS/ASC final rule with comment period. They will be assigned comment indicator "NI" in Addendum B to reflect that their interim final OPPS treatment is open to public comment on the CY 2011 OPPS/ASC final rule with comment period.

There are several nonpass-through drugs and biologicals that were payable in CY 2009 and/or CY 2010, for which we do not have CY 2009 hospital claims data available for this proposed rule and for which there are no other HCPCS codes that describe different doses of the same drug. These drugs and biologicals do have pricing information available for the ASP methodology. We note that there are currently no therapeutic radiopharmaceuticals in this category. In order to determine the packaging status of these products for CY 2011, we calculated an estimate of the per day cost of each of these items by multiplying the payment rate for each product based on ASP+6 percent, similar to other nonpass-through drugs and biologicals paid separately under the OPPS, by an estimated average number of units of each product that would typically be furnished to a patient during one administration in the hospital outpatient setting. We are proposing to package items for which we estimated the per administration cost to be less than or equal to $70, which is the general packaging threshold that we are proposing for drugs, nonimplantable biologicals, and

therapeutic radiopharmaceuticals in CY 2011. We are proposing to pay separately for items with an estimated per day cost greater than $70 (with the exception of diagnostic radiopharmaceuticals, contrast agents and implantable biologicals, which we are proposing to continue to package regardless of cost (as discussed in more detail in section V.B.2.d of this proposed rule) in CY 2011. We are proposing that the CY 2011 payment for separately payable items without CY 2009 claims data would be ASP+6 percent, similar to payment for other separately payable nonpass-through drugs and biologicals under the OPPS. In accordance with the ASP methodology used in the physician's office setting, in the absence of ASP data, we are proposing to use the WAC for the product to establish the initial payment rate. However, we note that if the WAC is also unavailable, we would make payment at 95 percent of the most recent AWP available.

The proposed estimated units per day and status indicators for these items are displayed in Table 27 below.

TABLE 27.—DRUGS AND BIOLOGICALS WITHOUT CY 2009 CLAIMS DATA

CY 2011 HCPCS Code	CY 2011 Long Descriptor	Estimated Average Number of Units Per Administration	Proposed CY 2011 SI	Proposed CY 2011 APC
90681	Rotavirus vaccine, human, attenuated, 2 dose schedule, live, for oral use	1	K	1239
90725	cholera vaccine for injectable use	1	K	1271
J0205	injection, alglucerase, per 10 units	420	K	0900
J0364	Injection, apomorphine hydrochloride, 1 mg	12	N	
J1835	Injection, itraconazole, 50 mg	8	K	1303
J2724	Injection, protein c concentrate, intravenous, human, 10 iu	2240	K	1139
J3355	Injection, urofollitropin, 75 IU	2	K	1741
J3485	Injection, zidovudine, 10 mg	42	N	
J7185	Injection, factor viii (antihemophilic factor, recombinant) (xyntha), per i.u.	1750	K	1268
J9215	Injection, interferon, alfa-n3, (human leukocyte derived), 250,000 iu	5	K	0865
J9226	Histrelin implant (supprelin la), 50 mg	1	K	1142
J9357	Injection, valrubicin, intravesical, 200 mg	4	K	1235
Q0515	Injection, sermorelin acetate, 1 microgram	70	K	3050
Q2017	Injection ,teniposide, 50 mg	9.35	K	7035

Finally, there were five drugs and biologicals, shown in Table 28 below, that were payable in CY 2009, but for which we lacked CY 2009 claims data and any other pricing information for the ASP methodology for this proposed rule. In CY 2009, for similar items without CY 2007 claims data and without pricing information for the ASP methodology, we previously stated that we were unable to determine their per day cost and we packaged these items for the year, assigning these items status indicator "N."

For CY 2010, we finalized a policy to change the status indicator for drugs and biologicals to status indicator "E" (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)) that we understood were not currently sold or had been identified as obsolete. In addition, we noted that we would provide separate payment for these drugs and biologicals if pricing information reflecting recent sales becomes available mid-year in CY 2010 for the ASP methodology. If pricing information became available, we would assign the products status indicator "K" and pay for them separately for the remainder of CY 2010.

For CY 2011, we are proposing to continue our CY 2010 policy to assign status indicator "E" to drugs and biologicals that lack CY 2009 claims data and pricing information for the ASP methodology. All drugs and biologicals without CY 2009 hospital claims data and data based on the ASP methodology that are assigned status indicator "E" on this basis at the time of this proposed rule for CY 2011 are displayed in Table 26 below. If pricing information becomes available, we are proposing to assign the products status indicator "K" and pay for them separately for the remainder of CY 2011.

TABLE 28.—DRUGS AND BIOLOGICALS WITHOUT CY 2009 CLAIMS DATA AND WITHOUT PRICING INFORMATION FOR THE ASP METHODOLOGY

CY 2011 HCPCS Code	CY 2011 Long Descriptor	Proposed CY 2011 SI
J0190	Injection, biperiden lactate, per 5 mg	E
J1435	Injection, estrone, per 1 mg	E
J3320	Injection, spectinomycin dihydrochloride, up to 2 gm	E
J3400	Injection, triflupromazine hcl, up to 20 mg	E
Q0174	Thiethylperazine maleate, 10 mg, oral, fda approved prescription anti-emetic, for use as a compl	E

VI. Proposed Estimate of OPPS Transitional Pass-Through Spending for Drugs, Biologicals, Radiopharmaceuticals, and Devices

A. Background

Section 1833(t)(6)(E) of the Act limits the total projected amount of transitional pass-through payments for drugs, biologicals, radiopharmaceuticals, and categories of devices for a given year to an "applicable percentage" (defined below) of total program payments estimated to be made under section 1833(t) of the Act for all covered services furnished for that year under the hospital OPPS. For a year (or portion of a year) before CY 2004, the applicable percentage means 2.5 percent; for CY 2004 and subsequent years, the applicable percentage means a percentage specified by the Secretary up to (but not to exceed) 2.0 percent.

If we estimate before the beginning of the calendar year that the total amount of pass-through payments in that year would exceed the applicable percentage, section 1833(t)(6)(E)(iii) of the Act requires a uniform reduction in the amount of each of the transitional pass-through payments made in that year to ensure that the limit is not exceeded. We make an estimate of pass-through spending to determine not only whether payments exceed the applicable percentage, but also to determine the appropriate reduction to the conversion factor for the projected level of pass-through spending in the following year in order to ensure that total estimated pass-through spending for the prospective payment year is budget neutral as required by section 1883(t)(6)(E) of the Act.

For devices, developing an estimate of pass-through spending in CY 2011 entails estimating spending for two groups of items. The first group of items consists of device categories that were recently made eligible for pass-through payment and that would continue to be eligible for pass-through payment in CY 2011. The CY 2008 OPPS/ASC final rule with comment period (72 FR 66778) describes the methodology we have used in previous years to develop the pass-through spending estimate for known device categories continuing into the applicable update year. The second group contains items that we know are newly eligible, or project would be newly eligible, for device pass-through payment in the remaining quarters of CY 2010 or beginning in CY 2011. As discussed in section V.A.4. of the CY 2010 final rule with comment period (74 FR 60529), beginning in CY 2010, the pass-through evaluation process and pass-through payment for implantable biologicals newly approved for pass-through payment beginning on or after January 1, 2010, that are always surgically inserted or implanted (through a surgical incision or a natural orifice) is the device pass-through process and payment methodology only. Therefore, we are proposing that the estimate of pass-through spending for implantable biologicals newly eligible for pass-through payment beginning in CY 2011 be included in the pass-through spending estimate for this second group of device categories. The sum of the proposed CY 2011 pass-through estimates for these two groups of device categories equals the total proposed CY 2011 pass-through spending estimate for device categories with pass-through status.

For devices eligible for pass-through payment, section 1833(t)(6)(D)(ii) of the Act establishes the pass-through payment amount as the amount by which the hospital's charges for the device, adjusted to cost, exceeds the portion of the otherwise applicable Medicare OPD fee schedule that the Secretary determines is associated with the device. As discussed in section IV.A.2. of this proposed rule, we deduct from the pass-through payment for an identified device category eligible for pass-through payment an amount that reflects the portion of the APC payment amount that we determine is associated with the cost of the device, defined as the device APC offset amount, when we believe that predecessor device costs for the device category newly approved for pass-through payment are already packaged into the existing APC structure. For each device category that becomes newly eligible for device pass-through payment, including implantable biologicals from CY 2010 forward, we estimate pass-through spending to be the difference between payment for the device category and the device APC offset amount, if applicable, for the procedures that would use the device. If we determine that predecessor device costs for the new device category are not already included in the existing APC structure, the pass-through spending estimate for the device category would be the full payment at charges adjusted to cost.

For drugs and biologicals eligible for pass-through payment, section 1833(t)(6)(D)(i) of the Act establishes the pass-through payment amount as the amount by which the amount authorized under section 1842(o) of the Act (or, if the drug or biological is covered under a competitive acquisition contract under section 1847B of the Act, an amount determined by the Secretary equal to the average price for the drug or biological for all competitive acquisition areas and year established under such section as calculated and adjusted by the Secretary) exceeds the portion of the otherwise applicable fee schedule amount that the Secretary determines is associated with the drug or biological. Because we are proposing to pay for most nonpass-through separately payable drugs and nonimplantable biologicals under the CY 2011 OPPS at ASP+6 percent, which represents the otherwise applicable fee schedule amount associated with most pass-through drugs and biologicals, and

because we are proposing to pay for CY 2011 pass-through drugs and nonimplantable biologicals at ASP+6 percent or the Part B drug CAP rate, if applicable, our proposed estimate of drug and nonimplantable biological pass-through payment for CY 2011 would be zero. Furthermore, payment for certain drugs, specifically diagnostic radiopharmaceuticals, contrast agents, and implantable biologicals without pass-through status, would always be packaged into payment for the associated procedures because these products would never be separately paid. However, all pass-through diagnostic radiopharmaceuticals, contrast agents, and those implantable biologicals with pass-through status approved prior to CY 2010 would be paid at ASP+6 percent or the Part B drug CAP rate, if applicable, like other pass-through drugs and biologicals. Therefore, our proposed estimate of pass-through payment for all diagnostic radiopharmaceuticals and contrast agents and those implantable biologicals with pass-through status approved prior to CY 2011 is not zero.

In section V.A.4. of this proposed rule, we discuss our policy to determine if the cost of certain "policy-packaged" drugs, including diagnostic radiopharmaceuticals and contrast agents, are already packaged into the existing APC structure. If we determine that a "policy-packaged" drug approved for pass-through payment resembles predecessor diagnostic radiopharmaceuticals or contrast agents already included in the costs of the APCs that would be associated with the drug receiving pass-through payment, we are proposing to offset the amount of pass-through payment for diagnostic radiopharmaceuticals and contrast agents. For these drugs, the APC offset amount would be the portion of the APC payment for the specific procedure performed with the pass-through diagnostic radiopharmaceutical or contrast agent that is attributable to diagnostic radiopharmaceuticals or contrast agents, which we refer to as the "policy-packaged" drug APC offset amount. If we determine that an offset is appropriate for a specific diagnostic radiopharmaceutical or contrast agent receiving pass-through payment, we would reduce our estimate of pass-through payment for these drugs by this amount. We have not established a policy to offset pass-through payment for implantable biologicals when approved for pass-through payment as a drug or biological, that is, for CY 2009 and earlier, so we would consider full payment at ASP+6 percent for these implantable biologicals receiving biological pass-through payment as of CY 2011 in our proposed estimate of CY 2011 pass-through spending for drugs and biologicals.

We note that the Part B drug CAP program has been suspended beginning January 1, 2009. We refer readers to the Medicare Learning Network (MLN) Matters Special Edition article SE0833 for more information on this suspension. As of the publication of this proposed rule, the Part B drug CAP program has not been reinstituted. Therefore, for this proposed rule, we are proposing to continue to not have an effective Part B drug CAP rate for pass-through drugs and biologicals. Similar to pass-through estimates for devices, the first group of drugs and biologicals requiring a pass-through payment estimate consists of those products that were recently made eligible for pass-through payment and that would continue to be eligible for pass-through payment in CY 2011. The second group contains drugs and nonimplantable biologicals that we know are newly eligible, or project would be newly eligible, in the remaining quarters of CY 2010 or beginning in CY 2011. The sum of the CY 2011 pass-through estimates for these two groups of drugs and biologicals would equal the total CY 2010 pass-through spending estimate for drugs and biologicals with pass-through status.

B. Proposed Estimate of Pass-Through Spending

We are proposing to set the applicable pass-through payment percentage limit at 2.0 percent of the total projected OPPS payments for CY 2011, consistent with our OPPS policy from CY 2004 through CY 2010 (74 FR 60530).

For the first group of devices for pass-through payment estimate purposes, there currently are no device categories receiving pass-through payment in CY 2010 that would continue for payment during CY 2011. Therefore, we are proposing a device pass-through payment estimate for the first group of pass-through device categories of $0.

We also are proposing for CY 2011 to continue to employ the device pass-through process and payment methodology for implantable biologicals that are always surgically inserted or implanted (through a surgical incision or a natural orifice) that we used for CY 2010. We are proposing to consider existing implantable biologicals approved for pass-through payment under the drugs and biologicals pass-through provision prior to CY 2010 as drugs and biologicals for pass-through payment estimate purposes until they expire from pass-through status. Therefore, the proposed pass-through spending estimate for the first group of pass-through devices does not include implantable biologicals that were granted pass-through status prior to CY 2010. Finally, we are proposing to continue to provide payment for implantable biologicals newly eligible for pass-through payment beginning in CY 2010 or CY 2011 based on hospital charges adjusted to cost that is applicable for pass-through device categories, rather than the ASP methodology that is applicable to pass-through drugs and biologicals. Therefore, we are proposing that the estimate of pass-through spending for implantable biologicals first paid as pass-through devices in CY 2011 would be based on the payment methodology for pass-through devices and would be included in the device pass-through spending estimate.

In estimating our proposed CY 2011 pass-through spending for device categories in the second group, that is, device categories that we knew at the time of the development of the proposed rule would be newly eligible for pass-through payment in CY 2011 (of which there are none), additional device categories (including categories that describe implantable biologicals) that we estimated could be approved for pass-through status subsequent to the development of the proposed rule and before January 1, 2011, and contingent projections for new categories (including categories that describe implantable biologicals in the second through fourth quarters of CY 2011), we are proposing to use the general methodology described in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66778), while also taking into account recent OPPS experience in approving new pass-through device categories. While there are no new device categories (including categories that describe implantable biologicals) for CY 2011 of which we are aware at the time of development of this proposed rule, there are possible new device categories for pass-through payment based on current applications. Therefore, the estimate of CY 2011 pass-through spending for this second group of device categories is $72.1 million.

Employing our established methodology that the estimate of pass-through device spending in CY 2011 incorporates CY 2011 estimates of pass-through spending for known device categories continuing in CY 2011, those known or projected to be first effective January 1, 2011, and those device categories projected to be approved during subsequent quarters of CY 2010

or CY 2011, our proposed CY 2011 estimate of total pass-through spending for device categories is $72.1 million.

To estimate CY 2011 proposed pass-through spending for drugs and biologicals in the first group, specifically those drugs (including radiopharmaceuticals and contrast agents) and biologicals (including implantable biologicals) recently made eligible for pass-through payment and continuing on pass-through status for CY 2011, we are proposing to utilize the most recent Medicare physician's office data regarding their utilization, information provided in the respective pass-through applications, historical hospital claims data, pharmaceutical industry information, and clinical information regarding those drugs or biologicals, in order to project the CY 2011 OPPS utilization of the products.

For the known drugs and biologicals (excluding diagnostic radiopharmaceuticals, contrast agents, and implantable biologicals) that would be continuing on pass-through status in CY 2011, we then estimate the proposed pass-through payment amount as the difference between ASP+6 percent or the Part B drug CAP rate, as applicable, and ASP+6 percent, aggregated across the projected CY 2011 OPPS utilization of these products, which is zero for this group of drugs and biologicals. Because payment for a diagnostic radiopharmaceutical or contrast agent would be packaged if the product were not paid separately due to its pass-through status, we include in the pass-through estimate the difference between payment for the drug or biological at ASP+6 percent (or WAC+6 percent, or 95 percent of AWP, if ASP information is not available) and the "policy-packaged" drug APC offset amount, if we determined that the diagnostic radiopharmaceutical or contrast agent approved for pass-through payment resembles predecessor diagnostic radiopharmaceuticals or contrast agents already included in the costs of the APCs that would be associated with the drug receiving pass-through payment. Because payment for an implantable biological eligible for pass-through payment in CY 2009 and continuing on pass-through status in CY 2011 would be packaged if the product were not paid separately due to its pass-through status and because we had not established a pass-through payment offset policy for implantable biologicals when approved for pass-through payment as biologicals, that is, for CY 2009 and earlier, we are including in the proposed pass-through spending estimate the full payment for these implantable biologicals at ASP+6 percent (or WAC+6 percent or 95 percent of AWP, if ASP information is not available). Based on these results, we are proposing the spending estimate for this first group of drugs and biologicals to be $9 million, while we are proposing our spending estimate for the second group of drugs and biologicals to be $5.8 million.

To estimate CY 2011 pass-through spending for drugs and nonimplantable biologicals in the second group (that is, drugs and nonimplantable biologicals that we knew at the time of development of this proposed rule would be newly eligible for pass-through payment in CY 2011, additional drugs and nonimplantable biologicals that we estimated could be approved for pass-through status subsequent to the development of this proposed rule and before January 1, 2011, and projections for new drugs and nonimplantable biologicals that could be initially eligible for pass-through payment in the second through fourth quarters of CY 2011), we are proposing to use utilization estimates from pass-through applicants, pharmaceutical industry data, clinical information, recent trends in the per unit ASPs of hospital outpatient drugs, and projected annual changes in service volume and intensity as our basis for making the CY 2011 proposed pass-through payment estimate. We also are considering the most recent OPPS experience in approving new pass-through drugs and nonimplantable biologicals. Consistent with our policy established in CY 2010 (74 FR 60531 through 60532), we also are proposing to include new implantable biologicals that we expect to be approved for pass-through status as devices beginning in CY 2011 in the second group of items considered for device pass-through estimate purposes. Therefore, we are not proposing to include implantable biologicals in the second group of items in the proposed drug and biological pass-through spending estimate.

Based on the results of these analyses, we are proposing that the spending estimate for this second group of drugs and biologicals to be $5.8 million.

As described in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60476), under our current policy, beginning in CY 2010, implantable biologicals that are surgically inserted or implanted (through a surgical incision or a natural orifice) and that were not receiving pass-through payment as biologicals prior to January 1, 2010, will be evaluated under the device pass-through process and paid according to the device payment methodology. We are proposing to continue to consider implantable biologicals approved for pass-through payment under the drug and biological pass-through provision prior to CY 2010 as drugs and biologicals for pass-through payment estimate purposes. These implantable biologicals that have been approved for pass-through status prior to CY 2010 continue to be considered drugs and biologicals until they expire from pass-through status. Therefore, the pass-through spending estimate for the first group of pass-through device categories does not include implantable biologicals that have been granted pass-through status prior to CY 2010.

Consistent with the current policy established in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60476), we are proposing to continue to provide that payment for implantable biologicals newly eligible for pass-through payment beginning in CY 2011 is based on hospital charges adjusted to cost, rather than the ASP methodology that is applicable to pass-through drugs and biologicals. Therefore, we are proposing that the estimate of pass-through spending for implantable biologicals first paid as pass-through devices in CY 2011 would be based on the payment methodology for pass-through devices, and would be included in the proposed CY 2011 device pass-through spending estimate for the second group of pass-through device categories.

The proposed CY 2011 pass-through spending estimate for the first group of pass-through device categories is $0. The proposed estimate of CY 2010 pass-through spending for the second group of pass-through device categories is $72.1 million. Our proposed CY 2011 estimate of total pass-through spending for device categories is $72.1 million.

The estimate for pass-through spending for the first group of drugs and biologicals is $9.0 million for CY 2011. The estimate for pass-through spending for the second group of drugs and biologicals is $5.8 million for CY 2011. As discussed in section V.A. of this proposed rule, radiopharmaceuticals are considered drugs for pass-through purposes. Therefore, we have included radiopharmaceuticals in our proposed CY 2011 pass-through spending estimate for drugs and biologicals. Our proposed CY 2011 estimate of total pass-through spending for drugs and biologicals is $14.8 million.

In summary, in accordance with the methodology described above in this section, we estimate that total pass-through spending for the device categories and the drugs and biologicals that are continuing to receive pass-through payment in CY 2011 and those

device categories, drugs, and nonimplantable biologicals that first become eligible for pass-through payment during CY 2011 would be approximately $86.9 million, which represents 0.20 percent of total OPPS projected total payments for CY 2011. We estimate that pass-through spending in CY 2011 would not amount to 2.0 percent of total projected OPPS CY 2011 program spending.

VII. Proposed OPPS Payment for Brachytherapy Sources

A. Background

Section 1833(t)(2)(H) of the Act, as added by section 621(b)(2)(C) of Public Law 108–173 (MMA), mandated the creation of additional groups of covered OPD services that classify devices of brachytherapy consisting of a seed or seeds (or radioactive source) ("brachytherapy sources") separately from other services or groups of services. The additional groups must reflect the number, isotope, and radioactive intensity of the brachytherapy sources furnished and include separate groups for palladium-103 and iodine-125 sources.

Section 1833(t)(16)(C) of the Act, as added by section 621(b)(1) of Public Law 108–173, established payment for brachytherapy sources furnished from January 1, 2004 through December 31, 2006, based on a hospital's charges for each brachytherapy source furnished adjusted to cost. Under section 1833(t)(16)(C) of the Act, charges for the brachytherapy sources may not be used in determining any outlier payments under the OPPS for that period in which payment is based on charges adjusted to cost. Consistent with our practice under the OPPS to exclude items paid at cost from budget neutrality consideration, these items were excluded from budget neutrality for that time period as well.

In our CY 2007 annual OPPS rulemaking, we proposed and finalized a policy of prospective payment based on median costs for the 11 brachytherapy sources for which we had claims data. We based the prospective payment rates on median costs for each source from our CY 2005 claims data (71 FR 68102 through 71 FR 68115).

Subsequent to publication of the CY 2007 OPPS/ASC final rule with comment period, section 107 of Public Law 109–432 (MIEA–TRHCA) amended section 1833 of the Act. Specifically, section 107(a) of Public Law 109–432 amended section 1833(t)(16)(C) of the Act by extending the payment period for brachytherapy sources based on a hospital's charges adjusted to cost for one additional year, through December 31, 2007. Therefore, we continued to pay for brachytherapy sources based on charges adjusted to cost for CY 2007.

Section 107(b)(1) of Public Law 109–432 amended section 1833(t)(2)(H) of the Act by adding a requirement for the establishment of separate payment groups for "stranded and non-stranded" brachytherapy sources furnished on or after July 1, 2007, in addition to the existing requirements for separate payment groups based on the number, isotope, and radioactive intensity of brachytherapy sources under section 1833(t)(2)(H) of the Act. Section 107(b)(2) of Public Law 109–432 authorized the Secretary to implement this requirement by "program instruction or otherwise." We note that public commenters who responded to the CY 2007 OPPS/ASC proposed rule asserted that stranded sources, which they described as embedded into the stranded suture material and separated within the strand by material of an absorbable nature at specified intervals, had greater production costs than non-stranded sources (71 FR 68113 through 68114).

As a result of the statutory requirement to create separate groups for stranded and non-stranded sources as of July 1, 2007, we established several coding changes through a transmittal, effective July 1, 2007 (Transmittal 1259, dated June 1, 2007). Based on public comments received on the CY 2007 OPPS/ASC proposed rule and industry input, we were aware of three sources available in stranded and non-stranded forms at that time: iodine-125; palladium-103; and cesium-131 (72 FR 42746). We created six new HCPCS codes to differentiate the stranded and non-stranded versions of iodine, palladium, and cesium sources.

In Transmittal 1259, we indicated that if we receive information that any of the other sources now designated as non-stranded are also FDA-approved and marketed as a stranded source, we would create a code for the stranded source. We also established two "Not Otherwise Specified" (NOS) codes for billing stranded and non-stranded sources that are not yet known to us and for which we do not have source-specific codes. We established HCPCS code C2698 (Brachytherapy source, stranded, not otherwise specified, per source) for stranded NOS sources and HCPCS code C2699 (Brachytherapy source, non-stranded, not otherwise specified, per source) for non-stranded NOS sources.

In the CY 2008 OPPS/ASC final rule with comment period (72 FR 66784), we again finalized prospective payment for brachytherapy sources, beginning in CY 2008, with payment rates determined using the CY 2006 claims-based costs per source for each brachytherapy source. Consistent with our policy regarding APC payments made on a prospective basis, we finalized the policy in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66686) to subject the cost of brachytherapy sources to the outlier provision of section 1833(t)(5) of the Act, and also to subject brachytherapy source payment weights to scaling for purposes of budget neutrality. Therefore, brachytherapy sources could receive outlier payments if the costs of furnishing brachytherapy sources met the criteria for outlier payment, that is, if brachytherapy sources are paid prospectively. In addition, as noted in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66683), implementation of prospective payment for brachytherapy sources would provide opportunities for hospitals to receive additional payments under certain circumstances through the 7.1 percent rural SCH adjustment (discussed in section II.E. of this proposed rule).

For CY 2008, we also proposed and finalized a policy regarding payment for new brachytherapy sources for which we have no claims data (72 FR 42749 and 72 FR 66786, respectively). We indicated we would assign future new HCPCS codes for new brachytherapy sources to their own APCs, with prospective payment rates set based on our consideration of external data and other relevant information regarding the expected costs of the sources to hospitals. Finally, we proposed and finalized our policy to discontinue using status indicator "H" (Pass-Through Device Categories. Separate cost based pass-through payment; not subject to copayment) because we would not be paying charges adjusted to costs after December 31, 2007, and instead adopted a policy of using status indicator "K" (which includes, among others, "Brachytherapy Sources. Paid under OPPS; separate APC payment") for CY 2008 (72 FR 42749 and 72 FR 66785, respectively).

After we finalized these policies for CY 2008, section 106(a) of Public Law 110–173 (MMSEA) extended the charges-adjusted-to-cost payment methodology for brachytherapy sources for an additional 6 months, through June 30, 2008. Because our final CY 2008 policies paid for brachytherapy sources at prospective rates based on median costs, we were unable to implement these policies during this extension.

In the CY 2009 OPPS/ASC proposed rule (73 FR 41502), we again proposed prospective payment rates for brachytherapy sources for CY 2009. We proposed to pay for brachytherapy sources at prospective rates based on their source-specific median costs as calculated from CY 2007 claims data available for CY 2009 ratesetting. Subsequent to issuance of the CY 2009 OPPS/ASC proposed rule, Public Law 110–275 (MIPPA) was enacted on July 15, 2008. Section 142 of Public Law 110–275 amended section 1833(t)(16)(C) of the Act, as amended by section 106(a) of Public Law 110–173 (MMSEA), to further extend the payment period for brachytherapy sources based on a hospital's charges adjusted to cost from July 1, 2008 through December 31, 2009. Therefore, we continued to pay for brachytherapy sources at charges adjusted to cost in CY 2008 from July 1 through December 31, and we maintained the assignment of status indicator "H" to brachytherapy sources for claims processing purposes in CY 2008. For CY 2009, we continued to pay for all separately payable brachytherapy sources based on a hospital's charges adjusted to cost. Because brachytherapy sources are paid at charges adjusted to cost, we did not subject them to outlier payments under section 1833(t)(5) of the Act, or subject brachytherapy source payment weights to scaling for purposes of budget neutrality. Moreover, during the CY 2009 period of payment at charges adjusted to cost, brachytherapy sources were not eligible for the 7.1 percent rural SCH adjustment (as discussed in detail in section II.E. of this proposed rule).

Furthermore, for CY 2009, we did not adopt the policy we established in the CY 2008 OPPS/ASC final rule with comment period of paying stranded and non-stranded NOS codes for brachytherapy sources, HCPCS codes C2698 and C2699, based on a rate equal to the lowest stranded or non-stranded prospective payment for such sources. Also, for CY 2009, we did not adopt the policy we established in the CY 2008 OPPS/ASC final rule with comment period regarding payment for new brachytherapy sources for which we have no claims data. NOS HCPCS codes C2698 and C2699 and newly established specific source codes were paid at charges adjusted to cost through December 31, 2009, consistent with the provisions of section 142 of Public Law 110–275.

For CY 2009, we finalized our proposal to create new status indicator "U" (Brachytherapy Sources. Paid under OPPS; separate APC payment) for brachytherapy source payment, instead of using status indicator "K" as proposed and finalized for CY 2008 for prospective payment, or status indicator "H," used during the period of charges adjusted to cost payment. As noted in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68670), assigning a status indicator, such as status indicator "K," to several types of items and services with potentially differing payment policies added unnecessary complexity to our operations. Status indicator "U" is used only for brachytherapy sources, regardless of their specific payment methodology for any period of time.

Under section 142 of Public Law 110–275, payment for brachytherapy sources was mandated at charges adjusted to cost only through CY 2009. In the CY 2010 OPPS/ASC final rule with comment period (74 FR 60533 through 60537), we adopted for CY 2010 the general OPPS prospective payment methodology for brachytherapy sources, consistent with section 1833(t)(2)(C) of the Act.

B. Proposed OPPS Payment Policy

As we have previously stated (72 FR 66780, 73 FR 41502, and 74 FR 60533 and 60534), we believe that adopting the general OPPS prospective payment methodology for brachytherapy sources is appropriate for a number of reasons. The general OPPS payment methodology uses median costs based on claims data to set the relative payment weights for hospital outpatient services. This payment methodology results in more consistent, predictable, and equitable payment amounts per source across hospitals by eliminating some of the extremely high and low payment amounts resulting from payment based on hospitals' charges adjusted to cost. We believe the OPPS prospective payment methodology would also provide hospitals with incentives for efficiency in the provision of brachytherapy services to Medicare beneficiaries. Moreover, this approach is consistent with our payment methodology for the vast majority of items and services paid under the OPPS.

We are proposing to use the median costs from CY 2009 claims data for setting the proposed CY 2011 payment rates for brachytherapy sources, as we are proposing for most other items and services that will be paid under the CY 2011 OPPS. We are proposing to continue the other payment policies for brachytherapy sources we finalized in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60537). We are proposing to pay for the stranded and non-stranded NOS codes, HCPCS codes C2698 and C2699, at a rate equal to the lowest stranded or non-stranded prospective payment rate for such sources, respectively, on a per source basis (as opposed, for example, to a per mCi), which is based on the policy we established in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66785). The proposed payment methodology for NOS sources would provide payment to a hospital for new sources, and at the same time encourage interested parties to quickly bring new sources to our attention so that specific coding and payment could be established.

We also are proposing to continue the policy we implemented in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60537) regarding payment for new brachytherapy sources for which we have no claims data, based on the same reasons we discussed in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66786; which was superseded by section 142 of Pub. L. 110–275). That policy is intended to enable us to assign future new HCPCS codes for new brachytherapy sources to their own APCs, with prospective payment rates set based on our consideration of external data and other relevant information regarding the expected costs of the sources to hospitals.

Consistent with our policy regarding APC payments made on a prospective basis, as we did for CY 2010, we are proposing to subject brachytherapy sources to outlier payments under section 1833(t)(5) of the Act, and also to subject brachytherapy source payment weights to scaling for purposes of budget neutrality. Therefore, brachytherapy sources could receive outlier payments if the costs of furnishing brachytherapy sources meet the criteria for outlier payment, that is, if they are prospectively paid. In addition, as noted in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60534), implementation of prospective payments for brachytherapy sources would provide opportunities for hospitals to receive additional payments in CY 2010 under certain circumstances through the 7.1 percent rural adjustment, as described in section II.E. of this proposed rule.

Therefore, we are proposing to pay for brachytherapy sources at prospective payment rates based on their source-specific median costs for CY 2011. The separately payable brachytherapy source HCPCS codes, long descriptors, APCs, status indicators, and approximate APC median costs that we are proposing for CY 2011 are presented in Table 29 below.

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TABLE 29.—PROPOSED SEPARATELY PAYABLE BRACHYTHERAPY SOURCES FOR CY 2011

CY 2010 HCPCS Code	CY 2010 Long Descriptor	Proposed CY 2011 APC	Proposed CY 2011 SI	Proposed CY 2011 Approximate APC Median Cost
A9527	Iodine I-125, sodium iodide solution, therapeutic, per millicurie	2632	U	$21
C1716	Brachytherapy source, non-stranded, Gold-198, per source	1716	U	$188
C1717	Brachytherapy source, non-stranded, High Dose Rate Iridium-192, per source	1717	U	$225
C1719	Brachytherapy source, non-stranded, Non-High Dose Rate Iridium-192, per source	1719	U	$23
C2616	Brachytherapy source, non-stranded, Yttrium-90, per source	2616	U	$17,108
C2634	Brachytherapy source, non-stranded, High Activity, Iodine-125, greater than 1.01 mCi (NIST), per source	2634	U	$53
C2635	Brachytherapy source, non-stranded, High Activity, Palladium-103, greater than 2.2 mCi (NIST), per source	2635	U	$30
C2636	Brachytherapy linear source, non-stranded, Palladium-103, per 1MM	2636	U	$37
C2638	Brachytherapy source, stranded, Iodine-125, per source	2638	U	$39
C2639	Brachytherapy source, non-stranded, Iodine-125, per source	2639	U	$37
C2640	Brachytherapy source, stranded, Palladium-103, per source	2640	U	$65
C2641	Brachytherapy source, non-stranded, Palladium-103, per source	2641	U	$64
C2642	Brachytherapy source, stranded, Cesium-131, per source	2642	U	$117
C2643	Brachytherapy source, non-stranded, Cesium-131, per source	2643	U	$64
C2698	Brachytherapy source, stranded, not otherwise specified, per source	2698	U	*$39

CY 2010 HCPCS Code	CY 2010 Long Descriptor	Proposed CY 2011 APC	Proposed CY 2011 SI	Proposed CY 2011 Approximate APC Median Cost
C2699	Brachytherapy source, non-stranded, not otherwise specified, per source	2699	U	*$23

*Median cost is that of the lowest cost stranded or non-stranded source upon which proposed CY 2011 payment for the NOS HCPCS code is based.

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We continue to invite hospitals and other parties to submit recommendations to us for new HCPCS codes to describe new brachytherapy sources consisting of a radioactive isotope, including a detailed rationale to support recommended new sources. Such recommendations should be directed to the Division of Outpatient Care, Mail Stop C4–05–17, Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244. We will continue to add new brachytherapy source codes and descriptors to our systems for payment on a quarterly basis.

VIII. Proposed OPPS Payment for Drug Administration Services

A. Background

In CY 2005, in response to the recommendations made by public commenters and the hospital industry, OPPS transitioned from Level II HCPCS Q-codes to the use of CPT codes for drug administration services. These CPT codes allowed specific reporting of services regarding the number of hours for an infusion and provided consistency in coding between Medicare and other payers. (For a discussion regarding coding and payment for drug administration services prior to CY 2005, we refer readers to the CY 2008 OPPS/ASC final rule with comment period (72 FR 66787).)

While hospitals began adopting CPT codes for outpatient drug administration services in CY 2005, physicians paid under the MPFS were using HCPCS G-codes in CY 2005 to report office-based drug administration services. These HCPCS G-codes were developed in anticipation of substantial revisions to the drug administration CPT codes by the CPT Editorial Panel that were expected for CY 2006.

In CY 2006, as anticipated, the CPT Editorial Panel revised its coding structure for drug administration services and incorporated new concepts, such as initial, sequential, and concurrent services, into a structure that previously distinguished services based on type of administration (chemotherapy/nonchemotherapy), method of administration (injection/infusion/push), and for infusion services, first hour and additional hours. For CY 2006, we implemented the CY 2006 drug administration CPT codes that did not reflect the concepts of initial, sequential, and concurrent services under the OPPS, and we created HCPCS C-codes that generally paralleled the CY 2005 CPT codes for reporting these other services.

For CY 2007, as a result of public comments on the proposed rule and feedback from the hospital community and the APC Panel, we implemented the full set of CPT codes for drug administration services, including codes incorporating the concepts of initial, sequential, and concurrent services. In addition, the CY 2007 update process offered us the first opportunity to consider data gathered from the use of CY 2005 CPT codes for purposes of ratesetting. For CY 2007, we used CY 2005 claims data to implement a six-level APC structure for drug administration services. In CY 2008, we continued to use the full set of CPT codes for drug administration services and continued our assignment of drug administration services to this six-level APC structure.

For CY 2009, we continued to allow hospitals to use the full set of CPT codes for drug administration services but moved from a six-level APC structure to a five-level APC structure. We note that, while there were changes in the CPT numerical coding for nonchemotherapy drug administration services in CY 2009, the existing CPT codes were only renumbered, and there were no significant changes to the code descriptors themselves. As we discussed in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68672), the CY 2009 ratesetting process afforded us the first opportunity to examine hospital claims data for the full set of CPT codes that reflected the concepts of initial, sequential, and concurrent services. For CY 2009, we performed our standard annual OPPS review of the clinical and resource characteristics of the drug administration CPT codes assigned to the six-level CY 2008 APC structure based on the CY 2007 claims data available for the CY 2009 OPPS/ASC proposed rule. As a result of our hospital cost analysis and detailed clinical review, we adopted a five-level APC structure for CY 2009 drug administration services to more appropriately reflect their resource utilization in APCs that also group clinically similar services. As we noted in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68671), these APCs generally demonstrated the clinically expected and actually observed comparative relationships between the median costs of different types of drug administration services, including initial and additional services; chemotherapy and other diagnostic, prophylactic, or therapeutic services; injections and infusions; and simple and complex methods of drug administration.

After analyzing the assignment of CPT codes for drug administration into the five-level APC structure by utilizing our standard annual OPPS review for clinical cohesiveness and resource homogeneity, we continued our five-level APC structure for payment for drug administration services in the HOPD for CY 2010. In addition, we used the full set of CPT codes for drug administration and included all separately payable drug administration add-on codes on the CY 2010 bypass list in order to create pseudo single claims for these codes that would enable us to use the claims data to set payment rates for them. As we stated in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60538) since CY 2007, we continue to update the bypass methodology to reflect changing drug administration HCPCS codes that are recognized under the OPPS.

B. Proposed Coding and Payment for Drug Administration Services

For CY 2011, we are proposing to continue to use the full set of CPT codes for reporting drug administration services and to continue to pay separately for the same set of drug administration codes under the CY 2011 OPPS as were paid separate in the CY 2010 OPPS. As a part of our standard annual review, we analyzed the CY 2009 claims data that reflect assignments of CPT codes for drug administration into the five-level APC structure and have found that the assignment of separately paid drug administration codes to five APCs continues to appropriately reflect the relative resources required to furnish these services. In addition, as has been our standard policy since the CY 2007 OPPS (71 FR 68117), we are proposing to continue to include all separately payable drug administration add-on codes on the bypass list so that we can use the cost data we derive from claims for these codes to establish payment rates for them.

Since this approach was first adopted for CY 2007, we have updated and expanded the bypass methodology to reflect changing drug administration HCPCS codes that are recognized under the OPPS. We placed all of the add-on CPT codes for drug administration services, including the sequential infusion and intravenous push codes, on the bypass list in CY 2009 (73 FR 68513) in order to continue this framework for transforming these otherwise unusable multiple bills into "pseudo" single claims that can be used for OPPS ratesetting purposes. We believe that this longstanding methodology results in appropriate payment rates for the add-on CPT codes for drug administration; therefore, we are proposing to continue to use this methodology for the CY 2011 OPPS because we believe this methodology takes into account all of the packaging on claims for drug administration services and therefore provides a reasonable framework for developing median costs for drug administration services that are often provided in combination with one another (74 FR 60539).

At its February 2010 meeting, the APC Panel recommended that CMS make CPT code 96368 (Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); concurrent infusion (List separately in addition to code for primary procedure) and CPT code 93676 (Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of the same substance/drug provided in a facility (List separately in addition to code for primary, separately payable procedure) separately payable for the CY 2011 OPPS at an appropriate payment rate as determined by CMS. We are not proposing to accept this APC Panel recommendation because these two codes each describe services that, by definition, are always provided in conjunction with an initial drug administration code and therefore are appropriately packaged into the payment for the separately payable services that they usually accompany. These services have been packaged since the inception of the OPPS, and we continue to believe they are appropriately packaged into the payment for the separately payable services without which, under CPT guidelines and definitions, they cannot be appropriately reported. We refer readers to section II.A.3. of this proposed rule for a more detailed discussion of payment for packaged services.

Table 30 below displays the proposed configuration of the five drug administration APCs for CY 2011 and the proposed median cost for each of the proposed drug administration APCs. We believe the updated CY 2009 claims data and the most recent cost report data for the drug administration CPT show that these codes share sufficiently similar clinical and resource characteristics to justify their continued placement in the five levels of drug administration APCs that were in effect in the CY 2010 OPPS. The median cost for each of the separately paid drug administration CPT codes is contained in the CPT median cost file that is provided as supporting documentation to this proposed rule at the Web site at: *http://www.cms.hhs.gov/HospitalOutpatientPPS/*. The proposed CY 2011 payment rate for each of the proposed drug administration APCs is contained in Addendum B of this proposed rule.

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TABLE 30.—PROPOSED CY 2011 DRUG ADMINISTRATION APCs

CY 2011 HCPCS Code	Proposed CY 2011 APC	Proposed CY 2011 Approximate APC Median Cost	CY 2010 Long Descriptor
90471	0436	$27	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular \injections); one vaccine (single or combination vaccine/toxoid)
90472			Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)
90473			Immunization administration by intranasal or oral route; one vaccine (single or combination vaccine/toxoid)
90474			Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)
95115			Professional services for allergen immunotherapy not including provision of allergenic extracts; single injection
95117			Professional services for allergen immunotherapy not including provision of allergenic extracts; 2 or more injections
95165			Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens (specify number of doses)
96361			Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure)
96366			Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)
96371			Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); additional pump set-up with establishment of new subcutaneous infusion site(s) (List separately in addition to code for primary procedure)
96372			Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular

CY 2011 HCPCS Code	Proposed CY 2011 APC	Proposed CY 2011 Approximate APC Median Cost	CY 2010 Long Descriptor
96379			Unlisted therapeutic, prophylactic, or diagnostic intravenous or intra-arterial injection or infusion
96549			Unlisted chemotherapy procedure
95144	0437	$38	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy, single dose vial(s) (specify number of vials)
95145			Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); single stinging insect venom
95148			Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); 4 single stinging insect venoms
95149			Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); 5 single stinging insect venoms
95170			Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; whole body extract of biting insect or other arthropod (specify number of doses)
96367			Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion, up to 1 hour (List separately in addition to code for primary procedure)
96370			Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)
96373			Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intra-arterial
96374			Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug
96375			Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in additional to code for primary procedure)
96401			Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic
96402			Chemotherapy administration, subcutaneous or intramuscular; hormonal anti-neoplastic
96405			Chemotherapy administration; intralesional, up to and including 7 lesions

CY 2011 HCPCS Code	Proposed CY 2011 APC	Proposed CY 2011 Approximate APC Median Cost	CY 2010 Long Descriptor
96415			Chemotherapy administration, intravenous infusion technique; each additional hour (List separately in addition to code for primary procedure)
95146	0438	$78	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); 2 single stinging insect venoms
95147			Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); 3 single stinging insect venoms
96360			Intravenous infusion, hydration; initial, 31 minutes to 1 hour
96411			Chemotherapy administration; intravenous, push technique, each additional substance/drug (List separately in addition to code for primary procedure)
96417			Chemotherapy administration, intravenous infusion technique; each additional sequential infusion (different substance/drug), up to 1 hour (List separately in addition to code for primary procedure)
96420			Chemotherapy administration, intra-arterial; push technique
96423			Chemotherapy administration, intra-arterial; infusion technique, each additional hour (List separately in addition to code for primary procedure)
96542			Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir, single or multiple agents
95990	0439	$129	Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular);
95991			Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular); administered by physician
96365			Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour
96369			Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); initial, up to 1 hour, including pump set-up and establishment of subcutaneous infusion site(s)

CY 2011 HCPCS Code	Proposed CY 2011 APC	Proposed CY 2011 Approximate APC Median Cost	CY 2010 Long Descriptor
96406			Chemotherapy administration; intralesional, more than 7 lesions
96409			Chemotherapy administration; intravenous, push technique, single or initial substance/drug
96440			Chemotherapy administration into pleural cavity, requiring and including thoracentesis
96521			Refilling and maintenance of portable pump
96522			Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (eg, intravenous, intra-arterial)
96413	0440	$208	Chemotherapy administration; intravenous infusion technique; up to 1 hour, single or initial substance/drug
96416			Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of a portable or implantable pump
96422			Chemotherapy administration, intra-arterial; infusion technique, up to 1 hour
96425			Chemotherapy administration, intra-arterial; infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump
96445			Chemotherapy administration into peritoneal cavity, requiring and including peritoneocentesis
96450			Chemotherapy administration, into CNS (eg, intrathecal), requiring and including spinal puncture
C8957			Intravenous infusion for therapy/diagnosis; initiation of prolonged infusion (more than eight hours), requiring use of portable or implantable pump

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IX. Proposed OPPS Payment for Hospital Outpatient Visits

A. Background

Currently, hospitals report visit HCPCS codes to describe three types of OPPS services: clinic visits; emergency department visits; and critical care services. For OPPS purposes, we recognize clinic visit codes as those codes defined in the CPT code book to report evaluation and management (E/M) services provided in the physician's office or in an outpatient or other ambulatory facility. We recognize emergency department visit codes as those codes used to report E/M services provided in the emergency department. Emergency department visit codes consist of five CPT codes that apply to Type A emergency departments and five Level II HCPCS codes that apply to Type B emergency departments. For OPPS purposes, we recognize critical care codes as those CPT codes used by hospitals to report critical care services that involve the "direct delivery by a physician(s) of medical care for a critically ill or critically injured patient," as defined by the CPT code book. In Transmittal 1139, Change Request 5438, dated December 22, 2006, we stated that, under the OPPS, the time that can be reported as critical care is the time spent by a physician and/or hospital staff engaged in active face-to-face critical care of a critically ill or critically injured patient. Under the OPPS, we also recognize HCPCS code G0390 (Trauma response team associated with hospital critical care service) for the reporting of a trauma response in association with critical care services.

We are proposing to continue to recognize these CPT and HCPCS codes describing clinic visits, Type A and Type B emergency department visits, critical care services, and trauma team activation provided in association with critical care services for CY 2011. These codes are listed below in Table 31.

BILLING CODE 4120–01–P

TABLE 31.—PROPOSED HCPCS CODES USED TO REPORT CLINIC AND EMERGENCY DEPARTMENT VISITS AND CRITICAL CARE SERVICES

CY 2010 HCPCS Code	CY 2010 Descriptor
Clinic Visit HCPCS Codes	
99201	Office or other outpatient visit for the evaluation and management of a new patient (Level 1)
99202	Office or other outpatient visit for the evaluation and management of a new patient (Level 2)
99203	Office or other outpatient visit for the evaluation and management of a new patient (Level 3)
99204	Office or other outpatient visit for the evaluation and management of a new patient (Level 4)
99205	Office or other outpatient visit for the evaluation and management of a new patient (Level 5)
99211	Office or other outpatient visit for the evaluation and management of an established patient (Level 1)
99212	Office or other outpatient visit for the evaluation and management of an established patient (Level 2)
99213	Office or other outpatient visit for the evaluation and management of an established patient (Level 3)
99214	Office or other outpatient visit for the evaluation and management of an established patient (Level 4)
99215	Office or other outpatient visit for the evaluation and management of an established patient (Level 5)
Emergency Department Visit HCPCS Codes	
99281	Emergency department visit for the evaluation and management of a patient (Level 1)
99282	Emergency department visit for the evaluation and management of a patient (Level 2)
99283	Emergency department visit for the evaluation and management of a patient (Level 3)
99284	Emergency department visit for the evaluation and management of a patient (Level 4)
99285	Emergency department visit for the evaluation and management of a patient (Level 5)
G0380	Type B emergency department visit (Level 1)
G0381	Type B emergency department visit (Level 2)
G0382	Type B emergency department visit (Level 3)
G0383	Type B emergency department visit (Level 4)
G0384	Type B emergency department visit (Level 5)
Critical Care Services HCPCS Codes	
99291	Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes
99292	Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes
G0390	Trauma response associated with hospital critical care service

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During the February 2010 APC Panel meeting, the APC Panel recommended that CMS continue to report on clinic and emergency department visits and observation services in the claims data, and that if CMS identifies changes in patterns of utilization or cost, it bring those issues before the Visits and Observation Subcommittee for future consideration. The APC Panel also recommended that the work of the Visits and Observation Subcommittee continue. We are adopting these recommendations and plan to provide the requested data and analyses to the APC Panel at an upcoming meeting.

B. Proposed Policies for Hospital Outpatient Visits

1. Clinic Visits: New and Established Patient Visits

As reflected in Table 31, hospitals use different CPT codes for clinic visits based on whether the patient being treated is a new patient or an established patient. Beginning in CY 2009, we refined the definitions of a new patient and an established patient to reflect whether or not the patient has been registered as an inpatient or outpatient of the hospital within the past 3 years. A patient who has been registered as an inpatient or outpatient of the hospital within the 3 years prior to a visit would be considered to be an established patient for that visit, while a patient who has not been registered as an inpatient or outpatient of the hospital within the 3 years prior to a visit would be considered to be a new patient for that visit. We refer readers to the CY 2009 OPPS/ASC final rule with comment period (73 FR 68677 through 68680) for a full discussion of the refined definitions.

We continue to believe that defining new or established patient status based on whether the patient has been registered as an inpatient or outpatient of the hospital within the 3 years prior to a visit will reduce hospitals' administrative burden associated with reporting appropriate clinic visit CPT codes. For CY 2011, we are proposing to continue recognizing the refined definitions of a new patient and an established patient, and applying our policy of calculating median costs for clinic visits under the OPPS using historical hospital claims data. As discussed in section II.A.2.e.(1) of this proposed rule and consistent with our CY 2010 policy, when calculating the median costs for the clinic visit APCs (0604 through 0608), we would utilize our methodology that excludes those claims for visits that are eligible for payment through the extended assessment and management composite APC 8002 (Level I Extended Assessment and Management Composite). We continue to believe that this approach results in the most accurate cost estimates for APCs 0604 through 0608 for CY 2011.

2. Emergency Department Visits

Since CY 2007, we have recognized two different types of emergency departments for payment purposes under the OPPS—Type A emergency departments and Type B emergency departments. As described in greater detail below, by providing payment for two types of emergency departments, we recognize, for OPPS payment purposes, both the CPT definition of an emergency department, which requires the facility to be available 24 hours, and the requirements for emergency departments specified in the provisions of the Emergency Medical Treatment and Labor Act (EMTALA) (Pub. L. 99–272), which do not stipulate 24-hour availability but do specify other obligations for hospitals that offer emergency services. For more detailed information on the EMTALA provisions, we refer readers to the CY 2009 OPPS/ASC final rule with comment period (73 FR 68680).

In the CY 2007 OPPS/ASC final rule with comment period (71 FR 68132), we finalized the definition of a Type A emergency department to distinguish it from a Type B emergency department. A Type A emergency department must be available to provide services 24 hours a day, 7 days a week, and meet one or both of the following requirements related to the EMTALA definition of a dedicated emergency department specified at 42 CFR 489.24(b), specifically: (1) It is licensed by the State in which it is located under the applicable State law as an emergency room or emergency department; or (2) it is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment. For CY 2007 (71 FR 68140), we assigned the five CPT E/M emergency department visit codes for services provided in Type A emergency departments to five created Emergency Visit APCs, specifically APC 0609 (Level 1 Emergency Visits), APC 0613 (Level 2 Emergency Visits), APC 0614 (Level 3 Emergency Visits), APC 0615 (Level 4 Emergency Visits), and APC 0616 (Level 5 Emergency Visits). We defined a Type B emergency department as any dedicated emergency department that incurred EMTALA obligations but did not meet the CPT definition of an emergency department. For example, a hospital department that may be characterized as a Type B emergency department would meet the definition of a dedicated emergency department but may not be available 24 hours a day, 7 days a week. Hospitals with such dedicated emergency departments incur EMTALA obligations with respect to an individual who presents to the department and requests, or has a request made on his or her behalf, examination or treatment for a medical condition.

To determine whether visits to Type B emergency departments have different resource costs than visits to either clinics or Type A emergency departments, in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68132), we finalized a set of five HCPCS G-codes for use by hospitals to report visits to all entities that meet the definition of a dedicated emergency department under the EMTALA regulations but that are not Type A emergency departments. These codes are called "Type B emergency department visit codes." In the CY 2007 OPPS/ASC final rule with comment period (71 FR 68132), we explained that these new HCPCS G-codes would serve as a vehicle to capture median cost and resource differences among visits provided by Type A emergency departments, Type B emergency departments, and clinics. We stated that the reporting of specific HCPCS G-codes for emergency department visits provided in Type B emergency departments would permit us to specifically collect and analyze the hospital resource costs of visits to these facilities in order to determine if, in the future, a proposal for an alternative payment policy might be warranted. We expected hospitals to adjust their charges appropriately to reflect differences in Type A and Type B emergency department visit costs.

As we noted in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68681), the CY 2007 claims data used for that rulemaking were from the first year of claims data available for analysis that included hospitals' cost data for these new Type B emergency department HCPCS visit codes. Based on our analysis of the CY 2007 claims data, we confirmed that the median costs of Type B emergency department visits were less than the median costs of Type A emergency department visits for all but the level 5 visit. In other words, the median costs from the CY 2007 hospital claims represented real differences in the hospital resource costs for the same level of visits in a

Type A or Type B emergency department. Therefore, for CY 2009, we adopted the August 2008 APC Panel recommendation to assign levels 1 through 4 Type B emergency department visits to their own APCs and to assign the level 5 Type B emergency department visit to the same APC as the level 5 Type A emergency department visit.

As discussed in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60548 through 60551), analyses of CY 2008 hospitals' cost data from claims data used for CY 2010 ratesetting for the emergency department HCPCS G-codes demonstrated that the pattern of relative cost differences between Type A and Type B emergency department visits was largely consistent with the distributions we observed in the CY 2007 data, with the exception that, in the CY 2008 data, we observed a relatively lower HCPCS code-specific median cost associated with level 5 Type B emergency department visits compared to the HCPCS code-specific median cost of level 5 Type A emergency department visits. As a result, for CY 2010, we finalized a policy to continue to pay levels 1 through 4 Type B emergency department visits through four levels of APCs, and to pay for level 5 Type B emergency department visits through new APC 0630 (Level 5 Type B Emergency Department Visit), to which the level 5 Type B emergency department visit HCPCS code is the only service assigned.

Based on the CY 2009 claims data available for this proposed rule, we note that the pattern of relative cost differences between Type A and Type B emergency department visits is consistent with the distributions we observed in the CY 2008 claims data, as demonstrated in Table 32 below. Therefore, we are proposing to continue to pay for Type B emergency department visits in CY 2011 based on their median costs through five levels of APCs: APC 0626 (Level 1 Type B Emergency Department Visit), APC 0627 (Level 2 Type B Emergency Department Visit), APC 0628 (Level 3 Type B Emergency Department Visit), APC 0629 (Level 4 Type B Emergency Department Visit), and APC 0630. As we stated in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60550), we continue to believe that this configuration pays appropriately for each level of Type B emergency department visits based on estimated resource costs from more recent claims data. We also note that, as discussed in section II.A.2.e.(1) of this proposed rule and consistent with our CY 2010 policy, when calculating the median costs for the emergency department visit and critical care APCs (0609 through 0617 and 0626 through 0630), we are proposing to utilize our methodology that excludes those claims for visits that are eligible for payment through the extended assessment and management composite APC 8002. We believe that this approach will result in the most accurate cost estimates for APCs 0604 through 0608 for CY 2011.

Table 32 below displays the proposed median costs for each level of Type B emergency department visit APCs under the proposed CY 2011 configuration, compared to the proposed median costs for each level of clinic visit APCs and each level of Type A emergency department visit APCs.

TABLE 32.—COMPARISON OF PROPOSED MEDIAN COSTS FOR CLINIC VISIT APCs, TYPE B EMERGENCY DEPARTMENT VISIT APCs, AND TYPE A EMERGENCY DEPARTMENT VISIT APCs

Visit Level	Proposed CY 2011 Clinic Visit Approximate APC Median Cost	Proposed CY 2011 Type B Emergency Department Approximate APC Median Cost	Proposed CY 2011 Type A Emergency Visit Approximate APC Median Cost
Level 1	$52	$44	$54
Level 2	$74	$65	$92
Level 3	$95	$104	$146
Level 4	$125	$169	$234
Level 5	$172	$270	$347

During the February 2010 APC Panel meeting, the APC Panel requested that CMS provide information about the common diagnoses and services furnished with critical care services. We are accepting the APC Panel's recommendation and will provide the requested information at an upcoming meeting of the APC Panel.

3. Visit Reporting Guidelines

Since April 7, 2000, we have instructed hospitals to report facility resources for clinic and emergency department hospital outpatient visits using the CPT E/M codes and to develop internal hospital guidelines for reporting the appropriate visit level. Because a national set of hospital-specific codes and guidelines do not currently exist, we have advised hospitals that each hospital's internal guidelines that determine the levels of clinic and emergency department visits to be reported should follow the intent of the CPT code descriptors, in that the guidelines should be designed to reasonably relate the intensity of hospital resources to the different levels of effort represented by the codes.

As noted in detail in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66802 through 66805), we observed a normal and stable distribution of clinic and emergency department visit levels in hospital claims over the past several years. The data indicated that hospitals, on average, were billing all five levels of visit codes with varying frequency, in a consistent pattern over time. Overall, both the clinic and emergency department visit distributions indicated that hospitals were billing consistently over time and in a manner that distinguished between visit levels, resulting in relatively normal distributions nationally for the OPPS, as well as for specific classes of hospitals. The results of these analyses were generally consistent with our

understanding of the clinical and resource characteristics of different levels of hospital outpatient clinic and emergency department visits. In the CY 2008 OPPS/ASC proposed rule (72 FR 42764 through 42765), we specifically invited public comment as to whether a pressing need for national guidelines continued at this point in the maturation of the OPPS, or if the current system where hospitals create and apply their own internal guidelines to report visits was currently more practical and appropriately flexible for hospitals. We explained that, although we have reiterated our goal since CY 2000 of creating national guidelines, this complex undertaking for these important and common hospital services was proving more challenging than we initially anticipated as we received new and expanded information from the public on current hospital reporting practices that led to appropriate payment for the hospital resources associated with clinic and emergency department visits. We stated our belief that many hospitals had worked diligently and carefully to develop and implement their own internal guidelines that reflected the scope and types of services they provided throughout the hospital outpatient system. Based on public comments, as well as our own knowledge of how clinics operate, it seemed unlikely that one set of straightforward national guidelines could apply to the reporting of visits in all hospitals and specialty clinics. In addition, the stable distribution of clinic and emergency department visits reported under the OPPS over the past several years indicated that hospitals, both nationally in the aggregate and grouped by specific hospital classes, were generally billing in an appropriate and consistent manner as we would expect in a system that accurately distinguished among different levels of service based on the associated hospital resources.

Therefore, we did not propose to implement national visit guidelines for clinic or emergency department visits for CY 2008. Since publication of the CY 2008 OPPS/ASC final rule with comment period, we have again examined the distribution of clinic and Type A emergency department visit levels based upon updated CY 2009 claims data available for this CY 2011 proposed rule and confirmed that we continue to observe a normal and stable distribution of clinic and emergency department visit levels in hospital claims. We continue to believe that, based on the use of their own internal guidelines, hospitals are generally billing in an appropriate and consistent manner that distinguishes among different levels of visits based on their required hospital resources. As a result of our updated analyses, we are encouraging hospitals to continue to report visits during CY 2011 according to their own internal hospital guidelines. In the absence of national guidelines, we will continue to regularly reevaluate patterns of hospital outpatient visit reporting at varying levels of disaggregation below the national level to ensure that hospitals continue to bill appropriately and differentially for these services. As originally noted in detail in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66648), we continue to expect that hospitals will not purposely change their visit guidelines or otherwise upcode clinic and emergency department visits for purposes of extended assessment and management composite APC payment.

In addition, we note our continued expectation that hospitals' internal guidelines will comport with the principles listed in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66805). We encourage hospitals with more specific questions related to the creation of internal guidelines to contact their servicing fiscal intermediary or MAC.

We appreciate all of the comments we have received in the past from the public on visit guidelines, and we encourage continued submission of comments throughout the year that would assist us and other stakeholders interested in the development of national guidelines. Until national guidelines are established, hospitals should continue using their own internal guidelines to determine the appropriate reporting of different levels of clinic and emergency department visits. While we understand the interest of some hospitals in having us move quickly to promulgate national guidelines that would ensure standardized reporting of hospital outpatient visit levels, we believe that the issues and concerns identified both by us and others are important and require serious consideration prior to the implementation of national guidelines.

Because of our commitment to provide hospitals with 6 to 12 months notice prior to implementation of national guidelines, we would not implement national guidelines prior to CY 2012. Our goal is to ensure that OPPS national or hospital-specific visit guidelines continue to facilitate consistent and accurate reporting of hospital outpatient visits in a manner that is resource-based and supportive of appropriate OPPS payments for the efficient and effective provision of services to beneficiaries during visits in hospital outpatient settings.

X. Proposed Payment for Partial Hospitalization Services

A. Background

Partial hospitalization is an intensive outpatient program of psychiatric services provided to patients as an alternative to inpatient psychiatric care for individuals who have an acute mental illness. Sections 1861(ff)(1) and (ff)(2) of the Act specify the items and services that are defined as partial hospitalization services and the conditions under which Medicare payment for the items and services will be made. Section 1861(ff)(3) of the Act specifies that a partial hospitalization program (PHP) is one that is furnished by a hospital or community mental health center (CMHC) that meets the requirements specified under that subsection of the Act.

Section 1301(a) of the recently enacted Health Care and Education Reconciliation Act of 2010 (HCERA 2010) (Pub. L. 111–152, enacted on March 30, 2010) revised the definition of a CMHC set forth at section 1861(ff)(3)(B) of the Act by adding a provision that the CMHC, effective on the first day of the first calendar quarter that begins at least 12 months after the date of enactment (that is, April 1, 2011), must provide at least 40 percent of its services to individuals who are not eligible for benefits under Title XVIII of the Act (Medicare). Section 1301(b) of HCERA 2010 amended the description of a PHP to specify that the program must be a distinct and organized intensive ambulatory treatment service offering less than 24-hour daily care "other than in an individual's home or in an inpatient or residential setting." We discuss our proposal to incorporate these two provisions of HCERA 2010 in our regulations under section X.C. of this proposed rule.

Section 1833(t)(1)(B)(i) of the Act provides the Secretary with the authority to designate the HOPD services to be covered under the OPPS. The existing Medicare regulations at 42 CFR 419.21 that implement this provision specify that payments under the OPPS will be made for partial hospitalization services furnished by CMHCs as well as those services furnished by hospitals to their outpatients. Section 1833(t)(2)(C) of the Act requires the Secretary to establish relative payment weights for covered

HOPD services (and any APCs) based on median (or mean, at the election of the Secretary) hospital costs using data on claims from 1996 and data from the most recent available cost reports. Because a day of care is the unit that defines the structure and scheduling of partial hospitalization services, we established a per diem payment methodology for the PHP APCs, effective for services furnished on or after August 1, 2000 (65 FR 18452 through 18455).

From CY 2003 through CY 2006, the median per diem cost for CMHCs fluctuated significantly from year to year (from a high of $685 in CY 2003 to a low of $154 in CY 2006), while the median per diem cost for hospital-based PHPs remained relatively constant ($177–$225). We believe that CMHCs may have increased and decreased their charges in response to Medicare payment policies.

Due to these significant fluctuations and declines in CMHC PHP median per diem costs, in developing the CY 2008 update, we began an effort to strengthen the PHP benefit through extensive data analysis and policy and payment changes (72 FR 66670 through 66676). Specifically, we proposed and finalized two refinements to the methodology for computing the PHP median. First, we remapped 10 revenue codes that are common among hospital-based PHP claims to the most appropriate cost centers. Secondly, we refined our methodology for calculating PHP per diem costs by computing the median using a per day methodology. A complete discussion of these refinements can be found in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66671 through 66672).

In CY 2009, we implemented several regulatory, policy, and payment changes, including a two-tiered payment approach for PHP services under which we pay one amount for days with 3 services (APC 0172 (Level I Partial Hospitalization)) and a higher amount for days with 4 or more services (APC 0173 (Level II Partial Hospitalization)). We refer readers to section X.C.2. of the CY 2009 OPPS/ASC final rule with comment period (73 FR 68688 through 68693) for a full discussion of the two-tiered payment system. In addition, for CY 2009, we finalized our policy to deny payment for any PHP claims for days when fewer than 3 units of therapeutic services are provided. As noted in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68694), we believe that 3 services should be the minimum number of services allowed in a PHP day because a day with 1 or 2 services does not meet the statutory intent of a PHP. Three services are a minimum threshold that will take into consideration unforeseen circumstances, such as medical appointments, while maintaining the integrity of the PHP benefit.

Furthermore, for CY 2009, we revised the regulations at 42 CFR 410.43 to codify existing basic PHP patient eligibility criteria and to add a reference to current physician certification requirements at 42 CFR 424.24 to conform our regulations to our longstanding policy (73 FR 68694 through 68695). We believe these changes have helped to strengthen the PHP benefit. We also revised the partial hospitalization benefit to include several coding updates. We refer readers to section X.C.2. of the CY 2009 OPPS/ASC final rule with comment period (73 FR 68694 through 68697) for a full discussion of these requirements.

For CY 2010, we retained the two-tiered payment approach for PHP services and used only hospital-based PHP data in computing the per diem payment rates. We used only hospital-based PHP data because we were concerned about further reducing both PHP APC per diem payment rates without knowing the impact of the policy and payment changes we made in CY 2009. Because of the 2-year lag between data collection and rulemaking, the changes we made in CY 2009 are reflected for the first time in the claims data that we are using to determine proposed payment rates for this CY 2011 rulemaking.

B. Proposed PHP APC Update for CY 2011

For CY 2011, we used CY 2009 claims data and computed median per diem costs in the following three categories: (1) All days; (2) days with 3 services; and (3) days with 4 or more services. These proposed median per diem costs were computed separately for CMHC PHPs and hospital-based PHPs and are shown in Table 33 below.

TABLE 33.—PHP MEDIAN PER DIEM COSTS FOR CMHC AND HOSPITAL-BASED PHPs, BY CATEGORY, BASED ON CY 2009 CLAIMS DATA

Category	CMHC PHPs	Hospital-Based PHPs	Combined
All Days	$123.17	$235.58	$132.28
Days with 3 services	$118.19	$184.47	$140.96
Days with 4 or more services	$123.35	$235.58	$131.56

Using CY 2009 data and the refined methodology for computing PHP per diem costs that we adopted in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66672), we computed a median per diem cost from all claims for CY 2011 of $132.28. The data indicate that, although CMHCs provided more days with 4 or more services in CY 2009 than in CY 2008, their median per diem cost for 4 or more services ($123.35) is substantially lower than the median per diem cost for the same units of service provided in hospital-based PHPs ($235.58). The median per diem cost for claims containing 4 or more services for all PHP claims, regardless of site of service, is $131.56. Medians for claims containing 3 services is $118.19 for CMHC PHPs, $184.47 for hospital-based PHPs, and $140.96 for all PHP service claims, regardless of site of service.

These data, along with data from previous years, show the shift in cost and utilization for CMHCs and hospital-based PHPs under the two-tiered

payment system. Since CY 2009 (using 2007 data), CMHC costs decreased from $139 in CY 2009 to $118 in CY 2011 for Level I services (3 services) and from $172 in CY 2009 to $123 in CY 2011 for Level II services (4 or more services). For hospital-based PHPs, costs increased from $157 in CY 2009 to $184 in CY 2011 for Level I services (3 services) and from $200 in CY 2009 to $236 in CY 2011 for Level II services (4 or more services). For the past two years, we have based the PHP APC per diem payment rates on only hospital-based PHP data because including the CMHC data would have lowered the PHP APC per diem rates and raised concerns about appropriate payment for PHP services. Specifically, we were concerned about paying hospital-based PHP programs a rate that is lower than what their cost structure reflects, which in turn could lead to hospital-based program closures and possible access problems. We also were concerned about further reducing the payment rates without knowing the impact of the policy and payment changes we made in CY 2009.

Because the CMHC cost data has significantly decreased again this year, we believe that we can no longer ignore the pattern and continue to base the PHP payment rates using only hospital-based data. We are confident that the CY 2009 claims data reflect that CMHCs continue to have a lower cost structure than hospitals and not the impact of CY 2009 policies. Therefore, we believe that we cannot continue to treat these two provider types the same in terms of payment, particularly because their cost differences continue to be so disparate. We also believe that we need to continue to protect hospital-based PHPs from receiving inadequate payments, given that they offer the widest access to PHP services because they are located across the country. We believe that the results of our analysis of the claims data indicate a need to establish payment rates for each provider type based on its own unique cost structures.

Therefore, for CY 2011, we are proposing to compute four separate PHP APC per diem payment rates, two for CMHC PHPs (for Level I and Level II services using only CMHC data) and two for hospital-based PHPs (Level I and Level II services using only hospital-based PHP data). Creating the proposed four payment rates (two for CMHC PHPs and two for hospital-based PHPs) would support continued access to the PHP benefit, including a more intensive level of care, while also providing appropriate payment based on the unique cost structures of CMHC PHPs and hospital-based PHPs. We request public comments on our proposal to provide four separate PHP APC per diem payment rates, two for CMHC PHPs and two for hospital-based PHPs.

The proposed APCs median per diem costs for PHP services for CY 2011 are as follows:

TABLE 34.—PROPOSED CY 2011 MEDIAN PER DIEM COSTS FOR CMHC PHP SERVICES

Proposed APC	Group Title	Proposed Median Per Diem Costs
0172	Level 1 Partial Hospitalization (3 services) for CMHCs	$118.19
0173	Level II Partial Hospitalization (4 or more services) for CMHCs	$123.35

TABLE 35.—PROPOSED CY 2011 MEDIAN PER DIEM COSTS FOR HOSPITAL-BASED PHP SERVICES

Proposed APC	Group Title	Proposed Median
0175	Level 1 Partial Hospitalization (3 services) for hospital-based PHPs	$184.47
0176	Level II Partial Hospitalization (4 or more services) for hospital-based PHPs	$235.58

We note that this proposal is consistent with the recommendation by several commenters in the CY 2010 OPPS/ASC final rule with comment period that CMS adopt two additional payment rates that are site specific APCs for PHP services, where the hospital-based PHP APCs for Level I services (3 services) and Level II services (4 or more services) would be established using only hospital-based data and the CMHC PHP APCs for Level I services (3 services) and Level II services (4 or more services) would be established using only CMHC data (74 FR 60557).

C. Proposed Changes to Regulations To Incorporate Provisions of HCERA 2010

As stated in section X.A. of this proposed rule, section 1301 of HCERA 2010 made a change to the statutory definition of a CMHC and a change to the description of what constitutes a PHP. Specifically, section 1301(a) of HCERA 2010 revised the definition of a CMHC set forth at section 1861(ff)(3)(B) of the Act by adding a provision to the existing provisions under which a CMHC, effective on the first day of the first calendar quarter that begins at least 12 months after the date of enactment (that is, April 1, 2011), must provide at least 40 percent of its services to individuals who are not eligible for benefits under Title XVIII of the Act (Medicare). Section 1301(b) of HCERA 2010 amended the description of a PHP to specify that the program must be a distinct and organized intensive ambulatory treatment service offering less than 24-hour daily care "other than

in an individual's home or in an inpatient or residential setting."

Our existing regulations at 42 CFR 410.2 incorporate the statutory definitions of "Community mental health center (CMHC)" and "Partial hospitalization services." We are proposing to revise the definition of a CMHC in § 410.2 to include the additional requirement provided for under the amendment made by section 1301(a) of HCERA 2010. Under existing § 410.2, we define "partial hospitalization services" to mean "a distinct and organized intensive ambulatory treatment program that offers less than 24-hour daily care and furnishes the services described in § 410.43." We are proposing to revise this definition to incorporate the amendment made by section 1301(b) of HCERA 2010 to describe partial hospitalization services as a distinct and organized intensive ambulatory treatment program that offers less than 24-hour daily care "other than in an individual's home or in an inpatient residential setting" and furnishes the services described in § 410.43.

D. Proposed Separate Threshold for Outlier Payments to CMHCs

In the November 7, 2003 final rule with comment period (68 FR 63469 through 63470), we indicated that, given the difference in PHP charges between hospitals and CMHCs, we did not believe it was appropriate to make outlier payments to CMHCs using the outlier percentage target amount and threshold established for hospitals. Prior to that time, there was a significant difference in the amount of outlier payments made to hospitals and CMHCs for PHP services. In addition, further analysis indicated that using the same OPPS outlier threshold for both hospitals and CMHCs did not limit outlier payments to high cost cases and resulted in excessive outlier payments to CMHCs. Therefore, beginning in CY 2004, we established a separate outlier threshold for CMHCs. The separate outlier threshold for CMHCs has resulted in more commensurate outlier payments.

In CY 2004, the separate outlier threshold for CMHCs resulted in $1.8 million in outlier payments to CMHCs. In CY 2005, the separate outlier threshold for CMHCs resulted in $0.5 million in outlier payments to CMHCs. In contrast, in CY 2003, more than $30 million was paid to CMHCs in outlier payments. We believe this difference in outlier payments indicates that the separate outlier threshold for CMHCs has been successful in keeping outlier payments to CMHCs in line with the percentage of OPPS payments made to CMHCs.

As noted in section II.F. of this proposed rule, we are proposing to continue our policy of identifying 1.0 percent of the aggregate total payments under the OPPS for outlier payments for CY 2011. We are proposing that a portion of that 1.0 percent, an amount equal to 0.04 percent of outlier payments (or 0.0004 percent of total OPPS payments), would be allocated to CMHCs for PHP outliers. As discussed in section II.F. of this proposed rule, we are proposing to set a dollar threshold in addition to an APC multiplier threshold for OPPS outlier payments. However, because the PHP APC is the only APC for which CMHCs may receive payment under the OPPS, we would not expect to redirect outlier payments by imposing a dollar threshold. Therefore, we are not proposing to set a dollar threshold for CMHC outliers. As noted in section II.F. of this proposed rule, we are proposing to set the outlier threshold for CMHCs for CY 2011 at 3.40 times the APC payment amount and the CY 2011 outlier payment percentage applicable to costs in excess of the threshold at 50 percent. Specifically, we are proposing to establish that if a CMHC's cost for partial hospitalization services, paid under either APC 0172 or APC 0173, exceeds 3.40 times the payment for APC 0173, the outlier payment would be calculated as 50 percent of the amount by which the cost exceeds 3.40 times the APC 0173 payment rate.

XI. Proposed Procedures That Will Be Paid Only as Inpatient Procedures

A. Background

Section 1833(t)(1)(B)(i) of the Act gives the Secretary broad authority to determine the services to be covered and paid for under the OPPS. Before implementation of the OPPS in August 2000, Medicare paid reasonable costs for services provided in the HOPD. The claims submitted were subject to medical review by the fiscal intermediaries to determine the appropriateness of providing certain services in the outpatient setting. We did not specify in our regulations those services that were appropriate to provide only in the inpatient setting and that, therefore, should be payable only when provided in that setting.

In the April 7, 2000 final rule with comment period (65 FR 18455), we identified procedures that are typically provided only in an inpatient setting and, therefore, would not be paid by Medicare under the OPPS. These procedures comprise what is referred to as the "inpatient list." The inpatient list specifies those services for which the hospital will be paid only when provided in the inpatient setting because of the nature of the procedure, the underlying physical condition of the patient, or the need for at least 24 hours of postoperative recovery time or monitoring before the patient can be safely discharged. As we discussed in that rule and in the November 30, 2001 final rule with comment period (66 FR 59856), we may use any of a number of criteria we have specified when reviewing procedures to determine whether or not they should be removed from the inpatient list and assigned to an APC group for payment under the OPPS when provided in the hospital outpatient setting. Those criteria include the following:

- Most outpatient departments are equipped to provide the services to the Medicare population.
- The simplest procedure described by the code may be performed in most outpatient departments.
- The procedure is related to codes that we have already removed from the inpatient list.

In the November 1, 2002 final rule with comment period (67 FR 66741), we added the following criteria for use in reviewing procedures to determine whether they should be removed from the inpatient list and assigned to an APC group for payment under the OPPS:

- A determination is made that the procedure is being performed in numerous hospitals on an outpatient basis; or
- A determination is made that the procedure can be appropriately and safely performed in an ASC, and is on the list of approved ASC procedures or has been proposed by us for addition to the ASC list.

The list of codes that we are proposing to be paid by Medicare in CY 2011 only as inpatient procedures is included as Addendum E to this proposed rule.

B. Proposed Changes to the Inpatient List

For the CY 2011 OPPS, we are proposing to use the same methodology as described in the November 15, 2004 final rule with comment period (69 FR 65835) to identify a subset of procedures currently on the inpatient list that are being performed a significant amount of the time on an outpatient basis. Using this methodology, we identified three procedures that met the criteria for potential removal from the inpatient list. We then clinically reviewed these three potential procedures for possible

removal from the inpatient list and found them to be appropriate candidates for removal from the inpatient list. During the February 2010 meeting of the APC Panel, we solicited the APC Panel's input on the appropriateness of removing the following three procedures from the CY 2011 inpatient list: CPT codes 21193 (Reconstruction of mandibular rami; horizontal, vertical, C, or L osteotomy; without bone graft); 21395 (Open treatment of orbital floor blowout fracture; periorbital approach with bone graft (includes obtaining graft)); and 25909 (Amputation, forearm, through radius and ulna; reamputation). Following the discussion at its February 2010 meeting, the APC Panel recommended that CMS remove from the CY 2011 inpatient list the three CPT codes that we had identified: CPT codes 21193, 21395, and 25909.

For the CY 2011 OPPS, we are proposing to accept the APC Panel's recommendations to remove the procedures described by CPT codes 21193, 21395, and 25909 from the inpatient list because we agree with the APC Panel that the procedures may be appropriately provided as hospital outpatient procedures for some Medicare beneficiaries. The three procedures that we are proposing to remove from the inpatient list for CY 2011 and their CPT codes, long descriptors, and proposed APC assignments are displayed in Table 36 below.

TABLE 36.—PROCEDURES PROPOSED FOR REMOVAL FROM THE INPATIENT LIST AND THEIR PROPOSED APC ASSIGNMENTS FOR CY 2011

CPT Code	Long Descriptor	Proposed CY 2011 APC Assignment	Proposed CY 2011 Status Indicator
21193	Reconstruction of mandibular rami; horizontal, vertical, C, or L osteotomy; without bone graft	0256	T
21395	Open treatment of orbital floor blowout fracture; periorbital approach with bone graft (includes obtaining graft	0256	T
25909	Amputation, forearm, through radius and ulna; reamputation	0049	T

XII. Proposed OPPS Nonrecurring Technical and Policy Changes and Clarifications

A. Physician Supervision

1. Background

In the CY 2000 OPPS final rule with comment period (65 FR 18524–18526), we amended our regulations to establish, as a condition of payment, the requirements for physician supervision of diagnostic and therapeutic services provided to hospital outpatients incident to a physician's service. We adopted physician supervision policies as a condition of payment to ensure that Medicare pays for high quality hospital outpatient services provided to beneficiaries in a safe and effective manner and consistent with Medicare requirements. We clarified and restated the various payment requirements for physician supervision of therapeutic and diagnostic services through notice and comment rulemaking in the CY 2009 OPPS/ASC proposed rule and final rule with comment period (73 FR 41518 through 41519 and 73 FR 68702 through 68704, respectively). In response to concerns about our policy restatement that were expressed following the publication of the CY 2009 final rule with comment period, we met with stakeholders and further delineated our physician supervision policies for both therapeutic and diagnostic services in the CY 2010 OPPS/ASC proposed rule and final rule with comment period (74 FR 35365 and 74 FR 60679 through 60680, respectively).

While we received and responded to many comments in the course of the CY 2010 rulemaking, addressing supervision for both diagnostic and therapeutic services, it was not until after publication of the CY 2010 OPPS/ASC final rule with comment period that we received substantial comments from the CAH community in response to a technical correction we made to codify our long standing view that CAHs are subject to the supervision policy for payment of therapeutic services in the regulations at 42 CFR 410.27. In addition, the broader hospital community continues to indicate that it would prefer that we modify the current supervision policy to permit a lower level of supervision for therapeutic services.

By way of introduction, we have defined supervision in the hospital outpatient setting by drawing on the three levels of supervision that we defined for the physician office setting at § 410.32(b): general, direct and personal supervision. Over time, we have tailored these definitions to apply them in the hospital outpatient setting, but we have maintained the following premises. General supervision means that a service is furnished under the overall direction and control of the physician, but his or her physical presence is not required during the performance of the procedure. Direct supervision means that the physician is physically present on site and is immediately available to furnish assistance and direction throughout the performance of the procedure. However, it does not mean the physician must be present in the same room when the procedure is being performed. Personal supervision means the physician is present in the room when the service is being performed.

a. Outpatient Therapeutic Services

As set forth in the CY 2000 OPPS final rule with comment period establishing the hospital outpatient prospective payment system, direct supervision is the standard for supervision of hospital outpatient therapeutic services covered and paid by Medicare in hospitals and provider based departments (PBDs) of hospitals. In that rule, we defined "direct supervision" to mean that "the

physician must be present and on the premises of the location and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed." In the CY 2000 OPPS final rule with comment period, we finalized regulation text in § 410.27(f) specifying that direct supervision is required in PBDs of hospitals. In the preamble discussion we emphasized the importance of the direct supervision requirement for off-campus provider based departments. We also stated that the language of § 410.27(f) "applies to services furnished at an entity that is located off the campus of a hospital that we designate as having provider-based status as a department of a hospital in accordance with § 413.65." We disagreed with commenters that the requirement for direct supervision in the off campus provider-based hospital department was more stringent than that required on the hospital campus. We noted that section 1861(s)(2)(B) of the Act authorizes payment for hospital services incident to physicians' services furnished to outpatients. We stated that "we require that hospital services and supplies furnished to outpatients that are incident to physician services be furnished on a physician's order by hospital personnel and under a physician's supervision" (65 FR 18525). We further stated that "we assume the physician supervision requirement is met on hospital premises because staff physicians would always be nearby within the hospital."

In manual guidance, we have clarified that we expect services incident to physicians' services to be performed under direct supervision. We provide in Section 20.5.1, Chapter 6, of the Medicare Benefit Policy Manual (Pub. 100–04) that services and supplies must be furnished on a physician's order and delivered under supervision. Section 20.5.1 indicates further that each occasion of a service by a nonphysician does not need to also be the occasion of the actual rendition of a personal professional service by the physician responsible for the care of the patient. Nevertheless, as stipulated in that same section of the Manual "during any course of treatment rendered by auxiliary personnel, the physician must personally see the patient periodically and sufficiently often enough to assess the course of treatment and the patient's progress and, where necessary, to change the treatment regimen."

In the CY 2009 OPPS/ASC proposed rule and final rule with comment period, we provided a restatement and clarification of the requirements for physician supervision of hospital outpatient diagnostic and therapeutic services that were set forth in the CY 2000 OPPS final rule with comment period. We chose to restate the existing physician supervision policy for hospital outpatient therapeutic services in part because we were concerned that some stakeholders may have misunderstood our use of the term "assume" in the following statement, "We assume the physician requirement is met on hospital premises because staff physicians would always be nearby within the hospital. The effect of the regulations in this final rule is to extend this assumption to a department of a hospital that is located on the campus of the hospital" (65 FR 18525). We were concerned that stakeholders might believe that this statement meant that we do not require any supervision in the hospital or in an on-campus PBD for hospital outpatient therapeutic services, or that we only require general supervision for those services.

In our policy restatement in the CY 2009 OPPS/ASC rulemaking, we reiterated that direct supervision is the standard for physician supervision, as set forth in the CY 2000 OPPS final rule with comment period, for supervision of hospital outpatient therapeutic services covered and paid by Medicare in hospitals and PBDs of hospitals. We stated clearly that we expect direct physician supervision of all hospital outpatient therapeutic services, regardless of their on-campus or off-campus location, but indicated that we would continue to emphasize the physician supervision requirements in off-campus PBDs as we did in the CY 2000 OPPS final rule with comment period. We noted that if there were problems with outpatient care in a hospital or in an on-campus PBD where direct supervision was not in place (that is, the expectation of direct supervision was not met), we would consider that to be a quality concern.

After we published the CY 2009 OPPS/ASC final rule with comment period, we received significantly more public feedback than during the rulemaking cycle about our restatement of our supervision policy for both diagnostic and therapeutic services. We met with stakeholders in the early part of 2009 as we prepared for the CY 2010 rulemaking cycle, as well as reviewed all public input that we received, to craft a response to these concerns regarding the supervision requirements. For therapeutic services, we considered the concerns of various stakeholders along with our position that direct supervision for therapeutic services is appropriate and aligned with the statutory requirement that Medicare only makes payment for therapeutic services in the hospital outpatient setting that are "incident to" physician services.

In the CY 2010 OPPS/ASC final rule with comment period, we finalized our proposal to allow, in addition to clinical psychologists, certain other nonphysician practitioners to directly supervise services that they may perform themselves under their State license and scope of practice and hospital-granted or CAH-granted privileges. The nonphysician practitioners that were permitted to provide direct supervision of therapeutic services under the CY 2010 OPPS/ASC final rule with comment period are physician assistants, nurse practitioners, clinical nurse specialists, certified nurse-midwives, and licensed clinical social workers. These nonphysician practitioners may directly supervise outpatient therapeutic services that they may personally furnish in accordance with State law and all additional requirements, including the Medicare coverage rules relating to their services specified in our regulations at 42 CFR 410.71, 410.73, 410.74, 410.75, 410.76, and 410.77 (for example, requirements for collaboration with, or general supervision by, a physician). In implementing the new benefits for pulmonary rehabilitation, cardiac rehabilitation, and intensive cardiac rehabilitation added by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, Pub. L. 110–275), we required that direct supervision of services furnished in the hospital outpatient department must be provided by a doctor of medicine or osteopathy as required by statute.

For services furnished on a hospital's main campus, we finalized a modification of our proposed definition of "direct supervision" in new paragraph (a)(1)(iv)(A) of § 410.27 that allows for the supervisory physician or nonphysician practitioner to be anywhere on the hospital campus. Therefore, as of CY 2010, direct supervision on the hospital or CAH campus or in an on-campus PBD means that "the supervisory physician or nonphysician practitioner must be present on the same campus and immediately available to furnish assistance and direction throughout the performance of the procedure." Because the term "in the hospital or CAH" applies broadly to "incident to" requirements such as the site-of-service requirement for therapeutic services provided by the hospital directly and under arrangement, we also established

a definition of "in the hospital" in new paragraph § 410.27(g) as meaning areas in the main building(s) of a hospital or CAH that are under the ownership, financial, and administrative control of the hospital or CAH; that are operated as part of the hospital; and for which the hospital bills the services furnished under the hospital's or CAH's CMS Certification Number (CCN). In the preamble to the CY 2010 OPPS/ASC final rule with comment period, as part of the discussion of various public comments on the definition of the hospital campus, and on the supervision requirement specifically, we stated that we would recognize other areas or structures of the hospital's campus that are not part of the hospital, such as physician offices, rural health centers, skilled nursing facilities, or other entities that participate separately under Medicare to be part of the hospital's campus.

In the CY 2010 OPPS/ASC final rule with comment period, we also finalized our proposal to add paragraph (a)(1)(iv)(B) to § 410.27. This paragraph updated our previous regulation at § 410.27(f) to reflect that, for off-campus PBDs of hospitals, the physician or nonphysician practitioner must be present in the off-campus PBD, as defined in § 413.65, and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician or nonphysician practitioner must be in the room when the procedure is performed. In addition, we finalized the proposed technical change to clarify the language in § 410.27(f) by removing the phrase "present and on the premises of the location" and replacing it with the phrase "present in the off-campus provider-based department."

Finally, we finalized a technical correction to the title of § 410.27 to read "Outpatient hospital or CAH services and supplies incident to a physician service: Conditions," to clarify in the title that the requirements for payment of hospital outpatient therapeutic services incident to a physician or nonphysician practitioner service in that section apply to both hospitals and CAHs. Similarly, we included the phrase "hospital or CAH" throughout the text of § 410.27 wherever the text referred only to "hospital." We viewed this as a technical correction because the statute applies the same regulations to hospitals and CAHs when appropriate. Specifically, the definition of "hospital" in section 1861(e) of the Act expressly excludes CAHs "unless the context otherwise requires." Accordingly, we do not believe it is necessary for a regulation to reference specifically the applicability to CAHs for those regulations to be appropriate given the "context" for CAHs. Although payment to CAHs is authorized under section 1834(g) of the Act, many of the payment rules applicable to hospitals paid under sections 1886(d) and 1833(t) of the Act apply to CAHs.

We believe that the supervision requirements should apply in the context of CAHs because they represent appropriate safety and quality requirements for Medicare payment of outpatient services. In the early part of this year, the CAH community asserted that the CAH CoPs offer more flexibility in staffing requirements than the rule requiring direct supervision, and that the CAH CoPs address the general availability of physician and nonphysician practitioners on the CAH campus. The hospital CoPs at 42 CFR 482.22 require hospital medical staff to be composed of doctors of medicine or osteopathy and, in accordance with State law, may also be composed of other practitioners appointed by the governing body. They also require 24 hour nursing services that are provided by or supervised by a registered nurse. Under section 1820(c)(2)(B) of the Act, among other criteria, a CAH must meet the same staffing requirements as would apply under section 1861(e) of the Act to a hospital located in a rural area. However, there are some exceptions to these staffing requirements. Section 1820(c)(2)(B)(iv) of the Act specifies that the CAH need not meet hospital staffing requirements under section 1861(e) of the Act regarding the days and hours in which it is open and fully staffed; the facility may provide certain services under arrangement at an off-site location; that inpatient care may be provided by a physician assistant, nurse practitioner, or clinical nurse specialist subject to the oversight of a physician, who need not be present in the facility.

The CAH CoPs in 42 CFR 485.631 are specific in recognizing the statutory authority to be staffed by nonphysician practitioners rather than physicians, provided a doctor of medicine or osteopathy, nurse practitioner, clinical nurse specialist, or physician assistant is available to furnish patient care services at all times the CAH operates. The requirement that the practitioner "be available" in § 485.631 has been interpreted to mean that the nonphysician practitioner or physician is available by phone, but not necessarily physically present on the CAH campus. The CAH CoPs also specify standards for emergency personnel under § 485.618, requiring that a doctor of medicine or osteopathy, or a nonphysician practitioner such as a physician assistant, a nurse practitioner, or a clinical nurse specialist, with training or experience in emergency care, be on call and immediately available by telephone or radio contact, and available on site within 30 minutes, on a 24-hour a day basis in most areas.

However, in the Medicare program, payment requirements are frequently different from those identified in the CoPs because the two sets of rules serve very separate and distinct purposes. CoPs apply largely at the facility level, while payment regulations apply at the service level. Payment regulations, such as requirements for how contracted entities providing services to hospital patients, support program goals of appropriate and accurate payment for quality services. In contrast, for all providers including CAHs, the CoPs authorize hospitals to participate in the Medicare program. We establish CoPs as minimum standards for patient health and safety, and CoPs focus on creating a foundation to ensure quality and safe care for beneficiaries throughout a given facility, irrespective of the payment system or service provided. CoPs do not ensure that payment is appropriate for specific types of purchased services nor can they substitute for payment requirements since that is not their function.

In summary, requirements established for purposes of payment frequently differ from the requirements established by the CoPs for many providers, including hospitals and CAHs. Whereas payment regulations establish basic parameters defining the services being purchased, CoPs (including both the hospital CoPs and the CAH CoPs) establish standards to ensure a minimum level of quality and safety for operating as a hospital or a CAH. The minimum standards established as CoPs are not always adequate to address the particular quality, safety and other requirements for payment for a service or group of services.

b. Outpatient Diagnostic Services

As we stated in the CY 2009 OPPS/ASC and CY 2000 OPPS proposed rules and final rules with comment period, section 1861(s)(2)(C) of the Act authorizes payment for diagnostic services that are furnished to a hospital outpatient for the purpose of diagnostic study. We have further defined the requirements for diagnostic services furnished to hospital outpatients, including requirements for physician supervision of diagnostic services, in §§ 410.28 and 410.32 of our regulations. For CY 2010, we finalized a proposal to require that all hospital outpatient

diagnostic services provided directly or under arrangement, whether provided in the hospital, in a PBD of a hospital, or at a nonhospital location, follow the physician supervision requirements for individual tests as listed in the MPFS Relative Value File in order to receive payment. The existing definitions of general and personal supervision as defined in §§ 410.32(b)(3)(i) and (b)(3)(iii) also apply. For services furnished directly or under arrangement in the hospital or on-campus PBD, "direct supervision" means that the physician must be present on the same campus and immediately available to furnish assistance and direction throughout the performance of the procedure. For the purposes of § 410.28, as for the general purposes of § 410.27, the definition of "in the hospital" as incorporated in § 410.27(g) applies.

These policies are an extension of the supervision requirements for outpatient diagnostic tests performed in a provider-based department that were adopted at the inception of the OPPS in the CY 2000 OPPS final rule with comment period. The MPFS Relative Value File is updated quarterly and is available on the CMS Web site at: *http://www.cms.gov/PhysicianFeeSched/*. For diagnostic services not listed in the MPFS, we have indicated that Medicare contractors, in consultation with their medical directors, would define appropriate supervision levels in order to determine whether claims for these services are reasonable and necessary.

We note that the current requirement in §§ 410.28(e)(1) and (e)(2) that physician supervision of diagnostic services provided in the hospital or in any provider-based department follow the levels for diagnostic services established under the MPFS explicitly applies to hospitals that are paid pursuant to section 1833(t) of the Act, which is the statutory authority for the OPPS. Because Medicare makes payments to CAHs pursuant to section 1834(g) of the Act, at this time, CAHs are not subject to this supervision requirement.

2. Issues Regarding the Supervision of Hospital Outpatient Services Raised by Hospitals and Other Stakeholders

Following the adoption of our policies in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60575 through 60591), beginning in January 2010, we began to receive a sizable amount of correspondence, as well as numerous phone calls, and questions through other public avenues, including the regular open door forum calls, from the rural hospital and CAH community indicating its belief that the requirement for direct supervision for therapeutic services finalized in that rule is at odds with longstanding and prevailing practice in rural communities. These hospitals and their representatives stated that they generally function with a reduced level of supervision for the provision of therapeutic services and that while they furnish services under a physician's or appropriate nonphysician practitioner's order, frequently no physician or nonphysician practitioner is physically present anywhere in the CAH or small rural hospital while the therapeutic services are being furnished. CAHs, in particular, noted that the provisions in their CoPs allow a CAH to operate under the reduced staffing requirements specified above. Specifically, under the CoPs, CAHs must have a physician or one of several types of nonphysician practitioners available by phone at all times, but not on campus, and in most areas of the country, for emergencies, the CAH must have a physician or certain other nonphysician practitioners with training or experience in emergency care physically available onsite within 30 minutes.

Both CAHs and rural hospitals have stated that the flexibility to allow nonphysician practitioners to supervise services that we authorized in the CY 2010 OPPS/ASC final rule with comment period is helpful for meeting the direct supervision requirement for all therapeutic services, but that a shortage of qualified practitioners in rural areas continues to make it difficult to staff a physician or nonphysician practitioner for supervision purposes. They also noted that a practitioner retained on the campus of a small rural hospital or CAH to meet supervision requirements may not have other patients or medical activities to complete. In an urban or large urban hospital, a practitioner would be able to see other patients or engage in other activities so long as those activities could be interrupted, such that they would be immediately available to supervise.

In a series of questions and answers about supervision on the CMS Web site (*http://www.cms.gov/HospitalOutpatientPPS/05_OPPSGuidance.asp#TopOfPage*), we provided additional guidance regarding our regulations about who can supervise services in order to explain to CAHs and small rural hospitals the flexibility we believe exists within our requirement for direct supervision. For example, in that document, we state that we believe the emergency physician or non-physician practitioner, who would be the most likely practitioners staffing a small rural hospital or CAH, can directly supervise outpatient services so long as the emergency physician in the emergency department of the campus meets the other requirements of direct supervision. That is, the individual needs to be immediately available, so that, if needed, he or she could reasonably be interrupted to furnish assistance and direction in the delivery of therapeutic services provided elsewhere in the hospital. We believe that most emergency physicians can appropriately supervise many services within the scope of their knowledge, skills, licensure, and hospital-granted privileges, including observation services. With regard to whether an emergency physician or a nonphysician practitioner could be interrupted, such that the individual could be immediately available, we have stated that each hospital would need to assess the level of activity in their emergency department and determine whether at least one emergency physician or nonphysician practitioner could be interrupted to furnish assistance and direction in the treatment of outpatients.

In their correspondence and discussion in public forums, CAHs and small rural hospitals explicitly have raised concerns about services that extend after regular operating hours, especially observation services. They also asserted that direct supervision is not clinically necessary for some services that have a significant monitoring component that is typically performed by nursing or other auxiliary staff typically, including IV hydration, blood transfusions, and chemotherapy. They stated that their facilities have protocols to safely deliver all of these services, including chemotherapy, relying on nursing or other hospital staff to provide the service and having a physician or non-physician practitioner available by phone to furnish assistance and direction throughout the duration of the therapeutic service.

In the early part of this year, small rural hospitals and CAHs indicated that, regulations notwithstanding, many of them did not have appropriate staff arrangements to provide the required supervision of some services, particularly services being provided after hours or consisting of a significant monitoring component that lasted for an extended period of time. In response to rising concerns among the rural community about these rules and the inability of some hospitals to meet the direct supervision requirement, we issued a statement on March 15, 2010, indicating that we would not enforce the rules for supervision of hospital outpatient therapeutic procedures

furnished in CAHs in CY 2010 (*http://www.cms.gov/HospitalOutpatientPPS/01_overview.asp#TopOfPage*). We also stated that we would proactively revisit the rules surrounding the supervision of services furnished by CAHs in the CY 2011 OPPS/ASC proposed rule.

With regard to diagnostic services, unlike supervision of therapeutic services, we have had only limited dialogue with various stakeholders about our CY 2010 policy to recognize the supervision levels for diagnostic services under the MPFS for the provision of diagnostic services in the hospital. Individual stakeholders have asked about supervision of specific diagnostic services and have noted that our requirement that the hospitals follow the supervision levels for diagnostic services in the hospital identified in the MPFS Relative Value Unit file has required some modest changes in hospital staffing practices. We also have received questions requesting clarification about related supervision requirements for nonphysician practitioners. We note that adopting the supervision levels defined under the MPFS for diagnostic services in 42 CFR 410.32 means that nonphysician practitioners that are not specifically excluded under § 410.32(b) from the level of supervision required by the MPFS are subject to supervision by a physician at the level of supervision required by the diagnostic test. We also discussed in our CY 2010 OPPS/ASC final rule with comment period that diagnostic X-ray and other diagnostic tests must be furnished under the appropriate level of supervision by a physician as defined in section 1861(r) of the Act (74 FR 60588 through 60590).

3. Proposed Policies for Supervision of Outpatient Therapeutic Services in Hospitals and CAHs

As indicated in our March 15, 2010 statement, we are revisiting the issue of supervision of outpatient therapeutic services in CAHs to ensure a robust public discussion about supervision requirements for payment in hospital outpatient departments, including those located in rural communities, and CAH outpatient departments. In this proposed rule, we are proposing modest changes to our supervision policy for therapeutic services that reflect our continuing commitment to require direct supervision for the provision of therapeutic services in the hospital outpatient setting as a requirement for payment. We are proposing these changes for all hospitals, including CAHs, because we believe that Medicare should purchase a basic quality of service for all Medicare beneficiaries. Specifically, we are proposing to identify a limited set of services with a significant monitoring component that can extend for a sizable period of time, that are not surgical, and that typically have a low risk of complication after assessment at the beginning of the service, as "nonsurgical extended duration therapeutic services." We are proposing for these services that there would be a requirement for direct supervision for the initiation of the service followed by general supervision for the remainder of the service. We are proposing to adopt the definition of "general supervision" in § 410.32(b)(3)(i), which is the same definition of general supervision that we already recognize as appropriate for diagnostic services with a general supervision level requirement under the MPFS. Finally, at the end of this proposal, we include several discussion points designed to focus public comments and generate sufficient detail to assist us in crafting a final policy.

In the CY 2010 OPPS/ASC final rule with comment period, we affirmed our belief that direct supervision is the appropriate supervision requirement for therapeutic services provided in the hospital outpatient setting. In that rule, we finalized a definition of direct supervision in the hospital or in an on-campus department of the hospital to mean that the physician or nonphysician practitioner is present on the same campus and immediately available to furnish assistance and direction throughout the performance of the procedure (74 FR 60591).

In considering the significant correspondence from CAHs and rural communities, as well as public discussion on the issue of supervision through the open door forum and calls with individual hospitals and other hospital representatives, we sought to identify some means of offering flexibility within the supervision requirement to hospitals and CAHs, while continuing to ensure that Medicare purchases services delivered with a basic level of quality and safety and also fulfills the statutory requirement for payment of therapeutic outpatient services in the hospital that are provided "incident to" physician services. We recognize the concerns of CAHs and rural hospitals that it could be difficult to staff a physician or nonphysician practitioner on the campus of the CAH or small rural hospital to supervise services that have a significant monitoring component and lack an active component being performed by the physician or nonphysician practitioner, especially when these services extend into after business hours or overnight. CAHs and rural hospitals explicitly identified observation services, IV hydration, chemotherapy, and blood transfusions as the services that are particularly challenging to provide under direct supervision. Observation services, in particular, can extend for a significant period of time. Data from the 85X claims indicate that most observation care lasts longer than 12 hours and almost all such care ends within 48 hours, suggesting that observation care frequently extends after business hours and through the night.

We recognize that any service with an extended duration and a significant monitoring component could challenge hospitals' ability to ensure direct supervision, and we decided to concentrate on these services. We set out to identify services with a significant monitoring component extending after business hours as identified by the CAHs and hospitals in rural communities and for which we could offer some flexibility in meeting the requirement for direct supervision of therapeutic services without compromising the quality and safety of services for which Medicare makes payment. One way to provide flexibility would be to allow a reduced level of supervision for part of these services. CAHs have already stated that their longstanding practice has been to provide therapeutic services under general supervision, which comports with the minimum requirements set forth in their CoPs to participate in the Medicare program that a physician or certain nonphysician practitioner must be available by phone but not physically present on the CAH campus. As defined in § 410.32(b)(3)(i), "general supervision" means the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure. We have established a requirement for direct supervision for all hospital outpatient services in our CY 2000 and CY 2010 rulemaking processes. However, we reasoned that, for certain extended duration services, we could adopt a general supervision requirement for some portion of the service, as long as we believed that such flexibility would not undermine the quality and safety of purchased services. Therefore, we are proposing to require, for a limited set of nonsurgical extended duration therapeutic services, direct supervision during the initiation of the service followed by general supervision for the remainder of the service.

We are proposing to define "initiation of the service" as the beginning portion

of a service ending when the patient is stable and the supervising physician or appropriate nonphysician practitioner believes the remainder of the service can be delivered safely under their general direction and control without their physical presence on the hospital campus or in the PBD of the hospital. We considered further defining the term "stable" in this definition as there is an established definition in the EMTALA regulations at section 489.24(b). In those regulations, "stabilized" with respect to an emergency medical condition means "that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer for the individual from a facility * * *". However, this language is set within the context of emergency services, not hospital outpatient therapeutic services generally, and we have been clear that supervision is more than emergency response. Ultimately, we were not certain that this definition would be appropriate for a payment requirement for supervision of outpatient therapeutic services.

We also are not proposing to further define the term "initiation" or to set time limits on this portion of the service because we believe that the determination that a patient is sufficiently stable to transfer from direct supervision to general supervision, and the timing of that decision, are clinical judgments. Because some of the services identified for this proposed policy have the potential for shorter durations, such as an hour, we believe it is best to leave the determination of when to move from direct to general supervision to the discretion of the supervising physician or nonphysician practitioner. However, we are considering whether the point of transfer from direct supervision to general supervision should be documented in the medical record or identified in a hospital protocol, and we invite public comment on how CMS might review the physician or nonphysician practitioner's decision to move from direct to general supervision to monitor for proper billing should an adverse event occur.

We considered four criteria when identifying the list of services to which this new policy of direct supervision during the initiation of the service followed by general supervision for the remainder of the service would apply. We first accepted the two criteria identified in correspondence and discussion with CAHs and rural hospitals, that the service be of extended duration, frequently extending beyond normal business hours, and that the service largely consist of a significant monitoring component typically conducted by nursing or other auxiliary staff. We added a third criterion that the service must be of sufficiently low risk, such that the service typically would not require direct supervision often during the service. We believe this criterion is appropriate because, as we have previously discussed, our requirement for direct supervision is grounded in the statutory "incident to" payment authority, as well as the need to ensure that Medicare purchases services that represent a basic level of quality and safety. We have noted that, unlike an inpatient admission, the provision of outpatient services lacks certain safeguards such as a detailed medical history and a plan of care (74 FR 60578 through 60588). Finally, we excluded all surgical services including recovery time from potential inclusion because, although monitoring of any patient in recovery is a key component of surgery, it is not the focus or a substantial component of the service and because we believe the surgeon should personally evaluate the patient's medical status during the recovery period.

Using these four criteria, we identified a list of nonsurgical therapeutic services that have a tendency to last for a long period of time, that largely consist of monitoring, and that have a low risk that the physician's physical presence will be needed once the patient is stable. To identify this list of potential services, we reviewed all medical services, including the services and procedures specifically identified by CAHs and rural hospitals in their correspondence and public discussion. The proposed list of nonsurgical extended duration therapeutic services appears in Table 37 below. We explicitly did not include chemotherapy or blood transfusions in our proposed list of nonsurgical extended duration therapeutic services because we believe that these services require the physician's or nonphysician practitioner's recurrent physical presence in order to evaluate the patient's condition in the event it is necessary to redirect the service.

We included observation services on the proposed list of nonsurgical extended duration services. In Section 20.6 of Chapter 2 of the Medicare Benefit Policy Manual (Pub. 100–02), we define observation care as "a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital." Therefore, the acuity of patients receiving observation services and the amount of recurrent supervisory review that may be necessary for these services can vary significantly. Observation services can be of low acuity and can have a low probability that the supervising physician or nonphysician practitioner's physical presence would be needed to step in and perform the service or otherwise furnish assistance. We do note in Section 290.5.1 of Chapter 4 of the Medicare Claims Processing Manual (Pub. 100–04) that, for observation services, (a) "the beneficiary must be in the care of a physician during the period of observation, as documented in the medical record by outpatient registration, discharge, and other appropriate progress notes that are timed, written, and signed by the physician, and (b) the medical record also must include documentation that the physician explicitly assessed patient risk to determine that the beneficiary would benefit from observation services." We would continue to expect hospitals and CAHs to fulfill these specific requirements associated with observation care, so the supervising physician or appropriate nonphysician practitioner must continue to evaluate the patient periodically and include written notes in the medical record.

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TABLE 37.--PROPOSED LIST OF NONSURGICAL EXTENDED DURATION THERAPEUTIC SERVICES

HCPCS Code	Long Description
C8957	Intravenous infusion for therapy/diagnosis; initiation of prolonged infusion (more than 8 hours), requiring use of portable or implantable pump
G0378	Hospital observation service, per hour
G0379	Direct admission of patient for hospital observation care
96360	Intravenous infusion, hydration; initial, 31 minutes to 1 hour
96361	Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure)
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour
96366	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)
96367	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion, up to 1 hour (List separately in addition to code for primary procedure)
96368	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); concurrent infusion (List separately in addition to code for primary procedure)
96369	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); initial, up to 1 hour, including pump set-up and establishment of subcutaneous infusion site(s)
96370	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)
96371	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); additional pump set-up with establishment of new subcutaneous infusion site(s) (List separately in addition to code for primary procedure)
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular
96374	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug
96375	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure)
96376	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of the same substance/drug provided in a facility (List separately in addition to code for primary procedure)

In summary, we are proposing to require direct supervision as defined in § 410.27(a)(1)(iv) during an initiation period, followed by a minimum standard of general supervision as defined in § 410.32(b)(3)(i) for the duration of the service, for a limited set of "nonsurgical extended duration therapeutic services" identified in Table 37 above. We are proposing to add a new paragraph (a)(1)(v) to § 410.27 for this provision. In new § 410.27(a)(1)(v)(A), we are proposing to define "nonsurgical extended duration therapeutic services" as services that can last a significant period of time, have a substantial monitoring component, have a low risk of requiring the physician's or appropriate nonphysician practitioner's physical presence to furnish assistance and direction after the initiation of the service, and are not primarily surgical in nature. In new § 410.27(a)(1)(v)(B), we are proposing to define "initiation of the service" as the beginning portion of a service ending when the patient is stable and the supervising physician or appropriate nonphysician practitioner believes the remainder of the service can be delivered safely under his or her general direction and control without needing his or her physical presence on the hospital campus or in the PBD of the hospital. We note that in the CY 2010 OPPS/ASC final rule with comment period, in presenting the regulation text changes for § 410.27, paragraph (a)(2) (relating to PHP services) was inadvertently deleted from the Code of Federal Regulations. We are proposing to restore paragraph (a)(2) as it originally appeared in the regulations.

In crafting this proposal, we considered other avenues to offer flexibility within our requirement for direct supervision. We summarize below the alternatives we considered in order to focus public comments and generate sufficient detail to assist us in developing the final policy. In addition to considering the proposed policy to permit general supervision after an initial period of direct supervision for a limited subset of services, we also considered offering hospitals the flexibility to broaden the list to include chemotherapy and blood transfusions, which some stakeholders also maintain do not require direct supervision. Because we were concerned that these services had a high probability of needing a physician or nonphysician practitioner to redirect the service, we reasoned that we would have to require hospitals to create internal guidelines specifying a supervision level and protocols for staffing that supervision level for every nonsurgical extended duration therapeutic service. We considered proposing minimum requirements for these internal supervision guidelines, including annual review and approval by a governing committee, periodic internal evaluation of implementation, and the ability to make these guidelines available to Medicare program auditors if requested. Further, these guidelines would be reviewed thoroughly by CMS should a quality issue arise. Given the complexity of services such as chemotherapy and blood transfusions, and the probability that the physician's or nonphysician practitioner's physical presence will be required during the service, we decided to propose a policy to ensure greater safety for these higher acuity services. We also chose not to pursue this internal guidelines option because we believed that hospitals would find these requirements onerous and that the policy would not necessarily provide the flexibility that CAHs and rural hospitals desire. We are seeking public comment on whether hospitals agree with our assessment about the challenge of crafting, maintaining, and implementing internal guidelines about supervision and whether general supervision is clinically appropriate and safe for chemotherapy, blood transfusions, and similar services.

We also considered whether for payment purposes we should explicitly exclude outpatient CAH services from all supervision requirements. As discussed above, one of the grounds for applying the direct supervision requirement to outpatient therapeutic services furnished in hospitals is that these services are outpatient hospital services furnished "incident to" physicians' services under section 1861(s)(2)(B) of the Act and paid under the OPPS pursuant to section 1833(t) of the Act. In contrast, "outpatient critical access hospital services" are defined under section 1861(mm)(3) of the Act, and CAHs are reimbursed for outpatient CAH services based on their reasonable costs pursuant to section 1834(g) of the Act. We believe that outpatient CAH services are correctly viewed as being furnished "incident to" physicians' services. Section 1861(mm)(3) of the Act defines "outpatient critical access hospital services" as "medical and other health services furnished by a critical access hospital on an outpatient basis." The term "medical and other health services" is defined at section 1861(s) of the Act as including "hospital services * * * incident to physicians' services rendered to outpatients." Furthermore, the same considerations regarding the need to ensure that services furnished to Medicare beneficiaries represent a basic level of quality and safety that apply to outpatient hospital services are equally applicable to outpatient CAH services. As a result, we believe it is appropriate to apply the same supervision requirements to outpatient therapeutic services furnished in hospitals and CAHs. We acknowledge that statutory provisions allow CAHs some flexibility in their staffing requirements to operate with more nursing staff and nonphysician practitioners rather than physicians if those are the practitioners that are available, and that our regulations recognize those reduced staffing requirements in the CoPs by establishing that, at a minimum, the physician or nonphysician practitioner must be available, but not necessarily on the CAH campus. Some have suggested, however, that these regulations which establish only minimal requirements reduce the quality and safety of CAH services and that CAHs should be required to disclose their reduced staffing levels to patients prior to providing services. Accordingly, we have elected not to propose to exempt CAHs from all direct supervision requirements because we believe that Medicare should purchase from CAHs services that are of the same basic level of safety and quality as from other hospitals, and because we also believe that both small rural hospitals paid under the OPPS through section 1833(t) of the Act and CAHs paid at reasonable cost under section 1834(g) of the Act have similar staffing and resource constraints. In fact, given that CAHs are reimbursed based on their reasonable costs, we reasoned that CAHs might be better able to hire staff to provide direct supervision. We welcome public comment on the topic of exempting CAHs from a direct supervision requirement for outpatient therapeutic services, including comments in response to our concerns about making such a proposal.

4. Supervision of Hospital Outpatient Diagnostic Services

We have received limited correspondence and questions on our policy finalized in the CY 2010 OPPS/ASC final rule with comment period to adopt for outpatient hospital diagnostic services the physician supervision levels in § 410.32(b)(3) established under the MPFS and indicated on the Practice Expense Relative Value Unit file. As discussed above, the CY 2010 policy applies to hospitals and not to CAHs. However, we have received questions asking whether nonphysician

practitioners previously performing diagnostic tests without physician supervision, within their State scope of practice and hospital-granted privileges, can continue to perform those tests without physician supervision. The CY 2010 policy now requires physician supervision of those services, unless the nonphysician practitioner is specifically exempted under § 410.32(b)(2) or there is some other provision addressing supervision for that type of nonphysician practitioner. As part of a broader proposal addressing clinical nurse-midwives as defined in § 410.77(b)(2) of the regulations, we are making a clarifying proposal in the CY 2011 MPFS proposed rule that clinical nurse-midwives should be excepted from requiring physician supervision for the diagnostic tests that they are authorized to perform under applicable State laws. Comments on that proposal should be submitted through the comment process for that proposed rule (CMS–1503–P).

B. Proposed Payment for Preventive Services

1. Definition of "Preventive Services"

Section 4104(a) of the Affordable Care Act revised section 1861(ddd) of the Act by adding a new paragraph (3), which defines the term "preventive services." Preventive services are defined as:

- Screening and preventive services currently described in section 1861(ww)(2) of the Act, except for electrocardiograms described in section 1861(ww)(2)(M) of the Act;
- An initial preventive physical examination (IPPE) as defined in section 1861(ww) of the Act; and
- Personalized prevention plan services (PPPS), also known as the "Annual Wellness Visit," as defined in section 1861(hhh) of the Act (which was added by section 4103 of the Affordable Care Act).

The services specified in the definition of "preventive services" at section 1861(ddd)(3)(A) of the Act, as cross-referenced to section 1861(ww)(2) of the Act, excluding electrocardiograms, include the following:

- Pneumococcal, influenza, and hepatitis B vaccine and administration.
- Screening mammography.
- Screening pap smear and screening pelvic examination.
- Prostate cancer screening tests.
- Colorectal cancer screening tests.
- Diabetes outpatient self-management training (DSMT).
- Bone mass measurement.
- Screening for glaucoma.
- Medical nutrition therapy (MNT) services.
- Cardiovascular screening blood tests.
- Diabetes screening tests.
- Ultrasound screening for abdominal aortic aneurysm (AAA).
- Additional preventive services identified for coverage through the national coverage determination (NCD) process.

We note that currently the only additional preventive service identified for coverage through the NCD process is HIV testing. A proposed national coverage determination for smoking cessation services for asymptomatic patients (CAG–00420N, "Proposed Coverage Decision Memorandum for Counseling to Prevent Tobacco Use"), was released in May 2010 on the CMS Web site at: *http://www.cms.gov/mcd/index_list.asp?list_type=nca*. We will address the applicability of section 4104 of the Affordable Care Act to these services if an NCD establishing them as additional preventive services is finalized before the CY 2011 OPPS/ASC final rule with comment period is issued.

We are specifying our proposals to implement the coverage and payment provisions for PPPS in the CY 2011 Medicare Physician Fee Schedule (MPFS) proposed rule. Therefore, public comments on the proposed coverage of and payment for PPPS under the provisions of the Affordable Care Act should be submitted in response to the CY 2011 MPFS proposed rule. The implementing regulations regarding coverage of the IPPE are already established under existing 42 CFR 410.16 and remain unchanged by the Affordable Care Act. As discussed below in section XII.B.2. of this proposed rule, we are presenting our proposals for the application or waiver of the coinsurance requirements and the deductible for preventive services as provided for under sections 4104(b) and (c) of the Affordable Care Act.

2. Coinsurance and Deductible for Preventive Services

Sections 4104(b) and 10406 of the Affordable Care Act amended section 1833(a)(1) of the Act to require 100 percent payment for the IPPE and for those preventive services recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B for any indication or population and that are appropriate for the individual. This requirement waives any coinsurance or copayment that would otherwise be applicable under section 1833(a)(1) of the Act for those items and services listed in section 1861(ww)(2) of the Act (excluding electrocardiograms) to which the USPSTF has given a grade of A or B. In addition, section 4103(c) of the Affordable Care Act waives the coinsurance or copayment for the annual wellness visit providing PPPS. The coinsurance or copayment represents the beneficiary's share of the payment to the provider or supplier for furnished services. Coinsurance generally refers to a percentage (for example, 20 percent) of the Medicare payment rate for which the beneficiary is liable and is applicable under the MPFS and ASC payment system, while copayment generally refers to an established amount that the beneficiary must pay that is not necessarily related to a particular percentage of the Medicare payment rate, and is applicable under the OPPS. We refer readers to the CY 2011 MPFS proposed rule for the proposed provisions related to payment for preventive services, including waiver of the deductible and copayment, under the MPFS, and to section XV.D.1.d. of this proposed rule for our proposals to implement the provisions related to payment for preventive services under the ASC payment system.

Section 4104(c) of the Affordable Care Act amended section 1833(b)(1) of the Act to waive the Part B deductible for preventive services described in section 1861(ddd)(3)(A) of the Act that have a grade of A or B from the USPSTF. In addition, section 4103(c)(4) of the Affordable Care Act waives the Part B deductible for the annual wellness visit providing PPPS. These provisions are effective for services furnished on and after January 1, 2011. We note that section 101(b)(2) of the MIPPA previously amended section 1833(b) of the Act to waive the deductible for the IPPE, effective January 1, 2009.

Not all preventive services described in paragraph (A) of section 1861(ddd)(3) of the Act are recommended by the USPSTF with a grade of A or B, and therefore, some of the preventive services do not meet the criteria in sections 1833(a)(1) and 1833(b)(1) of the Act for the waiver of deductible and coinsurance. However, the changes made by section 4104 of the Affordable Care Act do not affect most of the pre-existing specific provisions listed in existing § 410.160(b) and § 410.152 of the regulations (which reflect the provisions found in sections 1833(a) and 1833(b) of the Act) that waive the deductible and coinsurance for specific services. For example, section 1833(a)(1)(D) of the Act waives the coinsurance and section 1833(b)(3) of the Act waives the deductible for clinical laboratory tests (including those furnished for screening purposes).

Section 4104 of the Affordable Care Act does not change this provision and the waiver for both the deductible and coinsurance remains in place for all laboratory tests, regardless of whether the particular clinical laboratory test meets the criteria of section 4104 for waiver of deductible and coinsurance as a preventive service.

The following preventive services listed in section 1833(ddd)(3)(A) of the Act are not recommended by the USPSTF with a grade of A or B for any indication or population: digital rectal examination provided as a prostate cancer screening service; glaucoma screening; diabetes outpatient self-management training; and barium enema provided as a colorectal cancer screening service.

Specifically, HCPCS code G0102 (Prostate cancer screening; digital rectal exam), which does not have a grade of A or B from the USPSTF for any indication or population, will continue to be subject to the deductible and coinsurance. However, the deductible and coinsurance for HCPCS code G0103 (Prostate cancer screening; prostate specific antigen test (PSA)) will continue to be waived under section 1833(a)(1)(D) of the Act as a clinical laboratory test, even though it also does not have a grade of A or B from the USPSTF.

Glaucoma screening services, described by HCPCS codes G0117 (Glaucoma screening for high risk patients furnished by an optometrist or ophthalmologist) and G0118 (Glaucoma screening for high risk patient furnished under the direct supervision of an optometrist or ophthalmologist), will continue to be subject to the deductible and coinsurance requirements because these services are not recommended with a grade of A or B by the USPSTF for any indication or population. Similarly, diabetes outpatient self-management training is currently not rated by the USPSTF; therefore, the deductible and coinsurance requirements will continue to apply.

Barium enemas provided as colorectal cancer screening tests, described by HCPCS codes G0106 (Colorectal cancer screening; alternative to G0104, screening sigmoidoscopy, barium enema) and G0120 (Colorectal cancer screening; alternative to G0105, screening colonoscopy, barium enema) do not have a grade of A or B from the USPSTF for any indication or population. However, the deductible does not apply to barium enemas provided as colorectal cancer screening tests, because colorectal cancer screening tests are explicitly excluded from the deductible under section 1833(b)(8) of the Act. However, there is no specific exclusion of barium enemas from the coinsurance requirement at section 1833(b)(1) of the Act. Therefore, this requirement, as applicable, continues to apply to barium enemas. We note that the USPSTF has given a grade of A to colonoscopy, flexible sigmoidoscopy, and fecal occult blood screening tests, and that, as a result, these services qualify for the statutory waiver of both the deductible and coinsurance.

We also note that the USPSTF ceased to make recommendations with regard to vaccines and vaccine administration after CY 1996, so as not to conflict with the recommendations of the CDC's Advisory Committee on Immunization Practices. However, the USPSTF's most recent vaccine recommendations, which were never withdrawn by the USPSTF, gave a grade of B to the influenza and pneumococcal vaccines and their administration and a grade of A to the hepatitis B vaccine and its administration. While sections 1833(a)(1) and 1833(b)(1) of the Act require that the preventive services receive a grade of A or B from the USPSTF for the coinsurance and deductible to be waived, the statute does not specify that the recommended grade must be furnished within any given timeframe. The USPSTF grades for these preventive services are the most current USPSTF grade and have never been withdrawn. Therefore, we believe that these preventive services meet the requirements of the statute for the waiver of the deductible and coinsurance. We also note that the CDC's Advisory Committee on Immunization Practices currently recommends influenza, pneumococcal, and hepatitis B vaccines.

Table 38 below displays the HCPCS codes (paid under the OPPS or at reasonable cost) that we are proposing as "preventive services" under section 1861(ddd)(3)(A) of the Act. Table 38 also provides the most recent USPSTF grade, if any, that is the basis for our proposed policy with regard to waiver of the deductible and coinsurance, as applicable. In developing recommendations regarding preventive services, we recognize that the USPSTF may make recommendations that are specific to an indication or population, at times including characteristics such as gender and age in its recommendations. While we are proposing to waive the deductible and coinsurance for any Medicare covered preventive service recommended with a grade of A or B for any indication or population, with no limits on the indication or population as long as the USPSTF has recommended the preventive service for at least one indication and/or population with a grade of A or B, we note that all existing Medicare coverage policies for such services, including any limitations based on indication or population, continue to apply. In some cases, national coverage policies may currently limit Medicare coverage based on the indication or population, consistent with the USPSTF recommendations with a grade of A or B for the indication or population. In other cases where Medicare does not explicitly noncover preventive services for a specific population or indication, we would expect that, particularly in those cases where the USPSTF recommendation grade is a D (that is, the USPTF recommends against the service because there is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits), practitioners would only order those preventive services that are clinically appropriate for the beneficiary. If we have future concerns about the appropriateness of preventive services for an indication or population in light of the USPSTF's recommendations, we may consider using our authority under section 1834(n)(1) of the Act (as added by section 4105 of the Affordable Care Act) to modify Medicare coverage of any preventive service consistent with the recommendations of the USPSTF.

We note that section 4103(c)(3)(A) of the Affordable Care Act excludes the PPPS from payment under the OPPS and establishes payment for the PPPS when performed in a hospital outpatient department under the MPFS. In this OPPS/ASC proposed rule, we are proposing to add a new § 419.22(t) to the regulations to specify that the PPPS is excluded from payment under the OPPS. In the process of revising the regulations to reflect the exclusion of PPPS from the OPPS, we noticed the need for existing § 419.21(e) to be updated to reflect that an IPPE may be performed within 12 months after the date of the individual's initial enrollment in Part B effective January 1, 2009. We also noticed that existing § 419.22(m) of the regulations should be updated to reflect that a revised payment methodology for end-stage renal disease (ESRD) services will go into effect on January 1, 2011. Therefore, we also are proposing to revise §§ 419.21(e) and 419.22(m). We refer readers to the CY 2011 MPFS proposed rule for a discussion of the proposed changes to § 410.160(b) and § 410.152 of the regulations to implement the provisions related to the

definition of preventive services and the waiver of the coinsurance and deductible for preventive services as specified by sections 4103 and 4104 of the Affordable Care Act.

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TABLE 38.--PROPOSED CY 2011 DEDUCTIBLE AND COINSURANCE FOR OPPS PREVENTIVE SERVICES UNDER SECTION 1861(ddd)(3)(A) OF THE ACT* (INCLUDES THE INITIAL PREVENTIVE PHYSICAL EXAMINATION (IPPE))

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating[1]	CY 2010 Coinsurance Deductible	CY 2011 Coinsurance Deductible
Initial Preventive Physical Examination (IPPE)	G0402	Initial preventive physical examination; face to face visits, services limited to new beneficiary during the first 12 months of Medicare enrollment	*Not Rated	Coinsurance applies and deductible is waived	Waived
	G0404	Electrocardiogram, routine ECG with 12 leads; tracing only, without interpretation and report, performed as a screening for the initial preventive physical examination		Not Waived	Not Waived
Ultrasound Screening for Abdominal Aortic Aneurysm (AAA)	G0389	Ultrasound, B-scan and/or real time with image documentation; for abdominal aortic aneurysm (AAA) ultrasound screening	B	Coinsurance applies and deductible is waived	Waived
Screening Pap Test	Q0091	Screening papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory	A	Coinsurance applies and deductible is waived	Waived
Screening Pelvic Exam	G0101	Cervical or vaginal cancer screening; pelvic and clinical breast examination	A	Coinsurance applies and deductible is waived	Waived
Bone Mass Measurement	G0130	Single energy x-ray absorptiometry (sexa) bone density study, one or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)	B	Not Waived	Waived

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating[1]	CY 2010 Coinsurance Deductible	CY 2011 Coinsurance Deductible
	77078	Computed tomography, bone mineral density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)		Not Waived	Waived
	77079	Computed tomography, bone mineral density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)		Not Waived	Waived
	77080	Dual-energy x-ray absorptiometry (dxa), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)		Not Waived	Waived
	77081	Dual-energy x-ray absorptiometry (dxa), bone density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)		Not Waived	Waived
	77083	Radiographic absorptiometry (eg, photodensitometry, radiogrammetry), 1 or more sites		Not Waived	Waived
	76977	Ultrasound bone density measurement and interpretation, peripheral site(s), any method		Not Waived	Waived
Colorectal Cancer Screening	G0104	Colorectal cancer screening; flexible sigmoidoscopy	A	Coinsurance applies and deductible is waived	Waived
	G0105	Colorectal cancer screening; colonoscopy on individual at high risk		Coinsurance applies and deductible is waived	Waived
	G0121	Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk		Coinsurance applies and deductible is waived	Waived

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating[1]	CY 2010 Coinsurance Deductible	CY 2011 Coinsurance Deductible
	G0106	Colorectal cancer screening; alternative to G0104, screening sigmoidoscopy, barium enema	*Not Rated	Coinsurance applies and deductible is waived	Coinsurance applies and deductible is waived
	G0120	Colorectal cancer screening; alternative to G0105, screening colonoscopy, barium enema.		Coinsurance applies and deductible is waived	Coinsurance applies and deductible is waived
Prostate Cancer Screening	G0102	Prostate cancer screening; digital rectal examination	D	Not Waived	Not Waived
Glaucoma Screening	G0117	Glaucoma screening for high risk patients furnished by an optometrist or ophthalmologist	I	Not Waived	Not Waived
	G0118	Glaucoma screening for high risk patient furnished under the direct supervision of an optometrist or ophthalmologist		Not Waived	Not Waived
Influenza Virus Vaccine	90655	Influenza virus vaccine, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use	B	Waived	Waived
	90656	Influenza virus vaccine, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use		Waived	Waived
	90657	Influenza virus vaccine, split virus, when administered to children 6-35 months of age, for intramuscular use		Waived	Waived

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating[1]	CY 2010 Coinsurance Deductible	CY 2011 Coinsurance Deductible
	90658	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use		Waived	Waived
	90660	Influenza virus vaccine, live, for intranasal use		Waived	Waived
	90662	Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use		Waived	Waived
	G0008	Administration of influenza virus vaccine		Waived	Waived
	G9141	Influenza a (h1n1) immunization administration (includes the physician counseling the patient/family)		Waived	Waived
	G9142	Influenza a (h1n1) vaccine, any route of administration		Waived	Waived
Pneumo-coccal Vaccine	90669	Pneumococcal conjugate vaccine, polyvalent, when administered to children younger than 5 years, for intramuscular use	B	Waived	Waived
	90670	Pneumococcal vacc, 13 val im		Waived	Waived
	90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use		Waived	Waived

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating[1]	CY 2010 Coinsurance Deductible	CY 2011 Coinsurance Deductible
	G0009	Administration of pneumococcal vaccine		Waived	Waived
Hepatitis B Vaccine	90740	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use	A	Not Waived	Waived
	90743	Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use		Not Waived	Waived
	90744	Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use		Not Waived	Waived
	90746	Hepatitis B vaccine, adult dosage, for intramuscular use		Not Waived	Waived
	90747	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use		Not Waived	Waived

*This table lists only the preventive services, as defined by the Affordable Care Act, that are paid under the OPPS or at reasonable cost, and excludes preventive services such as screening mammography and cardiovascular screening blood tests that are paid under another fee schedule such as the MPFS or the Clinical Laboratory Fee Schedule. A listing of all services defined by the Affordable Care Act as preventive services can be found in the CY 2011 MPFS proposed rule. We note that any preventive service must meet the Medicare coverage guidelines for the service including being appropriate to the beneficiary to whom it is being furnished.

[1] **U.S. Preventive Services Task Force Recommendations:**
A -- The USPSTF strongly recommends that clinicians routinely provide [the service] to eligible patients. (The USPSTF found good evidence that [the service] improves important health outcomes and concludes that benefits substantially outweigh harms.)
B -- The USPSTF recommends that clinicians routinely provide [the service] to eligible patients. (The USPSTF found at least fair evidence that [the service] improves important health outcomes and concludes that benefits outweigh harms.)
C -- The USPSTF makes no recommendation for or against routine provision of [the service]. (The USPSTF found at least fair evidence that [the service] can improve health outcomes but concludes that the balance of benefits and harms is too close to justify a general recommendation.)
D -- The USPSTF recommends against routinely providing [the service] to asymptomatic patients. (The USPSTF found at least fair evidence that [the service] is ineffective or that harms outweigh benefits.)
I -- The USPSTF concludes that the evidence is insufficient to recommend for or against routinely providing [the service]. (Evidence that [the service] is effective is lacking, of poor quality, or conflicting and the balance of benefits and harms cannot be determined.)

<FNP>

3. Extension of Waiver of Deductible to Services Furnished in Connection With or in Relation to a Colorectal Cancer Screening Test That Becomes Diagnostic or Therapeutic

Section 4104(c) of the Affordable Care Act amended section 1833(b) of the Act to waive the Part B deductible for colorectal cancer screening tests that become diagnostic. Specifically, section 4104(c)(2) of the Affordable Care Act waives the deductible with respect to a colorectal cancer screening test regardless of the code that is billed for the establishment of a diagnosis as a result of the test, or for the removal of tissue or other matter or other procedure that is furnished in connection with, as a result of, and in the same clinical encounter as a screening test.

We are proposing that all surgical services furnished on the same date as a planned screening colonoscopy, planned flexible sigmoidoscopy, or barium enema be viewed as being furnished in connection with, as a result of, and in the same clinical encounter as the screening test. We believe that this interpretation is appropriate because we believe that it would be very rare for an unrelated surgery to occur on the same date as one of these scheduled screening tests. Moreover, we believe that the risk of improper expenditures would be very small under this policy because it is the deductible, and not the coinsurance, that is waived for the related procedures other than the screening tests. In the event of a legislative change to this policy (for example, a statutory change that would waive the coinsurance for these related services in addition to the deductible), we would reassess the appropriateness of this proposed definition of services that are furnished in connection with, as a result of, and in the same clinical encounter as the colorectal cancer screening test that becomes diagnostic. We also note that the annual deductible would likely be met when any surgical procedure (related or not) is performed on the same day as the scheduled screening test.

We are proposing to implement this provision by creating a HCPCS modifier that providers would append to the diagnostic procedure code that is reported instead of the screening colonoscopy or screening flexible sigmoidoscopy HCPCS code or as a result of the barium enema when the screening test becomes a diagnostic service. The claims processing system would respond to the modifier by waiving the deductible for all surgical services on the same date as the diagnostic test. Coinsurance or copayment would continue to apply to the diagnostic test and to other services furnished in connection with, as a result of, and in the same clinical encounter as the screening test.

C. Payment for Pulmonary Rehabilitation, Cardiac Rehabilitation, and Intensive Cardiac Rehabilitation Services Furnished to Hospital Outpatients

In the CY 2010 OPPS/ASC final rule with comment period (74 FR 60566 through 60574), we addressed the provisions of section 144(a) of the Medicare Improvements for Patients and Providers Act (MIPPA, Pub. L. 110–275). Section 144(a) provided for Medicare Part B coverage and payment for pulmonary and cardiac rehabilitation services furnished to beneficiaries with chronic obstructive pulmonary disease and certain other conditions, effective January 1, 2010. Medicare Part B coverage is provided for items and services under a cardiac rehabilitation (CR) program, a pulmonary rehabilitation (PR) program, and an intensive cardiac rehabilitation (ICR) program furnished in a physician's office, a hospital on an outpatient basis, or in other settings as the Secretary determines appropriate. We have received questions as to whether a CAH outpatient department is a covered setting for services furnished under these programs because the amendments made to the Act by section 144(a) of the MMA do not specifically define CAHs as hospitals for this benefit.

In this proposed rule, we are clarifying that a CAH outpatient department is considered a covered setting for PR, CR and ICR programs, provided that the programs meet all of the regulatory requirements, including, but not limited to, direct supervision of all services by a physician, specified in 42 CFR 410.27(a)(1)(iv)(A) and 410.47(a)(2)(ii). We can establish that CAHs are a covered setting because the law and implementing regulations specify that PR, CR and ICR services are covered in the hospital outpatient setting, and we define a hospital outpatient in the regulations and program instructions as "a person * * * who * * * receives services * * * directly from the hospital or CAH" (42 CFR 410.2 and the Medicare Benefit Policy Manual, Chapter 6, Section 20.2, available at the CMS Web site at: *http://www.cms.gov/manuals/Downloads/bp102c06.pdf*). We also note that under section 1861(e) of the Act, the context of the term "hospital" as used in the coverage provisions for PR, CR and ICR reflects the inclusion of CAHs.

D. Expansion of Multiple Procedure Reduction Under the Medicare Physician Fee Schedule (MPFS) to Therapy Services

Hospitals are paid for outpatient physical therapy (which includes speech language pathology services) and outpatient occupational therapy under the Medicare Physician Fee Schedule (MPFS). Outpatient physical therapy (which includes speech language pathology services) and outpatient occupational therapy services, as described in section 1833(a)(8) of the Act, are excluded from the OPPS by section 1833(t)(1)(B)(iv) of the Act. Section 1833(a)(8) of the Act provides that outpatient physical and occupational therapy are to be paid as provided in section 1834(k)of the Act. Section 1834(k)(3) of the Act specifies that these services are paid under the fee schedule established under section 1848 of the Act and section 1848 of the Act establishes payment under the MPFS.

For CY 2011, we are proposing to revise the MPFS to apply a multiple procedure reduction to payment for all outpatient physical and occupational therapy services paid under the MPFS. This proposal is contained in the CY 2011 MPFS proposed rule (CMS–1503–P, Medicare Program; Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2011). To be considered in the development of the final policy for CY 2011, public comments on this issue should be submitted in response to the CY 2011 MPFS proposed rule.

XIII. Proposed OPPS Payment Status and Comment Indicators

A. Proposed OPPS Payment Status Indicator Definitions

Payment status indicators (SIs) that we assign to HCPCS codes and APCs play an important role in determining payment for services under the OPPS. They indicate whether a service represented by a HCPCS code is payable under the OPPS or another payment system and also whether particular OPPS policies apply to the code. Our proposed CY 2011 status indicator assignments for APCs and HCPCS codes are shown in Addendum A and Addendum B, respectively, to this proposed rule.

For CY 2011, we are not proposing to make any changes to the status indicators that were listed in Addendum D1 of the CY 2010 OPPS/ASC final rule with comment period.

These status indicators are listed in the tables under sections XIII.A.1., 2., 3., and 4. of this proposed rule.

1. Proposed Payment Status Indicators To Designate Services That Are Paid Under the OPPS

BILLING CODE 4120–01–P

Indicator	Item/Code/Service	OPPS Payment Status
G	Pass-Through Drugs and Biologicals	Paid under OPPS; separate APC payment.
H	Pass-Through Device Categories	Separate cost-based pass-through payment; not subject to copayment.
K	Nonpass-Through Drugs and Nonimplantable Biologicals, including Therapeutic Radiopharmaceuticals	Paid under OPPS; separate APC payment.
N	Items and Services Packaged into APC Rates	Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment.
P	Partial Hospitalization	Paid under OPPS; per diem APC payment.
Q1	STVX-Packaged Codes	Paid under OPPS; Addendum B displays APC assignments when services are separately payable. (1) Packaged APC payment if billed on the same date of service as a HCPCS code assigned status indicator "S," "T," "V," or "X." (2) In all other circumstances, payment is made through a separate APC payment.

Indicator	Item/Code/Service	OPPS Payment Status
Q2	T-Packaged Codes	Paid under OPPS; Addendum B displays APC assignments when services are separately payable. (1) Packaged APC payment if billed on the same date of service as a HCPCS code assigned status indicator "T." (2) In all other circumstances, payment is made through a separate APC payment.
Q3	Codes that may be paid through a composite APC	Paid under OPPS; Addendum B displays APC assignments when services are separately payable. Addendum M displays composite APC assignments when codes are paid through a composite APC. (1) Composite APC payment based on OPPS composite-specific payment criteria. Payment is packaged into a single payment for specific combinations of service. (2) In all other circumstances, payment is made through a separate APC payment or packaged into payment for other services.
R	Blood and Blood Products	Paid under OPPS; separate APC payment.
S	Significant Procedure, Not Discounted When Multiple	Paid under OPPS; separate APC payment.
T	Significant Procedure, Multiple Reduction Applies	Paid under OPPS; separate APC payment.
U	Brachytherapy Sources	Paid under OPPS; separate APC payment.
V	Clinic or Emergency Department Visit	Paid under OPPS; separate APC payment.
X	Ancillary Services	Paid under OPPS; separate APC payment.

BILLING CODE 4120–01–C

Section 142 of Public Law 110–275 (MIPPA) required CMS to pay for therapeutic radiopharmaceuticals for the period of July 1, 2008, through December 31, 2009, at hospitals' charges adjusted to the costs. The status indicator "H" was assigned to therapeutic radiopharmaceuticals to indicate that an item was paid at charges adjusted to cost during CY 2009. In the CY 2010 OPPS/ASC final rule with comment period (74 FR 60593), we changed our policy to pay prospectively and separately for therapeutic radiopharmaceuticals with average per day costs greater than the CY 2010 drug packaging threshold of $65 under the OPPS. Therefore, we changed the status indicator for HCPCS codes used to report separately payable therapeutic radiopharmaceuticals from "H" to "K," which indicated that an item is separately paid under the OPPS at the APC payment rate established for the item. We refer readers to section V.B.5. of the CY 2010 OPPS/ASC final rule with comment period for discussion of the final CY 2010 changes to our payment policy for therapeutic radiopharmaceuticals (74 FR 60593). For CY 2011 OPPS, we are proposing to continue to pay for therapeutic radiopharmaceuticals under the OPPS at the APC payment rate established for the item. (We refer readers to our discussion of this proposal for payment of therapeutic radiopharmaceuticals in section V.B.3. of this proposed rule.)

For CY 2010, we established a policy to consider implantable biologicals that are not on pass-through status as a biological before January 1, 2010, as devices for pass-through evaluation and payment beginning in CY 2010. Therefore, pass-through implantable biologicals were assigned a status indicator of "H," while nonpass-through implantable biologicals were assigned a status indicator of "N" beginning in CY 2010. Those implantable biologicals that have been granted pass-through status under the drug and biological criteria prior to January 1, 2010, continued to be assigned a status indicator of "G" until they are proposed for expiration from pass-through status during our annual rulemaking cycle. In the CY 2010 OPPS/ASC final rule with comment period (74 FR 60593), we assigned status indicator "K" to nonimplantable biologicals and adjusted the definition of status indicator "K" accordingly. For CY 2011, we are not proposing any changes to current policy. We discuss our proposed treatment of drugs, biologicals, and radiopharmaceuticals with new or

continuing pass-through status in CY 2011 in section V.A.3. of this proposed rule, and we discuss our proposed treatment of drugs and biologicals with expiring pass-through status in CY 2010 including the specific implantable biologicals to which this policy is proposed to apply for CY 2011 OPPS in section V.A.2. of this proposed rule.

The proposed CY 2011 status indicators are displayed in both the table above and in Addendum D1 to this proposed rule.

2. Proposed Payment Status Indicators To Designate Services That Are Paid Under a Payment System Other Than the OPPS

We are not proposing any changes to the status indicators listed below for the CY 2011 OPPS.

Indicator	Item/Code/Service	OPPS Payment Status
A	Services furnished to a hospital outpatient that are paid under a fee schedule or payment system other than OPPS, for example:	Not paid under OPPS. Paid by fiscal intermediaries/MACs under a fee schedule or payment system other than OPPS.
	• Ambulance Services	
	• Clinical Diagnostic Laboratory Services	Not subject to deductible or coinsurance.
	• Non-Implantable Prosthetic and Orthotic Devices	
	• EPO for ESRD Patients	
	• Physical, Occupational, and Speech Therapy	
	• Routine Dialysis Services for ESRD Patients Provided in a Certified Dialysis Unit of a Hospital	
	• Diagnostic Mammography	
	• Screening Mammography	Not subject to deductible.
C	Inpatient Procedures	Not paid under OPPS. Admit patient. Bill as inpatient.
F	Corneal Tissue Acquisition; Certain CRNA Services; and Hepatitis B Vaccines	Not paid under OPPS. Paid at reasonable cost.
L	Influenza Vaccine; Pneumococcal Pneumonia Vaccine	Not paid under OPPS. Paid at reasonable cost; not subject to deductible or coinsurance.
M	Items and Services Not Billable to the Fiscal Intermediary/MAC	Not paid under OPPS.
Y	Non-Implantable Durable Medical Equipment	Not paid under OPPS. All institutional providers other than home health agencies bill to DMERC.

The proposed CY 2011 status indicators displayed in the table above are also displayed in Addendum D1 to this proposed rule.

3. Proposed Payment Status Indicators To Designate Services That Are Not Recognized Under the OPPS But That May Be Recognized by Other Institutional Providers

We are not proposing any changes to the status indicators listed below for the CY 2011 OPPS.

Indicator	Item/Code/Service	OPPS Payment Status
B	Codes that are not recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and13x)	Not paid under OPPS.
		• May be paid by fiscal intermediaries/MACs when submitted on a different bill type, for example, 75x (CORF), but not paid under OPPS.
		• An alternate code that is recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x) may be available.

The proposed status indicators are also displayed in Addendum D1 to this proposed rule.

4. Proposed Payment Status Indicators To Designate Services That Are Not Payable by Medicare on Outpatient Claims

We are not proposing any changes to the payment status indicators listed below for the CY 2011 OPPS.

Indicator	Item/Code/Service	OPPS Payment Status
D	Discontinued Codes	Not paid under OPPS or any other Medicare payment system.
E	Items, Codes, and Services:	Not paid by Medicare when submitted on outpatient claims (any outpatient bill type).
	• That are not covered by any Medicare outpatient benefit based on statutory exclusion	
	• That are not covered by any Medicare outpatient benefit for reasons other than statutory exclusion.	
	• That are not recognized by Medicare for outpatient claims; alternate code for the same item or service may be available	
	• For which separate payment is not provided on outpatient claims	

Addendum B, with a complete listing of HCPCS codes including proposed payment status indicators for each code and proposed APC assignments for CY 2011, is available electronically on the CMS Web site under supporting documentation for this proposed rule at: *http://www.cms.hhs.gov/HospitalOutpatientPPS/HORD/list.asp#TopOfPage.*

B. Proposed Comment Indicator Definitions

For the CY 2011 OPPS, we are proposing to use the same two comment indicators that are in effect for the CY 2010 OPPS.

- "CH"—Active HCPCS codes in current and next calendar year; status indicator and/or APC assignment have changed or active HCPCS code that will be discontinued at the end of the current calendar year.
- "NI"—New code for the next calendar year or existing code with substantial revision to its code descriptor in the next calendar year as compared to current calendar year, interim APC assignment; comments will be accepted on the interim APC assignment for the new code.

We are using the "CH" indicator in this proposed rule to call attention to proposed changes in the payment status indicator and/or APC assignment for HCPCS codes for CY 2011 compared to their assignment as of June 30, 2010. We believe that using the "CH" indicator in this proposed rule will help facilitate the public's review of the changes that we are proposing for CY 2011. The use of the comment indicator "CH" in association with a composite APC indicates that we have proposed a

change to the configuration of the composite APC in this proposed rule.

We are proposing to use the "CH" comment indicator in the CY 2011 OPPS/ASC final rule with comment period to indicate HCPCS codes for which the status indicator or APC assignment, or both, would change in CY 2011 compared to their assignment as of December 31, 2010.

We are not proposing any changes to our policy regarding the use of comment indicator "NI." In our CY 2010 OPPS/ASC final rule with comment period, we expanded the definition of comment indicator "NI" to include an existing code with a substantial revision to its code descriptor in the next calendar year as compared to the current calendar year to indicate that the code's CY 2010 OPPS treatment was open to public comment on the CY 2010 OPPS/ASC final rule with comment period.

In the CY 2010 OPPS/ASC final rule with comment period, there are numerous instances in which the descriptor of a previously existing Category I CPT code was substantially revised for the next calendar year so that it described a new service or procedure that could have been assigned a new code number by the CPT Editorial Panel and that new code number would then had been assigned the "NI" comment indicator. We anticipate that, for CY 2011, not all new services or procedures will be assigned a new CPT code number, but instead will be described by an existing CPT code number with a substantially revised code descriptor. We are proposing to continue to assign the comment indicator "NI" to these codes in order to allow for comment on our proposed payment for these substantially revised codes. Like all codes labeled with comment indicator "NI," in a final rule, we will respond to public comments and finalize their OPPS treatment in the CY 2012 OPPS/ASC final rule with comment period. In accordance with our usual practice, CPT and Level II HCPCS code numbers that are new for CY 2011 will also be labeled with comment indicator "NI" in Addendum B to the CY 2011 OPPS/ASC final rule with comment period.

Only HCPCS codes with comment indicator "NI" in the CY 2011 OPPS/ASC final rule with comment period will be subject to comment. HCPCS codes that do not appear with comment indicator "NI" in the CY 2011 OPPS/ASC final rule with comment period will not be open to public comment, unless we specifically have requested additional comments elsewhere in the final rule with comment period. The CY 2011 treatment of HCPCS codes that appears in the CY 2011 OPPS/ASC final rule with comment period to which comment indicator "NI" is not appended will be open to public comment during the comment period for this proposed rule, and we will respond to those comments in the final rule with comment period.

We are not proposing any changes to the definitions of the OPPS comment indicators for CY 2011. Their proposed definitions are listed in Addendum D2 to this proposed rule.

XIV. OPPS Policy and Payment Recommendations

A. MedPAC Recommendations

MedPAC was established under section 1805 of the Act to advise the U.S. Congress on issues affecting the Medicare program. As required under the statute, MedPAC submits reports to Congress not later than March and June of each year that contain its Medicare payment policy recommendations. This section describes recent recommendations relevant to the OPPS that have been made by MedPAC.

The March 2010 MedPAC "Report to Congress: Medicare Payment Policy" included the following recommendation relating specifically to the Medicare hospital OPPS:

Recommendation 2A–1: The Congress should increase payment rates for the acute inpatient and outpatient prospective payment systems in 2011 by the projected rate of increase in the hospital market basket index, concurrent with implementation of a quality incentive payment program.

CMS Response: Subsequent to the issuance of the MedPAC report, Congress enacted the Affordable Care Act. Section 1833(t)(3)(F) as added by section 3401 of the Affordable Care Act and as amended by section 10319 of the Affordable Care Act and section 1105 of the HCERA provides that after determining the OPD fee schedule increase factor, the Secretary shall reduce such increase factor by 0.25 percentage point in 2011. As discussed in section II.B. of this proposed rule, we are proposing to increase the full CY 2011 conversion factor by the projected rate of increase in the hospital market basket less the mandated 0.25 percentage point reduction. Simultaneously, we are proposing for CY 2011 to reduce the annual update factor by 2.0 percentage points for hospitals that are defined under section 1886(d)(1)(B) of the Act and that do not meet the hospital outpatient quality data reporting required by section 1833(t)(17) of the Act. We would make this adjustment after the application of the 0.25 percentage point reduction. For the adjustment under section 1833(t)(17) of the Act, we are proposing to calculate two conversion factors: a full conversion factor based on the annual update factor, adjusted by the 0.25 percentage point reduction required by the Affordable Care Act for CY 2011; and a reduced conversion factor that reflects the 2.0 percentage points reduction to the annual update factor, as adjusted by the 0.25 percentage point reduction. CMS implemented the Hospital Outpatient Quality Data Reporting Program (HOP QDRP) in CY 2008 and is proposing to continue this program in CY 2011 (as discussed in section XVI. of this proposed rule).

The full March 2010 MedPAC report can be downloaded from MedPAC's Web site at: *http://www.medpac.gov/documents/Mar10_EntireReport.pdf.*

B. APC Panel Recommendations

Recommendations made by the APC Panel at its February 2010 meeting are discussed in the sections of this proposed rule that correspond to topics addressed by the APC Panel. The report and recommendations from the APC Panel's February 17–18, 2010 meeting are available on the CMS Web site at: *http://www.cms.gov/FACA/05_AdvisoryPanelonAmbulatoryPaymentClassificationGroups.asp.*

C. OIG Recommendations

The mission of the Office of the Inspector General (OIG), as mandated by Public Law 95–452, as amended, is to protect the integrity of the U.S. Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections. As of the publication of the proposed rule, there were no OIG reports that resulted in OIG recommendations for OPPS policy changes for CY 2011.

XV. Proposed Updates to the Ambulatory Surgical Center (ASC) Payment System

A. Background

1. Legislative Authority for the ASC Payment System

Section 1832(a)(2)(F)(i) of the Act provides that benefits under Medicare Part B include payment for facility services furnished in connection with surgical procedures specified by the Secretary that are performed in an Ambulatory Surgical Center (ASC). To participate in the Medicare program as an ASC, a facility must meet the standards specified in section

1832(a)(2)(F)(i) of the Act, which are set forth in 42 CFR part 416, Subpart B and Subpart C of our regulations. The regulations at 42 CFR part 416, Subpart B describe the general conditions and requirements for ASCs, and the regulations at Subpart C explain the specific conditions for coverage for ASCs.

Section 141(b) of the Social Security Act Amendments of 1994, Public Law 103–432, required establishment of a process for reviewing the appropriateness of the payment amount provided under section 1833(i)(2)(A)(iii) of the Act for intraocular lenses (IOLs) that belong to a class of new technology intraocular lenses (NTIOLs). That process was the subject of a final rule entitled "Adjustment in Payment Amounts for New Technology Intraocular Lenses Furnished by Ambulatory Surgical Centers," published on June 16, 1999, in the **Federal Register** (64 FR 32198).

Section 626(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Public Law 108–173, added subparagraph (D) to section 1833(i)(2) of the Act, which required the Secretary to implement a revised ASC payment system to be effective not later than January 1, 2008. Section 626(c) of the MMA amended section 1833(a)(1) of the Act by adding new subparagraph (G), which requires that, beginning with implementation of the revised ASC payment system, payment for surgical procedures furnished in ASCs shall be 80 percent of the lesser of the actual charge for the services or the amount determined by the Secretary under the revised payment system.

Section 5103 of the Deficit Reduction Act of 2005 (DRA), Public Law 109–171, amended section 1833(i)(2) of the Act by adding new subparagraph (E) to place a limitation on payment amounts for surgical procedures furnished in ASCs on or after January 1, 2007, but before the effective date of the revised ASC payment system (that is, January 1, 2008). Section 1833(i)(2)(E) of the Act provides that if the standard overhead amount under section 1833(i)(2)(A) of the Act for an ASC facility service for such surgical procedures, without application of any geographic adjustment, exceeds the Medicare payment amount under the hospital OPPS for the service for that year, without application of any geographic adjustment, the Secretary shall substitute the OPPS payment amount for the ASC standard overhead amount.

Section 109(b) of the Medicare Improvements and Extension Act of 2006 of the Tax Relief and Health Care Act of 2006 (MIEA–TRHCA), Public Law 109–432, amended section 1833(i)(2)(D) of the Act, in part, by redesignating clause (iv) as clause (v) and adding a new clause (iv) and by adding new section 1833(i)(7)(A). These amendments provide the Secretary the authority to require ASCs to submit data on quality measures and to reduce the annual update by 2 percentage points for an ASC that fails to submit data as required by the Secretary on selected quality measures. Section 109(b) of the MIEA–TRHCA also amended section 1833(i) of the Act by adding new section 1833(i)(7)(B), which requires that, to the extent the Secretary establishes such an ASC quality reporting program, certain quality of care reporting requirements mandated for hospitals paid under the OPPS, under sections 1833(t)(17)(B), (C), (D) and (E) of the Act, as added by section 109(a) of the MIEA–TRHCA, be applied in a similar manner to ASCs unless otherwise specified by the Secretary.

Sections 4104 and 10406 of the Affordable Care Act amend sections 1833(a)(1) and (b)(1) of the Act to waive the coinsurance and the Part B deductible for those preventive services described in section 1861(ww)(2) of the Act (excluding electrocardiograms) that are recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B for any indication or population and that are appropriate for the individual. Section 4104(c) of the Affordable Care Act amends section 1833(b)(1) of the Act to waive the Part B deductible for colorectal cancer screening tests that become diagnostic. These provisions apply to these items and services furnished in an ASC on or after January 1, 2011.

Section 3401(k) of the Affordable Care Act amends section 1833(i)(2)(D) of the Act to require that, effective for CY 2011 and subsequent years, any annual update under the ASC payment system be reduced by a productivity adjustment, which is equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity (as projected by the Secretary for the 10-year period ending with the applicable fiscal year, year, cost reporting period, or other annual period). Application of this productivity adjustment to the ASC payment system may result in the update to the ASC payment system being less than zero for a year and may result in payment rates under the ASC payment system for a year being less than such payment rates for the preceding year.

For a detailed discussion of the legislative history related to ASCs, we refer readers to the June 12, 1998 proposed rule (63 FR 32291 through 32292).

2. Prior Rulemaking

On August 2, 2007, we published in the **Federal Register** (72 FR 42470) the final rule for the revised ASC payment system, effective January 1, 2008 (the "August 2, 2007 final rule"). In that final rule, we revised our criteria for identifying surgical procedures that are eligible for Medicare payment when furnished in ASCs and adopted the method we would use to set payment rates for ASC covered surgical procedures and covered ancillary services furnished in association with those covered surgical procedures beginning in CY 2008. We also established a policy for treating new and revised HCPCS and CPT codes under the ASC payment system. This policy is consistent with the OPPS to the extent possible (72 FR 42533). Additionally, we established a standard ASC ratesetting methodology that bases payment for most services on the list of ASC covered surgical procedures on the OPPS relative payment weight multiplied by an ASC conversion factor. We also established modifications to this methodology for subsets of services, such as device-intensive services (where the estimated device portion of the ASC payment is the same as that paid under the OPPS) and services that are predominantly performed in the office setting and covered ancillary radiology services (where ASC payment may be based on the MPFS non-facility practice expense (PE) Relative Value Units (RVUs)). Additionally, we established a policy for updating the conversion factor, the relative payment weights, and the ASC payment rates on an annual basis. We also annually update the list of procedures for which Medicare would not make an ASC payment.

In the CY 2008 OPPS/ASC final rule with comment period (72 FR 66827), we updated and finalized the CY 2008 ASC rates and lists of covered surgical procedures and covered ancillary services. We also made regulatory changes to 42 CFR Parts 411, 414, and 416 related to our final policies to provide payments to physicians who perform noncovered ASC procedures in ASCs based on the facility PE RVUs, to exclude covered ancillary radiology services and covered ancillary drugs and biologicals from the categories of designated health services (DHS) that are subject to the physician self-referral prohibition, and to reduce ASC

payments for surgical procedures when the ASC receives full or partial credit toward the cost of the implantable device. In the CY 2009 OPPS/ASC final rule with comment period (73 FR 68722), we updated and finalized the CY 2009 ASC rates and lists of covered surgical procedures and covered ancillary services.

In the CY 2010 OPPS/ASC final rule with comment period (74 FR 60596), we updated and finalized the CY 2010 ASC rates and lists of covered surgical procedures and covered ancillary services. We also corrected some of those ASC rates in a correction notice published in the **Federal Register** on December 31, 2009 (74 FR 69502). In that correction notice, we revised the ASC rates to reflect changes in the MPFS conversion factor and PE RVUs listed for some CPT codes in Addendum B to the CY 2010 MPFS final rule with comment period (74 FR 62017), which were incorrect due to methodological errors and, consequently, were corrected in a correction notice to that final rule with comment period (74 FR 65449). We also are publishing a second correction notice in the **Federal Register** around the time of this proposed rule to address changes to the ASC rates resulting from corrections to the PE RVUs identified subsequent to publication of the December 31, 2009 correction notice. Finally, we are publishing a notice around the time of this proposed rule in the **Federal Register** to reflect changes to CY 2010 ASC payment rates for certain ASC services due to changes to the OPPS and MPFS under ACA. It also reflects technical changes to the ASC payment rates announced in prior correction notices.

3. Policies Governing Changes to the Lists of Codes and Payment Rates for ASC Covered Surgical Procedures and Covered Ancillary Services

The August 2, 2007 final rule established our policies for determining which procedures are ASC covered surgical procedures and covered ancillary services. Under §§ 416.2 and 416.166 of the regulations, subject to certain exclusions, covered surgical procedures are surgical procedures that are separately paid under the OPPS, that would not be expected to pose a significant risk to beneficiary safety when performed in an ASC, and that would not be expected to require active medical monitoring and care at midnight following the procedure ("overnight stay"). We adopted this standard for defining which surgical procedures are covered surgical procedures under the ASC payment system as an indicator of the complexity of the procedure and its appropriateness for Medicare payment in ASCs. We use this standard only for purposes of evaluating procedures to determine whether or not they are appropriate for Medicare beneficiaries in ASCs. We define surgical procedures as those described by Category I CPT codes in the surgical range from 10000 through 69999, as well as those Category III CPT codes and Level II HCPCS codes that crosswalk or are clinically similar to ASC covered surgical procedures (72 FR 42478). We note that we added over 800 surgical procedures to the list of covered surgical procedures for ASC payment in CY 2008, the first year of the revised ASC payment system, based on the criteria for payment that we adopted in the August 2, 2007 final rule as described above in this section. Patient safety and health outcomes continue to be important to us as more health care moves to the ambulatory care setting. Therefore, as we gain additional experience with the ASC payment system, we are interested in any information the public may have regarding the comparative patient outcomes of surgical care provided in ambulatory settings, including HOPDs, ASCs, and physicians' offices, particularly with regard to the Medicare population.

In the August 2, 2007 final rule, we also established our policy to make separate ASC payments for the following ancillary items and services when they are provided integral to ASC covered surgical procedures: brachytherapy sources; certain implantable items that have pass-through status under the OPPS; certain items and services that we designate as contractor-priced, including, but not limited to, procurement of corneal tissue; certain drugs and biologicals for which separate payment is allowed under the OPPS; and certain radiology services for which separate payment is allowed under the OPPS. These covered ancillary services are specified in § 416.164(b) and, as stated previously, are eligible for separate ASC payment (72 FR 42495). Payment for ancillary items and services that are not paid separately under the ASC payment system is packaged into the ASC payment for the covered surgical procedure.

We update the lists of, and payment rates for, covered surgical procedures and covered ancillary services, in conjunction with the annual proposed and final rulemaking process to update the OPPS and the ASC payment system (§ 416.173; 72 FR 42535). In addition, as discussed in detail below in section XV.B., because we base ASC payment policies for covered surgical procedures, drugs, biologicals, and certain other covered ancillary services on the OPPS payment policies, we also provide quarterly updates for ASC services throughout the year (January, April, July, and October), just as we do for the OPPS. The updates are to implement newly created Level II HCPCS and Category III CPT codes for ASC payment and to update the payment rates for separately paid drugs and biologicals based on the most recently submitted ASP data. New Category I CPT codes, except vaccine codes, are released only once a year and, therefore, are implemented through the January quarterly update. New Category I CPT vaccine codes are released twice a year and thus are implemented through the January and July quarterly updates.

In our annual updates to the ASC list of, and payment rates for, covered surgical procedures and covered ancillary services, we undertake a review of excluded surgical procedures (including all procedures newly proposed for removal from the OPPS inpatient list), new procedures, and procedures for which there is revised coding, to identify any that we believe meet the criteria for designation as ASC covered surgical procedures or covered ancillary services. Updating the lists of covered surgical procedures and covered ancillary services, as well as their payment rates, in association with the annual OPPS rulemaking cycle is particularly important because the OPPS relative payment weights and, in some cases, payment rates, are used as the basis for the payment of covered surgical procedures and covered ancillary services under the revised ASC payment system. This joint update process ensures that the ASC updates occur in a regular, predictable, and timely manner.

B. Proposed Treatment of New Codes

1. Proposed Process for Recognizing New Category I and Category III CPT Codes and Level II HCPCS Codes

CPT and Level II HCPCS codes are used to report procedures, services, items, and supplies under the ASC payment system. Specifically, we recognize the following codes on ASC claims: (1) Category I CPT codes, which describe medical services and procedures; (2) Category III CPT codes, which describe new and emerging technologies, services, and procedures; and (3) Level II HCPCS codes, which are used primarily to identify products, supplies, temporary procedures, and services not described by CPT codes. CPT codes are established by the

American Medical Association (AMA) and the Level II HCPCS codes are established by the CMS HCPCS Workgroup. These codes are updated and changed throughout the year. CPT and HCPCS code changes that affect ASCs are addressed both through the ASC quarterly update Change Requests (CRs) and through the annual rulemaking cycle. CMS releases new Level II HCPCS codes to the public or recognizes the release of new CPT codes by the AMA and makes these codes effective (that is, the codes are recognized on Medicare claims) outside of the formal rulemaking process via ASC quarterly update CRs. This quarterly process offers ASCs access to codes that may more accurately describe items or services furnished and/or provides payment or more accurate payment for these items or services in a more timely manner than if we waited for the annual rulemaking process. We solicit comments on the new codes recognized for ASC payment and finalize our proposals related to these codes through our annual rulemaking process.

We finalized a policy in the August 2, 2007 final rule to evaluate each year all new Category I and Category III CPT codes and Level II HCPCS codes that describe surgical procedures, and to make preliminary determinations in the annual OPPS/ASC final rule with comment period regarding whether or not they meet the criteria for payment in the ASC setting and, if so, whether they are office-based procedures (72 FR 42533 through 42535). In addition, we identify new codes as ASC covered ancillary services based upon the final payment policies of the revised ASC payment system.

In Table 39 below, we summarize our proposed process for updating the HCPCS codes recognized under the ASC payment system.

TABLE 39.—PROPOSED COMMENT TIMEFRAME FOR NEW HCPCS CODES

OPPS/ASC Quarterly Update CR	Type of Code	Effective Date	Comments Sought	When Finalized
April l, 2010	Level II HCPCS Codes	April 1, 2010	CY 2011 OPPS/ASC proposed rule	CY 2011 OPPS/ASC final rule with comment period
July 1, 2010	Level II HCPCS Codes	July 1, 2010	CY 2011 OPPS/ASC proposed rule	CY 2011 OPPS/ASC final rule with comment period
	Category I (certain vaccine codes) and III CPT codes	July 1, 2010	CY 2011 OPPS/ASC proposed rule	CY 2011 OPPS/ASC final rule with comment period
October 1, 2010	Level II HCPCS Codes	October 1, 2010	CY 2011 OPPS/ASC final rule with comment period	CY 2012 OPPS/ASC final rule with comment period
January 1, 2011	Level II HCPCS Codes	January 1, 2011	CY 2011 OPPS/ASC final rule with comment period	CY 20112 OPPS/ASC final rule with comment period
	Category I and III CPT Codes	January 1, 2011	CY 2011 OPPS/ASC final rule with comment period	CY 2012 OPPS/ASC final rule with comment period

This process is discussed in detail below and we have separated our discussion based on whether we are proposing to solicit public comments in this CY 2011 proposed rule on a specific group of the CPT and Level II HCPCS codes (and respond to those comments in the CY 2011 OPPS/ASC final rule with comment period) or whether we are proposing to solicit public comments on another specific group of the codes in the CY 2011 final rule with comment period (and respond to those comments in the CY 2012 OPPS/ASC final rule with comment period). We sought public comments in the CY 2010 OPPS/ASC final rule with comment period on the new CPT and HCPCS codes that were effective January 1, 2010. These new codes were flagged with comment indicator "N1" in Addendum AA and BB to the CY 2010 OPPS/ASC final rule with comment period to indicate that we were assigning them an interim payment status and payment rate, if applicable, which were subject to public comment following publication of the CY 2010 OPPS/ASC final rule with comment period. We will respond to public

comments and finalize our proposed ASC treatment of these codes in the CY 2011 OPPS/ASC final rule with comment period.

2. Proposed Treatment of New Level II HCPCS Codes and Category III CPT Codes Implemented in April and July 2010 for Which We Are Soliciting Public Comments in This Proposed Rule

In the April and July CRs, we made effective for April 1 or July 1, 2010, a total of 14 new Level II HCPCS codes and 7 new Category III CPT codes that were not addressed in the CY 2010 OPPS/ASC final rule with comment period. (We note that one Level II HCPCS code, C9262, that was added in the April 2010 CR, was deleted June 30, 2010 and replaced with Q2025 effective July 1, 2010). The 13 new Level II HCPCS codes describe covered ancillary services.

Through the April 2010 ASC quarterly update (Transmittal 1943, CR 6866, dated April 6, 2010), we added six new drug and biological Level II HCPCS codes to the list of covered ancillary services. Specifically, as displayed in Table 40, these included HCPCS codes C9258 (Injection, telavancin, 10 mg), C9259 (Injection, pralatrexate, 1 mg), C9260 (Injection, ofatumumab, 10 mg), C9261 (Injection, ustekinumab, 1 mg), C9262 (Fludarabine phosphate, oral, 1 mg), and C9263 (Injection, ecallantide, 1 mg).

Through the July 2010 quarterly update (Transmittal 1984, Change Request 7008, dated June 11, 2010), we are adding seven new drug and biological Level II HCPCS codes to the list of covered ancillary services. Specifically, as displayed in Table 41, we provide separate payment for HCPCS codes C9264 (Injection, tocilizumab, 1 mg), C9265 (Injection, romidepsin, 1 mg), C9266 (Injection, collagenase clostridium histolyticum, 0.1 mg), C9267 (Injection, von Willebrand factor complex (human), Wilate, per 100 IU VWF: RCO), C9268 (Capsaicin, patch, 10cm2), C9367 (Skin substitute, Endoform Dermal Template, per square centimeter), and Q2025 (Fludarabine phosphate oral, 10mg). As noted above, HCPCS code C9262 was made effective April 1, 2010, and deleted June 30, 2010, when it was replaced with HCPCS code Q2025.

We assigned payment indicator "K2" (Drugs and biologicals paid separately when provided integral to a surgical procedure on the ASC list; payment based on OPPS rate) to these 13 new Level II to indicate that they are separately paid when provided in ASCs. In this CY 2011 OPPS/ASC proposed rule, we are soliciting public comment on the proposed CY 2010 ASC payment indicators and payment rates for the drugs and biologicals, as listed in Tables 40 and 41 below. Those HCPCS codes became payable in ASCs, beginning in April or July 2010, respectively, and are paid at the ASC rates posted for the appropriate calendar quarter on the CMS Web site at *http://www.cms.gov/ASCPayment/.*

The codes listed in Table 40 are included in Addendum BB to this proposed rule. (We note that Level II HCPCS code C9262 was deleted June 30, 2010, and replaced with Q2025 effective July 1, 2010, and therefore is not included in Addendum BB and is not open to public comment. Instead, Level II HCPCS code Q2025 is open for public comment.)

However, because HCPCS codes that become effective for July (listed in Table 41) are not available to us in time for incorporation into the Addenda to the OPPS/ASC proposed rule, our policy is to include these HCPCS codes and their proposed payment indicators and payment rates in the preamble to the proposed rule but not in the Addenda to the proposed rule. These codes and their final payment indicators and rates will be included in the appropriate Addendum to the CY 2011 OPPS/ASC final rule with comment period. Thus, the codes implemented by the July 2010 ASC quarterly update CR and their proposed CY 2011 payment rates (based on July 2010 ASP data) that are displayed in Table 41 are not included in Addendum BB to this proposed rule. We are proposing to include these services reported using the new Level II HCPCS codes displayed in Tables 40 and 41 as covered ancillary services for payment to ASCs for CY 2011. The final list of covered ancillary services and the associated payment weights and payment indicators will be included in Addendum BB to the CY 2011 OPPS/ASC final rule with comment period, consistent with our annual update policy.

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TABLE 40.—NEW LEVEL II HCPCS CODES FOR COVERED ANCILLARY SERVICES IMPLEMENTED IN APRIL 2010

CY 2010 HCPCS Code	CY 2010 Long Descriptor	Proposed CY 2011 Payment Indicator
C9258	Injection, telavancin, 10 mg	K2
C9259	Injection, pralatrexate, 1 mg	K2
C9260	Injection, ofatumumab, 10 mg	K2
C9261	Injection, ustekinumab, 1 mg	K2
C9262*	Fludarabine phosphate, oral, 1 mg	D5
C9263	Injection, ecallantide, 1 mg	K2

*Level II HCPCS code C9262 was deleted June 30, 2010, and replaced with Q2025 effective July 1, 2010. Because Addendum BB to this proposed rule is based on the codes effective in April, C9262 appears as having a proposed payment indicator of "K2."

TABLE 41.—NEW LEVEL II HCPCS CODES FOR COVERED ANCILLARY SERVICES IMPLEMENTED IN JULY 2010

CY 2010 HCPCS Code	CY 2010 Descriptor	Proposed CY 2011 Payment Indicator	Proposed CY 2011 ASC Payment Rate*
C9264	Injection, tocilizumab, 1 mg	K2	$3.52
C9265	Injection, romidepsin, 1 mg	K2	$223.78
C9266	Injection, collagenase clostridium histolyticum, 0.1 mg	K2	$382.78
C9267	Injection, von Willebrand factor complex (human), Wilate, per 100 IU VWF: RCO	K2	$122.07
C9268	Capsaicin, patch, 10cm2	K2	$11.18
C9367	Skin substitute, Endoform Dermal Template, per square centimeter	K2	$4.35
Q2025**	Fludarabine phosphate oral, 10mg	K2	$8.18

* Based on July 2010 ASP information.

**Level II HCPCS code Q2025 replaced C9262.

Through the July 2010 quarterly update CR, we also implemented ASC payment for seven new Category III CPT codes and one new Level II HCPCS code as ASC covered surgical procedures, effective July 1, 2010. These codes are listed in Table 42 below, along with their proposed payment indicators and proposed payment rates for CY 2011. Because new Category III CPT and Level II HCPCS codes that become effective for July are not available to us in time for incorporation into the Addenda to the OPPS/ASC proposed rule, our policy is to include the codes, their proposed payment indicators, and proposed payment rates in the preamble to the proposed rule but not in the Addenda to the proposed rule. These codes and their final payment indicators and rates will be included in the Addenda to the OPPS/ASC final rule with comment period. The new mid-year codes for the covered surgical procedures implemented in July 2010 are displayed in Table 42 below, along with their proposed payment indicators and proposed payment rates. These codes and their final payment indicators and rates will be included in Addendum AA to the CY 2011 OPPS/ASC final rule with comment period.

TABLE 42.—NEW CATEGORY III CPT CODES AND LEVEL II HCPCS CODE IMPLEMENTED IN JULY 2010 AS ASC COVERED SURGICAL PROCEDURES

CY 2010 CPT Code	CY 2010 Long Descriptor	Proposed CY 2011 Payment Indicator**	Proposed CY 2011 ASC Payment Rate
0226T	Anoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); diagnostic, including collection of specimen(s) by brushing or washing when performed	R2*	$26.78
0227T	Anoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); with biopsy(ies)	R2*	$231.07
0228T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, cervical or thoracic; single level	G2	$288.11
0229T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, cervical or thoracic; each additional level (List separately in addition to code for primary procedure)	G2	$148.93
0230T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, lumbar or sacral; single level	G2	$288.11
0231T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, lumbar or sacral; each additional level (List separately in addition to code for primary procedure)	G2	$148.93
0232T	Injection(s), platelet rich plasma, any tissue, including image guidance, harvesting and preparation when performed	R2*	$26.78
C9800	Dermal injection procedure(s) for facial lipodystrophy syndrome (LDS) and provision of Radiesse or Sculptra dermal filler, including all items and supplies	R2*	$177.60

* If designation is temporary.

**Proposed payment indicators are based on a comparison of the proposed rates according to the ASC standard ratesetting methodology and the MPFS proposed rates. At the time this proposed rule is being finalized for publication, current law authorizes a negative update to the MPFS payment rates for CY 2011. Therefore, this proposed rule reflects a negative update to the MPFS payment rates for CY 2011. If Congress revises the MPFS update for CY 2011, we will recalculate the ASC payment rates using the revised update factor in the CY 2011 OPPS/ASC final rule with comment period.

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For CY 2011, we are soliciting public comments on the proposed payment indicators and the payment rates, if applicable, for the new Level II HCPCS codes and Category III CPT codes that were newly recognized in April or July 2010 through the respective quarterly update CRs. These codes are listed in Tables 40, 41, and 42 of this proposed rule. We are proposing to finalize their payment indicators and their payment rates, if applicable, in the CY 2011 OPPS/ASC final rule with comment period.

3. Proposed Process for New Level II HCPCS Codes and Category I and III CPT Codes for Which We Will Be Soliciting Public Comments in the CY 2011 OPPS/ASC Final Rule With Comment Period

As has been our practice in the past, we incorporate those new Category I and Category III CPT codes and new Level II HCPCS codes that are effective January 1 in the final rule with comment period updating the ASC payment system for the following calendar year. These codes are released to the public via the CMS HCPCS (for Level II HCPCS codes) and AMA Web sites (for CPT codes), and also through the January ASC quarterly update CRs. In the past, we also have released new Level II HCPCS codes that are effective October 1 through the October ASC quarterly update CRs and incorporated these new codes in the final rule with comment period updating the ASC payment system for the following calendar year. All of these codes are flagged with comment indicator "NI" in Addenda AA and BB to the OPPS/ASC final rule with comment period to indicate that we are assigning them an interim payment status which is subject to public comment. Specifically, the payment indicator and payment rate, if applicable, for all such codes flagged with comment indicator "NI" are open to public comment in the OPPS/ASC final rule with comment period, and we respond to these comments in the final rule with comment period for the next calendar year's OPPS/ASC update. We are proposing to continue this process for CY 2011.

For CY 2011, we are proposing to include in Addenda AA and BB to the CY 2011 OPPS/ASC final rule with comment period the new Category I and III CPT codes effective January 1, 2011 (including those Category III CPT codes that were released by the AMA in July 2010) that would be incorporated in the January 2011 ASC quarterly update CR and the new Level II HCPCS codes, effective October 1, 2010 or January 1, 2011, that would be released by CMS in its October 2010 and January 2011 ASC quarterly update CRs. These codes would be flagged with comment indicator "NI" in Addenda AA and BB to the CY 2011 OPPS/ASC final rule with comment period to indicate that we have assigned them an interim payment status. Their payment indicators and payment rates, if applicable, would be open to public comment in the CY 2011 OPPS/ASC final rule with comment period and would be finalized in the CY 2012 OPPS/ASC final rule with comment period.

C. Proposed Update to the Lists of ASC Covered Surgical Procedures and Covered Ancillary Services

1. Covered Surgical Procedures

a. Proposed Additions to the List of ASC Covered Surgical Procedures

We are proposing to update the list of ASC covered surgical procedures by adding five procedures to the list. These five procedures were among those excluded from the ASC list for CY 2010 because we believed they did not meet the definition of a covered surgical procedure based on our expectation that they would pose a significant safety risk to Medicare beneficiaries or would require an overnight stay if performed in ASCs. We conducted a review of all HCPCS codes that currently are paid under the OPPS, but not included on the ASC list of covered surgical procedures, to determine if changes in technology and/or medical practice changed the clinical appropriateness of these procedures for the ASC setting. We determined that these five procedures could be safely performed in the ASC setting and are therefore proposing to include them on the list of ASC covered surgical procedures for CY 2011.

The five procedures that we are proposing to add to the ASC list of covered surgical procedures, including their HCPCS code long descriptors and proposed CY 2010 payment indicators, are displayed in Table 43 below.

TABLE 43.—PROPOSED NEW ASC COVERED SURGICAL PROCEDURES FOR CY 2011

CY 2010 HCPCS Code	CY 2010 Long Descriptor	Proposed CY 2011 ASC Payment Indicator*
37204	Transcatheter occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method, non-central nervous system, non-head or neck	G2
37205	Transcatheter placement of an intravascular stent(s), (except coronary, carotid, and vertebral vessel), percutaneous; initial vessel	P3
37206	Transcatheter placement of an intravascular stent(s), (except coronary, carotid, and vertebral vessel), percutaneous; each additional vessel (list separately in addition to code for primary procedure)	P3
37210	Laser enucleation of the prostate with morcellation, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed (Do not report 52649 with 52000, 52276, 52281, 52601, 52647, 52648, 53020, 55250)	P3
50593	Uterine fibroid embolization (ufe, embolization of the uterine arteries to treat uterine fibroids, leiomyomata), percutaneous approach inclusive of vascular access, vessel selection, embolization, and all radiological supervision and interpretation, intraprocedural road mapping, and imaging guidance necessary to complete the procedure	P2

*Proposed payment indicators are based on a comparison of the proposed rates according to the ASC standard ratesetting methodology and the MPFS proposed rates. At the time this proposed rule is being finalized for publication, current law authorizes a negative update to the MPFS payment rates for CY 2011. Therefore, this proposed rule reflects a negative update to the MPFS payment rates for CY 2011. If Congress revises the MPFS update for CY 2011, we will recalculate the ASC payment rates using the revised update factor in the CY 2011 OPPS/ASC final rule with comment period.

b. Proposed Covered Surgical Procedures Designated as Office-Based

(1) Background

In the August 2, 2007 ASC final rule, we finalized our policy to designate as "office-based" those procedures that are added to the ASC list of covered surgical procedures in CY 2008 or later years that we determine are performed predominantly (more than 50 percent of the time) in physicians' offices based on consideration of the most recent available volume and utilization data for each individual procedure code and/or, if appropriate, the clinical characteristics, utilization, and volume of related codes. In that rule, we also finalized our policy to exempt all procedures on the CY 2007 ASC list from application of the office-based classification (72 FR 42512). The procedures that were added to the ASC list of covered surgical procedures beginning in CY 2008 that we determined were office-based were identified in Addendum AA to that rule by payment indicator "P2" (Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS non-facility PE RVUs; payment based on OPPS relative payment weight); "P3" (Office-based surgical procedures added to ASC list in CY 2008 or later with MPFS non-facility PE RVUs; payment based on MPFS non-facility PE RVUs); or "R2" (Office-based surgical procedure added to ASC list in CY 2008 or later without MPFS non-facility PE RVUs; payment based on OPPS relative payment weight), depending on whether we estimated it would be paid according to the standard ASC payment methodology based on its OPPS relative payment weight or at the MPFS non-facility PE RVU amount.

Consistent with our final policy to annually review and update the list of surgical procedures eligible for payment in ASCs, each year we identify surgical procedures as either temporarily or permanently office-based after taking into account updated volume and utilization data.

(2) Proposed Changes to Covered Surgical Procedures Designated as Office-Based for CY 2011

In developing this proposed rule, we followed our policy to annually review and update the surgical procedures for which ASC payment is made and to identify new procedures that may be

appropriate for ASC payment, including their potential designation as office-based. We reviewed CY 2009 volume and utilization data and the clinical characteristics for all surgical procedures that are assigned payment indicator "G2" in CY 2010, as well as for those procedures assigned one of the temporary office-based payment indicators, specifically "P2*," "P3*," or "R2*" in the CY 2010 ASC final rule with comment period (74 FR 60605 through 60608). We also examined the data for the five procedures that we are proposing to add to the ASC list of covered surgical procedures for CY 2011 (listed in Table 43 above) to determine if these procedures should be designated as office-based.

Our review of the CY 2009 volume and utilization data resulted in our identification of six surgical procedures that we believe meet the criteria for designation as office-based. The data indicate that the procedures are performed more than 50 percent of the time in physicians' offices. Our medical advisors believe the services are of a level of complexity consistent with other procedures performed routinely in physicians' offices. The six procedures we are proposing to permanently designate as office-based are listed in Table 44 below. We note that four of these procedures are procedures that we also are proposing to add to the ASC list of covered surgical procedures for CY 2011: CPT code 37205; CPT code 37206; CPT code 37210; and CPT code 50593. The other two procedures are already on the ASC list of covered surgical procedures.

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TABLE 44.—ASC COVERED SURGICAL PROCEDURES PROPOSED FOR OFFICE-BASED DESIGNATION FOR CY 2011

CY 2010 HCPCS Code	CY 2010 Long Descriptor	CY 2010 ASC Payment Indicator	Proposed CY 2011 ASC Payment Indicator*
20697	Application of multiplane (pins or wires in more than one plane), unilateral, external fixation with stereotactic computer-assisted adjustment (eg, spatial frame), including imaging; exchange (ie, removal and replacement of strut, each	G2	P2
27767	Closed treatment of posterior malleolus fracture; without manipulation	G2	P2
37205	Transcatheter placement of an intravascular stent(s), (except coronary, carotid, and vertebral vessel), percutaneous; initial vessel	X5	P3
37206	Transcatheter placement of an intravascular stent(s), (except coronary, carotid, and vertebral vessel), percutaneous; each additional vessel (list separately in addition to code for primary procedure)	X5	P3
37210	Laser enucleation of the prostate with morcellation, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed (Do not report 52649 with 52000, 52276, 52281, 52601, 52647, 52648, 53020, 55250)	X5	P3
50593	Uterine fibroid embolization (ufe, embolization of the uterine arteries to treat uterine fibroids, leiomyomata), percutaneous	X5	P2

CY 2010 HCPCS Code	CY 2010 Long Descriptor	CY 2010 ASC Payment Indicator	Proposed CY 2011 ASC Payment Indicator*
	approach inclusive of vascular access, vessel selection, embolization, and all radiological supervision and interpretation, intraprocedural road mapping, and imaging guidance necessary to complete the procedure		

*Proposed payment indicators are based on a comparison of the proposed rates according to the ASC standard ratesetting methodology and the MPFS proposed rates. At the time this proposed rule is being finalized for publication, current law authorizes a negative update to the MPFS payment rates for CY 2011. Therefore, this proposed rule reflects a negative update to the MPFS payment rates for CY 2011. If Congress revises the MPFS update for CY 2011, we will recalculate the ASC payment rates using the revised update factor in the CY 2011 OPPS/ASC final rule with comment period.

We also reviewed CY 2009 volume and utilization data and other information for the six procedures proposed for temporary office-based status in the CY 2010 OPPS/ASC proposed rule (74 FR 35382) and finalized for temporary office-based status in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60607). Among these six procedures, there were almost no claims data for three procedures: CPT code 0099T (Implantation of intrastromal corneal ring segments); CPT code 0124T (Conjunctival drug placement); and CPT code 67229 (Treatment of extensive or progressive retinopathy, one or more sessions; preterm infant (less than 37 weeks gestation at birth), performed from birth up to 1 year of age (e.g., retinopathy of prematurity), photocoagulation or cryotherapy). Consequently, we are proposing to maintain their temporary office-based designations for CY 2011. We also are proposing to maintain in CY 2011 the temporary office-based designation for the four codes that became effective in the July 2010 ASC quarterly update: CPT code 0226T (Angoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); diagnostic, including collection of specimen(s) by brushing or washing when performed); CPT code 0227T (Angoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); with biopsy(ies)); CPT code 0232T (Injection(s), platelet rich plasma, any tissue, including image guidance, harvesting and preparation when performed); and HCPCS code C9800 (Dermal injection procedure(s) for facial lipodystrophy syndrome (LDS) and provision of Radiesse or Sculptra dermal filler, including all items and supplies), because no data are available for these codes at this time.

As a result of our review of the remaining three procedures that have temporary office-based designations for CY 2010 for which we do have claims data, we are proposing to make permanent the office based designations for all of them for CY 2011. The three surgical procedure codes are: CPT code 46930 (Destruction of internal hemorrhoid(s) by thermal energy (e.g., infrared coagulation, cautery, radiofrequency)); CPT code 64455 (Injection(s), anesthetic agent and/or steroid, plantar common digital nerve(s) (eg, Morton's neuroma)); and CPT code 64632 (Destruction by neurolytic agent; plantar common digital nerve). The volume and utilization data for these CPT codes are sufficient to support our determination that these procedures are performed predominantly in physicians' offices. Therefore, we are proposing to make permanent the office-based designations for the 3 procedures for CY 2011.

The procedures that we are proposing to permanently designate as office-based for CY 2011 that were temporarily designated as office-based procedures in CY 2010 are displayed in Table 45 below. The procedures that we are proposing to temporarily designate as office-based for CY 2011 are displayed in Table 46 below. The procedures for which the proposed office-based designation for CY 2011 is temporary also are indicated by an asterisk in Addendum AA to this proposed rule.

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TABLE 45.—CY 2010 TEMPORARILY DESIGNATED OFFICE-BASED ASC COVERED SURGICAL PROCEDURES PROPOSED FOR PERMANENT OFFICE-BASED FOR CY 2011

CY 2010 HCPCS Code	CY 2010 Long Descriptor	CY 2010 ASC Payment Indicator	Proposed CY 2011 ASC Payment Indicator**
46930	Destruction of internal hemorrhoid(s) by thermal energy (e.g., infrared coagulation, cautery, radiofrequency)	P3*	P3
64455	Injection(s), anesthetic agent and/or steroid, plantar common digital nerve(s) (e.g., Morton's neuroma)	P3*	P3
64632	Destruction by neurolytic agent; plantar common digital nerve	P3*	P3

* If designation is temporary.

**Proposed payment indicators are based on a comparison of the proposed rates according to the ASC standard ratesetting methodology and the MPFS proposed rates. At the time this proposed rule is being finalized for publication, current law authorizes a negative update to the MPFS payment rates for CY 2011. Therefore, this proposed rule reflects a negative update to the MPFS payment rates for CY 2011. If Congress revises the MPFS update for CY 2011, we will recalculate the ASC payment rates using the revised update factor in the CY 2011 OPPS/ASC final rule with comment period.

TABLE 46.—CY 2010 TEMPORARILY DESIGNATED OFFICE-BASED ASC COVERED SURGICAL PROCEDURES PROPOSED FOR TEMPORARY OFFICE-BASED DESIGNATION IN CY 2011

CY 2010 HCPCS Code	CY 2010 Long Descriptor	CY 2010 ASC Payment Indicator	Proposed CY 2011 ASC Payment Indicator**
0099T	Implantation of intrastromal corneal ring segments	R2*	R2*
0124T	Conjunctival incision with posterior extrascleral placement of pharmacological agent (does not include supply of medication)	R2*	R2*
0226T	Angoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); diagnostic, including collection of specimen(s) by brushing or washing when performed	P2*	R2*
0227T	Angoscopy, high resolution (HRA) (with magnification and chemical agent enhancement); with biopsy(ies)	P2*	R2*
0232T	Injection(s), platelet rich plasma, any tissue, including image guidance, harvesting and preparation when performed	P2*	R2*
67229	Treatment of extensive or progressive retinopathy, one or more sessions; preterm infant (less than 37 weeks gestation at birth), performed from birth up to 1 year of age (eg, retinopathy of prematurity), photocoagulation or cryotherapy	R2*	R2*
C9800	Dermal injection procedure(s) for facial lipodystrophy syndrome (LDS) and provision of Radiesse or Sculptra dermal filler, including all items and supplies	R2*	R2*

* If designation is temporary.

**Proposed payment indicators are based on a comparison of the proposed rates according to the ASC standard ratesetting methodology and the MPFS proposed rates. At the time this proposed rule is being finalized for publication, current law authorizes a negative update to the MPFS payment rates for CY 2011. Therefore, this proposed rule reflects a negative update to the MPFS payment rates for CY 2011. If Congress revises the MPFS update for CY 2011, we will recalculate the ASC payment rates using the revised update factor in the CY 2011 OPPS/ASC final rule with comment period.

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Displayed in Table 47 below are new (or substantially revised) CY 2010 HCPCS codes to which we assigned temporary office-based payment indicators in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60608). As explained in section XV.B.1. of that final rule with comment period (74 FR 60599 and 60607), we reviewed all of the newly created HCPCS codes that became available after the issuance of the CY 2009 OPPS/ASC proposed rule that are used to report surgical procedures in CY 2010 to evaluate their appropriateness for the ASC list of covered surgical procedures. Of the procedures reported by new or substantially revised CY 2010 HCPCS codes that we determined should not be excluded from the ASC list based on our clinical review, including assessment of available utilization and volume data for any closely related procedures and consideration of other available information, we determined that 16 of the procedures would predominantly be performed in physicians' offices. However, because we had no utilization data for the procedures specifically described by these new HCPCS codes, we made the office-based designations temporary rather than permanent and

stated that we would reevaluate the procedures when data become available (74 FR 60607 through 60608). The temporary payment indicators for the 16 office-based procedures displayed in Table 47 were interim designations and were open to public comment during the 60-day comment period following the release of the CY 2010 OPPS/ASC final rule with comment period. We will respond to public comments received during that 60-day comment period as well as the comment period following this proposed rule in the CY 2011 OPPS/ASC final rule with comment period.

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TABLE 47.—PROPOSED CY 2011 PAYMENT INDICATORS FOR NEW CY 2010 HCPCS CODES FOR ASC COVERED SURGICAL PROCEDURES DESIGNATED AS TEMPORARILY OFFICE-BASED ON AN INTERIM BASIS IN THE CY 2010 OPPS/ASC FINAL RULE WITH COMMENT PERIOD

CY 2010 HCPCS Code	CY 2010 Long Descriptor	CY 2010 ASC Payment Indicator	Proposed CY 2011 ASC Payment Indicator**
21015	Radical resection of tumor (eg, malignant neoplasm), soft tissue of face or scalp; less than 2 cm	R2 *	R2**
21555	Excision, tumor, soft tissue of neck or anterior thorax, subcutaneous; less than 3 cm	P3*	P3**
21930	Excision, tumor, soft tissue of back or flank, subcutaneous; less than 3 cm	P3*	P3**
23075	Excision, tumor, soft tissue of shoulder area, subcutaneous; less than 3 cm	P3*	P3**
24075	Excision, tumor, soft tissue of upper arm or elbow area, subcutaneous; less than 3 cm	P3*	P3**
25075	Excision, tumor, soft tissue of forearm and/or wrist area, subcutaneous; less than 3 cm	P3*	P3**
26115	Excision, tumor or vascular malformation, soft tissue of hand or finger, subcutaneous; less than 1.5 cm	P3*	P3**
27047	Excision, tumor, soft tissue of pelvis and hip area, subcutaneous; less than 3 cm	P3*	P3**
27327	Excision, tumor, soft tissue of thigh or knee area, subcutaneous; less than 3 cm	P3*	P3**
27618	Excision, tumor, soft tissue of leg or ankle area, subcutaneous; less than 3 cm	P3*	P3**
28039	Excision, tumor, soft tissue of foot or toe, subcutaneous; 1.5 cm or greater	P3*	P3**
28041	Excision, tumor, soft tissue of foot or toe, subfascial (eg, intramuscular); 1.5 cm or greater	R2*	R2**
28043	Excision, tumor, soft tissue of foot or toe, subcutaneous; less than 1.5 cm	P3*	P3**
28045	Excision, tumor, soft tissue of foot or toe, subfascial (eg, intramuscular); less than 1.5 cm	P3*	P3**
28046	Radical resection of tumor (eg, malignant neoplasm), soft tissue of foot or toe; less than 3 cm	R2*	R2**
37761	Ligation of perforator vein(s), subfascial, open, including ultrasound guidance, when performed, 1 leg	R2*	R2**

* If designation is temporary.

**Proposed payment indicators are based on a comparison of the proposed rates according to the ASC standard rate setting methodology and the MPFS proposed rates. At the time this proposed rule is being finalized for publication, current law authorizes a negative update to the MPFS payment rates for CY 2011. Therefore, this proposed rule reflects a negative update to the MPFS payment rates for CY 2011. If Congress revises the MPFS update for CY 2011, we will recalculate the ASC payment rates using the revised update factor in the CY 2011 OPPS/ASC final rule with comment period.

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c. ASC Covered Surgical Procedures Designated as Device-Intensive

(1) Background

As discussed in the August 2, 2007 final rule (72 FR 42503 through 42508), we adopted a modified payment methodology for calculating the ASC payment rates for covered surgical procedures that are assigned to the subset of OPPS device-dependent APCs with a device offset percentage greater than 50 percent of the APC cost under the OPPS, in order to ensure that payment for the procedure is adequate to provide packaged payment for the high-cost implantable devices used in those procedures. We assigned payment indicators "H8" (Device-intensive procedure on ASC list in CY 2007; paid at adjusted rate) and "J8" (Device-intensive procedure added to ASC list in CY 2008 or later; paid at adjusted rate) to identify the procedures that were eligible for ASC payment calculated according to the modified methodology, depending on whether the procedure was included on the ASC list of covered surgical procedures prior to CY 2008 and, therefore, subject to transitional payment as discussed in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68739 through 68742). The device-intensive procedures for which the modified rate calculation methodology applies in CY 2010 were displayed in Table 68 and in Addendum AA to the CY 2010 OPPS/ASC final rule with comment period (74 FR 60610 through 60611 and 60692 through 60752).

(2) Proposed Changes to List of Covered Surgical Procedures Designated as Device Intensive for CY 2011

We are proposing to update the ASC list of covered surgical procedures that are eligible for payment according to the device-intensive procedure payment methodology for CY 2011, consistent with the proposed OPPS device-dependent APC update, reflecting the proposed APC assignments of procedures, designation of APCs as device dependent, and APC device offset percentages based on the CY 2009 OPPS claims and cost report data available for the proposed rule. The OPPS device-dependent APCs are discussed further in section II.A.2.d.(1) of this proposed rule. The ASC covered surgical procedures that we are proposing to designate as device-intensive and that would be subject to the device-intensive procedure payment methodology for CY 2011 are listed in Table 48 below. The CPT code, the CPT code short descriptor, the proposed CY 2011 ASC payment indicator, the proposed CY 2011 OPPS APC assignment and title, and the proposed CY 2011 OPPS APC device offset percentage are also listed in Table 48 below. Each proposed device-intensive procedure is assigned payment indicator "H8" or "J8" depending on whether it was subject to transitional payment prior to CY 2011, and all of these procedures are included in Addendum AA to this proposed rule.

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TABLE 48.--ASC COVERED SURGICAL PROCEDURES PROPOSED FOR DEVICE-INTENSIVE DESIGNATION FOR CY 2011

CY 2010 CPT Code	CY 2010 Short Descriptor	Proposed CY 2011 ASC Payment Indicator	Proposed CY 2011 OPPS APC	OPPS APC Title	Proposed CY 2011 Device-Dependent APC Offset Percentage
24361	Reconstruct elbow joint	H8	0425	Level II Arthroplasty or Implantation with Prosthesis	59%
24363	Replace elbow joint	H8	0425	Level II Arthroplasty or Implantation with Prosthesis	59%
24366	Reconstruct head of radius	H8	0425	Level II Arthroplasty or Implantation with Prosthesis	59%
25441	Reconstruct wrist joint	H8	0425	Level II Arthroplasty or Implantation with Prosthesis	59%
25442	Reconstruct wrist joint	H8	0425	Level II Arthroplasty or Implantation with Prosthesis	59%
25446	Wrist replacement	H8	0425	Level II Arthroplasty or Implantation with Prosthesis	59%
27446	Revision of knee joint	J8	0425	Level II Arthroplasty or Implantation with Prosthesis	59%
33206	Insertion of heart pacemaker	J8	0089	Insertion/Replacement of Permanent Pacemaker and Electrodes	70%
33207	Insertion of heart pacemaker	J8	0089	Insertion/Replacement of Permanent Pacemaker and Electrodes	70%
33208	Insertion of heart pacemaker	J8	0655	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker	73%
33212	Insertion of pulse generator	H8	0090	Insertion/Replacement of Pacemaker Pulse Generator	72%
33213	Insertion of pulse generator	H8	0654	Insertion/Replacement of a permanent dual chamber pacemaker	73%
33214	Upgrade of pacemaker system	J8	0655	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker	73%
33224	Insert pacing lead & connect	J8	0418	Insertion of Left Ventricular Pacing Elect.	72%
33225	Lventric pacing lead add-on	J8	0418	Insertion of Left Ventricular Pacing Elect.	72%
33240	Insert pulse generator	J8	0107	Insertion of Cardioverter-Defibrillator	88%
33249	Eltrd/insert pace-defib	J8	0108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads	87%

CY 2010 CPT Code	CY 2010 Short Descriptor	Proposed CY 2011 ASC Payment Indicator	Proposed CY 2011 OPPS APC	OPPS APC Title	Proposed CY 2011 Device-Dependent APC Offset Percentage
33282	Implant pat-active ht record	J8	0680	Insertion of Patient Activated Event Recorders	71%
53440	Male sling procedure	H8	0385	Level I Prosthetic Urological Procedures	61%
53444	Insert tandem cuff	H8	0385	Level I Prosthetic Urological Procedures	61%
53445	Insert uro/ves nck sphincter	H8	0386	Level II Prosthetic Urological Procedures	71%
53447	Remove/replace ur sphincter	H8	0386	Level II Prosthetic Urological Procedures	71%
54400	Insert semi-rigid prosthesis	H8	0385	Level I Prosthetic Urological Procedures	61%
54401	Insert self-contd prosthesis	H8	0386	Level II Prosthetic Urological Procedures	71%
54405	Insert multi-comp penis pros	H8	0386	Level II Prosthetic Urological Procedures	71%
54410	Remove/replace penis prosth	H8	0386	Level II Prosthetic Urological Procedures	71%
54416	Remv/repl penis contain pros	H8	0386	Level II Prosthetic Urological Procedures	71%
55873	Cryoablate prostate	H8	0674	Prostate Cryoablation	58%
61885	Insrt/redo neurostim 1 array	H8	0039	Level I Implantation of Neurostimulator Generator	85%
61886	Implant neurostim arrays	H8	0315	Level II Implantation of Neurostimulator Generator	88%
62361	Implant spine infusion pump	H8	0227	Implantation of Drug Infusion Device	81%
62362	Implant spine infusion pump	H8	0227	Implantation of Drug Infusion Device	81%
63650	Implant neuroelectrodes	H8	0040	Percutaneous Implantation of Neurostimulator Electrodes	56%
63655	Implant neuroelectrodes	J8	0061	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electr	63%
63685	Insrt/redo spine n generator	H8	0039	Level I Implantation of Neurostimulator Generator	85%
64553	Implant neuroelectrodes	H8	0040	Percutaneous Implantation of Neurostimulator Electrodes	56%
64555	Implant neuroelectrodes	J8	0040	Percutaneous Implantation of Neurostimulator Electrodes	56%

CY 2010 CPT Code	CY 2010 Short Descriptor	Proposed CY 2011 ASC Payment Indicator	Proposed CY 2011 OPPS APC	OPPS APC Title	Proposed CY 2011 Device-Dependent APC Offset Percentage
64560	Implant neuroelectrodes	J8	0040	Percutaneous Implantation of Neurostimulator Electrodes	56%
64561	Implant neuroelectrodes	H8	0040	Percutaneous Implantation of Neurostimulator Electrodes	56%
64565	Implant neuroelectrodes	J8	0040	Percutaneous Implantation of Neurostimulator Electrodes	56%
64573	Implant neuroelectrodes	H8	0225	Implantation of Neurostimulator Electrodes, Cranial Nerve	78%
64575	Implant neuroelectrodes	H8	0061	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electr	63%
64577	Implant neuroelectrodes	H8	0061	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electr	63%
64580	Implant neuroelectrodes	H8	0061	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electr	63%
64581	Implant neuroelectrodes	H8	0061	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electr	63%
64590	Insrt/redo pn/gastr stimul	H8	0039	Level I Implantation of Neurostimulator Generator	85%
65770	Revise cornea with implant	H8	0293	Level VI Anterior Segment Eye Procedures	59%
69714	Implant temple bone w/stimul	H8	0425	Level II Arthroplasty or Implantation with Prosthesis	59%
69715	Temple bne implnt w/stimulat	H8	0425	Level II Arthroplasty or Implantation with Prosthesis	59%
69717	Temple bone implant revision	H8	0425	Level II Arthroplasty or Implantation with Prosthesis	59%
69718	Revise temple bone implant	H8	0425	Level II Arthroplasty or Implantation with Prosthesis	59%
69930	Implant cochlear device	H8	0259	Level VII ENT Procedures	86%

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d. ASC Treatment of Surgical Procedures Proposed for Removal From the OPPS Inpatient List for CY 2011

As we discussed in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68724), we adopted a policy to include in our annual evaluation procedures proposed for removal from the OPPS inpatient list for possible inclusion on the ASC list of covered surgical procedures. We evaluated each of the three procedures we are proposing to remove from the OPPS inpatient list for CY 2011 according to the criteria for exclusion from the list of covered ASC surgical procedures. We believe that all of these procedures should continue to be excluded from the ASC list of covered surgical procedures for CY 2011 because they would be expected to pose a significant risk to beneficiary safety or to require an overnight stay in ASCs. A full discussion about the APC Panel's recommendations regarding the procedures we are proposing to remove from the OPPS inpatient list for CY 2011 and the procedures we are proposing to remove from the OPPS inpatient list for CY 2011 may be found in section XI.B. of this proposed rule. The HCPCS codes for these three procedures and their long descriptors are listed in Table 49 below.

TABLE 49.—PROCEDURES PROPOSED FOR EXCLUSION FROM THE ASC LIST OF COVERED PROCEDURES FOR CY 2011 THAT ARE PROPOSED FOR REMOVAL FROM THE CY 2011 OPPS INPATIENT LIST

CY 2010 HCPCS Code	CY 2010 Long Descriptor
21193	Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft
21395	Open treatment of orbital floor blowout fracture; periorbital approach with bone graft (includes obtaining graft)
25909	Amputation, forearm, through radius and ulna; re-amputation

2. Covered Ancillary Services

Consistent with the established ASC payment system policy, we are proposing to update the ASC list of covered ancillary services to reflect the proposed payment status for the services under the CY 2011 OPPS. Maintaining consistency with the OPPS may result in proposed changes to ASC payment indicators for some covered ancillary items and services because of changes that are being proposed under the OPPS for CY 2011. For example, a covered ancillary service that was separately paid under the revised ASC payment system in CY 2010 may be proposed for packaged status under the CY 2011 OPPS and, therefore, also under the ASC payment system for CY 2011. Comment indicator "CH," discussed in section XV.F. of this proposed rule, is used in Addendum BB to this proposed rule to indicate covered ancillary services for which we are proposing a change in the ASC payment indicator to reflect a proposed change in the OPPS treatment of the service for CY 2011.

Except for the Level II HCPCS codes listed in Table 41 of this proposed rule, all ASC covered ancillary services and their proposed payment indicators for CY 2011 are included in Addendum BB to this proposed rule.

D. Proposed ASC Payment for Covered Surgical Procedures and Covered Ancillary Services

1. Proposed Payment for Covered Surgical Procedures

a. Background

Our ASC payment policies for covered surgical procedures under the revised ASC payment system are fully described in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66828 through 66831). Under our established policy for the revised ASC payment system, the ASC standard ratesetting methodology of multiplying the ASC relative payment weight for the procedure by the ASC conversion factor for that same year is used to calculate the national unadjusted payment rates for procedures with payment indicator "G2." For procedures assigned payment indicator "A2," our final policy established blended rates to be used during the transitional period and, beginning in CY 2011, ASC rates calculated according to the ASC standard ratesetting methodology. The rate calculation established for device intensive procedures (payment indicators "H8" and "J8") is structured so that the packaged device payment amount is the same as under the OPPS, and only the service portion of the rate is subject to the ASC standard ratesetting methodology. In the CY 2010 OPPS/ASC final rule with comment period (74 FR 60596 through 60629), we updated the CY 2009 ASC payment rates for ASC covered surgical procedures with payment indicators of "A2," "G2," "H8," and "J8" using CY 2008 data, consistent with the CY 2010 OPPS update. Payment rates for device-intensive procedures also were updated to incorporate the CY 2010 OPPS device offset percentages.

Payment rates for office-based procedures (payment indicators "P2," "P3," and "R2") are the lower of the MPFS non-facility PE RVU amount (we refer readers to the CY 2011 MPFS proposed rule) or the amount calculated using the ASC standard ratesetting methodology for the procedure. In the CY 2010 OPPS/ASC final rule with comment period (74 FR 60596 through 60629), we updated the payment amounts for office-based procedures (payment indicators "P2," "P3," and "R2") using the most recent available MPFS and OPPS data. We compared the estimated CY 2010 rate for each of the office-based procedures, calculated according to the ASC standard ratesetting methodology, to the MPFS nonfacility PE RVU amount (multiplied by the conversion factor) to determine which was lower and, therefore, would be the CY 2010 payment rate for the procedure according to the final policy of the revised ASC payment system (§ 416.171(d)).

b. Proposed Update to ASC-Covered Surgical Procedure Payment Rates for CY 2011

We are proposing to update ASC payment rates for CY 2011 using the established rate calculation methodologies under § 416.171. Under § 416.171(c)(4), the transitional payment rates are no longer used for CY 2011 and subsequent calendar years for a covered surgical procedure designated in accordance with § 416.166. Thus, we are proposing to calculate CY 2011 payments for procedures formerly subject to the transitional payment methodology (payment indicators "A2" and "H8") using the proposed CY 2011 ASC rate calculated according to the ASC standard ratesetting methodology, incorporating the device-intensive procedure methodology, as appropriate, for procedures assigned ASC payment indicator "H8." We are not proposing to modify the payment indicators for procedures that were subject to transitional payment prior to CY 2011 but will consider doing so in future rulemaking. We are proposing to continue to use the amount calculated under the ASC standard ratesetting methodology for procedures assigned payment indicator "G2."

We are proposing that payment rates for office-based procedures (payment indicators "P2," "P3," and "R2") and device-intensive procedures that were not subject to transitional payment (payment indicator "J8") be calculated according to our established policies, incorporating the device-intensive procedure methodology as appropriate. Thus, we are proposing to update the payment amounts for device-intensive procedures based on the CY 2011 OPPS proposal that reflects updated OPPS device offset percentages, and to make payment for office-based procedures at

the lesser of the CY 2011 proposed MPFS non-facility PE RVU amount or the proposed CY 2011 ASC payment amount calculated according to the standard ratesetting methodology.

c. Proposed Adjustment to ASC Payments for No Cost/Full Credit and Partial Credit Devices

Our ASC policy with regard to payment for costly devices implanted in ASCs at no cost or with full or partial credit as set forth in § 416.179 is consistent with the OPPS policy. The proposed CY 2011 OPPS APCs and devices subject to the adjustment policy are discussed in section IV.B.2. of this proposed rule. The established ASC policy includes adoption of the OPPS policy for reduced payment to providers when a specified device is furnished without cost or with full or partial credit for the cost of the device for those ASC covered surgical procedures that are assigned to APCs under the OPPS to which this policy applies. We refer readers to the CY 2009 OPPS/ASC final rule with comment period for a full discussion of the ASC payment adjustment policy for no cost/full credit and partial credit devices (73 FR 68742 through 68745).

Consistent with the OPPS, we are proposing to update the list of ASC covered device intensive procedures and devices that would be subject to the no cost/full credit and partial credit device adjustment policy for CY 2011. Table 50 below displays the ASC covered device-intensive procedures that we are proposing would be subject to the no cost/full credit and partial credit device adjustment policy for CY 2011. Specifically, when a procedure that is listed in Table 50 is performed to implant a device that is listed in Table 51 below, where that device is furnished at no cost or with full credit from the manufacturer, the ASC would append the HCPCS "FB" modifier on the line with the procedure to implant the device. The contractor would reduce payment to the ASC by the device offset amount that we estimate represents the cost of the device when the necessary device is furnished without cost to the ASC or with full credit. We would provide the same amount of payment reduction based on the device offset amount in ASCs that would apply under the OPPS under the same circumstances. We continue to believe that the reduction of ASC payment in these circumstances is necessary to pay appropriately for the covered surgical procedure being furnished by the ASC.

We also are proposing to reduce the payment for implantation procedures listed in Table 50 by one-half of the device offset amount that would be applied if a device was provided at no cost or with full credit, if the credit to the ASC is 50 percent or more of the cost of the new device. The ASC would append the HCPCS "FC" modifier to the HCPCS code for a surgical procedure listed in Table 50 when the facility receives a partial credit of 50 percent or more of the cost of a device listed in Table 51 below. In order to report that they received a partial credit of 50 percent or more of the cost of a new device, ASCs would have the option of either: (1) Submitting the claim for the device replacement procedure to their Medicare contractor after the procedure's performance but prior to manufacturer acknowledgment of credit for the device, and subsequently contacting the contractor regarding a claim adjustment once the credit determination is made; or (2) holding the claim for the device implantation procedure until a determination is made by the manufacturer on the partial credit and submitting the claim with the "FC" modifier appended to the implantation procedure HCPCS code if the partial credit is 50 percent or more of the cost of the replacement device. Beneficiary coinsurance would continue to be based on the reduced payment amount.

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TABLE 50.—PROPOSED CY 2011 PROCEDURES TO WHICH THE NO COST/FULL CREDIT AND PARTIAL CREDIT DEVICE ADJUSTMENT POLICY WOULD APPLY

CY 2010 CPT Code	CY 2010 Short Descriptor	Proposed CY 2011 ASC Payment Indicator	Proposed CY 2011 OPPS APC	OPPS APC Title	Proposed CY 2011 OPPS Full APC Offset Percentage	Proposed CY 2011 OPPS Partial APC Offset Percentage
24361	Reconstruct elbow joint	H8	0425	Level II Arthroplasty or Implantation with Prosthesis	59%	29%
24363	Replace elbow joint	H8	0425	Level II Arthroplasty or Implantation with Prosthesis	59%	29%
24366	Reconstruct head of radius	H8	0425	Level II Arthroplasty or Implantation with Prosthesis	59%	29%
25441	Reconstruct wrist joint	H8	0425	Level II Arthroplasty or Implantation with Prosthesis	59%	29%
25442	Reconstruct wrist joint	H8	0425	Level II Arthroplasty or Implantation with Prosthesis	59%	29%
25446	Wrist replacement	H8	0425	Level II Arthroplasty or Implantation with Prosthesis	59%	29%
27446	Revision of knee joint	J8	0425	Level II Arthroplasty or Implantation with Prosthesis	59%	29%
33206	Insertion of heart pacemaker	J8	0089	Insertion/Replacement of Permanent Pacemaker and Electrodes	70%	35%
33207	Insertion of heart pacemaker	J8	0089	Insertion/Replacement of Permanent Pacemaker and Electrodes	70%	35%
33208	Insertion of heart pacemaker	J8	0655	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker	73%	37%
33212	Insertion of pulse generator	H8	0090	Insertion/Replacement of Pacemaker Pulse Generator	72%	36%
33213	Insertion of pulse generator	H8	0654	Insertion/Replacement of a permanent dual chamber pacemaker	73%	37%
33214	Upgrade of pacemaker system	J8	0655	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker	73%	37%
33224	Insert pacing lead & connect	J8	0418	Insertion of Left Ventricular Pacing Elect.	72%	36%
33225	Lventric pacing lead add-on	J8	0418	Insertion of Left Ventricular Pacing Elect.	72%	36%
33240	Insert pulse generator	J8	0107	Insertion of Cardioverter-Defibrillator	88%	44%
33249	Eltrd/insert pace-defib	J8	0108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads	87%	44%

CY 2010 CPT Code	CY 2010 Short Descriptor	Proposed CY 2011 ASC Payment Indicator	Proposed CY 2011 OPPS APC	OPPS APC Title	Proposed CY 2011 OPPS Full APC Offset Percentage	Proposed CY 2011 OPPS Partial APC Offset Percentage
33282	Implant pat-active ht record	J8	0680	Insertion of Patient Activated Event Recorders	71%	35%
53440	Male sling procedure	H8	0385	Level I Prosthetic Urological Procedures	61%	30%
53444	Insert tandem cuff	H8	0385	Level I Prosthetic Urological Procedures	61%	30%
53445	Insert uro/ves nck sphincter	H8	0386	Level II Prosthetic Urological Procedures	71%	36%
53447	Remove/replace ur sphincter	H8	0386	Level II Prosthetic Urological Procedures	71%	36%
54400	Insert semi-rigid prosthesis	H8	0385	Level I Prosthetic Urological Procedures	61%	30%
54401	Insert self-contd prosthesis	H8	0386	Level II Prosthetic Urological Procedures	71%	36%
54405	Insert multi-comp penis pros	H8	0386	Level II Prosthetic Urological Procedures	71%	36%
54410	Remove/replace penis prosth	H8	0386	Level II Prosthetic Urological Procedures	71%	36%
54416	Remv/repl penis contain pros	H8	0386	Level II Prosthetic Urological Procedures	71%	36%
61885	Insrt/redo neurostim 1 array	H8	0039	Level I Implantation of Neurostimulator Generator	85%	43%
61886	Implant neurostim arrays	H8	0315	Level II Implantation of Neurostimulator Generator	88%	44%
62361	Implant spine infusion pump	H8	0227	Implantation of Drug Infusion Device	81%	41%
62362	Implant spine infusion pump	H8	0227	Implantation of Drug Infusion Device	81%	41%
63650	Implant neuroelectrodes	H8	0040	Percutaneous Implantation of Neurostimulator Electrodes	56%	28%
63655	Implant neuroelectrodes	J8	0061	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electr	63%	31%
63685	Insrt/redo spine n generator	H8	0039	Level I Implantation of Neurostimulator Generator	85%	43%
64553	Implant neuroelectrodes	H8	0040	Percutaneous Implantation of Neurostimulator Electrodes	56%	28%
64555	Implant neuroelectrodes	J8	0040	Percutaneous Implantation of Neurostimulator Electrodes	56%	28%

CY 2010 CPT Code	CY 2010 Short Descriptor	Proposed CY 2011 ASC Payment Indicator	Proposed CY 2011 OPPS APC	OPPS APC Title	Proposed CY 2011 OPPS Full APC Offset Percentage	Proposed CY 2011 OPPS Partial APC Offset Percentage
64560	Implant neuroelectrodes	J8	0040	Percutaneous Implantation of Neurostimulator Electrodes	56%	28%
64561	Implant neuroelectrodes	H8	0040	Percutaneous Implantation of Neurostimulator Electrodes	56%	28%
64565	Implant neuroelectrodes	J8	0040	Percutaneous Implantation of Neurostimulator Electrodes	56%	28%
64573	Implant neuroelectrodes	H8	0225	Implantation of Neurostimulator Electrodes, Cranial Nerve	78%	39%
64575	Implant neuroelectrodes	H8	0061	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electr	63%	31%
64577	Implant neuroelectrodes	H8	0061	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electr	63%	31%
64580	Implant neuroelectrodes	H8	0061	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electr	63%	31%
64581	Implant neuroelectrodes	H8	0061	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electr	63%	31%
64590	Insrt/redo pn/gastr stimul	H8	0039	Level I Implantation of Neurostimulator Generator	85%	43%
69714	Implant temple bone w/stimul	H8	0425	Level II Arthroplasty or Implantation with Prosthesis	59%	29%
69715	Temple bne implnt w/stimulat	H8	0425	Level II Arthroplasty or Implantation with Prosthesis	59%	29%
69717	Temple bone implant revision	H8	0425	Level II Arthroplasty or Implantation with Prosthesis	59%	29%
69718	Revise temple bone implant	H8	0425	Level II Arthroplasty or Implantation with Prosthesis	59%	29%
69930	Implant cochlear device	H8	0259	Level VII ENT Procedures	86%	43%

TABLE 51.— PROPOSED DEVICES FOR WHICH THE "FB" OR "FC" MODIFIER MUST BE REPORTED WITH THE PROCEDURE CODE IN CY 2011 WHEN FURNISHED AT NO COST OR WITH FULL OR PARTIAL CREDIT

CY 2010 Device HCPCS Code	CY 2010 Short Descriptor
C1721	AICD, dual chamber
C1722	AICD, single chamber
C1764	Event recorder, cardiac
C1767	Generator, neurostim, imp
C1771	Rep dev, urinary, w/sling
C1772	Infusion pump, programmable
C1776	Joint device (implantable)
C1778	Lead, neurostimulator
C1779	Lead, pmkr, transvenous VDD
C1785	Pmkr, dual, rate-resp
C1786	Pmkr, single, rate-resp
C1813	Prosthesis, penile, inflatab
C1815	Pros, urinary sph, imp
C1820	Generator, neuro rechg bat sys
C1881	Dialysis access system
C1882	AICD, other than sing/dual
C1891	Infusion pump, non-prog, perm
C1897	Lead, neurostim, test kit
C1898	Lead, pmkr, other than trans
C1900	Lead coronary venous
C2619	Pmkr, dual, non rate-resp
C2620	Pmkr, single, non rate-resp
C2621	Pmkr, other than sing/dual
C2622	Prosthesis, penile, non-inf
C2626	Infusion pump, non-prog, temp
C2631	Rep dev, urinary, w/o sling
L8614	Cochlear device/system
L8680	Implt neurostim elctr each
L8685	Implt nrostm pls gen sng rec
L8686	Implt nrostm pls gen sng non
L8687	Implt nrostm pls gen dua rec
L8688	Implt nrostm pls gen dua non
L8690	Aud osseo dev, int/ext comp

d. Proposed Waiver of Coinsurance and Deductible for Certain Preventive Services

As discussed in detail in section XII.B. of this proposed rule and in the CY 2011 MPFS proposed rule, sections 4104(b) and 10406 of the Affordable Care Act amended section 1833(a)(1) of the Act, in pertinent part, to waive the coinsurance for those preventive services described in section 1861(ww)(2) of the Act (excluding electrocardiograms) that are recommended by the USPSTF with a grade of A or B for any indication or population and that are appropriate for the individual. Section 4104(c) of the Affordable Care Act amended section 1833(b)(1) of the Act to waive the Part B deductible for these preventive services. These provisions apply to these items and services furnished in ASCs on or after January 1, 2011. In section XII.B. of this proposed rule and in the CY 2011 MPFS proposed rule, we are proposing to define the preventive services to which this provision applies and to apply the criteria specified in section 4104 of the Affordable Care Act for the waiver of coinsurance and deductible.

Table 52 identifies the ASC covered surgical and ancillary services that are included in the proposed definition of preventive services in section XII.B. of this proposed rule and in the CY 2011 MPFS proposed rule. All of the ASC covered surgical and ancillary services that are included in the chart below are preventive services that are recommended by the USPSTF with a grade of A or B. Therefore, we are

proposing to update § 416.160(a)(4) and add new § 416.160(a)(5) on the scope and basis of the ASC regulations and to update § 410.152(l) in this proposed rule to reflect the waiver of coinsurance and deductible for these services. We refer readers to the CY 2011 MPFS proposed rule for a discussion of the proposed changes to § 410.160(b) and proposed additional changes to § 410.152 of our regulations to implement the provisions related to the definition of preventive services and the waiver of the coinsurance and deductible for preventive services as specified by sections 4103, 4104, and 10406 of the Affordable Care Act.

TABLE 52.--PROPOSED CY 2011 ASC PREVENTIVE SERVICES FOR WHICH COINSURANCE AND DEDUCTIBLE WOULD BE WAIVED IN CY 2011

Service	CY 2010 CPT/ HCPCS Code	CY 2010 Long Descriptor	CY 2011 Coins. / Deductible	Proposed CY 2011 ASC Payment Indicator
Bone Mass Measurement	G0130	Single energy x-ray absorptiometry (sexa) bone density study, one or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)	Waived	Z3
	77078	Computed tomography, bone mineral density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)	Waived	Z2
	77079	Computed tomography, bone mineral density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)	Waived	Z3
	77080	Dual-energy x-ray absorptiometry (dxa), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)	Waived	Z2
	77081	Dual-energy x-ray absorptiometry (dxa), bone density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)	Waived	Z3
	77083	Radiographic absorptiometry (eg, photodensitometry, radiogrammetry), 1 or more sites	Waived	Z3
	76977	Ultrasound bone density measurement and interpretation, peripheral site(s), any method	Waived	Z3

Service	CY 2010 CPT/ HCPCS Code	CY 2010 Long Descriptor	CY 2011 Coins. / Deductible	Proposed CY 2011 ASC Payment Indicator
Colorectal Cancer Screening	G0104	Colorectal cancer screening; flexible sigmoidoscopy	Waived	P3
	G0105	Colorectal cancer screening; colonoscopy on individual at high risk	Waived	A2
	G0121	Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk	Waived	A2
Influenza Virus Vaccine	90655	Influenza virus vaccine, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use	Waived	L1
	90656	Influenza virus vaccine, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use	Waived	L1
	90657	Influenza virus vaccine, split virus, when administered to children 6-35 months of age, for intramuscular use	Waived	L1
	90658	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use	Waived	L1
	90660	Influenza virus vaccine, live, for intranasal use	Waived	L1
	90662	Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use	Waived	L1
	G9141	Influenza a (h1n1) immunization administration (includes the physician counseling the patient/family)	Waived	L1

Service	CY 2010 CPT/ HCPCS Code	CY 2010 Long Descriptor	CY 2011 Coins. / Deductible	Proposed CY 2011 ASC Payment Indicator
	G9142	Influenza a (h1n1) vaccine, any route of administration	Waived	L1
Pneumococcal Vaccine	90669	Pneumococcal conjugate vaccine, polyvalent, when administered to children younger than 5 years, for intramuscular use	Waived	L1
	90670	Pneumococcal conjugate vaccine, 13 valent, for intramuscular use	Waived	L1
	90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use	Waived	L1
Hepatitis B Vaccine	90740	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use	Waived	F4
	90743	Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use	Waived	F4
	90744	Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use	Waived	F4
	90746	Hepatitis B vaccine, adult dosage, for intramuscular use	Waived	F4
	90747	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use	Waived	F4

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Section 4104(c) of the Affordable Care Act amended section 1833(b) of the Act to waive the Part B deductible for colorectal cancer screening tests that become diagnostic. Specifically, section 4104(c)(2) of the Affordable Care Act waives the deductible with respect to a colorectal cancer screening test "regardless of the code that is billed for the establishment of a diagnosis as a result of the test, or for the removal of tissue or other matter or other procedure that is furnished in connection with, as a result of, and in the same clinical encounter as a screening test." As discussed in section XII.B. of this proposed rule and in the CY 2011 MPFS proposed rule, we are proposing that all surgical services furnished on the same date as a planned screening colonoscopy or planned flexible sigmoidoscopy would be considered as being "furnished in connection with, as a result of, and in the same clinical encounter as the screening test." We believe that this interpretation is appropriate because we believe that it would be very rare for an unrelated surgery to occur on the same date as one of these scheduled screening tests. Moreover, we believe that the risk of improper expenditures would be very small under this policy because it is the deductible, and not the coinsurance, that is waived for the related procedures other than the screening tests. In the event of a legislative change to this policy (for example, a statutory change that would waive the coinsurance for these related services in addition to the deductible), we would reassess the appropriateness of this proposed definition of services that are furnished in connection with, as a result of, and in the same clinical encounter as the colorectal cancer screening test that becomes diagnostic. We also note that the annual deductible would likely be met when any surgical procedure (related or not) is performed on the same day as the scheduled screening test.

We are proposing to implement this provision by creating a HCPCS modifier that ASCs would append to the diagnostic procedure code that is reported instead of the screening colonoscopy or screening flexible sigmoidoscopy HCPCS code. The claims

processing system would respond to the modifier by waiving the deductible for all surgical services on the same date as the diagnostic test. Coinsurance or copayment would continue to apply to the diagnostic test and to other services furnished in connection with, as a result of, and in the same clinical encounter as the screening test.

2. Proposed Payment for Covered Ancillary Services

a. Background

Our final payment policies under the revised ASC payment system for covered ancillary services vary according to the particular type of service and its payment policy under the OPPS. Our overall policy provides separate ASC payment for certain ancillary items and services integrally related to the provision of ASC covered surgical procedures that are paid separately under the OPPS and provides packaged ASC payment for other ancillary items and services that are packaged under the OPPS. Thus, we established a final policy to align ASC payment bundles with those under the OPPS (72 FR 42495).

Our ASC payment policies provide separate payment for drugs and biologicals that are separately paid under the OPPS at the OPPS rates, while we pay for separately payable radiology services at the lower of the MPFS non-facility PE RVU (or technical component) amount or the rate calculated according to the ASC standard ratesetting methodology (72 FR 42497). In all cases, ancillary items and services must be provided integral to the performance of ASC covered surgical procedures for which the ASC bills Medicare, in order for those ancillary services also to be paid.

ASC payment policy for brachytherapy sources generally mirrors the payment policy under the OPPS. We finalized our policy in the CY 2008 OPPS/ASC final rule with comment period (72 FR 42499) to pay for brachytherapy sources applied in ASCs at the same prospective rates that were adopted under the OPPS or, if OPPS rates were unavailable, at contractor-priced rates. Subsequent to publication of that rule, section 106 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Pub. L. 110–173) mandated that, for the period January 1, 2008 through June 30, 2008, brachytherapy sources be paid under the OPPS at charges adjusted to cost. Therefore, consistent with our final overall ASC payment policy, we paid ASCs at contractor-priced rates for brachytherapy sources provided in ASCs during that period of time. Beginning July 1, 2008, brachytherapy sources applied in ASCs were to be paid at the same prospectively set rates that were finalized in the CY 2008 OPPS/ASC final rule with comment period (72 FR 67165 through 67188). Immediately prior to the publication of the CY 2009 OPPS/ASC proposed rule, section 142 of the Medicare Improvements for Patients and Providers Act of 2008 (Pub. L. 110–275) amended section 1833(t)(16)(C) of the Act (as amended by section 106 of the Medicare, Medicaid, and SCHIP Extension Act of 2007, Pub. L. 110–173) to extend the requirement that brachytherapy sources be paid under the OPPS at charges adjusted to cost through December 31, 2009. Therefore, consistent with final ASC payment policy, ASCs continued to be paid at contractor-priced rates for brachytherapy sources provided integral to ASC covered surgical procedures during that period of time.

Other separately paid covered ancillary services in ASCs, specifically corneal tissue acquisition and device categories with OPPS pass-through status, do not have prospectively established ASC payment rates according to the final policies of the revised ASC payment system (72 FR 42502 and 42509; § 416.164(b)). Under the revised ASC payment system, corneal tissue acquisition is paid based on the invoiced costs for acquiring the corneal tissue for transplantation. As discussed in section IV.A.1. of this proposed rule, new pass-through device categories may be established on a quarterly basis, but currently there are no OPPS device pass-through categories that would continue for OPPS pass-through payment (and, correspondingly, separate ASC payment) in CY 2011.

b. Proposed Payment for Covered Ancillary Services for CY 2011

For CY 2011, we are proposing to update the ASC payment rates and make changes to ASC payment indicators as necessary to maintain consistency between the OPPS and ASC payment system regarding the packaged or separately payable status of services and the proposed CY 2011 OPPS and ASC payment rates. The proposed CY 2011 OPPS payment methodologies for separately payable drugs and biologicals and brachytherapy sources are discussed in sections V. and VII. of this proposed rule, respectively, and we are proposing to set the CY 2011 ASC payment rates for those services equal to the proposed CY 2011 OPPS rates.

Consistent with established ASC payment policy (72 FR 42497), the proposed CY 2011 payment for separately payable covered radiology services is based on a comparison of the CY 2011 proposed MPFS non-facility PE RVU amounts (we refer readers to the CY 2011 MPFS proposed rule) and the proposed CY 2011 ASC payment rates calculated according to the ASC standard ratesetting methodology and then set at the lower of the two amounts. Alternatively, payment for a radiology service may be packaged into the payment for the ASC covered surgical procedure if the radiology service is packaged under the OPPS. The payment indicators in Addendum BB indicate whether the proposed payment rates for radiology services are based on the MPFS nonfacility PE RVU amount or the ASC standard rate setting methodology, or whether payment for a radiology service is packaged into the payment for the covered surgical procedure (payment indicator "N1"). Radiology services that we are proposing to pay based on the ASC standard ratesetting methodology are assigned payment indicator "Z2" (Radiology service paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS relative payment weight) and those for which the proposed payment is based on the MPFS non-facility PE RVU amount are assigned payment indicator "Z3" (Radiology service paid separately when provided integral to a surgical procedure on ASC list; payment based on MPFS non-facility PE RVUs).

All covered ancillary services and their proposed payment indicators are listed in Addendum BB to this proposed rule.

E. New Technology Intraocular Lenses (NTIOLs)

1. Background

In the CY 2007 OPPS/ASC final rule with comment period (71 FR 68176), we finalized our current process for reviewing applications to establish new active classes of new technology intraocular lenses (NTIOLs) and for recognizing new candidate intraocular lenses (IOLs) inserted during or subsequent to cataract extraction as belonging to a NTIOL class that is qualified for a payment adjustment. Specifically, we established the following process:

- We announce annually in the **Federal Register** a document that proposes the update of ASC payment rates for the following calendar year, a list of all requests to establish new NTIOL classes accepted for review during the calendar year in which the proposal is published and the deadline for submission of public comments

regarding those requests. In accordance with section 141(b)(3) of Public Law 103–432 and our regulations at § 416.185(b), the deadline for receipt of public comments is 30 days following publication of the list of requests.

- In the **Federal Register** document that finalizes the update of ASC payment rates for the following calendar year, we—
  - ° Provide a list of determinations made as a result of our review of all new class requests and public comments; and
  - ° Announce the deadline for submitting requests for review of an application for a new NTIOL class for the following calendar year.

In determining whether a lens belongs to a new class of NTIOLs and whether the ASC payment amount for insertion of that lens in conjunction with cataract surgery is appropriate, we expect that the insertion of the candidate IOL would result in significantly improved clinical outcomes compared to currently available IOLs. In addition, to establish a new NTIOL class, the candidate lens must be distinguishable from lenses already approved as members of active or expired classes of NTIOLs that share a predominant characteristic associated with improved clinical outcomes that was identified for each class. Furthermore, in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68227), we finalized our proposal to base our determinations on consideration of the following factors set out at § 416.195:

- The IOL must have been approved by the FDA and claims of specific clinical benefits and/or lens characteristics with established clinical relevance in comparison with currently available IOLs must have been approved by the FDA for use in labeling and advertising;
- The IOL is not described by an active or expired NTIOL class; that is, it does not share the predominant, class-defining characteristic associated with improved clinical outcomes with designated members of an active or expired NTIOL class; and
- Evidence demonstrates that use of the IOL results in measurable, clinically meaningful, improved outcomes in comparison with use of currently available IOLs. According to the statute, and consistent with previous examples provided by CMS, superior outcomes that we consider include the following:
  - ○ Reduced risk of intraoperative or postoperative complication or trauma;
  - ○ Accelerated postoperative recovery;
  - ○ Reduced induced astigmatism;
  - ○ Improved postoperative visual acuity;
  - ○ More stable postoperative vision; and/or
  - ○ Other comparable clinical advantages, such as—
  - ○ Reduced dependence on other eyewear (for example, spectacles, contact lenses, and reading glasses);
  - ○ Decreased rate of subsequent diagnostic or therapeutic interventions, such as the need for YAG laser treatment;
  - ○ Decreased incidence of subsequent IOL exchange; and
  - ○ Decreased blurred vision, glare, other quantifiable symptom or vision deficiency.

For a request to be considered complete, we require submission of the information that is found in the guidance document entitled "Application Process and Information Requirements for Requests for a New Class of New Technology Intraocular Lens (NTIOL)" posted on the CMS Web site at: *http://www.cms.gov/ASCPayment/08_NTIOLs.asp#TopOfPage.*

As we stated in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68180), there are three possible outcomes from our review of a request for establishment of a new NTIOL class. As appropriate, for each completed request for consideration of a candidate IOL into a new class that is received by the established deadline, one of the following determinations is announced annually in the final rule updating the ASC payment rates for the next calendar year:

- The request for a payment adjustment is approved for the candidate IOL for 5 full years as a member of a new NTIOL class described by a new HCPCS code;
- The request for a payment adjustment is approved for the candidate IOL for the balance of time remaining as a member of an active NTIOL class; or
- The request for a payment adjustment is not approved.

We also discussed our plan to summarize briefly in the final rule with comment period the evidence that we reviewed, the public comments, and the basis for our determinations in consideration of applications for establishment of a new NTIOL class. We established that when a new NTIOL class is created, we identify the predominant characteristic of NTIOLs in that class that sets them apart from other IOLs (including those previously approved as members of other expired or active NTIOL classes) and that is associated with improved clinical outcomes. The date of implementation of a payment adjustment in the case of approval of an IOL as a member of a new NTIOL class would be set prospectively as of 30 days after publication of the ASC payment update final rule, consistent with the statutory requirement.

2. NTIOL Application Process for Payment Adjustment

In CY 2007, we posted an updated guidance document to the CMS Web site to provide process and information requirements for applications requesting a review of the appropriateness of the payment amount for insertion of an IOL to ensure that the ASC payment for covered surgical procedures includes payment that is reasonable and related to the cost of acquiring a lens that is approved as belonging to a new class of NTIOLs. This guidance document can be accessed on the CMS Web site at: *http://www.cms.gov/ASCPayment/downloads/NTIOLprocess.pdf.*

We note that we have also issued a guidance document entitled "Revised Process for Recognizing Intraocular Lenses Furnished by Ambulatory Surgery Centers (ASCs) as Belonging to an Active Subset of New Technology Intraocular Lenses (NTIOLs)." This guidance document can be accessed on the CMS Web site at: *http://www.cms.gov/ASCPayment/Downloads/Request_for_inclusion_in_current_NTIOL_subset.pdf.*

This second guidance document provides specific details regarding requests for recognition of IOLs as belonging to an existing, active NTIOL class, the review process, and information required for a request to review. Currently, there is one active NTIOL class whose defining characteristic is the reduction of spherical aberration. We accept requests throughout the year to review the appropriateness of recognizing an IOL as a member of an active class of NTIOLs. That is, review of candidate lenses for membership in an existing, active NTIOL class is ongoing and not limited to the annual review process that applies to the establishment of new NTIOL classes. We ordinarily complete the review of such a request within 90 days of receipt of all information that we consider pertinent to our review, and upon completion of our review, we notify the requestor of our determination and post on the CMS Web site notification of a lens newly approved for a payment adjustment as an NTIOL belonging to an active NTIOL class when furnished in an ASC.

3. Classes of NTIOLs Approved and New Requests for Payment Adjustment

a. Background

Since implementation of the process for adjustment of payment amounts for NTIOLs that was established in the June 16, 1999 **Federal Register**, we have approved three classes of NTIOLs, as shown in the following table, with the associated qualifying IOLs to date:

NTIOL Class	HCPCS Code	$50 Approved for Services Furnished On or After	NTIOL Characteristic	IOLs Eligible for Adjustment
1	Q1001	May 18, 2000, through May 18, 2005	Multifocal	Allergan AMO Array Multifocal lens, model SA40N
2	Q1002	May 18, 2000, through May 18, 2005	Reduction in Preexisting Astigmatism	STAAR Surgical Elastic Ultraviolet-Absorbing Silicone Posterior Chamber IOL with Toric Optic, models AA4203T, AA4203TF, and AA4203TL
3	Q1003	February 27, 2006, through February 26, 2011	Reduced Spherical Aberration	Advanced Medical Optics (AMO) Tecnis® IOL models Z9000, Z9001, Z9002, ZA9003, and AR40xEM and Tecnis® 1-Piece model ZCB00; Alcon Acrysof® IQ Model SN60WF, Acrysert Delivery System model SN60WS and Acrysof ® IQ Toric model SN6ATT; Bausch & Lomb Sofport AO models LI61AO and LI61AOV and Akreos AO models AO60 and MI60, Crystalens® AT-50AO and AT-52AO; STAAR Affinity Collamer model CQ2015A and CC4204A and Elastimide model AQ2015A; Hoya model FY-60AD, FC-60AD, PY-60AD, and PC-60AD

b. Request to Establish New NTIOL Class for CY 2010 and Deadline for Public Comment

As explained in the guidance document on the CMS Web site, the deadline for each year's requests for review of the appropriateness of the ASC payment amount for insertion of a candidate IOL as a member of a new class of NTIOLs is announced in the final rule updating the ASC and OPPS payment rates for that calendar year. Therefore, a request for review for a new class of NTIOLs for CY 2011 must have been submitted to CMS by March 8, 2010, the due date published in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60621). We received one request for review to establish a new NTIOL class for CY 2011 by the March 8, 2010 due date. A summary of this request follows.

Requestor/Manufacturer: Alcon Laboratories, Inc.

Lens Model Number: Acrysof® Natural IOLs, Models: SN60WF, SN60AT, MN60MA, and MN60AC.

Summary of the Request: Alcon Laboratories, Inc. (Alcon) submitted a request for CMS to determine that its Acrysof® Natural intraocular lenses meet the criteria for recognition as NTIOL and to concurrently establish a new class of NTIOLs for blue light filtering to improve driving safety under glare conditions, with these lenses as members. As part of its request, Alcon submitted descriptive information about the candidate IOLs as outlined in the guidance document that we make available on the CMS Web site for the establishment of a new class of NTIOLs, as well as information regarding approval of the candidate IOL by the

U.S Food and Drug Administration (FDA). This information included the approved labeling for the candidate lenses, a summary of the IOLs' safety and effectiveness, a copy of the FDA's approval notification, and instructions for their use. In addition, Alcon also submitted a number of studies in support of its claim that the blue light filtering design features of the candidate lenses would improve driving safety under glare conditions. We note that we have previously considered another candidate IOL for which ASC payment review was requested on the basis of blue light filtering properties. We discussed these lenses in the July 23, 2004 and March 25, 2005 NTIOL proposed and final rules published in the **Federal Register** (69 FR 44029 and 70 FR 15337, respectively).

In its CY 2011 request, Alcon asserts that its request is based on new research and measurement technologies that demonstrate that the Acrysof® Natural IOLs with a blue light filtering chromophore filter light in a manner that approximates the human crystalline lens in the 400–475 nm blue light wavelength range to reduce glare that impairs the ability of the eye to differentiate objects from the background. Alcon further states that glare reduction can help beneficiaries avoid hazards that can be caused by glare. Alcon also states that at present, there are no active or expired NTIOL classes that describe IOLs similar to its IOL.

We established in the CY 2007 OPPS/ASC final rule with comment period that when reviewing a request for recognition of an IOL as an NTIOL and a concurrent request to establish a new class of NTIOLs, we would base our determination on consideration of the three major criteria that are outlined in the discussion above. We have begun our review of Alcon's request to recognize its Acrysof® Natural IOLs as NTIOLs and concurrently establish a new class of NTIOLs. We are soliciting public comment on these candidate IOLs with respect to the established NTIOL criteria as discussed above.

First, for an IOL to be recognized as an NTIOL we require that the IOL must have been approved by the FDA and claims of specific clinical benefits and/or lens characteristics with established clinical relevance in comparison with currently available IOLs must have been approved by the FDA for use in labeling and advertising. We note that FDA approval for the candidate lens was granted in May 2007 and that Alcon provided FDA approval documentation, including a copy of the FDA's approval notification, the FDA's summary of the IOL's safety and effectiveness, and the labeling approved by the FDA in its request for a new class of NTIOLs. The approved labels for the Alcon IOLs all state, "Alcon's proprietary blue light filtering chromophore filters light in a manner that approximates the human crystalline lens in the 400–475 nm blue light wavelength range." The FDA label does not otherwise reference specific clinical benefits or lens characteristics of blue light filtering on glare. We are interested in public comments on the specific clinical benefits or lens characteristics with established clinical relevance for the blue light filter effects on glare. Specifically, we are interested in public comments regarding the assertion that the specific blue light filter properties associated with the candidate IOLs improve driving safety via the reduction of glare.

Second, we also require that the candidate IOL not be described by an active or expired NTIOL class; that is, it does not share the predominant, class-defining characteristic associated with improved clinical outcomes with designated members of an active or expired NTIOL class. As noted in the table above regarding active and expired NTIOL classes, since implementation of the NTIOL review process that was established in the June 16, 1999 **Federal Register**, we have approved three classes of NTIOLs: Multifocal and Reduction in Preexisting Astigmatism classes, both of which were created in 2000 and expired in 2005, and the currently active Reduced Spherical Aberration class, which was created in 2006 and will expire in 2011. The class-defining characteristic specific to IOLs that are members of these classes is evident in the name assigned to the class. For example, IOLs recognized as members of the reduced spherical aberration class are characterized by their aspheric design that results in reduced spherical aberration. We refer readers to the table above for information about the NTIOL classes that have been created since the implementation of the review process. Based on this information, the candidate lens may not be described by an active or expired NTIOL class. Its proposed class-defining characteristic and associated clinical benefits that were described in the submitted request, specifically the blue light filtering properties, may not be similar to the class-defining characteristics and associated benefits of the two expired NTIOL classes, the Multifocal and Reduction in Preexisting Astigmatism classes, or to the class-defining characteristic and associated benefits of the currently active Reduced Spherical Aberration class. We welcome public comments that address whether the proposed class-defining characteristic and associated clinical benefits of the candidate Alcon IOLs are described by the expired or currently active NTIOL classes.

Third, our NTIOL evaluation criteria also require that an applicant submit evidence demonstrating that use of the IOL results in measurable, clinically meaningful, improved outcomes in comparison to use of currently available IOLs. We note that in the CY 2007 OPPS/ASC final rule with comment period, we sought comments as to what constitutes currently available IOLs for purposes of such comparisons, and we received several comments in response to our solicitation (71 FR 68178). We agreed with commenters that we should remain flexible with respect to our view of "currently available lenses" for purposes of reviewing NTIOL requests, in order to allow for consideration of technological advances in lenses over time. For purposes of reviewing this request to establish a new NTIOL class for CY 2011, we believe that foldable, spherical, monofocal IOLs made of acrylic, silicone, or polymethylmethacrylate materials represent the currently available lenses against which the candidate NTIOL to establish a new class should be compared. The Alcon request asserts that the proprietary blue light filtering chromophore incorporated into the design of the candidate lenses and asserted associated benefits makes them different from IOLs that are currently available in the U.S. market. We are again seeking public comment on our view of "currently available lenses" for the purposes of this CY 2011 review.

We reviewed the evidence submitted as part of the request, including two peer-reviewed articles and two related clinical studies. The first of the submitted articles discussed the effect of the candidate lenses on glare disability, while the second article discussed the effects of glare on driving in simulated driving conditions. The requestor also submitted data from two clinical studies directly related to the submitted articles discussed above. One cross sectional study with a planned sample size of 70 subjects evaluated glare disability by comparing the candidate lenses against control lenses which did not include the blue light filtering chromophore. Results from this study suggest that subjects implanted with the applicant IOLs had significantly faster photostress recovery times than subjects who had control IOLs implanted without the blue light filtering chromophore. We note that this

cross sectional study is ongoing; consequently the preliminary results submitted with the request only reflect 40 subjects from the planned total sample size. The requestor also submitted data from a second clinical study with a total sample size of 34 that evaluated the benefit of the blue light filtering chromophore on driving performance in patients implanted with the candidate IOLs compared to patients implanted with non blue light filtering IOLs. The results from this study suggested that incorporation of the yellow chromophore into the design of the candidate lenses reduce glare disability and thereby improve the ability of older drivers implanted with the candidate lenses to drive safely. Overall, the evidence submitted provides us with important information that is critical to our review of this request. However, in making our decision as to whether to establish a new class of NTIOL based on the primary characteristic of the candidate lenses, we are also interested in what other information the public can contribute related to the asserted benefits of the blue light filtering optic. Specifically, we are seeking public comment and relevant data on the following:

- Are there other peer-reviewed data that would support or disprove the claims of clinical benefit made by the applicant?
- The presented studies compare the blue filtering optic to clear IOLs, are there other IOLs or other clinical alternatives for reducing glare?
- Is the sample size used in both studies sufficient considering all confounding variables including, but not limited to age, sex, race, time from surgery, status of eyes (which eye received the IOL or both eyes, for example) to conclude that a blue light filtering optic would reduce glare in the Medicare population?
- What kind of study design would be appropriate to prove the claim of significant clinical benefit due to glare reduction on which the new class would be based?
- Are the submitted data enough to clarify that the blue filtering optic is responsible for reduction in glare disability as asserted by applicant?

We welcome public comments and relevant data specifically addressing whether use of the Alcon Acrysof® Natural IOLs result in measurable, clinically meaningful, improved outcomes in comparison with use of currently available IOLs. Additionally, in accordance with our established NTIOL review process, we are seeking public comments on all of the review criteria for establishing a new NTIOL class that would be based on the ability of the Acrysof® Natural IOLs to filter blue light and subsequently help beneficiaries avoid hazards that can be caused by glare while driving. All comments on this request must be received by September 2, 2010. The announcement of CMS's determination regarding this request will appear in the CY 2011 OPPS/ASC final rule with comment period. If a determination of membership of the candidate lens in a new or currently active NTIOL class is made, this determination will be effective 30 days following the date that the final rule with comment period is published in the **Federal Register**.

4. Proposed Payment Adjustment

The current payment adjustment for a 5-year period from the implementation date of a new NTIOL class is $50. In the CY 2007 OPPS/ASC final rule with comment period, we revised § 416.200(a) through (c) to clarify how the IOL payment adjustment is made and how an NTIOL is paid after expiration of the payment adjustment, and made minor editorial changes to § 416.200(d). For CY 2008, CY 2009, and CY 2010, we did not revise the payment adjustment amount, and we are not proposing to revise the payment adjustment amount for CY 2011 in light of our limited experience with the revised ASC payment system, implemented initially on January 1, 2008.

5. Proposed ASC Payment for Insertion of IOLs

In accordance with the final policies of the revised ASC payment system, for CY 2011, payment for IOL insertion procedures is established according to the standard payment methodology of the revised payment system, which multiplies the ASC conversion factor by the ASC payment weight for the surgical procedure to implant the IOL. CY 2011 ASC payment for the cost of a conventional lens is packaged into the payment for the associated covered surgical procedures performed by the ASC. The HCPCS codes for IOL insertion procedures were included in Table 53 below, and their proposed CY 2011 payment rates may be found in Addendum AA to this proposed rule.

TABLE 53.--INSERTION OF IOL PROCEDURES

CY 2010 HCPCS Code	CY 2010 Long Descriptor
66983	Intracapsular cataract extraction with insertion of intraocular lens prosthesis (one stage procedure)
66984	Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification)
66985	Insertion of intraocular lens prosthesis (secondary implant), not associated with concurrent cataract removal
66986	Exchange of intraocular lens

F. Proposed ASC Payment and Comment Indicators

1. Background

In addition to the payment indicators that we introduced in the August 2, 2007 final rule, we also created final comment indicators for the ASC payment system in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66855). We created Addendum DD1 to define ASC payment indicators that we use in Addenda AA and BB to provide payment information regarding covered surgical procedures and covered ancillary services, respectively, under the revised ASC payment system. The ASC payment indicators in Addendum DD1 are intended to capture policy-relevant characteristics of HCPCS codes that may receive packaged or separate payment in ASCs, such as whether they were on the ASC list of covered services prior to CY 2008; payment designation, such as device-intensive or office-based and the corresponding ASC payment methodology; and their classification as separately payable ancillary services including radiology services, brachytherapy sources, OPPS pass-through devices, corneal tissue acquisition services, drugs or biologicals, or NTIOLs.

We also created Addendum DD2 that lists the ASC comment indicators. The ASC comment indicators used in Addenda AA and BB to the proposed rules and final rules with comment period serve to identify, for the revised ASC payment system, the status of a specific HCPCS code and its payment indicator with respect to the timeframe when comments will be accepted. The comment indicator "NI" is used in the OPPS/ASC final rule with comment period to indicate new HCPCS codes for the next calendar year for which the interim payment indicator assigned is subject to comment. The comment indicator "NI" is also assigned to existing codes with substantial revisions to their descriptors such that we consider them to be describing new services, as discussed in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60622). We will respond to public comments and finalize the ASC treatment of all codes labeled with comment indicator "NI" in the CY 2011 OPPS/ASC final rule with comment period.

The "CH" comment indicator is used in Addenda AA and BB to this CY 2011 proposed rule to indicate that a new payment indicator (in comparison with the indicator for the CY 2010 ASC April quarterly update) is proposed for assignment to an active HCPCS code for the next calendar year; an active HCPCS code is proposed for addition to the list of procedures or services payable in ASCs; or an active HCPCS code is proposed for deletion at the end of the current calendar year. The "CH" comment indicators that are published in the final rule with comment period are provided to alert readers that a change has been made from one calendar year to the next, but do not indicate that the change is subject to comment. The full definitions of the payment indicators and comment indicators are provided in Addenda DD1 and DD2 to this proposed rule.

2. Proposed ASC Payment and Comment Indicators

We are not proposing any changes to the definitions of the ASC payment and comment indicators for CY 2011. We will consider proposing to modify the payment indicators for procedures that were subject to transitional payment prior to CY 2011 in future rulemaking. We refer readers to Addenda DD1 and DD2 to this proposed rule for the complete list.

G. ASC Policy and Payment Recommendations

MedPAC was established under section 1805 of the Act to advise Congress on issues affecting the Medicare program. Subparagraphs (B), (C), and (D) of sections 1805(b)(1 of the Act require MedPAC to submit reports to Congress not later than March 1 and June 15 of each year that present its Medicare payment policy reviews and recommendations. The following section describes a recent MedPAC recommendation that is relevant to the ASC payment system.

The March 2010 MedPAC "Report to the Congress: Medicare Payment Policy" included the following recommendation relating specifically to the ASC payment system for CY 2011:

Recommendation 2C: The Congress should implement a 0.6 percent increase in payment rates for ambulatory surgical center services in calendar year 2011 concurrent with requiring ambulatory surgical centers to submit cost and quality data.

CMS Response: In the August 2, 2007 final rule (72 FR 42518 through 42519), we adopted a policy to update the ASC conversion factor for consistency with section 1833(i)(2)(C) of the Act, which requires that, if the Secretary has not updated the ASC payment amounts in a calendar year, the payment amounts shall be increased by the percentage increase in the Consumer Price Index for All Urban Consumers (CPI–U) as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved. The statute set the update at zero for CY 2008 and CY 2009. We indicated that we planned to implement the annual updates through an adjustment to the conversion factor under the ASC payment system beginning in CY 2010 when the statutory requirement for a zero update no longer applies. Further, we noted that that we would update the conversion factor for the CY 2010 ASC payment system by the percentage increase in the CPI–U, consistent with our policy as codified under § 416.171(a)(2).

As we indicated in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60622), we did not require ASCs to submit cost data to the Secretary for CY 2010. We explained that the 2006 GAO report, "Medicare: Payment for Ambulatory Surgical Centers Should Be Based on the Hospital Outpatient Payment System" (GAO–07–86), concluded that the APC groups in the OPPS reflect the relative costs of surgical procedures performed in ASCs in the same way they reflect the relative costs of the same procedures when they are performed in HOPDs. Consistent with the GAO findings, CMS is using the OPPS as the basis for the ASC payment system, which provides for an annual revision of the ASC payment rates under the budget neutral ASC payment system. In addition, we noted that, under the methodology of the revised ASC payment system, we do not utilize ASC cost information to set and revise the payment rates for ASCs but, instead, rely on the relativity of hospital outpatient costs developed for the OPPS, consistent with the recommendation of the GAO. Furthermore, we explained that we have never required ASCs to routinely submit cost data and expressed our concern that a new Medicare requirement for ASCs to do so could be administratively burdensome for ASCs. In 2009, MedPAC made a similar recommendation to that made in Recommendation 2C above. In light of that MedPAC recommendation, in the CY 2010 OPPS/ASC proposed rule (74 FR 35391), we solicited public comment on the feasibility of ASCs submitting cost information to CMS, including whether costs should be collected from a sample or the universe of ASCs, the administrative burden associated with such an activity, the form that such a submission could take considering existing Medicare requirements for other types of facilities and the scope of ASC services, the expected accuracy of such cost information, and any other issues or

concerns of interest to the public on this topic.

In the CY 2010 OPPS/ASC final rule with comment period (74 FR 60623), we summarized and responded to these comments. As noted in that final rule with comment period, commenters' expressed varied opinions regarding the feasibility of requiring ASCs to submit cost data to the Secretary. Some commenters believed that requiring ASC to submit such data would not be an insurmountable obstacle and pointed out that other small facilities submit cost reports to CMS. They stated that ASC cost reports are necessary to assess the adequacy of Medicare payments and evaluate the ASC update. Other commenters, however, opposed the requirement that ASCs submit cost data to CMS because they believed such a requirement would be unnecessary and administratively burdensome. Commenters generally supported a requirement that ASCs report quality data. We refer readers to the CY 2010 OPPS/ASC final rule with comment period for a full discussion of the comments we received on the feasibility of requiring ASCs to report cost and quality data (74 FR 60623). We responded that we would keep the commenters' perspectives in mind as we further consider the adequacy of the Medicare ASC payment rates and move toward implementation of ASC quality reporting.

Consistent with our CY 2010 policy, we are proposing not to require ASCs to submit cost data to the Secretary for CY 2011. We continue to believe that our established methodology results in appropriate payment rates for ASCs. As noted in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60623), section 109(b) of the MIEA–TRHCA (Pub. L. 109–432) gives the Secretary the authority to implement ASC quality measure reporting and to reduce the payment update for ASCs that fail to report those required measures. We restate our belief that promoting high quality care in the ASC setting through quality reporting is highly desirable and fully in line with our efforts under other payment systems. As discussed in section XVI.H. of this proposed rule, we are proposing not to require ASC quality data reporting for CY 2011, but our intention is to implement ASC quality reporting in a future rulemaking.

Section 3006(f) of the Affordable Care Act, as added by section 10301(a) of the Affordable Care Act, requires CMS to develop a plan on implementing a value-based purchasing program for ASCs that will consider measures of quality and efficiency in ASCs, among other requirements. The Secretary must submit a report to Congress containing this plan not later than January 1, 2011.

H. Calculation of the ASC Conversion Factor and ASC Payment Rates

1. Background

In the August 2, 2007 final rule (72 FR 42493), we established our policy to base ASC relative payment weights and payment rates under the revised ASC payment system on APC groups and relative payment weights. Consistent with that policy and the requirement at section 1833(i)(2)(D)(ii) of the Act that the revised payment system be implemented so that it would be budget neutral, the initial ASC conversion factor (CY 2008) was calculated so that estimated total Medicare payments under the revised ASC payment system in the first year would be budget neutral to estimated total Medicare payments under the prior (CY 2007) ASC payment system. That is, application of the ASC conversion factor was designed to result in aggregate Medicare expenditures under the revised ASC payment system in CY 2008 equal to aggregate Medicare expenditures that would have occurred in CY 2008 in the absence of the revised system, taking into consideration the cap on ASC payments in CY 2007 as required under section 1833(i)(2)(E) of the Act (72 FR 42522).

We note that we consider the term "expenditures" in the context of the budget neutrality requirement under section 1833(i)(2)(D)(ii) of the Act to mean expenditures from the Medicare Part B Trust Fund. We do not consider expenditures to include beneficiary coinsurance and copayments. This distinction was important for the CY 2008 ASC budget neutrality model that considered payments across hospital outpatient, ASC, and MPFS payment systems. However, because coinsurance is almost always 20 percent for ASC services, this interpretation of expenditures has minimal impact for subsequent budget neutrality adjustments calculated within the revised ASC payment system.

In the CY 2008 OPPS/ASC final rule with comment period (72 FR 66857 through 66858), we set out a step-by-step illustration of the final budget neutrality adjustment calculation based on the methodology finalized in the August 2, 2007 final rule (72 FR 42521 through 42531) and as applied to updated data available for the CY 2008 OPPS/ASC final rule with comment period. The application of that methodology to the data available for the CY 2008 OPPS/ASC final rule with comment period resulted in a budget neutrality adjustment of 0.65.

For CY 2008, we adopted the OPPS relative payment weights as the ASC relative payment weights for most services and, consistent with the final policy, we calculated the CY 2008 ASC payment rates by multiplying the ASC relative payment weights by the final CY 2008 ASC conversion factor of $41.401. For covered office-based surgical procedures and covered ancillary radiology services, the established policy is to set the relative payment weights so that the national unadjusted ASC payment rate does not exceed the MPFS unadjusted non-facility PE RVU amount. Further, as discussed in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66841 through 66843), we also adopted alternative rate setting methodologies for specific types of services (for example, device-intensive procedures).

As discussed in the August 2, 2007 final rule (72 FR 42518) and as codified under § 416.172(c) of the regulations, the revised ASC payment system accounts for geographic wage variation when calculating individual ASC payments by applying the pre-floor and pre-reclassified hospital wage indices to the labor-related share, which is 50 percent of the ASC payment amount. Beginning in CY 2008, CMS accounted for geographic wage variation in labor cost when calculating individual ASC payments by applying the pre-floor and pre-reclassified hospital wage index values that CMS calculates for payment, using updated Core Based Statistical Areas (CBSAs) issued by the Office of Management and Budget in June 2003. The reclassification provision provided at section 1886(d)(10) of the Act is specific to hospitals. We believe the use of the most recent available raw pre-floor and pre-reclassified hospital wage indices results in the most appropriate adjustment to the labor portion of ASC costs. In addition, use of the unadjusted hospital wage data avoids further reductions in certain rural statewide wage index values that result from reclassification. We continue to believe that the unadjusted hospital wage indices, which are updated yearly and are used by many other Medicare payment systems, appropriately account for geographic variation in labor costs for ASCs.

We note that in certain instances there might be urban or rural areas for which there is no IPPS hospital whose wage index data would be used to set the wage index for that area. For these areas, our policy has been to use the average of the wage indices for CBSAs (or metropolitan divisions as applicable)

that are contiguous to the area that has no wage index (where "contiguous" is defined as sharing a border). We have applied a proxy wage index based on this methodology to ASCs located in CBSA 25980 Hinesville-Fort Stewart, GA, and CBSA 22 Rural Massachusetts. For CY 2011, we have identified another area, specifically, CBSA 11340 Anderson, SC for which there is no IPPS hospital whose wage index data would be used to set the wage index for that area. Generally, we would use the methodology described above; however in this situation all of the areas contiguous to CBSA 11340 Anderson, SC are rural. Therefore, for this type of unique situation, we are proposing to set the ASC wage index by calculating the average of all wage indices for urban areas in the state. In other situations, where there are no IPPS hospitals located in a relevant labor market area, we would continue our current policy of calculating an urban or rural area's wage index by calculating the average of the wage indices for CBSAs (or metropolitan divisions where applicable) that are contiguous to the area with no wage index.

2. Proposed Calculation of the ASC Payment Rates

a. Updating the ASC Relative Payment Weights for CY 2011 and Future Years

We update the ASC relative payment weights each year using the national OPPS relative payment weights (and MPFS non-facility PE RVU amounts, as applicable) for that same calendar year and uniformly scale the ASC relative payment weights for each update year to make them budget neutral (72 FR 42531 through 42532). Consistent with our established policy, we are proposing to scale the CY 2011 relative payment weights for ASCs according to the following method. Holding ASC utilization and the mix of services constant from CY 2008 for CY 2011, we are proposing to compare the total payment weight using the CY 2010 ASC relative payment weights under the 75/25 blend (of the CY 2007 payment rate calculated under the ASC standard ratesetting methodology and the ASC payment rate calculated under the ASC standard methodology) with the total payment weight using the CY 2011 ASC relative payment weights (calculated under the ASC standard rate setting methodology) to take into account the changes in the OPPS relative payment weights between CY 2010 and CY 2011. We would use the ratio of CY 2010 to CY 2011 total payment weight (the weight scaler) to scale the ASC relative payment weights for CY 2011. The proposed CY 2011 ASC scaler is 0.9090 and scaling would apply to the ASC relative payment weights of the covered surgical procedures and covered ancillary radiology services for which the ASC payment rates are based on OPPS relative payment weights.

Scaling would not apply in the case of ASC payment for separately payable covered ancillary services that have a predetermined national payment amount (that is, their national ASC payment amounts are not based on OPPS relative payment weights), such as drugs and biologicals that are separately paid or services that are contractor-priced or paid at reasonable cost in ASCs. Any service with a predetermined national payment amount would be included in the ASC budget neutrality comparison, but scaling of the ASC relative payment weights would not apply to those services. The ASC payment weights for those services without predetermined national payment amounts (that is, those services with national payment amounts that would be based on OPPS relative payment weights if a payment limitation did not apply) would be scaled to eliminate any difference in the total payment weight between the current year and the update year.

For any given year's ratesetting, we typically use the most recent full calendar year of claims data to model budget neutrality adjustments. We currently have available 98 percent of CY 2009 ASC claims data. To create an analytic file to support calculation of the weight scaler and budget neutrality adjustment for the wage index (discussed below), we summarized available CY 2009 ASC claims by provider and by HCPCS code. We created a unique supplier identifier solely for the purpose of identifying unique ASCs within the CY 2009 claims data. We used the supplier zip code reported on the claim to associate State, county, and CBSA with each ASC. This file, available to the public as a supporting data file for this proposed rule, is posted on the CMS Web site at: *http://www.cms.gov/ASCPayment/01_Overview.asp#TopOfPage*.

b. Updating the ASC Conversion Factor

Under the OPPS, we typically apply a budget neutrality adjustment for provider-level changes, most notably a change in the wage index values for the upcoming year, to the conversion factor. Consistent with our final ASC payment policy, for the CY 2011 ASC payment system, we are proposing to calculate and apply the pre-floor and pre-reclassified hospital wage indices that are used for ASC payment adjustment to the ASC conversion factor, just as the OPPS wage index adjustment is calculated and applied to the OPPS conversion factor (73 FR 41539). For CY 2011, we calculated this proposed adjustment for the ASC payment system by using the most recent CY 2009 claims data available and estimating the difference in total payment that would be created by introducing the CY 2011 pre-floor and pre-reclassified hospital wage indices. Specifically, holding CY 2009 ASC utilization and service-mix and CY 2010 national payment rates after application of the weight scaler constant, we calculated the total adjusted payment using the CY 2010 pre-floor and pre-reclassified hospital wage indices and the total adjusted payment using the proposed CY 2011 pre-floor and pre-reclassified hospital wage indices. We used the 50-percent labor-related share for both total adjusted payment calculations. We then compared the total adjusted payment calculated with the CY 2010 pre-floor and pre-reclassified hospital wage indices to the total adjusted payment calculated with the proposed CY 2011 pre-floor and pre-reclassified hospital wage indices and applied the resulting ratio of 1.0006 (the proposed CY 2011 ASC wage index budget neutrality adjustment) to the CY 2010 ASC conversion factor to calculate the proposed CY 2011 ASC conversion factor.

Section 1833(i)(2)(C) of the Act requires that, if the Secretary has not updated the ASC payment amounts in a calendar year, the payment amounts shall be increased by the percentage increase in the CPI–U as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved. Because the Secretary does update the ASC payment amounts annually, we adopted a policy, which we codified at § 416.171(a)(2)(ii), to update the ASC conversion factor using the CPI–U for CY 2010 and subsequent calendar years. Therefore, the annual update to the ASC payment system is the CPI–U (referred to as the CPI–U update factor). Section 3401(k) of the Affordable Care Act amends section 1833(i)(2)(D) of the Act by adding a new clause (v) which requires that "any annual update under [the ASC payment] system for the year * * * shall be reduced by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II)" (which we refer to as the MFP adjustment) effective with the calendar year beginning January 1, 2011. Section 3401(k) of the Affordable Care Act states that application of the MFP adjustment to the ASC payment

system may result in the update to the ASC payment system being less than zero for a year and may result in payment rates under the ASC payment system for a year being less than such payment rates for the preceding year. We are proposing to revise § 416.160 and § 416.171 to reflect this provision of the Affordable Care Act.

In accordance with section 1833(i)(2)(C)(i) of the Act, before applying the MFP adjustment, the Secretary first determines the "percentage increase" in the CPI–U, which we interpret cannot be a negative number. Thus, in the instance where the percentage change in the CPI–U for a year is negative, we are proposing to hold the CPI–U update factor for the ASC payment system to zero. Section 1833(i)(2)(D)(v) of the Act, as added by section 3401(k) of the Affordable Care Act, then requires that the Secretary reduce the CPI–U update factor (which would be held to zero if the CPI–U percentage change is negative) by the MFP adjustment, and states that application of the MFP adjustment may reduce this percentage change below zero. If the application of the MFP adjustment to the CPI–U percentage increase would result in a MFP-adjusted CPI–U update factor that is less than zero, then the annual update to the ASC payment rates would be negative and payments would decrease relative to the prior year.

Table 54 provides illustrative examples of how the MFP would be applied to the ASC payment system. These examples show the implication of a positive CPI–U update factor with a small MFP, a positive CPI–U update factor with a large MFP adjustment, and a CPI–U update factor of 0. We discuss in greater detail the methodology for calculating the MFP for the ASC payment system and the other payment systems affected by the MFP adjustment (found in section 1886(b)(3)(B)(xi)(II) of the Act, as added by section 3401(a) of the Affordable Care Act) in the CY 2011 MPFS proposed rule. Comments on the specific mathematical calculation of the MFP should be made to that proposed rule. Comments on the application of the MFP to the CPI–U update factor under the ASC payment system should be made to this proposed rule.

TABLE 54: MULTIFACTOR PRODUCTIVITY ADJUSTED PAYMENT UPDATE: ILLUSTRATIVE EXAMPLES

CPI-U (Percent)	MFP (Percent)	MFP- Adjusted CPI-U Update Factor (Percent)
4.0	1.3	2.7
4.0	4.7	-0.7
0.0	0.2	-0.2

NOTE: Numbers may not sum due to rounding.

For this proposed rule, for the 12-month period ending with the midpoint of CY 2011, the Secretary estimates that the CPI–U is 1.6 percent. The Secretary estimates that the MFP adjustment is 1.6. As discussed in the CY 2011 MPFS proposed rule, we are proposing to reduce the CPI–U of 1.6 percent by the MFP adjustment specific to this CPI–U, resulting in an MFP-adjusted CPI–U updated factor of 0 percent. Therefore, we are proposing to apply to the ASC conversion factor a 0 percent MFP-adjusted update.

For CY 2011, we also are proposing to adjust the CY 2010 ASC conversion factor ($41.873) by the wage adjustment for budget neutrality of 1.0006 in addition to the MFP-adjusted update factor of 0 discussed above, which results in a proposed CY 2011 ASC conversion factor of $41.898.

3. Display of Proposed ASC Payment Rates

Addenda AA and BB to this proposed rule display the proposed updated ASC payment rates for CY 2011 for covered surgical procedures and covered ancillary services, respectively. These addenda contain several types of information related to the proposed CY 2011 payment rates. Specifically, in Addendum AA, a "Y" in the column titled "Subject to Multiple Procedure Discounting" indicates that the surgical procedure would be subject to the multiple procedure payment reduction policy. As discussed in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66829 through 66830), most covered surgical procedures are subject to a 50-percent reduction in the ASC payment for the lower-paying procedure when more than one procedure is performed in a single operative session. Display of the comment indicator "CH" in the column titled "Comment Indicator" indicates a proposed change in payment policy for the item or service, including identifying discontinued HCPCS codes, designating items or services newly payable under the ASC payment system, and identifying items or services with changes in the ASC payment indicator for CY 2011.

The values displayed in the column titled "CY 2011 Payment Weight" are the proposed relative payment weights for each of the listed services for CY 2011. The payment weights for all covered surgical procedures and covered ancillary services whose ASC payment rates are based on OPPS relative payment weights are scaled for budget neutrality. Thus, scaling was not applied to the device portion of the device intensive procedures, services that are paid at the MPFS nonfacility PE RVU amount, separately payable covered ancillary services that have a predetermined national payment amount, such as drugs and biologicals that are separately paid under the OPPS, or services that are contractor-priced or paid at reasonable cost in ASCs.

To derive the proposed CY 2011 payment rate displayed in the "CY 2011 Payment" column, each ASC payment weight in the "CY 2011 Payment Weight" column is multiplied by the proposed CY 2011 conversion factor of $41.898. The conversion factor includes a budget neutrality adjustment for changes in the wage index values and the CPI–U update factor as reduced by the productivity adjustment (as discussed in section XV.H.2.b. of this proposed rule).

In Addendum BB, there are no relative payment weights displayed in the "CY 2011 Payment Weight" column for items and services with predetermined national payment

amounts, such as separately payable drugs and biologicals. The "CY 2011 Payment" column displays the proposed CY 2011 national unadjusted ASC payment rates for all items and services. The proposed CY 2011 ASC payment rates listed in the Addendum AA for separately payable drugs and biologicals are based on ASP data used for payment in physicians' offices in April 2010.

XVI. Reporting Quality Data for Annual Payment Rate Updates

A. Background

1. Overview

CMS has implemented quality measure reporting programs for multiple settings of care. These programs promote higher quality, more efficient health care for Medicare beneficiaries. The quality data reporting program for hospital outpatient care, known as the Hospital Outpatient Quality Data Reporting Program (HOP QDRP), has been generally modeled after the program for hospital inpatient services, the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program. Both of these quality reporting programs for hospital services, as well as the program for physicians and other eligible professionals, known as the Physician Quality Reporting Initiative (PQRI), have financial incentives for the reporting of quality data to CMS. CMS also has implemented quality reporting programs for home health agencies and skilled nursing facilities that are based on conditions of participation, and an end-stage renal disease quality reporting program that is based on conditions for coverage.

2. Hospital Outpatient Quality Data Reporting Under Section 109(a) of MIEA–TRHCA

Section 109(a) of the MIEA–TRHCA (Pub. L. 109–432) amended section 1833(t) of the Act by adding a new paragraph (17) which affects the annual payment update factor applicable to OPPS payments for services furnished by hospitals in outpatient settings on or after January 1, 2009. Section 1833(t)(17)(A) of the Act states that subsection (d) hospitals (as defined under section 1886(d)(1)(B) of the Act) that fail to report data required for the quality measures selected by the Secretary in the form and manner required by the Secretary under section 1833(t)(17)(B) of the Act will incur a 2.0 percentage point reduction to their annual payment update factor. Section 1833(t)(17)(B) of the Act requires that hospitals submit quality data in a form and manner, and at a time, that the Secretary specifies. Section 1833(t)(17)(A)(ii) of the Act specifies that any reduction would apply only to the payment year involved and would not be taken into account in computing the applicable annual payment update factor for a subsequent payment year.

Section 1833(t)(17)(C)(i) of the Act requires the Secretary to develop measures appropriate for the measurement of the quality of care (including medication errors) furnished by hospitals in outpatient settings, that these measures reflect consensus among affected parties and, to the extent feasible and practicable, that these measures include measures set forth by one or more national consensus building entities. The National Quality Forum (NQF) is a voluntary consensus standard setting organization that is composed of a diverse representation of consumer, purchaser, provider, academic, clinical, and other health care stakeholder organizations. NQF was established to standardize health care quality measurement and reporting through its consensus development process. We generally prefer to adopt NQF-endorsed measures for CMS quality reporting programs. However, we believe that consensus among affected parties also can be reflected by other means, including: consensus achieved during the measure development process; consensus shown through broad acceptance and use of measures; and consensus through public comment. We also note that section 1833(t)(17) of the Act does not require that each measure we adopt for the HOP QDRP be endorsed by a national consensus building entity, or by the NQF specifically.

Section 1833(t)(17)(C)(ii) of the Act allows the Secretary to "[select] measures that are the same as (or a subset of) the measures for which data are required to be submitted under section 1886(b)(3)(B)(viii)" of the Act (the RHQDAPU program). As we stated in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68758 through 68759), we do not believe that we should, without further analysis, adopt the RHQDAPU program measures as the measures for the HOP QDRP. We continue to believe that it is most appropriate and desirable to adopt measures that specifically apply to the hospital outpatient setting for the HOP QDRP.

Section 1833(t)(17)(D) of the Act gives the Secretary the authority to replace measures or indicators as appropriate, such as when all hospitals are effectively in compliance or when the measures or indicators have been subsequently shown not to represent the best clinical practice. Section 1833(t)(17)(E) of the Act requires the Secretary to establish procedures for making data submitted under the HOP QDRP available to the public. Such procedures include providing hospitals with the opportunity to review their data before these data are released to the public.

3. ASC Quality Data Reporting Under Section 109(b) of MIEA–TRHCA

Section 109(b) of the MIEA–TRHCA amended section 1833(i) of the Act by redesignating clause (iv) as clause (v) and adding new clause (iv) to paragraph (2)(D) and by adding new paragraph (7). Section 1833(i)(2)(D)(iv) of the Act authorizes, but does not require, the Secretary to implement the revised ASC payment system "so as to provide for a reduction in any annual update for failure to report on quality measures" beginning with payment for ASC services furnished on or after January 1, 2009.

Section 1833(i)(7)(A) of the Act states that the Secretary may provide that any ASC that fails to report data required for the quality measures selected by the Secretary in the form and manner required by the Secretary under section 1833(i)(7) of the Act will incur a reduction in any annual payment update of 2.0 percentage points. Section 1833(i)(7)(A) of the Act also specifies that a reduction for one year cannot be taken into account in computing the annual ASC payment update for a subsequent year.

Section 1833(i)(7)(B) of the Act provides that, "[e]xcept as the Secretary may otherwise provide," the hospital outpatient quality data provisions of subparagraphs (B) through (E) of section 1833(t)(17) of the Act, summarized above, shall apply to ASCs in a similar manner to the manner in which they apply under these paragraphs to hospitals under the HOP QDRP. We did not implement an ASC quality reporting program for CY 2008 (72 FR 66875) or for CY 2009 (73 FR 68780), or for CY 2010 (74 FR 60656).

We refer readers to section XVI.F. of this proposed rule for further discussion of ASC quality data reporting.

4. HOP QDRP Quality Measures for the CY 2009 Payment Determination

For the CY 2009 annual payment update, we required HOP QDRP reporting using seven quality measures—five Emergency Department (ED) Acute Myocardial Infarction (AMI) Cardiac Care measures and two Surgical Care measures. These measures address care provided to a large number of adult patients in hospital outpatient settings across a diverse set of conditions, and

were selected for the initial set of HOP QDRP measures based on their relevance as a set to all HOPDs.

Specifically, in order for hospitals to receive the full OPPS payment update for services furnished in CY 2009, in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66865 and 66871), we required that subsection (d) hospitals paid under the OPPS submit data on the following seven measures for hospital outpatient services furnished on or after April 1, 2008: (1) ED–AMI–1: Aspirin at Arrival; (2) ED–AMI–2: Median Time to Fibrinolysis; (3) ED–AMI–3: Fibrinolytic Therapy Received within 30 Minutes of Arrival; (4) ED–AMI–4: Median Time to Electrocardiogram (ECG); (5) ED–AMI–5: Median Time to Transfer for Primary PCI; (6) PQRI #20: Surgical Care-Timing of Antibiotic Prophylaxis; and (7) PQRI #21: Surgical Care-Selection of Antibiotic.

5. HOP QDRP Quality Measures for the CY 2010 Payment Determination

For the CY 2010 payment update, we required continued submission of data on the existing seven measures discussed above (73 FR 68761), and adopted four new imaging measures (73 FR 68766). For CY 2010, we also changed the measure designations for the existing seven measures to an "OP-#" format. For example, the designations of ED–AMI–2 and ED–AMI–3 were changed to OP–1 and OP–2 so that the eleven measures for the CY 2010 payment update were designated as OP–1 through OP–11. This change allowed us to maintain a consistent sequential designation system that we could expand as we add additional measures.

The four imaging measures that we adopted beginning with the CY 2010 payment determination (OP–8: MRI Lumbar Spine for Low Back Pain, OP–9: Mammography Follow-up Rates, OP–10: Abdomen CT—Use of Contrast Material, and OP–11: Thorax CT—Use of Contrast Material) are claims-based measures that CMS will calculate using Medicare Part B claims data without imposing upon hospitals the burden of additional chart abstraction. For purposes of the CY 2010 payment determination, we will calculate these measures using CY 2008 Medicare administrative claims data.

In the CY 2009 OPPS/ASC proposed rule, OP–10 had two submeasures listed: OP–10a: CT Abdomen—Use of contrast material excluding calculi of the kidneys, ureter, and/or urinary tract, and OP–10b: CT Abdomen—Use of contrast material for diagnosis of calculi in the kidneys, ureter, and or urinary tract. In the CY 2009 OPPS/ASC final rule with comment period (73 FR 68766), we finalized OP–10 (previously known as OP–10a): Abdomen CT—Use of Contrast Material. To clarify, we are calculating OP–10 excluding patients with impaired renal functions because they are not candidates for an abdominal CT with contrast. This exclusion is described in greater detail in the *Specifications Manual for Hospital Outpatient Department Quality Measures (HOPD Specifications Manual)* located at the QualityNet Web site (*http://www.QualityNet.org*).

The complete set of 11 measures to be used for the CY 2010 payment determination is listed at 73 FR 68766.

6. HOP QDRP Quality Measures, Technical Specification Updates, and Data Publication for the CY 2011 Payment Determination

a. Quality Measures

For the CY 2011 payment determination, we required hospitals to continue to submit data on the existing 11 HOP QDRP measures. These measures continue to address areas of topical importance regarding the quality of care provided in HOPDs, and reflect consensus among affected parties. Seven of these 11 measures are chart-abstracted measures in two areas of importance that are also measured for the inpatient setting: AMI cardiac care and surgical care. The remaining four measures address imaging efficiency in HOPDs.

For the CY 2011 payment determination, we did not add any new HOP QDRP measures. We indicated our sensitivity to the burden upon HOPDs associated with chart abstraction and stated that we seek to minimize the collection burden associated with quality measurement. We also stated that we will continue to assess whether we can collect data on additional quality measures through mechanisms other than chart abstraction, such as from Medicare administrative claims data and EHRs.

The complete set of 11 measures that will be used for the CY 2011 payment determination is listed at 74 FR 60637.

b. Maintenance of Technical Specifications for Quality Measures

Technical specifications for each HOP QDRP measure are listed in the *HOPD Specifications Manual*, which is posted on the CMS QualityNet Web site at *http://www.QualityNet.org.* We maintain the technical specifications for the measures by updating this HOPD Specifications Manual and including detailed instructions and calculation algorithms. In some cases where the specifications are available elsewhere, we may include links to Web sites hosting technical specifications. These resources are for hospitals to use when collecting and submitting data on required measures.

In the CY 2009 OPPS/ASC final rule with comment period (73 FR 68766 through 68767), we established a subregulatory process for updates to the technical specifications that we use to calculate HOP QDRP measures. This process is used when changes to the measure specifications are necessary due to changes in scientific evidence or in the measure as endorsed by the consensus entity. Changes of this nature may not coincide with the timing of our regulatory actions, but nevertheless require inclusion in the measure specifications so that the HOP QDRP measures are calculated based on the most up-to-date scientific and consensus standards. We indicated that notification of changes to the measure specifications on the QualityNet Web site, *http://www.QualityNet.org,* and in the HOPD Specifications Manual that occurred as a result of changes in scientific evidence or national consensus would occur no less than 3 months before any changes become effective for purposes of reporting under the HOP QDRP.

The HOPD Specifications Manual is released every 6 months and addenda are released as necessary providing at least 3 months of advance notice for insubstantial changes such as changes to ICD–9, CPT, NUBC, and HCPCS codes, and at least 6 months notice for substantive changes to data elements that would require significant systems changes.

c. Publication of HOP QDRP Data

Section 1833(t)(17)(E) of the Act requires that the Secretary establish procedures to make data collected under the HOP QDRP program available to the public. It also states that such procedures must ensure that a hospital has the opportunity to review the data that are to be made public with respect to the hospital prior to such data being made public. To meet these requirements, data that a hospital has submitted for the HOP QDRP are typically displayed on CMS Web sites such as the *Hospital Compare* Web site, *http://www.hospitalcompare.hhs.gov* after a preview period. The *Hospital Compare* Web site is an interactive Web tool that assists beneficiaries by providing information on hospital quality of care. This information encourages beneficiaries to work with their doctors and hospitals to discuss the quality of care hospitals provide to

patients, thereby providing an additional incentive to hospitals to improve the quality of care that they furnish.

In general, we strive to display hospital quality measures on the *Hospital Compare* Web site as soon as possible after they have been adopted and are available to CMS for reporting. However, information that may not be easily understood by the public and information with unresolved display issues or pending design considerations may be made available on other non-interactive CMS Web sites such as *http://www.cms.hhs.gov/HospitalQualityInits/.* Publicly reporting the information in this manner, though not on the *Hospital Compare* Web site, allows CMS to meet the requirement under section 1833(t)(17)(E) of the Act for establishing procedures to make quality data submitted available to the public following a preview period. We are proposing that, under circumstances when we have to display hospital quality information on non-interactive CMS Web sites for reasons discussed earlier, affected parties would be notified via CMS listserves, CMS e-mail blasts, national provider calls, and QualityNet announcements regarding the release of preview reports followed by the posting of data on a Web site other than *Hospital Compare.* The release of preview reports allows CMS to meet the requirement under section 1833(t)(17)(E) of the Act for establishing procedures to make quality data submitted available to the public following a preview period.

CMS also requires hospitals to complete and submit a registration form ("participation form") in order to participate in the HOP QDRP. With submission of this form, participating hospitals agree that they will allow CMS to publicly report the quality measures, including those that CMS calculates using Medicare claims, as required by the Act and the HOP QDRP.

In the CY 2009 OPPS/ASC final rule with comment period (73 FR 68778), we established that, for CY 2010, hospitals sharing the same CMS Certification Number (CCN, previously known as the Medicare Provider Number (MPN)) must combine data collection and submission across their multiple campuses for the clinical measures for public reporting purposes. We finalized the policy that, under the HOP QDRP, we will publish quality data by the corresponding CCN. This approach is consistent with the approach taken under the RHQDAPU program. In the CY 2009 OPPS/ASC final rule with comment period, we also stated that we intend to indicate instances where data from two or more hospitals are combined to form the publicly reported measures on the Web site.

In the CY 2010 OPPS/ASC final rule with comment period, we finalized our CY 2010 policy regarding publication of HOP QDRP data (74 FR 60652 through 60654). Section 1833(t)(17)(E) of the Act requires that the Secretary establish procedures to make data collected under the HOP QDRP available to the public; however, this section does not require that such data be validated before it is made public. We explained that, initially, we decided not to post "[i]nformation from non-validated data, including the initial reporting period (April—June 2008)" as discussed in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66874). We noted, however, that data submitted by hospitals are publicly reported regardless of whether those data are successfully validated for payment determination purposes under existing procedures for the RHQDAPU program. We also noted that, in the CY 2009 OPPS/ASC final rule with comment period, we stated that we intended to make the information collected under the HOP QDRP available to the public in 2010 (73 FR 68778).

In the CY 2010 OPPS/ASC proposed rule (74 FR 35404), we proposed to make data collected for quarters beginning with the third quarter of CY 2008 (July—September 2008) under the HOP QDRP publicly available, regardless of whether those data have been validated for payment determination purposes. In the CY 2010 OPPS/ASC final rule with comment period (74 FR 60654), we finalized our proposal to publicly report HOP QDRP data on *Hospital Compare* in 2010 with some modifications in the periods of time to be reported. For measures OP–1 through OP–5, we will publicly report data periods beginning with the 3rd quarter of 2008. For measures OP–6 and OP–7, we will publicly report data periods beginning with the 3rd quarter of 2009. For measures OP–8 through OP–11, we will report CY 2010 payment determination calculations using CY 2008 claims.

B. Proposed Expansion of HOP QDRP Quality Measures for the CY 2012, CY 2013, and CY 2014 Payment Determinations

1. Considerations in Expanding and Updating Quality Measures Under the HOP QDRP

In general, when selecting measures for the HOP QDRP program, we take into account several considerations and goals. These include: (a) Expanding the types of measures beyond process of care measures to include an increased number of outcome measures, efficiency measures, and patients' experience-of-care measures; (b) expanding the scope of hospital services to which the measures apply; (c) considering the burden on hospitals in collecting chart-abstracted data; (d) harmonizing the measures used in the HOP QDRP program with other CMS quality programs to align incentives and promote coordinated efforts to improve quality; (e) seeking to use measures based on alternative sources of data that do not require chart abstraction or that utilize data already being reported by many hospitals, such as data that hospitals report to clinical data registries, or all-payer claims data bases; and (f) weighing the relevance and utility of the measures compared to the burden on hospitals in submitting data under the HOP QDRP program.

Specifically, we give priority to quality measures that assess performance on: (a) Conditions that result in the greatest mortality and morbidity in the Medicare population; (b) conditions that are high volume and high cost for the Medicare program; and (c) conditions for which wide cost and treatment variations have been reported, despite established clinical guidelines. We have used and continue to use these criteria to guide our decisions regarding what measures to add to the HOP QDRP measure set.

In the CY 2009 OPPS/ASC final rule with comment period, we adopted four claims-based quality measures that do not require a hospital to submit chart-abstracted clinical data (73 FR 68766). This supports our goal of expanding the measures for the HOP QDRP while minimizing the burden upon hospitals and, in particular, without significantly increasing the chart abstraction burden. In addition to claims-based measures, we are considering registries [1] and EHRs as alternative ways to collect data from hospitals. Many hospitals submit data to and participate in existing registries. In addition, registries often capture outcome information and provide ongoing quality improvement feedback to registry participants. Instead of requiring hospitals to submit the same data to CMS that they are already submitting to registries, we could collect the data directly from the registries with the permission of the hospital, thereby enabling us to expand the HOP QDRP measure set without increasing the burden of data collection for those

[1] A registry is a collection of clinical data for purposes of assessing clinical performance, quality of care, and opportunities for quality improvement.

hospitals participating in the registries. The data that we would receive from registries would be used to calculate quality measures required under the HOP QDRP, and would be publicly reported like other HOP QDRP quality measures, encouraging improvements in the quality of care. In the CY 2010 OPPS/ASC final rule with comment period (74 FR 60633), we responded to public comments on such an approach.

In the CY 2009 OPPS/ASC final rule with comment period, we also stated our intention to explore mechanisms for data submission using EHRs (73 FR 68769). CMS has adopted the definition of Qualified EHR set forth by the Office of the National Coordinator for Health Information Technology (ONC) which has adopted the statutory definition of Qualified EHR as follows: Section 3000(13) of the PHSA defines Qualified EHR as an electronic record of health-related information on an individual that: (A) Includes patient demographic and clinical health information, such as medical history and problem lists; and (B) has the capacity: (i) To provide clinical decision support; (ii) to support physician order entry; (iii) to capture and query information relevant to health care quality; and (iv) to exchange electronic health information with, and integrate such information from other sources." CMS has also adopted the definition of Certified EHR by ONC as follows: Certified EHR technology means a complete EHR or a combination of EHR Modules, each of which: (1) Meets the requirements included in the definition of a Qualified EHR; and (2) has been tested and certified in accordance with the certification program established by the ONC as having met all applicable certification criteria adopted by the Secretary. Establishing a data submission mechanism using EHRs system will require interoperability between EHRs and CMS data collection systems, additional infrastructure development on the part of hospitals and CMS, and the adoption of standards for the capturing, formatting, and transmission of data elements that make up the measures. However, once these activities are accomplished, the adoption of measures that rely on data obtained directly from EHRs would enable us to expand the HOP QDRP measure set with less cost and burden to hospitals. In the CY 2010 OPPS/ASC final rule with comment period (74 FR 60633 through 60634), we responded to public comments on such an approach.

In prior years, we have proposed measures for one payment determination in a given rulemaking cycle. In prior rules, we have identified measures for future consideration, but have not proposed or finalized measures beyond those to be collected and used for the next sequential payment determination. In this CY 2011 rulemaking cycle, we are proposing the addition of new measures over a three year period of time for CY 2012, CY 2013, and CY 2014 payment determinations. We believe this proposed process would assist hospitals in planning, meeting future reporting requirements, and implementing quality improvement efforts. We also would have more time to develop, align, and implement the infrastructure necessary to collect data on the measures and make payment determinations. To the extent that we choose to finalize some or all of these measures for the CY 2012, CY 2013 and CY 2014 payment determinations, this would not preclude us from proposing additional measures or changing the list of measures for future payment determinations through subsequent rulemaking cycles that affect these future payment determinations. We invite comments on our intention to propose measures for more than one payment determination in a single rulemaking cycle.

2. Retirement of HOP QDRP Quality Measures

In the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule, we finalized a process for immediate retirement of RHQDAPU program measures based on evidence that the continued use of the measure as specified raises patient safety concerns (74 FR 43864 through 43865). In circumstances such as those prompting immediate retirement of the AMI–6 measure from the RHQDAPU program in December 2008 as discussed in the FY 2010 IPPS/LTCH final rule (74 FR 43864 through 43865) we do not believe that it would be appropriate to wait for the annual rulemaking cycle to retire a measure. We adopted this same immediate retirement policy for the HOP QDRP in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60635).

Specifically, we stated that if we receive evidence that continued collection of a measure that has been adopted for the HOP QDRP raises patient safety concerns, we would promptly retire the measure and notify hospitals and the public of the retirement of the measure and the reasons for its retirement through the usual means by which we communicate with hospitals, including but not limited to hospital e-mail blasts and the QualityNet Web site. We also stated that we would confirm the retirement of a measure retired in this manner in the next OPPS rulemaking cycle. However, for other circumstances in which we do not believe that continued use of a measure raises specific patient safety concerns, we stated that we intend to use the regular rulemaking process to retire a measure.

3. Proposed HOP QDRP Quality Measures for the CY 2012 Payment Determination

a. Proposed Retention of Existing HOP QDRP Measures for the CY 2012 Payment Determination

For the CY 2012 payment determination, we are proposing to retain the existing 11 HOP QDRP measures. These measures continue to address areas of topical importance regarding the quality of care provided in HOPDs, and reflect consensus among affected parties. Seven of these 11 measures are chart-abstracted measures in two areas of importance that are also measured for the inpatient setting: AMI cardiac care and surgical care. The remaining four measures are claims-based measures that address imaging efficiency in HOPDs.

We invite public comment on our proposal to retain the existing 11 HOP QDRP measures for the CY 2012 payment determination.

b. Proposed New Structural Measure for CY 2012 Payment Determination

For the CY 2012 payment determination, we are proposing to add one structural measure: "Ability for Providers with HIT to Receive Laboratory Data Electronically Directly into their Qualified/Certified EHR System as Discrete Searchable Data" (NQF # 0489). Structural measures allow the assessment of the conduciveness of the provider environment to processes and technologies that enable delivery of high quality care. This particular structural measure assesses the extent to which a provider uses a certified/qualified EHR system that incorporates an electronic data interchange with one or more laboratories allowing for direct electronic transmission of laboratory data into the EHR as discrete searchable data elements. We believe that electronic transmission of laboratory data into EHRs would enable greater timeliness of results reporting, because the results of the reports would be transmitted to the HOPD as soon as the laboratory data are available and be merged with clinical information for more timely clinical assessments, and laboratory value alerts. Electronic transmission of laboratory data would also lead to cost efficiency, expedite the

clinical decision process, and reduce redundancy of laboratory orders, and reduce human errors. Section 1833(t)(17)(C)(i) of the Act requires the Secretary to develop measures appropriate for the measurement of the quality of care furnished by hospitals in outpatient settings, that these measures reflect consensus among affected parties and, to the extent feasible and practicable, that these measures include measures set forth by one or more national consensus building entities. As discussed above, this structural measure is appropriate for measuring quality of care in the hospital outpatient department setting. This measure also meets the consensus requirement because it was endorsed in 2008 as part of an NQF project entitled "National Voluntary Consensus Standards for Health Information Technology: Structural Measures." Additionally, this measure was conditionally adopted by the Hospital Quality Alliance (HQA) in 2010. (The HQA is a public-private collaboration to improve the quality of care provided by the nation's hospitals by measuring and publicly reporting on that care.)

We are proposing that this structural measure would be submitted by HOPDs beginning with January 1, 2011 discharges via a Web-based tool available on the QualityNet Web site that is currently employed for the collection of structural measures for the RHQDAPU program. For this structural measure, HOPDs would submit the number of encounters out of all encounters for which laboratory results were documented in the EHR. We invite comments on our proposal to add this new structural measure to the HOP QDRP measurement set and the submission process for the CY 2012 payment determination.

c. Proposed New Claim-Based Measures for CY 2012 Payment Determination

For the CY 2012 payment determination, we are proposing to add four new claims-based imaging efficiency measures to the HOP QDRP measurement set, all of which were listed as under consideration for CY 2012 and subsequent years in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60637 through 60641). Imaging efficiency is a new area of measurement that we first implemented in the HOP QDRP for the CY 2010 payment determination and subsequently retained for the CY 2011 payment determination. There are currently four existing claims-based imaging efficiency measures in the HOP QDRP measurement set (OP–8 through OP–11). The four new proposed imaging efficiency measures for the CY 2012 payment determination are: (1) Pre-operative Evaluation for Low-Risk Non-Cardiac Surgery Risk Assessment, (2) Use of Stress Echocardiography, SPECT MPI, and Cardiac Stress MRI post CABG, (3) Simultaneous Use of Brain Computed Tomography (CT) and Sinus Computed Tomography (CT), and (4) Use of Brain Computed Tomography (CT) in the Emergency Department for Atraumatic Headache.

Like the current imaging efficiency measures in the HOP QDRP measurement set, these four measures are based on Medicare claims and will not require additional data submission on the part of hospitals. All four of these proposed measures are currently undergoing NQF review, and specifications for these measures are available at *www.imagingmeasures.com.*

The first new proposed imaging efficiency measure for the CY 2012 payment determination seeks to calculate relative use of stress echocardiography, stress MRI, and SPECT MPI prior to low-risk non-cardiac surgical procedures in the 30 days preceding the surgery. The second new proposed claims-based imaging efficiency measure for the CY 2012 payment determination seeks to estimate relative use of stress echocardiography and SPECT MPI in asymptomatic patients less than five years after a coronary artery bypass graft (CABG) procedure.

Cardiac imaging is a gap area that was not addressed in CMS' first set of Outpatient Imaging Efficiency measures. It is among the most common imaging services in the Medicare population. In the hospital outpatient setting, 762,419 SPECT MPI, Stress MRI and Stress Echocardiography procedures were performed in 2008 alone.[2] Further, between 1998 and 2006, the rate of myocardial perfusion imaging (MPI) use in Medicare beneficiaries increased 51 percent among cardiologists in the hospital setting, and by 215 percent in private offices. During the same time period, total Medicare Part B payments for MPI across all settings of care increased by 227 percent.[3]

SPECT MPI, Stress MRI, and Stress Echocardiography are specific procedures that must be ordered by a physician to be performed. Therefore, there is a distinct opportunity for the physician to order this procedure prudently based on best practices. While SPECT MPI, Stress MRI, and Stress Echocardiography enhance the quality of care when used appropriately, inappropriate usage of imaging would cause unnecessary waste of services, contribute no benefit to the quality of care, and could increase the patient's risk of cancer. An analysis by Gibbons et al.[4] found that, of all SPECT MPI procedures performed at the Mayo Clinic Rochester in May 2005, 14 percent were considered inappropriate using criteria published by the American College of Cardiology Foundation and the American Society of Nuclear Cardiology, and an additional 11 percent were of indeterminate appropriateness.[4] This study also found that during the same time period, 18 percent of all stress echocardiograms performed were inappropriate, and an additional 9 percent were indeterminate.

The third and fourth new proposed imaging efficiency measures for the CY 2012 payment determination pertain to appropriate use of Brain CT imaging in HOPDs. These are "Simultaneous Use of Brain Computed Tomography (CT) and Sinus Computed Tomography (CT)," and "Use of Brain Computed Tomography (CT) in the Emergency Department for Atraumatic Headache."

A recent report in the New England Journal of Medicine [5] raised serious concerns about the use and overuse of CT scanning, stating that for an estimated 62 million CT scans being performed per year, a third are unnecessary, resulting in patient safety issues including unnecessary radiation and contrast material exposure, and the danger associated with "false positive" findings. A CT scan exposes the patient to higher doses of radiation than a conventional x-ray and increases the patient's risk of cancer.

Brain CTs are often ordered in addition to a sinus CT for patients with sinusitis because headache is a common symptom related to sinusitis. However, simultaneous CT sinus and brain imaging for headache without suspected complications is generally considered inappropriate, as the standard anatomic coverage of a CT of the head includes

[2] The Lewin Group analysis of Medicare Calendar Year 2007 claims data prepared for the Centers for Medicare & Medicaid Services, HHS Contract No: HHSM–500–2005–0024I, Order No. 0002.

[3] Levin DC, Rao VM, Parker L, et al. Recent payment and utilization trends in radionuclide myocardial perfusion imaging: Comparison between self-referral and referral to radiologists. J Am Coll Radiol 2009;6:437–441.

[4] Gibbons RJ, Miller TD, Hodge D, et al. Application of appropriateness criteria to stress single-photon emission computed tomography sestamibi studies and stress echocardiograms in an academic medical center. J Am Coll Cardiology 2008;51:1283–9.

[5] Brenner DJ, Hall EJ. November 29, 2007. Computer Tomography—An Increasing Source of Radiation Exposure. New England J of Medicine 2007:357(22): 2277–84.

large portions of the paranasal sinuses; thus, ordering both procedures is duplicative and inefficient.[5, 6] The third new proposed imaging efficiency measure for the CY 2012 payment determination "Simultaneous Use of Brain CT and Sinus CT" assesses the extent to which patients with a headache who have a brain CT also have a sinus CT performed on the same date at the same facility. The measure excludes patients with trauma diagnoses, tumors or orbital cellulitis.

The fourth new proposed imaging efficiency measure for the CY 2012 payment determination, "Use of Brain Computed Tomography (CT) in the Emergency Department for Atraumatic Headache," assesses the extent to which patients presenting with a headache receive brain CT studies. The measure excludes patients admitted or transferred to an acute care hospital, patients with lumbar punctures, dizziness, paresthesia, lack of coordination, subarachnoid hemorrhage or thunderclap headaches. The lifetime prevalence of headache is over 90 percent for men and women and according to some studies, headache accounts for 16 million physician visits in the U.S. annually.[7] According to a study conducted by Goldstein et al. (2006) on U.S. emergency departments (EDs) from 1992 to 2001, headaches represent approximately 2 percent of U.S. ED visits.[8] An analysis of 2007 Medicare claims data found that approximately 200,000 Medicare beneficiaries had a visit to an ED with a primary diagnosis of headache with about half of these patients (not taking into account the previously mentioned exclusion of lumbar punctures, dizziness, paresthesia, lack of coordination, subarachnoid hemorrhage or thunderclap headaches) receiving a Brain CT coincident with the ED visit.[9] Unnecessary or duplicative studies are inefficient and detrimental to the patient because CT exposes the patient to higher doses of radiation than conventional x-ray and increases the patient's risk for cancer.[10]

Concern over the inappropriate use of CT Imaging in the ED setting has been driven by three primary factors: False positive interpretations, radiation exposure, and cost. There is generally a lower threshold for ordering neuro-imaging for headache in the ED because of physician time constraints and lack of ED physician familiarity with headache presentation.[11] Because of this lower threshold, the measurement of the use of CT Brain in the ED for patients with a diagnosis of atraumatic headache can help to raise the awareness of the need for quality improvement on the appropriate use of CT brain imaging in the ED and, as a result improve patient safety through reduction in unnecessary radiation exposure.

Section 1833(t)(17)(C)(i) of the Act requires the Secretary to develop measures appropriate for the measurement of the quality of care furnished by hospitals in outpatient settings, that these measures reflect consensus among affected parties and, to the extent feasible and practicable, that these measures include measures set forth by one or more national consensus building entities. As discussed above, these measures are appropriate for measuring quality of care in the hospital outpatient department setting. These measures also meet the consensus requirement because these measures underwent development through a consensus-based measure development process involving stakeholder input. We anticipate that they will be endorsed by the NQF.

For the CY 2012 payment determination, we are proposing to calculate these four measures using Medicare claims from CY 2010. We invite comments on our proposal to add these four new imaging efficiency measures to the HOP QDRP measurement set based on Medicare claims from CY 2010 for the CY 2012 payment determination.

d. Proposed New Chart-Abstracted Measures for CY 2012 Payment Determination

We are proposing to add one new chart-abstracted measure to the HOP QDRP measurement set for the CY 2012 payment determination: "Troponin Results for Emergency Department acute myocardial infarction (AMI) patients or chest pain patients (with *Probable Cardiac Chest Pain*) Received within 60 minutes of arrival." Troponin is used to help diagnose a heart attack, to detect and evaluate mild to severe heart injury, and to distinguish chest pain that may be due to other causes.

This measure is based upon the existing ED–AMI/Chest Pain populations for which we have adopted five measures in the current HOP QDRP measurement set. This measure is currently undergoing NQF review.

Both patients and clinicians are impacted by the timeliness of laboratory reporting.[12] Decreasing laboratory turnaround times increases ED efficiency, specifically by decreasing diversion time from treatment of patients and decreasing length of stay.[13] Decreasing the numbers of hours a day on diversion as well as decreasing patients' lengths of stay in EDs allows for the treatment of a greater number of patients. Studies have found correlations between the length of stay and mean turnaround times.[14] Efficiencies in throughput with tasks can lead to less diversion, less overcrowding, less elopements and less financial loss.[15] Section 1833(t)(17)(C)(i) of the Act requires the Secretary to develop measures appropriate for the measurement of the quality of care furnished by hospitals in outpatient settings, that these measures reflect consensus among affected parties and, to the extent feasible and practicable, that these measures include measures set forth by one or more national consensus building entities. As discussed above, this measure is appropriate for measuring quality of care in the hospital outpatient department setting. This measure also meets the consensus requirement because this measure underwent development through a consensus-based measure development process involving stakeholder input. We anticipate that

[5] Brenner DJ, Hall EJ. November 29, 2007. Computer Tomography—An Increasing Source of Radiation Exposure. New England J of Medicine: 357(22): 2277–84.

[6] Appropriateness Criteria—Headache. Reston, VA: American College of Radiology, 2009. Accessed November 25, 2009 at *http://www.acr.org/SecondaryMainMenuCategories/quality_safety/app_criteria.aspx.*

[7] Mellion ML, Jayaraman MV. August 2007. Use of neuroimaging in the workup of headache. Med Health R I.; 90(8):249–50.

[8] Goldstein JN, CA Camargo, AJ Pelletier, JA Edlow. 2006. Headache in the United States Emergency Departments: demographics, work-up and frequency of pathological diagnoses. Cephalalgia; 26(6) 684.

[9] The Lewin Group analysis of Medicare Calendar Year 2007 claims data prepared for the Centers for Medicare & Medicaid Services, HHS Contract No: HHSM–500–2005–0024I, Order No. 0002.

[10] Brenner DJ and Hall EJ. November 29, 2007. Computed Tomography—An Increasing Source of Radiation Exposure. N Engl J Med;357(22):2277–84.

[11] Ward TN, Leven M, Phillips JM. Evaluation and management of headache in the emergency department. Med Clin N Am 2001; 85(4) 971–85.

[12] Howanitz JH, and Howanitz PJ. Laboratory results: Timeliness as a quality attribute and strategy. Am J Clin Pathol. 2002 Sep; 116 (3):311–5.

[13] Storrow AB, Zhou C, Gaddis G, Han JH, Miller K, Klubert D, Laidig A, and Aronsky D. Decreasing lab turnaround time improves emergency department throughput and decreases emergency medical services diversion: A simulation model. Acad Emerg Med. 2008 Nov; 15 (11):1130–5.

[14] Holland LL, Smith LL, and Blick KE. Reducing laboratory turnaround time outliers can reduce emergency department length of stay: An 11-hospital study. Am J Clin Pathol. 2005 Nov; 124 (5):672–4.

[15] Falvo T, Grove L, Stachura R, and Zirkin W. The financial impact of ambulance diversions and patient elopements. Acad Emerg Med. 2007 Jan; 14 (1):58–62.

this measure will be endorsed by the NQF.

If adopted, data collection for this measure would begin with January 1, 2011 discharges, and data would be submitted quarterly beginning with the first quarter of 2011, as with all other chart-abstracted measures.

We invite public comment on our proposal to add this new chart-abstracted measure to the HOP QDRP measurement set and the submission process for the CY 2012 payment determination.

In summary, for the CY 2012 payment determination, we are proposing to retain the 11 existing HOP QDRP measures for the CY 2011 payment determination, to add one new structural measure, four new claims-based imaging efficiency measures, and one new chart-abstracted measure for the ED AMI population. Submission of data regarding the new structural measure would begin with January 1, 2011 discharges using a Web-based collection tool available on the QualityNet Web site. We are proposing to calculate the four imaging measures using Medicare claims from calendar year 2010. Data collection for the chart-abstracted measure would begin with January 1, 2011 discharges, and data would be submitted quaterly beginning with the first quarter of 2011, as with all other chart-abstracted measures. We invite public comment on this proposal for the CY 2012 payment determination.

The complete list of 17 proposed measures for the CY 2012 payment determination is shown below.

Proposed HOP QDRP Measurement Set to be Used for the CY 2012 Payment Determination
OP-1: Median Time to Fibrinolysis
OP-2: Fibrinolytic Therapy Received Within 30 Minutes
OP-3: Median Time to Transfer to Another Facility for Acute Coronary Intervention
OP-4: Aspirin at Arrival
OP-5: Median Time to ECG
OP-6: Timing of Antibiotic Prophylaxis
OP-7: Prophylactic Antibiotic Selection for Surgical Patients
OP-8: MRI Lumbar Spine for Low Back Pain
OP-9: Mammography Follow-up Rates
OP-10: Abdomen CT – Use of Contrast Material
OP-11: Thorax CT – Use of Contrast Material
The Ability for Providers with HIT to Receive Laboratory Data Electronically Directly into their Qualified/Certified EHR System as Discrete Searchable Data*
Preoperative Evaluation for Low Risk Non Cardiac Surgery Risk Assessment*
Use of Stress Echocardiography, SPECT MPI, and Cardiac Stress MRI post CABG*
Simultaneous Use of Brain Computed Tomography (CT) and Sinus Computed Tomography (CT)*
Use of Brain Computed Tomography (CT) in the Emergency Department for Atraumatic Headache*
Troponin Results for Emergency Department acute myocardial infarction (AMI) patients or chest pain patients (with Probable Cardiac Chest Pain) Received within 60 minutes of arrival.*

* Proposed new measure for CY 2012 payment determination

4. Proposed HOP QDRP Quality Measures for the CY 2013 Payment Determination

a. Proposed Retention of CY 2012 HOP QDRP Measures for the CY 2013 Payment Determination

In general, unless otherwise specified in the retirement section of a rule, we retain measures from one payment determination to another. For the CY 2013 payment determination, we are proposing to retain all of the measures adopted for the CY 2012 payment determination. We invite public comment on this proposal for the CY 2013 payment determination.

b. Proposed New Structural Measure for the CY 2013 Payment Determination

We are proposing to add one structural measure to the HOP QDRP measurement set for the CY 2013 payment determination: Tracking Clinical Results between Visits. EHRs enable providers to issue reminders when clinical results are not received within a predefined timeframe. This measure assesses the extent to which a provider uses a certified/qualified EHR system to track pending laboratory tests, diagnostic studies (including common preventive screenings) or patient referrals. Section 1833(t)(17)(C)(i) of the Act requires the Secretary to develop measures appropriate for the measurement of the quality of care furnished by hospitals in outpatient settings, that these measures reflect consensus among affected parties and, to the extent feasible and practicable, that these measures include measures

set forth by one or more national consensus building entities. As discussed above, this structural measure is appropriate for measuring quality of care in the hospital outpatient department setting. This measure also meets the consensus requirement because it was endorsed as part of an NQF Project entitled "National Voluntary Consensus Standards for Health IT" (NQF #0491). Additionally, this measure was conditionally approved by the HQA in March of 2010.

Submission of this measure would begin with first quarter CY 2012 discharges to be submitted via the Web-based tool used to collect other structural measures, such as the registry participation structural measures for the RHQDAPU program. We invite comments on this proposal to add this new structural measure to the HOP QDRP measurement set and the submission process for the CY 2013 payment determination.

c. Proposed New Chart-Abstracted Measures for the CY 2013 Payment Determination

We are proposing to add six new chart-abstracted measures to the HOP QDRP measurement set for the CY 2013 payment determination.

The six new chart-abstracted measures we are proposing for the CY 2013 payment determination are: (1) Median Time from ED Arrival to ED Departure for Discharged ED Patients; (2) Transition Record with Specified Elements Received by Discharged Patients; (3) Door to Diagnostic Evaluation by a Qualified Medical Professional; (4) ED-Median Time to Pain Management for Long Bone Fracture; (5) ED-Patient Left Before Being Seen; and (6) ED-Head CT Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Who Received Head CT Scan Interpretation Within 45 minutes of Arrival. The topics addressed by these measures include ED efficiency, Imaging Efficiency, and care coordination/transition for hospital outpatient departments. Many of these measures would expand the chart-abstraction population for the HOP QDRP measurement set beyond the current ED-AMI/Chest Pain, and Surgical Care patients for which we have currently adopted seven measures in the HOP QDRP measurement set. However, this population expansion would be occurring at a time when subsection (d) hospitals would begin collection of more global ED population measures for the RHQDAPU program. Thus, we have timed the expansion of the chart-abstracted measures for HOP QDRP to coincide with expansions that will be occurring for the RHQDAPU program in order to reduce the burden associated with expansion. We also anticipate that, in the future, these measures could be captured and submitted via EHRs, eliminating the chart abstraction burden associated with these measures. These measures are discussed below:

(1) Median Time From ED Arrival to ED Departure for Discharged ED Patients

This measure, which was listed as under consideration for CY 2012 and subsequent years in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60637 through 60641), addresses ED efficiency in the form of the median time from emergency department arrival to time of departure from the emergency room for patients discharged from the emergency department. Reducing the time patients spend in the ED can improve quality of care. Reducing this time potentially improves access for more patients needing emergency care and increases hospitals' capability to provide additional treatment as necessary. Overcrowding and heavy emergency resource demand have led to a number of problems, including ambulance refusals, prolonged patient waiting times, increased suffering for those who wait, rushed and unpleasant treatment environments, and potentially poor patient outcomes. ED crowding may result in delays in the administration of medication such as antibiotics for pneumonia and has been associated with perceptions of delayed emergency care. When EDs are overwhelmed, their ability to respond to community emergencies and disasters may be compromised. Section 1833(t)(17)(C)(i) of the Act requires the Secretary to develop measures appropriate for the measurement of the quality of care furnished by hospitals in outpatient settings, that these measures reflect consensus among affected parties and, to the extent feasible and practicable, that these measures include measures set forth by one or more national consensus building entities. As discussed above, this chart-abstracted measure is appropriate for measuring quality of care in the hospital outpatient department setting. This measure also meets the consensus requirement because it was endorsed in 2009 (NQF #0496) as part of an NQF project entitled "National Voluntary Consensus Standards for Emergency Care." Additionally, this measure was conditionally approved by the HQA in March of 2010.

(2) Transition Record With Specified Elements Received by Discharged Patients

This chart-abstracted measure assesses the percentage of patients, regardless of age, discharged from an ED to ambulatory care or home healthcare, or their caregiver(s), who received a transition record at the time of ED discharge including at a minimum, the following elements: major procedures and tests performed during the ED visit; principal diagnosis at discharge or chief complaint; patient instructions; plan for follow-up care (or statement that none is required)—including primary physician, other health care professional, or site designated for follow-up care; and list of new medications and changes to continued medications that patient should take after ED discharge, with the quantity prescribed and/or dispensed (or intended duration) and instructions for each. Transitions of care are a weakness in maintaining continuity of care and proper adherence/compliance with follow up instructions. Hand-offs between settings should be accompanied by clear instructions for medications and follow-up care. Information should be provided about the care delivered while in each setting, and for what reasons, not only for the benefit of the patient and their caregivers, but for practitioners that will be following up with the patient after they leave an acute care setting.

Section 1833(t)(17)(C)(i) of the Act requires the Secretary to develop measures appropriate for the measurement of the quality of care furnished by hospitals in outpatient settings, that these measures reflect consensus among affected parties and, to the extent feasible and practicable, that these measures include measures set forth by one or more national consensus building entities. As discussed above, this measure is appropriate for measuring quality of care in the hospital outpatient department setting. This measure also meets the consensus requirement because it was endorsed by the NQF as part of a Project entitled "Endorsing Preferred Practices and Performance Measures for Measuring and Reporting Care Coordination" (NQF #0649). This measure was conditionally approved by the HQA in March of 2010.

(3) Door to Diagnostic Evaluation by a Qualified Medical Professional (Door to Provider)

This measure assesses mean time between patient presentation to the ED and the first moment the patient is seen by a person who can initiate a

diagnostic evaluation or therapeutic plan (for example, medical student, resident, nurse practitioner; excludes triage personnel). Long wait times in the ED before diagnosis increases the likelihood that someone will leave the ED without treatment for a serious condition, and can worsen the severity of the condition with which they presented. Section 1833(t)(17)(C)(i) of the Act requires the Secretary to develop measures appropriate for the measurement of the quality of care furnished by hospitals in outpatient settings, that these measures reflect consensus among affected parties and, to the extent feasible and practicable, that these measures include measures set forth by one or more national consensus building entities. As discussed above, this measure is appropriate for measuring quality of care in the hospital outpatient department setting. This measure also meets the consensus requirement because it gained NQF endorsement as part of the project entitled "National Voluntary Consensus Standards for Emergency Care" (NQF #0498). This measure was conditionally approved by the HQA in March of 2010.

(4) ED-Median Time to Pain Management for Long Bone Fracture

This chart-abstracted measure addresses the topic of efficient pain management in the ED, and is currently being reviewed by NQF. Pain management in patients with long bone fractures is currently undertreated in emergency departments.[16] Patients with bone fractures continue to lack administration of pain medication as part of treatment regimens.[17] When standards are implemented for pain management of these patients, treatment for pain improve.[18] Section 1833(t)(17)(C)(i) of the Act requires the Secretary to develop measures appropriate for the measurement of the quality of care furnished by hospitals in outpatient settings, that these measures reflect consensus among affected parties and, to the extent feasible and practicable, that these measures include measures set forth by one or more national consensus building entities. As discussed above, this measure is appropriate for measuring quality of care in the hospital outpatient department setting. This measure also meets the consensus requirement because it underwent development through a consensus-based measure development process involving stakeholder input. We anticipate that this measure will be endorsed by the NQF.

(5) ED-Patient Left Without Being Seen

This measure is the sum of all patients leaving an ED who were not seen by a provider (for example, medical student, resident, nurse practitioner). A patient leaving before being seen is an indicator of emergency department overcrowding.[19] Patients who leave before being seen may not receive appropriate medical care and this lack of care may result in adverse outcomes.[20] National estimates for patients who leave before being seen by a provider average 1.9 percent.[21] Section 1833(t)(17)(C)(i) of the Act requires the Secretary to develop measures appropriate for the measurement of the quality of care furnished by hospitals in outpatient settings, that these measures reflect consensus among affected parties and, to the extent feasible and practicable, that these measures include measures set forth by one or more national consensus building entities. As discussed above, this measure is appropriate for measuring quality of care in the hospital outpatient department setting. This measure also meets the consensus requirement because it was endorsed by the NQF (NQF #0499) as part of the National Voluntary Consensus Standards for Emergency Care.

(6) ED-Head CT Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Who Received Head CT Scan Interpretation Within 45 Minutes of Arrival

This measure assesses whether head CT scan results for acute ischemic stroke or hemorrhagic stroke patients who received head CT scans in the ED were interpreted within 45 minutes of arrival. This chart-abstracted measure is currently under NQF review. Improved access to diagnostics assists clinicians in decisionmaking. Delayed diagnostic imaging and laboratory reports are expected to slow down clinical decision making process and subsequently increase length of stay in the ED. Similarly, decreasing radiology report turnaround times can have impacts across the facility and can assist in reducing the length of stay in the ED. It also can enhance decisionmaking capabilities for patient treatment plans because timely diagnostic imaging is available.[22] The Food and Drug Administration (FDA) approved the use of tissue plasminogen activator (t–PA) for treatment of acute ischemic stroke, which comprise 87 percent of stokes, when given within three hours of stroke symptom onset.[23] [24] Because of the therapeutic time window for treatment possibilities, timely completion and results of the CT scan are imperative for timely clinical decisionmaking and favorable outcomes. Section 1833(t)(17)(C)(i) of the Act requires the Secretary to develop measures appropriate for the measurement of the quality of care furnished by hospitals in outpatient settings, that these measures reflect consensus among affected parties and, to the extent feasible and practicable, that these measures include measures set forth by one or more national consensus building entities. As discussed above, this measure is appropriate for measuring quality of care in the hospital outpatient department setting. This measure also meets the consensus requirement because this measure underwent development through a consensus-based measure development process involving stakeholder input. We anticipate that this measure will be endorsed by the NQF.

The submission of the new chart-abstracted measures for the CY 2013 payment determination will begin with first quarter 2012 discharges, and data would be submitted quarterly, as with all other chart-abstracted measures. We invite comments on this proposal to add these new measures to the HOP QDRP measurement set and on the submission

[16] Ritsema, T.S., Kelen, G.D., Pronovost, R.J., and Pham, J.C.: The national trend in quality of emergency department pain management of long bone fractures. Acad Emerg Med. 2007 Feb 14; 14(2):163–9.

[17] Brown, J.C., Klein, E.J., Lewis, C.W., Johnston, B.D., and Cummings, P.: Emergency department analgesia for fracture pain. Ann Emerg Med. 2003 Aug; 42(2):197–205.

[18] Titler, M.G., Herr, K., Brooks, J.M., Xie, X.J., Ardery, G., Schilling, M.L., Marsh, J.L., Everett, L.Q., Clark, W.R.: Translating research into practice intervention improves management of acute pain in older hip fracture patients. Health Serv Res. 2009; 44(1), 264–87.

[19] United States General Accounting Office. Hospital emergency departments: Crowded conditions vary among hospitals and communities. Publication GAO–03–460, 2003.

[20] Rowe, B.H., Channan, P., Bullard, M., Blitz, S., Saunders, L.D., Rosychuk, R.J., Lari, H., Craig, W.R., Holroyd, B.R.: Characteristics of patients who leave emergency departments without being seen. Acad Emerg Med. 2006 Aug; 13(8):848–52.

[21] McCaig, L.F., Nawar, E.W.: National hospital ambulatory medical care survey: 2004 Emergency department summary. Adv Data. 2006 Jun 23; (372):1–29.

[22] Marquez L.O. Improving medical imaging report turnaround times. Radiol Mange. 2005 Jan–Feb; 27(1):34–7.

[23] National Stroke Association. STROKE the First Hours Guidelines for Acute Treatment, 2000.

[24] The ATLANTIS, ECASS, and NINDS rt–PA Study Group Investigators. Association of Outcome with early stroke treatment: pooled analysis of ATLANTIS, ECASS, and NINDS rt–PA stroke Trials. Lancet 2004; 363:768–774.

process for the CY 2013 payment determination.

In summary, for the CY 2013 payment determination, we are proposing to retain all of the measures adopted for the CY 2012 payment determination, and to adopt one new structural measure, and six new chart-abstracted measures for the CY 2013 payment determination on the topics of HOPD care transitions and ED efficiency. Submission of the new structural measure would begin with first quarter CY 2012 discharges to be submitted via a Web-based tool on the QualityNet Web site in 2012. The submission of the new chart-abstracted measures for the CY 2013 payment determination would begin with first quarter CY 2012 discharges, to be submitted in 2012. We invite comments on this proposal for the CY 2013 payment determination.

The complete list of 24 proposed measures for the CY 2013 payment determination is shown below.

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Proposed HOP QDRP Measurement Set to be Used for the CY 2013 Payment Determination
OP-1: Median Time to Fibrinolysis
OP-2: Fibrinolytic Therapy Received Within 30 Minutes
OP-3: Median Time to Transfer to Another Facility for Acute Coronary Intervention
OP-4: Aspirin at Arrival
OP-5: Median Time to ECG
OP-6: Timing of Antibiotic Prophylaxis
OP-7: Prophylactic Antibiotic Selection for Surgical Patients
OP-8: MRI Lumbar Spine for Low Back Pain
OP-9: Mammography Follow-up Rates
OP-10: Abdomen CT – Use of Contrast Material
OP-11: Thorax CT – Use of Contrast Material
The Ability for Providers with HIT to Receive Laboratory Data Electronically Directly into their Qualified/Certified EHR System as Discrete Searchable Data*
Preoperative Evaluation for Low Risk Non Cardiac Surgery Risk Assessment*
Use of Stress Echocardiography, SPECT MPI, and Cardiac Stress MRI post CABG*
Simultaneous Use of Brain Computed Tomography (CT) and Sinus Computed Tomography (CT)*
Use of Brain Computed Tomography (CT) in the Emergency Department for Atraumatic Headache*
Troponin Results for Emergency Department acute myocardial infarction (AMI) patients or chest pain patients (with Probable Cardiac Chest Pain) Received within 60 minutes of arrival *
Tracking Clinical Results between Visits**
Median Time from ED Arrival to ED Departure for Discharged ED Patients**
Transition Record with Specified Elements Received by Discharged Patients**
Door to Diagnostic Evaluation by a Qualified Medical Professional**
ED- Median Time to Pain Management for Long Bone Fracture **
ED- Patient Left Before Being Seen**
ED- Head CT Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke who Received Head CT Scan Interpretation Within 45 minutes of Arrival **

* Proposed new measure for CY 2012 payment determination

** Proposed new measure for CY 2013 payment determination

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5. Proposed HOP QDRP Quality Measures for the CY 2014 Payment Determination

a. Proposed Retention of CY 2013 HOP QDRP Measures for the CY 2014 Payment Determination

In general, unless otherwise specified in the retirement section of a rule, we retain measures from one payment determination to another. For the CY 2014 payment determination, we are proposing to retain all of the measures adopted for the CY 2013 payment determination. We invite comment on this proposal.

b. Proposed New Chart-Abstracted Measures for the CY 2014 Payment Determination

We are proposing to adopt six new chart-abstracted measures for the CY 2014 payment determination. Five of the six measures are Diabetes Care measures for HOPDs, and one measure is an additional imaging efficiency measure. The six measures we are proposing for the CY 2014 payment determination are: (1) Hemoglobin A1c Poor Control in Diabetic Patients; (2) Low Density Lipoprotein (LDL–C) Control in Diabetic Patients; (3) High Blood Pressure Control in Diabetic Patients; (4) Dilated Eye Exam in Diabetic Patients; (5) Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients; and (6) Exposure Time Reported for Procedures Using Fluoroscopy. We are proposing that submission of these measures for the CY 2014 payment determination begin with the first quarter CY 2013 discharges to be submitted in 2013. These measures are discussed below.

(1) Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetic Patients

This NQF-endorsed measure (NQF #0059) measures the percentage of adult patients with diabetes aged 18–75 years with most recent HgA1c level greater than 9 percent (poor control). Glycosylated hemoglobin (HgA1c) assay measures average blood glucose over the preceding two to three months, rather than just one point in time. HgA1c values vary less than fasting glucose values and give clinicians a better integrated view of the patient's average blood sugar over time. High HgA1c is a more reliable indicator of chronic high blood sugar. Lowered HgA1c levels are associated with reduced microvascular and neuropathic complications of diabetes.

In general, diabetes mellitus is a chronic disease that impacts the lives of a large portion of the population and consumes a significant amount of U.S. healthcare dollars. With the prevalence of diabetes in the Medicare-eligible population expected to double, costs are expected to increase almost fourfold to $171 million.[25] Uncontrolled diabetes often leads to biochemical imbalances that can lead to acute life-threatening events, such as diabetic ketoacidosis and hyperosmolar, or nonketotic coma. In patients with insulin-dependent diabetes, the risk of development or progression of retinopathy, nephropathy, and neuropathy can be reduced by 50 to 75 percent by intensive outpatient treatment of hyperglycemia compared to conventional treatment. Early treatment may help slow or halt the progression of diabetic complications, and following the guidelines for screening may assist those patients with no outward sign of diabetic complications to be identified earlier through regular screening tests. HgA1c should be performed during an initial assessment and during follow-up assessments, which should occur at no longer than three-month intervals.[26] Section 1833(t)(17)(C)(i) of the Act requires the Secretary to develop measures appropriate for the measurement of the quality of care furnished by hospitals in outpatient settings, that these measures reflect consensus among affected parties and, to the extent feasible and practicable, that these measures include measures set forth by one or more national consensus building entities. As discussed above, this measure is appropriate for measuring quality of care in the hospital outpatient department setting. This measure also meets the consensus requirement because, as noted above, it has been endorsed by the NQF.

(2) Diabetes Mellitus: Low Density Lipoprotein (LDL–C) Control in Diabetic Patients

This NQF-endorsed measure (NQF #0064) measures the percentage of adult patients with diabetes aged 18–75 years whose most recent LDL–C test result during the measurement year was <100 mg/dl. LDL–C measures the development of atherosclerotic plague which increases cardiac events risks for diabetic patients whose heart disease death rates are about two to four times higher than non-diabetics.[27] Improved dyslipidemia management helps to mitigate the risk for cardiovascular disease. Lipid-lowering therapy for diabetics has been a consistent recommendation in several guidelines, prompted by randomized trials supporting statin therapy to lower the risk of cardiovascular involvement for this population. Despite the evidence basis and guideline support, only a minority of patients with diabetes are prescribed statin treatment or achieve target LDL–C goals.[28] Early treatment may help slow or halt the progression of cardiovascular disease and impact the quality of the life of the diabetic patient, affecting the patient's life expectancy and decreasing costs involved in treating diabetic complications. Section 1833(t)(17)(C)(i) of the Act requires the Secretary to develop measures appropriate for the measurement of the quality of care furnished by hospitals in outpatient settings, that these measures reflect consensus among affected parties and, to the extent feasible and practicable, that these measures include measures set forth by one or more national consensus building entities. As discussed above, this measure is appropriate for measuring quality of care in the hospital outpatient department setting. This measure also meets the consensus requirement because, as noted above, it has been endorsed by the NQF. We also note that this measure was listed as under consideration for CY 2012 and subsequent years in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60637 through 60641).

(3) Diabetes Mellitus: High Blood Pressure Control in Diabetic Patients

This NQF-endorsed measure (NQF #0061) measures the percentage of patients visits with blood pressure measurement recorded among all patients visits aged >18 years with diagnosed hypertension. Blood pressure control reduces the risk of cardiovascular disease and microvascular complications in patients with diabetes. Most importantly, early treatment of high blood pressure may help slow or halt the progression of kidney involvement and damage.[29]

[25] Huang, E.S., Basu, A., O'Grady, M., Capretta, J.C.: Projecting the future diabetes population size and related costs for the U.S. Diabetes Care. 2009;32(12):2225–29.

[26] The American Association of Clinical Endocrinologists Medical Guidelines for the Management of Diabetes Mellitus: The AACE System of Intensive Diabetes Self-Management—2002 Update.

[27] American Diabetes Association. Standards of medical care in diabetes. Diabetes Care. 2007 Jan;30 (Suppl 1):S8–15.

[28] Das, S.R., Vaeth, P.A., Stanek, H.G., de Lemos, J.A., Dobbins, R.L., McGuire, D.K.: Increased cardiovascular risk associated with diabetes in Dallas County. Am Heart J 2006;151:1087–93.

[29] Centers for Disease Control and Prevention. National diabetes fact sheet: general information and national estimates on diabetes in the United States, 2007. Atlanta, GA: U.S. Department of

Blood pressure is a factor that can be controlled Well-controlled blood pressure impacts the quality of the life of the diabetic patient, affects the patient's life expectancy, and decreases the costs involved in treating diabetic complications. Section 1833(t)(17)(C)(i) of the Act requires the Secretary to develop measures appropriate for the measurement of the quality of care furnished by hospitals in outpatient settings, that these measures reflect consensus among affected parties and, to the extent feasible and practicable, that these measures include measures set forth by one or more national consensus building entities. As discussed above, this measure is appropriate for measuring quality of care in the hospital outpatient department setting. This measure also meets the consensus requirement because, as noted above, it has been endorsed by the NQF.

(4) Diabetes Mellitus: Dilated Eye Exam in Diabetic Patients

This NQF-endorsed measure (NQF #0055) measures the percentage of adult patients with diabetes age 18 to 75 years who received a dilated eye exam or seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist, or imaging to verify diagnosis from stereoscopic photos during the reporting year, or during the prior year, if patient is at low risk for retinopathy. A patient is considered low risk if the patient has no evidence of retinopathy in the prior year. A dilated eye exam helps to detect the risk for vision-threatening diabetic retinopathy which is prevalent among people with diabetes. Data from the 2007 National Diabetes Fact Sheet (using the most recent year of available data) shows that diabetic retinopathy causes up to 24,000 new cases of blindness each year.[30] However, dilated eye exams for diabetic patients can prevent retinopathy through early detection.[31]

Section 1833(t)(17)(C)(i) of the Act requires the Secretary to develop measures appropriate for the measurement of the quality of care furnished by hospitals in outpatient settings, that these measures reflect consensus among affected parties and, to the extent feasible and practicable, that these measures include measures set forth by one or more national consensus building entities. As discussed above, this measure is appropriate for measuring quality of care in the hospital outpatient department setting. This measure also meets the consensus requirement because, as noted above, this measure has been endorsed by the NQF. We note that this measure was listed as under consideration for CY 2012 and subsequent years in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60637 through 60641).

(5) Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients

This NQF-endorsed measure (NQF #0062) measures the percentage of adult diabetic patients aged 18–75 years with at least one test for microalbumin during the measurement year or who had evidence of medical attention for existing nephropathy (diagnosis of nephropathy or documentation of microalbuminuria or albuminuria). Urine screening for microalbumin detects abnormal amount of protein albumin leaks in the urine by the capillaries of the kidney. High levels of blood sugar in uncontrolled diabetes can cause damage to the capillaries in the kidneys. Early urine screenings for microalbumin may prevent kidney disease from worsening to end-stage renal disease (ESRD). Diabetics accounted for 44 percent of new cases of kidney disease. In 2005, a total of 178,689 diabetics with ESRD were on dialysis or received a kidney transplant in the United States and Puerto Rico.[32] In 2009, MedPAC reported costs for the 330,000 Medicare recipients receiving dialysis treatment for ESRD at over 8 billion dollars.[32] Section 1833(t)(17)(C)(i) of the Act requires the Secretary to develop measures appropriate for the measurement of the quality of care furnished by hospitals in outpatient settings, that these measures reflect consensus among affected parties and, to the extent feasible and practicable, that these measures include measures set forth by one or more national consensus building entities. As discussed above, this measure is appropriate for measuring quality of care in the hospital outpatient department setting. This measure also meets the consensus requirement because, as noted above, it has been endorsed by the NQF. We also note that this measure was listed as under consideration for CY 2012 and subsequent years in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60637 through 60641).

(6) Exposure Time Reported for Procedures Using Fluoroscopy

This measure documents the percentage of final reports for procedures using fluoroscopy that include documentation of radiation exposure or exposure time, an important measure for the HOPD setting. This measure is currently specified for physician level data collection through the PQRI program (74 FR 61825), and can be used for the hospital outpatient facility level. This measure evaluates the documentation of radiation exposure or radiation time during fluoroscopy. Data suggests that the lifetime risk for cancer can be increased, albeit by a small amount, with frequent or repeated exposure to ionizing radiation, including procedures using fluoroscopy.[33] To monitor these long term effects, the exposure time or radiation dose that a patient receives as a result of the procedure should be measured and recorded in the patient's record. The American College of Radiology (ACR) encourages practices to record actual fluoroscopy time for all fluoroscopic procedures. The fluoroscopy time for various procedures (for example, upper gastrointestinal, pediatric voiding cystourethrography) should then be compared with benchmark figures.[34] [35] The National Cancer Institute also recommends measuring and recording patient radiation dose, fluoroscopy time and additional available measures: Dose area product, cumulative dose, and skin dose. Section 1833(t)(17)(C)(i) of the Act requires the Secretary to develop measures appropriate for the measurement of the quality of care

Health and Human Services, Centers for Disease Control and Prevention, 2008.

[30] Centers for Disease Control and Prevention. National diabetes fact sheet: General information and national estimates on diabetes in the United States, 2007. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2008.

[31] American Diabetes Association. Standards of medical care in diabetes. Diabetes Care. 2007 Jan;30 (Suppl 1):S8–15.

[32] Centers for Disease Control and Prevention. National diabetes fact sheet: general information and national estimates on diabetes in the United States, 2007. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2008.

[32] MedPAC. Outpatient dialysis service: Assessing payment adequacy and updating payments. Report to the Congress; Medicare payment policy. 2009 Mar; 131–56.

[33] National Cancer Institute (NCI), The Society for Pediatric Radiology (SPR). Brochure: Radiation & pediatric computed tomography. A guide for health care providers. 2002. Available at; *http://www/cancer.gov/cancertopics/cause/radiation-risks-pediatric-CT.pdf*

[34] Amis E Jr, Butler P, Applegate K, Birnbaum S, Brateman L, Hevezi J, Mettler F, Morin R, Pentecost M, Smith G. American College of radiology white paper on radiation dose in medicine. Journal of American College of Radiology, 2007:4:272–284

[35] National Cancer Institute. Interventional fluoroscopy: Reducing radiation risks for patients and staff. 2005. Available at: *http://www.cancer.gov/cancertopics/interventionalfluoroscopy.*

furnished by hospitals in outpatient settings, that these measures reflect consensus among affected parties and, to the extent feasible and practicable, that these measures include measures set forth by one or more national consensus building entities. As discussed above, this measure is appropriate for measuring quality of care in the hospital outpatient department setting. This measure also meets the consensus requirement because it is NQF-endorsed (NQF # 0510). Additionally, this measure was conditionally approved by the HQA for the hospital outpatient setting in March of 2010.

In summary, for the CY 2014 payment determination, we are proposing to retain all of the measures adopted for the CY 2013 payment determination, and to adopt six new chart-abstracted measures for the CY 2014 payment determination on the topics of diabetes care and exposure time for procedures using fluoroscopy. We are proposing that submission of the new chart-abstracted measures for the CY 2014 payment determination begin with first quarter CY 2013 discharges to be submitted in 2013. We invite public comment on this proposal for the CY 2014 payment determination.

The complete list of 30 proposed measures for the CY 2014 payment determination is shown below.

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Proposed HOP QDRP Measurement Set to be Used for theCY 2014 Payment Determination
OP-1: Median Time to Fibrinolysis
OP-2: Fibrinolytic Therapy Received Within 30 Minutes
OP-3: Median Time to Transfer to Another Facility for Acute Coronary Intervention
OP-4: Aspirin at Arrival
OP-5: Median Time to ECG
OP-6: Timing of Antibiotic Prophylaxis
OP-7: Prophylactic Antibiotic Selection for Surgical Patients
OP-8: MRI Lumbar Spine for Low Back Pain
OP-9: Mammography Follow-up Rates
OP-10: Abdomen CT – Use of Contrast Material
OP-11: Thorax CT – Use of Contrast Material
The Ability for Providers with HIT to Receive Laboratory Data Electronically Directly into their Qualified/Certified EHR System as Discrete Searchable Data*
Preoperative Evaluation for Low Risk Non Cardiac Surgery Risk Assessment*
Use of Stress Echocardiography, SPECT MPI, and Cardiac Stress MRI post CABG*
Simultaneous Use of Brain Computed Tomography (CT) and Sinus Computed Tomography (CT)*
Use of Brain Computed Tomography (CT) in the Emergency Department for Atraumatic Headache*
Troponin Results for Emergency Department acute myocardial infarction (AMI) patients or chest pain patients (with Probable Cardiac Chest Pain) Received within 60 minutes of arrival *
Tracking Clinical Results between Visits**
Median Time from ED Arrival to ED Departure for Discharged ED Patients**
Transition Record with Specified Elements Received by Discharged Patients**
Door to Diagnostic Evaluation by a Qualified Medical Professional**
ED- Median Time to Pain Management for Long Bone Fracture **
ED- Patient Left Before Being Seen**
ED- Head CT Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke who Received Head CT Scan Interpretation Within 45 minutes of Arrival **
Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetic Patients***
Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetic Patients***
Diabetes Mellitus: High Blood Pressure Control in Diabetic Patients***
Diabetes Mellitus: Dilated Eye Exam in Diabetic Patients***
Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients***
Exposure Time Reported for Procedures Using Fluoroscopy***

* Proposed new measure for CY 2012 payment determination

** Proposed new measure for CY 2013 payment determination

*** Proposed new measure for CY 2014 payment determination

6. Possible Quality Measures Under Consideration for Future Inclusion in HOP QDRP

In previous years' rulemakings, we have provided lists of quality measures that are under consideration for future adoption into the HOP QRDP measurement set. Below is a list of measures under consideration for future rulemaking cycles.

Measures and Measurement Topics under Consideration for Future Payment Determinations Beginning with CY 2013
Measures for future development:
Adjuvant Chemotherapy is Considered or Administered within 4 Months of Surgery to Patients Under Age 80 with AJCC III Colon Cancer.
Adjuvant Hormonal Therapy for Patients with Breast Cancer
Needle Biopsy to Establish Diagnosis of Cancer Precedes Surgical Excision/Resection.
Pneumococcal Vaccination Status
Influenza Vaccination Status
Cardiac Rehabilitation Referral
Medication Reconciliation
Appropriate surgical site hair removal
Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
Heart Failure: Left Ventricular Ejection Fraction Assessment
Heart Failure: Combination Medical Therapy for Left Ventricular Systolic Dysfunction
Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction
Heart Failure: Counseling regarding Implantable Cardioverter-Defibrillator (ICD) Implantation for Patients with Left Ventricular Systolic Dysfunction on Combination Medical Therapy
Heart Failure: Patients with Left Ventricular Systolic Dysfunction on Combination Medical Therapy
Heart Failure: Symptom Management
Heart Failure: Symptom and Activity Assessment
Heart Failure: Patient Education
Heart Failure: End of Life Care Plan
Heart Failure: Overuse of Echocardiography
Heart Failure: Post-Discharge Appointment for Heart Failure Patients
Emergency Department Transfer Communication: Administrative Communications
Emergency Department Transfer Communication: Medication Information
Emergency Department Transfer Communication: Nursing Information
Emergency Department Transfer Communication: Patient Information
Emergency Department Transfer Communication: Physician Information
Emergency Department Transfer Communication: Procedures and Tests
Emergency Department Transfer Communication: Vital Signs

Measures and Measurement Topics under Consideration for Future Payment Determinations Beginning with CY 2013
Measurement Topics for future development:
Chemotherapy
Unplanned Reintubation
Unplanned Inpatient Transfer
Post-discharge follow up
Post-discharge ED visit within 72 hours
Safe Surgery Checklist
Immunization Refusal rate
Breast cancer detection rate

BILLING CODE 4120–01–C

We invite public comment on these quality measures and topics so that we may consider proposing to adopt them beginning with the CY 2013 payment determination. We also are seeking suggestions and rationales to support the adoption of measures and topics for the HOP QDRP which do not appear in the table above.

In addition, we are concerned about the lack of progress in reducing the rates of healthcare associated infections that was recently reported in the 2009 National Healthcare Quality Report (*http://www.ahrq.gov/qual/nhqr09/nhqr09.pdf*). For example, the report found that rates of postoperative sepsis increased by 8 percent. We view healthcare associated infections as a significant priority for quality measurement in order to ensure that health care does not result in avoidable harm and to inform the public about hospitals' performance with respect to these infections. We are inviting public comment on the option to include among our prioritization criteria quality measures that assess performance on healthcare associated infections. Also, while some HOP QDRP measures cover aspects of healthcare associated infections, we are inviting suggestions on additional measures that could be added to those that hospitals would report and that we would make available to the public in order promote improvement in healthcare associated infection rates.

C. Proposed Payment Reduction for Hospitals That Fail To Meet the HOP QDRP Requirements for the CY 2011 Payment Update

1. Background

Section 1833(t)(17)(A) of the Act, which applies to subsection (d) hospitals (as defined under section 1886(d)(1)(B) of the Act), requires that hospitals that fail to report data required for the quality measures selected by the Secretary, in the form and manner required by the Secretary under section 1833(t)(17)(B) of the Act, incur a 2.0 percentage point reduction to their OPD fee schedule increase factor, that is, the annual payment update factor. Section 1833(t)(17)(A)(ii) of the Act specifies that any reduction would apply only to the payment year involved and would not be taken into account in computing the applicable OPD fee schedule increase factor for a subsequent payment year.

In the CY 2009 OPPS/ASC final rule with comment period (73 FR 68769 through 68772), we discussed how the payment reduction for failure to meet the administrative, data collection, and data submission requirements of the HOP QDRP affected the CY 2009 payment update applicable to OPPS payments for HOPD services furnished by the hospitals defined under section 1886(d)(1)(B) of the Act to which the program applies. The application of a reduced OPD fee schedule increase factor results in reduced national unadjusted payment rates that apply to certain outpatient items and services provided by hospitals that are required to report outpatient quality data and that fail to meet the HOP QDRP requirements. All other hospitals paid under the OPPS receive the full OPPS payment update without the reduction.

The national unadjusted payment rates for many services paid under the OPPS equal the product of the OPPS conversion factor and the scaled relative weight for the APC to which the service is assigned. The OPPS conversion factor, which is updated annually by the OPD fee schedule increase factor, is used to calculate the OPPS payment rate for services with the following status indicators (listed in Addendum B to this proposed rule with comment period): "P," "Q1," "Q2," "Q3," "R," "S," "T," "V," "U," or "X." In the CY 2009 OPPS/ASC final rule with comment period (73 FR 68770), we adopted a policy that payment for all services assigned these status indicators would be subject to the reduction of the national unadjusted payment rates for applicable hospitals, with the exception of services assigned to New Technology APCs with assigned status indicator "S" or "T," and brachytherapy sources with assigned status indicator "U," which were paid at charges adjusted to cost in CY 2009. We excluded services assigned to New Technology APCs from the list of services subject to the reduced national unadjusted payment rates because the OPD fee schedule increase factor is not used to update the payment rates for these APCs.

In addition, section 1833(t)(16)(C) of the Act, as amended by section 142 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) (Pub. L. 110–275), specifically required that brachytherapy sources be paid during CY 2009 on the basis of charges adjusted to cost, rather than under the standard OPPS methodology. Therefore, the reduced conversion factor also was not applicable to CY 2009 payment for brachytherapy sources because payment would not be based on the OPPS conversion factor and, consequently, the payment rates for these services were not updated by the OPD fee schedule increase factor. However, in accordance with section 1833(t)(16)(C) of the Act, as amended by section 142 of the MIPPA, payment for brachytherapy sources at charges adjusted to cost expired on January 1, 2010. Therefore, in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60641), we finalized our CY 2010 proposal, without

modification, to apply the reduction to payment for brachytherapy sources to hospitals that fail to meet the quality data reporting requirements of the HOP QDRP for the CY 2010 OPD fee schedule increase factor.

The OPD fee schedule increase factor, or market basket update, is an input into the OPPS conversion factor, which is used to calculate OPPS payment rates. To implement the requirement to reduce the market basket update for hospitals that fail to meet reporting requirements, we calculate two conversion factors: a full market basket conversion factor (that is, the full conversion factor), and a reduced market basket conversion factor (that is, the reduced conversion factor). We then calculate a reduction ratio by dividing the reduced conversion factor by the full conversion factor. We refer to this reduction ratio as the "reporting ratio" to indicate that it applies to payment for hospitals that fail to meet their reporting requirements. Applying this reporting ratio to the OPPS payment amounts results in reduced national unadjusted payment rates that are mathematically equivalent to the reduced national unadjusted payment rates that would result if we multiplied the scaled OPPS relative weights by the reduced conversion factor. To determine the reduced national unadjusted payment rates that applied to hospitals that failed to meet their quality reporting requirements for the CY 2010 OPPS, we multiply the final full national unadjusted payment rate in Addendum B to the CY 2010 OPPS/ASC final rule with comment period by the CY 2010 OPPS final reporting ratio of 0.980 (74 FR 60642).

In the CY 2009 OPPS/ASC final rule with comment period (73 FR 68771 through 68772), we established a policy that the Medicare beneficiary's minimum unadjusted copayment and national unadjusted copayment for a service to which a reduced national unadjusted payment rate applies would each equal the product of the reporting ratio and the national unadjusted copayment or the minimum unadjusted copayment, as applicable, for the service. Under this policy, we apply the reporting ratio to both the minimum unadjusted copayment and national unadjusted copayment for those hospitals that receive the payment reduction for failure to meet the HOP QDRP reporting requirements. This application of the reporting ratio to the national unadjusted and minimum unadjusted copayments is calculated according to § 419.41 of our regulations, prior to any adjustment for hospitals' failure to meet the quality reporting standards according to § 419.43(h). Beneficiaries and secondary payers thereby share in the reduction of payments to these hospitals.

In the CY 2009 OPPS/ASC final rule with comment period (73 FR 68772), we established the policy that all other applicable adjustments to the OPPS national unadjusted payment rates apply in those cases when the OPD fee schedule increase factor is reduced for hospitals that fail to meet the requirements of the HOP QDRP. For example, the following standard adjustments apply to the reduced national unadjusted payment rates: the wage index adjustment; the multiple procedure adjustment; the interrupted procedure adjustment; the rural sole community hospital adjustment; and the adjustment for devices furnished with full or partial credit or without cost. We believe that these adjustments continue to be equally applicable to payments for hospitals that do not meet the HOP QDRP requirements. Similarly, outlier payments will continue to be made when the criteria are met. For hospitals that fail to meet the quality data reporting requirements, the hospitals' costs are compared to the reduced payments for purposes of outlier eligibility and payment calculation. This policy conforms to current practice under the IPPS. In the CY 2010 OPPS/ASC final rule with comment period (74 FR 60642), we continued this policy. For a complete discussion of the OPPS outlier calculation and eligibility criteria, we refer readers to section II.G. of this CY 2011 OPPS/ASC proposed rule.

2. Proposed Reporting Ratio Application and Associated Adjustment Policy for CY 2011

We are proposing to continue our established policy of applying the reduction of the OPD fee schedule increase factor through the use of a reporting ratio for those hospitals that fail to meet the HOP QDRP requirements for the full CY 2011 annual payment update factor. For the CY 2011 OPPS, the proposed reporting ratio is 0.980, calculated by dividing the reduced conversion factor of $66.930 by the full conversion factor of $68.267. We are proposing to continue to apply the reporting ratio to all services calculated using the OPPS conversion factor. For the CY 2011 OPPS, we are proposing to apply the reporting ratio, when applicable, to all HCPCS codes to which we have assigned status indicators "P," "Q1," "Q2," "Q3," "R," "S," "T," "V," "U," and "X." We are proposing to continue to exclude services paid under New Technology APCs. We are proposing to continue to apply the reporting ratio to the national unadjusted payment rates and the minimum unadjusted and national unadjusted copayment rates of all applicable services for those hospitals that fail to meet the HOP QDRP reporting requirements. We also are proposing to continue to apply all other applicable standard adjustments to the OPPS national unadjusted payment rates for hospitals that fail to meet the requirements of the HOP QDRP. Similarly, we are proposing to continue to calculate OPPS outlier eligibility and outlier payment based on the reduced payment rates for those hospitals that fail to meet the reporting requirements.

D. Proposed Requirements for HOPD Quality Data Reporting for CY 2012 and Subsequent Years

In order to participate in the HOP QDRP, hospitals must meet administrative, data collection and submission, and data validation requirements (if applicable). Hospitals that do not meet the requirements of the HOP QDRP, as well as hospitals not participating in the program and hospitals that withdraw from the program, will not receive the full OPPS payment rate update. Instead, in accordance with section 1833(t)(17)(A) of the Act, those hospitals will receive a reduction of 2.0 percentage points in their annual payment update factor for the applicable payment year. We established the payment determination requirements for the CY 2011 payment update in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60642 through 60652).

For payment determinations affecting the CY 2012 payment update, we are proposing to implement the requirements listed below. Most of these requirements are the same as the requirements we implemented for the CY 2011 payment determination, with some proposed modifications.

1. Administrative Requirements

To participate in the HOP QDRP, we are proposing that several administrative steps be completed. These steps would require the hospital to:

- Identify a QualityNet security administrator who follows the registration process located on the QualityNet Web site *(http://www.QualityNet.org)* and submits the information to the appropriate CMS-designated contractor. All CMS-designated contractors would be identified on the QualityNet Web site. The same person may be the QualityNet security administrator for both the RHQDAPU program and the HOP

QDRP. From our experience, we believe that the QualityNet security administrator typically fulfills a variety of tasks related to the hospital's ability to participate in the HOP QDRP, such as: creating, approving, editing and/or terminating QualityNet user accounts within the organization; monitoring QualityNet usage to maintain proper security and confidentiality measures; and serving as a point of contact for information regarding QualityNet and the HOP QDRP. The hospital would be required to maintain a current QualityNet security administrator for as long as the hospital participates in the program due to CMS information systems security requirements. While only a single QualityNet security administrator would be required for program purposes, we suggest to hospitals that it may be beneficial to have more than one QualityNet security administrator for back-up purposes.

- Register with QualityNet, regardless of the method used for data submission.
- Complete and submit an online participation form if this form (or a paper Notice of Participation form) has not been previously completed, if a hospital has previously withdrawn, or if the hospital acquires a new CCN. For HOP QDRP decisions affecting the CY 2012 payment determination, hospitals that share the same CCN would be required to complete a single online participation form. In the CY 2009 OPPS/ASC final rule with comment period (73 FR 68772), we implemented an online registration form and eliminated the paper form. At this time, the participation form for the HOP QDRP is separate from the RHQDAPU program and completing a form for each program is required. Agreeing to participate includes acknowledging that the data submitted to the CMS-designated contractor would be submitted to CMS and also may be shared with one or more other CMS contractors that support the implementation of the HOP QDRP and be publicly reported.

We are proposing to update and retain the following deadlines, which we established in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60643), for submitting the participation form:

Hospitals with Medicare acceptance dates on or after January 1, 2011: For the CY 2012 payment update, we are proposing that any hospital that has a Medicare acceptance date on or after January 1, 2011 (including a new hospital and hospitals that have merged) must submit a completed participation form no later than 180 days from the date identified as its Medicare acceptance date on the CMS Online System Certification and Reporting (OSCAR) system. Hospitals typically receive a package notifying them of their new CCN after they receive their Medicare acceptance date. The Medicare acceptance date is the earliest date that a hospital can receive Medicare payment for the services that it furnishes. Completing the participation form would include supplying the name and address of each hospital campus that shares the same CCN.

The use of the Medicare acceptance date as beginning the timeline for HOP QDRP participation allows CMS to monitor more effectively hospital compliance with the requirement to complete a participation form because a hospital's Medicare acceptance date is readily available to CMS through its data systems. In addition, providing an extended time period to register for the program would allow newly functioning hospitals sufficient time to get their operations fully functional before having to collect and submit quality data. We invite public comment on this proposed policy.

Hospitals with Medicare acceptance dates before January 1, 2011: For the CY 2012 payment update, we are proposing that any hospital that has a Medicare acceptance date on or before December 31, 2010 that is not currently participating in the HOP QDRP and wishes to participate in the CY 2012 HOP QDRP must submit a participation form by March 31, 2011. We are proposing a deadline of March 31, 2011, because we believe it would give hospitals sufficient time to decide whether they wish to participate in the HOP QDRP, as well as put into place the necessary staff and resources to timely report data for first quarter CY 2011 services. This requirement would apply to all hospitals whether or not the hospital billed for payment under the OPPS. We invite public comment on this proposed policy.

Under our current requirements, hospitals that want to withdraw from participation must follow the same deadlines as hospitals that want to participate. We are proposing to change this requirement. We are proposing to lengthen the time during which hospitals may withdraw from participation because we believe that hospitals should be allowed more time to consider this decision. In addition, this increased time to withdraw is comparable programmatically to our proposal under the RHQDAPU program (75 FR 23996). Specifically, for the CY 2012 payment update, we are proposing that any HOP QDRP participating hospital that wants to withdraw may do so at any time from January 1, 2011 to November 1, 2011. Hospitals that withdraw during this time period for the CY 2012 payment update would not be able to sign up to participate for the CY 2012 payment update, would have a 2.0 percentage point reduction in their CY 2012 payment update, and would be required to resubmit a participation form in order to participate for purposes of any future payment updates. We note that once a hospital has submitted a participation form, it is considered to be an active HOP QDRP participant until such time as the hospital submits a withdrawal form to CMS or the facility is designated as closed in the CMS OSCAR system. We invite public comment on this proposed policy.

2. Data Collection and Submission Requirements

a. General Data Collection and Submission Requirements

We are proposing that, to be eligible for the full CY 2012 OPPS payment update, hospitals would be required to:

- Submit data: Hospitals that would be participating in the HOP QDRP would be required to submit data for each applicable quarter by the deadline posted on the QualityNet Web site; there must be no lapse in data submission. For the CY 2012 annual payment update, the applicable quarters would be as follows: 3rd quarter CY 2010, 4th quarter CY 2010, 1st quarter CY 2011, and 2nd quarter CY 2011. Hospitals that did not participate in the CY 2011 HOP QDRP, but would like to participate in the CY 2012 HOP QDRP, and that have a Medicare acceptance date on the OSCAR system before January 1, 2011, would begin data submission for 1st quarter CY 2011 services using the CY 2012 measure set that would be finalized in the CY 2011 OPPS/ASC final rule with comment period. For those hospitals with Medicare acceptance dates on or after January 1, 2011, data submission must begin with the first full quarter following the submission of a completed online participation form. For the claims-based measures, we would calculate the measures using the hospital's Medicare claims data. For the CY 2012 payment update, we would utilize paid Medicare fee-for-service (FFS) claims submitted prior to January 1, 2011, to calculate these measures. For the structural measure to be used for the CY 2012 payment determination, hospitals would be required to submit data beginning with January 1, 2011 discharges using a Web-based tool

available on QualityNet beginning in 2011.

Sampling and Case Thresholds: It would not be necessary for a hospital to submit data for all eligible cases for some measures if sufficient eligible case thresholds are met. Instead, for those measures where a hospital has a sufficiently large number of cases, it would sample cases and submit data for these sampled cases rather than submitting data from all eligible cases. This sampling scheme, which includes the minimum number of cases based upon case volume, would be set out in the HOPD Specifications Manual at least three months in advance of the required data collection. We have proposed to change this notification timeframe for this sampling scheme to at least 3 months from at least 4 months to be consistent with the HOPD Specifications Manual release schedule. Hospitals would be required to meet the sampling requirements for required quality measures each reporting quarter.

In addition, in order to reduce the burden on hospitals that treat a low number of patients but otherwise meet the submission requirements for a particular quality measure, hospitals that have five or fewer claims (both Medicare and non-Medicare) for any measure included in a measure topic in a quarter would not be required to submit patient level data for the entire measure topic for that quarter. Even if hospitals would not be required to submit patient level data because they have five or fewer claims (both Medicare and non-Medicare) for any measure included in a measure topic in a quarter, we are proposing that they may voluntarily do so.

Hospitals would be required submit all required data according to the data submission schedule that will be available on the QualityNet Web site (*https://www.QualityNet.org*). This Web site meets or exceeds all current HIPAA requirements. Submission deadlines would, in general, be four months after the last day of each calendar quarter. Thus, for example, the submission deadline for data for services furnished during the first quarter of CY 2011 (January–March 2011) would be on or around August 1, 2011. The actual submission deadlines would be posted on the *http://www.QualityNet.org* Web site.

Hospitals would be required to submit data to the OPPS Clinical Warehouse using either the CMS Abstraction and Reporting Tool for Outpatient Department (CART–OPD) measures or the tool of a third-party vendor that meets the measure specification requirements for data transmission to QualityNet.

Hospitals would be required to submit quality data through My QualityNet, the secure portion of the QualityNet Web site, to the OPPS Clinical Warehouse. The OPPS Clinical Warehouse, which is maintained by a CMS-designated contractor, would submit the OPPS Clinical Warehouse data to CMS. OPPS Clinical Warehouse data are not currently considered to be Quality Improvement Organization (QIO) data; rather, we consider such data to be CMS data. However, it is possible that the information in the OPPS Clinical Warehouse may at some point become QIO information. If this occurs, these data would also become protected under the stringent QIO confidentiality regulations in 42 CFR Part 480.

Hospitals would be required to collect HOP QDRP data from outpatient episodes of care to which the required measures apply. For the purposes of the HOP QDRP, an outpatient "episode of care" is defined as care provided to a patient who has not been admitted as an inpatient, but who is registered on the hospital's medical records as an outpatient and receives services (rather than supplies alone) directly from the hospital. Every effort would be made to ensure that data elements common to both inpatient and outpatient settings are defined consistently for purposes of quality reporting (such as "time of arrival").

Hospitals would be required to submit quality data using the CCN under which the care was furnished.

To be accepted into the OPPS Clinical Warehouse, data submissions, at a minimum, would be required to be timely, complete, and accurate. Data submissions are considered to be "timely" when data are successfully accepted into the OPPS Clinical Warehouse on or before the reporting deadline. A "complete" submission would be determined based on whether the data satisfy the sampling criteria that are published and maintained in the HOPD Specifications Manual, and must correspond to both the aggregate number of cases submitted by a hospital and the number of Medicare claims the hospital submits for payment. We are aware of "data lags" that occur when hospitals submit claims, then cancel and correct those claims; efforts would be made to take such events into account that can change the aggregate Medicare case counts. To be considered "accurate," submissions would be required to pass validation, if applicable.

We strongly recommend that hospitals review OPPS Clinical Warehouse feedback reports and the HOP QDRP Provider Participation Reports that are accessible through their QualityNet accounts. These reports enable hospitals to verify whether the data they or their vendors submitted were accepted into the OPPS Clinical Warehouse and the date/time that such acceptance occurred. We also note that irrespective of whether a hospital submits data to the OPPS Clinical Warehouse itself or uses a vendor to complete the submissions, the hospital would be responsible for ensuring that HOP QDRP requirements are met.

Finally, during the past two years of the HOP QDRP, the submission of population and sampling data was not required, though, hospitals could submit, on a voluntary basis, the aggregate numbers of outpatient episodes of care which are eligible for submission under the HOP QDRP and sample size counts. These aggregated numbers of outpatient episodes represent the number of outpatient episodes of care in the universe of all possible cases eligible for data reporting under the HOP QDRP. For the CY 2012 payment update, we are proposing to require submission of this population and sample size data. Specifically, we are proposing that hospitals must submit on a quarterly basis, aggregate population and sample size counts for Medicare and non-Medicare encounters for the measure populations for which chart-abstracted data must be submitted. Under this proposal, hospitals would submit aggregate population and sample size counts for measure populations even if the hospital had not treated patients in a specific measure population; that is, if a hospital has not treated any patients in a specific HOP QDRP measure population, the hospital would still be required to submit a zero for its quarterly aggregate population and sample counts to meet the requirement.

We believe that hospitals have had sufficient time to become familiar with HOP QDRP data and to develop data systems necessary to support this requirement. We view it as vital for quality data reporting for hospitals to be able to determine accurately their aggregate population and appropriate sampling size data to assess their completeness of data reporting. We rely on hospitals to properly sample cases where sampling occurs so that representative data are submitted; for hospitals to correctly sample, it is necessary for them to be able to determine their aggregate population sizes. In addition, we believe it is highly beneficial for hospitals to develop systems that can determine whether or

not they have furnished services or billed for five or fewer cases for a particular measure topic on a quarterly basis.

We are proposing that the deadlines for the reporting of aggregate numbers of outpatient episodes of care and sample size counts would be the same as those for the reporting of data for the measures requiring chart abstraction, and these deadlines would be posted on the data submission schedule that would be available on the QualityNet Web site. Hospitals would be permitted to submit this information prior to the deadline; this would allow CMS to advise hospitals regarding their incomplete submission status as appropriate and give hospitals sufficient time to make appropriate revisions before the data submission deadline.

We plan to use the aggregate population and sample size data to assess data submission completeness and adherence to sampling requirements for Medicare and non-Medicare patients.

We invite public comment on these proposed requirements.

b. Extraordinary Circumstance Extension or Waiver for Reporting Quality Data

In our experience, there have been times when hospitals have been unable to submit required quality data due to extraordinary circumstances that are not within their control. It is our goal to not penalize hospitals for such circumstances and we do not want to unduly increase their burden during these times. Therefore, in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60046 through 600647), we adopted a process for hospitals to request and for CMS to grant extensions or waivers with respect to the reporting of required quality data when there are extraordinary circumstances beyond the control of the hospital. We are proposing to retain these procedures with some proposed modifications.

Under the process, in the event of extraordinary circumstances, such as natural disaster, not within the control of the hospital, for the hospital to receive consideration for an extension or waiver of the requirement to submit quality data for one or more quarters, a hospital would submit to CMS a request form that would be made available on the QualityNet Web site. The following information should be noted on the form:

- Hospital CCN;
- Hospital Name;
- CEO and any other designated personnel contact information, including name, e-mail address, telephone number, and mailing address (must include a physical address, a post office box address is not acceptable);
- Hospital's reason for requesting an extension or waiver;
- Evidence of the impact of the extraordinary circumstances, including but not limited to photographs, newspaper and other media articles; and
- A date when the hospital would again be able to submit HOP QDRP data, and a justification for the proposed date.

The request form would be signed by the hospital's CEO. A request form would be required to be submitted within 45 days of the date that the extraordinary circumstance occurred. We are proposing to remove the requirement found in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60646) that the hospital to include an identified reason for requesting an extension or waiver in addition to the hospital's reason for requesting an extension or waiver as a requirement. We believe that this requirement is redundant and removing it will reduce unnecessary hospital burden.

Following receipt of such a request, CMS would—

(1) Provide a written acknowledgement using the contact information provided in the request, to the CEO and any additional designated hospital personnel, notifying them that the hospital's request has been received;

(2) Provide a formal response to the CEO and any additional designated hospital personnel using the contact information provided in the request notifying them of our decision; and

(3) Complete any CY 2011 request for Extraordinary Circumstance Extension or Waiver for Reporting Quality Data requests reviews and communicate the results of these determinations within 90 days following our receipt of such a request. We are proposing to add a deadline for CMS response so that hospitals can have a designated timeline for when they should receive such a response.

This proposal would not preclude us from granting waivers or extensions to hospitals that have not requested them when we determine that an extraordinary circumstance, such as an act of nature (for example, hurricane) affects an entire region or locale. If we make the determination to grant a waiver or extension to hospitals in a region or locale, we would communicate this decision to hospitals and vendors through routine communication channels, including but not limited to e-mails and notices on the QualityNet Web site. We invite public comment on these proposals.

3. HOP QDRP Validation Requirements for Chart-Abstracted Data: Data Validation Approach for CY 2012 and Subsequent Years

a. Background

In the CY 2010 OPPS/ASC proposed rule, we solicited public comments on our proposed validation methodology (74 FR 35403 through 35404). We stated that we are considering building upon what we proposed as a validation approach for CY 2012 and subsequent years by, in addition to selecting a random sample of hospitals for validation purposes, selecting targeted hospitals based on criteria designed to measure whether the data they have reported raises a concern regarding data accuracy. These possible targeting criteria included identified abnormal data patterns, whether a hospital had previously failed validation, whether a hospital had not been previously selected for validation for 2 or more consecutive years, and some combination of some or all of the criteria.

We solicited public comments on whether such criteria, or another approach, should be applied in future years. We especially solicited suggestions for additional criteria that could be used to target hospitals for validation. We greatly appreciate all the public comments we received regarding the validation process proposed for CY 2012 and subsequent years. We responded to public comments on our proposed methodology for CY 2012 and subsequent years but did not finalize a validation process in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60650 through 60652). We noted that we would take all of the comments we received into account when we develop our validation proposals for CY 2012.

b. Proposed Data Validation Requirements for CY 2012

Similar to our proposal for the FY 2012 RHQDAPU program (75 FR 23991 through 23993), we are proposing to validate data from 800 randomly selected hospitals (approximately 20 percent of all participating HOP QDRP hospitals) each year, beginning with CY 2012 payment determination. We are proposing to sample 800 hospitals because we believe, based upon sampling simulation studies using HOP QDRP data, that sampling this number would provide a sufficient number for a representative sample of hospitals on various strata (for example, urban, rural, bed-size) while significantly reducing overall hospital burden. For CY 2012 payment determinations, we would

select only from hospitals participating for the CY 2012 payment update, so if a hospital submitted data for the CY 2011, but withdrew, this hospital would not be deemed as eligible for selection. We note that because 800 hospitals would be selected randomly, every HOP QDRP-participating hospital would be eligible each year for validation selection.

For each selected hospital, we are proposing to randomly select up to a total of 48 self-reported cases from the total number of cases (12 per quarter) that the hospital successfully submitted to the OPPS Clinical Warehouse. However, if a selected hospital has submitted less than 12 cases in any quarter, only those cases available would be validated. We believe that validating a larger number of cases per hospital, but only for 800 randomly selected hospitals, and validating these cases at the measure level (rather than the data element level) has several benefits. We are proposing up to a total of 48 cases per hospital because a sample size of about 50 is considered sufficient for detecting relationships and correlations, so a larger sample size is not deemed necessary (for reference, see Van Voohis, Wilson, Morgan, Carmen R. and Betsey L., (2007), *Understanding Power and Rules of Thumb for Determining Sample Sizes, Tutorials in Quantitative Methods for Psychology,* Volume 3(2), Pages 43–50). We believe that this approach is suitable for HOP QDRP data because it will: produce a more reliable estimate of whether a hospital's submitted data have been abstracted accurately; provide more statistically reliable estimates of the quality of care delivered in each selected hospital as well as at a national level; and reduce overall hospital burden because most hospitals will not be selected to undergo validation each year.

We would not be selecting cases stratified by measure or topic; our interest is whether the data submitted by hospitals accurately reflect the care delivered and documented in the medical record, not what the accuracy is by measure or whether there are differences by topic. Additionally, we note that, due to the distribution of HOP QDRP data submitted to date by hospital size, the data do not lend themselves to sampling by topic area. Specifically, small hospitals tend to have more AMI Cardiac Care cases and fewer Surgical Care cases, whereas, larger hospitals tend to have few if any AMI Cardiac Care cases and more Surgical Care cases.

Analysis of submitted HOP QDRP data indicate that this sampling design would provide sufficient case number of denominator cases per measure for determination of national and individual hospital measure estimates with acceptable levels of statistical certainty.

We are proposing to sample data for April 1, 2010 to March 31, 2011 services because this would provide a full year of the most recent data possible to use for the purpose of completing the validation in sufficient time for us to make the CY 2012 payment determinations.

A designated CMS contractor would, each quarter that applies to the validation, ask each of the 800 selected hospitals to submit medical documentation for up to 12 randomly selected cases submitted to and accepted by the HOP QDRP Clinical Warehouse. The CMS contractor would request paper copies of medical documentation corresponding to selected cases from each hospital via certified mail or other trackable method that requires a hospital representative to sign for the request letter; a trackable method would be utilized so that CMS would be assured that the hospital received the request. The hospital would have 45 calendar days from the date of the request as documented in the request letter to submit the requested documentation and have the documentation received by the CMS contractor. If the hospital does not comply within 30 calendar days of receipt of the initial medical documentation request, the CMS contractor would send a second letter by certified mail or other trackable method to the hospital, reminding the hospital that paper copies of the requested documentation must be submitted and received within 45 calendar days following the date of the initial CMS contractor request. If the hospital does not submit the requested documentation and the documentation is not received by the CMS contractor within the 45 calendar days, then the CMS contractor would assign a "zero" score to each data element for each selected case and the case would fail for all measures in the same topic (for example, OP–6 and OP–7 measures for a Surgical Care case).

We are proposing that the letter from the designated CMS contractor would be addressed to the hospital's medical record staff identified by the hospital for the submission of records under the RHQDAPU program (that is, the hospital's medical records staff identified by the hospital to their State QIO). If CMS has evidence that the hospital received both letters requesting medical records, the hospital would be deemed responsible for not returning the requested medical record documentation and the hospital would not be allowed to submit such medical documentation as part of its reconsideration request so that information not utilized in making a payment determination is not included in any reconsideration request.

Once the CMS contractor receives the requested medical documentation, the contractor would independently reabstract the same quality measure data elements that the hospital previously abstracted and submitted, and the contractor would then compare the two sets of data to determine whether the two sets of data match. Specifically, the contractor would conduct a measures level validation by calculating each measure within a submitted case using the independently reabstracted data and then comparing this to the measure reported by the hospital; a percent agreement would then be calculated. Specifically, the validation score for a hospital would equal the total number of measure matches divided by the total number of measures multiplied by 100 percent.

This method is the same as recommended in the CMS Hospital Value-Based Purchasing Report to Congress and is illustrated more fully on pages 83–84 of this report which can be found on our Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/HospitalVBPPlanRTCFINALSUBMITTED2007.pdf.* We believe that this approach is appropriate and it was supported by many commenters when we requested comment on HOP QDRP validation requirements outlined in the CY 2010 OPPS/ASC proposed rule (74 FR 35402 through 35403; 74 FR 60647 through 60652).

To receive the full OPPS payment update, we are proposing that hospitals must attain at least a 75 percent validation score, based upon our validation process, for the designated time period. We have selected 75 percent as the threshold for the validation score because we believe this level is reasonable for hospitals to achieve while still ensuring accuracy of the data. Additionally, this level is consistent with what we proposed for the RHQDAPU program (75 FR 23993). Since we are not validating all hospital measures submitted, it is necessary to calculate a confidence interval that incorporates sampling error. We would use the upper bound of a one-tailed 95 percent confidence interval to estimate the validation score. We are proposing to use a one-tail confidence interval to calculate the validation score because it appropriately reflects our concern of whether the confidence interval for the calculated validation score includes or

is above the 75 percent validation threshold for a hospital to be considered as submitting accurate data. If the calculated upper limit is above the required 75 percent validation score threshold, we would consider a hospital's data to be "validated" for payment purposes. The use of a one-tailed confidence interval and the 75 percent and threshold level are the same as proposed for the RHQDAPU program for FY 2012 payment determinations (75 FR 23991 through 23993).

For derivation of the upper bound of a one-tailed 95 percent confidence interval we are proposing to use a binomial distribution approach as we are looking at the percentage of measures submitted by a hospital matching what is calculated from the reabstracted data. Since the measure match rate for each hospital is a proportion, a binomial approach is appropriate, see Pagano, Robert R., (1990), *Understanding Statistics in the Behavioral Sciences,* 3rd Edition, Pages 175–188.

Thus, we are proposing the following formula which includes a finite population correction factor and a continuity correction factor for calculating the upper bound of the one-tailed 95 percent confidence interval:

$$\text{Upper Confidence Limit} = p + 1.645\left(\sqrt{\frac{p(1-p)}{n}}\right)\left(\sqrt{\frac{N-n}{N-1}}\right) + \frac{1}{2n}$$

In this formula, N represents the population for the reporting year, n represents the sample size for the reporting year, p (calculated as a percentage) represents the validation score for the reporting year (that is, the percentage of measures matching), and 1 − p represents the percentage of measures not matching. It should be noted that a confidence interval would not need to be calculated for hospitals that did not have enough cases to sample as the confidence interval is equal to zero (when the value of N is equal to n, N minus n equals zero and the upper confidence limit is equal to the validation score in the above formula). In addition, a confidence interval would not need to be calculated for those hospitals that have a validation score, p, that is greater than or equal to 75 percent because the hospital has attained the minimum threshold; the upper bound of any calculated confidence interval would be 75 percent or greater.

For further information on the proposed methodology for calculation of a 95 percent confidence interval for a binomial distribution utilizing a finite population correction, *see http://itl.nist.gov/div898/handbook/prc/section2/prc24.htm* and *http://courses.wcupa.edu/rbove/Berenson/10th%20ed%20CD-ROM%20topics/section7_3.pdf.*

We solicit public comments on this proposed validation methodology.

c. Additional Data Validation Conditions Under Consideration for CY 2013 and Subsequent Years

We are considering building upon what we are proposing as a validation approach for CY 2013 and subsequent years. We are considering, in addition to selecting a random sample of hospitals for validation purposes, selecting targeted hospitals based on criteria designed to measure whether the data they have reported raises a concern regarding data accuracy. Because hospitals have gained little experience with validation under the HOP QDRP, we are considering this approach for possible use beginning with the CY 2013 payment determination. Examples of targeting criteria could include:

- Abnormal data patterns identified such as consistently high HOP QDRP measure denominator exclusion rates resulting in unexpectedly low denominator counts;
- Whether a hospital had previously failed validation;
- Whether a hospital had not been previously selected for validation for 2 or more consecutive years;
- Whether a hospital had low submitted case numbers relative to population sizes; and/or
- Whether a hospital had any extreme outlier values for submitted data elements.

We invite comment on whether, in addition to random sampling for validation, we should use targeted validation and, if so, what criteria for targeting we should adopt.

E. Proposed HOP QDRP Reconsideration and Appeals Procedures

When the RHQDAPU program was initially implemented, it did not include a reconsideration process for hospitals. Subsequently, we received many requests for reconsideration of those payment decisions and, as a result, established a process by which participating hospitals would submit requests for reconsideration. We anticipated similar concerns with the HOP QDRP and, therefore, in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66875), we stated our intent to implement for the HOP QDRP a reconsideration process modeled after the reconsideration process we implemented for the RHQDAPU program. In the CY 2009 OPPS/ASC final rule with comment period (73 FR 68779), we adopted a mandatory reconsideration process that will apply to the CY 2010 payment decisions. In the CY 2010 OPPS/ASC final rule with comment period (74 FR 60654 through 60655), we continued this process for the CY 2011 payment update. We are proposing to continue this process for the CY 2012 payment update with some modification. Under this proposed process, the hospitals must—

- Submit to CMS, via QualityNet, a Reconsideration Request form that would be made available on the QualityNet Web site; this form would be submitted by February 3, 2012, and would contain the following information:
  - ○○ Hospital CCN.
  - ○○ Hospital Name.
  - ○○ CMS-identified reason for failure (as provided in any CMS notification of failure to the hospital).
  - ○○ Hospital basis for requesting reconsideration. This would identify the hospital's specific reason(s) for believing it met the HOP QDRP requirements and should receive a full annual payment update.
  - ○○ CEO and any additional designated hospital personnel contact information, including name, e-mail address, telephone number, and mailing address (must include physical address, not just a post office box).
  - ○○ A copy of all materials that the hospital submitted in order to receive the full payment update for CY 2012. Such material would include, but may not be limited to, the applicable Notice of Participation form or completed online registration form, and quality measure data that the hospital submitted via QualityNet.
- Submit paper copies of all the medical record documentation that it submitted for the initial validation. Hospitals would submit this

documentation to a designated CMS contractor which would have authority to review patient level information. We would post the address where hospitals are to ship this documentation on the QualityNet Web site. Final review of all mismatched data under a reconsideration request would be done by CMS.

• Provide a written justification for each appealed data element classified during the validation process as a mismatch. Only data elements that affect a hospital's validation score would be subject to reconsideration. We would review the data elements that were labeled as mismatched as well as the written justifications provided by the hospitals, and make a decision on the reconsideration request.

For CY 2011 reconsiderations, we required that a reconsideration request must be signed by the hospital CEO (74 FR 60654). However, we have found that this requirement increases the burden for hospitals as it hampers the electronic submission of the HOP QDRP reconsideration request form. Thus, we are proposing not to include this requirement; for CY 2012 reconsiderations, reconsideration request forms would not need to be signed by the hospital's CEO.

We invite public comment on these proposed requirements.

Following receipt of a request for reconsideration, CMS would—

• Provide an e-mail acknowledgement, using the contact information provided in the reconsideration request, to the CEO and any additional designated hospital personnel notifying them that the hospital's request has been received.

• Provide a formal response to the hospital CEO and any additional designated hospital personnel, using the contact information provided in the reconsideration request, notifying the hospital of the outcome of the reconsideration process.

We intend to complete any CY 2012 reconsideration reviews and communicate the results of these determinations within 90 days following the deadline for submitting requests for reconsideration. In the CY 2010 OPPS/ASC final rule with comment period 74 FR 60654 through 60655), in response to a comment, we indicated that we would "complete any reconsideration reviews and communicate the results of these determinations within 60 to 90 days following the date we receive the request for reconsideration." We are proposing to refine how we describe the time frame for CY 2011 from "60 to 90 days" to within "90 days" because designating a range of dates is unnecessary for this provision.

If a hospital is dissatisfied with the result of a HOP QDRP reconsideration decision, we are proposing that the hospital may file an appeal under 42 CFR Part 405, Subpart R (PRRB appeal).

Similar to our proposal for the RHQDAPU program (75 FR 23995 through 23996), the scope of our review when a hospital requests reconsideration because it failed our validation requirement would be as follows:

• Hospital requests reconsideration for CMS contractor-abstracted data elements classified as mismatches affecting validation scores. Hospitals would be required to have timely submitted requested medical record documentation to the CMS contractor during the quarterly validation process for the requested case to be eligible to be reconsidered on the basis of mismatched data elements.

• Hospital requests reconsideration for medical records submitted during the quarterly validation process and classified as invalid record selection. Invalid record selections would be defined as medical records submitted by hospitals during the quarterly validation process that do not match the patient's episode of care information as determined by the designated re-abstracting CMS contractor. In other words, the contractor determines that the hospital returned medical documentation that is different from that which was requested. If this designated contractor determines that the hospital submitted invalid or incorrect medical documentation, it would award a zero validation score for the case. During the reconsideration process, our review of invalid record selection would initially be limited to determining whether the medical documentation submitted initially to the designated CMS contractor was for the designated episode of care. If we determine during reconsideration that the hospital did submit medical documentation corresponding to the designated episode of care, then we would abstract data elements from the medical record documentation submitted by the hospital; otherwise, the case would not be abstracted.

• Hospital requests reconsideration for medical records not submitted to the CMS contractor within the 45 calendar day deadline. Our review would initially be limited to determining whether the CMS contractor received the requested medical record documentation within 45 calendar days, and whether the hospital received the initial medical record request and reminder notice. If we determine during reconsideration that the CMS contractor did receive the paper copy of the requested, supporting medical record documentation within 45 calendar days, then we would abstract data elements from the medical record documentation submitted by the hospital. If we determine that the hospital received two letters requesting medical documentation and still did not submit the requested documentation within the 45 calendar day period, CMS would not accept this documentation as part of the reconsideration and CMS would not abstract data from this documentation.

In sum, we are initially limiting the scope of our reconsideration reviews involving validation to information already submitted by the hospital during the quarterly validation process, and we would not abstract submitted medical record documentation that was not submitted to the CMS contractor during the quarterly validation process. We would expand the scope of our reconsideration reviews involving validation only if we find during the initial review that the hospital correctly and timely submitted the requested medical record documentation; only then would we abstract data elements from the medical record documentation submitted by the hospital as part of our reconsideration review.

If a hospital is dissatisfied with the result of a HOP QDRP reconsideration decision, the hospital would be able to file an appeal under 42 CFR part 405, Subpart R (PRRB appeal).

We invite public comment on these proposals.

F. Reporting of ASC Quality Data

As discussed above, section 109(b) of the MIEA–TRHCA amended section 1833(i) of the Act by redesignating clause (iv) as clause (v) and adding new clause (iv) to paragraph (2)(D) and by adding new paragraph (7). These amendments authorize the Secretary to require ASCs to submit data on quality measures and to reduce the annual payment update in a year by 2.0 percentage points for ASCs that fail to do so. However, these provisions permit, but do not require, the Secretary to take such action.

In the CY 2008 OPPS/ASC final rule with comment period (72 FR 66875), the CY 2009 OPPS/ASC final rule with comment period (73 FR 68780), and the CY 2010 OPPS/ASC final rule with comment period (74 FR 60656), we indicated that we intend to implement the provisions of section 109(b) of the MIEA–TRHCA in a future rulemaking. While promoting high quality care in the ASC setting through quality

reporting is highly desirable and fully in line with our efforts under other payment systems, the transition to the revised payment system in CY 2008 posed significant challenges to ASCs, and we determined that it would be most appropriate to allow time for ASCs to gain some experience with the revised payment system before introducing other new requirements. Further, by implementing quality reporting under the OPPS prior to establishing quality reporting for ASCs, CMS would gain experience with quality measurement in the ambulatory setting in order to identify the most appropriate measures for quality reporting in ASCs prior to the introduction of the requirement for ASCs. Finally, we are sensitive to the potential burden on ASCs associated with chart abstraction and believe that adopting such measures at this time is in contrast with our desire to minimize collection burden, particularly when measures may be reported via EHRs in the future.

We continue to believe that promoting high quality care in the ASC setting through quality reporting is highly desirable and fully in line with our efforts under other payment systems. However, we continue to have the concerns outlined above for CY 2011. We intend to implement the provisions of section 109(b) of the MIEA–TRHCA in a future rulemaking. We invite public comment on: (1) The deferral of quality data reporting for ASCs; (2) suggestions for quality measures geared toward the services provided by ASCs; and (3) potential reporting mechanisms for ASC quality data, including electronic submission of these data. In addition, we invite public comment on the following measures under future consideration for ASC quality data reporting:

- Patient Fall in the ASC;
- Patient Burn;
- Hospital Transfer/Admission;
- Wrong Site, Side, Patient, Procedure, Implant;
- Prophylactic IV Antibiotic Timing;
- Appropriate Surgical Site Hair Removal;
- Surgical site infection (SSI);
- Medication administration variance (MAV);
- Medication reconciliation; and
- VTE measures: outcome/assessment/prophylaxis.

We note that section 3006(f) of the Affordable Care Act, as added by section 10301(a) of the Affordable Care Act requires CMS to develop a plan to implement a value-based purchasing program for ASCs; this plan is due to Congress by January 1, 2011. We intend to align implementation of ASC quality reporting to be consistent with the value-based purchasing plan that will be developed. We intend to propose implementing the provisions of section 109(b) of the MIEA–TRHCA in CY 2012 rulemaking. We invite public comment on: (1) The timing of implementing quality data reporting for ASCs; (2) suggestions for quality measures for services provided by ASCs; and (3) potential reporting mechanisms for ASC quality data, including electronic submission of these data.

G. Electronic Health Records

As we stated in the CY 2010 OPPS/ASC final rule (74 FR 60656), we are actively seeking alternatives to manual chart abstraction for the collection of quality measures for its quality data reporting programs. Among these alternatives are claims-based measure calculations, collection of data from systematic registries widely used by hospitals, and electronic submission of quality measures using EHRs. In the CY 2009, we received suggestions during the public comment period that we adopt measures that can be collected via EHRs (73 FR 68769). We agree with the commenters about the importance of actively working to move to a system of data collection based on submission from EHRs. In section XVI.B.5.b. of this proposed rule, for the CY 2014 payment determination, we are proposing to adopt several chart-abstracted quality measures for diabetes mellitus, some of which have already been specified for EHR-based capture and submission, and others that are planned for EHR-based submission in the future. We have been engaged with health IT standard-setting organizations to promote the adoption of the necessary standards regarding data capture to facilitate data collection via EHRs, and have been collaborating with such organizations on standards for a number of quality measures. We encourage hospitals to take steps toward the adoption of EHRs that will allow for reporting of clinical quality data from the EHR directly to a CMS data repository. We also encourage hospitals that are implementing, upgrading, or developing EHR systems to ensure that such systems conform to standards adopted by HHS. We invite public comment on the future direction of EHR-based quality measurement submission.

XVII. Proposed Changes Relating to Payments to Hospitals for Direct Graduate Medical Education (GME) and Indirect Medical Education (IME) Costs

A. Background

Section 1886(h) of the Act, as added by section 9202 of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (Pub. L. 99–272) and implemented in regulations at 42 CFR 413.75 through 413.83, establishes a methodology for determining payments to hospitals for the direct costs of approved graduate medical education (GME) programs. Section 1886(h)(2) of the Act sets forth a methodology for the determination of a hospital-specific, base-period per resident amount (PRA) that is calculated by dividing a hospital's allowable direct costs of GME for a base period by its number of residents in the base period. The base period is, for most hospitals, the hospital's cost reporting period beginning in FY 1984 (that is, the period of October 1, 1983, through September 30, 1984). The base year PRA is updated annually for inflation. In general, Medicare direct GME payments are calculated by multiplying the applicable PRA by the weighted number of full-time equivalent (FTE) residents working in all areas of the hospital complex (and nonhospital sites, when applicable), and the hospital's Medicare share of total inpatient days.

Section 1886(d)(5)(B) of the Act provides for an additional payment amount under the IPPS for hospitals that have residents in an approved GME program in order to reflect the higher indirect patient care costs of teaching hospitals relative to nonteaching hospitals. The regulations regarding the calculation of this additional payment, known as the indirect medical education (IME) adjustment, are located at 42 CFR 412.105.

The Balanced Budget Act of 1997 (Pub. L. 105–33) established a limit on the number of allopathic and osteopathic residents that a hospital may include in its FTE resident count for direct GME and IME payment purposes. Under section 1886(h)(4)(F) of the Act, for cost reporting periods beginning on or after October 1, 1997, a hospital's unweighted FTE count of residents for purposes of direct GME may not exceed the hospital's unweighted FTE count for its most recent cost reporting period ending during the 1996 calendar year. Under section 1886(d)(5)(B)(v) of the Act, a similar limit on the FTE resident count for IME purposes is effective for

discharges occurring on or after October 1, 1997.

The recently enacted Patient Protection and Affordable Care Act (Pub. L. 111–148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152) made a number of statutory changes relating to the determination of a hospital's FTE resident count for direct GME and IME payment purposes and the manner in which FTE resident limits are calculated and applied to hospitals under certain circumstances. (These two pieces of legislation are collectively referred to in this document as the "Affordable Care Act.") Below we set forth our proposals to implement the provisions of the Affordable Care Act relating to Medicare direct GME and IME payments.

B. Counting Resident Time in Nonprovider Settings (Section 5504 of the Affordable Care Act)

1. Background and Changes Made by the Affordable Care Act

Effective July 1, 1987, the Social Security Act was amended to allow hospitals to count the time residents spend training in sites that are not part of the hospital (referred to as "nonprovider" or "nonhospital sites") for purposes of direct GME payments under certain conditions. Specifically, section 1886(h)(4)(E) of the Act requires that the Secretary's rules concerning the computation of FTE residents for purposes of direct GME payments "provide that only time spent in activities relating to patient care shall be counted and that all the time so spent by a resident under an approved medical residency training program shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed, if the hospital incurs all, or substantially all, of the costs for the training program in that setting." (Section 1886(h)(4)(E) of the Act, as added by section 9314 of the Omnibus Budget Reconciliation Act of 1986 (Pub. L. 99–509) (OBRA 86).) Regulations implementing this provision were published in the September 29, 1989 final rule (54 FR 40292) at 42 CFR 413.86(f)(3) (now § 413.78(c)), which stated that a hospital may count the time residents spend in nonprovider settings for purposes of direct GME payment if: (1) The residents spend their time in patient care activities; and (2) there is a written agreement between the hospital and the nonprovider entity stating that the hospital will incur all or substantially all of the costs of the program. The regulations at that time defined "all or substantially all" of the costs to include the residents' compensation for the time spent at the nonprovider setting. We also interpreted section 1886(h)(4)(E) of the Act to mean that only one single hospital was permitted to incur the costs of a particular training program and count the time residents spend training in a particular nonhospital setting.

Prior to October 1, 1997, for purposes of the IME payment adjustment, hospitals were not permitted to count the time residents spent training in nonhospital settings. However, section 4621(b)(2) of the Balanced Budget Act of 1997 revised section 1886(d)(5)(B) of the Act to allow providers to count time residents spend training in nonprovider sites for IME purposes, effective for discharges occurring on or after October 1, 1997. Specifically, section 1886(d)(5)(B)(iv) of the Act was amended to provide that "all the time spent by an intern or resident in patient care activities under an approved medical residency program at an entity in a nonhospital setting shall be counted towards the determination of full-time equivalency if the hospital incurs all, or substantially all, of the costs for the training program in that setting." In the July 31, 1998 final rule (63 FR 41005), at § 412.105(f)(1)(ii)(C) and § 413.86(f)(4), we specified the requirements that a hospital must meet in order to include the time spent by residents training in a nonhospital site in its FTE count for purposes of both direct GME and IME payments (we note that § 413.86(f)(4) is now redesignated as § 413.78(d)). In that final rule, we also redefined "all or substantially all of the costs for the training program in the nonhospital setting" as the residents' salaries and fringe benefits (including travel and lodging where applicable), *and* the portion of the cost of teaching physicians' salaries and fringe benefits attributable to direct GME.

In order to implement section 1886(h)(4)(E) (and later, section 1886(d)(5)(B)(iv)) of the Act, and to assist contractors in determining whether a hospital incurred "all or substantially all" of the costs of the program in the nonhospital setting, we required in § 413.86(f)(3) and (4) that there must be a written agreement between the hospital and the nonhospital site stating that the hospital will incur "all or substantially all" of the costs of training in the nonhospital setting (we note that § 413.86(f)(3) and (4) is now redesignated as § 413.78(c) and (d)). We later specified at § 413.78(d)(2) that the written agreement must indicate the amount of compensation provided by the hospital to the nonhospital site for supervisory teaching activities.

Section 713 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) imposed a 1-year moratorium relating to certain nonhospital site teaching physician costs for the period from January 1, 2004, through December 31, 2004. During this 1-year period, we were required to allow hospitals to count FTE allopathic or osteopathic family practice residents training in nonhospital settings for IME and direct GME payment purposes without regard to the financial arrangement between the hospital and the teaching physician practicing in the nonhospital setting to which the resident was assigned. We instructed our contractors (then referred to as only "fiscal intermediaries" or "FIs") regarding the effect of section 713 of the MMA in the One-Time Notification (OTN), "Changes to the FY 2004 Graduate Medical Education (GME) Payments as Required by the Medicare Modernization Act of 2003 (MMA)" (Change Request 3071, Transmittal 61, issued on March 12, 2004). Generally, we stated in the OTN that, when settling prior year cost reports during this 1-year period, or for family practice residents actually training in nonhospital settings during this 1-year period, contractors should allow hospitals to count allopathic and osteopathic family practice residents training in a nonhospital setting for direct GME and IME payment purposes without regard to the financial arrangement between the hospital and the nonhospital site pertaining to the teaching physicians' costs associated with the residency program. For further information on this provision and for a summary of comments and responses related to this provision, we refer readers to the FY 2005 IPPS final rule (69 FR 49176).

In an effort to respond to concerns expressed by hospitals about the administrative burden associated with meeting the written agreement requirements, in the FY 2005 IPPS final rule (69 FR 49179), at § 413.78(e), we revised our regulations to allow hospitals to choose to either enter into a written agreement with the nonhospital site before the hospital may begin to count residents training at the nonhospital site, or to pay concurrently for the cost of training at the nonhospital setting. That is, in the absence of a written agreement, hospitals are required to pay "all or substantially all" of the costs of the training program in the nonhospital setting by the end of the third month

following the month in which the training occurs.

On May 11, 2007, we published a final rule (72 FR 26949) that once again modified the definition of "all or substantially all of the costs for the training program in the nonhospital setting." That final rule further defined "all or substantially all" under § 413.75(b) to mean at least 90 percent of the total costs of the residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of the teaching physician's salaries attributable to direct GME. Although several public commenters had objected to our proposed redefinition of the "all or substantially all," we adopted the 90 percent rule because we believed it would substantially address concerns that had been voiced previously by the industry. With this modification, hospitals were no longer required to pay 100 percent of the residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the teaching physicians' costs attributable to direct GME at the nonhospital site. This change in policy also allowed providers to use an alternative, less burdensome method to calculate the GME teaching physician costs attributable to direct GME at nonhospital sites. In addition to the redefinition of "all or substantially all of the costs," the May 11, 2007 final rule also modified the regulation text at § 413.78(f)(3)(ii) to clarify that the required written agreement between a hospital and a nonhospital site must be in place before residents begin training at the nonhospital site. That final rule also specified the information that must be included in the written agreement, and stated that the amounts specified in the written agreement may be modified by June 30 of the applicable academic year.

Section 5504(a) of the Affordable Care Act made changes to section 1886(h)(4)(E) of the Act to significantly reduce the costs that hospitals must incur for residents training in nonhospital sites in order to count the FTE residents for purposes of Medicare direct GME payments. Specifically, section 5504(a) amended the statute to allow a hospital to count all the time that a resident trains in a nonhospital site so long as the hospital incurs the costs of the residents' salaries and fringe benefits for the time that the resident spends training in the nonhospital site. Section 5504(b) of the Affordable Care Act made similar changes to section 1886(d)(5)(iv) of the Act for IME payment purposes. For direct GME payments, the provision is effective for cost reporting periods beginning on or after July 1, 2010; for IME payments, the provision is effective for discharges occurring on or after July 1, 2010. The changes made by section 5504(a) and (b) also specify that if more than one hospital incurs the residency training costs in a nonhospital setting, those hospitals are to count a proportional share of the training time as determined by written agreement between the hospitals. In addition, section 5504(a) amended section 1886(h)(4)(E) of the Act to require hospitals to maintain documents indicating the amount of time their residents spend training in nonhospital sites relative to a base year, and to make those documents available to the Secretary.

Section 5504(c) of the Affordable Care Act specifies that the amendments made by the provisions of sections 5504(a) and (b) shall not be applied in a manner that would require the reopening of settled cost reports except where the provider has a jurisdictionally proper appeal pending on the issue of direct GME or IME payments as of March 23, 2010 (the date of the enactment of Pub. L. 111–148). We are proposing to interpret "pending, jurisdictionally proper appeal on direct GME or IME payments" to mean that in order for a hospital to request a change to its FTE count, direct GME or IME respectively, the "pending, jurisdictionally proper appeal" must be specific to direct GME or IME respectively. For example, in order for a hospital to increase its FTE count with regard to an ACA provision that is unique to IME (such as inclusion in the IME count of didactic time occurring in the hospital as specified by new section 1886(d)(5)(B)(x)(II)), the hospital's "pending, jurisdictionally proper appeal" must be on an IME issue; IME FTEs or the available bed count. However, if the hospital's "pending, jurisdictionally proper appeal" is on an issue that only affects direct GME payments, such as the initial residency period or the Medicare patient load, that appeal would not be sufficient in order for the hospital to increase its FTE count with regard to an ACA provision that is unique to IME, such as didactic time in the hospital setting.

2. Elimination of the "All or Substantially All of the Costs for the Training Program in the Nonhospital Setting" Requirement and New Cost Requirements for Hospitals

As stated earlier, in the May 11, 2007 final rule (72 FR 26949), we redefined the phrase "all or substantially all of the costs for the training program in the nonhospital setting" under § 413.75(b) of the regulations to mean at least 90 percent of the total costs of the residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of the teaching physicians' salaries attributable to nonpatient care direct GME. However, section 5504 of the Affordable Care Act revised the Act, effective on July 1, 2010, and eliminated the requirement that a hospital incur "all or substantially all of the costs for the training program in the nonhospital setting." Under the changes made by section 5504, hospitals are only required to incur the costs of the resident's salaries and fringe benefits during the time the resident spends in the nonhospital setting, and they no longer have to incur other training costs in the nonhospital site in order to count such time for direct GME and IME purposes.

We are proposing to revise our regulation at § 413.75(b) accordingly to conform to these new statutory requirements. Specifically, we are proposing to revise the existing definition of "all or substantially all of the costs for the training program in the nonhospital setting" to be effective for cost reporting periods beginning on or after July 1, 2007, and before July 1, 2010. We also are proposing to add a new § 413.78(g) that details how hospitals should count residents that train in nonhospital sites for cost reporting periods beginning on or after July 1, 2010. Specifically, we are proposing to require under § 413.78(g)(2) that a hospital or hospitals must incur the costs of the salaries and fringe benefits of the resident during the time the resident spends in the nonprovider setting in order to count the time spent by those residents for direct GME payment purposes. § 412.105(f) has also been revised to reflect these changes for the purposes of IME payments.

3. Proposed Revision to Regulations To Allow More Than One Hospital To Incur the Costs of Training Programs at Nonhospital Settings, Either Directly or Through a Third Party

As indicated above, prior to the enactment of the Affordable Care Act, we had interpreted both section 1886(h)(4)(E) of the Act (regarding direct GME) and section 1886(d)(5)(B)(iv) of the Act (regarding IME) as allowing a hospital to count the time spent by residents training in a nonhospital site only when one single hospital incurred the costs of a particular training program in a particular nonhospital setting. We noted that both sections of the statute specified that a hospital could count the time spent by residents training in a nonhospital site "if *the*

hospital incurs all or substantially all of the costs for the training program in *that* setting" (emphasis added). While we understand that, in some cases, hospitals share the costs of training their respective residents in the same programs at the same nonhospital site, we have historically only allowed a hospital to count time spent by those residents if one single hospital met the requirement to incur "all or substantially all" of the training program costs at a nonhospital site. Accordingly, two or more hospitals could not count the time spent by their residents training in a nonhospital site if they shared the training costs at the site or if a third party incurred the costs of training at a nonhospital site on behalf of several hospitals. Examples of third parties that might incur nonhospital site training program costs are a medical or dental school, or a GME administrative entity that is established to operate the GME program.

Sections 5504(a) and (b) of the Affordable Care Act specifically address the situation in which more than one hospital incurs the costs of training programs at nonhospital settings, either directly or through a third party. Sections 5504(a) and (b) amend sections 1886(h)(4)(E) and 1886(d)(5)(B)(iv) of the Act, respectively, to provide that when more than one hospital incurs these costs, either directly or through a third party, those hospitals "shall count a proportional share of the time, as determined by written agreement between the hospitals, that a resident spends training in that setting." Therefore, these statutory changes now allow hospitals to share the costs of resident training at nonhospital sites, so long as those hospitals divide the resident time proportionally pursuant to a written agreement, for the purposes of determining their respective direct GME and IME FTE resident counts at the nonhospital site. These provisions of the statute are effective for cost reporting periods beginning on or after July 1, 2010 for direct GME, and for discharges occurring on or after July 1, 2010 for IME. Accordingly, although hospitals that shared training costs at nonhospital sites could not count any of resident time spent training at those nonhospital sites prior to July 1, 2010, hospitals can count all of that training time beginning on or after July 1, 2010, as long as they divide the resident training time proportionally.

We are proposing to revise our regulations to reflect the statutory provision that allows hospitals to proportionally share the costs of resident training at nonhospital sites under a new paragraph (g)(2) of § 413.78 and to make a conforming cross-reference change under § 412.105(f)(1)(ii) of the IME regulations. While the statute allows hospitals to determine by an agreement the proportional share of time that residents spend training in the nonhospital site, we are proposing that hospitals must use some reasonable basis for establishing that proportion (proposed § 413.78(g)(2)(ii)). One such reasonable basis could be that each hospital counts the number of FTEs for which it incurs the salaries and fringe benefits. For example, if there are 10 FTEs training in a nonhospital setting in a particular program, and there are two hospitals that each incur the costs of the salaries and fringe benefits of 5 of those FTEs, each hospital could agree to count 50 percent of the FTEs (even if each hospital is not necessarily paying 50 percent of the cost, due to differences in resident salary amounts, this arrangement is acceptable, so long as 100 percent of the required cost is paid).

In addition to having a reasonable basis for establishing the proportion, hospitals also must be able to document the amount that they are paying collectively, and this amount must equate to at *least* the sum of all the salaries and fringe benefits of the residents for the amount of time that the residents are training in that site. The salaries and fringe benefits of the residents will vary depending upon the program year of the residents, and the specialty in which they are training. As we indicated in the May 11, 2007 final rule (72 FR 26961), hospitals must "take into account the actual salary and fringe benefits for each FTE resident that trains in the nonhospital site, which may vary by resident." Therefore, as also indicated in the May 11, 2007 final rule (72 FR 26970), global agreements that cover a variety of issues (GME and non-GME) between the hospital(s) and nonhospital site, and that only specify a lump sum payment amount with no break out of the residents' salaries and fringe benefits, do not provide sufficient information for the Medicare contractor to determine that "all or substantially all" of the costs (or, effective July 1, 2010, that all of the residents' salaries and fringe benefits) have been paid. Accordingly, we would expect that, regardless of whether there is one hospital paying the cost, or if more than one hospital is sharing the costs, hospitals would need to determine prior to the start of nonhospital rotations (with allowance for modification by June 30 of that academic year) the total cost of the salaries and fringe benefits of the residents that are training for the proportion of the year spent in each nonhospital site. Of course, in the instance where the residents remain on the payroll of one or more hospitals for the entire year, it would be easier to document that the hospital(s) continues to pay the residents' salaries and fringe benefits when the residents rotate to nonhospital sites. Similarly, where the residents are on the payroll of the medical or dental school, or of a third party GME administrative entity, and the hospitals reimburse the school or the third party for the *entire* salary and fringe benefit costs of the residents for both hospital and nonhospital training, the hospitals could easily document that they have incurred the requisite costs of training in nonhospital sites. In some circumstances, it may be more labor-intensive for a hospital or hospitals to document that they have incurred costs of training in the nonhospital site that equate to at least the sum of the salaries and fringe benefits of the FTE residents for the proportion of time spent in the nonhospital site. This is especially true in situations where funds are being transferred between one or more hospitals and a third party administrative entity not simply for Medicare GME purposes, but as part of global agreements that also address a variety of Medicare and non-Medicare issues. However, once the total costs for the residents' salaries and fringe benefits for time spent in the nonhospital site are determined and covered by the hospitals, the hospitals may decide among themselves the proportion of those costs each will incur, and may use a reasonable basis to allocate among themselves the proportion of FTE residents that each one will count, as discussed above.

As specified in section 5504, we are proposing further that the hospitals must record the proportion of the FTE resident time spent training in the nonhospital site that will be counted by each hospital for purposes of direct and indirect GME payment, as well as the reasonable basis for the proportion, in a written agreement between the hospitals. We are proposing to add this requirement in regulations at § 413.78(g)(2)(i). If hospitals have in place written agreements with the nonhospital site in accordance with our existing regulations at § 413.78(f)(3)(ii), we are proposing that the proportion of the FTE resident training time to be counted for IME and direct GME purposes by each hospital, and the basis for the proportion, may be recorded in that agreement (proposed § 413.78(g)(2)(iii)). We are proposing that if the hospitals choose to pay the

training program costs concurrently as described in § 413.78(g)(3)(i), that is, without a written agreement, the hospitals must still agree in writing to the proportion of costs and training time they plan to incur and count (proposed § 413.78(g)(2)(iv)) in addition to the basis for that proportion, as specified by the statute. That written agreement between the hospitals must be available for CMS review and for auditing purposes. In addition, we would expect that the hospitals' records of resident training time and training costs at nonhospital sites, as required by the Affordable Care Act and as discussed below, reflect the proportions of training time and costs as agreed upon and documented in whichever type of written agreement the hospitals used to record the proportional shares of resident training time that each will count for purposes of direct GME and IME payment.

4. Proposed Changes to Regulations Regarding Recordkeeping and Comparison to a Base Year

As stated above, section 5504(a) of the Affordable Care Act requires hospitals to maintain records of the amount of time that their residents spend in nonprovider settings, and to compare that time to the time spent by their residents in nonprovider sites in a base year as the Secretary may specify. This requirement is effective for cost reporting periods beginning on or after July 1, 2010. We are proposing to incorporate this statutory requirement for maintaining records under a new paragraph (g)(5) of § 413.78 of the regulations, and we anticipate amending the cost report for hospitals to include lines where hospitals can submit the required data, which is described below. These data will help CMS identify whether barriers to resident training in nonhospital sites exist. The original allowance of IME payments for training in nonhospital sights, as instituted by the BBA, was intended to act as an incentive to hospitals to increase such training. However, we have not seen a marked increase in the amount of training that occurs in nonhospital settings in the years since the implementation of the BBA. Advocates of expanding training in nonhospital sites have alleged that CMS' rules for counting residents in nonhospital sites regarding teaching physician salary costs were an obstacle to the expansion of training in nonhospital settings. The recordkeeping and reporting requirement added by section 5504(a) of the Affordable Care Act will provide the Secretary information to assess whether nonhospital site resident training increases as a result of the statutory revision of rules that were viewed as burdensome.

We understand that rotation schedules are a primary source of information that hospitals supply to Medicare contractors for determining where and for how much time each resident spends training in each hospital or nonhospital site. Therefore, we are proposing that rotation schedules be the source for establishing the amount of time that residents spend training in nonhospital sites, both in the base year and in subsequent years. The amendment to section 1886(h)(4)(E) of the Act by section 5504(a) of the Affordable Care Act states that the Secretary shall specify the aforementioned base year for the level of training at nonhospital sites. We are proposing that cost reporting periods beginning on or after July 1, 2009 and before June 30, 2010 be the base year against which we will compare subsequent years' data to determine if the amount of nonhospital training that occurs in subsequent years increases relative to that base year (proposed new § 413.78(g)(5)). We also are proposing that, to meet this documentation requirement, hospitals only need to maintain records of the total unweighted direct GME FTE count (before application of the direct GME FTE resident cap) of resident training time in nonhospital settings.

Section 5504(a) of the Affordable Care Act also made changes to require that these records be made available to the Secretary. In order for CMS to evaluate whether nonhospital site training has increased as a result of the changes made by section 5504 of the Affordable Care Act, we are proposing to include several additional cost report lines for hospitals to submit data for each of their primary care programs on a program-specific basis. With respect to hospitals' nonprimary care programs, hospitals would only need to supply that data on an overall hospital basis, and we are proposing to add one line on the cost report for hospitals to submit that data. We are only requiring program-specific data with respect to resident training time in nonhospital sites for primary care specialties because we believe that that is sufficient for the intent of this provision. The intent of this recordkeeping requirement is to see whether, as a result of the policy changes required under section 5504(a), there is an increase in the volume of residency training that takes place in nonhospital settings. Since residents at nonhospital sites typically train in primary care specialties, and in order to minimize the documentation burden on hospitals, we do not believe it is necessary to require program-specific data for other specialties that would provide only marginally useful information. For the purposes of this provision, we propose to use the definition of primary care resident in § 413.75(b) to identify those programs for which we are proposing to require program-specific data.

Once this information is made available to CMS, the data would be compared to the analogous data from the base year of cost reporting periods beginning on or after July 1, 2009 and before June 30, 2010, in order for CMS to determine whether the volume of nonhospital site training has increased. Specifically, we are proposing to use the total direct GME count of FTE training time in a primary care specialty in nonhospital sites (prior to application of direct GME FTE resident limits) as the gauge to determine if residency training time in nonhospital settings in that specialty has increased in an academic year relative to the base year. For example, if, in the base year, we find that 10.5 direct GME FTEs out of a total of 15 FTE family practice residents from a family practice residency program in a teaching hospital trained in nonhospital settings (that is, 70 percent of the FTE time of the residents in the family practice residency program was spent training in nonhospital sites), we would note the subsequent years' amount of direct GME FTE training time in nonhospital sites in that particular teaching program to see if that FTE proportion increased from 70 percent. This would help determine if more training time is spent by primary care residents in nonhospital sites. Or, for all of the nonprimary care teaching programs in a hospital, if 100 direct GME FTE residents out of 400 FTE residents spent time training in nonhospital settings (that is, 25 percent of the time spent by residents in the program is spent training in nonhospital sites), we would look to see if in subsequent years, more than 25 percent of the time spent by nonprimary care direct GME FTEs from that hospital is spent training in nonhospital sites.

C. Counting Resident Time for Didactic and Scholarly Activities and Other Activities (Section 5505 of the Affordable Care Act)

1. Background and Changes Made by the Affordable Care Act

Prior to the enactment of the Affordable Care Act, the time that residents spend training at a nonhospital setting in nonpatient care activities, as part of an approved

program, could not be included in a hospital's direct GME or IME FTE resident count. There were also differences in the rules for counting FTE resident time during the time that residents spend training in the hospital for direct GME and IME payments. For direct GME payment purposes, under 42 CFR 413.78(a), "residents in an approved program working in all areas of the hospital complex may be counted." As explained in the September 29, 1989 **Federal Register** (54 FR 40286), the hospital complex consists of the hospital and the hospital-based providers and subproviders. Therefore, the distinction between patient care activities and nonpatient care activities is not relevant to direct GME FTE count determinations when the residents are training in the hospital complex. However, for IME payment purposes, consistent with the regulations at 42 CFR 413.9 and 412.105(f)(1)(iii)(C), only time spent in patient care activities in the hospital is counted. It has been our longstanding policy that, regardless of the site of training, "we do not include residents in the IME count to the extent that the residents are not involved in furnishing patient care" (66 FR 39897, August 1, 2001).

Section 5505(a) of the Affordable Care Act added new subparagraph (J) to section 1886(h)(4) (as amended by section 5504) of the Act to allow hospitals to count certain nonpatient care activities that occur in certain nonprovider settings, including didactic conferences and seminars, in the hospital's direct GME FTE resident counts. The provision added by section 5505(a) allows a hospital to count the time that residents spend training in an approved program in a "nonprovider setting that is primarily engaged in furnishing patient care" for direct GME purposes, even if those residents are engaged in nonpatient care activities, such as didactic conferences and seminars (but not including research not associated with the treatment or diagnosis of a particular patient), during that training time at the nonhospital site. This statutory change is effective for cost reporting periods beginning on or after July 1, 2009. We are proposing to revise our regulations at § 413.78(f)(1) and (g)(1) to reflect the statutory provision.

Section 5505(b) of the Affordable Care Act addressed IME and added a new clause (x) to section 1886(d)(5)(B) of the Act which allows certain nonpatient care activities, including didactic conferences and seminars (but not including research not associated with the treatment or diagnosis of a particular patient), to be counted for IME purposes as well. However, for IME purposes, this change only applies to such activities during training that occurs in subsection (d) hospitals (which are IPPS hospitals), subsection (d) Puerto Rico hospitals (IPPS hospitals in Puerto Rico), hospitals that are reimbursed under a reimbursement system authorized under section 1814(b)(3) of the Act, or provider-based hospital outpatient departments. The IME provision is applicable to cost reporting periods beginning on or after January 1, 1983. We are proposing to revise our regulations at § 412.105(f)(1)(ii)(A) through (f)(1)(ii)(D) and (f)(1)(iii)(B) to reflect these statutory provisions.

As specified in section 1886(d)(5)(B)(x)(III) of the Act, as added by section 5505(b) of the Affordable Care Act, research activities that are not associated with the treatment or diagnosis of a particular patient are excluded from the allowable IME count of FTE residents, and this specific change applies to cost reporting periods beginning on or after October 1, 2001. We discuss this provision and our proposed implementation under section XVII.C.3. of this proposed rule.

Section 10501(j) of Public Law 111–152 amended section 5505 of Public Law 111–148 to clarify the application of the provisions of section 5505. The amendment prohibits the provisions of section 5505 from being applied in a manner that would require the reopening of settled cost reports except where the provider has a jurisdictionally proper appeal pending on the issue of direct GME or IME payments as of March 23, 2010 (the date of the enactment of Pub. L. 111–148). We are proposing to reflect this provision in the proposed revisions to our regulations under § 412.105(f)(1)(ii), § 412.105(f)(1)(iii)(C) and § 413.78(h). We are also proposing, as mentioned above with respect to Section 5504, to interpret "pending, jurisdictionally proper appeal on direct GME or IME payments" for this section to mean that in order for a hospital to request a change to its FTE count, direct GME or IME respectively, the "pending, jurisdictionally proper appeal" must be specific to direct GME or IME respectively. For example, in order for a hospital to increase its FTE count with regard to an ACA provision that is unique to IME (such as inclusion in the IME count of didactic time occurring in the hospital as specified by new section 1886(d)(5)(B)(x)(II)), the hospital's "pending, jurisdictionally proper appeal" must be on an IME issue; IME FTEs or the available bed count. However, if the hospital's "pending, jurisdictionally proper appeal" is on an issue that only affects direct GME payments, such as the initial residency period or the Medicare patient load, that appeal would not be sufficient in order for the hospital to increase its FTE count with regard to an Affordable Care Act provision that is unique to IME, such as didactic time in the hospital setting.

2. Definition of "Nonprovider Setting That Is Primarily Engaged in Furnishing Patient Care"

As stated above, section 5505(a) of the Affordable Care Act amended section 1886(h)(4) of the Act to allow hospitals to count the time that residents spend in certain nonpatient care activities in nonhospital sites towards the hospitals' direct GME resident count for cost reporting periods beginning on or after July 1, 2009. The amendments made by section 5505(a) to section 1886(h)(5) of the Act include a definition of the term "nonprovider setting that is primarily engaged in furnishing patient care" to mean "a nonprovider setting in which the primary activity is the care and treatment of patients, as defined by the Secretary." In past discussions regarding our policy to disallow time spent by residents in didactic nonpatient care activities, we have given extensive explanations of what we mean by the term "patient care activities." When section 1886(h)(4)(E) of the Act was first implemented, we specifically stated that "only time spent in activities relating to patient care may be counted [in nonhospital sites]" (54 FR 40292, September 29, 1989). In 1998, when we implemented the statute allowing FTE residents to be counted in nonhospital sites for IME, we reiterated that a hospital may only count resident training time "in nonhospital sites for indirect and direct GME, respectively, if the resident is involved in patient care" (63 FR 40986, July 31, 1998). In addition, we note that the scope of the term "patient care" had been well-established in the Medicare program even prior to issuance of the first rules on counting FTE residents for purposes of direct GME and IME payments. For example, prior to the IPPS, acute care hospitals were paid by Medicare for inpatient services based on their reasonable operating costs, or costs relating to the provision of reasonable and necessary "patient care." The longstanding regulation at 42 CFR 413.9 (Costs related to patient care) specifies that Medicare payment is limited to those services relating to "patient care," or to those relating to covered services for the care of beneficiaries. In the August 18, 2006 **Federal Register**, we defined the term "patient care activities"

at 42 CFR 413.75 in a way that was consistent with these previous, plain-language applications of the term (71 FR 48142). Therefore, we currently define "patient care" at § 413.75(b) as "the care and treatment of particular patients, including services for which a physician or other practitioner may bill, and orientation activities as defined in this section."

Section 5505(a) of the Affordable Care Act added a new subparagraph (K) to section 1886(h)(5) which defines the term "nonprovider setting that is primarily engaged in furnishing patient care" to mean "a nonprovider setting in which the primary activity is the care and treatment of particular patients, as defined by the Secretary." This definition uses the term "patient care" which we have defined previously, as discussed above. We are proposing to continue our current construction of the term "patient care" as described above and in current regulations and other guidance. Examples of nonprovider settings that would be "primarily engaged in furnishing patient care" are those settings in which the main mission is to provide patient care, such as doctors' offices and community health clinics. Nonprovider settings that *would* not meet these criteria include those with a main mission other than patient care. Examples of such settings are medical schools and dental schools, even if those schools are part of a larger system that includes institutions that are primarily engaged in patient care. Despite any affiliations with patient care settings, medical and dental schools are institutions that are primarily engaged in educational activities as opposed to patient care. Medical and dental schools retain their principal mission of education regardless of their participation in various systems and affiliations, parts of which may involve settings that are primarily engaged in furnishing patient care. Another example of a nonprovider setting that does not meet the "primarily engaged in furnishing patient care" criterion set forth in this section would be a hotel or convention center. While residents may attend didactic conferences and seminars in a hotel or convention center, that didactic time cannot be counted toward a hospital's direct GME FTE count because the main mission of a hotel or convention center is the provision of hospitality and meeting services. Thus, any such time spent in a hotel or convention center would not occur in a setting that is primarily engaged in furnishing patient care.

The exclusion of medical and dental schools from the definition of "nonprovider setting that is primarily engaged in furnishing patient care" is consistent with longstanding CMS policy, and we have addressed this policy several times in the past. We explained in response to comments in the aforementioned August 18, 2006 **Federal Register** that, "[W]e understand that it is quite common for hospitals, especially large academic medical centers, to be located on the same campus as a medical school, where the buildings are very closely situated or even connected, and the facilities are often shared. However * * * hospitals, nonhospital sites, and medical schools are structured separately for legal and financial purposes, and are recognized independently for state licensing and Medicare cost reporting purposes. As we stated in 2006, "to put it simply, a hospital is not a medical school, and a medical school is not a hospital" (71 FR 48093). In the August 22, 2007 **Federal Register**, we clarified that, "[T]he commenter is also correct that orientation activities in a related medical school cannot be counted * * * the nonhospital settings we were referring to in which orientation may be counted are those nonprovider settings such as physicians' offices or clinics, where patient care is routinely provided and a hospital is permitted to count the time spent by residents in accordance with our regulations at §§ 412.105(f)(1)(ii)(C) and 413.78(f), *not* other nonhospital settings where time spent by residents is not permitted to be counted for purposes of direct GME and IME" (72 FR 47382). Thus, while time spent by residents in certain nonpatient care activities may be counted for direct GME payment purposes in a nonhospital site primarily engaged in furnishing patient care, time spent by residents in nonpatient care activities at nonhospital sites that are *not* primarily engaged in patient care activities is not allowable for direct GME and IME payment purposes.

We are proposing to add, under § 413.75, the statutory definition of "nonprovider setting that is primarily engaged in furnishing patient care" to the definition of general terms used throughout the GME regulations.

3. Distinguishing Between Allowed "Nonpatient Care Activities" and Nonallowable Research Time

As discussed above, research time that is not associated with the treatment or diagnosis of a particular patient is specifically excluded from the "nonpatient care activities, such as didactic conferences and seminars" that are otherwise allowable under section 5505 of the Affordable Care Act for the purposes of direct GME in nonhospital sites for cost reporting periods beginning on or after July 1, 2009, and for purposes of IME in certain hospital settings for cost reporting periods beginning on or after January 1, 1983. There are several unique features of "research not associated with the treatment or diagnosis of a particular patient" that distinguish it from "nonpatient care activities, such as didactic conferences and seminars." "Research not associated with the treatment or diagnosis of a particular patient" usually comprises activities that are focused on developing new medical treatments, evaluating medical treatments for efficacy or safety, or elaborating upon knowledge that will contribute to the development and evaluation of new medical treatments in the future, rather than on establishing a diagnosis or furnishing therapeutic services for a particular patient.

Section 5505 further distinguishes "research not associated with the treatment or diagnosis of a particular patient" from "nonpatient care activities, such as didactic conferences and seminars," by specifying that nonpatient care activities include "didactic conferences and seminars." Conferences or seminars could include an administrative rotation, which would include resident training in the administrative aspects of medical care such as practice management.

4. Approved Leaves of Absence

In the FY 2008 IPPS proposed rule (72 FR 24814), we proposed to remove vacation, sick leave and other types of leave from the FTE calculation for IME and for direct GME purposes. We proposed this policy based on our belief that such leave time involved neither patient care nor nonpatient care activities. However, we did not finalize this proposed policy after many public commenters explained that the implementation of the policy would involve significant administrative burdens (FY 2008 IPPS final rule, 72 FR 47374). Thus, we did not revise our previously existing policy which allowed vacation and sick leave generally to be counted for direct GME and IME purposes. In the FY 2008 IPPS proposed rule, we also proposed to continue to count the time spent by residents in orientation activities in both the hospital and nonhospital settings. We proposed this policy because we recognized the distinct character of orientation activities as essential to the provision of patient care by residents. We did finalize our policy on orientation time, and in doing so, we specified that *patient care activities* means the care and treatment of

particular patients, including services for which a physician or other practitioner may bill, and orientation activities (§ 413.75(b)), effective for cost reporting periods beginning on or after October 1 2007.

Section 5505(a) of the Affordable Care Act added new subparagraph (K) to section 1886(h)(4) to clarify that hospitals may count residents' vacation, sick leave, and other approved leave time toward the hospitals' direct GME FTE resident count, so long as the leave does not prolong the total time the resident participates in his or her approved program. This direct GME provision regarding leave time is effective for cost reporting periods beginning on or after January 1, 1983. In addition, section 5505(b) of the Affordable Care Act allows hospitals to count residents' vacation, sick leave, and other approved leave time toward the hospitals' IME FTE resident count, as long as the leave does not prolong the total time the resident participates in his or her approved program. This IME provision regarding leave time is effective for cost reporting periods beginning on or after January 1, 1983.

We are proposing to revise our regulations to reflect these statutory changes regarding counting residents' vacation, sick leave, and other approved leave time toward the hospitals' direct FTE resident count under new § 413.78(h) for GME and under § 412.105(f)(1)(iii)(D) for IME. Please note that each hospital is to count the proportion of the leave of absence time as specified in 72 FR 47382. There, we explained that regardless of which hospital is paying the resident's salaries and fringe benefits, the hospital to which the resident is assigned during the time the vacation is taken is the hospital that counts that FTE time for direct GME and IME. If the rotation schedule does not clearly indicate where the resident is assigned during the time the vacation is taken, the hospitals to which the resident rotates over the course of the academic year would divide and count the resident's vacation time proportionately based on the amount of time spent in actual training at the respective hospitals. We are also proposing to specify that "other approved leave" includes those types of generally accepted leave of short duration (those that do not prolong the total time that the resident is participating in the approved training program) that have not been included in our resident leave time policies in the past. Examples of such "other approved leave" could include jury duty, other court leave, or voting leave.

D. Reductions and Increases to Hospitals' FTE Resident Caps for GME Payment Purposes (§§ 412.105(f)(1)(iv) and 413.79(m) and (o))

1. General Background on Methodology for Determining the FTE Resident Count

As we discuss in section XVII.A. of this proposed rule, Medicare makes both direct and indirect GME payments to hospitals that train residents in approved medical residency training programs. Direct GME payments are made in accordance with section 1886(h) of the Act, based generally on hospital-specific PRAs, the number of FTE residents, and the hospital's Medicare patient share. IME payments are made in accordance with section 1886(d)(5)(B) of the Act, based generally on the ratio of the hospital's FTE residents to the number of hospital beds. Accordingly, the calculation of both direct GME and IME payments is affected by the number of FTE residents that a hospital is allowed to count; generally, the greater the number of FTE residents a hospital counts, the greater the amount of Medicare direct GME and IME payments the hospital will receive. In an attempt to end the implicit incentive for hospitals to increase the number of FTE residents, Congress instituted a cap on the number of allopathic and osteopathic residents a hospital is allowed to count for direct GME and IME purposes under the provisions of section 1886(h)(4)(F) of the Act for direct GME and section 1886(d)(5)(B)(v) of the Act for IME. Dental and podiatric residents are not included in this statutorily mandated cap.

2. Reduction of Hospitals' FTE Resident Caps Under the Provisions of Section 5503 of the Affordable Care Act

Medicare makes direct GME and IME payments based on the number of FTE residents the hospital is permitted to count, as limited by the hospital's FTE resident caps. Some hospitals have trained a number of allopathic and osteopathic residents in excess of their FTE resident caps. Other hospitals have reduced their FTE resident counts to some level below their FTE resident caps. Section 5503 of the Affordable Care Act added a new section 1886(h)(8) to the Act to provide for reductions in the statutory FTE resident caps for direct GME under Medicare for certain hospitals, and authorizes a "redistribution" to other hospitals of the estimated number of FTE resident slots resulting from the reductions. Section 5503 also amended section 1886(d)(5)(B)(v) to require application of the provisions of 1886(h)(8) "in the same manner" to the FTE resident caps for IME. A previous redistribution of "unused" FTE resident slots was performed under section 422 of Public Law 108–173 (the Medicare Modernization Act of 2003). Section 422 provided for the redistribution of unused residency positions effective for portions of cost reporting periods beginning on or after July 1, 2005. While section 5503 of the Affordable Care Act is similar to section 422 of Public Law 108–173, there are substantive differences between the two provisions.

The new section 1886(h)(8)(A) of the Act provides that, effective July 1, 2011, a hospital's FTE resident cap will be reduced if its "reference resident level," is less than its "otherwise applicable resident limit," as these terms are described below. Rural hospitals with fewer than 250 acute care inpatient beds as well as those hospitals described in section XVII.D.5. of this proposed rule are exempt from a reduction. For other hospitals, any such reduction will be equal to 65 percent of the difference between the hospital's "otherwise applicable resident limit" and its "reference resident level."

Under the new section 1886(h)(8)(B) of the Act, the Secretary is authorized to increase the FTE resident caps for certain categories of hospitals for portions of cost reporting periods occurring on or after July 1, 2011, by an aggregate number that does not exceed the estimated overall reduction in FTE resident caps for all hospitals under section 1886(h)(8)(A) of the Act. A single hospital may receive an increase in its FTE resident cap of no more than 75 additional FTEs. That is, a hospital would be allowed to receive up to 75 additional slots for direct GME and up to 75 additional slots for IME. In determining which hospitals would receive an increase in their FTE resident caps, section 1886(h)(8)(B) of the Act directs us to—

- Take into account the demonstrated likelihood of the hospital filling the additional positions within the first three cost reporting periods beginning on or after July 1, 2011.
- Take into account whether the hospital has an accredited rural training track program.
- Distribute 70 percent of the resident slots to hospitals located in States with resident-to-population ratios in the lowest quartile.
- Distribute 30 percent of the resident slots to hospitals located in a State, a territory of the United States, or the District of Columbia that are among the top 10 States, territories, or Districts in terms of the ratio of the total population living in an area designated as a health

professional shortage area (HSPA), as of March 23, 2010, to the total population, and to hospitals located in rural areas.

In summary, section 5503 of the Affordable Care Act added a new section 1886(h)(8) of the Act that prescribes a methodology for determining reductions to certain hospitals' FTE resident caps based on unused FTE resident slots, provides for certain exceptions to the FTE resident cap reductions, and includes general criteria that CMS must consider in making a "redistribution" to other hospitals of the estimated number of FTE resident slots resulting from the reductions in the FTE resident caps. In this proposed rule, we are proposing procedures for determining whether, and by what amount, a hospital's FTE resident cap is subject to a reduction under section 1886(h)(8)(A) of the Act. We also are specifying an application process for hospitals that seek to receive increases in their FTE resident caps and the specific criteria that we will use to determine which hospitals will receive increases in their FTE resident caps under section 1886(h)(8)(B) of the Act.

3. Hospitals Subject to the FTE Resident Cap Reduction

As indicated earlier, section 1886(h)(8)(A) of the Act, as added by section 5503 of the Affordable Care Act, provides that if a hospital's "reference resident level" is less than its "otherwise applicable resident limit," its FTE resident cap(s) will be reduced by 65 percent of the difference between its "otherwise applicable resident limit" and its "reference resident level." Under section 1886(h)(8)(H)(i) (as added by section 5503 of the Affordable Care Act), the "reference resident level" refers to the number of unweighted allopathic and osteopathic FTE residents who are training at a hospital in a given cost reporting period. That is, the "reference resident level" refers to a hospital's allopathic and osteopathic FTE resident count for a specific period. Under section 1886(h)(8)(H)(ii) the "otherwise applicable resident limit" refers to a hospital's FTE resident cap established under sections 1886(h)(4)(F)(i) and (h)(4)(H) of the Act for direct GME payment purposes and a hospital's resident cap established under section 1886(d)(5)(B)(v) for IME payment purposes. For most hospitals, the permanent FTE cap under section 1886(h)(4)(F)(i) of the Act is based on: (1) For an urban hospital, the number of unweighted allopathic and osteopathic FTE residents in the hospital's most recent cost reporting period ending on or before December 31, 1996 (the "1996 cap"); (2) for a rural hospital, 130 percent of the 1996 cap, adjusted as specified under existing § 413.79(c)(2); and (3) any adjustments to the hospital's cap under paragraph (7), which specifies the previous "redistribution" of resident positions required by section 422 of Public Law 108–173. Section 1886(h)(4)(H) of the Act specifies that a hospital's FTE resident cap under subparagraph (F) may be adjusted for a new medical residency training program established on or after January 1, 1995, participation in a Medicare GME affiliated group, and establishment by an urban hospital of a separately accredited rural training track program. We are proposing that, in defining a hospital's "otherwise applicable resident limit" for purposes of section 1886(h)(8)(A) of the Act, we will look at the hospital's 1996 cap during its reference year, as adjusted for the following criteria: new programs as defined at § 413.79(e); participation in a Medicare GME affiliation agreement as defined at §§ 413.75(b) and 413.79(f); participation in an Emergency Medicare GME affiliation agreement as defined at § 413.79(f); participation in a hospital merger; and whether an urban hospital has a separately accredited rural training track program as defined at § 413.79(k). We discuss the applicability of Medicare GME affiliation agreements under section 1886(h)(8)(A) of the Act in more detail under section XVII.D.8.c. of this proposed rule and the treatment of hospital mergers under section XVII.D.8.d. of this proposed rule. Furthermore, section 1886(h)(8)(H)(iii) of the Act requires that, in determining a hospital's "otherwise applicable resident limit," section 1886(h)(7)(A) of the Act shall be taken into account. Section 1886(h)(7)(A) of the Act refers to the reduction to a hospital's cap(s) under section 422 of Public Law 108–173. The application of section 422 of Public Law 108–173 to the implementation of section 5503 of the Affordable Care Act is further discussed under section XVII.D.10. of this proposed rule.

In our discussion of the provisions of section 5503 of the Affordable Care Act under this section of this proposed rule, we generally refer to a hospital's number of unweighted allopathic and osteopathic FTE residents in a particular period as a hospital's "resident level." We also refer to a hospital's resident level in the applicable "reference period," as explained further below, as the hospital's "reference resident level." In addition, we refer to the "otherwise applicable resident limit" as the hospital's FTE resident cap that is applicable during the relevant cost reporting period. Thus, we are proposing, effective for portions of cost reporting periods beginning on or after July 1, 2011, we will permanently reduce the hospital's FTE resident cap by 65 percent of the difference between the reference resident level and the hospital's otherwise applicable resident limit for IME and direct GME respectively. For example, if a hospital's otherwise applicable resident limit for the reference period is 100, and its reference resident level is 80 FTEs, we will reduce the hospital's FTE resident cap by 13 FTEs [0.65 (100 − 80)] = 13. We are proposing to add new regulations at § 412.105(f)(1)(iv)(B)(2) for IME and at § 413.79(m) for direct GME to reflect our proposals regarding reductions to hospitals' FTE resident caps under section 5503.

4. Exemption From FTE Resident Cap Reduction for Certain Rural Hospitals

Section 1886(h)(8)(A)(ii)(I) of the Act, as added by section 5503 of the Affordable Care Act, specifically exempts rural hospitals (as defined in section 1886(d)(2)(D)(ii) of the Act) with fewer than 250 acute care inpatient beds from reductions to their FTE resident caps under section 1886(h)(8)(A). Section 1886(d)(2)(D)(ii) of the Act defines a rural area as any area outside a Metropolitan Statistical Area (MSA). Under the existing regulations at § 412.62(f)(ii), an "urban area" means: (1) An MSA or New England County Metropolitan Area (NECMA), as defined by the Executive Office of Management and Budget; or (2) the following New England counties: Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island. Under existing § 412.62(f)(iii), a "rural area" means any area outside an urban area. We note that we no longer use the term MSA, and instead use the term Core-Based Statistical Area (CBSA) for locality and wage index purposes. A hospital's bed size is based on its number of available beds, as determined for IME payment purposes under § 412.105(b) of the regulations. For purposes of determining whether a rural hospital has fewer than 250 beds, we are proposing to use data from the rural hospital's most recent cost reporting period ending on or before March 23, 2010. (This information may be found on Worksheet S–3, Part I of the Medicare cost report, CMS–2552–96, the sum of lines 1 and 6 through 10 in column 2, minus line 26 in column 6, divided by the number of days in the cost reporting period.) We are proposing that if a rural hospital has fewer than

250 beds in its most recent cost reporting period ending on or before March 23, 2010, the hospital would not be subject to a possible reduction to its FTE resident cap(s) under section 1886(h)(8)(A) of the Act. However, if a rural hospital has at least 250 beds in its most recent cost reporting period ending on or before March 23, 2010, we are proposing that the rural hospital would be subject to a reduction to its FTE resident cap(s).

5. Application of Section 5503 to Hospitals That Participate in Demonstration Projects or Voluntary Residency Reduction Programs and Certain Other Hospitals

In addition to certain rural hospitals as noted above, section 1886(h)(8)(A)(ii) of the Act also exempts certain other hospitals from a cap reduction.

Section 1886(h)(8)(A)(ii)(II) of the Act, as amended by section 5503 of the Affordable Care Act, specifically exempts "a hospital that was part of a qualifying entity which had a voluntary residency reduction plan approved under paragraph (6)(B) or under the authority of section 402 of Public Law 90–248, if the hospital demonstrates to the Secretary that it has a specific plan in place for filling the unused positions by not later than 2 years after the date of enactment of this paragraph." This language is referring to the National Voluntary Residency Reduction Plan (VRRP), the New York Medicare GME Demonstration (New York Demonstration), and the Utah Medicare GME Demonstration (Utah Demonstration).

In July 1997, 42 New York teaching hospitals participated in the New York Demonstration. An additional seven hospitals joined the New York Demonstration in July 1998. The purpose of the New York Demonstration was to test reimbursement changes associated with residency training to determine whether hospitals could use time-limited transition funding to replace and reengineer the services provided by a portion of their residency trainees. In exchange for reducing its count of residents by 20 to 25 percent over a 5-year period, while maintaining or increasing its primary care-to-specialty ratio of residents, a participating hospital (or consortium of hospitals) participating in the New York Demonstration would receive "hold harmless payments" for 6 years.

Since 2003, nine Utah teaching hospitals have participated in the Utah Demonstration to allocate Medicare GME funding to Utah hospitals based on health professions workforce planning. Under the Utah Demonstration, Medicare contractors redirect Medicare direct GME funds from each of the teaching hospitals in Utah and pay those amounts to the Utah Medical Education Council, an agency of the State government.

Under the VRRP approved under section 1886(h)(6)(B) of the Act, hospitals could use time-limited transition funding to replace the services provided by a portion of their residents. In exchange for reducing its count of residents by 20 to 25 percent over a 5-year period, while maintaining or increasing its primary care-to-specialty ratio of residents, a VRRP participating hospital would receive "hold harmless payments" for 5 years.

Based on the language of section 1886(h)(8)(A)(ii)(II) of the Act, we are proposing that hospitals that participated in the New York Demonstration, the Utah Demonstration, or a VRRP could be exempt from a cap reduction under section 1886(h)(8)(A) of the Act. We are proposing to not differentiate between those hospitals that withdrew from either demonstration prior to its completion and those hospitals that completed either demonstration. That is, we are proposing that any hospital that, at some point, participated in the New York Demonstration, the Utah Demonstration, or the VRRP could be exempt from a cap reduction. Specifically, consistent with the statutory language at section 1886(h)(8) of the Act, even though only seven hospitals actually completed the New York Demonstration, any hospital that participated in the New York Demonstration could be exempt from a cap reduction. As required under section 1886(h)(8)(A)(ii)(II) of the Act, to be exempt from the cap reduction, hospitals that had a VRRP approved under section 1886(h)(6)(B) of the Act or hospitals that participated in a demonstration project approved under section 402 of Pub. L. 90–248 must demonstrate to the Secretary that they have a plan in place for filling their unused slots within 2 years after the date of enactment of Pub. L. 111–148 (that is, by March 23, 2012). We are proposing that these hospitals must submit their plans specifying how they would fill their unused slots to CMS by December 1, 2010, in order to be exempt from a cap reduction.

In addition to the hospitals described under 1886(h)(8)(A)(ii)(II) of the Act, section 1886(h)(8)(A)(ii)(III) of the Act exempts a hospital described under section 1886(h)(4)(H)(v) of the Act from a cap reduction. Therefore, we are proposing that such hospital described under section 1886(h)(4)(H)(v) of the Act be exempt from a cap reduction.

Finally, section 1886(h)(8)(H)(i) of the Act provides that the hospital's reference resident level is the resident level for the one cost reporting period out of the three most recent cost reporting periods ending before March 23, 2010, with the highest resident level. Under section 1886(h)(8)(A)(i), that reference resident level is used to make the determination of whether a hospital's FTE resident cap(s) should be reduced. Therefore, we are proposing that if a hospital trains at or above its otherwise applicable resident level in *all* of its three most recent cost reporting periods ending before March 23, 2010, the hospital would be exempt from a cap reduction. A separate determination would be made regarding any reduction to the hospital's direct GME cap and its IME cap.

6. Determining the Estimated Number of FTE Resident Slots Available for Redistribution

In accordance with section 1886(h)(8)(A) of the Act, as added by section 5503 of the Affordable Care Act, we will determine the number of resident positions available for redistribution by estimating the expected reductions to hospitals' FTE resident caps. We believe that section 1886(h)(8)(A) of the Act allows us to distinguish between the FTE counts that are used to determine the number of FTE resident slots that are available for redistribution (that is, the "redistribution pool") and the actual number of FTE residents by which hospitals' FTE resident caps are ultimately reduced. We are proposing to estimate the reduction to a hospital's FTE cap under section 1886(h)(8)(A) of the Act for purposes of determining the number of FTEs that a hospital might contribute to the redistribution pool. We are proposing to estimate the redistribution pool for redistribution in accordance with section 1886(h)(8)(B)(i) of the Act, as added by section 5503(a)(4), which states: "The aggregate number of increases in the otherwise applicable resident limit under this subparagraph shall be equal to the aggregate reduction in such limits attributable to subparagraph (A) (*as estimated by the Secretary*)" (emphasis added). Therefore, we are proposing to estimate and redistribute the number of resident slots in the redistribution pool, and to ensure that the aggregate number of FTE residents by which we increase the FTE resident caps of qualifying hospitals under section 1886(h)(8)(B) of the Act is not more than CMS' estimate of the redistribution pool. We note if we

were subsequently to perform an audit, as described further in section XVII.D.7. of this proposed rule, in order to make a final determination regarding any reductions to a hospital's FTE resident cap, and find that the aggregate number of FTE resident reductions differed from the number CMS had initially estimated for the redistribution pool, the number of slots that can be redistributed from the redistribution pool to qualifying hospitals would not be affected.

To ensure that we will begin making payments for most hospitals based on the revised FTE resident caps by July 1, 2011, we are proposing to set a date by which we will have determined a hospital's reference resident level and compared it to the hospital's otherwise applicable FTE resident cap(s) to estimate whether, and by how much, the hospital's FTE cap(s) would be reduced. We are proposing that this date be May 1, 2011, and that date would apply for all hospitals for purposes of determining an estimate of whether and by how much their FTE resident caps should be reduced. In the event that the Medicare contractors have not completed an audit (explained further under section XVII.D.7. of this proposed rule) by May 1, 2011, we are proposing to estimate by May 1, 2011, the number of FTE residents by which a hospital's FTE resident cap is expected to be reduced. For example, a Medicare contractor may estimate by May 1, 2011, that Hospital A's FTE resident cap should be reduced by 10 FTEs. Thus, we would place 10 FTEs into the redistribution pool. It is possible that even after May 1, 2011, the contractor may continue to audit Hospital A's relevant cost reports to determine if, in fact, 10 FTEs is the appropriate number by which to reduce Hospital A's FTE resident cap, and could ultimately conclude that Hospital A's FTE resident cap should only be reduced by 8 FTEs. If the Medicare contractor does not make this revised determination based on the audit by May 1, 2011, we would reduce Hospital A's FTE resident cap by 8 FTEs effective July 1, 2011, but the number of FTE residents in the redistribution pool attributable to Hospital A would remain at 10 FTEs (the estimated number as of May 1, 2011). Similarly, if the Medicare contractor ultimately concluded that Hospital A's FTE resident cap should be reduced by 12 FTEs, but this final determination is not made by May 1, 2011, Hospital A's FTE resident cap would be reduced by 12 FTEs effective July 1, 2011, but the number of FTE residents in the redistribution pool attributable to Hospital A would remain at 10 FTEs. Therefore, because we believe that section 1886(h)(8)(B)(i) of the Act allows us to distinguish between the FTE counts that are used to determine the size of the redistribution pool, and the actual aggregate number of FTE residents by which hospitals' FTE resident caps are ultimately reduced, we are proposing to use estimated information to determine possible reductions to hospitals' FTE resident caps to estimate the number of FTE resident slots to be distributed under section 1886(h)(8)(B). In addition, we note that, as was done when we implemented section 422 of Pub. L. 108–173, Medicare contractors will provide hospitals with a time-limited opportunity to review cap reduction determinations for possible technical errors before they are finalized.

7. Reference Cost Reports That Are Under Appeal

We understand that there may be instances where a hospital's otherwise applicable resident limit or a hospital's FTE resident count for a reference cost reporting period might be under appeal. When implementing section 422 of Public Law 108–173, we stated in the August 11, 2004 **Federal Register** (69 FR 49118) that we believe that it is in the best interest of the Medicare program, CMS, the contractors, and the hospitals to adopt an approach that allows for finality as early as possible during the process of implementing this provision. We stated that we believed Congress gave some consideration to the challenges we would encounter in implementing a provision as complex as section 422 in such a short timeframe by providing the Secretary with the discretion to distinguish between the FTE counts that are used to estimate the number of FTE resident slots that are available for redistribution (that is, the "redistribution pool"), and the actual number of FTE residents by which hospitals' FTE resident caps are ultimately reduced.

Furthermore, as we stated in the August 11, 2004 **Federal Register** (69 FR 49118), the fact that the Congress took the unusual step of including the language at section 1886(h)(7)(D) of the Act which provides that, "There shall be no administrative or judicial review . . . with respect to determinations made under this paragraph," supports the position advocating for finality. If we had delayed determinations concerning hospital-specific FTE cap determinations until all affected cost reports are settled, audited, and appealed through the various channels normally available to providers, the language, and in particular the specified timeframe, under section 1886(h)(7)(D) of the Act would have been rendered meaningless. Therefore, despite the complexity of section 422 and the potential for profound and long-term GME payment ramifications, we believed that the Congress did not expect the implementation of section 422 provision to linger indefinitely. Rather, by limiting appeal rights and requiring an effective date of July 1, 2005, for reductions in FTE resident caps (which required implementation in a relatively short timeframe), the Congress expected section 1886(h)(7) of the Act, as added by section 422 of Public Law 108–173, to be implemented with expediency and finality.

Similarly, in implementing section 5503 of the Affordable Care Act, we note that determinations under section 1886(h)(8)(A)(i) of the Act are required to be made effective July 1, 2011, and, for the same reasons cited when we implemented section 422, we believe these determinations should be final on, or as quickly as possible after, that date. We note that section 5503(a)(3) of the Affordable Care Act modified section 1886(h)(7)(E) of the Act by inserting "or paragraph (8)" to specify that there shall be no administrative or judicial review with respect to determinations made under section 5503 as well. Therefore, as was our final policy when implementing section 422, we are proposing to not wait for appeals of reference period cost reports to be resolved before making a final determination as to whether and by how much a hospital's FTE resident cap will be reduced. However, we do perceive the need in certain instances to continue audit work for a limited time period past July 1, 2011, to promote the accuracy of FTE resident cap determinations. As under section 422, we are proposing to adopt a policy that would require the Medicare contractors to use the latest available cost report or audit data at the time they make their determinations. If, as of the time the Medicare contractor makes the determination as to whether and by how much a hospital's FTE resident cap should be reduced, there is a pending appeal of the hospital's otherwise applicable resident limit for the reference cost reporting period (that is, a final decision has not been rendered), the Medicare contractor would not wait until a decision is rendered, but would use the FTE resident cap from the initially settled (as indicated in the Notice of Program Reimbursement (NPR)) reference period cost report. Alternatively, if the appeal regarding the otherwise applicable resident limit has

been resolved as of the time that the Medicare contractor makes the determination as to whether and by how much a hospital's FTE resident cap should be reduced, the Medicare contractor would use the FTE resident level that will be used in issuing the subsequent NPR, as established through the appeal. If a reference period cost report has been submitted but not settled at the time the Medicare contractor is making the determination as to whether and by how much a hospital's FTE resident cap should be reduced, the reference resident level is subject to audit by the Medicare contractor, and the final determination regarding any possible reduction to the hospital's FTE resident cap is not subject to appeal. Although we would make every effort to provide contractors with the resources they need to complete as many audits as possible in time to notify each hospital by July 1, 2011, of their FTE cap determinations under section 1886(h)(8)(A) of the Act, there may be instances where the audits of the reference resident levels may not be completed by July 1, 2011. We anticipate that within the scope of their normal audit work, the Medicare contractors will complete as many of these audits as possible, and some of the audits may not be completed until December 31, 2011. We are proposing that, in accordance with section 1886(h)(8)(A) all cap determinations made after July 1, 2011 and through December 2011 will be effective retroactively to July 1, 2011.

8. Determining the Possible Reduction to a Hospital's FTE Resident Cap

a. Reference Resident Level—General

In order to determine if a hospital's reference resident level is less than the hospital's otherwise applicable FTE resident cap, section 1886(h)(8)(H) of the Act, as added by section 5503 of the Affordable Care Act, directs the Secretary to use one of three reference cost reporting periods. Section 1886(h)(8)(H) of the Act directs the Secretary to use a hospital's most recent cost reporting period ending before the date of enactment, which is March 23, 2010, with the highest resident level "for which a cost report has been settled (or, if not, submitted (subject to audit)), as determined by the Secretary," as the reference period. Generally, if the hospital's resident level for either direct GME or IME is less than the hospital's otherwise applicable resident limit for direct GME or IME, respectively, in the reference period, the hospital's FTE resident cap for direct GME and/or IME will be reduced by 65 percent of the difference between the resident level and the otherwise applicable resident limit. We note that, for purposes of determining a reduction to a hospital's direct GME cap, the unweighted direct GME cap will be compared to the direct GME FTE resident count. The following explanation is an example of how a hospital's cap(s) would be reduced under section 1886(h)(8)(A) of the Act. For purposes of this example, Hospital A's three most recent cost reporting periods ending before March 23, 2010, which have been submitted to the Medicare contractor are as follows: July 1, 2006–June 30, 2007; July 1, 2007–June 30, 2008; and July 1, 2008–June 30, 2009. Hospital A's FTE resident count and FTE resident caps (as adjusted for those items discussed in section XVII.D.3. of this proposed rule) are as noted in the table.

Cost Reporting Period	IME Unweighted FTE Count	Direct GME Unweighted FTE Count	IME FTE Cap	Direct GME Cap
July 1, 2006 – June 30, 2007	17	20	18	20
July 1, 2007 – June 30, 2008	16	21	20	20
July 1, 2008 – June 30, 20099	14	20	20	20

As noted earlier in this preamble, a separate determination regarding whether and by how much to reduce a hospital's cap will be made for its direct GME cap and for its IME cap. In order to determine whether Hospital A would be subject to a cap reduction, we must first determine whether Hospital A was training at or above its cap in all three most recent (settled or submitted) cost reporting periods ending before March 23, 2010. For purposes of a reduction to Hospital A's IME cap, we note from the chart above that in all three cost reporting periods, Hospital A is training below its otherwise applicable resident limit for IME. Therefore, we know that Hospital A would be subject to an IME cap reduction. In order to determine which cost reporting period should be used as the reference period to determine the FTE cap reduction, we would use the cost reporting period with the highest FTE resident count for IME, which would be July 1, 2006–June 30, 2007. Therefore, we calculate the difference between the otherwise applicable resident limit for IME for the reference period (July 1, 2006–June 30, 2007) and the reference resident level for IME, and determine the IME cap reduction based on 65 percent of the difference. For purposes of Hospital A's IME cap reduction, we would determine the difference between 18 (the otherwise applicable resident limit) and 17 (the reference resident level) and multiply that difference by 65 percent [(18 − 17) × .65] = 0.65. Therefore, the IME FTE cap for Hospital A would be reduced by 0.65 of an FTE. For purposes of a reduction to Hospital A's direct GME cap, we note from the chart above that Hospital A was training at or above its otherwise applicable resident limits for direct GME in all three cost reporting periods. Because a hospital that is training at or above its cap in *all* three cost reporting periods is exempt from a cap reduction, we would conclude that Hospital A's direct GME cap would not be reduced for direct GME payment purposes. We note that, in general, if a hospital was not participating in a Medicare GME affiliated group during any of its three most recent cost reporting periods ending before March 23, 2010, its reference cost reporting period will be the cost reporting period with the least amount of difference between the reference resident level and the otherwise applicable resident limit. In addition, we are proposing, that if a hospital has the same resident level for two or more cost reporting periods and that resident level is the "highest" resident level, we will use the cost reporting period of those "highest" cost reporting periods in which there is the least amount of difference between the resident level and the otherwise applicable resident limit to determine a cap reduction.

b. Audits of the Reference Cost Reporting Periods

As mentioned under XVII.D.8.a. of this proposed rule, to determine a possible reduction to a hospital's FTE resident cap, section 1886(h)(8)(H)(i) of the Act, as added by section 5503(a) of

Affordable Care Act, directs the Secretary to use, as the reference cost report, the one cost report out of the hospital's three most recent cost reporting periods ending before March 23, 2010, with the highest resident count "for which a cost report has been *settled* (or, *if not, submitted (subject to audit*), as determined by the Secretary" (emphasis added). We are proposing that if a hospital's cost report for the reference cost reporting period has been settled, the hospital's settled cost report, without further audit, would be used to determine possible reductions to the FTE resident caps. We note that the "settled" cost report does not necessarily mean the initial cost report settlement. The Medicare contractor may have previously settled the cost report, reopened it to audit it, and then settled the cost report again, issuing a revised NPR. Thus, we would refer to the more recently issued NPR for that cost reporting period. For those cost reporting periods that would be used as the reference cost reporting period, which have been submitted to the Medicare contractor but not settled, Medicare contractors may perform desk or onsite audits related to section 5503. In addition, if the reference period cost report is for a period other than 12 months, we are proposing that for direct GME, the Medicare contractor would prorate the FTE resident caps and unweighted FTE resident count to equal 12-month counts.

c. Medicare GME Affiliation Agreements

As described above, some hospitals that have resident levels below their FTE resident caps may have entered into Medicare GME affiliation agreements (as permitted under § 413.79(f) of our regulations) with other hospitals that would otherwise exceed their FTE resident caps. Thus, while some hospitals in the Medicare GME affiliated group were training a number of residents below their FTE resident caps prior to entering into a Medicare GME affiliation agreement, upon affiliating, their FTE resident caps were temporarily reduced because some or all of their excess FTE slots were temporarily added to the FTE resident caps of other hospitals as part of the affiliation agreement. Under section 422 of Pub. L. 108–173, the statute directed us to apply the provisions to hospitals that were members of the same affiliated group as of July 1, 2003. In implementing section 422, we based the FTE resident cap reductions for hospitals that were participating in a Medicare GME affiliated group on the aggregate cap and count data from all hospitals participating in the same Medicare GME affiliated group(s). If a hospital was training a number of residents below its FTE resident cap for the reference cost reporting period but the hospital was part of a Medicare GME affiliated group for some or all of that reference cost reporting period, the Medicare contractor determined if the *aggregate* affiliated count for all hospitals in the affiliated group was greater than the aggregate affiliated cap. If the aggregate affiliated count was greater than the aggregate cap, then there was no reduction made to the FTE caps of any hospital in the affiliated group (even for a hospital that was part of the affiliated group, but was training below its cap). However, we note that, in contrast to section 422 of Pub. L. 108–173, section 5503 of the Affordable Care Act does not include language specific to affiliated groups. Rather, section 1886(h)(8)(H) of the Act, as added by section 5503 of the Affordable Care Act, defines the reference resident level and the otherwise applicable resident limit with respect to "a hospital." Similarly, section 1886(h)(8)(A) refers only to "a hospital's" reference resident level. Thus in contrast to section 422 of Public Law 108–173, section 5503 is not amenable to determinations based on the aggregate experience of a Medicare GME affiliated group. Therefore, we are proposing that Medicare contractors would make determinations regarding FTE cap reductions under section 1886(h)(8)(A)(i) by considering the relationship of the individual hospital's otherwise applicable resident limit for the reference period (which is the FTE resident cap for a period as adjusted by any affiliation agreement(s)) to the individual hospital's reference resident level. That is, we are proposing that in a hospital's reference year, if that hospital is participating in a Medicare GME affiliated group and is training a number of residents below its FTE caps as adjusted pursuant to any affiliation agreements which can be found on Worksheet E, Part A, line 3.06 for IME, and Worksheet E–3 Part IV, line 3.03 for direct GME, the hospital's FTE resident caps would be subject to a reduction under section 1886(h)(8)(A)(i) even if the Medicare GME affiliated group as a whole may be training a number of residents above the group's aggregate FTE resident cap.

d. Treatment of Hospitals That Have Merged

We note that there may be instances where two hospitals merge on or after March 23, 2010, but were not merged in any or all of their three most recent cost reporting periods ending before March 23, 2010. For these hospitals, we are proposing that the Medicare contractors identify the hospitals' three most recent cost reporting periods ending before March 23, 2010, and treat the hospitals for purposes of section 1886(h)(8)(A)(i) as if they were merged during those periods in determining whether there should be a reduction to the merged facility's FTE resident cap(s). That is, we are proposing that for each of the 3 years, we would combine the FTE resident counts and caps of the formerly separate facilities in order to identify the reference period, and to calculate the reference resident level and the otherwise applicable resident limit for the merged facility (for IME and direct GME respectively), even if the two facilities have different fiscal year ends. In addition, if any of the cost reporting periods are less than 12 months or greater than 13 months, the Medicare contractor would prorate the FTE resident counts and FTE caps for direct GME to equal a 12-month cost reporting period.

9. Application of Section 5503 to Hospitals That File Low Utilization Medicare Cost Reports

In general, section 5503 of the Affordable Care Act applies to Medicare-participating hospitals that train residents in approved residency training programs. However, some Medicare-participating hospitals may choose to submit low utilization cost reports. These low utilization cost reports may not contain the cost report worksheet that is used to calculate payments for direct GME, Worksheet E–3 Part IV. That is, these cost reports may not contain FTE resident count and cap information. For example, because Medicare-participating children's hospitals primarily serve a non-Medicare population and, therefore, receive minimal Medicare payments, some teaching children's hospitals submit low utilization cost reports. If a children's hospital files a low utilization cost report in a given cost reporting period, and does not file the Worksheet E–3 Part IV, that hospital is not considered by Medicare to be a teaching hospital for that cost reporting period. In addition, although children's hospitals may have an FTE resident "cap" that is applicable for purposes of the Children's Hospital Graduate Medical Education (CHGME) Payment Program, administered by HRSA, this cap is not necessarily used for Medicare payment purposes. Therefore, we are proposing that if a low utilization hospital does not have a cap for Medicare payment purposes, it would not be subject to a negative cap

reduction under section 5503. In addition, we are proposing that if a low utilization hospital does have a cap for Medicare payment purposes (for example, it had filed a regular cost report in 1996) but did *not* file Worksheet E–3 Part IV as part of its cost report in *all* three most recent cost reporting periods ending before March 23, 2010, it will be exempt from cap reduction. In addition, we are proposing that if a low utilization hospital has a cap for Medicare payment purposes and filed Worksheet E–3 Part IV in at least one of its three most recent cost reports ending before March 23, 2010, the Medicare contractor would determine, based on the data of the available cost reports with Worksheet E–3 Part IV, whether a cap reduction is necessary under section 1886(h)(8)(A)(i).

For those low utilization hospitals that have an FTE cap for Medicare payment purposes and have filed Worksheet E–3 Part IV in any of the three most recent cost reporting periods ending before March 23, 2010, we are proposing that determinations as to whether, and by how much, that low utilization hospital's cap may be reduced using the same methodology that we are proposing to use for other Medicare-participating teaching hospitals. In addition, for purposes of section 1886(h)(8)(B) of the Act, we are proposing that, a low utilization hospital would be eligible to apply for an increase in its FTE resident cap under section 1886(h)(8)(B) of the Act, subject to the same demonstrated likelihood and evaluation criteria proposed in this proposed rule for all other hospitals. However, as explained further below in this preamble, section 1886(h)(8)(B)(ii) of the Act, as added by section 5503(a)(4) of the Affordable Care Act, specifies certain requirements and thresholds that a hospital that receives additional slots must meet in order to retain those slots. One requirement is that the hospital must ensure for a 5-year period that its number of FTE primary care residents is not less than the average number of FTE primary care residents during the 3 most recent cost reporting periods ending prior to March 23, 2010. Accordingly, we are proposing that an applying children's hospital must meet the same documentation requirements to establish this primary care average as other applying hospitals, which would mean that the children's hospital must have submitted a Worksheet E–3, Part IV with its Medicare cost report for those 3 most recent cost reporting periods ending prior to March 23, 2010. Furthermore, we are proposing that, in order to receive an increase in its FTE resident cap under section 1886(h)(8)(B) of the Act effective July 1, 2011, in addition to complying with the proposed application requirements as described in this preamble, the hospital would be required to file Worksheet E–3, Part IV, with its Medicare cost report for its cost reporting period that includes July 1, 2011 through and including its cost reporting period that includes June 30, 2016 (that is, the 5-year period). We are proposing that the low utilization hospital must meet this requirement because section 1886(h)(8)(B) is intended to allow a hospital to increase its FTE counts for purposes of Medicare GME payments. We do not believe it would be appropriate to grant an increase in a hospital's FTE resident cap under section 1886(h)(8)(B) of the Act if the hospital does not use the slots for Medicare purposes (but only, for example, for purposes of the CHGME Payment Program) as would be evidenced by not filing a Worksheet E–3, Part IV. Moreover, as explained further below, we are required under section 1886(h)(8)(B)(ii) and (iii) to ensure certain levels of primary care or general surgery training, and the information in Worksheet E–3 Part IV, would be necessary for that purpose.

10. Treatment of Hospitals With Caps That Have Been Reduced or Increased Under Section 422 of Pub. L. 108–173

For purposes of implementation of section 5503(a) of the Affordable Care Act, section 1886(h)(8)(H)(iii) of the Act states that the term "otherwise applicable resident limit," means, "with respect to a hospital, the limit otherwise applicable under subparagraphs (F)(i) and (H) of paragraph (4) on the resident level for the hospital determined without regard to this paragraph but taking into account paragraph (7)(A)." As noted earlier in this preamble, section 1886(h)(7)(A) of the Act, as added by section 422 of Pub. L. 108–173, provided for reductions to hospitals' caps if the hospitals were training a number of residents below their FTE resident caps during the relevant reference period, and for a "redistribution" that increased the FTE resident caps for certain hospitals. Although sections 1886(h)(4)(F)(i) and (H) refer to paragraph (7), which includes both cap reductions and increases made pursuant to section 422 of Pub. L. 108–173, we believe that specific mention of only paragraph (7)(A), which refers to cap reductions made under section 422, gives the Secretary the authority to only take into account the reductions made to hospitals' caps under section 1886(h)(7)(A), for purposes of implementing section 1886(h)(8)(A)(i) of the Act. That is, we believe specific mention of paragraph (7)(A) is meant to provide that in determining a hospital's otherwise applicable resident limit, the Secretary should take into account any reductions to its reference resident level made under section 1886(h)(7)(A) to determine whether a cap reduction under section 1886(h)(8)(A)(i) is necessary. Furthermore, section 1886(h)(8)(H)(i) requires that for purposes of determining the reference resident level, the Secretary is required to consider the hospital's three most recent cost reporting periods ending prior to March 23, 2010 that have been settled (or, if not, submitted (subject to audit)), as determined by the Secretary. In addition, we note that increases made under section 1886(h)(7)(B) were effective for portions of cost reporting periods beginning on or after July 1, 2005, and that some hospitals may still be filling their residency training programs with FTE resident slots gained under section 1886(h)(7)(B), during what may be their reference cost reporting period for purposes of section 1886(h)(8)(A)(i). Therefore, we believe that it would be inappropriate to include increases made under section 1886(h)(7)(B) in determining the hospital's reference resident level for purposes of cap reductions under section 1886(h)(8)(A)(i). Hospitals that received increases to their caps under section 1886(h)(7)(B) may still be "building" their residency programs using the additional FTE resident slots they received under section 1886(h)(7)(B). Therefore, it would be premature to remove any of those FTE resident slots. Accordingly, we are proposing that, in determining whether a cap reduction is necessary under section 1886(h)(8)(A)(i) we would compare the hospital's FTE resident count for its reference period to its FTE resident cap, as adjusted under section 1886(h)(7)(A). We are proposing that we would *not* consider any increases to its resident cap a hospital may have received under section 1886(h)(7).

11. Criteria for Determining Hospitals That Will Receive Increases in Their FTE Resident Caps

Generally, under section 1886(h)(8)(A) of the Act, as added by section 5503(a)(4) of the Affordable Care Act, the Secretary is to reduce the FTE resident caps for hospitals that were training a number of residents below their otherwise applicable resident limit in the reference period by 65 percent of the "excess" resident slots. Under section 1886(h)(8)(B), the Secretary is to

"redistribute" the estimated number of FTE reductions under section 1886(h)(8)(A) to increase the FTE resident caps for use by other hospitals. Under section 1886(h)(8)(B)(i) of the Act, the Secretary is authorized to increase the otherwise applicable FTE resident cap for each qualifying hospital that submits a timely application by a number that the Secretary may approve, for portions of cost reporting periods occurring on or after July 1, 2011. In implementing section 1886(h)(8)(B) of the Act, we note the difficulty in deciding which teaching hospitals are more "deserving" than others to receive the redistributed unused resident slots. Therefore, in addition to some considerations and priorities in redistribution that are specified in section 5503, we are proposing certain additional criteria that we believe will allow for an objective decision-making process.

Section 1886(h)(8)(B) of the Act, as added by section 5503 of the Affordable Care Act, establishes certain parameters in the statutory language for hospitals to meet to qualify to receive increases in their FTE resident caps. First, section 1886(h)(8)(B)(i) of the Act states that the aggregate number of increases in the otherwise applicable resident limits (caps) shall be equal to the aggregate reduction in the resident limits determined under section 1886(h)(8)(A) of the Act as estimated by the Secretary(as discussed in section XVII.D of this proposed rule). Section 1886(h)(8)(F) of the Act states that in no case will any hospital receive an FTE cap increase of more than 75 FTE positions as a result of the redistribution. In addition, section 1886(h)(8)(C) of the Act specifies that, in determining which hospitals will receive the increases to their FTE resident caps, the Secretary is required to take into account the demonstrated likelihood that the hospital would be able to fill the position(s) within the first three cost reporting periods beginning on or after July 1, 2011, and whether the hospital has an accredited rural training track program.

In setting up an application process for hospitals to apply for FTE resident cap increases from the redistribution pool (discussed in section XVII.D.8. of this proposed rule), we are proposing to consider the "demonstrated likelihood" criterion under section 1886(h)(8)(C)(i) as an eligibility criterion that a hospital must meet in order for CMS to further consider the hospital's application for an increase in its FTE resident cap. We are proposing that a hospital would meet the "demonstrated likelihood" criterion by demonstrating that it is either already training a number of FTE residents at or in excess of its current FTE caps (IME and direct GME FTE caps, respectively, *including any applicable section 422 cap add-on*), or that it does not have sufficient room under its current FTE caps to accommodate a planned new program or expansion of an existing program. We believe it is appropriate to consider a hospital's "demonstrated likelihood" as a requirement because we believe such hospitals will be best positioned to make immediate and efficient use of any FTE cap increase, and thereby, to use any resulting increase in Medicare GME payments to train the physician workforce that will provide care to Medicare beneficiaries. Thus, we are proposing that, in order to be eligible for consideration for an increase under section 1886(h)(8)(B) of the Act, a hospital must first demonstrate the likelihood that it will able to fill the slots within the first three cost reporting periods beginning on or after July 1, 2011, by meeting *at least one* of the following three criteria and by providing documentation that it meets the criterion in its application for an increase to its FTE resident cap:

• *Demonstrated Likelihood Criterion 1.* The hospital does not have sufficient room under its current FTE cap for a new residency program that it intends to establish on or after July 1, 2011 (that is, a newly approved program that begins training residents at any point within the hospital's first three cost reporting periods beginning on or after July 1, 2011). Under this criterion, the hospital would select one of the following:

(1) Hospital will establish a newly approved residency program. (Under this selection, the hospital would be required to check at least one of the following, if applicable):

• Application for approval of the new residency program has been submitted to the ACGME, AOA, or the ABMS by December 1, 2010. (The hospital would be required to attach a copy.)

• The hospital has submitted an institutional review document or program information form concerning the new program in an application for approval of the new program by December 1, 2010. (The hospital would be required to attach a copy.)

• The hospital has received written correspondence from the ACGME, AOA, or ABMS acknowledging receipt of the application for the new program, or other types of communication from the accrediting bodies concerning the new program approval process (such as notification of site visit). (The hospital would be required to attach a copy.)

(2) Hospital will likely fill the slots requested. (The hospital would be required to select at least one of the following, if applicable.)

• The hospital does not have sufficient room under its FTE cap, and the hospital's existing residency programs had a combined resident fill rate of at least 85 percent in each of program years 2007 through 2009. (The hospital would be required to attach documentation.)

• The hospital does not have sufficient room under its FTE cap, and the specialty program for which the hospital is applying has a resident fill rate either nationally, within the State, or within the CBSA in which the hospital is located, of at least 85 percent. (The hospital would be required to attach documentation.)

• *Demonstrated Likelihood Criterion 2.* The hospital does not have sufficient room under its FTE cap, and the hospital intends to use the additional FTEs to expand an existing residency training program within the hospital's first three cost reporting periods beginning on or after July 1, 2011.

(1) Hospital intends to expand an existing program. Under this selection, the hospital would be required to check at least one of the following, if applicable:

• The appropriate accrediting body (the ACGME, AOA, or ABMS) has approved the hospital's expansion of the number of FTE residents in the program. (The hospital would be required to attach documentation.)

• The American Osteopathic Association Residency Match Program has accepted or will be accepting the hospital's participation in the match for the existing program that will include additional resident slots in that residency training program. (The hospital would be required to attach documentation.)

• The hospital has submitted an institutional review document or program information form for the expansion of the existing residency training program by December 1, 2010. (The hospital would be required to attach documentation.)

(2) Hospital will likely fill the slots of the expanded existing residency program. Under this selection, the hospital would be required to check at least one of the following, if applicable:

• The hospital does not have sufficient room under its FTE cap, and the hospital has other previously established residency programs, with a resident fill rate of at least 85 percent in each of program years 2007 through 2009. (The hospital would be required to attach documentation.)

• The hospital does not have sufficient room under its FTE cap, and the hospital is expanding an existing program in a particular specialty with a resident fill rate either nationally, within the State, or within the CBSA in which the hospital is located, of at least 85 percent. (The hospital would be required to attach documentation.)

• *Demonstrated Likelihood Criterion 3.* Hospital is applying for an increase in its FTE resident cap because the hospital is already training residents in an existing residency training program(s) in excess of its direct GME FTE cap or IME FTE cap, or both. The hospital would be required to attach copies of *each* of the following:

—Copies of the Medicare cost reports that have been most recently submitted to the Medicare contractor by July 1, 2010 documenting on Worksheet E, Part A, Worksheet E–3, Part VI, and Worksheet E–3, Part VI, the resident counts and FTE resident caps for both direct GME and IME for the relevant cost reporting periods.

—Copies of the 2010 residency match information concerning the number of residents at the hospital in its existing programs (that is, all programs, not only the ones for which the hospital may be requesting more slots).

—Copies of the most recent accreditation letters on all of the hospital's training programs in which the hospital trains and counts FTE residents for direct GME and IME.

We are proposing that *each* hospital applying for an increase under section 1886(h)(8)(B)(i) would be required to meet at least one of the above criteria in order to demonstrate the likelihood that it will be able to fill the additional slots associated with any increase in the hospital's FTE resident cap within the first three cost reporting periods beginning on or after July 1, 2012. In other words, each hospital that wishes to apply for an increase in its FTE resident cap, as a preliminary matter, would be required to meet the "demonstrated likelihood" criterion in order for CMS to further consider the hospital's application for an increase in its FTE resident cap.

Although a hospital might be applying for additional slots for more than one specialty program, each application by a hospital must be program-specific. That is, the hospital would be required to complete a separate CMS evaluation form for each program and to demonstrate the likelihood of filling the slots in each program. However, in accordance with our general policy with respect to FTE resident caps, increases in the hospital's FTE resident caps under section 1886(h)(8)(B)(i) for direct GME and IME, once granted to a hospital, would no longer be program-specific. Rather, the hospital's adjusted FTE resident caps would be applied to the hospital's FTE resident counts, including any residents the hospital trains. We note, however, that for FTE residents counted as a result of an increase in the FTE resident caps under section 422 of Pub. L. 108–173, payment is calculated separately for direct GME purposes using the national average PRA and, for IME purposes using a multiplier of 0.66. If a hospital receives an increase to its FTE resident cap(s) under section 5503, and also received a cap increase under section 422, we are proposing that the hospital would first assess whether it is training a number of residents in excess of its combined 1996 FTE and section 5503 caps and, only if its number of FTE residents still exceeds this combined cap would the separate 422 payment rates be applied to the excess FTEs for IME and direct GME, respectively.

For purposes of the application for the increase to the FTE caps under section 1886(h)(8)(B)(i) of the Act, we are proposing to define "national fill rate" for each academic year, as we did when implementing section 422 of Public Law 108–173. That is, we defined "national fill rate" as the number of residents training in a program nationally as compared to the number of accredited slots in that program as of June 30 of that year. This information is available from the ACGME and the AOA. Furthermore, we are proposing to require that, for the purposes of an application for an increase to a hospital's FTE resident cap under section 1886(h)(8)(B) of the Act, a hospital must use the "fill rate" for the most recent academic year for which data are available.

We understand that hospitals may train fewer residents than the number of available accredited slots in their approved programs due to reasons other than an inability to fill those slots. Furthermore, because we understand that a national fill rate is not necessarily the only indicator of the ability of hospitals to fill residency positions in its CBSA or State, and there may be characteristics particular to a region, such as population density, variety of practice settings, or access to technology or procedures that may allow a specified area to have a fill rate in a specific program that exceeds the program's national fill rate, we are proposing several options for a hospital to satisfy the "fill rate'" criterion. In part, as when implementing section 422 of Public Law 108–173, we specified that the fill rate "threshold" is 85 percent. We believe that this rate will reasonably identify those programs that are likely to fill FTE resident positions in newly approved or expanded programs (while providing some latitude to account for other factors that affect the national fill rate), and to fully utilize an increase in FTE resident cap slots that may be available under section 1886(h)(8)(B) of the Act as added by section 5503. We are proposing that a hospital may demonstrate the likelihood of filling FTE resident positions associated with a possible increase in its FTE resident cap under section 5503 by documenting that any of the following applies to the new program or to an expansion of an existing program:

• The specialty program has a resident fill rate nationally, across all hospitals, of at least 85 percent.

• The specialty program has a resident fill rate within the State in which the hospital is located of at least 85 percent.

• If the hospital is located within an urban CBSA, the specialty program has a resident fill rate within the CBSA of at least 85 percent.

For the purposes of demonstrating the likelihood of filling FTE resident positions under section 1886(h)(8)(C)(i) of the Act, as added by section 5503, we are proposing that "national fill rate" means, for the most recent academic year for which data is available, the number of residents training in a program nationally (combined allopathic and osteopathic residents) compared to the number of accredited slots in that program nationally as of June 30 of that year. The proposed Demonstrated Likelihood Criterion 1 and Demonstrated Likelihood Criterion 2 also allow a hospital to demonstrate the likelihood of filling the requested slots by demonstrating that the hospital's existing residency programs had a "resident fill rate" of at least 85 percent in each program year from 2007 through 2009. For the purpose of fulfilling these demonstrated likelihood criteria, we are proposing to define "resident fill rate" to mean, for the most recent academic year for which data is available, the number of residents training in each program in total at a particular hospital as compared to the number of accredited slots in each program in total at that hospital as of June 30 of that year.

We also understand that, for certain programs, because of the length of the accreditation process and a relatively long match period, a hospital may be unable to accept its first class of PGY–1 residents until July 1, 2012. We are proposing that the hospital may still

apply to receive a full complement of residents for the 3 years beginning July 1, 2012, assuming the applicant hospital can demonstrate the likelihood that it will fill the slots relating to a possible increase in its FTE resident caps under section 1886(h)(8)(B)(i). However, if the applicant hospital does not demonstrate the likelihood that it will fill *any* FTE slots for programs described by the hospital on the CMS evaluation form(s) at *any* point within the hospital's first three cost reporting periods beginning on or after July 1, 2011, the hospital would not be eligible for further consideration by CMS of an increase to the hospital's FTE caps under section 1886(h)(8)(B)(i). Accordingly, our proposed Demonstrated Likelihood Criterion 1 would reflect that the hospital does not have sufficient room under its FTE cap to train residents in a newly approved residency program that it demonstrates it will establish within the hospital's first three cost reporting periods beginning on or after July 1, 2011 (that is, a newly approved program that begins training residents *at any point within the hospital's first three cost reporting periods beginning on or after July 1, 2011*) (emphasis added).

Under Demonstrated Likelihood Criterion 3, we are proposing to allow a hospital that is already training a number of FTE residents in an existing residency training program(s) in excess of its direct GME FTE cap or IME FTE cap, or both, to meet the demonstrated likelihood requirement. In order to document that it meets this criterion, a hospital would be required to submit copies of the 2010 "residency match" information concerning the number of residents the hospital has in an existing program. We believe the most recent match information could indicate that the hospital is expected to take in more residents than the number of cap slots it has available. For purposes of the application of this demonstrated likelihood criterion, we are defining "residency match" as a national process administered by the National Residency Matching Program (NRMP), including the NRMP's Specialties Matching Service, the San Francisco Matching Program, the American Osteopathic Association Residency Match Program, or the Urology Matching Program, by which applicants to approved medical residency programs are paired with programs on the basis of preferences expressed by both the applicants and the program directors.

We also note that under Demonstrated Likelihood Criteria 2 and 3, the hospital would be applying for an increase in its FTE cap because it is expanding an *existing* residency program, or it is already training residents in an *existing* residency training program(s) in excess of its FTE caps, respectively. By existing program, we are proposing that, as of July 1, 2010, the hospital is either already training residents in this program or programs, or the program exists at another hospital prior to July 1, 2011, but the residents begin to rotate at the applying hospital on or after July 1, 2011. We are providing several proposed methods for hospitals to be able to demonstrate to CMS under the proposed Demonstrated Likelihood Criterion 1 that they can fill the slots by showing to CMS that they are establishing a *new* residency program on or after July 1, 2011. We believe hospitals that establish new residency programs *before* July 1, 2011, could possibly also meet Demonstrated Likelihood Criterion 2, relating to a hospital that is expanding an existing residency program on or after July 1, 2011. From the perspective of applying for the cap increase under section 1886(h)(8)(B)(i), the new program that starts training residents in 2010 is an "existing residency program" because it began before July 1, 2011, and it is "expanding" if that program is increasing in the number of FTE residents in the first three cost reporting periods beginning on or after July 1, 2011.

We note that the listing of programs participating in the AOA Match Program will be available on the National Matching Services Web site as of November 1, 2010. Therefore, we are proposing that programs utilizing the AOA Match Program may, in addition to the two options listed above, demonstrate the intent to expand an existing program by documenting that the AOA has accepted the hospital's participation in the match program by the December 1, 2010 application deadline. Therefore, we are proposing that this method of demonstrating the hospital's intent to expand an existing program will be applicable for programs participating in the AOA Match Program.

12. Application Process for the Increases in Hospitals' FTE Resident Caps

In order for hospitals to be considered for increases to their FTE resident caps under section 1886(h)(8)(B)(i) of the Act, as added by section 5503(a)(4) of the Affordable Care Act, we are proposing to require that each qualifying hospital submit a timely application by December 1, 2010. As part of the requirements that a hospital must fulfill in order to complete an application for an increase to its FTE resident caps, we are proposing to require that the applicant hospital must include the total number of requested FTE resident slots (for all residency programs) for direct GME or IME, or both (not to exceed 75 FTEs for each, as specified under section 1886(h)(8)(F) of the Act). Thus, we would require that the hospital's total requests for increases in the IME and the direct GME caps (that is, the total number of requested FTE resident slots increases (for all residency programs at the hospitals)) would be required to be indicated on the same application for an increase under section 1886(h)(8)(B)(i). We are proposing that each hospital must submit the following information on its application for an increase in its FTE resident cap:

- The name and Medicare provider number of the hospital, and the name of the Medicare contractor to which the hospital submits its cost report.
- The total number of requested FTE resident slots (for all residency programs at the hospital) for direct GME or IME, or both (not to exceed 75 FTEs each).
- A completed copy of the CMS evaluation form (as described below) for each residency program for which the applicant hospital intends to use the requested increase in the number of FTE residents and source documentation to support the assertions made by the hospital on the evaluation form. (For example, if the hospital checks off on the evaluation form that the hospital is starting a new geriatrics program, the hospital would include documentation to support that assertion.)
- FTE resident counts for direct GME and IME and FTE resident caps for direct GME and IME reported by the hospital in the most recent as-filed cost report. (The hospital would be required to include copies of Worksheets E, Part A, E–3, Part IV, *and if a hospital received an increase to its FTE cap(s) under section 422 of Pub. L. 108–173,* a copy of E–3, Part VI.)
- An attestation, signed and dated by an officer or administrator of the hospital who signs the hospital's Medicare cost report, of the following information in the hospital's application for an increase in its FTE resident cap:

"I hereby certify that I understand that misrepresentation or falsification of any information contained in this application may be punishable by criminal, civil, and administrative action, fine and/or imprisonment under federal law. Furthermore, I understand that if services identified in this application were provided or procured through payment directly or indirectly of a kickback or where otherwise illegal, criminal, civil, and administrative

action, fines and/or imprisonment may result. I also certify that, to the best of my knowledge and belief, it is a true, correct, and complete application prepared from the books and records of the hospital in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding Medicare payment to hospitals for the training of interns and residents."

We are proposing that any hospital that wishes to apply for an increase in its FTE resident cap(s) under section 1886(h)(8)(B)(i) must submit a copy of its completed application (as described above) to the CMS Central Office and to the CMS Regional Office for the region in which the applicant hospital is located, and that the application must be received by CMS on or before December 1, 2010. (The mailing addresses for the CMS offices are indicated at the end of this section of the preamble.) We note that some hospitals' FTE counts will be subject to audit for purposes of possible cap reductions under section 1886(h)(8)(A)(i), and those audits may not be completed by December 1, 2010. Because the results of such an audit may be a factor in a hospital's decision whether to request an increase in its FTE resident cap under section 1886(h)(8)(B)(i) of the Act, we are proposing to allow a later date for those hospitals to apply for increases in their FTE resident caps. Therefore, if a hospital's resident level is audited for purposes of section 1886(h)(8)(A) of the Act, whether or not the hospital's FTE resident caps are reduced under section 1886(h)(8)(A) of the Act, if that hospital wishes to apply for an increase in its FTE resident cap(s) available under section 1886(h)(8)(B)(i) of the Act, we are proposing that the hospital must submit a completed application to CMS and that the application must be received on or before March 1, 2011.

We note that, although a hospital might be applying for an increase to its FTE caps either to start a new program or expand a particular program, the FTE caps are not program-specific; but rather, they are hospital-specific. A hospital, and not a particular residency training program, would be applying for an increase to its FTE caps. We are proposing that all completed applications that are timely received according to the above deadlines would be evaluated by CMS according to the criteria described under section XVII.D. of this proposed rule for determining the priority distribution of FTE resident slots. Hospitals that satisfy at least one of the "demonstrated likelihood" criteria would be further evaluated by the evaluation criteria described below.

13. CMS Evaluation of Applications for Increases in FTE Resident Caps

We are proposing to require hospitals to submit, with their applications for increases in their FTE resident caps, a completed copy of the CMS Evaluation Form. The CMS Evaluation Form will ask the hospital to check off which of the "demonstrated likelihood" criteria (described above in section XVII.D.11. of this proposed rule) the hospital meets. We also are proposing to require that the hospital provide the documentation that supports the "demonstrated likelihood" criteria it has checked off on the Evaluation Form.

Assuming that the applicant hospital meets the "demonstrated likelihood" requirement, we are proposing that the applicant hospital would indicate on the CMS Evaluation Form the category(ies) for which it believes it will qualify. We would use this indication to prioritize the applications. This prioritization is derived from section 1886(h)(8)(C) and (D) of the Act, as added by section 5503 of the Affordable Care Act. That section established considerations in redistribution and a priority order that must be applied in determining the hospitals that will receive increases in their FTE caps. As discussed above, the first consideration in redistribution is that the applicant hospital must demonstrate the likelihood of filling the slots requested within the first three cost reporting periods beginning on or after July 1, 2011. Another consideration is "whether the hospital has an accredited rural training track" (as described in section 1886(h)(4)(H)(iv) of the Act). Accordingly, we are proposing that, in distinguishing between hospitals within a priority category, and determining which hospitals will receive FTE cap increases, we would give preference to a hospital that has an accredited rural training track over a hospital that does not have such a program. Under section 1886(h)(4)(H)(iv) of the Act, as implemented in the regulations at § 413.79(k), an urban hospital that operates a rural training track (often known as separately accredited 1–2 tracks in family medicine) wherein residents rotate at the urban hospital for less than one-half of the duration of the program, and to a rural area for the remainder of the program, the urban hospital may include in its FTE count the FTE resident time spent training in the rural track, even if that time would be in excess of the hospital's FTE cap. We note that if an urban hospital is interested in starting a new rural training track, it need not apply for additional slots under section 1886(h)(8)(B)(i). Rather, under the existing regulations at § 413.79(k), the urban hospital may receive an increase to its FTE cap to reflect FTE residents training in the rural track. (For more details on rural training tracks, and the direct GME and IME payment rules associated with them, we refer readers to 66 FR 39902, August 1, 2001, and 68 FR 45454, August 1, 2003). However, because section 1886(h)(8)(C) of the Act states that the Secretary shall take into account "whether the hospital *has* an accredited rural training track" (emphasis added), we are proposing that an applying urban hospital that either *has* a separately accredited rural training track, or can document that it *will have* a separately accredited rural training track as of July 1, 2011, may receive preference over a hospital that, all other things being equal, does not and will not have a rural training track by that date. We note that section 1886(h)(8)(C) of the Act does not specify that a hospital must be applying for additional slots in order to expand its existing rural training track in order to qualify to receive additional slots. Rather, section 1886(h)(8)(C) of the Act merely states that "the Secretary *shall take into account* * * * whether the hospital has an accredited rural training track (as described in paragraph (4)(H)(iv))" (emphasis added). That is, the fact that an urban hospital *already has* (or, under this proposed rule, would have as of July 1, 2011) a separately accredited rural training track is sufficient to give preference in redistribution to such a hospital.

Section 1886(h)(8)(D) of the Act instructs the Secretary to "distribute the increase to hospitals based on the following factors":

- *Whether the hospital is located in a State with a resident-to-population ratio in the lowest quartile (as determined by the Secretary) (section 1886(h)(8)(D)(i) of the Act).* In order to determine which States are in the lowest quartile for resident-to-population ratios, we are proposing to use three sources of data, and the latest data available for each of those three sources. First, we are proposing to determine the number of allopathic residents in each state by using data from the ACGME's Data Resource Book for the Academic Year 2008–2009. As of publication of this proposed rule, this is the most recent data available from the ACGME. In this book, which is available free of charge on the ACGME's Web site, is a table titled "Number of Residents in Core and Subspecialty Programs, by State" (*www.acgme.org/acWebsite/dataBook/2008-2009_ACGME_Data_Resource_Book.pdf*). This table lists

each State (including Puerto Rico), and includes a column called "Number of Residents." We are proposing to use the data from this column called "Number of Residents" as part of the numerator to determine the resident-to-population ratio in each state. However, because these data only include residents enrolled in ACGME-accredited programs, we also are proposing to add to these numbers the number of residents enrolled in AOA-accredited programs. We are proposing to access data on the number of osteopathic residents in each State from the AOA, which was provided to CMS upon special request. These data are what is generally published in the AOA's *Journal of the American Osteopathic Association (JAOA).* As of the issuance of this proposed rule, the most recent data published in JAOA was that for the 2007–2008 academic year. However, because we have data from the ACGME for the 2008–2009 academic year, we requested and received data from the AOA for the 2008–2009 academic year as well. Although these data will not be published in the JAOA for some months, we have received permission from the AOA to publish it in this proposed rule (as indicated at the end of the GME discussion). These data are also presented in the form of a table listing each State (there are no osteopathic programs in Puerto Rico), and a column for the total number of residents in each State. Therefore, we are proposing that the numerator for the ratio for each State would be the sum of the residents from the 2008–2009 ACGME's table for that State, and the residents from the 2008–2009 AOA table for that State.

We understand that, although graduates of allopathic medical schools are precluded from training in AOA-accredited programs, there is no similar prohibition on osteopathic residents training in allopathic programs. Because there are osteopathic residents who enroll and participate in allopathic ACGME-accredited programs, we want to ensure that there is no double counting of residents in the numerator. We have learned from the ACGME that their data in the ACGME Data Resource Book include osteopaths, but only those training in ACGME-accredited programs. The AOA data do not include osteopathic residents who are training in ACGME-accredited programs; AOA data only include osteopathic residents enrolled and training in AOA-accredited programs. Therefore, we do not believe there is a concern about double counting with respect to osteopathic residents training in allopathic programs. However, we also are aware that there are some programs that are dually accredited by the ACMGE, and the AOA, and residents completing these programs are able to sit for both the ABMS and the AOA board examination in that specialty. We understand that the ACGME will include a resident in its resident count as long as that resident is training in an ACGME-accredited program, even if that program is dually accredited. The AOA has the same practice of including in its total count of residents those who are in AOA-accredited programs, even if it is a dual eligible program. Therefore, there is some degree of unavoidable double counting of residents in the total count. However, we understand that the number of residents in dually-accredited programs is less than 500, and because 500 is only 0.44 percent of the combined ACGME and AOA 2008–2009 resident count of 114, 416, we believe the effect of counting these residents by both the ACGME and AOA is negligible and would not harm the integrity of the data.

We are proposing to define "resident" in "resident-to-population" ratio as actual individual residents, as opposed to the FTE resident figures that are used for Medicare payment purposes. We believe it is appropriate to define "residents" as actual individual residents in this instance because the intent behind this criterion is to identify those States that have low numbers of physicians-in-training in relation to the general population for which those physicians-in-training are providing health care services. An "FTE" measure, which is the measure used for most Medicare payment purposes, does not accurately reflect the number of individual physicians-in-training providing services in a State.

With regard to State population data to be used in the denominator of each State's resident-to-population ratio, we again are proposing to use the latest available data on State populations. We are proposing to use data from the Census Bureau that is from the 2000 Census, but that have been updated with the most recent data available as of July 1, 2009. We accessed these data from the following Web site: *http://www.census.gov/popest/datasets.html.* On this Web page, the following data can be found: State population datasets—Population, population change and estimated components of population change: April 1, 2000 to July 1, 2009 (NST–EST2009–alldata). We are proposing to use the CSV file at this link. Specifically, we are proposing to use the data for State population from the column called POPESTIMATE2009 (column Q of the CSV spreadsheet). Therefore, we are proposing to determine each State's resident-to-population ratio, and specifically those States that fall within the lowest quartile by using the sum of the 2008–2009 ACGME and AOA resident data for each State, as described above, in the numerator for each State, and by using the population data updated as of July 1, 2009 in the denominator for each State from the column called POPESTIMATE2009 in column Q of the CSV spreadsheet. The following table lists each State, and is sorted by resident-to-population ratio from lowest to highest. The first 13 shaded states are the states in the lowest quartile.

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State Name	Census data as of July 1, 2009	ACGME resident data 2008-2009	AOA resident data 2008-2009	Total resident data	Resident to population ratio
Montana	974,989	20	0	20	0.0021%
Idaho	1,545,801	50	0	50	0.0032%
Alaska	698,473	35	3	38	0.0054%
Wyoming	544,270	40	4	44	0.0081%
Nevada	2,643,085	242	48	290	0.0110%
South Dakota	812,383	97	0	97	0.0119%
North Dakota	646,844	107	0	107	0.0165%
Mississippi	2,951,996	495	0	495	0.0168%
Florida	18,537,969	3,331	293	3,624	0.0195%
Puerto Rico Commonwealth	3,967,288	801	0	801	0.0202%
Indiana	6,423,113	1,278	20	1,298	0.0202%
Arizona	6,595,778	1,296	45	1,341	0.0203%
Georgia	9,829,211	2,044	8	2,052	0.0209%
Oregon	3,825,657	805	0	805	0.0210%
Colorado	5,024,748	1,135	0	1,135	0.0226%
Arkansas	2,889,450	703	3	706	0.0244%
South Carolina	4,561,242	1,115	8	1,123	0.0246%
Utah	2,784,572	687	0	687	0.0247%
Washington	6,664,195	1,652	0	1,652	0.0248%
Kansas	2,818,747	694	6	700	0.0248%
Oklahoma	3,687,050	735	189	924	0.0251%
Alabama	4,708,708	1,201	0	1,201	0.0255%
California	36,961,664	9,658	176	9,834	0.0266%
Maine	1,318,301	295	56	351	0.0266%
Kentucky	4,314,113	1,119	31	1,150	0.0267%
New Mexico	2,009,671	534	5	539	0.0268%
New Hampshire	1,324,575	368	4	372	0.0281%
Iowa	3,007,856	816	29	845	0.0281%
Texas	24,782,302	6,993	101	7,094	0.0286%
Virginia	7,882,590	2,229	46	2,275	0.0289%
Wisconsin	5,654,774	1,660	21	1,681	0.0297%
North Carolina	9,380,884	2,817	14	2,831	0.0302%
Hawaii	1,295,178	415	0	415	0.0320%
Tennessee	6,296,254	2,089	2	2,091	0.0332%

State Name	Census data as of July 1, 2009	ACGME resident data 2008-2009	AOA resident data 2008-2009	Total resident data	Resident to population ratio
New Jersey	8,707,739	2,731	319	3,050	0.0350%
Nebraska	1,796,619	641	0	641	0.0357%
Delaware	885,122	306	18	324	0.0366%
Louisiana	4,492,076	1,666	0	1,666	0.0371%
West Virginia	1,819,777	620	96	716	0.0393%
Minnesota	5,266,214	2,144	0	2,144	0.0407%
Vermont	621,760	259	0	259	0.0417%
Missouri	5,987,580	2,514	114	2,628	0.0439%
Maryland	5,699,478	2,632	0	2,632	0.0462%
Illinois	12,910,409	5,728	261	5,989	0.0464%
Ohio	11,542,645	5,293	565	5,858	0.0508%
Connecticut	3,518,288	2,010	13	2,023	0.0575%
Michigan	9,969,727	4,574	1,196	5,770	0.0579%
Pennsylvania	12,604,767	7,236	737	7,973	0.0633%
Rhode Island	1,053,209	725	0	725	0.0688%
Massachusetts	6,593,587	5,195	14	5,209	0.0790%
New York	19,541,453	15,821	489	16,310	0.0835%
District of Columbia	599,657	1,831	0	1,831	0.3053%

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Based on the foregoing proposed data, the following States fall within the lowest quartile for resident-to-population ratios: Montana, Idaho, Alaska, Wyoming, Nevada, South Dakota, North Dakota, Mississippi, Florida, Puerto Rico, Indiana, Arizona, and Georgia. Accordingly, we are proposing that, consistent with section 1886(h)(8)(D)(i) of the Act, a hospital located in any one of these States that applies for an increase to its FTE cap under section 1886(h)(8)(B) of the Act would receive preference over a hospital that is applying for an increase to its cap that is not located in one of these States.

• *Whether the hospital is located in a State, a territory of the United States, or the District of Columbia that is among the top 10 States, territories, or Districts in terms of (1) the total population of the State, territory, or District living in an area designated (under such section 332(a)(1)(A)) as a health professional shortage area (as of the date of enactment of this paragraph); to (2) the total population of the State, territory, or District (as determined by the Secretary based on the most recent available population data published by the Bureau of the Census).*

In order to determine which applying hospitals fall within this priority category, we need to determine the total population living in a HPSA in each State, territory, or District computed "as of the date of enactment," and we need to determine the total population of each State, territory, or District "(as determined by the Secretary based on the most recent available population data published by the Bureau of the Census)." "Territory" is referring to Puerto Rico, which currently has teaching hospitals, and "District of Columbia" refers to Washington D.C. For ease of reference, and consistent with the definition of "State" at section 210 of the Act, we are proposing to refer to "State, territory, or District" simply as "State." We have received data on the population of each HPSA from the Health Resources and Services Administration's (HRSA) Geospatial Warehouse. HRSA's Shortage Designation Branch develops shortage designation criteria and uses them to decide whether or not a geographic area, or population group, is a HPSA. HRSA updates HPSA statistics on its Web site on a daily basis, and we have requested and received the data reflective of the "date of enactment"; that is, March 23, 2010. Because HRSA updates the data on its Web site daily, the data as of March 23, 2010 are no longer available on its Web site. (General information on HPSAs and current data can be found on HRSA's Web site at: *http://bhpr.hrsa.gov/shortage/*).

HRSA designates three different kinds of HPSAs: Primary Care HPSAs, Dental HPSAs, and Mental Health HPSAs. While many areas may only be designated as one of these kinds of HPSAs, some areas may be designated as two or three of these kinds of areas. Thus, if we were to add the population in each State that is in a Primary Care HPSA, a Dental HPSA, and a Mental Health HPSA, we would be duplicating the HPSA populations in each State. Therefore, we are proposing to use *only* the population in each State that is in a Primary Care HPSA. We believe that it is appropriate to choose to recognize only the Primary Care HPSAs in each State for the purpose of implementing section 5503 because section 5503 is intended to encourage an increase in the number of primary care residents that are currently being trained in hospitals, as is evidenced by the "Requirements" in section 1886(h)(8)(B)(ii) of the Act, as added by section 5503(a)(4), which requires hospitals that receive additional slots under this section to maintain a certain average number of primary care resident positions, and that not less than 75 percent of the redistributed positions must be awarded for slots used in a primary care or a general surgery residency.

With respect to data on each State's total population "as determined by the Secretary based on the most recent available population data published by the Bureau of the Census," we are proposing to use the same data that we are using under the first priority

category with regard to determining resident-to-population ratios, as explained above. These data, which are the most recent available, were last updated on July 1, 2009. As explained above, we accessed these data from the following Web site: *http://www.census.gov/popest/datasets.html.* On this Web page, the following data can be found: State population datasets—population change and estimated components of population change: April 1, 2000 to July 1, 2009 (NST–EST2009–alldata). We are proposing to use the CSV file at this link. Specifically, we are proposing to use the data for State population from the column called POPESTIMATE2009 (column Q of the CSV spreadsheet).

The following table lists each State, its Primary Care HPSA population-to-State population ratio from highest to lowest, and whether that State falls within the top 10 States for such Primary Care HPSA population-to-State population ratios:

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State Name	Census data as of July 1, 2009	Primary Care HPSA	Primary Care HPSA to Population Ratio
Louisiana	4,492,076	3,119,598	69.4467%
Mississippi	2,951,996	1,781,774	60.3583%
Puerto Rico Commonwealth	3,967,288	2,282,408	57.5307%
New Mexico	2,009,671	1,036,774	51.5892%
South Dakota	812,383	351,926	43.3202%
District of Columbia	599,657	257,377	42.9207%
Montana	974,989	384,030	39.3881%
North Dakota	646,844	239,550	37.0337%
Wyoming	544,270	199,656	36.6833%
Alabama	4,708,708	1,725,293	36.6405%
Arizona	6,595,778	1,981,387	30.0402%
Illinois	12,910,409	3,858,062	29.8833%
Missouri	5,987,580	1,780,841	29.7422%
Idaho	1,545,801	453,347	29.3276%
Kentucky	4,314,113	1,155,928	26.7941%
South Carolina	4,561,242	1,159,709	25.4253%
Texas	24,782,302	6,040,714	24.3751%
Delaware	885,122	215,060	24.2972%
New York	19,541,453	4,691,714	24.0090%
Oklahoma	3,687,050	866,358	23.4973%
Georgia	9,829,211	2,276,546	23.1610%
Florida	18,537,969	4,287,169	23.1264%
Tennessee	6,296,254	1,455,365	23.1148%
Alaska	698,473	153,999	22.0480%
Kansas	2,818,747	570,639	20.2444%
Colorado	5,024,748	970,145	19.3073%
Michigan	9,969,727	1,916,653	19.2247%
Nevada	2,643,085	504,174	19.0752%
North Carolina	9,380,884	1,673,482	17.8393%
Iowa	3,007,856	536,519	17.8373%
Wisconsin	5,654,774	998,920	17.6651%
West Virginia	1,819,777	318,133	17.4820%
Arkansas	2,889,450	501,208	17.3461%
Utah	2,784,572	477,193	17.1370%
Washington	6,664,195	1,140,882	17.1196%
California	36,961,664	6,014,851	16.2732%
Virginia	7,882,590	1,222,771	15.5123%
Oregon	3,825,657	579,368	15.1443%
Rhode Island	1,053,209	156,064	14.8180%
Connecticut	3,518,288	477,837	13.5815%
Massachusetts	6,593,587	893,375	13.5492%
Indiana	6,423,113	816,234	12.7078%
Maine	1,318,301	156,116	11.8422%
Ohio	11,542,645	1,326,610	11.4931%
Pennsylvania	12,604,767	1,431,314	11.3553%
Minnesota	5,266,214	493,764	9.3761%
Maryland	5,699,478	523,260	9.1808%
Nebraska	1,796,619	146,196	8.1373%
Hawaii	1,295,178	93,107	7.1887%
Vermont	621,760	40,313	6.4837%
New Hampshire	1,324,575	84,038	6.3445%
New Jersey	8,707,739	376,405	4.3226%

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• *Whether the hospital is located in a rural area (as defined in section 1886(d)(2)(D)(ii) of the Act).* Section 1886(d)(2)(D)(ii) of the Act defines a rural area as any area outside a MSA. Under the existing regulations at § 412.62(f)(ii), an "urban area" means (1) a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA); or (2) the following New England counties: Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island. Under existing § 412.62(f)(iii), a "rural area" means any area outside an urban area. Thus, for purposes of the amendments made by section 5503, we are proposing that any hospital located in an area that is not in a MSA is a rural hospital, regardless of any reclassification under § 412.102 or § 412.103. We also point out that, since FY 2005, we no longer use the term MSA, but instead use CBSA, or Core-Based Statistical Area. There are urban CBSAs, and rural CBSAs are areas outside of an urban CBSA. We note that this definition of "rural" is consistent with our policy concerning designation of wage index areas.

We also are proposing that, in determining which applicant hospitals receive priority within the priority category of hospitals located in a State in the lowest quartile for resident-to-population ratios that hospitals in a State that is ranked *lower* in the quartile (with number one being the lowest) would receive preference over hospitals in states that are still within the quartile, but ranked higher. For example, all other things being equal, a hospital located in Montana would receive preference over a hospital located in Idaho, while this hospital would receive preference over a hospital located in Alaska, and so on. Similarly, we are proposing that, in determining which applicant hospitals receive priority within the priority category of hospitals located in a State that is among the top 10 of these areas in terms of the ratio of Primary Care HPSA population to total population, hospitals in an area that is ranked *higher* in the top 10 (with number 1 being highest and number 10 being lowest) would receive preference over hospitals in an area that are still within the top 10, but ranked lower. For example, all other things being equal, a hospital located in Louisiana would receive preference over a hospital located in Mississippi, while a hospital in Mississippi would receive preference over a hospital located in Puerto Rico, and so on.

As we described above, we are proposing that an applicant hospital indicate on the CMS Evaluation Form the category(ies) for which it believes it will qualify, and we will use this indication to prioritize the applications. Each of the categories (described below) is derived from the priorities established by section 1886(h)(8)(D) of the Act, as added by section 5503 of the Affordable Care Act. We are proposing to use the following categories to determine the order in which hospitals would be eligible to receive increases in their FTE resident caps:

• *First Level Priority Category:* The hospital is in a State whose resident-to-population ratio is within the lowest quartile, AND the hospital is in a State whose Primary Care HPSA to population ratio is in the top 10 States, AND the hospital is located in a rural area.

• *Second Level Priority Category:* The hospital is in a State whose resident-to-population ratio is within the lowest quartile, AND is *either* in a State whose Primary Care HPSA to population ratio is in the top 10 States, *or* it is located in a rural area, *or* is an urban hospital and has or will have as of July 1, 2010, a rural training track.

• *Third Level Priority Category:* The hospital is in a State whose resident-to-population ratio is within the lowest quartile.

• *Fourth Level Priority Category:* The hospital is in a State whose Primary Care HPSA to population ratio is in the top 10 States, AND either the hospital is located in a rural area *or* the hospital is an urban hospital and has, or will have as of July 1, 2010, a rural training track.

• *Fifth Level Priority Category:* The hospital is in a State whose Primary Care HPSA to population ratio is in the top 10 States, *or* the hospital is located in a rural area.

We believe it is appropriate to establish priority level categories based on the fact that some hospitals that apply for the additional resident slots may fit into more than one of the three statutory priority categories listed in section 1886(h)(8)(D) of the Act. Therefore, we are proposing to give consideration first to those hospitals that meet more than one of the statutory priority categories over those hospitals that meet only one of the statutory priorities. We are further proposing that a hospital that is in a State whose resident-to-population ratio is within the lowest quartile would receive priority over a hospital that is not located in one of these States. We believe this is consistent with the direction established at section 1886(h)(8)(E)(i) of the Act which specifies that the Secretary shall reserve 70 percent of all positions available for distribution for hospitals in a State whose resident-to-population ratio is within the lowest quartile. Only 30 percent of the positions are to be distributed to hospitals in States whose Primary Care HPSA to population ratio is in the top 10 States, and hospitals located in rural areas. In addition, as discussed above, the first consideration in redistribution under section 1886(h)(8)(C) of the Act is that the applicant hospital must demonstrate the likelihood of filling the slots requested within the first three cost reporting periods beginning on or after July 1, 2011. The second consideration is "whether the hospital has an accredited rural training track" (as described in section 1886(h)(4)(H)(iv) of the Act). Accordingly, we are proposing that, in distinguishing between hospitals within priority categories, and in determining which hospitals qualify to receive additional slots, we would give preference to a hospital that has an accredited rural training track as compared to a hospital that does not have such a program.

Because section 1886(h)(8)(E) of the Act specifies that 70 percent of the slots are to be reserved for hospitals that are in a State whose resident-to-population ratio is within the lowest quartile, and 30 percent of the positions are to be reserved for hospitals in States whose Primary Care HPSA to population ratio is in the top 10 States, and hospitals located in rural areas, we are proposing that no slots would be given to hospitals that do not fit within either of these categories.

14. CMS Evaluation of Application for Increases in FTE Resident Caps—Evaluation Criteria

We anticipate that there will be a limited number of slots available for distribution from the redistribution pool, while there will be a great demand for those limited slots. Therefore, as we did when implementing section 422 of Public Law 108–173, we are proposing to use additional criteria (some of which are the same as those used to implement section 422) for evaluating the applications for increases in hospitals' FTE resident caps within each of the seven level priority categories described above under section 5503. In addition, in implementing section 5503, we are proposing to assign a certain number of points to each evaluation criterion, such that some will be worth more points than others. We note that the criteria are not mutually exclusive. Hospitals may qualify for a number of different criteria and their "score" is the total point value for all criteria met by the hospital for

each program. Because we anticipate that the redistribution pool under section 5503 will be smaller than that under section 422, we believe a more rigorous and competitive ranking system is appropriate under section 5503. Thus, we are assigning a different amount of points to each Evaluation Criterion, rather than just assigning one point to each.

Evaluation Criterion One. The hospital that is requesting the increase in its FTE resident cap(s) has a Medicare inpatient utilization over 60 percent, as reflected in at least two of the hospital's last three most recent audited cost reporting periods for which there is a settled cost report. (5 Points) We have selected 60 percent utilization because we believe that level would identify hospitals where Medicare beneficiaries will benefit the most from the presence of a residency program, and it is consistent with the utilization percentage required for Medicare-dependent, small rural hospitals (MDHs) as specified in § 412.108. In addition, it identifies a type of hospital that warrants atypical treatment by the Medicare program because it is so reliant on Medicare funding.

Evaluation Criterion Two. The hospital will use the additional slots to establish a new geriatrics residency program, or to add residents to an existing geriatrics program. (5 Points) Section 5503 places a particular emphasis on increasing the number of residency positions in primary care specialties, as evidenced by the requirement at section 1886(h)(8)(B)(ii) of the Act that a hospital that receives slots must maintain at least the same number of primary care residents as it had during the three most recent cost reporting periods prior to enactment, and that not less than 75 percent of additional positions received must be in a primary care or a general surgery residency. Geriatrics is included in the definition of "primary care resident" at section 1886(h)(5)(H) of the Act. We believe that, of all the medical specialties, geriatrics is the one specialty that is devoted primarily to the care of the elderly, including Medicare beneficiaries. As such, we are proposing to give special consideration to geriatric programs to meet the "fill rate" criterion for demonstrating the likelihood of filling FTE resident slots under section 5503. Geriatrics is not a separately approved training program; rather, it is a subspecialty of another specialty program. For example, there is a geriatrics subspecialty of family practice or internal medicine. We are proposing that, for the purposes of meeting the 85 percent fill rate criterion, we would allow hospitals that are starting a new geriatrics program or expanding an existing geriatric program to use the fill rate associated with the overall specialty program (rather than the fill rate for the geriatric subspecialty) to meet this demonstrated likelihood criterion.

Evaluation Criterion Three. The hospital will use additional slots to establish a new or expand an existing primary care program with a demonstrated focus on training residents to pursue careers in primary care, rather than in nonprimary subspecialties of those primary care programs (for example, the hospital has an internal medicine program with a designated primary care track). (3 Points) As stated previously, section 5503 places a particular emphasis on encouraging the growth in the number of primary care residents, and specifically, physicians who practice in primary care, rather than only completing a primary care residency as a prerequisite for further subspecialty training. Although this proposed Evaluation Criterion applies to any primary care specialty, according to the 2010–2011 ACGME Green Book, 30.1 percent of accredited internal medicine programs offer a primary care track. However, the ACGME does not have separate standards for or does not separately accredit primary care tracks from categorical primary care programs. We understand that, particularly for internal medicine residents, these tracks are a way for graduating medical students who are interested in primary care to declare that interest early on, and in many cases, actually match into an internal medicine program with a primary care track through the National Residency Match Program. These residents may pursue their interest in primary care by choosing to do more electives in ambulatory and community-based settings throughout the 3 years of primary care training than residents with an interest in specialization might do. We believe that encouraging growth of these programs will increase the number of primary care practitioners. Therefore, we are proposing to give special consideration to hospitals that are applying for additional slots to start or expand a program(s) that particularly focuses on residents who wish to pursue careers in primary care, and we would prioritize among hospitals that are applying for slots in a primary care program(s) accordingly. One example of a hospital that demonstrates a focus on training residents to pursue careers in primary care is a hospital that has a primary care track in internal medicine. We are proposing that one way hospitals may qualify for a point under this evaluation criterion is by documenting that they are advertising that they have an internal medicine program with a primary care track in the March 2011 National Residency Match Program.

Evaluation Criterion Four. The hospital will use all the additional slots to establish a new or expand an existing primary care residency program or general surgery program. (5 Points) "Primary care resident" is defined at section 1886(h)(5)(H) of the Act as a resident enrolled in an approved medical residency training program in family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine, or osteopathic general practice. Section 1886(h)(8)(B)(ii)(II) of the Act states that not less than 75 percent of additional positions received must be in a primary care or a general surgery residency. Therefore, we are proposing to award 5 points to a hospital that goes beyond this minimum requirement, and documents that it will use *all* of the slots received for either primary care or general surgery programs.

Evaluation Criterion Five. The hospital is located in a Primary Care HPSA.—2 Points. We believe this evaluation criterion is consistent with the goal of reducing the shortage of primary care physicians, and increasing access to care in underserved areas.

Evaluation Criterion Six. The hospital is in a rural area (as defined under section 1886(d)(2)(D)(ii) of the Act) and is or will be on or after July 1, 2011, a training site for a rural track residency program (as specified under § 413.79(k)), but is unable to count all of the FTE residents training in the rural track because the rural hospital's FTE cap is lower than its unweighted count of allopathic or osteopathic FTE residents as of portions of cost reporting periods on or after July 1, 2011. (1 Point). We understand that there are some rural hospitals that serve as training sites for an urban hospital's rural training track. The residents in the rural track are counted in the urban hospital's FTE count, but because the rural training tracks are not necessarily considered "new" medical residency programs according to the regulations at § 413.79(l), the rural hospital cannot receive an increase to its FTE caps under § 413.79(e)(3) and, therefore, cannot receive direct GME and IME payments for training all or some of those residents. The rural hospital may be training residents in excess of its FTE resident cap prior to July 1, 2011 and, therefore, cannot receive IME or direct GME payment for some or all of the FTEs in the rural training track, or it

wishes to expand its rural training track above its FTE resident cap on or after July 1, 2011. We are proposing this evaluation criterion as a remedy to these scenarios to allow the rural hospital the possibility of receiving payment for FTEs in its rural training track.

We are proposing to use these criteria to evaluate the applications by hospitals for increases in their FTE resident caps that fall within each of the seven level priority categories. We are proposing to place each application in the appropriate priority level category based on a review of the information a hospital checks off on the proposed CMS Evaluation Form for each allopathic and osteopathic specialty program requested by the applicant hospital, and the corresponding requested FTE cap increase (the proposed form appears below). We propose to place all of these evaluation criteria on the Evaluation Form and to ask the hospital to check off which criteria on the form apply for each specialty program for which an FTE cap increase is requested. Based on the evaluation criteria checked off on the form, we are proposing to score each CMS Evaluation Form. The higher-scoring CMS Evaluation Form(s) for each applicant hospital within each level priority category would be awarded the FTE resident cap increases first. It is possible that a hospital may qualify for multiple points for the same program. For example, if a hospital would be applying for slots to start a primary care track within an internal medicine program, and also would be using *all* of the slots it receives in that internal medicine program, the hospital may receive points both for Evaluation Criterion Three and Evaluation Criterion Four. Similarly, if a hospital would be applying for slots to start or expand a geriatrics program, and the additional slots would all be used for the geriatrics program, then the hospital may receive points for both Evaluation Criterion Two and Evaluation Criterion Four. Further, as specified by section 1886(h)(8)(E) of the Act, 70 percent of all positions are reserved to be distributed to qualifying hospitals that are in States with resident-to-population ratios in the lowest quartile, and 30 percent of the positions are reserved to go to hospitals that are located in States with HPSA population to State population ratios within the top 10 and to rural hospitals. As we described above, we are proposing to award the cap increases in the order of the seven specified level priority categories because, as a general rule, we believe hospitals that meet more than one of the statutory priorities should be awarded the increases in their FTE resident caps first before other hospitals. We also believe that hospitals that meet a higher statutory priority category should receive first consideration over hospitals that meet lower statutory priorities. That is the reason, for instance, we are proposing that the first, second, and third level categories give preference to hospitals located in States with resident-to-population ratios in the lowest quartile before considering hospitals that are only located in States with high Primary Care HPSA population to State population ratios or to hospitals that are only rural. Furthermore, in the case where, for example, Hospital A's application for a program falls within the Level Priority Category One, but scores no points on the evaluation criteria on the CMS Evaluation Form for that program, and Hospital B's application for a program falls within the Level Priority Category Two, and scored 5 points on the evaluation criteria on the CMS Evaluation Form for the program, Hospital A would receive the section 5503 cap increase *before* Hospital B, because Hospital A qualified to be in the higher level priority category.

Thus, first level priority category hospitals that score highest on the evaluation criteria on the CMS Evaluation Form for a particular specialty program would receive the increases in their FTE resident caps first. For example, if Hospital D is a rural hospital that is located in Mississippi, thereby falling within the first level priority category, and Hospital D checks off on the CMS Evaluation Form that it has a Medicare utilization of 60 percent (5 points), is using all the slots to expand a primary care residency program (5 points), and is located in a Primary Care HPSA (2 points), Hospital D would receive a score of 12 points on the completed CMS Evaluation Form. We are proposing that we would first award FTE cap increases to hospitals whose CMS Evaluation Forms for a particular program receive the most points (if there are any), and then to those with successively fewer points within the level priority category. Hospital D would receive the increase in its FTE resident cap(s) requested on its application only after all the hospitals in the first level priority category whose applications receive 13 or more points are awarded their requests first. We are proposing to proceed through each level priority category accordingly, and only move on to distribute slots to hospitals in the next priority level category once all the qualifying applicants in the previous priority level category have received slots. Once we have distributed 70 percent of the slots to hospitals within States with resident-to-population ratios in the lowest quartile in accordance with the Priority Level Categories One through Three (or awarded increases to all qualified applicant hospitals located in States with resident to population ratios in the lowest quartile), we are proposing to then distribute the remaining slots to hospitals in the fourth and fifth level categories. Because of this requirement that 70 percent of the slots be reserved for distribution to hospitals within States with resident-to-population ratios in the lowest quartile, it is possible that after first distributing slots to hospitals with the highest scores on their CMS Evaluation Form, if there are requests for slots by those hospitals which in the aggregate exceed the 70 percent of slots available, there may be some remaining qualifying hospitals within the same priority level category that receive the same score on the CMS Evaluation Form. Thus, we would have no way of distinguishing among these hospitals of equal rank. If this situation occurs, we are proposing to prorate the remaining amount of slots in the "70 percent" pool, and distribute an equal share of slots to these hospitals of equal rank. If a similar situation occurs within the "30 percent" pool, we also are proposing to prorate the remaining amount of slots in the "30 percent" pool, and distribute an equal share of slots to hospitals of equal rank.

For example, assume all applicant hospitals in the first and second level priority categories receive the requested increases in their FTE resident caps, and that we have awarded cap increases for all the third level priority category hospitals that scored 5 or above on their CMS Evaluation Forms for each residency program. We next evaluate hospital applications and accompanying CMS Evaluation Forms in the third Level Priority Category (The hospital is in a State whose resident-to-population ratio is within the lowest quartile) with fewer than 5 points and we find that there is only a sufficient number of resident slots remaining in the estimated "70 percent" pool to grant half of the requests for slots from hospitals that scored 4 points. We are proposing to prorate all of the remaining FTEs among the 4-point CMS Evaluation Forms and accompanying applications in the third level priority category. Thus, after awarding slots to hospitals in the third level priority with at least 5 points, and to hospitals in the first two level priority categories, if we could have awarded a total of 200 FTE slots

for direct GME and 185 FTE slots for IME to only 50 percent of the 4-point CMS Evaluation Forms in the third level priority category (at the point that the estimated "70 percent" pool of FTE slots is spent), we are proposing to divide all of the 200 FTE slots remaining in the 70 percent pool for direct GME and 185 FTE slots for IME among *all* of the 4-point CMS Evaluation Forms and accompanying applications in that third priority category, no matter what level of FTE resident cap increase was requested on the individual hospital's application, but not to exceed the number of slots a hospital requested for IME and direct GME respectively.

We are also considering another possible scenario that could occur with respect to hospitals that fall into the Second Level Priority Category: The hospital is in a State whose resident-to-population ratio is within the lowest quartile, AND is *either* in a State whose Primary Care HPSA to population ratio is in the top 10 States, *or* it is located in a rural area, *or* is an urban hospital and has or will have as of July 1, 2010, a rural training track. Because a hospital in this second level priority category is located both in a State whose resident-to-population ratio is within the lowest quartile, AND is *either* in a State whose Primary Care HPSA to population ratio is in the top 10 States, *or* it is located in a rural area, we believe that its request for additional slots must first be fulfilled from the "70 percent pool." However, if there are insufficient slots in the "70 percent pool" to satisfy the requests of all otherwise qualified applicants in the second level priority category, then, rather than immediately prorating the remaining slots in the "70 percent pool" among the applicable hospitals in the second level priority category, we are proposing to draw from the "30 percent pool" to grant the full FTE cap increases (as applicable) to qualifying hospitals in the second level priority category.

Alternatively, although unlikely, we recognize that the reverse situation may occur, where there may not be a sufficient number of qualified applicants or requests for FTEs in order to distribute at least 70 percent of the slots hospitals located in the 13 States whose resident-to-population ratios are in the lowest quartile (priority level categories one through three). Should this occur, we are proposing to begin evaluating applications from the next category of qualifying hospitals (that is, those located in States that are among the top 10 States for Primary Care HPSA to population ratios, and rural hospitals—priority level categories four and five), and potentially distribute more than 30 percent of the slots to hospitals in those latter categories.

We recognize the complexity of the proposed evaluation process for the award of increases in hospital's FTE resident caps under section 1886(h)(8)(B) of the Act. Therefore, we have included the following examples depicting the proposed procedures:

Example 1

Hospital H is an urban hospital located in a State that is in the lowest quartile for resident-to-population ratios. Hospital H can demonstrate the likelihood that it will fill the requested five FTEs resident slots for direct GME and IME for expanding a geriatric program because it is currently training a number of FTE residents that exceeds both of its FTE caps, and has attached to its application for the increase a copy of Hospital H's past three Medicare cost reports (as filed or audited, whichever is most recent and available), which documents on Worksheet E, Part A, Worksheet E–3, Part IV, and Worksheet E–3, Part VI that, according to the resident counts and the FTE resident caps, Hospital H is training residents in excess of its caps. Hospital H is also located in a Primary Care HPSA (but is not located in a State that is among the top 10 States in terms of its Primary Care HPSA population to State population ratio).

We would evaluate Hospital H's application as follows: Hospital H is in the third Level Priority Category (The hospital is in a State whose resident-to-population ratio is within the lowest quartile), and receives a score of 12 (expanding a geriatrics program-Evaluation Criterion Two-5 points, using all slots for a primary care residency program-Evaluation Criterion Four-5 points, and is located in a Primary Care HPSA-Evaluation Criterion Five-2 points).

Example 2

Hospital J is a rural hospital located in Montana. Hospital J is a rotation site for an urban hospital's family practice rural track program, but is unable to count all of the FTE residents training in the rural track because the rural hospital's FTE cap is lower than its unweighted count of allopathic or osteopathic FTE residents as of portions of cost reporting periods on or after July 1, 2011. The rural hospital wishes to expand the number of FTE residents training in the family practice rural track. The rural hospital also wishes to serve as a training site for one pediatrics resident in a pediatrics program that already exists at the urban hospital (that is, it is not a new pediatrics program).

Hospital J would need to submit two CMS Evaluation Forms; one for family practice and another for pediatrics, and we would evaluate each accordingly. Both requests would put the hospital in the second level priority category (The hospital is in a State whose resident-to-population ratio is within the lowest quartile, AND is *either* in a State whose Primary Care HPSA to population ratio is in the top 10 States, *or* it is located in a rural area, *or* is an urban hospital and has or will have as of July 1, 2010, a rural training track), and it can demonstrate the likelihood of filling the slots (because it is already over its FTE caps based on the family medicine residents it is training in the rural track, and together with the urban hospital, it has requested from the ACGME accreditation to expand the number of family practice residents training in the rural track and to receive a pediatrics resident). For the family practice request, Hospital J would receive 5 points under Evaluation Criterion Four because *all* the slots it is requesting (that is, family practice *and* pediatrics) are for primary care programs, and it would receive 1 point under Evaluation Criterion Six because it is requesting the family practice slots for its rural training track, for a total of 6 points for the family practice request. For the pediatrics request, Hospital J would be placed in the second Priority Level Category, and receives 5 points under Evaluation Criterion Four because *all* the slots it is requesting (that is, family practice *and* pediatrics) are for primary care programs.

15. Exception If Positions Are Not Redistributed by July 1, 2011

Section 1886(h)(8)(E)(iii) of the Act states that in the case where, by July 1, 2011, the Secretary "does not distribute positions to hospitals," the Secretary shall distribute such positions to other hospitals in accordance with the considerations in redistribution specified at section 1886(h)(8)(C) of the Act (that is, the demonstrated likelihood of filling the slots and whether the hospital has a rural training track), and the priority for certain areas specified at section 1886(h)(8)(D) of the Act (that is, whether the hospital is located in a State with a resident-to-population ratio in the lowest quartile, whether the hospital is located in a State that is in top 10 States in terms of Primary Care HPSA population to State population, and whether the hospital is rural). We believe that the phrase "does not distribute positions to hospitals" contemplates the scenario where there would be more slots available than the amount that qualifying hospitals

requested, and therefore, CMS would be left with slots in the distribution pool as of July 1, 2011. The Secretary is directed to initiate another round of applications after July 1, 2011, in which hospitals that could demonstrate that they could use the slots would apply and possibly receive a portion of the remaining slots, until all the slots in the pool are redistributed. Should the situation arise where there are unused slots available as of July 1, 2011, we would propose a process for redistributing those slots "in accordance with the considerations in redistribution specified at section 1886(h)(8)(C)." We would then alert the public through another round of notice and comment rulemaking to establish the application timeframe, criteria, process and other relevant information at that time.

16. Application of Direct GME PRAs for Primary Care and Nonprimary Care Residents and Conforming Changes for the IME Multiplier

Section 1886(h)(8)(G) of the Act states that, "With respect to additional residency positions in a hospital attributable to the increase provided under this paragraph, the approved FTE per resident amounts are deemed to be equal to the hospital per resident amounts for primary care and nonprimary care computed under paragraph (2)(D) for that hospital." Hospitals that receive increases in their FTE resident caps under section 1886(h)(8)(B)(i) will receive direct GME payments associated with those FTE residents in the same manner as they receive direct GME payments for their other (non-section 422) FTE residents, that is, using the primary care PRA that is reported on Worksheet E–3, Part IV, line 3.23, and the nonprimary care PRA reported on line 3.17 of the same worksheet. This provision in section 5503 differs from section 422 in that hospitals that received additional slots under section 422 receive direct GME payment for FTE residents attributable to those slots using a single locality-adjusted national average PRA (42 CFR 413.77(g)), and the payment determination is made on Worksheet E–3, Part VI. Thus, if a hospital received additional slots under section 422, and they train a number of residents that is sufficient to require them to count FTE residents under those slots, the hospital will continue to receive direct GME payment for those slots using the locality-adjusted national average PRA. However, we are proposing that a hospital that receives additional slots under section 5503 would be paid for FTE residents counted under those slots using the same primary care and nonprimary PRAs for which payment is made for FTE residents subject to the 1996 FTE cap. We are expecting to revise Worksheet E–3, Part IV to add a line on which hospitals would report the number of FTEs by which the hospital's FTE caps were increased for direct GME slots received under section 5503. To create a hospital's total adjusted direct GME FTE cap, the increase granted under section 1886(h)(8)(B)(i) would be added to the 1996 direct GME FTE cap and would include any applicable new program adjustment received under § 413.79(e), and any applicable adjustments for the cost reporting period due to a Medicare GME affiliation agreement. In a given cost reporting year, we are proposing that a hospital would only count FTE residents under its direct GME section 422 cap slots on Worksheet E–3, Part VI if the number of unweighted allopathic and osteopathic residents it is training exceeds the total adjusted direct GME cap (including the section 5503 slots) on Worksheet E–3, Part IV.

In addition, with respect to the IME adjustment, we are proposing that a hospital that receives an increase in its FTE cap under section 1886(h)(8)(B)(i) will count FTE residents under those slots, and payment will be made with respect to residents counted under those slots, using the same IME multiplier for which payment is made for FTE residents subject to the 1996 FTE cap (that is, currently a multiplier of 1.35). This is because section 1886(d)(5)(B)(x) of the Act, as added by section 5503(b)(2), states, "For discharges occurring on or after July 1, 2011, insofar as an additional payment amount under this subparagraph is attributable to resident positions distributed to a hospital under subsection (h)(8)(B), the indirect teaching adjustment factor shall be computed in the same manner as provided under clause (ii) with respect to such resident positions." This provision in section 5503 differs from section 422 in that hospitals that received additional slots under section 422 receive IME payment for FTE residents counted under those slots using a special multiplier of 0.66 (42 CFR 412.105(e)(2)), and the payment determination is made on Worksheet E–3, Part VI. We also are expecting to revise Worksheet E, Part A to add a line in which applicable hospitals would report the amount of additional IME slots received under section 5503. To create a hospital's total adjusted IME FTE cap, this additional amount would be added to the 1996 IME FTE cap, any applicable new program adjustment received under § 413.79(e), and any applicable adjustments for the period due to a Medicare GME affiliation agreement. In a given cost reporting year, we are proposing that a hospital would only use its IME section 422 cap slots on Worksheet E–3, Part VI if the number of unweighted allopathic and osteopathic residents it is training exceeds the total adjusted IME cap (including the section 5503 slots) on Worksheet E, Part A. Finally, under section 422 of Pub. L. 108–173, hospitals that were members of the same Medicare GME affiliated group on or after July 1, 2005, and that received additional FTE cap slots under section 422 are precluded from including those additional section 422 slots in the aggregate affiliated cap. This is in part because section 422 specified that a hospital would receive direct GME and IME payments for additional slots awarded under section 422 with rates that were different from the non-section 422 cap slots, and tracking the different direct GME and IME payment rates associated with FTE residents that are counted as a result of the section 422 cap increases and those that were not would be extremely difficult for the Medicare contractors. In addition, in order to qualify for additional slots under section 422, the hospitals had to document a need for those slots. Similarly, under section 5503, we are proposing that hospitals that receive additional slots under section 5503 *cannot* use these slots as part of the aggregate cap in a Medicare GME affiliation agreement. This is because we believe that once a hospital has demonstrated that it truly needs the additional slots, has made the effort to carefully document that it will fill those slots within three years, and once we have determined that the characteristics of the hospital and its training program warrant an increase in the hospital's FTE resident caps under section 1886(h)(8)(B)(i), we do not believe it would be appropriate for the hospital to transfer those positions to another hospital, albeit temporarily, under the terms of a Medicare GME affiliation agreement. To do so would be to undermine the goals and specifications for the redistribution of residency positions as set forth under section 5503.

We note that section 1886(h)(8)(B) of the Act, which addresses the increases in hospitals' FTE resident caps, makes no reference to section 1886(h)(4)(G) or 1886(d)(5)(B)(vi)(II) of the Act, which are the provisions concerning the rolling average count of FTE residents. Furthermore, there is no mention of

section 1886(d)(5)(B)(vi)(I) of the Act, the provision regarding the cap on the IME resident-to-bed ratio, in section 1886(h)(8)(B) of the Act either. That is, the statute does not provide for an exclusion from application of the rolling average for residents counted as a result of FTE cap increases under section 1886(h)(8)(B)(i) of the Act, nor does the statute exempt the residents counted pursuant to FTE cap increases under section 1886(h)(8)(B)(i) from the application of the cap on the IME resident-to-bed ratio. In light of the absence of a specific directive in section 1886(h)(8)(B)(i) of the Act exempting those residents from application of the rolling average for direct GME and IME, and the cap on the IME resident-to-bed ratio, and with no apparent reason to treat residents counted as a result of the FTE cap increases under section 1886(h)(8)(B) of the Act differently, we are proposing to require that if a hospital increases its direct GME or IME FTE count of residents under an increase in the hospital's FTE resident cap under section 1886(h)(8)(B)(i) of the Act, those FTE residents would be immediately subject to the rolling average calculation and the cap on the IME resident-to-bed ratio. Furthermore, we believe that, given potentially significant shifts of FTE resident positions among hospitals as a result of section 1886(h)(8) of the Act, the inclusion of FTE residents counted as a result of FTE cap increases under section 1886(h)(8)(B)(i) of the Act in the rolling average would introduce a measure of stability and predictability, and mitigate radical shifts in GME payments from period to period.

17. Other Issues Related to a Request for Increase in the FTE Caps Under Section 5503

• Rural Hospitals or Urban Nonteaching Hospitals

Rural hospitals may receive an adjustment to their FTE caps for establishing a new residency program under § 413.79(e)(1)(iii) of the existing regulations at any time. Therefore, if a rural hospital is interested in starting a new program, or interested in participating in training residents in a new program on or after July 1, 2011, it need not apply for slots under section 5503 for that new program. If a rural hospital seeks to expand an existing program, and does not have sufficient space under its existing FTE caps to cover those additional residents, the rural hospital may apply for an increase to its FTE caps under section 5503. Similarly, an urban hospital may request additional slots under section 5503 for the purpose of expanding an existing program. A hospital, rural or urban, that is not yet a teaching hospital and does not have a cap established, may *not* apply for a permanent adjustment to their FTE caps under section 5503 since a non-teaching hospital may apply for a permanent cap adjustment under current Medicare regulations at § 413.79(e). Also, if an urban non-teaching hospital becomes a teaching hospital because it begins to serve as a rotating site for another hospital's existing program, it may apply for additional slots under section 5503, which would not preempt the hospital from later getting a new cap adjustment under § 413.79(e) for starting a new program.

• Closed Teaching Hospitals

We note that under section 5506 of Public Law 111–148, as explained further in section XVII.E. of this proposed rule, the FTE resident caps of teaching hospitals that close on or after March 23, 2008 are to be redistributed to other qualifying hospitals according to specific criteria. Assuming a teaching hospital closed recently, it is possible that based on the closed teaching hospital's three most recent cost reporting periods ending prior to March 23, 2010, its FTE resident caps could be subject to reduction under section 5503. However, so as to avoid duplication of FTE resident slots in the redistribution processes under sections 5503 and 5506, we are proposing that if a hospital closes on or after March 23, 2008, then its FTE resident cap slots would not be redistributed under section 5503, but would be reserved for redistribution under section 5506.

• Requirements for Hospitals That Receive Additional Slots Under Section 5503

Section 1886(h)(8)(B)(ii) of the Act, as added by section 5503(a)(4) of the Affordable Care Act, specifies requirements and thresholds that a hospital that applies for and receives additional slots effective July 1, 2011 must meet in order to retain those slots. Under section 422 of Public Law 108–173, hospitals that received additional slots were not held accountable for meeting any requirements once those slots were received effective July 1, 2005, nor did section 422 require that CMS conduct any subsequent reviews of the hospitals that received the slots in order to determine that the hospitals were meeting certain thresholds. However, section 1886(h)(8)(B)(i) of the Act, as added by section 5503 of the Affordable Care Act specifies requirements that a hospital that receives an increase in its FTE resident caps under section 1886(h)(8)(B)(i) must meet, at least for a 5-year period beginning on and after July 1, 2011, and section 1886(h)(8)(B)(iii) directs the Secretary to reduce the FTE caps of the hospital by the same number of FTE residents by which the hospital's FTE caps were increased if the hospital fails to meet these requirements. Specifically, section 1886(h)(8)(B)(ii) of the Act states, "a hospital that receives an increase in the otherwise applicable resident limit under this subparagraph shall ensure, during the 5-year period beginning on the date of such increase, that—

(I) The number of full-time equivalent primary care residents, as defined in paragraph (5)(H) (as determined by the Secretary), excluding any additional positions under subclause (II), is not less than the average number of full-time equivalent primary care residents (as so determined) during the 3 most recent cost reporting periods ending prior to the date of enactment of this paragraph; and

(II) Not less than 75 percent of the positions attributable to such increase are in a primary care or general surgery residency (as determined by the Secretary).

The Secretary may determine whether a hospital has met the requirements under this clause during such 5-year period in such manner and at such time as the Secretary determines appropriate, including at the end of such 5-year period."

Section 1886(h)(5)(H) of the Act defines "primary care resident" as a resident enrolled in an approved medical residency training program in family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine, or osteopathic general practice. We are proposing that a hospital that is applying to receive additional slots would have to submit data from the 3 most recent cost reporting periods ending before March 23, 2010 (the date of enactment) on the number of unweighted FTE residents in these primary care programs. We note that this primary care average is based on the hospital's total FTE count that would otherwise be allowable in absence of the FTE cap; if a hospital is training FTE residents in excess of its FTE caps, it would still determine the 3-year average based on the total number of unweighted primary care FTE residents. A total primary care FTE count, one for IME and one for direct GME, is sufficient for the hospital for each of these 3 cost reporting periods; a hospital need not report these data by specialty.

However, we note that, currently, the Medicare cost report does not track a hospital's number of primary care residents. For direct GME, on Worksheet E–3, Part IV, line 3.19, the hospital's number of weighted primary care and OB/GYN residents is reported. Thus, if a hospital trains OB/GYN residents in addition to primary care residents, we are proposing that the OB/GYN count must be subtracted from the number reported on line 3.19 of Worksheet E–3, Part IV for the hospital's 3 most recent cost reporting periods ending before March 23, 2010. This would produce a weighted FTE count for direct GME. In any case, the source documentation for these data is the rotation schedules for the applicable years. For IME, on Worksheet E, Part A, there is no line that currently records the number of primary care residents, as the distinction between primary care and non-primary care residents is only necessary in the direct GME payment formula (due to the use of a primary care and OB/GYN PRA and a nonprimary care PRA for certain years).

Therefore, we are proposing that the applicant hospital must develop from its rotation schedules three IME FTE primary care counts to correspond to its three most recent cost reporting periods ending before March 23, 2010. As part of its application, we are proposing that the hospital must include the documentation that it used to arrive at its direct GME and IME primary care FTE counts, including a copy of Worksheet E–3, Part IV for direct GME, and if the hospital has an OB/GYN program, the rotation schedules corresponding to the three most recent cost reporting periods ending prior to March 23, 2010 for OB/GYN, and the rotation schedules for all primary care residency programs used to establish the IME primary care FTE count corresponding to the three most recent cost reporting periods ending prior to March 23, 2010. Although we have considered proposing that a hospital may demonstrate that it is complying with the requirement to maintain the primary care average with only a single unweighted FTE count, rather than one FTE count for direct GME and one FTE count for IME, we believe that we need to propose to require documentation from both a direct GME and an IME FTE count because section 5503 of the Affordable Care Act amended section 1886(d)(5)(B)(v) of the Act to make the entire section 1886(h)(8), of which maintenance of this primary care average is a part, applicable for purposes of IME. Thus, both section 1886(h) of the Act for direct GME and section 1886(d)(5)(B) of the Act for IME are equally impacted by section 5503. Furthermore, we are proposing that the FTE counts for IME and direct GME used to derive these primary care averages are subject to audit by the Medicare contractors, and that, as part of reviews or audits performed by the Medicare contractors in accordance with their normal audit plans, the Medicare contractors would check whether a hospital is maintaining its primary care average in each of the cost reports in the 5-year period as early as tentative settlement of those five respective cost reports, and may take prompt action accordingly to adjust a hospital's FTE caps and direct GME and IME interim payments.

In addition to maintaining this average number of primary care residents, section 1886(h)(8)(B)(ii)(II) of the Act also requires that a hospital that receives an increase to its FTE resident caps under section 1886(h)(8)(B)(i) must ensure that 75 percent of those slots are used to train primary care or general surgery residents. A hospital that applies for additional slots may or may not already train at least 75 percent or more of its residents in primary care or general surgery programs. At a minimum, the applicant hospital is required to maintain the average number of FTE primary care residents that it trained during the three most recent cost reporting periods ending prior to March 23, 2010. Further, we are proposing that in addition to the primary care residents used to maintain the primary care average, the applicant hospital must separately ensure that at least 75 percent of the increased FTE cap slots it receives are used to count FTE residents in primary care or general surgery. We are proposing that the hospital must be able to document that, during each of the five years in the five-year period of July 1, 2011 to June 30, 2016, for IME and direct GME respectively, and for *each* cost report during those five years, that not only is it maintaining its primary care average, but that 75 percent of the increased FTE cap slots that it received are being used to count residents training in primary care or general surgery programs. For example, Hospital A has a June 30 fiscal year end, an FTE cap of 100 FTEs, and a total FTE count of 110. In its three most recent cost reports ending prior to March 23, 2010 (fiscal year end June 30, 2009, June 30, 2008, and June 30, 2007), Hospital A was training 60 primary care FTE residents, 50 primary care FTE residents, and 40 primary care FTE residents respectively. The average number of primary care FTE residents during those three years is 50. Hospital A applied for and received 10 additional FTE cap slots under section 5503. Beginning July 1, 2011, for each cost report ending June 30, 2012, June 30, 2013, June 30, 2014, June 30, 2015, and June 30, 2016, Hospital A must ensure that it does not train less than 50 primary care FTE residents, and it must ensure that it trains an *additional* 7.5 FTEs of the 10 slots it receives in either primary care or general surgery. In another example, Hospital B has a December 31 fiscal year end, an FTE cap of 10 FTEs, and a total FTE count of 12. In its 3 most recent cost reports ending prior to March 23, 2010 (fiscal year end December 31, 2009, December 31, 2008 and December 31, 2007), Hospital A was training 12 primary care FTE residents in each of the 3 years. The average number of primary care FTE residents is 12. Hospital B applied for and received 4 additional FTE cap slots under section 5503. Beginning July 1, 2011 and ending June 30, 2016, Hospital B must ensure that it does not train less than 12 primary care FTE residents, and it must ensure that it trains an *additional* 3 FTEs of the 4 slots it receives in either primary care or general surgery. We are proposing that the Medicare contractors would check whether a hospital is maintaining this 75-percent threshold as part of reviews or audits performed by the Medicare contractors in accordance with their normal audit plans in the 5-year period as early as tentative settlement of those five respective cost reports, and may take action accordingly to adjust a hospital's FTE resident caps and direct GME and IME interim payments.

It is possible that there are hospitals that are not currently training, nor have they trained in any of their three cost reporting periods ending prior to March 23, 2010, any primary care residents at all, but that such hospitals are applying for an increase to their FTE caps for a new primary care or general surgery program that they would like to start. Such hospitals would have a primary care average of zero. Because the intent of section 5503 is to try to increase the number of primary care (or general surgery) residents in training, we are proposing that such hospitals would be able to apply for additional slots under section 5503. Should such a hospital receive an FTE cap increase, we are proposing that 75 percent of the increased FTE cap slots must be used to count FTE residents in either primary care or general surgery. We are proposing that a hospital is required to document in *each* of the 5 years that it has maintained the primary care average

and that at least 75 percent of the slots it receives is used for training either primary care and/or general surgery residents rather than only once at the end of the 5-year period. As explained more fully below, if a hospital has not met these requirements, we believe it would be less disruptive financially and administratively to a hospital if we make the adjustment to the hospital's FTE resident caps under section 1886(h)(8)(B)(iii)(I) and recover any overpayment after 1 year rather than after the conclusion of the full 5 year monitoring period under section 1886(h)(8)(B)(ii).

Section 1886(h)(8)(B)(ii) of the Act also states that "The Secretary may determine whether a hospital has met the requirements under this clause *during such 5-year period in such manner and at such time as the Secretary determines appropriate, including at the end of such 5-year period*" (emphasis added). We are proposing that the "5-year period beginning on the date of such increase" is July 1, 2011 through June 30, 2016, because the effective date of section 5503 is for portions of cost reporting periods beginning on or after July 1, 2011. Thus, it is during this 5-year period that an "average number of full-time equivalent primary care residents" must be maintained, and that 75 percent of the additional slots must be trained in primary care or general surgery, for IME and direct GME respectively. However, the Secretary is given some discretion as to how and when she determines whether a hospital is meeting or has met the requirements "during such 5-year period." Although we believe that the 5-year period must be within July 1, 2011 through June 30, 2016, we believe we have flexibility to determine which cost reporting periods within that 5-year period we may use to assess whether the hospital is consistently meeting the required criteria. For the sake of administrative simplicity, on behalf of hospitals and the Medicare contractors, we are proposing that the Medicare contractors, in accordance with their normal audit plans, would make assessments based on a hospital's fiscal year when possible, such that the Medicare contractors could make a first assessment for an initial "short" period, then annually as each of the hospital's fiscal year ends until there is another final "short" assessment period that starts after the provider's last fiscal year end within the 5-year window and runs through June 30, 2016. If a hospital has a June 30 fiscal year end, we are proposing that the Medicare contractor could assess whether the hospital is meeting the required criteria five times, starting with its cost reporting period beginning on July 1, 2011, and ending with its fifth cost reporting period that starts on July 1, 2015 (and ending June 30, 2016). However, for hospitals that have a fiscal year end of other than June 30, we are proposing that the Medicare contractors could assess whether the hospital met the requirements for the portion of its cost reporting period that occurs after July 1, 2011, its subsequent full cost reporting periods, and then ending with the portion of the cost reporting period prior to June 30, 2016. In other words, we are proposing that the hospital would be considered to meet the required criteria in "Year 1" if it meets the requirements based on an annualized FTE count from July 1, 2011 through the end of its cost reporting period; in each of years 2 through 4, it must meet the requirements based on its next 3 cost reporting periods; and in year 5, it must meet the requirements based on an annualized FTE count from the first day of its cost reporting period through June 30, 2016 (which is the last day on which a hospital has any obligation to meet these requirements). For example, assume Hospital C has a September 30 fiscal year end, and receives 16 additional slots under section 5503, and has a primary care average of 30 FTE residents. We are proposing that during the period of July 1, 2011 through June 30, 2016, Hospital C must demonstrate that it is training at least 75 percent of its 16 slots in primary care or general surgery (that is, 12 slots), and that it maintains a primary care FTE count of 30, as follows:

Year 1—July 1, 2011 to September 30, 2011, with an annualized count of 3 (that is, 12 divided by 4) additional FTEs in primary care/general surgery, and an annualized count of 7.5 (that is, 30 divided by 4) FTEs training in primary care residency programs.

Year 2—October 1, 2011 to September 30, 2012, with 12 FTEs in primary care/general surgery, and 30 FTEs in primary care programs.

Year 3—October 1, 2012 to September 30, 2013, with 12 FTEs in primary care/general surgery, and 30 FTEs in primary care programs.

Year 4—October 1, 2012 to September 30, 2014, with 12 FTEs in primary care/general surgery, and 30 FTEs in primary care programs.

Year 5—October 1, 2014 to September 30, 2015, with 12 FTEs in primary care/general surgery, and 30 FTEs in primary care programs.

Year 6—October 1, 2015 to June 30, 2016, with an annualized count of 9 additional FTEs in primary care/general surgery, and an annualized count of 22.5 FTEs training in primary care residency programs.

We are proposing to reserve the right to assess as many times as necessary in the 5-year period that a hospital is meeting the required criteria. Furthermore, if a Medicare contractor determines during an audit that a hospital did not meet the requirements during, for example, the second year, the contractor could go back and audit the first year (full, or short period), and make a retroactive adjustment. We also understand that we should consider that hospitals might not immediately fill all the slots they receive, particularly because they are only required to demonstrate the likelihood of filling the slots within the first three cost reporting periods beginning on or after July 1, 2011. Accordingly, in the preceding example in which Hospital C was awarded 16 slots and has a September 30 fiscal year end, assume it only added 2 actual residents immediately on July 1, 2011. Two residents equate to 0.5 FTE for the 3-month period of July 1, 2011 to September 30, 2011. Seventy five percent of 0.5 FTE equals 0.375. We are proposing that at least 0.375 of the new FTEs added for the period of July 1, 2011 to September 30, 2011 must be in primary care or general surgery in order to meet the requirement in "Year 1."

In a case where the Medicare contractor determines that a hospital did not meet the requirements in a cost reporting year within the 5-year time period, section 1886(h)(8)(B)(iii) of the Act states that "the Secretary shall—

(I) Reduce the otherwise applicable resident limit of the hospital by the amount by which such limit was increased under this paragraph; and

(II) Provide for the distribution of positions attributable to such reduction in accordance with the requirements of this paragraph." Hospitals have different fiscal year ends and are subject to different audit schedules, which may occur several years after a hospital's cost report is submitted. Therefore, even though we are proposing that the Medicare contractors may make adjustments to a hospital's direct GME and IME payments as early as tentative settlement, it may be several years after June 30, 2016 before CMS determines the exact number of reductions, if any, that are applied to the FTE caps of hospitals that received additional slots, but that failed to meet the requirements under section 1886(h)(8)(B)(ii) of the Act, discussed above. However, once we have determined the number of slots available for a second redistribution, we would distribute them "in accordance with the requirements of this

paragraph." That is, we would distribute the slots to hospitals that applied under this first redistribution and that qualified to receive the slots they requested, but for whom we did not have sufficient slots in the "pool" to grant them the full number of FTE slots that they requested. As discussed above in section XVII.D. of this proposed rule, because of the requirement that 70 percent of the slots be redistributed to hospitals within States with resident-to-population ratios in the lowest quartile, it is possible that, after first distributing slots to hospitals with the highest scores on their CMS Evaluation Form, there may be some remaining qualifying hospitals within the same priority level category that receive the same score on the CMS Evaluation Form. Thus, we would have no way of distinguishing among these hospitals of equal rank. If this situation occurs, we are proposing to prorate the remaining amount of slots in the "70 percent" pool, and distribute an equal share of slots to these hospitals of equal rank. If a similar situation occurs within the "30 percent" pool, we also are proposing to prorate the remaining amount of slots in the "30 percent" pool and distribute an equal share of slots to hospitals of equal rank. Accordingly, in the event that there is a second redistribution process pursuant to section 1886(h)(8)(B)(iii)(II), we are proposing to distribute the slots in the "pool" (created by the failure of one or more hospitals to meet the criteria specified under section 1886(h)(8)(B)(ii)) to those hospitals that did not receive all of the slots for which they technically qualified, and for which we had to prorate under the first redistribution. If we have sufficient slots to fully satisfy the original requests of those qualifying hospitals, we would assign them the difference between the prorated amount awarded under the first redistribution and the amount of slots they requested on their original application (assuming they actually otherwise qualified for all the slots they requested). In other words, we would go back to the original applications and continue to assign slots to those hospitals that originally qualified to receive slots under section 5503, but for which we did not have sufficient slots to satisfy their requests. We are proposing to assign the additional slots in the same priority order as under the first redistribution process under section 5503, resuming where we left off, until all the slots have been distributed. After such point, there would be no further harvesting of slots or redistribution under section 5503.

We are proposing to add new regulations at § 412.105(f)(1)(iv)(C)(2) for IME and at § 413.79(n) for direct GME to reflect our proposals regarding hospitals receiving increases to their FTE resident caps under section 5503, and the requirements that hospitals must meet in order to keep those FTE slots, and not be subject to a removal of those FTE slots during the 5-year period of July 1, 2011 through June 30, 2016.

- No Administrative or Judicial Review

Section 5503(a)(3) of the Affordable Care Act amended section 1886(h)(7)(E) of the Act by adding "or paragraph (8)" such that section 1886(h)(7)(E) of the Act now specifies that "There shall be no administrative or judicial review under section 1869, 1878, or otherwise, with respect to determinations made under this paragraph or paragraph (8)." As stated in the preceding section regarding reference cost reports that are under appeal, we believe the fact that Congress included this language clearly means that the Congress intended for our determination with regard to FTE resident cap reductions under section 1886(h)(8)(A) to be final, and not subject to appeal. Because of this statutory language, together with the requirement that all reductions and increases in FTE resident caps be made effective July 1, 2011, we do not believe it would be appropriate to allow hospitals (or CMS) to appeal determinations concerning the FTE cap reductions or the FTE cap increases) under section 1886(h)(8) of the Act. In addition, as indicated previously, we believe that Congress intended this provision to be implemented fairly, but efficiently, avoiding the delays and uncertainty that would be produced by an appeals process. Furthermore, we note that, as explained previously in this preamble, as was done under section 422 of Public Law 108–173, Medicare contractors will provide hospitals with a time-limited opportunity to review cap reduction determinations for possible technical errors before they are finalized.

BILLING CODE 4120–01–P

ADDENDUM

Trainees in Osteopathic Programs as Reported - By State 2008-2009

State	Interns		Residents		Total	
	Programs	Trainees	Programs	Trainees	Programs	Trainees
Alaska	1	3	0	0	1	3
Arizona	3	15	7	30	10	45
Arkansas	1	0	1	3	2	3
California	6	64	23	112	29	176
Colorado	1	0	0	0	1	0
Connecticut	1	10	1	3	2	13
Delaware	1	12	1	6	2	18
Florida	13	111	38	182	51	293
Georgia	3	5	3	3	6	8
Illinois	15	77	36	184	51	261
Indiana	3	8	3	12	6	20
Iowa	2	8	3	21	5	29
Kansas	1	3	1	3	2	6
Kentucky	6	16	7	15	13	31
Maine	4	14	9	42	13	56
Massachusetts	3	11	2	3	5	14
Michigan	24	338	174	858	198	1196
Minnesota	1	0	1	0	2	0
Mississippi	0	0	1	0	1	0
Missouri	5	24	21	90	26	114
Nevada	1	25	4	23	5	48
New Hampshire	1	4	0	0	1	4
New Jersey	9	83	48	236	57	319
New Mexico	1	1	1	4	2	5
New York	21	191	52	298	73	489
North Carolina	2	7	2	7	4	14
North Dakota	1	0	0	0	1	0
Ohio	17	168	97	397	114	565
Oklahoma	4	54	25	135	29	189
Oregon	1	0	6	0	7	0
Pennsylvania	43	282	97	455	140	737
Rhode Island	0	0	2	0	2	0
South Carolina	1	5	1	3	2	8
Tennessee	2	2	0	0	2	2
Texas	9	39	20	62	29	101
Virginia	5	16	9	30	14	46
Washington	0	0	1	0	1	0
West Virginia	8	43	18	53	26	96
Wisconsin	2	5	2	16	4	21
Wyoming	1	1	1	3	2	4
Total	**223**	**1,645**	**718**	**3,289**	**941**	**4,934**

Source: The American Osteopathic Association

Draft CMS Evaluation Form

As Part of the Application for the Increase in a Hospital's FTE Cap(s) under Section 5503 of the Affordable Care Act

Directions: Please fill out the information below for each residency program for which the applicant hospital intends to use the increase in its FTE cap(s). The applicant hospital is responsible for complying with the other requirements listed in the CY 2011 Hospital Outpatient Prospective Payment System Final Rule with Comment Period in order to complete its application for the increase in its FTE cap(s) under section 5503 of The Affordable Care Act, Pub. L. 111-148.

NAME OF HOSPITAL: _____

MEDICARE PROVIDER NUMBER: _____

NAME OF MEDICARE CONTRACTOR: _____

NAME OF SPECIALTY TRAINING PROGRAM: _____

(Check one): □ Allopathic Program □ Osteopathic Program

NUMBER OF FTE SLOTS REQUESTED FOR PROGRAM:

Direct GME: _____ **IME:** _____

Section A: Demonstrated Likelihood of Filling the FTE Slots

(Place an "X" in the box for the applicable criterion and subcriteria.)

A1: Demonstrated Likelihood Criterion 1. The hospital does not have sufficient room under its FTE cap for a new residency program that it intends to establish on or after July 1, 2011 (that is, a newly approved program that begins training residents at any point within the hospital's first three cost reporting periods beginning on or after July 1, 2011).

(1) Hospital will establish this newly approved residency program. **(The hospital must check at least one of the following, if applicable.)**

☐ Application for approval of the new residency program has been submitted to the ACGME, AOA or the ABMS by December 1, 2010. **(The hospital must attach a copy.)**

☐ The hospital has submitted an institutional review document or program information form concerning the new program in an application for approval of the new program by December 1, 2010. **(The hospital must attach a copy.)**

☐ The hospital has received written correspondence from the ACGME, AOA or ABMS acknowledging receipt of the application for the new program, or other types of communication from the accrediting bodies concerning the new program approval process (such as notification of site visit). **(The hospital must attach a copy.)**

(2) Hospital will likely fill the slots requested. **(The hospital must check at least one of the following, if applicable.)**

☐ The hospital does not have sufficient room under its FTE cap, and the hospital's existing residency programs had a resident fill rate of at least 85 percent in each of program years 2007 through 2009. **(The hospital must attach documentation.)**

☐ The hospital does not have sufficient room under its FTE cap, and the specialty program for which the hospital is applying has a resident fill rate either nationally, within the State, or within the CBSA in which the hospital is located, of at least 85 percent. **(The hospital must attach documentation.)**

☐ A2: Demonstrated Likelihood Criterion 2. The hospital does not have sufficient room under its FTE cap, and the hospital intends to use the additional FTEs to expand an existing residency training program within the hospital's first three cost reporting periods beginning on or after July 1, 2011.

☐ (1) Hospital intends to expand an existing program. **(The hospital must check at least one of the following, if applicable.)**

☐ The appropriate accrediting body (the ACGME, AOA or ABMS) has approved the hospital's expansion of the number of FTE residents in the program. **(The hospital must attach documentation.)**

☐ The American Osteopathic Association Residency Match Program has accepted or will be accepting the hospital's participation in the match for the existing program that will include additional resident slots in that residency training program. **(The hospital must attach documentation.)**

☐ The hospital has submitted an institutional review document or program information form for the expansion of the existing residency training program by December 1, 2010. **(The hospital must attach documentation).**

☐ (2) Hospital will likely fill the slots of the expanded residency program. **(Check at least one of the following, if applicable.)**

☐ The hospital does not have sufficient room under its FTE cap, and the hospital has other previously established residency programs, with a resident fill rate of at least 85 percent in each of program years 2007 through 2009.) **(The hospital must attach documentation.)**

☐ The hospital does not have sufficient room under its FTE cap, and the hospital is expanding an existing program in a particular specialty with a resident fill rate either nationally, within the State, or within the CBSA in which the hospital is located, of at least 85 percent. **(The hospital must attach documentation.)**

☐ A3: Demonstrated Likelihood Criterion 3. Hospital is applying for an increase in its FTE resident cap because the hospital is already training residents in an existing residency training program(s) in excess of its direct GME FTE cap or IME FTE cap, or both. **(Copies of EACH of the following must be attached.)**

- Copies of the Medicare cost reports that have been most recently submitted to the Medicare contractor by July 1, 2010 documenting on Worksheet E, Part A, Worksheet E-3, Part VI, and Worksheet E-3, Part VI the resident counts and FTE resident caps for both direct GME and IME for the relevant cost reporting periods.

- Copies of the 2010 residency match information concerning the number of residents at the hospital in its existing programs.

- Copies of the most recent accreditation letters on all of the hospital's training programs in which the hospital trains and counts FTE residents for direct GME and IME.

Section B. Level Priority Category

(Place an "X" in the appropriate box that is applicable to the level priority category that describes the applicant hospital.)

☐ First Level Priority Category: The hospital is in a State whose resident-to-population ratio is within the lowest quartile, AND the hospital is in a State whose Primary Care HPSA to population ratio is in the top 10 States, AND the hospital is located in a rural area.

☐ Second Level Priority Category: The hospital is in a State whose resident-to-population ratio is within the lowest quartile, AND is either in a State whose Primary Care HPSA to population ratio is in the top 10 States, or it is located in a rural area, or is an urban hospital and has or will have as of July 1, 2010, a rural training track.

☐ Third Level Priority Category: The hospital is in a State whose resident-to-population ratio is within the lowest quartile.

Fourth Level Priority Category: The hospital is in a State whose Primary Care HPSA to population ratio is in the top 10 States, AND either the hospital is located in a rural area or the hospital is an urban hospital and has, or will have as of July 1, 2010, a rural training track.

☐ Fifth Level Priority Category: The hospital is in a State whose Primary Care HPSA to population ratio is in the top 10 States, or the hospital is located in a rural area.

Section C. Evaluation Criteria

(Place an "X" in the box for each criterion that is appropriate for the applicant hospital and for the program for which the increase in the FTE cap is requested.)

☐ Evaluation Criterion One. *The hospital that is requesting the increase in its FTE resident cap(s) has a Medicare inpatient utilization over 60 percent, as reflected in at least two of the hospital's last three most recent audited cost reporting periods for which there is a settled cost report.* 5 POINTS.

☐ Evaluation Criterion Two. *The hospital will use the additional slots to establish a new geriatrics residency program, or to add residents to an existing geriatrics program.* 5 POINTS.

☐ Evaluation Criterion Three. *The hospital will use additional slots to establish a new or expand an existing primary care program with a demonstrated focus on training residents to pursue careers in primary care, rather than in non-primary subspecialties of those primary care programs (for example, the hospital has an internal medicine program with a designated primary care track).* 3 POINTS.

☐ Evaluation Criterion Four. *The hospital will use all the additional slots to establish a new or expand an existing primary care residency program or general surgery program.* – 5 POINTS.

☐ Evaluation Criterion Five. *The hospital is located in a Primary Care HPSA.* 2 POINTS.

☐ Evaluation Criterion Six. *The hospital is in a rural area (as defined under section 1886(d)(2)(D)(ii) of the Act) and is or will be on or after July 1, 2011, a training site for a rural track residency program (as specified under §413.79(k)), but is unable to count all of the FTE residents training in the rural track because the rural hospital's FTE cap is lower than its unweighted count of allopathic or osteopathic FTE residents as of portions of cost reporting periods on or after July 1, 2011.* 1 POINT.

Application Process and CMS Central Office and Regional Office Mailing Addresses for Receiving Increases in FTE Resident Caps

In order for hospitals to be considered for increases in their FTE resident caps, each qualifying hospital must submit a timely application. The following information must be submitted on applications to receive an increase in FTE resident caps:

- The name and Medicare provider number of the hospital.
- The name of the Medicare contractor to which the hospital submits its Medicare cost report.
- The total number of requested FTE resident slots for direct GME or IME, or both, up to 75 direct GME FTE and 75 IME FTE per hospital.
- A completed copy of the CMS Evaluation Form for each residency program for which the hospital intends to use the requested increase in FTE residents.
- Source documentation to support the assertions made by the hospital on the CMS Evaluation Form.
- FTE resident counts for direct GME and IME and FTE resident caps for direct GME and IME reported by the hospital in the most recent as-filed cost report. (Include copies of Worksheets E, Part A, E–3, Part IV, *and if a hospital received an increase to its FTE cap(s) under section 422 of the MMA,* a copy of E–3, Part VI).
- As part of its application, we are proposing that the hospital must include the documentation that it used to arrive at its direct GME and IME primary care FTE counts, including a copy of Worksheet E–3, Part IV for direct GME, and if the hospital has an OB/GYN program, the rotation schedules corresponding to the 3 most recent cost reporting periods ending prior to March 23, 2010 for OB/GYN, and the rotation schedules for all primary care residency programs used to establish the IME primary care FTE count corresponding to the 3 most recent cost reporting periods ending prior to March 23, 2010.
- An attestation, signed and dated by an officer or administrator of the hospital who signs the hospital's Medicare cost report, of the following information:

"I hereby certify that I understand that misrepresentation or falsification of any information contained in this application may be punishable by criminal, civil, and administrative action, fine and/or imprisonment under federal law. Furthermore, I understand that if services identified in this application were provided or procured through payment directly or indirectly of a kickback or where otherwise illegal, criminal, civil, and administrative action, fines and/or imprisonment may result. I also certify that, to the best of my knowledge and belief, it is a true, correct, and complete application prepared from the books and records of the hospital in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding Medicare payment to hospitals for the training of interns and residents."

The completed application and supporting documentation (as described above) must be submitted to the CMS Central Office and the CMS Regional Office for the region in which the applicant hospital is located. The application must be received on or before December 1, 2010. The addresses of the CMS central office and regional offices are listed below.

CMS Central and CMS Regional Office Mailing Addresses for Applications for Increases in FTE Resident Caps

Central Office

Centers for Medicare and Medicaid Services (CMS)
Director, Division of Acute Care
7500 Security Boulevard
Mail Stop C4–08–06
Baltimore, Maryland 21244
(410) 786–4548

Region I (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont)

Centers for Medicare and Medicaid Services (CMS)
Associate Regional Administrator, Division of Financial Management and Fee for Service Operations
Region I
JFK Federal Building
Room 23275
Boston, MA 02203
Phone: (617) 565–1331

Region II (New York, New Jersey, U.S. Virgin Islands, and Puerto Rico)

Centers for Medicare and Medicaid Services (CMS)
Associate Regional Administrator, Division of Financial Management and Fee for Service Operations
Region II
26 Federal Plaza, 38th Floor
New York, NY 10278
Phone: (212) 616–2545

Region III (Delaware, Maryland, Pennsylvania, Virginia and West Virginia, and the District of Columbia)

Centers for Medicare and Medicaid Services (CMS)
Associate Regional Administrator, Division of Financial Management and Fee for Service Operations
Region III
Public Ledger Building, Suite 216
150 South Independence Mall West
Philadelphia, PA 19106
Phone: (215) 861–4140

Region IV (Alabama, North Carolina, South Carolina, Florida, Georgia, Kentucky, Mississippi, and Tennessee)

Centers for Medicare and Medicaid Services (CMS)
Associate Regional Administrator, Division of Financial Management and Fee for Service Operations
Region IV
Atlanta Federal Center
61 Forsyth Street, SW., Suite 4T20
Atlanta, GA 30303–8909
Phone: (404) 562–7300

Region V (Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin)

Centers for Medicare and Medicaid Services (CMS)
Associate Regional Administrator, Division of Financial Management and Fee for Service Operations
Region V
233 North Michigan Avenue, Suite 600
Chicago, IL 60601
Phone: (312) 886–6432

Region VI (Arkansas, Louisiana, New Mexico, Oklahoma, and Texas)

Centers for Medicare and Medicaid Services (CMS)
Associate Regional Administrator, Division of Financial Management and Fee for Service Operations
Region VI
1301 Young Street, Suite 714
Dallas, TX 75202
Phone: (214) 767–6423

Region VII (Iowa, Kansas, Missouri, and Nebraska)

Centers for Medicare and Medicaid Services (CMS)
Associate Regional Administrator, Division of Financial Management and Fee for Service Operations
Region VII
Richard Bolling Federal Building
Room 235
601 East 12th Street
Kansas City, MO 64106
(816) 564–1843

Region VIII (Colorado, Montana, North Dakota, South Dakota, Utah and Wyoming)

Centers for Medicare and Medicaid Services (CMS)
Associate Regional Administrator, Division of Financial Management and Fee for Service Operations
Region VIII
Colorado State Bank Building
1600 Broadway, Suite 700
Denver, CO 80202

Phone: (303) 844–2111

Region IX (Arizona, California, Hawaii, and Nevada and Territories of American Samoa, Guam and the Commonwealth of the Northern Mariana Islands)

Centers for Medicare and Medicaid Services (CMS)
Associate Regional Administrator, Division of Financial Management and Fee for Service Operations
Region IX
90 7th Street, Suite 5–300 (SW)
San Francisco, CA 94103–6708
Phone: (415) 744–3501

Region X (Alaska, Idaho, Oregon, and Washington)

Centers for Medicare and Medicaid Services (CMS)
Associate Regional Administrator, Division of Medicare Financial Management
Region X
2201 Sixth Avenue, MS/RX–46
Seattle, WA 98121
Phone: (206) 615–2094

E. Preservation of Resident Cap Positions From Closed Hospitals (Section 5506 of the Affordable Care Act) (§ 412.105(f)(1)(ix)(B) and § 413.79(o)(2))

1. Background

As we explain in Section XVII.A. of this proposed rule, Medicare makes both direct GME and IME payments to hospitals that train residents in approved medical residency training programs. Direct GME payments are made in accordance with section 1886(h) of the Act, based generally on hospital-specific PRAs, the number of FTE residents a hospital trains, and the hospital's Medicare patient share. IME payments are made in accordance with section 1886(d)(5)(B) of the Act, based generally on the ratio of the hospital's FTE residents to the number of hospital beds. Accordingly, the calculation of both direct GME and IME payments is affected by the number of FTE residents that a hospital is allowed to count; generally, the greater the number of FTE residents a hospital counts, the greater the amount of Medicare direct GME and IME payments the hospital will receive. In an attempt to end the implicit incentive for hospitals to increase the number of FTE residents, Congress instituted a cap on the number of allopathic and osteopathic residents a hospital is allowed to count for direct GME and IME purposes under the provisions of section 1886(h)(4)(F) of the Act for direct GME and section 1886(d)(5)(B)(v) of the Act for IME. Dental and podiatric residents were not included in this statutorily mandated cap. For most hospitals, the limit, or cap, is the unweighted number of allopathic and osteopathic FTE residents training in the hospital's most recent cost reporting period ending on or before December 31, 1996. Thus, each teaching hospital FTE resident cap is unique to the number of FTE residents that it trained in the hospital's most recent cost reporting period ending on or before December 31, 1996.

Under existing regulations at § 413.79(h) for direct GME and § 412.105(f)(1)(ix) for IME, a hospital that is training FTE residents at or in excess of its FTE resident caps and takes in residents displaced by the closure of another teaching hospital may receive a temporary increase to its FTE residents caps so that it may receive direct GME and IME payment associated with those displaced FTE residents. However, those temporary FTE resident cap increases are associated with those specific displaced FTE residents, and the increases expire as those displaced residents complete their training program. Thus, if a teaching hospital closes, its direct GME and IME FTE resident cap slots would be "lost," because those cap slots are associated with a specific hospital's Medicare provider agreement, which would be retired upon the hospital's closure. The closure of a teaching hospital, particularly if it is a large academic medical center, could mean not only the displacement of hundreds of residents, but also the permanent loss of hundreds of Medicare-funded residency training slots and a sophisticated GME infrastructure that could take many years to rebuild, threatening the availability of health care services in a community. Section 5506 of the Affordable Care Act addresses this situation by amending section 1886(h)(4)(H) of the Act to add a new clause (vi) that instructs the Secretary to establish a process by regulation under which, in the event a teaching hospital closes, the Secretary will permanently increase the FTE resident caps for hospitals that meet certain criteria by the number of FTE resident positions in the closed hospital's training programs.

Section 5506 of the Affordable Care Act specifically instructs the Secretary to increase the FTE resident caps for other hospitals based upon the FTE resident positions in teaching hospitals that closed "on or after a date that is 2 years before the date of enactment" (that is, March 23, 2008). Although certain of the FTE cap increases granted pursuant to section 5506 will be based on hospital closures that occurred prior to this notice and comment rulemaking procedure, the process we are proposing to establish in the CY 2011 OPPS Final Rule would also be used for all future teaching hospital closures. We are in the process of instructing the Medicare contractors to notify us of every teaching hospital that has closed since March 23, 2008, and of the direct GME and IME FTE caps for each of those closed hospitals. We plan to use this information to determine how many slots are currently available for increases to other hospitals' FTE resident caps.

We note that section 1886(h)(4)(H)(vi)(IV) of the Act, as added by section 5506(a) of the Affordable Care Act, states that "The aggregate number of increases in the otherwise applicable resident limits for the hospitals under this clause shall be equal to the number of resident positions in the approved medical residency programs that closed on or after" March 23, 2008. For purposes of implementing this section 1886(h)(4)(H)(vi)(IV), we are proposing to interpret "the number of resident positions" to mean the number that is equal to the IME and direct GME FTE resident caps of a hospital that closed, or will close. We do not believe the intent of this provision is to distribute and pay for more FTE resident slots than the amount equal to a closed hospital's IME and direct GME FTE resident caps, in the instance where a closed hospital was training more FTE residents than its FTE resident caps. Further, in the situation where a closed hospital was training FTE residents below its caps, we believe that for the sake of ensuring that a community could retain up to its full training strength, we believe it is appropriate to distribute, not the actual number of slots the closed hospital had been training prior to its closure, but the number of FTE resident slots equal to the IME and direct GME FTE caps of the closed hospital.

2. Definition of a "Closed Hospital"

Section 1886(h)(4)(H)(vi) of the Act, as added by section 5506(a) of the Affordable Care Act, states that "the Secretary shall, by regulation, establish a process under which, in the case where a hospital (other than a hospital described in clause (v)) with an approved medical residency program closes on or after" March 23, 2008, the Secretary shall increase the FTE resident caps of other hospitals accordingly (emphasis added). Under existing regulations at § 489.52 and § 413.79(h), "closure of a hospital" means the hospital terminates its Medicare provider agreement. We are

proposing to define a "closed teaching hospital" for purposes of section 5506 in a similar manner, but would also specify that the FTE resident cap slots of the hospital that closed no longer exist as part of any other hospital's permanent FTE resident cap. Thus, we are proposing that this provision would not apply to hospitals that declare bankruptcy but are still participating under the same Medicare provider agreement, nor would it apply to teaching hospitals that remain open, but close one or more residency programs. It also would not apply to mergers, because in the case of a merger, the Medicare provider agreement of one hospital is subsumed into the provider agreement of the surviving provider; no provider agreement is retired, even if operations at one facility are scaled back or ceased.

However, we are proposing that the proposed revised definition of hospital closure for purposes of implementing section 5506 *would* apply in the case of acquisitions, where the new owner *retires* the Medicare provider agreement of the hospital it purchased, thus abdicating the FTE resident cap slots associated with that provider agreement, even if the new owner will continue to operate the hospital exactly as it had been operated before the acquisition (that is, makes no changes to the bed size, infrastructure, services, and GME programs). We believe this is appropriate because section 5506 of the Affordable Care Act specifically addresses hospital "closure" and ensures preservation of the FTE cap slots within a community when a teaching hospital does "close," based on specified criteria for redistributing the slots from the closed hospital to increase the FTE caps for other hospitals. However, as we explain further below, it is possible for the new hospital formed in an acquisition to receive preference in receiving an increase to its FTE resident caps based on redistributed slots from the closed hospital that it acquired.

Section 1886(h)(4)(H)(vi) of the Act, as added by section 5506(a), also states that "the Secretary shall, by regulation, establish a process under which, in the case where a hospital (*other than a hospital described in clause (v)*) with an approved medical residency program closes * * *" (emphasis added). A hospital described in section 1886(h)(4)(H)(v) of the Act is an entity that enters into a provider agreement pursuant to section 1866(a) of the Act to provide hospital services on the same physical site previously used by Medicare Provider No. 05–0578. Accordingly, we are proposing not to redistribute any FTE cap slots associated with Medicare Provider Number 05–0578.

3. Priority for Hospitals in Certain Areas

Section 1886(h)(4)(H)(vi)(II), as added by section 5506(a) of the Affordable Care Act, specifies that the Secretary shall distribute the FTE cap increases in the following priority order, "with preference given within each category to hospitals that are members of the same affiliated group" (as defined by the Secretary) as the closed hospital:

- First, to hospitals located in the same core-based statistical area (CBSA) as, or in a CBSA contiguous to, the hospital that closed.
- Second, to hospitals located in the same State as the closed hospital.
- Third, to hospitals located in the same region as the hospital that closed.
- Fourth, if the slots have not yet been fully distributed, to qualifying hospitals in accordance with the criteria established under section 5503 ("Distribution of Additional Residency Positions") of the Affordable Care Act.

First, we are proposing to use the same pre-reclassification CBSAs that are used for wage index purposes under the IPPS in determining which hospitals are located in the same or contiguous CBSAs as the CBSA in which the hospital that closed was located, without regard to any reclassifications made under the provisions of §§ 412.102, 412.103, 412.230, 412.232, 412.234, and 412.235 of the regulations. Second, we are proposing to define "State" in the second priority category to include Puerto Rico and the District of Columbia. Third, we are proposing to define "region" in the third priority category as Census Region, consistent with the use of the term elsewhere in the GME regulations. (The term is used for purposes of establishing direct GME PRAs of certain new teaching hospitals at § 413.77(e)(1)(iii).) Fourth, as specified in the fourth priority category, we are proposing to employ the criteria for redistribution of residency positions described in section 5503 of the Affordable Care Act, as implemented in the proposed revised regulations at § 413.79(n), should there be any slots not redistributed under the first through third priority categories.

With regard to members of the same Medicare GME affiliated group, we are proposing to give priority within each category to hospitals that are members of the same Medicare GME affiliated group as the hospital that closed. A Medicare GME affiliated group, as defined at § 413.75(b), consists of hospitals that enter into a Medicare GME affiliation agreement, also as defined at § 413.75(b), for the purpose of cross-training residents and that, under the terms of the agreement, aggregate and make temporary adjustments to their respective individual FTE resident caps. To provide flexibility to hospitals that have affiliated with the hospital that closed, we are proposing to refer to the most recent Medicare GME affiliation agreement of which the closed hospital was a member. Hospitals that were listed as participants of the Medicare GME affiliated group on that most recent affiliation agreement before the closure of the hospital will receive preference in receiving FTE cap increases based on the redistributed slots.

4. Application Process

We are proposing to establish an application process for hospitals to apply to CMS to receive an increase in FTE caps based on slots from closed hospitals. Section 5506 of the Affordable Care Act did not specify an effective date or an application deadline for hospitals to request an increase to their caps when a hospital closes. Accordingly, with respect to the first application process to be implemented for section 1886(h)(4)(H)(vi) of the Act, as added by section 5506(a) of the Affordable Care Act, and which includes all teaching hospital closures back to March 23, 2008, we are proposing that the application deadline would be January 1, 2011. For future teaching hospital closures, we are proposing that we would inform the public through an appropriate medium that increases to hospitals' FTE resident caps are available for redistribution due to the closure of a teaching hospital, and the application deadline would be 4 months following the issuance of that notice to the public.

5. Ranking Criteria

Unlike the application process for FTE cap increases under section 1886(h)(8) of the Act as added by section 5503 of the Affordable Care Act, we are not proposing to establish a "point" system to distinguish between hospitals within each of the first three priority categories. Rather, within each of the three first statutory priority categories in section XVII.E.3. of this proposed rule (that is, same or contiguous CBSAs, same State, and same Region), we are proposing to rank categories in which we would assign slots *first* to hospitals that fall within the first ranking category *before* assigning slots to those hospitals that fall within the second ranking category, and would assign slots to those hospitals that fall within the second ranking category *before* assigning slots to hospitals in the

third ranking category, and so forth. We are not proposing to use these ranking categories within the fourth priority category because, under that fourth priority category, the Secretary would use the process established under section 5503 for section 1886(h)(8) of the Act. In order to maintain stability in existing GME programs, these proposed ranking categories generally give preference to applying hospitals that demonstrate a commitment to continue training residents in the same programs that the closed hospital operated, or that had a training relationship with the closed hospital (such as a Medicare GME affiliation agreement).

• *Ranking Criterion One.* The applying hospital is requesting the increase in its FTE resident cap(s) because it is assuming (or assumed) an entire program (or programs) from the hospital that closed, and the applying hospital is continuing to operate the program(s) exactly as it had been operated by the hospital that closed (that is, same residents, same program director, and same (or many of the same) teaching staff). We are proposing this ranking criterion because we understand that there are situations where, when a hospital is acquired and its provider agreement is retired and a new provider agreement is established in the place of the old one, the new formed "acquiring" hospital continues to operate the GME programs seamlessly and in the same manner as under the previous provider agreement. If this situation occurs, we believe the new hospital with the new provider agreement is demonstrating a strong commitment to not only maintain the GME programs in the community for the long term (that is, continuity), but to also allow the residents that were at the hospital when the change in provider agreement occurred to continue to train there, such that no residents are displaced and no training is interrupted.

Alternatively, it is possible that perhaps a year or more prior to a hospital's closure, the hospital closed some or all of its residency programs, and another hospital assumed an entire program (or programs) at the time of the residency program's closure, and the applying hospital has continued to operate that program seamlessly, as it had been operated at the hospital that ultimately closed. Since the applying hospital has also demonstrated a strong commitment to continuity of the residency program(s) in the community by assuming the program(s) even prior to the other hospital's closure, we are proposing that the applying hospital would be categorized in Ranking Criterion One.

• *Ranking Criterion Two.* The applying hospital was listed as a participant of a Medicare GME affiliated group on the most recent Medicare GME affiliation agreement of which the closed hospital was a member before the hospital closed, and under the terms of that Medicare GME affiliation agreement, the applying hospital *received* slots from the hospital that closed, and the applying hospital will use the additional slots to continue to train at least the number of FTE residents it had trained under the terms of the Medicare GME affiliation agreement. We are proposing this ranking criterion because section 1886(h)(4)(H)(vi) of the Act, as added by section 5506(a) of the Affordable Care Act, directs the Secretary to give preference to hospitals that are members of the same affiliated group as the hospital that closed. We believe that, generally, if the applying hospital was affiliated to *receive* slots from the hospital that closed, then the applying hospital was relying on that number of FTE resident slots that it received in order to maintain its fair share of the cross-training of the residents in the jointly operated programs. In the absence of those slots received from the closed hospital, the applying hospital may not be able to continue training that number of FTE residents, and those same residents would not only be displaced from the closed hospital, but might essentially become "displaced" from the affiliated hospitals in which they were used to doing a portion of their training. Accordingly, we are proposing this ranking criterion to allow hospitals that were affiliated with the closed hospitals to at least maintain their fair share of the training of the residents in the programs that they had jointly operated with the closed hospital. We note that we are proposing this ranking criterion regarding affiliated hospitals as second, after the first ranking criterion regarding applying hospitals that assume an entire program or programs from the closed hospital because, even though section 5506 of the Affordable Care Act directs the Secretary to give preference to members of the same affiliated group, we believe that a hospital that assumes the responsibility for an entire program or programs demonstrates a commitment to maintain the programs to an even greater degree than does a hospital that was affiliated with the hospital that closed and may only be maintaining a portion of the residency program or programs.

• *Ranking Criterion Three.* The applying hospital took in residents displaced by the closure of the hospital, but is not assuming an entire program or programs, and will use the additional slots to continue training residents in the same programs as the displaced residents, even after those displaced residents complete their training (that is, the applying hospital is permanently expanding its own existing programs). Similar to Ranking Criterion Two, hospitals fitting into Ranking Criterion Three also demonstrate a commitment to protect residents displaced by a hospital's closure, and to ensure that there is a degree of continuity in the community with respect to the particular training program or programs that the closed hospital operated. However, because an applying hospital fitting into this category was not part of the same Medicare GME affiliated group as the closed hospital, we are proposing that this category would be ranked as third, below Ranking Criterion Two which relates to hospitals that were members of the same affiliated group as the closed hospital.

The next five proposed ranking criteria would apply in the instance where there are still slots available from the closed hospital after distributing slots to hospitals falling within the first three ranking criteria. Thus, hospitals fitting into Ranking Criteria Four through Eight would not fit into Ranking Criteria One, Two, or Three, but they can demonstrate that they will use the slots in a manner that is consistent with current Medicare policy goals, as indicated in section 5503 of the Affordable Care Act, such as using the slots for a geriatrics or for other primary care residency programs, or for a general surgery residency program.

• *Ranking Criterion Four.* The applying hospital does not fit into Ranking Criteria One, Two, or Three, and will use additional slots to establish a new or expand an existing geriatrics residency program.

• *Ranking Criterion Five.* The applying hospital does not fit into Ranking Criteria One, Two, or Three, is located in a Primary Care HPSA, and will use all the additional slots to establish a new or expand an existing primary care residency program.

• *Ranking Criterion Six.* The applying hospital does not fit into Ranking Criteria One, Two, or Three, and will use all the additional slots to establish a new or expand an existing primary care residency program.

• *Ranking Criterion Seven.* The applying hospital does not fit into Ranking Criteria One, Two, or Three, and will use all the additional slots to establish a new or expand an existing general surgery residency program.

• *Ranking Criterion Eight.* The applying hospital does not fit into Ranking Criteria One through Seven.

6. Demonstrated Likelihood of Filling the Positions Within a Certain Time Period

Section 1886(h)(4)(H)(vi) of the Act, as added by section 5506(a) of the Affordable Care Act, does not place a limit on the number of slots an applying hospital may request, although under section 1886(h)(4)(H)(iv)(IV) of the Act, the Secretary must ensure that the aggregate number of increases to hospitals' FTE residents caps are equal to the FTE residents caps of the hospital that closed. However, section 1886(h)(4)(H)(iv)(III) of the Act specifies that the Secretary may only award slots to an applying hospital "if the Secretary determines that the hospital has demonstrated a likelihood of filling the positions made available under this clause within 3 years." We are proposing that hospitals *must provide documentation* to demonstrate the likelihood of filling requested slots under section 5506 within 3 years. For example, the applying hospital would document that it does not have sufficient room under its FTE resident caps to take in the additional residents, and has approval from the relevant accrediting body to take over the closed hospital's residency program(s), or expand its own residency program(s) to reflect a permanent commitment to train additional residents. We are proposing that "within 3 years" would mean within the 3 academic years immediately following the application deadline to receive slots after a particular hospital closes. For example, where the application deadline is January 1, 2011, the immediately following academic year is July 1, 2011, and therefore, hospitals must demonstrate the likelihood of filling their slots by June 30, 2014.

7. No Duplication of FTE Cap Slots

Section 5506(d) of the Affordable Care Act specifies that "the Secretary shall give consideration to the effect of the amendments made by this section on any temporary adjustment to a hospital's FTE cap under § 413.79(h) * * * (as in effect on the date of enactment of this Act) in order to ensure that there is no duplication of FTE slots * * *" Under existing regulations at § 413.79(h), hospitals that take in residents that are displaced by the closure of another hospital may receive temporary increases to their FTE resident caps so that they may receive payment for training the specific displaced residents. The temporary cap adjustment lasts only for the duration of a specific displaced resident's training. In distributing slots permanently under section 5506, we may need to be cognizant of the number of FTE residents for whom a temporary FTE cap adjustment was provided, and when those residents will complete their training, at which point the temporary slot associated with those displaced residents would be available for permanent redistribution.

We believe that it will only be necessary to delay permanent assignment of FTE cap slots in instances where if, after fulfilling the requests of hospitals that qualify to receive additional slots under Ranking Criteria One, Two, and Three, there are still excess slots available. In the case where an applying hospital fits within Ranking Criterion One, we are proposing to revise the existing regulations at § 413.79(h) limiting temporary cap adjustments for displaced *residents by the number of FTE residents in the program(s) in which the applying hospital is operating seamlessly.* We are proposing to immediately assign permanently that number of FTE slots to the qualifying hospital. For example, if teaching hospital B assumes an entire internal medicine program with 20 FTEs from closed hospital A, no temporary FTE cap adjustment under § 413.79(h) would be needed for those internal medicine residents, and teaching hospital B would immediately receive a permanent FTE resident cap increase of 10 FTE residents. Similarly, in the case where an applying hospital fits within Ranking Criterion Two, we are proposing to revise the existing regulations at § 413.79(h) limiting temporary cap adjustments for displaced residents *by the number of FTE residents that the applying hospital received under the terms of the affiliation agreement from the closed hospital.* We are proposing to immediately assign permanently that number of FTE slots to the qualifying hospital. For example, if teaching hospital D had received 30 FTE slots from closed hospital C under the terms of a Medicare GME affiliation agreement for the purposes of a shared rotational arrangement (as defined at § 413.75(b)) for a general surgery program, teaching hospital D would immediately receive a permanent FTE resident cap increase of 30 FTE residents, which would enable hospital D to continue to receive direct GME and IME payment for its share of training 30 general surgery residents.

Lastly, in the case where an applying hospital fits within Ranking Criterion Three, we are proposing to revise § 413.79(h) to provide for temporary cap adjustments for displaced residents *by the number of displaced FTE residents the applying hospital takes in,* and to immediately assign permanently that number of FTE slots to the qualifying hospital. For example, if Hospital E takes in three FTE displaced residents in a family medicine program, and not only trains those three displaced residents until they complete their training, but permanently expands its existing family medicine program such that it will add three more FTEs in the place of three that completed their training, we would immediately assign three FTEs permanently to Hospital E, bypassing any temporary adjustment under § 413.79(h). Accordingly, there would be no duplication of FTE slots when distributing slots to hospitals that qualify under the first three ranking criteria.

If, after distributing the slots from a closed hospital to increase the FTE caps for applying hospitals that fall within Ranking Criteria One, Two, and Three, there are still excess slots available, it is possible that those excess slots might be associated with displaced residents for whom temporary cap adjustments under § 413.79(h) *are* necessary. That is, it is possible that in the case where applying hospitals do not permanently assume *all* of the closed hospital's residents and programs, temporary cap transfers under § 413.79(h) would be necessary to allow the remaining residents to complete their training. Therefore, we are proposing to distribute the slots accordingly to increase the FTE resident caps for hospitals that fall within Ranking Criteria Four through Seven. However, to avoid duplicate FTE counting, we would only permanently assign the slots to the qualified hospitals falling within Ranking Criteria Four through Seven once the displaced residents have completed their training and their temporary cap adjustments have expired.

We are proposing to add new regulations text at § 412.105(f)(1)(ix)(B) for IME and § 413.79(o)(2)) for direct GME to reflect the provisions of section 5506 of the Affordable Care Act. In addition, we have proposed some very minor changes to direct GME and IME existing text in order to clarify meaning and standardize the terminology that is used throughout.

8. Other Payment Issues Regarding Hospitals That Receive Increase in FTE Caps Based on Slots From Closed Hospitals

We note that section 1886(h)(4)(H)(vi) of the Act, as added by the Affordable Care Act, makes no reference to section 1886(h)(4)(G) or 1886(d)(5)(B)(vi)(II) of

the Act, which are the provisions concerning the rolling average count of FTE residents. Furthermore, there is no mention of section 1886(d)(5)(B)(vi)(I) of the Act, the provision regarding the cap on the IME resident-to-bed ratio, in section 1886(h)(4)(H)(vi) either. That is, the statute does not provide for an exclusion from application of the rolling average for residents counted as a result of FTE cap increases under section 1886(h)(4)(H)(vi) of the Act, nor does the statute exempt these residents from the application of the cap on the IME resident-to-bed ratio. In light of the absence of a specific directive in section 1886(h)(4)(H)(vi) of the Act exempting those residents from application of the rolling average for direct GME and IME, and the cap on the IME resident-to-bed ratio, and with no apparent reason to treat residents counted as a result of the FTE cap increases under section (h)(4)(H)(vi) of the Act differently, we are proposing to require that if a hospital increases its direct GME or IME FTE count of residents as a result of an FTE resident cap increase under section 1886(h)(4)(H)(vi) of the Act, those FTE residents would be immediately subject to the rolling average calculation and the cap on the IME resident-to-bed ratio.

We also note that section 1886(h)(4)(H)(vi) of the Act for direct GME and section 1886(d)(5)(B)(v) of the Act for IME does not specify use of a special direct GME PRA or IME multiplier for residents counted by a hospital under an FTE cap increase received after the closure of another hospital. Therefore, we are proposing that residents counted by a hospital under a permanent adjustment to the hospital's FTE resident caps under the provisions of section 5506 of the Affordable Care Act would be paid for using the receiving hospital's otherwise applicable direct GME PRA (which is hospital-specific) and IME multiplier (which is the same for all hospitals). Further, as we have proposed with respect to FTE resident cap increases awarded under section 5503 (section XVII.D. of this proposed rule), we are proposing that these slots may not be used as part of the aggregate FTE resident cap under a Medicare GME affiliation agreement. We believe this prohibition is appropriate given that the receiving hospital has demonstrated that it needs the additional slots, and therefore, those slots should remain at the receiving hospital.

9. Application—No Reopening of Settled Cost Reports

Section 5506(c) of the Affordable Care Act specifies that the changes made by the provisions of sections 5506(a) and (b) should not be applied in a manner that would require the reopening of settled cost reports for which there is not a pending, jurisdictionally proper appeal on direct GME or IME payments as of March 23, 2010 (the date of the enactment of Pub. L. 111–148). Such language would typically be appropriate for a provision with a retroactive effective date (such as section 5505), and since section 5506 does not have a retroactive effective date, we are unsure of the purpose of this language in section 5506. Nevertheless, we are proposing to reflect this provision in the proposed revisions under § 412.105(f)(1)(ix)(B), and § 413.79(o)(2)(ii) of the regulations. In addition, as we explained previously regarding sections 5504 and 5505, we are proposing to interpret "pending, jurisdictionally proper appeal on direct GME or IME payments" to mean that in order for a hospital to request a change to its FTE count, direct GME or IME respectively, the "pending, jurisdictionally proper appeal" must be specific to direct GME or IME respectively. For example, in order for a hospital to increase its FTE count with regard to an Affordable Care Act provision that is unique to IME (such as inclusion in the IME count of didactic time occurring in the hospital as specified by new section 1886(d)(5)(B)(x)(II)), the hospital's "pending, jurisdictionally proper appeal" must be on an IME issue; IME FTEs or the available bed count. However, if the hospital's "pending, jurisdictionally proper appeal" is on an issue that only affects direct GME payments, such as the initial residency period or the Medicare patient load, that appeal would not be sufficient in order for the hospital to increase its FTE count with regard to an Affordable Care Act provision that is unique to IME, such as didactic time in the hospital setting.

BILLING CODE 4120–01–P

CMS Evaluation Form
As Part of the Application for the Increase in a Hospital's FTE Cap(s) Under Section 5506 of the Affordable Care Act: Preservation of FTE Cap Slots from Teaching Hospitals that Close

Directions: Please fill out the information below for each residency program for which the applicant hospital intends to use the increase in its FTE cap(s). The applicant hospital is responsible for complying with the other requirements listed in the CY 2011 Hospital Outpatient Prospective Payment System rule in order to complete its application for the increase in its FTE cap(s) under section 5506 of Public Law 111-148.

NAME OF HOSPITAL: _____

MEDICARE PROVIDER NUMBER: _____

NAME OF MEDICARE CONTRACTOR: _____

NAME OF SPECIALTY TRAINING PROGRAM: _____

(Check one): □ Allopathic Program □ Osteopathic Program

NUMBER OF FTE SLOTS REQUESTED FOR PROGRAM:

Direct GME: _____ **IME:** _____

Section A: Demonstrated Likelihood of Filling the FTE Slots

Demonstrated Likelihood: Hospital must provide documentation to demonstrate the likelihood of filling requested slots under section 5506 within 3 years. For example, the applying hospital would document that it does not have sufficient room under its FTE resident caps to take in the additional residents, and has approval from the relevant accrediting body to take over the closed hospital's residency program(s), or expand its own residency program(s) to reflect a permanent commitment to train additional residents.

(1) Hospital will establish this newly approved residency program or will expand an existing residency program. **(The hospital must check at least one of the following, if applicable.)**

☐ Application for approval of the new residency program has been submitted to the ACGME, AOA or the ABMS. **(The hospital must attach a copy.)**

☐ The hospital has submitted an institutional review document or program information form concerning the new program in an application for approval of the new program. **(The hospital must attach a copy.)**

☐ The hospital has received written correspondence from the ACGME, AOA or ABMS acknowledging receipt of the application for the new or expanded program, or other types of communication from the accrediting bodies concerning the new program approval process (such as notification of site visit). **(The hospital must attach a copy.)**

(2) Hospital does not have sufficient room under its direct GME FTE cap or IME FTE cap, or both, and has or is seeking approval from the relevant accrediting body to take over the closed hospital's residency program(s), or expand its own residency program(s) to reflect a permanent commitment to train additional residents. **(The hospital must check at least one of the following, if applicable.)**

☐ Application for approval of the residency program has been submitted to the ACGME, AOA or the ABMS. **(The hospital must attach a copy.)**

☐ The hospital has submitted an institutional review document or program information form concerning the program in an application for approval of the program. **(The hospital must attach a copy.)**

☐ The hospital has received written correspondence from the ACGME, AOA or ABMS acknowledging receipt of the application for the program, or other types of communication from the accrediting bodies concerning the program approval process (such as notification of site visit). **(The hospital must attach a copy.)**

(3) Hospital will likely fill the slots requested. **(The hospital must check the following, if applicable.)**

☐ The hospital does not have sufficient room under its direct GME FTE cap or IME FTE cap, or both. **(Copies of EACH of the following must be attached.)**

- Copies of the Medicare cost reports that have been most recently submitted to the Medicare contractor documenting on Worksheet E, Part A, Worksheet E-3, Part VI, and Worksheet E-3, Part VI the resident counts and FTE resident caps for both direct GME and IME for the relevant cost reporting periods.

- Copies of the most recent residency match information concerning the number of residents at the hospital in its existing programs.

- Copies of the most recent accreditation letters on all of the hospital's training programs in which the hospital trains and counts FTE residents for direct GME and IME.

(4) Applying hospital was listed as a participant of a Medicare GME affiliated group on the most recent Medicare GME affiliation agreement of which the closed hospital was a member before the hospital closed, and under the terms of that Medicare GME affiliation agreement, the applying hospital received slots from the hospital that closed, and the applying hospital will use the additional slots to continue to train at least the number of FTE residents it had trained under the terms of the Medicare GME affiliation agreement. **(Copies of EACH of the following must be attached.)**

- Copies of the most recent Medicare GME affiliation agreement of which the applying hospital and the closed hospital were a member of before the hospital closed.

- Copies of the Medicare cost reports that have been most recently submitted to the Medicare contractor documenting on Worksheet E, Part A, Worksheet E-3, Part VI, and Worksheet E-3, Part VI the resident counts and FTE resident caps for both direct GME and IME for the relevant cost reporting periods.

- Copies of the most recent accreditation letters for all of the hospital's training programs in which the hospital had a shared rotational arrangement (as defined at §413.75(b)) with the closed hospital.

Section B. Level Priority Category

(Place an "X" in the appropriate box that is applicable to the level priority category that describes the applicant hospital.)

a) □ First, to hospitals located in the same core-based statistical area (CBSA) as, or in a CBSA contiguous to, the hospital that closed.

b) □ Second, to hospitals located in the same State as the closed hospital.

c) □ Third, to hospitals located in the same region as the hospital that closed.

d) □ Fourth, if the slots have not yet been fully distributed, to qualifying hospitals in accordance with the criteria established under section 5503, "Distribution of Additional Residency Positions"

Section C. Evaluation Criteria

(Place an "X" in the box for each criterion that is appropriate for the applicant hospital and for the program for which the increase in the FTE cap is requested.)

□ Ranking Criterion One. *The applying hospital is requesting the increase in its FTE resident cap(s) because it is assuming (or assumed) an entire program (or programs) from the hospital that closed, and the applying hospital is continuing to operate the program(s) exactly as it had been operated by the hospital that closed (that is, same residents, same program director, same (or many of the same) teaching staff)*

□ Ranking Criterion Two. *The applying hospital was listed as a participant of a Medicare GME affiliated group on the most recent Medicare GME affiliation agreement of which the closed hospital was a member before the hospital closed, and under the terms of that Medicare GME affiliation agreement, the applying hospital received slots from the hospital that closed, and the applying hospital will use the additional slots to continue to train at least the number of FTE residents it had trained under the terms of the Medicare GME affiliation agreement.*

□ Ranking Criterion Three. *The applying hospital took in residents displaced by the closure of the hospital, but is not assuming an entire program or programs, and will*

use the additional slots to continue training residents in the same programs as the displaced residents, even after those displaced residents complete their training (that is, the applying hospital is permanently expanding its own existing programs).

☐ Ranking Criterion Four.- *The applying hospital does not fit into Ranking Criteria 1, 2, or 3, and will use additional slots to establish a new or expand an existing geriatrics residency program.*

☐ Ranking Criterion Five.- *The applying hospital does not fit into Ranking Criteria 1, 2, or 3, is located in a Primary Care HPSA, and will use all the additional slots to establish a new or expand an existing primary care residency program.*

☐ Ranking Criterion Six.- *The applying hospital does not fit into Ranking Criteria 1, 2, or 3, and will use all the additional slots to establish a new or expand an existing primary care residency program.*

☐ Ranking Criterion Seven.- *The applying hospital does not fit into Ranking Criteria 1, 2, or 3, and will use all the additional slots to establish a new or expand an existing general surgery residency program.*

☐ Ranking Criterion Eight.- *The applying hospital does not fit into Ranking Criteria 1 through 7.*

Application Process and CMS Central Office and Regional Office Mailing Addresses for Receiving Increases in FTE Resident Caps

BILLING CODE 4120–01–C

In order for hospitals to be considered for increases in their FTE resident caps, each qualifying hospital must submit a timely application. The following information must be submitted on applications to receive an increase in FTE resident caps:

- The name and Medicare provider number, and Medicare contractor (to which the hospital submits its cost report) of the hospital.
- The total number of requested FTE resident slots for direct GME or IME, or both.
- A completed copy of the CMS Evaluation Form for each residency program for which the hospital intends to use the requested increase in FTE residents.
- Source documentation to support the assertions made by the hospital on the CMS Evaluation Form.
- FTE resident counts for direct GME and IME and FTE resident caps for direct GME and IME reported by the hospital in the most recent as-filed cost report. (Include copies of Worksheets E, Part A, E–3, Part IV, *and if a hospital received an increase to its FTE cap(s) under section 422 of the MMA,* a copy of E–3, Part VI).
- An attestation, signed and dated by an officer or administrator of the hospital who signs the hospital's Medicare cost report, of the following information:

"I hereby certify that I understand that misrepresentation or falsification of any information contained in this application may be punishable by criminal, civil, and administrative action, fine and/or imprisonment under federal law. Furthermore, I understand that if services identified in this application were provided or procured through payment directly or indirectly of a kickback or where otherwise illegal, criminal, civil, and administrative action, fines and/or imprisonment may result. I also certify that, to the best of my knowledge and belief, it is a true, correct, and complete application prepared from the

books and records of the hospital in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding Medicare payment to hospitals for the training of interns and residents."

The completed application and supporting documentation (as described above) must be submitted to the CMS Central Office and the CMS Regional Office for the region in which the applicant hospital is located. The addresses of the CMS Central Office and Regional Offices are listed below.

CMS Central and CMS Regional Office Mailing Addresses for Applications for Increases in FTE Resident Caps

Central Office

Centers for Medicare and Medicaid Services (CMS)
Director, Division of Acute Care
7500 Security Boulevard
Mail Stop C4–08–06
Baltimore, Maryland 21244
(410) 786–4548

Region I (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont)

Centers for Medicare and Medicaid Services (CMS)
Associate Regional Administrator, Division of Financial Management and Fee for Service Operations
Region I
JFK Federal Building
Room 23275
Boston, MA 02203
Phone: (617) 565–1331

Region II (New York, New Jersey, U.S. Virgin Islands, and Puerto Rico)

Centers for Medicare and Medicaid Services (CMS)
Associate Regional Administrator, Division of Financial Management and Fee for Service Operations
Region II
26 Federal Plaza, 38th Floor
New York, NY 10278
Phone: (212) 616–2545

Region III (Delaware, Maryland, Pennsylvania, Virginia and West Virginia, and the District of Columbia)

Centers for Medicare and Medicaid Services (CMS)
Associate Regional Administrator, Division of Financial Management and Fee for Service Operations
Region III
Public Ledger Building, Suite 216
150 South Independence Mall West
Philadelphia, PA 19106
Phone: (215) 861–4140

Region IV (Alabama, North Carolina, South Carolina, Florida, Georgia, Kentucky, Mississippi, and Tennessee)

Centers for Medicare and Medicaid Services (CMS)
Associate Regional Administrator, Division of Financial Management and Fee for Service Operations
Region IV
Atlanta Federal Center
61 Forsyth Street, S.W., Suite 4T20
Atlanta, GA 30303–8909
Phone: (404) 562–7300

Region V (Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin)

Centers for Medicare and Medicaid Services (CMS)
Associate Regional Administrator, Division of Financial Management and Fee for Service Operations
Region V
233 North Michigan Avenue, Suite 600
Chicago, IL 60601
Phone: (312) 886–6432

Region VI (Arkansas, Louisiana, New Mexico, Oklahoma, and Texas)

Centers for Medicare and Medicaid Services (CMS)
Associate Regional Administrator, Division of Financial Management and Fee for Service Operations
Region VI
1301 Young Street, Suite 714
Dallas, TX 75202
Phone: (214) 767–6423

Region VII (Iowa, Kansas, Missouri, and Nebraska)

Centers for Medicare and Medicaid Services (CMS)
Associate Regional Administrator, Division of Financial Management and Fee for Service Operations
Region VII
Richard Bolling Federal Building
Room 235
601 East 12th Street
Kansas City, MO 64106
(816) 564–1843

Region VIII (Colorado, Montana, North Dakota, South Dakota, Utah and Wyoming)

Centers for Medicare and Medicaid Services (CMS)
Associate Regional Administrator, Division of Financial Management and Fee for Service Operations
Region VIII
Colorado State Bank Building
1600 Broadway, Suite 700
Denver, CO 80202
Phone: (303) 844–2111

Region IX (Arizona, California, Hawaii, and Nevada and Territories of American Samoa, Guam and the Commonwealth of the Northern Mariana Islands)

Centers for Medicare and Medicaid Services (CMS)
Associate Regional Administrator, Division of Financial Management and Fee for Service Operations
Region IX
90 7th Street, Suite 5–300 (SW)
San Francisco, CA 94103–6708
Phone: (415) 744–3501

Region X (Alaska, Idaho, Oregon, and Washington)

Centers for Medicare and Medicaid Services (CMS)
Associate Regional Administrator, Division of Financial Management and Fee for Service Operations
Region X
2201 Sixth Avenue, MS/RX–46
Seattle, WA 98121
Phone: (206) 615–2094

XVIII. Proposed Changes to Whole Hospital and Rural Provider Exceptions to the Physician Self-Referral Prohibition and Related Changes to Provider Agreement Regulations

A. Background

Section 1877 of the Act, also known as the physician self-referral law: (1) Prohibits a physician from making referrals for certain "designated health services" (DHS) payable by Medicare to an entity with which he or she (or an immediate family member) has a financial relationship (ownership or compensation), unless an exception applies; and (2) prohibits the entity from filing claims with Medicare (or billing another individual, entity, or third party payer) for those DHS furnished as a result of a prohibited referral. The Act establishes a number of specific exceptions and grants the Secretary the authority to create regulatory exceptions that pose no risk of program or patient abuse.

Section 1877(d) of the Act sets forth additional exceptions related to ownership or investment interests held by a physician (or an immediate family member of a physician) in an entity that furnishes DHS. Section 1877(d)(1) of the Act provides that an ownership or investment interest in a hospital located in Puerto Rico shall not be considered to be an ownership or investment interest. Section 1877(d)(2) of the Act provides an exception for ownership or investment interests in rural providers. In order for an entity to qualify for the exception, the DHS must be furnished in a rural area (as defined in section 1886(d)(2) of the Act) and substantially

all of the DHS furnished by the entity are furnished to individuals residing in a rural area. Section 1877(d)(3) of the Act provides an exception, known as the "whole hospital" exception, for ownership or investment interests in a hospital located outside of Puerto Rico, provided that the referring physician is authorized to perform services at the hospital and the ownership or investment interest is in the hospital itself (and not merely in a subdivision of the hospital).

B. Changes Made by the Affordable Care Act Relating to the Whole Hospital and Rural Provider Exceptions to Ownership and Investment Prohibition

Section 6001(a) of the Affordable Care Act amended the whole hospital and rural provider exceptions to impose additional restrictions on physician ownership or investment in hospitals to qualify for such exceptions. The statute defines a "physician owner or investor" in a hospital as a physician or an immediate family member of a physician who has a direct or indirect ownership or investment interest in the hospital. We will refer to hospitals with such "physician owners or investors" as "physician-owned hospitals."

Section 6001(a)(2) of the Affordable Care Act provides that in order to satisfy the whole hospital exception, a physician-owned hospital must meet the requirements described in a new section 1877(i)(1) of the Act no later than September 23, 2011. Section 6001(a)(1) amended the rural provider exception to require that hospitals located in rural areas also satisfy the requirements of new section 1877(i)(1) of the Act no later than September 23, 2011.

Section 6001(a)(3) of the Affordable Care Act, as amended by the HCERA, sets forth the terms of new section 1877(i)(1) of the Act. Under section 1877(i)(1) of the Act, a hospital must:

(1) Have physician owners or investors and a provider agreement in effect no later than December 31, 2010;

(2) Not expand facility capacity beyond the number of operating rooms, procedure rooms, and beds for which the hospital was licensed as of March 23, 2010, unless an exception is granted by the Secretary;

(3) Comply with certain reporting and disclosure requirements and not condition any physician ownership or investment interests directly or indirectly on a physician making or influencing referrals to or generating other business for the hospital;

(4) Comply with certain requirements designed to ensure that all ownership and investment interests in the hospital are bona fide;

(5) Inform patients before admission if the hospital does not have a physician available on the premises during all hours and receive a signed acknowledgment that the patient understands this fact; and

(6) Not have been converted from an ASC on or after March 23, 2010.

In addition, section 1877(i)(2) of the Act requires the Secretary to collect, publish, and update on an annual basis on the CMS Web site (*http://www.cms.hhs.gov*) the physician and other ownership information submitted by hospitals under section 1877(i)(1)(C)(*i*) of the Act. Section 1877(i)(3) of the Act requires the Secretary to create an exception process related to the prohibition on expansion of facility capacity and publish in the **Federal Register** the final decision with respect to each applicant hospital.

Section 6001(b)(1) of the Affordable Care Act requires the Secretary to establish policies and procedures to ensure compliance with the requirements described in section 1877(i)(1) of the Act, which may include unannounced site reviews of hospitals. Section 6001(b)(2) of the Affordable Care Act requires the Secretary, beginning no later than May 1, 2012, to conduct audits to determine whether hospitals are in compliance with the requirements of new section 1877(i)(1).

As noted above, physician-owned hospitals must meet the requirements of new section 1877(i)(1) of the Act not later than 18 months after the date of enactment (that is, by September 23, 2011). We have received numerous inquiries concerning how this language relates to several of the requirements set forth in section 1877(i)(1) of the Act that specify earlier deadlines. We believe that compliance with all requirements must occur no later than September 23, 2011, and failure to satisfy earlier deadlines will preclude use of the revised exceptions after the earlier deadline has passed. For example, section 1877(i)(1)(A) of the Act provides that the hospital must have had physician ownership or investment on December 31, 2010, and a provider agreement in effect on that date. Failure to obtain a provider agreement that is effective on or before December 31, 2010, will preclude use of the revised rural provider and whole hospital exceptions on and after January 1, 2011. Another example can be seen in section 1877(i)(1)(D)(i) of the Act, which provides that the percentage of the total value of physician ownership or investment interests held in the hospital, in the aggregate, must not exceed such percentage as of March 23, 2010. Therefore, if a hospital has no physician ownership or investment as of March 23, 2010, and later adds physician owners or investors, the hospital will not satisfy the whole hospital and rural provider exceptions. Most of the provisions within section 1877(i)(1) of the Act do not specify an explicit deadline for compliance. Thus, we are proposing that the deadline for compliance with all provisions within section 1877(i)(1) of the Act that do not contain an explicit deadline is September 23, 2011, that is, 18 months after the date of enactment.

Below, we discuss changes we are proposing to make to our regulations in response to section 6001 of the Affordable Care Act, as amended.

C. Proposed Changes to Physician Self-Referral Regulations

In order to conform our regulations to the amendments made to the rural provider exception by section 6001(a)(1) of the Affordable Care Act, we are proposing to revise § 411.356(c)(1) to specify that, in the case where the rural provider is a hospital, the hospital must meet the requirements of proposed new § 411.362 no later than September 23, 2011.

Similarly, we are proposing to revise § 411.356(c)(3) to add a new paragraph (iv) that provides that the hospital must meet the requirements in new § 411.362 not later than September 23, 2011. In new § 411.362, we set forth the additional requirements for both exceptions as mandated by section 1877(i)(1) of the Act.

1. Physician Ownership and Provider Agreement

Section 1877(i)(1)(A) of the Act requires that, in order to use the rural provider and whole hospital exception under section 1877(D)(3)(d) of the Act, the hospital must have physician ownership or investment on December 31, 2010, and a provider agreement under section 1866 of the Act in effect on this date. We are proposing to incorporate these requirements in § 411.362(b)(1) of the regulations.

Section 1877(i)(5) of the Act defines a "physician owner or investor" as a physician (or an immediate family member of such physician) with a direct or an indirect ownership or investment interest in the hospital. We are proposing to incorporate this statutory definition in § 411.362(a)(1) of the regulations.

2. Limitation on Expansion of Facility Capacity

Section 1877(i)(1)(B) of the Act requires that the number of operating rooms, procedure rooms, and beds for which the hospital is licensed at any time on or after March 23, 2010, be no greater than the number of operating rooms, procedure rooms, and beds for which the hospital was licensed on that date. However, section 1877(i)(3)(C) of the Act authorizes the Secretary to permit a physician-owned hospital to increase capacity above its "baseline number of operating rooms, procedure rooms, and beds." Section 1877(i)(3)(C)(iii) of the Act, as amended by section 1106(2)(B) of the HCERA, defines the term "baseline number of operating rooms, procedure rooms, and beds" to mean "the number of operating rooms, procedure rooms, and beds for which the hospital is licensed as of [March 23, 2010] (or, in the case of a hospital that did not have a provider agreement in effect as of that date, but does have an agreement in effect on December 31, 2010, the effective date of such provider agreement)." Although section 1877(i)(1)(B) of the Act does not contain language regarding facility capacity as of the effective date of a provider agreement issued between March 23, 2010 and December 31, 2010, we must read sections 1877(i)(1)(B) and 1877(i)(3)(C)(iii) of the Act together and interpret them harmoniously. Accordingly, in proposed § 411.362(b)(2), we specify that the hospital will be limited to the number of operating rooms, procedure rooms, and beds for which the hospital is licensed on March 23, 2010, or if the hospital did not have a provider agreement in effect as of that date, but does have an agreement in effect on December 31, 2010, the effective date of such provider agreement.

The limitation on expansion of facility capacity applies to operating rooms, procedure rooms, and beds for which the hospital is licensed. It is important to note that the limitation on expansion applies to operating rooms and procedure rooms regardless of whether a State licenses these rooms. Referrals are prohibited if made by physician owners and investors after facility expansion and prior to the Secretary's granting of an exception to the capacity restriction. Exceptions for expanding facility capacity will protect only those referrals made after the exception is granted.

Section 1877(i)(3)(G) of the Act specifies that "the term 'procedure rooms' includes rooms in which catheterizations, angiographies, angiograms, and endoscopies are performed, except such term shall not include emergency rooms or departments (exclusive of rooms in which catheterizations, angiographies, angiograms, and endoscopies are performed)." Under our proposed definition of procedure rooms at § 411.362(a)(2), the term is limited to the types of rooms specified in the statute. Although the statute would permit us to define "procedure rooms" to include rooms where other services are performed, we are not proposing to do so at this time. We encourage public comments on whether "procedure rooms" should include rooms where additional services, such as CT or PET scans, or other services, are performed.

Section 1877(i)(3)(A) of the Act gives the Secretary until January 1, 2012, to promulgate regulations concerning the process for a hospital to apply for an exception and provides that the implementation of this process must be completed by February 1, 2012. We plan to issue a separate rulemaking document that will provide for implementation of this exceptions process.

3. Preventing Conflicts of Interest

Section 1877(i)(1)(C)(i) of the Act requires the hospital to submit to the Secretary an annual report containing a detailed description of the identity of each physician owner or investor and any other owners or investors of the hospital, and the nature and extent of all ownership and investment interests in the hospital. We plan to propose procedures for this reporting requirement in a separate rulemaking.

Section 1877(i)(1)(C)(ii)–(iv) of the Act requires hospitals to: (1) Develop procedures requiring a referring physician owner or investor to disclose (in time to permit the patient to make a meaningful decision about receipt of care) his or her ownership interest to the patient and, if applicable, the treating physician's ownership or investment interest; (2) not condition any physician ownership or investment interests either directly or indirectly on the physician making or influencing referrals to the hospital or otherwise generating business for the hospital; and (3) disclose on any public Web site for the hospital and in any public advertising that it is owned or invested in by physicians. Compliance with these three requirements must be achieved no later than September 23, 2011.

To incorporate these requirements into our regulations, we are proposing to: (1) Add § 411.362(b)(3)(ii)(A) to specify that a hospital must require each referring physician owner or investor to agree, as a condition of continued medical staff membership or admitting privileges, to provide written disclosure of his or her ownership or investment interest in the hospital (and, if applicable, the treating physician's ownership or investment interest in the hospital) to all patients the physician refers to the hospital, at the time the referral is made; (2) add § 411.362(b)(3)(ii)(B) to specify that a hospital may not condition any physician ownership or investment interests either directly or indirectly on the physician owner or investor making or influencing referrals to the hospital or otherwise generating business for the hospital; and (3) add § 411.362(b)(3)(ii)(C) to specify that the hospital must disclose on any public Web site for the hospital and in any public advertising that the hospital is owned or invested in by physicians.

Proposed § 411.362(b)(3)(ii)(A) defines the procedures that a hospital must have in place to require its physician owners and investors to make certain patient disclosures. We do not believe the disclosures to be made by physicians will be burdensome. For example, a physician owner or investor could provide a written, form notice to each patient that discloses the physician's ownership or investment interest in the hospital, informs the patient that his or her treating physician may have an ownership or investment interest in the hospital, and directs the patient to review an attached list identifying all other physician owners or investors in the hospital. This notice may be used by the patient to make a meaningful decision regarding his or her receipt of care.

We are soliciting public comments on several different issues relating to preventing conflicts of interest. First, we are seeking public comments on the benefits and drawbacks of our proposal, discussed above, relating to the procedures hospitals must have in place to require referring physician owners and investors to make the patient disclosures set forth in section 1877(i)(1)(C)(ii) of the Act. We are interested in receiving information about other methods and alternative approaches to address this issue and what should constitute sufficient hospital procedures to require such disclosures to a patient by a referring physician owner or investor.

Second, we are aware that a patient may have multiple conditions for which there are a variety of physician specialists who are responsible for different aspects of a patient's care, even though the statute refers to a single "treating physician." We are not

proposing to define "treating physician." We will consider treating physicians to be those physicians who are responsible for any aspect of a patient's care or treatment. We welcome public comments on this approach.

Finally, we encourage public comments on the methods a hospital should be required to use in disclosing its physician ownership or investment in public advertising pursuant to section 1877(i)(1)(C)(iv) of the Act. For example, we are interested in comments on whether a hospital should be required to disclose physician ownership or investment on its homepage, any particular page on its Web site (for example, an "About Us" page), or all pages on its Web site; the types of media that constitute, or do not constitute, public advertising; and whether a minimum font size should be required for the disclosure.

4. Ensuring *Bona Fide* Investment

Section 1877(i)(1)(D) of the Act sets forth seven different requirements related to ensuring *bona fide* investment in order for hospitals to qualify for the rural provider and whole hospital exceptions set forth in the physician self-referral law. First, the percentage of the total value of the ownership or investment interests held in the hospital, or in an entity whose assets include the hospital, by physician owners or investors in the aggregate may not exceed such percentage as of March 23, 2010. Second, any ownership or investment interests that the hospital offers to a physician owner or investor must not be offered on more favorable terms than the terms offered to a person who is not a physician owner or investor. Third, the hospital (or any owner or investor in the hospital) must not directly or indirectly provide loans or financing for any investment in the hospital by a physician owner or investor. Fourth, the hospital (or any owner or investor in the hospital) must not directly or indirectly guarantee a loan, make a payment toward a loan, or otherwise subsidize a loan, for any individual physician owner or investor or group of physician owners or investors that is related to acquiring any ownership or investment interest in the hospital. Fifth, ownership or investment returns must be distributed to each owner or investor in the hospital in an amount that is directly proportional to the ownership or investment interest of such owner or investor in the hospital. Sixth, physician owners and investors must not receive, directly or indirectly, any guaranteed receipt of or right to purchase other business interests related to the hospital, including the purchase or lease of any property under the control of other owners or investors in the hospital or located near the premises of the hospital. Lastly, the hospital must not offer a physician owner or investor the opportunity to purchase or lease any property under the control of the hospital or any other owner or investor in the hospital on more favorable terms than the terms offered to an individual who is not a physician owner or investor. We note that additional or different factors may be relevant to a determination of whether an investment is *bona fide* for purposes of complying with other laws, including fraud and abuse laws.

We are proposing to add § 411.362(b)(4) to incorporate these provisions in our regulations. We recognize that section 1877(i)(1)(A) of the Act provides that the hospital must have had physician ownership or investment on December 31, 2010, while section 1877(i)(1)(D)(i) of the Act assumes the existence of physician ownership or investment on March 23, 2010 and further provides that the percentage of the total value of physician ownership or investment interests held in the hospital, in the aggregate, on that date must not increase. Reading these provisions together, we conclude the following: (i) If a hospital had no physician ownership or investment as of March 23, 2010, it will not qualify for the whole hospital or rural provider exceptions if it adds any physician owners or investors after that date; and (ii) if a hospital had physician ownership or investment as of March 23, 2010, it may reduce the number of physician owners or investors, provided that the percentage of the total value of physician ownership or investment interests, in the aggregate, remains the same or decreases.

The second through seventh requirements tied to ensuring *bona fide* investment (sections 1877(i)(1)(D)(ii) through 1877(i)(1)(D)(vii) of the Act) do not specify any deadlines for compliance. Accordingly, compliance with the second through seventh requirements must be achieved no later than September 23, 2011.

If we determine that further guidance related to any aspect of section 1877(i)(1)(D) of the Act is necessary, we will provide clarification in future rulemaking. Furthermore, a hospital may request an advisory opinion (pursuant to §§ 411.370 through 411.389) for a determination of whether an existing or proposed arrangement meets the requirements for hospitals to ensure that investment is *bona fide*.

5. Patient Safety

Section 1877(i)(1)(E) of the Act, as added by the Affordable Care Act, requires a hospital that is owned or invested in by physicians to disclose to a patient before admission if it does not have a physician available on the premises to provide services during all hours that the hospital is providing services to such patient. Following this disclosure, the hospital must receive a signed acknowledgment of such fact from the patient. In addition, the hospital must have the capacity to provide assessment and initial treatment for patients and refer and transfer such patients to hospitals with the capability to treat the patients involved. We see no reason to treat the safety of inpatients differently than outpatients. Accordingly, given the language and purpose of the statute, we propose to apply these patient safety requirements to inpatients as well as outpatients. Hospitals must meet these requirements no later than September 23, 2011. We are proposing to incorporate these provisions into our regulations at § 411.362(b)(5).

6. Conversion From ASC

Section 1877(i)(1)(F) of the Act, as added by the Affordable Care Act, also prohibits the use of the rural provider and whole hospital exceptions by physician-owned hospitals that were converted from an ASC to a hospital on or after March 23, 2010. We are proposing to add § 411.362(b)(6) to reflect this provision in our regulations.

7. Publication of Information Reported

As discussed in section XVIII.B. of this proposed rule, section 1877(i)(1)(C) of the Act, as added by the Affordable Care Act, requires the hospital to submit to the Secretary an annual report containing a detailed description of the identity of each physician owner or investor and any other owners or investors of the hospital and the nature and extent of all ownership and investment interests in the hospital. The process for collecting this information must be determined no later than September 23, 2011. Section 1877(i)(2) of the Act requires that the Secretary publish, and update on an annual basis, the information submitted by hospitals under section 1877(i)(1)(C) of the Act on the CMS Web site. As with the annual report requirement set forth in section XVIII.B. of this proposed rule, we are not making a proposal related to this provision at this time.

8. Enforcement

Section 6001(b)(1) of the Affordable Care Act requires the Secretary to

establish policies and procedures to ensure compliance with the requirements described in section 1877(i) of the Act, and states that these policies and procedures may include unannounced site reviews of hospitals. Section 6001(b)(2) of the Affordable Care Act requires the Secretary, beginning not later than May 1, 2012, to conduct audits to determine if physician-owned hospitals are in compliance with section 1877(i)(1) of the Act. We will comply with the statutory mandate, but are not proposing any regulations on this topic at this time.

D. Proposed Related Changes to Provider Agreement Regulations

Section 1866 of the Act states that a provider of services shall be qualified to participate in the Medicare program and shall be eligible for Medicare payments if it files a Medicare provider agreement and abides by the requirements applicable to Medicare provider agreements. These requirements are incorporated in our regulations at 42 CFR part 489, Subparts A and B (Provider Agreements and Supplier Approval). Section 1861(e) of the Act defines the term "hospital." Section 1861(e)(9) of the Act defines a hospital and authorizes the Secretary to establish requirements as determined necessary in the interest of patient health and safety. Section 5006 of the Deficit Reduction Act of 2005 mandated the Secretary to develop a strategic and implementing plan to address certain issues with respect to physician ownership of specialty hospitals. As part of that plan, we used our authority under sections 1866 and 1861(e)(9) of the Act (as well as our general rulemaking authority under sections 1102 and 1871 of the Act) to impose certain additional requirements on physician-owned hospitals as part of their provider agreements. These new requirements were established in the FY 2008 IPPS final rule with comment period (72 FR 47385 through 47391) and the FY 2009 IPPS final rule (73 FR 48686 through 48688).

Specifically, we amended the regulations at § 489.3 governing Medicare provider agreements to define a "physician-owned hospital" as any participating hospital (including a CAH) in which a physician or immediate family member of a physician has an ownership or investment interest, unless the ownership or investment interest satisfies the exceptions at § 411.356(a) or (b) regarding publicly-traded securities and mutual funds. In addition, we added a new provision at § 489.20(u)(1) to require a physician-owned hospital to agree to furnish patients with written notice, in a manner reasonably designed to be understood by all patients, that it is physician-owned and that the list of physician owners is available upon request. Further, we added a new provision at § 489.20(u)(2) to compel hospitals to require that all physician owners who are also members of the hospital's medical staff to disclose, in writing, their ownership interest in the hospital (and that of any immediate family member) to all patients they refer to the hospital, as a condition of continued medical staff membership. Patient disclosure is required at the time the physician makes a referral.

We also added a new provision to require that hospitals and CAHs: (1) Furnish all patients written notice at the beginning of their inpatient hospital stay or outpatient service if a doctor of medicine or a doctor of osteopathy is not present in the hospital 24 hours per day, 7 days per week; and (2) describe how the hospital or CAH will meet the medical needs of any patient who develops an emergency medical condition at a time when no physician is present in the hospital or CAH. These requirements are codified at § 489.20(w). The requirements of § 489.20(u) and (w) were made applicable to both inpatient hospital stays and outpatient services because, as we stated in the FY 2008 IPPS final rule with comment period, these provisions are in the interest of the health and safety of all individuals who receive services in these institutions. The notice requirements are intended to permit individuals to make more informed decisions regarding their treatment.

We are proposing to modify the Medicare provider agreement regulations in Subpart B of Part 489 in order to make the rules consistent with new § 411.362, as required by the Affordable Care Act. Furthermore, incorporating the additional requirements of the Affordable Care Act is in the best interest of the health and safety of individuals who receive services in hospitals and CAHs. With respect to § 489.20(u), we are proposing to: (1) Add a provision in § 489.20(u)(1)(ii) to specify that the hospital must disclose on any public Web site for the hospital and in any public advertising that it is owned or invested in by physicians; (2) amend § 489.20(u)(2) to specify that a referring physician owner or investor must also disclose in writing, if applicable, the treating physician's ownership or investment interest in the hospital; and (3) add § 489.20(u)(3) to specify that a hospital may not condition any physician ownership or investment interests either directly or indirectly on the physician making or influencing referrals to the hospital or otherwise generating business for the hospital.

Regarding § 489.20(w), we are proposing to specify that, in the case of a hospital where a doctor of medicine or a doctor of osteopathy is not present in the hospital 24 hours per day, 7 days per week, before admitting a patient or providing an outpatient service, the hospital must receive a signed acknowledgment from the patient stating that the patient understands that a physician may not be present during all hours services are rendered to the patient.

We encourage public comments on whether the changes to the provider agreement regulations (Part 489) are necessary or whether the amendments and additions made to the whole hospital and rural provider exceptions within subpart J of Part 411 of our regulations are sufficient to provide guidance relating to section 6001 of the Affordable Care Act.

XX. Files Available to the Public Via the Internet

A. Information in Addenda Related to the CY 2011 Hospital OPPS

Addenda A and B to this proposed rule provide various data pertaining to the proposed CY 2011 payment for items and services under the OPPS. Addendum A, which includes a list of all proposed APCs to be payable under the OPPS, and Addendum B, which includes a list of all active HCPCS codes with their proposed CY 2011 OPPS payment status and comment indicators, are available to the public by clicking "Hospital Outpatient Regulations and Notices" on the CMS Web site at: *http://www.cms.gov/HospitalOutpatientPPS/.*

For the convenience of the public, we also are including on the CMS Web site a table that displays the HCPCS code data in Addendum B sorted by proposed APC assignment, identified as Addendum C.

Addendum D1 defines the payment status indicators that we are proposing to use in Addenda A and B. Addendum D2 defines the comment indicators that we are proposing to use in Addendum B. Addendum E lists the proposed HCPCS codes that we propose would only be payable to hospitals as inpatient procedures and would not be payable under the OPPS. Addendum L contains the proposed out-migration wage adjustment for CY 2011. Addendum M lists the proposed HCPCS codes that would be members of a composite APC

and identifies the composite APC to which each would be assigned. This addendum also identifies the proposed status indicator for the HCPCS code and a proposed comment indicator if there is a proposed change in the code's status with regard to its membership in the composite APC. Each of the proposed HCPCS codes included in Addendum M has a single procedure payment APC, listed in Addendum B, to which it would be assigned when the criteria for assignment to the composite APC are not met. When the criteria for payment of the code through the composite APC are met, one unit of the composite APC payment is paid, thereby providing packaged payment for all services that are assigned to the composite APC according to the specific I/OCE logic that applies to the APC. We refer readers to the discussion of composite APCs in section II.A.2.e. of this proposed rule for a complete description of the composite APCs.

These addenda and other supporting OPPS data files are available on the CMS Web site at: *http://www.cms.gov/HospitalOutpatientPPS/.*

B. Information in Addenda Related to the CY 2011 ASC Payment System

Addenda AA and BB to this proposed rule provide various data pertaining to the proposed CY 2011 payment for the covered surgical procedures and covered ancillary services for which ASCs may receive separate payment. Addendum AA lists the proposed ASC covered surgical procedures and the proposed CY 2011 payment indicators and payment rates for each procedure. Addendum BB displays the proposed ASC covered ancillary services, and their proposed CY 2011 payment indicators and payment rates. All proposed ASC relative payment weights and payment rates for CY 2011 are a result of applying the revised ASC payment system methodology established in the final rule for the revised ASC payment system published in the **Federal Register** on August 2, 2007 (72 FR 42470 through 42548) to the CY 2011 OPPS and MPFS ratesetting information.

Addendum DD1 defines the proposed payment indicators that are used in Addenda AA and BB. Addendum DD2 defines the proposed comment indicators that are used in Addenda AA and BB.

Addendum EE (available only on the CMS Web site) lists the surgical procedures that we are proposing to exclude from Medicare payment if furnished in ASCs. The proposed excluded procedures listed in Addendum EE are surgical procedures that would be assigned to the OPPS inpatient list, would not be covered by Medicare, would be reported using a CPT unlisted code, or have been determined to pose a significant safety risk or are expected to require an overnight stay when performed in ASCs.

These addenda and other supporting ASC data files are included on the CMS Web site at: *http://www.cms.gov/ASCPayment/.* The MPFS data files are located at: *http://www.cms.gov/PhysicianFeeSched/.*

The links to all of the proposed FY 2011 IPPS wage index-related tables (that we are proposing to use for the CY 2011 OPPS) that were published in the June 2, 2010 supplemental FY 2011 IPPS/LTCH PPS proposed rule (75 FR 30918) are accessible on the CMS Web site at: *http://www.cms.gov/AcuteInpatientPPS/WIFN.*

XXI. Collection of Information Requirements

A. Legislative Requirement for Solicitation of Comments

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and to solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

B. Proposed Requirements Specified in the Regulation Text

This proposed rule contains the following proposed information collection requirements specified in regulatory text:

1. ICRs Regarding Redistribution of Medical Residency Slots

Existing regulations at § 413.78 outline the requirements for the determination of the total number of FTE residents in determining direct GME payments to hospitals. Section XVII.B.2.c. of the preamble of this proposed rule discusses the requirement for hospitals that share the costs of resident training in nonprovider settings, as permitted by the Affordable Care Act, to count a proportional share of the time and to record that proportion in a written agreement. We are proposing that this proportion must be included on a distinct written agreement for hospitals that pay nonhospital sites concurrently, without a written agreement as described in existing regulations. The burden associated with this requirement is the time and effort put forth by the hospital to prepare a written agreement. We estimate it would take one hospital 15 minutes to meet this requirement. Hospitals that already have a written agreement with a nonhospital site may include the proportion on that existing agreement.

In section XVII.B.2.d. of the preamble of this proposed rule, we discuss the requirement under the Affordable Care Act for hospitals to maintain records of the amount of time that their residents spend training in nonhospital sites, and to compare that time to the time spent by their residents in nonprovider sites in a base year as the Secretary may specify. We believe that a large part of the information that hospitals would be required to record for the purposes of this provision is contained in rotation schedules, which all hospitals are already required to maintain. Therefore, we do not believe that this requirement poses an undue administrative burden for the purposes of the PRA.

Existing regulations at § 412.105 and § 413.79 outline the requirements for the determination of the weighted number of FTE residents for IME and direct GME payments to hospitals. In sections XVII.B.4. and 5. of the preamble of this proposed rule, we discuss our proposals that a hospital seeking an adjustment to the limit on its unweighted resident count under section 5503 or section 5506 of the Affordable Care Act must provide documentation justifying the adjustment. Sections XVII.B.4. and 5. of the preamble of this proposed rule specify the information that a request would have to include. These requirements are exempt from the PRA in accordance with the provisions of the Affordable Care Act.

2. ICRs Regarding Basic Commitments of Providers (§ 489.20) and Additional Requirements Concerning Physician Ownership and Investment in Hospitals (§ 411.362)

Current § 489.20(u)(1) states that, in the case of a physician-owned hospital as defined in § 489.3, the hospital must furnish written notice to all patients at the beginning of their hospital stay or

outpatient visit that the hospital is a physician-owned facility. The burden associated with the requirements in this section is the time and effort necessary for a hospital to furnish written notice to all patients that the hospital is a physician-owned hospital. Whereas this requirement is subject to the PRA, the associated burden is currently approved under OMB control number 0938–1034, with an expiration date of February 28, 2011.

Our proposed amendment to § 489.20(u)(1) and proposed new § 411.362(b)(3)(ii)(C) would require disclosure by a hospital on any public Web site for the hospital and in any public advertising that the hospital is owned or invested in by physicians. The burden associated with this disclosure requirement is the time and effort necessary for hospitals to draft and post such a disclosure on their Web sites (where applicable) and to include such a disclosure in any existing or future public advertising that the hospitals may utilize. We estimate that 265 hospitals must comply with this requirement. In addition, we estimate that it will take each hospital 1 hour to develop and place this information on its Web site and/or in a public advertisement. The estimated annual hospital burden associated with placing the aforementioned information in Web sites, public advertisement, or both is 265 hours at a cost of $3,993.55. In addition, we estimate that it will take 30 minutes annually for a hospital to review and update the information contained in its Web site, public advertising or both. The estimated annual burden associated with the annual review and update of the information is 132.5 hours at a cost of $1,996.77.

Our proposed amendment to § 489.20(u)(2) and proposed new § 411.362(b)(3)(ii)(A) would require the hospital to have procedures in place to require that each referring physician agree, as a condition of his or her continued medical staff membership or admitting privileges, to provide written disclosure of his or her ownership or investment interest in the hospital (and, if applicable a treating physician's ownership or investment interest in the hospital) to all patients whom the physician refers to the hospital. These provisions impose a burden on both hospitals and physicians.

With respect to hospitals, the burden associated with this requirement is the time and effort necessary for hospitals to develop, draft, and implement changes to its medical staff bylaws and other policies governing admitting privileges. Approximately 265 hospitals would be required to comply with these requirements. We estimate that it will require a hospital's general counsel 2 hours to revise a hospital's medical staff bylaws and policies governing admitting privileges. Therefore, the total annual hospital burden would be 530 hours at a cost of $32,875.90.

With respect to physicians, the burden associated with this requirement is the time and effort necessary for a referring physician owner or investor to develop a list of all other physician owners or investors in the hospital and draft a form notice to patients that discloses the referring physician's ownership or investment interest in the hospital, informs the patient that a treating physician(s) of the patient may have an ownership or investment interest in the hospital, and directs the patient to review a list identifying all other physician owners or investors in the hospital. This list may be used by patients in making their health care decisions. Under existing § 489.20(u)(1), hospitals are currently required to provide a list of their physician owners or investors to patients upon request at the beginning of their inpatient stay or outpatient visit. Because hospitals already maintain lists of their owners and investors, we estimate that it will take each physician 1 hour annually to obtain such a list from the hospital, draft a disclosure notice, and make copies that will be distributed to patients. In addition, we estimate that it will take 30 seconds to provide the disclosure notice to each patient and an additional 30 seconds to record proof of disclosure in each patient's medical record.

Although we can estimate the number of physician-owned hospitals, we are unable to quantify the number of physicians (or their immediate family members) who possess an ownership or investment interest in hospitals. There are limited data available concerning physician ownership in hospitals. The studies to date, including those by CMS and the GAO, pertain to physician ownership in specialty hospitals (cardiac, orthopedic, and surgical hospitals). These specialty hospitals published data concerning the average percentage of shares of direct ownership by physicians (less than 2 percent), indirect ownership through group practices, and the aggregate percentage of physician ownership, but did not publish the number of physician owners in these types of hospitals. More importantly, § 489.20(u)(2) applies to physician ownership in any type of hospital. Our other research involved a review of enrollment data. However, the CMS Medicare enrollment application (CMS–855) requires physicians to report only those ownership interests that are 5 percent or more (direct or indirect), and thus, most physician ownership is not captured. While we acknowledge there is a burden associated with this ICR, we have no way to quantify this requirement's burden. Therefore, because we are unable to estimate the total physician burden associated with this reporting requirement, we are assigning 1 burden hour to this requirement and we are also seeking public comment pertaining to this burden allocation and will reevaluate this issue in the final rule stage of rulemaking.

Existing § 489.20(w) requires hospitals, as defined in § 489.24(b), to furnish all patients notice in accordance with § 482.13(b)(2), at the beginning of their hospital stay or outpatient visit if a doctor of medicine or a doctor of osteopathy is not present in the hospital 24 hours per day, 7 days per week. The notice must indicate how the hospital will meet the medical needs of any inpatient who develops an emergency medical condition, as defined in § 489.24(b), at a time when there is no physician present in the hospital. The burden associated with this requirement is the time and effort necessary for each hospital to develop a standard notice to furnish to its patients. Although this requirement is subject to the PRA, the associated burden is approved under OMB control number 0938–1034, with a current expiration date of February 28, 2011.

Our proposed new §§ 489.20(w)(2) and 411.362(b)(5)(i) would require that, following a hospital's disclosure to a patient that it does not have a physician available during all hours that the hospital is providing services to such patient, the hospital must obtain a signed acknowledgment from the patient stating that the patient understands that no physician is available for that period. The burden associated with this requirement is the time and effort necessary for each hospital to add an acknowledgment line to its current form, disclose the form to the patient, obtain the patient's signature, and copy and record the form in the patient's medical record. The requirements in proposed § 489.20(w) would apply to all hospitals (not just physician-owned hospitals), as defined in § 489.24(b). We estimate that there are approximately 2,557 hospitals and CAHs that may not have a physician on-site at all times. We estimate that it will take each hospital 30 minutes to amend its current disclosure form to add an acknowledgment line, an additional 30 seconds to obtain the patient's

signature, and an additional 30 seconds to include a copy of the notice in the patient's medical record. The estimated annual burden associated with developing an amended form, obtaining patient signatures, and copying and recording the form is 1,196,932.6 hours at a cost of $18,518,081.15.

C. Associated Information Collections Not Specified in Regulatory Text

In this proposed rule, we make reference to proposed associated information collection requirements that are not discussed in the regulation text contained in this document. The following is a discussion of those requirements.

1. Hospital Outpatient Quality Data Reporting Program (HOP QDRP)

As previously stated in section XVI. of this proposed rule, the quality data reporting program for hospital outpatient care, known as the Hospital Outpatient Quality Data Reporting Program (HOP QDRP), has been generally modeled after the quality data reporting program for hospital inpatient services, the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program. Section 109(a) of the MIEA–TRHCA (Pub. L. 109–432) amended section 1833(t) of the Act by adding a new subsection (17) which affects the annual payment update factor applicable to OPPS payments for services furnished by hospitals in outpatient settings on or after January 1, 2009. Section 1833(t)(17)(A) of the Act states that subsection (d) hospitals (as defined under section 1886(d)(1)(B) of the Act) that fail to report data required for the quality measures selected by the Secretary in the form and manner required by the Secretary under section 1833(t)(17)(B) of the Act will incur a 2.0 percentage point reduction to their annual payment update factor. Section 1833(t)(17)(B) of the Act requires that hospitals submit quality data in a form and manner, and at a time, that the Secretary specifies. Section 1833(t)(17)(A)(ii) of the Act specifies that any reduction would apply only to the payment year involved and would not be taken into account in computing the applicable annual payment update factor for a subsequent payment year. Section 1833(t)(17)(C)(i) of the Act requires the Secretary to develop measures appropriate for the measurement of the quality of care (including medication errors) furnished by hospitals in outpatient settings, that these measures reflect consensus among affected parties and, to the extent feasible and practicable, that these measures include measures set forth by one or more national consensus building entities.

2. HOP QDRP Quality Measures for the CY 2012, CY 2013 and CY 2014 Payment Determinations

In the CY 2009 final rule with comment period (73 FR 68766), we retained the seven chart-abstracted measure we used in CY 2009 and adopted 4 new claims-based imaging measures for use in CY 2010, bringing the total number to 11 measures. In the CY 2010 OPPS/ASC final rule with comment period (74 FR 60637), we adopted the same 11 measures and the same data submission requirements related to the 7 data abstracted measures for CY 2011 payment determinations. For the CY 2012 payment update, we are proposing that hospitals continue to submit data for the existing 7 chart-abstracted measures (we would continue to use the 4 claims-based measures) and to add 1 new chart-abstracted AMI measure, 4 additional claims-based imaging efficiency measures, and 1 structural measure regarding Health IT. These 17 measures are listed in the table below. For the CY 2013 payment determination, we are proposing that hospitals continue to submit data for all of the nonclaims-based measures previously adopted for the CY 2012 payment determination (we would continue to use the claims-based measures previously adopted), and to adopt 1 new structural measure on tracking clinical results, and 6 new chart-abstracted measures for the CY 2013 payment determination on the topics of HOPD care transitions, and ED efficiency, for a total of 24 measures. For the CY 2014 payment determination, we are proposing that hospitals continue to submit data for all of the measures previously adopted for the CY 2013 payment determination (we would continue to use the claims-based measures previously adopted), and to adopt 6 new chart-abstracted measures on the topics of diabetes care and exposure time for procedures using fluoroscopy, for a total of 30 measures. These proposed measures are listed below.

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Proposed HOP QDRP Measurement Sets to be Used for the CY 2012, CY 2013 and CY 2014 Payment Determinations
OP-1: Median Time to Fibrinolysis
OP-2: Fibrinolytic Therapy Received Within 30 Minutes
OP-3: Median Time to Transfer to Another Facility for Acute Coronary Intervention
OP-4: Aspirin at Arrival
OP-5: Median Time to ECG
OP-6: Timing of Antibiotic Prophylaxis
OP-7: Prophylactic Antibiotic Selection for Surgical Patients
OP-8: MRI Lumbar Spine for Low Back Pain
OP-9: Mammography Follow-up Rates
OP-10: Abdomen CT – Use of Contrast Material
OP-11: Thorax CT – Use of Contrast Material
The Ability for Providers with HIT to Receive Laboratory Data Electronically Directly into their Qualified/Certified EHR System as Discrete Searchable Data*
Preoperative Evaluation for Low Risk Non Cardiac Surgery Risk Assessment*
Use of Stress Echocardiography, SPECT MPI, and Cardiac Stress MRI post CABG*
Simultaneous Use of Brain Computed Tomography (CT) and Sinus Computed Tomography (CT)*
Use of Brain Computed Tomography (CT) in the Emergency Department for Atraumatic Headache*
Troponin Results for Emergency Department acute myocardial infarction (AMI) patients or chest pain patients (with *Probable Cardiac Chest Pain*) Received within 60 minutes of arrival *
Median Time from ED Arrival to ED Departure for Discharged ED Patients**
Transition Record with Specified Elements Received by Discharged Patients**
Tracking Clinical Results between Visits**
Door to Diagnostic Evaluation by a Qualified Medical Professional**
ED- Median Time to Pain Management for Long Bone Fracture **
ED- Patient Left Before Being Seen**
ED- Head CT Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke who Received Head CT Scan Interpretation Within 45 minutes of Arrival **
Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetic Patients***
Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetic Patients***
Diabetes Mellitus: High Blood Pressure Control in Diabetic Patients***
Diabetes Mellitus: Dilated Eye Exam in Diabetic Patients***
Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients***
Exposure Time Reported for Procedures Using Fluoroscopy***

* Proposed new measure for CY 2012 payment determination.

** Proposed new measure for CY 2013 payment determination.

*** Proposed new measure for CY 2014 payment determination.

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For the CY 2012 payment determination, hospitals would submit data related to the 8 chart-abstracted measures and we would calculate the 8 claims-based measures using administrative paid claims data and not require additional hospital data submissions. For the structural measure, hospitals would enter data into a Web-based collection tool.

As part of the data submission process pertaining to the 17 measures listed above for the CY 2012 payment determination, hospitals must also complete and submit a notice of participation in the HOP QDRP. By submitting this document, hospitals agree that they will allow CMS to publicly report the quality measures as required by the HOP QDRP.

For the CY 2012 payment determination, the burden associated with this section is the time and effort associated with completing the notice of participation as well as collecting and submitting the data on the eight data abstracted measures and the one structural measure. We estimate that there will be approximately 3,200 respondents per year. For hospitals to collect and submit the information on the required measures, we estimate it will take 35 minutes per sampled case. We estimate there will be a total of 930,000 cases per year, approximately 290 cases per year per respondent. The estimated annual burden associated with the aforementioned submission requirements for chart-abstracted data is 542,500 hours (930,000 cases per year × 0.583 hours/case). For the structural measure, we estimate that it will require 10 minutes per hospital for one instance per year; the estimated annual burden associated with this requirement is 533 hours (3,200 hospitals × 0.167 hours per hospital).

We invite public comment on the burden associated with these information collection requirements.

3. Proposed HOP QDRP Validation Requirements

In addition to requirements for submitting of quality data, hospitals must also comply with the requirements for data validation in CY 2012. Similar to our proposed policy for the FY 2012 RHQDAPU program (75 FR 23991 through 23993), we are proposing to validate data from 800 randomly selected hospitals each year under the HOP QDRP, beginning with the CY 2012 payment determination. We note that, because the 800 hospitals would be selected randomly, every HOP QDRP-participating hospital would be eligible each year for validation selection. For each selected hospital, we would randomly select up to 48 patient episodes of care per year (12 per quarter) for validation purposes from the total number of cases that the hospital successfully submitted to the OPPS Clinical Warehouse during the applicable time period. However, if a selected hospital has submitted less than 12 cases in one or more quarters, only those cases available will be validated.

The burden associated with the proposed CY 2012 requirement is the time and effort necessary to submit validation data to a CMS contractor. We estimate that it will take each of the 800 sampled hospitals approximately 12 hours to comply with these data submission requirements. To comply with the requirements, we estimate each hospital must submit 48 cases for the affected year for review. We estimate that 800 hospitals must comply with these requirements to submit a total of 38,400 charts across all sampled hospitals. The estimated annual burden associated with the data validation process for CY 2012 and subsequent years is 9,600 hours.

We invite public comment on this information collection requirement.

4. Proposed HOP QDRP Reconsideration and Appeals Procedures

In the CY 2009 OPPS/ASC final rule with comment period (73 FR 68779), we adopted a mandatory reconsideration process that will apply to the CY 2010 payment decisions. In the CY 2010 OPPS/ASC final rule with comment period (74 FR 60654 through 60655), we continued this process for the CY 2011 payment update. We are proposing to continue this process for the CY 2012 payment update with some modifications. We have proposed to eliminate a requirement that the reconsideration request form be signed by the hospital CEO to facilitate electronic submission of the form and reduce hospital burden. Under this proposed process, the hospitals would be required to meet all of the requirements specified in section XVI.E. of this proposed rule. While there is burden associated with filing a reconsideration request, section 5 CFR 1320.4 of the Paperwork Reduction Act of 1995 excludes collection activities during the conduct of administrative actions such as redeterminations, reconsiderations, and/or appeals. Specifically, these actions are taken after the initial determination or denial of payment.

5. Additional Topics

While we are seeking OMB approval for the information collection requirements associated with the HOP QDRP and the data validation processes, we also are seeking public comment on several issues that may ultimately affect the burden associated with HOP QDRP and the data validation processes. Specifically, this proposed rule lists proposed quality measures for CY 2012 through CY 2014 payment determinations as well as other possible quality measures under consideration for CY 2013 and subsequent years. We also are soliciting public comments to explore the use of registries to comply with the HOP QDRP submission requirements, the use of EHRs as a data submission tool, the use of a standardized process for the retirement of HOP QDRP quality measures, the continued use of an extraordinary circumstance extension or waiver for reporting quality data, and the implementation of additional data validation conditions.

If you comment on these information collection and recordkeeping requirements, please do either of the following:

1. Submit your comments electronically as specified in the **ADDRESSES** section of this proposed rule; or

2. Submit your comments to the Office of Information and Regulatory Affairs, Office of Management and Budget,

Attention: CMS Desk Officer, (CMS–1504–P)

Fax: (202) 395–6974; or

E-mail: *OIRA_submission@omb.eop.gov*.

XXII. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this proposed rule, and, when we proceed with a subsequent document(s), we will respond to those comments in the preamble to that document(s).

XXIII. Regulatory Impact Analysis

A. Overall Impact

We have examined the impacts of this proposed rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), Executive Order 13132 on Federalism, and the Congressional Review Act (5 U.S.C. 804(2)).

1. Executive Order 12866

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules that have economically significant effects ($100 million or more in any 1 year) or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal government or communities (58 FR 51741).

We estimate that the effects of the OPPS provisions that would be implemented by this proposed rule would result in expenditures exceeding $100 million in any 1 year. We estimate the total increase (from proposed changes in this proposed rule as well as enrollment, utilization, and case-mix changes) in expenditures under the OPPS for CY 2011 compared to CY 2010 to be approximately $3.9 billion. Because this proposed rule for the OPPS is "economically significant" as measured by the $100 million threshold and also a major rule under the Congressional Review Act, we have prepared a regulatory impact analysis that, to the best of our ability, presents the costs and benefits of this rulemaking. Table 55 of this proposed rule displays the redistributional impact of the CY 2011 proposed changes on OPPS payment to various groups of hospitals.

We estimate that the effects of the ASC provisions that would be implemented by this proposed rule for the ASC payment system would not exceed $100 million in any 1 year and, therefore, are not economically significant. We estimate the total increase (from proposed changes in this proposed rule as well as enrollment, utilization, and case-mix changes) in expenditures under the ASC payment system for CY 2011 compared to CY 2010 to be approximately $0. However, because this proposed rule for the ASC payment system substantially affects ASCs, we have prepared a regulatory impact analysis of changes to the ASC payment system that, to the best of our ability, presents the costs and benefits of this rulemaking. Table 57 and Table 58 of this proposed rule display the redistributional impact of the CY 2011 changes on ASC payment, grouped by specialty area and then grouped by procedures with the greatest ASC expenditures, respectively.

2. Regulatory Flexibility Act (RFA)

The RFA requires agencies to analyze options for regulatory relief of small businesses if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Many hospitals, other providers, ASCs, and other suppliers are considered to be small entities, either by being nonprofit organizations or by meeting the Small Business Administration (SBA) definition of a small business (hospitals having revenues of $34.5 million or less in any 1 year and ASCs having revenues of $10 million or less in any 1 year). (For details on the latest standards for health care providers, we refer readers to the SBA's Web site at: *http://sba.gov/idc/groups/public/documents/sba_homepage/serv_sstd_tablepdf.pdf* (refer to the 620000 series).)

For purposes of the RFA, we have determined that many hospitals and most ASCs would be considered small entities according to the SBA size standards. Individuals and States are not included in the definition of a small entity. Therefore, the Secretary has determined that this proposed rule would have a significant impact on a substantial number of small entities. Because we acknowledge that many of the affected entities are small entities, the analyses presented throughout this proposed rule constitute our proposed regulatory flexibility analysis. Therefore, we are soliciting public comments on our estimates and analyses of the impact of this proposed rule on those small entities.

3. Small Rural Hospitals

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we now define a small rural hospital as a hospital that is located outside an urban area and has fewer than 100 beds. Section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98–21) designated hospitals in certain New England counties as belonging to the adjacent urban areas. Thus, for OPPS purposes, we continue to classify these hospitals as urban hospitals. We believe that the proposed changes to the OPPS in this proposed rule would affect both a substantial number of rural hospitals as well as other classes of hospitals and that the effects on some may be significant. Also, the changes to the ASC payment system in this proposed rule would affect rural ASCs. Therefore, the Secretary has determined that this proposed rule would have a significant impact on the operations of a substantial number of small rural hospitals.

4. Unfunded Mandates

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. That threshold level is currently approximately $135 million. This proposed rule would not mandate any requirements for State, local, or tribal governments, nor would it affect private sector costs.

5. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct costs on State and local governments, preempts State law, or otherwise has Federalism implications.

We have examined the OPPS and ASC provisions included in this proposed rule in accordance with Executive Order 13132, Federalism, and have determined that they would not have a substantial direct effect on State, local or tribal governments, preempt State law, or otherwise have a Federalism implication. As reflected in Table 55 below, we estimate that OPPS payments to governmental hospitals (including State and local governmental hospitals) would increase by 2.2 percent under this proposed rule. While we do not know the number of ASCs with government ownership, we anticipate that it is small. We believe that the provisions related to payments to ASCs in CY 2011 would not affect payments to any ASCs owned by government entities.

The following analysis, in conjunction with the remainder of this document, demonstrates that this proposed rule is consistent with the regulatory philosophy and principles identified in Executive Order 12866, the RFA, and section 1102(b) of the Act.

This proposed rule would affect payments to a substantial number of small rural hospitals and a small number of rural ASCs, as well as other

classes of hospitals and ASCs, and some effects may be significant.

B. Effects of OPPS Changes in This Proposed Rule

We are proposing to make several changes to the OPPS that are required by the statute. We are required under section 1833(t)(3)(C)(ii) of the Act to update annually the conversion factor used to determine the APC payment rates. We also are required under section 1833(t)(9)(A) of the Act to revise, not less often than annually, the wage index and other adjustments, including pass-through payments and outlier payments. In addition, we must review the clinical integrity of payment groups and weights at least annually. Accordingly, in this proposed rule, we are proposing to update the conversion factor and the wage index adjustment for hospital outpatient services furnished beginning January 1, 2011, as we discuss in sections II.B. and II.C., respectively, of this proposed rule. We discuss our implementation of section 10324 of the Affordable Care Act, as amended by HCERA, authorizing a wage index of 1.00 for certain frontier states. We also are proposing to revise the relative APC payment weights using claims data for services furnished from January 1, 2009, through December 31, 2009, and updated cost report information. We are proposing to continue the current payment adjustment for rural SCHs, including EACHs. We are proposing an adjustment for cancer hospitals identified under 1886(d)(1)(B)(v) of the Act in accordance with section 3138 of the Affordable Care Act, as amended by HCERA. Finally, we list the 18 drugs and biologicals in Table 20 of this proposed rule that we are proposing to remove from pass-through payment status for CY 2011.

Under this proposed rule, we estimate that the proposed update change to the conversion factor and other adjustments (but not including the effects of outlier payments, pass-through estimates, the expiration of section 508 wages on September 30, 2010, and the application of the frontier wage adjustment for CY 2011) as provided by the statute would increase total OPPS payments by 2.1 percent in CY 2011. The proposed changes to the APC weights, the changes to the wage indices, the continuation of a payment adjustment for rural SCHs, including EACHs, and the proposed payment adjustment for cancer hospitals would not increase OPPS payments because these changes to the OPPS are budget neutral. However, these proposed updates do change the distribution of payments within the budget neutral system as shown in Table 55 below and described in more detail in this section. We also estimate that the total change in payments between CY 2010 and CY 2011, considering all payments, including changes in estimated total outlier payments, pass-through payments, the expiration of additional money for specified section 508 reclassification and special exception wages indices, and the application of the frontier adjustment outside of budget neutrality, would increase total OPPS payments by 2.2 percent.

1. Alternatives Considered

Alternatives to the changes we are making and the reasons that we have chosen the options are discussed throughout this proposed rule. Some of the major issues discussed in this proposed rule and the options considered are discussed below.

a. Alternatives Considered for the Extension of Waiver of Deductible to Services Furnished in Connection With or in Relation to a Colorectal Screening Test That Becomes Diagnostic

Section 4104(c)(2)of the Affordable Care Act waives the deductible with respect to a colorectal cancer screening test regardless of the code that is billed for the establishment of a diagnosis as a result of the test, or for the removal of tissue or other matter or other procedure that is furnished in connection with, as a result of, and in the same clinical encounter as a screening test. We are proposing for CY 2011 that the deductible be waived for all surgical services furnished on the same date as a planned screening colonoscopy, planned flexible sigmoidoscopy, or barium enema as being furnished in connection with, as a result of, and in the same clinical encounter as the screening test. As discussed in detail in XII.B.3 of this rule, we are proposing to implement this provision by creating a HCPCS modifier that hospitals would append to the diagnostic procedure code that is reported instead of the screening colonoscopy or screening flexible sigmoidoscopy HCPCS code or as a result of the barium enema when the screening test becomes a diagnostic service. The claims processing system would respond to the modifier by waiving the deductible for all surgical services on the same date as the diagnostic test. Coinsurance or copayment would continue to apply to the diagnostic test and other services furnished in connection with, as a result of, and in the same clinical encounter as the screening test.

We considered three alternatives for the extension of waiver of deductible to services furnished in connection with or in relation to a colorectal screening test that becomes diagnostic for CY 2011. The first alternative we considered, but are not proposing, was to define a limited set of colonoscopy codes to which the waiver could apply when performed on the same date as a procedure that began as a screening colonoscopy, screening flexible sigmoidoscopy, or barium enema. We did not choose this alternative because it is virtually impossible to create a valid and complete list of appropriate procedures to handle all situations, due to the range of problems that could be identified and complications that could occur with any invasive procedures.

Furthermore, we believe this alternative would be complex to implement. Although this alternative narrows the potential for hospitals to abuse the waiver of the deductible by applying it to unrelated services, we believe the potential for abuse of the waiver of the deductible to be minimal. The Part B deductible is a fixed amount that the beneficiary pays before Medicare begins to pay and typically would be met after receiving one to two services.

The second alternative we considered, but are not proposing, was to define a broader, but still limited set of codes (for example, selected surgical services) to which the waiver could apply when performed on the same date as a procedure that began as a screening colonoscopy, screening flexible sigmoidoscopy, or barium enema. Although this alternative would encompass a broader set of codes, we believe it is virtually impossible to create a valid and complete list of appropriate procedures to handle all situations, due to the range of problems that could be identified and complications that could occur with any invasive procedures. While we acknowledge that this alternative narrows the potential for abuse of the waiver of the deductible, we believe the potential for abuse is minimal and that this alternative would be complex to implement. For these reasons we did not choose to define a broader set of limited codes to which the waiver could apply when performed on the same date as a procedure that began as a screening colonoscopy, screening flexible sigmoidoscopy, or barium enema.

The third alternative we considered, and the one we are proposing for CY 2011, is to apply the waiver to any surgical procedure on the same date as a screening colonoscopy, flexible sigmoidoscopy, or barium enema that

providers report is "in connection with or as a result of" the procedure that began as a screening test. We are proposing to create a HCPCS modifier that providers would append to the diagnostic procedure code that is reported instead of the screening colonoscopy or screening flexible sigmoidoscopy HCPCS code or as a result of the barium enema when the screening test becomes a diagnostic service. We chose this alternative because we believe it provides the greatest ease of public understanding and provider application. We believe that this alternative is appropriate because we believe that it would be very rare for an unrelated surgery to occur on the same date as one of these scheduled screening tests. Moreover, we believe that the risk of improper expenditures would be very small under this policy because it is the deductible, and not the coinsurance, that is waived for the related procedures other than the screening tests. As noted above, the Part B deductible is a fixed amount that the beneficiary pays before Medicare begins to pay and typically would be met after receiving one to two services.

b. Alternatives Considered for Payment of the Acquisition and Pharmacy Overhead Costs of Drugs and Biologicals That Do Not Have Pass-Through Status

We are proposing that, for CY 2011, the OPPS would make payment for separately payable drugs and biologicals at ASP+6 percent, and this payment would continue to represent combined payment for both the acquisition and pharmacy overhead costs of separately payable drugs and biologicals. As discussed in detail in section V.B.3. of this proposed rule, we believe that approximately $150 million of the estimated $593 million in pharmacy overhead cost currently attributed to coded packaged drugs with an ASP and $50 million of the estimated $628 million in pharmacy overhead cost currently attributed to coded and uncoded packaged drugs without an ASP should, instead, be attributed to separately payable drugs and biologicals to provide an adjustment for the pharmacy overhead costs of these separately payable products. As a result, we also are proposing to reduce the cost of packaged drugs and biologicals that is included in the payment for procedural APCs to offset the $200 million adjustment to payment for separately payable drugs and biologicals. We are proposing that any redistribution of pharmacy overhead cost that may arise from CY 2011 final rule claims data would occur only from some drugs and biologicals to other drugs and biologicals, thereby maintaining the estimated total cost of drugs and biologicals under the OPPS.

We considered three alternatives for payment of the acquisition and pharmacy overhead costs of drugs and biologicals that do not have pass-through status for CY 2011. The first alternative we considered, but are not proposing, was to continue our standard policy of comparing the estimated aggregate cost of separately payable drugs and biologicals in our claims data to the estimated aggregate ASP dollars for separately payable drugs and biologicals, using the ASP as a proxy for average acquisition cost, to calculate the estimated percent of ASP that would serve as the best proxy for the combined acquisition and pharmacy overhead costs of separately payable drugs and biologicals (70 FR 68642). Under this standard methodology, using April 2010 ASP information and costs derived from CY 2009 OPPS claims data, we estimated the combined acquisition and overhead costs of separately payable drugs and biologicals to be ASP plus 0 percent. As discussed in section V.B.3. of this proposed rule, we also determined that the combined acquisition and overhead costs of packaged drugs are 283 percent of ASP. We did not choose this alternative because we believe that this analysis indicates that our standard drug payment methodology has the potential to "compress" the calculated costs of separately payable drugs and biologicals to some degree. Further, we recognize that the attribution of pharmacy overhead costs to packaged or separately payable drugs and biologicals through our standard drug payment methodology of a combined payment for acquisition and pharmacy overhead costs depends, in part, on the treatment of all drugs and biologicals each year under our annual drug packaging threshold. Changes to the packaging threshold may result in changes to payment for the overhead cost of drugs and biologicals that do not reflect actual changes in hospital pharmacy overhead cost for those products.

The second alternative we considered, but are not proposing, was to adopt the APC Panel's February 2010 recommendation to redistribute a larger portion of the overhead cost from packaged drugs to separately payable drugs for payment of drugs and biologicals that do not have pass-through status. We did not choose this alternative because, as we discussed in V.B.3. of this proposed rule, we are not confident that we know the amount of overhead cost available for redistribution in the uncoded packaged drugs and, therefore, do not know if it is appropriate to redistribute more payment from uncoded packaged drugs to separately paid drugs. Presenters at the APC Panel meeting provided analyses suggesting that the uncoded packaged drug cost contain exactly the same drugs as those in the coded packaged drug cost, leading to a recommendation that we could assume the same proportional amount of overhead cost appears in the uncoded packaged drug cost as observed in the coded packaged drug cost in order to increase the amount of "overhead" drug cost available for redistribution from uncoded packaged drugs to separately payable drugs. However, we do not believe we should assume that the costs reported under uncoded pharmacy revenue code lines are for the same drugs and biologicals, with the same ASPs, and overhead costs as the costs of packaged drugs and biologicals reported with a HCPCS code. For these reasons, we are not accepting the APC Panel's recommendation to redistribute a larger portion of overhead costs from packaged drugs to separately payable drugs for CY 2011.

The third alternative we considered and the one we are proposing for CY 2011 is to continue our CY 2010 redistribution methodology and redistribute $200 million in overhead costs from packaged coded and uncoded drugs to separately payable drugs which would result in a payment for non-pass-through separately payable drugs and biologicals at ASP+6 percent, which would continue to represent a combined payment for both the acquisition costs of separately payable drugs and the pharmacy overhead costs applicable to these products. We also are proposing to reduce the cost of packaged drugs that is included in the payment for procedural APCs to offset the $200 million adjustment to payment for separately payable drugs and biologicals, resulting in payment for packaged drugs and biologicals of ASP+186 percent under our proposal. We chose this alternative because we believe that it provides the most appropriate redistribution of pharmacy overhead costs associated with drugs and biologicals, based on the analyses discussed in section V.B.3. of this proposed rule, and is the alternative that is most consistent with the principles of a prospective payment system.

c. Alternatives Considered for the Physician Supervision of Hospital Outpatient Services

As we discussed extensively in previous sections, the goal of the proposal on supervision is to address

the concerns that have been brought to our attention since we issued our last rule on this subject in CY 2010. The primary issue raised by CAHs, rural hospitals and other small hospitals both during CY 2010 rulemaking and, in particular, following CY 2010 rulemaking was difficulty in staffing their facilities to meet our requirement for direct supervision of all outpatient therapeutic services, but especially services that involve a significant amount of monitoring by auxiliary staff, that may extend past regular business hours, and that typically are lower clinical complexity and risk. We focused on these issues for our CY 2011 proposal, and we are proposing to define a limited set of outpatient therapeutic services as "nonsurgical extended duration therapeutic services" that would require, at a minimum, direct supervision during an initial period followed by general supervision for the remaining duration of the service. We are proposing to select therapeutic services that are nonsurgical, that can last a significant period of time, that have a substantial monitoring component, and that have a low risk of requiring the physician's or appropriate non-physician practitioner's physical presence to furnish assistance and direction after the initiation of the service. Specifically, for observation services, IV hydration, and several injection procedures identified in Table 37 of this proposed rule, CMS would require direct supervision only at the initiation of the service and would then allow general supervision for the remainder of the service. We would apply the current definitions of general and direct supervision delineated at 42 CFR 410.32(b)(3)(i) and § 410.27(a)(1)(iv), respectively. General supervision would thus mean that the service is furnished under the physician's or non-physician practitioner's overall direction and control, but his or her physical presence is not required during the performance of the service. Direct supervision would mean that the physician or non-physician practitioner is immediately available throughout the performance of the service to furnish assistance and direction, but he or she does not need to be present in the room when the service is being performed. We are proposing to define "initiation of the service" as the beginning portion of a service ending when the patient is stable and the supervising physician or appropriate non-physician practitioner believes the remainder of the service can safely be delivered under his or her general direction and control without needing his or her physical presence on the hospital campus or in the PBD of the hospital. Under this proposal, we would continue to uphold direct supervision as the minimum standard of supervision for all outpatient therapeutic services, which we continue to believe is appropriate for ensuring some minimum level of quality and safety in purchased hospital outpatient services that are provided incident to physicians' services.

We considered but did not propose two other avenues of offering flexibility while largely maintaining our minimum requirement for direct supervision of outpatient therapeutic services. First, we considered offering hospitals the flexibility of broadening the list of nonsurgical extended duration therapeutic services to include more complex and potentially acute services like chemotherapy administration and blood transfusions, which some stakeholders also maintain do not require direct supervision. Because we were concerned that these services had a higher probability of needing a physician or non-physician practitioner to redirect service, we reasoned that we would have to require hospitals to create internal guidelines specifying a supervision level and protocols for staffing that supervision level for every nonsurgical extended duration therapeutic service. We considered minimum requirements for these internal supervision guidelines, including annual review and approval by a governing committee, periodic internal evaluation of their implementation, and the ability to make these guidelines available to auditors if requested. Further, auditors would review those guidelines if a quality or patient safety event would occur. Given the complexity of these services and the probability that direct supervision would be necessary to ensure a minimum level of quality and safety, we concluded that we should continue to require direct supervision for these services. We also chose not to propose this internal guidelines alternative because a variable standard of supervision for these services could be administratively difficult for us to audit and evaluate. Finally, we chose not to propose this option because we believed that hospitals might find it burdensome to create and maintain customized internal guidelines, especially without a clear means of assessing whether their internal guidelines and implementation of those guidelines would meet audit standards.

Second, we considered whether, for payment purposes, we should deliberately exclude CAHs from all supervision requirements. We acknowledge that statutory provisions allow CAHs some flexibility in their staffing requirements to operate with more nursing staff and non-physician practitioners rather than physicians if those are the practitioners that are available, and that our regulations recognize those reduced staffing requirements in the CoPs by establishing that, at a minimum, the physician or non-physician practitioner must be available, but not necessarily physically present on the CAH campus. Some have suggested that these requirements reduce the quality and safety of CAH services, and that CAHs should disclose their reduced staffing levels to patients prior to providing services. We did not choose to propose this option because we believe that Medicare should purchase the same basic level of safety and quality from CAHs as from all other hospitals, and for all beneficiaries, especially small rural hospitals with a small number of beds. We do not believe that these small rural hospitals paid under the OPPS through section 1833(t) of the Act and CAHs paid at reasonable cost under section 1834(g) of the Act have such different resource constraints that they require different staffing rules for purposes of supervision. In fact, with payment at cost, we reasoned that CAHs might be better able than other small hospitals to hire staff to provide direct supervision of therapeutic outpatient services.

In summary, we are proposing to define a list of nonsurgical extended duration therapeutic services for a policy of direct supervision followed by general supervision after the initiation of the service because this alternative is responsive to the primary concerns raised by CAHs and small rural hospitals, because it is administratively feasible to implement, and because we believe it continues to support our policy of direct supervision. We believe that this proposed policy will maintain an adequate level of safety and quality of care in the therapeutic services for hospital outpatients that Medicare purchases.

2. Limitations of Our Analysis

The distributional impacts presented here are the projected effects of the proposed CY 2011 policy changes on various hospital groups. We post on the CMS Web site our hospital-specific estimated payments for CY 2011 with the other supporting documentation for this proposed rule. To view the hospital-specific estimates, we refer readers to the CMS Web site at: *http://www.cms.hhs.gov/*

HospitalOutpatientPPS/. Select "regulations and notices" from the left side of the page and then select "CMS–1504–P" from the list of regulations and notices. The hospital-specific file layout and the hospital-specific file are listed with the other supporting documentation for this proposed rule. We show hospital-specific data only for hospitals whose claims were used for modeling the impacts shown in Table 55 below. We do not show hospital-specific impacts for hospitals whose claims we were unable to use. We refer readers to section II.A.2. of this proposed rule for a discussion of the hospitals whose claims we do not use for ratesetting and impact purposes.

We estimate the effects of the proposed individual policy changes by estimating payments per service, while holding all other payment policies constant. We use the best data available, but do not attempt to predict behavioral responses to our policy changes. In addition, we do not make adjustments for future changes in variables such as service volume, service mix, or number of encounters. As we have done in previous rules, we are soliciting public comment and information about the anticipated effects of our proposed changes on providers and our methodology for estimating them.

3. Estimated Effects of This Proposed Rule on Hospitals

Table 55 below shows the estimated impact of this proposed rule on hospitals. Historically, the first line of the impact table, which estimates the change in payments to all hospitals, has always included cancer and children's hospitals, which are held harmless to their pre-BBA payment-to-cost ratio. We also include CMHCs in the first line that includes all providers because we include CMHCs in our weight scalar estimate.

We present separate impacts for CMHCs in Table 55 because CMHCs are paid only for partial hospitalization services and CMHCs are a different provider type from hospitals. For CY 2010, CMHCs and hospitals were paid under two APCs for services under the OPPS: APC 0172 (Level 1 Partial Hospitalization (3 services)) and APC 0173 (Level II Partial Hospitalization (4 or more services)). For CY 2011, we are proposing to pay CMHCs under APC 0172 (Level I Partial Hospitalization (3 services) for CMHCs) and APC 0173 (Level II Partial Hospitalization (4 or more services) for CMHCs), and to pay hospitals for partial hospitalization services under APC 0175 (Level I Partial Hospitalization (3 services) for Hospital-based PHPs) and APC 0176 (Level II Partial Hospitalization (4 or more services) for Hospital-based PHPs). We display the impact on CMHCs of this proposed policy change below and we discuss the impact on CMHCs in section XXII.B.4. of this proposed rule.

We also present separate impacts for cancer hospitals in Table 55 to illustrate the impact associated with our CY 2011 proposal for an adjustment for cancer hospitals authorized by section 3138 of the Affordable Care Act, as amended by HCERA, and discussed in section II.F. of this proposed rule. Cancer hospitals are held harmless to the proportional amount of payment they received before the OPPS was implemented in 2001. We discuss the impact of this adjustment on cancer hospitals in section XXII.B.5 of this proposed rule.

The estimated increase in the total payments made under the OPPS is limited by the increase to the conversion factor set under the methodology in the statute. The distributional impacts presented do not include assumptions about changes in volume and service mix. Section 3137 of the Affordable Care Act, as amended by the HCERA, extended additional payment to section 508 reclassification hospitals and special exception hospital wages outside budget neutrality through September 30, 2010. The amounts attributable to these reclassifications are incorporated into the CY 2010 estimates in Table 55. Section 10324 of the Affordable Care Act, as amended by HCERA, further authorized additional expenditures outside budget neutrality for hospitals in certain frontier states to have a wage index of 1.00. The amounts attributable to this Frontier state wage index adjustment are incorporated into the CY 2011 estimates in Table 55.

Table 55 shows the estimated redistribution of hospital and CMHC payments among providers as a result of APC reconfiguration and recalibration; wage indices and the rural adjustment; the cancer hospital adjustment; the combined impact of the APC recalibration, wage and rural adjustment effects, the cancer hospital adjustment, and the market basket update to the conversion factor; the Frontier wage index adjustment; and, finally, estimated redistribution considering all proposed payments for CY 2011 relative to all payments for CY 2010, including the impact of changes in the outlier threshold, expiring section 508 wage indices, and changes to the pass-through payment estimate. We did not model an explicit budget neutrality adjustment for the rural adjustment for SCHs because we are not proposing to make any changes to the policy for CY 2011. Because the proposed updates to the conversion factor, including the update of the market basket and the subtraction of additional money dedicated to pass-through payment for CY 2011, are applied uniformly across services, observed redistributions of payments in the impact table for hospitals largely depend on the mix of services furnished by a hospital (for example, how the APCs for the hospital's most frequently furnished services would change), and the impact of the wage index changes on the hospital. However, total payments made under this system and the extent to which this proposed rule would redistribute money during implementation also would depend on changes in volume, practice patterns, and the mix of services billed between CY 2010 and CY 2011 by various groups of hospitals, which CMS cannot forecast.

Overall, the proposed OPPS rates for CY 2011 would have a positive effect for providers paid under the OPPS, resulting in a 2.2 percent estimated increase in Medicare payments. Removing cancer and children's hospitals, because their payments are held harmless to the pre-BBA ratio between payment and cost, and CMHCs suggests that these proposed changes would result in a 2.1 percent estimated increase in Medicare payments to all other hospitals.

To illustrate the impact of the proposed CY 2011 changes, our analysis begins with a baseline simulation model that uses the final CY 2010 weights, the FY 2010 final IPPS wage indices that include reclassifications, and the final CY 2010 conversion factor. Column 2 in Table 55 shows the independent effect of the proposed changes resulting from the reclassification of services among APC groups and the recalibration of APC weights, based on 12 months of CY 2009 OPPS hospital claims data and the most recent cost report data. We modeled the effect of the proposed APC recalibration changes for CY 2011 by varying only the weights (the final CY 2010 weights versus the proposed CY 2011 weights calculated using the service mix and volume in the CY 2009 claims used for this proposed rule) and calculating the percent difference in weight. Column 2 also reflects the effect of the proposed changes resulting from the APC reclassification and recalibration changes and any changes in multiple procedure discount patterns or conditional packaging that occur as a result of the proposed changes in the relative magnitude of payment weights.

Column 3 reflects the independent effects of the proposed updated wage indices, including the application of budget neutrality for the rural floor

policy on a nationwide basis. This column excludes the effects of the frontier wage index adjustment, which is not budget neutral and is shown in column 6. We did not model a budget neutrality adjustment for the rural adjustment for SCHs because we are making no changes to the policy for CY 2011. We modeled the independent effect of updating the wage indices by varying only the wage indices, holding APC relative weights, service mix, and the rural adjustment constant and using the proposed CY 2011 scaled weights and a CY 2010 conversion factor that included a budget neutrality adjustment for the effect of changing the wage indices between CY 2010 and CY 2011.

Column 4 demonstrates the independent effect of the cancer hospital payment adjustment. We modeled the independent effect of the cancer adjustment by varying only the payment to cancer hospitals after applying provider specific adjustments that cumulatively result in the proposed 40.5 percent adjustment while holding APC relative weights, service mix, the rural adjustment and wage indices constant and using a CY 2010 conversion factor.

Column 5 demonstrates the combined "budget neutral" impact of APC recalibration (that is, Column 2), the wage index update (that is, Column 3), the cancer hospital adjustment (that is, Column 4), as well as the impact of updating the conversion factor with the adjusted market basket update. We modeled the independent effect of the budget neutrality adjustments and the adjusted market basket update by using the weights and wage indices for each year, and using a CY 2010 conversion factor that included the market basket update and a budget neutrality adjustment for differences in wage indices.

Column 6 demonstrates the impact of the budget neutral adjustments and the market basket update reflected in Column 5 combined with the non-budget neutral Frontier wage index adjustment, discussed in section II.C.1. of this proposed rule.

Finally, Column 7 depicts the full impact of the proposed CY 2011 policies on each hospital group by including the effect of all the proposed changes for CY 2011 (including the APC reconfiguration and recalibration shown in Column 2) and comparing them to all estimated payments in CY 2010 (these CY 2010 estimated payments include the payments resulting from the non-budget neutral increases to wage indices under section 508 of Public Law 108–173 as extended by Public Law 111–148). Column 7 shows the combined budget neutral effects of Columns 2 through 5, plus the impact of the Frontier wage index adjustment; the proposed change to the fixed-dollar outlier threshold from $2,175 to $2,025 as discussed in section II.G. of this proposed rule; the expiration of section 508 reclassifications; the change in the HOP QDRP payment reduction for the small number of hospitals in our impact model that failed to meet the reporting requirements (see section XVI.D. of this proposed rule); and the impact of increasing the estimate of the percentage of total OPPS payments dedicated to transitional pass-through payments. Of the 106 hospitals that failed to meet the HOP QDRP reporting requirements for the full CY 2010 update (and assumed, for modeling purposes, to be the same number for CY 2011), we included 24 in our model because they had both CY 2009 claims data and recent cost report data. We estimate that the cumulative effect of all changes for CY 2011 would increase payments to all providers by 2.2 percent for CY 2011. We modeled the independent effect of all changes in Column 7 using the final weights for CY 2010 and the proposed weights for CY 2011. We used the final conversion factor for CY 2010 of $67.241, which was announced in the notice describing implementation of the Affordable Care Act provisions published around the same time as this proposed rule and the proposed CY 2011 conversion factor of $68.267 discussed in section II.B. of this proposed rule.

Column 7 also contains simulated outlier payments for each year. We used the charge inflation factor used in the FY 2011 IPPS/RY 2011 LTCH PPS proposed rule of 5.16 percent (1.0516) to increase individual costs on the CY 2009 claims, and we used the most recent overall CCR in the April 2010 Outpatient Provider-Specific File (OPSF) (75 FR 24068). Using the CY 2009 claims and a 5.16 percent charge inflation factor, we currently estimate that outlier payments for CY 2010, using a multiple threshold of 1.75 and a fixed-dollar threshold of $2,175, would be approximately 0.85 percent of total payments. Outlier payments of 0.85 percent are incorporated in the CY 2010 comparison in Column 7. We used the same set of claims and a charge inflation factor of 10.59 percent (1.1059) and the CCRs in the April 2010 OPSF, with an adjustment of 0.9890, to reflect relative changes in cost and charge inflation between CY 2009 and CY 2011, to model the CY 2011 outliers at 1.0 percent of total payments using a multiple threshold of 1.75 and a fixed-dollar threshold of $2,025.

Column 1: Total Number of Hospitals

The first line in Column 1 in Table 55 shows the total number of providers (4,140), including cancer and children's hospitals and CMHCs for which we were able to use CY 2009 hospital outpatient claims to model CY 2010 and CY 2011 payments, by classes of hospitals. We excluded all hospitals for which we could not accurately estimate CY 2010 or CY 2011 payment and entities that are not paid under the OPPS. The latter entities include CAHs, all-inclusive hospitals, and hospitals located in Guam, the U.S. Virgin Islands, Northern Mariana Islands, American Samoa, and the State of Maryland. This process is discussed in greater detail in section II.A. of this proposed rule. At this time, we are unable to calculate a disproportionate share (DSH) variable for hospitals not participating in the IPPS. Hospitals for which we do not have a DSH variable are grouped separately and generally include freestanding psychiatric hospitals, rehabilitation hospitals, and long-term care hospitals. We show the total number (3,871) of OPPS hospitals, excluding the hold-harmless cancer and children's hospitals and CMHCs, on the second line of the table. We excluded cancer and children's hospitals because section 1833(t)(7)(D) of the Act permanently holds harmless cancer hospitals and children's hospitals to their proportional payment relative to reasonable cost prior to payment under the OPPS and, therefore, we removed them from our impact analyses. We show the isolated impact on 207 CMHCs at the bottom of the impact table and discuss that impact separately below. We show the isolated impact on the 11 cancer hospitals in the last row of the impact table.

Column 2: Proposed APC Changes Due to Reassignment and Recalibration

This column shows the combined effects of the reconfiguration, recalibration, and other policies (such as our proposal to set payment for separately payable drugs and biologicals at ASP+6 percent with an accompanying reduction in the amount of cost associated with packaged drugs and biologicals and changes in payment for PHP services). Overall, we estimate that proposed changes in APC reassignment and recalibration across all services paid under the OPPS would increase payments to urban hospitals by 0.5 percent. We estimate that both large and other urban hospitals would see an increase of 0.5 percent, all attributable to recalibration. We estimate that urban hospitals billing fewer than 11,000 lines

for OPPS services would experience increases of 1.1 to 1.3 percent, while urban hospitals billing 11,000 or more lines for OPPS services would see increases of 0.5 to 0.8 percent.

Overall, we estimate that rural hospitals would experience an increase of 0.5 percent as a result of changes to the APC structure. We estimate that rural hospitals of all bed sizes would experience increases of 0.4 to 0.7 percent as a result of APC recalibration. We estimate that rural hospitals that report fewer than 5,000 lines for OPPS services would experience a decrease of 0.4 percent, while rural hospitals that report more than 5,000 lines for OPPS services would see increases of 0.5 percent to 0.6 percent.

Among teaching hospitals, we estimate that the impact resulting from APC recalibration would include an increase of 0.5 percent for major and minor teaching hospitals.

Classifying hospitals by type of ownership suggests that voluntary and governmental hospitals would see an increase of 0.5 percent, and proprietary hospitals would see an estimated increase of 0.6 percent.

Finally, we estimate that hospitals for which DSH payments are not available would experience decreases of 1.5 to 1.8 percent. We estimate that most other classes of hospitals would experience modest increases from CY 2010 to CY 2011 resulting from APC recalibration.

Column 3: Proposed New Wage Indices and the Effect of the Rural Adjustment

This column estimates the impact of applying the proposed FY 2011 IPPS wage indices for the CY 2011 OPPS without the influence of the Frontier wage index adjustment or the expiration of the section 508 wage index adjustment, which are not budget neutral. The Frontier wage index adjustment is reflected in the combined impact shown in columns 6 and 7. The expiring section 508 adjustment is reflected in column 7. We are not changing the rural payment adjustment for CY 2011. We estimate that the combination of updated wage data and nationwide application of rural floor budget neutrality would redistribute payment among regions. We also updated the list of counties qualifying for the section 505 out-migration adjustment. Overall, we estimate that urban hospitals would experience an increase of 0.1 percent from CY 2010 to CY 2011, and that rural hospitals would experience a decrease of 0.3 percent as a result of the updated wage indices. We estimate that hospitals in rural New England States and rural West North Central States would experience decreases of 1.9 and 0.8 percent, respectively. We estimate that urban Pacific and rural West South Central States would experience increases of 1.1 percent and 0.6 percent, respectively.

Column 4: Cancer Hospital Adjustment

This column estimates the budget neutral impact of applying the proposed hospital-specific CY 2011 cancer adjustment, authorized by section 3138 of the Affordable Care Act, as amended by the HCERA, which results in an aggregate increase in payments to dedicated cancer hospitals of 40.5% for the CY 2011 OPPS. We estimate that all other hospitals will experience a decrease of 0.7 percent in CY 2011 as a result of redistributing payments to the cancer hospitals under this proposed adjustment.

Column 5: All Proposed Budget Neutrality Changes and Market Basket Update

We estimate that the addition of the proposed market basket update of 2.15 percent (which includes the reduction to the OPD fee schedule update factor of 0.25 percentage points as required by section 3401(i) and 10319(g) of the Affordable Care Act and section 1105(e) of HCERA) would mitigate the negative impacts on hospital payments for CY 2011 created by the budget neutrality adjustments made in Columns 2, 3, and 4. Hospitals for which DSH is not available (generally hospitals not paid under the IPPS, including freestanding psychiatric, rehabilitation, and long-term care hospitals) experience the smallest increases of between 0.2 and 0.5 percent. In general, Column 5 shows that all hospitals would experience an estimated increase of 2.0 percent, attributable to the 2.15 percent OPD fee schedule update factor increase (that is, the market basket) combined with the budget neutrality adjustments.

Overall, we estimate that these proposed changes would increase payments to urban hospitals by 2.1 percent. We estimate that large urban hospitals would experience an increase of 2.2 percent, and "other" urban hospitals would experience a 1.9 percent increase. We estimate that rural hospitals would experience a 1.6 percent increase as a result of the proposed market basket update and other budget neutrality adjustments. We estimate that rural hospitals that bill less than 5,000 lines of OPPS services would experience an increase of 1.4 percent and that rural hospitals that bill more than 5,000 lines of OPPS services would experience increases of 1.5 to 2.3 percent.

Among teaching hospitals, we estimate that the observed impacts resulting from the market basket update and other budget neutrality adjustments would include an increase of 2.0 and 1.9 percent, respectively, for major and minor teaching hospitals.

Classifying hospitals by type of ownership suggests that voluntary, proprietary, and governmental hospitals would experience estimated increases of 1.9 percent, 2.2 percent, and 2.0 percent, respectively.

Column 6: Frontier Wage Index Adjustment

This column shows the impact of all budget neutrality adjustments, application of the 2.15 percent OPD fee schedule update factor, and the non-budget neutral impact of applying the Frontier wage adjustment (that is, the Frontier wage index change in addition to all changes reflected in column 5).

We estimate that hospitals in the urban West North Central and urban Mountain States will experience increases of 2.5 and 2.3 percent, respectively. Hospitals in the rural regions of the West North Central and Mountain States would experience estimated increases of 2.3 and 4.1 percent, respectively.

Column 7: All Proposed Changes for CY 2011

Column 7 compares all proposed changes for CY 2011 to estimated final payment for CY 2010, including the change in the outlier threshold, payment reductions for hospitals that failed to meet the HOP QDRP reporting requirements, the influence of the expiration of the section 508 wage adjustment, and the difference in pass-through estimates that are not included in the combined percentages shown in Column 6. This column includes estimated payment for a handful of hospitals receiving reduced payment because they did not meet their hospital outpatient quality measure reporting requirements; however, we estimate that the anticipated change in payment between CY 2010 and CY 2011 for these hospitals would be negligible. (We further discuss the estimated impacts of hospitals' failure to meet these requirements below in section XXII.D. of this proposed rule.) Overall, we estimate that providers would experience an increase of 2.2 percent under this proposed rule in CY 2011 relative to total spending in CY 2010. The projected 2.2 percent increase for all providers in Column 7 of Table 55 reflects the proposed 2.15 percent adjusted OPD fee schedule update factor increase, less 0.06 percent for the

change in the pass-through estimate between CY 2010 and CY 2011, plus 0.15 percent for the difference in estimated outlier payments between CY 2010 (0.85 percent) and CY 2011 (1.0 percent), and less 0.09 percent due to the expiration of the special, non-budget neutral wage index payments made under section 508, plus .09 percent due to the Frontier wage index adjustment. When we exclude cancer and children's hospitals (which are held harmless to their pre-OPPS costs) and CMHCs, the estimated increase is 2.1 percent.

We estimate that the combined effect of all changes for CY 2011 would increase payments to urban hospitals by 2.1 percent. We estimate that large urban hospitals would experience a 2.2 percent increase, while "other" urban hospitals would experience an increase of 2.0 percent. We estimate that urban hospitals that bill less than 5,000 lines of OPPS services would experience an increase of 3.3 percent, and we estimate that all urban hospitals that bill more than 5,000 lines of OPPS services would experience increases between 2.1 percent and 3.4 percent.

Overall, we estimate that rural hospitals would experience a 1.8 percent increase as a result of the combined effects of all changes for CY 2011. We estimate that rural hospitals that bill less than 5,000 lines of OPPS services would experience an increase of 3.4 percent and rural hospitals that bill greater than 5,000 lines of OPPS services would experience increases ranging from 1.7 percent to 2.5 percent.

Among teaching hospitals, we estimate that the impacts resulting from the combined effects of all changes would include an increase of 2.1 percent for both major and minor teaching hospitals.

Classifying hospitals by type of ownership, we estimate that proprietary hospitals would gain 2.3 percent, governmental hospitals would experience an increase of 2.2 percent, and voluntary hospitals would experience an increase of 2.0 percent.

4. Estimated Effects of This Proposed Rule on CMHCs

The bottom of Table 55 demonstrates the isolated impact on CMHCs. CMHCs are currently paid under two APCs for services under the OPPS: APC 0172 (Level 1 Partial Hospitalization (3 services)) and APC 0173 (Level II Partial Hospitalization (4 or more services)). This proposed rule proposes to further refine payment within these Partial Hospitalization APCs for CY 2011 by providing two payment rates for Partial Hospitalization services for each provider type (CMHCs and hospital-based PHPs). Specifically, APC 0172 would be retitled: "Level I Partial Hospitalization (3 services) for CMHCs;" APC 0173 would be retitled: "Level II Partial Hospitalization (4 or more services) for CMHCs;" new APC 0175 would be titled "Level I Partial Hospitalization (3 services) for Hospital-based PHPs" and new APC 0176 would be titled: "Level II Partial Hospitalization (4 or more services) for Hospital-based PHPs." We are proposing payment rates for each APC based on the cost data derived from claims and cost reports for the provider type to which the APC is specific. We modeled the impact of this APC policy change assuming that CMHCs would continue to provide the same number of days of PHP care, with each day having either three services or four or more services, as seen in the CY 2009 claims data. We excluded days with one or two services. Because the relative weights for APC 0172 (Level 1 Partial Hospitalization (3 services)) and APC 0173 (Level II Partial Hospitalization (4 or more services)) both decline in CY 2011 to reflect CMHC cost data for Partial Hospitalization services provided by CMHCs under this proposed rule, we estimate that there would be a 44.0 percent decrease in payments to CMHCs due to these APC policy changes (shown in Column 2).

Column 3 shows that the estimated impact of adopting the CY 2011 wage index values would result in a 0.9 percent increase in payments to CMHCs. We note that all providers paid under the OPPS, including CMHCs, would receive a 2.15 percent adjusted market basket increase. Combining this proposed market basket increase, along with proposed changes in APC policy for CY 2011 and the proposed CY 2011 wage index updates, the proposed cancer hospital adjustment, proposed changes in outlier and pass-through payments, and the expiration of section 508 wages, we estimate that the combined impact on CMHCs for CY 2011 would be a 41.7 percent decrease in payment.

The impact on hospitals of the proposed changes to payment rates to hospitals for partial hospitalization services is reflected in the impact of all proposed changes on hospitals.

5. Estimated Effects of This Proposed Rule on Cancer Hospitals

The bottom of Table 55 demonstrates the isolated impact on the 11 cancer hospitals meeting the classification criteria in 1886(d)(1)(B)(v) of the Act. Section 3138 of the Affordable Care Act, as amended by HCERA, authorized the Secretary to conduct a study to determine if these hospitals are more costly than other hospitals paid under the OPPS, and if they are more costly, the Secretary shall make an appropriate adjustment that is budget neutral. As discussed in section II.F. of this proposed rule, we found that these hospitals are more costly and proposed an adjustment. These cancer hospitals currently are held harmless under section 1833(t)(7)(D) of the Act, and most of them receive additional payments outside budget neutrality. In general, the effect of this proposal is to make more payments to cancer hospitals than received under the OPPS, but within budget neutrality, effectively redistributing money from other hospitals to fund this adjustment. The proposed adjustment is hospital-specific, raising payment for each hospital to 86.7 percent of reasonable cost.

Column 2 demonstrates cancer hospitals receiving a modest increase of 0.3 percent after recalibration of the APC groups and weights. Column 3 shows that the estimated impact of adopting the CY 2011 wage index values would result in a 0.1 percent increase in payments to cancer hospitals within the PPS. Column 4 demonstrates the budget neutral impact of applying a hospital-specific adjustment to the 11 designated cancer hospitals. We estimate that the cancer hospitals will experience an aggregate increase in payment of 40.5%. All providers paid under the OPPS would receive a 2.15 percent adjusted market basket increase under this proposal. Combining this proposed market basket increase, along with proposed changes in APC policy for CY 2011 and the proposed CY 2011 wage index updates, the proposed cancer hospital adjustment, proposed changes in outlier and pass-through payments, and the expiration of section 508 wages, we estimate that the combined impact on cancer hospitals within the PPS system would be a 39.9 percent increase. Cancer hospitals remain eligible for hold harmless payments to the extent that their PPS amount, including the cancer adjustment, is less than the estimated amount of payment they would have received under reasonable cost payment for any given year.

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TABLE 55. ESTIMATED IMPACT OF THE PROPOSED CY 2011 HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

	Number of Hospitals (1)	APC Recalibration (2)	New Wage Index and Rural Adjustment (3)	New Cancer Hospital Adjustment (4)	Comb (cols 2,3) with Market Basket Update (5)	Frontier Wage Index Adjustment (6)	All Changes (7)
ALL PROVIDERS *	4,140	0.0	0.0	0.0	2.1	2.2	2.2
ALL HOSPITALS	3,871	0.5	0.0	-0.7	2.0	2.1	2.1
(excludes hospitals permanently held harmless and CMHCs)							
URBAN HOSPITALS	2,893	0.5	0.1	-0.7	2.1	2.1	2.1
LARGE URBAN	1,569	0.5	0.2	-0.7	2.2	2.2	2.2
(GT 1 MILL.)							
OTHER URBAN	1,324	0.5	0.0	-0.7	1.9	2.1	2.0
(LE 1 MILL.)							
RURAL HOSPITALS	978	0.5	-0.3	-0.7	1.6	1.9	1.8
SOLE COMMUNITY	391	0.5	-0.4	-0.7	1.5	2.0	1.8
OTHER RURAL	587	0.5	-0.3	-0.7	1.7	1.8	1.9
BEDS (URBAN)							
0 - 99 BEDS	976	0.7	0.0	-0.7	2.2	2.4	2.4
100-199 BEDS	855	0.6	0.1	-0.7	2.1	2.2	2.1
200-299 BEDS	453	0.6	0.0	-0.7	2.1	2.2	2.2
300-499 BEDS	413	0.5	0.1	-0.7	2.1	2.2	2.2
500 + BEDS	196	0.4	0.0	-0.7	1.9	1.9	2.0
BEDS (RURAL)							
0 - 49 BEDS	347	0.4	0.1	-0.7	1.9	2.2	2.2
50- 100 BEDS	375	0.6	-0.5	-0.7	1.6	1.7	1.7
101- 149 BEDS	146	0.5	-0.3	-0.7	1.7	1.9	1.8
150- 199 BEDS	62	0.6	-0.2	-0.7	1.9	2.4	2.3
200 + BEDS	48	0.5	-0.6	-0.7	1.4	1.4	1.4
VOLUME (URBAN)							
LT 5,000 Lines	593	1.3	0.3	-0.7	3.0	3.2	3.3
5,000 - 10,999 Lines	159	1.1	0.5	-0.7	3.1	3.3	3.4
11,000 - 20,999 Lines	243	0.8	0.2	-0.7	2.5	2.5	2.6
21,000 - 42,999 Lines	528	0.6	0.3	-0.7	2.4	2.4	2.3
GT 42,999 Lines	1,370	0.5	0.0	-0.7	2.0	2.1	2.1

	Number of Hospitals (1)	APC Recalibration (2)	New Wage Index and Rural Adjustment (3)	New Cancer Hospital Adjustment (4)	Comb (cols 2,3) with Market Basket Update (5)	Frontier Wage Index Adjustment (6)	All Changes (7)
VOLUME (RURAL)							
LT 5,000 Lines	76	-0.4	0.4	-0.7	1.4	3.2	3.4
5,000 - 10,999 Lines	96	0.6	0.3	-0.7	2.3	2.4	2.5
11,000 - 20,999 Lines	198	0.5	0.0	-0.7	2.0	2.3	2.2
21,000 - 42,999 Lines	308	0.5	-0.2	-0.7	1.8	2.0	2.0
GT 42,999 Lines	300	0.5	-0.4	-0.7	1.5	1.8	1.7
REGION (URBAN)							
NEW ENGLAND	150	0.5	-0.6	-0.7	1.4	1.4	1.3
MIDDLE ATLANTIC	362	0.6	-0.2	-0.7	1.9	1.9	1.7
SOUTH ATLANTIC	447	0.6	-0.1	-0.7	2.0	2.0	2.1
EAST NORTH CENT.	466	0.5	0.1	-0.7	2.1	2.1	2.0
EAST SOUTH CENT.	178	0.4	-0.3	-0.7	1.6	1.6	1.6
WEST NORTH CENT.	187	0.5	-0.2	-0.7	1.8	2.5	2.5
WEST SOUTH CENT.	472	0.5	0.1	-0.7	2.1	2.1	2.2
MOUNTAIN	192	0.5	-0.1	-0.7	1.9	2.3	2.4
PACIFIC	391	0.5	1.1	-0.7	3.0	3.0	3.2
PUERTO RICO	48	0.1	-0.4	-0.7	1.2	1.2	1.4
REGION (RURAL)							
NEW ENGLAND	24	0.6	-1.9	-0.7	0.2	0.2	0.3
MIDDLE ATLANTIC	67	0.6	-0.3	-0.7	1.8	1.8	1.9
SOUTH ATLANTIC	164	0.6	-0.3	-0.7	1.8	1.8	1.9
EAST NORTH CENT.	127	0.5	-0.6	-0.7	1.4	1.4	1.3
EAST SOUTH CENT.	177	0.4	-0.3	-0.7	1.7	1.7	1.6
WEST NORTH CENT.	103	0.5	-0.8	-0.7	1.2	2.3	2.1
WEST SOUTH CENT.	216	0.3	0.6	-0.7	2.4	2.4	2.4
MOUNTAIN	70	0.6	0.2	-0.7	2.2	4.1	3.9
PACIFIC	30	0.5	-0.1	-0.7	2.0	2.0	1.7
TEACHING STATUS							
NON-TEACHING	2,890	0.5	0.0	-0.7	2.0	2.1	2.1
MINOR	699	0.5	0.0	-0.7	1.9	2.1	2.1
MAJOR	282	0.5	0.0	-0.7	2.0	2.0	2.1
DSH PATIENT PERCENT							
0	6	2.3	0.0	-0.7	3.7	3.7	4.0
GT 0 - 0.10	396	0.7	0.1	-0.7	2.2	2.3	2.3

	Number of Hospitals (1)	APC Recalibration (2)	New Wage Index and Rural Adjustment (3)	New Cancer Hospital Adjustment (4)	Comb (cols 2,3) with Market Basket Update (5)	Frontier Wage Index Adjustment (6)	All Changes (7)
0.10 - 0.16	395	0.5	0.0	-0.7	2.0	2.1	2.0
0.16 - 0.23	771	0.4	-0.2	-0.7	1.7	1.9	1.9
0.23 - 0.35	997	0.5	0.0	-0.7	2.0	2.1	2.1
GE 0.35	723	0.6	0.2	-0.7	2.2	2.2	2.4
DSH NOT AVAILABLE **	583	-1.8	0.5	-0.7	0.2	0.2	0.2
URBAN TEACHING/DSH							
TEACHING & DSH	889	0.5	0.0	-0.7	2.0	2.1	2.1
NO TEACHING/DSH	1,445	0.6	0.1	-0.7	2.2	2.2	2.2
NO TEACHING/NO DSH	6	2.3	0.0	-0.7	3.7	3.7	4.0
DSH NOT AVAILABLE**	553	-1.5	0.5	-0.7	0.5	0.5	0.6
TYPE OF OWNERSHIP							
VOLUNTARY	2,064	0.5	0.0	-0.7	1.9	2.1	2.0
PROPRIETARY	1,230	0.6	0.1	-0.7	2.2	2.3	2.3
GOVERNMENT	577	0.5	0.0	-0.7	2.0	2.1	2.2
CMHCs	207	-44.0	0.9	-0.7	-41.7	-41.7	-41.7
Cancer Hospitals	11	0.3	0.1	40.5	43.2	43.2	39.9

Column (1) shows total hospitals.

Column (2) shows the impact of changes resulting from the reclassification of HCPCS codes among APC groups and the recalibration of APC weights based on 2009 hospital claims data.

Column (3) shows the budget neutral impact of updating the wage index by applying the FY 2011 hospital inpatient wage index. We did not propose any changes to the rural adjustment.

Column (4) shows the budget neutral impact of applying a hospital-specific adjustment to all OPPS services at the 11 designated cancer hospitals.

Column (5) shows the impact of all budget neutrality adjustments and the addition of the market basket update.

Column (6) shows the non-budget neutral impact of applying the frontier adjustment

Column (7) shows the additional adjustments to the conversion factor resulting from a change in the pass-through estimate and adds outlier payments. This column also shows the expiration of section 508 wages on September 30, 2010 and the application of the Frontier wage adjustment for CY 2011.

*These 4,140 providers include children and cancer hospitals, which are held harmless to pre-BBA payments, and CMHCs.

** Complete DSH numbers are not available for providers that are not paid under IPPS, including rehabilitation, psychiatric, and long-term care hospitals.

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6. Estimated Effect of This Proposed Rule on Beneficiaries

For services for which the beneficiary pays a copayment of 20 percent of the payment rate, the beneficiary share of payment would increase for services for which the OPPS payments would rise and would decrease for services for which the OPPS payments would fall. For example, for a service assigned to Level IV Needle Biopsy/Aspiration Except Bone Marrow (APC 0037) in the CY 2010 OPPS, the national unadjusted copayment is $228.76, and the minimum unadjusted copayment is $208.46. For CY 2011, the national unadjusted copayment for APC 0037 would be $228.76, the same rate in effect for CY 2010. The minimum

unadjusted copayment for APC 0037 would be $215.24 or 20 percent of the CY 2011 national unadjusted payment rate for APC 0037 of $1,076.16. The minimum unadjusted copayment would rise because the payment rate for APC 0037 would rise for CY 2011. In all cases, the statute limits beneficiary liability for copayment for a procedure to the hospital inpatient deductible for the applicable year. The CY 2010 hospital inpatient deductible is $1,100. The CY 2011 hospital inpatient deductible is not yet available.

In order to better understand the impact of changes in copayment on beneficiaries, we modeled the percent change in total copayment liability using CY 2009 claims. We estimate, using the claims of the 4,140 hospitals and CMHCs on which our modeling is based, that total beneficiary liability for copayments would decline as an overall percentage of total payments, from 22.4 percent in CY 2010 to 22.1 percent in CY 2011.

7. Conclusion

The changes in this proposed rule would affect all classes of hospitals and CMHCs. We estimated that some classes of hospitals would experience significant gains and others less significant gains, but all classes of hospitals would experience positive updates in OPPS payments in CY 2011 with one exception. We estimate that CMHCs would see an overall decrease in payment of 41.7 percent due to the recalibration of payment rates for Partial Hospitalization services at CMHCs which bases payment for CMHCs on cost report and claims data submitted by CMHCs. Specifically, dedicated cancer hospitals would experience an aggregate increase in payment of 40.5 percent, although because the cancer adjustment is hospital-specific, dedicated cancer hospitals will experience different increases.

Table 55 demonstrates the estimated distributional impact of the OPPS budget neutrality requirements that would result in a 2.2 percent increase in payments for all services paid under the OPPS in CY 2011, after considering all changes to APC reconfiguration and recalibration, as well as the adjusted market basket increase, wage index changes, including the Frontier wage index adjustment and the expiration of section 508 wage index reclassifications, the cancer hospital adjustment, estimated payment for outliers, and changes to the pass-through payment estimate. The accompanying discussion, in combination with the rest of this proposed rule, constitutes a regulatory impact analysis.

8. Accounting Statement

As required by OMB Circular A–4 (available at *http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf*), in Table 56, we have prepared an accounting statement showing the CY 2011 estimated hospital OPPS incurred benefit impact associated with the proposed CY 2011 hospital outpatient market basket update shown in this proposed rule based on the FY 2011 President's Budget. All estimated impacts are classified as transfers.

TABLE 56--ACCOUNTING STATEMENT: CY 2011 ESTIMATED HOSPITAL OPPS TRANSFERS FROM CY 2010 TO CY 2011 ASSOCIATED WITH THE PROPOSED CY 2011 HOSPITAL OUTPATIENT MARKET BASKET UPDATE

Category	Transfers
Annualized Monetized Transfers	$0.7 billion
From Whom to Whom	Federal Government to outpatient hospitals and other providers who received payment under the hospital OPPS
Total	$0.7 billion

C. Effects of ASC Payment System Changes in This Proposed Rule

On August 2, 2007, we published in the **Federal Register** the final rule for the revised ASC payment system, effective January 1, 2008 (72 FR 42470). In that final rule, we adopted the methodologies to set payment rates for covered ASC services to implement the revised payment system so that it would be designed to result in budget neutrality as required by section 626 of Public Law 108–173; established that the OPPS relative payment weights would be the basis for payment and that we would update the system annually as part of the OPPS rulemaking cycle; and provided that the revised ASC payment rates would be phased-in over 4 years. During the 4-year transition to full implementation of the ASC payment rates, payments for surgical procedures performed in ASCs that were on the CY 2007 ASC list of covered surgical procedures were made using a blend of the CY 2007 ASC payment rate and the ASC payment rate calculated according to the ASC standard ratesetting methodology for the applicable transitional year. In CY 2009, we paid ASCs using a 50/50 blend, in which payment was calculated by adding 50 percent of the CY 2007 ASC rate for a surgical procedure on the CY 2007 ASC list of covered surgical procedures and 50 percent of the CY 2009 ASC rate calculated according to the ASC standard ratesetting methodology for the same procedure. For CY 2010, we transitioned the blend to a 25/75 blend of the CY 2007 ASC rate and the CY 2010 ASC payment rate calculated according to the ASC standard ratesetting methodology. Beginning in CY 2011, we would pay ASCs for all covered surgical procedures, including those on the CY 2007 ASC list, at the ASC payment rates calculated according to the ASC standard ratesetting methodology.

ASC payment rates are calculated by multiplying the ASC conversion factor by the ASC relative payment weight. As discussed fully in section XV. of this proposed rule, we set the proposed CY 2011 ASC relative payment weights by scaling CY 2011 ASC relative payment weights by the ASC scalar of 0.9090. The estimated effects of the updated relative payment weights on payment rates during this first year of full implementation of the ASC payment rates calculated according to the ASC standard ratesetting methodology are varied and are reflected in the estimated payments displayed in Tables 57 and 58 below.

Beginning in CY 2011, section 3401 of the Affordable Care Act requires that the annual update to the ASC payment system, which is the consumer price index for all urban consumers (CPI–U), be reduced by the productivity adjustment. The Affordable Care Act defines the productivity adjustment to be equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity (MFP) (as projected by the Secretary for the 10-year period ending with the applicable fiscal year, year, cost reporting period, or other annual period). We calculated the CY 2011 ASC conversion factor by adjusting the CY 2010 ASC conversion factor by 1.0006 to account for changes in the pre-floor and pre-reclassified hospital wage indices between CY 2010 and CY 2011 and by applying the CY 2011 MFP-adjusted CPI–U of 0 percent (1.6 percent CPI–U minus 1.6 percent MFP). The proposed CY 2011 ASC conversion factor is $41.898.

1. Alternatives Considered

Alternatives to the changes we are making and the reasons that we have chosen specific options are discussed throughout this proposed rule. Some of the major ASC issues discussed in this proposed rule and the options considered are discussed below.

a. Alternatives Considered for Office-Based Procedures

According to our final policy for the revised ASC payment system, we designate as office-based those procedures that are added to the ASC list of covered surgical procedures in CY 2008 or later years and that we determine are predominantly performed in physicians' offices based on consideration of the most recent available volume and utilization data for each individual procedure HCPCS code and/or, if appropriate, the clinical characteristics, utilization, and volume of related HCPCS codes. We establish payment for procedures designated as office-based at the lesser of the MPFS nonfacility practice expense payment amount or the ASC rate developed according to the standard methodology of the revised ASC payment system.

In developing this proposed rule, we reviewed the full CY 2009 utilization data for all surgical procedures added to the ASC list of covered surgical procedures in CY 2008 or later years and for those procedures for which the office-based designation is temporary in the CY 2010 OPPS/ASC final rule with comment period (74 FR 60605 through 60608). Based on that review, and as discussed in section XV.C.1.b. of this proposed rule, we are proposing to newly designate six surgical procedures as permanent office-based (four of which we are also proposing to add to the ASC list of covered surgical procedures for CY 2011) and to make permanent the office-based designations of three existing surgical procedures that have temporary office-based designations in CY 2010. We also are proposing temporary office-based designations for 7 procedures in CY 2011. We considered two alternatives in developing this policy.

The first alternative we considered was to make no change to the procedure payment designations. This would mean that we would pay for the 9 procedures we are proposing to designate as permanently office-based and the 7 procedures we are proposing to designate as temporarily office-based at an ASC payment rate calculated according to the standard ratesetting methodology of the revised ASC payment system. We did not select this alternative because our analysis of the data and our clinical review indicated that all 9 procedures we are proposing to designate as permanently office-based as well as the 7 procedures that we are proposing to designate temporarily as office-based could be considered to be predominantly performed in physicians' offices. Consistent with our final policy adopted in the August 2, 2007 final rule (72 FR 42509 through 42513), we were concerned that making payments at the standard ASC payment rate for the 9 procedures designated as office-based and 7 procedures designated as temporarily office-based could create financial incentives for the procedures to shift from physicians' offices to ASCs for reasons unrelated to clinical decisions regarding the most appropriate setting for surgical care. Further, consistent with our policy, we believe that when adequate data become available to make permanent determinations about procedures with temporary office-based designations, maintaining the temporary designation is no longer appropriate.

The second alternative we considered and the one we are proposing for CY 2011 is to designate six additional procedures as office-based for CY 2011 and to make permanent the office-based designations of three of the procedures with temporary office-based designations in CY 2010. We also are proposing to designate 7 procedures as temporarily office-based in CY 2011. We chose this alternative because our claims data and clinical review indicate that these procedures could be considered to be predominantly performed in physicians' offices. We believe that designating these procedures as office-based, which results in the CY 2010 ASC payment rate for these procedures potentially being capped at the CY 2010 physicians' office rate (that is, the MPFS nonfacility practice expense payment amount), if applicable, is an appropriate step to ensure that Medicare payment policy does not create financial incentives for such procedures to shift unnecessarily from physicians' offices to ASCs, consistent with our final policy adopted in the August 2, 2007 final rule.

b. Alternatives Considered for Covered Surgical Procedures

According to our final policy for the revised ASC payment system, we designate as covered all surgical procedures that we determine would not be expected to pose a significant risk to beneficiary safety or would not be expected to require an overnight stay when performed on Medicare beneficiaries in an ASC.

In developing this proposed rule, we reviewed the clinical characteristics and full CY 2009 utilization data, if applicable, for all procedures reported by Category III CPT codes implemented July 1, 2010, and surgical procedures that were excluded from ASC payment for CY 2010. Based on this review, we identified 8 new surgical procedures described by Category III CPT codes that were new for July 2010 and 5 surgical procedures excluded from ASC payment for CY 2010, that we determined were appropriate for addition to the ASC list of covered surgical procedures. We considered two alternatives in developing this policy.

The first alternative we considered was to make no change to the ASC list of covered surgical procedures for CY 2010. We did not choose this alternative because our analysis of data and clinical review indicated that the 13 procedures we are designating as covered surgical procedures for CY 2011 would not be expected to pose a significant risk to beneficiary safety in ASCs and would not be expected to require an overnight stay. Consistent with our final policy, we were concerned that by continuing to exclude them from the list of ASC covered surgical procedures, we may unnecessarily limit beneficiaries' access to the services in the most clinically appropriate settings.

The second alternative we considered and the one we are proposing for CY 2011 was to designate 13 additional procedures as ASC covered surgical procedures for CY 2011. We chose this alternative because our claims data and clinical review indicate that these procedures would not be expected to

pose a significant risk to beneficiary safety and would not be expected to require an overnight stay, and thus they meet the criteria for inclusion on the list of ASC covered surgical procedures. We believe that adding these procedures to the list of covered surgical procedures is an appropriate step to ensure that beneficiary access to services is not limited unnecessarily.

c. Alternatives Considered for the Extension of Waiver of Deductible to Services Furnished in Connection With or in Relation to a Colorectal Screening Test That Becomes Diagnostic

Section 4104(c)(2) of the Affordable Care Act waives the deductible with respect to a colorectal cancer screening test regardless of the code that is billed for the establishment of a diagnosis as a result of the test, or for the removal of tissue or other matter or other procedure that is furnished in connection with, as a result of, and in the same clinical encounter as a screening test. We are proposing for CY 2011 that the deductible be waived for all surgical services furnished in an ASC on the same date as a planned screening colonoscopy or planned flexible sigmoidoscopy as being furnished in connection with, as a result of, and in the same clinical encounter as the screening test (we note that barium enemas are not ASC covered ancillary or surgical procedures). As discussed in detail under the alternatives considered for the OPPS (section XXII.B.1.a above), we considered three alternatives for the extension of waiver of deductible to services furnished in connection with or in relation to a colorectal screening test that becomes diagnostic for CY 2011. The first alternative we considered, but are not proposing for the reasons previously discussed, was to define a limited set of colonoscopy codes to which the waiver could apply when performed on the same date as a procedure that began as a screening colonoscopy or screening flexible sigmoidoscopy. The second alternative we considered, but are not proposing for the reasons previously discussed, was to define a broader, but still limited set of codes (for example, selected surgical services) to which the waiver could apply when performed on the same date as a procedure that began as a screening colonoscopy or screening flexible sigmoidoscopy. The third alternative we considered, and the one we are proposing for CY 2011, is to apply the waiver to any surgical procedure on the same date as a screening colonoscopy or flexible sigmoidoscopy performed in an ASC that providers report began as a screening test. As we discuss above, we chose this alternative because we believe it provides the greatest ease of public understanding and provider application. We believe that this alternative is appropriate because we believe that it would be very rare for an unrelated surgery to occur on the same date as one of these scheduled screening tests. Moreover, we believe that the risk of improper expenditures would be very small under this policy because it is the deductible, and not the coinsurance, that is waived for the related procedures other than the screening tests (that is, the Part B deductible is a fixed amount that the beneficiary pays before Medicare begins to pay and typically would be met after receiving one to two services).

2. Limitations of Our Analysis

Presented here are the projected effects of the proposed changes for CY 2011 on Medicare payment to ASCs. A key limitation of our analysis is our inability to predict changes in ASC service mix between CY 2009 and CY 2011 with precision. We believe that the net effect on Medicare expenditures resulting from the proposed CY 2011 changes would be small in the aggregate for all ASCs. However, such changes may have differential effects across surgical specialty groups as ASCs continue to adjust to the payment rates based on the policies of the revised ASC payment system. We are unable to accurately project such changes at a disaggregated level. Clearly, individual ASCs would experience changes in payment that differ from the aggregated estimated impacts presented below.

3. Estimated Effects of This Proposed Rule to ASCs

Some ASCs are multispecialty facilities that perform the gamut of surgical procedures, from excision of lesions to hernia repair to cataract extraction; others focus on a single specialty and perform only a limited range of surgical procedures, such as eye, digestive system, or orthopedic procedures. The combined effect on an individual ASC of the proposed update to the CY 2011 payments would depend on a number of factors, including, but not limited to, the mix of services the ASC provides, the volume of specific services provided by the ASC, the percentage of its patients who are Medicare beneficiaries, and the extent to which an ASC provides different services in the coming year. The following discussion presents tables that display estimates of the impact of the proposed CY 2011 update to the revised ASC payment system on Medicare payments to ASCs, assuming the same mix of services as reflected in our CY 2009 claims data. Table 57 depicts the estimated aggregate percent change in payment by surgical specialty or ancillary items and services group by comparing estimated CY 2010 payments to estimated proposed CY 2011 payments, and Table 58 shows a comparison of estimated CY 2010 payments to estimated proposed CY 2011 payments for procedures that we estimate would receive the most Medicare payment in CY 2011.

Table 57 shows the estimated effects on aggregate proposed Medicare payments under the revised ASC payment system by surgical specialty or ancillary items and services group. We have aggregated the surgical HCPCS codes by specialty group, grouped all HCPCS codes for covered ancillary items and services into a single group, and then estimated the effect on aggregated payment for surgical specialty and ancillary items and services groups. The groups are sorted for display in descending order by estimated Medicare program payment to ASCs. The following is an explanation of the information presented in Table 57.

- Column 1—*Surgical Specialty or Ancillary Items and Services Group* indicates the surgical specialty into which ASC procedures are grouped or the ancillary items and services group which includes all HCPCS codes for covered ancillary items and services. To group surgical procedures by surgical specialty, we used the CPT code range definitions and Level II HCPCS codes and Category III CPT codes, as appropriate, to account for all surgical procedures to which the Medicare program payments are attributed.
- Column 2—*Estimated ASC Payments* were calculated using CY 2009 ASC utilization (the most recent full year of ASC utilization) and CY 2010 ASC payment rates. The surgical specialty and ancillary items and services groups are displayed in descending order based on estimated CY 2010 ASC payments.
- Column 3—*Estimated CY 2011 Percent Change (Fully Implemented Payment Rates)* is the aggregate percentage increase or decrease in Medicare program payment to ASCs for each surgical specialty or ancillary items and services group that would be attributable to proposed updates to ASC payment rates for CY 2011 compared to CY 2010.

As seen in Table 57, we estimate that the proposed update to ASC rates for CY 2011 would result in a 1 percent decrease in aggregate payment amounts for eye and ocular adnexa procedures, a

6 percent decrease in aggregate payment amounts for digestive system procedures, and a 1 percent increase in aggregate payment amounts for nervous system procedures.

Generally, for the surgical specialty groups that account for less ASC utilization and spending, we estimate that the payment effects of the proposed CY 2011 update are positive. We estimate that ASC payments for procedures in those surgical specialties would increase in CY 2011. For instance, we estimate that, in the aggregate, payment for integumentary system procedures would increase by 3 percent under the proposed CY 2011 rates. We estimate similar effects for genitourinary, cardiovascular, musculoskeletal, respiratory, hematologic and lymphatic systems, and auditory system procedures as well.

An estimated increase in aggregate payment for the specialty group does not mean that all procedures in the group would experience increased payment rates. For example, the estimated modest increase for CY 2011 for nervous system procedures is likely due to increase in the ASC payment weight for some of the high volume procedures, such as CPT code 64721 (Neuroplasty and/or transposition; median nerve at carpal tunnel).

Also displayed in Table 57 is a separate estimate of Medicare ASC payments for the group of separately payable covered ancillary items and services. We estimate that aggregate payments for these items and services would decrease by 2 percent for CY 2011. The payment estimates for the covered surgical procedures include the costs of packaged ancillary items and services. In rules for years prior to CY 2010, we did not have ASC payment data for covered ancillary items and services because, prior to CY 2008, they were paid under other fee schedules or packaged into payment for the covered surgical procedures. Beginning with the CY 2010 OPPS/ASC rulemaking, we have utilization data for those services as well as for all of the covered surgical procedures provided in ASCs under the revised payment system.

TABLE 57—ESTIMATED IMPACT OF THE PROPOSED CY 2011 UPDATE TO THE ASC PAYMENT SYSTEM ON AGGREGATE CY 2011 MEDICARE PROGRAM PAYMENTS BY SURGICAL SPECIALTY OR ANCILLARY ITEMS AND SERVICES GROUP

Surgical Specialty Group (1)	Estimated CY 2010 ASC Payments (in Millions) (2)	Estimated CY 2011 Percent Change (Fully Implemented) (3)
Total	3,231	0
Eye and ocular adnexa	1,410	-1
Digestive system	697	-6
Nervous system	386	1
Musculoskeletal system	350	11
Genitourinary system	128	7
Integumentary system	122	3
Respiratory system	36	14
Cardiovascular system	24	4
Ancillary items and services	18	-2
Auditory system	8	9
Hematologic & lymphatic systems	4	15

Table 58 below shows the estimated impact of the proposed updates to the revised ASC payment system on aggregate ASC payments for selected surgical procedures during CY 2011. The table displays 30 of the procedures receiving the greatest estimated CY 2010 aggregate Medicare payments to ASCs. The HCPCS codes are sorted in descending order by estimated CY 2010 program payment.

- Column 1—*HCPCS code.*
- Column 2—*Short Descriptor* of the HCPCS code.
- Column 3—*Estimated CY 2010 Allowed Charges* were calculated using CY 2009 ASC utilization (the most recent full year of ASC utilization) and the CY 2010 ASC payment rates. The estimated CY 2010 allowed charges are expressed in millions of dollars.
- Column 4—*Estimated CY 2010 Percent Change (Fully Implemented Payment Rates)* reflects the percent differences between the estimated ASC payment for CY 2010 and the estimated payment for CY 2011 based on the proposed update.

As displayed in Table 58, 21 of the 30 procedures with the greatest estimated aggregate CY 2010 Medicare payment are included in the 3 surgical specialty groups that are estimated to account for the most Medicare payment to ASCs in CY 2011, specifically eye and ocular adnexa, digestive system, and nervous system surgical groups. Consistent with the estimated payment effects on the surgical specialty groups displayed in Table 57, the estimated effects of the proposed CY 2011 update on ASC payment for individual procedures shown in Table 58 are varied.

The ASC procedure for which the most Medicare payment is estimated to be made in CY 2010 is the cataract removal procedure reported with CPT code 66984 (Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (e.g.,

irrigation and aspiration or phacoemulsification)). We estimate that the proposed update to the ASC rates would result in a 2 percent payment decrease for this procedure in CY 2011. The estimated payment effects on two of the three other eye and ocular adnexa procedures included in Table 58 are more significant. We estimate that the proposed payment rate for CPT code 66821 (Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); laser surgery (e.g., YAG laser) (one or more stages)) would decrease by 9 percent and payment for CPT code 67904 (Repair eyelid defect) would increase by 9 percent.

We estimate that the proposed payment rates for all of the digestive system procedures included in Table 58 would decrease by 1 to 10 percent in CY 2011. Those estimated decreases are consistent with decreases in the previous 3 years under the revised ASC payment system and are expected because, under the previous ASC payment system, the payment rates for many high volume endoscopy procedures were almost the same as the payments for the procedures under the OPPS.

The estimated effects of the proposed CY 2011 update on the 9 nervous system procedures for which the most Medicare ASC payment is estimated to be made in CY 2010 would be variable. Our estimates indicate that the proposed CY 2011 update would result in payment increases of 2 to 10 percent for 5 of the 9 procedures and result in a 1 percent decrease for the other 4 nervous system procedures. The nervous system procedures for which we estimate a positive effect on CY 2010 payments include CPT codes 64721 (Neuroplasty and/or transposition; median nerve at carpal tunnel) and 64622 (Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, single level), which are expected to have payment increases of 10 percent and 6 percent, respectively.

The estimated payment effects for most of the remaining procedures listed in Table 58 would be positive. For example, the proposed payment rates for musculoskeletal CPT codes 29880 (Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving)) and 29881 (Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving)) would be estimated to increase 10 percent over the CY 2010 transitional payment rates. Musculoskeletal procedures would be expected to account for a greater percentage of CY 2011 Medicare ASC spending as we estimate that payment for procedures in that surgical specialty group would increase under the revised payment system in CY 2011.

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TABLE 58.--ESTIMATED IMPACT OF THE PROPOSED UPDATE TO CY 2011 ASC PAYMENT SYSTEM ON AGGREGATE PAYMENTS FOR SELECTED PROCEDURES

HCPCS Code*	Short Descriptor	Estimated CY 2010 Allowed Charges (in mil)	Estimated CY 2011 Percent change (fully implemented payment)
(1)	(2)	(3)	(4)
66984	Cataract surg w/iol, 1 stage	1,091	-2%
43239	Upper GI endoscopy, biopsy	162	-8%
45380	Colonoscopy and biopsy	129	-7%
45378	Diagnostic colonoscopy	109	-7%
45385	Lesion removal colonoscopy	88	-7%
66982	Cataract surgery, complex	73	-2%
62311	Inject spine l/s (cd)	66	-1%
66821	After cataract laser surgery	63	-9%
64483	Inj foramen epidural l/s	61	-1%
15823	Revision of upper eyelid	40	-5%
64493	Inj paravert f jnt l/s 1 lev	36	2%
G0105	Colorectal scrn; hi risk ind	32	-10%
63650	Implant neuroelectrodes	30	3%
29881	Knee arthroscopy/surgery	28	10%
45384	Lesion remove colonoscopy	28	-7%
G0121	Colon ca scrn not hi rsk ind	27	-10%
64721	Carpal tunnel surgery	26	10%
29826	Shoulder arthroscopy/surgery	24	16%
43235	Uppr gi endoscopy, diagnosis	24	-1%
29880	Knee arthroscopy/surgery	23	10%
52000	Cystoscopy	21	-7%
63685	Insrt/redo spine n generator	20	5%
29827	Arthroscop rotator cuff repr	20	12%
64622	Destr paravertebrl nerve l/s	17	6%
28285	Repair of hammertoe	17	11%
62310	Inject spine c/t	15	-1%
26055	Incise finger tendon sheath	14	7%
67904	Repair eyelid defect	13	9%
64623	Destr paravertebral n add-on	13	-1%
50590	Fragmenting of kidney stone	13	-4%

*Note that HCPCS codes proposed for deletion for CY 2010 are not displayed in this table.

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The previous ASC payment system served as an incentive to ASCs to focus on providing procedures for which they determined Medicare payments would support their continued operation. We note that, historically, the ASC payment rates for many of the most frequently performed procedures in ASCs were similar to the OPPS payment rates for the same procedures. Conversely, procedures with ASC payment rates that were substantially lower than the OPPS rates have historically been performed least often in ASCs. We believed that the revised ASC payment system would encourage greater efficiency in ASCs and would promote significant increases in the breadth of surgical procedures performed in ASCs because it distributes payments across the entire spectrum of covered surgical procedures based on a coherent system of relative weights that are related to the clinical and facility resource requirements of those procedures.

The CY 2009 claims data that we used to develop the proposed CY 2011 ASC payment system relative weights and rates reflect the second year of utilization under the revised payment system. Although the changes in the claims data are not large, the data reflect increased Medicare ASC spending for procedures that were newly added to the ASC list in CY 2008. Our estimates based on CY 2009 data indicate that for CY 2011 there would be especially noticeable increases in spending for respiratory systems, and hematologic and lymphatic systems, compared to the previous ASC payment system.

4. Estimated Effects of This Proposed Rule on Beneficiaries

We estimate that the proposed CY 2011 update to the ASC payment system would be generally positive for beneficiaries with respect to the new procedures that we are adding to the ASC list of covered surgical procedures and for those that we are designating as office-based for CY 2010. First, as discussed in section XV.D.1.d. of this proposed rule, we are proposing to waive either the coinsurance, the Part B deductible, or both for certain preventive services recommended by the USPSTF with a grade of A or B for any indication or population and that are appropriate for the individual to comply with sections 4104 and 10406 of the Affordable Care Act. Other than these services, the ASC coinsurance rate for all procedures is 20 percent. This contrasts with procedures performed in HOPDs, where the beneficiary is responsible for copayments that range from 20 percent to 40 percent of the procedure payment. Second, ASC payment rates under the revised payment system are lower than payment rates for the same procedures under the OPPS; therefore, the beneficiary coinsurance amount under the ASC payment system almost always would be less than the OPPS copayment amount for the same services. (The only exceptions would be if the ASC coinsurance amount exceeds the inpatient deductible. The statute requires that copayment amounts under the OPPS not exceed the inpatient deductible.) For new procedures that we are proposing to add to the ASC list of covered surgical procedures in CY 2011, as well as for procedures already included on the list, and that are furnished in an ASC rather than the HOPD setting, the beneficiary coinsurance amount would be less than the OPPS copayment amount. Furthermore, the proposed additions to the ASC list of covered surgical procedures would provide beneficiaries access to more surgical procedures in ASCs. Beneficiary coinsurance for services migrating from physicians' offices to ASCs may decrease or increase under the revised ASC payment system, depending on the particular service and the relative payment amounts for that service in the physician's office compared to the ASC. However, for those additional procedures that we are proposing to designate as office-based in CY 2011, the beneficiary coinsurance amount would be no greater than the beneficiary coinsurance in the physician's office.

In addition, as finalized in the August 2, 2007 final rule (72 FR 42521), in CY 2011, the final year of the 4-year transition to the ASC payment rates calculated according to the ASC standard ratesetting methodology of the revised ASC payment system, ASC payment rates for a number of commonly furnished ASC procedures would continue to be reduced, resulting in lower beneficiary coinsurance amounts for these ASC services in CY 2011.

5. Conclusion

The proposed updates to the ASC payment system for CY 2011 would affect each of the approximately 5,000 ASCs currently approved for participation in the Medicare program. The effect on an individual ASC would depend on its mix of patients, the proportion of the ASC's patients that are Medicare beneficiaries, the degree to which the payments for the procedures offered by the ASC are changed under the revised payment system, and the extent to which the ASC provides a different set of procedures in the coming year.

The CY 2011 proposed update to the revised ASC payment system includes an MFP-adjusted CPI–U increase factor of 0 percent that we estimate would result in the same amount of Medicare expenditures in CY 2011 than was estimated to be made in CY 2010. We estimate that the proposed update to the revised ASC payment system, including the addition of surgical procedures to the list of covered surgical procedures, would have minimal effect on Medicare expenditures compared to the estimated level of Medicare expenditures in CY 2010.

6. Accounting Statement

As required by OMB Circular A–4 (available at *http://www.whitehousegov/omb/circulars/a004/a-4.pdf*), in Table 59 below, we have prepared an accounting statement showing the classification of the expenditures associated with the statutorily authorized 0.0 percent update to the CY 2011 revised ASC payment system, based on the provisions of this proposed rule and the baseline spending estimates for ASCs in the FY 2011 President's Budget. This table provides our best estimate of Medicare payments to suppliers as a result of the proposed update to the CY 2011 ASC payment system, as presented in this proposed rule. All expenditures are classified as transfers.

TABLE 59.--ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED TRANSFERS FROM CY 2010 TO CY 2011 AS A RESULT OF THE PROPOSED CY 2011 UPDATE TO THE REVISED ASC PAYMENT SYSTEM

Category	Transfers
Annualized Monetized Transfers	$0
From Whom to Whom	Federal Government to Medicare Providers and Suppliers
Total	$0

D. Effects of Proposed Requirements for Hospital Reporting of Quality Data for Annual Hospital Payment Update

In section XVI. of the CY 2009 OPPS/ASC final rule with comment period (73 FR 68758), we discussed our requirements for subsection (d) hospitals to report quality data under the HOP QDRP in order to receive the full payment update for CY 2010. In section XVI. of this proposed rule, we proposed additional policies affecting the HOP QDRP for CY 2012, CY 2013, and CY 2014. We estimate that about 90 hospitals may not receive the full payment update in CY 2011. Most of these hospitals receive little to no OPPS reimbursement on an annual basis. However, at this time, information is not available to determine the precise number of hospitals that do not meet the requirements for the full hospital market basket increase for CY 2011. We also estimate that 90 hospitals may not

receive the full payment update in CY 2012. We are unable at this time to estimate the number of hospitals that may not receive the full payment update in CY 2013 and CY 2014.

In section XVI.E.3.a. of the CY 2010 OPPS/ASC final rule with comment period, for the CY 2011 payment update, as part of the validation process, we are requiring hospitals to submit paper copies of requested medical records to a designated contractor within the required timeframe. Failure to submit requested documentation can result in a 2 percentage point reduction in a hospital's update, but the failure to attain a validation score threshold would not. Of the 90 hospitals that we estimate would not receive the full payment update for CY 2011, we estimate that no more than 20 hospitals would fail the validation documentation submission requirement for the CY 2011 payment update.

In section XVI.E.3.b. of the CY 2010 OPPS/ASC final rule with comment period, we did not, at that time, adopt our proposal in the CY 2010 OPPS/ASC proposed rule (74 FR 35403) to expand the CY 2011 validation requirement for the CY 2012 payment update. Instead, we stated that we would consider the public comments we received on that proposal, as well as any analyses we conduct of the CY 2011 validation process, and propose a CY 2012 validation process as a part of the CY 2011 OPPS/ASC rulemaking. We believe that this approach would give HOP QDRP hospitals experience with the validation process and allow these hospitals sufficient time to prepare for the CY 2012 validation.

In this proposed rule, we are proposing to validate data submitted by 800 hospitals for purposes of the CY 2012 HOP QDRP payment determination. For CY 2011 and under our proposal for CY 2012 in this proposed rule, we stated that we would calculate the validation matches for CY 2011 (we note, however, that the validation results would not affect the CY 2011 payment update) and CY 2012 by assessing whether the measure data submitted by the hospital matches the independently reabstracted measure data. In addition, for the CY 2012 payment update in this proposed rule, we are proposing to validate data for only 800 hospitals out of the approximately 3,200 HOP QDRP participating hospitals. We believe that this approach is suitable for HOP QDRP data because it will: Produce a more reliable estimate of whether a hospital's submitted data have been abstracted accurately; provide more statistically reliable estimates of the quality of care delivered in each selected hospital as well as at the national level; and reduce overall hospital burden because most hospitals will not be selected to undergo validation each year. We have proposed a threshold of 75 percent as the threshold for the validation score because we believe this level is reasonable for hospitals to achieve while still ensuring accuracy of the data. Additionally, this level is consistent with what has been proposed in the RHQDAPU program (75 FR 23993). As a result, we believe that the effect of our proposed validation process for CY 2012 would be minimal in terms of the number of hospitals that would not meet all program requirements.

The validation requirement of a maximum of 12 cases per hospital per quarter will result in medical record documentation for approximately 9,600 cases per quarter being submitted to a designated CMS contractor. We would pay for the cost of sending this medical record documentation to the designated CMS contractor at the rate of 12 cents per page for copying and approximately $1.00 per case for postage. We have found, based on experience that an outpatient medical chart is up to 10 pages. Thus, as a result of validation requirements effective for the CY 2012 annual payment update, we would have expenditures of approximately $21,120 per quarter. Again, as we would pay for the data collection effort, we believe that a requirement for medical record documentation for a maximum of 12 cases per quarter for 800 hospitals represents a minimal burden to HOP QDRP-participating hospitals.

E. Effects of Proposed Changes in Payments to Hospitals for Direct GME and IME Costs

1. Redistribution of Residency Slots

As discussed in section XVII. of this proposed rule, section 5503 of the Affordable Care Act added a new section 1886(h)(8) to the Act that provides for reductions in the statutory FTE resident caps under Medicare for certain hospitals and authorizes a "redistribution" of the FTE resident slots resulting from the reduction in the FTE resident caps to other hospitals.

At this time, we are unable to project how many FTE resident slots will be available for redistribution under section 5503 of the Affordable Care Act. Unlike section 422 of the Medicare Modernization Act, which also provided for a redistribution of FTE resident slots but provided that the redistributed slots would be paid using the national average per resident amount (PRA) for direct GME payment purposes, section 5503 of the Affordable Care Act requires that hospitals be paid for their additional FTE resident slots using the hospitals' specific PRAs. Since we are unable to determine the number of FTE resident slots that will be redistributed under section 5503 or which hospitals will be receiving additional FTE resident slots, we cannot calculate a direct GME impact for section 5503. We do not know the PRAs and Medicare utilization rates of hospitals that will be receiving additional FTE resident slots. For purposes of determining an impact for IME payment purposes, section 5503 requires us to use an IME multiplier of 1.35, however, we do not know the intern and resident to bed ratio for the hospitals that will receive additional FTE resident slots or the volume or case mix of Medicare discharges at those hospitals. Therefore, we cannot determine a financial impact for purposes of direct GME and IME for this provision.

2. Counting Resident Time in Nonprovider Settings

In section XVII. of this proposed rule, we discuss our proposed implementation of several changes made by section 5504 of the Affordable Care Act with regard to counting resident time in nonprovider settings for GME and IME payment purposes. Specifically, section 5504 eliminates the requirement for hospitals to incur "all or substantially all of the costs for the training program in the nonhospital setting," and now hospitals must only incur the costs of the salaries and fringe benefits of residents who train in nonhospital sites It also allows more than one hospital to incur the costs of training programs at nonhospital settings, either directly or through a third party. In addition, section 5504 creates a recordkeeping requirement for hospitals to track the time residents spend training in nonhospital settings, which CMS must compare to analogous data from a base year.

With respect to the recordkeeping requirement, we are proposing that rotation schedules be the source for establishing the amount of time that residents spend training in nonhospital sites, both in the base year and in subsequent years. In addition, we are proposing that cost reporting periods beginning on or after July 1, 2009 and before June 30, 2010 be the base year against which we will compare subsequent years' data to determine if the amount of nonhospital training that occurs in subsequent years increases relative to that base year. We also are proposing that hospitals only need to maintain records of the direct GME FTE

count of resident training time in nonhospital settings. Finally, we are proposing to include several additional lines on the Medicare cost report for hospitals to submit these data. Hospitals would be required to report these data on a program-specific basis for their primary care programs, and on an overall hospital basis for their nonprimary care programs. These data will help CMS identify whether barriers to resident training in nonhospital sites continue to exist.

We do not believe that any of these proposed policies will have a significant financial impact on the Medicare program. While these policies may allow hospitals to count additional FTEs training in nonhospital sites, we do not believe that this constitutes significant financial impact on the Medicare program, since those residents would have been training at the hospital if they were not training at the nonhospital site. We note that the FTE slot redistribution discussed above that is required by section 5503 of the Affordable Care Act may have an impact on the hospitals' ability to increase the number of residents training at nonhospital sites, unless it moves the training that is currently conducted at the hospital to a nonhospital site. Therefore, the financial impact of section 5504 will be minimal.

3. Counting Resident Time for Didactic and Scholarly Activities and Other Activities

In section XVII. of this proposed rule, we discuss our proposals to implement the provisions of section 5505 of the Affordable Care Act that make several changes to existing CMS policy with respect to counting resident training time for didactic, scholarly and other activities. Specifically, section 5505(a) allows a hospital to count the time that residents spend training in an approved program in a "nonprovider setting that is primarily engaged in furnishing patient care" for direct GME purposes. Section 5505(b) allows nonpatient care activities to count toward resident time for IME purposes as well, but only in certain hospital settings. These nonpatient care activities do not include research activities that are not associated with the treatment or diagnosis of a particular patient. Section 5505 also allows hospitals to count the time spent by residents on vacation, sick leave, or other approved leave in the hospitals' direct GME and IME resident counts, as long as the leave time does not prolong the total time that the resident is participating in the approved training program. In our discussion of the provisions of section 5505, we described the definitions of the various new terms used in this section of the Affordable Care Act.

We do not believe that any of the proposed policies to implement section 5505 will have a significant financial impact on the Medicare program. While all of these provisions allow teaching hospitals to claim more resident training time on their respective cost reports, a hospital is limited as to how many resident FTEs it can count. In addition, we note that the FTE slot redistribution that is required by section 5503 of the Affordable Care Act discussed earlier may impact hospitals' ability to increase the number of residents training at nonhospital sites, unless a hospital moves the training that is currently conducted at the hospital to a nonhospital site. Therefore, the financial impact of section 5505 is minimal.

4. Preservation of Resident Cap Positions From Closed Hospitals

In section XVII.C. of this proposed rule, we discuss our proposals to implement section 5506 of the Affordable Care Act. Prior to the passage of the Affordable Care Act, if a teaching hospital closed, its direct GME and IME FTE resident cap slots would be "lost," because those slots are associated with a specific hospital's Medicare provider agreement. Section 5506 of the Affordable Care Act addresses this situation by instructing the Secretary to establish a process by regulation that would redistribute slots from teaching hospitals that close to hospitals that meet certain criteria.

Section 5506 applies to teaching hospitals that closed "on or after a date that is 2 years before the date of enactment," that is, March 23, 2008. Accordingly, although section 5506 does address certain teaching hospital closures that have already occurred, the focus of this provision is primarily on future teaching hospital closures, and ensuring that FTE resident cap slots are not lost to a community. We are unable to project which teaching hospitals will close, how many FTE resident slots they have, and to which hospitals those slots would be ultimately redistributed. Therefore, we cannot determine a financial impact for this provision.

F. Effects of Proposed Changes to Physician Self-Referral Regulations and Related Proposed Changes to Provider Agreement Regulations

Most physicians who have ownership or investment interests in hospitals ("physician-owned hospitals") and who refer DHS to the hospital, are subject to the physician self-referral prohibition, and are unable to qualify for the ownership and investment exception at section 1877(d)(1) of the Act. Section 1877(d)(1) of the Act provides an exception for ownership or investment in publicly traded securities in a corporation where there is stockholder equity exceeding $75 million at the end of the corporation's most recent fiscal year or on average during the previous 3 fiscal years; or the ownership or investment interest involves mutual funds in a company that has assets greater than $75 million. Studies by the OIG and GAO have concluded that physician-owned hospitals tend to be smaller and are unable to meet the $75 million threshold. Therefore, most physician-owned hospitals avail themselves of the rural provider or hospital ownership exceptions (sections 1877(d)(2) and (d)(3) of the Act, respectively). As discussed in section XVIII. of this proposed rule, section 6001 of the Affordable Care Act amended section 1877 of the Act to impose additional requirements in order to qualify for the rural provider and hospital ownership or investment exceptions. Our proposals under section XVIII. of this proposed rule would incorporate these requirements into our regulations.

Our proposed revisions to the regulations would limit the creation of new Medicare participating hospitals in which physician owners or investors intend to refer patients for DHS by requiring such hospitals to have physician ownership and a provider agreement in effect on December 31, 2010, as provided for by section 6001 of the Affordable Care Act. This proposed revision would affect facilities with physician ownership or investment that are currently under development but may be unable to have a provider agreement in effect on December 31, 2010. We believe there would only be a few facilities or hospital projects under development that would be unable to meet either of these criteria.

In addition to the effect on the creation of new physician-owned hospitals, the proposed revision of the regulations to incorporate the provisions of section 6001 of the Affordable Care Act would impact existing physician-owned hospitals that currently avail themselves of the rural provider or whole hospital exception. Specifically, a physician-owned hospital would be prohibited from expanding the number of beds, operating rooms, and procedure rooms beyond those for which it was licensed as of March 23, 2010, or, in the case of a hospital that did not have a provider agreement in effect as of this date but does have a provider agreement

in effect on December 31, 2010, the effective date of the provider agreement. We believe there are only a few hospitals that were in the midst of an expansion that was not completed by March 23, 2010 (or, in the case of a hospital that did not have a provider agreement in effect as this date but does have a provider agreement in effect on December 31, 2010), and thus, may not be able to use the new beds, operating rooms, and procedures rooms. We believe that most facilities and their investors were aware of the possible legislation that would limit facility expansion and, thus, did not continue to pursue expansion of their facilities.

Our proposed regulations would require hospitals to have procedures in place that require referring physicians to disclose to patients the referring physicians' ownership or investment interests in the hospital, as well as any ownership or investment interest in the hospital held by a treating physician. This proposal also would require hospitals to disclose on any public Web site for the hospital or in any public advertising that it is owned or invested in by physicians. Finally, under the proposed revision of the regulations, a hospital would not condition any physician ownership or investment either directly or indirectly on the physician making or influencing referrals to the hospital or otherwise generating business for the hospital. Most physician-owned hospitals comply with the current provisions of § 489.20(u). Thus, they have procedures in place to require referring physician owners or investors to disclose their ownership or investment interests to patients. We believe most physicians and hospitals will be minimally affected by the additional requirements.

Our proposed revisions to the regulations would require that hospitals must ensure that all ownership and investment interests are *bona fide,* a step that we believe most prudent hospitals are already undertaking. We believe most of the new statutory and proposed regulatory provisions would have little, if any, impact on physician-owned hospitals or physicians. The only provision that may have a minor impact is the provision found under section 1877(i)(1)(D)(*i*) of the Act and proposed § 411.362(b)(4)(i) that prohibits physician-owned hospitals from increasing the percentage of the total value of the ownership or investment interests held in the hospital, or in an entity whose assets include the hospital by physician owners or investments beyond that which existed on March 23, 2010. Therefore, hospitals and other entities that own the hospital must monitor the percentages of ownership or investment to ensure that the percentage is not increased. We believe this proposal would have a minor effect on some hospitals and their physician owners or investors.

Our proposed revisions to the regulations also would require hospitals to take certain steps to ensure patient safety, most of which are practices or procedures that we believe most hospitals currently undertake. Building upon the safety requirements found in existing § 489.20(w), we are proposing to require under proposed §§ 411.362(b)(5)(i) and 489.20(w)(2) that, before admitting a patient, the hospitals must receive a signed acknowledgment from the patient stating that the patient understands that a physician may not be present during the time services are furnished to a patient. In addition, proposed §§ 411.362(b)(5)(ii) and 489.20(w)(1) would require hospitals to have the capacity to provide assessment and initial treatment for patients and the ability to refer and transfer patients to hospitals with the capability to treat the needs of the patient involved. We believe requesting a signed acknowledgment would impose a minimal burden on hospitals. Also, most hospitals currently have in place procedures to ensure that they have the capacity to provide assessment and initial treatment for patients and the ability to refer and transfer patients.

Lastly, our proposed revisions to the regulations would prohibit a facility that was previously an ASC and was converted into a hospital from qualifying for the rural provider or whole hospital ownership exceptions to the self-referral prohibition. Although we have no direct data on this point, we believe there are only a few ASCs that are being converted to a hospital, and, thus, the effect is minimal.

We believe that our proposals in XVIII. of this proposed rule would affect a relatively small number of physician-owned hospitals and physicians. We are uncertain of the exact numbers of hospitals with physician ownership or investment that would be impacted by the proposals and their restrictions. However, the most recent studies by CMS (August 8, 2006 Final Report to the Congress Required under Section 5006 of the Deficit Reduction Act of 2005) and MedPAC (June 2005 Report to the Congress) concluded that there were approximately 128 physician-owned specialty hospitals (those that focus primarily on patients with a cardiac condition, orthopedic condition, or those receiving a surgical procedure). We recognize that there are other hospitals with physician ownership that do not meet the definition of a specialty hospital but we do not have verifiable data on the number of these facilities. However, we have recently received information from a trade association representing physician-owned hospitals that there are approximately 265 hospitals that would be subject to the provisions of our proposed rule.

The proposed changes concerning disclosure of physician ownership in hospitals and patient safety are consistent with the physician self-referral statute and regulations, our existing regulations governing basic commitments of providers, and the current practices of most hospitals. Thus, our proposed requirements would present a negligible impact on physician-owned hospitals. Physician-owned hospitals would have a one-time cost associated with creating or modifying a notice to be used when a physician is not on the premises 24 hours a day. In addition, these hospitals would incur the costs associated with ensuring that a signed acknowledgment is received from patients. Similarly, the costs borne by individual physicians to implement the provisions would be limited to a one-time cost associated with developing a disclosure notice that discloses the ownership of the referring and, where applicable, the treating physician.

Overall, we believe that beneficiaries would be positively impacted by these proposed provisions. Specifically, additional information concerning disclosures of ownership and patient safety measures equip patients to make informed decisions about where they elect to receive care. Our proposals make no significant changes that have the potential to impede patient access to health care facilities and services. We believe that our proposals are necessary to conform our regulations to the amendments to section 1877 of the Act. We also believe the proposed regulations would help minimize anticompetitive behavior that can affect the decision as to where a beneficiary receives health care services and would possibly enhance the quality of the services furnished.

G. Executive Order 12866

In accordance with the provisions of Executive Order 12866, this proposed rule was reviewed by the OMB.

List of Subjects

42 CFR Part 410

Health facilities, Health professions, Laboratories, Medicare, Rural areas, X-rays.

42 CFR Part 411

Kidney diseases, Medicare, Physician referral, Reporting and recordkeeping requirements.

42 CFR Part 412

Administrative practice and procedure, Health facilities, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 416

Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 419

Hospitals, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 482

Grant programs—health, Hospitals, Medicaid, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 489

Health facilities, Medicare, Reporting and recordkeeping requirements.

For reasons stated in the preamble of this document, the Centers for Medicare & Medicaid Services is proposing to amend 42 CFR Chapter IV as set forth below:

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

1. The authority citation for Part 410 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

2. Section 410.2 is amended by—

a. Under the definition of "Community mental health center (CMHC)", removing the word "and" at the end of paragraph (4); removing the period at the end of paragraph (5) and adding in its place "; and"; and adding a new paragraph (6).

b. Revising the definition of "Partial hospitalization services".

The additions and revisions read as follows:

§ 410.2 Definitions.

* * * * *

Community mental health center (CMHC) means an entity that—

* * * * *

(6) Provides at least 40 percent of its services to individuals who are not eligible for benefits under title XVIII of the Social Security Act.

* * * * *

Partial hospitalization services means a distinct and organized intensive ambulatory treatment program that offers less than 24-hour daily care other than in an individual's home or in an inpatient or residential setting and furnishes the services as described in § 410.43.

* * * * *

3. Section 410.27 is amended by—

a. Removing the word "and" at the end of paragraph (a)(1)(iii).

b. Adding a new paragraph (a)(1)(v).

c. Adding a new paragraph (a)(2).

d. Revising paragraph (b).

The addition and revisions read as follows:

§ 410.27 Outpatient hospital or CAH services and supplies incident to a physician or nonphysician practitioner service: Conditions.

(a) * * *

(1) * * *

(v) Certain nonsurgical extended duration therapeutic services that are designated by CMS as requiring direct supervision, as defined in (a)(1)(iv) of this section, by a physician or nonphysician practitioner only at the initiation of the service, after which general supervision, as defined in § 410.32(b)(3)(i), is required.

(A) Nonsurgical extended duration therapeutic services are services that can last a significant period of time, have a substantial monitoring component, and have a low risk of requiring the physician's or appropriate nonphysician practitioner's physical presence to furnish assistance and direction after the initiation of the service.

(B) Initiation of the service means the beginning portion of a service ending when the patient is stable and the supervising physician or appropriate nonphysician practitioner believes the remainder of the service can safely be delivered under his or her general direction and control without needing the supervising physician's or appropriate nonphysician practitioner's physical presence on the hospital campus or in the provider-based department of the hospital.

(2) In the case of partial hospitalization services, also meet the conditions of paragraph (d) of this section.

(b) Drugs and biologicals also are subject to the limitations specified in § 410.29.

* * * * *

4. Section 410.152 is amended by revising paragraph (i)(2) to read as follows:

§ 410.152 Amounts of payment.

* * * * *

(i) * * *

(2) For ASC services furnished on or after January 1, 2008, in connection with the covered surgical procedures specified in § 416.166 of this subchapter, except as provided in paragraphs (i)(2)(i), (i)(2)(ii), and (l) of this section, Medicare Part B pays the lesser of 80 percent of the actual charge or 80 percent of the prospective payment amount, geographically adjusted, if applicable, as determined under Subpart F of Part 416 of this subchapter. Part B coinsurance is 20 percent of the actual charge or 20 percent of the prospective payment amount, geographically adjusted, if applicable.

(i) If the limitation described in § 416.167(b)(3) of this subchapter applies, Medicare pays 80 percent of the amount determined under Subpart B of Part 414 of this subchapter and Part B coinsurance is 20 percent of the applicable payment amount, except as provided in paragraph (l) of this section.

(ii) Between January 1, 2008 and December 31, 2010, Medicare Part B pays 75 percent of the applicable payment amount for screening flexible sigmoidoscopies and screening colonoscopies, and Part B coinsurance is 25 percent of the applicable payment amount.

PART 411—EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT

5. The authority citation for Part 411 continues to read as follows:

Authority: Secs. 1102, 1860D–1 through 1860D–42, 1871, and 1877 of the Social Security Act (42 U.S.C. 1302, 1395w–101 through 1395w–152, 1395hh and 1395nn).

6. Section 411.356 is amended by—

a. Republishing the introductory text of paragraph (c) and revising paragraph (c)(1).

b. Removing the word "and" at the end of paragraph (c)(3)(ii).

c. Removing the period at the end of paragraph (c)(3)(iii) and adding "; and" in its place.

d. Adding a new paragraph (c)(3)(iv).

The revision and addition read as follows:

§ 411.356 Exceptions to the referral prohibition related to ownership or investment interests.

* * * * *

(c) *Specific providers.* Ownership or investment in the following entities, for purposes of the services specified:

(1) A rural provider, in the case of DHS furnished in a rural area (as defined at § 411.351 of this subpart) by the provider. A "rural provider" is an entity that furnishes substantially all (not less than 75 percent) of the DHS that it furnishes to residents of a rural area and, for the 18-month period beginning on December 8, 2003 (or such other period as Congress may specify), is not a specialty hospital, and in the case where the entity is a hospital, the hospital meets the requirements of § 411.362 no later than September 23, 2011.

* * * * *

(3) * * *

(iv) The hospital meets the requirements described in § 411.362 not later than September 23, 2011.

7. A new § 411.362 is added to read as follows:

§ 411.362 Additional requirements concerning physician ownership and investment in hospitals.

(a) *Definitions.* For purposes of this section—

Physician owner or investor means a physician (or immediate family member of the physician) with a direct or an indirect ownership or investment interest in the hospital.

Procedure room means a room in which catheterizations, angiographies, angiograms, and endoscopies are performed, except such term shall not include an emergency room or department (exclusive of rooms in which catheterizations, angiographies, angiograms, and endoscopies are performed).

(b) *General requirements.* (1) *Physician ownership and provider agreement.* The hospital had physician ownership or investment on December 31, 2010; and a provider agreement under section 1866 of the Act in effect on that date.

(2) *Prohibition on facility expansion.* The hospital may not increase the number of operating rooms, procedure rooms, and beds beyond that for which the hospital is licensed on March 23, 2010 (or, in the case of a hospital that did not have a provider agreement in effect as of this date, but does have a provider agreement in effect on December 31, 2010, the effective date of such agreement), unless an exception is granted by the Secretary pursuant to section 1877(i)(3) of the Social Security Act.

(3) *Disclosure of conflicts of interest.*

(i) [Reserved].

(ii) The hospital must—

(A) Require each referring physician owner or investor who is a member of the hospital's medical staff to agree, as a condition of continued medical staff membership or admitting privileges, to provide written disclosure of his or her ownership or investment interest in the hospital (and, if applicable, the ownership or investment interest of any treating physician) to all patients whom the physician refers to the hospital. Disclosure must be required at the time the referral is made.

(B) Not condition any physician ownership or investment interests either directly or indirectly on the physician owner or investor making or influencing referrals to the hospital or otherwise generating business for the hospital.

(C) Disclose on any public Web site for the hospital or in any public advertising that the hospital is owned or invested in by physicians.

(4) *Ensuring bona fide investment.* The hospital satisfies the following criteria:

(i) The percentage of the total value of the ownership or investment interests held in the hospital, or in an entity whose assets include the hospital, by physician owners or investors in the aggregate does not exceed such percentage as of March 23, 2010.

(ii) Any ownership or investment interests that the hospital offers to a physician owner or investor are not offered on more favorable terms than the terms offered to a person who is not a physician owner or investor.

(iii) The hospital (or any owner or investor in the hospital) does not directly or indirectly provide loans or financing for any investment in the hospital by a physician owner or investor.

(iv) The hospital (or any owner or investor in the hospital) does not directly or indirectly guarantee a loan, make a payment toward a loan, or otherwise subsidize a loan, for any individual physician owner or investor or group of physician owners or investors that is related to acquiring any ownership or investment interest in the hospital.

(v) Ownership or investment returns are distributed to each owner or investor in the hospital in an amount that is directly proportional to the ownership or investment interest of such owner or investor in the hospital.

(vi) Physician owners and investors do not receive, directly or indirectly, any guaranteed receipt of or right to purchase other business interests related to the hospital, including the purchase or lease of any property under the control of other owners or investors in the hospital or located near the premises of the hospital.

(vii) The hospital does not offer a physician owner or investor the opportunity to purchase or lease any property under the control of the hospital or any other owner or investor in the hospital on more favorable terms than the terms offered to an individual who is not a physician owner or investor.

(5) *Patient safety.* The hospital satisfies the following criteria:

(i) If the hospital does not have a physician available on the premises to provide services during all hours in which the hospital is providing services to the patient, the hospital must disclose this information to the patient. Before providing services to the patient, the hospital must receive a signed acknowledgment from the patient stating that the patient understands that a physician may not be present during all hours services are furnished to the patient.

(ii) The hospital must have the capacity to provide assessment and initial treatment for all patients, and the ability to refer and transfer patients to hospitals with the capability to treat the needs of the patient that the hospital is unable to address. For purposes of this paragraph, the hospital inpatient stay or outpatient visit begins with the provision of a package of information regarding scheduled preadmission testing and registration for a planned hospital admission for inpatient care or an outpatient service.

(6) *Prohibition on conversion from an ambulatory surgery center.* The hospital must not have been converted from an ambulatory surgical center to a hospital on or after March 23, 2010.

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

8. The authority citation for Part 412 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh), and sec. 124 of Pub. L. 106–113 (113 Stat. 1501A–332).

9. Section 412.105 is amended—

a. Revising paragraph (f)(1)(ii).

b. Revising paragraph (f)(1)(iii)(C).

c. Adding a new paragraph (f)(1)(iii)(D).

d. Revising paragraph (f)(1)(iv)(B).

e. Revising paragraph (f)(1)(iv)(C).

f. Revising paragraph (f)(1)(ix).

The revisions and addition read as follows:

§ 412.105 Special treatment: Hospitals that incur indirect costs for graduate medical education programs.

* * * * *

(f) * * *

(1) * * *

(ii) In order to be counted, the resident must be assigned to one of the following areas:

(A) The portion of the hospital subject to the hospital inpatient prospective payment system.

(B) The outpatient department of a hospital that meets provider-based status as defined at § 413.65(a)(2) of this subchapter.

(C) The portions of a hospital located in Puerto Rico that are subject to the hospital inpatient prospective payment system, including off-campus outpatient departments that meet provider-based status as defined at § 413.65(a)(2) of this subchapter.

(D) The portions of a hospital that are reimbursed under a reimbursement system authorized under section 1814(b)(3) of the Act.

(E) Effective for discharges occurring on or after October 1, 1997, the time spent by a resident in a nonhospital setting in patient care activities, as defined in § 413.75(b) of this subchapter, under an approved medical residency training program is counted towards the determination of full-time equivalency if the criteria set forth in § 413.78(c), (d), (e), (f), or (g) of this subchapter, as applicable, are met.

(iii) * * *

(C) Effective for cost reporting periods beginning on or after January 1, 1983, except for research activities described in paragraph (f)(1)(iii)(B) of this section, the time a resident is training in an approved medical residency program in a hospital setting, as described in paragraphs (f)(1)(ii)(A) through (f)(1)(ii)(D) of this section, must be spent in either patient care activities, as defined in § 413.75(b) of this subchapter, or in nonpatient care activities, such as didactic conferences and seminars, to be counted. This provision may not be applied in a manner that would require the reopening of settled cost reports, except those cost reports on which, as of March 23, 2010, there is a pending, jurisdictionally proper appeal on direct GME or IME payments.

(D) Effective for cost reporting periods beginning on or after January 1, 1983, the time spent by a resident in an approved medical residency program on vacation, sick leave, or other approved leave that does not prolong the total time the resident is participating in the approved program beyond the normal duration of the program is countable. This provision may not be applied in a manner that would require the reopening of settled cost reports, except those cost reports on which, as of March 23, 2010, there is a pending, jurisdictionally proper appeal on direct GME or IME payments.

(iv) * * *

(B)(1) Effective for portions of cost reporting periods beginning on or after July 1, 2005, a hospital's otherwise applicable FTE resident cap may be reduced if its reference resident level, as determined under § 413.79(c)(1)(ii)(A) of this subchapter, is less than its otherwise applicable FTE resident cap in a reference cost reporting period, in accordance with the provisions of § 413.79(c)(3) of this subchapter. The reduction is 75 percent of the difference between the otherwise applicable FTE resident cap and the reference resident level.

(2) Effective for portions of cost reporting periods beginning on or after July 1, 2011, a hospital's otherwise applicable FTE resident cap may be reduced if its reference resident level, as determined under § 413.79(c)(1)(ii)(B) of this subchapter, is less than its otherwise applicable FTE resident cap in a reference cost reporting period, in accordance with the provisions of § 413.79(m) of this subchapter. The reduction shall take into account the hospital's FTE resident cap as reduced under paragraph (f)(1)(E)(iv)(B)(1). The reduction is 65 percent of the difference between the otherwise applicable FTE resident cap and the reference resident level.

(C)(1) Effective for portions of cost reporting periods beginning on or after July 1, 2005, a hospital may qualify to receive an increase in its otherwise applicable FTE resident cap (up to 25 additional FTEs) if the criteria specified in § 413.79(c)(4) of this subchapter are met.

(2) Effective for portions of cost reporting periods beginning on or after July 1, 2011, a hospital may qualify to receive an increase in its otherwise applicable FTE resident cap (up to 75 additional FTEs) if the criteria specified in § 413.79(n) of this subchapter are met. The increase shall be made to the hospital's FTE resident cap as reduced under paragraph (f)(1)(E)(iv)(B)(1).

* * * * *

(ix)(A) A hospital may receive a temporary adjustment to its FTE resident cap to reflect residents added because of another hospital's closure if the hospitals meets the criteria specified in §§ 413.79(h)(1) and (h)(2) of this subchapter. If a hospital that closes its residency training program agrees to temporarily reduce its FTE resident cap according to the criteria specified in §§ 413.79(h)(1) and (h)(3)(ii) of this subchapter, another hospital(s) may receive a temporary adjustment to its FTE resident cap to reflect residents added because of the closure of the residency training program if the criteria specified in §§ 413.79(h)(1) and (h)(3)(i) of this subchapter are met.

(B) A hospital may receive a permanent adjustment to its FTE resident cap as a result of slots that were redistributed from a closed hospital, as defined at § 413.79(h)(1)(i) of this subchapter, if the hospital meets the requirements at § 413.79(o) of this subchapter.

* * * * *

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; OPTIONAL PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES

10. The authority citation for Part 413 continues to read as follows:

Authority: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (i), and (n), 1861(v), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395d(d), 1395f(b), 1395g, 1395l(a), (i), and (n), 1395x(v), 1395hh, 1395rr, 1395tt, and 1395ww); and sec. 124 of Pub. L. 106–133 (113 Stat. 1501A–332).

11. Section 413.75(b) is amended by—

a. Revising paragraph (2) under the definition of "All or substantially all of the costs for the training program in the nonhospital setting".

b. Adding a definition of "Nonprovider setting that is primarily engaged in furnishing patient care".

The revision and addition read as follows:

§ 413.75 Direct GME payments: General requirements.

* * * * *

(b) * * *

All or substantially all of the costs for the training program in the nonhospital setting means—

* * * * *

(2) Effective for cost reporting periods beginning on or after July 1, 2007 and before July 1, 2010, at least 90 percent of the total of the costs of the residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of teaching physicians' salaries attributable to nonpatient care direct GME activities.

* * * * *

Nonprovider setting that is primarily engaged in furnishing patient care

means a nonprovider setting in which the primary activity is the care and treatment of patients.

* * * * *

12. Section 413.78 is amended by—

a. Revising the introductory text of paragraph (f).

b. Revising paragraph (f)(1).

c. Adding a new paragraph (g).

d. Adding a new paragraph (h).

The revisions and additions read as follows:

§ 413.78 Direct GME payments: Determination of the total number of FTE residents.

* * * * *

(f) For cost reporting periods beginning on or after July 1, 2007 and before July 1, 2010, the time residents spend in nonprovider settings such as freestanding clinics, nursing homes, and physicians' offices in connection with approved programs may be included in determining the number of FTE residents in the calculation of a hospital's resident count if the following conditions are met—

(1) The resident spends his or her time in patient care activities, except that for cost reporting periods beginning on or after July 1, 2009, the time spent training in nonpatient care activities, such as didactic conferences and seminars, but excluding research not associated with the treatment or diagnosis of a particular patient, in a nonprovider setting that is primarily engaged in furnishing patient care activities, as defined at § 413.75(b), also may be counted.

* * * * *

(g) For cost reporting periods beginning on or after July 1, 2010, the time residents spend in nonprovider settings such as freestanding clinics, nursing homes, and physicians' offices in connection with approved programs may be included in determining the number of FTE residents in the calculation of a hospital's resident count if the following conditions are met—

(1) The resident spends his or her time—

(i) In patient care activities, or,

(ii) In nonpatient care activities, such as didactic conferences and seminars, but excluding research not associated with the treatment or diagnosis of a particular patient, in a nonprovider setting that is primarily engaged in furnishing patient care activities, as defined at § 413.75(b).

(2) The hospital or hospitals must incur the costs of the salaries and fringe benefits of the resident during the time the resident spends in the nonprovider setting.

(i) If more than one hospital incurs these costs, either directly or through a third party, the hospitals must count a proportional share of the time that residents train at the nonhospital setting(s) as recorded in a written agreement between the hospitals.

(ii) Hospitals must have a reasonable basis for establishing that proportion of the cost and the FTE time that each will incur and count.

(iii) If hospitals already arrange payment to the nonhospital site via a written agreement as described in § 413.78(g)(3)(ii), the proportion may be recorded in that agreement.

(iv) If hospitals choose to pay the nonhospital site concurrently as described in § 413.78(g)(4)(i), the hospitals must record the proportion of cost and FTE time they are incurring and counting in a written agreement between the hospitals.

(3) For cost reporting periods beginning prior to July 1, 2010, the hospitals must comply with one of the following:

(i) The hospital or hospitals must pay for all or substantially all of the costs for the training program in a nonhospital setting(s) attributable to training that occurs during a month by the end of the third month following the month in which the training in the nonhospital site occurred.

(ii) There is a written agreement between the hospital or hospitals and the outside entity that states that the residents' salaries and fringe benefits (including travel and lodging where applicable) during the time the resident spends in the nonhospital setting is to be paid by the hospital(s). Hospitals may modify the amounts specified in the written agreement by the end of the academic year (that is, June 30) to reflect that the costs of the training program in the nonhospital site have been incurred.

(iii) If the hospital has in place an emergency Medicare GME affiliation agreement in accordance with § 413.79(f)(6), during the period covered by the emergency Medicare GME affiliation agreement—

(A) The hospital must pay all or substantially all of the costs of the training program in a nonhospital setting(s) attributable to training that occurs during a month by the end of the sixth month after the month in which the training in the nonhospital site occurs. For the costs that would otherwise be required to be incurred by the hospital during the period of August 29, 2005 through November 1, 2007, the participating hospital must incur the costs by April 29, 2008; or

(B) There is a written agreement between the hospital and the outside entity that states that the residents' salaries and fringe benefits (including travel and lodging where applicable) during the time the resident spends in the nonhospital setting is to be paid by the hospital. The written agreement must be submitted to the contractor by 180 days after the training at the nonhospital site begins. Hospitals may modify the amounts specified in the written agreement by the end of the academic year (that is, June 30) to reflect that the costs of the training program in the nonhospital site have been incurred. For written agreements that would otherwise be required to be submitted prior to the date the training begins in the nonhospital site during the period of August 29, 2005 through November 1, 2007, the hospital must submit the written agreement to its contractor by April 29, 2008.

(4) For cost reporting periods beginning on or after July 1, 2010, the hospitals must comply with one of the following:

(i) The hospital or hospitals must incur the costs of the salaries and fringe benefits of the resident during the time the resident spends in the nonprovider setting by the end of the third month following the month in which the training in the nonhospital site occurred.

(ii) There is a written agreement between the hospital or hospitals and the outside entity that states that the residents' salaries and fringe benefits (including travel and lodging where applicable) during the time the resident spends in the nonhospital setting is to be paid by the hospital(s). Hospitals may modify the amounts specified in the written agreement by the end of the academic year (that is, June 30) to reflect that the costs of the training program in the nonhospital site have been incurred.

(5) The hospital is subject to the principles of community support and redistribution of costs as specified in § 413.81.

(6) For cost reporting periods beginning on or after July 1, 2010, a hospital must maintain and make available records of the FTE count determined for direct GME purposes under this section that its residents spend in nonprovider sites, in order to compare that time to the time spent by its residents in nonprovider sites in the base year July 1, 2009 through June 30, 2010. The hospital must supply the CMS contractor with the data for each of its primary care programs on a program-specific basis, and with data for its nonprimary care programs on an overall basis.

(h) Effective for cost reporting periods beginning on or after January 1, 1983,

the time spent by a resident in an approved medical residency program on vacation, sick leave, or other approved leave that does not prolong the total time the resident is participating in the approved program beyond the normal duration of the program is countable. This provision cannot be applied in a manner that would require the reopening of settled cost reports, except those cost reports on which there is a pending, jurisdictionally proper appeal on direct GME or IME payments as of March 23, 2010.

13. Section 413.79 is amended by—

a. Revising paragraph (c)(1)(ii).

b. Revising the introductory text of paragraph (c)(2).

c. Revising paragraph (c)(2)(iv).

d. Revising the heading of paragraph (c)(3).

e. Revising the heading of paragraph (c)(4).

f. Revising the heading of paragraph (c)(5).

g. Adding a new paragraph (m).

h. Adding a new paragraph (n).

i. Adding a new paragraph (o).

§ 413.79 Direct GME payments: Determination of the weighted number of FTE residents.

* * * * *

(c) * * *

(1) * * *

(ii)(A) For purposes of paragraph (c)(3) of this section, *reference resident level* refers to a hospital's resident level in the applicable reference period specified under paragraph (c)(3) of this section.

(B) For purposes of paragraph (m) of this section, *reference resident level* means with respect to a hospital, the highest resident level for any of the three most recent cost reporting periods ending before March 23, 2010, for which a cost report has been either settled or submitted (subject to audit).

* * * * *

(2) *Determination of the FTE resident cap.* Subject to the provisions of paragraphs (c)(3) through (c)(6) and (m) through (o) of this section and § 413.81, for purposes of determining direct GME payment—

* * * * *

(iv) Hospitals that are part of the same Medicare GME affiliated group or the same emergency Medicare GME affiliated group (as described under § 413.75(b)) may elect to apply the limit on an aggregate basis as described under paragraph (f) of this section.

* * * * *

(3) *Determination of the reduction to the FTE resident cap due to unused FTE resident slots under section 422 of Public Law 108–173.* * * *

(4) *Determination of an increase in the otherwise applicable resident cap under section 422 of Public Law 108–173.* * * *

(5) *Special rules for hospitals that participate in demonstration projects or voluntary resident reduction plans for purposes of section 422 of Public Law 108–173.* * * *

* * * * *

(m) *Determination of the reduction to the FTE resident cap due to unused FTE resident slots under section 5503 of Public Law 111–148.* If a hospital's reference resident level, as defined under paragraph (c)(1)(ii)(B) of this section is less than its otherwise applicable FTE resident cap as determined under paragraph (c)(2) of this section or paragraph (e) of this section in the reference cost reporting period (as described under paragraph (m)(5) of this section), for portions of cost reporting periods beginning on or after July 1, 2011, the hospital's otherwise applicable FTE resident cap is reduced by 65 percent of the difference between the otherwise applicable FTE resident cap and the reference resident level. The reduction shall take into account the hospital's FTE resident cap as reduced under paragraph (c)(3) of this section. Under this provision—

(1) *Exemption for certain rural hospitals.* A rural hospital, as defined at subpart D of paragraph 412 of this subchapter, with fewer than 250 beds (as determined at § 412.105(b)) in its most recent cost reporting period ending on or before March 23, 2010, is exempt from any reduction to its otherwise applicable FTE resident cap under paragraph (m) of this section.

(2) *Exemption for certain hospitals that participate in demonstration projects or voluntary residency reduction plans.* A hospital that was participating in a demonstration project under section 402 of Public Law 90–248 or the voluntary reduction plan under § 413.88, is exempt from any reduction to its otherwise applicable FTE resident cap under paragraph (m) of this section if by December 1, 2010, it submits a plan to CMS for filling all of its unused FTE resident slots by not later than March 23, 2012.

(3) *Exemption for a hospital described at section 1886(h)(4)(H)(v) of the Act.* A hospital described at section 1886(h)(4)(H)(v) of the Act, is exempt from any reduction to its otherwise applicable FTE resident cap under paragraph (m) of this section.

(4) *Exemptions for certain other hospitals.* A hospital training at or above its otherwise applicable FTE resident cap as determined under paragraph (c)(2) of this section for all three most recent cost reporting periods ending prior to March 23, 2010 (as described under section (iv) of this paragraph), is exempt from any reduction to its otherwise applicable FTE resident cap under paragraph (m) of this section.

(5) *Reference cost reporting period.* (i) To determine a hospital's reference resident level, CMS determines, for a hospital's three most recent cost reporting periods ending before March 23, 2010, the cost reporting period with the highest resident level, for which a cost report has been settled or if the cost report has not been settled, the as-submitted cost report (subject to audit).

(ii) If the cost report that is used to determine a hospital's otherwise applicable FTE resident cap in the reference period is not equal to 12 months, the Medicare contractor may make appropriate modifications to apply the provisions of paragraph (m) of this section based on the equivalent of a 12-month cost reporting period.

(iii) If a hospital is a member of a Medicare GME affiliated group during its reference cost reporting period, and its reference resident level is less than its otherwise applicable FTE resident cap as adjusted by the terms of the Medicare GME affiliation agreement, the hospital's FTE resident cap will be reduced as described under paragraph (m) of this section.

(n) *Determination of an increase in the otherwise applicable resident cap under section 5503 of Public Law 111–148.* (1) For portions of cost reporting periods beginning on or after July 1, 2011, a hospital may receive an increase in its otherwise applicable FTE resident cap (as determined by CMS) up to an additional 75 FTEs if the hospital meets the requirements and qualifying criteria of section 1886(h)(8) of the Act and implementing instructions issued by CMS and if the hospital submits an application to CMS within the timeframe specified by CMS.

(2) A hospital that receives an increase in the otherwise applicable resident cap under paragraph (n)(1) of this section must ensure, during the 5-year period beginning on July 1, 2011 and ending on June 30, 2016, that—

(i) The number of FTE primary care residents, as defined in § 413.75(b), excluding any additional positions under this paragraph, is not less than the average number of FTE primary care residents (as so determined) during the three most recent cost reporting periods ending prior to March 23, 2010; and not less than 75 percent of the positions attributable to such increase are in a primary care or general surgery residency programs.

(ii) CMS may determine whether a hospital has met the requirements under paragraph (n)(1) of this section during the 5-year period of July 1, 2011 through June 30, 2016 in such manner and at such time as CMS determines appropriate, including at the end of such 5-year period.

(iii) In a case where the Medicare contractor determines that a hospital did not meet the requirements in a cost reporting period within the 5-year time period, the Medicare contractor will reduce the otherwise applicable resident cap of the hospital by the amount by which such limit was increased under paragraph (n)(1) of this section.

(o) *Determination of an increase in the FTE resident cap due to slots redistributed from a closed hospital.* (1) Except in the case of the closure of the hospital with Medicare Provider Number 05–0578, in the instance of a hospital closure, as defined at (h)(1)(i) of this section, the FTE resident cap of the closed hospital would be redistributed, and a hospital that meets the requirements and qualifying criteria of section 1886(h)(4)(H)(vi) of the Act and implementing instructions issued by CMS, including submission of a timely application to CMS, may receive an increase in its FTE resident cap, as determined by CMS.

(2)(i) Except in the case of the closure of the hospital with Medicare Provider Number 05–0578, in redistributing the FTE resident cap of a closed hospital, consideration shall be given to ensure that there is no duplication of FTE slots between FTE slots redistributed under this paragraph and temporary adjustments to FTE resident caps provider under paragraph (h)(2) of this section.

(ii) The provisions of this paragraph (o) will not be applied in a manner that will require the reopening of settled cost reports, except where the provider has a pending, jurisdictionally proper appeal on direct GME or IME payments as of March 23, 2010.

PART 416—AMBULATORY SURGICAL SERVICES

14. The authority citation for Part 416 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

15. Section 416.160 is amended by—

a. Revising paragraph (a)(1).

b. Revising paragraph (a)(4).

c. Adding a new paragraph (a)(5).

The revisions and addition read as follows:

§ 416.160 Basis and scope.

(a) * * *

(1) Section 1833(i)(2)(D) of the Act requires the Secretary to implement a revised payment system for payment of surgical services furnished in ASCs. The statute requires that, in the year such system is implemented, the system shall be designed to result in the same amount of aggregate expenditures for such services as would be made if there was no requirement for a revised payment system. The revised payment system shall be implemented no earlier than January 1, 2006, and no later than January 1, 2008. The statute also requires that, for CY 2011 and each subsequent year, any annual update to the ASC payment system be reduced by a productivity adjustment. There shall be no administrative or judicial review under section 1869 of the Act, section 1878 of the Act, or otherwise of the classification system, the relative weights, payment amounts, and the geographic adjustment factor, if any, of the revised payment system.

* * * * *

(4) Section 1834(d) of the Act specifies that, when screening colonoscopies or screening flexible sigmoidoscopies are performed in an ASC or hospital outpatient department, payment shall be based on the lesser of the amount under the fee schedule that would apply to such services if they were performed in a hospital outpatient department in an area or the amount under the fee schedule that would apply to such services if they were performed in an ambulatory surgical center in the same area. Section 1834(d) of the Act also specifies that, in the case of screening flexible sigmoidoscopy and screening colonoscopy services, the payment amounts must not exceed the payment rates established for the related diagnostic services.

(5) Section 1833(a)(1) of the Act requires 100 percent payment for preventive services described in section 1861(ww)(2) of the Act (excluding electrocardiograms) to which the United States Preventive Services Task Force (USPSTF) has given a grade of A or B for any indication or population. Section 1833(b)(1) of the Act also specifies that the Part B deductible shall not apply with respect to preventive services described in section 1861(ww)(2) of the Act (excluding electrocardiograms) to which the USPSTF has given a grade of A or B for any indication or population.

* * * * *

16. Section 416.171 is amended by adding a new paragraph (a)(2)(iii) to read as follows:

§ 416.171 Determination of payment rates for ASC services.

(a) * * *

(2) * * *

(iii) *Productivity adjustment.*

(A) For calendar year 2011 and subsequent years, the Consumer Price Index for All Urban Consumers determined in paragraph (a)(2)(ii) of this section is reduced by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act.

(B) The application of the provisions of paragraph (a)(2)(iii)(A) of this section may result in the update being less than 0.0 for a year, and may result in payment rates for a year being less than the payment rates for the preceding year.

* * * * *

PART 419—PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES

17. The authority citation for Part 419 continues to read as follows:

Authority: Secs. 1102, 1833(t), and 1871 of the Social Security Act (42 U.S.C. 1302, 1395(t), and 1395hh).

18. Section 419.21 is amended by—

a. Redesignating paragraph (e) as paragraph (e)(1).

b. Revising the newly redesignated paragraph (e)(1).

c. Adding a new paragraph (e)(2).

The revision and addition read as follows:

§ 419.21 Hospital outpatient services subject to the outpatient prospective payment system.

* * * * *

(e)(1) Effective January 1, 2005 through December 31, 2008, an initial preventive physical examination, as defined in § 410.16 of this chapter, if the examination is performed no later than 6 months after the individual's initial Part B coverage date that begins on or after January 1, 2005.

(2) Effective January 1, 2009, an initial preventive physical examination, as defined in § 410.16 of this chapter, if the examination is performed no later than 12 months after the date of the individual's initial enrollment in Part B.

19. Section 419.22 is amended by—

a. Revising paragraph (m).

b. Adding a new paragraph (t).

The revision and addition read as follows:

§ 419.22 Hospital outpatient services excluded from payment under the hospital outpatient prospective payment system.

* * * * *

(m)(1) Services provided on or before December 31, 2010, for patients with

ESRD that are paid under the ESRD composite rate and drugs and supplies furnished during dialysis but not included in the composite rate.

(2) Renal dialysis services provided on or after January 1, 2011, for patients with ESRD that are paid under the ESRD benefit, as described in Subpart H of Part 413 of this chapter.

* * * * *

(t) Effective January 1, 2011, annual wellness visit providing personalized prevention plan services as defined in § 410.15 of this chapter.

20. Section 419.32 is amended by revising paragraph (b)(1)(iv) to read as follows:

§ 419.32 Calculation of prospective payment rates for hospital outpatient services.

* * * * *

(b) * * *

(1) * * *

(iv)(A) For calendar year 2003 and subsequent years, by the hospital inpatient market basket percentage increase applicable under section 1886(b)(3)(B)(iii) of the Act.

(B) The percentage increase determined under paragraph (b)(1)(iv)(A) of this section is reduced by the following for the specific calendar year:

(*i*) For calendar year 2010, 0.25 percentage point; and

(*ii*) For calendar year 2011, 0.25 percentage point.

* * * * *

21. Section 419.43 is amended by—

a. Revising paragraph (c).

b. Adding a new paragraph (i).

The revision and addition read as follows:

§ 419.43 Adjustments to national program payment and beneficiary copayment amounts.

* * * * *

(c) *Wage index factor.*—(1) CMS uses the hospital inpatient prospective payment system wage index established in accordance with Part 412 of this chapter to make the adjustment specified under paragraph (a) of this section.

(2) For services furnished beginning January 1, 2011, the wage index factor provided for in paragraph (c)(1) of this section applicable to any hospital outpatient department that is located in a frontier State, as defined in § 412.64(m) of this chapter, may not be less than 1.00.

(3) The additional payments made under the provisions of paragraph (c)(2) of this section are not implemented in a budget neutral manner.

* * * * *

(i) *Payment adjustment for certain cancer hospitals.*—(1) *General rule.* CMS provides for an additional payment for covered hospital outpatient services furnished on or after January 1, 2011, by cancer hospitals described in section 1886(d)(1)(B)(v) of the Act.

(2) *Amount of adjustment.* The amount of the additional payment under paragraph (i)(1) of this section is determined by CMS and is based on the difference between costs incurred by hospitals described in section 1886(d)(1)(B)(v) of the Act and costs incurred by other hospitals that are paid under the hospital outpatient prospective payment system, including the costs of drugs and biologicals.

(3) *Budget neutrality.* CMS establishes the payment adjustment under paragraph (i)(2) of this section in a budget neutral manner, excluding services and groups specified in paragraph (i)(4) of this section.

(4) *Excluded services and groups.* The following services or groups are excluded from qualification for the payment adjustment in paragraph (i)(2) of this section:

(i) Devices paid under 419.66; and

(ii) Items and services paid at charges adjusted to cost by application of a hospital specific cost-to-charge ratio.

22. Section 419.70 is amended by—

a. Revising the introductory text of paragraph (d)(2).

b. Adding a new paragraph (d)(6).

The revision and addition read as follows:

§ 419.70 Transitional adjustments to limit decline in payments.

* * * * *

(d) * * *

(2) *Temporary treatment for small rural hospitals on or after January 1, 2006.* For covered hospital outpatient services furnished in a calendar year from January 1, 2006, through December 31, 2010, for which the prospective payment system amount is less than the pre-BBA amount, the amount of payment under this part is increased by 95 percent of that difference for services furnished during 2006, 90 percent of that difference for services furnished during 2007, and 85 percent of that difference for services furnished during 2008, 2009, and 2010, if the hospital—

* * * * *

(6) *Temporary treatment for sole community hospitals on or after January 1, 2010 and through December 31, 2010.* For covered hospital outpatient services furnished on or after January 1, 2010 through December 31, 2010, for which the prospective payment system amount is less than the pre-BBA amount, the amount of payment under this part is increased by 85 percent of that difference if the hospital is a sole community hospital as defined in § 412.92 of this chapter or is an essential access community hospital as described under § 412.109 of this chapter.

* * * * *

PART 482—CONDITIONS OF PARTICIPATION FOR HOSPITALS

23. The authority citation for Part 482 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

24. Section 482.12 is amended by adding a new paragraph (g) to read as follows:

§ 482.12 Condition of participation: Governing body.

* * * * *

(g) *Standard: Inpatient rights.* A hospital must have the capacity to provide assessment and initial treatment for all patients and the ability to refer and transfer patients to hospitals with capabilities to treat the needs of the patient that the hospital is unable to address.

PART 489—PROVIDER AGREEMENTS AND SUPPLIER APPROVAL

25. The authority citation for Part 489 continues to read as follows:

Authority: Secs. 1102, 1819, 1820(e), 1861, 1864(m), 1866, 1869, and 1871 of the Social Security Act (42 U.S.C. 1302, 1395i–3, 1395x, 1395aa(m), 1395cc, 1395ff, and 1395hh).

26. Section 489.20 is amended by—

a. Republishing the introductory text of paragraph (u).

b. Revising paragraph (u)(1).

c. Revising paragraph (u)(2).

d. Adding a new paragraph (u)(3).

e. Revising paragraph (w).

The revisions and addition read as follows:

§ 489.20 Basic commitments.

* * * * *

(u) Except as provided in paragraph (v) of this section, in the case of a physician-owned hospital as defined at § 489.3—

(1)(i) To furnish written notice to each patient at the beginning of the patient's hospital stay or outpatient visit that the hospital is a physician-owned hospital, in order to assist the patient in making an informed decision regarding his or her care, in accordance with § 482.13(b)(2) of this subchapter. The notice should disclose, in a manner reasonably designed to be understood by all patients, the fact that the hospital meets the Federal definition of a

physician-owned hospital specified in § 489.3 and that the list of the hospital's owners or investors who are physicians or immediate family members (as defined at § 411.351 of this chapter) of physicians is available upon request and must be provided to the patient at the time the request for the list is made by or on behalf of the patient. For purposes of this paragraph (u)(1), the hospital stay or outpatient visit begins with the provision of a package of information regarding scheduled preadmission testing and registration for a planned hospital admission for inpatient care or an outpatient service; and

(ii) To disclose on any public Web site for the hospital and in any public advertising that the hospital is owned or invested in by physicians.

(2) To require each physician who is a member of the hospital's medical staff to agree, as a condition of continued medical staff membership or admitting privileges, to disclose, in writing, to all patients the physician refers to the hospital any ownership or investment interest in the hospital that is held by the physician or by an immediate family member (as defined at § 411.351 of this chapter) of the physician, and any ownership or investment interest in the hospital by the patient's treating physician(s). Disclosure must be required at the time the referral is made.

(3) To ensure that the hospital does not condition any physician ownership or investment interests either directly or indirectly on the physician owner or investor making or influencing referrals to the hospital or otherwise generating business for the hospital.

* * * * *

(w)(1) In the case of a hospital as defined in § 489.24(b), to furnish written notice to all patients at the beginning of their hospital stay or outpatient visit if a doctor of medicine or a doctor of osteopathy is not present in the hospital 24 hours per day, 7 days per week, in order to assist the patients in making informed decisions regarding their care, in accordance with § 482.13(b)(2) of this subchapter. The notice must indicate how the hospital will meet the medical needs of any patient who develops an emergency medical condition, as defined in § 489.24(b), at a time when there is no physician present in the hospital. For purposes of this paragraph, the hospital stay or outpatient visit begins with the provision of a package of information regarding scheduled preadmission testing and registration for a planned hospital admission for inpatient care or outpatient service.

(2) Before admitting a patient or providing an outpatient service, the hospital must receive a signed acknowledgment from the patient stating that the patient understands that a physician may not be present during all hours services are furnished to the patient.

* * * * *

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; Program No. 93.774, Medicare—Supplementary Medical Insurance Program; andProgram No. 93.778 (Medical Assistance)

Dated: June 24, 2010.

Marilyn Tavenner,

Acting Administrator and Chief Operating Officer, Centers for Medicare & Medicaid Services.

Dated: June 30, 2010

Kathleen Sebelius,

Secretary.

BILLING CODE 4120–01–P

ADDENDUM A.—PROPOSED OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0001	Level I Photochemotherapy	S	0.5422	$37.01	.	$7.41
0002	Fine Needle Biopsy/Aspiration	T	1.7752	$121.19	.	$24.24
0003	Bone Marrow Biopsy/Aspiration	T	3.6353	$248.17	.	$49.64
0004	Level I Needle Biopsy/ Aspiration Except Bone Marrow	T	4.6624	$318.29	.	$63.66
0005	Level II Needle Biopsy/Aspiration Except Bone Marrow	T	8.1600	$557.06	.	$111.42
0006	Level I Incision & Drainage	T	1.4939	$101.98	.	$20.40
0007	Level II Incision & Drainage	T	13.3268	$909.78	.	$181.96
0008	Level III Incision and Drainage	T	20.2481	$1,382.28	.	$276.46
0012	Level I Debridement & Destruction	T	0.4253	$29.03	.	$5.81
0013	Level II Debridement & Destruction	T	0.8782	$59.95	.	$11.99
0015	Level III Debridement & Destruction	T	1.5303	$104.47	.	$20.90
0016	Level IV Debridement & Destruction	T	2.8176	$192.35	.	$38.47
0017	Level V Debridement & Destruction	T	21.8217	$1,489.70	.	$297.94
0019	Level I Excision/ Biopsy	T	4.9184	$335.76	.	$67.16
0020	Level II Excision/ Biopsy	T	8.7772	$599.19	.	$119.84
0021	Level III Excision/ Biopsy	T	18.2223	$1,243.98	.	$248.80
0022	Level IV Excision/ Biopsy	T	24.1269	$1,647.07	$354.45	$329.42
0028	Level I Breast Surgery	T	25.7651	$1,758.91	.	$351.79
0029	Level II Breast Surgery	T	34.3618	$2,345.78	$581.52	$469.16
0030	Level III Breast Surgery	T	45.1924	$3,085.15	$747.07	$617.03
0031	Smoking Cessation Services	X	0.3066	$20.93	.	$4.19
0034	Mental Health Services Composite	S	3.3838	$231.00	.	$46.20
0035	Vascular Puncture and Minor Diagnostic Procedures	X	0.2446	$16.70	.	$3.34
0037	Level IV Needle Biopsy/Aspiration Except Bone Marrow	T	15.7640	$1,076.16	$228.76	$215.24
0039	Level I Implantation of Neurostimulator Generator	S	210.3341	$14,358.88	.	$2,871.78
0040	Percutaneous Implantation of Neurostimulator Electrodes	S	65.4002	$4,464.68	.	$892.94
0041	Level I Arthroscopy	T	30.3175	$2,069.68	.	$413.94
0042	Level II Arthroscopy	T	48.2063	$3,290.90	$804.74	$658.18
0045	Bone/Joint Manipulation Under Anesthesia	T	15.5647	$1,062.56	$268.44	$212.52
0047	Arthroplasty without Prosthesis	T	39.0731	$2,667.40	$534.09	$533.48
0048	Level I Arthroplasty or Implantation with Prosthesis	T	60.2668	$4,114.23	.	$822.85
0049	Level I Musculoskeletal Procedures Except Hand and Foot	T	23.2249	$1,585.49	.	$317.10
0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	32.4253	$2,213.58	.	$442.72

ADDENDUM A.—PROPOSED OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	47.3761	$3,234.22	.	$646.85
0052	Level IV Musculoskeletal Procedures Except Hand and Foot	T	88.5249	$6,043.33	.	$1,208.67
0053	Level I Hand Musculoskeletal Procedures	T	17.3655	$1,185.49	$253.49	$237.10
0054	Level II Hand Musculoskeletal Procedures	T	29.8184	$2,035.61	.	$407.13
0055	Level I Foot Musculoskeletal Procedures	T	22.6974	$1,549.48	$355.34	$309.90
0056	Level II Foot Musculoskeletal Procedures	T	55.5064	$3,789.26	.	$757.86
0057	Bunion Procedures	T	33.3853	$2,279.11	$475.91	$455.83
0058	Level I Strapping and Cast Application	S	1.1409	$77.89	.	$15.58
0060	Manipulation Therapy	S	0.3636	$24.82	.	$4.97
0061	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electr	S	88.8954	$6,068.62	.	$1,213.73
0062	Level I Treatment Fracture/Dislocation	T	26.6924	$1,822.21	$372.87	$364.45
0063	Level II Treatment Fracture/Dislocation	T	48.0827	$3,282.46	.	$656.50
0064	Level III Treatment Fracture/Dislocation	T	66.5750	$4,544.88	.	$908.98
0065	Level I Stereotactic Radiosurgery, MRgFUS, and MEG	S	13.7821	$940.86	.	$188.18
0066	Level II Stereotactic Radiosurgery, MRgFUS, and MEG	S	36.8580	$2,516.19	.	$503.24
0067	Level III Stereotactic Radiosurgery, MRgFUS, and MEG	S	50.0116	$3,414.14	.	$682.83
0069	Thoracoscopy	T	35.4455	$2,419.76	$591.64	$483.96
0070	Thoracentesis/Lavage Procedures	T	5.6491	$385.65	.	$77.13
0071	Level I Endoscopy Upper Airway	T	0.9225	$62.98	.	$12.60
0072	Level II Endoscopy Upper Airway	T	1.8778	$128.19	.	$25.64
0073	Level III Endoscopy Upper Airway	T	4.0416	$275.91	$64.31	$55.19
0074	Level IV Endoscopy Upper Airway	T	21.9959	$1,501.59	.	$300.32
0075	Level V Endoscopy Upper Airway	T	31.4168	$2,144.73	$445.92	$428.95
0076	Level I Endoscopy Lower Airway	T	10.5445	$719.84	$189.82	$143.97
0077	Level I Pulmonary Treatment	S	0.4180	$28.54	$7.74	$5.71
0078	Level III Pulmonary Treatment	S	1.4237	$97.19	.	$19.44
0079	Ventilation Initiation and Management	S	2.8784	$196.50	.	$39.30
0080	Diagnostic Cardiac Catheterization	T	39.8374	$2,719.58	$838.92	$543.92
0082	Coronary or Non-Coronary Atherectomy	T	97.8929	$6,682.85	.	$1,336.57
0083	Coronary or Non-Coronary Angioplasty and Percutaneous Valvuloplasty	T	52.1947	$3,563.18	.	$712.64
0084	Level I Electrophysiologic Procedures	S	10.1429	$692.43	.	$138.49
0085	Level II Electrophysiologic Procedures	T	53.4167	$3,646.60	.	$729.32
0086	Level III Electrophysiologic Procedures	T	116.6136	$7,960.86	.	$1,592.18
0088	Thrombectomy	T	41.8116	$2,854.35	$655.22	$570.87
0089	Insertion/Replacement of Permanent Pacemaker and Electrodes	T	112.4202	$7,674.59	$1,615.11	$1,534.92

ADDENDUM A.—PROPOSED OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0090	Insertion/Replacement of Pacemaker Pulse Generator	T	92.6057	$6,321.91	$1,530.07	$1,264.39
0091	Level II Vascular Ligation	T	44.4254	$3,032.79	.	$606.56
0092	Level I Vascular Ligation	T	27.5456	$1,880.46	.	$376.10
0093	Vascular Reconstruction/Fistula Repair without Device	T	36.5266	$2,493.56	.	$498.72
0094	Level I Resuscitation and Cardioversion	S	2.4281	$165.76	$46.29	$33.16
0095	Cardiac Rehabilitation	S	0.5678	$38.76	$13.86	$7.76
0096	Level II Noninvasive Physiologic Studies	S	1.5710	$107.25	$37.13	$21.45
0097	Level I Noninvasive Physiologic Studies	S	0.9646	$65.85	$23.66	$13.17
0099	Electrocardiograms/Cardiography	S	0.3998	$27.29	.	$5.46
0100	Cardiac Stress Tests	X	2.6301	$179.55	$41.44	$35.91
0101	Tilt Table Evaluation	S	4.3590	$297.58	$100.24	$59.52
0102	Level II Pulmonary Treatment	S	0.9754	$66.59	.	$13.32
0103	Miscellaneous Vascular Procedures	T	19.1796	$1,309.33	.	$261.87
0104	Transcatheter Placement of Intracoronary Stents	T	81.9089	$5,591.67	.	$1,118.34
0105	Repair/Revision/Removal of Pacemakers, AICDs, or Vascular Devices	T	23.2281	$1,585.71	.	$317.15
0106	Insertion/Replacement of Pacemaker Leads and/or Electrodes	T	52.6182	$3,592.09	.	$718.42
0107	Insertion of Cardioverter-Defibrillator	T	335.0724	$22,874.39	.	$4,574.88
0108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads	T	389.7128	$26,604.52	.	$5,320.91
0110	Transfusion	S	3.4107	$232.84	.	$46.57
0111	Blood Product Exchange	S	12.5247	$855.02	$198.40	$171.01
0112	Apheresis and Stem Cell Procedures	S	33.8904	$2,313.60	.	$462.72
0113	Excision Lymphatic System	T	25.2939	$1,726.74	.	$345.35
0114	Thyroid/Lymphadenectomy Procedures	T	50.9844	$3,480.55	.	$696.11
0115	Cannula/Access Device Procedures	T	33.3074	$2,273.80	.	$454.76
0121	Level I Tube or Catheter Changes or Repositioning	T	6.3264	$431.88	.	$86.38
0126	Level I Urinary and Procedures	T	1.0983	$74.98	$16.21	$15.00
0127	Level IV Stereotactic Radiosurgery, MRgFUS, and MEG	S	105.7702	$7,220.61	.	$1,444.13
0128	Echocardiogram with Contrast	S	7.1663	$489.22	$162.90	$97.85
0129	Level I Closed Treatment Fracture Finger/Toe/Trunk	T	1.6325	$111.45	.	$22.29
0130	Level I Laparoscopy	T	38.7195	$2,643.26	$659.53	$528.66
0131	Level II Laparoscopy	T	48.0382	$3,279.42	$1,001.89	$655.89
0132	Level III Laparoscopy	T	71.1086	$4,854.37	$1,226.23	$970.88
0133	Level I Skin Repair	T	1.3598	$92.83	$25.67	$18.57
0134	Level II Skin Repair	T	3.1890	$217.70	.	$43.54

ADDENDUM A.—PROPOSED OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0135	Level III Skin Repair	T	4.6616	$318.23	.	$63.65
0136	Level IV Skin Repair	T	17.1353	$1,169.78	.	$233.96
0137	Level V Skin Repair	T	22.1186	$1,509.97	.	$302.00
0138	Level II Closed Treatment Fracture Finger/Toe/Trunk	T	5.2593	$359.04	.	$71.81
0139	Level III Closed Treatment Fracture Finger/Toe/Trunk	T	20.9892	$1,432.87	.	$286.58
0140	Esophageal Dilation without Endoscopy	T	6.4279	$438.81	.	$87.77
0141	Level I Upper GI Procedures	T	8.8811	$606.29	$143.38	$121.26
0142	Small Intestine Endoscopy	T	10.1443	$692.52	$152.78	$138.51
0143	Lower GI Endoscopy	T	9.3206	$636.29	$186.06	$127.26
0146	Level I Sigmoidoscopy and Anoscopy	T	5.7839	$394.85	.	$78.97
0147	Level II Sigmoidoscopy and Anoscopy	T	9.5024	$648.70	.	$129.74
0148	Level I Anal/Rectal Procedures	T	6.2678	$427.88	.	$85.58
0149	Level III Anal/Rectal Procedures	T	24.5978	$1,679.22	.	$335.85
0150	Level IV Anal/Rectal Procedures	T	32.6184	$2,226.76	.	$445.36
0151	Endoscopic Retrograde Cholangio-Pancreatography (ERCP)	T	23.0632	$1,574.46	.	$314.90
0152	Level I Percutaneous Abdominal and Biliary Procedures	T	32.3789	$2,210.41	.	$442.09
0153	Peritoneal and Abdominal Procedures	T	26.2068	$1,789.06	$368.04	$357.82
0154	Hernia/Hydrocele Procedures	T	33.3680	$2,277.93	$464.85	$455.59
0155	Level II Anal/Rectal Procedures	T	16.1014	$1,099.19	.	$219.84
0156	Level III Urinary and Anal Procedures	T	3.0859	$210.67	.	$42.14
0157	Colorectal Cancer Screening: Barium Enema	S	1.3220	$90.25	.	$18.05
0158	Colorectal Cancer Screening: Colonoscopy	T	8.2505	$563.24		
0159	Colorectal Cancer Screening: Flexible Sigmoidoscopy	S	5.1653	$352.62		
0160	Level I Cystourethroscopy and other Genitourinary Procedures	T	7.2012	$491.60	.	$98.32
0161	Level II Cystourethroscopy and other Genitourinary Procedures	T	17.7215	$1,209.79	.	$241.96
0162	Level III Cystourethroscopy and other Genitourinary Procedures	T	26.4198	$1,803.60	.	$360.72
0163	Level IV Cystourethroscopy and other Genitourinary Procedures	T	37.4369	$2,555.70	.	$511.14
0164	Level II Urinary and Anal Procedures	T	2.0672	$141.12	.	$28.23
0165	Level IV Urinary and Anal Procedures	T	20.5471	$1,402.69	.	$280.54
0166	Level I Urethral Procedures	T	21.3781	$1,459.42	.	$291.89
0168	Level II Urethral Procedures	T	32.3809	$2,210.55	.	$442.11
0169	Lithotripsy	T	41.7267	$2,848.56	$997.74	$569.72
0170	Dialysis	S	7.0059	$478.27	.	$95.66
0172	Level I Partial Hospitalization (3 services) for CMHCs	P	1.6977	$115.90	.	$23.18

ADDENDUM A.—PROPOSED OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0173	Level II Partial Hospitalization (4 or more services) for CMHCs	P	1.7718	$120.96	.	$24.20
0174	Level IV Laparoscopy	T	112.2008	$7,659.61	$2,064.24	$1,531.93
0175	Level I Partial Hospitalization (3 services) for Hospital-based PHPs	P	2.6497	$180.89	.	$36.18
0176	Level II Partial Hospitalization (4 or more services) for Hospital-based PHPs	P	3.3838	$231.00	.	$46.20
0181	Level II Male Genital Procedures	T	36.4186	$2,486.19	$620.84	$497.24
0183	Level I Male Genital Procedures	T	23.7895	$1,624.04	.	$324.81
0184	Prostate Biopsy	T	13.3380	$910.55	.	$182.11
0188	Level II Female Reproductive Proc	T	1.5975	$109.06	.	$21.82
0189	Level III Female Reproductive Proc	T	3.5572	$242.84	.	$48.57
0190	Level I Hysteroscopy	T	23.1990	$1,583.73	$424.28	$316.75
0191	Level I Female Reproductive Proc	T	0.1514	$10.34	$2.08	$2.07
0192	Level IV Female Reproductive Proc	T	6.7542	$461.09	.	$92.22
0193	Level V Female Reproductive Proc	T	20.7158	$1,414.21	.	$282.85
0195	Level VI Female Reproductive Procedures	T	35.7350	$2,439.52	.	$487.91
0202	Level VII Female Reproductive Procedures	T	45.2093	$3,086.30	$981.50	$617.26
0203	Level IV Nerve Injections	T	13.3062	$908.37	$225.43	$181.68
0204	Level I Nerve Injections	T	2.6660	$182.00	$40.13	$36.40
0206	Level II Nerve Injections	T	3.8796	$264.85	.	$52.97
0207	Level III Nerve Injections	T	7.7204	$527.05	.	$105.41
0208	Laminotomies and Laminectomies	T	51.7137	$3,530.34	.	$706.07
0209	Level II Extended EEG, Sleep, and Cardiovascular Studies	S	11.4620	$782.48	$268.73	$156.50
0213	Level I Extended EEG, Sleep, and Cardiovascular Studies	S	2.4455	$166.95	$53.58	$33.39
0215	Level I Nerve and Muscle Tests	S	0.6295	$42.97	.	$8.60
0216	Level III Nerve and Muscle Tests	S	2.7192	$185.63	.	$37.13
0218	Level II Nerve and Muscle Tests	S	1.1923	$81.39	.	$16.28
0220	Level I Nerve Procedures	T	19.3535	$1,321.21	.	$264.25
0221	Level II Nerve Procedures	T	37.5345	$2,562.37	.	$512.48
0224	Implantation of Catheter/Reservoir/Shunt	T	41.9698	$2,865.15	.	$573.03
0225	Implantation of Neurostimulator Electrodes, Cranial Nerve	S	212.7796	$14,525.82	.	$2,905.17
0227	Implantation of Drug Infusion Device	T	194.6115	$13,285.54	.	$2,657.11
0229	Transcatherter Placement of Intravascular Shunts	T	96.8443	$6,611.27	.	$1,322.26
0230	Level I Eye Tests & Treatments	S	0.5913	$40.37	.	$8.08
0231	Level III Eye Tests & Treatments	S	2.2924	$156.50	.	$31.30
0232	Level I Anterior Segment Eye Procedures	T	2.4827	$169.49	$40.82	$33.90
0233	Level III Anterior Segment Eye Procedures	T	17.0898	$1,166.67	$263.12	$233.34
0234	Level IV Anterior Segment Eye Procedures	T	24.5236	$1,674.15	$511.31	$334.83

ADDENDUM A.—PROPOSED OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0235	Level I Posterior Segment Eye Procedures	T	5.2921	$361.28	.	$72.26
0237	Level II Posterior Segment Eye Procedures	T	23.2772	$1,589.06	.	$317.82
0238	Level I Repair and Plastic Eye Procedures	T	3.1607	$215.77	.	$43.16
0239	Level II Repair and Plastic Eye Procedures	T	7.7830	$531.32	.	$106.27
0240	Level III Repair and Plastic Eye Procedures	T	19.9889	$1,364.58	$296.20	$272.92
0241	Level IV Repair and Plastic Eye Procedures	T	26.8719	$1,834.46	$383.45	$366.90
0242	Level V Repair and Plastic Eye Procedures	T	39.3413	$2,685.71	$597.36	$537.15
0243	Strabismus/Muscle Procedures	T	25.3150	$1,728.18	$416.98	$345.64
0244	Corneal and Amniotic Membrane Transplant	T	39.0380	$2,665.01	$803.26	$533.01
0245	Level I Cataract Procedures without IOL Insert	T	14.3198	$977.57	$196.91	$195.52
0246	Cataract Procedures with IOL Insert	T	24.7788	$1,691.57	$495.96	$338.32
0247	Laser Eye Procedures	T	5.5659	$379.97	$104.31	$76.00
0249	Level II Cataract Procedures without IOL Insert	T	31.0191	$2,117.58	$516.99	$423.52
0250	Level I ENT Procedures	T	1.1743	$80.17	$25.10	$16.04
0251	Level II ENT Procedures	T	3.4369	$234.63	.	$46.93
0252	Level III ENT Procedures	T	7.8743	$537.55	$109.16	$107.51
0253	Level IV ENT Procedures	T	17.4151	$1,188.88	$282.29	$237.78
0254	Level V ENT Procedures	T	25.5397	$1,743.52	.	$348.71
0255	Level II Anterior Segment Eye Procedures	T	7.8769	$537.73	$129.50	$107.55
0256	Level VI ENT Procedures	T	44.8441	$3,061.37	.	$612.28
0259	Level VII ENT Procedures	T	454.7997	$31,047.81	$8,543.66	$6,209.57
0260	Level I Plain Film Except Teeth	X	0.6683	$45.62	.	$9.13
0261	Level II Plain Film Except Teeth Including Bone Density Measurement	X	1.1314	$77.24	.	$15.45
0262	Plain Film of Teeth	X	0.4853	$33.13	.	$6.63
0263	Level I Miscellaneous Radiology Procedures	X	3.3875	$231.25	.	$46.25
0265	Level I Diagnostic and Screening Ultrasound	S	0.9262	$63.23	$22.28	$12.65
0266	Level II Diagnostic and Screening Ultrasound	S	1.4262	$97.36	$37.53	$19.48
0267	Level III Diagnostic and Screening Ultrasound	S	2.2748	$155.29	$60.50	$31.06
0269	Level II Echocardiogram Without Contrast	S	5.7019	$389.25	.	$77.85
0270	Level III Echocardiogram Without Contrast	S	8.1944	$559.41	$132.96	$111.89
0272	Fluoroscopy	X	1.2472	$85.14	$31.07	$17.03
0274	Myelography	S	7.4103	$505.88	.	$101.18
0275	Arthrography	S	4.0041	$273.35	$68.90	$54.67
0276	Level I Digestive Radiology	S	1.2890	$88.00	$34.66	$17.60
0277	Level II Digestive Radiology	S	2.0916	$142.79	$53.90	$28.56
0278	Diagnostic Urography	S	2.5910	$176.88	$58.44	$35.38
0279	Level II Angiography and Venography	S	29.7399	$2,030.25	.	$406.05
0280	Level III Angiography and Venography	S	48.7134	$3,325.52	.	$665.11
0282	Miscellaneous Computed Axial Tomography	S	1.7637	$120.40	$37.80	$24.08

ADDENDUM A.—PROPOSED OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0283	Computed Tomography with Contrast	S	4.4120	$301.19	$96.62	$60.24
0284	Magnetic Resonance Imaging and Magnetic Resonance Angiography with Contrast	S	6.4555	$440.70	$146.85	$88.14
0288	Bone Density:Axial Skeleton	S	1.0562	$72.10	$28.51	$14.42
0293	Level VI Anterior Segment Eye Procedures	T	113.4961	$7,748.04	.	$1,549.61
0299	Hyperthermia and Radiation Treatment Procedures	S	5.7142	$390.09	.	$78.02
0300	Level I Radiation Therapy	S	1.4418	$98.43	.	$19.69
0301	Level II Radiation Therapy	S	2.3741	$162.07	.	$32.42
0303	Treatment Device Construction	X	2.9021	$198.12	$66.95	$39.63
0304	Level I Therapeutic Radiation Treatment Preparation	X	1.5401	$105.14	$34.63	$21.03
0305	Level II Therapeutic Radiation Treatment Preparation	X	4.0762	$278.27	$91.38	$55.66
0307	Myocardial Positron Emission Tomography (PET) imaging	S	16.1009	$1,099.16	.	$219.84
0308	Non-Myocardial Positron Emission Tomography (PET) imaging	S	15.3994	$1,051.27	.	$210.26
0310	Level III Therapeutic Radiation Treatment Preparation	X	13.5651	$926.05	$325.27	$185.21
0312	Radioelement Applications	S	5.0976	$348.00	.	$69.60
0313	Brachytherapy	S	10.4062	$710.40	$268.63	$142.08
0315	Level II Implantation of Neurostimulator Generator	S	270.0348	$18,434.47	.	$3,686.90
0317	Level II Miscellaneous Radiology Procedures	X	5.9820	$408.37	.	$81.68
0320	Electroconvulsive Therapy	S	6.0291	$411.59	.	$82.32
0322	Brief Individual Psychotherapy	S	1.1744	$80.17	.	$16.04
0323	Extended Individual Psychotherapy	S	1.6309	$111.34	.	$22.27
0324	Family Psychotherapy	S	1.8392	$125.56	.	$25.12
0325	Group Psychotherapy	S	0.7880	$53.79	$11.47	$10.76
0330	Dental Procedures	S	9.9085	$676.42	.	$135.29
0332	Computed Tomography without Contrast	S	2.8569	$195.03	$75.24	$39.01
0333	Computed Tomography without Contrast followed by Contrast	S	4.8922	$333.98	$116.13	$66.80
0336	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast	S	5.1052	$348.52	$137.34	$69.71
0337	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast followed by Contrast	S	7.9271	$541.16	$197.83	$108.24
0340	Minor Ancillary Procedures	X	0.6899	$47.10	.	$9.42
0341	Skin Tests	X	0.0804	$5.49	$2.09	$1.10
0342	Level I Pathology	X	0.1596	$10.90	.	$2.18
0343	Level II Pathology	X	0.5351	$36.53	$10.84	$7.31
0344	Level III Pathology	X	0.8227	$56.16	$15.56	$11.24

ADDENDUM A.—PROPOSED OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0345	Level I Transfusion Laboratory Procedures	X	0.2168	$14.80	.	$2.96
0346	Level II Transfusion Laboratory Procedures	X	0.3619	$24.71	.	$4.95
0347	Level III Transfusion Laboratory Procedures	X	0.6903	$47.12	$9.43	$9.43
0350	Administration of flu and PPV vaccine	S	0.3853	$26.30		
0360	Level I Alimentary Tests	X	1.7011	$116.13	$33.88	$23.23
0361	Level II Alimentary Tests	X	4.0753	$278.21	$83.23	$55.65
0363	Level I Otorhinolaryngologic Function Tests	X	0.8721	$59.54	$16.71	$11.91
0364	Level I Audiometry	X	0.4612	$31.48	$7.03	$6.30
0365	Level II Audiometry	X	1.2498	$85.32	$18.52	$17.07
0366	Level III Audiometry	X	1.5786	$107.77	$24.61	$21.56
0367	Level I Pulmonary Test	X	0.5872	$40.09	$13.75	$8.02
0368	Level II Pulmonary Tests	X	0.8679	$59.25	$20.93	$11.85
0369	Level III Pulmonary Tests	X	3.0374	$207.35	$42.19	$41.47
0370	Allergy Tests	X	1.4793	$100.99	.	$20.20
0373	Level I Neuropsychological Testing	X	1.1738	$80.13	.	$16.03
0375	Ancillary Outpatient Services When Patient Expires	S	94.3159	$6,438.66	.	$1,287.74
0377	Level II Cardiac Imaging	S	11.2555	$768.38	.	$153.68
0378	Level II Pulmonary Imaging	S	4.7678	$325.48	$124.64	$65.10
0381	Single Allergy Tests	X	0.4215	$28.77	.	$5.76
0382	Level II Neuropsychological Testing	X	2.5561	$174.50	.	$34.90
0383	Cardiac Computed Tomographic Imaging	S	3.7795	$258.02	.	$51.61
0384	GI Procedures with Stents	T	27.4802	$1,875.99	.	$375.20
0385	Level I Prosthetic Urological Procedures	S	102.2894	$6,982.99	.	$1,396.60
0386	Level II Prosthetic Urological Procedures	S	168.1193	$11,477.00	.	$2,295.40
0387	Level II Hysteroscopy	T	38.2775	$2,613.09	$655.55	$522.62
0388	Discography	S	24.9242	$1,701.50	.	$340.30
0389	Level I Non-imaging Nuclear Medicine	S	1.5770	$107.66	$28.71	$21.54
0390	Level I Endocrine Imaging	S	2.0375	$139.09	$49.95	$27.82
0391	Level II Endocrine Imaging	S	3.2886	$224.50	$65.96	$44.90
0392	Level II Non-imaging Nuclear Medicine	S	2.6029	$177.69	$43.31	$35.54
0393	Hematologic Processing & Studies	S	5.8770	$401.21	.	$80.25
0394	Hepatobiliary Imaging	S	4.2112	$287.49	$98.44	$57.50
0395	GI Tract Imaging	S	3.6081	$246.31	$89.56	$49.27
0396	Bone Imaging	S	3.6637	$250.11	$95.02	$50.03
0397	Vascular Imaging	S	3.5928	$245.27	.	$49.06
0398	Level I Cardiac Imaging	S	4.3724	$298.49	$95.61	$59.70
0400	Hematopoietic Imaging	S	3.7861	$258.47	$91.52	$51.70
0401	Level I Pulmonary Imaging	S	2.9903	$204.14	$73.80	$40.83
0402	Level II Nervous System Imaging	S	9.0850	$620.21	.	$124.05
0403	Level I Nervous System Imaging	S	3.4106	$232.83	$72.42	$46.57
0404	Renal and Genitourinary Studies	S	4.7288	$322.82	$82.54	$64.57

ADDENDUM A.—PROPOSED OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0406	Level I Tumor/Infection Imaging	S	4.2872	$292.67	$88.01	$58.54
0407	Level I Radionuclide Therapy	S	3.2871	$224.40	$78.13	$44.88
0408	Level III Tumor/Infection Imaging	S	12.6011	$860.24	.	$172.05
0409	Red Blood Cell Tests	X	0.1134	$7.74	$2.18	$1.55
0412	IMRT Treatment Delivery	S	6.4458	$440.04	.	$88.01
0413	Level II Radionuclide Therapy	S	5.1912	$354.39	.	$70.88
0414	Level II Tumor/Infection Imaging	S	7.1451	$487.77	.	$97.56
0415	Level II Endoscopy Lower Airway	T	28.5180	$1,946.84	$459.92	$389.37
0418	Insertion of Left Ventricular Pacing Elect.	T	143.1583	$9,772.99	.	$1,954.60
0422	Level II Upper GI Procedures	T	16.3107	$1,113.48	$271.47	$222.70
0423	Level II Percutaneous Abdominal and Biliary Procedures	T	57.2089	$3,905.48	.	$781.10
0425	Level II Arthroplasty or Implantation with Prosthesis	T	122.1766	$8,340.63	.	$1,668.13
0426	Level II Strapping and Cast Application	S	2.4913	$170.07	.	$34.02
0427	Level II Tube or Catheter Changes or Repositioning	T	16.3601	$1,116.85	.	$223.37
0428	Level III Sigmoidoscopy and Anoscopy	T	24.5869	$1,678.47	.	$335.70
0429	Level V Cystourethroscopy and other Genitourinary Procedures	T	46.5713	$3,179.28	.	$635.86
0432	Health and Behavior Services	S	0.4597	$31.38	.	$6.28
0433	Level II Pathology	X	0.2465	$16.83	$5.17	$3.37
0434	Cardiac Defect Repair	T	158.2753	$10,804.98	.	$2,161.00
0436	Level I Drug Administration	S	0.3853	$26.30	.	$5.26
0437	Level II Drug Administration	S	0.5491	$37.49	.	$7.50
0438	Level III Drug Administration	S	1.1156	$76.16	.	$15.24
0439	Level IV Drug Administration	S	1.8498	$126.28	.	$25.26
0440	Level V Drug Administration	S	2.9855	$203.81	.	$40.77
0442	Dosimetric Drug Administration	S	31.9890	$2,183.79	.	$436.76
0604	Level 1 Hospital Clinic Visits	V	0.7431	$50.73	.	$10.15
0605	Level 2 Hospital Clinic Visits	V	1.0573	$72.18	.	$14.44
0606	Level 3 Hospital Clinic Visits	V	1.3650	$93.18	.	$18.64
0607	Level 4 Hospital Clinic Visits	V	1.7939	$122.46	.	$24.50
0608	Level 5 Hospital Clinic Visits	V	2.4657	$168.33	.	$33.67
0609	Level 1 Type A Emergency Visits	V	0.7735	$52.80	$12.64	$10.56
0613	Level 2 Type A Emergency Visits	V	1.3150	$89.77	$21.06	$17.96
0614	Level 3 Type A Emergency Visits	V	2.1031	$143.57	$34.50	$28.72
0615	Level 4 Type A Emergency Visits	V	3.3549	$229.03	$48.49	$45.81
0616	Level 5 Type A Emergency Visits	V	4.9888	$340.57	$72.86	$68.12
0617	Critical Care	S	7.7626	$529.93	$111.59	$105.99
0618	Trauma Response with Critical Care	S	13.9990	$955.67	.	$191.14
0621	Level I Vascular Access Procedures	T	11.4058	$778.64	.	$155.73

ADDENDUM A.—PROPOSED OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0622	Level II Vascular Access Procedures	T	25.6930	$1,753.98	.	$350.80
0623	Level III Vascular Access Procedures	T	30.8594	$2,106.68	.	$421.34
0624	Phlebotomy and Minor Vascular Access Device Procedures	X	0.6338	$43.27	$12.65	$8.66
0626	Level 1 Type B Emergency Visits	V	0.6250	$42.67	.	$8.54
0627	Level 2 Type B Emergency Visits	V	0.9279	$63.34	.	$12.67
0628	Level 3 Type B Emergency Visits	V	1.4941	$102.00	.	$20.40
0629	Level 4 Type B Emergency Visits	V	2.4251	$165.55	.	$33.11
0630	Level 5 Type B Emergency Visits	V	3.8788	$264.79	.	$52.96
0648	Level IV Breast Surgery	T	62.9000	$4,293.99	.	$858.80
0651	Complex Interstitial Radiation Source Application	S	14.3321	$978.41	.	$195.69
0652	Insertion of Intraperitoneal and Pleural Catheters	T	31.1286	$2,125.06	.	$425.02
0653	Vascular Reconstruction/Fistula Repair with Device	T	44.7437	$3,054.52	.	$610.91
0654	Insertion/Replacement of a permanent dual chamber pacemaker	T	108.1716	$7,384.55	.	$1,476.91
0655	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker	T	138.0708	$9,425.68	.	$1,885.14
0656	Transcatheter Placement of Intracoronary Drug-Eluting Stents	T	104.6619	$7,144.95	.	$1,428.99
0659	Hyperbaric Oxygen	S	1.5650	$106.84	.	$21.37
0660	Level II Otorhinolaryngologic Function Tests	X	1.4013	$95.66	$25.67	$19.14
0661	Level IV Pathology	X	2.3687	$161.70	.	$32.34
0662	CT Angiography	S	5.0605	$345.47	$114.75	$69.10
0664	Level I Proton Beam Radiation Therapy	S	13.2159	$902.21	.	$180.45
0665	Bone Density:AppendicularSkeleton	S	0.4667	$31.86	$11.60	$6.38
0667	Level II Proton Beam Radiation Therapy	S	17.2884	$1,180.23	.	$236.05
0668	Level I Angiography and Venography	S	10.6287	$725.59	.	$145.12
0672	Level III Posterior Segment Eye Procedures	T	40.6474	$2,774.88	.	$554.98
0673	Level V Anterior Segment Eye Procedures	T	44.5131	$3,038.78	$649.56	$607.76
0674	Prostate Cryoablation	T	116.8825	$7,979.22	.	$1,595.85
0676	Thrombolysis and Other Device Revisions	T	2.3844	$162.78	.	$32.56
0678	External Counterpulsation	T	1.4509	$99.05	.	$19.81
0679	Level II Resuscitation and Cardioversion	S	5.4877	$374.63	$95.30	$74.93
0680	Insertion of Patient Activated Event Recorders	S	78.5933	$5,365.33	.	$1,073.07
0683	Level II Photochemotherapy	S	2.8503	$194.58	.	$38.92
0685	Level III Needle Biopsy/Aspiration Except Bone Marrow	T	9.9046	$676.16	.	$135.24
0687	Revision/Removal of Neurostimulator Electrodes	T	21.9323	$1,497.25	$397.37	$299.45
0688	Revision/Removal of Neurostimulator Pulse	T	29.5816	$2,019.45	$768.94	$403.89

ADDENDUM A.—PROPOSED OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
	Generator Receiver					
0690	Level I Electronic Analysis of Devices	S	0.5225	$35.67	$8.67	$7.14
0691	Level III Electronic Analysis of Devices	S	2.4765	$169.06	.	$33.82
0692	Level II Electronic Analysis of Devices	S	1.6175	$110.42	.	$22.09
0694	Mohs Surgery	T	5.0842	$347.08	$91.69	$69.42
0697	Level I Echocardiogram Without Contrast	S	3.1630	$215.93	.	$43.19
0698	Level II Eye Tests & Treatments	S	0.9316	$63.60	.	$12.72
0699	Level IV Eye Tests & Treatments	T	16.6419	$1,136.09	.	$227.22
0701	Sr89 strontium	K		$805.83	.	$161.17
0726	Dexrazoxane HCl injection	K		$261.24	.	$52.25
0728	Filgrastim 300 mcg injection	K		$223.05	.	$44.61
0731	Sargramostim injection	K		$25.25	.	$5.05
0735	Ampho b cholesteryl sulfate	K		$14.00	.	$2.80
0736	Amphotericin b liposome inj	K		$15.78	.	$3.16
0738	Rasburicase	K		$172.53	.	$34.51
0747	Chlorothiazide sodium inj	K		$352.37	.	$70.48
0751	Mechlorethamine hcl inj	K		$154.50	.	$30.90
0752	Dactinomycin injection	K		$570.53	.	$114.11
0759	Naltrexone, depot form	K		$2.43	.	$0.49
0800	Leuprolide acetate	K		$516.09	.	$103.22
0802	Etoposide oral	K		$28.26	.	$5.66
0807	Aldesleukin injection	K		$844.43	.	$168.89
0809	Bcg live intravesical vac	K		$121.25	.	$24.25
0810	Goserelin acetate implant	K		$195.23	.	$39.05
0812	Carmustine injection	K		$176.41	.	$35.29
0814	Asparaginase injection	K		$60.94	.	$12.19
0820	Daunorubicin injection	K		$19.46	.	$3.90
0821	Daunorubicin citrate inj	K		$56.31	.	$11.27
0823	Docetaxel injection	K		$17.86	.	$3.58
0825	Nelarabine injection	K		$105.91	.	$21.19
0827	Floxuridine injection	K		$42.99	.	$8.60
0828	Gemcitabine hcl injection	K		$145.10	.	$29.02
0830	Irinotecan injection	K		$9.15	.	$1.83
0831	Ifosfomide injection	K		$30.76	.	$6.16
0832	Idarubicin hcl injection	K		$63.57	.	$12.72
0835	Cosyntropin injection NOS	K		$73.19	.	$14.64
0836	Interferon alfa-2b inj	K		$15.84	.	$3.17
0838	Interferon gamma 1-b inj	K		$430.93	.	$86.19
0840	Inj melphalan hydrochl	K		$1,500.32	.	$300.07
0842	Fludarabine phosphate inj	K		$205.81	.	$41.17
0843	Pegaspargase injection	K		$2,747.44	.	$549.49

ADDENDUM A.—PROPOSED OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0844	Pentostatin injection	K		$1,246.38	.	$249.28
0849	Rituximab injection	K		$578.40	.	$115.68
0850	Streptozocin injection	K		$282.86	.	$56.58
0851	Thiotepa injection	K		$113.52	.	$22.71
0852	Topotecan injection	K		$1,058.90	.	$211.78
0856	Porfimer sodium injection	K		$2,934.28	.	$586.86
0858	Inj cladribine	K		$28.22	.	$5.65
0861	Leuprolide acetate injeciton	K		$4.27	.	$0.86
0864	Mitoxantrone hydrochl	K		$45.26	.	$9.06
0865	Interferon alfa-n3 inj	K		$18.23	.	$3.65
0868	Oral aprepitant	K		$5.67	.	$1.14
0873	Hyalgan/supartz inj per dose	K		$91.96	.	$18.40
0874	Synvisc or synvisc-one	K		$11.78	.	$2.36
0875	Euflexxa inj per dose	K		$113.79	.	$22.76
0877	Orthovisc inj per dose	K		$176.70	.	$35.34
0878	Gallium nitrate injection	K		$2.03	.	$0.41
0884	Rho d immune globulin inj	K		$77.47	.	$15.50
0887	Azathioprine parenteral	K		$96.29	.	$19.26
0890	Lymphocyte immune globulin	K		$487.88	.	$97.58
0900	Alglucerase injection	K		$41.98	.	$8.40
0901	Alpha 1 proteinase inhibitor	K		$3.77	.	$0.76
0902	Injection,onabotulinumtoxinA	K		$5.49	.	$1.10
0903	Cytomegalovirus imm IV /vial	K		$878.82	.	$175.77
0904	Gamma globulin 4 CC inj	K		$64.13	.	$12.83
0910	Interferon beta-1b / .25 MG	K		$176.67	.	$35.34
0913	Ganciclovir long act implant	K		$16,960.00	.	$3,392.00
0916	Injection imiglucerase /unit	K		$4.20	.	$0.84
0917	Adenosine injection	K		$82.72	.	$16.55
0920	Gamma globulin 6 CC inj	K		$96.23	.	$19.25
0921	Gamma globulin 7 CC inj	K		$112.17	.	$22.44
0922	Gamma globulin 8 CC inj	K		$128.27	.	$25.66
0923	Gamma globulin 9 CC inj	K		$160.34	.	$32.07
0924	Gamma globulin 10 CC inj	K		$160.34	.	$32.07
0925	Factor viii	K		$0.87	.	$0.18
0927	Factor viii recombinant	K		$1.09	.	$0.22
0928	Factor ix complex	K		$0.88	.	$0.18
0929	Anti-inhibitor	K		$1.55	.	$0.31
0931	Factor IX non-recombinant	K		$0.91	.	$0.19
0932	Factor IX recombinant	K		$1.11	.	$0.23
0933	Gamma globulin > 10 CC inj	K		$160.34	.	$32.07
0934	Capecitabine, oral	K		$20.66	.	$4.14

ADDENDUM A.—PROPOSED OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0935	Clonidine hydrochloride	K		$98.64	.	$19.73
0943	Octagam injection	K		$37.69	.	$7.54
0944	Gammagard liquid injection	K		$38.53	.	$7.71
0945	Rhophylac injection	K		$5.21	.	$1.05
0946	Hepagam b im injection	K		$50.63	.	$10.13
0947	Flebogamma injection	K		$37.01	.	$7.41
0948	Gamunex injection	K		$37.63	.	$7.53
0949	Frozen plasma, pooled, sd	R	0.8126	$55.47	.	$11.10
0950	Whole blood for transfusion	R	2.9637	$202.32	.	$40.47
0951	Reclast injection	K		$222.92	.	$44.59
0952	Cryoprecipitate each unit	R	0.7391	$50.46	.	$10.10
0954	RBC leukocytes reduced	R	2.7694	$189.06	.	$37.82
0955	Plasma, frz between 8-24hour	R	1.0672	$72.85	.	$14.57
0956	Plasma protein fract,5%,50ml	R	0.3751	$25.61	.	$5.13
0957	Platelets, each unit	R	1.0506	$71.72	.	$14.35
0958	Plaelet rich plasma unit	R	2.0520	$140.08	.	$28.02
0959	Red blood cells unit	R	2.1860	$149.23	.	$29.85
0960	Washed red blood cells unit	R	4.3079	$294.09	.	$58.82
0961	Albumin (human),5%, 50ml	K		$16.89	.	$3.38
0963	Albumin (human), 5%, 250 ml	K		$60.58	.	$12.12
0964	Albumin (human), 25%, 20 ml	K		$25.67	.	$5.14
0965	Albumin (human), 25%, 50ml	K		$62.05	.	$12.41
0966	Plasmaprotein fract,5%,250ml	R	1.6989	$115.98	.	$23.20
0967	Blood split unit	R	2.9552	$201.74	.	$40.35
0968	Platelets leukoreduced irrad	R	2.0209	$137.96	.	$27.60
0969	RBC leukoreduced irradiated	R	3.6796	$251.20	.	$50.24
1009	Cryoprecipitatereducedplasma	R	1.1663	$79.62	.	$15.93
1010	Blood, l/r, cmv-neg	R	2.7600	$188.42	.	$37.69
1011	Platelets, hla-m, l/r, unit	R	10.5854	$722.63	.	$144.53
1013	Platelets leukocytes reduced	R	1.5839	$108.13	.	$21.63
1015	Injection glatiramer acetate	K		$82.34	.	$16.47
1016	Blood, l/r, froz/degly/wash	R	1.4749	$100.69	.	$20.14
1017	Plt, aph/pher, l/r, cmv-neg	R	6.2876	$429.24	.	$85.85
1018	Blood, l/r, irradiated	R	2.4465	$167.02	.	$33.41
1019	Plate pheres leukoredu irrad	R	9.6439	$658.36	.	$131.68
1020	Plt, pher, l/r cmv-neg, irr	R	8.5688	$584.97	.	$117.00
1021	RBC, frz/deg/wsh, l/r, irrad	R	4.1093	$280.53	.	$56.11
1022	RBC, l/r, cmv-neg, irrad	R	4.3870	$299.49	.	$59.90
1023	Pralidoxime chloride inj	K		$90.79	.	$18.16
1052	Injection, voriconazole	K		$5.82	.	$1.17
1064	I131 iodide cap, rx	K		$18.20	.	$3.64

ADDENDUM A.—PROPOSED OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
1083	Adalimumab injection	K		$374.48	.	$74.90
1084	Denileukin diftitox inj	K		$1,494.82	.	$298.97
1086	Temozolomide	K		$8.83	.	$1.77
1138	Hepagam b intravenous, inj	K		$50.63	.	$10.13
1139	Protein c concentrate	K		$12.19	.	$2.44
1142	Supprelin LA implant	K		$14,990.44	.	$2,998.09
1150	I131 iodide sol, rx	K		$13.72	.	$2.75
1166	Cytarabine liposome inj	K		$488.90	.	$97.78
1167	Inj, epirubicin hcl	K		$2.48	.	$0.50
1168	Inj, temsirolimus	K		$49.83	.	$9.97
1178	Busulfan injection	K		$14.45	.	$2.89
1203	Verteporfin injection	K		$9.50	.	$1.90
1207	Octreotide injection, depot	K		$109.01	.	$21.81
1213	Antihemophilic viii/vwf comp	K		$0.92	.	$0.19
1214	Inj IVIG privigen 500 mg	K		$35.10	.	$7.02
1220	Calcitonin salmon injection	K		$49.26	.	$9.86
1221	Dimethyl sulfoxide 50%	K		$69.98	.	$14.00
1222	Pentastarch 10% solution	K		$161.82	.	$32.37
1226	Inj streptokinase /250000 IU	K		$32.12	.	$6.43
1232	Mitomycin 5 MG inj	K		$20.35	.	$4.07
1233	Mitomycin 20 MG inj	K		$81.44	.	$16.29
1234	Mitomycin 40 MG inj	K		$162.86	.	$32.58
1235	Valrubicin injection	K		$960.22	.	$192.05
1236	Levoleucovorin injection	G		$0.78	.	$0.16
1237	Inj iron dextran	K		$12.63	.	$2.53
1238	Topotecan oral	G		$74.66	.	$14.94
1239	Rotavirus vacc 2 dose oral	K		$102.50	.	$20.50
1240	Apligraf skin sub	K		$32.71	.	$6.55
1241	Oasis wound matrix skin sub	K		$4.62	.	$0.93
1242	Oasis burn matrix skin sub	K		$4.62	.	$0.93
1243	Integra BMWD skin sub	K		$14.84	.	$2.97
1244	Integra DRT skin sub	K		$10.00	.	$2.00
1245	Dermagraft skin sub	K		$40.10	.	$8.02
1246	Graftjacket skin sub	K		$92.04	.	$18.41
1247	Integra matrix skin sub	K		$17.99	.	$3.60
1248	Primatrix skin sub	K		$34.35	.	$6.87
1249	Cymetra allograft	K		$342.34	.	$68.47
1250	Graftjacket express allograf	K		$342.34	.	$68.47
1251	Integra flowable wound matri	K		$914.43	.	$182.89
1252	Gammagraft skin sub	K		$7.40	.	$1.48
1253	Triamcinolone A inj PRS-free	K		$3.21	.	$0.65

ADDENDUM A.—PROPOSED OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
1254	Adenovirus vaccine, type 4	K		$173.84	.	$34.77
1255	Rotovirus vacc 3 dose, oral	K		$73.76	.	$14.76
1256	Brompheniramine maleate inj	K		$9.24	.	$1.85
1260	Nandrolone decanoate 100 MG	K		$71.34	.	$14.27
1263	Antithrombin iii injection	K		$2.31	.	$0.47
1266	Interferon alfacon-1 inj	K		$4.80	.	$0.96
1268	Xyntha inj	K		$1.08	.	$0.22
1270	Alloderm skin sub	K		$32.57	.	$6.52
1271	Cholera vaccine, injectable	K		$103.90	.	$20.78
1272	Acetylcysteine injection	K		$2.45	.	$0.49
1274	Edetate calcium disodium inj	K		$197.37	.	$39.48
1275	Vivaglobin, inj	K		$7.20	.	$1.44
1279	Factor VIII (porcine)	K		$8.21	.	$1.65
1280	Corticotropin injection	K		$2,441.70	.	$488.34
1281	Bevacizumab injection	K		$1.44	.	$0.29
1282	Gamma globulin 2 CC inj	K		$32.07	.	$6.42
1283	Gamma globulin 3 CC inj	K		$48.10	.	$9.62
1284	Gamma globulin 5 CC inj	K		$80.16	.	$16.04
1285	Nandrolone decanoate 50 MG	K		$7.08	.	$1.42
1286	Nandrolone decanoate 200 MG	K		$43.59	.	$8.72
1287	Alloskin skin sub	K		$7.34	.	$1.47
1288	Visualization adjunct	K		$1.82	.	$0.37
1289	AbobotulinumtoxinA	K		$7.71	.	$1.55
1290	Human fibrinogen conc inj	G		$72.89	.	$14.58
1291	Rilonacept injection	K		$24.09	.	$4.82
1295	Sm 153 lexidronam	K		$5,613.99	.	$1,122.80
1296	Degarelix injection	G		$2.60	.	$0.52
1297	Ferumoxytol, non-esrd	G		$0.82	.	$0.17
1298	Cosyntropin cortrosyn inj	K		$90.95	.	$18.19
1299	Gadofosveset trisodium inj	G		$12.89		
1302	Inj benztropine mesylate	K		$42.16	.	$8.44
1303	Itraconazole injection	K		$42.28	.	$8.46
1304	Perphenazine injeciton	K		$29.11	.	$5.83
1306	Urea injection	K		$83.87	.	$16.78
1307	Oral busulfan	K		$3.65	.	$0.73
1308	Mecasermin injection	K		$125.21	.	$25.05
1309	Paclitaxel injection	K		$11.46	.	$2.30
1491	New Technology - Level IA ($0-$10)	S		$5.00	.	$1.00
1492	New Technology - Level IB ($10-$20)	S		$15.00	.	$3.00
1493	New Technology - Level IC ($20-$30)	S		$25.00	.	$5.00
1494	New Technology - Level ID ($30-$40)	S		$35.00	.	$7.00

ADDENDUM A.—PROPOSED OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
1495	New Technology - Level IE ($40-$50)	S		$45.00	.	$9.00
1496	New Technology - Level IA ($0-$10)	T		$5.00	.	$1.00
1497	New Technology - Level IB($10-$20)	T		$15.00	.	$3.00
1498	New Technology - Level IC ($20-$30)	T		$25.00	.	$5.00
1499	New Technology - Level ID($30-$40)	T		$35.00	.	$7.00
1500	New Technology - Level IE ($40-$50)	T		$45.00	.	$9.00
1502	New Technology - Level II ($50 - $100)	S		$75.00	.	$15.00
1503	New Technology - Level III ($100 - $200)	S		$150.00	.	$30.00
1504	New Technology - Level IV ($200 - $300)	S		$250.00	.	$50.00
1505	New Technology - Level V ($300 - $400)	S		$350.00	.	$70.00
1506	New Technology - Level VI ($400 - $500)	S		$450.00	.	$90.00
1507	New Technology - Level VII ($500 - $600)	S		$550.00	.	$110.00
1508	New Technology - Level VIII ($600 - $700)	S		$650.00	.	$130.00
1509	New Technology - Level IX ($700 - $800)	S		$750.00	.	$150.00
1510	New Technology - Level X ($800 - $900)	S		$850.00	.	$170.00
1511	New Technology - Level XI ($900 - $1000)	S		$950.00	.	$190.00
1512	New Technology - Level XII ($1000 - $1100)	S		$1,050.00	.	$210.00
1513	New Technology - Level XIII ($1100 - $1200)	S		$1,150.00	.	$230.00
1514	New Technology - Level XIV ($1200- $1300)	S		$1,250.00	.	$250.00
1515	New Technology - Level XV ($1300 - $1400)	S		$1,350.00	.	$270.00
1516	New Technology - Level XVI ($1400 - $1500)	S		$1,450.00	.	$290.00
1517	New Technology - Level XVII ($1500-$1600)	S		$1,550.00	.	$310.00
1518	New Technology - Level XVIII ($1600-$1700)	S		$1,650.00	.	$330.00
1519	New Technology - Level IXX ($1700-$1800)	S		$1,750.00	.	$350.00
1520	New Technology - Level XX ($1800-$1900)	S		$1,850.00	.	$370.00
1521	New Technology - Level XXI ($1900-$2000)	S		$1,950.00	.	$390.00
1522	New Technology - Level XXII ($2000-$2500)	S		$2,250.00	.	$450.00
1523	New Technology - Level XXIII ($2500-$3000)	S		$2,750.00	.	$550.00
1524	New Technology - Level XXIV ($3000-$3500)	S		$3,250.00	.	$650.00
1525	New Technology - Level XXV ($3500-$4000)	S		$3,750.00	.	$750.00
1526	New Technology - Level XXVI ($4000-$4500)	S		$4,250.00	.	$850.00
1527	New Technology - Level XXVII ($4500-$5000)	S		$4,750.00	.	$950.00
1528	New Technology - Level XXVIII ($5000-$5500)	S		$5,250.00	.	$1,050.00
1529	New Technology - Level XXIX ($5500-$6000)	S		$5,750.00	.	$1,150.00
1530	New Technology - Level XXX ($6000-$6500)	S		$6,250.00	.	$1,250.00
1531	New Technology - Level XXXI ($6500-$7000)	S		$6,750.00	.	$1,350.00
1532	New Technology - Level XXXII ($7000-$7500)	S		$7,250.00	.	$1,450.00
1533	New Technology - Level XXXIII ($7500-$8000)	S		$7,750.00	.	$1,550.00
1534	New Technology - Level XXXIV ($8000-$8500)	S		$8,250.00	.	$1,650.00

ADDENDUM A.—PROPOSED OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
1535	New Technology - Level XXXV ($8500-$9000)	S		$8,750.00	.	$1,750.00
1536	New Technology - Level XXXVI ($9000-$9500)	S		$9,250.00	.	$1,850.00
1537	New Technology - Level XXXVII ($9500-$10000)	S		$9,750.00	.	$1,950.00
1539	New Technology - Level II ($50 - $100)	T		$75.00	.	$15.00
1540	New Technology - Level III ($100 - $200)	T		$150.00	.	$30.00
1541	New Technology - Level IV ($200 - $300)	T		$250.00	.	$50.00
1542	New Technology - Level V ($300 - $400)	T		$350.00	.	$70.00
1543	New Technology - Level VI ($400 - $500)	T		$450.00	.	$90.00
1544	New Technology - Level VII ($500 - $600)	T		$550.00	.	$110.00
1545	New Technology - Level VIII ($600 - $700)	T		$650.00	.	$130.00
1546	New Technology - Level IX ($700 - $800)	T		$750.00	.	$150.00
1547	New Technology - Level X ($800 - $900)	T		$850.00	.	$170.00
1548	New Technology - Level XI ($900 - $1000)	T		$950.00	.	$190.00
1549	New Technology - Level XII ($1000 - $1100)	T		$1,050.00	.	$210.00
1550	New Technology - Level XIII ($1100 - $1200)	T		$1,150.00	.	$230.00
1551	New Technology - Level XIV ($1200- $1300)	T		$1,250.00	.	$250.00
1552	New Technology - Level XV ($1300 - $1400)	T		$1,350.00	.	$270.00
1553	New Technology - Level XVI ($1400 - $1500)	T		$1,450.00	.	$290.00
1554	New Technology - Level XVII ($1500-$1600)	T		$1,550.00	.	$310.00
1555	New Technology - Level XVIII ($1600-$1700)	T		$1,650.00	.	$330.00
1556	New Technology - Level XIX ($1700-$1800)	T		$1,750.00	.	$350.00
1557	New Technology - Level XX ($1800-$1900)	T		$1,850.00	.	$370.00
1558	New Technology - Level XXI ($1900-$2000)	T		$1,950.00	.	$390.00
1559	New Technology - Level XXII ($2000-$2500)	T		$2,250.00	.	$450.00
1560	New Technology - Level XXIII ($2500-$3000)	T		$2,750.00	.	$550.00
1561	New Technology - Level XXIV ($3000-$3500)	T		$3,250.00	.	$650.00
1562	New Technology - Level XXV ($3500-$4000)	T		$3,750.00	.	$750.00
1563	New Technology - Level XXVI ($4000-$4500)	T		$4,250.00	.	$850.00
1564	New Technology - Level XXVII ($4500-$5000)	T		$4,750.00	.	$950.00
1565	New Technology - Level XXVIII ($5000-$5500)	T		$5,250.00	.	$1,050.00
1566	New Technology - Level XXIX ($5500-$6000)	T		$5,750.00	.	$1,150.00
1567	New Technology - Level XXX ($6000-$6500)	T		$6,250.00	.	$1,250.00
1568	New Technology - Level XXXI ($6500-$7000)	T		$6,750.00	.	$1,350.00
1569	New Technology - Level XXXII ($7000-$7500)	T		$7,250.00	.	$1,450.00
1570	New Technology - Level XXXIII ($7500-$8000)	T		$7,750.00	.	$1,550.00
1571	New Technology - Level XXXIV ($8000-$8500)	T		$8,250.00	.	$1,650.00
1572	New Technology - Level XXXV ($8500-	T		$8,750.00	.	$1,750.00

ADDENDUM A.—PROPOSED OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
	$9000)					
1573	New Technology - Level XXXVI ($9000-$9500)	T		$9,250.00	.	$1,850.00
1574	New Technology - Level XXXVII ($9500-$10000)	T		$9,750.00	.	$1,950.00
1605	Abciximab injection	K		$462.83	.	$92.57
1607	Eptifibatide injection	K		$19.00	.	$3.80
1608	Etanercept injection	K		$191.55	.	$38.31
1609	Rho(D) immune globulin h, sd	K		$18.55	.	$3.71
1612	Daclizumab, parenteral	K		$351.10	.	$70.22
1613	Trastuzumab injection	K		$66.41	.	$13.29
1630	Hep b ig, im	K		$115.97	.	$23.20
1631	Baclofen intrathecal trial	K		$73.50	.	$14.70
1633	Alefacept	K		$30.63	.	$6.13
1643	Y90 ibritumomab, rx	K		$31,434.63	.	$6,286.93
1645	I131 tositumomab, rx	K		$23,132.09	.	$4,626.42
1670	Tetanus immune globulin inj	K		$136.81	.	$27.37
1675	P32 Na phosphate	K		$196.49	.	$39.30
1676	P32 chromic phosphate	K		$113.44	.	$22.69
1683	Basiliximab	K		$1,755.73	.	$351.15
1684	Corticorelin ovine triflutal	K		$4.48	.	$0.90
1685	Darbepoetin alfa, non-esrd	K		$2.88	.	$0.58
1686	Epoetin alfa, non-esrd	K		$9.44	.	$1.89
1687	Digoxin immune fab (ovine)	K		$487.78	.	$97.56
1688	Ethanolamine oleate	K		$149.97	.	$30.00
1689	Fomepizole	K		$7.64	.	$1.53
1690	Hemin	K		$8.18	.	$1.64
1693	Lepirudin	K		$234.37	.	$46.88
1694	Ziconotide injection	K		$6.50	.	$1.30
1695	Nesiritide injection	K		$38.37	.	$7.68
1696	Palifermin injection	K		$11.34	.	$2.27
1697	Pegaptanib sodium injection	K		$1,030.34	.	$206.07
1700	Inj secretin synthetic human	K		$20.31	.	$4.07
1701	Treprostinil injection	K		$55.88	.	$11.18
1704	Humate-P, inj	K		$0.88	.	$0.18
1705	Factor viia	K		$1.36	.	$0.28
1709	Azacitidine injection	K		$4.99	.	$1.00
1710	Clofarabine injection	K		$116.49	.	$23.30
1711	Vantas implant	K		$1,515.25	.	$303.05
1712	Paclitaxel protein bound	K		$9.43	.	$1.89
1716	Brachytx, non-str, Gold-198	U	2.7019	$184.45	.	$36.89
1717	Brachytx, non-str, HDR Ir-192	U	3.2259	$220.22	.	$44.05

ADDENDUM A.—PROPOSED OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
1719	Brachytx, NS, Non-HDRIr-192	U	0.3366	$22.98	.	$4.60
1738	Oxaliplatin	K		$6.83	.	$1.37
1739	Pegademase bovine, 25 iu	K		$247.34	.	$49.47
1740	Diazoxide injection	K		$114.32	.	$22.87
1741	Urofollitropin, 75 iu	K		$60.01	.	$12.01
2210	Methyldopate hcl injection	K		$36.34	.	$7.27
2616	Brachytx, non-str,Yttrium-90	U	245.7374	$16,775.76	.	$3,355.16
2632	Iodine I-125 sodium iodide	U	0.3077	$21.01	.	$4.21
2634	Brachytx, non-str, HA, I-125	U	0.7596	$51.86	.	$10.38
2635	Brachytx, non-str, HA, P-103	U	0.4337	$29.61	.	$5.93
2636	Brachy linear, non-str,P-103	U	0.5280	$36.04	.	$7.21
2638	Brachytx, stranded, I-125	U	0.5662	$38.65	.	$7.73
2639	Brachytx, non-stranded,I-125	U	0.5292	$36.13	.	$7.23
2640	Brachytx, stranded, P-103	U	0.9334	$63.72	.	$12.75
2641	Brachytx, non-stranded,P-103	U	0.9135	$62.36	.	$12.48
2642	Brachytx, stranded, C-131	U	1.6774	$114.51	.	$22.91
2643	Brachytx, non-stranded,C-131	U	0.9143	$62.42	.	$12.49
2698	Brachytx, stranded, NOS	U	0.5662	$38.65	.	$7.73
2699	Brachytx, non-stranded, NOS	U	0.3366	$22.98	.	$4.60
2731	Immune globulin, powder	K		$30.86	.	$6.18
2770	Quinupristin/dalfopristin	K		$147.06	.	$29.42
3041	Bivalirudin	K		$2.41	.	$0.49
3043	Gamma globulin 1 CC inj	K		$16.03	.	$3.21
3050	Sermorelin acetate injection	K		$1.80	.	$0.36
7000	Amifostine	K		$327.97	.	$65.60
7011	Oprelvekin injection	K		$245.08	.	$49.02
7034	Somatropin injection	K		$55.46	.	$11.10
7035	Teniposide	K		$324.55	.	$64.91
7036	Urokinase 250,000 IU inj	K		$457.73	.	$91.55
7038	Monoclonal antibodies	K		$1,133.50	.	$226.70
7041	Tirofiban HCl	K		$7.39	.	$1.48
7042	Capecitabine, oral	K		$6.28	.	$1.26
7043	Infliximab injection	K		$58.74	.	$11.75
7046	Doxorubicin hcl liposome inj	K		$472.01	.	$94.41
7048	Alteplase recombinant	K		$37.35	.	$7.47
7049	Filgrastim 480 mcg injection	K		$348.68	.	$69.74
7051	Leuprolide acetate implant	K		$4,819.82	.	$963.97
7308	Aminolevulinic acid hcl top	K		$134.54	.	$26.91
8000	Cardiac Electrophysiologic Evaluation and Ablation Composite	T	155.6137	$10,623.28	.	$2,124.66
8001	LDR Prostate Brachytherapy Composite	T	46.9015	$3,201.82	.	$640.37
8002	Level I Extended Assessment & Management Composite	V	5.7633	$393.44	.	$78.69

ADDENDUM A.—PROPOSED OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
8003	Level II Extended Assessment & Management Composite	V	10.6788	$729.01	.	$145.81
8004	Ultrasound Composite	S	2.8299	$193.19	.	$38.64
8005	CT and CTA without Contrast Composite	S	6.1855	$422.27	.	$84.46
8006	CT and CTA with Contrast Composite	S	9.3145	$635.87	.	$127.18
8007	MRI and MRA without Contrast Composite	S	10.5169	$717.96	.	$143.60
8008	MRI and MRA with Contrast Composite	S	14.7671	$1,008.11	.	$201.63
9001	Linezolid injection	K		$32.57	.	$6.52
9002	Tenecteplase injection	K		$46.74	.	$9.35
9003	Palivizumab	K		$510.69	.	$102.14
9004	Gemtuzumab ozogamicin inj	K		$2,687.21	.	$537.45
9005	Reteplase injection	K		$1,555.98	.	$311.20
9006	Tacrolimus injection	K		$139.41	.	$27.89
9012	Arsenic trioxide injection	K		$37.43	.	$7.49
9018	Inj, rimabotulinumtoxinB	K		$10.58	.	$2.12
9019	Caspofungin acetate	K		$11.59	.	$2.32
9022	IM inj interferon beta 1-a	K		$193.93	.	$38.79
9023	Rho d immune globulin	K		$25.14	.	$5.03
9024	Amphotericin b lipid complex	K		$9.84	.	$1.97
9032	Baclofen 10 MG injection	K		$203.89	.	$40.78
9033	Cidofovir injection	K		$761.10	.	$152.22
9038	Inj estrogen conjugate	K		$88.68	.	$17.74
9042	Glucagon hydrochloride	K		$81.41	.	$16.29
9044	Ibutilide fumarate injection	K		$416.61	.	$83.33
9046	Iron sucrose injection	K		$0.37	.	$0.08
9104	Antithymocyte globuln rabbit	K		$386.48	.	$77.30
9108	Thyrotropin injection	K		$1,053.42	.	$210.69
9110	Alemtuzumab injection	K		$578.02	.	$115.61
9115	Zoledronic acid	K		$221.12	.	$44.23
9119	Injection, pegfilgrastim 6mg	K		$2,432.50	.	$486.50
9120	Injection, Fulvestrant	K		$82.22	.	$16.45
9121	Injection, argatroban	K		$18.39	.	$3.68
9122	Triptorelin pamoate	K		$164.10	.	$32.82
9124	Daptomycin injection	K		$0.43	.	$0.09
9125	Risperidone, long acting	K		$5.06	.	$1.02
9126	Natalizumab injection	K		$7.97	.	$1.60
9133	Rabies ig, im/sc	K		$139.75	.	$27.95
9134	Rabies ig, heat treated	K		$152.38	.	$30.48
9135	Varicella-zoster ig, im	K		$147.58	.	$29.52
9137	Bcg vaccine, percut	K		$109.47	.	$21.90
9139	Rabies vaccine, im	K		$181.27	.	$36.26

ADDENDUM A.—PROPOSED OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
9140	Rabies vaccine, id	K		$98.12	.	$19.63
9143	Meningococcal vaccine, sc	K		$103.41	.	$20.69
9144	Encephalitis vaccine, sc	K		$102.08	.	$20.42
9145	Meningococcal vaccine, im	K		$103.41	.	$20.69
9207	Bortezomib injection	K		$38.24	.	$7.65
9208	Agalsidase beta injection	K		$136.24	.	$27.25
9209	Laronidase injection	K		$25.56	.	$5.12
9210	Palonosetron hcl	K		$17.62	.	$3.53
9213	Pemetrexed injection	K		$50.63	.	$10.13
9214	Bevacizumab injection	K		$57.57	.	$11.52
9215	Cetuximab injection	K		$49.73	.	$9.95
9217	Leuprolide acetate suspnsion	K		$220.41	.	$44.09
9224	Galsulfase injection	K		$339.90	.	$67.98
9225	Fluocinolone acetonide implt	K		$19,345.00	.	$3,869.00
9227	Micafungin sodium injection	K		$1.10	.	$0.22
9228	Tigecycline injection	K		$1.16	.	$0.24
9229	Ibandronate sodium injection	K		$141.39	.	$28.28
9230	Abatacept injection	K		$19.96	.	$4.00
9231	Decitabine injection	K		$29.65	.	$5.93
9232	Idursulfase injection	K		$455.03	.	$91.01
9233	Ranibizumab injection	K		$404.70	.	$80.94
9234	Alglucosidase alfa injection	K		$127.08	.	$25.42
9235	Panitumumab injection	K		$87.24	.	$17.45
9236	Eculizumab injection	K		$182.61	.	$36.53
9237	Inj, lanreotide acetate	K		$29.30	.	$5.86
9240	Injection, ixabepilone	K		$63.74	.	$12.75
9242	Injection, fosaprepitant	K		$1.62	.	$0.33
9243	Bendamustine injection	K		$18.47	.	$3.70
9244	Regadenoson injection	K		$50.73	.	$10.15
9245	Romiplostim injection	K		$44.18	.	$8.84
9247	Inj, iobenguane, I-123, dx	G		$2,282.67		
9248	Inj, clevidipine butyrate	K		$2.98	.	$0.60
9249	Certolizumab pegol inj	G		$3.78	.	$0.76
9250	Artiss fibrin sealant	G		$136.64	.	$27.33
9251	C1 esterase inhibitor inj	G		$42.75	.	$8.55
9252	Plerixafor injection	G		$268.58	.	$53.72
9253	Temozolomide injection	G		$4.90	.	$0.98
9254	Injection, lacosamide	K		$0.18	.	$0.04
9255	Paliperidone palmitate inj	G		$6.54	.	$1.31
9256	Dexamethasone intravitreal	G		$196.10	.	$39.22
9258	Telavancin injection	G		$0.21	.	$0.05

ADDENDUM A.—PROPOSED OPPS APCs FOR CY 2011

APC	Group Title	SI	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
9259	Pralatrexate injection	G		$165.63	.	$33.13
9260	Ofatumumab injection	G		$46.64	.	$9.33
9261	Ustekinumab injection	G		$107.43	.	$21.49
9262	Fludarabine phosphate, oral	G		$81.77	.	$16.36
9263	Ecallantide injection	G		$280.90	.	$56.18
9300	Omalizumab injection	K		$19.77	.	$3.96
9358	SurgiMend, fetal	K		$10.67	.	$2.14
9360	SurgiMend, neonatal	G		$11.24	.	$2.25
9361	NeuroMend nerve wrap	G		$265.18		
9362	Implnt,bon void filler-strip	G		$50.88		
9363	Integra Meshed Bil Wound Mat	G		$17.88	.	$3.58
9364	Porcine implant, Permacol	G		$17.67		
9500	Platelets, irradiated	R	2.2804	$155.68	.	$31.14
9501	Platelet pheres leukoreduced	R	7.7397	$528.37	.	$105.68
9502	Platelet pheresis irradiated	R	6.8837	$469.93	.	$93.99
9503	Fr frz plasma donor retested	R	0.9734	$66.45	.	$13.29
9504	RBC deglycerolized	R	5.1865	$354.07	.	$70.82
9505	RBC irradiated	R	3.1620	$215.86	.	$43.18
9506	Granulocytes, pheresis unit	R	23.7666	$1,622.47	.	$324.50
9507	Platelets, pheresis	R	6.5766	$448.96	.	$89.80
9508	Plasma 1 donor frz w/in 8 hr	R	1.1671	$79.67	.	$15.94

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
0016T	Thermotx choroid vasc lesion	Y		R2	4.8105	$201.55
0017T	Photocoagulat macular drusen	Y		R2	4.8105	$201.55
0099T*	Implant corneal ring	Y		R2	15.5346	$650.87
0100T	Prosth retina receive&gen	Y		G2	36.9485	$1,548.07
0101T	Extracorp shockwv tx,hi enrg	Y		G2	29.4746	$1,234.93
0102T	Extracorp shockwv tx,anesth	Y		G2	29.4746	$1,234.93
0123T	Scleral fistulization	Y		G2	22.292	$933.99
0124T*	Conjunctival drug placement	Y		R2	2.2568	$94.56
0176T	Aqu canal dilat w/o retent	Y		A2	40.4623	$1,695.29
0177T	Aqu canal dilat w retent	Y		A2	40.4623	$1,695.29
0186T	Suprachoroidal drug delivery	Y		G2	21.159	$886.52
0190T	Place intraoc radiation src	Y		G2	21.159	$886.52
0191T	Insert ant segment drain int	Y		G2	22.292	$933.99
0192T	Insert ant segment drain ext	Y		G2	40.4624	$1,695.29
0193T	Rf bladder neck microremodel	Y		G2	18.6773	$782.54
0200T	Perq sacral augmt unilat inj	Y		G2	21.1114	$884.53
0201T	Perq sacral augmt bilat inj	Y		G2	29.4746	$1,234.93
0213T	Us facet jt inj cerv/t 1 lev	Y		G2	7.0178	$294.03
0214T	Us facet jt inj cerv/t 2 lev	Y		G2	2.4234	$101.54
0215T	Us facet jt inj cerv/t 3 lev	Y		G2	2.4234	$101.54
0216T	Us facet jt inj ls 1 level	Y		G2	7.0178	$294.03
0217T	Us facet jt inj ls 2 level	Y		G2	2.4234	$101.54
0218T	Us facet jt inj ls 3 level	Y		G2	2.4234	$101.54
10021	Fna w/o image	Y	CH	P3		$64.82
10022	Fna w/image	Y		G2	4.2381	$177.57
10040	Acne surgery	Y		P2	0.7983	$33.45
10060	Drainage of skin abscess	Y		P3		$44.93
10061	Drainage of skin abscess	Y		P2	1.358	$56.90
10080	Drainage of pilonidal cyst	Y		P2	1.358	$56.90
10081	Drainage of pilonidal cyst	Y		P3		$110.98
10120	Remove foreign body	Y		P3		$61.13
10121	Remove foreign body	Y		A2	16.564	$694.00
10140	Drainage of hematoma/fluid	Y		P3		$66.29
10160	Puncture drainage of lesion	Y	CH	P3		$54.26
10180	Complex drainage, wound	Y		A2	18.4054	$771.15
11000	Debride infected skin	Y		P3		$21.11

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
11001	Debride infected skin add-on	Y		P3		$6.87
11010	Debride skin, fx	Y		A2	4.4709	$187.32
11011	Debride skin/muscle, fx	Y		A2	4.4709	$187.32
11012	Debride skin/muscle/bone, fx	Y		A2	4.4709	$187.32
11040	Debride skin, partial	Y		P3		$19.40
11041	Debride skin, full	Y		P3		$21.36
11042	Debride skin/tissue	Y		A2	2.5612	$107.31
11043	Debride tissue/muscle	Y		A2	2.5612	$107.31
11044	Debride tissue/muscle/bone	Y		A2	7.9784	$334.28
11055	Trim skin lesion	Y		P3		$22.83
11056	Trim skin lesions, 2 to 4	Y		P3		$25.04
11057	Trim skin lesions, over 4	Y		P3		$28.23
11100	Biopsy, skin lesion	Y	CH	P3		$50.33
11101	Biopsy, skin add-on	Y		P3		$12.03
11200	Removal of skin tags	Y		P2	0.7983	$33.45
11201	Remove skin tags add-on	Y		P3		$5.16
11300	Shave skin lesion	Y		P2	0.7983	$33.45
11301	Shave skin lesion	Y		P2	0.7983	$33.45
11302	Shave skin lesion	Y		P2	0.7983	$33.45
11303	Shave skin lesion	Y	CH	P3		$57.45
11305	Shave skin lesion	Y	CH	P3		$30.69
11306	Shave skin lesion	Y		P2	0.7983	$33.45
11307	Shave skin lesion	Y		P2	0.7983	$33.45
11308	Shave skin lesion	Y		P2	0.7983	$33.45
11310	Shave skin lesion	Y		P2	0.7983	$33.45
11311	Shave skin lesion	Y		P2	0.7983	$33.45
11312	Shave skin lesion	Y		P2	0.7983	$33.45
11313	Shave skin lesion	Y		P2	0.7983	$33.45
11400	Exc tr-ext b9+marg 0.5 < cm	Y		P3		$58.19
11401	Exc tr-ext b9+marg 0.6-1 cm	Y		P3		$65.80
11402	Exc tr-ext b9+marg 1.1-2 cm	Y		P3		$72.18
11403	Exc tr-ext b9+marg 2.1-3 cm	Y		P3		$78.08
11404	Exc tr-ext b9+marg 3.1-4 cm	Y		A2	16.564	$694.00
11406	Exc tr-ext b9+marg > 4.0 cm	Y		A2	16.564	$694.00
11420	Exc h-f-nk-sp b9+marg 0.5 <	Y		P3		$55.00
11421	Exc h-f-nk-sp b9+marg 0.6-1	Y		P3		$66.78
11422	Exc h-f-nk-sp b9+marg 1.1-2	Y		P3		$72.92
11423	Exc h-f-nk-sp b9+marg 2.1-3	Y		P3		$81.27
11424	Exc h-f-nk-sp b9+marg 3.1-4	Y		A2	16.564	$694.00

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
11426	Exc h-f-nk-sp b9+marg > 4 cm	Y		A2	21.9314	$918.88
11440	Exc face-mm b9+marg 0.5 < cm	Y		P3		$62.36
11441	Exc face-mm b9+marg 0.6-1 cm	Y		P3		$72.43
11442	Exc face-mm b9+marg 1.1-2 cm	Y		P3		$80.04
11443	Exc face-mm b9+marg 2.1-3 cm	Y		P3		$89.12
11444	Exc face-mm b9+marg 3.1-4 cm	Y		A2	7.9784	$334.28
11446	Exc face-mm b9+marg > 4 cm	Y		A2	21.9314	$918.88
11450	Removal, sweat gland lesion	Y		A2	21.9314	$918.88
11451	Removal, sweat gland lesion	Y		A2	21.9314	$918.88
11462	Removal, sweat gland lesion	Y		A2	21.9314	$918.88
11463	Removal, sweat gland lesion	Y		A2	21.9314	$918.88
11470	Removal, sweat gland lesion	Y		A2	21.9314	$918.88
11471	Removal, sweat gland lesion	Y		A2	21.9314	$918.88
11600	Exc tr-ext mlg+marg 0.5 < cm	Y		P3		$83.48
11601	Exc tr-ext mlg+marg 0.6-1 cm	Y		P3		$99.44
11602	Exc tr-ext mlg+marg 1.1-2 cm	Y		P3		$108.77
11603	Exc tr-ext mlg+marg 2.1-3 cm	Y		P3		$117.11
11604	Exc tr-ext mlg+marg 3.1-4 cm	Y		A2	7.9784	$334.28
11606	Exc tr-ext mlg+marg > 4 cm	Y		A2	16.564	$694.00
11620	Exc h-f-nk-sp mlg+marg 0.5 <	Y		P3		$85.69
11621	Exc h-f-nk-sp mlg+marg 0.6-1	Y		P3		$100.66
11622	Exc h-f-nk-sp mlg+marg 1.1-2	Y		P3		$111.22
11623	Exc h-f-nk-sp mlg+marg 2.1-3	Y		P3		$121.53
11624	Exc h-f-nk-sp mlg+marg 3.1-4	Y		A2	16.564	$694.00
11626	Exc h-f-nk-sp mlg+mar > 4 cm	Y		A2	21.9314	$918.88
11640	Exc face-mm malig+marg 0.5 <	Y		P3		$90.11
11641	Exc face-mm malig+marg 0.6-1	Y		P3		$104.84
11642	Exc face-mm malig+marg 1.1-2	Y		P3		$116.87
11643	Exc face-mm malig+marg 2.1-3	Y		P3		$127.67
11644	Exc face-mm malig+marg 3.1-4	Y		A2	16.564	$694.00
11646	Exc face-mm mlg+marg > 4 cm	Y		A2	21.9314	$918.88
11719	Trim nail(s)	Y		P3		$10.80
11720	Debride nail, 1-5	Y		P3		$13.26
11721	Debride nail, 6 or more	Y		P3		$15.71
11730	Removal of nail plate	Y		P2	0.7983	$33.45
11732	Remove nail plate, add-on	Y		P3		$15.71
11740	Drain blood from under nail	Y		P2	0.3866	$16.20
11750	Removal of nail bed	Y		P3		$85.20
11752	Remove nail bed/finger tip	Y		P3		$120.30

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
11755	Biopsy, nail unit	Y		P3		$57.70
11760	Repair of nail bed	Y		G2	1.2361	$51.79
11762	Reconstruction of nail bed	Y		P3		$109.75
11765	Excision of nail fold, toe	Y		P2	0.7983	$33.45
11770	Removal of pilonidal lesion	Y		A2	21.9314	$918.88
11771	Removal of pilonidal lesion	Y		A2	21.9314	$918.88
11772	Removal of pilonidal lesion	Y		A2	21.9314	$918.88
11900	Injection into skin lesions	Y		P3		$25.29
11901	Added skin lesions injection	Y	CH	P3		$28.23
11920	Correct skin color defects	Y		P3		$77.34
11921	Correct skin color defects	Y		P3		$86.91
11922	Correct skin color defects	Y		P3		$28.97
11950	Therapy for contour defects	Y		P3		$27.01
11951	Therapy for contour defects	Y		P3		$36.09
11952	Therapy for contour defects	Y	CH	P3		$44.44
11954	Therapy for contour defects	Y		P2	1.2361	$51.79
11960	Insert tissue expander(s)	Y		A2	20.106	$842.39
11970	Replace tissue expander	Y		A2	43.0648	$1,804.33
11971	Remove tissue expander(s)	Y		A2	21.9314	$918.88
11976	Removal of contraceptive cap	Y		P3		$51.80
11980	Implant hormone pellet(s)	N		P2	0.6271	$26.27
11981	Insert drug implant device	N		P2	0.6271	$26.27
11982	Remove drug implant device	N		P2	0.6271	$26.27
11983	Remove/insert drug implant	N		P2	0.6271	$26.27
12001	Repair superficial wound(s)	Y		P2	1.2361	$51.79
12002	Repair superficial wound(s)	Y		P2	1.2361	$51.79
12004	Repair superficial wound(s)	Y		P2	1.2361	$51.79
12005	Repair superficial wound(s)	Y		A2	1.2361	$51.79
12006	Repair superficial wound(s)	Y		A2	1.2361	$51.79
12007	Repair superficial wound(s)	Y		A2	1.2361	$51.79
12011	Repair superficial wound(s)	Y		P2	1.2361	$51.79
12013	Repair superficial wound(s)	Y		P2	1.2361	$51.79
12014	Repair superficial wound(s)	Y		P2	1.2361	$51.79
12015	Repair superficial wound(s)	Y		G2	1.2361	$51.79
12016	Repair superficial wound(s)	Y		A2	1.2361	$51.79
12017	Repair superficial wound(s)	Y		A2	1.2361	$51.79
12018	Repair superficial wound(s)	Y		A2	1.2361	$51.79
12020	Closure of split wound	Y		A2	4.2374	$177.54
12021	Closure of split wound	Y		A2	2.8987	$121.45

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
12031	Intmd wnd repair s/tr/ext	Y		P2	1.2361	$51.79
12032	Intmd wnd repair s/tr/ext	Y		P2	2.8988	$121.45
12034	Intmd wnd repair s/tr/ext	Y		A2	1.2361	$51.79
12035	Intmd wnd repair s/tr/ext	Y		A2	1.2361	$51.79
12036	Intmd wnd repair s/tr/ext	Y		A2	2.8987	$121.45
12037	Intmd wnd repair s/tr/ext	Y		A2	2.8987	$121.45
12041	Intmd wnd repair n-hf/genit	Y		P2	1.2361	$51.79
12042	Intmd wnd repair n-hg/genit	Y		P2	1.2361	$51.79
12044	Intmd wnd repair n-hg/genit	Y		A2	1.2361	$51.79
12045	Intmd wnd repair n-hg/genit	Y		A2	2.8987	$121.45
12046	Intmd wnd repair n-hg/genit	Y		A2	2.8987	$121.45
12047	Intmd wnd repair n-hg/genit	Y		A2	2.8987	$121.45
12051	Intmd wnd repair face/mm	Y	CH	P3		$117.60
12052	Intmd wnd repair face/mm	Y		P2	1.2361	$51.79
12053	Intmd wnd repair face/mm	Y		P2	1.2361	$51.79
12054	Intmd wnd repair, face/mm	Y		A2	1.2361	$51.79
12055	Intmd wnd repair face/mm	Y		A2	2.8987	$121.45
12056	Intmd wnd repair face/mm	Y		A2	2.8987	$121.45
12057	Intmd wnd repair face/mm	Y		A2	2.8987	$121.45
13100	Repair of wound or lesion	Y		A2	4.2374	$177.54
13101	Repair of wound or lesion	Y		A2	4.2374	$177.54
13102	Repair wound/lesion add-on	Y		A2	4.2374	$177.54
13120	Repair of wound or lesion	Y		A2	2.8987	$121.45
13121	Repair of wound or lesion	Y		A2	2.8987	$121.45
13122	Repair wound/lesion add-on	Y		A2	1.2361	$51.79
13131	Repair of wound or lesion	Y		A2	2.8987	$121.45
13132	Repair of wound or lesion	Y		A2	4.2374	$177.54
13133	Repair wound/lesion add-on	Y		A2	2.8987	$121.45
13150	Repair of wound or lesion	Y		A2	4.2374	$177.54
13151	Repair of wound or lesion	Y		A2	4.2374	$177.54
13152	Repair of wound or lesion	Y		A2	4.2374	$177.54
13153	Repair wound/lesion add-on	Y		A2	2.8987	$121.45
13160	Late closure of wound	Y		A2	20.106	$842.39
14000	Skin tissue rearrangement	Y		A2	15.5759	$652.60
14001	Skin tissue rearrangement	Y		A2	15.5759	$652.60
14020	Skin tissue rearrangement	Y		A2	15.5759	$652.60
14021	Skin tissue rearrangement	Y		A2	15.5759	$652.60
14040	Skin tissue rearrangement	Y		A2	15.5759	$652.60
14041	Skin tissue rearrangement	Y		A2	15.5759	$652.60

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
14060	Skin tissue rearrangement	Y		A2	15.5759	$652.60
14061	Skin tissue rearrangement	Y		A2	15.5759	$652.60
14301	Skin tissue rearrangement	Y		G2	20.1058	$842.39
14302	Skin tissue rearrange add-on	Y		G2	20.1058	$842.39
14350	Skin tissue rearrangement	Y		A2	20.106	$842.39
15002	Wound prep, trk/arm/leg	Y		A2	4.2374	$177.54
15003	Wound prep, addl 100 cm	Y		A2	4.2374	$177.54
15004	Wound prep, f/n/hf/g	Y		A2	4.2374	$177.54
15005	Wnd prep, f/n/hf/g, addl cm	Y		A2	4.2374	$177.54
15040	Harvest cultured skin graft	Y		A2	2.8987	$121.45
15050	Skin pinch graft	Y		A2	4.2374	$177.54
15100	Skin splt grft, trnk/arm/leg	Y		A2	20.106	$842.39
15101	Skin splt grft t/a/l, add-on	Y		A2	20.106	$842.39
15110	Epidrm autogrft trnk/arm/leg	Y		A2	4.2374	$177.54
15111	Epidrm autogrft t/a/l add-on	Y		A2	4.2374	$177.54
15115	Epidrm a-grft face/nck/hf/g	Y		A2	4.2374	$177.54
15116	Epidrm a-grft f/n/hf/g addl	Y		A2	4.2374	$177.54
15120	Skn splt a-grft fac/nck/hf/g	Y		A2	20.106	$842.39
15121	Skn splt a-grft f/n/hf/g add	Y		A2	20.106	$842.39
15130	Derm autograft, trnk/arm/leg	Y		A2	15.5759	$652.60
15131	Derm autograft t/a/l add-on	Y		A2	15.5759	$652.60
15135	Derm autograft face/nck/hf/g	Y		A2	15.5759	$652.60
15136	Derm autograft, f/n/hf/g add	Y		A2	15.5759	$652.60
15150	Cult epiderm grft t/arm/leg	Y		A2	4.2374	$177.54
15151	Cult epiderm grft t/a/l addl	Y		A2	4.2374	$177.54
15152	Cult epiderm graft t/a/l +%	Y		A2	4.2374	$177.54
15155	Cult epiderm graft, f/n/hf/g	Y		A2	4.2374	$177.54
15156	Cult epidrm grft f/n/hfg add	Y		A2	4.2374	$177.54
15157	Cult epiderm grft f/n/hfg +%	Y		A2	4.2374	$177.54
15170	Acell graft trunk/arms/legs	Y		G2	4.2374	$177.54
15171	Acell graft t/arm/leg add-on	Y		G2	2.8988	$121.45
15175	Acellular graft, f/n/hf/g	Y		G2	4.2374	$177.54
15176	Acell graft, f/n/hf/g add-on	Y		G2	4.2374	$177.54
15200	Skin full graft, trunk	Y		A2	15.5759	$652.60
15201	Skin full graft trunk add-on	Y		A2	15.5759	$652.60
15220	Skin full graft sclp/arm/leg	Y		A2	15.5759	$652.60
15221	Skin full graft add-on	Y		A2	4.2374	$177.54
15240	Skin full grft face/genit/hf	Y		A2	15.5759	$652.60
15241	Skin full graft add-on	Y		A2	4.2374	$177.54

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
15260	Skin full graft een & lips	Y		A2	15.5759	$652.60
15261	Skin full graft add-on	Y		A2	15.5759	$652.60
15300	Apply skinallogrft, t/arm/lg	Y		A2	4.2374	$177.54
15301	Apply sknallogrft t/a/l addl	Y		A2	4.2374	$177.54
15320	Apply skin allogrft f/n/hf/g	Y		A2	4.2374	$177.54
15321	Aply sknallogrft f/n/hfg add	Y		A2	4.2374	$177.54
15330	Aply acell alogrft t/arm/leg	Y		A2	4.2374	$177.54
15331	Aply acell grft t/a/l add-on	Y		A2	4.2374	$177.54
15335	Apply acell graft, f/n/hf/g	Y		A2	4.2374	$177.54
15336	Aply acell grft f/n/hf/g add	Y		A2	4.2374	$177.54
15340	Apply cult skin substitute	Y		G2	2.8988	$121.45
15341	Apply cult skin sub add-on	Y		G2	2.8988	$121.45
15360	Apply cult derm sub, t/a/l	Y		G2	2.8988	$121.45
15361	Aply cult derm sub t/a/l add	Y		G2	2.8988	$121.45
15365	Apply cult derm sub f/n/hf/g	Y		G2	2.8988	$121.45
15366	Apply cult derm f/hf/g add	Y		G2	2.8988	$121.45
15400	Apply skin xenograft, t/a/l	Y		A2	4.2374	$177.54
15401	Apply skn xenogrft t/a/l add	Y		A2	4.2374	$177.54
15420	Apply skin xgraft, f/n/hf/g	Y		A2	4.2374	$177.54
15421	Apply skn xgrft f/n/hf/g add	Y		A2	4.2374	$177.54
15430	Apply acellular xenograft	Y		A2	4.2374	$177.54
15431	Apply acellular xgraft add	Y		A2	4.2374	$177.54
15570	Form skin pedicle flap	Y		A2	20.106	$842.39
15572	Form skin pedicle flap	Y		A2	20.106	$842.39
15574	Form skin pedicle flap	Y		A2	20.106	$842.39
15576	Form skin pedicle flap	Y		A2	20.106	$842.39
15600	Skin graft	Y		A2	20.106	$842.39
15610	Skin graft	Y		A2	20.106	$842.39
15620	Skin graft	Y		A2	20.106	$842.39
15630	Skin graft	Y		A2	20.106	$842.39
15650	Transfer skin pedicle flap	Y		A2	20.106	$842.39
15731	Forehead flap w/vasc pedicle	Y		A2	20.106	$842.39
15732	Muscle-skin graft, head/neck	Y		A2	20.106	$842.39
15734	Muscle-skin graft, trunk	Y		A2	20.106	$842.39
15736	Muscle-skin graft, arm	Y		A2	20.106	$842.39
15738	Muscle-skin graft, leg	Y		A2	20.106	$842.39
15740	Island pedicle flap graft	Y		A2	15.5759	$652.60
15750	Neurovascular pedicle graft	Y		A2	20.106	$842.39
15760	Composite skin graft	Y		A2	20.106	$842.39

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
15770	Derma-fat-fascia graft	Y		A2	20.106	$842.39
15775	Hair transplant punch grafts	Y		A2	1.2361	$51.79
15776	Hair transplant punch grafts	Y		A2	1.2361	$51.79
15780	Abrasion treatment of skin	Y		P3		$337.84
15781	Abrasion treatment of skin	Y		P2	4.4708	$187.32
15782	Abrasion treatment of skin	Y		P2	4.4708	$187.32
15783	Abrasion treatment of skin	Y		P2	2.5612	$107.31
15786	Abrasion, lesion, single	Y		P2	0.7983	$33.45
15787	Abrasion, lesions, add-on	Y		P3		$24.55
15788	Chemical peel, face, epiderm	Y		P2	0.7983	$33.45
15789	Chemical peel, face, dermal	Y		P2	1.391	$58.28
15792	Chemical peel, nonfacial	Y		P2	1.391	$58.28
15793	Chemical peel, nonfacial	Y		P2	0.7983	$33.45
15819	Plastic surgery, neck	Y		G2	2.8988	$121.45
15820	Revision of lower eyelid	Y		A2	20.106	$842.39
15821	Revision of lower eyelid	Y		A2	20.106	$842.39
15822	Revision of upper eyelid	Y		A2	20.106	$842.39
15823	Revision of upper eyelid	Y		A2	20.106	$842.39
15824	Removal of forehead wrinkles	Y		A2	20.106	$842.39
15825	Removal of neck wrinkles	Y		A2	20.106	$842.39
15826	Removal of brow wrinkles	Y		A2	20.106	$842.39
15828	Removal of face wrinkles	Y		A2	20.106	$842.39
15829	Removal of skin wrinkles	Y		A2	20.106	$842.39
15830	Exc skin abd	Y		A2	21.9314	$918.88
15832	Excise excessive skin tissue	Y		A2	21.9314	$918.88
15833	Excise excessive skin tissue	Y		A2	21.9314	$918.88
15834	Excise excessive skin tissue	Y		A2	21.9314	$918.88
15835	Excise excessive skin tissue	Y		A2	21.9314	$918.88
15836	Excise excessive skin tissue	Y		A2	16.564	$694.00
15837	Excise excessive skin tissue	Y		G2	16.5641	$694.00
15838	Excise excessive skin tissue	Y		G2	16.5641	$694.00
15839	Excise excessive skin tissue	Y		A2	16.564	$694.00
15840	Graft for face nerve palsy	Y		A2	20.106	$842.39
15841	Graft for face nerve palsy	Y		A2	20.106	$842.39
15842	Flap for face nerve palsy	Y		G2	20.1058	$842.39
15845	Skin and muscle repair, face	Y		A2	20.106	$842.39
15847	Exc skin abd add-on	Y		A2	21.9314	$918.88
15850	Removal of sutures	Y		G2	2.5612	$107.31
15851	Removal of sutures	Y		P3		$42.72

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
15852	Dressing change not for burn	N		R2	0.6271	$26.27
15860	Test for blood flow in graft	N		G2	0.6271	$26.27
15876	Suction assisted lipectomy	Y		A2	20.106	$842.39
15877	Suction assisted lipectomy	Y		A2	20.106	$842.39
15878	Suction assisted lipectomy	Y		A2	20.106	$842.39
15879	Suction assisted lipectomy	Y		A2	20.106	$842.39
15920	Removal of tail bone ulcer	Y		A2	4.4709	$187.32
15922	Removal of tail bone ulcer	Y		A2	20.106	$842.39
15931	Remove sacrum pressure sore	Y		A2	21.9314	$918.88
15933	Remove sacrum pressure sore	Y		A2	21.9314	$918.88
15934	Remove sacrum pressure sore	Y		A2	20.106	$842.39
15935	Remove sacrum pressure sore	Y		A2	20.106	$842.39
15936	Remove sacrum pressure sore	Y		A2	15.5759	$652.60
15937	Remove sacrum pressure sore	Y		A2	20.106	$842.39
15940	Remove hip pressure sore	Y		A2	21.9314	$918.88
15941	Remove hip pressure sore	Y		A2	21.9314	$918.88
15944	Remove hip pressure sore	Y		A2	20.106	$842.39
15945	Remove hip pressure sore	Y		A2	20.106	$842.39
15946	Remove hip pressure sore	Y		A2	20.106	$842.39
15950	Remove thigh pressure sore	Y		A2	21.9314	$918.88
15951	Remove thigh pressure sore	Y		A2	21.9314	$918.88
15952	Remove thigh pressure sore	Y		A2	15.5759	$652.60
15953	Remove thigh pressure sore	Y		A2	15.5759	$652.60
15956	Remove thigh pressure sore	Y		A2	15.5759	$652.60
15958	Remove thigh pressure sore	Y		A2	15.5759	$652.60
16000	Initial treatment of burn(s)	Y		P3		$23.32
16020	Dress/debrid p-thick burn, s	Y		P3		$35.60
16025	Dress/debrid p-thick burn, m	Y		A2	1.3912	$58.28
16030	Dress/debrid p-thick burn, l	Y		A2	1.3912	$58.28
16035	Incision of burn scab, initi	Y		G2	1.391	$58.28
17000	Destruct premalg lesion	Y		P2	0.7983	$33.45
17003	Destruct premalg les, 2-14	Y		P3		$3.19
17004	Destroy premlg lesions 15+	Y		P3		$70.71
17106	Destruction of skin lesions	Y		P2	2.5612	$107.31
17107	Destruction of skin lesions	Y		P2	2.5612	$107.31
17108	Destruction of skin lesions	Y		P2	2.5612	$107.31
17110	Destruct b9 lesion, 1-14	Y		P2	0.7983	$33.45
17111	Destruct lesion, 15 or more	Y		P2	1.391	$58.28
17250	Chemical cautery, tissue	Y		P3		$39.28

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
17260	Destruction of skin lesions	Y		P3		$40.51
17261	Destruction of skin lesions	Y		P2	1.391	$58.28
17262	Destruction of skin lesions	Y		P2	1.391	$58.28
17263	Destruction of skin lesions	Y		P2	1.391	$58.28
17264	Destruction of skin lesions	Y		P2	1.391	$58.28
17266	Destruction of skin lesions	Y	CH	P3		$97.23
17270	Destruction of skin lesions	Y		P2	1.391	$58.28
17271	Destruction of skin lesions	Y		P2	1.391	$58.28
17272	Destruction of skin lesions	Y		P2	1.391	$58.28
17273	Destruction of skin lesions	Y	CH	P3		$88.39
17274	Destruction of skin lesions	Y	CH	P3		$99.93
17276	Destruction of skin lesions	Y		P2	2.5612	$107.31
17280	Destruction of skin lesions	Y		P2	1.391	$58.28
17281	Destruction of skin lesions	Y		P3		$75.62
17282	Destruction of skin lesions	Y		P3		$86.42
17283	Destruction of skin lesions	Y	CH	P3		$99.44
17284	Destruction of skin lesions	Y		P2	2.5612	$107.31
17286	Destruction of skin lesions	Y		P2	2.5612	$107.31
17311	Mohs, 1 stage, h/n/hf/g	Y		P2	4.6215	$193.63
17312	Mohs addl stage	Y	CH	P3		$192.24
17313	Mohs, 1 stage, t/a/l	Y		P2	4.6215	$193.63
17314	Mohs, addl stage, t/a/l	Y	CH	P3		$178.00
17315	Mohs surg, addl block	Y		P3		$33.15
17340	Cryotherapy of skin	Y		P3		$13.99
17360	Skin peel therapy	Y		P2	0.7983	$33.45
17380	Hair removal by electrolysis	Y		R2	0.7983	$33.45
19000	Drainage of breast lesion	Y		P3		$53.77
19001	Drain breast lesion add-on	Y		P3		$7.37
19020	Incision of breast lesion	Y		A2	18.4054	$771.15
19030	Injection for breast x-ray	N		N1		
19100	Bx breast percut w/o image	Y		A2	4.2381	$177.57
19101	Biopsy of breast, open	Y		A2	23.4204	$981.27
19102	Bx breast percut w/image	Y		A2	7.4175	$310.77
19103	Bx breast percut w/device	Y		A2	14.3296	$600.38
19105	Cryosurg ablate fa, each	Y		P2	31.2349	$1,308.68
19110	Nipple exploration	Y		A2	23.4204	$981.27
19112	Excise breast duct fistula	Y		A2	23.4204	$981.27
19120	Removal of breast lesion	Y		A2	23.4204	$981.27
19125	Excision, breast lesion	Y		A2	23.4204	$981.27

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19126	Excision, addl breast lesion	Y		A2	23.4204	$981.27
19290	Place needle wire, breast	N		N1		
19291	Place needle wire, breast	N		N1		
19295	Place breast clip, percut	N		N1		
19296	Place po breast cath for rad	Y		A2	57.176	$2,395.56
19297	Place breast cath for rad	Y		A2	57.176	$2,395.56
19298	Place breast rad tube/caths	Y		A2	57.176	$2,395.56
19300	Removal of breast tissue	Y		A2	23.4204	$981.27
19301	Partical mastectomy	Y		A2	23.4204	$981.27
19302	P-mastectomy w/ln removal	Y		A2	41.0798	$1,721.17
19303	Mast, simple, complete	Y		A2	31.2349	$1,308.68
19304	Mast, subq	Y		A2	31.2349	$1,308.68
19316	Suspension of breast	Y		A2	31.2349	$1,308.68
19318	Reduction of large breast	Y		A2	41.0798	$1,721.17
19324	Enlarge breast	Y		A2	41.0798	$1,721.17
19325	Enlarge breast with implant	Y		A2	57.176	$2,395.56
19328	Removal of breast implant	Y		A2	31.2349	$1,308.68
19330	Removal of implant material	Y		A2	31.2349	$1,308.68
19340	Immediate breast prosthesis	Y		A2	41.0798	$1,721.17
19342	Delayed breast prosthesis	Y		A2	57.176	$2,395.56
19350	Breast reconstruction	Y		A2	23.4204	$981.27
19355	Correct inverted nipple(s)	Y		A2	31.2349	$1,308.68
19357	Breast reconstruction	Y		A2	57.176	$2,395.56
19366	Breast reconstruction	Y		A2	31.2349	$1,308.68
19370	Surgery of breast capsule	Y		A2	31.2349	$1,308.68
19371	Removal of breast capsule	Y		A2	31.2349	$1,308.68
19380	Revise breast reconstruction	Y		A2	41.0798	$1,721.17
19396	Design custom breast implant	Y		G2	31.2349	$1,308.68
20000	Incision of abscess	Y		P2	1.358	$56.90
20005	Incision of deep abscess	Y		A2	21.1115	$884.53
20103	Explore wound, extremity	Y		G2	12.1141	$507.56
20150	Excise epiphyseal bar	Y		G2	43.0649	$1,804.33
20200	Muscle biopsy	Y		A2	16.564	$694.00
20205	Deep muscle biopsy	Y		A2	16.564	$694.00
20206	Needle biopsy, muscle	Y		A2	7.4175	$310.77
20220	Bone biopsy, trocar/needle	Y		A2	7.9784	$334.28
20225	Bone biopsy, trocar/needle	Y		A2	16.564	$694.00
20240	Bone biopsy, excisional	Y		A2	21.9314	$918.88
20245	Bone biopsy, excisional	Y		A2	21.9314	$918.88

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
20250	Open bone biopsy	Y		A2	21.1115	$884.53
20251	Open bone biopsy	Y		A2	21.1115	$884.53
20500	Injection of sinus tract	Y		P3		$43.21
20501	Inject sinus tract for x-ray	N		N1		
20520	Removal of foreign body	Y		P3		$82.74
20525	Removal of foreign body	Y		A2	21.9314	$918.88
20526	Ther injection, carp tunnel	Y		P3		$26.27
20550	Inj tendon sheath/ligament	Y		P3		$19.89
20551	Inj tendon origin/insertion	Y		P3		$20.38
20552	Inj trigger point, 1/2 muscl	Y		P3		$19.40
20553	Inject trigger points, =/> 3	Y		P3		$22.34
20555	Place ndl musc/tis for rt	Y		R2	29.4746	$1,234.93
20600	Drain/inject, joint/bursa	Y		P3		$20.13
20605	Drain/inject, joint/bursa	Y		P3		$22.59
20610	Drain/inject, joint/bursa	Y		P3		$32.41
20612	Aspirate/inj ganglion cyst	Y		P3		$21.85
20615	Treatment of bone cyst	Y		P3		$88.39
20650	Insert and remove bone pin	Y		A2	21.1115	$884.53
20662	Application of pelvis brace	Y		R2	21.1114	$884.53
20663	Application of thigh brace	Y		R2	21.1114	$884.53
20665	Removal of fixation device	N		G2	0.6271	$26.27
20670	Removal of support implant	Y		A2	16.564	$694.00
20680	Removal of support implant	Y		A2	21.9314	$918.88
20690	Apply bone fixation device	Y		A2	29.4747	$1,234.93
20692	Apply bone fixation device	Y		A2	29.4747	$1,234.93
20693	Adjust bone fixation device	Y		A2	21.1115	$884.53
20694	Remove bone fixation device	Y		A2	21.1115	$884.53
20696	Comp multiplane ext fixation	Y		G2	29.4746	$1,234.93
20697	Comp ext fixate strut change	Y	CH	P2	19.0792	$799.38
20822	Replantation digit, complete	Y		G2	27.1049	$1,135.64
20900	Removal of bone for graft	Y		A2	29.4747	$1,234.93
20902	Removal of bone for graft	Y		A2	29.4747	$1,234.93
20910	Remove cartilage for graft	Y		A2	20.106	$842.39
20912	Remove cartilage for graft	Y		A2	20.106	$842.39
20920	Removal of fascia for graft	Y		A2	15.5759	$652.60
20922	Removal of fascia for graft	Y		A2	15.5759	$652.60
20924	Removal of tendon for graft	Y		A2	29.4747	$1,234.93
20926	Removal of tissue for graft	Y		A2	4.2374	$177.54
20950	Fluid pressure, muscle	Y		G2	1.358	$56.90

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
20972	Bone/skin graft, metatarsal	Y		G2	50.4553	$2,113.98
20973	Bone/skin graft, great toe	Y		R2	50.4553	$2,113.98
20975	Electrical bone stimulation	N		N1		
20979	Us bone stimulation	N		P3		$19.64
20982	Ablate, bone tumor(s) perq	Y		G2	43.0649	$1,804.33
20985	Cptr-asst dir ms px	N		N1		
21010	Incision of jaw joint	Y		A2	23.2154	$972.69
21011	Exc face les sc < 2 cm	Y		P3		$149.77
21012	Exc face les sc = 2 cm	Y		R2	7.9785	$334.28
21013	Exc face tum deep < 2 cm	Y		P3		$209.18
21014	Exc face tum deep = 2 cm	Y		R2	7.9785	$334.28
21015*	Resect face tum < 2 cm	Y		R2	16.5641	$694.00
21016	Resect face tum = 2 cm	Y		G2	21.9314	$918.88
21025	Excision of bone, lower jaw	Y		A2	40.7633	$1,707.90
21026	Excision of facial bone(s)	Y		A2	40.7633	$1,707.90
21029	Contour of face bone lesion	Y		A2	40.7633	$1,707.90
21030	Excise max/zygoma b9 tumor	Y		P3		$219.49
21031	Remove exostosis, mandible	Y		P3		$178.98
21032	Remove exostosis, maxilla	Y		P3		$182.67
21034	Excise max/zygoma mlg tumor	Y		A2	40.7633	$1,707.90
21040	Excise mandible lesion	Y		A2	23.2154	$972.69
21044	Removal of jaw bone lesion	Y		A2	40.7633	$1,707.90
21046	Remove mandible cyst complex	Y		A2	40.7633	$1,707.90
21047	Excise lwr jaw cyst w/repair	Y		A2	40.7633	$1,707.90
21048	Remove maxilla cyst complex	Y		R2	40.7633	$1,707.90
21050	Removal of jaw joint	Y		A2	40.7633	$1,707.90
21060	Remove jaw joint cartilage	Y		A2	40.7633	$1,707.90
21070	Remove coronoid process	Y		A2	40.7633	$1,707.90
21073	Mnpj of tmj w/anesth	Y		P3		$172.11
21076	Prepare face/oral prosthesis	Y		P3		$309.36
21077	Prepare face/oral prosthesis	Y		P3		$742.21
21079	Prepare face/oral prosthesis	Y		P3		$531.80
21080	Prepare face/oral prosthesis	Y		P3		$606.19
21081	Prepare face/oral prosthesis	Y		P3		$558.56
21082	Prepare face/oral prosthesis	Y		P3		$539.65
21083	Prepare face/oral prosthesis	Y		P3		$528.36
21084	Prepare face/oral prosthesis	Y		P3		$602.02
21085	Prepare face/oral prosthesis	Y		P3		$241.59
21086	Prepare face/oral prosthesis	Y		P3		$529.10

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
21087	Prepare face/oral prosthesis	Y		P3		$525.66
21088	Prepare face/oral prosthesis	Y		R2	40.7633	$1,707.90
21100	Maxillofacial fixation	Y		A2	40.7633	$1,707.90
21110	Interdental fixation	Y		P2	7.1577	$299.89
21116	Injection, jaw joint x-ray	N		N1		
21120	Reconstruction of chin	Y		A2	23.2154	$972.69
21121	Reconstruction of chin	Y		A2	23.2154	$972.69
21122	Reconstruction of chin	Y		A2	23.2154	$972.69
21123	Reconstruction of chin	Y		A2	23.2154	$972.69
21125	Augmentation, lower jaw bone	Y		A2	23.2154	$972.69
21127	Augmentation, lower jaw bone	Y		A2	40.7633	$1,707.90
21137	Reduction of forehead	Y		G2	23.2156	$972.69
21138	Reduction of forehead	Y		G2	40.7633	$1,707.90
21139	Reduction of forehead	Y		G2	40.7633	$1,707.90
21150	Reconstruct midface, lefort	Y		G2	40.7633	$1,707.90
21181	Contour cranial bone lesion	Y		A2	23.2154	$972.69
21198	Reconstr lwr jaw segment	Y		G2	40.7633	$1,707.90
21199	Reconstr lwr jaw w/advance	Y		G2	40.7633	$1,707.90
21206	Reconstruct upper jaw bone	Y		A2	40.7633	$1,707.90
21208	Augmentation of facial bones	Y		A2	40.7633	$1,707.90
21209	Reduction of facial bones	Y		A2	40.7633	$1,707.90
21210	Face bone graft	Y		A2	40.7633	$1,707.90
21215	Lower jaw bone graft	Y		A2	40.7633	$1,707.90
21230	Rib cartilage graft	Y		A2	40.7633	$1,707.90
21235	Ear cartilage graft	Y		A2	23.2154	$972.69
21240	Reconstruction of jaw joint	Y		A2	40.7633	$1,707.90
21242	Reconstruction of jaw joint	Y		A2	40.7633	$1,707.90
21243	Reconstruction of jaw joint	Y		A2	40.7633	$1,707.90
21244	Reconstruction of lower jaw	Y		A2	40.7633	$1,707.90
21245	Reconstruction of jaw	Y		A2	40.7633	$1,707.90
21246	Reconstruction of jaw	Y		A2	40.7633	$1,707.90
21248	Reconstruction of jaw	Y		A2	40.7633	$1,707.90
21249	Reconstruction of jaw	Y		A2	40.7633	$1,707.90
21260	Revise eye sockets	Y		G2	40.7633	$1,707.90
21267	Revise eye sockets	Y		A2	40.7633	$1,707.90
21270	Augmentation, cheek bone	Y		A2	40.7633	$1,707.90
21275	Revision, orbitofacial bones	Y		A2	40.7633	$1,707.90
21280	Revision of eyelid	Y		A2	40.7633	$1,707.90
21282	Revision of eyelid	Y		A2	15.8303	$663.26

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
21295	Revision of jaw muscle/bone	Y		A2	7.1579	$299.89
21296	Revision of jaw muscle/bone	Y		A2	23.2154	$972.69
21310	Treatment of nose fracture	Y		A2	1.0674	$44.72
21315	Treatment of nose fracture	Y		A2	15.8303	$663.26
21320	Treatment of nose fracture	Y		A2	15.8303	$663.26
21325	Treatment of nose fracture	Y		A2	23.2154	$972.69
21330	Treatment of nose fracture	Y		A2	23.2154	$972.69
21335	Treatment of nose fracture	Y		A2	23.2154	$972.69
21336	Treat nasal septal fracture	Y		A2	24.2634	$1,016.59
21337	Treat nasal septal fracture	Y		A2	15.8303	$663.26
21338	Treat nasoethmoid fracture	Y		A2	23.2154	$972.69
21339	Treat nasoethmoid fracture	Y		A2	23.2154	$972.69
21340	Treatment of nose fracture	Y		A2	40.7633	$1,707.90
21345	Treat nose/jaw fracture	Y		A2	23.2154	$972.69
21355	Treat cheek bone fracture	Y		A2	40.7633	$1,707.90
21356	Treat cheek bone fracture	Y		A2	23.2154	$972.69
21360	Treat cheek bone fracture	Y		G2	23.2156	$972.69
21390	Treat eye socket fracture	Y		G2	40.7633	$1,707.90
21400	Treat eye socket fracture	Y		A2	7.1579	$299.89
21401	Treat eye socket fracture	Y		A2	15.8303	$663.26
21406	Treat eye socket fracture	Y		G2	40.7633	$1,707.90
21407	Treat eye socket fracture	Y		G2	40.7633	$1,707.90
21421	Treat mouth roof fracture	Y		A2	23.2154	$972.69
21440	Treat dental ridge fracture	Y		P3		$290.20
21445	Treat dental ridge fracture	Y		A2	23.2154	$972.69
21450	Treat lower jaw fracture	Y		A2	3.1243	$130.89
21451	Treat lower jaw fracture	Y		A2	7.1579	$299.89
21452	Treat lower jaw fracture	Y		A2	15.8303	$663.26
21453	Treat lower jaw fracture	Y		A2	40.7633	$1,707.90
21454	Treat lower jaw fracture	Y		A2	23.2154	$972.69
21461	Treat lower jaw fracture	Y		A2	40.7633	$1,707.90
21462	Treat lower jaw fracture	Y		A2	40.7633	$1,707.90
21465	Treat lower jaw fracture	Y		A2	40.7633	$1,707.90
21480	Reset dislocated jaw	Y		A2	1.0674	$44.72
21485	Reset dislocated jaw	Y		A2	15.8303	$663.26
21490	Repair dislocated jaw	Y		A2	40.7633	$1,707.90
21495	Treat hyoid bone fracture	Y		G2	15.8303	$663.26
21497	Interdental wiring	Y		A2	15.8303	$663.26
21501	Drain neck/chest lesion	Y		A2	18.4054	$771.15

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
21502	Drain chest lesion	Y		A2	21.1115	$884.53
21550	Biopsy of neck/chest	Y		G2	16.5641	$694.00
21552	Exc neck les sc = 3 cm	Y		G2	21.9314	$918.88
21554	Exc neck tum deep = 5 cm	Y		G2	21.9314	$918.88
21555*	Exc neck les sc < 3 cm	Y		P3		$174.32
21556	Exc neck tum deep < 5 cm	Y		G2	21.9314	$918.88
21557	Resect neck tum < 5 cm	Y		G2	16.5641	$694.00
21558	Resect neck tum = 5 cm	Y		G2	21.9314	$918.88
21600	Partial removal of rib	Y		A2	29.4747	$1,234.93
21610	Partial removal of rib	Y		A2	29.4747	$1,234.93
21685	Hyoid myotomy & suspension	Y		G2	7.1577	$299.89
21700	Revision of neck muscle	Y		A2	21.1115	$884.53
21720	Revision of neck muscle	Y		A2	21.1115	$884.53
21725	Revision of neck muscle	Y		A2	1.3578	$56.90
21800	Treatment of rib fracture	Y		A2	1.4841	$62.17
21805	Treatment of rib fracture	Y		A2	24.2634	$1,016.59
21820	Treat sternum fracture	Y		A2	1.4841	$62.17
21920	Biopsy soft tissue of back	Y		P3		$121.78
21925	Biopsy soft tissue of back	Y		A2	21.9314	$918.88
21930*	Exc back les sc < 3 cm	Y		P3		$181.93
21931	Exc back les sc = 3 cm	Y		G2	21.9314	$918.88
21932	Exc back tum deep < 5 cm	Y		G2	16.5641	$694.00
21933	Exc back tum deep = 5 cm	Y		G2	21.9314	$918.88
21935	Resect back tum < 5 cm	Y		G2	16.5641	$694.00
21936	Resect back tum = 5 cm	Y		G2	21.9314	$918.88
22102	Remove part, lumbar vertebra	Y		G2	47.0078	$1,969.53
22103	Remove extra spine segment	Y		G2	47.0078	$1,969.53
22305	Treat spine process fracture	Y		A2	1.4841	$62.17
22310	Treat spine fracture	Y		A2	4.7807	$200.30
22315	Treat spine fracture	Y		A2	19.0792	$799.38
22505	Manipulation of spine	Y		A2	14.1484	$592.79
22520	Percut vertebroplasty thor	Y		A2	29.4747	$1,234.93
22521	Percut vertebroplasty lumb	Y		A2	29.4747	$1,234.93
22522	Percut vertebroplasty addl	Y		A2	29.4747	$1,234.93
22523	Percut kyphoplasty, thor	Y		G2	80.4691	$3,371.49
22524	Percut kyphoplasty, lumbar	Y		G2	80.4691	$3,371.49
22525	Percut kyphoplasty, add-on	Y		G2	80.4691	$3,371.49
22900	Exc back tum deep < 5 cm	Y		G2	21.9314	$918.88
22901	Exc back tum deep = 5 cm	Y		G2	21.9314	$918.88

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
22902	Exc abd les sc < 3 cm	Y		G2	16.5641	$694.00
22903	Exc abd les sc > 3 cm	Y		G2	21.9314	$918.88
22904	Resect abd tum < 5 cm	Y		G2	16.5641	$694.00
22905	Resect abd tum > 5 cm	Y		G2	21.9314	$918.88
23000	Removal of calcium deposits	Y		A2	16.564	$694.00
23020	Release shoulder joint	Y		A2	43.0648	$1,804.33
23030	Drain shoulder lesion	Y		A2	18.4054	$771.15
23031	Drain shoulder bursa	Y		A2	18.4054	$771.15
23035	Drain shoulder bone lesion	Y		A2	21.1115	$884.53
23040	Exploratory shoulder surgery	Y		A2	29.4747	$1,234.93
23044	Exploratory shoulder surgery	Y		A2	29.4747	$1,234.93
23065	Biopsy shoulder tissues	Y		P3		$86.18
23066	Biopsy shoulder tissues	Y		A2	21.9314	$918.88
23071	Exc shoulder les sc > 3 cm	Y		G2	21.9314	$918.88
23073	Exc shoulder tum deep > 5 cm	Y		G2	21.9314	$918.88
23075*	Exc shoulder les sc < 3 cm	Y		P3		$156.64
23076	Exc shoulder tum deep < 5 cm	Y		G2	16.5641	$694.00
23077	Resect shoulder tum < 5 cm	Y		G2	16.5641	$694.00
23078	Resect shoulder tum > 5 cm	Y		G2	21.9314	$918.88
23100	Biopsy of shoulder joint	Y		A2	21.1115	$884.53
23101	Shoulder joint surgery	Y		A2	29.4747	$1,234.93
23105	Remove shoulder joint lining	Y		A2	29.4747	$1,234.93
23106	Incision of collarbone joint	Y		A2	29.4747	$1,234.93
23107	Explore treat shoulder joint	Y		A2	29.4747	$1,234.93
23120	Partial removal, collar bone	Y		A2	29.4747	$1,234.93
23125	Removal of collar bone	Y		A2	29.4747	$1,234.93
23130	Remove shoulder bone, part	Y		A2	43.0648	$1,804.33
23140	Removal of bone lesion	Y		A2	21.1115	$884.53
23145	Removal of bone lesion	Y		A2	29.4747	$1,234.93
23146	Removal of bone lesion	Y		A2	29.4747	$1,234.93
23150	Removal of humerus lesion	Y		A2	29.4747	$1,234.93
23155	Removal of humerus lesion	Y		A2	29.4747	$1,234.93
23156	Removal of humerus lesion	Y		A2	29.4747	$1,234.93
23170	Remove collar bone lesion	Y		A2	29.4747	$1,234.93
23172	Remove shoulder blade lesion	Y		A2	29.4747	$1,234.93
23174	Remove humerus lesion	Y		A2	29.4747	$1,234.93
23180	Remove collar bone lesion	Y		A2	29.4747	$1,234.93
23182	Remove shoulder blade lesion	Y		A2	29.4747	$1,234.93
23184	Remove humerus lesion	Y		A2	29.4747	$1,234.93

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
23190	Partial removal of scapula	Y		A2	29.4747	$1,234.93
23195	Removal of head of humerus	Y		A2	29.4747	$1,234.93
23330	Remove shoulder foreign body	Y		A2	7.9784	$334.28
23331	Remove shoulder foreign body	Y		A2	21.9314	$918.88
23350	Injection for shoulder x-ray	N		N1		
23395	Muscle transfer,shoulder/arm	Y		A2	43.0648	$1,804.33
23397	Muscle transfers	Y		A2	80.4692	$3,371.49
23400	Fixation of shoulder blade	Y		A2	29.4747	$1,234.93
23405	Incision of tendon & muscle	Y		A2	29.4747	$1,234.93
23406	Incise tendon(s) & muscle(s)	Y		A2	29.4747	$1,234.93
23410	Repair rotator cuff, acute	Y		A2	43.0648	$1,804.33
23412	Repair rotator cuff, chronic	Y		A2	43.0648	$1,804.33
23415	Release of shoulder ligament	Y		A2	43.0648	$1,804.33
23420	Repair of shoulder	Y		A2	43.0648	$1,804.33
23430	Repair biceps tendon	Y		A2	43.0648	$1,804.33
23440	Remove/transplant tendon	Y		A2	43.0648	$1,804.33
23450	Repair shoulder capsule	Y		A2	80.4692	$3,371.49
23455	Repair shoulder capsule	Y		A2	80.4692	$3,371.49
23460	Repair shoulder capsule	Y		A2	80.4692	$3,371.49
23462	Repair shoulder capsule	Y		A2	43.0648	$1,804.33
23465	Repair shoulder capsule	Y		A2	80.4692	$3,371.49
23466	Repair shoulder capsule	Y		A2	43.0648	$1,804.33
23480	Revision of collar bone	Y		A2	43.0648	$1,804.33
23485	Revision of collar bone	Y		A2	80.4692	$3,371.49
23490	Reinforce clavicle	Y		A2	80.4692	$3,371.49
23491	Reinforce shoulder bones	Y		A2	80.4692	$3,371.49
23500	Treat clavicle fracture	Y		A2	1.4841	$62.17
23505	Treat clavicle fracture	Y		A2	19.0792	$799.38
23515	Treat clavicle fracture	Y		A2	60.5167	$2,535.53
23520	Treat clavicle dislocation	Y		A2	4.7807	$200.30
23525	Treat clavicle dislocation	Y		A2	4.7807	$200.30
23530	Treat clavicle dislocation	Y		A2	43.7071	$1,831.24
23532	Treat clavicle dislocation	Y		A2	24.2634	$1,016.59
23540	Treat clavicle dislocation	Y		A2	1.4841	$62.17
23545	Treat clavicle dislocation	Y		A2	4.7807	$200.30
23550	Treat clavicle dislocation	Y		A2	43.7071	$1,831.24
23552	Treat clavicle dislocation	Y		A2	43.7071	$1,831.24
23570	Treat shoulder blade fx	Y		A2	1.4841	$62.17
23575	Treat shoulder blade fx	Y		A2	4.7807	$200.30

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
23585	Treat scapula fracture	Y		A2	60.5167	$2,535.53
23600	Treat humerus fracture	Y		P2	1.4839	$62.17
23605	Treat humerus fracture	Y		A2	19.0792	$799.38
23615	Treat humerus fracture	Y		A2	60.5167	$2,535.53
23616	Treat humerus fracture	Y		A2	60.5167	$2,535.53
23620	Treat humerus fracture	Y		P2	1.4839	$62.17
23625	Treat humerus fracture	Y		A2	19.0792	$799.38
23630	Treat humerus fracture	Y		A2	60.5167	$2,535.53
23650	Treat shoulder dislocation	Y		A2	1.4841	$62.17
23655	Treat shoulder dislocation	Y		A2	14.1484	$592.79
23660	Treat shoulder dislocation	Y		A2	43.7071	$1,831.24
23665	Treat dislocation/fracture	Y		A2	4.7807	$200.30
23670	Treat dislocation/fracture	Y		A2	60.5167	$2,535.53
23675	Treat dislocation/fracture	Y		A2	1.4841	$62.17
23680	Treat dislocation/fracture	Y		A2	43.7071	$1,831.24
23700	Fixation of shoulder	Y		A2	14.1484	$592.79
23800	Fusion of shoulder joint	Y		A2	80.4692	$3,371.49
23802	Fusion of shoulder joint	Y		A2	80.4692	$3,371.49
23921	Amputation follow-up surgery	Y		A2	15.5759	$652.60
23930	Drainage of arm lesion	Y		A2	18.4054	$771.15
23931	Drainage of arm bursa	Y		A2	18.4054	$771.15
23935	Drain arm/elbow bone lesion	Y		A2	21.1115	$884.53
24000	Exploratory elbow surgery	Y		A2	29.4747	$1,234.93
24006	Release elbow joint	Y		A2	29.4747	$1,234.93
24065	Biopsy arm/elbow soft tissue	Y		P3		$118.34
24066	Biopsy arm/elbow soft tissue	Y		A2	16.564	$694.00
24071	Exc arm/elbow les sc = 3 cm	Y		G2	21.9314	$918.88
24073	Ex arm/elbow tum deep > 5 cm	Y		G2	21.9314	$918.88
24075*	Exc arm/elbow les sc < 3 cm	Y		P3		$216.06
24076	Ex arm/elbow tum deep < 5 cm	Y		G2	16.5641	$694.00
24077	Resect arm/elbow tum < 5 cm	Y		G2	16.5641	$694.00
24079	Resect arm/elbow tum > 5 cm	Y		G2	21.9314	$918.88
24100	Biopsy elbow joint lining	Y		A2	21.1115	$884.53
24101	Explore/treat elbow joint	Y		A2	29.4747	$1,234.93
24102	Remove elbow joint lining	Y		A2	29.4747	$1,234.93
24105	Removal of elbow bursa	Y		A2	21.1115	$884.53
24110	Remove humerus lesion	Y		A2	21.1115	$884.53
24115	Remove/graft bone lesion	Y		A2	29.4747	$1,234.93
24116	Remove/graft bone lesion	Y		A2	29.4747	$1,234.93

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
24120	Remove elbow lesion	Y		A2	21.1115	$884.53
24125	Remove/graft bone lesion	Y		A2	29.4747	$1,234.93
24126	Remove/graft bone lesion	Y		A2	29.4747	$1,234.93
24130	Removal of head of radius	Y		A2	29.4747	$1,234.93
24134	Removal of arm bone lesion	Y		A2	29.4747	$1,234.93
24136	Remove radius bone lesion	Y		A2	29.4747	$1,234.93
24138	Remove elbow bone lesion	Y		A2	29.4747	$1,234.93
24140	Partial removal of arm bone	Y		A2	29.4747	$1,234.93
24145	Partial removal of radius	Y		A2	29.4747	$1,234.93
24147	Partial removal of elbow	Y		A2	29.4747	$1,234.93
24149	Radical resection of elbow	Y		G2	29.4746	$1,234.93
24152	Resect radius tumor	Y		G2	43.0649	$1,804.33
24155	Removal of elbow joint	Y		A2	43.0648	$1,804.33
24160	Remove elbow joint implant	Y		A2	29.4747	$1,234.93
24164	Remove radius head implant	Y		A2	29.4747	$1,234.93
24200	Removal of arm foreign body	Y		P3		$88.63
24201	Removal of arm foreign body	Y		A2	16.564	$694.00
24220	Injection for elbow x-ray	N		N1		
24300	Manipulate elbow w/anesth	Y		G2	14.1483	$592.79
24301	Muscle/tendon transfer	Y		A2	29.4747	$1,234.93
24305	Arm tendon lengthening	Y		A2	29.4747	$1,234.93
24310	Revision of arm tendon	Y		A2	21.1115	$884.53
24320	Repair of arm tendon	Y		A2	43.0648	$1,804.33
24330	Revision of arm muscles	Y		A2	80.4692	$3,371.49
24331	Revision of arm muscles	Y		A2	43.0648	$1,804.33
24332	Tenolysis, triceps	Y		G2	21.1114	$884.53
24340	Repair of biceps tendon	Y		A2	43.0648	$1,804.33
24341	Repair arm tendon/muscle	Y		A2	43.0648	$1,804.33
24342	Repair of ruptured tendon	Y		A2	43.0648	$1,804.33
24343	Repr elbow lat ligmnt w/tiss	Y		G2	29.4746	$1,234.93
24344	Reconstruct elbow lat ligmnt	Y		G2	80.4691	$3,371.49
24345	Repr elbw med ligmnt w/tissu	Y		A2	29.4747	$1,234.93
24346	Reconstruct elbow med ligmnt	Y		G2	80.4691	$3,371.49
24357	Repair elbow, perc	Y		G2	29.4746	$1,234.93
24358	Repair elbow w/deb, open	Y		G2	29.4746	$1,234.93
24359	Repair elbow deb/attch open	Y		G2	29.4746	$1,234.93
24360	Reconstruct elbow joint	Y		A2	35.5174	$1,488.11
24361	Reconstruct elbow joint	Y		H8	162.8173	$6,821.72
24362	Reconstruct elbow joint	Y		A2	54.7826	$2,295.28

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
24363	Replace elbow joint	Y		H8	162.8173	$6,821.72
24365	Reconstruct head of radius	Y		A2	35.5174	$1,488.11
24366	Reconstruct head of radius	Y		H8	162.8173	$6,821.72
24400	Revision of humerus	Y		A2	80.4692	$3,371.49
24410	Revision of humerus	Y		A2	43.0648	$1,804.33
24420	Revision of humerus	Y		A2	43.0648	$1,804.33
24430	Repair of humerus	Y		A2	80.4692	$3,371.49
24435	Repair humerus with graft	Y		A2	80.4692	$3,371.49
24470	Revision of elbow joint	Y		A2	43.0648	$1,804.33
24495	Decompression of forearm	Y		A2	29.4747	$1,234.93
24498	Reinforce humerus	Y		A2	80.4692	$3,371.49
24500	Treat humerus fracture	Y		A2	1.4841	$62.17
24505	Treat humerus fracture	Y		A2	1.4841	$62.17
24515	Treat humerus fracture	Y		A2	60.5167	$2,535.53
24516	Treat humerus fracture	Y		A2	60.5167	$2,535.53
24530	Treat humerus fracture	Y		A2	1.4841	$62.17
24535	Treat humerus fracture	Y		A2	4.7807	$200.30
24538	Treat humerus fracture	Y		A2	24.2634	$1,016.59
24545	Treat humerus fracture	Y		A2	60.5167	$2,535.53
24546	Treat humerus fracture	Y		A2	60.5167	$2,535.53
24560	Treat humerus fracture	Y		A2	1.4841	$62.17
24565	Treat humerus fracture	Y		A2	1.4841	$62.17
24566	Treat humerus fracture	Y		A2	24.2634	$1,016.59
24575	Treat humerus fracture	Y		A2	60.5167	$2,535.53
24576	Treat humerus fracture	Y		A2	1.4841	$62.17
24577	Treat humerus fracture	Y		A2	4.7807	$200.30
24579	Treat humerus fracture	Y		A2	60.5167	$2,535.53
24582	Treat humerus fracture	Y		A2	24.2634	$1,016.59
24586	Treat elbow fracture	Y		A2	60.5167	$2,535.53
24587	Treat elbow fracture	Y		A2	60.5167	$2,535.53
24600	Treat elbow dislocation	Y		A2	1.4841	$62.17
24605	Treat elbow dislocation	Y		A2	14.1484	$592.79
24615	Treat elbow dislocation	Y		A2	60.5167	$2,535.53
24620	Treat elbow fracture	Y		A2	19.0792	$799.38
24635	Treat elbow fracture	Y		A2	60.5167	$2,535.53
24640	Treat elbow dislocation	Y		P3		$51.07
24650	Treat radius fracture	Y		P2	1.4839	$62.17
24655	Treat radius fracture	Y		A2	4.7807	$200.30
24665	Treat radius fracture	Y		A2	43.7071	$1,831.24

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
24666	Treat radius fracture	Y		A2	60.5167	$2,535.53
24670	Treat ulnar fracture	Y		A2	1.4841	$62.17
24675	Treat ulnar fracture	Y		A2	1.4841	$62.17
24685	Treat ulnar fracture	Y		A2	43.7071	$1,831.24
24800	Fusion of elbow joint	Y		A2	43.0648	$1,804.33
24802	Fusion/graft of elbow joint	Y		A2	80.4692	$3,371.49
24925	Amputation follow-up surgery	Y		A2	21.1115	$884.53
25000	Incision of tendon sheath	Y		A2	21.1115	$884.53
25001	Incise flexor carpi radialis	Y		G2	21.1114	$884.53
25020	Decompress forearm 1 space	Y		A2	29.4747	$1,234.93
25023	Decompress forearm 1 space	Y		A2	29.4747	$1,234.93
25024	Decompress forearm 2 spaces	Y		A2	29.4747	$1,234.93
25025	Decompress forearm 2 spaces	Y		A2	29.4747	$1,234.93
25028	Drainage of forearm lesion	Y		A2	21.1115	$884.53
25031	Drainage of forearm bursa	Y		A2	21.1115	$884.53
25035	Treat forearm bone lesion	Y		A2	21.1115	$884.53
25040	Explore/treat wrist joint	Y		A2	29.4747	$1,234.93
25065	Biopsy forearm soft tissues	Y		P3		$119.81
25066	Biopsy forearm soft tissues	Y		A2	21.9314	$918.88
25071	Exc forearm les sc > 3 cm	Y		G2	21.9314	$918.88
25073	Exc forearm tum deep = 3 cm	Y		G2	21.9314	$918.88
25075*	Exc forearm les sc < 3 cm	Y		P3		$169.65
25076	Exc forearm tum deep < 3 cm	Y		G2	16.5641	$694.00
25077	Resect forearm/wrist tum<3cm	Y		G2	16.5641	$694.00
25078	Resect forearm/wrist tum=3cm	Y		G2	21.9314	$918.88
25085	Incision of wrist capsule	Y		A2	21.1115	$884.53
25100	Biopsy of wrist joint	Y		A2	21.1115	$884.53
25101	Explore/treat wrist joint	Y		A2	29.4747	$1,234.93
25105	Remove wrist joint lining	Y		A2	29.4747	$1,234.93
25107	Remove wrist joint cartilage	Y		A2	29.4747	$1,234.93
25109	Excise tendon forearm/wrist	Y		G2	21.1114	$884.53
25110	Remove wrist tendon lesion	Y		A2	21.1115	$884.53
25111	Remove wrist tendon lesion	Y		A2	21.1115	$884.53
25112	Reremove wrist tendon lesion	Y		A2	21.1115	$884.53
25115	Remove wrist/forearm lesion	Y		A2	21.1115	$884.53
25116	Remove wrist/forearm lesion	Y		A2	21.1115	$884.53
25118	Excise wrist tendon sheath	Y		A2	29.4747	$1,234.93
25119	Partial removal of ulna	Y		A2	29.4747	$1,234.93
25120	Removal of forearm lesion	Y		A2	29.4747	$1,234.93

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
25125	Remove/graft forearm lesion	Y		A2	29.4747	$1,234.93
25126	Remove/graft forearm lesion	Y		A2	29.4747	$1,234.93
25130	Removal of wrist lesion	Y		A2	29.4747	$1,234.93
25135	Remove & graft wrist lesion	Y		A2	29.4747	$1,234.93
25136	Remove & graft wrist lesion	Y		A2	29.4747	$1,234.93
25145	Remove forearm bone lesion	Y		A2	29.4747	$1,234.93
25150	Partial removal of ulna	Y		A2	29.4747	$1,234.93
25151	Partial removal of radius	Y		A2	29.4747	$1,234.93
25210	Removal of wrist bone	Y		A2	29.4747	$1,234.93
25215	Removal of wrist bones	Y		A2	29.4747	$1,234.93
25230	Partial removal of radius	Y		A2	29.4747	$1,234.93
25240	Partial removal of ulna	Y		A2	29.4747	$1,234.93
25246	Injection for wrist x-ray	N		N1		
25248	Remove forearm foreign body	Y		A2	21.1115	$884.53
25250	Removal of wrist prosthesis	Y		A2	29.4747	$1,234.93
25251	Removal of wrist prosthesis	Y		A2	29.4747	$1,234.93
25259	Manipulate wrist w/anesthes	Y		G2	19.0792	$799.38
25260	Repair forearm tendon/muscle	Y		A2	29.4747	$1,234.93
25263	Repair forearm tendon/muscle	Y		A2	29.4747	$1,234.93
25265	Repair forearm tendon/muscle	Y		A2	29.4747	$1,234.93
25270	Repair forearm tendon/muscle	Y		A2	29.4747	$1,234.93
25272	Repair forearm tendon/muscle	Y		A2	29.4747	$1,234.93
25274	Repair forearm tendon/muscle	Y		A2	29.4747	$1,234.93
25275	Repair forearm tendon sheath	Y		A2	29.4747	$1,234.93
25280	Revise wrist/forearm tendon	Y		A2	29.4747	$1,234.93
25290	Incise wrist/forearm tendon	Y		A2	29.4747	$1,234.93
25295	Release wrist/forearm tendon	Y		A2	21.1115	$884.53
25300	Fusion of tendons at wrist	Y		A2	29.4747	$1,234.93
25301	Fusion of tendons at wrist	Y		A2	29.4747	$1,234.93
25310	Transplant forearm tendon	Y		A2	43.0648	$1,804.33
25312	Transplant forearm tendon	Y		A2	43.0648	$1,804.33
25315	Revise palsy hand tendon(s)	Y		A2	43.0648	$1,804.33
25316	Revise palsy hand tendon(s)	Y		A2	80.4692	$3,371.49
25320	Repair/revise wrist joint	Y		A2	43.0648	$1,804.33
25332	Revise wrist joint	Y		A2	35.5174	$1,488.11
25335	Realignment of hand	Y		A2	43.0648	$1,804.33
25337	Reconstruct ulna/radioulnar	Y		A2	43.0648	$1,804.33
25350	Revision of radius	Y		A2	43.0648	$1,804.33
25355	Revision of radius	Y		A2	43.0648	$1,804.33

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
25360	Revision of ulna	Y		A2	43.0648	$1,804.33
25365	Revise radius & ulna	Y		A2	80.4692	$3,371.49
25370	Revise radius or ulna	Y		A2	43.0648	$1,804.33
25375	Revise radius & ulna	Y		A2	43.0648	$1,804.33
25390	Shorten radius or ulna	Y		A2	43.0648	$1,804.33
25391	Lengthen radius or ulna	Y		A2	80.4692	$3,371.49
25392	Shorten radius & ulna	Y		A2	29.4747	$1,234.93
25393	Lengthen radius & ulna	Y		A2	43.0648	$1,804.33
25394	Repair carpal bone, shorten	Y		G2	43.0649	$1,804.33
25400	Repair radius or ulna	Y		A2	80.4692	$3,371.49
25405	Repair/graft radius or ulna	Y		A2	80.4692	$3,371.49
25415	Repair radius & ulna	Y		A2	80.4692	$3,371.49
25420	Repair/graft radius & ulna	Y		A2	80.4692	$3,371.49
25425	Repair/graft radius or ulna	Y		A2	80.4692	$3,371.49
25426	Repair/graft radius & ulna	Y		A2	43.0648	$1,804.33
25430	Vasc graft into carpal bone	Y		G2	43.0649	$1,804.33
25431	Repair nonunion carpal bone	Y		G2	43.0649	$1,804.33
25440	Repair/graft wrist bone	Y		A2	80.4692	$3,371.49
25441	Reconstruct wrist joint	Y		H8	162.8173	$6,821.72
25442	Reconstruct wrist joint	Y		H8	162.8173	$6,821.72
25443	Reconstruct wrist joint	Y		A2	54.7826	$2,295.28
25444	Reconstruct wrist joint	Y		A2	54.7826	$2,295.28
25445	Reconstruct wrist joint	Y		A2	54.7826	$2,295.28
25446	Wrist replacement	Y		H8	162.8173	$6,821.72
25447	Repair wrist joint(s)	Y		A2	35.5174	$1,488.11
25449	Remove wrist joint implant	Y		A2	35.5174	$1,488.11
25450	Revision of wrist joint	Y		A2	43.0648	$1,804.33
25455	Revision of wrist joint	Y		A2	43.0648	$1,804.33
25490	Reinforce radius	Y		A2	43.0648	$1,804.33
25491	Reinforce ulna	Y		A2	43.0648	$1,804.33
25492	Reinforce radius and ulna	Y		A2	43.0648	$1,804.33
25500	Treat fracture of radius	Y		P2	1.4839	$62.17
25505	Treat fracture of radius	Y		A2	4.7807	$200.30
25515	Treat fracture of radius	Y		A2	43.7071	$1,831.24
25520	Treat fracture of radius	Y		A2	4.7807	$200.30
25525	Treat fracture of radius	Y		A2	43.7071	$1,831.24
25526	Treat fracture of radius	Y		A2	43.7071	$1,831.24
25530	Treat fracture of ulna	Y		P2	1.4839	$62.17
25535	Treat fracture of ulna	Y		A2	1.4841	$62.17

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
25545	Treat fracture of ulna	Y		A2	43.7071	$1,831.24
25560	Treat fracture radius & ulna	Y		P2	1.4839	$62.17
25565	Treat fracture radius & ulna	Y		A2	4.7807	$200.30
25574	Treat fracture radius & ulna	Y		A2	60.5167	$2,535.53
25575	Treat fracture radius/ulna	Y		A2	60.5167	$2,535.53
25600	Treat fracture radius/ulna	Y		P2	1.4839	$62.17
25605	Treat fracture radius/ulna	Y		A2	4.7807	$200.30
25606	Treat fx distal radial	Y		A2	24.2634	$1,016.59
25607	Treat fx rad extra-articul	Y		A2	60.5167	$2,535.53
25608	Treat fx rad intra-articul	Y		A2	60.5167	$2,535.53
25609	Treat fx radial 3+ frag	Y		A2	60.5167	$2,535.53
25622	Treat wrist bone fracture	Y		P2	1.4839	$62.17
25624	Treat wrist bone fracture	Y		A2	4.7807	$200.30
25628	Treat wrist bone fracture	Y		A2	43.7071	$1,831.24
25630	Treat wrist bone fracture	Y		P2	1.4839	$62.17
25635	Treat wrist bone fracture	Y		A2	4.7807	$200.30
25645	Treat wrist bone fracture	Y		A2	43.7071	$1,831.24
25650	Treat wrist bone fracture	Y		P2	1.4839	$62.17
25651	Pin ulnar styloid fracture	Y		G2	24.2634	$1,016.59
25652	Treat fracture ulnar styloid	Y		G2	43.7072	$1,831.24
25660	Treat wrist dislocation	Y		A2	1.4841	$62.17
25670	Treat wrist dislocation	Y		A2	24.2634	$1,016.59
25671	Pin radioulnar dislocation	Y		A2	24.2634	$1,016.59
25675	Treat wrist dislocation	Y		A2	1.4841	$62.17
25676	Treat wrist dislocation	Y		A2	24.2634	$1,016.59
25680	Treat wrist fracture	Y		A2	1.4841	$62.17
25685	Treat wrist fracture	Y		A2	24.2634	$1,016.59
25690	Treat wrist dislocation	Y		A2	19.0792	$799.38
25695	Treat wrist dislocation	Y		A2	24.2634	$1,016.59
25800	Fusion of wrist joint	Y		A2	80.4692	$3,371.49
25805	Fusion/graft of wrist joint	Y		A2	80.4692	$3,371.49
25810	Fusion/graft of wrist joint	Y		A2	80.4692	$3,371.49
25820	Fusion of hand bones	Y		A2	43.0648	$1,804.33
25825	Fuse hand bones with graft	Y		A2	80.4692	$3,371.49
25830	Fusion, radioulnar jnt/ulna	Y		A2	80.4692	$3,371.49
25907	Amputation follow-up surgery	Y		A2	21.1115	$884.53
25922	Amputate hand at wrist	Y		A2	21.1115	$884.53
25929	Amputation follow-up surgery	Y		A2	15.5759	$652.60
25931	Amputation follow-up surgery	Y		G2	21.1114	$884.53

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
26010	Drainage of finger abscess	Y		P2	1.358	$56.90
26011	Drainage of finger abscess	Y		A2	12.1142	$507.56
26020	Drain hand tendon sheath	Y		A2	15.7852	$661.37
26025	Drainage of palm bursa	Y		A2	15.7852	$661.37
26030	Drainage of palm bursa(s)	Y		A2	15.7852	$661.37
26034	Treat hand bone lesion	Y		A2	15.7852	$661.37
26035	Decompress fingers/hand	Y		G2	15.7852	$661.37
26037	Decompress fingers/hand	Y		G2	15.7852	$661.37
26040	Release palm contracture	Y		A2	15.7852	$661.37
26045	Release palm contracture	Y		A2	27.1049	$1,135.64
26055	Incise finger tendon sheath	Y		A2	15.7852	$661.37
26060	Incision of finger tendon	Y		A2	15.7852	$661.37
26070	Explore/treat hand joint	Y		A2	15.7852	$661.37
26075	Explore/treat finger joint	Y		A2	15.7852	$661.37
26080	Explore/treat finger joint	Y		A2	15.7852	$661.37
26100	Biopsy hand joint lining	Y		A2	15.7852	$661.37
26105	Biopsy finger joint lining	Y		A2	15.7852	$661.37
26110	Biopsy finger joint lining	Y		A2	15.7852	$661.37
26111	Exc hand les sc > 1.5 cm	Y		G2	21.9314	$918.88
26113	Exc hand tum deep > 1.5 cm	Y		G2	21.9314	$918.88
26115*	Exc hand les sc < 1.5 cm	Y		P3		$274.74
26116	Exc hand tum deep < 1.5 cm	Y		G2	16.5641	$694.00
26117	Exc hand tum ra < 3 cm	Y		G2	16.5641	$694.00
26118	Exc hand tum ra > 3 cm	Y		G2	21.9314	$918.88
26121	Release palm contracture	Y		A2	27.1049	$1,135.64
26123	Release palm contracture	Y		A2	27.1049	$1,135.64
26125	Release palm contracture	Y		A2	15.7852	$661.37
26130	Remove wrist joint lining	Y		A2	15.7852	$661.37
26135	Revise finger joint, each	Y		A2	27.1049	$1,135.64
26140	Revise finger joint, each	Y		A2	15.7852	$661.37
26145	Tendon excision, palm/finger	Y		A2	15.7852	$661.37
26160	Remove tendon sheath lesion	Y		A2	15.7852	$661.37
26170	Removal of palm tendon, each	Y		A2	15.7852	$661.37
26180	Removal of finger tendon	Y		A2	15.7852	$661.37
26185	Remove finger bone	Y		A2	15.7852	$661.37
26200	Remove hand bone lesion	Y		A2	15.7852	$661.37
26205	Remove/graft bone lesion	Y		A2	27.1049	$1,135.64
26210	Removal of finger lesion	Y		A2	15.7852	$661.37
26215	Remove/graft finger lesion	Y		A2	15.7852	$661.37

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
26230	Partial removal of hand bone	Y		A2	15.7852	$661.37
26235	Partial removal, finger bone	Y		A2	15.7852	$661.37
26236	Partial removal, finger bone	Y		A2	15.7852	$661.37
26250	Extensive hand surgery	Y		A2	15.7852	$661.37
26260	Resect prox finger tumor	Y		A2	15.7852	$661.37
26262	Resect distal finger tumor	Y		A2	15.7852	$661.37
26320	Removal of implant from hand	Y		A2	16.564	$694.00
26340	Manipulate finger w/anesth	Y		G2	4.7807	$200.30
26350	Repair finger/hand tendon	Y		A2	27.1049	$1,135.64
26352	Repair/graft hand tendon	Y		A2	27.1049	$1,135.64
26356	Repair finger/hand tendon	Y		A2	27.1049	$1,135.64
26357	Repair finger/hand tendon	Y		A2	27.1049	$1,135.64
26358	Repair/graft hand tendon	Y		A2	27.1049	$1,135.64
26370	Repair finger/hand tendon	Y		A2	27.1049	$1,135.64
26372	Repair/graft hand tendon	Y		A2	27.1049	$1,135.64
26373	Repair finger/hand tendon	Y		A2	27.1049	$1,135.64
26390	Revise hand/finger tendon	Y		A2	27.1049	$1,135.64
26392	Repair/graft hand tendon	Y		A2	27.1049	$1,135.64
26410	Repair hand tendon	Y		A2	15.7852	$661.37
26412	Repair/graft hand tendon	Y		A2	27.1049	$1,135.64
26415	Excision, hand/finger tendon	Y		A2	27.1049	$1,135.64
26416	Graft hand or finger tendon	Y		A2	27.1049	$1,135.64
26418	Repair finger tendon	Y		A2	15.7852	$661.37
26420	Repair/graft finger tendon	Y		A2	27.1049	$1,135.64
26426	Repair finger/hand tendon	Y		A2	27.1049	$1,135.64
26428	Repair/graft finger tendon	Y		A2	27.1049	$1,135.64
26432	Repair finger tendon	Y		A2	15.7852	$661.37
26433	Repair finger tendon	Y		A2	15.7852	$661.37
26434	Repair/graft finger tendon	Y		A2	27.1049	$1,135.64
26437	Realignment of tendons	Y		A2	15.7852	$661.37
26440	Release palm/finger tendon	Y		A2	15.7852	$661.37
26442	Release palm & finger tendon	Y		A2	27.1049	$1,135.64
26445	Release hand/finger tendon	Y		A2	15.7852	$661.37
26449	Release forearm/hand tendon	Y		A2	27.1049	$1,135.64
26450	Incision of palm tendon	Y		A2	15.7852	$661.37
26455	Incision of finger tendon	Y		A2	15.7852	$661.37
26460	Incise hand/finger tendon	Y		A2	15.7852	$661.37
26471	Fusion of finger tendons	Y		A2	15.7852	$661.37
26474	Fusion of finger tendons	Y		A2	15.7852	$661.37

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
26476	Tendon lengthening	Y		A2	15.7852	$661.37
26477	Tendon shortening	Y		A2	15.7852	$661.37
26478	Lengthening of hand tendon	Y		A2	15.7852	$661.37
26479	Shortening of hand tendon	Y		A2	15.7852	$661.37
26480	Transplant hand tendon	Y		A2	27.1049	$1,135.64
26483	Transplant/graft hand tendon	Y		A2	27.1049	$1,135.64
26485	Transplant palm tendon	Y		A2	27.1049	$1,135.64
26489	Transplant/graft palm tendon	Y		A2	27.1049	$1,135.64
26490	Revise thumb tendon	Y		A2	27.1049	$1,135.64
26492	Tendon transfer with graft	Y		A2	27.1049	$1,135.64
26494	Hand tendon/muscle transfer	Y		A2	27.1049	$1,135.64
26496	Revise thumb tendon	Y		A2	27.1049	$1,135.64
26497	Finger tendon transfer	Y		A2	27.1049	$1,135.64
26498	Finger tendon transfer	Y		A2	27.1049	$1,135.64
26499	Revision of finger	Y		A2	27.1049	$1,135.64
26500	Hand tendon reconstruction	Y		A2	15.7852	$661.37
26502	Hand tendon reconstruction	Y		A2	27.1049	$1,135.64
26508	Release thumb contracture	Y		A2	15.7852	$661.37
26510	Thumb tendon transfer	Y		A2	27.1049	$1,135.64
26516	Fusion of knuckle joint	Y		A2	27.1049	$1,135.64
26517	Fusion of knuckle joints	Y		A2	27.1049	$1,135.64
26518	Fusion of knuckle joints	Y		A2	27.1049	$1,135.64
26520	Release knuckle contracture	Y		A2	15.7852	$661.37
26525	Release finger contracture	Y		A2	15.7852	$661.37
26530	Revise knuckle joint	Y		A2	35.5174	$1,488.11
26531	Revise knuckle with implant	Y		A2	54.7826	$2,295.28
26535	Revise finger joint	Y		A2	35.5174	$1,488.11
26536	Revise/implant finger joint	Y		A2	54.7826	$2,295.28
26540	Repair hand joint	Y		A2	15.7852	$661.37
26541	Repair hand joint with graft	Y		A2	27.1049	$1,135.64
26542	Repair hand joint with graft	Y		A2	15.7852	$661.37
26545	Reconstruct finger joint	Y		A2	27.1049	$1,135.64
26546	Repair nonunion hand	Y		A2	27.1049	$1,135.64
26548	Reconstruct finger joint	Y		A2	27.1049	$1,135.64
26550	Construct thumb replacement	Y		A2	27.1049	$1,135.64
26555	Positional change of finger	Y		A2	27.1049	$1,135.64
26560	Repair of web finger	Y		A2	15.7852	$661.37
26561	Repair of web finger	Y		A2	27.1049	$1,135.64
26562	Repair of web finger	Y		A2	27.1049	$1,135.64

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
26565	Correct metacarpal flaw	Y		A2	27.1049	$1,135.64
26567	Correct finger deformity	Y		A2	27.1049	$1,135.64
26568	Lengthen metacarpal/finger	Y		A2	27.1049	$1,135.64
26580	Repair hand deformity	Y		A2	15.7852	$661.37
26587	Reconstruct extra finger	Y		A2	15.7852	$661.37
26590	Repair finger deformity	Y		A2	15.7852	$661.37
26591	Repair muscles of hand	Y		A2	27.1049	$1,135.64
26593	Release muscles of hand	Y		A2	15.7852	$661.37
26596	Excision constricting tissue	Y		A2	15.7852	$661.37
26600	Treat metacarpal fracture	Y		P2	1.4839	$62.17
26605	Treat metacarpal fracture	Y		A2	1.4841	$62.17
26607	Treat metacarpal fracture	Y		A2	19.0792	$799.38
26608	Treat metacarpal fracture	Y		A2	24.2634	$1,016.59
26615	Treat metacarpal fracture	Y		A2	43.7071	$1,831.24
26641	Treat thumb dislocation	Y		P2	1.4839	$62.17
26645	Treat thumb fracture	Y		A2	4.7807	$200.30
26650	Treat thumb fracture	Y		A2	24.2634	$1,016.59
26665	Treat thumb fracture	Y		A2	43.7071	$1,831.24
26670	Treat hand dislocation	Y		P2	1.4839	$62.17
26675	Treat hand dislocation	Y		A2	4.7807	$200.30
26676	Pin hand dislocation	Y		A2	24.2634	$1,016.59
26685	Treat hand dislocation	Y		A2	24.2634	$1,016.59
26686	Treat hand dislocation	Y		A2	60.5167	$2,535.53
26700	Treat knuckle dislocation	Y		P2	1.4839	$62.17
26705	Treat knuckle dislocation	Y		A2	1.4841	$62.17
26706	Pin knuckle dislocation	Y		A2	19.0792	$799.38
26715	Treat knuckle dislocation	Y		A2	24.2634	$1,016.59
26720	Treat finger fracture, each	Y		P2	1.4839	$62.17
26725	Treat finger fracture, each	Y		P2	1.4839	$62.17
26727	Treat finger fracture, each	Y		A2	24.2634	$1,016.59
26735	Treat finger fracture, each	Y		A2	24.2634	$1,016.59
26740	Treat finger fracture, each	Y		P2	1.4839	$62.17
26742	Treat finger fracture, each	Y		A2	1.4841	$62.17
26746	Treat finger fracture, each	Y		A2	24.2634	$1,016.59
26750	Treat finger fracture, each	Y		P2	1.4839	$62.17
26755	Treat finger fracture, each	Y		G2	1.4839	$62.17
26756	Pin finger fracture, each	Y		A2	24.2634	$1,016.59
26765	Treat finger fracture, each	Y		A2	24.2634	$1,016.59
26770	Treat finger dislocation	Y		G2	1.4839	$62.17

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
26775	Treat finger dislocation	Y		P3		$148.29
26776	Pin finger dislocation	Y		A2	24.2634	$1,016.59
26785	Treat finger dislocation	Y		A2	24.2634	$1,016.59
26820	Thumb fusion with graft	Y		A2	27.1049	$1,135.64
26841	Fusion of thumb	Y		A2	27.1049	$1,135.64
26842	Thumb fusion with graft	Y		A2	27.1049	$1,135.64
26843	Fusion of hand joint	Y		A2	27.1049	$1,135.64
26844	Fusion/graft of hand joint	Y		A2	27.1049	$1,135.64
26850	Fusion of knuckle	Y		A2	27.1049	$1,135.64
26852	Fusion of knuckle with graft	Y		A2	27.1049	$1,135.64
26860	Fusion of finger joint	Y		A2	27.1049	$1,135.64
26861	Fusion of finger jnt, add-on	Y		A2	27.1049	$1,135.64
26862	Fusion/graft of finger joint	Y		A2	27.1049	$1,135.64
26863	Fuse/graft added joint	Y		A2	27.1049	$1,135.64
26910	Amputate metacarpal bone	Y		A2	27.1049	$1,135.64
26951	Amputation of finger/thumb	Y		A2	15.7852	$661.37
26952	Amputation of finger/thumb	Y		A2	15.7852	$661.37
26990	Drainage of pelvis lesion	Y		A2	21.1115	$884.53
26991	Drainage of pelvis bursa	Y		A2	21.1115	$884.53
27000	Incision of hip tendon	Y		A2	21.1115	$884.53
27001	Incision of hip tendon	Y		A2	29.4747	$1,234.93
27003	Incision of hip tendon	Y		A2	29.4747	$1,234.93
27033	Exploration of hip joint	Y		A2	43.0648	$1,804.33
27035	Denervation of hip joint	Y		A2	43.0648	$1,804.33
27040	Biopsy of soft tissues	Y		A2	7.9784	$334.28
27041	Biopsy of soft tissues	Y		A2	7.9784	$334.28
27043	Exc hip pelvis les sc > 3 cm	Y		G2	21.9314	$918.88
27045	Exc hip/pelv tum deep > 5 cm	Y		G2	21.9314	$918.88
27047*	Exc hip/pelvis les sc < 3 cm	Y		P3		$197.15
27048	Exc hip/pelv tum deep < 5 cm	Y		G2	16.5641	$694.00
27049	Resect hip/pelv tum < 5 cm	Y		G2	16.5641	$694.00
27050	Biopsy of sacroiliac joint	Y		A2	21.1115	$884.53
27052	Biopsy of hip joint	Y		A2	21.1115	$884.53
27059	Resect hip/pelv tum > 5 cm	Y		G2	21.9314	$918.88
27060	Removal of ischial bursa	Y		A2	21.1115	$884.53
27062	Remove femur lesion/bursa	Y		A2	21.1115	$884.53
27065	Removal of hip bone lesion	Y		A2	21.1115	$884.53
27066	Removal of hip bone lesion	Y		A2	29.4747	$1,234.93
27067	Remove/graft hip bone lesion	Y		A2	29.4747	$1,234.93

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
27080	Removal of tail bone	Y		A2	29.4747	$1,234.93
27086	Remove hip foreign body	Y		A2	7.9784	$334.28
27087	Remove hip foreign body	Y		A2	21.1115	$884.53
27093	Injection for hip x-ray	N		N1		
27095	Injection for hip x-ray	N		N1		
27097	Revision of hip tendon	Y		A2	29.4747	$1,234.93
27098	Transfer tendon to pelvis	Y		A2	29.4747	$1,234.93
27100	Transfer of abdominal muscle	Y		A2	43.0648	$1,804.33
27105	Transfer of spinal muscle	Y		A2	43.0648	$1,804.33
27110	Transfer of iliopsoas muscle	Y		A2	43.0648	$1,804.33
27111	Transfer of iliopsoas muscle	Y		A2	43.0648	$1,804.33
27193	Treat pelvic ring fracture	Y		A2	1.4841	$62.17
27194	Treat pelvic ring fracture	Y		A2	14.1484	$592.79
27200	Treat tail bone fracture	Y		P2	1.4839	$62.17
27202	Treat tail bone fracture	Y		A2	43.7071	$1,831.24
27220	Treat hip socket fracture	Y		G2	1.4839	$62.17
27230	Treat thigh fracture	Y		A2	1.4841	$62.17
27238	Treat thigh fracture	Y		A2	4.7807	$200.30
27246	Treat thigh fracture	Y		A2	4.7807	$200.30
27250	Treat hip dislocation	Y		A2	1.4841	$62.17
27252	Treat hip dislocation	Y		A2	14.1484	$592.79
27256	Treat hip dislocation	Y		G2	1.4839	$62.17
27257	Treat hip dislocation	Y		A2	14.1484	$592.79
27265	Treat hip dislocation	Y		A2	1.4841	$62.17
27266	Treat hip dislocation	Y		A2	14.1484	$592.79
27267	Cltx thigh fx	Y		G2	1.4839	$62.17
27275	Manipulation of hip joint	Y		A2	14.1484	$592.79
27301	Drain thigh/knee lesion	Y		A2	18.4054	$771.15
27305	Incise thigh tendon & fascia	Y		A2	21.1115	$884.53
27306	Incision of thigh tendon	Y		A2	21.1115	$884.53
27307	Incision of thigh tendons	Y		A2	21.1115	$884.53
27310	Exploration of knee joint	Y		A2	29.4747	$1,234.93
27323	Biopsy, thigh soft tissues	Y		A2	7.9784	$334.28
27324	Biopsy, thigh soft tissues	Y		A2	21.9314	$918.88
27325	Neurectomy, hamstring	Y		A2	17.5922	$737.08
27326	Neurectomy, popliteal	Y		A2	17.5922	$737.08
27327*	Exc thigh/knee les sc < 3 cm	Y		P3		$191.01
27328	Exc thigh/knee tum deep <5cm	Y		G2	16.5641	$694.00
27329	Resect thigh/knee tum < 5 cm	Y		G2	16.5641	$694.00

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
27330	Biopsy, knee joint lining	Y		A2	29.4747	$1,234.93
27331	Explore/treat knee joint	Y		A2	29.4747	$1,234.93
27332	Removal of knee cartilage	Y		A2	29.4747	$1,234.93
27333	Removal of knee cartilage	Y		A2	29.4747	$1,234.93
27334	Remove knee joint lining	Y		A2	29.4747	$1,234.93
27335	Remove knee joint lining	Y		A2	29.4747	$1,234.93
27337	Exc thigh/knee les sc > 3 cm	Y		G2	21.9314	$918.88
27339	Exc thigh/knee tum deep >5cm	Y		G2	21.9314	$918.88
27340	Removal of kneecap bursa	Y		A2	21.1115	$884.53
27345	Removal of knee cyst	Y		A2	21.1115	$884.53
27347	Remove knee cyst	Y		A2	21.1115	$884.53
27350	Removal of kneecap	Y		A2	29.4747	$1,234.93
27355	Remove femur lesion	Y		A2	29.4747	$1,234.93
27356	Remove femur lesion/graft	Y		A2	29.4747	$1,234.93
27357	Remove femur lesion/graft	Y		A2	29.4747	$1,234.93
27358	Remove femur lesion/fixation	Y		A2	29.4747	$1,234.93
27360	Partial removal, leg bone(s)	Y		A2	29.4747	$1,234.93
27364	Resect thigh/knee tum >5 cm	Y		G2	21.9314	$918.88
27370	Injection for knee x-ray	N		N1		
27372	Removal of foreign body	Y		A2	21.9314	$918.88
27380	Repair of kneecap tendon	Y		A2	21.1115	$884.53
27381	Repair/graft kneecap tendon	Y		A2	21.1115	$884.53
27385	Repair of thigh muscle	Y		A2	21.1115	$884.53
27386	Repair/graft of thigh muscle	Y		A2	21.1115	$884.53
27390	Incision of thigh tendon	Y		A2	21.1115	$884.53
27391	Incision of thigh tendons	Y		A2	21.1115	$884.53
27392	Incision of thigh tendons	Y		A2	21.1115	$884.53
27393	Lengthening of thigh tendon	Y		A2	29.4747	$1,234.93
27394	Lengthening of thigh tendons	Y		A2	29.4747	$1,234.93
27395	Lengthening of thigh tendons	Y		A2	43.0648	$1,804.33
27396	Transplant of thigh tendon	Y		A2	29.4747	$1,234.93
27397	Transplants of thigh tendons	Y		A2	43.0648	$1,804.33
27400	Revise thigh muscles/tendons	Y		A2	43.0648	$1,804.33
27403	Repair of knee cartilage	Y		A2	29.4747	$1,234.93
27405	Repair of knee ligament	Y		A2	43.0648	$1,804.33
27407	Repair of knee ligament	Y		A2	80.4692	$3,371.49
27409	Repair of knee ligaments	Y		A2	80.4692	$3,371.49
27416	Osteochondral knee autograft	Y		G2	43.0649	$1,804.33
27418	Repair degenerated kneecap	Y		A2	43.0648	$1,804.33

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
27420	Revision of unstable kneecap	Y		A2	43.0648	$1,804.33
27422	Revision of unstable kneecap	Y		A2	43.0648	$1,804.33
27424	Revision/removal of kneecap	Y		A2	43.0648	$1,804.33
27425	Lat retinacular release open	Y		A2	29.4747	$1,234.93
27427	Reconstruction, knee	Y		A2	80.4692	$3,371.49
27428	Reconstruction, knee	Y		A2	80.4692	$3,371.49
27429	Reconstruction, knee	Y		A2	80.4692	$3,371.49
27430	Revision of thigh muscles	Y		A2	43.0648	$1,804.33
27435	Incision of knee joint	Y		A2	43.0648	$1,804.33
27437	Revise kneecap	Y		A2	35.5174	$1,488.11
27438	Revise kneecap with implant	Y		A2	54.7826	$2,295.28
27440	Revision of knee joint	Y		G2	35.5174	$1,488.11
27441	Revision of knee joint	Y		A2	35.5174	$1,488.11
27442	Revision of knee joint	Y		A2	35.5174	$1,488.11
27443	Revision of knee joint	Y		A2	35.5174	$1,488.11
27446	Revision of knee joint	Y		J8	162.8173	$6,821.72
27475	Surgery to stop leg growth	Y		G2	29.4746	$1,234.93
27479	Surgery to stop leg growth	Y		G2	29.4746	$1,234.93
27496	Decompression of thigh/knee	Y		A2	29.4747	$1,234.93
27497	Decompression of thigh/knee	Y		A2	21.1115	$884.53
27498	Decompression of thigh/knee	Y		A2	29.4747	$1,234.93
27499	Decompression of thigh/knee	Y		A2	29.4747	$1,234.93
27500	Treatment of thigh fracture	Y		A2	4.7807	$200.30
27501	Treatment of thigh fracture	Y		A2	1.4841	$62.17
27502	Treatment of thigh fracture	Y		A2	19.0792	$799.38
27503	Treatment of thigh fracture	Y		A2	1.4841	$62.17
27508	Treatment of thigh fracture	Y		A2	1.4841	$62.17
27509	Treatment of thigh fracture	Y		A2	24.2634	$1,016.59
27510	Treatment of thigh fracture	Y		A2	4.7807	$200.30
27516	Treat thigh fx growth plate	Y		A2	1.4841	$62.17
27517	Treat thigh fx growth plate	Y		A2	1.4841	$62.17
27520	Treat kneecap fracture	Y		A2	1.4841	$62.17
27530	Treat knee fracture	Y		A2	1.4841	$62.17
27532	Treat knee fracture	Y		A2	19.0792	$799.38
27538	Treat knee fracture(s)	Y		A2	1.4841	$62.17
27550	Treat knee dislocation	Y		A2	1.4841	$62.17
27552	Treat knee dislocation	Y		A2	14.1484	$592.79
27560	Treat kneecap dislocation	Y		A2	1.4841	$62.17
27562	Treat kneecap dislocation	Y		A2	14.1484	$592.79

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
27566	Treat kneecap dislocation	Y		A2	43.7071	$1,831.24
27570	Fixation of knee joint	Y		A2	14.1484	$592.79
27594	Amputation follow-up surgery	Y		A2	21.1115	$884.53
27600	Decompression of lower leg	Y		A2	21.1115	$884.53
27601	Decompression of lower leg	Y		A2	21.1115	$884.53
27602	Decompression of lower leg	Y		A2	21.1115	$884.53
27603	Drain lower leg lesion	Y		A2	18.4054	$771.15
27604	Drain lower leg bursa	Y		A2	21.1115	$884.53
27605	Incision of achilles tendon	Y		A2	20.632	$864.44
27606	Incision of achilles tendon	Y		A2	21.1115	$884.53
27607	Treat lower leg bone lesion	Y		A2	21.1115	$884.53
27610	Explore/treat ankle joint	Y		A2	29.4747	$1,234.93
27612	Exploration of ankle joint	Y		A2	29.4747	$1,234.93
27613	Biopsy lower leg soft tissue	Y		P3		$114.41
27614	Biopsy lower leg soft tissue	Y		A2	21.9314	$918.88
27615	Resect leg/ankle tum < 5 cm	Y		G2	16.5641	$694.00
27616	Resect leg/ankle tum > 5 cm	Y		G2	21.9314	$918.88
27618*	Exc leg/ankle tum < 3 cm	Y		P3		$193.96
27619	Exc leg/ankle tum deep <5 cm	Y		G2	16.5641	$694.00
27620	Explore/treat ankle joint	Y		A2	29.4747	$1,234.93
27625	Remove ankle joint lining	Y		A2	29.4747	$1,234.93
27626	Remove ankle joint lining	Y		A2	29.4747	$1,234.93
27630	Removal of tendon lesion	Y		A2	21.1115	$884.53
27632	Exc leg/ankle les sc > 3 cm	Y		G2	21.9314	$918.88
27634	Exc leg/ankle tum deep >5 cm	Y		G2	21.9314	$918.88
27635	Remove lower leg bone lesion	Y		A2	29.4747	$1,234.93
27637	Remove/graft leg bone lesion	Y		A2	29.4747	$1,234.93
27638	Remove/graft leg bone lesion	Y		A2	29.4747	$1,234.93
27640	Partial removal of tibia	Y		A2	43.0648	$1,804.33
27641	Partial removal of fibula	Y		A2	29.4747	$1,234.93
27647	Resect talus/calcaneus tum	Y		A2	43.0648	$1,804.33
27648	Injection for ankle x-ray	N		N1		
27650	Repair achilles tendon	Y		A2	43.0648	$1,804.33
27652	Repair/graft achilles tendon	Y		A2	80.4692	$3,371.49
27654	Repair of achilles tendon	Y		A2	43.0648	$1,804.33
27656	Repair leg fascia defect	Y		A2	21.1115	$884.53
27658	Repair of leg tendon, each	Y		A2	21.1115	$884.53
27659	Repair of leg tendon, each	Y		A2	21.1115	$884.53
27664	Repair of leg tendon, each	Y		A2	29.4747	$1,234.93

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
27665	Repair of leg tendon, each	Y		A2	29.4747	$1,234.93
27675	Repair lower leg tendons	Y		A2	21.1115	$884.53
27676	Repair lower leg tendons	Y		A2	29.4747	$1,234.93
27680	Release of lower leg tendon	Y		A2	29.4747	$1,234.93
27681	Release of lower leg tendons	Y		A2	29.4747	$1,234.93
27685	Revision of lower leg tendon	Y		A2	29.4747	$1,234.93
27686	Revise lower leg tendons	Y		A2	29.4747	$1,234.93
27687	Revision of calf tendon	Y		A2	29.4747	$1,234.93
27690	Revise lower leg tendon	Y		A2	43.0648	$1,804.33
27691	Revise lower leg tendon	Y		A2	43.0648	$1,804.33
27692	Revise additional leg tendon	Y		A2	43.0648	$1,804.33
27695	Repair of ankle ligament	Y		A2	29.4747	$1,234.93
27696	Repair of ankle ligaments	Y		A2	29.4747	$1,234.93
27698	Repair of ankle ligament	Y		A2	29.4747	$1,234.93
27700	Revision of ankle joint	Y		A2	35.5174	$1,488.11
27704	Removal of ankle implant	Y		A2	21.1115	$884.53
27705	Incision of tibia	Y		A2	43.0648	$1,804.33
27707	Incision of fibula	Y		A2	21.1115	$884.53
27709	Incision of tibia & fibula	Y		A2	29.4747	$1,234.93
27720	Repair of tibia	Y		G2	43.7072	$1,831.24
27726	Repair fibula nonunion	Y		G2	43.7072	$1,831.24
27730	Repair of tibia epiphysis	Y		A2	29.4747	$1,234.93
27732	Repair of fibula epiphysis	Y		A2	29.4747	$1,234.93
27734	Repair lower leg epiphyses	Y		A2	29.4747	$1,234.93
27740	Repair of leg epiphyses	Y		A2	29.4747	$1,234.93
27742	Repair of leg epiphyses	Y		A2	43.0648	$1,804.33
27745	Reinforce tibia	Y		A2	80.4692	$3,371.49
27750	Treatment of tibia fracture	Y		A2	1.4841	$62.17
27752	Treatment of tibia fracture	Y		A2	19.0792	$799.38
27756	Treatment of tibia fracture	Y		A2	24.2634	$1,016.59
27758	Treatment of tibia fracture	Y		A2	43.7071	$1,831.24
27759	Treatment of tibia fracture	Y		A2	60.5167	$2,535.53
27760	Cltx medial ankle fx	Y		A2	1.4841	$62.17
27762	Cltx med ankle fx w/mnpj	Y		A2	19.0792	$799.38
27766	Optx medial ankle fx	Y		A2	43.7071	$1,831.24
27767	Cltx post ankle fx	Y	CH	P2	1.4839	$62.17
27768	Cltx post ankle fx w/mnpj	Y		G2	1.4839	$62.17
27769	Optx post ankle fx	Y		G2	43.7072	$1,831.24
27780	Treatment of fibula fracture	Y		A2	1.4841	$62.17

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
27781	Treatment of fibula fracture	Y		A2	19.0792	$799.38
27784	Treatment of fibula fracture	Y		A2	43.7071	$1,831.24
27786	Treatment of ankle fracture	Y		A2	1.4841	$62.17
27788	Treatment of ankle fracture	Y		A2	1.4841	$62.17
27792	Treatment of ankle fracture	Y		A2	43.7071	$1,831.24
27808	Treatment of ankle fracture	Y		A2	1.4841	$62.17
27810	Treatment of ankle fracture	Y		A2	4.7807	$200.30
27814	Treatment of ankle fracture	Y		A2	43.7071	$1,831.24
27816	Treatment of ankle fracture	Y		A2	1.4841	$62.17
27818	Treatment of ankle fracture	Y		A2	4.7807	$200.30
27822	Treatment of ankle fracture	Y		A2	43.7071	$1,831.24
27823	Treatment of ankle fracture	Y		A2	60.5167	$2,535.53
27824	Treat lower leg fracture	Y		A2	1.4841	$62.17
27825	Treat lower leg fracture	Y		A2	19.0792	$799.38
27826	Treat lower leg fracture	Y		A2	43.7071	$1,831.24
27827	Treat lower leg fracture	Y		A2	60.5167	$2,535.53
27828	Treat lower leg fracture	Y		A2	60.5167	$2,535.53
27829	Treat lower leg joint	Y		A2	43.7071	$1,831.24
27830	Treat lower leg dislocation	Y		A2	1.4841	$62.17
27831	Treat lower leg dislocation	Y		A2	19.0792	$799.38
27832	Treat lower leg dislocation	Y		A2	43.7071	$1,831.24
27840	Treat ankle dislocation	Y		A2	4.7807	$200.30
27842	Treat ankle dislocation	Y		A2	14.1484	$592.79
27846	Treat ankle dislocation	Y		A2	43.7071	$1,831.24
27848	Treat ankle dislocation	Y		A2	43.7071	$1,831.24
27860	Fixation of ankle joint	Y		A2	14.1484	$592.79
27870	Fusion of ankle joint, open	Y		A2	80.4692	$3,371.49
27871	Fusion of tibiofibular joint	Y		A2	80.4692	$3,371.49
27884	Amputation follow-up surgery	Y		A2	21.1115	$884.53
27889	Amputation of foot at ankle	Y		A2	29.4747	$1,234.93
27892	Decompression of leg	Y		A2	29.4747	$1,234.93
27893	Decompression of leg	Y		A2	29.4747	$1,234.93
27894	Decompression of leg	Y		A2	29.4747	$1,234.93
28001	Drainage of bursa of foot	Y		P3		$114.41
28002	Treatment of foot infection	Y		A2	21.1115	$884.53
28003	Treatment of foot infection	Y		A2	21.1115	$884.53
28005	Treat foot bone lesion	Y		A2	20.632	$864.44
28008	Incision of foot fascia	Y		A2	20.632	$864.44
28010	Incision of toe tendon	Y		P3		$83.72

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
28011	Incision of toe tendons	Y		A2	20.632	$864.44
28020	Exploration of foot joint	Y		A2	20.632	$864.44
28022	Exploration of foot joint	Y		A2	20.632	$864.44
28024	Exploration of toe joint	Y		A2	20.632	$864.44
28035	Decompression of tibia nerve	Y		A2	17.5922	$737.08
28039*	Exc foot/toe tum sc > 1.5 cm	Y		P3		$201.57
28041*	Exc foot/toe tum deep >1.5cm	Y		R2	21.9314	$918.88
28043*	Exc foot/toe tum sc < 1.5 cm	Y		P3		$156.64
28045*	Exc foot/toe tum deep <1.5cm	Y		P3		$203.29
28046*	Resect foot/toe tumor < 3 cm	Y		R2	16.5641	$694.00
28047	Resect foot/toe tumor > 3 cm	Y		G2	21.9314	$918.88
28050	Biopsy of foot joint lining	Y		A2	20.632	$864.44
28052	Biopsy of foot joint lining	Y		A2	20.632	$864.44
28054	Biopsy of toe joint lining	Y		A2	20.632	$864.44
28055	Neurectomy, foot	Y		A2	17.5922	$737.08
28060	Partial removal, foot fascia	Y		A2	20.632	$864.44
28062	Removal of foot fascia	Y		A2	20.632	$864.44
28070	Removal of foot joint lining	Y		A2	20.632	$864.44
28072	Removal of foot joint lining	Y		A2	20.632	$864.44
28080	Removal of foot lesion	Y		A2	20.632	$864.44
28086	Excise foot tendon sheath	Y		A2	20.632	$864.44
28088	Excise foot tendon sheath	Y		A2	20.632	$864.44
28090	Removal of foot lesion	Y		A2	20.632	$864.44
28092	Removal of toe lesions	Y		A2	20.632	$864.44
28100	Removal of ankle/heel lesion	Y		A2	20.632	$864.44
28102	Remove/graft foot lesion	Y		A2	50.4554	$2,113.98
28103	Remove/graft foot lesion	Y		A2	50.4554	$2,113.98
28104	Removal of foot lesion	Y		A2	20.632	$864.44
28106	Remove/graft foot lesion	Y		A2	50.4554	$2,113.98
28107	Remove/graft foot lesion	Y		A2	50.4554	$2,113.98
28108	Removal of toe lesions	Y		A2	20.632	$864.44
28110	Part removal of metatarsal	Y		A2	20.632	$864.44
28111	Part removal of metatarsal	Y		A2	20.632	$864.44
28112	Part removal of metatarsal	Y		A2	20.632	$864.44
28113	Part removal of metatarsal	Y		A2	20.632	$864.44
28114	Removal of metatarsal heads	Y		A2	20.632	$864.44
28116	Revision of foot	Y		A2	20.632	$864.44
28118	Removal of heel bone	Y		A2	20.632	$864.44
28119	Removal of heel spur	Y		A2	20.632	$864.44

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
28120	Part removal of ankle/heel	Y		A2	20.632	$864.44
28122	Partial removal of foot bone	Y		A2	20.632	$864.44
28124	Partial removal of toe	Y		P3		$194.94
28126	Partial removal of toe	Y		A2	20.632	$864.44
28130	Removal of ankle bone	Y		A2	20.632	$864.44
28140	Removal of metatarsal	Y		A2	20.632	$864.44
28150	Removal of toe	Y		A2	20.632	$864.44
28153	Partial removal of toe	Y		A2	20.632	$864.44
28160	Partial removal of toe	Y		A2	20.632	$864.44
28171	Resect tarsal tumor	Y		A2	20.632	$864.44
28173	Resect metatarsal tumor	Y		A2	20.632	$864.44
28175	Resect phalanx of toe tumor	Y		A2	20.632	$864.44
28190	Removal of foot foreign body	Y		P3		$118.83
28192	Removal of foot foreign body	Y		A2	16.564	$694.00
28193	Removal of foot foreign body	Y		A2	7.9784	$334.28
28200	Repair of foot tendon	Y		A2	20.632	$864.44
28202	Repair/graft of foot tendon	Y		A2	20.632	$864.44
28208	Repair of foot tendon	Y		A2	20.632	$864.44
28210	Repair/graft of foot tendon	Y		A2	50.4554	$2,113.98
28220	Release of foot tendon	Y		P3		$183.65
28222	Release of foot tendons	Y		A2	20.632	$864.44
28225	Release of foot tendon	Y		A2	20.632	$864.44
28226	Release of foot tendons	Y		A2	20.632	$864.44
28230	Incision of foot tendon(s)	Y		P3		$179.72
28232	Incision of toe tendon	Y		P3		$172.85
28234	Incision of foot tendon	Y		A2	20.632	$864.44
28238	Revision of foot tendon	Y		A2	50.4554	$2,113.98
28240	Release of big toe	Y		A2	20.632	$864.44
28250	Revision of foot fascia	Y		A2	20.632	$864.44
28260	Release of midfoot joint	Y		A2	20.632	$864.44
28261	Revision of foot tendon	Y		A2	20.632	$864.44
28262	Revision of foot and ankle	Y		A2	20.632	$864.44
28264	Release of midfoot joint	Y		A2	50.4554	$2,113.98
28270	Release of foot contracture	Y		A2	20.632	$864.44
28272	Release of toe joint, each	Y		P3		$166.22
28280	Fusion of toes	Y		A2	20.632	$864.44
28285	Repair of hammertoe	Y		A2	20.632	$864.44
28286	Repair of hammertoe	Y		A2	20.632	$864.44
28288	Partial removal of foot bone	Y		A2	20.632	$864.44

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
28289	Repair hallux rigidus	Y		A2	20.632	$864.44
28290	Correction of bunion	Y		A2	30.3473	$1,271.49
28292	Correction of bunion	Y		A2	30.3473	$1,271.49
28293	Correction of bunion	Y		A2	30.3473	$1,271.49
28294	Correction of bunion	Y		A2	30.3473	$1,271.49
28296	Correction of bunion	Y		A2	30.3473	$1,271.49
28297	Correction of bunion	Y		A2	30.3473	$1,271.49
28298	Correction of bunion	Y		A2	30.3473	$1,271.49
28299	Correction of bunion	Y		A2	30.3473	$1,271.49
28300	Incision of heel bone	Y		A2	50.4554	$2,113.98
28302	Incision of ankle bone	Y		A2	20.632	$864.44
28304	Incision of midfoot bones	Y		A2	50.4554	$2,113.98
28305	Incise/graft midfoot bones	Y		A2	50.4554	$2,113.98
28306	Incision of metatarsal	Y		A2	20.632	$864.44
28307	Incision of metatarsal	Y		A2	20.632	$864.44
28308	Incision of metatarsal	Y		A2	20.632	$864.44
28309	Incision of metatarsals	Y		A2	50.4554	$2,113.98
28310	Revision of big toe	Y		A2	20.632	$864.44
28312	Revision of toe	Y		A2	20.632	$864.44
28313	Repair deformity of toe	Y		A2	20.632	$864.44
28315	Removal of sesamoid bone	Y		A2	20.632	$864.44
28320	Repair of foot bones	Y		A2	50.4554	$2,113.98
28322	Repair of metatarsals	Y		A2	50.4554	$2,113.98
28340	Resect enlarged toe tissue	Y		A2	20.632	$864.44
28341	Resect enlarged toe	Y		A2	20.632	$864.44
28344	Repair extra toe(s)	Y		A2	20.632	$864.44
28345	Repair webbed toe(s)	Y		A2	20.632	$864.44
28400	Treatment of heel fracture	Y		A2	1.4841	$62.17
28405	Treatment of heel fracture	Y		A2	19.0792	$799.38
28406	Treatment of heel fracture	Y		A2	24.2634	$1,016.59
28415	Treat heel fracture	Y		A2	60.5167	$2,535.53
28420	Treat/graft heel fracture	Y		A2	43.7071	$1,831.24
28430	Treatment of ankle fracture	Y		P2	1.4839	$62.17
28435	Treatment of ankle fracture	Y		A2	1.4841	$62.17
28436	Treatment of ankle fracture	Y		A2	24.2634	$1,016.59
28445	Treat ankle fracture	Y		A2	43.7071	$1,831.24
28446	Osteochondral talus autogrft	Y		G2	50.4553	$2,113.98
28450	Treat midfoot fracture, each	Y		P2	1.4839	$62.17
28455	Treat midfoot fracture, each	Y		P2	1.4839	$62.17

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
28456	Treat midfoot fracture	Y		A2	24.2634	$1,016.59
28465	Treat midfoot fracture, each	Y		A2	43.7071	$1,831.24
28470	Treat metatarsal fracture	Y		P2	1.4839	$62.17
28475	Treat metatarsal fracture	Y		P2	1.4839	$62.17
28476	Treat metatarsal fracture	Y		A2	24.2634	$1,016.59
28485	Treat metatarsal fracture	Y		A2	43.7071	$1,831.24
28490	Treat big toe fracture	Y		P2	1.4839	$62.17
28495	Treat big toe fracture	Y		P2	1.4839	$62.17
28496	Treat big toe fracture	Y		A2	24.2634	$1,016.59
28505	Treat big toe fracture	Y		A2	24.2634	$1,016.59
28510	Treatment of toe fracture	Y		P3		$50.82
28515	Treatment of toe fracture	Y		P2	1.4839	$62.17
28525	Treat toe fracture	Y		A2	24.2634	$1,016.59
28530	Treat sesamoid bone fracture	Y		P3		$49.10
28531	Treat sesamoid bone fracture	Y		A2	24.2634	$1,016.59
28540	Treat foot dislocation	Y		P2	1.4839	$62.17
28545	Treat foot dislocation	Y		A2	24.2634	$1,016.59
28546	Treat foot dislocation	Y		A2	24.2634	$1,016.59
28555	Repair foot dislocation	Y		A2	43.7071	$1,831.24
28570	Treat foot dislocation	Y		P3		$68.75
28575	Treat foot dislocation	Y		A2	19.0792	$799.38
28576	Treat foot dislocation	Y		A2	24.2634	$1,016.59
28585	Repair foot dislocation	Y		A2	24.2634	$1,016.59
28600	Treat foot dislocation	Y		P2	1.4839	$62.17
28605	Treat foot dislocation	Y		A2	1.4841	$62.17
28606	Treat foot dislocation	Y		A2	24.2634	$1,016.59
28615	Repair foot dislocation	Y		A2	43.7071	$1,831.24
28630	Treat toe dislocation	Y	CH	P3		$56.22
28635	Treat toe dislocation	Y		A2	14.1484	$592.79
28636	Treat toe dislocation	Y		A2	24.2634	$1,016.59
28645	Repair toe dislocation	Y		A2	24.2634	$1,016.59
28660	Treat toe dislocation	Y		P3		$41.00
28665	Treat toe dislocation	Y		A2	14.1484	$592.79
28666	Treat toe dislocation	Y		A2	24.2634	$1,016.59
28675	Repair of toe dislocation	Y		A2	24.2634	$1,016.59
28705	Fusion of foot bones	Y		A2	50.4554	$2,113.98
28715	Fusion of foot bones	Y		A2	80.4692	$3,371.49
28725	Fusion of foot bones	Y		A2	50.4554	$2,113.98
28730	Fusion of foot bones	Y		A2	50.4554	$2,113.98

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
28735	Fusion of foot bones	Y		A2	50.4554	$2,113.98
28737	Revision of foot bones	Y		A2	50.4554	$2,113.98
28740	Fusion of foot bones	Y		A2	50.4554	$2,113.98
28750	Fusion of big toe joint	Y		A2	50.4554	$2,113.98
28755	Fusion of big toe joint	Y		A2	20.632	$864.44
28760	Fusion of big toe joint	Y		A2	50.4554	$2,113.98
28810	Amputation toe & metatarsal	Y		A2	20.632	$864.44
28820	Amputation of toe	Y		A2	20.632	$864.44
28825	Partial amputation of toe	Y		A2	20.632	$864.44
28890	High energy eswt, plantar f	Y		P3		$146.08
29000	Application of body cast	N		G2	1.0371	$43.45
29010	Application of body cast	N		P2	2.2646	$94.88
29015	Application of body cast	N		P2	2.2646	$94.88
29020	Application of body cast	N		G2	1.0371	$43.45
29025	Application of body cast	N		P2	1.0371	$43.45
29035	Application of body cast	N		P2	2.2646	$94.88
29040	Application of body cast	N		G2	1.0371	$43.45
29044	Application of body cast	N		P2	2.2646	$94.88
29046	Application of body cast	N		G2	2.2646	$94.88
29049	Application of figure eight	N	CH	P3		$38.06
29055	Application of shoulder cast	N		P2	2.2646	$94.88
29058	Application of shoulder cast	N	CH	P3		$33.39
29065	Application of long arm cast	N		P3		$40.02
29075	Application of forearm cast	N		P3		$38.55
29085	Apply hand/wrist cast	N	CH	P3		$39.53
29086	Apply finger cast	N		P3		$33.88
29105	Apply long arm splint	N	CH	P3		$34.37
29125	Apply forearm splint	N		P3		$30.20
29126	Apply forearm splint	N		P3		$32.16
29130	Application of finger splint	N		P3		$13.75
29131	Application of finger splint	N		P3		$20.13
29200	Strapping of chest	N		P3		$19.64
29240	Strapping of shoulder	N		P3		$20.87
29260	Strapping of elbow or wrist	N		P3		$20.62
29280	Strapping of hand or finger	N		P3		$21.11
29305	Application of hip cast	N		P2	2.2646	$94.88
29325	Application of hip casts	N		P2	2.2646	$94.88
29345	Application of long leg cast	N		P3		$52.54
29355	Application of long leg cast	N		P3		$52.54

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
29358	Apply long leg cast brace	N		P3		$65.80
29365	Application of long leg cast	N		P3		$49.60
29405	Apply short leg cast	N		P3		$36.83
29425	Apply short leg cast	N		P3		$37.32
29435	Apply short leg cast	N		P3		$47.14
29440	Addition of walker to cast	N		P3		$17.68
29445	Apply rigid leg cast	N		P3		$48.86
29450	Application of leg cast	N		P2	1.0371	$43.45
29505	Application, long leg splint	N	CH	P3		$33.39
29515	Application lower leg splint	N		P3		$29.22
29520	Strapping of hip	N		P3		$20.13
29530	Strapping of knee	N		P3		$20.62
29540	Strapping of ankle and/or ft	N		P3		$15.71
29550	Strapping of toes	N		P3		$15.96
29580	Application of paste boot	N		P3		$21.36
29581	Apply multlay comprs lwr leg	N		P2	1.0371	$43.45
29590	Application of foot splint	N		P3		$17.19
29700	Removal/revision of cast	N		P3		$28.73
29705	Removal/revision of cast	N		P3		$24.55
29710	Removal/revision of cast	N		P3		$44.68
29715	Removal/revision of cast	N	CH	P3		$33.15
29720	Repair of body cast	N	CH	P3		$36.34
29730	Windowing of cast	N		P3		$23.57
29740	Wedging of cast	N		P3		$30.94
29750	Wedging of clubfoot cast	N	CH	P3		$33.64
29800	Jaw arthroscopy/surgery	Y		A2	27.5586	$1,154.65
29804	Jaw arthroscopy/surgery	Y		A2	27.5586	$1,154.65
29805	Shoulder arthroscopy, dx	Y		A2	27.5586	$1,154.65
29806	Shoulder arthroscopy/surgery	Y		A2	43.8195	$1,835.95
29807	Shoulder arthroscopy/surgery	Y		A2	43.8195	$1,835.95
29819	Shoulder arthroscopy/surgery	Y		A2	43.8195	$1,835.95
29820	Shoulder arthroscopy/surgery	Y		A2	43.8195	$1,835.95
29821	Shoulder arthroscopy/surgery	Y		A2	43.8195	$1,835.95
29822	Shoulder arthroscopy/surgery	Y		A2	27.5586	$1,154.65
29823	Shoulder arthroscopy/surgery	Y		A2	43.8195	$1,835.95
29824	Shoulder arthroscopy/surgery	Y		A2	27.5586	$1,154.65
29825	Shoulder arthroscopy/surgery	Y		A2	43.8195	$1,835.95
29826	Shoulder arthroscopy/surgery	Y		A2	43.8195	$1,835.95
29827	Arthroscop rotator cuff repr	Y		A2	43.8195	$1,835.95

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
29828	Arthroscopy biceps tenodesis	Y		G2	43.8195	$1,835.95
29830	Elbow arthroscopy	Y		A2	27.5586	$1,154.65
29834	Elbow arthroscopy/surgery	Y		A2	27.5586	$1,154.65
29835	Elbow arthroscopy/surgery	Y		A2	27.5586	$1,154.65
29836	Elbow arthroscopy/surgery	Y		A2	27.5586	$1,154.65
29837	Elbow arthroscopy/surgery	Y		A2	27.5586	$1,154.65
29838	Elbow arthroscopy/surgery	Y		A2	27.5586	$1,154.65
29840	Wrist arthroscopy	Y		A2	27.5586	$1,154.65
29843	Wrist arthroscopy/surgery	Y		A2	27.5586	$1,154.65
29844	Wrist arthroscopy/surgery	Y		A2	27.5586	$1,154.65
29845	Wrist arthroscopy/surgery	Y		A2	27.5586	$1,154.65
29846	Wrist arthroscopy/surgery	Y		A2	27.5586	$1,154.65
29847	Wrist arthroscopy/surgery	Y		A2	43.8195	$1,835.95
29848	Wrist endoscopy/surgery	Y		A2	27.5586	$1,154.65
29850	Knee arthroscopy/surgery	Y		A2	27.5586	$1,154.65
29851	Knee arthroscopy/surgery	Y		A2	43.8195	$1,835.95
29855	Tibial arthroscopy/surgery	Y		A2	43.8195	$1,835.95
29856	Tibial arthroscopy/surgery	Y		A2	43.8195	$1,835.95
29860	Hip arthroscopy, dx	Y		A2	43.8195	$1,835.95
29861	Hip arthroscopy/surgery	Y		A2	43.8195	$1,835.95
29862	Hip arthroscopy/surgery	Y		A2	43.8195	$1,835.95
29863	Hip arthroscopy/surgery	Y		A2	43.8195	$1,835.95
29866	Autgrft implnt, knee w/scope	Y		G2	43.8195	$1,835.95
29870	Knee arthroscopy, dx	Y		A2	27.5586	$1,154.65
29871	Knee arthroscopy/drainage	Y		A2	27.5586	$1,154.65
29873	Knee arthroscopy/surgery	Y		A2	27.5586	$1,154.65
29874	Knee arthroscopy/surgery	Y		A2	27.5586	$1,154.65
29875	Knee arthroscopy/surgery	Y		A2	27.5586	$1,154.65
29876	Knee arthroscopy/surgery	Y		A2	27.5586	$1,154.65
29877	Knee arthroscopy/surgery	Y		A2	27.5586	$1,154.65
29879	Knee arthroscopy/surgery	Y		A2	27.5586	$1,154.65
29880	Knee arthroscopy/surgery	Y		A2	27.5586	$1,154.65
29881	Knee arthroscopy/surgery	Y		A2	27.5586	$1,154.65
29882	Knee arthroscopy/surgery	Y		A2	27.5586	$1,154.65
29883	Knee arthroscopy/surgery	Y		A2	27.5586	$1,154.65
29884	Knee arthroscopy/surgery	Y		A2	27.5586	$1,154.65
29885	Knee arthroscopy/surgery	Y		A2	43.8195	$1,835.95
29886	Knee arthroscopy/surgery	Y		A2	27.5586	$1,154.65
29887	Knee arthroscopy/surgery	Y		A2	27.5586	$1,154.65

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
29888	Knee arthroscopy/surgery	Y		A2	80.4692	$3,371.49
29889	Knee arthroscopy/surgery	Y		A2	80.4692	$3,371.49
29891	Ankle arthroscopy/surgery	Y		A2	43.8195	$1,835.95
29892	Ankle arthroscopy/surgery	Y		A2	80.4692	$3,371.49
29893	Scope, plantar fasciotomy	Y		A2	20.632	$864.44
29894	Ankle arthroscopy/surgery	Y		A2	27.5586	$1,154.65
29895	Ankle arthroscopy/surgery	Y		A2	27.5586	$1,154.65
29897	Ankle arthroscopy/surgery	Y		A2	27.5586	$1,154.65
29898	Ankle arthroscopy/surgery	Y		A2	27.5586	$1,154.65
29899	Ankle arthroscopy/surgery	Y		A2	43.8195	$1,835.95
29900	Mcp joint arthroscopy, dx	Y		A2	27.5586	$1,154.65
29901	Mcp joint arthroscopy, surg	Y		A2	27.5586	$1,154.65
29902	Mcp joint arthroscopy, surg	Y		A2	27.5586	$1,154.65
29904	Subtalar arthro w/fb rmvl	Y		G2	27.5586	$1,154.65
29905	Subtalar arthro w/exc	Y		G2	27.5586	$1,154.65
29906	Subtalar arthro w/deb	Y		G2	27.5586	$1,154.65
29907	Subtalar arthro w/fusion	Y		G2	43.8195	$1,835.95
30000	Drainage of nose lesion	Y	CH	P3		$121.29
30020	Drainage of nose lesion	Y	CH	P3		$120.06
30100	Intranasal biopsy	Y		P3		$73.41
30110	Removal of nose polyp(s)	Y		P3		$114.66
30115	Removal of nose polyp(s)	Y		A2	15.8303	$663.26
30117	Removal of intranasal lesion	Y		A2	15.8303	$663.26
30118	Removal of intranasal lesion	Y		A2	23.2154	$972.69
30120	Revision of nose	Y		A2	23.2154	$972.69
30124	Removal of nose lesion	Y		R2	7.1577	$299.89
30125	Removal of nose lesion	Y		A2	40.7633	$1,707.90
30130	Excise inferior turbinate	Y		A2	15.8303	$663.26
30140	Resect inferior turbinate	Y		A2	23.2154	$972.69
30150	Partial removal of nose	Y		A2	40.7633	$1,707.90
30160	Removal of nose	Y		A2	40.7633	$1,707.90
30200	Injection treatment of nose	Y		P3		$58.19
30210	Nasal sinus therapy	Y		P3		$74.15
30220	Insert nasal septal button	Y		A2	7.1579	$299.89
30300	Remove nasal foreign body	N		P2	0.6271	$26.27
30310	Remove nasal foreign body	Y		A2	15.8303	$663.26
30320	Remove nasal foreign body	Y		A2	15.8303	$663.26
30400	Reconstruction of nose	Y		A2	40.7633	$1,707.90
30410	Reconstruction of nose	Y		A2	40.7633	$1,707.90

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
30420	Reconstruction of nose	Y		A2	40.7633	$1,707.90
30430	Revision of nose	Y		A2	23.2154	$972.69
30435	Revision of nose	Y		A2	40.7633	$1,707.90
30450	Revision of nose	Y		A2	40.7633	$1,707.90
30460	Revision of nose	Y		A2	40.7633	$1,707.90
30462	Revision of nose	Y		A2	40.7633	$1,707.90
30465	Repair nasal stenosis	Y		A2	40.7633	$1,707.90
30520	Repair of nasal septum	Y		A2	23.2154	$972.69
30540	Repair nasal defect	Y		A2	40.7633	$1,707.90
30545	Repair nasal defect	Y		A2	40.7633	$1,707.90
30560	Release of nasal adhesions	Y		A2	3.1243	$130.89
30580	Repair upper jaw fistula	Y		A2	40.7633	$1,707.90
30600	Repair mouth/nose fistula	Y		A2	40.7633	$1,707.90
30620	Intranasal reconstruction	Y		A2	40.7633	$1,707.90
30630	Repair nasal septum defect	Y		A2	23.2154	$972.69
30801	Ablate inf turbinate, superf	Y		A2	7.1579	$299.89
30802	Ablate inf turbinate submuc	Y		A2	15.8303	$663.26
30901	Control of nosebleed	Y	CH	P3		$39.77
30903	Control of nosebleed	Y		A2	1.0674	$44.72
30905	Control of nosebleed	Y		A2	1.0674	$44.72
30906	Repeat control of nosebleed	Y		A2	1.0674	$44.72
30915	Ligation, nasal sinus artery	Y		A2	25.0391	$1,049.08
30920	Ligation, upper jaw artery	Y		A2	25.0391	$1,049.08
30930	Ther fx, nasal inf turbinate	Y		A2	15.8303	$663.26
31000	Irrigation, maxillary sinus	Y		P3		$94.03
31002	Irrigation, sphenoid sinus	Y		R2	7.1577	$299.89
31020	Exploration, maxillary sinus	Y		A2	23.2154	$972.69
31030	Exploration, maxillary sinus	Y		A2	40.7633	$1,707.90
31032	Explore sinus, remove polyps	Y		A2	40.7633	$1,707.90
31040	Exploration behind upper jaw	Y		R2	23.2156	$972.69
31050	Exploration, sphenoid sinus	Y		A2	40.7633	$1,707.90
31051	Sphenoid sinus surgery	Y		A2	40.7633	$1,707.90
31070	Exploration of frontal sinus	Y		A2	23.2154	$972.69
31075	Exploration of frontal sinus	Y		A2	40.7633	$1,707.90
31080	Removal of frontal sinus	Y		A2	40.7633	$1,707.90
31081	Removal of frontal sinus	Y		A2	40.7633	$1,707.90
31084	Removal of frontal sinus	Y		A2	40.7633	$1,707.90
31085	Removal of frontal sinus	Y		A2	40.7633	$1,707.90
31086	Removal of frontal sinus	Y		A2	40.7633	$1,707.90

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31087	Removal of frontal sinus	Y		A2	40.7633	$1,707.90
31090	Exploration of sinuses	Y		A2	40.7633	$1,707.90
31200	Removal of ethmoid sinus	Y		A2	40.7633	$1,707.90
31201	Removal of ethmoid sinus	Y		A2	40.7633	$1,707.90
31205	Removal of ethmoid sinus	Y		A2	40.7633	$1,707.90
31231	Nasal endoscopy, dx	Y		P2	1.7069	$71.52
31233	Nasal/sinus endoscopy, dx	Y		A2	1.707	$71.52
31235	Nasal/sinus endoscopy, dx	Y		A2	19.9943	$837.72
31237	Nasal/sinus endoscopy, surg	Y		A2	19.9943	$837.72
31238	Nasal/sinus endoscopy, surg	Y		A2	19.9943	$837.72
31239	Nasal/sinus endoscopy, surg	Y		A2	28.5579	$1,196.52
31240	Nasal/sinus endoscopy, surg	Y		A2	19.9943	$837.72
31254	Revision of ethmoid sinus	Y		A2	28.5579	$1,196.52
31255	Removal of ethmoid sinus	Y		A2	28.5579	$1,196.52
31256	Exploration maxillary sinus	Y		A2	28.5579	$1,196.52
31267	Endoscopy, maxillary sinus	Y		A2	28.5579	$1,196.52
31276	Sinus endoscopy, surgical	Y		A2	28.5579	$1,196.52
31287	Nasal/sinus endoscopy, surg	Y		A2	28.5579	$1,196.52
31288	Nasal/sinus endoscopy, surg	Y		A2	28.5579	$1,196.52
31300	Removal of larynx lesion	Y		A2	23.2154	$972.69
31320	Diagnostic incision, larynx	Y		A2	40.7633	$1,707.90
31400	Revision of larynx	Y		A2	40.7633	$1,707.90
31420	Removal of epiglottis	Y		A2	40.7633	$1,707.90
31500	Insert emergency airway	N		G2	2.2071	$92.47
31502	Change of windpipe airway	N		G2	1.2941	$54.22
31505	Diagnostic laryngoscopy	Y		P2	0.8386	$35.14
31510	Laryngoscopy with biopsy	Y		A2	19.9943	$837.72
31511	Remove foreign body, larynx	Y		A2	1.707	$71.52
31512	Removal of larynx lesion	Y		A2	19.9943	$837.72
31513	Injection into vocal cord	Y		A2	1.707	$71.52
31515	Laryngoscopy for aspiration	Y		A2	19.9943	$837.72
31520	Dx laryngoscopy, newborn	Y		G2	1.7069	$71.52
31525	Dx laryngoscopy excl nb	Y		A2	19.9943	$837.72
31526	Dx laryngoscopy w/oper scope	Y		A2	19.9943	$837.72
31527	Laryngoscopy for treatment	Y		A2	28.5579	$1,196.52
31528	Laryngoscopy and dilation	Y		A2	19.9943	$837.72
31529	Laryngoscopy and dilation	Y		A2	19.9943	$837.72
31530	Laryngoscopy w/fb removal	Y		A2	19.9943	$837.72
31531	Laryngoscopy w/fb & op scope	Y		A2	19.9943	$837.72

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
31535	Laryngoscopy w/biopsy	Y		A2	19.9943	$837.72
31536	Laryngoscopy w/bx & op scope	Y		A2	19.9943	$837.72
31540	Laryngoscopy w/exc of tumor	Y		A2	19.9943	$837.72
31541	Larynscop w/tumr exc + scope	Y		A2	19.9943	$837.72
31545	Remove vc lesion w/scope	Y		A2	28.5579	$1,196.52
31546	Remove vc lesion scope/graft	Y		A2	28.5579	$1,196.52
31560	Laryngoscop w/arytenoidectom	Y		A2	28.5579	$1,196.52
31561	Larynscop, remve cart + scop	Y		A2	28.5579	$1,196.52
31570	Laryngoscope w/vc inj	Y		A2	19.9943	$837.72
31571	Laryngoscop w/vc inj + scope	Y		A2	28.5579	$1,196.52
31575	Diagnostic laryngoscopy	Y		P3		$52.30
31576	Laryngoscopy with biopsy	Y		A2	19.9943	$837.72
31577	Remove foreign body, larynx	Y		A2	3.6737	$153.92
31578	Removal of larynx lesion	Y		A2	28.5579	$1,196.52
31579	Diagnostic laryngoscopy	Y		P3		$91.82
31580	Revision of larynx	Y		A2	40.7633	$1,707.90
31582	Revision of larynx	Y		A2	40.7633	$1,707.90
31588	Revision of larynx	Y		A2	40.7633	$1,707.90
31590	Reinnervate larynx	Y		A2	40.7633	$1,707.90
31595	Larynx nerve surgery	Y		A2	40.7633	$1,707.90
31603	Incision of windpipe	Y		A2	7.1579	$299.89
31605	Incision of windpipe	Y		G2	7.1577	$299.89
31611	Surgery/speech prosthesis	Y		A2	23.2154	$972.69
31612	Puncture/clear windpipe	Y		A2	23.2154	$972.69
31613	Repair windpipe opening	Y		A2	23.2154	$972.69
31614	Repair windpipe opening	Y		A2	40.7633	$1,707.90
31615	Visualization of windpipe	Y		A2	7.1579	$299.89
31620	Endobronchial us add-on	N		N1		
31622	Dx bronchoscope/wash	Y		A2	9.5849	$401.59
31623	Dx bronchoscope/brush	Y		A2	9.5849	$401.59
31624	Dx bronchoscope/lavage	Y		A2	9.5849	$401.59
31625	Bronchoscopy w/biopsy(s)	Y		A2	9.5849	$401.59
31626	Bronchoscopy w/markers	Y		G2	9.585	$401.59
31627	Navigational bronchoscopy	N		N1		
31628	Bronchoscopy/lung bx, each	Y		A2	9.5849	$401.59
31629	Bronchoscopy/needle bx, each	Y		A2	9.5849	$401.59
31630	Bronchoscopy dilate/fx repr	Y		A2	25.923	$1,086.12
31631	Bronchoscopy, dilate w/stent	Y		A2	25.923	$1,086.12
31632	Bronchoscopy/lung bx, addl	Y		G2	9.585	$401.59

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31633	Bronchoscopy/needle bx addl	Y		G2	9.585	$401.59
31635	Bronchoscopy w/fb removal	Y		A2	9.5849	$401.59
31636	Bronchoscopy, bronch stents	Y		A2	25.923	$1,086.12
31637	Bronchoscopy, stent add-on	Y		A2	9.5849	$401.59
31638	Bronchoscopy, revise stent	Y		A2	25.923	$1,086.12
31640	Bronchoscopy w/tumor excise	Y		A2	25.923	$1,086.12
31641	Bronchoscopy, treat blockage	Y		A2	25.923	$1,086.12
31643	Diag bronchoscope/catheter	Y		A2	9.5849	$401.59
31645	Bronchoscopy, clear airways	Y		A2	9.5849	$401.59
31646	Bronchoscopy, reclear airway	Y		A2	9.5849	$401.59
31656	Bronchoscopy, inj for x-ray	Y		A2	9.5849	$401.59
31715	Injection for bronchus x-ray	N		N1		
31717	Bronchial brush biopsy	Y		A2	3.6737	$153.92
31720	Clearance of airways	N		A2	0.38	$15.92
31730	Intro, windpipe wire/tube	Y		A2	3.6737	$153.92
31750	Repair of windpipe	Y		A2	40.7633	$1,707.90
31755	Repair of windpipe	Y		A2	40.7633	$1,707.90
31820	Closure of windpipe lesion	Y		A2	23.2154	$972.69
31825	Repair of windpipe defect	Y		A2	23.2154	$972.69
31830	Revise windpipe scar	Y		A2	23.2154	$972.69
32400	Needle biopsy chest lining	Y		A2	9.0033	$377.22
32405	Biopsy, lung or mediastinum	Y		A2	9.0033	$377.22
32420	Puncture/clear lung	Y		A2	5.1351	$215.15
32421	Thoracentesis for aspiration	Y		A2	5.1351	$215.15
32422	Thoracentesis w/tube insert	Y		G2	5.135	$215.15
32550	Insert pleural cath	Y		G2	28.2959	$1,185.54
32552	Remove lung catheter	N		G2	1.2941	$54.22
32553	Ins mark thor for rt perq	N		G2	12.3307	$516.63
32960	Therapeutic pneumothorax	Y		G2	5.135	$215.15
32998	Perq rf ablate tx, pul tumor	Y		G2	52.0029	$2,178.82
33010	Drainage of heart sac	Y		A2	5.1351	$215.15
33011	Repeat drainage of heart sac	Y		A2	5.1351	$215.15
33206	Insertion of heart pacemaker	Y		J8	159.0066	$6,662.06
33207	Insertion of heart pacemaker	Y		J8	159.0066	$6,662.06
33208	Insertion of heart pacemaker	Y		J8	198.3627	$8,311.00
33210	Insertion of heart electrode	Y		G2	47.8299	$2,003.98
33211	Insertion of heart electrode	Y		G2	47.8299	$2,003.98
33212	Insertion of pulse generator	Y		H8	132.1295	$5,535.96
33213	Insertion of pulse generator	Y		H8	155.3449	$6,508.64

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33214	Upgrade of pacemaker system	Y		J8	198.3627	$8,311.00
33215	Reposition pacing-defib lead	Y		G2	21.1143	$884.65
33216	Insert 1 electrode pm-defib	Y		G2	47.8299	$2,003.98
33217	Insert 2 electrode pm-defib	Y		G2	47.8299	$2,003.98
33218	Repair lead pace-defib, one	Y		G2	21.1143	$884.65
33220	Repair lead pace-defib, dual	Y		G2	21.1143	$884.65
33222	Revise pocket, pacemaker	Y		A2	15.5759	$652.60
33223	Revise pocket for defib	Y		A2	15.5759	$652.60
33224	Insert pacing lead & connect	Y		J8	204.4024	$8,564.05
33225	L ventric pacing lead add-on	Y		J8	204.4024	$8,564.05
33226	Reposition l ventric lead	Y		G2	21.1143	$884.65
33233	Removal of pacemaker system	Y		A2	21.1144	$884.65
33234	Removal of pacemaker system	Y		G2	21.1143	$884.65
33235	Removal pacemaker electrode	Y		G2	21.1143	$884.65
33240	Insert pulse generator	Y		J8	517.5292	$21,683.44
33241	Remove pulse generator	Y		G2	21.1143	$884.65
33249	Eltrd/insert pace-defib	Y		J8	600.0685	$25,141.67
33282	Implant pat-active ht record	N		J8	111.6435	$4,677.64
33284	Remove pat-active ht record	Y		G2	7.9785	$334.28
33508	Endoscopic vein harvest	N		N1		
34490	Removal of vein clot	Y		G2	38.0067	$1,592.40
35188	Repair blood vessel lesion	Y		A2	38.0066	$1,592.40
35207	Repair blood vessel lesion	Y		A2	38.0066	$1,592.40
35460	Repair venous blockage	Y		G2	47.445	$1,987.85
35473	Repair arterial blockage	Y		G2	47.445	$1,987.85
35475	Repair arterial blockage	Y		G2	47.445	$1,987.85
35476	Repair venous blockage	Y		G2	47.445	$1,987.85
35492	Atherectomy, percutaneous	Y		G2	88.9846	$3,728.28
35572	Harvest femoropopliteal vein	N		N1		
35761	Exploration of artery/vein	Y		G2	33.2027	$1,391.13
35875	Removal of clot in graft	Y		A2	38.0066	$1,592.40
35876	Removal of clot in graft	Y		A2	38.0066	$1,592.40
36000	Place needle in vein	N		N1		
36002	Pseudoaneurysm injection trt	N		G2	2.0678	$86.64
36005	Injection ext venography	N		N1		
36010	Place catheter in vein	N		N1		
36011	Place catheter in vein	N		N1		
36012	Place catheter in vein	N		N1		
36013	Place catheter in artery	N		N1		

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36014	Place catheter in artery	N		N1		
36015	Place catheter in artery	N		N1		
36100	Establish access to artery	N		N1		
36120	Establish access to artery	N		N1		
36140	Establish access to artery	N		N1		
36147	Access av dial grft for eval	Y		P2	2.1674	$90.81
36148	Access av dial grft for proc	N		N1		
36160	Establish access to aorta	N		N1		
36200	Place catheter in aorta	N		N1		
36215	Place catheter in artery	N		N1		
36216	Place catheter in artery	N		N1		
36217	Place catheter in artery	N		N1		
36218	Place catheter in artery	N		N1		
36245	Place catheter in artery	N		N1		
36246	Place catheter in artery	N		N1		
36247	Place catheter in artery	N		N1		
36248	Place catheter in artery	N		N1		
36260	Insertion of infusion pump	Y		A2	28.0512	$1,175.29
36261	Revision of infusion pump	Y		A2	21.1144	$884.65
36262	Removal of infusion pump	Y		A2	21.1144	$884.65
36400	Bl draw < 3 yrs fem/jugular	N		N1		
36405	Bl draw < 3 yrs scalp vein	N		N1		
36406	Bl draw < 3 yrs other vein	N		N1		
36410	Non-routine bl draw > 3 yrs	N		N1		
36416	Capillary blood draw	N		N1		
36420	Vein access cutdown < 1 yr	N		R2	0.2223	$9.31
36425	Vein access cutdown > 1 yr	N		R2	0.2223	$9.31
36430	Blood transfusion service	N		P3		$24.55
36440	Bl push transfuse, 2 yr or <	N		R2	3.1003	$129.90
36450	Bl exchange/transfuse, nb	N		R2	3.1003	$129.90
36455	Bl exchange/transfuse non-nb	N		G2	3.1003	$129.90
36468	Injection(s), spider veins	Y		R2	0.7983	$33.45
36469	Injection(s), spider veins	Y		R2	0.7983	$33.45
36470	Injection therapy of vein	Y		P2	0.7983	$33.45
36471	Injection therapy of veins	Y		P2	0.7983	$33.45
36475	Endovenous rf, 1st vein	Y		A2	40.3828	$1,691.95
36476	Endovenous rf, vein add-on	Y		A2	25.0391	$1,049.08
36478	Endovenous laser, 1st vein	Y		A2	25.0391	$1,049.08
36479	Endovenous laser vein addon	Y		A2	25.0391	$1,049.08

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36481	Insertion of catheter, vein	N		N1		
36500	Insertion of catheter, vein	N		N1		
36510	Insertion of catheter, vein	N		N1		
36511	Apheresis wbc	N		G2	11.385	$477.01
36512	Apheresis rbc	N		G2	11.385	$477.01
36513	Apheresis platelets	N		G2	11.385	$477.01
36514	Apheresis plasma	N		G2	11.385	$477.01
36515	Apheresis, adsorp/reinfuse	N		P2	30.8064	$1,290.73
36516	Apheresis, selective	N		P2	30.8064	$1,290.73
36522	Photopheresis	N		G2	30.8064	$1,290.73
36555	Insert non-tunnel cv cath	Y		A2	10.3678	$434.39
36556	Insert non-tunnel cv cath	Y		A2	10.3678	$434.39
36557	Insert tunneled cv cath	Y		A2	23.3551	$978.52
36558	Insert tunneled cv cath	Y		A2	23.3551	$978.52
36560	Insert tunneled cv cath	Y		A2	28.0512	$1,175.29
36561	Insert tunneled cv cath	Y		A2	28.0512	$1,175.29
36563	Insert tunneled cv cath	Y		A2	28.0512	$1,175.29
36565	Insert tunneled cv cath	Y		A2	28.0512	$1,175.29
36566	Insert tunneled cv cath	Y		A2	28.0512	$1,175.29
36568	Insert picc cath	Y		A2	10.3678	$434.39
36569	Insert picc cath	Y		A2	10.3678	$434.39
36570	Insert picvad cath	Y		A2	23.3551	$978.52
36571	Insert picvad cath	Y		A2	23.3551	$978.52
36575	Repair tunneled cv cath	Y		A2	5.7506	$240.94
36576	Repair tunneled cv cath	Y		A2	10.3678	$434.39
36578	Replace tunneled cv cath	Y		A2	23.3551	$978.52
36580	Replace cvad cath	Y		A2	10.3678	$434.39
36581	Replace tunneled cv cath	Y		A2	23.3551	$978.52
36582	Replace tunneled cv cath	Y		A2	28.0512	$1,175.29
36583	Replace tunneled cv cath	Y		A2	28.0512	$1,175.29
36584	Replace picc cath	Y		A2	10.3678	$434.39
36585	Replace picvad cath	Y		A2	23.3551	$978.52
36589	Removal tunneled cv cath	Y		A2	5.7506	$240.94
36590	Removal tunneled cv cath	Y		A2	10.3678	$434.39
36591	Draw blood off venous device	N		N1		
36592	Collect blood from picc	N		N1		
36593	Declot vascular device	Y		P3		$20.13
36595	Mech remov tunneled cv cath	Y		G2	23.3549	$978.52
36596	Mech remov tunneled cv cath	Y		G2	10.3679	$434.39

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36597	Reposition venous catheter	Y		G2	10.3679	$434.39
36598	Inj w/fluor, eval cv device	Y		P3		$60.89
36600	Withdrawal of arterial blood	N		N1		
36620	Insertion catheter, artery	N		N1		
36625	Insertion catheter, artery	N		N1		
36640	Insertion catheter, artery	Y		A2	28.0512	$1,175.29
36680	Insert needle, bone cavity	Y		G2	1.6137	$67.61
36800	Insertion of cannula	Y		A2	30.2764	$1,268.52
36810	Insertion of cannula	Y		A2	30.2764	$1,268.52
36815	Insertion of cannula	Y		A2	30.2764	$1,268.52
36818	Av fuse, uppr arm, cephalic	Y		A2	38.0066	$1,592.40
36819	Av fuse, uppr arm, basilic	Y		A2	38.0066	$1,592.40
36820	Av fusion/forearm vein	Y		A2	38.0066	$1,592.40
36821	Av fusion direct any site	Y		A2	38.0066	$1,592.40
36825	Artery-vein autograft	Y		A2	38.0066	$1,592.40
36830	Artery-vein nonautograft	Y		A2	38.0066	$1,592.40
36831	Open thrombect av fistula	Y		A2	38.0066	$1,592.40
36832	Av fistula revision, open	Y		A2	38.0066	$1,592.40
36833	Av fistula revision	Y		A2	38.0066	$1,592.40
36835	Artery to vein shunt	Y		A2	30.2764	$1,268.52
36860	External cannula declotting	Y		A2	2.1674	$90.81
36861	Cannula declotting	Y		A2	30.2764	$1,268.52
36870	Percut thrombect av fistula	Y		A2	40.6721	$1,704.08
37184	Prim art mech thrombectomy	Y		G2	38.0067	$1,592.40
37185	Prim art m-thrombect add-on	Y		G2	38.0067	$1,592.40
37186	Sec art m-thrombect add-on	Y		G2	38.0067	$1,592.40
37187	Venous mech thrombectomy	Y		G2	38.0067	$1,592.40
37188	Venous m-thrombectomy add-on	Y		G2	38.0067	$1,592.40
37200	Transcatheter biopsy	Y		G2	28.0512	$1,175.29
37203	Transcatheter retrieval	Y		G2	28.0512	$1,175.29
37204	Transcatheter occlusion	Y	CH	G2	88.9846	$3,728.28
37205	Transcath iv stent, percut	Y	CH	P3		$2,856.13
37206	Transcath iv stent/perc addl	Y	CH	P3		$1,743.93
37210	Embolization uterine fibroid	Y	CH	P3		$2,266.64
37250	Iv us first vessel add-on	N		N1		
37251	Iv us each add vessel add-on	N		N1		
37500	Endoscopy ligate perf veins	Y		A2	40.3828	$1,691.95
37607	Ligation of a-v fistula	Y		A2	25.0391	$1,049.08
37609	Temporal artery procedure	Y		A2	16.564	$694.00

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37650	Revision of major vein	Y		A2	25.0391	$1,049.08
37700	Revise leg vein	Y		A2	25.0391	$1,049.08
37718	Ligate/strip short leg vein	Y		A2	25.0391	$1,049.08
37722	Ligate/strip long leg vein	Y		A2	40.3828	$1,691.95
37735	Removal of leg veins/lesion	Y		A2	40.3828	$1,691.95
37760	Ligate leg veins radical	Y		A2	25.0391	$1,049.08
37761*	Ligate leg veins open	Y		R2	25.039	$1,049.08
37765	Phleb veins - extrem - to 20	Y	CH	P3		$186.84
37766	Phleb veins - extrem 20+	Y	CH	P3		$212.62
37780	Revision of leg vein	Y		A2	25.0391	$1,049.08
37785	Ligate/divide/excise vein	Y		A2	25.0391	$1,049.08
37790	Penile venous occlusion	Y		A2	33.1047	$1,387.01
38200	Injection for spleen x-ray	N		N1		
38204	BI donor search management	N		N1		
38206	Harvest auto stem cells	N		G2	11.385	$477.01
38220	Bone marrow aspiration	Y		P3		$78.57
38221	Bone marrow biopsy	Y		P3		$80.78
38230	Bone marrow collection	N		G2	30.8064	$1,290.73
38241	Bone marrow/stem transplant	N		G2	30.8064	$1,290.73
38242	Lymphocyte infuse transplant	N		R2	11.385	$477.01
38300	Drainage, lymph node lesion	Y		A2	12.1142	$507.56
38305	Drainage, lymph node lesion	Y		A2	18.4054	$771.15
38308	Incision of lymph channels	Y		A2	22.992	$963.33
38500	Biopsy/removal, lymph nodes	Y		A2	22.992	$963.33
38505	Needle biopsy, lymph nodes	Y		A2	7.4175	$310.77
38510	Biopsy/removal, lymph nodes	Y		A2	22.992	$963.33
38520	Biopsy/removal, lymph nodes	Y		A2	22.992	$963.33
38525	Biopsy/removal, lymph nodes	Y		A2	22.992	$963.33
38530	Biopsy/removal, lymph nodes	Y		A2	22.992	$963.33
38542	Explore deep node(s), neck	Y		A2	46.3447	$1,941.75
38550	Removal, neck/armpit lesion	Y		A2	22.992	$963.33
38555	Removal, neck/armpit lesion	Y		A2	22.992	$963.33
38570	Laparoscopy, lymph node biop	Y		A2	43.6665	$1,829.55
38571	Laparoscopy, lymphadenectomy	Y		A2	64.6377	$2,708.19
38572	Laparoscopy, lymphadenectomy	Y		A2	43.6665	$1,829.55
38700	Removal of lymph nodes, neck	Y		G2	22.9922	$963.33
38740	Remove armpit lymph nodes	Y		A2	46.3447	$1,941.75
38745	Remove armpit lymph nodes	Y		A2	46.3447	$1,941.75
38760	Remove groin lymph nodes	Y		A2	22.992	$963.33

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38790	Inject for lymphatic x-ray	N		N1		
38792	Identify sentinel node	N		N1		
38794	Access thoracic lymph duct	N		N1		
40490	Biopsy of lip	Y		P3		$57.70
40500	Partial excision of lip	Y		A2	15.8303	$663.26
40510	Partial excision of lip	Y		A2	23.2154	$972.69
40520	Partial excision of lip	Y		A2	15.8303	$663.26
40525	Reconstruct lip with flap	Y		A2	23.2154	$972.69
40527	Reconstruct lip with flap	Y		A2	23.2154	$972.69
40530	Partial removal of lip	Y		A2	23.2154	$972.69
40650	Repair lip	Y		A2	7.1579	$299.89
40652	Repair lip	Y		A2	7.1579	$299.89
40654	Repair lip	Y		A2	7.1579	$299.89
40700	Repair cleft lip/nasal	Y		A2	40.7633	$1,707.90
40701	Repair cleft lip/nasal	Y		A2	40.7633	$1,707.90
40702	Repair cleft lip/nasal	Y		R2	40.7633	$1,707.90
40720	Repair cleft lip/nasal	Y		A2	40.7633	$1,707.90
40761	Repair cleft lip/nasal	Y		A2	40.7633	$1,707.90
40800	Drainage of mouth lesion	Y		P2	1.358	$56.90
40801	Drainage of mouth lesion	Y		A2	7.1579	$299.89
40804	Removal, foreign body, mouth	N		P2	0.6271	$26.27
40805	Removal, foreign body, mouth	Y		P3		$150.75
40806	Incision of lip fold	Y		P3		$65.80
40808	Biopsy of mouth lesion	Y		P3		$102.14
40810	Excision of mouth lesion	Y		P3		$106.56
40812	Excise/repair mouth lesion	Y		P3		$135.28
40814	Excise/repair mouth lesion	Y		A2	15.8303	$663.26
40816	Excision of mouth lesion	Y		A2	23.2154	$972.69
40818	Excise oral mucosa for graft	Y		A2	3.1243	$130.89
40819	Excise lip or cheek fold	Y		A2	7.1579	$299.89
40820	Treatment of mouth lesion	Y		P3		$149.52
40830	Repair mouth laceration	Y		G2	3.1241	$130.89
40831	Repair mouth laceration	Y		A2	7.1579	$299.89
40840	Reconstruction of mouth	Y		A2	23.2154	$972.69
40842	Reconstruction of mouth	Y		A2	23.2154	$972.69
40843	Reconstruction of mouth	Y		A2	23.2154	$972.69
40844	Reconstruction of mouth	Y		A2	40.7633	$1,707.90
40845	Reconstruction of mouth	Y		A2	40.7633	$1,707.90
41000	Drainage of mouth lesion	Y		P3		$76.36

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
41005	Drainage of mouth lesion	Y		A2	3.1243	$130.89
41006	Drainage of mouth lesion	Y		A2	23.2154	$972.69
41007	Drainage of mouth lesion	Y		A2	15.8303	$663.26
41008	Drainage of mouth lesion	Y		A2	15.8303	$663.26
41009	Drainage of mouth lesion	Y		A2	3.1243	$130.89
41010	Incision of tongue fold	Y		A2	7.1579	$299.89
41015	Drainage of mouth lesion	Y		A2	3.1243	$130.89
41016	Drainage of mouth lesion	Y		A2	7.1579	$299.89
41017	Drainage of mouth lesion	Y		A2	7.1579	$299.89
41018	Drainage of mouth lesion	Y		A2	7.1579	$299.89
41019	Place needles h&n for rt	Y		G2	23.2156	$972.69
41100	Biopsy of tongue	Y		P3		$80.04
41105	Biopsy of tongue	Y		P3		$79.79
41108	Biopsy of floor of mouth	Y		P3		$73.90
41110	Excision of tongue lesion	Y		P3		$106.80
41112	Excision of tongue lesion	Y		A2	15.8303	$663.26
41113	Excision of tongue lesion	Y		A2	15.8303	$663.26
41114	Excision of tongue lesion	Y		A2	23.2154	$972.69
41115	Excision of tongue fold	Y		P3		$123.01
41116	Excision of mouth lesion	Y		A2	15.8303	$663.26
41120	Partial removal of tongue	Y		A2	23.2154	$972.69
41250	Repair tongue laceration	Y		A2	1.0674	$44.72
41251	Repair tongue laceration	Y		A2	3.1243	$130.89
41252	Repair tongue laceration	Y		A2	7.1579	$299.89
41500	Fixation of tongue	Y		A2	23.2154	$972.69
41510	Tongue to lip surgery	Y		A2	15.8303	$663.26
41512	Tongue suspension	Y		G2	7.1577	$299.89
41520	Reconstruction, tongue fold	Y		A2	7.1579	$299.89
41530	Tongue base vol reduction	Y		G2	23.2156	$972.69
41800	Drainage of gum lesion	Y		A2	1.3578	$56.90
41805	Removal foreign body, gum	Y		P3		$132.34
41806	Removal foreign body,jawbone	Y		P3		$171.13
41820	Excision, gum, each quadrant	Y		R2	7.1577	$299.89
41821	Excision of gum flap	Y		G2	7.1577	$299.89
41822	Excision of gum lesion	Y		P3		$136.26
41823	Excision of gum lesion	Y		P3		$196.91
41825	Excision of gum lesion	Y		P3		$107.78
41826	Excision of gum lesion	Y		P3		$144.86
41827	Excision of gum lesion	Y		A2	23.2154	$972.69

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
41828	Excision of gum lesion	Y		P3		$127.18
41830	Removal of gum tissue	Y		P3		$178.00
41850	Treatment of gum lesion	Y		R2	15.8303	$663.26
41870	Gum graft	Y		G2	23.2156	$972.69
41872	Repair gum	Y		P3		$172.85
41874	Repair tooth socket	Y		P3		$171.37
42000	Drainage mouth roof lesion	Y		A2	3.1243	$130.89
42100	Biopsy roof of mouth	Y		P3		$68.75
42104	Excision lesion, mouth roof	Y		P3		$103.85
42106	Excision lesion, mouth roof	Y		P3		$130.13
42107	Excision lesion, mouth roof	Y		A2	23.2154	$972.69
42120	Remove palate/lesion	Y		A2	40.7633	$1,707.90
42140	Excision of uvula	Y		A2	7.1579	$299.89
42145	Repair palate, pharynx/uvula	Y		A2	23.2154	$972.69
42160	Treatment mouth roof lesion	Y		P3		$117.11
42180	Repair palate	Y		A2	3.1243	$130.89
42182	Repair palate	Y		A2	40.7633	$1,707.90
42200	Reconstruct cleft palate	Y		A2	40.7633	$1,707.90
42205	Reconstruct cleft palate	Y		A2	40.7633	$1,707.90
42210	Reconstruct cleft palate	Y		A2	40.7633	$1,707.90
42215	Reconstruct cleft palate	Y		A2	40.7633	$1,707.90
42220	Reconstruct cleft palate	Y		A2	40.7633	$1,707.90
42225	Reconstruct cleft palate	Y		G2	40.7633	$1,707.90
42226	Lengthening of palate	Y		A2	40.7633	$1,707.90
42227	Lengthening of palate	Y		G2	40.7633	$1,707.90
42235	Repair palate	Y		A2	15.8303	$663.26
42260	Repair nose to lip fistula	Y		A2	23.2154	$972.69
42280	Preparation, palate mold	Y		P3		$68.99
42281	Insertion, palate prosthesis	Y		G2	15.8303	$663.26
42300	Drainage of salivary gland	Y		A2	15.8303	$663.26
42305	Drainage of salivary gland	Y		A2	15.8303	$663.26
42310	Drainage of salivary gland	Y		A2	3.1243	$130.89
42320	Drainage of salivary gland	Y		A2	3.1243	$130.89
42330	Removal of salivary stone	Y		P3		$103.36
42335	Removal of salivary stone	Y		P3		$172.36
42340	Removal of salivary stone	Y		A2	15.8303	$663.26
42400	Biopsy of salivary gland	Y		P3		$55.49
42405	Biopsy of salivary gland	Y		A2	23.2154	$972.69
42408	Excision of salivary cyst	Y		A2	15.8303	$663.26

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
42409	Drainage of salivary cyst	Y		A2	15.8303	$663.26
42410	Excise parotid gland/lesion	Y		A2	40.7633	$1,707.90
42415	Excise parotid gland/lesion	Y		A2	40.7633	$1,707.90
42420	Excise parotid gland/lesion	Y		A2	40.7633	$1,707.90
42425	Excise parotid gland/lesion	Y		A2	40.7633	$1,707.90
42440	Excise submaxillary gland	Y		A2	40.7633	$1,707.90
42450	Excise sublingual gland	Y		A2	23.2154	$972.69
42500	Repair salivary duct	Y		A2	23.2154	$972.69
42505	Repair salivary duct	Y		A2	40.7633	$1,707.90
42507	Parotid duct diversion	Y		A2	40.7633	$1,707.90
42508	Parotid duct diversion	Y		A2	40.7633	$1,707.90
42509	Parotid duct diversion	Y		A2	40.7633	$1,707.90
42510	Parotid duct diversion	Y		A2	40.7633	$1,707.90
42550	Injection for salivary x-ray	N		N1		
42600	Closure of salivary fistula	Y		A2	15.8303	$663.26
42650	Dilation of salivary duct	Y		P3		$38.30
42660	Dilation of salivary duct	Y		P3		$44.93
42665	Ligation of salivary duct	Y		A2	23.2154	$972.69
42700	Drainage of tonsil abscess	Y		A2	3.1243	$130.89
42720	Drainage of throat abscess	Y		A2	15.8303	$663.26
42725	Drainage of throat abscess	Y		A2	40.7633	$1,707.90
42800	Biopsy of throat	Y		P3		$73.66
42802	Biopsy of throat	Y		A2	15.8303	$663.26
42804	Biopsy of upper nose/throat	Y		A2	15.8303	$663.26
42806	Biopsy of upper nose/throat	Y		A2	23.2154	$972.69
42808	Excise pharynx lesion	Y		A2	23.2154	$972.69
42809	Remove pharynx foreign body	N		G2	0.6271	$26.27
42810	Excision of neck cyst	Y		A2	23.2154	$972.69
42815	Excision of neck cyst	Y		A2	40.7633	$1,707.90
42820	Remove tonsils and adenoids	Y		A2	23.2154	$972.69
42821	Remove tonsils and adenoids	Y		A2	23.2154	$972.69
42825	Removal of tonsils	Y		A2	23.2154	$972.69
42826	Removal of tonsils	Y		A2	23.2154	$972.69
42830	Removal of adenoids	Y		A2	23.2154	$972.69
42831	Removal of adenoids	Y		A2	23.2154	$972.69
42835	Removal of adenoids	Y		A2	23.2154	$972.69
42836	Removal of adenoids	Y		A2	23.2154	$972.69
42860	Excision of tonsil tags	Y		A2	23.2154	$972.69
42870	Excision of lingual tonsil	Y		A2	23.2154	$972.69

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
42890	Partial removal of pharynx	Y		A2	40.7633	$1,707.90
42892	Revision of pharyngeal walls	Y		A2	40.7633	$1,707.90
42900	Repair throat wound	Y		A2	7.1579	$299.89
42950	Reconstruction of throat	Y		A2	23.2154	$972.69
42955	Surgical opening of throat	Y		A2	23.2154	$972.69
42960	Control throat bleeding	Y		A2	1.0674	$44.72
42962	Control throat bleeding	Y		A2	40.7633	$1,707.90
42970	Control nose/throat bleeding	Y		R2	1.0674	$44.72
42972	Control nose/throat bleeding	Y		A2	15.8303	$663.26
43030	Throat muscle surgery	Y		G2	15.8303	$663.26
43130	Removal of esophagus pouch	Y		G2	40.7633	$1,707.90
43200	Esophagus endoscopy	Y		A2	8.0729	$338.24
43201	Esoph scope w/submucous inj	Y		A2	8.0729	$338.24
43202	Esophagus endoscopy, biopsy	Y		A2	8.0729	$338.24
43204	Esoph scope w/sclerosis inj	Y		A2	8.0729	$338.24
43205	Esophagus endoscopy/ligation	Y		A2	8.0729	$338.24
43215	Esophagus endoscopy	Y		A2	8.0729	$338.24
43216	Esophagus endoscopy/lesion	Y		A2	14.8265	$621.20
43217	Esophagus endoscopy	Y		A2	8.0729	$338.24
43219	Esophagus endoscopy	Y		A2	24.9797	$1,046.59
43220	Esoph endoscopy, dilation	Y		A2	8.0729	$338.24
43226	Esoph endoscopy, dilation	Y		A2	8.0729	$338.24
43227	Esoph endoscopy, repair	Y		A2	8.0729	$338.24
43228	Esoph endoscopy, ablation	Y		A2	14.8265	$621.20
43231	Esoph endoscopy w/us exam	Y		A2	8.0729	$338.24
43232	Esoph endoscopy w/us fn bx	Y		A2	8.0729	$338.24
43234	Upper GI endoscopy, exam	Y		A2	8.0729	$338.24
43235	Uppr gi endoscopy, diagnosis	Y		A2	8.0729	$338.24
43236	Uppr gi scope w/submuc inj	Y		A2	8.0729	$338.24
43237	Endoscopic us exam, esoph	Y		A2	8.0729	$338.24
43238	Uppr gi endoscopy w/us fn bx	Y		A2	8.0729	$338.24
43239	Upper GI endoscopy, biopsy	Y		A2	8.0729	$338.24
43240	Esoph endoscope w/drain cyst	Y		A2	8.0729	$338.24
43241	Upper GI endoscopy with tube	Y		A2	8.0729	$338.24
43242	Uppr gi endoscopy w/us fn bx	Y		A2	14.8265	$621.20
43243	Upper gi endoscopy & inject	Y		A2	8.0729	$338.24
43244	Upper GI endoscopy/ligation	Y		A2	8.0729	$338.24
43245	Uppr gi scope dilate strictr	Y		A2	8.0729	$338.24
43246	Place gastrostomy tube	Y		A2	8.0729	$338.24

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43247	Operative upper GI endoscopy	Y		A2	8.0729	$338.24
43248	Uppr gi endoscopy/guide wire	Y		A2	8.0729	$338.24
43249	Esoph endoscopy, dilation	Y		A2	8.0729	$338.24
43250	Upper GI endoscopy/tumor	Y		A2	8.0729	$338.24
43251	Operative upper GI endoscopy	Y		A2	8.0729	$338.24
43255	Operative upper GI endoscopy	Y		A2	8.0729	$338.24
43256	Uppr gi endoscopy w/stent	Y		A2	24.9797	$1,046.59
43257	Uppr gi scope w/thrml txmnt	Y		A2	14.8265	$621.20
43258	Operative upper GI endoscopy	Y		A2	8.0729	$338.24
43259	Endoscopic ultrasound exam	Y		A2	8.0729	$338.24
43260	Endo cholangiopancreatograph	Y		A2	20.9645	$878.37
43261	Endo cholangiopancreatograph	Y		A2	20.9645	$878.37
43262	Endo cholangiopancreatograph	Y		A2	20.9645	$878.37
43263	Endo cholangiopancreatograph	Y		A2	20.9645	$878.37
43264	Endo cholangiopancreatograph	Y		A2	20.9645	$878.37
43265	Endo cholangiopancreatograph	Y		A2	20.9645	$878.37
43267	Endo cholangiopancreatograph	Y		A2	20.9645	$878.37
43268	Endo cholangiopancreatograph	Y		A2	24.9797	$1,046.59
43269	Endo cholangiopancreatograph	Y		A2	24.9797	$1,046.59
43271	Endo cholangiopancreatograph	Y		A2	20.9645	$878.37
43272	Endo cholangiopancreatograph	Y		A2	20.9645	$878.37
43273	Endoscopic pancreatoscopy	Y		G2	20.9644	$878.37
43450	Dilate esophagus	Y		A2	5.843	$244.81
43453	Dilate esophagus	Y		A2	5.843	$244.81
43456	Dilate esophagus	Y		A2	5.843	$244.81
43458	Dilate esophagus	Y		A2	8.0729	$338.24
43600	Biopsy of stomach	Y		A2	8.0729	$338.24
43653	Laparoscopy, gastrostomy	Y		A2	43.6665	$1,829.55
43752	Nasal/orogastric w/stent	N		G2	1.1337	$47.50
43760	Change gastrostomy tube	Y		A2	2.1674	$90.81
43761	Reposition gastrostomy tube	Y		A2	8.0729	$338.24
43870	Repair stomach opening	Y		A2	14.8265	$621.20
43886	Revise gastric port, open	Y		G2	20.1058	$842.39
43887	Remove gastric port, open	Y		G2	4.2374	$177.54
43888	Change gastric port, open	Y		G2	20.1058	$842.39
44100	Biopsy of bowel	Y		A2	8.0729	$338.24
44312	Revision of ileostomy	Y		A2	20.106	$842.39
44340	Revision of colostomy	Y		A2	20.106	$842.39
44360	Small bowel endoscopy	Y		A2	9.2212	$386.35

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44361	Small bowel endoscopy/biopsy	Y		A2	9.2212	$386.35
44363	Small bowel endoscopy	Y		A2	9.2212	$386.35
44364	Small bowel endoscopy	Y		A2	9.2212	$386.35
44365	Small bowel endoscopy	Y		A2	9.2212	$386.35
44366	Small bowel endoscopy	Y		A2	9.2212	$386.35
44369	Small bowel endoscopy	Y		A2	9.2212	$386.35
44370	Small bowel endoscopy/stent	Y		A2	24.9797	$1,046.59
44372	Small bowel endoscopy	Y		A2	9.2212	$386.35
44373	Small bowel endoscopy	Y		A2	9.2212	$386.35
44376	Small bowel endoscopy	Y		A2	9.2212	$386.35
44377	Small bowel endoscopy/biopsy	Y		A2	9.2212	$386.35
44378	Small bowel endoscopy	Y		A2	9.2212	$386.35
44379	S bowel endoscope w/stent	Y		A2	24.9797	$1,046.59
44380	Small bowel endoscopy	Y		A2	9.2212	$386.35
44382	Small bowel endoscopy	Y		A2	9.2212	$386.35
44383	Ileoscopy w/stent	Y		A2	24.9797	$1,046.59
44385	Endoscopy of bowel pouch	Y		A2	8.4722	$354.98
44386	Endoscopy, bowel pouch/biop	Y		A2	8.4722	$354.98
44388	Colonoscopy	Y		A2	8.4722	$354.98
44389	Colonoscopy with biopsy	Y		A2	8.4722	$354.98
44390	Colonoscopy for foreign body	Y		A2	8.4722	$354.98
44391	Colonoscopy for bleeding	Y		A2	8.4722	$354.98
44392	Colonoscopy & polypectomy	Y		A2	8.4722	$354.98
44393	Colonoscopy, lesion removal	Y		A2	8.4722	$354.98
44394	Colonoscopy w/snare	Y		A2	8.4722	$354.98
44397	Colonoscopy w/stent	Y		A2	24.9797	$1,046.59
44500	Intro, gastrointestinal tube	Y		G2	5.7507	$240.94
44701	Intraop colon lavage add-on	N		N1		
45000	Drainage of pelvic abscess	Y		A2	14.6363	$613.23
45005	Drainage of rectal abscess	Y		A2	14.6363	$613.23
45020	Drainage of rectal abscess	Y		A2	14.6363	$613.23
45100	Biopsy of rectum	Y		A2	22.3595	$936.81
45108	Removal of anorectal lesion	Y		A2	22.3595	$936.81
45150	Excision of rectal stricture	Y		A2	22.3595	$936.81
45160	Excision of rectal lesion	Y		A2	22.3595	$936.81
45171	Exc rect tum transanal part	Y		G2	14.6362	$613.23
45172	Exc rect tum transanal full	Y		G2	22.3594	$936.81
45190	Destruction, rectal tumor	Y		A2	22.3595	$936.81
45300	Proctosigmoidoscopy dx	Y		P3		$58.43

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
45303	Proctosigmoidoscopy dilate	Y		P2	8.6377	$361.90
45305	Proctosigmoidoscopy w/bx	Y		A2	8.6376	$361.90
45307	Proctosigmoidoscopy fb	Y		A2	22.3495	$936.40
45308	Proctosigmoidoscopy removal	Y		A2	8.6376	$361.90
45309	Proctosigmoidoscopy removal	Y		A2	8.6376	$361.90
45315	Proctosigmoidoscopy removal	Y		A2	8.6376	$361.90
45317	Proctosigmoidoscopy bleed	Y		A2	8.6376	$361.90
45320	Proctosigmoidoscopy ablate	Y		A2	22.3495	$936.40
45321	Proctosigmoidoscopy volvul	Y		A2	22.3495	$936.40
45327	Proctosigmoidoscopy w/stent	Y		A2	24.9797	$1,046.59
45330	Diagnostic sigmoidoscopy	Y		P3		$70.96
45331	Sigmoidoscopy and biopsy	Y		A2	5.2575	$220.28
45332	Sigmoidoscopy w/fb removal	Y		A2	5.2575	$220.28
45333	Sigmoidoscopy & polypectomy	Y		A2	8.6376	$361.90
45334	Sigmoidoscopy for bleeding	Y		A2	8.6376	$361.90
45335	Sigmoidoscopy w/submuc inj	Y		A2	5.2575	$220.28
45337	Sigmoidoscopy & decompress	Y		A2	5.2575	$220.28
45338	Sigmoidoscopy w/tumr remove	Y		A2	8.6376	$361.90
45339	Sigmoidoscopy w/ablate tumr	Y		A2	8.6376	$361.90
45340	Sig w/balloon dilation	Y		A2	8.6376	$361.90
45341	Sigmoidoscopy w/ultrasound	Y		A2	8.6376	$361.90
45342	Sigmoidoscopy w/us guide bx	Y		A2	8.6376	$361.90
45345	Sigmoidoscopy w/stent	Y		A2	24.9797	$1,046.59
45355	Surgical colonoscopy	Y		A2	8.4722	$354.98
45378	Diagnostic colonoscopy	Y		A2	8.4722	$354.98
45379	Colonoscopy w/fb removal	Y		A2	8.4722	$354.98
45380	Colonoscopy and biopsy	Y		A2	8.4722	$354.98
45381	Colonoscopy, submucous inj	Y		A2	8.4722	$354.98
45382	Colonoscopy/control bleeding	Y		A2	8.4722	$354.98
45383	Lesion removal colonoscopy	Y		A2	8.4722	$354.98
45384	Lesion remove colonoscopy	Y		A2	8.4722	$354.98
45385	Lesion removal colonoscopy	Y		A2	8.4722	$354.98
45386	Colonoscopy dilate stricture	Y		A2	8.4722	$354.98
45387	Colonoscopy w/stent	Y		A2	24.9797	$1,046.59
45391	Colonoscopy w/endoscope us	Y		A2	8.4722	$354.98
45392	Colonoscopy w/endoscopic fnb	Y		A2	8.4722	$354.98
45500	Repair of rectum	Y		A2	22.3595	$936.81
45505	Repair of rectum	Y		A2	29.6501	$1,242.28
45520	Treatment of rectal prolapse	Y		P2	0.7983	$33.45

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
45541	Correct rectal prolapse	Y		G2	29.6501	$1,242.28
45560	Repair of rectocele	Y		A2	29.6501	$1,242.28
45900	Reduction of rectal prolapse	Y		A2	5.6974	$238.71
45905	Dilation of anal sphincter	Y		A2	22.3595	$936.81
45910	Dilation of rectal narrowing	Y		A2	22.3595	$936.81
45915	Remove rectal obstruction	Y		A2	14.6363	$613.23
45990	Surg dx exam, anorectal	Y		A2	22.3595	$936.81
46020	Placement of seton	Y		A2	22.3595	$936.81
46030	Removal of rectal marker	Y		A2	5.6974	$238.71
46040	Incision of rectal abscess	Y		A2	22.3595	$936.81
46045	Incision of rectal abscess	Y		A2	22.3595	$936.81
46050	Incision of anal abscess	Y		A2	14.6363	$613.23
46060	Incision of rectal abscess	Y		A2	22.3595	$936.81
46070	Incision of anal septum	Y		G2	14.6362	$613.23
46080	Incision of anal sphincter	Y		A2	22.3595	$936.81
46083	Incise external hemorrhoid	Y		P2	1.8791	$78.73
46200	Removal of anal fissure	Y		A2	22.3595	$936.81
46220	Excise anal ext tag/papilla	Y		A2	14.6363	$613.23
46221	Ligation of hemorrhoid(s)	Y		P3		$110.98
46230	Removal of anal tags	Y		A2	22.3595	$936.81
46250	Remove ext hem groups = 2	Y		A2	22.3595	$936.81
46255	Remove int/ext hem 1 group	Y		A2	22.3595	$936.81
46257	Remove in/ex hem grp & fiss	Y		A2	22.3595	$936.81
46258	Remove in/ex hem grp w/fistu	Y		A2	22.3595	$936.81
46260	Remove in/ex hem groups = 2	Y		A2	22.3595	$936.81
46261	Remove in/ex hem grps & fiss	Y		A2	22.3595	$936.81
46262	Remove in/ex hem grps w/fist	Y		A2	22.3595	$936.81
46270	Remove anal fist subq	Y		A2	22.3595	$936.81
46275	Remove anal fist inter	Y		A2	22.3595	$936.81
46280	Remove anal fist complex	Y		A2	22.3595	$936.81
46285	Remove anal fist 2 stage	Y		A2	22.3595	$936.81
46288	Repair anal fistula	Y		A2	22.3595	$936.81
46320	Removal of hemorrhoid clot	Y		P3		$74.64
46500	Injection into hemorrhoid(s)	Y		P3		$105.33
46505	Chemodenervation anal musc	Y		G2	22.3594	$936.81
46600	Diagnostic anoscopy	N		P2	0.6271	$26.27
46604	Anoscopy and dilation	Y	CH	P3		$358.95
46606	Anoscopy and biopsy	Y		P3		$116.13
46608	Anoscopy, remove for body	Y		A2	8.6376	$361.90

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
46610	Anoscopy, remove lesion	Y		A2	22.3495	$936.40
46611	Anoscopy	Y		A2	8.6376	$361.90
46612	Anoscopy, remove lesions	Y		A2	22.3495	$936.40
46614	Anoscopy, control bleeding	Y		P3		$59.91
46615	Anoscopy	Y		A2	22.3495	$936.40
46700	Repair of anal stricture	Y		A2	22.3595	$936.81
46706	Repr of anal fistula w/glue	Y		A2	29.6501	$1,242.28
46707	Repair anorectal fist w/plug	Y		G2	29.6501	$1,242.28
46750	Repair of anal sphincter	Y		A2	29.6501	$1,242.28
46753	Reconstruction of anus	Y		A2	22.3595	$936.81
46754	Removal of suture from anus	Y		A2	22.3595	$936.81
46760	Repair of anal sphincter	Y		A2	29.6501	$1,242.28
46761	Repair of anal sphincter	Y		A2	29.6501	$1,242.28
46762	Implant artificial sphincter	Y		A2	29.6501	$1,242.28
46900	Destruction, anal lesion(s)	Y	CH	P3		$107.29
46910	Destruction, anal lesion(s)	Y		P3		$112.94
46916	Cryosurgery, anal lesion(s)	Y		P2	1.391	$58.28
46917	Laser surgery, anal lesions	Y		A2	19.836	$831.08
46922	Excision of anal lesion(s)	Y		A2	19.836	$831.08
46924	Destruction, anal lesion(s)	Y		A2	19.836	$831.08
46930	Destroy internal hemorrhoids	Y		P3		$99.44
46940	Treatment of anal fissure	Y		P3		$86.18
46942	Treatment of anal fissure	Y		P3		$83.97
46945	Remove by ligat int hem grp	Y		P3		$138.23
46946	Remove by ligat int hem grps	Y		A2	14.6363	$613.23
46947	Hemorrhoidopexy by stapling	Y		A2	29.6501	$1,242.28
47000	Needle biopsy of liver	Y		A2	9.0033	$377.22
47001	Needle biopsy, liver add-on	N		N1		
47382	Percut ablate liver rf	Y		G2	52.0029	$2,178.82
47500	Injection for liver x-rays	N		N1		
47505	Injection for liver x-rays	N		N1		
47510	Insert catheter, bile duct	Y		A2	29.4324	$1,233.16
47511	Insert bile duct drain	Y		A2	29.4324	$1,233.16
47525	Change bile duct catheter	Y		A2	14.8714	$623.08
47530	Revise/reinsert bile tube	Y		A2	14.8714	$623.08
47552	Biliary endoscopy thru skin	Y		A2	29.4324	$1,233.16
47553	Biliary endoscopy thru skin	Y		A2	29.4324	$1,233.16
47554	Biliary endoscopy thru skin	Y		A2	29.4324	$1,233.16
47555	Biliary endoscopy thru skin	Y		A2	29.4324	$1,233.16

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47556	Biliary endoscopy thru skin	Y		A2	29.4324	$1,233.16
47560	Laparoscopy w/cholangio	Y		A2	35.196	$1,474.64
47561	Laparo w/cholangio/biopsy	Y		A2	35.196	$1,474.64
47562	Laparoscopic cholecystectomy	Y		G2	43.6667	$1,829.55
47563	Laparo cholecystectomy/graph	Y		G2	43.6667	$1,829.55
47564	Laparo cholecystectomy/explr	Y		G2	43.6667	$1,829.55
47630	Remove bile duct stone	Y		A2	29.4324	$1,233.16
48102	Needle biopsy, pancreas	Y		A2	9.0033	$377.22
49080	Puncture, peritoneal cavity	Y		A2	5.1351	$215.15
49081	Removal of abdominal fluid	Y		A2	5.1351	$215.15
49180	Biopsy, abdominal mass	Y		A2	9.0033	$377.22
49250	Excision of umbilicus	Y		A2	23.8219	$998.09
49320	Diag laparo separate proc	Y		A2	35.196	$1,474.64
49321	Laparoscopy, biopsy	Y		A2	35.196	$1,474.64
49322	Laparoscopy, aspiration	Y		A2	35.196	$1,474.64
49324	Lap insertion perm ip cath	Y		G2	35.196	$1,474.64
49325	Lap revision perm ip cath	Y		G2	35.196	$1,474.64
49326	Lap w/omentopexy add-on	Y		G2	35.196	$1,474.64
49400	Air injection into abdomen	N		N1		
49402	Remove foreign body, adbomen	Y		A2	23.8219	$998.09
49411	Ins mark abd/pel for rt perq	N		P3		$267.37
49419	Insrt abdom cath for chemotx	Y		A2	30.2764	$1,268.52
49420	Insert abdom drain, temp	Y		A2	28.2961	$1,185.54
49421	Insert abdom drain, perm	Y		A2	28.2961	$1,185.54
49422	Remove perm cannula/catheter	Y		A2	21.1144	$884.65
49423	Exchange drainage catheter	Y		G2	14.8713	$623.08
49424	Assess cyst, contrast inject	N		N1		
49426	Revise abdomen-venous shunt	Y		A2	23.8219	$998.09
49427	Injection, abdominal shunt	N		N1		
49429	Removal of shunt	Y		G2	21.1143	$884.65
49435	Insert subq exten to ip cath	Y		G2	14.8713	$623.08
49436	Embedded ip cath exit-site	Y		G2	14.8713	$623.08
49440	Place gastrostomy tube perc	Y		G2	8.0729	$338.24
49441	Place duod/jej tube perc	Y		G2	8.0729	$338.24
49442	Place cecostomy tube perc	Y		G2	14.6362	$613.23
49446	Change g-tube to g-j perc	Y		G2	8.0729	$338.24
49450	Replace g/c tube perc	Y		G2	5.7507	$240.94
49451	Replace duod/jej tube perc	Y		G2	5.7507	$240.94
49452	Replace g-j tube perc	Y		G2	5.7507	$240.94

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49460	Fix g/colon tube w/device	Y		G2	5.7507	$240.94
49465	Fluoro exam of g/colon tube	N		N1		
49495	Rpr ing hernia baby, reduc	Y		A2	30.3315	$1,270.83
49496	Rpr ing hernia baby, blocked	Y		A2	30.3315	$1,270.83
49500	Rpr ing hernia, init, reduce	Y		A2	30.3315	$1,270.83
49501	Rpr ing hernia, init blocked	Y		A2	30.3315	$1,270.83
49505	Prp i/hern init reduc >5 yr	Y		A2	30.3315	$1,270.83
49507	Prp i/hern init block >5 yr	Y		A2	30.3315	$1,270.83
49520	Rerepair ing hernia, reduce	Y		A2	30.3315	$1,270.83
49521	Rerepair ing hernia, blocked	Y		A2	30.3315	$1,270.83
49525	Repair ing hernia, sliding	Y		A2	30.3315	$1,270.83
49540	Repair lumbar hernia	Y		A2	30.3315	$1,270.83
49550	Rpr rem hernia, init, reduce	Y		A2	30.3315	$1,270.83
49553	Rpr fem hernia, init blocked	Y		A2	30.3315	$1,270.83
49555	Rerepair fem hernia, reduce	Y		A2	30.3315	$1,270.83
49557	Rerepair fem hernia, blocked	Y		A2	30.3315	$1,270.83
49560	Rpr ventral hern init, reduc	Y		A2	30.3315	$1,270.83
49561	Rpr ventral hern init, block	Y		A2	30.3315	$1,270.83
49565	Rerepair ventrl hern, reduce	Y		A2	30.3315	$1,270.83
49566	Rerepair ventrl hern, block	Y		A2	30.3315	$1,270.83
49568	Hernia repair w/mesh	Y		A2	30.3315	$1,270.83
49570	Rpr epigastric hern, reduce	Y		A2	30.3315	$1,270.83
49572	Rpr epigastric hern, blocked	Y		A2	30.3315	$1,270.83
49580	Rpr umbil hern, reduc < 5 yr	Y		A2	30.3315	$1,270.83
49582	Rpr umbil hern, block < 5 yr	Y		A2	30.3315	$1,270.83
49585	Rpr umbil hern, reduc > 5 yr	Y		A2	30.3315	$1,270.83
49587	Rpr umbil hern, block > 5 yr	Y		A2	30.3315	$1,270.83
49590	Repair spigelian hernia	Y		A2	30.3315	$1,270.83
49600	Repair umbilical lesion	Y		A2	30.3315	$1,270.83
49650	Lap ing hernia repair init	Y		A2	43.6665	$1,829.55
49651	Lap ing hernia repair recur	Y		A2	43.6665	$1,829.55
49652	Lap vent/abd hernia repair	Y		G2	64.6377	$2,708.19
49653	Lap vent/abd hern proc comp	Y		G2	64.6377	$2,708.19
49654	Lap inc hernia repair	Y		G2	64.6377	$2,708.19
49655	Lap inc hern repair comp	Y		G2	64.6377	$2,708.19
49656	Lap inc hernia repair recur	Y		G2	64.6377	$2,708.19
49657	Lap inc hern recur comp	Y		G2	64.6377	$2,708.19
50080	Removal of kidney stone	Y		G2	42.3333	$1,773.68
50081	Removal of kidney stone	Y		G2	42.3333	$1,773.68

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50200	Renal biopsy perq	Y		A2	9.0033	$377.22
50382	Change ureter stent, percut	Y		G2	24.0156	$1,006.21
50384	Remove ureter stent, percut	Y		G2	16.1088	$674.93
50385	Change stent via transureth	Y		G2	24.0156	$1,006.21
50386	Remove stent via transureth	Y		P2	6.5459	$274.26
50387	Change ext/int ureter stent	Y		G2	14.8713	$623.08
50389	Remove renal tube w/fluoro	Y		G2	6.5459	$274.26
50390	Drainage of kidney lesion	Y		A2	9.0033	$377.22
50391	Instll rx agnt into rnal tub	Y	CH	P3		$40.02
50392	Insert kidney drain	Y		A2	16.1089	$674.93
50393	Insert ureteral tube	Y		A2	24.0157	$1,006.21
50394	Injection for kidney x-ray	N		N1		
50395	Create passage to kidney	Y		A2	24.0157	$1,006.21
50396	Measure kidney pressure	Y		A2	1.8791	$78.73
50398	Change kidney tube	Y		A2	14.8714	$623.08
50551	Kidney endoscopy	Y		A2	6.5459	$274.26
50553	Kidney endoscopy	Y		A2	24.0157	$1,006.21
50555	Kidney endoscopy & biopsy	Y		A2	6.5459	$274.26
50557	Kidney endoscopy & treatment	Y		A2	24.0157	$1,006.21
50561	Kidney endoscopy & treatment	Y		A2	24.0157	$1,006.21
50562	Renal scope w/tumor resect	Y		G2	6.5459	$274.26
50570	Kidney endoscopy	Y		G2	6.5459	$274.26
50572	Kidney endoscopy	Y		G2	6.5459	$274.26
50574	Kidney endoscopy & biopsy	Y		G2	6.5459	$274.26
50575	Kidney endoscopy	Y		G2	34.0301	$1,425.79
50576	Kidney endoscopy & treatment	Y		G2	16.1088	$674.93
50580	Kidney endoscopy & treatment	Y		G2	16.1088	$674.93
50590	Fragmenting of kidney stone	Y		G2	37.9296	$1,589.17
50592	Perc rf ablate renal tumor	Y		G2	52.0029	$2,178.82
50593	Perc cryo ablate renal tum	Y	CH	P2	52.0029	$2,178.82
50684	Injection for ureter x-ray	N		N1		
50686	Measure ureter pressure	Y		P2	0.9984	$41.83
50688	Change of ureter tube/stent	Y		A2	14.8714	$623.08
50690	Injection for ureter x-ray	N		N1		
50727	Revise ureter	Y		G2	18.6773	$782.54
50947	Laparo new ureter/bladder	Y		A2	43.6665	$1,829.55
50948	Laparo new ureter/bladder	Y		A2	43.6665	$1,829.55
50951	Endoscopy of ureter	Y		A2	6.5459	$274.26
50953	Endoscopy of ureter	Y		A2	6.5459	$274.26

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50955	Ureter endoscopy & biopsy	Y		A2	24.0157	$1,006.21
50957	Ureter endoscopy & treatment	Y		A2	24.0157	$1,006.21
50961	Ureter endoscopy & treatment	Y		A2	24.0157	$1,006.21
50970	Ureter endoscopy	Y		A2	6.5459	$274.26
50972	Ureter endoscopy & catheter	Y		A2	6.5459	$274.26
50974	Ureter endoscopy & biopsy	Y		A2	16.1089	$674.93
50976	Ureter endoscopy & treatment	Y		A2	16.1089	$674.93
50980	Ureter endoscopy & treatment	Y		A2	24.0157	$1,006.21
51020	Incise & treat bladder	Y		A2	24.0157	$1,006.21
51030	Incise & treat bladder	Y		A2	24.0157	$1,006.21
51040	Incise & drain bladder	Y		A2	24.0157	$1,006.21
51045	Incise bladder/drain ureter	Y		A2	6.5459	$274.26
51050	Removal of bladder stone	Y		A2	24.0157	$1,006.21
51065	Remove ureter calculus	Y		A2	24.0157	$1,006.21
51080	Drainage of bladder abscess	Y		A2	18.4054	$771.15
51100	Drain bladder by needle	Y		P3		$24.55
51101	Drain bladder by trocar/cath	Y		P2	0.9984	$41.83
51102	Drain bl w/cath insertion	Y		A2	18.6773	$782.54
51500	Removal of bladder cyst	Y		A2	30.3315	$1,270.83
51520	Removal of bladder lesion	Y		A2	24.0157	$1,006.21
51535	Repair of ureter lesion	Y		G2	24.0156	$1,006.21
51600	Injection for bladder x-ray	N		N1		
51605	Preparation for bladder xray	N		N1		
51610	Injection for bladder x-ray	N		N1		
51700	Irrigation of bladder	Y		P3		$39.28
51701	Insert bladder catheter	N		P2	0.6271	$26.27
51702	Insert temp bladder cath	N		P2	0.6271	$26.27
51703	Insert bladder cath, complex	Y		P2	0.9984	$41.83
51705	Change of bladder tube	Y		P3		$53.28
51710	Change of bladder tube	Y		A2	5.7506	$240.94
51715	Endoscopic injection/implant	Y		A2	29.4341	$1,233.23
51720	Treatment of bladder lesion	Y		P3		$42.97
51725	Simple cystometrogram	Y	CH	P3		$94.53
51726	Complex cystometrogram	Y		A2	2.8049	$117.53
51727	Cystometrogram w/up	Y		P2	2.8051	$117.53
51728	Cystometrogram w/vp	Y		P2	2.8051	$117.53
51729	Cystometrogram w/vp&up	Y		P2	2.8051	$117.53
51736	Urine flow measurement	N		P3		$16.45
51741	Electro-uroflowmetry, first	Y		P3		$19.15

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51784	Anal/urinary muscle study	Y		P2	0.9984	$41.83
51785	Anal/urinary muscle study	Y		A2	1.8791	$78.73
51792	Urinary reflex study	Y		P2	0.9984	$41.83
51797	Intraabdominal pressure test	Y	CH	P3		$66.04
51798	Us urine capacity measure	N		P3		$13.75
51880	Repair of bladder opening	Y		A2	24.0157	$1,006.21
51992	Laparo sling operation	Y		A2	43.6665	$1,829.55
52000	Cystoscopy	Y		A2	6.5459	$274.26
52001	Cystoscopy, removal of clots	Y		A2	16.1089	$674.93
52005	Cystoscopy & ureter catheter	Y		A2	24.0157	$1,006.21
52007	Cystoscopy and biopsy	Y		A2	24.0157	$1,006.21
52010	Cystoscopy & duct catheter	Y		A2	6.5459	$274.26
52204	Cystoscopy w/biopsy(s)	Y		A2	24.0157	$1,006.21
52214	Cystoscopy and treatment	Y		A2	24.0157	$1,006.21
52224	Cystoscopy and treatment	Y		A2	24.0157	$1,006.21
52234	Cystoscopy and treatment	Y		A2	24.0157	$1,006.21
52235	Cystoscopy and treatment	Y		A2	24.0157	$1,006.21
52240	Cystoscopy and treatment	Y		A2	24.0157	$1,006.21
52250	Cystoscopy and radiotracer	Y		A2	24.0157	$1,006.21
52260	Cystoscopy and treatment	Y		A2	16.1089	$674.93
52265	Cystoscopy and treatment	Y	CH	P3		$215.57
52270	Cystoscopy & revise urethra	Y		A2	16.1089	$674.93
52275	Cystoscopy & revise urethra	Y		A2	24.0157	$1,006.21
52276	Cystoscopy and treatment	Y		A2	24.0157	$1,006.21
52277	Cystoscopy and treatment	Y		A2	24.0157	$1,006.21
52281	Cystoscopy and treatment	Y		A2	16.1089	$674.93
52282	Cystoscopy, implant stent	Y		A2	34.03	$1,425.79
52283	Cystoscopy and treatment	Y		A2	24.0157	$1,006.21
52285	Cystoscopy and treatment	Y		A2	16.1089	$674.93
52290	Cystoscopy and treatment	Y		A2	24.0157	$1,006.21
52300	Cystoscopy and treatment	Y		A2	24.0157	$1,006.21
52301	Cystoscopy and treatment	Y		A2	24.0157	$1,006.21
52305	Cystoscopy and treatment	Y		A2	24.0157	$1,006.21
52310	Cystoscopy and treatment	Y		A2	16.1089	$674.93
52315	Cystoscopy and treatment	Y		A2	24.0157	$1,006.21
52317	Remove bladder stone	Y		A2	24.0157	$1,006.21
52318	Remove bladder stone	Y		A2	24.0157	$1,006.21
52320	Cystoscopy and treatment	Y		A2	24.0157	$1,006.21
52325	Cystoscopy, stone removal	Y		A2	24.0157	$1,006.21

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
52327	Cystoscopy, inject material	Y		A2	34.03	$1,425.79
52330	Cystoscopy and treatment	Y		A2	24.0157	$1,006.21
52332	Cystoscopy and treatment	Y		A2	24.0157	$1,006.21
52334	Create passage to kidney	Y		A2	24.0157	$1,006.21
52341	Cysto w/ureter stricture tx	Y		A2	24.0157	$1,006.21
52342	Cysto w/up stricture tx	Y		A2	24.0157	$1,006.21
52343	Cysto w/renal stricture tx	Y		A2	24.0157	$1,006.21
52344	Cysto/uretero, stricture tx	Y		A2	24.0157	$1,006.21
52345	Cysto/uretero w/up stricture	Y		A2	24.0157	$1,006.21
52346	Cystouretero w/renal strict	Y		A2	24.0157	$1,006.21
52351	Cystouretero & or pyeloscope	Y		A2	24.0157	$1,006.21
52352	Cystouretero w/stone remove	Y		A2	24.0157	$1,006.21
52353	Cystouretero w/lithotripsy	Y		A2	34.03	$1,425.79
52354	Cystouretero w/biopsy	Y		A2	24.0157	$1,006.21
52355	Cystouretero w/excise tumor	Y		A2	24.0157	$1,006.21
52400	Cystouretero w/congen repr	Y		A2	24.0157	$1,006.21
52402	Cystourethro cut ejacul duct	Y		A2	24.0157	$1,006.21
52450	Incision of prostate	Y		A2	24.0157	$1,006.21
52500	Revision of bladder neck	Y		A2	24.0157	$1,006.21
52601	Prostatectomy (TURP)	Y		A2	34.03	$1,425.79
52630	Remove prostate regrowth	Y		A2	34.03	$1,425.79
52640	Relieve bladder contracture	Y		A2	24.0157	$1,006.21
52647	Laser surgery of prostate	Y		A2	42.3333	$1,773.68
52648	Laser surgery of prostate	Y		A2	42.3333	$1,773.68
52700	Drainage of prostate abscess	Y		A2	24.0157	$1,006.21
53000	Incision of urethra	Y		A2	19.4327	$814.19
53010	Incision of urethra	Y		A2	19.4327	$814.19
53020	Incision of urethra	Y		A2	19.4327	$814.19
53025	Incision of urethra	Y		R2	19.4327	$814.19
53040	Drainage of urethra abscess	Y		A2	19.4327	$814.19
53060	Drainage of urethra abscess	Y		P3		$58.43
53080	Drainage of urinary leakage	Y		A2	19.4327	$814.19
53085	Drainage of urinary leakage	Y		G2	19.4327	$814.19
53200	Biopsy of urethra	Y		A2	19.4327	$814.19
53210	Removal of urethra	Y		A2	29.4341	$1,233.23
53215	Removal of urethra	Y		A2	19.4327	$814.19
53220	Treatment of urethra lesion	Y		A2	29.4341	$1,233.23
53230	Removal of urethra lesion	Y		A2	29.4341	$1,233.23
53235	Removal of urethra lesion	Y		A2	19.4327	$814.19

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
53240	Surgery for urethra pouch	Y		A2	29.4341	$1,233.23
53250	Removal of urethra gland	Y		A2	19.4327	$814.19
53260	Treatment of urethra lesion	Y		A2	19.4327	$814.19
53265	Treatment of urethra lesion	Y		A2	19.4327	$814.19
53270	Removal of urethra gland	Y		A2	19.4327	$814.19
53275	Repair of urethra defect	Y		A2	19.4327	$814.19
53400	Revise urethra, stage 1	Y		A2	29.4341	$1,233.23
53405	Revise urethra, stage 2	Y		A2	29.4341	$1,233.23
53410	Reconstruction of urethra	Y		A2	29.4341	$1,233.23
53420	Reconstruct urethra, stage 1	Y		A2	29.4341	$1,233.23
53425	Reconstruct urethra, stage 2	Y		A2	29.4341	$1,233.23
53430	Reconstruction of urethra	Y		A2	29.4341	$1,233.23
53431	Reconstruct urethra/bladder	Y		A2	29.4341	$1,233.23
53440	Male sling procedure	N		H8	137.6421	$5,766.93
53442	Remove/revise male sling	Y		A2	29.4341	$1,233.23
53444	Insert tandem cuff	N		H8	137.6421	$5,766.93
53445	Insert uro/ves nck sphincter	N		H8	239.1324	$10,019.17
53446	Remove uro sphincter	Y		A2	29.4341	$1,233.23
53447	Remove/replace ur sphincter	N		H8	239.1324	$10,019.17
53449	Repair uro sphincter	Y		A2	29.4341	$1,233.23
53450	Revision of urethra	Y		A2	29.4341	$1,233.23
53460	Revision of urethra	Y		A2	19.4327	$814.19
53502	Repair of urethra injury	Y		A2	19.4327	$814.19
53505	Repair of urethra injury	Y		A2	29.4341	$1,233.23
53510	Repair of urethra injury	Y		A2	19.4327	$814.19
53515	Repair of urethra injury	Y		A2	29.4341	$1,233.23
53520	Repair of urethra defect	Y		A2	29.4341	$1,233.23
53600	Dilate urethra stricture	Y		P3		$30.20
53601	Dilate urethra stricture	Y	CH	P3		$34.86
53605	Dilate urethra stricture	Y		A2	16.1089	$674.93
53620	Dilate urethra stricture	Y		P3		$45.42
53621	Dilate urethra stricture	Y		P3		$47.88
53660	Dilation of urethra	Y	CH	P3		$34.13
53661	Dilation of urethra	Y	CH	P3		$33.39
53665	Dilation of urethra	Y		A2	19.4327	$814.19
53850	Prostatic microwave thermotx	Y	CH	P3		$1,411.00
53852	Prostatic rf thermotx	Y	CH	P3		$1,330.96
53855	Insert prost urethral stent	Y		P2	1.8791	$78.73
54000	Slitting of prepuce	Y		A2	19.4327	$814.19

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
54001	Slitting of prepuce	Y		A2	19.4327	$814.19
54015	Drain penis lesion	Y		A2	18.4054	$771.15
54050	Destruction, penis lesion(s)	Y		P2	0.7983	$33.45
54055	Destruction, penis lesion(s)	Y		P3		$52.30
54056	Cryosurgery, penis lesion(s)	Y		P2	0.7983	$33.45
54057	Laser surg, penis lesion(s)	Y		A2	19.836	$831.08
54060	Excision of penis lesion(s)	Y		A2	19.836	$831.08
54065	Destruction, penis lesion(s)	Y		A2	19.836	$831.08
54100	Biopsy of penis	Y		A2	16.564	$694.00
54105	Biopsy of penis	Y		A2	21.9314	$918.88
54110	Treatment of penis lesion	Y		A2	33.1047	$1,387.01
54111	Treat penis lesion, graft	Y		A2	33.1047	$1,387.01
54112	Treat penis lesion, graft	Y		A2	33.1047	$1,387.01
54115	Treatment of penis lesion	Y		A2	18.4054	$771.15
54120	Partial removal of penis	Y		A2	33.1047	$1,387.01
54150	Circumcision w/regionl block	Y		A2	21.6247	$906.03
54160	Circumcision, neonate	Y		A2	21.6247	$906.03
54161	Circum 28 days or older	Y		A2	21.6247	$906.03
54162	Lysis penil circumic lesion	Y		A2	21.6247	$906.03
54163	Repair of circumcision	Y		A2	21.6247	$906.03
54164	Frenulotomy of penis	Y		A2	21.6247	$906.03
54200	Treatment of penis lesion	Y		P3		$51.31
54205	Treatment of penis lesion	Y		A2	33.1047	$1,387.01
54220	Treatment of penis lesion	Y		A2	1.8791	$78.73
54230	Prepare penis study	N		N1		
54231	Dynamic cavernosometry	Y		P3		$49.35
54235	Penile injection	Y		P3		$35.11
54240	Penis study	Y		P3		$24.80
54250	Penis study	Y		P3		$8.84
54300	Revision of penis	Y		A2	33.1047	$1,387.01
54304	Revision of penis	Y		A2	33.1047	$1,387.01
54308	Reconstruction of urethra	Y		A2	33.1047	$1,387.01
54312	Reconstruction of urethra	Y		A2	33.1047	$1,387.01
54316	Reconstruction of urethra	Y		A2	33.1047	$1,387.01
54318	Reconstruction of urethra	Y		A2	33.1047	$1,387.01
54322	Reconstruction of urethra	Y		A2	33.1047	$1,387.01
54324	Reconstruction of urethra	Y		A2	33.1047	$1,387.01
54326	Reconstruction of urethra	Y		A2	33.1047	$1,387.01
54328	Revise penis/urethra	Y		A2	33.1047	$1,387.01

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
54340	Secondary urethral surgery	Y		A2	33.1047	$1,387.01
54344	Secondary urethral surgery	Y		A2	33.1047	$1,387.01
54348	Secondary urethral surgery	Y		A2	33.1047	$1,387.01
54352	Reconstruct urethra/penis	Y		A2	33.1047	$1,387.01
54360	Penis plastic surgery	Y		A2	33.1047	$1,387.01
54380	Repair penis	Y		A2	33.1047	$1,387.01
54385	Repair penis	Y		A2	33.1047	$1,387.01
54400	Insert semi-rigid prosthesis	N		H8	137.6421	$5,766.93
54401	Insert self-contd prosthesis	N		H8	239.1324	$10,019.17
54405	Insert multi-comp penis pros	N		H8	239.1324	$10,019.17
54406	Remove muti-comp penis pros	Y		A2	33.1047	$1,387.01
54408	Repair multi-comp penis pros	Y		A2	33.1047	$1,387.01
54410	Remove/replace penis prosth	N		H8	239.1324	$10,019.17
54415	Remove self-contd penis pros	Y		A2	33.1047	$1,387.01
54416	Remv/repl penis contain pros	N		H8	239.1324	$10,019.17
54420	Revision of penis	Y		A2	33.1047	$1,387.01
54435	Revision of penis	Y		A2	33.1047	$1,387.01
54440	Repair of penis	Y		A2	33.1047	$1,387.01
54450	Preputial stretching	Y		A2	2.8049	$117.53
54500	Biopsy of testis	Y		A2	14.3296	$600.38
54505	Biopsy of testis	Y		A2	21.6247	$906.03
54512	Excise lesion testis	Y		A2	21.6247	$906.03
54520	Removal of testis	Y		A2	21.6247	$906.03
54522	Orchiectomy, partial	Y		A2	21.6247	$906.03
54530	Removal of testis	Y		A2	30.3315	$1,270.83
54550	Exploration for testis	Y		A2	30.3315	$1,270.83
54560	Exploration for testis	Y		G2	21.6247	$906.03
54600	Reduce testis torsion	Y		A2	21.6247	$906.03
54620	Suspension of testis	Y		A2	21.6247	$906.03
54640	Suspension of testis	Y		A2	30.3315	$1,270.83
54660	Revision of testis	Y		A2	21.6247	$906.03
54670	Repair testis injury	Y		A2	21.6247	$906.03
54680	Relocation of testis(es)	Y		A2	21.6247	$906.03
54690	Laparoscopy, orchiectomy	Y		A2	43.6665	$1,829.55
54692	Laparoscopy, orchiopexy	Y		G2	64.6377	$2,708.19
54700	Drainage of scrotum	Y		A2	21.6247	$906.03
54800	Biopsy of epididymis	Y		A2	4.2381	$177.57
54830	Remove epididymis lesion	Y		A2	21.6247	$906.03
54840	Remove epididymis lesion	Y		A2	21.6247	$906.03

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54860	Removal of epididymis	Y		A2	21.6247	$906.03
54861	Removal of epididymis	Y		A2	21.6247	$906.03
54865	Explore epididymis	Y		A2	21.6247	$906.03
54900	Fusion of spermatic ducts	Y		A2	21.6247	$906.03
54901	Fusion of spermatic ducts	Y		A2	21.6247	$906.03
55000	Drainage of hydrocele	Y		P3		$50.09
55040	Removal of hydrocele	Y		A2	30.3315	$1,270.83
55041	Removal of hydroceles	Y		A2	30.3315	$1,270.83
55060	Repair of hydrocele	Y		A2	21.6247	$906.03
55100	Drainage of scrotum abscess	Y		A2	12.1142	$507.56
55110	Explore scrotum	Y		A2	21.6247	$906.03
55120	Removal of scrotum lesion	Y		A2	21.6247	$906.03
55150	Removal of scrotum	Y		A2	21.6247	$906.03
55175	Revision of scrotum	Y		A2	21.6247	$906.03
55180	Revision of scrotum	Y		A2	21.6247	$906.03
55200	Incision of sperm duct	Y		A2	21.6247	$906.03
55250	Removal of sperm duct(s)	Y		A2	21.6247	$906.03
55300	Prepare, sperm duct x-ray	N		N1		
55400	Repair of sperm duct	Y		A2	21.6247	$906.03
55450	Ligation of sperm duct	Y		P3		$156.64
55500	Removal of hydrocele	Y		A2	21.6247	$906.03
55520	Removal of sperm cord lesion	Y		A2	21.6247	$906.03
55530	Revise spermatic cord veins	Y		A2	21.6247	$906.03
55535	Revise spermatic cord veins	Y		A2	30.3315	$1,270.83
55540	Revise hernia & sperm veins	Y		A2	30.3315	$1,270.83
55550	Laparo ligate spermatic vein	Y		A2	43.6665	$1,829.55
55600	Incise sperm duct pouch	Y		R2	21.6247	$906.03
55680	Remove sperm pouch lesion	Y		A2	21.6247	$906.03
55700	Biopsy of prostate	Y		A2	12.1244	$507.98
55705	Biopsy of prostate	Y		A2	12.1244	$507.98
55706	Prostate saturation sampling	Y		G2	12.1242	$507.98
55720	Drainage of prostate abscess	Y		A2	24.0157	$1,006.21
55725	Drainage of prostate abscess	Y		A2	24.0157	$1,006.21
55860	Surgical exposure, prostate	Y		G2	18.6773	$782.54
55870	Electroejaculation	Y		P3		$60.89
55873	Cryoablate prostate	Y		H8	154.894	$6,489.75
55875	Transperi needle place, pros	N		A2	34.03	$1,425.79
55876	Place rt device/marker, pros	N		P3		$55.24
55920	Place needles pelvic for rt	Y		G2	23.822	$998.09

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56405	I & D of vulva/perineum	Y		P3		$35.85
56420	Drainage of gland abscess	Y	CH	P3		$47.63
56440	Surgery for vulva lesion	Y		A2	18.8307	$788.97
56441	Lysis of labial lesion(s)	Y		A2	18.8307	$788.97
56442	Hymenotomy	Y		A2	18.8307	$788.97
56501	Destroy, vulva lesions, sim	Y		P3		$48.61
56515	Destroy vulva lesion/s compl	Y		A2	19.836	$831.08
56605	Biopsy of vulva/perineum	Y		P3		$27.99
56606	Biopsy of vulva/perineum	Y		P3		$11.54
56620	Partial removal of vulva	Y		A2	18.8307	$788.97
56625	Complete removal of vulva	Y		A2	18.8307	$788.97
56700	Partial removal of hymen	Y		A2	18.8307	$788.97
56740	Remove vagina gland lesion	Y		A2	18.8307	$788.97
56800	Repair of vagina	Y		A2	18.8307	$788.97
56805	Repair clitoris	Y		G2	18.8307	$788.97
56810	Repair of perineum	Y		A2	18.8307	$788.97
56820	Exam of vulva w/scope	Y		P3		$36.34
56821	Exam/biopsy of vulva w/scope	Y		P3		$46.89
57000	Exploration of vagina	Y		A2	18.8307	$788.97
57010	Drainage of pelvic abscess	Y		A2	18.8307	$788.97
57020	Drainage of pelvic fluid	Y		A2	6.1397	$257.24
57022	I & d vaginal hematoma, pp	Y		R2	12.1141	$507.56
57023	I & d vag hematoma, non-ob	Y		A2	18.4054	$771.15
57061	Destroy vag lesions, simple	Y		P3		$44.44
57065	Destroy vag lesions, complex	Y		A2	18.8307	$788.97
57100	Biopsy of vagina	Y		P3		$28.97
57105	Biopsy of vagina	Y		A2	18.8307	$788.97
57130	Remove vagina lesion	Y		A2	18.8307	$788.97
57135	Remove vagina lesion	Y		A2	18.8307	$788.97
57150	Treat vagina infection	Y		P3		$18.91
57155	Insert uteri tandems/ovoids	Y		A2	6.1397	$257.24
57160	Insert pessary/other device	Y		P3		$29.71
57170	Fitting of diaphragm/cap	Y		P2	0.1376	$5.77
57180	Treat vaginal bleeding	Y		A2	1.4521	$60.84
57200	Repair of vagina	Y		A2	18.8307	$788.97
57210	Repair vagina/perineum	Y		A2	18.8307	$788.97
57220	Revision of urethra	Y		A2	41.0953	$1,721.81
57230	Repair of urethral lesion	Y		A2	32.4832	$1,360.98
57240	Repair bladder & vagina	Y		A2	32.4832	$1,360.98

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57250	Repair rectum & vagina	Y		A2	32.4832	$1,360.98
57260	Repair of vagina	Y		A2	32.4832	$1,360.98
57265	Extensive repair of vagina	Y		A2	41.0953	$1,721.81
57267	Insert mesh/pelvic flr addon	Y		A2	32.4832	$1,360.98
57268	Repair of bowel bulge	Y		A2	32.4832	$1,360.98
57287	Revise/remove sling repair	Y		G2	32.4831	$1,360.98
57288	Repair bladder defect	Y		A2	41.0953	$1,721.81
57289	Repair bladder & vagina	Y		A2	32.4832	$1,360.98
57291	Construction of vagina	Y		A2	32.4832	$1,360.98
57295	Revise vag graft via vagina	Y		G2	18.8307	$788.97
57300	Repair rectum-vagina fistula	Y		A2	32.4832	$1,360.98
57320	Repair bladder-vagina lesion	Y		G2	32.4831	$1,360.98
57400	Dilation of vagina	Y		A2	18.8307	$788.97
57410	Pelvic examination	Y		A2	18.8307	$788.97
57415	Remove vaginal foreign body	Y		A2	18.8307	$788.97
57420	Exam of vagina w/scope	Y		P3		$37.56
57421	Exam/biopsy of vag w/scope	Y		P3		$49.10
57426	Revise prosth vag graft lap	Y		G2	18.8307	$788.97
57452	Exam of cervix w/scope	Y		P3		$35.35
57454	Bx/curett of cervix w/scope	Y		P3		$43.95
57455	Biopsy of cervix w/scope	Y		P3		$45.91
57456	Endocerv curettage w/scope	Y		P3		$44.19
57460	Bx of cervix w/scope, leep	Y		P3		$127.18
57461	Conz of cervix w/scope, leep	Y		P3		$136.26
57500	Biopsy of cervix	Y		P3		$58.92
57505	Endocervical curettage	Y		P3		$39.04
57510	Cauterization of cervix	Y		P3		$40.51
57511	Cryocautery of cervix	Y	CH	P3		$48.86
57513	Laser surgery of cervix	Y		A2	18.8307	$788.97
57520	Conization of cervix	Y		A2	18.8307	$788.97
57522	Conization of cervix	Y		A2	18.8307	$788.97
57530	Removal of cervix	Y		A2	32.4832	$1,360.98
57550	Removal of residual cervix	Y		A2	32.4832	$1,360.98
57556	Remove cervix, repair bowel	Y		A2	41.0953	$1,721.81
57558	D&c of cervical stump	Y		A2	18.8307	$788.97
57700	Revision of cervix	Y		A2	18.8307	$788.97
57720	Revision of cervix	Y		A2	18.8307	$788.97
57800	Dilation of cervical canal	Y		P3		$21.36
58100	Biopsy of uterus lining	Y		P3		$35.11

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
58110	Bx done w/colposcopy add-on	N		N1		
58120	Dilation and curettage	Y		A2	18.8307	$788.97
58145	Myomectomy vag method	Y		A2	32.4832	$1,360.98
58301	Remove intrauterine device	Y		P3		$32.41
58321	Artificial insemination	Y		P3		$29.71
58322	Artificial insemination	Y		P3		$30.69
58323	Sperm washing	Y		P3		$5.89
58340	Catheter for hysterography	N		N1		
58345	Reopen fallopian tube	Y		R2	18.8307	$788.97
58346	Insert heyman uteri capsule	Y		A2	18.8307	$788.97
58350	Reopen fallopian tube	Y		A2	32.4832	$1,360.98
58353	Endometr ablate, thermal	Y		A2	32.4832	$1,360.98
58356	Endometrial cryoablation	Y		P3		$1,237.42
58545	Laparoscopic myomectomy	Y		A2	35.196	$1,474.64
58546	Laparo-myomectomy, complex	Y		A2	43.6665	$1,829.55
58550	Laparo-asst vag hysterectomy	Y		A2	64.6377	$2,708.19
58552	Laparo-vag hyst incl t/o	Y		G2	43.6667	$1,829.55
58555	Hysteroscopy, dx, sep proc	Y		A2	21.0879	$883.54
58558	Hysteroscopy, biopsy	Y		A2	21.0879	$883.54
58559	Hysteroscopy, lysis	Y		A2	21.0879	$883.54
58560	Hysteroscopy, resect septum	Y		A2	34.7943	$1,457.81
58561	Hysteroscopy, remove myoma	Y		A2	34.7943	$1,457.81
58562	Hysteroscopy, remove fb	Y		A2	21.0879	$883.54
58563	Hysteroscopy, ablation	Y		A2	34.7943	$1,457.81
58565	Hysteroscopy, sterilization	Y		A2	41.0953	$1,721.81
58600	Division of fallopian tube	Y		G2	32.4831	$1,360.98
58615	Occlude fallopian tube(s)	Y		G2	18.8307	$788.97
58660	Laparoscopy, lysis	Y		A2	43.6665	$1,829.55
58661	Laparoscopy, remove adnexa	Y		A2	43.6665	$1,829.55
58662	Laparoscopy, excise lesions	Y		A2	43.6665	$1,829.55
58670	Laparoscopy, tubal cautery	Y		A2	43.6665	$1,829.55
58671	Laparoscopy, tubal block	Y		A2	43.6665	$1,829.55
58672	Laparoscopy, fimbrioplasty	Y		A2	43.6665	$1,829.55
58673	Laparoscopy, salpingostomy	Y		A2	43.6665	$1,829.55
58800	Drainage of ovarian cyst(s)	Y		A2	18.8307	$788.97
58805	Drainage of ovarian cyst(s)	Y		G2	32.4831	$1,360.98
58820	Drain ovary abscess, open	Y		A2	32.4832	$1,360.98
58900	Biopsy of ovary(s)	Y		A2	18.8307	$788.97
58970	Retrieval of oocyte	Y		A2	3.2336	$135.48

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
58974	Transfer of embryo	Y		A2	3.2336	$135.48
58976	Transfer of embryo	Y		A2	3.2336	$135.48
59000	Amniocentesis, diagnostic	Y		P3		$51.07
59001	Amniocentesis, therapeutic	Y		R2	6.1396	$257.24
59012	Fetal cord puncture,prenatal	Y		G2	3.2335	$135.48
59015	Chorion biopsy	Y		P3		$43.95
59020	Fetal contract stress test	Y		P3		$22.34
59025	Fetal non-stress test	Y		P3		$12.03
59070	Transabdom amnioinfus w/us	Y		G2	1.4521	$60.84
59072	Umbilical cord occlud w/us	Y		G2	3.2335	$135.48
59076	Fetal shunt placement, w/us	Y		G2	3.2335	$135.48
59100	Remove uterus lesion	Y		R2	32.4831	$1,360.98
59150	Treat ectopic pregnancy	Y		G2	43.6667	$1,829.55
59151	Treat ectopic pregnancy	Y		G2	43.6667	$1,829.55
59160	D & c after delivery	Y		A2	18.8307	$788.97
59200	Insert cervical dilator	Y		P3		$27.99
59300	Episiotomy or vaginal repair	Y		P3		$63.34
59320	Revision of cervix	Y		A2	18.8307	$788.97
59412	Antepartum manipulation	Y		G2	18.8307	$788.97
59414	Deliver placenta	Y		G2	18.8307	$788.97
59812	Treatment of miscarriage	Y		A2	18.8307	$788.97
59820	Care of miscarriage	Y		A2	18.8307	$788.97
59821	Treatment of miscarriage	Y		A2	18.8307	$788.97
59840	Abortion	Y		A2	18.8307	$788.97
59841	Abortion	Y		A2	18.8307	$788.97
59866	Abortion (mpr)	Y		G2	3.2335	$135.48
59870	Evacuate mole of uterus	Y		A2	18.8307	$788.97
59871	Remove cerclage suture	Y		A2	18.8307	$788.97
60000	Drain thyroid/tongue cyst	Y		A2	7.1579	$299.89
60100	Biopsy of thyroid	Y		P3		$37.56
60200	Remove thyroid lesion	Y		A2	46.3447	$1,941.75
60210	Partial thyroid excision	Y		G2	46.3448	$1,941.75
60212	Partial thyroid excision	Y		G2	46.3448	$1,941.75
60220	Partial removal of thyroid	Y		G2	46.3448	$1,941.75
60225	Partial removal of thyroid	Y		G2	46.3448	$1,941.75
60280	Remove thyroid duct lesion	Y		A2	46.3447	$1,941.75
60281	Remove thyroid duct lesion	Y		A2	46.3447	$1,941.75
60300	Aspir/inj thyroid cyst	Y		P3		$52.30
61000	Remove cranial cavity fluid	Y		R2	7.0178	$294.03

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
61001	Remove cranial cavity fluid	Y		R2	7.0178	$294.03
61020	Remove brain cavity fluid	Y		A2	7.0178	$294.03
61026	Injection into brain canal	Y		A2	7.0178	$294.03
61050	Remove brain canal fluid	Y		A2	7.0178	$294.03
61055	Injection into brain canal	Y		A2	7.0178	$294.03
61070	Brain canal shunt procedure	Y		A2	5.7506	$240.94
61215	Insert brain-fluid device	Y		A2	38.1505	$1,598.43
61330	Decompress eye socket	Y		G2	40.7633	$1,707.90
61334	Explore orbit/remove object	Y		G2	40.7633	$1,707.90
61770	Incise skull for treatment	Y		G2	34.1189	$1,429.51
61790	Treat trigeminal nerve	Y		A2	17.5922	$737.08
61791	Treat trigeminal tract	Y		A2	12.0953	$506.77
61795	Brain surgery using computer	N		N1		
61880	Revise/remove neuroelectrode	Y		G2	19.9365	$835.30
61885	Insrt/redo neurostim 1 array	N		H8	320.6516	$13,434.66
61886	Implant neurostim arrays	N		H8	416.5122	$17,451.03
61888	Revise/remove neuroreceiver	Y		A2	26.8896	$1,126.62
62160	Neuroendoscopy add-on	N		N1		
62194	Replace/irrigate catheter	Y		A2	7.0178	$294.03
62225	Replace/irrigate catheter	Y		A2	14.8714	$623.08
62230	Replace/revise brain shunt	Y		A2	38.1505	$1,598.43
62252	Csf shunt reprogram	N		P3		$39.77
62263	Epidural lysis mult sessions	Y		A2	7.0178	$294.03
62264	Epidural lysis on single day	Y		A2	12.0953	$506.77
62267	Interdiscal perq aspir, dx	Y		G2	4.2381	$177.57
62268	Drain spinal cord cyst	Y		A2	7.0178	$294.03
62269	Needle biopsy, spinal cord	Y		A2	9.0033	$377.22
62270	Spinal fluid tap, diagnostic	Y		A2	3.5267	$147.76
62272	Drain cerebro spinal fluid	Y		A2	3.5267	$147.76
62273	Inject epidural patch	Y		A2	7.0178	$294.03
62280	Treat spinal cord lesion	Y		A2	7.0178	$294.03
62281	Treat spinal cord lesion	Y		A2	7.0178	$294.03
62282	Treat spinal canal lesion	Y		A2	7.0178	$294.03
62284	Injection for myelogram	N		N1		
62287	Percutaneous diskectomy	Y		A2	34.1188	$1,429.51
62290	Inject for spine disk x-ray	N		N1		
62291	Inject for spine disk x-ray	N		N1		
62292	Injection into disk lesion	Y		R2	7.0178	$294.03
62294	Injection into spinal artery	Y		A2	7.0178	$294.03

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
62310	Inject spine c/t	Y		A2	7.0178	$294.03
62311	Inject spine l/s (cd)	Y		A2	7.0178	$294.03
62318	Inject spine w/cath, c/t	Y		A2	7.0178	$294.03
62319	Inject spine w/cath l/s (cd)	Y		A2	12.0953	$506.77
62350	Implant spinal canal cath	Y		A2	38.1505	$1,598.43
62355	Remove spinal canal catheter	Y		A2	12.0953	$506.77
62360	Insert spine infusion device	Y		A2	38.1505	$1,598.43
62361	Implant spine infusion pump	Y		H8	291.0141	$12,192.91
62362	Implant spine infusion pump	Y		H8	291.0141	$12,192.91
62365	Remove spine infusion device	Y		A2	34.1188	$1,429.51
62367	Analyze spine infusion pump	N		P3		$15.96
62368	Analyze spine infusion pump	N		P3		$21.36
63600	Remove spinal cord lesion	Y		A2	17.5922	$737.08
63610	Stimulation of spinal cord	Y		A2	17.5922	$737.08
63615	Remove lesion of spinal cord	Y		R2	17.5923	$737.08
63650	Implant neuroelectrodes	N		H8	86.0561	$3,605.58
63655	Implant neuroelectrodes	N		J8	120.9392	$5,067.11
63661	Remove spine eltrd perq aray	Y		G2	19.9365	$835.30
63662	Remove spine eltrd plate	Y		G2	19.9365	$835.30
63663	Revise spine eltrd perq aray	Y		G2	19.9365	$835.30
63664	Revise spine eltrd plate	Y		G2	19.9365	$835.30
63685	Insrt/redo spine n generator	N		H8	320.6516	$13,434.66
63688	Revise/remove neuroreceiver	Y		A2	26.8896	$1,126.62
63744	Revision of spinal shunt	Y		A2	38.1505	$1,598.43
63746	Removal of spinal shunt	Y		A2	12.0953	$506.77
64400	N block inj, trigeminal	Y		P3		$49.10
64402	N block inj, facial	Y		P3		$45.42
64405	N block inj, occipital	Y		P3		$41.74
64408	N block inj, vagus	Y		P3		$49.10
64410	N block inj, phrenic	Y		A2	7.0178	$294.03
64412	N block inj, spinal accessor	Y		P3		$72.67
64413	N block inj, cervical plexus	Y		P3		$45.42
64415	N block inj, brachial plexus	Y		A2	3.5267	$147.76
64416	N block cont infuse, b plex	Y		G2	7.0178	$294.03
64417	N block inj, axillary	Y		A2	3.5267	$147.76
64418	N block inj, suprascapular	Y		P3		$62.36
64420	N block inj, intercost, sng	Y		A2	3.5267	$147.76
64421	N block inj, intercost, mlt	Y		A2	7.0178	$294.03
64425	N block inj, ilio-ing/hypogi	Y		P3		$45.91

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64430	N block inj, pudendal	Y		A2	7.0178	$294.03
64435	N block inj, paracervical	Y		P3		$59.17
64445	N block inj, sciatic, sng	Y		P3		$55.00
64446	N blk inj, sciatic, cont inf	Y		G2	12.0953	$506.77
64447	N block inj fem, single	Y		R2	7.0178	$294.03
64448	N block inj fem, cont inf	Y		G2	7.0178	$294.03
64449	N block inj, lumbar plexus	Y		G2	7.0178	$294.03
64450	N block, other peripheral	Y		P3		$39.28
64455	N block inj, plantar digit	Y		P3		$14.73
64479	Inj foramen epidural c/t	Y		A2	7.0178	$294.03
64480	Inj foramen epidural add-on	Y		A2	3.5267	$147.76
64483	Inj foramen epidural l/s	Y		A2	7.0178	$294.03
64484	Inj foramen epidural add-on	Y		A2	3.5267	$147.76
64490	Inj paravert f jnt c/t 1 lev	Y		G2	7.0178	$294.03
64491	Inj paravert f jnt c/t 2 lev	Y		G2	2.4234	$101.54
64492	Inj paravert f jnt c/t 3 lev	Y		G2	2.4234	$101.54
64493	Inj paravert f jnt l/s 1 lev	Y		G2	7.0178	$294.03
64494	Inj paravert f jnt l/s 2 lev	Y		G2	2.4234	$101.54
64495	Inj paravert f jnt l/s 3 lev	Y		G2	2.4234	$101.54
64505	N block, spenopalatine gangl	Y		P3		$34.37
64508	N block, carotid sinus s/p	Y		P3		$79.30
64510	N block, stellate ganglion	Y		A2	7.0178	$294.03
64517	N block inj, hypogas plxs	Y		A2	7.0178	$294.03
64520	N block, lumbar/thoracic	Y		A2	7.0178	$294.03
64530	N block inj, celiac pelus	Y		A2	7.0178	$294.03
64553	Implant neuroelectrodes	N		H8	86.0561	$3,605.58
64555	Implant neuroelectrodes	N		J8	86.0561	$3,605.58
64560	Implant neuroelectrodes	N		J8	86.0561	$3,605.58
64561	Implant neuroelectrodes	N		H8	86.0561	$3,605.58
64565	Implant neuroelectrodes	N		J8	86.0561	$3,605.58
64573	Implant neuroelectrodes	N		H8	313.8252	$13,148.65
64575	Implant neuroelectrodes	N		H8	120.9392	$5,067.11
64577	Implant neuroelectrodes	N		H8	120.9392	$5,067.11
64580	Implant neuroelectrodes	N		H8	120.9392	$5,067.11
64581	Implant neuroelectrodes	N		H8	120.9392	$5,067.11
64585	Revise/remove neuroelectrode	Y		A2	19.9365	$835.30
64590	Insrt/redo pn/gastr stimul	N		H8	320.6516	$13,434.66
64595	Revise/rmv pn/gastr stimul	Y		A2	26.8896	$1,126.62
64600	Injection treatment of nerve	Y		A2	12.0953	$506.77

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64605	Injection treatment of nerve	Y		A2	17.5922	$737.08
64610	Injection treatment of nerve	Y		A2	17.5922	$737.08
64612	Destroy nerve, face muscle	Y		P3		$57.70
64613	Destroy nerve, neck muscle	Y		P3		$53.52
64614	Destroy nerve, extrem musc	Y		P3		$60.89
64620	Injection treatment of nerve	Y		A2	7.0178	$294.03
64622	Destr paravertebrl nerve l/s	Y		A2	12.0953	$506.77
64623	Destr paravertebral n add-on	Y		A2	7.0178	$294.03
64626	Destr paravertebrl nerve c/t	Y		A2	7.0178	$294.03
64627	Destr paravertebral n add-on	Y		A2	2.4235	$101.54
64630	Injection treatment of nerve	Y		A2	7.0178	$294.03
64632	N block inj, common digit	Y		P3		$28.23
64640	Injection treatment of nerve	Y		P3		$81.51
64650	Chemodenerv eccrine glands	Y		P3		$30.20
64653	Chemodenerv eccrine glands	Y		P3		$33.64
64680	Injection treatment of nerve	Y		A2	7.0178	$294.03
64681	Injection treatment of nerve	Y		A2	12.0953	$506.77
64702	Revise finger/toe nerve	Y		A2	17.5922	$737.08
64704	Revise hand/foot nerve	Y		A2	17.5922	$737.08
64708	Revise arm/leg nerve	Y		A2	17.5922	$737.08
64712	Revision of sciatic nerve	Y		A2	17.5922	$737.08
64713	Revision of arm nerve(s)	Y		A2	17.5922	$737.08
64714	Revise low back nerve(s)	Y		A2	17.5922	$737.08
64716	Revision of cranial nerve	Y		A2	17.5922	$737.08
64718	Revise ulnar nerve at elbow	Y		A2	17.5922	$737.08
64719	Revise ulnar nerve at wrist	Y		A2	17.5922	$737.08
64721	Carpal tunnel surgery	Y		A2	17.5922	$737.08
64722	Relieve pressure on nerve(s)	Y		A2	17.5922	$737.08
64726	Release foot/toe nerve	Y		A2	17.5922	$737.08
64727	Internal nerve revision	Y		A2	17.5922	$737.08
64732	Incision of brow nerve	Y		A2	17.5922	$737.08
64734	Incision of cheek nerve	Y		A2	17.5922	$737.08
64736	Incision of chin nerve	Y		A2	17.5922	$737.08
64738	Incision of jaw nerve	Y		A2	17.5922	$737.08
64740	Incision of tongue nerve	Y		A2	17.5922	$737.08
64742	Incision of facial nerve	Y		A2	17.5922	$737.08
64744	Incise nerve, back of head	Y		A2	17.5922	$737.08
64746	Incise diaphragm nerve	Y		A2	17.5922	$737.08
64761	Incision of pelvis nerve	Y		G2	17.5923	$737.08

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64763	Incise hip/thigh nerve	Y		G2	17.5923	$737.08
64766	Incise hip/thigh nerve	Y		G2	34.1189	$1,429.51
64771	Sever cranial nerve	Y		A2	17.5922	$737.08
64772	Incision of spinal nerve	Y		A2	17.5922	$737.08
64774	Remove skin nerve lesion	Y		A2	17.5922	$737.08
64776	Remove digit nerve lesion	Y		A2	17.5922	$737.08
64778	Digit nerve surgery add-on	Y		A2	17.5922	$737.08
64782	Remove limb nerve lesion	Y		A2	17.5922	$737.08
64783	Limb nerve surgery add-on	Y		A2	17.5922	$737.08
64784	Remove nerve lesion	Y		A2	17.5922	$737.08
64786	Remove sciatic nerve lesion	Y		A2	34.1188	$1,429.51
64787	Implant nerve end	Y		A2	17.5922	$737.08
64788	Remove skin nerve lesion	Y		A2	17.5922	$737.08
64790	Removal of nerve lesion	Y		A2	17.5922	$737.08
64792	Removal of nerve lesion	Y		A2	34.1188	$1,429.51
64795	Biopsy of nerve	Y		A2	17.5922	$737.08
64802	Remove sympathetic nerves	Y		A2	17.5922	$737.08
64820	Remove sympathetic nerves	Y		G2	17.5923	$737.08
64821	Remove sympathetic nerves	Y		A2	27.1049	$1,135.64
64822	Remove sympathetic nerves	Y		G2	27.1049	$1,135.64
64823	Remove sympathetic nerves	Y		G2	27.1049	$1,135.64
64831	Repair of digit nerve	Y		A2	34.1188	$1,429.51
64832	Repair nerve add-on	Y		A2	34.1188	$1,429.51
64834	Repair of hand or foot nerve	Y		A2	34.1188	$1,429.51
64835	Repair of hand or foot nerve	Y		A2	34.1188	$1,429.51
64836	Repair of hand or foot nerve	Y		A2	34.1188	$1,429.51
64837	Repair nerve add-on	Y		A2	34.1188	$1,429.51
64840	Repair of leg nerve	Y		A2	34.1188	$1,429.51
64856	Repair/transpose nerve	Y		A2	34.1188	$1,429.51
64857	Repair arm/leg nerve	Y		A2	34.1188	$1,429.51
64858	Repair sciatic nerve	Y		A2	34.1188	$1,429.51
64859	Nerve surgery	Y		A2	34.1188	$1,429.51
64861	Repair of arm nerves	Y		A2	34.1188	$1,429.51
64862	Repair of low back nerves	Y		A2	34.1188	$1,429.51
64864	Repair of facial nerve	Y		A2	34.1188	$1,429.51
64865	Repair of facial nerve	Y		A2	34.1188	$1,429.51
64870	Fusion of facial/other nerve	Y		A2	34.1188	$1,429.51
64872	Subsequent repair of nerve	Y		A2	34.1188	$1,429.51
64874	Repair & revise nerve add-on	Y		A2	34.1188	$1,429.51

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
64876	Repair nerve/shorten bone	Y		A2	34.1188	$1,429.51
64885	Nerve graft, head or neck	Y		A2	34.1188	$1,429.51
64886	Nerve graft, head or neck	Y		A2	34.1188	$1,429.51
64890	Nerve graft, hand or foot	Y		A2	34.1188	$1,429.51
64891	Nerve graft, hand or foot	Y		A2	34.1188	$1,429.51
64892	Nerve graft, arm or leg	Y		A2	34.1188	$1,429.51
64893	Nerve graft, arm or leg	Y		A2	34.1188	$1,429.51
64895	Nerve graft, hand or foot	Y		A2	34.1188	$1,429.51
64896	Nerve graft, hand or foot	Y		A2	34.1188	$1,429.51
64897	Nerve graft, arm or leg	Y		A2	34.1188	$1,429.51
64898	Nerve graft, arm or leg	Y		A2	34.1188	$1,429.51
64901	Nerve graft add-on	Y		A2	34.1188	$1,429.51
64902	Nerve graft add-on	Y		A2	34.1188	$1,429.51
64905	Nerve pedicle transfer	Y		A2	34.1188	$1,429.51
64907	Nerve pedicle transfer	Y		A2	34.1188	$1,429.51
64910	Nerve repair w/allograft	Y		G2	34.1189	$1,429.51
65091	Revise eye	Y		A2	35.7611	$1,498.32
65093	Revise eye with implant	Y		A2	35.7611	$1,498.32
65101	Removal of eye	Y		A2	35.7611	$1,498.32
65103	Remove eye/insert implant	Y		A2	35.7611	$1,498.32
65105	Remove eye/attach implant	Y		A2	35.7611	$1,498.32
65110	Removal of eye	Y		A2	35.7611	$1,498.32
65112	Remove eye/revise socket	Y		A2	35.7611	$1,498.32
65114	Remove eye/revise socket	Y		A2	35.7611	$1,498.32
65125	Revise ocular implant	Y		G2	24.4266	$1,023.43
65130	Insert ocular implant	Y		A2	24.4265	$1,023.43
65135	Insert ocular implant	Y		A2	24.4265	$1,023.43
65140	Attach ocular implant	Y		A2	35.7611	$1,498.32
65150	Revise ocular implant	Y		A2	24.4265	$1,023.43
65155	Reinsert ocular implant	Y		A2	35.7611	$1,498.32
65175	Removal of ocular implant	Y		A2	18.1698	$761.28
65205	Remove foreign body from eye	N		P3		$18.66
65210	Remove foreign body from eye	N		P3		$24.31
65220	Remove foreign body from eye	N		G2	0.8468	$35.48
65222	Remove foreign body from eye	N		P3		$26.52
65235	Remove foreign body from eye	Y		A2	15.5346	$650.87
65260	Remove foreign body from eye	Y		A2	4.8105	$201.55
65265	Remove foreign body from eye	Y		A2	21.159	$886.52
65270	Repair of eye wound	Y		A2	18.1698	$761.28

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
65272	Repair of eye wound	Y		A2	22.292	$933.99
65275	Repair of eye wound	Y		A2	22.292	$933.99
65280	Repair of eye wound	Y		A2	21.159	$886.52
65285	Repair of eye wound	Y		A2	36.9483	$1,548.07
65286	Repair of eye wound	Y	CH	P3		$296.83
65290	Repair of eye socket wound	Y		A2	23.0114	$964.13
65400	Removal of eye lesion	Y		A2	15.5346	$650.87
65410	Biopsy of cornea	Y		A2	15.5346	$650.87
65420	Removal of eye lesion	Y		A2	15.5346	$650.87
65426	Removal of eye lesion	Y		A2	22.292	$933.99
65430	Corneal smear	N		P2	0.8468	$35.48
65435	Curette/treat cornea	Y		P3		$29.46
65436	Curette/treat cornea	Y		P3		$132.58
65450	Treatment of corneal lesion	N		G2	2.0838	$87.31
65600	Revision of cornea	Y		P3		$152.22
65710	Corneal transplant	Y		A2	35.4855	$1,486.77
65730	Corneal transplant	Y		A2	35.4855	$1,486.77
65750	Corneal transplant	Y		A2	35.4855	$1,486.77
65755	Corneal transplant	Y		A2	35.4855	$1,486.77
65756	Corneal trnspl, endothelial	Y		G2	35.4855	$1,486.77
65757	Prep corneal endo allograft	N		N1		
65770	Revise cornea with implant	Y		H8	151.1101	$6,331.21
65772	Correction of astigmatism	Y		A2	15.5346	$650.87
65775	Correction of astigmatism	Y		A2	15.5346	$650.87
65780	Ocular reconst, transplant	Y		A2	35.4855	$1,486.77
65781	Ocular reconst, transplant	Y		A2	35.4855	$1,486.77
65782	Ocular reconst, transplant	Y		A2	35.4855	$1,486.77
65800	Drainage of eye	Y		A2	7.1602	$299.99
65805	Drainage of eye	Y		A2	15.5346	$650.87
65810	Drainage of eye	Y		A2	22.292	$933.99
65815	Drainage of eye	Y		A2	22.292	$933.99
65820	Relieve inner eye pressure	Y		A2	22.292	$933.99
65850	Incision of eye	Y		A2	22.292	$933.99
65855	Laser surgery of eye	Y		P3		$123.25
65860	Incise inner eye adhesions	Y		P3		$114.17
65865	Incise inner eye adhesions	Y		A2	15.5346	$650.87
65870	Incise inner eye adhesions	Y		A2	22.292	$933.99
65875	Incise inner eye adhesions	Y		A2	22.292	$933.99
65880	Incise inner eye adhesions	Y		A2	15.5346	$650.87

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
65900	Remove eye lesion	Y		A2	2.2567	$94.56
65920	Remove implant of eye	Y		A2	22.292	$933.99
65930	Remove blood clot from eye	Y		A2	22.292	$933.99
66020	Injection treatment of eye	Y		A2	15.5346	$650.87
66030	Injection treatment of eye	Y		A2	15.5346	$650.87
66130	Remove eye lesion	Y		A2	22.292	$933.99
66150	Glaucoma surgery	Y		A2	22.292	$933.99
66155	Glaucoma surgery	Y		A2	22.292	$933.99
66160	Glaucoma surgery	Y		A2	22.292	$933.99
66165	Glaucoma surgery	Y		A2	22.292	$933.99
66170	Glaucoma surgery	Y		A2	22.292	$933.99
66172	Incision of eye	Y		A2	22.292	$933.99
66180	Implant eye shunt	Y		A2	40.4623	$1,695.29
66185	Revise eye shunt	Y		A2	22.292	$933.99
66220	Repair eye lesion	Y		A2	36.9483	$1,548.07
66225	Repair/graft eye lesion	Y		A2	40.4623	$1,695.29
66250	Follow-up surgery of eye	Y		A2	15.5346	$650.87
66500	Incision of iris	Y		A2	2.2567	$94.56
66505	Incision of iris	Y		A2	7.1602	$299.99
66600	Remove iris and lesion	Y		A2	22.292	$933.99
66605	Removal of iris	Y		A2	22.292	$933.99
66625	Removal of iris	Y		A2	7.1602	$299.99
66630	Removal of iris	Y		A2	22.292	$933.99
66635	Removal of iris	Y		A2	22.292	$933.99
66680	Repair iris & ciliary body	Y		A2	22.292	$933.99
66682	Repair iris & ciliary body	Y		A2	22.292	$933.99
66700	Destruction, ciliary body	Y		A2	15.5346	$650.87
66710	Ciliary transscleral therapy	Y		A2	15.5346	$650.87
66711	Ciliary endoscopic ablation	Y		A2	15.5346	$650.87
66720	Destruction, ciliary body	Y		A2	15.5346	$650.87
66740	Destruction, ciliary body	Y		A2	22.292	$933.99
66761	Revision of iris	Y		P3		$172.36
66762	Revision of iris	Y	CH	P3		$176.04
66770	Removal of inner eye lesion	Y	CH	P3		$191.51
66820	Incision, secondary cataract	Y		G2	7.1601	$299.99
66821	After cataract laser surgery	Y		A2	5.0594	$211.98
66825	Reposition intraocular lens	Y		A2	22.292	$933.99
66830	Removal of lens lesion	Y		A2	7.1602	$299.99
66840	Removal of lens material	Y		A2	13.0166	$545.37

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
66850	Removal of lens material	Y		A2	28.1963	$1,181.37
66852	Removal of lens material	Y		A2	28.1963	$1,181.37
66920	Extraction of lens	Y		A2	28.1963	$1,181.37
66930	Extraction of lens	Y		A2	28.1963	$1,181.37
66940	Extraction of lens	Y		A2	13.0166	$545.37
66982	Cataract surgery, complex	Y		A2	22.524	$943.71
66983	Cataract surg w/iol, 1 stage	Y		A2	22.524	$943.71
66984	Cataract surg w/iol, 1 stage	Y		A2	22.524	$943.71
66985	Insert lens prosthesis	Y		A2	22.524	$943.71
66986	Exchange lens prosthesis	Y		A2	22.524	$943.71
66990	Ophthalmic endoscope add-on	N		N1		
67005	Partial removal of eye fluid	Y		A2	21.159	$886.52
67010	Partial removal of eye fluid	Y		A2	36.9483	$1,548.07
67015	Release of eye fluid	Y		A2	36.9483	$1,548.07
67025	Replace eye fluid	Y		A2	36.9483	$1,548.07
67027	Implant eye drug system	Y		A2	36.9483	$1,548.07
67028	Injection eye drug	Y		P3		$76.11
67030	Incise inner eye strands	Y		A2	21.159	$886.52
67031	Laser surgery, eye strands	Y		A2	5.0594	$211.98
67036	Removal of inner eye fluid	Y		A2	36.9483	$1,548.07
67039	Laser treatment of retina	Y		A2	36.9483	$1,548.07
67040	Laser treatment of retina	Y		A2	36.9483	$1,548.07
67041	Vit for macular pucker	Y		G2	36.9485	$1,548.07
67042	Vit for macular hole	Y		G2	36.9485	$1,548.07
67043	Vit for membrane dissect	Y		G2	36.9485	$1,548.07
67101	Repair detached retina	Y		P3		$291.19
67105	Repair detached retina	Y		P2	5.0594	$211.98
67107	Repair detached retina	Y		A2	36.9483	$1,548.07
67108	Repair detached retina	Y		A2	36.9483	$1,548.07
67110	Repair detached retina	Y		P3		$312.55
67112	Rerepair detached retina	Y		A2	36.9483	$1,548.07
67113	Repair retinal detach, cplx	Y		G2	36.9485	$1,548.07
67115	Release encircling material	Y		A2	21.159	$886.52
67120	Remove eye implant material	Y		A2	21.159	$886.52
67121	Remove eye implant material	Y		A2	36.9483	$1,548.07
67141	Treatment of retina	Y		A2	4.8105	$201.55
67145	Treatment of retina	Y	CH	P3		$186.10
67208	Treatment of retinal lesion	Y	CH	P3		$200.59
67210	Treatment of retinal lesion	Y		P2	5.0594	$211.98

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
67218	Treatment of retinal lesion	Y		A2	21.159	$886.52
67220	Treatment of choroid lesion	Y		P2	4.8105	$201.55
67221	Ocular photodynamic ther	Y		P3		$105.82
67225	Eye photodynamic ther add-on	Y		P3		$8.10
67227	Treatment of retinal lesion	Y		A2	21.159	$886.52
67228	Treatment of retinal lesion	Y		P2	5.0594	$211.98
67229*	Tr retinal les preterm inf	Y		R2	5.0594	$211.98
67250	Reinforce eye wall	Y		A2	18.1698	$761.28
67255	Reinforce/graft eye wall	Y		A2	21.159	$886.52
67311	Revise eye muscle	Y		A2	23.0114	$964.13
67312	Revise two eye muscles	Y		A2	23.0114	$964.13
67314	Revise eye muscle	Y		A2	23.0114	$964.13
67316	Revise two eye muscles	Y		A2	23.0114	$964.13
67318	Revise eye muscle(s)	Y		A2	23.0114	$964.13
67320	Revise eye muscle(s) add-on	Y		A2	23.0114	$964.13
67331	Eye surgery follow-up add-on	Y		A2	23.0114	$964.13
67332	Rerevise eye muscles add-on	Y		A2	23.0114	$964.13
67334	Revise eye muscle w/suture	Y		A2	23.0114	$964.13
67335	Eye suture during surgery	Y		A2	23.0114	$964.13
67340	Revise eye muscle add-on	Y		A2	23.0114	$964.13
67343	Release eye tissue	Y		A2	23.0114	$964.13
67345	Destroy nerve of eye muscle	Y		P3		$78.08
67346	Biopsy, eye muscle	Y		A2	15.1275	$633.81
67400	Explore/biopsy eye socket	Y		A2	18.1698	$761.28
67405	Explore/drain eye socket	Y		A2	24.4265	$1,023.43
67412	Explore/treat eye socket	Y		A2	18.1698	$761.28
67413	Explore/treat eye socket	Y		A2	24.4265	$1,023.43
67414	Explr/decompress eye socket	Y		G2	35.7612	$1,498.32
67415	Aspiration, orbital contents	Y		A2	18.1698	$761.28
67420	Explore/treat eye socket	Y		A2	35.7611	$1,498.32
67430	Explore/treat eye socket	Y		A2	35.7611	$1,498.32
67440	Explore/drain eye socket	Y		A2	35.7611	$1,498.32
67445	Explr/decompress eye socket	Y		A2	35.7611	$1,498.32
67450	Explore/biopsy eye socket	Y		A2	35.7611	$1,498.32
67500	Inject/treat eye socket	N		G2	2.0838	$87.31
67505	Inject/treat eye socket	Y		P3		$26.52
67515	Inject/treat eye socket	Y		P3		$27.74
67550	Insert eye socket implant	Y		A2	35.7611	$1,498.32
67560	Revise eye socket implant	Y		A2	24.4265	$1,023.43

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
67570	Decompress optic nerve	Y		A2	35.7611	$1,498.32
67700	Drainage of eyelid abscess	Y		P2	2.8731	$120.38
67710	Incision of eyelid	Y		P3		$121.78
67715	Incision of eyelid fold	Y		A2	18.1698	$761.28
67800	Remove eyelid lesion	Y		P3		$48.12
67801	Remove eyelid lesions	Y		P3		$58.68
67805	Remove eyelid lesions	Y		P3		$75.62
67808	Remove eyelid lesion(s)	Y		A2	18.1698	$761.28
67810	Biopsy of eyelid	Y	CH	P3		$109.99
67820	Revise eyelashes	N		P3		$15.96
67825	Revise eyelashes	Y		P3		$48.61
67830	Revise eyelashes	Y		A2	7.0748	$296.42
67835	Revise eyelashes	Y		A2	18.1698	$761.28
67840	Remove eyelid lesion	Y		P3		$130.62
67850	Treat eyelid lesion	Y		P3		$102.14
67875	Closure of eyelid by suture	Y		G2	7.0747	$296.42
67880	Revision of eyelid	Y		A2	15.5346	$650.87
67882	Revision of eyelid	Y		A2	18.1698	$761.28
67900	Repair brow defect	Y		A2	24.4265	$1,023.43
67901	Repair eyelid defect	Y		A2	18.1698	$761.28
67902	Repair eyelid defect	Y		A2	24.4265	$1,023.43
67903	Repair eyelid defect	Y		A2	18.1698	$761.28
67904	Repair eyelid defect	Y		A2	18.1698	$761.28
67906	Repair eyelid defect	Y		A2	18.1698	$761.28
67908	Repair eyelid defect	Y		A2	18.1698	$761.28
67909	Revise eyelid defect	Y		A2	18.1698	$761.28
67911	Revise eyelid defect	Y		A2	18.1698	$761.28
67912	Correction eyelid w/implant	Y		A2	18.1698	$761.28
67914	Repair eyelid defect	Y		A2	18.1698	$761.28
67915	Repair eyelid defect	Y		P3		$147.31
67916	Repair eyelid defect	Y		A2	18.1698	$761.28
67917	Repair eyelid defect	Y		A2	18.1698	$761.28
67921	Repair eyelid defect	Y		A2	18.1698	$761.28
67922	Repair eyelid defect	Y		P3		$142.89
67923	Repair eyelid defect	Y		A2	18.1698	$761.28
67924	Repair eyelid defect	Y		A2	18.1698	$761.28
67930	Repair eyelid wound	Y		P3		$149.77
67935	Repair eyelid wound	Y		A2	18.1698	$761.28
67938	Remove eyelid foreign body	N		P2	2.0838	$87.31

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HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
67950	Revision of eyelid	Y		A2	18.1698	$761.28
67961	Revision of eyelid	Y		A2	18.1698	$761.28
67966	Revision of eyelid	Y		A2	18.1698	$761.28
67971	Reconstruction of eyelid	Y		A2	18.1698	$761.28
67973	Reconstruction of eyelid	Y		A2	24.4265	$1,023.43
67974	Reconstruction of eyelid	Y		A2	18.1698	$761.28
67975	Reconstruction of eyelid	Y		A2	18.1698	$761.28
68020	Incise/drain eyelid lining	Y		P3		$42.97
68040	Treatment of eyelid lesions	N		P3		$21.61
68100	Biopsy of eyelid lining	Y		P3		$78.57
68110	Remove eyelid lining lesion	Y		P3		$103.12
68115	Remove eyelid lining lesion	Y		A2	18.1698	$761.28
68130	Remove eyelid lining lesion	Y		A2	15.5346	$650.87
68135	Remove eyelid lining lesion	Y		P3		$55.24
68200	Treat eyelid by injection	N		P3		$15.71
68320	Revise/graft eyelid lining	Y		A2	24.4265	$1,023.43
68325	Revise/graft eyelid lining	Y		A2	24.4265	$1,023.43
68326	Revise/graft eyelid lining	Y		A2	18.1698	$761.28
68328	Revise/graft eyelid lining	Y		A2	24.4265	$1,023.43
68330	Revise eyelid lining	Y		A2	22.292	$933.99
68335	Revise/graft eyelid lining	Y		A2	24.4265	$1,023.43
68340	Separate eyelid adhesions	Y		A2	18.1698	$761.28
68360	Revise eyelid lining	Y		A2	22.292	$933.99
68362	Revise eyelid lining	Y		A2	22.292	$933.99
68371	Harvest eye tissue, alograft	Y		A2	15.5346	$650.87
68400	Incise/drain tear gland	Y		P2	2.8731	$120.38
68420	Incise/drain tear sac	Y		P3		$152.47
68440	Incise tear duct opening	Y		P3		$44.44
68500	Removal of tear gland	Y		A2	24.4265	$1,023.43
68505	Partial removal, tear gland	Y		A2	24.4265	$1,023.43
68510	Biopsy of tear gland	Y		A2	18.1698	$761.28
68520	Removal of tear sac	Y		A2	24.4265	$1,023.43
68525	Biopsy of tear sac	Y		A2	18.1698	$761.28
68530	Clearance of tear duct	Y		P2	2.8731	$120.38
68540	Remove tear gland lesion	Y		A2	18.1698	$761.28
68550	Remove tear gland lesion	Y		A2	24.4265	$1,023.43
68700	Repair tear ducts	Y		A2	18.1698	$761.28
68705	Revise tear duct opening	Y	CH	P3		$103.36
68720	Create tear sac drain	Y		A2	24.4265	$1,023.43

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
68745	Create tear duct drain	Y		A2	24.4265	$1,023.43
68750	Create tear duct drain	Y		A2	24.4265	$1,023.43
68760	Close tear duct opening	Y		P3		$87.90
68761	Close tear duct opening	Y		P3		$61.87
68770	Close tear system fistula	Y		A2	24.4265	$1,023.43
68801	Dilate tear duct opening	N		P2	0.8468	$35.48
68810	Probe nasolacrimal duct	Y		A2	2.8732	$120.38
68811	Probe nasolacrimal duct	Y		A2	18.1698	$761.28
68815	Probe nasolacrimal duct	Y		A2	18.1698	$761.28
68816	Probe nl duct w/balloon	Y		G2	18.1699	$761.28
68840	Explore/irrigate tear ducts	N		P3		$50.58
68850	Injection for tear sac x-ray	N		N1		
69000	Drain external ear lesion	Y		P2	1.358	$56.90
69005	Drain external ear lesion	Y		P3		$92.07
69020	Drain outer ear canal lesion	Y		P2	1.358	$56.90
69100	Biopsy of external ear	Y		P3		$50.82
69105	Biopsy of external ear canal	Y		P3		$76.60
69110	Remove external ear, partial	Y		A2	16.564	$694.00
69120	Removal of external ear	Y		A2	23.2154	$972.69
69140	Remove ear canal lesion(s)	Y		A2	23.2154	$972.69
69145	Remove ear canal lesion(s)	Y		A2	16.564	$694.00
69150	Extensive ear canal surgery	Y		A2	7.1579	$299.89
69200	Clear outer ear canal	N		P2	0.6271	$26.27
69205	Clear outer ear canal	Y		A2	21.9314	$918.88
69210	Remove impacted ear wax	N		P3		$18.91
69220	Clean out mastoid cavity	Y		P2	0.7983	$33.45
69222	Clean out mastoid cavity	Y		P3		$117.36
69300	Revise external ear	Y		A2	23.2154	$972.69
69310	Rebuild outer ear canal	Y		A2	40.7633	$1,707.90
69320	Rebuild outer ear canal	Y		A2	40.7633	$1,707.90
69400	Inflate middle ear canal	Y		P3		$80.53
69401	Inflate middle ear canal	Y		P3		$43.21
69405	Catheterize middle ear canal	Y		P3		$112.45
69420	Incision of eardrum	Y		P3		$98.45
69421	Incision of eardrum	Y		A2	15.8303	$663.26
69424	Remove ventilating tube	Y		P3		$68.25
69433	Create eardrum opening	Y		P3		$98.70
69436	Create eardrum opening	Y		A2	15.8303	$663.26
69440	Exploration of middle ear	Y		A2	23.2154	$972.69

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
69450	Eardrum revision	Y		A2	40.7633	$1,707.90
69501	Mastoidectomy	Y		A2	40.7633	$1,707.90
69502	Mastoidectomy	Y		A2	23.2154	$972.69
69505	Remove mastoid structures	Y		A2	40.7633	$1,707.90
69511	Extensive mastoid surgery	Y		A2	40.7633	$1,707.90
69530	Extensive mastoid surgery	Y		A2	40.7633	$1,707.90
69540	Remove ear lesion	Y		P3		$114.66
69550	Remove ear lesion	Y		A2	40.7633	$1,707.90
69552	Remove ear lesion	Y		A2	40.7633	$1,707.90
69601	Mastoid surgery revision	Y		A2	40.7633	$1,707.90
69602	Mastoid surgery revision	Y		A2	40.7633	$1,707.90
69603	Mastoid surgery revision	Y		A2	40.7633	$1,707.90
69604	Mastoid surgery revision	Y		A2	40.7633	$1,707.90
69605	Mastoid surgery revision	Y		A2	40.7633	$1,707.90
69610	Repair of eardrum	Y		P3		$155.66
69620	Repair of eardrum	Y		A2	23.2154	$972.69
69631	Repair eardrum structures	Y		A2	40.7633	$1,707.90
69632	Rebuild eardrum structures	Y		A2	40.7633	$1,707.90
69633	Rebuild eardrum structures	Y		A2	40.7633	$1,707.90
69635	Repair eardrum structures	Y		A2	40.7633	$1,707.90
69636	Rebuild eardrum structures	Y		A2	40.7633	$1,707.90
69637	Rebuild eardrum structures	Y		A2	40.7633	$1,707.90
69641	Revise middle ear & mastoid	Y		A2	40.7633	$1,707.90
69642	Revise middle ear & mastoid	Y		A2	40.7633	$1,707.90
69643	Revise middle ear & mastoid	Y		A2	40.7633	$1,707.90
69644	Revise middle ear & mastoid	Y		A2	40.7633	$1,707.90
69645	Revise middle ear & mastoid	Y		A2	40.7633	$1,707.90
69646	Revise middle ear & mastoid	Y		A2	40.7633	$1,707.90
69650	Release middle ear bone	Y		A2	23.2154	$972.69
69660	Revise middle ear bone	Y		A2	40.7633	$1,707.90
69661	Revise middle ear bone	Y		A2	40.7633	$1,707.90
69662	Revise middle ear bone	Y		A2	40.7633	$1,707.90
69666	Repair middle ear structures	Y		A2	40.7633	$1,707.90
69667	Repair middle ear structures	Y		A2	40.7633	$1,707.90
69670	Remove mastoid air cells	Y		A2	40.7633	$1,707.90
69676	Remove middle ear nerve	Y		A2	40.7633	$1,707.90
69700	Close mastoid fistula	Y		A2	40.7633	$1,707.90
69711	Remove/repair hearing aid	Y		A2	40.7633	$1,707.90
69714	Implant temple bone w/stimul	Y		H8	162.8173	$6,821.72

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment
69715	Temple bne implnt w/stimulat	Y		H8	162.8173	$6,821.72
69717	Temple bone implant revision	Y		H8	162.8173	$6,821.72
69718	Revise temple bone implant	Y		H8	162.8173	$6,821.72
69720	Release facial nerve	Y		A2	40.7633	$1,707.90
69740	Repair facial nerve	Y		A2	40.7633	$1,707.90
69745	Repair facial nerve	Y		A2	40.7633	$1,707.90
69801	Incise inner ear	Y		A2	23.2154	$972.69
69802	Incise inner ear	Y		A2	23.2154	$972.69
69805	Explore inner ear	Y		A2	40.7633	$1,707.90
69806	Explore inner ear	Y		A2	40.7633	$1,707.90
69820	Establish inner ear window	Y		A2	40.7633	$1,707.90
69840	Revise inner ear window	Y		A2	40.7633	$1,707.90
69905	Remove inner ear	Y		A2	40.7633	$1,707.90
69910	Remove inner ear & mastoid	Y		A2	40.7633	$1,707.90
69915	Incise inner ear nerve	Y		A2	40.7633	$1,707.90
69930	Implant cochlear device	Y		H8	694.0902	$29,080.99
69990	Microsurgery add-on	N		N1		
C9716	Radiofrequency energy to anu	Y		G2	29.6501	$1,242.28
C9724	EPS gast cardia plic	Y		G2	14.8264	$621.20
C9725	Place endorectal app	Y		G2	5.6974	$238.71
C9726	Rxt breast appl place/remov	Y		G2	23.4205	$981.27
C9727	Insert palate implants	Y		G2	7.1577	$299.89
C9728	Place device/marker, non pro	N		R2	12.3307	$516.63
G0104**	CA screen;flexi sigmoidscope	N		P3		$70.96
G0105**	Colorectal scrn; hi risk ind	Y		A2	7.4996	$314.22
G0121**	Colon ca scrn not hi rsk ind	Y		A2	7.4996	$314.22
G0127	Trim nail(s)	Y		P3		$10.80
G0186	Dstry eye lesn,fdr vssl tech	Y		R2	4.8105	$201.55
G0247	Routine footcare pt w lops	Y		P3		$19.40
G0259	Inject for sacroiliac joint	N		N1		
G0260	Inj for sacroiliac jt anesth	Y		A2	7.0178	$294.03
G0268	Removal of impacted wax md	N		N1		
G0269	Occlusive device in vein art	N		N1		
G0289	Arthro, loose body + chondro	N		N1		
G0364	Bone marrow aspirate &biopsy	N		P3		$4.66

NOTE 1: The Medicare program payment is 80 percent of the total payment amount and beneficiary coinsurance is 20 percent of the total payment amount. Section 4104 of the Affordable Care Act (ACA) waives coinsurance for most preventive services, identified with a double asterisk (**).

ADDENDUM B.—PROPOSED OPPS PAYMENT BY HCPCS CODE FOR CY 2011

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
00100	Anesth, salivary gland		N					
00102	Anesth, repair of cleft lip		N					
00103	Anesth, blepharoplasty		N					
00104	Anesth, electroshock		N					
00120	Anesth, ear surgery		N					
00124	Anesth, ear exam		N					
00126	Anesth, tympanotomy		N					
00140	Anesth, procedures on eye		N					
00142	Anesth, lens surgery		N					
00144	Anesth, corneal transplant		N					
00145	Anesth, vitreoretinal surg		N					
00147	Anesth, iridectomy		N					
00148	Anesth, eye exam		N					
00160	Anesth, nose/sinus surgery		N					
00162	Anesth, nose/sinus surgery		N					
00164	Anesth, biopsy of nose		N					
00170	Anesth, procedure on mouth		N					
00172	Anesth, cleft palate repair		N					
00174	Anesth, pharyngeal surgery		N					
00176	Anesth, pharyngeal surgery		C					
00190	Anesth, face/skull bone surg		N					
00192	Anesth, facial bone surgery		C					
00210	Anesth, cranial surg nos		N					
00211	Anesth, cran surg, hemotoma		C					
00212	Anesth, skull drainage		N					
00214	Anesth, skull drainage		C					
00215	Anesth, skull repair/fract		C					

ADDENDUM AA.—PROPOSED ASC COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING SURGICAL PROCEDURES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Proposed CY 2011 Comment Indicator	Proposed CY 2011 Payment Indicator	Proposed CY 2011 Payment Weight	Proposed CY 2011 Payment

NOTE 2: Payment indicators for "office-based" procedures (P2, P3) are based on a comparison of the final rates according to the ASC standard ratesetting methodology and the MPFS. At the time we compiled this addenda, current law requires a negative update to the MPFS payment rates for CY 2011. For a discussion of those rates, we refer readers to the CY 2011 MPFS proposed rule.

*: Asterisked codes(*) indicate that the procedure's "office-based," designation is temporary because we have insufficient claims data. We will reconsider this designation when new claims data become available.

**: Double asterisked codes (**) indicate that coinsurance is waived under section 4103 of the Affordable Care Act, which waives coinsurance for most preventive services.

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
00216	Anesth, head vessel surgery		N					
00218	Anesth, special head surgery		N					
00220	Anesth, intrcrn nerve		N					
00222	Anesth, head nerve surgery		N					
00300	Anesth, head/neck/ptrunk		N					
00320	Anesth, neck organ, 1 & over		N					
00322	Anesth, biopsy of thyroid		N					
00326	Anesth, larynx/trach, < 1 yr		N					
00350	Anesth, neck vessel surgery		N					
00352	Anesth, neck vessel surgery		N					
00400	Anesth, skin, ext/per/atrunk		N					
00402	Anesth, surgery of breast		N					
00404	Anesth, surgery of breast		N					
00406	Anesth, surgery of breast		N					
00410	Anesth, correct heart rhythm		N					
00450	Anesth, surgery of shoulder		N					
00452	Anesth, surgery of shoulder		C					
00454	Anesth, collar bone biopsy		N					
00470	Anesth, removal of rib		N					
00472	Anesth, chest wall repair		N					
00474	Anesth, surgery of rib(s)		C					
00500	Anesth, esophageal surgery		N					
00520	Anesth, chest procedure		N					
00522	Anesth, chest lining biopsy		N					
00524	Anesth, chest drainage		C					
00528	Anesth, chest partition view		N					
00529	Anesth, chest partition view		N					
00530	Anesth, pacemaker insertion		N					
00532	Anesth, vascular access		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
00534	Anesth, cardioverter/defib		N					
00537	Anesth, cardiac electrophys		N					
00539	Anesth, trach-bronch reconst		N					
00540	Anesth, chest surgery		C					
00541	Anesth, one lung ventilation		N					
00542	Anesth, release of lung		C					
00546	Anesth, lung,chest wall surg		C					
00548	Anesth, trachea,bronchi surg		N					
00550	Anesth, sternal debridement		N					
00560	Anesth, heart surg w/o pump		C					
00561	Anesth, heart surg < age 1		C					
00562	Anesth hrt surg w/pmp age 1+		C					
00563	Anesth, heart surg w/arrest		N					
00566	Anesth, cabg w/o pump		N					
00567	Anesth, cabg w/pump		C					
00580	Anesth, heart/lung transplnt		C					
00600	Anesth, spine, cord surgery		N					
00604	Anesth, sitting procedure		C					
00620	Anesth, spine, cord surgery		N					
00622	Anesth, removal of nerves		C					
00625	Anes spine tranthor w/o vent		N					
00626	Anes, spine transthor w/vent		N					
00630	Anesth, spine, cord surgery		N					
00632	Anesth, removal of nerves		C					
00634	Anesth for chemonucleolysis		N					
00635	Anesth, lumbar puncture		N					
00640	Anesth, spine manipulation		N					
00670	Anesth, spine, cord surgery		C					
00700	Anesth, abdominal wall surg		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
00702	Anesth, for liver biopsy		N					
00730	Anesth, abdominal wall surg		N					
00740	Anesth, upper gi visualize		N					
00750	Anesth, repair of hernia		N					
00752	Anesth, repair of hernia		N					
00754	Anesth, repair of hernia		N					
00756	Anesth, repair of hernia		N					
00770	Anesth, blood vessel repair		N					
00790	Anesth, surg upper abdomen		N					
00792	Anesth, hemorr/excise liver		C					
00794	Anesth, pancreas removal		C					
00796	Anesth, for liver transplant		C					
00797	Anesth, surgery for obesity		N					
00800	Anesth, abdominal wall surg		N					
00802	Anesth, fat layer removal		C					
00810	Anesth, low intestine scope		N					
00820	Anesth, abdominal wall surg		N					
00830	Anesth, repair of hernia		N					
00832	Anesth, repair of hernia		N					
00834	Anesth, hernia repair< 1 yr		N					
00836	Anesth hernia repair preemie		N					
00840	Anesth, surg lower abdomen		N					
00842	Anesth, amniocentesis		N					
00844	Anesth, pelvis surgery		C					
00846	Anesth, hysterectomy		C					
00848	Anesth, pelvic organ surg		C					
00851	Anesth, tubal ligation		N					
00860	Anesth, surgery of abdomen		N					
00862	Anesth, kidney/ureter surg		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
00864	Anesth, removal of bladder		C					
00865	Anesth, removal of prostate		C					
00866	Anesth, removal of adrenal		C					
00868	Anesth, kidney transplant		C					
00870	Anesth, bladder stone surg		N					
00872	Anesth kidney stone destruct		N					
00873	Anesth kidney stone destruct		N					
00880	Anesth, abdomen vessel surg		N					
00882	Anesth, major vein ligation		C					
00902	Anesth, anorectal surgery		N					
00904	Anesth, perineal surgery		C					
00906	Anesth, removal of vulva		N					
00908	Anesth, removal of prostate		C					
00910	Anesth, bladder surgery		N					
00912	Anesth, bladder tumor surg		N					
00914	Anesth, removal of prostate		N					
00916	Anesth, bleeding control		N					
00918	Anesth, stone removal		N					
00920	Anesth, genitalia surgery		N					
00921	Anesth, vasectomy		N					
00922	Anesth, sperm duct surgery		N					
00924	Anesth, testis exploration		N					
00926	Anesth, removal of testis		N					
00928	Anesth, removal of testis		N					
00930	Anesth, testis suspension		N					
00932	Anesth, amputation of penis		C					
00934	Anesth, penis, nodes removal		C					
00936	Anesth, penis, nodes removal		C					
00938	Anesth, insert penis device		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
00940	Anesth, vaginal procedures		N					
00942	Anesth, surg on vag/urethral		N					
00944	Anesth, vaginal hysterectomy		C					
00948	Anesth, repair of cervix		N					
00950	Anesth, vaginal endoscopy		N					
00952	Anesth, hysteroscope/graph		N					
01112	Anesth, bone aspirate/bx		N					
01120	Anesth, pelvis surgery		N					
01130	Anesth, body cast procedure		N					
01140	Anesth, amputation at pelvis		C					
01150	Anesth, pelvic tumor surgery		C					
01160	Anesth, pelvis procedure		N					
01170	Anesth, pelvis surgery		N					
01173	Anesth, fx repair, pelvis		N					
01180	Anesth, pelvis nerve removal		N					
01190	Anesth, pelvis nerve removal		N					
01200	Anesth, hip joint procedure		N					
01202	Anesth, arthroscopy of hip		N					
01210	Anesth, hip joint surgery		N					
01212	Anesth, hip disarticulation		C					
01214	Anesth, hip arthroplasty		C					
01215	Anesth, revise hip repair		N					
01220	Anesth, procedure on femur		N					
01230	Anesth, surgery of femur		N					
01232	Anesth, amputation of femur		C					
01234	Anesth, radical femur surg		C					
01250	Anesth, upper leg surgery		N					
01260	Anesth, upper leg veins surg		N					
01270	Anesth, thigh arteries surg		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
01272	Anesth, femoral artery surg		C					
01274	Anesth, femoral embolectomy		C					
01320	Anesth, knee area surgery		N					
01340	Anesth, knee area procedure		N					
01360	Anesth, knee area surgery		N					
01380	Anesth, knee joint procedure		N					
01382	Anesth, dx knee arthroscopy		N					
01390	Anesth, knee area procedure		N					
01392	Anesth, knee area surgery		N					
01400	Anesth, knee joint surgery		N					
01402	Anesth, knee arthroplasty		C					
01404	Anesth, amputation at knee		C					
01420	Anesth, knee joint casting		N					
01430	Anesth, knee veins surgery		N					
01432	Anesth, knee vessel surg		N					
01440	Anesth, knee arteries surg		N					
01442	Anesth, knee artery surg		C					
01444	Anesth, knee artery repair		C					
01462	Anesth, lower leg procedure		N					
01464	Anesth, ankle/ft arthroscopy		N					
01470	Anesth, lower leg surgery		N					
01472	Anesth, achilles tendon surg		N					
01474	Anesth, lower leg surgery		N					
01480	Anesth, lower leg bone surg		N					
01482	Anesth, radical leg surgery		N					
01484	Anesth, lower leg revision		N					
01486	Anesth, ankle replacement		C					
01490	Anesth, lower leg casting		N					
01500	Anesth, leg arteries surg		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
01502	Anesth, lwr leg embolectomy		C					
01520	Anesth, lower leg vein surg		N					
01522	Anesth, lower leg vein surg		N					
01610	Anesth, surgery of shoulder		N					
01620	Anesth, shoulder procedure		N					
01622	Anes dx shoulder arthroscopy		N					
01630	Anesth, surgery of shoulder		N					
01634	Anesth, shoulder joint amput		C					
01636	Anesth, forequarter amput		C					
01638	Anesth, shoulder replacement		C					
01650	Anesth, shoulder artery surg		N					
01652	Anesth, shoulder vessel surg		C					
01654	Anesth, shoulder vessel surg		C					
01656	Anesth, arm-leg vessel surg		C					
01670	Anesth, shoulder vein surg		N					
01680	Anesth, shoulder casting		N					
01682	Anesth, airplane cast		N					
01710	Anesth, elbow area surgery		N					
01712	Anesth, uppr arm tendon surg		N					
01714	Anesth, uppr arm tendon surg		N					
01716	Anesth, biceps tendon repair		N					
01730	Anesth, uppr arm procedure		N					
01732	Anesth, dx elbow arthroscopy		N					
01740	Anesth, upper arm surgery		N					
01742	Anesth, humerus surgery		N					
01744	Anesth, humerus repair		N					
01756	Anesth, radical humerus surg		C					
01758	Anesth, humeral lesion surg		N					
01760	Anesth, elbow replacement		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
01770	Anesth, uppr arm artery surg		N					
01772	Anesth, uppr arm embolectomy		N					
01780	Anesth, upper arm vein surg		N					
01782	Anesth, uppr arm vein repair		N					
01810	Anesth, lower arm surgery		N					
01820	Anesth, lower arm procedure		N					
01829	Anesth, dx wrist arthroscopy		N					
01830	Anesth, lower arm surgery		N					
01832	Anesth, wrist replacement		N					
01840	Anesth, lwr arm artery surg		N					
01842	Anesth, lwr arm embolectomy		N					
01844	Anesth, vascular shunt surg		N					
01850	Anesth, lower arm vein surg		N					
01852	Anesth, lwr arm vein repair		N					
01860	Anesth, lower arm casting		N					
01916	Anesth, dx arteriography		N					
01920	Anesth, catheterize heart		N					
01922	Anesth, cat or MRI scan		N					
01924	Anes, ther interven rad, art		N					
01925	Anes, ther interven rad, car		N					
01926	Anes, tx interv rad hrt/cran		N					
01930	Anes, ther interven rad, vei		N					
01931	Anes, ther interven rad, tip		N					
01932	Anes, tx interv rad, th vein		N					
01933	Anes, tx interv rad, cran v		N					
01935	Anesth, perc img dx sp proc		N					
01936	Anesth, perc img tx sp proc		N					
01951	Anesth, burn, less 4 percent		N					
01952	Anesth, burn, 4-9 percent		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
01953	Anesth, burn, each 9 percent		N					
01958	Anesth, antepartum manipul		N					
01960	Anesth, vaginal delivery		N					
01961	Anesth, cs delivery		N					
01962	Anesth, emer hysterectomy		N					
01963	Anesth, cs hysterectomy		N					
01965	Anesth, inc/missed ab proc		N					
01966	Anesth, induced ab procedure		N					
01967	Anesth/analg, vag delivery		N					
01968	Anes/analg cs deliver add-on		N					
01969	Anesth/analg cs hyst add-on		N					
01990	Support for organ donor		C					
01991	Anesth, nerve block/inj		N					
01992	Anesth, n block/inj, prone		N					
01996	Hosp manage cont drug admin		N					
01999	Unlisted anesth procedure		N					
10021	Fna w/o image		T	0002	1.7752	$121.19	.	$24.24
10022	Fna w/image		T	0004	4.6624	$318.29	.	$63.66
10040	Acne surgery		T	0013	0.8782	$59.95	.	$11.99
10060	Drainage of skin abscess		T	0006	1.4939	$101.98	.	$20.40
10061	Drainage of skin abscess		T	0006	1.4939	$101.98	.	$20.40
10080	Drainage of pilonidal cyst		T	0006	1.4939	$101.98	.	$20.40
10081	Drainage of pilonidal cyst		T	0007	13.3268	$909.78	.	$181.96
10120	Remove foreign body		T	0016	2.8176	$192.35	.	$38.47
10121	Remove foreign body		T	0021	18.2223	$1,243.98	.	$248.80
10140	Drainage of hematoma/fluid		T	0007	13.3268	$909.78	.	$181.96
10160	Puncture drainage of lesion		T	0006	1.4939	$101.98	.	$20.40
10180	Complex drainage, wound		T	0008	20.2481	$1,382.28	.	$276.46
11000	Debride infected skin	CH	T	0016	2.8176	$192.35	.	$38.47

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
11001	Debride infected skin add-on		T	0013	0.8782	$59.95	.	$11.99
11004	Debride genitalia & perineum		C					
11005	Debride abdom wall		C					
11006	Debride genit/per/abdom wall		C					
11008	Remove mesh from abd wall		C					
11010	Debride skin, fx		T	0019	4.9184	$335.76	.	$67.16
11011	Debride skin/muscle, fx		T	0019	4.9184	$335.76	.	$67.16
11012	Debride skin/muscle/bone, fx		T	0019	4.9184	$335.76	.	$67.16
11040	Debride skin, partial		T	0015	1.5303	$104.47	.	$20.90
11041	Debride skin, full		T	0015	1.5303	$104.47	.	$20.90
11042	Debride skin/tissue		T	0016	2.8176	$192.35	.	$38.47
11043	Debride tissue/muscle		T	0016	2.8176	$192.35	.	$38.47
11044	Debride tissue/muscle/bone		T	0020	8.7772	$599.19	.	$119.84
11055	Trim skin lesion		T	0013	0.8782	$59.95	.	$11.99
11056	Trim skin lesions, 2 to 4		T	0013	0.8782	$59.95	.	$11.99
11057	Trim skin lesions, over 4		T	0013	0.8782	$59.95	.	$11.99
11100	Biopsy, skin lesion		T	0015	1.5303	$104.47	.	$20.90
11101	Biopsy, skin add-on		T	0013	0.8782	$59.95	.	$11.99
11200	Removal of skin tags		T	0013	0.8782	$59.95	.	$11.99
11201	Remove skin tags add-on		T	0013	0.8782	$59.95	.	$11.99
11300	Shave skin lesion		T	0013	0.8782	$59.95	.	$11.99
11301	Shave skin lesion		T	0013	0.8782	$59.95	.	$11.99
11302	Shave skin lesion		T	0013	0.8782	$59.95	.	$11.99
11303	Shave skin lesion		T	0015	1.5303	$104.47	.	$20.90
11305	Shave skin lesion		T	0013	0.8782	$59.95	.	$11.99
11306	Shave skin lesion		T	0013	0.8782	$59.95	.	$11.99
11307	Shave skin lesion		T	0013	0.8782	$59.95	.	$11.99
11308	Shave skin lesion		T	0013	0.8782	$59.95	.	$11.99
11310	Shave skin lesion		T	0013	0.8782	$59.95	.	$11.99

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
11311	Shave skin lesion		T	0013	0.8782	$59.95	.	$11.99
11312	Shave skin lesion		T	0013	0.8782	$59.95	.	$11.99
11313	Shave skin lesion		T	0013	0.8782	$59.95	.	$11.99
11400	Exc tr-ext b9+marg 0.5 < cm		T	0019	4.9184	$335.76	.	$67.16
11401	Exc tr-ext b9+marg 0.6-1 cm		T	0019	4.9184	$335.76	.	$67.16
11402	Exc tr-ext b9+marg 1.1-2 cm		T	0019	4.9184	$335.76	.	$67.16
11403	Exc tr-ext b9+marg 2.1-3 cm		T	0020	8.7772	$599.19	.	$119.84
11404	Exc tr-ext b9+marg 3.1-4 cm		T	0021	18.2223	$1,243.98	.	$248.80
11406	Exc tr-ext b9+marg > 4.0 cm		T	0021	18.2223	$1,243.98	.	$248.80
11420	Exc h-f-nk-sp b9+marg 0.5 <		T	0020	8.7772	$599.19	.	$119.84
11421	Exc h-f-nk-sp b9+marg 0.6-1		T	0020	8.7772	$599.19	.	$119.84
11422	Exc h-f-nk-sp b9+marg 1.1-2		T	0020	8.7772	$599.19	.	$119.84
11423	Exc h-f-nk-sp b9+marg 2.1-3		T	0021	18.2223	$1,243.98	.	$248.80
11424	Exc h-f-nk-sp b9+marg 3.1-4		T	0021	18.2223	$1,243.98	.	$248.80
11426	Exc h-f-nk-sp b9+marg > 4 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
11440	Exc face-mm b9+marg 0.5 < cm		T	0019	4.9184	$335.76	.	$67.16
11441	Exc face-mm b9+marg 0.6-1 cm		T	0019	4.9184	$335.76	.	$67.16
11442	Exc face-mm b9+marg 1.1-2 cm		T	0020	8.7772	$599.19	.	$119.84
11443	Exc face-mm b9+marg 2.1-3 cm		T	0020	8.7772	$599.19	.	$119.84
11444	Exc face-mm b9+marg 3.1-4 cm		T	0020	8.7772	$599.19	.	$119.84
11446	Exc face-mm b9+marg > 4 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
11450	Removal, sweat gland lesion		T	0022	24.1269	$1,647.07	$354.45	$329.42
11451	Removal, sweat gland lesion		T	0022	24.1269	$1,647.07	$354.45	$329.42
11462	Removal, sweat gland lesion		T	0022	24.1269	$1,647.07	$354.45	$329.42
11463	Removal, sweat gland lesion		T	0022	24.1269	$1,647.07	$354.45	$329.42
11470	Removal, sweat gland lesion		T	0022	24.1269	$1,647.07	$354.45	$329.42
11471	Removal, sweat gland lesion		T	0022	24.1269	$1,647.07	$354.45	$329.42
11600	Exc tr-ext mlg+marg 0.5 < cm		T	0020	8.7772	$599.19	.	$119.84
11601	Exc tr-ext mlg+marg 0.6-1 cm		T	0019	4.9184	$335.76	.	$67.16

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
11602	Exc tr-ext mlg+marg 1.1-2 cm		T	0019	4.9184	$335.76	.	$67.16
11603	Exc tr-ext mlg+marg 2.1-3 cm		T	0020	8.7772	$599.19	.	$119.84
11604	Exc tr-ext mlg+marg 3.1-4 cm		T	0020	8.7772	$599.19	.	$119.84
11606	Exc tr-ext mlg+marg > 4 cm		T	0021	18.2223	$1,243.98	.	$248.80
11620	Exc h-f-nk-sp mlg+marg 0.5 <		T	0020	8.7772	$599.19	.	$119.84
11621	Exc h-f-nk-sp mlg+marg 0.6-1		T	0019	4.9184	$335.76	.	$67.16
11622	Exc h-f-nk-sp mlg+marg 1.1-2		T	0020	8.7772	$599.19	.	$119.84
11623	Exc h-f-nk-sp mlg+marg 2.1-3		T	0021	18.2223	$1,243.98	.	$248.80
11624	Exc h-f-nk-sp mlg+marg 3.1-4		T	0021	18.2223	$1,243.98	.	$248.80
11626	Exc h-f-nk-sp mlg+mar > 4 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
11640	Exc face-mm malig+marg 0.5 <	CH	T	0019	4.9184	$335.76	.	$67.16
11641	Exc face-mm malig+marg 0.6-1	CH	T	0019	4.9184	$335.76	.	$67.16
11642	Exc face-mm malig+marg 1.1-2	CH	T	0019	4.9184	$335.76	.	$67.16
11643	Exc face-mm malig+marg 2.1-3		T	0020	8.7772	$599.19	.	$119.84
11644	Exc face-mm malig+marg 3.1-4		T	0021	18.2223	$1,243.98	.	$248.80
11646	Exc face-mm mlg+marg > 4 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
11719	Trim nail(s)		T	0012	0.4253	$29.03	.	$5.81
11720	Debride nail, 1-5		T	0013	0.8782	$59.95	.	$11.99
11721	Debride nail, 6 or more		T	0013	0.8782	$59.95	.	$11.99
11730	Removal of nail plate		T	0013	0.8782	$59.95	.	$11.99
11732	Remove nail plate, add-on		T	0013	0.8782	$59.95	.	$11.99
11740	Drain blood from under nail		T	0012	0.4253	$29.03	.	$5.81
11750	Removal of nail bed		T	0019	4.9184	$335.76	.	$67.16
11752	Remove nail bed/finger tip		T	0022	24.1269	$1,647.07	$354.45	$329.42
11755	Biopsy, nail unit		T	0019	4.9184	$335.76	.	$67.16
11760	Repair of nail bed		T	0133	1.3598	$92.83	$25.67	$18.57
11762	Reconstruction of nail bed		T	0136	17.1353	$1,169.78	.	$233.96
11765	Excision of nail fold, toe		T	0013	0.8782	$59.95	.	$11.99
11770	Removal of pilonidal lesion		T	0022	24.1269	$1,647.07	$354.45	$329.42

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
11771	Removal of pilonidal lesion		T	0022	24.1269	$1,647.07	$354.45	$329.42
11772	Removal of pilonidal lesion		T	0022	24.1269	$1,647.07	$354.45	$329.42
11900	Injection into skin lesions		T	0013	0.8782	$59.95	.	$11.99
11901	Added skin lesions injection		T	0013	0.8782	$59.95	.	$11.99
11920	Correct skin color defects		T	0134	3.189	$217.70	.	$43.54
11921	Correct skin color defects		T	0134	3.189	$217.70	.	$43.54
11922	Correct skin color defects		T	0134	3.189	$217.70	.	$43.54
11950	Therapy for contour defects		T	0133	1.3598	$92.83	$25.67	$18.57
11951	Therapy for contour defects		T	0133	1.3598	$92.83	$25.67	$18.57
11952	Therapy for contour defects		T	0133	1.3598	$92.83	$25.67	$18.57
11954	Therapy for contour defects		T	0133	1.3598	$92.83	$25.67	$18.57
11960	Insert tissue expander(s)		T	0137	22.1186	$1,509.97	.	$302.00
11970	Replace tissue expander		T	0051	47.3761	$3,234.22	.	$646.85
11971	Remove tissue expander(s)		T	0022	24.1269	$1,647.07	$354.45	$329.42
11975	Insert contraceptive cap		E					
11976	Removal of contraceptive cap		T	0019	4.9184	$335.76	.	$67.16
11977	Removal/reinsert contra cap		E					
11980	Implant hormone pellet(s)		X	0340	0.6899	$47.10	.	$9.42
11981	Insert drug implant device		X	0340	0.6899	$47.10	.	$9.42
11982	Remove drug implant device		X	0340	0.6899	$47.10	.	$9.42
11983	Remove/insert drug implant		X	0340	0.6899	$47.10	.	$9.42
12001	Repair superficial wound(s)		T	0133	1.3598	$92.83	$25.67	$18.57
12002	Repair superficial wound(s)		T	0133	1.3598	$92.83	$25.67	$18.57
12004	Repair superficial wound(s)		T	0133	1.3598	$92.83	$25.67	$18.57
12005	Repair superficial wound(s)		T	0133	1.3598	$92.83	$25.67	$18.57
12006	Repair superficial wound(s)		T	0133	1.3598	$92.83	$25.67	$18.57
12007	Repair superficial wound(s)		T	0133	1.3598	$92.83	$25.67	$18.57
12011	Repair superficial wound(s)		T	0133	1.3598	$92.83	$25.67	$18.57
12013	Repair superficial wound(s)		T	0133	1.3598	$92.83	$25.67	$18.57

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
12014	Repair superficial wound(s)		T	0133	1.3598	$92.83	$25.67	$18.57
12015	Repair superficial wound(s)		T	0133	1.3598	$92.83	$25.67	$18.57
12016	Repair superficial wound(s)		T	0133	1.3598	$92.83	$25.67	$18.57
12017	Repair superficial wound(s)		T	0133	1.3598	$92.83	$25.67	$18.57
12018	Repair superficial wound(s)		T	0133	1.3598	$92.83	$25.67	$18.57
12020	Closure of split wound		T	0135	4.6616	$318.23	.	$63.65
12021	Closure of split wound		T	0134	3.189	$217.70	.	$43.54
12031	Intmd wnd repair s/tr/ext		T	0133	1.3598	$92.83	$25.67	$18.57
12032	Intmd wnd repair s/tr/ext		T	0134	3.189	$217.70	.	$43.54
12034	Intmd wnd repair s/tr/ext		T	0133	1.3598	$92.83	$25.67	$18.57
12035	Intmd wnd repair s/tr/ext		T	0133	1.3598	$92.83	$25.67	$18.57
12036	Intmd wnd repair s/tr/ext		T	0134	3.189	$217.70	.	$43.54
12037	Intmd wnd repair s/tr/ext		T	0134	3.189	$217.70	.	$43.54
12041	Intmd wnd repair n-hf/genit		T	0133	1.3598	$92.83	$25.67	$18.57
12042	Intmd wnd repair n-hg/genit		T	0133	1.3598	$92.83	$25.67	$18.57
12044	Intmd wnd repair n-hg/genit		T	0133	1.3598	$92.83	$25.67	$18.57
12045	Intmd wnd repair n-hg/genit		T	0134	3.189	$217.70	.	$43.54
12046	Intmd wnd repair n-hg/genit		T	0134	3.189	$217.70	.	$43.54
12047	Intmd wnd repair n-hg/genit		T	0134	3.189	$217.70	.	$43.54
12051	Intmd wnd repair face/mm	CH	T	0134	3.189	$217.70	.	$43.54
12052	Intmd wnd repair face/mm		T	0133	1.3598	$92.83	$25.67	$18.57
12053	Intmd wnd repair face/mm		T	0133	1.3598	$92.83	$25.67	$18.57
12054	Intmd wnd repair, face/mm		T	0133	1.3598	$92.83	$25.67	$18.57
12055	Intmd wnd repair face/mm		T	0134	3.189	$217.70	.	$43.54
12056	Intmd wnd repair face/mm		T	0134	3.189	$217.70	.	$43.54
12057	Intmd wnd repair face/mm		T	0134	3.189	$217.70	.	$43.54
13100	Repair of wound or lesion		T	0135	4.6616	$318.23	.	$63.65
13101	Repair of wound or lesion		T	0135	4.6616	$318.23	.	$63.65
13102	Repair wound/lesion add-on		T	0135	4.6616	$318.23	.	$63.65

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
13120	Repair of wound or lesion		T	0134	3.189	$217.70	.	$43.54
13121	Repair of wound or lesion		T	0134	3.189	$217.70	.	$43.54
13122	Repair wound/lesion add-on		T	0133	1.3598	$92.83	$25.67	$18.57
13131	Repair of wound or lesion		T	0134	3.189	$217.70	.	$43.54
13132	Repair of wound or lesion		T	0135	4.6616	$318.23	.	$63.65
13133	Repair wound/lesion add-on		T	0134	3.189	$217.70	.	$43.54
13150	Repair of wound or lesion		T	0135	4.6616	$318.23	.	$63.65
13151	Repair of wound or lesion		T	0135	4.6616	$318.23	.	$63.65
13152	Repair of wound or lesion		T	0135	4.6616	$318.23	.	$63.65
13153	Repair wound/lesion add-on		T	0134	3.189	$217.70	.	$43.54
13160	Late closure of wound		T	0137	22.1186	$1,509.97	.	$302.00
14000	Skin tissue rearrangement		T	0136	17.1353	$1,169.78	.	$233.96
14001	Skin tissue rearrangement		T	0136	17.1353	$1,169.78	.	$233.96
14020	Skin tissue rearrangement		T	0136	17.1353	$1,169.78	.	$233.96
14021	Skin tissue rearrangement		T	0136	17.1353	$1,169.78	.	$233.96
14040	Skin tissue rearrangement		T	0136	17.1353	$1,169.78	.	$233.96
14041	Skin tissue rearrangement		T	0136	17.1353	$1,169.78	.	$233.96
14060	Skin tissue rearrangement		T	0136	17.1353	$1,169.78	.	$233.96
14061	Skin tissue rearrangement		T	0136	17.1353	$1,169.78	.	$233.96
14301	Skin tissue rearrangement		T	0137	22.1186	$1,509.97	.	$302.00
14302	Skin tissue rearrange add-on		T	0137	22.1186	$1,509.97	.	$302.00
14350	Skin tissue rearrangement		T	0137	22.1186	$1,509.97	.	$302.00
15002	Wound prep, trk/arm/leg		T	0135	4.6616	$318.23	.	$63.65
15003	Wound prep, addl 100 cm		T	0135	4.6616	$318.23	.	$63.65
15004	Wound prep, f/n/hf/g		T	0135	4.6616	$318.23	.	$63.65
15005	Wnd prep, f/n/hf/g, addl cm		T	0135	4.6616	$318.23	.	$63.65
15040	Harvest cultured skin graft		T	0134	3.189	$217.70	.	$43.54
15050	Skin pinch graft		T	0135	4.6616	$318.23	.	$63.65
15100	Skin splt grft, trnk/arm/leg		T	0137	22.1186	$1,509.97	.	$302.00

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
15101	Skin splt grft t/a/l, add-on		T	0137	22.1186	$1,509.97	.	$302.00
15110	Epidrm autogrft trnk/arm/leg		T	0135	4.6616	$318.23	.	$63.65
15111	Epidrm autogrft t/a/l add-on		T	0135	4.6616	$318.23	.	$63.65
15115	Epidrm a-grft face/nck/hf/g		T	0135	4.6616	$318.23	.	$63.65
15116	Epidrm a-grft f/n/hf/g addl		T	0135	4.6616	$318.23	.	$63.65
15120	Skn splt a-grft fac/nck/hf/g		T	0137	22.1186	$1,509.97	.	$302.00
15121	Skn splt a-grft f/n/hf/g add		T	0137	22.1186	$1,509.97	.	$302.00
15130	Derm autograft, trnk/arm/leg		T	0136	17.1353	$1,169.78	.	$233.96
15131	Derm autograft t/a/l add-on		T	0136	17.1353	$1,169.78	.	$233.96
15135	Derm autograft face/nck/hf/g		T	0136	17.1353	$1,169.78	.	$233.96
15136	Derm autograft, f/n/hf/g add		T	0136	17.1353	$1,169.78	.	$233.96
15150	Cult epiderm grft t/arm/leg		T	0135	4.6616	$318.23	.	$63.65
15151	Cult epiderm grft t/a/l addl		T	0135	4.6616	$318.23	.	$63.65
15152	Cult epiderm graft t/a/l +%		T	0135	4.6616	$318.23	.	$63.65
15155	Cult epiderm graft, f/n/hf/g		T	0135	4.6616	$318.23	.	$63.65
15156	Cult epidrm grft f/n/hfg add		T	0135	4.6616	$318.23	.	$63.65
15157	Cult epiderm grft f/n/hfg +%		T	0135	4.6616	$318.23	.	$63.65
15170	Acell graft trunk/arms/legs		T	0135	4.6616	$318.23	.	$63.65
15171	Acell graft t/arm/leg add-on		T	0134	3.189	$217.70	.	$43.54
15175	Acellular graft, f/n/hf/g		T	0135	4.6616	$318.23	.	$63.65
15176	Acell graft, f/n/hf/g add-on		T	0135	4.6616	$318.23	.	$63.65
15200	Skin full graft, trunk		T	0136	17.1353	$1,169.78	.	$233.96
15201	Skin full graft trunk add-on		T	0136	17.1353	$1,169.78	.	$233.96
15220	Skin full graft sclp/arm/leg		T	0136	17.1353	$1,169.78	.	$233.96
15221	Skin full graft add-on		T	0135	4.6616	$318.23	.	$63.65
15240	Skin full grft face/genit/hf		T	0136	17.1353	$1,169.78	.	$233.96
15241	Skin full graft add-on		T	0135	4.6616	$318.23	.	$63.65
15260	Skin full graft een & lips		T	0136	17.1353	$1,169.78	.	$233.96
15261	Skin full graft add-on		T	0136	17.1353	$1,169.78	.	$233.96

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
15300	Apply skinallogrft, t/arm/lg		T	0135	4.6616	$318.23	.	$63.65
15301	Apply sknallogrft t/a/l addl		T	0135	4.6616	$318.23	.	$63.65
15320	Apply skin allogrft f/n/hf/g		T	0135	4.6616	$318.23	.	$63.65
15321	Aply sknallogrft f/n/hfg add		T	0135	4.6616	$318.23	.	$63.65
15330	Aply acell alogrft t/arm/leg		T	0135	4.6616	$318.23	.	$63.65
15331	Aply acell grft t/a/l add-on		T	0135	4.6616	$318.23	.	$63.65
15335	Apply acell graft, f/n/hf/g		T	0135	4.6616	$318.23	.	$63.65
15336	Aply acell grft f/n/hf/g add		T	0135	4.6616	$318.23	.	$63.65
15340	Apply cult skin substitute		T	0134	3.189	$217.70	.	$43.54
15341	Apply cult skin sub add-on		T	0134	3.189	$217.70	.	$43.54
15360	Apply cult derm sub, t/a/l		T	0134	3.189	$217.70	.	$43.54
15361	Aply cult derm sub t/a/l add		T	0134	3.189	$217.70	.	$43.54
15365	Apply cult derm sub f/n/hf/g		T	0134	3.189	$217.70	.	$43.54
15366	Apply cult derm f/hf/g add		T	0134	3.189	$217.70	.	$43.54
15400	Apply skin xenograft, t/a/l		T	0135	4.6616	$318.23	.	$63.65
15401	Apply skn xenogrft t/a/l add		T	0135	4.6616	$318.23	.	$63.65
15420	Apply skin xgraft, f/n/hf/g		T	0135	4.6616	$318.23	.	$63.65
15421	Apply skn xgrft f/n/hf/g add		T	0135	4.6616	$318.23	.	$63.65
15430	Apply acellular xenograft		T	0135	4.6616	$318.23	.	$63.65
15431	Apply acellular xgraft add		T	0135	4.6616	$318.23	.	$63.65
15570	Form skin pedicle flap		T	0137	22.1186	$1,509.97	.	$302.00
15572	Form skin pedicle flap		T	0137	22.1186	$1,509.97	.	$302.00
15574	Form skin pedicle flap		T	0137	22.1186	$1,509.97	.	$302.00
15576	Form skin pedicle flap		T	0137	22.1186	$1,509.97	.	$302.00
15600	Skin graft		T	0137	22.1186	$1,509.97	.	$302.00
15610	Skin graft		T	0137	22.1186	$1,509.97	.	$302.00
15620	Skin graft		T	0137	22.1186	$1,509.97	.	$302.00
15630	Skin graft		T	0137	22.1186	$1,509.97	.	$302.00
15650	Transfer skin pedicle flap		T	0137	22.1186	$1,509.97	.	$302.00

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
15731	Forehead flap w/vasc pedicle		T	0137	22.1186	$1,509.97	.	$302.00
15732	Muscle-skin graft, head/neck		T	0137	22.1186	$1,509.97	.	$302.00
15734	Muscle-skin graft, trunk		T	0137	22.1186	$1,509.97	.	$302.00
15736	Muscle-skin graft, arm		T	0137	22.1186	$1,509.97	.	$302.00
15738	Muscle-skin graft, leg		T	0137	22.1186	$1,509.97	.	$302.00
15740	Island pedicle flap graft		T	0136	17.1353	$1,169.78	.	$233.96
15750	Neurovascular pedicle graft		T	0137	22.1186	$1,509.97	.	$302.00
15756	Free myo/skin flap microvasc		C					
15757	Free skin flap, microvasc		C					
15758	Free fascial flap, microvasc		C					
15760	Composite skin graft		T	0137	22.1186	$1,509.97	.	$302.00
15770	Derma-fat-fascia graft		T	0137	22.1186	$1,509.97	.	$302.00
15775	Hair transplant punch grafts		T	0133	1.3598	$92.83	$25.67	$18.57
15776	Hair transplant punch grafts		T	0133	1.3598	$92.83	$25.67	$18.57
15780	Abrasion treatment of skin		T	0022	24.1269	$1,647.07	$354.45	$329.42
15781	Abrasion treatment of skin		T	0019	4.9184	$335.76	.	$67.16
15782	Abrasion treatment of skin		T	0019	4.9184	$335.76	.	$67.16
15783	Abrasion treatment of skin		T	0016	2.8176	$192.35	.	$38.47
15786	Abrasion, lesion, single		T	0013	0.8782	$59.95	.	$11.99
15787	Abrasion, lesions, add-on		T	0013	0.8782	$59.95	.	$11.99
15788	Chemical peel, face, epiderm		T	0013	0.8782	$59.95	.	$11.99
15789	Chemical peel, face, dermal		T	0015	1.5303	$104.47	.	$20.90
15792	Chemical peel, nonfacial		T	0015	1.5303	$104.47	.	$20.90
15793	Chemical peel, nonfacial		T	0013	0.8782	$59.95	.	$11.99
15819	Plastic surgery, neck		T	0134	3.189	$217.70	.	$43.54
15820	Revision of lower eyelid		T	0137	22.1186	$1,509.97	.	$302.00
15821	Revision of lower eyelid		T	0137	22.1186	$1,509.97	.	$302.00
15822	Revision of upper eyelid		T	0137	22.1186	$1,509.97	.	$302.00
15823	Revision of upper eyelid		T	0137	22.1186	$1,509.97	.	$302.00

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
15824	Removal of forehead wrinkles		T	0137	22.1186	$1,509.97	.	$302.00
15825	Removal of neck wrinkles		T	0137	22.1186	$1,509.97	.	$302.00
15826	Removal of brow wrinkles		T	0137	22.1186	$1,509.97	.	$302.00
15828	Removal of face wrinkles		T	0137	22.1186	$1,509.97	.	$302.00
15829	Removal of skin wrinkles		T	0137	22.1186	$1,509.97	.	$302.00
15830	Exc skin abd		T	0022	24.1269	$1,647.07	$354.45	$329.42
15832	Excise excessive skin tissue		T	0022	24.1269	$1,647.07	$354.45	$329.42
15833	Excise excessive skin tissue		T	0022	24.1269	$1,647.07	$354.45	$329.42
15834	Excise excessive skin tissue		T	0022	24.1269	$1,647.07	$354.45	$329.42
15835	Excise excessive skin tissue		T	0022	24.1269	$1,647.07	$354.45	$329.42
15836	Excise excessive skin tissue		T	0021	18.2223	$1,243.98	.	$248.80
15837	Excise excessive skin tissue		T	0021	18.2223	$1,243.98	.	$248.80
15838	Excise excessive skin tissue		T	0021	18.2223	$1,243.98	.	$248.80
15839	Excise excessive skin tissue		T	0021	18.2223	$1,243.98	.	$248.80
15840	Graft for face nerve palsy		T	0137	22.1186	$1,509.97	.	$302.00
15841	Graft for face nerve palsy		T	0137	22.1186	$1,509.97	.	$302.00
15842	Flap for face nerve palsy		T	0137	22.1186	$1,509.97	.	$302.00
15845	Skin and muscle repair, face		T	0137	22.1186	$1,509.97	.	$302.00
15847	Exc skin abd add-on		T	0022	24.1269	$1,647.07	$354.45	$329.42
15850	Removal of sutures		T	0016	2.8176	$192.35	.	$38.47
15851	Removal of sutures		T	0016	2.8176	$192.35	.	$38.47
15852	Dressing change not for burn		X	0340	0.6899	$47.10	.	$9.42
15860	Test for blood flow in graft		X	0340	0.6899	$47.10	.	$9.42
15876	Suction assisted lipectomy		T	0137	22.1186	$1,509.97	.	$302.00
15877	Suction assisted lipectomy		T	0137	22.1186	$1,509.97	.	$302.00
15878	Suction assisted lipectomy		T	0137	22.1186	$1,509.97	.	$302.00
15879	Suction assisted lipectomy		T	0137	22.1186	$1,509.97	.	$302.00
15920	Removal of tail bone ulcer		T	0019	4.9184	$335.76	.	$67.16
15922	Removal of tail bone ulcer		T	0137	22.1186	$1,509.97	.	$302.00

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
15931	Remove sacrum pressure sore		T	0022	24.1269	$1,647.07	$354.45	$329.42
15933	Remove sacrum pressure sore		T	0022	24.1269	$1,647.07	$354.45	$329.42
15934	Remove sacrum pressure sore		T	0137	22.1186	$1,509.97	.	$302.00
15935	Remove sacrum pressure sore		T	0137	22.1186	$1,509.97	.	$302.00
15936	Remove sacrum pressure sore		T	0136	17.1353	$1,169.78	.	$233.96
15937	Remove sacrum pressure sore		T	0137	22.1186	$1,509.97	.	$302.00
15940	Remove hip pressure sore		T	0022	24.1269	$1,647.07	$354.45	$329.42
15941	Remove hip pressure sore		T	0022	24.1269	$1,647.07	$354.45	$329.42
15944	Remove hip pressure sore		T	0137	22.1186	$1,509.97	.	$302.00
15945	Remove hip pressure sore		T	0137	22.1186	$1,509.97	.	$302.00
15946	Remove hip pressure sore		T	0137	22.1186	$1,509.97	.	$302.00
15950	Remove thigh pressure sore		T	0022	24.1269	$1,647.07	$354.45	$329.42
15951	Remove thigh pressure sore		T	0022	24.1269	$1,647.07	$354.45	$329.42
15952	Remove thigh pressure sore		T	0136	17.1353	$1,169.78	.	$233.96
15953	Remove thigh pressure sore		T	0136	17.1353	$1,169.78	.	$233.96
15956	Remove thigh pressure sore		T	0136	17.1353	$1,169.78	.	$233.96
15958	Remove thigh pressure sore		T	0136	17.1353	$1,169.78	.	$233.96
15999	Removal of pressure sore		T	0019	4.9184	$335.76	.	$67.16
16000	Initial treatment of burn(s)		T	0013	0.8782	$59.95	.	$11.99
16020	Dress/debrid p-thick burn, s		T	0015	1.5303	$104.47	.	$20.90
16025	Dress/debrid p-thick burn, m		T	0015	1.5303	$104.47	.	$20.90
16030	Dress/debrid p-thick burn, l		T	0015	1.5303	$104.47	.	$20.90
16035	Incision of burn scab, initi		T	0015	1.5303	$104.47	.	$20.90
16036	Escharotomy; addl incision		C					
17000	Destruct premalg lesion		T	0013	0.8782	$59.95	.	$11.99
17003	Destruct premalg les, 2-14		T	0012	0.4253	$29.03	.	$5.81
17004	Destroy premlg lesions 15+		T	0016	2.8176	$192.35	.	$38.47
17106	Destruction of skin lesions		T	0016	2.8176	$192.35	.	$38.47
17107	Destruction of skin lesions		T	0016	2.8176	$192.35	.	$38.47

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
17108	Destruction of skin lesions		T	0016	2.8176	$192.35	.	$38.47
17110	Destruct b9 lesion, 1-14		T	0013	0.8782	$59.95	.	$11.99
17111	Destruct lesion, 15 or more		T	0015	1.5303	$104.47	.	$20.90
17250	Chemical cautery, tissue		T	0015	1.5303	$104.47	.	$20.90
17260	Destruction of skin lesions		T	0015	1.5303	$104.47	.	$20.90
17261	Destruction of skin lesions		T	0015	1.5303	$104.47	.	$20.90
17262	Destruction of skin lesions		T	0015	1.5303	$104.47	.	$20.90
17263	Destruction of skin lesions		T	0015	1.5303	$104.47	.	$20.90
17264	Destruction of skin lesions		T	0015	1.5303	$104.47	.	$20.90
17266	Destruction of skin lesions		T	0016	2.8176	$192.35	.	$38.47
17270	Destruction of skin lesions		T	0015	1.5303	$104.47	.	$20.90
17271	Destruction of skin lesions		T	0015	1.5303	$104.47	.	$20.90
17272	Destruction of skin lesions		T	0015	1.5303	$104.47	.	$20.90
17273	Destruction of skin lesions		T	0016	2.8176	$192.35	.	$38.47
17274	Destruction of skin lesions		T	0016	2.8176	$192.35	.	$38.47
17276	Destruction of skin lesions		T	0016	2.8176	$192.35	.	$38.47
17280	Destruction of skin lesions		T	0015	1.5303	$104.47	.	$20.90
17281	Destruction of skin lesions		T	0016	2.8176	$192.35	.	$38.47
17282	Destruction of skin lesions		T	0016	2.8176	$192.35	.	$38.47
17283	Destruction of skin lesions		T	0016	2.8176	$192.35	.	$38.47
17284	Destruction of skin lesions		T	0016	2.8176	$192.35	.	$38.47
17286	Destruction of skin lesions		T	0016	2.8176	$192.35	.	$38.47
17311	Mohs, 1 stage, h/n/hf/g		T	0694	5.0842	$347.08	$91.69	$69.42
17312	Mohs addl stage		T	0694	5.0842	$347.08	$91.69	$69.42
17313	Mohs, 1 stage, t/a/l		T	0694	5.0842	$347.08	$91.69	$69.42
17314	Mohs, addl stage, t/a/l		T	0694	5.0842	$347.08	$91.69	$69.42
17315	Mohs surg, addl block		T	0694	5.0842	$347.08	$91.69	$69.42
17340	Cryotherapy of skin		T	0013	0.8782	$59.95	.	$11.99
17360	Skin peel therapy		T	0013	0.8782	$59.95	.	$11.99

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
17380	Hair removal by electrolysis		T	0013	0.8782	$59.95	.	$11.99
17999	Skin tissue procedure		T	0012	0.4253	$29.03	.	$5.81
19000	Drainage of breast lesion		T	0004	4.6624	$318.29	.	$63.66
19001	Drain breast lesion add-on		T	0002	1.7752	$121.19	.	$24.24
19020	Incision of breast lesion		T	0008	20.2481	$1,382.28	.	$276.46
19030	Injection for breast x-ray		N					
19100	Bx breast percut w/o image		T	0004	4.6624	$318.29	.	$63.66
19101	Biopsy of breast, open		T	0028	25.7651	$1,758.91	.	$351.79
19102	Bx breast percut w/image		T	0005	8.16	$557.06	.	$111.42
19103	Bx breast percut w/device		T	0037	15.764	$1,076.16	$228.76	$215.24
19105	Cryosurg ablate fa, each		T	0029	34.3618	$2,345.78	$581.52	$469.16
19110	Nipple exploration		T	0028	25.7651	$1,758.91	.	$351.79
19112	Excise breast duct fistula		T	0028	25.7651	$1,758.91	.	$351.79
19120	Removal of breast lesion		T	0028	25.7651	$1,758.91	.	$351.79
19125	Excision, breast lesion		T	0028	25.7651	$1,758.91	.	$351.79
19126	Excision, addl breast lesion		T	0028	25.7651	$1,758.91	.	$351.79
19260	Removal of chest wall lesion		T	0021	18.2223	$1,243.98	.	$248.80
19271	Revision of chest wall		C					
19272	Extensive chest wall surgery		C					
19290	Place needle wire, breast		N					
19291	Place needle wire, breast		N					
19295	Place breast clip, percut		N					
19296	Place po breast cath for rad		T	0648	62.9	$4,293.99	.	$858.80
19297	Place breast cath for rad		T	0648	62.9	$4,293.99	.	$858.80
19298	Place breast rad tube/caths		T	0648	62.9	$4,293.99	.	$858.80
19300	Removal of breast tissue		T	0028	25.7651	$1,758.91	.	$351.79
19301	Partical mastectomy		T	0028	25.7651	$1,758.91	.	$351.79
19302	P-mastectomy w/ln removal		T	0030	45.1924	$3,085.15	$747.07	$617.03
19303	Mast, simple, complete		T	0029	34.3618	$2,345.78	$581.52	$469.16

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
19304	Mast, subq		T	0029	34.3618	$2,345.78	$581.52	$469.16
19305	Mast, radical		C					
19306	Mast, rad, urban type		C					
19307	Mast, mod rad		T	0030	45.1924	$3,085.15	$747.07	$617.03
19316	Suspension of breast		T	0029	34.3618	$2,345.78	$581.52	$469.16
19318	Reduction of large breast		T	0030	45.1924	$3,085.15	$747.07	$617.03
19324	Enlarge breast		T	0030	45.1924	$3,085.15	$747.07	$617.03
19325	Enlarge breast with implant		T	0648	62.9	$4,293.99	.	$858.80
19328	Removal of breast implant		T	0029	34.3618	$2,345.78	$581.52	$469.16
19330	Removal of implant material		T	0029	34.3618	$2,345.78	$581.52	$469.16
19340	Immediate breast prosthesis		T	0030	45.1924	$3,085.15	$747.07	$617.03
19342	Delayed breast prosthesis		T	0648	62.9	$4,293.99	.	$858.80
19350	Breast reconstruction		T	0028	25.7651	$1,758.91	.	$351.79
19355	Correct inverted nipple(s)		T	0029	34.3618	$2,345.78	$581.52	$469.16
19357	Breast reconstruction		T	0648	62.9	$4,293.99	.	$858.80
19361	Breast reconstr w/lat flap		C					
19364	Breast reconstruction		C					
19366	Breast reconstruction		T	0029	34.3618	$2,345.78	$581.52	$469.16
19367	Breast reconstruction		C					
19368	Breast reconstruction		C					
19369	Breast reconstruction		C					
19370	Surgery of breast capsule		T	0029	34.3618	$2,345.78	$581.52	$469.16
19371	Removal of breast capsule		T	0029	34.3618	$2,345.78	$581.52	$469.16
19380	Revise breast reconstruction		T	0030	45.1924	$3,085.15	$747.07	$617.03
19396	Design custom breast implant		T	0029	34.3618	$2,345.78	$581.52	$469.16
19499	Breast surgery procedure		T	0028	25.7651	$1,758.91	.	$351.79
20000	Incision of abscess		T	0006	1.4939	$101.98	.	$20.40
20005	Incision of deep abscess		T	0049	23.2249	$1,585.49	.	$317.10
20100	Explore wound, neck		T	0252	7.8743	$537.55	$109.16	$107.51

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
20101	Explore wound, chest		T	0137	22.1186	$1,509.97	.	$302.00
20102	Explore wound, abdomen		T	0137	22.1186	$1,509.97	.	$302.00
20103	Explore wound, extremity		T	0007	13.3268	$909.78	.	$181.96
20150	Excise epiphyseal bar		T	0051	47.3761	$3,234.22	.	$646.85
20200	Muscle biopsy		T	0021	18.2223	$1,243.98	.	$248.80
20205	Deep muscle biopsy		T	0021	18.2223	$1,243.98	.	$248.80
20206	Needle biopsy, muscle		T	0005	8.16	$557.06	.	$111.42
20220	Bone biopsy, trocar/needle		T	0020	8.7772	$599.19	.	$119.84
20225	Bone biopsy, trocar/needle		T	0021	18.2223	$1,243.98	.	$248.80
20240	Bone biopsy, excisional		T	0022	24.1269	$1,647.07	$354.45	$329.42
20245	Bone biopsy, excisional		T	0022	24.1269	$1,647.07	$354.45	$329.42
20250	Open bone biopsy		T	0049	23.2249	$1,585.49	.	$317.10
20251	Open bone biopsy		T	0049	23.2249	$1,585.49	.	$317.10
20500	Injection of sinus tract		T	0252	7.8743	$537.55	$109.16	$107.51
20501	Inject sinus tract for x-ray		N					
20520	Removal of foreign body		T	0019	4.9184	$335.76	.	$67.16
20525	Removal of foreign body		T	0022	24.1269	$1,647.07	$354.45	$329.42
20526	Ther injection, carp tunnel		T	0204	2.666	$182.00	$40.13	$36.40
20550	Inj tendon sheath/ligament		T	0204	2.666	$182.00	$40.13	$36.40
20551	Inj tendon origin/insertion		T	0204	2.666	$182.00	$40.13	$36.40
20552	Inj trigger point, 1/2 muscl		T	0204	2.666	$182.00	$40.13	$36.40
20553	Inject trigger points, =/> 3		T	0204	2.666	$182.00	$40.13	$36.40
20555	Place ndl musc/tis for rt		T	0050	32.4253	$2,213.58	.	$442.72
20600	Drain/inject, joint/bursa		T	0204	2.666	$182.00	$40.13	$36.40
20605	Drain/inject, joint/bursa		T	0204	2.666	$182.00	$40.13	$36.40
20610	Drain/inject, joint/bursa		T	0204	2.666	$182.00	$40.13	$36.40
20612	Aspirate/inj ganglion cyst		T	0204	2.666	$182.00	$40.13	$36.40
20615	Treatment of bone cyst		T	0004	4.6624	$318.29	.	$63.66
20650	Insert and remove bone pin		T	0049	23.2249	$1,585.49	.	$317.10

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
20660	Apply, rem fixation device		T	0138	5.2593	$359.04	.	$71.81
20661	Application of head brace		C					
20662	Application of pelvis brace		T	0049	23.2249	$1,585.49	.	$317.10
20663	Application of thigh brace		T	0049	23.2249	$1,585.49	.	$317.10
20664	Halo brace application		C					
20665	Removal of fixation device		X	0340	0.6899	$47.10	.	$9.42
20670	Removal of support implant		T	0021	18.2223	$1,243.98	.	$248.80
20680	Removal of support implant		T	0022	24.1269	$1,647.07	$354.45	$329.42
20690	Apply bone fixation device		T	0050	32.4253	$2,213.58	.	$442.72
20692	Apply bone fixation device		T	0050	32.4253	$2,213.58	.	$442.72
20693	Adjust bone fixation device		T	0049	23.2249	$1,585.49	.	$317.10
20694	Remove bone fixation device		T	0049	23.2249	$1,585.49	.	$317.10
20696	Comp multiplane ext fixation		T	0050	32.4253	$2,213.58	.	$442.72
20697	Comp ext fixate strut change		T	0139	20.9892	$1,432.87	.	$286.58
20802	Replantation, arm, complete		C					
20805	Replant forearm, complete		C					
20808	Replantation hand, complete		C					
20816	Replantation digit, complete		C					
20822	Replantation digit, complete		T	0054	29.8184	$2,035.61	.	$407.13
20824	Replantation thumb, complete		C					
20827	Replantation thumb, complete		C					
20838	Replantation foot, complete		C					
20900	Removal of bone for graft		T	0050	32.4253	$2,213.58	.	$442.72
20902	Removal of bone for graft		T	0050	32.4253	$2,213.58	.	$442.72
20910	Remove cartilage for graft		T	0137	22.1186	$1,509.97	.	$302.00
20912	Remove cartilage for graft		T	0137	22.1186	$1,509.97	.	$302.00
20920	Removal of fascia for graft		T	0136	17.1353	$1,169.78	.	$233.96
20922	Removal of fascia for graft		T	0136	17.1353	$1,169.78	.	$233.96
20924	Removal of tendon for graft		T	0050	32.4253	$2,213.58	.	$442.72

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
20926	Removal of tissue for graft		T	0135	4.6616	$318.23	.	$63.65
20930	Sp bone algrft morsel add-on		C					
20931	Sp bone algrft struct add-on		C					
20936	Sp bone agrft local add-on		C					
20937	Sp bone agrft morsel add-on		C					
20938	Sp bone agrft struct add-on		C					
20950	Fluid pressure, muscle		T	0006	1.4939	$101.98	.	$20.40
20955	Fibula bone graft, microvasc		C					
20956	Iliac bone graft, microvasc		C					
20957	Mt bone graft, microvasc		C					
20962	Other bone graft, microvasc		C					
20969	Bone/skin graft, microvasc		C					
20970	Bone/skin graft, iliac crest		C					
20972	Bone/skin graft, metatarsal		T	0056	55.5064	$3,789.26	.	$757.86
20973	Bone/skin graft, great toe		T	0056	55.5064	$3,789.26	.	$757.86
20974	Electrical bone stimulation		A					
20975	Electrical bone stimulation		N					
20979	Us bone stimulation		X	0340	0.6899	$47.10	.	$9.42
20982	Ablate, bone tumor(s) perq		T	0051	47.3761	$3,234.22	.	$646.85
20985	Cptr-asst dir ms px		N					
20999	Musculoskeletal surgery		T	0049	23.2249	$1,585.49	.	$317.10
21010	Incision of jaw joint		T	0254	25.5397	$1,743.52	.	$348.71
21011	Exc face les sc < 2 cm		T	0020	8.7772	$599.19	.	$119.84
21012	Exc face les sc = 2 cm		T	0020	8.7772	$599.19	.	$119.84
21013	Exc face tum deep < 2 cm		T	0020	8.7772	$599.19	.	$119.84
21014	Exc face tum deep = 2 cm		T	0020	8.7772	$599.19	.	$119.84
21015	Resect face tum < 2 cm		T	0021	18.2223	$1,243.98	.	$248.80
21016	Resect face tum = 2 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
21025	Excision of bone, lower jaw		T	0256	44.8441	$3,061.37	.	$612.28

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
21026	Excision of facial bone(s)		T	0256	44.8441	$3,061.37	.	$612.28
21029	Contour of face bone lesion		T	0256	44.8441	$3,061.37	.	$612.28
21030	Excise max/zygoma b9 tumor		T	0254	25.5397	$1,743.52	.	$348.71
21031	Remove exostosis, mandible		T	0254	25.5397	$1,743.52	.	$348.71
21032	Remove exostosis, maxilla		T	0254	25.5397	$1,743.52	.	$348.71
21034	Excise max/zygoma mlg tumor		T	0256	44.8441	$3,061.37	.	$612.28
21040	Excise mandible lesion		T	0254	25.5397	$1,743.52	.	$348.71
21044	Removal of jaw bone lesion		T	0256	44.8441	$3,061.37	.	$612.28
21045	Extensive jaw surgery		C					
21046	Remove mandible cyst complex		T	0256	44.8441	$3,061.37	.	$612.28
21047	Excise lwr jaw cyst w/repair		T	0256	44.8441	$3,061.37	.	$612.28
21048	Remove maxilla cyst complex		T	0256	44.8441	$3,061.37	.	$612.28
21049	Excis uppr jaw cyst w/repair		T	0256	44.8441	$3,061.37	.	$612.28
21050	Removal of jaw joint		T	0256	44.8441	$3,061.37	.	$612.28
21060	Remove jaw joint cartilage		T	0256	44.8441	$3,061.37	.	$612.28
21070	Remove coronoid process		T	0256	44.8441	$3,061.37	.	$612.28
21073	Mnpj of tmj w/anesth		T	0252	7.8743	$537.55	$109.16	$107.51
21076	Prepare face/oral prosthesis		T	0254	25.5397	$1,743.52	.	$348.71
21077	Prepare face/oral prosthesis		T	0256	44.8441	$3,061.37	.	$612.28
21079	Prepare face/oral prosthesis		T	0256	44.8441	$3,061.37	.	$612.28
21080	Prepare face/oral prosthesis		T	0256	44.8441	$3,061.37	.	$612.28
21081	Prepare face/oral prosthesis		T	0256	44.8441	$3,061.37	.	$612.28
21082	Prepare face/oral prosthesis		T	0256	44.8441	$3,061.37	.	$612.28
21083	Prepare face/oral prosthesis		T	0256	44.8441	$3,061.37	.	$612.28
21084	Prepare face/oral prosthesis		T	0256	44.8441	$3,061.37	.	$612.28
21085	Prepare face/oral prosthesis		T	0253	17.4151	$1,188.88	$282.29	$237.78
21086	Prepare face/oral prosthesis		T	0256	44.8441	$3,061.37	.	$612.28
21087	Prepare face/oral prosthesis		T	0256	44.8441	$3,061.37	.	$612.28
21088	Prepare face/oral prosthesis		T	0256	44.8441	$3,061.37	.	$612.28

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
21089	Prepare face/oral prosthesis		T	0250	1.1743	$80.17	$25.10	$16.04
21100	Maxillofacial fixation		T	0256	44.8441	$3,061.37	.	$612.28
21110	Interdental fixation		T	0252	7.8743	$537.55	$109.16	$107.51
21116	Injection, jaw joint x-ray		N					
21120	Reconstruction of chin		T	0254	25.5397	$1,743.52	.	$348.71
21121	Reconstruction of chin		T	0254	25.5397	$1,743.52	.	$348.71
21122	Reconstruction of chin		T	0254	25.5397	$1,743.52	.	$348.71
21123	Reconstruction of chin		T	0254	25.5397	$1,743.52	.	$348.71
21125	Augmentation, lower jaw bone		T	0254	25.5397	$1,743.52	.	$348.71
21127	Augmentation, lower jaw bone		T	0256	44.8441	$3,061.37	.	$612.28
21137	Reduction of forehead		T	0254	25.5397	$1,743.52	.	$348.71
21138	Reduction of forehead		T	0256	44.8441	$3,061.37	.	$612.28
21139	Reduction of forehead		T	0256	44.8441	$3,061.37	.	$612.28
21141	Reconstruct midface, lefort		C					
21142	Reconstruct midface, lefort		C					
21143	Reconstruct midface, lefort		C					
21145	Reconstruct midface, lefort		C					
21146	Reconstruct midface, lefort		C					
21147	Reconstruct midface, lefort		C					
21150	Reconstruct midface, lefort		T	0256	44.8441	$3,061.37	.	$612.28
21151	Reconstruct midface, lefort		C					
21154	Reconstruct midface, lefort		C					
21155	Reconstruct midface, lefort		C					
21159	Reconstruct midface, lefort		C					
21160	Reconstruct midface, lefort		C					
21172	Reconstruct orbit/forehead		T	0256	44.8441	$3,061.37	.	$612.28
21175	Reconstruct orbit/forehead		T	0256	44.8441	$3,061.37	.	$612.28
21179	Reconstruct entire forehead		C					
21180	Reconstruct entire forehead		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
21181	Contour cranial bone lesion		T	0254	25.5397	$1,743.52	.	$348.71
21182	Reconstruct cranial bone		C					
21183	Reconstruct cranial bone		C					
21184	Reconstruct cranial bone		C					
21188	Reconstruction of midface		C					
21193	Reconst lwr jaw w/o graft	CH	T	0256	44.8441	$3,061.37	.	$612.28
21194	Reconst lwr jaw w/graft		C					
21195	Reconst lwr jaw w/o fixation		T	0256	44.8441	$3,061.37	.	$612.28
21196	Reconst lwr jaw w/fixation		C					
21198	Reconstr lwr jaw segment		T	0256	44.8441	$3,061.37	.	$612.28
21199	Reconstr lwr jaw w/advance		T	0256	44.8441	$3,061.37	.	$612.28
21206	Reconstruct upper jaw bone		T	0256	44.8441	$3,061.37	.	$612.28
21208	Augmentation of facial bones		T	0256	44.8441	$3,061.37	.	$612.28
21209	Reduction of facial bones		T	0256	44.8441	$3,061.37	.	$612.28
21210	Face bone graft		T	0256	44.8441	$3,061.37	.	$612.28
21215	Lower jaw bone graft		T	0256	44.8441	$3,061.37	.	$612.28
21230	Rib cartilage graft		T	0256	44.8441	$3,061.37	.	$612.28
21235	Ear cartilage graft		T	0254	25.5397	$1,743.52	.	$348.71
21240	Reconstruction of jaw joint		T	0256	44.8441	$3,061.37	.	$612.28
21242	Reconstruction of jaw joint		T	0256	44.8441	$3,061.37	.	$612.28
21243	Reconstruction of jaw joint		T	0256	44.8441	$3,061.37	.	$612.28
21244	Reconstruction of lower jaw		T	0256	44.8441	$3,061.37	.	$612.28
21245	Reconstruction of jaw		T	0256	44.8441	$3,061.37	.	$612.28
21246	Reconstruction of jaw		T	0256	44.8441	$3,061.37	.	$612.28
21247	Reconstruct lower jaw bone		C					
21248	Reconstruction of jaw		T	0256	44.8441	$3,061.37	.	$612.28
21249	Reconstruction of jaw		T	0256	44.8441	$3,061.37	.	$612.28
21255	Reconstruct lower jaw bone		C					
21256	Reconstruction of orbit		T	0256	44.8441	$3,061.37	.	$612.28

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
21260	Revise eye sockets		T	0256	44.8441	$3,061.37	.	$612.28
21261	Revise eye sockets		T	0256	44.8441	$3,061.37	.	$612.28
21263	Revise eye sockets		T	0256	44.8441	$3,061.37	.	$612.28
21267	Revise eye sockets		T	0256	44.8441	$3,061.37	.	$612.28
21268	Revise eye sockets		C					
21270	Augmentation, cheek bone		T	0256	44.8441	$3,061.37	.	$612.28
21275	Revision, orbitofacial bones		T	0256	44.8441	$3,061.37	.	$612.28
21280	Revision of eyelid		T	0256	44.8441	$3,061.37	.	$612.28
21282	Revision of eyelid		T	0253	17.4151	$1,188.88	$282.29	$237.78
21295	Revision of jaw muscle/bone		T	0252	7.8743	$537.55	$109.16	$107.51
21296	Revision of jaw muscle/bone		T	0254	25.5397	$1,743.52	.	$348.71
21299	Cranio/maxillofacial surgery		T	0250	1.1743	$80.17	$25.10	$16.04
21310	Treatment of nose fracture		T	0250	1.1743	$80.17	$25.10	$16.04
21315	Treatment of nose fracture		T	0253	17.4151	$1,188.88	$282.29	$237.78
21320	Treatment of nose fracture		T	0253	17.4151	$1,188.88	$282.29	$237.78
21325	Treatment of nose fracture		T	0254	25.5397	$1,743.52	.	$348.71
21330	Treatment of nose fracture		T	0254	25.5397	$1,743.52	.	$348.71
21335	Treatment of nose fracture		T	0254	25.5397	$1,743.52	.	$348.71
21336	Treat nasal septal fracture		T	0062	26.6924	$1,822.21	$372.87	$364.45
21337	Treat nasal septal fracture		T	0253	17.4151	$1,188.88	$282.29	$237.78
21338	Treat nasoethmoid fracture		T	0254	25.5397	$1,743.52	.	$348.71
21339	Treat nasoethmoid fracture		T	0254	25.5397	$1,743.52	.	$348.71
21340	Treatment of nose fracture		T	0256	44.8441	$3,061.37	.	$612.28
21343	Treatment of sinus fracture		C					
21344	Treatment of sinus fracture		C					
21345	Treat nose/jaw fracture		T	0254	25.5397	$1,743.52	.	$348.71
21346	Treat nose/jaw fracture		C					
21347	Treat nose/jaw fracture		C					
21348	Treat nose/jaw fracture		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
21355	Treat cheek bone fracture		T	0256	44.8441	$3,061.37	.	$612.28
21356	Treat cheek bone fracture		T	0254	25.5397	$1,743.52	.	$348.71
21360	Treat cheek bone fracture		T	0254	25.5397	$1,743.52	.	$348.71
21365	Treat cheek bone fracture		T	0256	44.8441	$3,061.37	.	$612.28
21366	Treat cheek bone fracture		C					
21385	Treat eye socket fracture		T	0256	44.8441	$3,061.37	.	$612.28
21386	Treat eye socket fracture		T	0256	44.8441	$3,061.37	.	$612.28
21387	Treat eye socket fracture		T	0256	44.8441	$3,061.37	.	$612.28
21390	Treat eye socket fracture		T	0256	44.8441	$3,061.37	.	$612.28
21395	Treat eye socket fracture	CH	T	0256	44.8441	$3,061.37	.	$612.28
21400	Treat eye socket fracture		T	0252	7.8743	$537.55	$109.16	$107.51
21401	Treat eye socket fracture		T	0253	17.4151	$1,188.88	$282.29	$237.78
21406	Treat eye socket fracture		T	0256	44.8441	$3,061.37	.	$612.28
21407	Treat eye socket fracture		T	0256	44.8441	$3,061.37	.	$612.28
21408	Treat eye socket fracture		T	0256	44.8441	$3,061.37	.	$612.28
21421	Treat mouth roof fracture		T	0254	25.5397	$1,743.52	.	$348.71
21422	Treat mouth roof fracture		C					
21423	Treat mouth roof fracture		C					
21431	Treat craniofacial fracture		C					
21432	Treat craniofacial fracture		C					
21433	Treat craniofacial fracture		C					
21435	Treat craniofacial fracture		C					
21436	Treat craniofacial fracture		C					
21440	Treat dental ridge fracture		T	0254	25.5397	$1,743.52	.	$348.71
21445	Treat dental ridge fracture		T	0254	25.5397	$1,743.52	.	$348.71
21450	Treat lower jaw fracture		T	0251	3.4369	$234.63	.	$46.93
21451	Treat lower jaw fracture		T	0252	7.8743	$537.55	$109.16	$107.51
21452	Treat lower jaw fracture		T	0253	17.4151	$1,188.88	$282.29	$237.78
21453	Treat lower jaw fracture		T	0256	44.8441	$3,061.37	.	$612.28

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
21454	Treat lower jaw fracture		T	0254	25.5397	$1,743.52	.	$348.71
21461	Treat lower jaw fracture		T	0256	44.8441	$3,061.37	.	$612.28
21462	Treat lower jaw fracture		T	0256	44.8441	$3,061.37	.	$612.28
21465	Treat lower jaw fracture		T	0256	44.8441	$3,061.37	.	$612.28
21470	Treat lower jaw fracture		T	0256	44.8441	$3,061.37	.	$612.28
21480	Reset dislocated jaw		T	0250	1.1743	$80.17	$25.10	$16.04
21485	Reset dislocated jaw		T	0253	17.4151	$1,188.88	$282.29	$237.78
21490	Repair dislocated jaw		T	0256	44.8441	$3,061.37	.	$612.28
21495	Treat hyoid bone fracture		T	0253	17.4151	$1,188.88	$282.29	$237.78
21497	Interdental wiring		T	0253	17.4151	$1,188.88	$282.29	$237.78
21499	Head surgery procedure		T	0250	1.1743	$80.17	$25.10	$16.04
21501	Drain neck/chest lesion		T	0008	20.2481	$1,382.28	.	$276.46
21502	Drain chest lesion		T	0049	23.2249	$1,585.49	.	$317.10
21510	Drainage of bone lesion		C					
21550	Biopsy of neck/chest		T	0021	18.2223	$1,243.98	.	$248.80
21552	Exc neck les sc = 3 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
21554	Exc neck tum deep = 5 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
21555	Exc neck les sc < 3 cm		T	0021	18.2223	$1,243.98	.	$248.80
21556	Exc neck tum deep < 5 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
21557	Resect neck tum < 5 cm		T	0021	18.2223	$1,243.98	.	$248.80
21558	Resect neck tum = 5 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
21600	Partial removal of rib		T	0050	32.4253	$2,213.58	.	$442.72
21610	Partial removal of rib		T	0050	32.4253	$2,213.58	.	$442.72
21615	Removal of rib		C					
21616	Removal of rib and nerves		C					
21620	Partial removal of sternum		C					
21627	Sternal debridement		C					
21630	Extensive sternum surgery		C					
21632	Extensive sternum surgery		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
21685	Hyoid myotomy & suspension		T	0252	7.8743	$537.55	$109.16	$107.51
21700	Revision of neck muscle		T	0049	23.2249	$1,585.49	.	$317.10
21705	Revision of neck muscle/rib		C					
21720	Revision of neck muscle		T	0049	23.2249	$1,585.49	.	$317.10
21725	Revision of neck muscle		T	0006	1.4939	$101.98	.	$20.40
21740	Reconstruction of sternum		C					
21742	Repair stern/nuss w/o scope		T	0051	47.3761	$3,234.22	.	$646.85
21743	Repair sternum/nuss w/scope		T	0051	47.3761	$3,234.22	.	$646.85
21750	Repair of sternum separation		C					
21800	Treatment of rib fracture		T	0129	1.6325	$111.45	.	$22.29
21805	Treatment of rib fracture		T	0062	26.6924	$1,822.21	$372.87	$364.45
21810	Treatment of rib fracture(s)		C					
21820	Treat sternum fracture		T	0129	1.6325	$111.45	.	$22.29
21825	Treat sternum fracture		C					
21899	Neck/chest surgery procedure		T	0250	1.1743	$80.17	$25.10	$16.04
21920	Biopsy soft tissue of back		T	0020	8.7772	$599.19	.	$119.84
21925	Biopsy soft tissue of back		T	0022	24.1269	$1,647.07	$354.45	$329.42
21930	Exc back les sc < 3 cm		T	0021	18.2223	$1,243.98	.	$248.80
21931	Exc back les sc = 3 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
21932	Exc back tum deep < 5 cm		T	0021	18.2223	$1,243.98	.	$248.80
21933	Exc back tum deep = 5 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
21935	Resect back tum < 5 cm		T	0021	18.2223	$1,243.98	.	$248.80
21936	Resect back tum = 5 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
22010	I&d, p-spine, c/t/cerv-thor		C					
22015	I&d, p-spine, l/s/ls		C					
22100	Remove part of neck vertebra		T	0208	51.7137	$3,530.34	.	$706.07
22101	Remove part, thorax vertebra		T	0208	51.7137	$3,530.34	.	$706.07
22102	Remove part, lumbar vertebra		T	0208	51.7137	$3,530.34	.	$706.07
22103	Remove extra spine segment		T	0208	51.7137	$3,530.34	.	$706.07

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
22110	Remove part of neck vertebra		C					
22112	Remove part, thorax vertebra		C					
22114	Remove part, lumbar vertebra		C					
22116	Remove extra spine segment		C					
22206	Cut spine 3 col, thor		C					
22207	Cut spine 3 col, lumb		C					
22208	Cut spine 3 col, addl seg		C					
22210	Revision of neck spine		C					
22212	Revision of thorax spine		C					
22214	Revision of lumbar spine		C					
22216	Revise, extra spine segment		C					
22220	Revision of neck spine		C					
22222	Revision of thorax spine		T	0208	51.7137	$3,530.34	.	$706.07
22224	Revision of lumbar spine		C					
22226	Revise, extra spine segment		C					
22305	Treat spine process fracture		T	0129	1.6325	$111.45	.	$22.29
22310	Treat spine fracture		T	0138	5.2593	$359.04	.	$71.81
22315	Treat spine fracture		T	0139	20.9892	$1,432.87	.	$286.58
22318	Treat odontoid fx w/o graft		C					
22319	Treat odontoid fx w/graft		C					
22325	Treat spine fracture		C					
22326	Treat neck spine fracture		C					
22327	Treat thorax spine fracture		C					
22328	Treat each add spine fx		C					
22505	Manipulation of spine		T	0045	15.5647	$1,062.56	$268.44	$212.52
22520	Percut vertebroplasty thor		T	0050	32.4253	$2,213.58	.	$442.72
22521	Percut vertebroplasty lumb		T	0050	32.4253	$2,213.58	.	$442.72
22522	Percut vertebroplasty addl		T	0050	32.4253	$2,213.58	.	$442.72
22523	Percut kyphoplasty, thor		T	0052	88.5249	$6,043.33	.	$1,208.67

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
22524	Percut kyphoplasty, lumbar		T	0052	88.5249	$6,043.33	.	$1,208.67
22525	Percut kyphoplasty, add-on		T	0052	88.5249	$6,043.33	.	$1,208.67
22526	Idet, single level		E					
22527	Idet, 1 or more levels		E					
22532	Lat thorax spine fusion		C					
22533	Lat lumbar spine fusion		C					
22534	Lat thor/lumb, addl seg		C					
22548	Neck spine fusion		C					
22554	Neck spine fusion		C					
22556	Thorax spine fusion		C					
22558	Lumbar spine fusion		C					
22585	Additional spinal fusion		C					
22590	Spine & skull spinal fusion		C					
22595	Neck spinal fusion		C					
22600	Neck spine fusion		C					
22610	Thorax spine fusion		C					
22612	Lumbar spine fusion		T	0208	51.7137	$3,530.34	.	$706.07
22614	Spine fusion, extra segment		T	0208	51.7137	$3,530.34	.	$706.07
22630	Lumbar spine fusion		C					
22632	Spine fusion, extra segment		C					
22800	Fusion of spine		C					
22802	Fusion of spine		C					
22804	Fusion of spine		C					
22808	Fusion of spine		C					
22810	Fusion of spine		C					
22812	Fusion of spine		C					
22818	Kyphectomy, 1-2 segments		C					
22819	Kyphectomy, 3 or more		C					
22830	Exploration of spinal fusion		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
22840	Insert spine fixation device		C					
22841	Insert spine fixation device		C					
22842	Insert spine fixation device		C					
22843	Insert spine fixation device		C					
22844	Insert spine fixation device		C					
22845	Insert spine fixation device		C					
22846	Insert spine fixation device		C					
22847	Insert spine fixation device		C					
22848	Insert pelv fixation device		C					
22849	Reinsert spinal fixation		C					
22850	Remove spine fixation device		C					
22851	Apply spine prosth device		T	0049	23.2249	$1,585.49	.	$317.10
22852	Remove spine fixation device		C					
22855	Remove spine fixation device		C					
22856	Cerv artific diskectomy		C					
22857	Lumbar artif diskectomy		C					
22861	Revise cerv artific disc		C					
22862	Revise lumbar artif disc		C					
22864	Remove cerv artif disc		C					
22865	Remove lumb artif disc		C					
22899	Spine surgery procedure		T	0049	23.2249	$1,585.49	.	$317.10
22900	Exc back tum deep < 5 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
22901	Exc back tum deep = 5 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
22902	Exc abd les sc < 3 cm		T	0021	18.2223	$1,243.98	.	$248.80
22903	Exc abd les sc > 3 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
22904	Resect abd tum < 5 cm		T	0021	18.2223	$1,243.98	.	$248.80
22905	Resect abd tum > 5 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
22999	Abdomen surgery procedure		T	0049	23.2249	$1,585.49	.	$317.10
23000	Removal of calcium deposits		T	0021	18.2223	$1,243.98	.	$248.80

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
23020	Release shoulder joint		T	0051	47.3761	$3,234.22	.	$646.85
23030	Drain shoulder lesion		T	0008	20.2481	$1,382.28	.	$276.46
23031	Drain shoulder bursa		T	0008	20.2481	$1,382.28	.	$276.46
23035	Drain shoulder bone lesion		T	0049	23.2249	$1,585.49	.	$317.10
23040	Exploratory shoulder surgery		T	0050	32.4253	$2,213.58	.	$442.72
23044	Exploratory shoulder surgery		T	0050	32.4253	$2,213.58	.	$442.72
23065	Biopsy shoulder tissues		T	0020	8.7772	$599.19	.	$119.84
23066	Biopsy shoulder tissues		T	0022	24.1269	$1,647.07	$354.45	$329.42
23071	Exc shoulder les sc > 3 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
23073	Exc shoulder tum deep > 5 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
23075	Exc shoulder les sc < 3 cm		T	0021	18.2223	$1,243.98	.	$248.80
23076	Exc shoulder tum deep < 5 cm		T	0021	18.2223	$1,243.98	.	$248.80
23077	Resect shoulder tum < 5 cm		T	0021	18.2223	$1,243.98	.	$248.80
23078	Resect shoulder tum > 5 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
23100	Biopsy of shoulder joint		T	0049	23.2249	$1,585.49	.	$317.10
23101	Shoulder joint surgery		T	0050	32.4253	$2,213.58	.	$442.72
23105	Remove shoulder joint lining		T	0050	32.4253	$2,213.58	.	$442.72
23106	Incision of collarbone joint		T	0050	32.4253	$2,213.58	.	$442.72
23107	Explore treat shoulder joint		T	0050	32.4253	$2,213.58	.	$442.72
23120	Partial removal, collar bone		T	0050	32.4253	$2,213.58	.	$442.72
23125	Removal of collar bone		T	0050	32.4253	$2,213.58	.	$442.72
23130	Remove shoulder bone, part		T	0051	47.3761	$3,234.22	.	$646.85
23140	Removal of bone lesion		T	0049	23.2249	$1,585.49	.	$317.10
23145	Removal of bone lesion		T	0050	32.4253	$2,213.58	.	$442.72
23146	Removal of bone lesion		T	0050	32.4253	$2,213.58	.	$442.72
23150	Removal of humerus lesion		T	0050	32.4253	$2,213.58	.	$442.72
23155	Removal of humerus lesion		T	0050	32.4253	$2,213.58	.	$442.72
23156	Removal of humerus lesion		T	0050	32.4253	$2,213.58	.	$442.72
23170	Remove collar bone lesion		T	0050	32.4253	$2,213.58	.	$442.72

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
23172	Remove shoulder blade lesion		T	0050	32.4253	$2,213.58	.	$442.72
23174	Remove humerus lesion		T	0050	32.4253	$2,213.58	.	$442.72
23180	Remove collar bone lesion		T	0050	32.4253	$2,213.58	.	$442.72
23182	Remove shoulder blade lesion		T	0050	32.4253	$2,213.58	.	$442.72
23184	Remove humerus lesion		T	0050	32.4253	$2,213.58	.	$442.72
23190	Partial removal of scapula		T	0050	32.4253	$2,213.58	.	$442.72
23195	Removal of head of humerus		T	0050	32.4253	$2,213.58	.	$442.72
23200	Resect clavicle tumor		C					
23210	Resect scapula tumor		C					
23220	Resect prox humerus tumor		C					
23330	Remove shoulder foreign body		T	0020	8.7772	$599.19	.	$119.84
23331	Remove shoulder foreign body		T	0022	24.1269	$1,647.07	$354.45	$329.42
23332	Remove shoulder foreign body		C					
23350	Injection for shoulder x-ray		N					
23395	Muscle transfer,shoulder/arm		T	0051	47.3761	$3,234.22	.	$646.85
23397	Muscle transfers		T	0052	88.5249	$6,043.33	.	$1,208.67
23400	Fixation of shoulder blade		T	0050	32.4253	$2,213.58	.	$442.72
23405	Incision of tendon & muscle		T	0050	32.4253	$2,213.58	.	$442.72
23406	Incise tendon(s) & muscle(s)		T	0050	32.4253	$2,213.58	.	$442.72
23410	Repair rotator cuff, acute		T	0051	47.3761	$3,234.22	.	$646.85
23412	Repair rotator cuff, chronic		T	0051	47.3761	$3,234.22	.	$646.85
23415	Release of shoulder ligament		T	0051	47.3761	$3,234.22	.	$646.85
23420	Repair of shoulder		T	0051	47.3761	$3,234.22	.	$646.85
23430	Repair biceps tendon		T	0051	47.3761	$3,234.22	.	$646.85
23440	Remove/transplant tendon		T	0051	47.3761	$3,234.22	.	$646.85
23450	Repair shoulder capsule		T	0052	88.5249	$6,043.33	.	$1,208.67
23455	Repair shoulder capsule		T	0052	88.5249	$6,043.33	.	$1,208.67
23460	Repair shoulder capsule		T	0052	88.5249	$6,043.33	.	$1,208.67
23462	Repair shoulder capsule		T	0051	47.3761	$3,234.22	.	$646.85

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
23465	Repair shoulder capsule		T	0052	88.5249	$6,043.33	.	$1,208.67
23466	Repair shoulder capsule		T	0051	47.3761	$3,234.22	.	$646.85
23470	Reconstruct shoulder joint		T	0425	122.1766	$8,340.63	.	$1,668.13
23472	Reconstruct shoulder joint		C					
23480	Revision of collar bone		T	0051	47.3761	$3,234.22	.	$646.85
23485	Revision of collar bone		T	0052	88.5249	$6,043.33	.	$1,208.67
23490	Reinforce clavicle	CH	T	0052	88.5249	$6,043.33	.	$1,208.67
23491	Reinforce shoulder bones		T	0052	88.5249	$6,043.33	.	$1,208.67
23500	Treat clavicle fracture		T	0129	1.6325	$111.45	.	$22.29
23505	Treat clavicle fracture		T	0139	20.9892	$1,432.87	.	$286.58
23515	Treat clavicle fracture		T	0064	66.575	$4,544.88	.	$908.98
23520	Treat clavicle dislocation		T	0138	5.2593	$359.04	.	$71.81
23525	Treat clavicle dislocation		T	0138	5.2593	$359.04	.	$71.81
23530	Treat clavicle dislocation		T	0063	48.0827	$3,282.46	.	$656.50
23532	Treat clavicle dislocation		T	0062	26.6924	$1,822.21	$372.87	$364.45
23540	Treat clavicle dislocation		T	0129	1.6325	$111.45	.	$22.29
23545	Treat clavicle dislocation		T	0138	5.2593	$359.04	.	$71.81
23550	Treat clavicle dislocation		T	0063	48.0827	$3,282.46	.	$656.50
23552	Treat clavicle dislocation		T	0063	48.0827	$3,282.46	.	$656.50
23570	Treat shoulder blade fx		T	0129	1.6325	$111.45	.	$22.29
23575	Treat shoulder blade fx		T	0138	5.2593	$359.04	.	$71.81
23585	Treat scapula fracture		T	0064	66.575	$4,544.88	.	$908.98
23600	Treat humerus fracture		T	0129	1.6325	$111.45	.	$22.29
23605	Treat humerus fracture		T	0139	20.9892	$1,432.87	.	$286.58
23615	Treat humerus fracture		T	0064	66.5750	$4,544.88	.	$908.98
23616	Treat humerus fracture		T	0064	66.5750	$4,544.88	.	$908.98
23620	Treat humerus fracture		T	0129	1.6325	$111.45	.	$22.29
23625	Treat humerus fracture		T	0139	20.9892	$1,432.87	.	$286.58
23630	Treat humerus fracture		T	0064	66.5750	$4,544.88	.	$908.98

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
23650	Treat shoulder dislocation		T	0129	1.6325	$111.45	.	$22.29
23655	Treat shoulder dislocation		T	0045	15.5647	$1,062.56	$268.44	$212.52
23660	Treat shoulder dislocation		T	0063	48.0827	$3,282.46	.	$656.50
23665	Treat dislocation/fracture		T	0138	5.2593	$359.04	.	$71.81
23670	Treat dislocation/fracture		T	0064	66.5750	$4,544.88	.	$908.98
23675	Treat dislocation/fracture		T	0129	1.6325	$111.45	.	$22.29
23680	Treat dislocation/fracture		T	0063	48.0827	$3,282.46	.	$656.50
23700	Fixation of shoulder		T	0045	15.5647	$1,062.56	$268.44	$212.52
23800	Fusion of shoulder joint		T	0052	88.5249	$6,043.33	.	$1,208.67
23802	Fusion of shoulder joint	CH	T	0052	88.5249	$6,043.33	.	$1,208.67
23900	Amputation of arm & girdle		C					
23920	Amputation at shoulder joint		C					
23921	Amputation follow-up surgery		T	0136	17.1353	$1,169.78	.	$233.96
23929	Shoulder surgery procedure		T	0129	1.6325	$111.45	.	$22.29
23930	Drainage of arm lesion		T	0008	20.2481	$1,382.28	.	$276.46
23931	Drainage of arm bursa		T	0008	20.2481	$1,382.28	.	$276.46
23935	Drain arm/elbow bone lesion		T	0049	23.2249	$1,585.49	.	$317.10
24000	Exploratory elbow surgery		T	0050	32.4253	$2,213.58	.	$442.72
24006	Release elbow joint		T	0050	32.4253	$2,213.58	.	$442.72
24065	Biopsy arm/elbow soft tissue		T	0021	18.2223	$1,243.98	.	$248.80
24066	Biopsy arm/elbow soft tissue		T	0021	18.2223	$1,243.98	.	$248.80
24071	Exc arm/elbow les sc = 3 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
24073	Ex arm/elbow tum deep > 5 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
24075	Exc arm/elbow les sc < 3 cm		T	0021	18.2223	$1,243.98	.	$248.80
24076	Ex arm/elbow tum deep < 5 cm		T	0021	18.2223	$1,243.98	.	$248.80
24077	Resect arm/elbow tum < 5 cm		T	0021	18.2223	$1,243.98	.	$248.80
24079	Resect arm/elbow tum > 5 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
24100	Biopsy elbow joint lining		T	0049	23.2249	$1,585.49	.	$317.10
24101	Explore/treat elbow joint		T	0050	32.4253	$2,213.58	.	$442.72

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
24102	Remove elbow joint lining		T	0050	32.4253	$2,213.58	.	$442.72
24105	Removal of elbow bursa		T	0049	23.2249	$1,585.49	.	$317.10
24110	Remove humerus lesion		T	0049	23.2249	$1,585.49	.	$317.10
24115	Remove/graft bone lesion		T	0050	32.4253	$2,213.58	.	$442.72
24116	Remove/graft bone lesion		T	0050	32.4253	$2,213.58	.	$442.72
24120	Remove elbow lesion		T	0049	23.2249	$1,585.49	.	$317.10
24125	Remove/graft bone lesion		T	0050	32.4253	$2,213.58	.	$442.72
24126	Remove/graft bone lesion		T	0050	32.4253	$2,213.58	.	$442.72
24130	Removal of head of radius		T	0050	32.4253	$2,213.58	.	$442.72
24134	Removal of arm bone lesion		T	0050	32.4253	$2,213.58	.	$442.72
24136	Remove radius bone lesion		T	0050	32.4253	$2,213.58	.	$442.72
24138	Remove elbow bone lesion		T	0050	32.4253	$2,213.58	.	$442.72
24140	Partial removal of arm bone		T	0050	32.4253	$2,213.58	.	$442.72
24145	Partial removal of radius		T	0050	32.4253	$2,213.58	.	$442.72
24147	Partial removal of elbow		T	0050	32.4253	$2,213.58	.	$442.72
24149	Radical resection of elbow		T	0050	32.4253	$2,213.58	.	$442.72
24150	Resect distal humerus tumor		T	0051	47.3761	$3,234.22	.	$646.85
24152	Resect radius tumor		T	0051	47.3761	$3,234.22	.	$646.85
24155	Removal of elbow joint		T	0051	47.3761	$3,234.22	.	$646.85
24160	Remove elbow joint implant		T	0050	32.4253	$2,213.58	.	$442.72
24164	Remove radius head implant		T	0050	32.4253	$2,213.58	.	$442.72
24200	Removal of arm foreign body		T	0019	4.9184	$335.76	.	$67.16
24201	Removal of arm foreign body		T	0021	18.2223	$1,243.98	.	$248.80
24220	Injection for elbow x-ray		N					
24300	Manipulate elbow w/anesth		T	0045	15.5647	$1,062.56	$268.44	$212.52
24301	Muscle/tendon transfer		T	0050	32.4253	$2,213.58	.	$442.72
24305	Arm tendon lengthening		T	0050	32.4253	$2,213.58	.	$442.72
24310	Revision of arm tendon		T	0049	23.2249	$1,585.49	.	$317.10
24320	Repair of arm tendon		T	0051	47.3761	$3,234.22	.	$646.85

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
24330	Revision of arm muscles		T	0052	88.5249	$6,043.33	.	$1,208.67
24331	Revision of arm muscles		T	0051	47.3761	$3,234.22	.	$646.85
24332	Tenolysis, triceps		T	0049	23.2249	$1,585.49	.	$317.10
24340	Repair of biceps tendon		T	0051	47.3761	$3,234.22	.	$646.85
24341	Repair arm tendon/muscle		T	0051	47.3761	$3,234.22	.	$646.85
24342	Repair of ruptured tendon		T	0051	47.3761	$3,234.22	.	$646.85
24343	Repr elbow lat ligmnt w/tiss		T	0050	32.4253	$2,213.58	.	$442.72
24344	Reconstruct elbow lat ligmnt		T	0052	88.5249	$6,043.33	.	$1,208.67
24345	Repr elbw med ligmnt w/tissu		T	0050	32.4253	$2,213.58	.	$442.72
24346	Reconstruct elbow med ligmnt	CH	T	0052	88.5249	$6,043.33	.	$1,208.67
24357	Repair elbow, perc		T	0050	32.4253	$2,213.58	.	$442.72
24358	Repair elbow w/deb, open		T	0050	32.4253	$2,213.58	.	$442.72
24359	Repair elbow deb/attch open		T	0050	32.4253	$2,213.58	.	$442.72
24360	Reconstruct elbow joint		T	0047	39.0731	$2,667.40	$534.09	$533.48
24361	Reconstruct elbow joint		T	0425	122.1766	$8,340.63	.	$1,668.13
24362	Reconstruct elbow joint		T	0048	60.2668	$4,114.23	.	$822.85
24363	Replace elbow joint		T	0425	122.1766	$8,340.63	.	$1,668.13
24365	Reconstruct head of radius		T	0047	39.0731	$2,667.40	$534.09	$533.48
24366	Reconstruct head of radius		T	0425	122.1766	$8,340.63	.	$1,668.13
24400	Revision of humerus	CH	T	0052	88.5249	$6,043.33	.	$1,208.67
24410	Revision of humerus		T	0051	47.3761	$3,234.22	.	$646.85
24420	Revision of humerus		T	0051	47.3761	$3,234.22	.	$646.85
24430	Repair of humerus		T	0052	88.5249	$6,043.33	.	$1,208.67
24435	Repair humerus with graft		T	0052	88.5249	$6,043.33	.	$1,208.67
24470	Revision of elbow joint		T	0051	47.3761	$3,234.22	.	$646.85
24495	Decompression of forearm		T	0050	32.4253	$2,213.58	.	$442.72
24498	Reinforce humerus		T	0052	88.5249	$6,043.33	.	$1,208.67
24500	Treat humerus fracture		T	0129	1.6325	$111.45	.	$22.29
24505	Treat humerus fracture		T	0129	1.6325	$111.45	.	$22.29

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
24515	Treat humerus fracture		T	0064	66.575	$4,544.88	.	$908.98
24516	Treat humerus fracture		T	0064	66.575	$4,544.88	.	$908.98
24530	Treat humerus fracture		T	0129	1.6325	$111.45	.	$22.29
24535	Treat humerus fracture		T	0138	5.2593	$359.04	.	$71.81
24538	Treat humerus fracture		T	0062	26.6924	$1,822.21	$372.87	$364.45
24545	Treat humerus fracture		T	0064	66.575	$4,544.88	.	$908.98
24546	Treat humerus fracture		T	0064	66.575	$4,544.88	.	$908.98
24560	Treat humerus fracture		T	0129	1.6325	$111.45	.	$22.29
24565	Treat humerus fracture		T	0129	1.6325	$111.45	.	$22.29
24566	Treat humerus fracture		T	0062	26.6924	$1,822.21	$372.87	$364.45
24575	Treat humerus fracture		T	0064	66.575	$4,544.88	.	$908.98
24576	Treat humerus fracture		T	0129	1.6325	$111.45	.	$22.29
24577	Treat humerus fracture		T	0138	5.2593	$359.04	.	$71.81
24579	Treat humerus fracture		T	0064	66.575	$4,544.88	.	$908.98
24582	Treat humerus fracture		T	0062	26.6924	$1,822.21	$372.87	$364.45
24586	Treat elbow fracture		T	0064	66.575	$4,544.88	.	$908.98
24587	Treat elbow fracture		T	0064	66.575	$4,544.88	.	$908.98
24600	Treat elbow dislocation		T	0129	1.6325	$111.45	.	$22.29
24605	Treat elbow dislocation		T	0045	15.5647	$1,062.56	$268.44	$212.52
24615	Treat elbow dislocation		T	0064	66.575	$4,544.88	.	$908.98
24620	Treat elbow fracture		T	0139	20.9892	$1,432.87	.	$286.58
24635	Treat elbow fracture		T	0064	66.575	$4,544.88	.	$908.98
24640	Treat elbow dislocation		T	0129	1.6325	$111.45	.	$22.29
24650	Treat radius fracture		T	0129	1.6325	$111.45	.	$22.29
24655	Treat radius fracture		T	0138	5.2593	$359.04	.	$71.81
24665	Treat radius fracture		T	0063	48.0827	$3,282.46	.	$656.50
24666	Treat radius fracture		T	0064	66.575	$4,544.88	.	$908.98
24670	Treat ulnar fracture		T	0129	1.6325	$111.45	.	$22.29
24675	Treat ulnar fracture		T	0129	1.6325	$111.45	.	$22.29

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
24685	Treat ulnar fracture		T	0063	48.0827	$3,282.46	.	$656.50
24800	Fusion of elbow joint		T	0051	47.3761	$3,234.22	.	$646.85
24802	Fusion/graft of elbow joint	CH	T	0052	88.5249	$6,043.33	.	$1,208.67
24900	Amputation of upper arm		C					
24920	Amputation of upper arm		C					
24925	Amputation follow-up surgery		T	0049	23.2249	$1,585.49	.	$317.10
24930	Amputation follow-up surgery		C					
24931	Amputate upper arm & implant		C					
24935	Revision of amputation		T	0052	88.5249	$6,043.33	.	$1,208.67
24940	Revision of upper arm		C					
24999	Upper arm/elbow surgery		T	0129	1.6325	$111.45	.	$22.29
25000	Incision of tendon sheath		T	0049	23.2249	$1,585.49	.	$317.10
25001	Incise flexor carpi radialis		T	0049	23.2249	$1,585.49	.	$317.10
25020	Decompress forearm 1 space		T	0050	32.4253	$2,213.58	.	$442.72
25023	Decompress forearm 1 space		T	0050	32.4253	$2,213.58	.	$442.72
25024	Decompress forearm 2 spaces		T	0050	32.4253	$2,213.58	.	$442.72
25025	Decompress forearm 2 spaces		T	0050	32.4253	$2,213.58	.	$442.72
25028	Drainage of forearm lesion		T	0049	23.2249	$1,585.49	.	$317.10
25031	Drainage of forearm bursa		T	0049	23.2249	$1,585.49	.	$317.10
25035	Treat forearm bone lesion		T	0049	23.2249	$1,585.49	.	$317.10
25040	Explore/treat wrist joint		T	0050	32.4253	$2,213.58	.	$442.72
25065	Biopsy forearm soft tissues		T	0020	8.7772	$599.19	.	$119.84
25066	Biopsy forearm soft tissues		T	0022	24.1269	$1,647.07	$354.45	$329.42
25071	Exc forearm les sc > 3 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
25073	Exc forearm tum deep = 3 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
25075	Exc forearm les sc < 3 cm		T	0021	18.2223	$1,243.98	.	$248.80
25076	Exc forearm tum deep < 3 cm		T	0021	18.2223	$1,243.98	.	$248.80
25077	Resect forearm/wrist tum<3cm		T	0021	18.2223	$1,243.98	.	$248.80
25078	Resect forearm/wrist tum=3cm		T	0022	24.1269	$1,647.07	$354.45	$329.42

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
25085	Incision of wrist capsule		T	0049	23.2249	$1,585.49	.	$317.10
25100	Biopsy of wrist joint		T	0049	23.2249	$1,585.49	.	$317.10
25101	Explore/treat wrist joint		T	0050	32.4253	$2,213.58	.	$442.72
25105	Remove wrist joint lining		T	0050	32.4253	$2,213.58	.	$442.72
25107	Remove wrist joint cartilage		T	0050	32.4253	$2,213.58	.	$442.72
25109	Excise tendon forearm/wrist		T	0049	23.2249	$1,585.49	.	$317.10
25110	Remove wrist tendon lesion		T	0049	23.2249	$1,585.49	.	$317.10
25111	Remove wrist tendon lesion		T	0049	23.2249	$1,585.49	.	$317.10
25112	Reremove wrist tendon lesion		T	0049	23.2249	$1,585.49	.	$317.10
25115	Remove wrist/forearm lesion		T	0049	23.2249	$1,585.49	.	$317.10
25116	Remove wrist/forearm lesion		T	0049	23.2249	$1,585.49	.	$317.10
25118	Excise wrist tendon sheath		T	0050	32.4253	$2,213.58	.	$442.72
25119	Partial removal of ulna		T	0050	32.4253	$2,213.58	.	$442.72
25120	Removal of forearm lesion		T	0050	32.4253	$2,213.58	.	$442.72
25125	Remove/graft forearm lesion		T	0050	32.4253	$2,213.58	.	$442.72
25126	Remove/graft forearm lesion		T	0050	32.4253	$2,213.58	.	$442.72
25130	Removal of wrist lesion		T	0050	32.4253	$2,213.58	.	$442.72
25135	Remove & graft wrist lesion		T	0050	32.4253	$2,213.58	.	$442.72
25136	Remove & graft wrist lesion		T	0050	32.4253	$2,213.58	.	$442.72
25145	Remove forearm bone lesion		T	0050	32.4253	$2,213.58	.	$442.72
25150	Partial removal of ulna		T	0050	32.4253	$2,213.58	.	$442.72
25151	Partial removal of radius		T	0050	32.4253	$2,213.58	.	$442.72
25170	Resect radius/ulnar tumor		T	0051	47.3761	$3,234.22	.	$646.85
25210	Removal of wrist bone		T	0050	32.4253	$2,213.58	.	$442.72
25215	Removal of wrist bones		T	0050	32.4253	$2,213.58	.	$442.72
25230	Partial removal of radius		T	0050	32.4253	$2,213.58	.	$442.72
25240	Partial removal of ulna		T	0050	32.4253	$2,213.58	.	$442.72
25246	Injection for wrist x-ray		N					
25248	Remove forearm foreign body		T	0049	23.2249	$1,585.49	.	$317.10

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
25250	Removal of wrist prosthesis		T	0050	32.4253	$2,213.58	.	$442.72
25251	Removal of wrist prosthesis		T	0050	32.4253	$2,213.58	.	$442.72
25259	Manipulate wrist w/anesthes		T	0139	20.9892	$1,432.87	.	$286.58
25260	Repair forearm tendon/muscle		T	0050	32.4253	$2,213.58	.	$442.72
25263	Repair forearm tendon/muscle		T	0050	32.4253	$2,213.58	.	$442.72
25265	Repair forearm tendon/muscle		T	0050	32.4253	$2,213.58	.	$442.72
25270	Repair forearm tendon/muscle		T	0050	32.4253	$2,213.58	.	$442.72
25272	Repair forearm tendon/muscle		T	0050	32.4253	$2,213.58	.	$442.72
25274	Repair forearm tendon/muscle		T	0050	32.4253	$2,213.58	.	$442.72
25275	Repair forearm tendon sheath		T	0050	32.4253	$2,213.58	.	$442.72
25280	Revise wrist/forearm tendon		T	0050	32.4253	$2,213.58	.	$442.72
25290	Incise wrist/forearm tendon		T	0050	32.4253	$2,213.58	.	$442.72
25295	Release wrist/forearm tendon		T	0049	23.2249	$1,585.49	.	$317.10
25300	Fusion of tendons at wrist		T	0050	32.4253	$2,213.58	.	$442.72
25301	Fusion of tendons at wrist		T	0050	32.4253	$2,213.58	.	$442.72
25310	Transplant forearm tendon		T	0051	47.3761	$3,234.22	.	$646.85
25312	Transplant forearm tendon		T	0051	47.3761	$3,234.22	.	$646.85
25315	Revise palsy hand tendon(s)		T	0051	47.3761	$3,234.22	.	$646.85
25316	Revise palsy hand tendon(s)		T	0052	88.5249	$6,043.33	.	$1,208.67
25320	Repair/revise wrist joint		T	0051	47.3761	$3,234.22	.	$646.85
25332	Revise wrist joint		T	0047	39.0731	$2,667.40	$534.09	$533.48
25335	Realignment of hand		T	0051	47.3761	$3,234.22	.	$646.85
25337	Reconstruct ulna/radioulnar		T	0051	47.3761	$3,234.22	.	$646.85
25350	Revision of radius		T	0051	47.3761	$3,234.22	.	$646.85
25355	Revision of radius		T	0051	47.3761	$3,234.22	.	$646.85
25360	Revision of ulna		T	0051	47.3761	$3,234.22	.	$646.85
25365	Revise radius & ulna	CH	T	0052	88.5249	$6,043.33	.	$1,208.67
25370	Revise radius or ulna		T	0051	47.3761	$3,234.22	.	$646.85
25375	Revise radius & ulna		T	0051	47.3761	$3,234.22	.	$646.85

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
25390	Shorten radius or ulna		T	0051	47.3761	$3,234.22	.	$646.85
25391	Lengthen radius or ulna	CH	T	0052	88.5249	$6,043.33	.	$1,208.67
25392	Shorten radius & ulna		T	0050	32.4253	$2,213.58	.	$442.72
25393	Lengthen radius & ulna		T	0051	47.3761	$3,234.22	.	$646.85
25394	Repair carpal bone, shorten		T	0051	47.3761	$3,234.22	.	$646.85
25400	Repair radius or ulna	CH	T	0052	88.5249	$6,043.33	.	$1,208.67
25405	Repair/graft radius or ulna		T	0052	88.5249	$6,043.33	.	$1,208.67
25415	Repair radius & ulna		T	0052	88.5249	$6,043.33	.	$1,208.67
25420	Repair/graft radius & ulna		T	0052	88.5249	$6,043.33	.	$1,208.67
25425	Repair/graft radius or ulna	CH	T	0052	88.5249	$6,043.33	.	$1,208.67
25426	Repair/graft radius & ulna		T	0051	47.3761	$3,234.22	.	$646.85
25430	Vasc graft into carpal bone		T	0051	47.3761	$3,234.22	.	$646.85
25431	Repair nonunion carpal bone		T	0051	47.3761	$3,234.22	.	$646.85
25440	Repair/graft wrist bone		T	0052	88.5249	$6,043.33	.	$1,208.67
25441	Reconstruct wrist joint		T	0425	122.1766	$8,340.63	.	$1,668.13
25442	Reconstruct wrist joint		T	0425	122.1766	$8,340.63	.	$1,668.13
25443	Reconstruct wrist joint		T	0048	60.2668	$4,114.23	.	$822.85
25444	Reconstruct wrist joint		T	0048	60.2668	$4,114.23	.	$822.85
25445	Reconstruct wrist joint		T	0048	60.2668	$4,114.23	.	$822.85
25446	Wrist replacement		T	0425	122.1766	$8,340.63	.	$1,668.13
25447	Repair wrist joint(s)		T	0047	39.0731	$2,667.40	$534.09	$533.48
25449	Remove wrist joint implant		T	0047	39.0731	$2,667.40	$534.09	$533.48
25450	Revision of wrist joint		T	0051	47.3761	$3,234.22	.	$646.85
25455	Revision of wrist joint		T	0051	47.3761	$3,234.22	.	$646.85
25490	Reinforce radius		T	0051	47.3761	$3,234.22	.	$646.85
25491	Reinforce ulna		T	0051	47.3761	$3,234.22	.	$646.85
25492	Reinforce radius and ulna		T	0051	47.3761	$3,234.22	.	$646.85
25500	Treat fracture of radius		T	0129	1.6325	$111.45	.	$22.29
25505	Treat fracture of radius		T	0138	5.2593	$359.04	.	$71.81

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
25515	Treat fracture of radius		T	0063	48.0827	$3,282.46	.	$656.50
25520	Treat fracture of radius		T	0138	5.2593	$359.04	.	$71.81
25525	Treat fracture of radius		T	0063	48.0827	$3,282.46	.	$656.50
25526	Treat fracture of radius		T	0063	48.0827	$3,282.46	.	$656.50
25530	Treat fracture of ulna		T	0129	1.6325	$111.45	.	$22.29
25535	Treat fracture of ulna		T	0129	1.6325	$111.45	.	$22.29
25545	Treat fracture of ulna		T	0063	48.0827	$3,282.46	.	$656.50
25560	Treat fracture radius & ulna		T	0129	1.6325	$111.45	.	$22.29
25565	Treat fracture radius & ulna		T	0138	5.2593	$359.04	.	$71.81
25574	Treat fracture radius & ulna		T	0064	66.575	$4,544.88	.	$908.98
25575	Treat fracture radius/ulna		T	0064	66.575	$4,544.88	.	$908.98
25600	Treat fracture radius/ulna		T	0129	1.6325	$111.45	.	$22.29
25605	Treat fracture radius/ulna		T	0138	5.2593	$359.04	.	$71.81
25606	Treat fx distal radial		T	0062	26.6924	$1,822.21	$372.87	$364.45
25607	Treat fx rad extra-articul		T	0064	66.575	$4,544.88	.	$908.98
25608	Treat fx rad intra-articul		T	0064	66.575	$4,544.88	.	$908.98
25609	Treat fx radial 3+ frag		T	0064	66.575	$4,544.88	.	$908.98
25622	Treat wrist bone fracture		T	0129	1.6325	$111.45	.	$22.29
25624	Treat wrist bone fracture		T	0138	5.2593	$359.04	.	$71.81
25628	Treat wrist bone fracture		T	0063	48.0827	$3,282.46	.	$656.50
25630	Treat wrist bone fracture		T	0129	1.6325	$111.45	.	$22.29
25635	Treat wrist bone fracture		T	0138	5.2593	$359.04	.	$71.81
25645	Treat wrist bone fracture		T	0063	48.0827	$3,282.46	.	$656.50
25650	Treat wrist bone fracture		T	0129	1.6325	$111.45	.	$22.29
25651	Pin ulnar styloid fracture		T	0062	26.6924	$1,822.21	$372.87	$364.45
25652	Treat fracture ulnar styloid		T	0063	48.0827	$3,282.46	.	$656.50
25660	Treat wrist dislocation		T	0129	1.6325	$111.45	.	$22.29
25670	Treat wrist dislocation		T	0062	26.6924	$1,822.21	$372.87	$364.45
25671	Pin radioulnar dislocation		T	0062	26.6924	$1,822.21	$372.87	$364.45

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
25675	Treat wrist dislocation		T	0129	1.6325	$111.45	.	$22.29
25676	Treat wrist dislocation		T	0062	26.6924	$1,822.21	$372.87	$364.45
25680	Treat wrist fracture		T	0129	1.6325	$111.45	.	$22.29
25685	Treat wrist fracture		T	0062	26.6924	$1,822.21	$372.87	$364.45
25690	Treat wrist dislocation		T	0139	20.9892	$1,432.87	.	$286.58
25695	Treat wrist dislocation		T	0062	26.6924	$1,822.21	$372.87	$364.45
25800	Fusion of wrist joint		T	0052	88.5249	$6,043.33	.	$1,208.67
25805	Fusion/graft of wrist joint	CH	T	0052	88.5249	$6,043.33	.	$1,208.67
25810	Fusion/graft of wrist joint		T	0052	88.5249	$6,043.33	.	$1,208.67
25820	Fusion of hand bones		T	0051	47.3761	$3,234.22	.	$646.85
25825	Fuse hand bones with graft		T	0052	88.5249	$6,043.33	.	$1,208.67
25830	Fusion, radioulnar jnt/ulna		T	0052	88.5249	$6,043.33	.	$1,208.67
25900	Amputation of forearm		C					
25905	Amputation of forearm		C					
25907	Amputation follow-up surgery		T	0049	23.2249	$1,585.49	.	$317.10
25909	Amputation follow-up surgery	CH	T	0049	23.2249	$1,585.49	.	$317.10
25915	Amputation of forearm		C					
25920	Amputate hand at wrist		C					
25922	Amputate hand at wrist		T	0049	23.2249	$1,585.49	.	$317.10
25924	Amputation follow-up surgery		C					
25927	Amputation of hand		C					
25929	Amputation follow-up surgery		T	0136	17.1353	$1,169.78	.	$233.96
25931	Amputation follow-up surgery		T	0049	23.2249	$1,585.49	.	$317.10
25999	Forearm or wrist surgery		T	0129	1.6325	$111.45	.	$22.29
26010	Drainage of finger abscess		T	0006	1.4939	$101.98	.	$20.40
26011	Drainage of finger abscess		T	0007	13.3268	$909.78	.	$181.96
26020	Drain hand tendon sheath		T	0053	17.3655	$1,185.49	$253.49	$237.10
26025	Drainage of palm bursa		T	0053	17.3655	$1,185.49	$253.49	$237.10
26030	Drainage of palm bursa(s)		T	0053	17.3655	$1,185.49	$253.49	$237.10

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
26034	Treat hand bone lesion		T	0053	17.3655	$1,185.49	$253.49	$237.10
26035	Decompress fingers/hand		T	0053	17.3655	$1,185.49	$253.49	$237.10
26037	Decompress fingers/hand		T	0053	17.3655	$1,185.49	$253.49	$237.10
26040	Release palm contracture	CH	T	0053	17.3655	$1,185.49	$253.49	$237.10
26045	Release palm contracture		T	0054	29.8184	$2,035.61	.	$407.13
26055	Incise finger tendon sheath		T	0053	17.3655	$1,185.49	$253.49	$237.10
26060	Incision of finger tendon		T	0053	17.3655	$1,185.49	$253.49	$237.10
26070	Explore/treat hand joint		T	0053	17.3655	$1,185.49	$253.49	$237.10
26075	Explore/treat finger joint		T	0053	17.3655	$1,185.49	$253.49	$237.10
26080	Explore/treat finger joint		T	0053	17.3655	$1,185.49	$253.49	$237.10
26100	Biopsy hand joint lining		T	0053	17.3655	$1,185.49	$253.49	$237.10
26105	Biopsy finger joint lining		T	0053	17.3655	$1,185.49	$253.49	$237.10
26110	Biopsy finger joint lining		T	0053	17.3655	$1,185.49	$253.49	$237.10
26111	Exc hand les sc > 1.5 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
26113	Exc hand tum deep > 1.5 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
26115	Exc hand les sc < 1.5 cm		T	0021	18.2223	$1,243.98	.	$248.80
26116	Exc hand tum deep < 1.5 cm		T	0021	18.2223	$1,243.98	.	$248.80
26117	Exc hand tum ra < 3 cm		T	0021	18.2223	$1,243.98	.	$248.80
26118	Exc hand tum ra > 3 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
26121	Release palm contracture		T	0054	29.8184	$2,035.61	.	$407.13
26123	Release palm contracture		T	0054	29.8184	$2,035.61	.	$407.13
26125	Release palm contracture		T	0053	17.3655	$1,185.49	$253.49	$237.10
26130	Remove wrist joint lining		T	0053	17.3655	$1,185.49	$253.49	$237.10
26135	Revise finger joint, each		T	0054	29.8184	$2,035.61	.	$407.13
26140	Revise finger joint, each		T	0053	17.3655	$1,185.49	$253.49	$237.10
26145	Tendon excision, palm/finger		T	0053	17.3655	$1,185.49	$253.49	$237.10
26160	Remove tendon sheath lesion		T	0053	17.3655	$1,185.49	$253.49	$237.10
26170	Removal of palm tendon, each		T	0053	17.3655	$1,185.49	$253.49	$237.10
26180	Removal of finger tendon		T	0053	17.3655	$1,185.49	$253.49	$237.10

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
26185	Remove finger bone		T	0053	17.3655	$1,185.49	$253.49	$237.10
26200	Remove hand bone lesion		T	0053	17.3655	$1,185.49	$253.49	$237.10
26205	Remove/graft bone lesion		T	0054	29.8184	$2,035.61	.	$407.13
26210	Removal of finger lesion		T	0053	17.3655	$1,185.49	$253.49	$237.10
26215	Remove/graft finger lesion		T	0053	17.3655	$1,185.49	$253.49	$237.10
26230	Partial removal of hand bone		T	0053	17.3655	$1,185.49	$253.49	$237.10
26235	Partial removal, finger bone		T	0053	17.3655	$1,185.49	$253.49	$237.10
26236	Partial removal, finger bone		T	0053	17.3655	$1,185.49	$253.49	$237.10
26250	Extensive hand surgery		T	0053	17.3655	$1,185.49	$253.49	$237.10
26260	Resect prox finger tumor		T	0053	17.3655	$1,185.49	$253.49	$237.10
26262	Resect distal finger tumor		T	0053	17.3655	$1,185.49	$253.49	$237.10
26320	Removal of implant from hand		T	0021	18.2223	$1,243.98	.	$248.80
26340	Manipulate finger w/anesth		T	0138	5.2593	$359.04	.	$71.81
26350	Repair finger/hand tendon		T	0054	29.8184	$2,035.61	.	$407.13
26352	Repair/graft hand tendon		T	0054	29.8184	$2,035.61	.	$407.13
26356	Repair finger/hand tendon		T	0054	29.8184	$2,035.61	.	$407.13
26357	Repair finger/hand tendon		T	0054	29.8184	$2,035.61	.	$407.13
26358	Repair/graft hand tendon		T	0054	29.8184	$2,035.61	.	$407.13
26370	Repair finger/hand tendon		T	0054	29.8184	$2,035.61	.	$407.13
26372	Repair/graft hand tendon		T	0054	29.8184	$2,035.61	.	$407.13
26373	Repair finger/hand tendon		T	0054	29.8184	$2,035.61	.	$407.13
26390	Revise hand/finger tendon		T	0054	29.8184	$2,035.61	.	$407.13
26392	Repair/graft hand tendon		T	0054	29.8184	$2,035.61	.	$407.13
26410	Repair hand tendon		T	0053	17.3655	$1,185.49	$253.49	$237.10
26412	Repair/graft hand tendon		T	0054	29.8184	$2,035.61	.	$407.13
26415	Excision, hand/finger tendon		T	0054	29.8184	$2,035.61	.	$407.13
26416	Graft hand or finger tendon		T	0054	29.8184	$2,035.61	.	$407.13
26418	Repair finger tendon		T	0053	17.3655	$1,185.49	$253.49	$237.10
26420	Repair/graft finger tendon		T	0054	29.8184	$2,035.61	.	$407.13

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
26426	Repair finger/hand tendon		T	0054	29.8184	$2,035.61	.	$407.13
26428	Repair/graft finger tendon		T	0054	29.8184	$2,035.61	.	$407.13
26432	Repair finger tendon		T	0053	17.3655	$1,185.49	$253.49	$237.10
26433	Repair finger tendon		T	0053	17.3655	$1,185.49	$253.49	$237.10
26434	Repair/graft finger tendon		T	0054	29.8184	$2,035.61	.	$407.13
26437	Realignment of tendons		T	0053	17.3655	$1,185.49	$253.49	$237.10
26440	Release palm/finger tendon		T	0053	17.3655	$1,185.49	$253.49	$237.10
26442	Release palm & finger tendon		T	0054	29.8184	$2,035.61	.	$407.13
26445	Release hand/finger tendon		T	0053	17.3655	$1,185.49	$253.49	$237.10
26449	Release forearm/hand tendon		T	0054	29.8184	$2,035.61	.	$407.13
26450	Incision of palm tendon		T	0053	17.3655	$1,185.49	$253.49	$237.10
26455	Incision of finger tendon		T	0053	17.3655	$1,185.49	$253.49	$237.10
26460	Incise hand/finger tendon		T	0053	17.3655	$1,185.49	$253.49	$237.10
26471	Fusion of finger tendons		T	0053	17.3655	$1,185.49	$253.49	$237.10
26474	Fusion of finger tendons		T	0053	17.3655	$1,185.49	$253.49	$237.10
26476	Tendon lengthening		T	0053	17.3655	$1,185.49	$253.49	$237.10
26477	Tendon shortening		T	0053	17.3655	$1,185.49	$253.49	$237.10
26478	Lengthening of hand tendon		T	0053	17.3655	$1,185.49	$253.49	$237.10
26479	Shortening of hand tendon		T	0053	17.3655	$1,185.49	$253.49	$237.10
26480	Transplant hand tendon		T	0054	29.8184	$2,035.61	.	$407.13
26483	Transplant/graft hand tendon		T	0054	29.8184	$2,035.61	.	$407.13
26485	Transplant palm tendon		T	0054	29.8184	$2,035.61	.	$407.13
26489	Transplant/graft palm tendon		T	0054	29.8184	$2,035.61	.	$407.13
26490	Revise thumb tendon		T	0054	29.8184	$2,035.61	.	$407.13
26492	Tendon transfer with graft		T	0054	29.8184	$2,035.61	.	$407.13
26494	Hand tendon/muscle transfer		T	0054	29.8184	$2,035.61	.	$407.13
26496	Revise thumb tendon		T	0054	29.8184	$2,035.61	.	$407.13
26497	Finger tendon transfer		T	0054	29.8184	$2,035.61	.	$407.13
26498	Finger tendon transfer		T	0054	29.8184	$2,035.61	.	$407.13

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
26499	Revision of finger		T	0054	29.8184	$2,035.61	.	$407.13
26500	Hand tendon reconstruction		T	0053	17.3655	$1,185.49	$253.49	$237.10
26502	Hand tendon reconstruction		T	0054	29.8184	$2,035.61	.	$407.13
26508	Release thumb contracture		T	0053	17.3655	$1,185.49	$253.49	$237.10
26510	Thumb tendon transfer		T	0054	29.8184	$2,035.61	.	$407.13
26516	Fusion of knuckle joint		T	0054	29.8184	$2,035.61	.	$407.13
26517	Fusion of knuckle joints		T	0054	29.8184	$2,035.61	.	$407.13
26518	Fusion of knuckle joints		T	0054	29.8184	$2,035.61	.	$407.13
26520	Release knuckle contracture		T	0053	17.3655	$1,185.49	$253.49	$237.10
26525	Release finger contracture		T	0053	17.3655	$1,185.49	$253.49	$237.10
26530	Revise knuckle joint		T	0047	39.0731	$2,667.40	$534.09	$533.48
26531	Revise knuckle with implant		T	0048	60.2668	$4,114.23	.	$822.85
26535	Revise finger joint		T	0047	39.0731	$2,667.40	$534.09	$533.48
26536	Revise/implant finger joint		T	0048	60.2668	$4,114.23	.	$822.85
26540	Repair hand joint		T	0053	17.3655	$1,185.49	$253.49	$237.10
26541	Repair hand joint with graft		T	0054	29.8184	$2,035.61	.	$407.13
26542	Repair hand joint with graft		T	0053	17.3655	$1,185.49	$253.49	$237.10
26545	Reconstruct finger joint		T	0054	29.8184	$2,035.61	.	$407.13
26546	Repair nonunion hand		T	0054	29.8184	$2,035.61	.	$407.13
26548	Reconstruct finger joint		T	0054	29.8184	$2,035.61	.	$407.13
26550	Construct thumb replacement		T	0054	29.8184	$2,035.61	.	$407.13
26551	Great toe-hand transfer		C					
26553	Single transfer, toe-hand		C					
26554	Double transfer, toe-hand		C					
26555	Positional change of finger		T	0054	29.8184	$2,035.61	.	$407.13
26556	Toe joint transfer		C					
26560	Repair of web finger		T	0053	17.3655	$1,185.49	$253.49	$237.10
26561	Repair of web finger		T	0054	29.8184	$2,035.61	.	$407.13
26562	Repair of web finger		T	0054	29.8184	$2,035.61	.	$407.13

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
26565	Correct metacarpal flaw		T	0054	29.8184	$2,035.61	.	$407.13
26567	Correct finger deformity		T	0054	29.8184	$2,035.61	.	$407.13
26568	Lengthen metacarpal/finger		T	0054	29.8184	$2,035.61	.	$407.13
26580	Repair hand deformity		T	0053	17.3655	$1,185.49	$253.49	$237.10
26587	Reconstruct extra finger		T	0053	17.3655	$1,185.49	$253.49	$237.10
26590	Repair finger deformity		T	0053	17.3655	$1,185.49	$253.49	$237.10
26591	Repair muscles of hand		T	0054	29.8184	$2,035.61	.	$407.13
26593	Release muscles of hand		T	0053	17.3655	$1,185.49	$253.49	$237.10
26596	Excision constricting tissue		T	0053	17.3655	$1,185.49	$253.49	$237.10
26600	Treat metacarpal fracture		T	0129	1.6325	$111.45	.	$22.29
26605	Treat metacarpal fracture		T	0129	1.6325	$111.45	.	$22.29
26607	Treat metacarpal fracture		T	0139	20.9892	$1,432.87	.	$286.58
26608	Treat metacarpal fracture		T	0062	26.6924	$1,822.21	$372.87	$364.45
26615	Treat metacarpal fracture		T	0063	48.0827	$3,282.46	.	$656.50
26641	Treat thumb dislocation		T	0129	1.6325	$111.45	.	$22.29
26645	Treat thumb fracture		T	0138	5.2593	$359.04	.	$71.81
26650	Treat thumb fracture		T	0062	26.6924	$1,822.21	$372.87	$364.45
26665	Treat thumb fracture		T	0063	48.0827	$3,282.46	.	$656.50
26670	Treat hand dislocation		T	0129	1.6325	$111.45	.	$22.29
26675	Treat hand dislocation		T	0138	5.2593	$359.04	.	$71.81
26676	Pin hand dislocation		T	0062	26.6924	$1,822.21	$372.87	$364.45
26685	Treat hand dislocation		T	0062	26.6924	$1,822.21	$372.87	$364.45
26686	Treat hand dislocation		T	0064	66.575	$4,544.88	.	$908.98
26700	Treat knuckle dislocation		T	0129	1.6325	$111.45	.	$22.29
26705	Treat knuckle dislocation		T	0129	1.6325	$111.45	.	$22.29
26706	Pin knuckle dislocation		T	0139	20.9892	$1,432.87	.	$286.58
26715	Treat knuckle dislocation		T	0062	26.6924	$1,822.21	$372.87	$364.45
26720	Treat finger fracture, each		T	0129	1.6325	$111.45	.	$22.29
26725	Treat finger fracture, each		T	0129	1.6325	$111.45	.	$22.29

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
26727	Treat finger fracture, each		T	0062	26.6924	$1,822.21	$372.87	$364.45
26735	Treat finger fracture, each		T	0062	26.6924	$1,822.21	$372.87	$364.45
26740	Treat finger fracture, each		T	0129	1.6325	$111.45	.	$22.29
26742	Treat finger fracture, each		T	0129	1.6325	$111.45	.	$22.29
26746	Treat finger fracture, each		T	0062	26.6924	$1,822.21	$372.87	$364.45
26750	Treat finger fracture, each		T	0129	1.6325	$111.45	.	$22.29
26755	Treat finger fracture, each		T	0129	1.6325	$111.45	.	$22.29
26756	Pin finger fracture, each		T	0062	26.6924	$1,822.21	$372.87	$364.45
26765	Treat finger fracture, each		T	0062	26.6924	$1,822.21	$372.87	$364.45
26770	Treat finger dislocation		T	0129	1.6325	$111.45	.	$22.29
26775	Treat finger dislocation		T	0045	15.5647	$1,062.56	$268.44	$212.52
26776	Pin finger dislocation		T	0062	26.6924	$1,822.21	$372.87	$364.45
26785	Treat finger dislocation		T	0062	26.6924	$1,822.21	$372.87	$364.45
26820	Thumb fusion with graft		T	0054	29.8184	$2,035.61	.	$407.13
26841	Fusion of thumb		T	0054	29.8184	$2,035.61	.	$407.13
26842	Thumb fusion with graft		T	0054	29.8184	$2,035.61	.	$407.13
26843	Fusion of hand joint		T	0054	29.8184	$2,035.61	.	$407.13
26844	Fusion/graft of hand joint		T	0054	29.8184	$2,035.61	.	$407.13
26850	Fusion of knuckle		T	0054	29.8184	$2,035.61	.	$407.13
26852	Fusion of knuckle with graft		T	0054	29.8184	$2,035.61	.	$407.13
26860	Fusion of finger joint		T	0054	29.8184	$2,035.61	.	$407.13
26861	Fusion of finger jnt, add-on		T	0054	29.8184	$2,035.61	.	$407.13
26862	Fusion/graft of finger joint		T	0054	29.8184	$2,035.61	.	$407.13
26863	Fuse/graft added joint		T	0054	29.8184	$2,035.61	.	$407.13
26910	Amputate metacarpal bone		T	0054	29.8184	$2,035.61	.	$407.13
26951	Amputation of finger/thumb		T	0053	17.3655	$1,185.49	$253.49	$237.10
26952	Amputation of finger/thumb		T	0053	17.3655	$1,185.49	$253.49	$237.10
26989	Hand/finger surgery		T	0129	1.6325	$111.45	.	$22.29
26990	Drainage of pelvis lesion		T	0049	23.2249	$1,585.49	.	$317.10

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
26991	Drainage of pelvis bursa		T	0049	23.2249	$1,585.49	.	$317.10
26992	Drainage of bone lesion		C					
27000	Incision of hip tendon		T	0049	23.2249	$1,585.49	.	$317.10
27001	Incision of hip tendon		T	0050	32.4253	$2,213.58	.	$442.72
27003	Incision of hip tendon		T	0050	32.4253	$2,213.58	.	$442.72
27005	Incision of hip tendon		C					
27006	Incision of hip tendons		T	0050	32.4253	$2,213.58	.	$442.72
27025	Incision of hip/thigh fascia		C					
27027	Buttock fasciotomy		T	0049	23.2249	$1,585.49	.	$317.10
27030	Drainage of hip joint		C					
27033	Exploration of hip joint		T	0051	47.3761	$3,234.22	.	$646.85
27035	Denervation of hip joint		T	0051	47.3761	$3,234.22	.	$646.85
27036	Excision of hip joint/muscle		C					
27040	Biopsy of soft tissues		T	0020	8.7772	$599.19	.	$119.84
27041	Biopsy of soft tissues		T	0020	8.7772	$599.19	.	$119.84
27043	Exc hip pelvis les sc > 3 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
27045	Exc hip/pelv tum deep > 5 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
27047	Exc hip/pelvis les sc < 3 cm		T	0021	18.2223	$1,243.98	.	$248.80
27048	Exc hip/pelv tum deep < 5 cm		T	0021	18.2223	$1,243.98	.	$248.80
27049	Resect hip/pelv tum < 5 cm		T	0021	18.2223	$1,243.98	.	$248.80
27050	Biopsy of sacroiliac joint		T	0049	23.2249	$1,585.49	.	$317.10
27052	Biopsy of hip joint		T	0049	23.2249	$1,585.49	.	$317.10
27054	Removal of hip joint lining		C					
27057	Buttock fasciotomy w/dbrdmt		T	0049	23.2249	$1,585.49	.	$317.10
27059	Resect hip/pelv tum > 5 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
27060	Removal of ischial bursa		T	0049	23.2249	$1,585.49	.	$317.10
27062	Remove femur lesion/bursa		T	0049	23.2249	$1,585.49	.	$317.10
27065	Removal of hip bone lesion		T	0049	23.2249	$1,585.49	.	$317.10
27066	Removal of hip bone lesion		T	0050	32.4253	$2,213.58	.	$442.72

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27067	Remove/graft hip bone lesion		T	0050	32.4253	$2,213.58	.	$442.72
27070	Partial removal of hip bone		C					
27071	Partial removal of hip bone		C					
27075	Resect hip tumor		C					
27076	Resect hip tum incl acetabul		C					
27077	Resect hip tum w/innom bone		C					
27078	Rsect hip tum incl femur		C					
27080	Removal of tail bone		T	0050	32.4253	$2,213.58	.	$442.72
27086	Remove hip foreign body		T	0020	8.7772	$599.19	.	$119.84
27087	Remove hip foreign body		T	0049	23.2249	$1,585.49	.	$317.10
27090	Removal of hip prosthesis		C					
27091	Removal of hip prosthesis		C					
27093	Injection for hip x-ray		N					
27095	Injection for hip x-ray		N					
27096	Inject sacroiliac joint		B					
27097	Revision of hip tendon		T	0050	32.4253	$2,213.58	.	$442.72
27098	Transfer tendon to pelvis		T	0050	32.4253	$2,213.58	.	$442.72
27100	Transfer of abdominal muscle		T	0051	47.3761	$3,234.22	.	$646.85
27105	Transfer of spinal muscle		T	0051	47.3761	$3,234.22	.	$646.85
27110	Transfer of iliopsoas muscle		T	0051	47.3761	$3,234.22	.	$646.85
27111	Transfer of iliopsoas muscle		T	0051	47.3761	$3,234.22	.	$646.85
27120	Reconstruction of hip socket		C					
27122	Reconstruction of hip socket		C					
27125	Partial hip replacement		C					
27130	Total hip arthroplasty		C					
27132	Total hip arthroplasty		C					
27134	Revise hip joint replacement		C					
27137	Revise hip joint replacement		C					
27138	Revise hip joint replacement		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27140	Transplant femur ridge		C					
27146	Incision of hip bone		C					
27147	Revision of hip bone		C					
27151	Incision of hip bones		C					
27156	Revision of hip bones		C					
27158	Revision of pelvis		C					
27161	Incision of neck of femur		C					
27165	Incision/fixation of femur		C					
27170	Repair/graft femur head/neck		C					
27175	Treat slipped epiphysis		C					
27176	Treat slipped epiphysis		C					
27177	Treat slipped epiphysis		C					
27178	Treat slipped epiphysis		C					
27179	Revise head/neck of femur		T	0052	88.5249	$6,043.33	.	$1,208.67
27181	Treat slipped epiphysis		C					
27185	Revision of femur epiphysis		C					
27187	Reinforce hip bones		C					
27193	Treat pelvic ring fracture		T	0129	1.6325	$111.45	.	$22.29
27194	Treat pelvic ring fracture		T	0045	15.5647	$1,062.56	$268.44	$212.52
27200	Treat tail bone fracture		T	0129	1.6325	$111.45	.	$22.29
27202	Treat tail bone fracture		T	0063	48.0827	$3,282.46	.	$656.50
27215	Treat pelvic fracture(s)		E					
27216	Treat pelvic ring fracture		E					
27217	Treat pelvic ring fracture		E					
27218	Treat pelvic ring fracture		E					
27220	Treat hip socket fracture		T	0129	1.6325	$111.45	.	$22.29
27222	Treat hip socket fracture		C					
27226	Treat hip wall fracture		C					
27227	Treat hip fracture(s)		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27228	Treat hip fracture(s)		C					
27230	Treat thigh fracture		T	0129	1.6325	$111.45	.	$22.29
27232	Treat thigh fracture		C					
27235	Treat thigh fracture		T	0050	32.4253	$2,213.58	.	$442.72
27236	Treat thigh fracture		C					
27238	Treat thigh fracture		T	0138	5.2593	$359.04	.	$71.81
27240	Treat thigh fracture		C					
27244	Treat thigh fracture		C					
27245	Treat thigh fracture		C					
27246	Treat thigh fracture		T	0138	5.2593	$359.04	.	$71.81
27248	Treat thigh fracture		C					
27250	Treat hip dislocation		T	0129	1.6325	$111.45	.	$22.29
27252	Treat hip dislocation		T	0045	15.5647	$1,062.56	$268.44	$212.52
27253	Treat hip dislocation		C					
27254	Treat hip dislocation		C					
27256	Treat hip dislocation		T	0129	1.6325	$111.45	.	$22.29
27257	Treat hip dislocation		T	0045	15.5647	$1,062.56	$268.44	$212.52
27258	Treat hip dislocation		C					
27259	Treat hip dislocation		C					
27265	Treat hip dislocation		T	0129	1.6325	$111.45	.	$22.29
27266	Treat hip dislocation		T	0045	15.5647	$1,062.56	$268.44	$212.52
27267	Cltx thigh fx		T	0129	1.6325	$111.45	.	$22.29
27268	Cltx thigh fx w/mnpj		C					
27269	Optx thigh fx		C					
27275	Manipulation of hip joint		T	0045	15.5647	$1,062.56	$268.44	$212.52
27280	Fusion of sacroiliac joint		C					
27282	Fusion of pubic bones		C					
27284	Fusion of hip joint		C					
27286	Fusion of hip joint		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27290	Amputation of leg at hip		C					
27295	Amputation of leg at hip		C					
27299	Pelvis/hip joint surgery		T	0129	1.6325	$111.45	.	$22.29
27301	Drain thigh/knee lesion		T	0008	20.2481	$1,382.28	.	$276.46
27303	Drainage of bone lesion		C					
27305	Incise thigh tendon & fascia		T	0049	23.2249	$1,585.49	.	$317.10
27306	Incision of thigh tendon		T	0049	23.2249	$1,585.49	.	$317.10
27307	Incision of thigh tendons		T	0049	23.2249	$1,585.49	.	$317.10
27310	Exploration of knee joint		T	0050	32.4253	$2,213.58	.	$442.72
27323	Biopsy, thigh soft tissues		T	0020	8.7772	$599.19	.	$119.84
27324	Biopsy, thigh soft tissues		T	0022	24.1269	$1,647.07	$354.45	$329.42
27325	Neurectomy, hamstring		T	0220	19.3535	$1,321.21	.	$264.25
27326	Neurectomy, popliteal		T	0220	19.3535	$1,321.21	.	$264.25
27327	Exc thigh/knee les sc < 3 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
27328	Exc thigh/knee tum deep <5cm		T	0021	18.2223	$1,243.98	.	$248.80
27329	Resect thigh/knee tum < 5 cm		T	0021	18.2223	$1,243.98	.	$248.80
27330	Biopsy, knee joint lining		T	0050	32.4253	$2,213.58	.	$442.72
27331	Explore/treat knee joint		T	0050	32.4253	$2,213.58	.	$442.72
27332	Removal of knee cartilage		T	0050	32.4253	$2,213.58	.	$442.72
27333	Removal of knee cartilage		T	0050	32.4253	$2,213.58	.	$442.72
27334	Remove knee joint lining		T	0050	32.4253	$2,213.58	.	$442.72
27335	Remove knee joint lining		T	0050	32.4253	$2,213.58	.	$442.72
27337	Exc thigh/knee les sc > 3 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
27339	Exc thigh/knee tum deep >5cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
27340	Removal of kneecap bursa		T	0049	23.2249	$1,585.49	.	$317.10
27345	Removal of knee cyst		T	0049	23.2249	$1,585.49	.	$317.10
27347	Remove knee cyst		T	0049	23.2249	$1,585.49	.	$317.10
27350	Removal of kneecap		T	0050	32.4253	$2,213.58	.	$442.72
27355	Remove femur lesion		T	0050	32.4253	$2,213.58	.	$442.72

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27356	Remove femur lesion/graft		T	0050	32.4253	$2,213.58	.	$442.72
27357	Remove femur lesion/graft		T	0050	32.4253	$2,213.58	.	$442.72
27358	Remove femur lesion/fixation		T	0050	32.4253	$2,213.58	.	$442.72
27360	Partial removal, leg bone(s)		T	0050	32.4253	$2,213.58	.	$442.72
27364	Resect thigh/knee tum >5 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
27365	Resect femur/knee tumor		C					
27370	Injection for knee x-ray		N					
27372	Removal of foreign body		T	0022	24.1269	$1,647.07	$354.45	$329.42
27380	Repair of kneecap tendon		T	0049	23.2249	$1,585.49	.	$317.10
27381	Repair/graft kneecap tendon		T	0049	23.2249	$1,585.49	.	$317.10
27385	Repair of thigh muscle		T	0049	23.2249	$1,585.49	.	$317.10
27386	Repair/graft of thigh muscle		T	0049	23.2249	$1,585.49	.	$317.10
27390	Incision of thigh tendon		T	0049	23.2249	$1,585.49	.	$317.10
27391	Incision of thigh tendons		T	0049	23.2249	$1,585.49	.	$317.10
27392	Incision of thigh tendons		T	0049	23.2249	$1,585.49	.	$317.10
27393	Lengthening of thigh tendon		T	0050	32.4253	$2,213.58	.	$442.72
27394	Lengthening of thigh tendons		T	0050	32.4253	$2,213.58	.	$442.72
27395	Lengthening of thigh tendons		T	0051	47.3761	$3,234.22	.	$646.85
27396	Transplant of thigh tendon		T	0050	32.4253	$2,213.58	.	$442.72
27397	Transplants of thigh tendons		T	0051	47.3761	$3,234.22	.	$646.85
27400	Revise thigh muscles/tendons		T	0051	47.3761	$3,234.22	.	$646.85
27403	Repair of knee cartilage		T	0050	32.4253	$2,213.58	.	$442.72
27405	Repair of knee ligament		T	0051	47.3761	$3,234.22	.	$646.85
27407	Repair of knee ligament		T	0052	88.5249	$6,043.33	.	$1,208.67
27409	Repair of knee ligaments	CH	T	0052	88.5249	$6,043.33	.	$1,208.67
27412	Autochondrocyte implant knee		T	0052	88.5249	$6,043.33	.	$1,208.67
27415	Osteochondral knee allograft		T	0052	88.5249	$6,043.33	.	$1,208.67
27416	Osteochondral knee autograft		T	0051	47.3761	$3,234.22	.	$646.85
27418	Repair degenerated kneecap		T	0051	47.3761	$3,234.22	.	$646.85

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27420	Revision of unstable kneecap		T	0051	47.3761	$3,234.22	.	$646.85
27422	Revision of unstable kneecap		T	0051	47.3761	$3,234.22	.	$646.85
27424	Revision/removal of kneecap		T	0051	47.3761	$3,234.22	.	$646.85
27425	Lat retinacular release open		T	0050	32.4253	$2,213.58	.	$442.72
27427	Reconstruction, knee	CH	T	0052	88.5249	$6,043.33	.	$1,208.67
27428	Reconstruction, knee		T	0052	88.5249	$6,043.33	.	$1,208.67
27429	Reconstruction, knee		T	0052	88.5249	$6,043.33	.	$1,208.67
27430	Revision of thigh muscles		T	0051	47.3761	$3,234.22	.	$646.85
27435	Incision of knee joint		T	0051	47.3761	$3,234.22	.	$646.85
27437	Revise kneecap		T	0047	39.0731	$2,667.40	$534.09	$533.48
27438	Revise kneecap with implant		T	0048	60.2668	$4,114.23	.	$822.85
27440	Revision of knee joint		T	0047	39.0731	$2,667.40	$534.09	$533.48
27441	Revision of knee joint		T	0047	39.0731	$2,667.40	$534.09	$533.48
27442	Revision of knee joint		T	0047	39.0731	$2,667.40	$534.09	$533.48
27443	Revision of knee joint		T	0047	39.0731	$2,667.40	$534.09	$533.48
27445	Revision of knee joint		C					
27446	Revision of knee joint		T	0425	122.1766	$8,340.63	.	$1,668.13
27447	Total knee arthroplasty		C					
27448	Incision of thigh		C					
27450	Incision of thigh		C					
27454	Realignment of thigh bone		C					
27455	Realignment of knee		C					
27457	Realignment of knee		C					
27465	Shortening of thigh bone		C					
27466	Lengthening of thigh bone		C					
27468	Shorten/lengthen thighs		C					
27470	Repair of thigh		C					
27472	Repair/graft of thigh		C					
27475	Surgery to stop leg growth		T	0050	32.4253	$2,213.58	.	$442.72

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27477	Surgery to stop leg growth		C					
27479	Surgery to stop leg growth		T	0050	32.4253	$2,213.58	.	$442.72
27485	Surgery to stop leg growth		C					
27486	Revise/replace knee joint		C					
27487	Revise/replace knee joint		C					
27488	Removal of knee prosthesis		C					
27495	Reinforce thigh		C					
27496	Decompression of thigh/knee		T	0050	32.4253	$2,213.58	.	$442.72
27497	Decompression of thigh/knee		T	0049	23.2249	$1,585.49	.	$317.10
27498	Decompression of thigh/knee		T	0050	32.4253	$2,213.58	.	$442.72
27499	Decompression of thigh/knee		T	0050	32.4253	$2,213.58	.	$442.72
27500	Treatment of thigh fracture		T	0138	5.2593	$359.04	.	$71.81
27501	Treatment of thigh fracture		T	0129	1.6325	$111.45	.	$22.29
27502	Treatment of thigh fracture		T	0139	20.9892	$1,432.87	.	$286.58
27503	Treatment of thigh fracture		T	0129	1.6325	$111.45	.	$22.29
27506	Treatment of thigh fracture		C					
27507	Treatment of thigh fracture		C					
27508	Treatment of thigh fracture		T	0129	1.6325	$111.45	.	$22.29
27509	Treatment of thigh fracture		T	0062	26.6924	$1,822.21	$372.87	$364.45
27510	Treatment of thigh fracture		T	0138	5.2593	$359.04	.	$71.81
27511	Treatment of thigh fracture		C					
27513	Treatment of thigh fracture		C					
27514	Treatment of thigh fracture		C					
27516	Treat thigh fx growth plate		T	0129	1.6325	$111.45	.	$22.29
27517	Treat thigh fx growth plate		T	0129	1.6325	$111.45	.	$22.29
27519	Treat thigh fx growth plate		C					
27520	Treat kneecap fracture		T	0129	1.6325	$111.45	.	$22.29
27524	Treat kneecap fracture		T	0063	48.0827	$3,282.46	.	$656.50
27530	Treat knee fracture		T	0129	1.6325	$111.45	.	$22.29

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27532	Treat knee fracture		T	0139	20.9892	$1,432.87	.	$286.58
27535	Treat knee fracture		C					
27536	Treat knee fracture		C					
27538	Treat knee fracture(s)		T	0129	1.6325	$111.45	.	$22.29
27540	Treat knee fracture		C					
27550	Treat knee dislocation		T	0129	1.6325	$111.45	.	$22.29
27552	Treat knee dislocation		T	0045	15.5647	$1,062.56	$268.44	$212.52
27556	Treat knee dislocation		C					
27557	Treat knee dislocation		C					
27558	Treat knee dislocation		C					
27560	Treat kneecap dislocation		T	0129	1.6325	$111.45	.	$22.29
27562	Treat kneecap dislocation		T	0045	15.5647	$1,062.56	$268.44	$212.52
27566	Treat kneecap dislocation		T	0063	48.0827	$3,282.46	.	$656.50
27570	Fixation of knee joint		T	0045	15.5647	$1,062.56	$268.44	$212.52
27580	Fusion of knee		C					
27590	Amputate leg at thigh		C					
27591	Amputate leg at thigh		C					
27592	Amputate leg at thigh		C					
27594	Amputation follow-up surgery		T	0049	23.2249	$1,585.49	.	$317.10
27596	Amputation follow-up surgery		C					
27598	Amputate lower leg at knee		C					
27599	Leg surgery procedure		T	0129	1.6325	$111.45	.	$22.29
27600	Decompression of lower leg		T	0049	23.2249	$1,585.49	.	$317.10
27601	Decompression of lower leg		T	0049	23.2249	$1,585.49	.	$317.10
27602	Decompression of lower leg		T	0049	23.2249	$1,585.49	.	$317.10
27603	Drain lower leg lesion		T	0008	20.2481	$1,382.28	.	$276.46
27604	Drain lower leg bursa		T	0049	23.2249	$1,585.49	.	$317.10
27605	Incision of achilles tendon		T	0055	22.6974	$1,549.48	$355.34	$309.90
27606	Incision of achilles tendon		T	0049	23.2249	$1,585.49	.	$317.10

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27607	Treat lower leg bone lesion		T	0049	23.2249	$1,585.49	.	$317.10
27610	Explore/treat ankle joint		T	0050	32.4253	$2,213.58	.	$442.72
27612	Exploration of ankle joint		T	0050	32.4253	$2,213.58	.	$442.72
27613	Biopsy lower leg soft tissue		T	0020	8.7772	$599.19	.	$119.84
27614	Biopsy lower leg soft tissue		T	0022	24.1269	$1,647.07	$354.45	$329.42
27615	Resect leg/ankle tum < 5 cm		T	0021	18.2223	$1,243.98	.	$248.80
27616	Resect leg/ankle tum > 5 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
27618	Exc leg/ankle tum < 3 cm		T	0021	18.2223	$1,243.98	.	$248.80
27619	Exc leg/ankle tum deep <5 cm		T	0021	18.2223	$1,243.98	.	$248.80
27620	Explore/treat ankle joint		T	0050	32.4253	$2,213.58	.	$442.72
27625	Remove ankle joint lining		T	0050	32.4253	$2,213.58	.	$442.72
27626	Remove ankle joint lining		T	0050	32.4253	$2,213.58	.	$442.72
27630	Removal of tendon lesion		T	0049	23.2249	$1,585.49	.	$317.10
27632	Exc leg/ankle les sc > 3 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
27634	Exc leg/ankle tum deep >5 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
27635	Remove lower leg bone lesion		T	0050	32.4253	$2,213.58	.	$442.72
27637	Remove/graft leg bone lesion		T	0050	32.4253	$2,213.58	.	$442.72
27638	Remove/graft leg bone lesion		T	0050	32.4253	$2,213.58	.	$442.72
27640	Partial removal of tibia		T	0051	47.3761	$3,234.22	.	$646.85
27641	Partial removal of fibula		T	0050	32.4253	$2,213.58	.	$442.72
27645	Resect tibia tumor		C					
27646	Resect fibula tumor		C					
27647	Resect talus/calcaneus tum		T	0051	47.3761	$3,234.22	.	$646.85
27648	Injection for ankle x-ray		N					
27650	Repair achilles tendon		T	0051	47.3761	$3,234.22	.	$646.85
27652	Repair/graft achilles tendon		T	0052	88.5249	$6,043.33	.	$1,208.67
27654	Repair of achilles tendon		T	0051	47.3761	$3,234.22	.	$646.85
27656	Repair leg fascia defect		T	0049	23.2249	$1,585.49	.	$317.10
27658	Repair of leg tendon, each		T	0049	23.2249	$1,585.49	.	$317.10

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27659	Repair of leg tendon, each		T	0049	23.2249	$1,585.49	.	$317.10
27664	Repair of leg tendon, each		T	0050	32.4253	$2,213.58	.	$442.72
27665	Repair of leg tendon, each		T	0050	32.4253	$2,213.58	.	$442.72
27675	Repair lower leg tendons		T	0049	23.2249	$1,585.49	.	$317.10
27676	Repair lower leg tendons		T	0050	32.4253	$2,213.58	.	$442.72
27680	Release of lower leg tendon		T	0050	32.4253	$2,213.58	.	$442.72
27681	Release of lower leg tendons		T	0050	32.4253	$2,213.58	.	$442.72
27685	Revision of lower leg tendon		T	0050	32.4253	$2,213.58	.	$442.72
27686	Revise lower leg tendons		T	0050	32.4253	$2,213.58	.	$442.72
27687	Revision of calf tendon		T	0050	32.4253	$2,213.58	.	$442.72
27690	Revise lower leg tendon		T	0051	47.3761	$3,234.22	.	$646.85
27691	Revise lower leg tendon		T	0051	47.3761	$3,234.22	.	$646.85
27692	Revise additional leg tendon		T	0051	47.3761	$3,234.22	.	$646.85
27695	Repair of ankle ligament		T	0050	32.4253	$2,213.58	.	$442.72
27696	Repair of ankle ligaments		T	0050	32.4253	$2,213.58	.	$442.72
27698	Repair of ankle ligament		T	0050	32.4253	$2,213.58	.	$442.72
27700	Revision of ankle joint		T	0047	39.0731	$2,667.40	$534.09	$533.48
27702	Reconstruct ankle joint		C					
27703	Reconstruction, ankle joint		C					
27704	Removal of ankle implant		T	0049	23.2249	$1,585.49	.	$317.10
27705	Incision of tibia		T	0051	47.3761	$3,234.22	.	$646.85
27707	Incision of fibula		T	0049	23.2249	$1,585.49	.	$317.10
27709	Incision of tibia & fibula		T	0050	32.4253	$2,213.58	.	$442.72
27712	Realignment of lower leg		C					
27715	Revision of lower leg		C					
27720	Repair of tibia		T	0063	48.0827	$3,282.46	.	$656.50
27722	Repair/graft of tibia		T	0064	66.575	$4,544.88	.	$908.98
27724	Repair/graft of tibia		C					
27725	Repair of lower leg		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27726	Repair fibula nonunion		T	0063	48.0827	$3,282.46	.	$656.50
27727	Repair of lower leg		C					
27730	Repair of tibia epiphysis		T	0050	32.4253	$2,213.58	.	$442.72
27732	Repair of fibula epiphysis		T	0050	32.4253	$2,213.58	.	$442.72
27734	Repair lower leg epiphyses		T	0050	32.4253	$2,213.58	.	$442.72
27740	Repair of leg epiphyses		T	0050	32.4253	$2,213.58	.	$442.72
27742	Repair of leg epiphyses		T	0051	47.3761	$3,234.22	.	$646.85
27745	Reinforce tibia		T	0052	88.5249	$6,043.33	.	$1,208.67
27750	Treatment of tibia fracture		T	0129	1.6325	$111.45	.	$22.29
27752	Treatment of tibia fracture		T	0139	20.9892	$1,432.87	.	$286.58
27756	Treatment of tibia fracture		T	0062	26.6924	$1,822.21	$372.87	$364.45
27758	Treatment of tibia fracture		T	0063	48.0827	$3,282.46	.	$656.50
27759	Treatment of tibia fracture		T	0064	66.575	$4,544.88	.	$908.98
27760	Cltx medial ankle fx		T	0129	1.6325	$111.45	.	$22.29
27762	Cltx med ankle fx w/mnpj		T	0139	20.9892	$1,432.87	.	$286.58
27766	Optx medial ankle fx		T	0063	48.0827	$3,282.46	.	$656.50
27767	Cltx post ankle fx		T	0129	1.6325	$111.45	.	$22.29
27768	Cltx post ankle fx w/mnpj		T	0129	1.6325	$111.45	.	$22.29
27769	Optx post ankle fx		T	0063	48.0827	$3,282.46	.	$656.50
27780	Treatment of fibula fracture		T	0129	1.6325	$111.45	.	$22.29
27781	Treatment of fibula fracture		T	0139	20.9892	$1,432.87	.	$286.58
27784	Treatment of fibula fracture		T	0063	48.0827	$3,282.46	.	$656.50
27786	Treatment of ankle fracture		T	0129	1.6325	$111.45	.	$22.29
27788	Treatment of ankle fracture		T	0129	1.6325	$111.45	.	$22.29
27792	Treatment of ankle fracture		T	0063	48.0827	$3,282.46	.	$656.50
27808	Treatment of ankle fracture		T	0129	1.6325	$111.45	.	$22.29
27810	Treatment of ankle fracture		T	0138	5.2593	$359.04	.	$71.81
27814	Treatment of ankle fracture		T	0063	48.0827	$3,282.46	.	$656.50
27816	Treatment of ankle fracture		T	0129	1.6325	$111.45	.	$22.29

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27818	Treatment of ankle fracture		T	0138	5.2593	$359.04	.	$71.81
27822	Treatment of ankle fracture		T	0063	48.0827	$3,282.46	.	$656.50
27823	Treatment of ankle fracture		T	0064	66.575	$4,544.88	.	$908.98
27824	Treat lower leg fracture		T	0129	1.6325	$111.45	.	$22.29
27825	Treat lower leg fracture		T	0139	20.9892	$1,432.87	.	$286.58
27826	Treat lower leg fracture		T	0063	48.0827	$3,282.46	.	$656.50
27827	Treat lower leg fracture		T	0064	66.575	$4,544.88	.	$908.98
27828	Treat lower leg fracture		T	0064	66.575	$4,544.88	.	$908.98
27829	Treat lower leg joint		T	0063	48.0827	$3,282.46	.	$656.50
27830	Treat lower leg dislocation		T	0129	1.6325	$111.45	.	$22.29
27831	Treat lower leg dislocation		T	0139	20.9892	$1,432.87	.	$286.58
27832	Treat lower leg dislocation		T	0063	48.0827	$3,282.46	.	$656.50
27840	Treat ankle dislocation		T	0138	5.2593	$359.04	.	$71.81
27842	Treat ankle dislocation		T	0045	15.5647	$1,062.56	$268.44	$212.52
27846	Treat ankle dislocation		T	0063	48.0827	$3,282.46	.	$656.50
27848	Treat ankle dislocation		T	0063	48.0827	$3,282.46	.	$656.50
27860	Fixation of ankle joint		T	0045	15.5647	$1,062.56	$268.44	$212.52
27870	Fusion of ankle joint, open		T	0052	88.5249	$6,043.33	.	$1,208.67
27871	Fusion of tibiofibular joint		T	0052	88.5249	$6,043.33	.	$1,208.67
27880	Amputation of lower leg		C					
27881	Amputation of lower leg		C					
27882	Amputation of lower leg		C					
27884	Amputation follow-up surgery		T	0049	23.2249	$1,585.49	.	$317.10
27886	Amputation follow-up surgery		C					
27888	Amputation of foot at ankle		C					
27889	Amputation of foot at ankle		T	0050	32.4253	$2,213.58	.	$442.72
27892	Decompression of leg		T	0050	32.4253	$2,213.58	.	$442.72
27893	Decompression of leg		T	0050	32.4253	$2,213.58	.	$442.72
27894	Decompression of leg		T	0050	32.4253	$2,213.58	.	$442.72

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
27899	Leg/ankle surgery procedure		T	0129	1.6325	$111.45	.	$22.29
28001	Drainage of bursa of foot		T	0007	13.3268	$909.78	.	$181.96
28002	Treatment of foot infection		T	0049	23.2249	$1,585.49	.	$317.10
28003	Treatment of foot infection		T	0049	23.2249	$1,585.49	.	$317.10
28005	Treat foot bone lesion		T	0055	22.6974	$1,549.48	$355.34	$309.90
28008	Incision of foot fascia		T	0055	22.6974	$1,549.48	$355.34	$309.90
28010	Incision of toe tendon		T	0055	22.6974	$1,549.48	$355.34	$309.90
28011	Incision of toe tendons		T	0055	22.6974	$1,549.48	$355.34	$309.90
28020	Exploration of foot joint		T	0055	22.6974	$1,549.48	$355.34	$309.90
28022	Exploration of foot joint		T	0055	22.6974	$1,549.48	$355.34	$309.90
28024	Exploration of toe joint		T	0055	22.6974	$1,549.48	$355.34	$309.90
28035	Decompression of tibia nerve		T	0220	19.3535	$1,321.21	.	$264.25
28039	Exc foot/toe tum sc > 1.5 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
28041	Exc foot/toe tum deep >1.5cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
28043	Exc foot/toe tum sc < 1.5 cm		T	0021	18.2223	$1,243.98	.	$248.80
28045	Exc foot/toe tum deep <1.5cm		T	0021	18.2223	$1,243.98	.	$248.80
28046	Resect foot/toe tumor < 3 cm		T	0021	18.2223	$1,243.98	.	$248.80
28047	Resect foot/toe tumor > 3 cm		T	0022	24.1269	$1,647.07	$354.45	$329.42
28050	Biopsy of foot joint lining		T	0055	22.6974	$1,549.48	$355.34	$309.90
28052	Biopsy of foot joint lining		T	0055	22.6974	$1,549.48	$355.34	$309.90
28054	Biopsy of toe joint lining		T	0055	22.6974	$1,549.48	$355.34	$309.90
28055	Neurectomy, foot		T	0220	19.3535	$1,321.21	.	$264.25
28060	Partial removal, foot fascia		T	0055	22.6974	$1,549.48	$355.34	$309.90
28062	Removal of foot fascia		T	0055	22.6974	$1,549.48	$355.34	$309.90
28070	Removal of foot joint lining		T	0055	22.6974	$1,549.48	$355.34	$309.90
28072	Removal of foot joint lining		T	0055	22.6974	$1,549.48	$355.34	$309.90
28080	Removal of foot lesion		T	0055	22.6974	$1,549.48	$355.34	$309.90
28086	Excise foot tendon sheath		T	0055	22.6974	$1,549.48	$355.34	$309.90
28088	Excise foot tendon sheath		T	0055	22.6974	$1,549.48	$355.34	$309.90

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
28090	Removal of foot lesion		T	0055	22.6974	$1,549.48	$355.34	$309.90
28092	Removal of toe lesions		T	0055	22.6974	$1,549.48	$355.34	$309.90
28100	Removal of ankle/heel lesion		T	0055	22.6974	$1,549.48	$355.34	$309.90
28102	Remove/graft foot lesion		T	0056	55.5064	$3,789.26	.	$757.86
28103	Remove/graft foot lesion		T	0056	55.5064	$3,789.26	.	$757.86
28104	Removal of foot lesion		T	0055	22.6974	$1,549.48	$355.34	$309.90
28106	Remove/graft foot lesion		T	0056	55.5064	$3,789.26	.	$757.86
28107	Remove/graft foot lesion		T	0056	55.5064	$3,789.26	.	$757.86
28108	Removal of toe lesions		T	0055	22.6974	$1,549.48	$355.34	$309.90
28110	Part removal of metatarsal		T	0055	22.6974	$1,549.48	$355.34	$309.90
28111	Part removal of metatarsal		T	0055	22.6974	$1,549.48	$355.34	$309.90
28112	Part removal of metatarsal		T	0055	22.6974	$1,549.48	$355.34	$309.90
28113	Part removal of metatarsal		T	0055	22.6974	$1,549.48	$355.34	$309.90
28114	Removal of metatarsal heads		T	0055	22.6974	$1,549.48	$355.34	$309.90
28116	Revision of foot		T	0055	22.6974	$1,549.48	$355.34	$309.90
28118	Removal of heel bone		T	0055	22.6974	$1,549.48	$355.34	$309.90
28119	Removal of heel spur		T	0055	22.6974	$1,549.48	$355.34	$309.90
28120	Part removal of ankle/heel		T	0055	22.6974	$1,549.48	$355.34	$309.90
28122	Partial removal of foot bone		T	0055	22.6974	$1,549.48	$355.34	$309.90
28124	Partial removal of toe		T	0055	22.6974	$1,549.48	$355.34	$309.90
28126	Partial removal of toe		T	0055	22.6974	$1,549.48	$355.34	$309.90
28130	Removal of ankle bone		T	0055	22.6974	$1,549.48	$355.34	$309.90
28140	Removal of metatarsal		T	0055	22.6974	$1,549.48	$355.34	$309.90
28150	Removal of toe		T	0055	22.6974	$1,549.48	$355.34	$309.90
28153	Partial removal of toe		T	0055	22.6974	$1,549.48	$355.34	$309.90
28160	Partial removal of toe		T	0055	22.6974	$1,549.48	$355.34	$309.90
28171	Resect tarsal tumor		T	0055	22.6974	$1,549.48	$355.34	$309.90
28173	Resect metatarsal tumor		T	0055	22.6974	$1,549.48	$355.34	$309.90
28175	Resect phalanx of toe tumor		T	0055	22.6974	$1,549.48	$355.34	$309.90

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
28190	Removal of foot foreign body		T	0020	8.7772	$599.19	.	$119.84
28192	Removal of foot foreign body		T	0021	18.2223	$1,243.98	.	$248.80
28193	Removal of foot foreign body		T	0020	8.7772	$599.19	.	$119.84
28200	Repair of foot tendon		T	0055	22.6974	$1,549.48	$355.34	$309.90
28202	Repair/graft of foot tendon		T	0055	22.6974	$1,549.48	$355.34	$309.90
28208	Repair of foot tendon		T	0055	22.6974	$1,549.48	$355.34	$309.90
28210	Repair/graft of foot tendon		T	0056	55.5064	$3,789.26	.	$757.86
28220	Release of foot tendon		T	0055	22.6974	$1,549.48	$355.34	$309.90
28222	Release of foot tendons		T	0055	22.6974	$1,549.48	$355.34	$309.90
28225	Release of foot tendon		T	0055	22.6974	$1,549.48	$355.34	$309.90
28226	Release of foot tendons		T	0055	22.6974	$1,549.48	$355.34	$309.90
28230	Incision of foot tendon(s)		T	0055	22.6974	$1,549.48	$355.34	$309.90
28232	Incision of toe tendon		T	0055	22.6974	$1,549.48	$355.34	$309.90
28234	Incision of foot tendon		T	0055	22.6974	$1,549.48	$355.34	$309.90
28238	Revision of foot tendon		T	0056	55.5064	$3,789.26	.	$757.86
28240	Release of big toe		T	0055	22.6974	$1,549.48	$355.34	$309.90
28250	Revision of foot fascia		T	0055	22.6974	$1,549.48	$355.34	$309.90
28260	Release of midfoot joint		T	0055	22.6974	$1,549.48	$355.34	$309.90
28261	Revision of foot tendon		T	0055	22.6974	$1,549.48	$355.34	$309.90
28262	Revision of foot and ankle		T	0055	22.6974	$1,549.48	$355.34	$309.90
28264	Release of midfoot joint		T	0056	55.5064	$3,789.26	.	$757.86
28270	Release of foot contracture		T	0055	22.6974	$1,549.48	$355.34	$309.90
28272	Release of toe joint, each		T	0055	22.6974	$1,549.48	$355.34	$309.90
28280	Fusion of toes		T	0055	22.6974	$1,549.48	$355.34	$309.90
28285	Repair of hammertoe		T	0055	22.6974	$1,549.48	$355.34	$309.90
28286	Repair of hammertoe		T	0055	22.6974	$1,549.48	$355.34	$309.90
28288	Partial removal of foot bone		T	0055	22.6974	$1,549.48	$355.34	$309.90
28289	Repair hallux rigidus		T	0055	22.6974	$1,549.48	$355.34	$309.90
28290	Correction of bunion		T	0057	33.3853	$2,279.11	$475.91	$455.83

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
28292	Correction of bunion		T	0057	33.3853	$2,279.11	$475.91	$455.83
28293	Correction of bunion		T	0057	33.3853	$2,279.11	$475.91	$455.83
28294	Correction of bunion		T	0057	33.3853	$2,279.11	$475.91	$455.83
28296	Correction of bunion		T	0057	33.3853	$2,279.11	$475.91	$455.83
28297	Correction of bunion		T	0057	33.3853	$2,279.11	$475.91	$455.83
28298	Correction of bunion		T	0057	33.3853	$2,279.11	$475.91	$455.83
28299	Correction of bunion		T	0057	33.3853	$2,279.11	$475.91	$455.83
28300	Incision of heel bone		T	0056	55.5064	$3,789.26	.	$757.86
28302	Incision of ankle bone		T	0055	22.6974	$1,549.48	$355.34	$309.90
28304	Incision of midfoot bones		T	0056	55.5064	$3,789.26	.	$757.86
28305	Incise/graft midfoot bones		T	0056	55.5064	$3,789.26	.	$757.86
28306	Incision of metatarsal		T	0055	22.6974	$1,549.48	$355.34	$309.90
28307	Incision of metatarsal		T	0055	22.6974	$1,549.48	$355.34	$309.90
28308	Incision of metatarsal		T	0055	22.6974	$1,549.48	$355.34	$309.90
28309	Incision of metatarsals		T	0056	55.5064	$3,789.26	.	$757.86
28310	Revision of big toe		T	0055	22.6974	$1,549.48	$355.34	$309.90
28312	Revision of toe		T	0055	22.6974	$1,549.48	$355.34	$309.90
28313	Repair deformity of toe		T	0055	22.6974	$1,549.48	$355.34	$309.90
28315	Removal of sesamoid bone		T	0055	22.6974	$1,549.48	$355.34	$309.90
28320	Repair of foot bones		T	0056	55.5064	$3,789.26	.	$757.86
28322	Repair of metatarsals		T	0056	55.5064	$3,789.26	.	$757.86
28340	Resect enlarged toe tissue		T	0055	22.6974	$1,549.48	$355.34	$309.90
28341	Resect enlarged toe		T	0055	22.6974	$1,549.48	$355.34	$309.90
28344	Repair extra toe(s)		T	0055	22.6974	$1,549.48	$355.34	$309.90
28345	Repair webbed toe(s)		T	0055	22.6974	$1,549.48	$355.34	$309.90
28360	Reconstruct cleft foot		T	0056	55.5064	$3,789.26	.	$757.86
28400	Treatment of heel fracture		T	0129	1.6325	$111.45	.	$22.29
28405	Treatment of heel fracture		T	0139	20.9892	$1,432.87	.	$286.58
28406	Treatment of heel fracture		T	0062	26.6924	$1,822.21	$372.87	$364.45

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
28415	Treat heel fracture		T	0064	66.575	$4,544.88	.	$908.98
28420	Treat/graft heel fracture		T	0063	48.0827	$3,282.46	.	$656.50
28430	Treatment of ankle fracture		T	0129	1.6325	$111.45	.	$22.29
28435	Treatment of ankle fracture		T	0129	1.6325	$111.45	.	$22.29
28436	Treatment of ankle fracture		T	0062	26.6924	$1,822.21	$372.87	$364.45
28445	Treat ankle fracture		T	0063	48.0827	$3,282.46	.	$656.50
28446	Osteochondral talus autogrft		T	0056	55.5064	$3,789.26	.	$757.86
28450	Treat midfoot fracture, each		T	0129	1.6325	$111.45	.	$22.29
28455	Treat midfoot fracture, each		T	0129	1.6325	$111.45	.	$22.29
28456	Treat midfoot fracture		T	0062	26.6924	$1,822.21	$372.87	$364.45
28465	Treat midfoot fracture, each		T	0063	48.0827	$3,282.46	.	$656.50
28470	Treat metatarsal fracture		T	0129	1.6325	$111.45	.	$22.29
28475	Treat metatarsal fracture		T	0129	1.6325	$111.45	.	$22.29
28476	Treat metatarsal fracture		T	0062	26.6924	$1,822.21	$372.87	$364.45
28485	Treat metatarsal fracture		T	0063	48.0827	$3,282.46	.	$656.50
28490	Treat big toe fracture		T	0129	1.6325	$111.45	.	$22.29
28495	Treat big toe fracture		T	0129	1.6325	$111.45	.	$22.29
28496	Treat big toe fracture		T	0062	26.6924	$1,822.21	$372.87	$364.45
28505	Treat big toe fracture		T	0062	26.6924	$1,822.21	$372.87	$364.45
28510	Treatment of toe fracture		T	0129	1.6325	$111.45	.	$22.29
28515	Treatment of toe fracture		T	0129	1.6325	$111.45	.	$22.29
28525	Treat toe fracture		T	0062	26.6924	$1,822.21	$372.87	$364.45
28530	Treat sesamoid bone fracture		T	0129	1.6325	$111.45	.	$22.29
28531	Treat sesamoid bone fracture		T	0062	26.6924	$1,822.21	$372.87	$364.45
28540	Treat foot dislocation		T	0129	1.6325	$111.45	.	$22.29
28545	Treat foot dislocation		T	0062	26.6924	$1,822.21	$372.87	$364.45
28546	Treat foot dislocation		T	0062	26.6924	$1,822.21	$372.87	$364.45
28555	Repair foot dislocation		T	0063	48.0827	$3,282.46	.	$656.50
28570	Treat foot dislocation		T	0138	5.2593	$359.04	.	$71.81

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
28575	Treat foot dislocation		T	0139	20.9892	$1,432.87	.	$286.58
28576	Treat foot dislocation		T	0062	26.6924	$1,822.21	$372.87	$364.45
28585	Repair foot dislocation		T	0062	26.6924	$1,822.21	$372.87	$364.45
28600	Treat foot dislocation		T	0129	1.6325	$111.45	.	$22.29
28605	Treat foot dislocation		T	0129	1.6325	$111.45	.	$22.29
28606	Treat foot dislocation		T	0062	26.6924	$1,822.21	$372.87	$364.45
28615	Repair foot dislocation		T	0063	48.0827	$3,282.46	.	$656.50
28630	Treat toe dislocation		T	0129	1.6325	$111.45	.	$22.29
28635	Treat toe dislocation		T	0045	15.5647	$1,062.56	$268.44	$212.52
28636	Treat toe dislocation		T	0062	26.6924	$1,822.21	$372.87	$364.45
28645	Repair toe dislocation		T	0062	26.6924	$1,822.21	$372.87	$364.45
28660	Treat toe dislocation		T	0129	1.6325	$111.45	.	$22.29
28665	Treat toe dislocation		T	0045	15.5647	$1,062.56	$268.44	$212.52
28666	Treat toe dislocation		T	0062	26.6924	$1,822.21	$372.87	$364.45
28675	Repair of toe dislocation		T	0062	26.6924	$1,822.21	$372.87	$364.45
28705	Fusion of foot bones		T	0056	55.5064	$3,789.26	.	$757.86
28715	Fusion of foot bones		T	0052	88.5249	$6,043.33	.	$1,208.67
28725	Fusion of foot bones		T	0056	55.5064	$3,789.26	.	$757.86
28730	Fusion of foot bones		T	0056	55.5064	$3,789.26	.	$757.86
28735	Fusion of foot bones		T	0056	55.5064	$3,789.26	.	$757.86
28737	Revision of foot bones		T	0056	55.5064	$3,789.26	.	$757.86
28740	Fusion of foot bones		T	0056	55.5064	$3,789.26	.	$757.86
28750	Fusion of big toe joint		T	0056	55.5064	$3,789.26	.	$757.86
28755	Fusion of big toe joint		T	0055	22.6974	$1,549.48	$355.34	$309.90
28760	Fusion of big toe joint		T	0056	55.5064	$3,789.26	.	$757.86
28800	Amputation of midfoot		C					
28805	Amputation thru metatarsal		T	0055	22.6974	$1,549.48	$355.34	$309.90
28810	Amputation toe & metatarsal		T	0055	22.6974	$1,549.48	$355.34	$309.90
28820	Amputation of toe		T	0055	22.6974	$1,549.48	$355.34	$309.90

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
28825	Partial amputation of toe		T	0055	22.6974	$1,549.48	$355.34	$309.90
28890	High energy eswt, plantar f		T	0050	32.4253	$2,213.58	.	$442.72
28899	Foot/toes surgery procedure		T	0129	1.6325	$111.45	.	$22.29
29000	Application of body cast		S	0058	1.1409	$77.89	.	$15.58
29010	Application of body cast		S	0426	2.4913	$170.07	.	$34.02
29015	Application of body cast		S	0426	2.4913	$170.07	.	$34.02
29020	Application of body cast		S	0058	1.1409	$77.89	.	$15.58
29025	Application of body cast		S	0058	1.1409	$77.89	.	$15.58
29035	Application of body cast		S	0426	2.4913	$170.07	.	$34.02
29040	Application of body cast		S	0058	1.1409	$77.89	.	$15.58
29044	Application of body cast		S	0426	2.4913	$170.07	.	$34.02
29046	Application of body cast		S	0426	2.4913	$170.07	.	$34.02
29049	Application of figure eight		S	0058	1.1409	$77.89	.	$15.58
29055	Application of shoulder cast		S	0426	2.4913	$170.07	.	$34.02
29058	Application of shoulder cast		S	0058	1.1409	$77.89	.	$15.58
29065	Application of long arm cast		S	0426	2.4913	$170.07	.	$34.02
29075	Application of forearm cast		S	0426	2.4913	$170.07	.	$34.02
29085	Apply hand/wrist cast		S	0058	1.1409	$77.89	.	$15.58
29086	Apply finger cast		S	0058	1.1409	$77.89	.	$15.58
29105	Apply long arm splint		S	0058	1.1409	$77.89	.	$15.58
29125	Apply forearm splint		S	0058	1.1409	$77.89	.	$15.58
29126	Apply forearm splint		S	0058	1.1409	$77.89	.	$15.58
29130	Application of finger splint		S	0058	1.1409	$77.89	.	$15.58
29131	Application of finger splint		S	0058	1.1409	$77.89	.	$15.58
29200	Strapping of chest		S	0058	1.1409	$77.89	.	$15.58
29240	Strapping of shoulder		S	0058	1.1409	$77.89	.	$15.58
29260	Strapping of elbow or wrist		S	0058	1.1409	$77.89	.	$15.58
29280	Strapping of hand or finger		S	0058	1.1409	$77.89	.	$15.58
29305	Application of hip cast		S	0426	2.4913	$170.07	.	$34.02

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
29325	Application of hip casts		S	0426	2.4913	$170.07	.	$34.02
29345	Application of long leg cast		S	0426	2.4913	$170.07	.	$34.02
29355	Application of long leg cast		S	0426	2.4913	$170.07	.	$34.02
29358	Apply long leg cast brace		S	0426	2.4913	$170.07	.	$34.02
29365	Application of long leg cast		S	0426	2.4913	$170.07	.	$34.02
29405	Apply short leg cast		S	0426	2.4913	$170.07	.	$34.02
29425	Apply short leg cast		S	0426	2.4913	$170.07	.	$34.02
29435	Apply short leg cast		S	0426	2.4913	$170.07	.	$34.02
29440	Addition of walker to cast		S	0058	1.1409	$77.89	.	$15.58
29445	Apply rigid leg cast		S	0426	2.4913	$170.07	.	$34.02
29450	Application of leg cast		S	0058	1.1409	$77.89	.	$15.58
29505	Application, long leg splint		S	0058	1.1409	$77.89	.	$15.58
29515	Application lower leg splint		S	0058	1.1409	$77.89	.	$15.58
29520	Strapping of hip		S	0058	1.1409	$77.89	.	$15.58
29530	Strapping of knee		S	0058	1.1409	$77.89	.	$15.58
29540	Strapping of ankle and/or ft		S	0058	1.1409	$77.89	.	$15.58
29550	Strapping of toes		S	0058	1.1409	$77.89	.	$15.58
29580	Application of paste boot		S	0058	1.1409	$77.89	.	$15.58
29581	Apply multlay comprs lwr leg		S	0058	1.1409	$77.89	.	$15.58
29590	Application of foot splint		S	0058	1.1409	$77.89	.	$15.58
29700	Removal/revision of cast		S	0058	1.1409	$77.89	.	$15.58
29705	Removal/revision of cast		S	0058	1.1409	$77.89	.	$15.58
29710	Removal/revision of cast		S	0426	2.4913	$170.07	.	$34.02
29715	Removal/revision of cast		S	0058	1.1409	$77.89	.	$15.58
29720	Repair of body cast		S	0058	1.1409	$77.89	.	$15.58
29730	Windowing of cast		S	0058	1.1409	$77.89	.	$15.58
29740	Wedging of cast		S	0058	1.1409	$77.89	.	$15.58
29750	Wedging of clubfoot cast		S	0058	1.1409	$77.89	.	$15.58
29799	Casting/strapping procedure		S	0058	1.1409	$77.89	.	$15.58

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
29800	Jaw arthroscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94
29804	Jaw arthroscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94
29805	Shoulder arthroscopy, dx		T	0041	30.3175	$2,069.68	.	$413.94
29806	Shoulder arthroscopy/surgery		T	0042	48.2063	$3,290.90	$804.74	$658.18
29807	Shoulder arthroscopy/surgery		T	0042	48.2063	$3,290.90	$804.74	$658.18
29819	Shoulder arthroscopy/surgery		T	0042	48.2063	$3,290.90	$804.74	$658.18
29820	Shoulder arthroscopy/surgery		T	0042	48.2063	$3,290.90	$804.74	$658.18
29821	Shoulder arthroscopy/surgery		T	0042	48.2063	$3,290.90	$804.74	$658.18
29822	Shoulder arthroscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94
29823	Shoulder arthroscopy/surgery		T	0042	48.2063	$3,290.90	$804.74	$658.18
29824	Shoulder arthroscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94
29825	Shoulder arthroscopy/surgery		T	0042	48.2063	$3,290.90	$804.74	$658.18
29826	Shoulder arthroscopy/surgery		T	0042	48.2063	$3,290.90	$804.74	$658.18
29827	Arthroscop rotator cuff repr		T	0042	48.2063	$3,290.90	$804.74	$658.18
29828	Arthroscopy biceps tenodesis		T	0042	48.2063	$3,290.90	$804.74	$658.18
29830	Elbow arthroscopy		T	0041	30.3175	$2,069.68	.	$413.94
29834	Elbow arthroscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94
29835	Elbow arthroscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94
29836	Elbow arthroscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94
29837	Elbow arthroscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94
29838	Elbow arthroscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94
29840	Wrist arthroscopy		T	0041	30.3175	$2,069.68	.	$413.94
29843	Wrist arthroscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94
29844	Wrist arthroscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94
29845	Wrist arthroscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94
29846	Wrist arthroscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94
29847	Wrist arthroscopy/surgery		T	0042	48.2063	$3,290.90	$804.74	$658.18
29848	Wrist endoscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94
29850	Knee arthroscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
29851	Knee arthroscopy/surgery		T	0042	48.2063	$3,290.90	$804.74	$658.18
29855	Tibial arthroscopy/surgery		T	0042	48.2063	$3,290.90	$804.74	$658.18
29856	Tibial arthroscopy/surgery		T	0042	48.2063	$3,290.90	$804.74	$658.18
29860	Hip arthroscopy, dx		T	0042	48.2063	$3,290.90	$804.74	$658.18
29861	Hip arthroscopy/surgery		T	0042	48.2063	$3,290.90	$804.74	$658.18
29862	Hip arthroscopy/surgery		T	0042	48.2063	$3,290.90	$804.74	$658.18
29863	Hip arthroscopy/surgery		T	0042	48.2063	$3,290.90	$804.74	$658.18
29866	Autgrft implnt, knee w/scope		T	0042	48.2063	$3,290.90	$804.74	$658.18
29867	Allgrft implnt, knee w/scope		T	0042	48.2063	$3,290.90	$804.74	$658.18
29868	Meniscal trnspl, knee w/scpe		T	0042	48.2063	$3,290.90	$804.74	$658.18
29870	Knee arthroscopy, dx		T	0041	30.3175	$2,069.68	.	$413.94
29871	Knee arthroscopy/drainage		T	0041	30.3175	$2,069.68	.	$413.94
29873	Knee arthroscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94
29874	Knee arthroscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94
29875	Knee arthroscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94
29876	Knee arthroscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94
29877	Knee arthroscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94
29879	Knee arthroscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94
29880	Knee arthroscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94
29881	Knee arthroscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94
29882	Knee arthroscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94
29883	Knee arthroscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94
29884	Knee arthroscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94
29885	Knee arthroscopy/surgery		T	0042	48.2063	$3,290.90	$804.74	$658.18
29886	Knee arthroscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94
29887	Knee arthroscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94
29888	Knee arthroscopy/surgery		T	0052	88.5249	$6,043.33	.	$1,208.67
29889	Knee arthroscopy/surgery		T	0052	88.5249	$6,043.33	.	$1,208.67
29891	Ankle arthroscopy/surgery		T	0042	48.2063	$3,290.90	$804.74	$658.18

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
29892	Ankle arthroscopy/surgery		T	0052	88.5249	$6,043.33	.	$1,208.67
29893	Scope, plantar fasciotomy		T	0055	22.6974	$1,549.48	$355.34	$309.90
29894	Ankle arthroscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94
29895	Ankle arthroscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94
29897	Ankle arthroscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94
29898	Ankle arthroscopy/surgery		T	0041	30.3175	$2,069.68	.	$413.94
29899	Ankle arthroscopy/surgery		T	0042	48.2063	$3,290.90	$804.74	$658.18
29900	Mcp joint arthroscopy, dx		T	0041	30.3175	$2,069.68	.	$413.94
29901	Mcp joint arthroscopy, surg		T	0041	30.3175	$2,069.68	.	$413.94
29902	Mcp joint arthroscopy, surg		T	0041	30.3175	$2,069.68	.	$413.94
29904	Subtalar arthro w/fb rmvl		T	0041	30.3175	$2,069.68	.	$413.94
29905	Subtalar arthro w/exc		T	0041	30.3175	$2,069.68	.	$413.94
29906	Subtalar arthro w/deb		T	0041	30.3175	$2,069.68	.	$413.94
29907	Subtalar arthro w/fusion		T	0042	48.2063	$3,290.90	$804.74	$658.18
29999	Arthroscopy of joint		T	0041	30.3175	$2,069.68	.	$413.94
30000	Drainage of nose lesion		T	0251	3.4369	$234.63	.	$46.93
30020	Drainage of nose lesion		T	0251	3.4369	$234.63	.	$46.93
30100	Intranasal biopsy		T	0252	7.8743	$537.55	$109.16	$107.51
30110	Removal of nose polyp(s)		T	0253	17.4151	$1,188.88	$282.29	$237.78
30115	Removal of nose polyp(s)		T	0253	17.4151	$1,188.88	$282.29	$237.78
30117	Removal of intranasal lesion		T	0253	17.4151	$1,188.88	$282.29	$237.78
30118	Removal of intranasal lesion		T	0254	25.5397	$1,743.52	.	$348.71
30120	Revision of nose		T	0254	25.5397	$1,743.52	.	$348.71
30124	Removal of nose lesion		T	0252	7.8743	$537.55	$109.16	$107.51
30125	Removal of nose lesion		T	0256	44.8441	$3,061.37	.	$612.28
30130	Excise inferior turbinate		T	0253	17.4151	$1,188.88	$282.29	$237.78
30140	Resect inferior turbinate		T	0254	25.5397	$1,743.52	.	$348.71
30150	Partial removal of nose		T	0256	44.8441	$3,061.37	.	$612.28
30160	Removal of nose		T	0256	44.8441	$3,061.37	.	$612.28

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
30200	Injection treatment of nose		T	0252	7.8743	$537.55	$109.16	$107.51
30210	Nasal sinus therapy		T	0252	7.8743	$537.55	$109.16	$107.51
30220	Insert nasal septal button		T	0252	7.8743	$537.55	$109.16	$107.51
30300	Remove nasal foreign body		X	0340	0.6899	$47.10	.	$9.42
30310	Remove nasal foreign body		T	0253	17.4151	$1,188.88	$282.29	$237.78
30320	Remove nasal foreign body		T	0253	17.4151	$1,188.88	$282.29	$237.78
30400	Reconstruction of nose		T	0256	44.8441	$3,061.37	.	$612.28
30410	Reconstruction of nose		T	0256	44.8441	$3,061.37	.	$612.28
30420	Reconstruction of nose		T	0256	44.8441	$3,061.37	.	$612.28
30430	Revision of nose		T	0254	25.5397	$1,743.52	.	$348.71
30435	Revision of nose		T	0256	44.8441	$3,061.37	.	$612.28
30450	Revision of nose		T	0256	44.8441	$3,061.37	.	$612.28
30460	Revision of nose		T	0256	44.8441	$3,061.37	.	$612.28
30462	Revision of nose		T	0256	44.8441	$3,061.37	.	$612.28
30465	Repair nasal stenosis		T	0256	44.8441	$3,061.37	.	$612.28
30520	Repair of nasal septum		T	0254	25.5397	$1,743.52	.	$348.71
30540	Repair nasal defect		T	0256	44.8441	$3,061.37	.	$612.28
30545	Repair nasal defect		T	0256	44.8441	$3,061.37	.	$612.28
30560	Release of nasal adhesions		T	0251	3.4369	$234.63	.	$46.93
30580	Repair upper jaw fistula		T	0256	44.8441	$3,061.37	.	$612.28
30600	Repair mouth/nose fistula		T	0256	44.8441	$3,061.37	.	$612.28
30620	Intranasal reconstruction		T	0256	44.8441	$3,061.37	.	$612.28
30630	Repair nasal septum defect		T	0254	25.5397	$1,743.52	.	$348.71
30801	Ablate inf turbinate, superf		T	0252	7.8743	$537.55	$109.16	$107.51
30802	Ablate inf turbinate submuc		T	0253	17.4151	$1,188.88	$282.29	$237.78
30901	Control of nosebleed		T	0250	1.1743	$80.17	$25.10	$16.04
30903	Control of nosebleed		T	0250	1.1743	$80.17	$25.10	$16.04
30905	Control of nosebleed		T	0250	1.1743	$80.17	$25.10	$16.04
30906	Repeat control of nosebleed		T	0250	1.1743	$80.17	$25.10	$16.04

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
30915	Ligation, nasal sinus artery		T	0092	27.5456	$1,880.46	.	$376.10
30920	Ligation, upper jaw artery		T	0092	27.5456	$1,880.46	.	$376.10
30930	Ther fx, nasal inf turbinate		T	0253	17.4151	$1,188.88	$282.29	$237.78
30999	Nasal surgery procedure		T	0250	1.1743	$80.17	$25.10	$16.04
31000	Irrigation, maxillary sinus		T	0251	3.4369	$234.63	.	$46.93
31002	Irrigation, sphenoid sinus		T	0252	7.8743	$537.55	$109.16	$107.51
31020	Exploration, maxillary sinus		T	0254	25.5397	$1,743.52	.	$348.71
31030	Exploration, maxillary sinus		T	0256	44.8441	$3,061.37	.	$612.28
31032	Explore sinus, remove polyps		T	0256	44.8441	$3,061.37	.	$612.28
31040	Exploration behind upper jaw		T	0254	25.5397	$1,743.52	.	$348.71
31050	Exploration, sphenoid sinus		T	0256	44.8441	$3,061.37	.	$612.28
31051	Sphenoid sinus surgery		T	0256	44.8441	$3,061.37	.	$612.28
31070	Exploration of frontal sinus		T	0254	25.5397	$1,743.52	.	$348.71
31075	Exploration of frontal sinus		T	0256	44.8441	$3,061.37	.	$612.28
31080	Removal of frontal sinus		T	0256	44.8441	$3,061.37	.	$612.28
31081	Removal of frontal sinus		T	0256	44.8441	$3,061.37	.	$612.28
31084	Removal of frontal sinus		T	0256	44.8441	$3,061.37	.	$612.28
31085	Removal of frontal sinus		T	0256	44.8441	$3,061.37	.	$612.28
31086	Removal of frontal sinus		T	0256	44.8441	$3,061.37	.	$612.28
31087	Removal of frontal sinus		T	0256	44.8441	$3,061.37	.	$612.28
31090	Exploration of sinuses		T	0256	44.8441	$3,061.37	.	$612.28
31200	Removal of ethmoid sinus		T	0256	44.8441	$3,061.37	.	$612.28
31201	Removal of ethmoid sinus		T	0256	44.8441	$3,061.37	.	$612.28
31205	Removal of ethmoid sinus		T	0256	44.8441	$3,061.37	.	$612.28
31225	Removal of upper jaw		C					
31230	Removal of upper jaw		C					
31231	Nasal endoscopy, dx		T	0072	1.8778	$128.19	.	$25.64
31233	Nasal/sinus endoscopy, dx		T	0072	1.8778	$128.19	.	$25.64
31235	Nasal/sinus endoscopy, dx		T	0074	21.9959	$1,501.59	.	$300.32

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
31237	Nasal/sinus endoscopy, surg		T	0074	21.9959	$1,501.59	.	$300.32
31238	Nasal/sinus endoscopy, surg		T	0074	21.9959	$1,501.59	.	$300.32
31239	Nasal/sinus endoscopy, surg		T	0075	31.4168	$2,144.73	$445.92	$428.95
31240	Nasal/sinus endoscopy, surg		T	0074	21.9959	$1,501.59	.	$300.32
31254	Revision of ethmoid sinus		T	0075	31.4168	$2,144.73	$445.92	$428.95
31255	Removal of ethmoid sinus		T	0075	31.4168	$2,144.73	$445.92	$428.95
31256	Exploration maxillary sinus		T	0075	31.4168	$2,144.73	$445.92	$428.95
31267	Endoscopy, maxillary sinus		T	0075	31.4168	$2,144.73	$445.92	$428.95
31276	Sinus endoscopy, surgical		T	0075	31.4168	$2,144.73	$445.92	$428.95
31287	Nasal/sinus endoscopy, surg		T	0075	31.4168	$2,144.73	$445.92	$428.95
31288	Nasal/sinus endoscopy, surg		T	0075	31.4168	$2,144.73	$445.92	$428.95
31290	Nasal/sinus endoscopy, surg		C					
31291	Nasal/sinus endoscopy, surg		C					
31292	Nasal/sinus endoscopy, surg		T	0075	31.4168	$2,144.73	$445.92	$428.95
31293	Nasal/sinus endoscopy, surg		T	0075	31.4168	$2,144.73	$445.92	$428.95
31294	Nasal/sinus endoscopy, surg		T	0075	31.4168	$2,144.73	$445.92	$428.95
31299	Sinus surgery procedure		T	0250	1.1743	$80.17	$25.10	$16.04
31300	Removal of larynx lesion		T	0254	25.5397	$1,743.52	.	$348.71
31320	Diagnostic incision, larynx		T	0256	44.8441	$3,061.37	.	$612.28
31360	Removal of larynx		C					
31365	Removal of larynx		C					
31367	Partial removal of larynx		C					
31368	Partial removal of larynx		C					
31370	Partial removal of larynx		C					
31375	Partial removal of larynx		C					
31380	Partial removal of larynx		C					
31382	Partial removal of larynx		C					
31390	Removal of larynx & pharynx		C					
31395	Reconstruct larynx & pharynx		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
31400	Revision of larynx		T	0256	44.8441	$3,061.37	.	$612.28
31420	Removal of epiglottis		T	0256	44.8441	$3,061.37	.	$612.28
31500	Insert emergency airway		S	0094	2.4281	$165.76	$46.29	$33.16
31502	Change of windpipe airway		S	0078	1.4237	$97.19	.	$19.44
31505	Diagnostic laryngoscopy		T	0071	0.9225	$62.98	.	$12.60
31510	Laryngoscopy with biopsy		T	0074	21.9959	$1,501.59	.	$300.32
31511	Remove foreign body, larynx		T	0072	1.8778	$128.19	.	$25.64
31512	Removal of larynx lesion		T	0074	21.9959	$1,501.59	.	$300.32
31513	Injection into vocal cord		T	0072	1.8778	$128.19	.	$25.64
31515	Laryngoscopy for aspiration		T	0074	21.9959	$1,501.59	.	$300.32
31520	Dx laryngoscopy, newborn		T	0072	1.8778	$128.19	.	$25.64
31525	Dx laryngoscopy excl nb		T	0074	21.9959	$1,501.59	.	$300.32
31526	Dx laryngoscopy w/oper scope		T	0074	21.9959	$1,501.59	.	$300.32
31527	Laryngoscopy for treatment		T	0075	31.4168	$2,144.73	$445.92	$428.95
31528	Laryngoscopy and dilation		T	0074	21.9959	$1,501.59	.	$300.32
31529	Laryngoscopy and dilation		T	0074	21.9959	$1,501.59	.	$300.32
31530	Laryngoscopy w/fb removal		T	0074	21.9959	$1,501.59	.	$300.32
31531	Laryngoscopy w/fb & op scope		T	0074	21.9959	$1,501.59	.	$300.32
31535	Laryngoscopy w/biopsy		T	0074	21.9959	$1,501.59	.	$300.32
31536	Laryngoscopy w/bx & op scope		T	0074	21.9959	$1,501.59	.	$300.32
31540	Laryngoscopy w/exc of tumor		T	0074	21.9959	$1,501.59	.	$300.32
31541	Larynscop w/tumr exc + scope		T	0074	21.9959	$1,501.59	.	$300.32
31545	Remove vc lesion w/scope		T	0075	31.4168	$2,144.73	$445.92	$428.95
31546	Remove vc lesion scope/graft		T	0075	31.4168	$2,144.73	$445.92	$428.95
31560	Laryngoscop w/arytenoidectom		T	0075	31.4168	$2,144.73	$445.92	$428.95
31561	Larynscop, remve cart + scop		T	0075	31.4168	$2,144.73	$445.92	$428.95
31570	Laryngoscope w/vc inj		T	0074	21.9959	$1,501.59	.	$300.32
31571	Laryngoscop w/vc inj + scope		T	0075	31.4168	$2,144.73	$445.92	$428.95
31575	Diagnostic laryngoscopy		T	0072	1.8778	$128.19	.	$25.64

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
31576	Laryngoscopy with biopsy		T	0074	21.9959	$1,501.59	.	$300.32
31577	Remove foreign body, larynx		T	0073	4.0416	$275.91	$64.31	$55.19
31578	Removal of larynx lesion		T	0075	31.4168	$2,144.73	$445.92	$428.95
31579	Diagnostic laryngoscopy		T	0073	4.0416	$275.91	$64.31	$55.19
31580	Revision of larynx		T	0256	44.8441	$3,061.37	.	$612.28
31582	Revision of larynx		T	0256	44.8441	$3,061.37	.	$612.28
31584	Treat larynx fracture		C					
31587	Revision of larynx		C					
31588	Revision of larynx		T	0256	44.8441	$3,061.37	.	$612.28
31590	Reinnervate larynx		T	0256	44.8441	$3,061.37	.	$612.28
31595	Larynx nerve surgery		T	0256	44.8441	$3,061.37	.	$612.28
31599	Larynx surgery procedure		T	0250	1.1743	$80.17	$25.10	$16.04
31600	Incision of windpipe		T	0254	25.5397	$1,743.52	.	$348.71
31601	Incision of windpipe		T	0254	25.5397	$1,743.52	.	$348.71
31603	Incision of windpipe		T	0252	7.8743	$537.55	$109.16	$107.51
31605	Incision of windpipe		T	0252	7.8743	$537.55	$109.16	$107.51
31610	Incision of windpipe		T	0254	25.5397	$1,743.52	.	$348.71
31611	Surgery/speech prosthesis		T	0254	25.5397	$1,743.52	.	$348.71
31612	Puncture/clear windpipe		T	0254	25.5397	$1,743.52	.	$348.71
31613	Repair windpipe opening		T	0254	25.5397	$1,743.52	.	$348.71
31614	Repair windpipe opening		T	0256	44.8441	$3,061.37	.	$612.28
31615	Visualization of windpipe		T	0252	7.8743	$537.55	$109.16	$107.51
31620	Endobronchial us add-on		N					
31622	Dx bronchoscope/wash		T	0076	10.5445	$719.84	$189.82	$143.97
31623	Dx bronchoscope/brush		T	0076	10.5445	$719.84	$189.82	$143.97
31624	Dx bronchoscope/lavage		T	0076	10.5445	$719.84	$189.82	$143.97
31625	Bronchoscopy w/biopsy(s)		T	0076	10.5445	$719.84	$189.82	$143.97
31626	Bronchoscopy w/markers		T	0076	10.5445	$719.84	$189.82	$143.97
31627	Navigational bronchoscopy		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
31628	Bronchoscopy/lung bx, each		T	0076	10.5445	$719.84	$189.82	$143.97
31629	Bronchoscopy/needle bx, each		T	0076	10.5445	$719.84	$189.82	$143.97
31630	Bronchoscopy dilate/fx repr		T	0415	28.518	$1,946.84	$459.92	$389.37
31631	Bronchoscopy, dilate w/stent		T	0415	28.518	$1,946.84	$459.92	$389.37
31632	Bronchoscopy/lung bx, addl		T	0076	10.5445	$719.84	$189.82	$143.97
31633	Bronchoscopy/needle bx addl		T	0076	10.5445	$719.84	$189.82	$143.97
31635	Bronchoscopy w/fb removal		T	0076	10.5445	$719.84	$189.82	$143.97
31636	Bronchoscopy, bronch stents		T	0415	28.518	$1,946.84	$459.92	$389.37
31637	Bronchoscopy, stent add-on		T	0076	10.5445	$719.84	$189.82	$143.97
31638	Bronchoscopy, revise stent		T	0415	28.518	$1,946.84	$459.92	$389.37
31640	Bronchoscopy w/tumor excise		T	0415	28.518	$1,946.84	$459.92	$389.37
31641	Bronchoscopy, treat blockage		T	0415	28.518	$1,946.84	$459.92	$389.37
31643	Diag bronchoscope/catheter		T	0076	10.5445	$719.84	$189.82	$143.97
31645	Bronchoscopy, clear airways		T	0076	10.5445	$719.84	$189.82	$143.97
31646	Bronchoscopy, reclear airway		T	0076	10.5445	$719.84	$189.82	$143.97
31656	Bronchoscopy, inj for x-ray		T	0076	10.5445	$719.84	$189.82	$143.97
31715	Injection for bronchus x-ray		N					
31717	Bronchial brush biopsy		T	0073	4.0416	$275.91	$64.31	$55.19
31720	Clearance of airways		S	0077	0.418	$28.54	$7.74	$5.71
31725	Clearance of airways		C					
31730	Intro, windpipe wire/tube		T	0073	4.0416	$275.91	$64.31	$55.19
31750	Repair of windpipe		T	0256	44.8441	$3,061.37	.	$612.28
31755	Repair of windpipe		T	0256	44.8441	$3,061.37	.	$612.28
31760	Repair of windpipe		C					
31766	Reconstruction of windpipe		C					
31770	Repair/graft of bronchus		C					
31775	Reconstruct bronchus		C					
31780	Reconstruct windpipe		C					
31781	Reconstruct windpipe		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
31785	Remove windpipe lesion		T	0254	25.5397	$1,743.52	.	$348.71
31786	Remove windpipe lesion		C					
31800	Repair of windpipe injury		C					
31805	Repair of windpipe injury		C					
31820	Closure of windpipe lesion		T	0254	25.5397	$1,743.52	.	$348.71
31825	Repair of windpipe defect		T	0254	25.5397	$1,743.52	.	$348.71
31830	Revise windpipe scar		T	0254	25.5397	$1,743.52	.	$348.71
31899	Airways surgical procedure		T	0076	10.5445	$719.84	$189.82	$143.97
32035	Exploration of chest		C					
32036	Exploration of chest		C					
32095	Biopsy through chest wall		C					
32100	Exploration/biopsy of chest		C					
32110	Explore/repair chest		C					
32120	Re-exploration of chest		C					
32124	Explore chest free adhesions		C					
32140	Removal of lung lesion(s)		C					
32141	Remove/treat lung lesions		C					
32150	Removal of lung lesion(s)		C					
32151	Remove lung foreign body		C					
32160	Open chest heart massage		C					
32200	Drain, open, lung lesion		C					
32201	Drain, percut, lung lesion		T	0070	5.6491	$385.65	.	$77.13
32215	Treat chest lining		C					
32220	Release of lung		C					
32225	Partial release of lung		C					
32310	Removal of chest lining		C					
32320	Free/remove chest lining		C					
32400	Needle biopsy chest lining		T	0685	9.9046	$676.16	.	$135.24
32402	Open biopsy chest lining		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
32405	Biopsy, lung or mediastinum		T	0685	9.9046	$676.16	.	$135.24
32420	Puncture/clear lung		T	0070	5.6491	$385.65	.	$77.13
32421	Thoracentesis for aspiration		T	0070	5.6491	$385.65	.	$77.13
32422	Thoracentesis w/tube insert		T	0070	5.6491	$385.65	.	$77.13
32440	Removal of lung		C					
32442	Sleeve pneumonectomy		C					
32445	Removal of lung		C					
32480	Partial removal of lung		C					
32482	Bilobectomy		C					
32484	Segmentectomy		C					
32486	Sleeve lobectomy		C					
32488	Completion pneumonectomy		C					
32491	Lung volume reduction		C					
32500	Partial removal of lung		C					
32501	Repair bronchus add-on		C					
32503	Resect apical lung tumor		C					
32504	Resect apical lung tum/chest		C					
32540	Removal of lung lesion		C					
32550	Insert pleural cath		T	0652	31.1286	$2,125.06	.	$425.02
32551	Insertion of chest tube		T	0070	5.6491	$385.65	.	$77.13
32552	Remove lung catheter		S	0078	1.4237	$97.19	.	$19.44
32553	Ins mark thor for rt perq		X	0310	13.5651	$926.05	$325.27	$185.21
32560	Treat pleurodesis w/agent		T	0070	5.6491	$385.65	.	$77.13
32561	Lyse chest fibrin init day		T	0070	5.6491	$385.65	.	$77.13
32562	Lyse chest fibrin subq day		T	0070	5.6491	$385.65	.	$77.13
32601	Thoracoscopy, diagnostic		T	0069	35.4455	$2,419.76	$591.64	$483.96
32602	Thoracoscopy, diagnostic		T	0069	35.4455	$2,419.76	$591.64	$483.96
32603	Thoracoscopy, diagnostic		T	0069	35.4455	$2,419.76	$591.64	$483.96
32604	Thoracoscopy, diagnostic		T	0069	35.4455	$2,419.76	$591.64	$483.96

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
32605	Thoracoscopy, diagnostic		T	0069	35.4455	$2,419.76	$591.64	$483.96
32606	Thoracoscopy, diagnostic		T	0069	35.4455	$2,419.76	$591.64	$483.96
32650	Thoracoscopy, surgical		C					
32651	Thoracoscopy, surgical		C					
32652	Thoracoscopy, surgical		C					
32653	Thoracoscopy, surgical		C					
32654	Thoracoscopy, surgical		C					
32655	Thoracoscopy, surgical		C					
32656	Thoracoscopy, surgical		C					
32657	Thoracoscopy, surgical		C					
32658	Thoracoscopy, surgical		C					
32659	Thoracoscopy, surgical		C					
32660	Thoracoscopy, surgical		C					
32661	Thoracoscopy, surgical		C					
32662	Thoracoscopy, surgical		C					
32663	Thoracoscopy, surgical		C					
32664	Thoracoscopy, surgical		C					
32665	Thoracoscopy, surgical		C					
32800	Repair lung hernia		C					
32810	Close chest after drainage		C					
32815	Close bronchial fistula		C					
32820	Reconstruct injured chest		C					
32850	Donor pneumonectomy		C					
32851	Lung transplant, single		C					
32852	Lung transplant with bypass		C					
32853	Lung transplant, double		C					
32854	Lung transplant with bypass		C					
32855	Prepare donor lung, single		C					
32856	Prepare donor lung, double		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
32900	Removal of rib(s)		C					
32905	Revise & repair chest wall		C					
32906	Revise & repair chest wall		C					
32940	Revision of lung		C					
32960	Therapeutic pneumothorax		T	0070	5.6491	$385.65	.	$77.13
32997	Total lung lavage		C					
32998	Perq rf ablate tx, pul tumor		T	0423	57.2089	$3,905.48	.	$781.10
32999	Chest surgery procedure		T	0070	5.6491	$385.65	.	$77.13
33010	Drainage of heart sac		T	0070	5.6491	$385.65	.	$77.13
33011	Repeat drainage of heart sac		T	0070	5.6491	$385.65	.	$77.13
33015	Incision of heart sac		C					
33020	Incision of heart sac		C					
33025	Incision of heart sac		C					
33030	Partial removal of heart sac		C					
33031	Partial removal of heart sac		C					
33050	Removal of heart sac lesion		C					
33120	Removal of heart lesion		C					
33130	Removal of heart lesion		C					
33140	Heart revascularize (tmr)		C					
33141	Heart tmr w/other procedure		C					
33202	Insert epicard eltrd, open		C					
33203	Insert epicard eltrd, endo		C					
33206	Insertion of heart pacemaker		T	0089	112.4202	$7,674.59	$1,615.11	$1,534.92
33207	Insertion of heart pacemaker		T	0089	112.4202	$7,674.59	$1,615.11	$1,534.92
33208	Insertion of heart pacemaker		T	0655	138.0708	$9,425.68	.	$1,885.14
33210	Insertion of heart electrode		T	0106	52.6182	$3,592.09	.	$718.42
33211	Insertion of heart electrode		T	0106	52.6182	$3,592.09	.	$718.42
33212	Insertion of pulse generator		T	0090	92.6057	$6,321.91	$1,530.07	$1,264.39
33213	Insertion of pulse generator		T	0654	108.1716	$7,384.55	.	$1,476.91

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
33214	Upgrade of pacemaker system		T	0655	138.0708	$9,425.68	.	$1,885.14
33215	Reposition pacing-defib lead		T	0105	23.2281	$1,585.71	.	$317.15
33216	Insert 1 electrode pm-defib		T	0106	52.6182	$3,592.09	.	$718.42
33217	Insert 2 electrode pm-defib		T	0106	52.6182	$3,592.09	.	$718.42
33218	Repair lead pace-defib, one		T	0105	23.2281	$1,585.71	.	$317.15
33220	Repair lead pace-defib, dual		T	0105	23.2281	$1,585.71	.	$317.15
33222	Revise pocket, pacemaker		T	0136	17.1353	$1,169.78	.	$233.96
33223	Revise pocket for defib		T	0136	17.1353	$1,169.78	.	$233.96
33224	Insert pacing lead & connect		T	0418	143.1583	$9,772.99	.	$1,954.60
33225	L ventric pacing lead add-on		T	0418	143.1583	$9,772.99	.	$1,954.60
33226	Reposition l ventric lead		T	0105	23.2281	$1,585.71	.	$317.15
33233	Removal of pacemaker system		T	0105	23.2281	$1,585.71	.	$317.15
33234	Removal of pacemaker system		T	0105	23.2281	$1,585.71	.	$317.15
33235	Removal pacemaker electrode		T	0105	23.2281	$1,585.71	.	$317.15
33236	Remove electrode/thoracotomy		C					
33237	Remove electrode/thoracotomy		C					
33238	Remove electrode/thoracotomy		C					
33240	Insert pulse generator		T	0107	335.0724	$22,874.39	.	$4,574.88
33241	Remove pulse generator		T	0105	23.2281	$1,585.71	.	$317.15
33243	Remove eltrd/thoracotomy		C					
33244	Remove eltrd, transven		T	0105	23.2281	$1,585.71	.	$317.15
33249	Eltrd/insert pace-defib		T	0108	389.7128	$26,604.52	.	$5,320.91
33250	Ablate heart dysrhythm focus		C					
33251	Ablate heart dysrhythm focus		C					
33254	Ablate atria, lmtd		C					
33255	Ablate atria w/o bypass, ext		C					
33256	Ablate atria w/bypass, exten		C					
33257	Ablate atria, lmtd, add-on		C					
33258	Ablate atria, x10sv, add-on		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
33259	Ablate atria w/bypass add-on		C					
33261	Ablate heart dysrhythm focus		C					
33265	Ablate atria, lmtd, endo		C					
33266	Ablate atria, x10sv, endo		C					
33282	Implant pat-active ht record		S	0680	78.5933	$5,365.33	.	$1,073.07
33284	Remove pat-active ht record		T	0020	8.7772	$599.19	.	$119.84
33300	Repair of heart wound		C					
33305	Repair of heart wound		C					
33310	Exploratory heart surgery		C					
33315	Exploratory heart surgery		C					
33320	Repair major blood vessel(s)		C					
33321	Repair major vessel		C					
33322	Repair major blood vessel(s)		C					
33330	Insert major vessel graft		C					
33332	Insert major vessel graft		C					
33335	Insert major vessel graft		C					
33400	Repair of aortic valve		C					
33401	Valvuloplasty, open		C					
33403	Valvuloplasty, w/cp bypass		C					
33404	Prepare heart-aorta conduit		C					
33405	Replacement of aortic valve		C					
33406	Replacement of aortic valve		C					
33410	Replacement of aortic valve		C					
33411	Replacement of aortic valve		C					
33412	Replacement of aortic valve		C					
33413	Replacement of aortic valve		C					
33414	Repair of aortic valve		C					
33415	Revision, subvalvular tissue		C					
33416	Revise ventricle muscle		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
33417	Repair of aortic valve		C					
33420	Revision of mitral valve		C					
33422	Revision of mitral valve		C					
33425	Repair of mitral valve		C					
33426	Repair of mitral valve		C					
33427	Repair of mitral valve		C					
33430	Replacement of mitral valve		C					
33460	Revision of tricuspid valve		C					
33463	Valvuloplasty, tricuspid		C					
33464	Valvuloplasty, tricuspid		C					
33465	Replace tricuspid valve		C					
33468	Revision of tricuspid valve		C					
33470	Revision of pulmonary valve		C					
33471	Valvotomy, pulmonary valve		C					
33472	Revision of pulmonary valve		C					
33474	Revision of pulmonary valve		C					
33475	Replacement, pulmonary valve		C					
33476	Revision of heart chamber		C					
33478	Revision of heart chamber		C					
33496	Repair, prosth valve clot		C					
33500	Repair heart vessel fistula		C					
33501	Repair heart vessel fistula		C					
33502	Coronary artery correction		C					
33503	Coronary artery graft		C					
33504	Coronary artery graft		C					
33505	Repair artery w/tunnel		C					
33506	Repair artery, translocation		C					
33507	Repair art, intramural		C					
33508	Endoscopic vein harvest		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
33510	CABG, vein, single		C					
33511	CABG, vein, two		C					
33512	CABG, vein, three		C					
33513	CABG, vein, four		C					
33514	CABG, vein, five		C					
33516	Cabg, vein, six or more		C					
33517	CABG, artery-vein, single		C					
33518	CABG, artery-vein, two		C					
33519	CABG, artery-vein, three		C					
33521	CABG, artery-vein, four		C					
33522	CABG, artery-vein, five		C					
33523	Cabg, art-vein, six or more		C					
33530	Coronary artery, bypass/reop		C					
33533	CABG, arterial, single		C					
33534	CABG, arterial, two		C					
33535	CABG, arterial, three		C					
33536	Cabg, arterial, four or more		C					
33542	Removal of heart lesion		C					
33545	Repair of heart damage		C					
33548	Restore/remodel, ventricle		C					
33572	Open coronary endarterectomy		C					
33600	Closure of valve		C					
33602	Closure of valve		C					
33606	Anastomosis/artery-aorta		C					
33608	Repair anomaly w/conduit		C					
33610	Repair by enlargement		C					
33611	Repair double ventricle		C					
33612	Repair double ventricle		C					
33615	Repair, modified fontan		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
33617	Repair single ventricle		C					
33619	Repair single ventricle		C					
33641	Repair heart septum defect		C					
33645	Revision of heart veins		C					
33647	Repair heart septum defects		C					
33660	Repair of heart defects		C					
33665	Repair of heart defects		C					
33670	Repair of heart chambers		C					
33675	Close mult vsd		C					
33676	Close mult vsd w/resection		C					
33677	Cl mult vsd w/rem pul band		C					
33681	Repair heart septum defect		C					
33684	Repair heart septum defect		C					
33688	Repair heart septum defect		C					
33690	Reinforce pulmonary artery		C					
33692	Repair of heart defects		C					
33694	Repair of heart defects		C					
33697	Repair of heart defects		C					
33702	Repair of heart defects		C					
33710	Repair of heart defects		C					
33720	Repair of heart defect		C					
33722	Repair of heart defect		C					
33724	Repair venous anomaly		C					
33726	Repair pul venous stenosis		C					
33730	Repair heart-vein defect(s)		C					
33732	Repair heart-vein defect		C					
33735	Revision of heart chamber		C					
33736	Revision of heart chamber		C					
33737	Revision of heart chamber		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
33750	Major vessel shunt		C					
33755	Major vessel shunt		C					
33762	Major vessel shunt		C					
33764	Major vessel shunt & graft		C					
33766	Major vessel shunt		C					
33767	Major vessel shunt		C					
33768	Cavopulmonary shunting		C					
33770	Repair great vessels defect		C					
33771	Repair great vessels defect		C					
33774	Repair great vessels defect		C					
33775	Repair great vessels defect		C					
33776	Repair great vessels defect		C					
33777	Repair great vessels defect		C					
33778	Repair great vessels defect		C					
33779	Repair great vessels defect		C					
33780	Repair great vessels defect		C					
33781	Repair great vessels defect		C					
33782	Nikaidoh proc		C					
33783	Nikaidoh proc w/ostia implt		C					
33786	Repair arterial trunk		C					
33788	Revision of pulmonary artery		C					
33800	Aortic suspension		C					
33802	Repair vessel defect		C					
33803	Repair vessel defect		C					
33813	Repair septal defect		C					
33814	Repair septal defect		C					
33820	Revise major vessel		C					
33822	Revise major vessel		C					
33824	Revise major vessel		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
33840	Remove aorta constriction		C					
33845	Remove aorta constriction		C					
33851	Remove aorta constriction		C					
33852	Repair septal defect		C					
33853	Repair septal defect		C					
33860	Ascending aortic graft		C					
33861	Ascending aortic graft		C					
33863	Ascending aortic graft		C					
33864	Ascending aortic graft		C					
33870	Transverse aortic arch graft		C					
33875	Thoracic aortic graft		C					
33877	Thoracoabdominal graft		C					
33880	Endovasc taa repr incl subcl		C					
33881	Endovasc taa repr w/o subcl		C					
33883	Insert endovasc prosth, taa		C					
33884	Endovasc prosth, taa, add-on		C					
33886	Endovasc prosth, delayed		C					
33889	Artery transpose/endovas taa		C					
33891	Car-car bp grft/endovas taa		C					
33910	Remove lung artery emboli		C					
33915	Remove lung artery emboli		C					
33916	Surgery of great vessel		C					
33917	Repair pulmonary artery		C					
33920	Repair pulmonary atresia		C					
33922	Transect pulmonary artery		C					
33924	Remove pulmonary shunt		C					
33925	Rpr pul art unifocal w/o cpb		C					
33926	Repr pul art, unifocal w/cpb		C					
33930	Removal of donor heart/lung		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
33933	Prepare donor heart/lung		C					
33935	Transplantation, heart/lung		C					
33940	Removal of donor heart		C					
33944	Prepare donor heart		C					
33945	Transplantation of heart		C					
33960	External circulation assist		C					
33961	External circulation assist		C					
33967	Insert ia percut device		C					
33968	Remove aortic assist device		C					
33970	Aortic circulation assist		C					
33971	Aortic circulation assist		C					
33973	Insert balloon device		C					
33974	Remove intra-aortic balloon		C					
33975	Implant ventricular device		C					
33976	Implant ventricular device		C					
33977	Remove ventricular device		C					
33978	Remove ventricular device		C					
33979	Insert intracorporeal device		C					
33980	Remove intracorporeal device		C					
33981	Replace vad pump ext		C					
33982	Replace vad intra w/o bp		C					
33983	Replace vad intra w/bp		C					
33999	Cardiac surgery procedure		T	0070	5.6491	$385.65	.	$77.13
34001	Removal of artery clot		C					
34051	Removal of artery clot		C					
34101	Removal of artery clot		T	0088	41.8116	$2,854.35	$655.22	$570.87
34111	Removal of arm artery clot		T	0088	41.8116	$2,854.35	$655.22	$570.87
34151	Removal of artery clot		C					
34201	Removal of artery clot		T	0088	41.8116	$2,854.35	$655.22	$570.87

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
34203	Removal of leg artery clot		T	0088	41.8116	$2,854.35	$655.22	$570.87
34401	Removal of vein clot		C					
34421	Removal of vein clot		T	0088	41.8116	$2,854.35	$655.22	$570.87
34451	Removal of vein clot		C					
34471	Removal of vein clot		T	0088	41.8116	$2,854.35	$655.22	$570.87
34490	Removal of vein clot		T	0088	41.8116	$2,854.35	$655.22	$570.87
34501	Repair valve, femoral vein		T	0088	41.8116	$2,854.35	$655.22	$570.87
34502	Reconstruct vena cava		C					
34510	Transposition of vein valve		T	0088	41.8116	$2,854.35	$655.22	$570.87
34520	Cross-over vein graft		T	0088	41.8116	$2,854.35	$655.22	$570.87
34530	Leg vein fusion		T	0088	41.8116	$2,854.35	$655.22	$570.87
34800	Endovas aaa repr w/sm tube		C					
34802	Endovas aaa repr w/2-p part		C					
34803	Endovas aaa repr w/3-p part		C					
34804	Endovas aaa repr w/1-p part		C					
34805	Endovas aaa repr w/long tube		C					
34806	Aneurysm press sensor add-on		C					
34808	Endovas iliac a device addon		C					
34812	Xpose for endoprosth, femorl		C					
34813	Femoral endovas graft add-on		C					
34820	Xpose for endoprosth, iliac		C					
34825	Endovasc extend prosth, init		C					
34826	Endovasc exten prosth, addl		C					
34830	Open aortic tube prosth repr		C					
34831	Open aortoiliac prosth repr		C					
34832	Open aortofemor prosth repr		C					
34833	Xpose for endoprosth, iliac		C					
34834	Xpose, endoprosth, brachial		C					
34900	Endovasc iliac repr w/graft		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
35001	Repair defect of artery		C					
35002	Repair artery rupture, neck		C					
35005	Repair defect of artery		C					
35011	Repair defect of artery		T	0653	44.7437	$3,054.52	.	$610.91
35013	Repair artery rupture, arm		C					
35021	Repair defect of artery		C					
35022	Repair artery rupture, chest		C					
35045	Repair defect of arm artery		C					
35081	Repair defect of artery		C					
35082	Repair artery rupture, aorta		C					
35091	Repair defect of artery		C					
35092	Repair artery rupture, aorta		C					
35102	Repair defect of artery		C					
35103	Repair artery rupture, groin		C					
35111	Repair defect of artery		C					
35112	Repair artery rupture,spleen		C					
35121	Repair defect of artery		C					
35122	Repair artery rupture, belly		C					
35131	Repair defect of artery		C					
35132	Repair artery rupture, groin		C					
35141	Repair defect of artery		C					
35142	Repair artery rupture, thigh		C					
35151	Repair defect of artery		C					
35152	Repair artery rupture, knee		C					
35180	Repair blood vessel lesion		T	0093	36.5266	$2,493.56	.	$498.72
35182	Repair blood vessel lesion		C					
35184	Repair blood vessel lesion		T	0093	36.5266	$2,493.56	.	$498.72
35188	Repair blood vessel lesion		T	0088	41.8116	$2,854.35	$655.22	$570.87
35189	Repair blood vessel lesion		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
35190	Repair blood vessel lesion		T	0093	36.5266	$2,493.56	.	$498.72
35201	Repair blood vessel lesion		T	0093	36.5266	$2,493.56	.	$498.72
35206	Repair blood vessel lesion		T	0093	36.5266	$2,493.56	.	$498.72
35207	Repair blood vessel lesion		T	0088	41.8116	$2,854.35	$655.22	$570.87
35211	Repair blood vessel lesion		C					
35216	Repair blood vessel lesion		C					
35221	Repair blood vessel lesion		C					
35226	Repair blood vessel lesion		T	0020	8.7772	$599.19	.	$119.84
35231	Repair blood vessel lesion		T	0093	36.5266	$2,493.56	.	$498.72
35236	Repair blood vessel lesion		T	0093	36.5266	$2,493.56	.	$498.72
35241	Repair blood vessel lesion		C					
35246	Repair blood vessel lesion		C					
35251	Repair blood vessel lesion		C					
35256	Repair blood vessel lesion		T	0093	36.5266	$2,493.56	.	$498.72
35261	Repair blood vessel lesion		T	0653	44.7437	$3,054.52	.	$610.91
35266	Repair blood vessel lesion		T	0653	44.7437	$3,054.52	.	$610.91
35271	Repair blood vessel lesion		C					
35276	Repair blood vessel lesion		C					
35281	Repair blood vessel lesion		C					
35286	Repair blood vessel lesion		T	0653	44.7437	$3,054.52	.	$610.91
35301	Rechanneling of artery		C					
35302	Rechanneling of artery		C					
35303	Rechanneling of artery		C					
35304	Rechanneling of artery		C					
35305	Rechanneling of artery		C					
35306	Rechanneling of artery		C					
35311	Rechanneling of artery		C					
35321	Rechanneling of artery		T	0093	36.5266	$2,493.56	.	$498.72
35331	Rechanneling of artery		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
35341	Rechanneling of artery		C					
35351	Rechanneling of artery		C					
35355	Rechanneling of artery		C					
35361	Rechanneling of artery		C					
35363	Rechanneling of artery		C					
35371	Rechanneling of artery		C					
35372	Rechanneling of artery		C					
35390	Reoperation, carotid add-on		C					
35400	Angioscopy		C					
35450	Repair arterial blockage		C					
35452	Repair arterial blockage		C					
35454	Repair arterial blockage		C					
35456	Repair arterial blockage		C					
35458	Repair arterial blockage		T	0083	52.1947	$3,563.18	.	$712.64
35459	Repair arterial blockage		T	0083	52.1947	$3,563.18	.	$712.64
35460	Repair venous blockage		T	0083	52.1947	$3,563.18	.	$712.64
35470	Repair arterial blockage		T	0083	52.1947	$3,563.18	.	$712.64
35471	Repair arterial blockage		T	0083	52.1947	$3,563.18	.	$712.64
35472	Repair arterial blockage		T	0083	52.1947	$3,563.18	.	$712.64
35473	Repair arterial blockage		T	0083	52.1947	$3,563.18	.	$712.64
35474	Repair arterial blockage		T	0083	52.1947	$3,563.18	.	$712.64
35475	Repair arterial blockage		T	0083	52.1947	$3,563.18	.	$712.64
35476	Repair venous blockage		T	0083	52.1947	$3,563.18	.	$712.64
35480	Atherectomy, open		C					
35481	Atherectomy, open		C					
35482	Atherectomy, open		C					
35483	Atherectomy, open		C					
35484	Atherectomy, open		T	0082	97.8929	$6,682.85	.	$1,336.57
35485	Atherectomy, open		T	0082	97.8929	$6,682.85	.	$1,336.57

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
35490	Atherectomy, percutaneous		T	0082	97.8929	$6,682.85	.	$1,336.57
35491	Atherectomy, percutaneous		T	0082	97.8929	$6,682.85	.	$1,336.57
35492	Atherectomy, percutaneous		T	0082	97.8929	$6,682.85	.	$1,336.57
35493	Atherectomy, percutaneous		T	0082	97.8929	$6,682.85	.	$1,336.57
35494	Atherectomy, percutaneous		T	0082	97.8929	$6,682.85	.	$1,336.57
35495	Atherectomy, percutaneous		T	0082	97.8929	$6,682.85	.	$1,336.57
35500	Harvest vein for bypass		T	0103	19.1796	$1,309.33	.	$261.87
35501	Artery bypass graft		C					
35506	Artery bypass graft		C					
35508	Artery bypass graft		C					
35509	Artery bypass graft		C					
35510	Artery bypass graft		C					
35511	Artery bypass graft		C					
35512	Artery bypass graft		C					
35515	Artery bypass graft		C					
35516	Artery bypass graft		C					
35518	Artery bypass graft		C					
35521	Artery bypass graft		C					
35522	Artery bypass graft		C					
35523	Artery bypass graft		C					
35525	Artery bypass graft		C					
35526	Artery bypass graft		C					
35531	Artery bypass graft		C					
35533	Artery bypass graft		C					
35535	Artery bypass graft		C					
35536	Artery bypass graft		C					
35537	Artery bypass graft		C					
35538	Artery bypass graft		C					
35539	Artery bypass graft		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
35540	Artery bypass graft		C					
35548	Artery bypass graft		C					
35549	Artery bypass graft		C					
35551	Artery bypass graft		C					
35556	Artery bypass graft		C					
35558	Artery bypass graft		C					
35560	Artery bypass graft		C					
35563	Artery bypass graft		C					
35565	Artery bypass graft		C					
35566	Artery bypass graft		C					
35570	Artery bypass graft		C					
35571	Artery bypass graft		C					
35572	Harvest femoropopliteal vein		N					
35583	Vein bypass graft		C					
35585	Vein bypass graft		C					
35587	Vein bypass graft		C					
35600	Harvest art for cabg add-on		C					
35601	Artery bypass graft		C					
35606	Artery bypass graft		C					
35612	Artery bypass graft		C					
35616	Artery bypass graft		C					
35621	Artery bypass graft		C					
35623	Bypass graft, not vein		C					
35626	Artery bypass graft		C					
35631	Artery bypass graft		C					
35632	Artery bypass graft		C					
35633	Artery bypass graft		C					
35634	Artery bypass graft		C					
35636	Artery bypass graft		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
35637	Artery bypass graft		C					
35638	Artery bypass graft		C					
35642	Artery bypass graft		C					
35645	Artery bypass graft		C					
35646	Artery bypass graft		C					
35647	Artery bypass graft		C					
35650	Artery bypass graft		C					
35651	Artery bypass graft		C					
35654	Artery bypass graft		C					
35656	Artery bypass graft		C					
35661	Artery bypass graft		C					
35663	Artery bypass graft		C					
35665	Artery bypass graft		C					
35666	Artery bypass graft		C					
35671	Artery bypass graft		C					
35681	Composite bypass graft		C					
35682	Composite bypass graft		C					
35683	Composite bypass graft		C					
35685	Bypass graft patency/patch		T	0093	36.5266	$2,493.56	.	$498.72
35686	Bypass graft/av fist patency		T	0093	36.5266	$2,493.56	.	$498.72
35691	Arterial transposition		C					
35693	Arterial transposition		C					
35694	Arterial transposition		C					
35695	Arterial transposition		C					
35697	Reimplant artery each		C					
35700	Reoperation, bypass graft		C					
35701	Exploration, carotid artery		C					
35721	Exploration, femoral artery		C					
35741	Exploration popliteal artery		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
35761	Exploration of artery/vein		T	0093	36.5266	$2,493.56	.	$498.72
35800	Explore neck vessels		C					
35820	Explore chest vessels		C					
35840	Explore abdominal vessels		C					
35860	Explore limb vessels		T	0093	36.5266	$2,493.56	.	$498.72
35870	Repair vessel graft defect		C					
35875	Removal of clot in graft		T	0088	41.8116	$2,854.35	$655.22	$570.87
35876	Removal of clot in graft		T	0088	41.8116	$2,854.35	$655.22	$570.87
35879	Revise graft w/vein		T	0088	41.8116	$2,854.35	$655.22	$570.87
35881	Revise graft w/vein		T	0088	41.8116	$2,854.35	$655.22	$570.87
35883	Revise graft w/nonauto graft		T	0088	41.8116	$2,854.35	$655.22	$570.87
35884	Revise graft w/vein		T	0088	41.8116	$2,854.35	$655.22	$570.87
35901	Excision, graft, neck		C					
35903	Excision, graft, extremity		T	0093	36.5266	$2,493.56	.	$498.72
35905	Excision, graft, thorax		C					
35907	Excision, graft, abdomen		C					
36000	Place needle in vein		N					
36002	Pseudoaneurysm injection trt		S	0267	2.2748	$155.29	$60.50	$31.06
36005	Injection ext venography		N					
36010	Place catheter in vein		N					
36011	Place catheter in vein		N					
36012	Place catheter in vein		N					
36013	Place catheter in artery		N					
36014	Place catheter in artery		N					
36015	Place catheter in artery		N					
36100	Establish access to artery		N					
36120	Establish access to artery		N					
36140	Establish access to artery		N					
36147	Access av dial grft for eval		T	0676	2.3844	$162.78	.	$32.56

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
36148	Access av dial grft for proc		N					
36160	Establish access to aorta		N					
36200	Place catheter in aorta		N					
36215	Place catheter in artery		N					
36216	Place catheter in artery		N					
36217	Place catheter in artery		N					
36218	Place catheter in artery		N					
36245	Place catheter in artery		N					
36246	Place catheter in artery		N					
36247	Place catheter in artery		N					
36248	Place catheter in artery		N					
36260	Insertion of infusion pump		T	0623	30.8594	$2,106.68	.	$421.34
36261	Revision of infusion pump		T	0105	23.2281	$1,585.71	.	$317.15
36262	Removal of infusion pump		T	0105	23.2281	$1,585.71	.	$317.15
36299	Vessel injection procedure		N					
36400	Bl draw < 3 yrs fem/jugular		N					
36405	Bl draw < 3 yrs scalp vein		N					
36406	Bl draw < 3 yrs other vein		N					
36410	Non-routine bl draw > 3 yrs		N					
36415	Routine venipuncture		A					
36416	Capillary blood draw		N					
36420	Vein access cutdown < 1 yr		X	0035	0.2446	$16.70	.	$3.34
36425	Vein access cutdown > 1 yr		X	0035	0.2446	$16.70	.	$3.34
36430	Blood transfusion service		S	0110	3.4107	$232.84	.	$46.57
36440	Bl push transfuse, 2 yr or <		S	0110	3.4107	$232.84	.	$46.57
36450	Bl exchange/transfuse, nb		S	0110	3.4107	$232.84	.	$46.57
36455	Bl exchange/transfuse non-nb		S	0110	3.4107	$232.84	.	$46.57
36460	Transfusion service, fetal		S	0110	3.4107	$232.84	.	$46.57
36468	Injection(s), spider veins		T	0013	0.8782	$59.95	.	$11.99

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
36469	Injection(s), spider veins		T	0013	0.8782	$59.95	.	$11.99
36470	Injection therapy of vein		T	0013	0.8782	$59.95	.	$11.99
36471	Injection therapy of veins		T	0013	0.8782	$59.95	.	$11.99
36475	Endovenous rf, 1st vein		T	0091	44.4254	$3,032.79	.	$606.56
36476	Endovenous rf, vein add-on		T	0092	27.5456	$1,880.46	.	$376.10
36478	Endovenous laser, 1st vein		T	0092	27.5456	$1,880.46	.	$376.10
36479	Endovenous laser vein addon		T	0092	27.5456	$1,880.46	.	$376.10
36481	Insertion of catheter, vein		N					
36500	Insertion of catheter, vein		N					
36510	Insertion of catheter, vein		N					
36511	Apheresis wbc		S	0111	12.5247	$855.02	$198.40	$171.01
36512	Apheresis rbc		S	0111	12.5247	$855.02	$198.40	$171.01
36513	Apheresis platelets		S	0111	12.5247	$855.02	$198.40	$171.01
36514	Apheresis plasma		S	0111	12.5247	$855.02	$198.40	$171.01
36515	Apheresis, adsorp/reinfuse		S	0112	33.8904	$2,313.60	.	$462.72
36516	Apheresis, selective		S	0112	33.8904	$2,313.60	.	$462.72
36522	Photopheresis		S	0112	33.8904	$2,313.60	.	$462.72
36555	Insert non-tunnel cv cath		T	0621	11.4058	$778.64	.	$155.73
36556	Insert non-tunnel cv cath		T	0621	11.4058	$778.64	.	$155.73
36557	Insert tunneled cv cath		T	0622	25.693	$1,753.98	.	$350.80
36558	Insert tunneled cv cath		T	0622	25.693	$1,753.98	.	$350.80
36560	Insert tunneled cv cath		T	0623	30.8594	$2,106.68	.	$421.34
36561	Insert tunneled cv cath		T	0623	30.8594	$2,106.68	.	$421.34
36563	Insert tunneled cv cath		T	0623	30.8594	$2,106.68	.	$421.34
36565	Insert tunneled cv cath		T	0623	30.8594	$2,106.68	.	$421.34
36566	Insert tunneled cv cath		T	0623	30.8594	$2,106.68	.	$421.34
36568	Insert picc cath		T	0621	11.4058	$778.64	.	$155.73
36569	Insert picc cath		T	0621	11.4058	$778.64	.	$155.73
36570	Insert picvad cath		T	0622	25.693	$1,753.98	.	$350.80

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
36571	Insert picvad cath		T	0622	25.693	$1,753.98	.	$350.80
36575	Repair tunneled cv cath		T	0121	6.3264	$431.88	.	$86.38
36576	Repair tunneled cv cath		T	0621	11.4058	$778.64	.	$155.73
36578	Replace tunneled cv cath		T	0622	25.693	$1,753.98	.	$350.80
36580	Replace cvad cath		T	0621	11.4058	$778.64	.	$155.73
36581	Replace tunneled cv cath		T	0622	25.693	$1,753.98	.	$350.80
36582	Replace tunneled cv cath		T	0623	30.8594	$2,106.68	.	$421.34
36583	Replace tunneled cv cath		T	0623	30.8594	$2,106.68	.	$421.34
36584	Replace picc cath		T	0621	11.4058	$778.64	.	$155.73
36585	Replace picvad cath		T	0622	25.693	$1,753.98	.	$350.80
36589	Removal tunneled cv cath		T	0121	6.3264	$431.88	.	$86.38
36590	Removal tunneled cv cath		T	0621	11.4058	$778.64	.	$155.73
36591	Draw blood off venous device		Q1	0624	0.6338	$43.27	$12.65	$8.66
36592	Collect blood from picc		Q1	0624	0.6338	$43.27	$12.65	$8.66
36593	Declot vascular device		T	0676	2.3844	$162.78	.	$32.56
36595	Mech remov tunneled cv cath		T	0622	25.693	$1,753.98	.	$350.80
36596	Mech remov tunneled cv cath		T	0621	11.4058	$778.64	.	$155.73
36597	Reposition venous catheter		T	0621	11.4058	$778.64	.	$155.73
36598	Inj w/fluor, eval cv device		T	0676	2.3844	$162.78	.	$32.56
36600	Withdrawal of arterial blood		Q1	0035	0.2446	$16.70	.	$3.34
36620	Insertion catheter, artery		N					
36625	Insertion catheter, artery		N					
36640	Insertion catheter, artery		T	0623	30.8594	$2,106.68	.	$421.34
36660	Insertion catheter, artery		C					
36680	Insert needle, bone cavity		T	0002	1.7752	$121.19	.	$24.24
36800	Insertion of cannula		T	0115	33.3074	$2,273.80	.	$454.76
36810	Insertion of cannula		T	0115	33.3074	$2,273.80	.	$454.76
36815	Insertion of cannula		T	0115	33.3074	$2,273.80	.	$454.76
36818	Av fuse, uppr arm, cephalic		T	0088	41.8116	$2,854.35	$655.22	$570.87

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
36819	Av fuse, uppr arm, basilic		T	0088	41.8116	$2,854.35	$655.22	$570.87
36820	Av fusion/forearm vein		T	0088	41.8116	$2,854.35	$655.22	$570.87
36821	Av fusion direct any site		T	0088	41.8116	$2,854.35	$655.22	$570.87
36822	Insertion of cannula(s)		C					
36823	Insertion of cannula(s)		C					
36825	Artery-vein autograft		T	0088	41.8116	$2,854.35	$655.22	$570.87
36830	Artery-vein nonautograft		T	0088	41.8116	$2,854.35	$655.22	$570.87
36831	Open thrombect av fistula		T	0088	41.8116	$2,854.35	$655.22	$570.87
36832	Av fistula revision, open		T	0088	41.8116	$2,854.35	$655.22	$570.87
36833	Av fistula revision		T	0088	41.8116	$2,854.35	$655.22	$570.87
36835	Artery to vein shunt		T	0115	33.3074	$2,273.80	.	$454.76
36838	Dist revas ligation, hemo		T	0088	41.8116	$2,854.35	$655.22	$570.87
36860	External cannula declotting		T	0676	2.3844	$162.78	.	$32.56
36861	Cannula declotting		T	0115	33.3074	$2,273.80	.	$454.76
36870	Percut thrombect av fistula		T	0653	44.7437	$3,054.52	.	$610.91
37140	Revision of circulation		C					
37145	Revision of circulation		C					
37160	Revision of circulation		C					
37180	Revision of circulation		C					
37181	Splice spleen/kidney veins		C					
37182	Insert hepatic shunt (tips)		C					
37183	Remove hepatic shunt (tips)		T	0229	96.8443	$6,611.27	.	$1,322.26
37184	Prim art mech thrombectomy		T	0088	41.8116	$2,854.35	$655.22	$570.87
37185	Prim art m-thrombect add-on		T	0088	41.8116	$2,854.35	$655.22	$570.87
37186	Sec art m-thrombect add-on		T	0088	41.8116	$2,854.35	$655.22	$570.87
37187	Venous mech thrombectomy		T	0088	41.8116	$2,854.35	$655.22	$570.87
37188	Venous m-thrombectomy add-on		T	0088	41.8116	$2,854.35	$655.22	$570.87
37195	Thrombolytic therapy, stroke		T	0676	2.3844	$162.78	.	$32.56
37200	Transcatheter biopsy		T	0623	30.8594	$2,106.68	.	$421.34

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
37201	Transcatheter therapy infuse		T	0103	19.1796	$1,309.33	.	$261.87
37202	Transcatheter therapy infuse		T	0103	19.1796	$1,309.33	.	$261.87
37203	Transcatheter retrieval		T	0623	30.8594	$2,106.68	.	$421.34
37204	Transcatheter occlusion		T	0082	97.8929	$6,682.85	.	$1,336.57
37205	Transcath iv stent, percut		T	0229	96.8443	$6,611.27	.	$1,322.26
37206	Transcath iv stent/perc addl		T	0229	96.8443	$6,611.27	.	$1,322.26
37207	Transcath iv stent, open		T	0229	96.8443	$6,611.27	.	$1,322.26
37208	Transcath iv stent/open addl		T	0229	96.8443	$6,611.27	.	$1,322.26
37209	Change iv cath at thromb tx		T	0623	30.8594	$2,106.68	.	$421.34
37210	Embolization uterine fibroid		T	0229	96.8443	$6,611.27	.	$1,322.26
37215	Transcath stent, cca w/eps		C					
37216	Transcath stent, cca w/o eps		E					
37250	Iv us first vessel add-on		N					
37251	Iv us each add vessel add-on		N					
37500	Endoscopy ligate perf veins		T	0091	44.4254	$3,032.79	.	$606.56
37501	Vascular endoscopy procedure		T	0092	27.5456	$1,880.46	.	$376.10
37565	Ligation of neck vein		T	0093	36.5266	$2,493.56	.	$498.72
37600	Ligation of neck artery		T	0093	36.5266	$2,493.56	.	$498.72
37605	Ligation of neck artery		T	0091	44.4254	$3,032.79	.	$606.56
37606	Ligation of neck artery		T	0092	27.5456	$1,880.46	.	$376.10
37607	Ligation of a-v fistula		T	0092	27.5456	$1,880.46	.	$376.10
37609	Temporal artery procedure		T	0021	18.2223	$1,243.98	.	$248.80
37615	Ligation of neck artery		T	0092	27.5456	$1,880.46	.	$376.10
37616	Ligation of chest artery		C					
37617	Ligation of abdomen artery		C					
37618	Ligation of extremity artery		C					
37620	Revision of major vein		T	0091	44.4254	$3,032.79	.	$606.56
37650	Revision of major vein		T	0092	27.5456	$1,880.46	.	$376.10
37660	Revision of major vein		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
37700	Revise leg vein		T	0092	27.5456	$1,880.46	.	$376.10
37718	Ligate/strip short leg vein		T	0092	27.5456	$1,880.46	.	$376.10
37722	Ligate/strip long leg vein		T	0091	44.4254	$3,032.79	.	$606.56
37735	Removal of leg veins/lesion		T	0091	44.4254	$3,032.79	.	$606.56
37760	Ligate leg veins radical		T	0092	27.5456	$1,880.46	.	$376.10
37761	Ligate leg veins open		T	0092	27.5456	$1,880.46	.	$376.10
37765	Phleb veins - extrem - to 20		T	0092	27.5456	$1,880.46	.	$376.10
37766	Phleb veins - extrem 20+		T	0092	27.5456	$1,880.46	.	$376.10
37780	Revision of leg vein		T	0092	27.5456	$1,880.46	.	$376.10
37785	Ligate/divide/excise vein		T	0092	27.5456	$1,880.46	.	$376.10
37788	Revascularization, penis		C					
37790	Penile venous occlusion		T	0181	36.4186	$2,486.19	$620.84	$497.24
37799	Vascular surgery procedure		X	0624	0.6338	$43.27	$12.65	$8.66
38100	Removal of spleen, total		C					
38101	Removal of spleen, partial		C					
38102	Removal of spleen, total		C					
38115	Repair of ruptured spleen		C					
38120	Laparoscopy, splenectomy		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
38129	Laparoscope proc, spleen		T	0130	38.7195	$2,643.26	$659.53	$528.66
38200	Injection for spleen x-ray		N					
38204	Bl donor search management		N					
38205	Harvest allogenic stem cells		B					
38206	Harvest auto stem cells		S	0111	12.5247	$855.02	$198.40	$171.01
38207	Cryopreserve stem cells		S	0110	3.4107	$232.84	.	$46.57
38208	Thaw preserved stem cells		S	0110	3.4107	$232.84	.	$46.57
38209	Wash harvest stem cells		S	0110	3.4107	$232.84	.	$46.57
38210	T-cell depletion of harvest		S	0393	5.877	$401.21	.	$80.25
38211	Tumor cell deplete of harvst		S	0393	5.877	$401.21	.	$80.25
38212	Rbc depletion of harvest		S	0393	5.877	$401.21	.	$80.25

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
38213	Platelet deplete of harvest		S	0393	5.877	$401.21	.	$80.25
38214	Volume deplete of harvest		S	0393	5.877	$401.21	.	$80.25
38215	Harvest stem cell concentrte		S	0393	5.877	$401.21	.	$80.25
38220	Bone marrow aspiration		T	0003	3.6353	$248.17	.	$49.64
38221	Bone marrow biopsy		T	0003	3.6353	$248.17	.	$49.64
38230	Bone marrow collection		S	0112	33.8904	$2,313.60	.	$462.72
38240	Bone marrow/stem transplant		S	0112	33.8904	$2,313.60	.	$462.72
38241	Bone marrow/stem transplant		S	0112	33.8904	$2,313.60	.	$462.72
38242	Lymphocyte infuse transplant		S	0111	12.5247	$855.02	$198.40	$171.01
38300	Drainage, lymph node lesion		T	0007	13.3268	$909.78	.	$181.96
38305	Drainage, lymph node lesion		T	0008	20.2481	$1,382.28	.	$276.46
38308	Incision of lymph channels		T	0113	25.2939	$1,726.74	.	$345.35
38380	Thoracic duct procedure		C					
38381	Thoracic duct procedure		C					
38382	Thoracic duct procedure		C					
38500	Biopsy/removal, lymph nodes		T	0113	25.2939	$1,726.74	.	$345.35
38505	Needle biopsy, lymph nodes		T	0005	8.16	$557.06	.	$111.42
38510	Biopsy/removal, lymph nodes		T	0113	25.2939	$1,726.74	.	$345.35
38520	Biopsy/removal, lymph nodes		T	0113	25.2939	$1,726.74	.	$345.35
38525	Biopsy/removal, lymph nodes		T	0113	25.2939	$1,726.74	.	$345.35
38530	Biopsy/removal, lymph nodes		T	0113	25.2939	$1,726.74	.	$345.35
38542	Explore deep node(s), neck		T	0114	50.9844	$3,480.55	.	$696.11
38550	Removal, neck/armpit lesion		T	0113	25.2939	$1,726.74	.	$345.35
38555	Removal, neck/armpit lesion		T	0113	25.2939	$1,726.74	.	$345.35
38562	Removal, pelvic lymph nodes		C					
38564	Removal, abdomen lymph nodes		C					
38570	Laparoscopy, lymph node biop		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
38571	Laparoscopy, lymphadenectomy		T	0132	71.1086	$4,854.37	$1,226.23	$970.88
38572	Laparoscopy, lymphadenectomy		T	0131	48.0382	$3,279.42	$1,001.89	$655.89

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
38589	Laparoscope proc, lymphatic		T	0130	38.7195	$2,643.26	$659.53	$528.66
38700	Removal of lymph nodes, neck		T	0113	25.2939	$1,726.74	.	$345.35
38720	Removal of lymph nodes, neck		T	0113	25.2939	$1,726.74	.	$345.35
38724	Removal of lymph nodes, neck		C					
38740	Remove armpit lymph nodes		T	0114	50.9844	$3,480.55	.	$696.11
38745	Remove armpit lymph nodes		T	0114	50.9844	$3,480.55	.	$696.11
38746	Remove thoracic lymph nodes		C					
38747	Remove abdominal lymph nodes		C					
38760	Remove groin lymph nodes		T	0113	25.2939	$1,726.74	.	$345.35
38765	Remove groin lymph nodes		C					
38770	Remove pelvis lymph nodes		C					
38780	Remove abdomen lymph nodes		C					
38790	Inject for lymphatic x-ray		N					
38792	Identify sentinel node		Q1	0392	2.6029	$177.69	$43.31	$35.54
38794	Access thoracic lymph duct		N					
38999	Blood/lymph system procedure		S	0110	3.4107	$232.84	.	$46.57
39000	Exploration of chest		C					
39010	Exploration of chest		C					
39200	Removal chest lesion		C					
39220	Removal chest lesion		C					
39400	Visualization of chest		T	0069	35.4455	$2,419.76	$591.64	$483.96
39499	Chest procedure		C					
39501	Repair diaphragm laceration		C					
39502	Repair paraesophageal hernia		C					
39503	Repair of diaphragm hernia		C					
39520	Repair of diaphragm hernia		C					
39530	Repair of diaphragm hernia		C					
39531	Repair of diaphragm hernia		C					
39540	Repair of diaphragm hernia		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
39541	Repair of diaphragm hernia		C					
39545	Revision of diaphragm		C					
39560	Resect diaphragm, simple		C					
39561	Resect diaphragm, complex		C					
39599	Diaphragm surgery procedure		C					
40490	Biopsy of lip		T	0251	3.4369	$234.63	.	$46.93
40500	Partial excision of lip		T	0253	17.4151	$1,188.88	$282.29	$237.78
40510	Partial excision of lip		T	0254	25.5397	$1,743.52	.	$348.71
40520	Partial excision of lip		T	0253	17.4151	$1,188.88	$282.29	$237.78
40525	Reconstruct lip with flap		T	0254	25.5397	$1,743.52	.	$348.71
40527	Reconstruct lip with flap		T	0254	25.5397	$1,743.52	.	$348.71
40530	Partial removal of lip		T	0254	25.5397	$1,743.52	.	$348.71
40650	Repair lip		T	0252	7.8743	$537.55	$109.16	$107.51
40652	Repair lip		T	0252	7.8743	$537.55	$109.16	$107.51
40654	Repair lip		T	0252	7.8743	$537.55	$109.16	$107.51
40700	Repair cleft lip/nasal		T	0256	44.8441	$3,061.37	.	$612.28
40701	Repair cleft lip/nasal		T	0256	44.8441	$3,061.37	.	$612.28
40702	Repair cleft lip/nasal		T	0256	44.8441	$3,061.37	.	$612.28
40720	Repair cleft lip/nasal		T	0256	44.8441	$3,061.37	.	$612.28
40761	Repair cleft lip/nasal		T	0256	44.8441	$3,061.37	.	$612.28
40799	Lip surgery procedure		T	0250	1.1743	$80.17	$25.10	$16.04
40800	Drainage of mouth lesion		T	0006	1.4939	$101.98	.	$20.40
40801	Drainage of mouth lesion		T	0252	7.8743	$537.55	$109.16	$107.51
40804	Removal, foreign body, mouth		X	0340	0.6899	$47.10	.	$9.42
40805	Removal, foreign body, mouth		T	0252	7.8743	$537.55	$109.16	$107.51
40806	Incision of lip fold		T	0251	3.4369	$234.63	.	$46.93
40808	Biopsy of mouth lesion		T	0251	3.4369	$234.63	.	$46.93
40810	Excision of mouth lesion		T	0253	17.4151	$1,188.88	$282.29	$237.78
40812	Excise/repair mouth lesion		T	0253	17.4151	$1,188.88	$282.29	$237.78

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
40814	Excise/repair mouth lesion		T	0253	17.4151	$1,188.88	$282.29	$237.78
40816	Excision of mouth lesion		T	0254	25.5397	$1,743.52	.	$348.71
40818	Excise oral mucosa for graft		T	0251	3.4369	$234.63	.	$46.93
40819	Excise lip or cheek fold		T	0252	7.8743	$537.55	$109.16	$107.51
40820	Treatment of mouth lesion		T	0253	17.4151	$1,188.88	$282.29	$237.78
40830	Repair mouth laceration		T	0251	3.4369	$234.63	.	$46.93
40831	Repair mouth laceration		T	0252	7.8743	$537.55	$109.16	$107.51
40840	Reconstruction of mouth		T	0254	25.5397	$1,743.52	.	$348.71
40842	Reconstruction of mouth		T	0254	25.5397	$1,743.52	.	$348.71
40843	Reconstruction of mouth		T	0254	25.5397	$1,743.52	.	$348.71
40844	Reconstruction of mouth		T	0256	44.8441	$3,061.37	.	$612.28
40845	Reconstruction of mouth		T	0256	44.8441	$3,061.37	.	$612.28
40899	Mouth surgery procedure		T	0250	1.1743	$80.17	$25.10	$16.04
41000	Drainage of mouth lesion		T	0253	17.4151	$1,188.88	$282.29	$237.78
41005	Drainage of mouth lesion		T	0251	3.4369	$234.63	.	$46.93
41006	Drainage of mouth lesion		T	0254	25.5397	$1,743.52	.	$348.71
41007	Drainage of mouth lesion		T	0253	17.4151	$1,188.88	$282.29	$237.78
41008	Drainage of mouth lesion		T	0253	17.4151	$1,188.88	$282.29	$237.78
41009	Drainage of mouth lesion		T	0251	3.4369	$234.63	.	$46.93
41010	Incision of tongue fold		T	0252	7.8743	$537.55	$109.16	$107.51
41015	Drainage of mouth lesion		T	0251	3.4369	$234.63	.	$46.93
41016	Drainage of mouth lesion		T	0252	7.8743	$537.55	$109.16	$107.51
41017	Drainage of mouth lesion		T	0252	7.8743	$537.55	$109.16	$107.51
41018	Drainage of mouth lesion		T	0252	7.8743	$537.55	$109.16	$107.51
41019	Place needles h&n for rt		T	0254	25.5397	$1,743.52	.	$348.71
41100	Biopsy of tongue		T	0252	7.8743	$537.55	$109.16	$107.51
41105	Biopsy of tongue		T	0253	17.4151	$1,188.88	$282.29	$237.78
41108	Biopsy of floor of mouth		T	0019	4.9184	$335.76	.	$67.16
41110	Excision of tongue lesion		T	0253	17.4151	$1,188.88	$282.29	$237.78

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
41112	Excision of tongue lesion		T	0253	17.4151	$1,188.88	$282.29	$237.78
41113	Excision of tongue lesion		T	0253	17.4151	$1,188.88	$282.29	$237.78
41114	Excision of tongue lesion		T	0254	25.5397	$1,743.52	.	$348.71
41115	Excision of tongue fold		T	0252	7.8743	$537.55	$109.16	$107.51
41116	Excision of mouth lesion		T	0253	17.4151	$1,188.88	$282.29	$237.78
41120	Partial removal of tongue		T	0254	25.5397	$1,743.52	.	$348.71
41130	Partial removal of tongue		C					
41135	Tongue and neck surgery		C					
41140	Removal of tongue		C					
41145	Tongue removal, neck surgery		C					
41150	Tongue, mouth, jaw surgery		C					
41153	Tongue, mouth, neck surgery		C					
41155	Tongue, jaw, & neck surgery		C					
41250	Repair tongue laceration		T	0250	1.1743	$80.17	$25.10	$16.04
41251	Repair tongue laceration		T	0251	3.4369	$234.63	.	$46.93
41252	Repair tongue laceration		T	0252	7.8743	$537.55	$109.16	$107.51
41500	Fixation of tongue		T	0254	25.5397	$1,743.52	.	$348.71
41510	Tongue to lip surgery		T	0253	17.4151	$1,188.88	$282.29	$237.78
41512	Tongue suspension		T	0252	7.8743	$537.55	$109.16	$107.51
41520	Reconstruction, tongue fold		T	0252	7.8743	$537.55	$109.16	$107.51
41530	Tongue base vol reduction		T	0254	25.5397	$1,743.52	.	$348.71
41599	Tongue and mouth surgery		T	0250	1.1743	$80.17	$25.10	$16.04
41800	Drainage of gum lesion		T	0006	1.4939	$101.98	.	$20.40
41805	Removal foreign body, gum		T	0254	25.5397	$1,743.52	.	$348.71
41806	Removal foreign body,jawbone		T	0253	17.4151	$1,188.88	$282.29	$237.78
41820	Excision, gum, each quadrant		T	0252	7.8743	$537.55	$109.16	$107.51
41821	Excision of gum flap		T	0252	7.8743	$537.55	$109.16	$107.51
41822	Excision of gum lesion		T	0253	17.4151	$1,188.88	$282.29	$237.78
41823	Excision of gum lesion		T	0254	25.5397	$1,743.52	.	$348.71

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
41825	Excision of gum lesion		T	0253	17.4151	$1,188.88	$282.29	$237.78
41826	Excision of gum lesion		T	0254	25.5397	$1,743.52	.	$348.71
41827	Excision of gum lesion		T	0254	25.5397	$1,743.52	.	$348.71
41828	Excision of gum lesion		T	0253	17.4151	$1,188.88	$282.29	$237.78
41830	Removal of gum tissue		T	0253	17.4151	$1,188.88	$282.29	$237.78
41850	Treatment of gum lesion		T	0253	17.4151	$1,188.88	$282.29	$237.78
41870	Gum graft		T	0254	25.5397	$1,743.52	.	$348.71
41872	Repair gum		T	0253	17.4151	$1,188.88	$282.29	$237.78
41874	Repair tooth socket		T	0254	25.5397	$1,743.52	.	$348.71
41899	Dental surgery procedure		T	0250	1.1743	$80.17	$25.10	$16.04
42000	Drainage mouth roof lesion		T	0251	3.4369	$234.63	.	$46.93
42100	Biopsy roof of mouth		T	0252	7.8743	$537.55	$109.16	$107.51
42104	Excision lesion, mouth roof		T	0253	17.4151	$1,188.88	$282.29	$237.78
42106	Excision lesion, mouth roof		T	0253	17.4151	$1,188.88	$282.29	$237.78
42107	Excision lesion, mouth roof		T	0254	25.5397	$1,743.52	.	$348.71
42120	Remove palate/lesion		T	0256	44.8441	$3,061.37	.	$612.28
42140	Excision of uvula		T	0252	7.8743	$537.55	$109.16	$107.51
42145	Repair palate, pharynx/uvula		T	0254	25.5397	$1,743.52	.	$348.71
42160	Treatment mouth roof lesion		T	0253	17.4151	$1,188.88	$282.29	$237.78
42180	Repair palate		T	0251	3.4369	$234.63	.	$46.93
42182	Repair palate		T	0256	44.8441	$3,061.37	.	$612.28
42200	Reconstruct cleft palate		T	0256	44.8441	$3,061.37	.	$612.28
42205	Reconstruct cleft palate		T	0256	44.8441	$3,061.37	.	$612.28
42210	Reconstruct cleft palate		T	0256	44.8441	$3,061.37	.	$612.28
42215	Reconstruct cleft palate		T	0256	44.8441	$3,061.37	.	$612.28
42220	Reconstruct cleft palate		T	0256	44.8441	$3,061.37	.	$612.28
42225	Reconstruct cleft palate		T	0256	44.8441	$3,061.37	.	$612.28
42226	Lengthening of palate		T	0256	44.8441	$3,061.37	.	$612.28
42227	Lengthening of palate		T	0256	44.8441	$3,061.37	.	$612.28

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
42235	Repair palate		T	0253	17.4151	$1,188.88	$282.29	$237.78
42260	Repair nose to lip fistula		T	0254	25.5397	$1,743.52	.	$348.71
42280	Preparation, palate mold		T	0251	3.4369	$234.63	.	$46.93
42281	Insertion, palate prosthesis		T	0253	17.4151	$1,188.88	$282.29	$237.78
42299	Palate/uvula surgery		T	0250	1.1743	$80.17	$25.10	$16.04
42300	Drainage of salivary gland		T	0253	17.4151	$1,188.88	$282.29	$237.78
42305	Drainage of salivary gland		T	0253	17.4151	$1,188.88	$282.29	$237.78
42310	Drainage of salivary gland		T	0251	3.4369	$234.63	.	$46.93
42320	Drainage of salivary gland		T	0251	3.4369	$234.63	.	$46.93
42330	Removal of salivary stone		T	0253	17.4151	$1,188.88	$282.29	$237.78
42335	Removal of salivary stone		T	0253	17.4151	$1,188.88	$282.29	$237.78
42340	Removal of salivary stone		T	0253	17.4151	$1,188.88	$282.29	$237.78
42400	Biopsy of salivary gland		T	0005	8.16	$557.06	.	$111.42
42405	Biopsy of salivary gland		T	0254	25.5397	$1,743.52	.	$348.71
42408	Excision of salivary cyst		T	0253	17.4151	$1,188.88	$282.29	$237.78
42409	Drainage of salivary cyst		T	0253	17.4151	$1,188.88	$282.29	$237.78
42410	Excise parotid gland/lesion		T	0256	44.8441	$3,061.37	.	$612.28
42415	Excise parotid gland/lesion		T	0256	44.8441	$3,061.37	.	$612.28
42420	Excise parotid gland/lesion		T	0256	44.8441	$3,061.37	.	$612.28
42425	Excise parotid gland/lesion		T	0256	44.8441	$3,061.37	.	$612.28
42426	Excise parotid gland/lesion		C					
42440	Excise submaxillary gland		T	0256	44.8441	$3,061.37	.	$612.28
42450	Excise sublingual gland		T	0254	25.5397	$1,743.52	.	$348.71
42500	Repair salivary duct		T	0254	25.5397	$1,743.52	.	$348.71
42505	Repair salivary duct		T	0256	44.8441	$3,061.37	.	$612.28
42507	Parotid duct diversion		T	0256	44.8441	$3,061.37	.	$612.28
42508	Parotid duct diversion		T	0256	44.8441	$3,061.37	.	$612.28
42509	Parotid duct diversion		T	0256	44.8441	$3,061.37	.	$612.28
42510	Parotid duct diversion		T	0256	44.8441	$3,061.37	.	$612.28

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
42550	Injection for salivary x-ray		N					
42600	Closure of salivary fistula		T	0253	17.4151	$1,188.88	$282.29	$237.78
42650	Dilation of salivary duct		T	0252	7.8743	$537.55	$109.16	$107.51
42660	Dilation of salivary duct		T	0251	3.4369	$234.63	.	$46.93
42665	Ligation of salivary duct		T	0254	25.5397	$1,743.52	.	$348.71
42699	Salivary surgery procedure		T	0250	1.1743	$80.17	$25.10	$16.04
42700	Drainage of tonsil abscess		T	0251	3.4369	$234.63	.	$46.93
42720	Drainage of throat abscess		T	0253	17.4151	$1,188.88	$282.29	$237.78
42725	Drainage of throat abscess		T	0256	44.8441	$3,061.37	.	$612.28
42800	Biopsy of throat	CH	T	0252	7.8743	$537.55	$109.16	$107.51
42802	Biopsy of throat		T	0253	17.4151	$1,188.88	$282.29	$237.78
42804	Biopsy of upper nose/throat		T	0253	17.4151	$1,188.88	$282.29	$237.78
42806	Biopsy of upper nose/throat		T	0254	25.5397	$1,743.52	.	$348.71
42808	Excise pharynx lesion		T	0254	25.5397	$1,743.52	.	$348.71
42809	Remove pharynx foreign body		X	0340	0.6899	$47.10	.	$9.42
42810	Excision of neck cyst		T	0254	25.5397	$1,743.52	.	$348.71
42815	Excision of neck cyst		T	0256	44.8441	$3,061.37	.	$612.28
42820	Remove tonsils and adenoids		T	0254	25.5397	$1,743.52	.	$348.71
42821	Remove tonsils and adenoids		T	0254	25.5397	$1,743.52	.	$348.71
42825	Removal of tonsils		T	0254	25.5397	$1,743.52	.	$348.71
42826	Removal of tonsils		T	0254	25.5397	$1,743.52	.	$348.71
42830	Removal of adenoids		T	0254	25.5397	$1,743.52	.	$348.71
42831	Removal of adenoids		T	0254	25.5397	$1,743.52	.	$348.71
42835	Removal of adenoids		T	0254	25.5397	$1,743.52	.	$348.71
42836	Removal of adenoids		T	0254	25.5397	$1,743.52	.	$348.71
42842	Extensive surgery of throat		T	0254	25.5397	$1,743.52	.	$348.71
42844	Extensive surgery of throat		T	0256	44.8441	$3,061.37	.	$612.28
42845	Extensive surgery of throat		C					
42860	Excision of tonsil tags		T	0254	25.5397	$1,743.52	.	$348.71

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
42870	Excision of lingual tonsil		T	0254	25.5397	$1,743.52	.	$348.71
42890	Partial removal of pharynx		T	0256	44.8441	$3,061.37	.	$612.28
42892	Revision of pharyngeal walls		T	0256	44.8441	$3,061.37	.	$612.28
42894	Revision of pharyngeal walls		C					
42900	Repair throat wound		T	0252	7.8743	$537.55	$109.16	$107.51
42950	Reconstruction of throat		T	0254	25.5397	$1,743.52	.	$348.71
42953	Repair throat, esophagus		C					
42955	Surgical opening of throat		T	0254	25.5397	$1,743.52	.	$348.71
42960	Control throat bleeding		T	0250	1.1743	$80.17	$25.10	$16.04
42961	Control throat bleeding		C					
42962	Control throat bleeding		T	0256	44.8441	$3,061.37	.	$612.28
42970	Control nose/throat bleeding		T	0250	1.1743	$80.17	$25.10	$16.04
42971	Control nose/throat bleeding		C					
42972	Control nose/throat bleeding		T	0253	17.4151	$1,188.88	$282.29	$237.78
42999	Throat surgery procedure		T	0250	1.1743	$80.17	$25.10	$16.04
43020	Incision of esophagus		T	0252	7.8743	$537.55	$109.16	$107.51
43030	Throat muscle surgery		T	0253	17.4151	$1,188.88	$282.29	$237.78
43045	Incision of esophagus		C					
43100	Excision of esophagus lesion		C					
43101	Excision of esophagus lesion		C					
43107	Removal of esophagus		C					
43108	Removal of esophagus		C					
43112	Removal of esophagus		C					
43113	Removal of esophagus		C					
43116	Partial removal of esophagus		C					
43117	Partial removal of esophagus		C					
43118	Partial removal of esophagus		C					
43121	Partial removal of esophagus		C					
43122	Partial removal of esophagus		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
43123	Partial removal of esophagus		C					
43124	Removal of esophagus		C					
43130	Removal of esophagus pouch		T	0256	44.8441	$3,061.37	.	$612.28
43135	Removal of esophagus pouch		C					
43200	Esophagus endoscopy		T	0141	8.8811	$606.29	$143.38	$121.26
43201	Esoph scope w/submucous inj		T	0141	8.8811	$606.29	$143.38	$121.26
43202	Esophagus endoscopy, biopsy		T	0141	8.8811	$606.29	$143.38	$121.26
43204	Esoph scope w/sclerosis inj		T	0141	8.8811	$606.29	$143.38	$121.26
43205	Esophagus endoscopy/ligation		T	0141	8.8811	$606.29	$143.38	$121.26
43215	Esophagus endoscopy		T	0141	8.8811	$606.29	$143.38	$121.26
43216	Esophagus endoscopy/lesion	CH	T	0422	16.3107	$1,113.48	$271.47	$222.70
43217	Esophagus endoscopy		T	0141	8.8811	$606.29	$143.38	$121.26
43219	Esophagus endoscopy		T	0384	27.4802	$1,875.99	.	$375.20
43220	Esoph endoscopy, dilation		T	0141	8.8811	$606.29	$143.38	$121.26
43226	Esoph endoscopy, dilation		T	0141	8.8811	$606.29	$143.38	$121.26
43227	Esoph endoscopy, repair		T	0141	8.8811	$606.29	$143.38	$121.26
43228	Esoph endoscopy, ablation		T	0422	16.3107	$1,113.48	$271.47	$222.70
43231	Esoph endoscopy w/us exam		T	0141	8.8811	$606.29	$143.38	$121.26
43232	Esoph endoscopy w/us fn bx		T	0141	8.8811	$606.29	$143.38	$121.26
43234	Upper GI endoscopy, exam		T	0141	8.8811	$606.29	$143.38	$121.26
43235	Uppr gi endoscopy, diagnosis		T	0141	8.8811	$606.29	$143.38	$121.26
43236	Uppr gi scope w/submuc inj		T	0141	8.8811	$606.29	$143.38	$121.26
43237	Endoscopic us exam, esoph		T	0141	8.8811	$606.29	$143.38	$121.26
43238	Uppr gi endoscopy w/us fn bx		T	0141	8.8811	$606.29	$143.38	$121.26
43239	Upper GI endoscopy, biopsy		T	0141	8.8811	$606.29	$143.38	$121.26
43240	Esoph endoscope w/drain cyst		T	0141	8.8811	$606.29	$143.38	$121.26
43241	Upper GI endoscopy with tube		T	0141	8.8811	$606.29	$143.38	$121.26
43242	Uppr gi endoscopy w/us fn bx	CH	T	0422	16.3107	$1,113.48	$271.47	$222.70
43243	Upper gi endoscopy & inject		T	0141	8.8811	$606.29	$143.38	$121.26

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
43244	Upper GI endoscopy/ligation		T	0141	8.8811	$606.29	$143.38	$121.26
43245	Uppr gi scope dilate strictr		T	0141	8.8811	$606.29	$143.38	$121.26
43246	Place gastrostomy tube		T	0141	8.8811	$606.29	$143.38	$121.26
43247	Operative upper GI endoscopy		T	0141	8.8811	$606.29	$143.38	$121.26
43248	Uppr gi endoscopy/guide wire		T	0141	8.8811	$606.29	$143.38	$121.26
43249	Esoph endoscopy, dilation		T	0141	8.8811	$606.29	$143.38	$121.26
43250	Upper GI endoscopy/tumor		T	0141	8.8811	$606.29	$143.38	$121.26
43251	Operative upper GI endoscopy		T	0141	8.8811	$606.29	$143.38	$121.26
43255	Operative upper GI endoscopy		T	0141	8.8811	$606.29	$143.38	$121.26
43256	Uppr gi endoscopy w/stent		T	0384	27.4802	$1,875.99	.	$375.20
43257	Uppr gi scope w/thrml txmnt		T	0422	16.3107	$1,113.48	$271.47	$222.70
43258	Operative upper GI endoscopy		T	0141	8.8811	$606.29	$143.38	$121.26
43259	Endoscopic ultrasound exam		T	0141	8.8811	$606.29	$143.38	$121.26
43260	Endo cholangiopancreatograph		T	0151	23.0632	$1,574.46	.	$314.90
43261	Endo cholangiopancreatograph		T	0151	23.0632	$1,574.46	.	$314.90
43262	Endo cholangiopancreatograph		T	0151	23.0632	$1,574.46	.	$314.90
43263	Endo cholangiopancreatograph		T	0151	23.0632	$1,574.46	.	$314.90
43264	Endo cholangiopancreatograph		T	0151	23.0632	$1,574.46	.	$314.90
43265	Endo cholangiopancreatograph		T	0151	23.0632	$1,574.46	.	$314.90
43267	Endo cholangiopancreatograph		T	0151	23.0632	$1,574.46	.	$314.90
43268	Endo cholangiopancreatograph		T	0384	27.4802	$1,875.99	.	$375.20
43269	Endo cholangiopancreatograph		T	0384	27.4802	$1,875.99	.	$375.20
43271	Endo cholangiopancreatograph		T	0151	23.0632	$1,574.46	.	$314.90
43272	Endo cholangiopancreatograph		T	0151	23.0632	$1,574.46	.	$314.90
43273	Endoscopic pancreatoscopy		T	0151	23.0632	$1,574.46	.	$314.90
43279	Lap myotomy, heller		C					
43280	Laparoscopy, fundoplasty		T	0132	71.1086	$4,854.37	$1,226.23	$970.88
43281	Lap paraesophag hern repair		C					
43282	Lap paraesoph her rpr w/mesh		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
43289	Laparoscope proc, esoph		T	0130	38.7195	$2,643.26	$659.53	$528.66
43300	Repair of esophagus		C					
43305	Repair esophagus and fistula		C					
43310	Repair of esophagus		C					
43312	Repair esophagus and fistula		C					
43313	Esophagoplasty congenital		C					
43314	Tracheo-esophagoplasty cong		C					
43320	Fuse esophagus & stomach		C					
43324	Revise esophagus & stomach		C					
43325	Revise esophagus & stomach		C					
43326	Revise esophagus & stomach		C					
43330	Repair of esophagus		C					
43331	Repair of esophagus		C					
43340	Fuse esophagus & intestine		C					
43341	Fuse esophagus & intestine		C					
43350	Surgical opening, esophagus		C					
43351	Surgical opening, esophagus		C					
43352	Surgical opening, esophagus		C					
43360	Gastrointestinal repair		C					
43361	Gastrointestinal repair		C					
43400	Ligate esophagus veins		C					
43401	Esophagus surgery for veins		C					
43405	Ligate/staple esophagus		C					
43410	Repair esophagus wound		C					
43415	Repair esophagus wound		C					
43420	Repair esophagus opening		T	0254	25.5397	$1,743.52	.	$348.71
43425	Repair esophagus opening		C					
43450	Dilate esophagus		T	0140	6.4279	$438.81	.	$87.77
43453	Dilate esophagus		T	0140	6.4279	$438.81	.	$87.77

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
43456	Dilate esophagus		T	0140	6.4279	$438.81	.	$87.77
43458	Dilate esophagus		T	0141	8.8811	$606.29	$143.38	$121.26
43460	Pressure treatment esophagus		C					
43496	Free jejunum flap, microvasc		C					
43499	Esophagus surgery procedure		T	0141	8.8811	$606.29	$143.38	$121.26
43500	Surgical opening of stomach		C					
43501	Surgical repair of stomach		C					
43502	Surgical repair of stomach		C					
43510	Surgical opening of stomach	CH	T	0422	16.3107	$1,113.48	$271.47	$222.70
43520	Incision of pyloric muscle		C					
43600	Biopsy of stomach		T	0141	8.8811	$606.29	$143.38	$121.26
43605	Biopsy of stomach		C					
43610	Excision of stomach lesion		C					
43611	Excision of stomach lesion		C					
43620	Removal of stomach		C					
43621	Removal of stomach		C					
43622	Removal of stomach		C					
43631	Removal of stomach, partial		C					
43632	Removal of stomach, partial		C					
43633	Removal of stomach, partial		C					
43634	Removal of stomach, partial		C					
43635	Removal of stomach, partial		C					
43640	Vagotomy & pylorus repair		C					
43641	Vagotomy & pylorus repair		C					
43644	Lap gastric bypass/roux-en-y		C					
43645	Lap gastr bypass incl smll i		C					
43647	Lap impl electrode, antrum		S	0061	88.8954	$6,068.62	.	$1,213.73
43648	Lap revise/remv eltrd antrum		T	0130	38.7195	$2,643.26	$659.53	$528.66
43651	Laparoscopy, vagus nerve		T	0132	71.1086	$4,854.37	$1,226.23	$970.88

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
43652	Laparoscopy, vagus nerve		T	0132	71.1086	$4,854.37	$1,226.23	$970.88
43653	Laparoscopy, gastrostomy		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
43659	Laparoscope proc, stom		T	0130	38.7195	$2,643.26	$659.53	$528.66
43752	Nasal/orogastric w/stent		X	0272	1.2472	$85.14	$31.07	$17.03
43760	Change gastrostomy tube		T	0676	2.3844	$162.78	.	$32.56
43761	Reposition gastrostomy tube		T	0141	8.8811	$606.29	$143.38	$121.26
43770	Lap place gastr adj device		C					
43771	Lap revise gastr adj device		C					
43772	Lap rmvl gastr adj device		C					
43773	Lap replace gastr adj device		C					
43774	Lap rmvl gastr adj all parts		C					
43775	Lap sleeve gastrectomy		C					
43800	Reconstruction of pylorus		C					
43810	Fusion of stomach and bowel		C					
43820	Fusion of stomach and bowel		C					
43825	Fusion of stomach and bowel		C					
43830	Place gastrostomy tube		T	0422	16.3107	$1,113.48	$271.47	$222.70
43831	Place gastrostomy tube		T	0141	8.8811	$606.29	$143.38	$121.26
43832	Place gastrostomy tube		C					
43840	Repair of stomach lesion		C					
43842	V-band gastroplasty		E					
43843	Gastroplasty w/o v-band		C					
43845	Gastroplasty duodenal switch		C					
43846	Gastric bypass for obesity		C					
43847	Gastric bypass incl small i		C					
43848	Revision gastroplasty		C					
43850	Revise stomach-bowel fusion		C					
43855	Revise stomach-bowel fusion		C					
43860	Revise stomach-bowel fusion		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
43865	Revise stomach-bowel fusion		C					
43870	Repair stomach opening	CH	T	0422	16.3107	$1,113.48	$271.47	$222.70
43880	Repair stomach-bowel fistula		C					
43881	Impl/redo electrd, antrum		C					
43882	Revise/remove electrd antrum		C					
43886	Revise gastric port, open		T	0137	22.1186	$1,509.97	.	$302.00
43887	Remove gastric port, open		T	0135	4.6616	$318.23	.	$63.65
43888	Change gastric port, open		T	0137	22.1186	$1,509.97	.	$302.00
43999	Stomach surgery procedure		T	0141	8.8811	$606.29	$143.38	$121.26
44005	Freeing of bowel adhesion		C					
44010	Incision of small bowel		C					
44015	Insert needle cath bowel		C					
44020	Explore small intestine		C					
44021	Decompress small bowel		C					
44025	Incision of large bowel		C					
44050	Reduce bowel obstruction		C					
44055	Correct malrotation of bowel		C					
44100	Biopsy of bowel		T	0141	8.8811	$606.29	$143.38	$121.26
44110	Excise intestine lesion(s)		C					
44111	Excision of bowel lesion(s)		C					
44120	Removal of small intestine		C					
44121	Removal of small intestine		C					
44125	Removal of small intestine		C					
44126	Enterectomy w/o taper, cong		C					
44127	Enterectomy w/taper, cong		C					
44128	Enterectomy cong, add-on		C					
44130	Bowel to bowel fusion		C					
44132	Enterectomy, cadaver donor		C					
44133	Enterectomy, live donor		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
44135	Intestine transplnt, cadaver		C					
44136	Intestine transplant, live		C					
44137	Remove intestinal allograft		C					
44139	Mobilization of colon		C					
44140	Partial removal of colon		C					
44141	Partial removal of colon		C					
44143	Partial removal of colon		C					
44144	Partial removal of colon		C					
44145	Partial removal of colon		C					
44146	Partial removal of colon		C					
44147	Partial removal of colon		C					
44150	Removal of colon		C					
44151	Removal of colon/ileostomy		C					
44155	Removal of colon/ileostomy		C					
44156	Removal of colon/ileostomy		C					
44157	Colectomy w/ileoanal anast		C					
44158	Colectomy w/neo-rectum pouch		C					
44160	Removal of colon		C					
44180	Lap, enterolysis		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
44186	Lap, jejunostomy		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
44187	Lap, ileo/jejuno-stomy		C					
44188	Lap, colostomy		C					
44202	Lap, enterectomy		C					
44203	Lap resect s/intestine, addl		C					
44204	Laparo partial colectomy		C					
44205	Lap colectomy part w/ileum		C					
44206	Lap part colectomy w/stoma		T	0132	71.1086	$4,854.37	$1,226.23	$970.88
44207	L colectomy/coloproctostomy		T	0132	71.1086	$4,854.37	$1,226.23	$970.88
44208	L colectomy/coloproctostomy		T	0132	71.1086	$4,854.37	$1,226.23	$970.88

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
44210	Laparo total proctocolectomy		C					
44211	Lap colectomy w/proctectomy		C					
44212	Laparo total proctocolectomy		C					
44213	Lap, mobil splenic fl add-on		T	0130	38.7195	$2,643.26	$659.53	$528.66
44227	Lap, close enterostomy		C					
44238	Laparoscope proc, intestine		T	0130	38.7195	$2,643.26	$659.53	$528.66
44300	Open bowel to skin		C					
44310	Ileostomy/jejunostomy		C					
44312	Revision of ileostomy		T	0137	22.1186	$1,509.97	.	$302.00
44314	Revision of ileostomy		C					
44316	Devise bowel pouch		C					
44320	Colostomy		C					
44322	Colostomy with biopsies		C					
44340	Revision of colostomy		T	0137	22.1186	$1,509.97	.	$302.00
44345	Revision of colostomy		C					
44346	Revision of colostomy		C					
44360	Small bowel endoscopy		T	0142	10.1443	$692.52	$152.78	$138.51
44361	Small bowel endoscopy/biopsy		T	0142	10.1443	$692.52	$152.78	$138.51
44363	Small bowel endoscopy		T	0142	10.1443	$692.52	$152.78	$138.51
44364	Small bowel endoscopy		T	0142	10.1443	$692.52	$152.78	$138.51
44365	Small bowel endoscopy		T	0142	10.1443	$692.52	$152.78	$138.51
44366	Small bowel endoscopy		T	0142	10.1443	$692.52	$152.78	$138.51
44369	Small bowel endoscopy		T	0142	10.1443	$692.52	$152.78	$138.51
44370	Small bowel endoscopy/stent		T	0384	27.4802	$1,875.99	.	$375.20
44372	Small bowel endoscopy		T	0142	10.1443	$692.52	$152.78	$138.51
44373	Small bowel endoscopy		T	0142	10.1443	$692.52	$152.78	$138.51
44376	Small bowel endoscopy		T	0142	10.1443	$692.52	$152.78	$138.51
44377	Small bowel endoscopy/biopsy		T	0142	10.1443	$692.52	$152.78	$138.51
44378	Small bowel endoscopy		T	0142	10.1443	$692.52	$152.78	$138.51

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
44379	S bowel endoscope w/stent		T	0384	27.4802	$1,875.99	.	$375.20
44380	Small bowel endoscopy		T	0142	10.1443	$692.52	$152.78	$138.51
44382	Small bowel endoscopy		T	0142	10.1443	$692.52	$152.78	$138.51
44383	Ileoscopy w/stent		T	0384	27.4802	$1,875.99	.	$375.20
44385	Endoscopy of bowel pouch		T	0143	9.3206	$636.29	$186.06	$127.26
44386	Endoscopy, bowel pouch/biop		T	0143	9.3206	$636.29	$186.06	$127.26
44388	Colonoscopy		T	0143	9.3206	$636.29	$186.06	$127.26
44389	Colonoscopy with biopsy		T	0143	9.3206	$636.29	$186.06	$127.26
44390	Colonoscopy for foreign body		T	0143	9.3206	$636.29	$186.06	$127.26
44391	Colonoscopy for bleeding		T	0143	9.3206	$636.29	$186.06	$127.26
44392	Colonoscopy & polypectomy		T	0143	9.3206	$636.29	$186.06	$127.26
44393	Colonoscopy, lesion removal		T	0143	9.3206	$636.29	$186.06	$127.26
44394	Colonoscopy w/snare		T	0143	9.3206	$636.29	$186.06	$127.26
44397	Colonoscopy w/stent		T	0384	27.4802	$1,875.99	.	$375.20
44500	Intro, gastrointestinal tube		T	0121	6.3264	$431.88	.	$86.38
44602	Suture, small intestine		C					
44603	Suture, small intestine		C					
44604	Suture, large intestine		C					
44605	Repair of bowel lesion		C					
44615	Intestinal stricturoplasty		C					
44620	Repair bowel opening		C					
44625	Repair bowel opening		C					
44626	Repair bowel opening		C					
44640	Repair bowel-skin fistula		C					
44650	Repair bowel fistula		C					
44660	Repair bowel-bladder fistula		C					
44661	Repair bowel-bladder fistula		C					
44680	Surgical revision, intestine		C					
44700	Suspend bowel w/prosthesis		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
44701	Intraop colon lavage add-on		N					
44715	Prepare donor intestine		C					
44720	Prep donor intestine/venous		C					
44721	Prep donor intestine/artery		C					
44799	Unlisted procedure intestine		T	0153	26.2068	$1,789.06	$368.04	$357.82
44800	Excision of bowel pouch		C					
44820	Excision of mesentery lesion		C					
44850	Repair of mesentery		C					
44899	Bowel surgery procedure		C					
44900	Drain app abscess, open		C					
44901	Drain app abscess, percut		T	0037	15.764	$1,076.16	$228.76	$215.24
44950	Appendectomy		T	0153	26.2068	$1,789.06	$368.04	$357.82
44955	Appendectomy add-on		T	0153	26.2068	$1,789.06	$368.04	$357.82
44960	Appendectomy		C					
44970	Laparoscopy, appendectomy		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
44979	Laparoscope proc, app		T	0130	38.7195	$2,643.26	$659.53	$528.66
45000	Drainage of pelvic abscess		T	0155	16.1014	$1,099.19	.	$219.84
45005	Drainage of rectal abscess		T	0155	16.1014	$1,099.19	.	$219.84
45020	Drainage of rectal abscess		T	0155	16.1014	$1,099.19	.	$219.84
45100	Biopsy of rectum		T	0149	24.5978	$1,679.22	.	$335.85
45108	Removal of anorectal lesion		T	0149	24.5978	$1,679.22	.	$335.85
45110	Removal of rectum		C					
45111	Partial removal of rectum		C					
45112	Removal of rectum		C					
45113	Partial proctectomy		C					
45114	Partial removal of rectum		C					
45116	Partial removal of rectum		C					
45119	Remove rectum w/reservoir		C					
45120	Removal of rectum		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
45121	Removal of rectum and colon		C					
45123	Partial proctectomy		C					
45126	Pelvic exenteration		C					
45130	Excision of rectal prolapse		C					
45135	Excision of rectal prolapse		C					
45136	Excise ileoanal reservior		C					
45150	Excision of rectal stricture		T	0149	24.5978	$1,679.22	.	$335.85
45160	Excision of rectal lesion		T	0149	24.5978	$1,679.22	.	$335.85
45171	Exc rect tum transanal part		T	0155	16.1014	$1,099.19	.	$219.84
45172	Exc rect tum transanal full		T	0149	24.5978	$1,679.22	.	$335.85
45190	Destruction, rectal tumor		T	0149	24.5978	$1,679.22	.	$335.85
45300	Proctosigmoidoscopy dx		T	0146	5.7839	$394.85	.	$78.97
45303	Proctosigmoidoscopy dilate		T	0147	9.5024	$648.70	.	$129.74
45305	Proctosigmoidoscopy w/bx		T	0147	9.5024	$648.70	.	$129.74
45307	Proctosigmoidoscopy fb		T	0428	24.5869	$1,678.47	.	$335.70
45308	Proctosigmoidoscopy removal		T	0147	9.5024	$648.70	.	$129.74
45309	Proctosigmoidoscopy removal		T	0147	9.5024	$648.70	.	$129.74
45315	Proctosigmoidoscopy removal		T	0147	9.5024	$648.70	.	$129.74
45317	Proctosigmoidoscopy bleed		T	0147	9.5024	$648.70	.	$129.74
45320	Proctosigmoidoscopy ablate		T	0428	24.5869	$1,678.47	.	$335.70
45321	Proctosigmoidoscopy volvul		T	0428	24.5869	$1,678.47	.	$335.70
45327	Proctosigmoidoscopy w/stent		T	0384	27.4802	$1,875.99	.	$375.20
45330	Diagnostic sigmoidoscopy		T	0146	5.7839	$394.85	.	$78.97
45331	Sigmoidoscopy and biopsy		T	0146	5.7839	$394.85	.	$78.97
45332	Sigmoidoscopy w/fb removal		T	0146	5.7839	$394.85	.	$78.97
45333	Sigmoidoscopy & polypectomy		T	0147	9.5024	$648.70	.	$129.74
45334	Sigmoidoscopy for bleeding		T	0147	9.5024	$648.70	.	$129.74
45335	Sigmoidoscopy w/submuc inj		T	0146	5.7839	$394.85	.	$78.97
45337	Sigmoidoscopy & decompress		T	0146	5.7839	$394.85	.	$78.97

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
45338	Sigmoidoscopy w/tumr remove		T	0147	9.5024	$648.70	.	$129.74
45339	Sigmoidoscopy w/ablate tumr		T	0147	9.5024	$648.70	.	$129.74
45340	Sig w/balloon dilation		T	0147	9.5024	$648.70	.	$129.74
45341	Sigmoidoscopy w/ultrasound		T	0147	9.5024	$648.70	.	$129.74
45342	Sigmoidoscopy w/us guide bx		T	0147	9.5024	$648.70	.	$129.74
45345	Sigmoidoscopy w/stent		T	0384	27.4802	$1,875.99	.	$375.20
45355	Surgical colonoscopy		T	0143	9.3206	$636.29	$186.06	$127.26
45378	Diagnostic colonoscopy		T	0143	9.3206	$636.29	$186.06	$127.26
45379	Colonoscopy w/fb removal		T	0143	9.3206	$636.29	$186.06	$127.26
45380	Colonoscopy and biopsy		T	0143	9.3206	$636.29	$186.06	$127.26
45381	Colonoscopy, submucous inj		T	0143	9.3206	$636.29	$186.06	$127.26
45382	Colonoscopy/control bleeding		T	0143	9.3206	$636.29	$186.06	$127.26
45383	Lesion removal colonoscopy		T	0143	9.3206	$636.29	$186.06	$127.26
45384	Lesion remove colonoscopy		T	0143	9.3206	$636.29	$186.06	$127.26
45385	Lesion removal colonoscopy		T	0143	9.3206	$636.29	$186.06	$127.26
45386	Colonoscopy dilate stricture		T	0143	9.3206	$636.29	$186.06	$127.26
45387	Colonoscopy w/stent		T	0384	27.4802	$1,875.99	.	$375.20
45391	Colonoscopy w/endoscope us		T	0143	9.3206	$636.29	$186.06	$127.26
45392	Colonoscopy w/endoscopic fnb		T	0143	9.3206	$636.29	$186.06	$127.26
45395	Lap, removal of rectum		C					
45397	Lap, remove rectum w/pouch		C					
45400	Laparoscopic proc		C					
45402	Lap proctopexy w/sig resect		C					
45499	Laparoscope proc, rectum		T	0130	38.7195	$2,643.26	$659.53	$528.66
45500	Repair of rectum		T	0149	24.5978	$1,679.22	.	$335.85
45505	Repair of rectum		T	0150	32.6184	$2,226.76	.	$445.36
45520	Treatment of rectal prolapse		T	0013	0.8782	$59.95	.	$11.99
45540	Correct rectal prolapse		C					
45541	Correct rectal prolapse		T	0150	32.6184	$2,226.76	.	$445.36

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
45550	Repair rectum/remove sigmoid		C					
45560	Repair of rectocele		T	0150	32.6184	$2,226.76	.	$445.36
45562	Exploration/repair of rectum		C					
45563	Exploration/repair of rectum		C					
45800	Repair rect/bladder fistula		C					
45805	Repair fistula w/colostomy		C					
45820	Repair rectourethral fistula		C					
45825	Repair fistula w/colostomy		C					
45900	Reduction of rectal prolapse		T	0148	6.2678	$427.88	.	$85.58
45905	Dilation of anal sphincter		T	0149	24.5978	$1,679.22	.	$335.85
45910	Dilation of rectal narrowing		T	0149	24.5978	$1,679.22	.	$335.85
45915	Remove rectal obstruction		T	0155	16.1014	$1,099.19	.	$219.84
45990	Surg dx exam, anorectal		T	0149	24.5978	$1,679.22	.	$335.85
45999	Rectum surgery procedure		T	0148	6.2678	$427.88	.	$85.58
46020	Placement of seton		T	0149	24.5978	$1,679.22	.	$335.85
46030	Removal of rectal marker		T	0148	6.2678	$427.88	.	$85.58
46040	Incision of rectal abscess		T	0149	24.5978	$1,679.22	.	$335.85
46045	Incision of rectal abscess		T	0149	24.5978	$1,679.22	.	$335.85
46050	Incision of anal abscess		T	0155	16.1014	$1,099.19	.	$219.84
46060	Incision of rectal abscess		T	0149	24.5978	$1,679.22	.	$335.85
46070	Incision of anal septum		T	0155	16.1014	$1,099.19	.	$219.84
46080	Incision of anal sphincter		T	0149	24.5978	$1,679.22	.	$335.85
46083	Incise external hemorrhoid		T	0164	2.0672	$141.12	.	$28.23
46200	Removal of anal fissure		T	0149	24.5978	$1,679.22	.	$335.85
46220	Excise anal ext tag/papilla		T	0155	16.1014	$1,099.19	.	$219.84
46221	Ligation of hemorrhoid(s)		T	0148	6.2678	$427.88	.	$85.58
46230	Removal of anal tags		T	0149	24.5978	$1,679.22	.	$335.85
46250	Remove ext hem groups = 2		T	0149	24.5978	$1,679.22	.	$335.85
46255	Remove int/ext hem 1 group		T	0149	24.5978	$1,679.22	.	$335.85

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
46257	Remove in/ex hem grp & fiss		T	0149	24.5978	$1,679.22	.	$335.85
46258	Remove in/ex hem grp w/fistu		T	0149	24.5978	$1,679.22	.	$335.85
46260	Remove in/ex hem groups = 2		T	0149	24.5978	$1,679.22	.	$335.85
46261	Remove in/ex hem grps & fiss		T	0149	24.5978	$1,679.22	.	$335.85
46262	Remove in/ex hem grps w/fist		T	0149	24.5978	$1,679.22	.	$335.85
46270	Remove anal fist subq		T	0149	24.5978	$1,679.22	.	$335.85
46275	Remove anal fist inter		T	0149	24.5978	$1,679.22	.	$335.85
46280	Remove anal fist complex		T	0149	24.5978	$1,679.22	.	$335.85
46285	Remove anal fist 2 stage		T	0149	24.5978	$1,679.22	.	$335.85
46288	Repair anal fistula		T	0149	24.5978	$1,679.22	.	$335.85
46320	Removal of hemorrhoid clot		T	0149	24.5978	$1,679.22	.	$335.85
46500	Injection into hemorrhoid(s)		T	0155	16.1014	$1,099.19	.	$219.84
46505	Chemodenervation anal musc		T	0149	24.5978	$1,679.22	.	$335.85
46600	Diagnostic anoscopy		X	0340	0.6899	$47.10	.	$9.42
46604	Anoscopy and dilation		T	0147	9.5024	$648.70	.	$129.74
46606	Anoscopy and biopsy		T	0146	5.7839	$394.85	.	$78.97
46608	Anoscopy, remove for body		T	0147	9.5024	$648.70	.	$129.74
46610	Anoscopy, remove lesion		T	0428	24.5869	$1,678.47	.	$335.70
46611	Anoscopy		T	0147	9.5024	$648.70	.	$129.74
46612	Anoscopy, remove lesions		T	0428	24.5869	$1,678.47	.	$335.70
46614	Anoscopy, control bleeding		T	0146	5.7839	$394.85	.	$78.97
46615	Anoscopy		T	0428	24.5869	$1,678.47	.	$335.70
46700	Repair of anal stricture		T	0149	24.5978	$1,679.22	.	$335.85
46705	Repair of anal stricture		C					
46706	Repr of anal fistula w/glue		T	0150	32.6184	$2,226.76	.	$445.36
46707	Repair anorectal fist w/plug		T	0150	32.6184	$2,226.76	.	$445.36
46710	Repr per/vag pouch sngl proc		C					
46712	Repr per/vag pouch dbl proc		C					
46715	Rep perf anoper fistu		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
46716	Rep perf anoper/vestib fistu		C					
46730	Construction of absent anus		C					
46735	Construction of absent anus		C					
46740	Construction of absent anus		C					
46742	Repair of imperforated anus		C					
46744	Repair of cloacal anomaly		C					
46746	Repair of cloacal anomaly		C					
46748	Repair of cloacal anomaly		C					
46750	Repair of anal sphincter		T	0150	32.6184	$2,226.76	.	$445.36
46751	Repair of anal sphincter		C					
46753	Reconstruction of anus		T	0149	24.5978	$1,679.22	.	$335.85
46754	Removal of suture from anus		T	0149	24.5978	$1,679.22	.	$335.85
46760	Repair of anal sphincter		T	0150	32.6184	$2,226.76	.	$445.36
46761	Repair of anal sphincter		T	0150	32.6184	$2,226.76	.	$445.36
46762	Implant artificial sphincter		T	0150	32.6184	$2,226.76	.	$445.36
46900	Destruction, anal lesion(s)		T	0016	2.8176	$192.35	.	$38.47
46910	Destruction, anal lesion(s)		T	0017	21.8217	$1,489.70	.	$297.94
46916	Cryosurgery, anal lesion(s)		T	0015	1.5303	$104.47	.	$20.90
46917	Laser surgery, anal lesions		T	0017	21.8217	$1,489.70	.	$297.94
46922	Excision of anal lesion(s)		T	0017	21.8217	$1,489.70	.	$297.94
46924	Destruction, anal lesion(s)		T	0017	21.8217	$1,489.70	.	$297.94
46930	Destroy internal hemorrhoids		T	0148	6.2678	$427.88	.	$85.58
46940	Treatment of anal fissure		T	0149	24.5978	$1,679.22	.	$335.85
46942	Treatment of anal fissure		T	0148	6.2678	$427.88	.	$85.58
46945	Remove by ligat int hem grp		T	0155	16.1014	$1,099.19	.	$219.84
46946	Remove by ligat int hem grps		T	0155	16.1014	$1,099.19	.	$219.84
46947	Hemorrhoidopexy by stapling		T	0150	32.6184	$2,226.76	.	$445.36
46999	Anus surgery procedure		T	0148	6.2678	$427.88	.	$85.58
47000	Needle biopsy of liver		T	0685	9.9046	$676.16	.	$135.24

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
47001	Needle biopsy, liver add-on		N					
47010	Open drainage, liver lesion		C					
47011	Percut drain, liver lesion		T	0037	15.764	$1,076.16	$228.76	$215.24
47015	Inject/aspirate liver cyst		C					
47100	Wedge biopsy of liver		C					
47120	Partial removal of liver		C					
47122	Extensive removal of liver		C					
47125	Partial removal of liver		C					
47130	Partial removal of liver		C					
47133	Removal of donor liver		C					
47135	Transplantation of liver		C					
47136	Transplantation of liver		C					
47140	Partial removal, donor liver		C					
47141	Partial removal, donor liver		C					
47142	Partial removal, donor liver		C					
47143	Prep donor liver, whole		C					
47144	Prep donor liver, 3-segment		C					
47145	Prep donor liver, lobe split		C					
47146	Prep donor liver/venous		C					
47147	Prep donor liver/arterial		C					
47300	Surgery for liver lesion		C					
47350	Repair liver wound		C					
47360	Repair liver wound		C					
47361	Repair liver wound		C					
47362	Repair liver wound		C					
47370	Laparo ablate liver tumor rf		T	0174	112.2008	$7,659.61	$2,064.24	$1,531.93
47371	Laparo ablate liver cryosurg		T	0174	112.2008	$7,659.61	$2,064.24	$1,531.93
47379	Laparoscope procedure, liver		T	0130	38.7195	$2,643.26	$659.53	$528.66
47380	Open ablate liver tumor rf		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
47381	Open ablate liver tumor cryo		C					
47382	Percut ablate liver rf		T	0423	57.2089	$3,905.48	.	$781.10
47399	Liver surgery procedure		T	0004	4.6624	$318.29	.	$63.66
47400	Incision of liver duct		C					
47420	Incision of bile duct		C					
47425	Incision of bile duct		C					
47460	Incise bile duct sphincter		C					
47480	Incision of gallbladder		C					
47490	Incision of gallbladder		T	0152	32.3789	$2,210.41	.	$442.09
47500	Injection for liver x-rays		N					
47505	Injection for liver x-rays		N					
47510	Insert catheter, bile duct		T	0152	32.3789	$2,210.41	.	$442.09
47511	Insert bile duct drain		T	0152	32.3789	$2,210.41	.	$442.09
47525	Change bile duct catheter		T	0427	16.3601	$1,116.85	.	$223.37
47530	Revise/reinsert bile tube		T	0427	16.3601	$1,116.85	.	$223.37
47550	Bile duct endoscopy add-on		C					
47552	Biliary endoscopy thru skin		T	0152	32.3789	$2,210.41	.	$442.09
47553	Biliary endoscopy thru skin		T	0152	32.3789	$2,210.41	.	$442.09
47554	Biliary endoscopy thru skin		T	0152	32.3789	$2,210.41	.	$442.09
47555	Biliary endoscopy thru skin		T	0152	32.3789	$2,210.41	.	$442.09
47556	Biliary endoscopy thru skin		T	0152	32.3789	$2,210.41	.	$442.09
47560	Laparoscopy w/cholangio		T	0130	38.7195	$2,643.26	$659.53	$528.66
47561	Laparo w/cholangio/biopsy		T	0130	38.7195	$2,643.26	$659.53	$528.66
47562	Laparoscopic cholecystectomy		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
47563	Laparo cholecystectomy/graph		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
47564	Laparo cholecystectomy/explr		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
47570	Laparo cholecystoenterostomy		C					
47579	Laparoscope proc, biliary		T	0130	38.7195	$2,643.26	$659.53	$528.66
47600	Removal of gallbladder		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
47605	Removal of gallbladder		C					
47610	Removal of gallbladder		C					
47612	Removal of gallbladder		C					
47620	Removal of gallbladder		C					
47630	Remove bile duct stone		T	0152	32.3789	$2,210.41	.	$442.09
47700	Exploration of bile ducts		C					
47701	Bile duct revision		C					
47711	Excision of bile duct tumor		C					
47712	Excision of bile duct tumor		C					
47715	Excision of bile duct cyst		C					
47720	Fuse gallbladder & bowel		C					
47721	Fuse upper gi structures		C					
47740	Fuse gallbladder & bowel		C					
47741	Fuse gallbladder & bowel		C					
47760	Fuse bile ducts and bowel		C					
47765	Fuse liver ducts & bowel		C					
47780	Fuse bile ducts and bowel		C					
47785	Fuse bile ducts and bowel		C					
47800	Reconstruction of bile ducts		C					
47801	Placement, bile duct support		C					
47802	Fuse liver duct & intestine		C					
47900	Suture bile duct injury		C					
47999	Bile tract surgery procedure		T	0152	32.3789	$2,210.41	.	$442.09
48000	Drainage of abdomen		C					
48001	Placement of drain, pancreas		C					
48020	Removal of pancreatic stone		C					
48100	Biopsy of pancreas, open		C					
48102	Needle biopsy, pancreas		T	0685	9.9046	$676.16	.	$135.24
48105	Resect/debride pancreas		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
48120	Removal of pancreas lesion		C					
48140	Partial removal of pancreas		C					
48145	Partial removal of pancreas		C					
48146	Pancreatectomy		C					
48148	Removal of pancreatic duct		C					
48150	Partial removal of pancreas		C					
48152	Pancreatectomy		C					
48153	Pancreatectomy		C					
48154	Pancreatectomy		C					
48155	Removal of pancreas		C					
48160	Pancreas removal/transplant		E					
48400	Injection, intraop add-on		C					
48500	Surgery of pancreatic cyst		C					
48510	Drain pancreatic pseudocyst		C					
48511	Drain pancreatic pseudocyst		T	0037	15.764	$1,076.16	$228.76	$215.24
48520	Fuse pancreas cyst and bowel		C					
48540	Fuse pancreas cyst and bowel		C					
48545	Pancreatorrhaphy		C					
48547	Duodenal exclusion		C					
48548	Fuse pancreas and bowel		C					
48550	Donor pancreatectomy		E					
48551	Prep donor pancreas		C					
48552	Prep donor pancreas/venous		C					
48554	Transpl allograft pancreas		C					
48556	Removal, allograft pancreas		C					
48999	Pancreas surgery procedure		T	0004	4.6624	$318.29	.	$63.66
49000	Exploration of abdomen		C					
49002	Reopening of abdomen		C					
49010	Exploration behind abdomen		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
49020	Drain abdominal abscess		C					
49021	Drain abdominal abscess		T	0037	15.764	$1,076.16	$228.76	$215.24
49040	Drain, open, abdom abscess		C					
49041	Drain, percut, abdom abscess		T	0037	15.764	$1,076.16	$228.76	$215.24
49060	Drain, open, retrop abscess		C					
49061	Drain, percut, retroper absc		T	0037	15.764	$1,076.16	$228.76	$215.24
49062	Drain to peritoneal cavity		C					
49080	Puncture, peritoneal cavity		T	0070	5.6491	$385.65	.	$77.13
49081	Removal of abdominal fluid		T	0070	5.6491	$385.65	.	$77.13
49180	Biopsy, abdominal mass		T	0685	9.9046	$676.16	.	$135.24
49203	Exc abd tum 5 cm or less		C					
49204	Exc abd tum over 5 cm		C					
49205	Exc abd tum over 10 cm		C					
49215	Excise sacral spine tumor		C					
49220	Multiple surgery, abdomen		C					
49250	Excision of umbilicus		T	0153	26.2068	$1,789.06	$368.04	$357.82
49255	Removal of omentum		C					
49320	Diag laparo separate proc		T	0130	38.7195	$2,643.26	$659.53	$528.66
49321	Laparoscopy, biopsy		T	0130	38.7195	$2,643.26	$659.53	$528.66
49322	Laparoscopy, aspiration		T	0130	38.7195	$2,643.26	$659.53	$528.66
49323	Laparo drain lymphocele		T	0130	38.7195	$2,643.26	$659.53	$528.66
49324	Lap insertion perm ip cath		T	0130	38.7195	$2,643.26	$659.53	$528.66
49325	Lap revision perm ip cath		T	0130	38.7195	$2,643.26	$659.53	$528.66
49326	Lap w/omentopexy add-on		T	0130	38.7195	$2,643.26	$659.53	$528.66
49329	Laparo proc, abdm/per/oment		T	0130	38.7195	$2,643.26	$659.53	$528.66
49400	Air injection into abdomen		N					
49402	Remove foreign body, adbomen		T	0153	26.2068	$1,789.06	$368.04	$357.82
49411	Ins mark abd/pel for rt perq		X	0310	13.5651	$926.05	$325.27	$185.21
49419	Insrt abdom cath for chemotx		T	0115	33.3074	$2,273.80	.	$454.76

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
49420	Insert abdom drain, temp		T	0652	31.1286	$2,125.06	.	$425.02
49421	Insert abdom drain, perm		T	0652	31.1286	$2,125.06	.	$425.02
49422	Remove perm cannula/catheter		T	0105	23.2281	$1,585.71	.	$317.15
49423	Exchange drainage catheter		T	0427	16.3601	$1,116.85	.	$223.37
49424	Assess cyst, contrast inject		N					
49425	Insert abdomen-venous drain		C					
49426	Revise abdomen-venous shunt		T	0153	26.2068	$1,789.06	$368.04	$357.82
49427	Injection, abdominal shunt		N					
49428	Ligation of shunt		C					
49429	Removal of shunt		T	0105	23.2281	$1,585.71	.	$317.15
49435	Insert subq exten to ip cath		T	0427	16.3601	$1,116.85	.	$223.37
49436	Embedded ip cath exit-site		T	0427	16.3601	$1,116.85	.	$223.37
49440	Place gastrostomy tube perc		T	0141	8.8811	$606.29	$143.38	$121.26
49441	Place duod/jej tube perc		T	0141	8.8811	$606.29	$143.38	$121.26
49442	Place cecostomy tube perc		T	0155	16.1014	$1,099.19	.	$219.84
49446	Change g-tube to g-j perc		T	0141	8.8811	$606.29	$143.38	$121.26
49450	Replace g/c tube perc		T	0121	6.3264	$431.88	.	$86.38
49451	Replace duod/jej tube perc		T	0121	6.3264	$431.88	.	$86.38
49452	Replace g-j tube perc		T	0121	6.3264	$431.88	.	$86.38
49460	Fix g/colon tube w/device		T	0121	6.3264	$431.88	.	$86.38
49465	Fluoro exam of g/colon tube	CH	Q1	0277	2.0916	$142.79	$53.90	$28.56
49491	Rpr hern preemie reduc		T	0154	33.368	$2,277.93	$464.85	$455.59
49492	Rpr ing hern premie, blocked		T	0154	33.368	$2,277.93	$464.85	$455.59
49495	Rpr ing hernia baby, reduc		T	0154	33.368	$2,277.93	$464.85	$455.59
49496	Rpr ing hernia baby, blocked		T	0154	33.368	$2,277.93	$464.85	$455.59
49500	Rpr ing hernia, init, reduce		T	0154	33.368	$2,277.93	$464.85	$455.59
49501	Rpr ing hernia, init blocked		T	0154	33.368	$2,277.93	$464.85	$455.59
49505	Prp i/hern init reduc >5 yr		T	0154	33.368	$2,277.93	$464.85	$455.59
49507	Prp i/hern init block >5 yr		T	0154	33.368	$2,277.93	$464.85	$455.59

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
49520	Rerepair ing hernia, reduce		T	0154	33.368	$2,277.93	$464.85	$455.59
49521	Rerepair ing hernia, blocked		T	0154	33.368	$2,277.93	$464.85	$455.59
49525	Repair ing hernia, sliding		T	0154	33.368	$2,277.93	$464.85	$455.59
49540	Repair lumbar hernia		T	0154	33.368	$2,277.93	$464.85	$455.59
49550	Rpr rem hernia, init, reduce		T	0154	33.368	$2,277.93	$464.85	$455.59
49553	Rpr fem hernia, init blocked		T	0154	33.368	$2,277.93	$464.85	$455.59
49555	Rerepair fem hernia, reduce		T	0154	33.368	$2,277.93	$464.85	$455.59
49557	Rerepair fem hernia, blocked		T	0154	33.368	$2,277.93	$464.85	$455.59
49560	Rpr ventral hern init, reduc		T	0154	33.368	$2,277.93	$464.85	$455.59
49561	Rpr ventral hern init, block		T	0154	33.368	$2,277.93	$464.85	$455.59
49565	Rerepair ventrl hern, reduce		T	0154	33.368	$2,277.93	$464.85	$455.59
49566	Rerepair ventrl hern, block		T	0154	33.368	$2,277.93	$464.85	$455.59
49568	Hernia repair w/mesh		T	0154	33.368	$2,277.93	$464.85	$455.59
49570	Rpr epigastric hern, reduce		T	0154	33.368	$2,277.93	$464.85	$455.59
49572	Rpr epigastric hern, blocked		T	0154	33.368	$2,277.93	$464.85	$455.59
49580	Rpr umbil hern, reduc < 5 yr		T	0154	33.368	$2,277.93	$464.85	$455.59
49582	Rpr umbil hern, block < 5 yr		T	0154	33.368	$2,277.93	$464.85	$455.59
49585	Rpr umbil hern, reduc > 5 yr		T	0154	33.368	$2,277.93	$464.85	$455.59
49587	Rpr umbil hern, block > 5 yr		T	0154	33.368	$2,277.93	$464.85	$455.59
49590	Repair spigelian hernia		T	0154	33.368	$2,277.93	$464.85	$455.59
49600	Repair umbilical lesion		T	0154	33.368	$2,277.93	$464.85	$455.59
49605	Repair umbilical lesion		C					
49606	Repair umbilical lesion		C					
49610	Repair umbilical lesion		C					
49611	Repair umbilical lesion		C					
49650	Lap ing hernia repair init		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
49651	Lap ing hernia repair recur		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
49652	Lap vent/abd hernia repair		T	0132	71.1086	$4,854.37	$1,226.23	$970.88
49653	Lap vent/abd hern proc comp		T	0132	71.1086	$4,854.37	$1,226.23	$970.88

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
49654	Lap inc hernia repair		T	0132	71.1086	$4,854.37	$1,226.23	$970.88
49655	Lap inc hern repair comp		T	0132	71.1086	$4,854.37	$1,226.23	$970.88
49656	Lap inc hernia repair recur		T	0132	71.1086	$4,854.37	$1,226.23	$970.88
49657	Lap inc hern recur comp		T	0132	71.1086	$4,854.37	$1,226.23	$970.88
49659	Laparo proc, hernia repair		T	0130	38.7195	$2,643.26	$659.53	$528.66
49900	Repair of abdominal wall		C					
49904	Omental flap, extra-abdom		C					
49905	Omental flap, intra-abdom		C					
49906	Free omental flap, microvasc		C					
49999	Abdomen surgery procedure		T	0153	26.2068	$1,789.06	$368.04	$357.82
50010	Exploration of kidney		C					
50020	Renal abscess, open drain		T	0162	26.4198	$1,803.60	.	$360.72
50021	Renal abscess, percut drain		T	0037	15.764	$1,076.16	$228.76	$215.24
50040	Drainage of kidney		C					
50045	Exploration of kidney		C					
50060	Removal of kidney stone		C					
50065	Incision of kidney		C					
50070	Incision of kidney		C					
50075	Removal of kidney stone		C					
50080	Removal of kidney stone		T	0429	46.5713	$3,179.28	.	$635.86
50081	Removal of kidney stone		T	0429	46.5713	$3,179.28	.	$635.86
50100	Revise kidney blood vessels		C					
50120	Exploration of kidney		C					
50125	Explore and drain kidney		C					
50130	Removal of kidney stone		C					
50135	Exploration of kidney		C					
50200	Renal biopsy perq		T	0685	9.9046	$676.16	.	$135.24
50205	Renal biopsy open		C					
50220	Remove kidney, open		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
50225	Removal kidney open, complex		C					
50230	Removal kidney open, radical		C					
50234	Removal of kidney & ureter		C					
50236	Removal of kidney & ureter		C					
50240	Partial removal of kidney		C					
50250	Cryoablate renal mass open		C					
50280	Removal of kidney lesion		C					
50290	Removal of kidney lesion		C					
50300	Remove cadaver donor kidney		C					
50320	Remove kidney, living donor		C					
50323	Prep cadaver renal allograft		C					
50325	Prep donor renal graft		C					
50327	Prep renal graft/venous		C					
50328	Prep renal graft/arterial		C					
50329	Prep renal graft/ureteral		C					
50340	Removal of kidney		C					
50360	Transplantation of kidney		C					
50365	Transplantation of kidney		C					
50370	Remove transplanted kidney		C					
50380	Reimplantation of kidney		C					
50382	Change ureter stent, percut		T	0162	26.4198	$1,803.60	.	$360.72
50384	Remove ureter stent, percut		T	0161	17.7215	$1,209.79	.	$241.96
50385	Change stent via transureth		T	0162	26.4198	$1,803.60	.	$360.72
50386	Remove stent via transureth		T	0160	7.2012	$491.60	.	$98.32
50387	Change ext/int ureter stent		T	0427	16.3601	$1,116.85	.	$223.37
50389	Remove renal tube w/fluoro		T	0160	7.2012	$491.60	.	$98.32
50390	Drainage of kidney lesion		T	0685	9.9046	$676.16	.	$135.24
50391	Instll rx agnt into rnal tub		T	0126	1.0983	$74.98	$16.21	$15.00
50392	Insert kidney drain		T	0161	17.7215	$1,209.79	.	$241.96

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
50393	Insert ureteral tube		T	0162	26.4198	$1,803.60	.	$360.72
50394	Injection for kidney x-ray		N					
50395	Create passage to kidney		T	0162	26.4198	$1,803.60	.	$360.72
50396	Measure kidney pressure		T	0164	2.0672	$141.12	.	$28.23
50398	Change kidney tube		T	0427	16.3601	$1,116.85	.	$223.37
50400	Revision of kidney/ureter		C					
50405	Revision of kidney/ureter		C					
50500	Repair of kidney wound		C					
50520	Close kidney-skin fistula		C					
50525	Repair renal-abdomen fistula		C					
50526	Repair renal-abdomen fistula		C					
50540	Revision of horseshoe kidney		C					
50541	Laparo ablate renal cyst		T	0130	38.7195	$2,643.26	$659.53	$528.66
50542	Laparo ablate renal mass		T	0174	112.2008	$7,659.61	$2,064.24	$1,531.93
50543	Laparo partial nephrectomy		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
50544	Laparoscopy, pyeloplasty		T	0130	38.7195	$2,643.26	$659.53	$528.66
50545	Laparo radical nephrectomy		C					
50546	Laparoscopic nephrectomy		C					
50547	Laparo removal donor kidney		C					
50548	Laparo remove w/ureter		C					
50549	Laparoscope proc, renal		T	0130	38.7195	$2,643.26	$659.53	$528.66
50551	Kidney endoscopy		T	0160	7.2012	$491.60	.	$98.32
50553	Kidney endoscopy		T	0162	26.4198	$1,803.60	.	$360.72
50555	Kidney endoscopy & biopsy		T	0160	7.2012	$491.60	.	$98.32
50557	Kidney endoscopy & treatment		T	0162	26.4198	$1,803.60	.	$360.72
50561	Kidney endoscopy & treatment		T	0162	26.4198	$1,803.60	.	$360.72
50562	Renal scope w/tumor resect		T	0160	7.2012	$491.60	.	$98.32
50570	Kidney endoscopy		T	0160	7.2012	$491.60	.	$98.32
50572	Kidney endoscopy		T	0160	7.2012	$491.60	.	$98.32

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
50574	Kidney endoscopy & biopsy		T	0160	7.2012	$491.60	.	$98.32
50575	Kidney endoscopy		T	0163	37.4369	$2,555.70	.	$511.14
50576	Kidney endoscopy & treatment		T	0161	17.7215	$1,209.79	.	$241.96
50580	Kidney endoscopy & treatment		T	0161	17.7215	$1,209.79	.	$241.96
50590	Fragmenting of kidney stone		T	0169	41.7267	$2,848.56	$997.74	$569.72
50592	Perc rf ablate renal tumor		T	0423	57.2089	$3,905.48	.	$781.10
50593	Perc cryo ablate renal tum		T	0423	57.2089	$3,905.48	.	$781.10
50600	Exploration of ureter		C					
50605	Insert ureteral support		C					
50610	Removal of ureter stone		C					
50620	Removal of ureter stone		C					
50630	Removal of ureter stone		C					
50650	Removal of ureter		C					
50660	Removal of ureter		C					
50684	Injection for ureter x-ray		N					
50686	Measure ureter pressure		T	0126	1.0983	$74.98	$16.21	$15.00
50688	Change of ureter tube/stent		T	0427	16.3601	$1,116.85	.	$223.37
50690	Injection for ureter x-ray		N					
50700	Revision of ureter		C					
50715	Release of ureter		C					
50722	Release of ureter		C					
50725	Release/revise ureter		C					
50727	Revise ureter		T	0165	20.5471	$1,402.69	.	$280.54
50728	Revise ureter		C					
50740	Fusion of ureter & kidney		C					
50750	Fusion of ureter & kidney		C					
50760	Fusion of ureters		C					
50770	Splicing of ureters		C					
50780	Reimplant ureter in bladder		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
50782	Reimplant ureter in bladder		C					
50783	Reimplant ureter in bladder		C					
50785	Reimplant ureter in bladder		C					
50800	Implant ureter in bowel		C					
50810	Fusion of ureter & bowel		C					
50815	Urine shunt to intestine		C					
50820	Construct bowel bladder		C					
50825	Construct bowel bladder		C					
50830	Revise urine flow		C					
50840	Replace ureter by bowel		C					
50845	Appendico-vesicostomy		C					
50860	Transplant ureter to skin		C					
50900	Repair of ureter		C					
50920	Closure ureter/skin fistula		C					
50930	Closure ureter/bowel fistula		C					
50940	Release of ureter		C					
50945	Laparoscopy ureterolithotomy		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
50947	Laparo new ureter/bladder		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
50948	Laparo new ureter/bladder		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
50949	Laparoscope proc, ureter		T	0130	38.7195	$2,643.26	$659.53	$528.66
50951	Endoscopy of ureter		T	0160	7.2012	$491.60	.	$98.32
50953	Endoscopy of ureter		T	0160	7.2012	$491.60	.	$98.32
50955	Ureter endoscopy & biopsy		T	0162	26.4198	$1,803.60	.	$360.72
50957	Ureter endoscopy & treatment		T	0162	26.4198	$1,803.60	.	$360.72
50961	Ureter endoscopy & treatment		T	0162	26.4198	$1,803.60	.	$360.72
50970	Ureter endoscopy		T	0160	7.2012	$491.60	.	$98.32
50972	Ureter endoscopy & catheter		T	0160	7.2012	$491.60	.	$98.32
50974	Ureter endoscopy & biopsy		T	0161	17.7215	$1,209.79	.	$241.96
50976	Ureter endoscopy & treatment		T	0161	17.7215	$1,209.79	.	$241.96

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
50980	Ureter endoscopy & treatment		T	0162	26.4198	$1,803.60	.	$360.72
51020	Incise & treat bladder		T	0162	26.4198	$1,803.60	.	$360.72
51030	Incise & treat bladder		T	0162	26.4198	$1,803.60	.	$360.72
51040	Incise & drain bladder		T	0162	26.4198	$1,803.60	.	$360.72
51045	Incise bladder/drain ureter		T	0160	7.2012	$491.60	.	$98.32
51050	Removal of bladder stone		T	0162	26.4198	$1,803.60	.	$360.72
51060	Removal of ureter stone		T	0163	37.4369	$2,555.70	.	$511.14
51065	Remove ureter calculus		T	0162	26.4198	$1,803.60	.	$360.72
51080	Drainage of bladder abscess		T	0008	20.2481	$1,382.28	.	$276.46
51100	Drain bladder by needle		T	0164	2.0672	$141.12	.	$28.23
51101	Drain bladder by trocar/cath		T	0126	1.0983	$74.98	$16.21	$15.00
51102	Drain bl w/cath insertion		T	0165	20.5471	$1,402.69	.	$280.54
51500	Removal of bladder cyst		T	0154	33.368	$2,277.93	$464.85	$455.59
51520	Removal of bladder lesion		T	0162	26.4198	$1,803.60	.	$360.72
51525	Removal of bladder lesion		C					
51530	Removal of bladder lesion		C					
51535	Repair of ureter lesion		T	0162	26.4198	$1,803.60	.	$360.72
51550	Partial removal of bladder		C					
51555	Partial removal of bladder		C					
51565	Revise bladder & ureter(s)		C					
51570	Removal of bladder		C					
51575	Removal of bladder & nodes		C					
51580	Remove bladder/revise tract		C					
51585	Removal of bladder & nodes		C					
51590	Remove bladder/revise tract		C					
51595	Remove bladder/revise tract		C					
51596	Remove bladder/create pouch		C					
51597	Removal of pelvic structures		C					
51600	Injection for bladder x-ray		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
51605	Preparation for bladder xray		N					
51610	Injection for bladder x-ray		N					
51700	Irrigation of bladder		T	0164	2.0672	$141.12	.	$28.23
51701	Insert bladder catheter		X	0340	0.6899	$47.10	.	$9.42
51702	Insert temp bladder cath		X	0340	0.6899	$47.10	.	$9.42
51703	Insert bladder cath, complex		T	0126	1.0983	$74.98	$16.21	$15.00
51705	Change of bladder tube		T	0164	2.0672	$141.12	.	$28.23
51710	Change of bladder tube		T	0121	6.3264	$431.88	.	$86.38
51715	Endoscopic injection/implant		T	0168	32.3809	$2,210.55	.	$442.11
51720	Treatment of bladder lesion		T	0156	3.0859	$210.67	.	$42.14
51725	Simple cystometrogram		T	0156	3.0859	$210.67	.	$42.14
51726	Complex cystometrogram		T	0156	3.0859	$210.67	.	$42.14
51727	Cystometrogram w/up		T	0156	3.0859	$210.67	.	$42.14
51728	Cystometrogram w/vp		T	0156	3.0859	$210.67	.	$42.14
51729	Cystometrogram w/vp&up		T	0156	3.0859	$210.67	.	$42.14
51736	Urine flow measurement	CH	X	0340	0.6899	$47.10	.	$9.42
51741	Electro-uroflowmetry, first		T	0126	1.0983	$74.98	$16.21	$15.00
51784	Anal/urinary muscle study		T	0126	1.0983	$74.98	$16.21	$15.00
51785	Anal/urinary muscle study		T	0164	2.0672	$141.12	.	$28.23
51792	Urinary reflex study		T	0126	1.0983	$74.98	$16.21	$15.00
51797	Intraabdominal pressure test		T	0164	2.0672	$141.12	.	$28.23
51798	Us urine capacity measure		X	0340	0.6899	$47.10	.	$9.42
51800	Revision of bladder/urethra		C					
51820	Revision of urinary tract		C					
51840	Attach bladder/urethra		C					
51841	Attach bladder/urethra		C					
51845	Repair bladder neck		T	0202	45.2093	$3,086.30	$981.50	$617.26
51860	Repair of bladder wound		T	0162	26.4198	$1,803.60	.	$360.72
51865	Repair of bladder wound		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
51880	Repair of bladder opening		T	0162	26.4198	$1,803.60	.	$360.72
51900	Repair bladder/vagina lesion		C					
51920	Close bladder-uterus fistula		C					
51925	Hysterectomy/bladder repair		C					
51940	Correction of bladder defect		C					
51960	Revision of bladder & bowel		C					
51980	Construct bladder opening		C					
51990	Laparo urethral suspension		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
51992	Laparo sling operation		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
51999	Laparoscope proc, bla		T	0130	38.7195	$2,643.26	$659.53	$528.66
52000	Cystoscopy		T	0160	7.2012	$491.60	.	$98.32
52001	Cystoscopy, removal of clots		T	0161	17.7215	$1,209.79	.	$241.96
52005	Cystoscopy & ureter catheter		T	0162	26.4198	$1,803.60	.	$360.72
52007	Cystoscopy and biopsy		T	0162	26.4198	$1,803.60	.	$360.72
52010	Cystoscopy & duct catheter		T	0160	7.2012	$491.60	.	$98.32
52204	Cystoscopy w/biopsy(s)		T	0162	26.4198	$1,803.60	.	$360.72
52214	Cystoscopy and treatment		T	0162	26.4198	$1,803.60	.	$360.72
52224	Cystoscopy and treatment		T	0162	26.4198	$1,803.60	.	$360.72
52234	Cystoscopy and treatment		T	0162	26.4198	$1,803.60	.	$360.72
52235	Cystoscopy and treatment		T	0162	26.4198	$1,803.60	.	$360.72
52240	Cystoscopy and treatment		T	0162	26.4198	$1,803.60	.	$360.72
52250	Cystoscopy and radiotracer		T	0162	26.4198	$1,803.60	.	$360.72
52260	Cystoscopy and treatment		T	0161	17.7215	$1,209.79	.	$241.96
52265	Cystoscopy and treatment		T	0160	7.2012	$491.60	.	$98.32
52270	Cystoscopy & revise urethra		T	0161	17.7215	$1,209.79	.	$241.96
52275	Cystoscopy & revise urethra		T	0162	26.4198	$1,803.60	.	$360.72
52276	Cystoscopy and treatment		T	0162	26.4198	$1,803.60	.	$360.72
52277	Cystoscopy and treatment		T	0162	26.4198	$1,803.60	.	$360.72
52281	Cystoscopy and treatment		T	0161	17.7215	$1,209.79	.	$241.96

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
52282	Cystoscopy, implant stent		T	0163	37.4369	$2,555.70	.	$511.14
52283	Cystoscopy and treatment		T	0162	26.4198	$1,803.60	.	$360.72
52285	Cystoscopy and treatment		T	0161	17.7215	$1,209.79	.	$241.96
52290	Cystoscopy and treatment		T	0162	26.4198	$1,803.60	.	$360.72
52300	Cystoscopy and treatment		T	0162	26.4198	$1,803.60	.	$360.72
52301	Cystoscopy and treatment		T	0162	26.4198	$1,803.60	.	$360.72
52305	Cystoscopy and treatment		T	0162	26.4198	$1,803.60	.	$360.72
52310	Cystoscopy and treatment		T	0161	17.7215	$1,209.79	.	$241.96
52315	Cystoscopy and treatment		T	0162	26.4198	$1,803.60	.	$360.72
52317	Remove bladder stone		T	0162	26.4198	$1,803.60	.	$360.72
52318	Remove bladder stone		T	0162	26.4198	$1,803.60	.	$360.72
52320	Cystoscopy and treatment		T	0162	26.4198	$1,803.60	.	$360.72
52325	Cystoscopy, stone removal		T	0162	26.4198	$1,803.60	.	$360.72
52327	Cystoscopy, inject material		T	0163	37.4369	$2,555.70	.	$511.14
52330	Cystoscopy and treatment		T	0162	26.4198	$1,803.60	.	$360.72
52332	Cystoscopy and treatment		T	0162	26.4198	$1,803.60	.	$360.72
52334	Create passage to kidney		T	0162	26.4198	$1,803.60	.	$360.72
52341	Cysto w/ureter stricture tx		T	0162	26.4198	$1,803.60	.	$360.72
52342	Cysto w/up stricture tx		T	0162	26.4198	$1,803.60	.	$360.72
52343	Cysto w/renal stricture tx		T	0162	26.4198	$1,803.60	.	$360.72
52344	Cysto/uretero, stricture tx		T	0162	26.4198	$1,803.60	.	$360.72
52345	Cysto/uretero w/up stricture		T	0162	26.4198	$1,803.60	.	$360.72
52346	Cystouretero w/renal strict		T	0162	26.4198	$1,803.60	.	$360.72
52351	Cystouretero & or pyeloscope		T	0162	26.4198	$1,803.60	.	$360.72
52352	Cystouretero w/stone remove		T	0162	26.4198	$1,803.60	.	$360.72
52353	Cystouretero w/lithotripsy		T	0163	37.4369	$2,555.70	.	$511.14
52354	Cystouretero w/biopsy		T	0162	26.4198	$1,803.60	.	$360.72
52355	Cystouretero w/excise tumor		T	0162	26.4198	$1,803.60	.	$360.72
52400	Cystouretero w/congen repr		T	0162	26.4198	$1,803.60	.	$360.72

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
52402	Cystourethro cut ejacul duct		T	0162	26.4198	$1,803.60	.	$360.72
52450	Incision of prostate		T	0162	26.4198	$1,803.60	.	$360.72
52500	Revision of bladder neck		T	0162	26.4198	$1,803.60	.	$360.72
52601	Prostatectomy (TURP)		T	0163	37.4369	$2,555.70	.	$511.14
52630	Remove prostate regrowth		T	0163	37.4369	$2,555.70	.	$511.14
52640	Relieve bladder contracture		T	0162	26.4198	$1,803.60	.	$360.72
52647	Laser surgery of prostate		T	0429	46.5713	$3,179.28	.	$635.86
52648	Laser surgery of prostate		T	0429	46.5713	$3,179.28	.	$635.86
52649	Prostate laser enucleation		T	0429	46.5713	$3,179.28	.	$635.86
52700	Drainage of prostate abscess		T	0162	26.4198	$1,803.60	.	$360.72
53000	Incision of urethra		T	0166	21.3781	$1,459.42	.	$291.89
53010	Incision of urethra		T	0166	21.3781	$1,459.42	.	$291.89
53020	Incision of urethra		T	0166	21.3781	$1,459.42	.	$291.89
53025	Incision of urethra		T	0166	21.3781	$1,459.42	.	$291.89
53040	Drainage of urethra abscess		T	0166	21.3781	$1,459.42	.	$291.89
53060	Drainage of urethra abscess		T	0166	21.3781	$1,459.42	.	$291.89
53080	Drainage of urinary leakage		T	0166	21.3781	$1,459.42	.	$291.89
53085	Drainage of urinary leakage		T	0166	21.3781	$1,459.42	.	$291.89
53200	Biopsy of urethra		T	0166	21.3781	$1,459.42	.	$291.89
53210	Removal of urethra		T	0168	32.3809	$2,210.55	.	$442.11
53215	Removal of urethra		T	0166	21.3781	$1,459.42	.	$291.89
53220	Treatment of urethra lesion		T	0168	32.3809	$2,210.55	.	$442.11
53230	Removal of urethra lesion		T	0168	32.3809	$2,210.55	.	$442.11
53235	Removal of urethra lesion		T	0166	21.3781	$1,459.42	.	$291.89
53240	Surgery for urethra pouch		T	0168	32.3809	$2,210.55	.	$442.11
53250	Removal of urethra gland		T	0166	21.3781	$1,459.42	.	$291.89
53260	Treatment of urethra lesion		T	0166	21.3781	$1,459.42	.	$291.89
53265	Treatment of urethra lesion		T	0166	21.3781	$1,459.42	.	$291.89
53270	Removal of urethra gland		T	0166	21.3781	$1,459.42	.	$291.89

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
53275	Repair of urethra defect		T	0166	21.3781	$1,459.42	.	$291.89
53400	Revise urethra, stage 1		T	0168	32.3809	$2,210.55	.	$442.11
53405	Revise urethra, stage 2		T	0168	32.3809	$2,210.55	.	$442.11
53410	Reconstruction of urethra		T	0168	32.3809	$2,210.55	.	$442.11
53415	Reconstruction of urethra		C					
53420	Reconstruct urethra, stage 1		T	0168	32.3809	$2,210.55	.	$442.11
53425	Reconstruct urethra, stage 2		T	0168	32.3809	$2,210.55	.	$442.11
53430	Reconstruction of urethra		T	0168	32.3809	$2,210.55	.	$442.11
53431	Reconstruct urethra/bladder		T	0168	32.3809	$2,210.55	.	$442.11
53440	Male sling procedure		S	0385	102.2894	$6,982.99	.	$1,396.60
53442	Remove/revise male sling		T	0168	32.3809	$2,210.55	.	$442.11
53444	Insert tandem cuff		S	0385	102.2894	$6,982.99	.	$1,396.60
53445	Insert uro/ves nck sphincter		S	0386	168.1193	$11,477.00	.	$2,295.40
53446	Remove uro sphincter		T	0168	32.3809	$2,210.55	.	$442.11
53447	Remove/replace ur sphincter		S	0386	168.1193	$11,477.00	.	$2,295.40
53448	Remov/replc ur sphinctr comp		C					
53449	Repair uro sphincter		T	0168	32.3809	$2,210.55	.	$442.11
53450	Revision of urethra		T	0168	32.3809	$2,210.55	.	$442.11
53460	Revision of urethra		T	0166	21.3781	$1,459.42	.	$291.89
53500	Urethrlys, transvag w/ scope		T	0168	32.3809	$2,210.55	.	$442.11
53502	Repair of urethra injury		T	0166	21.3781	$1,459.42	.	$291.89
53505	Repair of urethra injury		T	0168	32.3809	$2,210.55	.	$442.11
53510	Repair of urethra injury		T	0166	21.3781	$1,459.42	.	$291.89
53515	Repair of urethra injury		T	0168	32.3809	$2,210.55	.	$442.11
53520	Repair of urethra defect		T	0168	32.3809	$2,210.55	.	$442.11
53600	Dilate urethra stricture		T	0156	3.0859	$210.67	.	$42.14
53601	Dilate urethra stricture		T	0126	1.0983	$74.98	$16.21	$15.00
53605	Dilate urethra stricture		T	0161	17.7215	$1,209.79	.	$241.96
53620	Dilate urethra stricture		T	0165	20.5471	$1,402.69	.	$280.54

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
53621	Dilate urethra stricture		T	0164	2.0672	$141.12	.	$28.23
53660	Dilation of urethra		T	0126	1.0983	$74.98	$16.21	$15.00
53661	Dilation of urethra		T	0126	1.0983	$74.98	$16.21	$15.00
53665	Dilation of urethra		T	0166	21.3781	$1,459.42	.	$291.89
53850	Prostatic microwave thermotx		T	0429	46.5713	$3,179.28	.	$635.86
53852	Prostatic rf thermotx		T	0429	46.5713	$3,179.28	.	$635.86
53855	Insert prost urethral stent		T	0164	2.0672	$141.12	.	$28.23
53899	Urology surgery procedure		T	0126	1.0983	$74.98	$16.21	$15.00
54000	Slitting of prepuce		T	0166	21.3781	$1,459.42	.	$291.89
54001	Slitting of prepuce		T	0166	21.3781	$1,459.42	.	$291.89
54015	Drain penis lesion		T	0008	20.2481	$1,382.28	.	$276.46
54050	Destruction, penis lesion(s)		T	0013	0.8782	$59.95	.	$11.99
54055	Destruction, penis lesion(s)		T	0017	21.8217	$1,489.70	.	$297.94
54056	Cryosurgery, penis lesion(s)		T	0013	0.8782	$59.95	.	$11.99
54057	Laser surg, penis lesion(s)		T	0017	21.8217	$1,489.70	.	$297.94
54060	Excision of penis lesion(s)		T	0017	21.8217	$1,489.70	.	$297.94
54065	Destruction, penis lesion(s)		T	0017	21.8217	$1,489.70	.	$297.94
54100	Biopsy of penis		T	0021	18.2223	$1,243.98	.	$248.80
54105	Biopsy of penis		T	0022	24.1269	$1,647.07	$354.45	$329.42
54110	Treatment of penis lesion		T	0181	36.4186	$2,486.19	$620.84	$497.24
54111	Treat penis lesion, graft		T	0181	36.4186	$2,486.19	$620.84	$497.24
54112	Treat penis lesion, graft		T	0181	36.4186	$2,486.19	$620.84	$497.24
54115	Treatment of penis lesion		T	0008	20.2481	$1,382.28	.	$276.46
54120	Partial removal of penis		T	0181	36.4186	$2,486.19	$620.84	$497.24
54125	Removal of penis		C					
54130	Remove penis & nodes		C					
54135	Remove penis & nodes		C					
54150	Circumcision w/regionl block		T	0183	23.7895	$1,624.04	.	$324.81
54160	Circumcision, neonate		T	0183	23.7895	$1,624.04	.	$324.81

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
54161	Circum 28 days or older		T	0183	23.7895	$1,624.04	.	$324.81
54162	Lysis penil circumic lesion		T	0183	23.7895	$1,624.04	.	$324.81
54163	Repair of circumcision		T	0183	23.7895	$1,624.04	.	$324.81
54164	Frenulotomy of penis		T	0183	23.7895	$1,624.04	.	$324.81
54200	Treatment of penis lesion		T	0164	2.0672	$141.12	.	$28.23
54205	Treatment of penis lesion		T	0181	36.4186	$2,486.19	$620.84	$497.24
54220	Treatment of penis lesion		T	0164	2.0672	$141.12	.	$28.23
54230	Prepare penis study		N					
54231	Dynamic cavernosometry		T	0165	20.5471	$1,402.69	.	$280.54
54235	Penile injection	CH	T	0156	3.0859	$210.67	.	$42.14
54240	Penis study		T	0126	1.0983	$74.98	$16.21	$15.00
54250	Penis study		T	0164	2.0672	$141.12	.	$28.23
54300	Revision of penis		T	0181	36.4186	$2,486.19	$620.84	$497.24
54304	Revision of penis		T	0181	36.4186	$2,486.19	$620.84	$497.24
54308	Reconstruction of urethra		T	0181	36.4186	$2,486.19	$620.84	$497.24
54312	Reconstruction of urethra		T	0181	36.4186	$2,486.19	$620.84	$497.24
54316	Reconstruction of urethra		T	0181	36.4186	$2,486.19	$620.84	$497.24
54318	Reconstruction of urethra		T	0181	36.4186	$2,486.19	$620.84	$497.24
54322	Reconstruction of urethra		T	0181	36.4186	$2,486.19	$620.84	$497.24
54324	Reconstruction of urethra		T	0181	36.4186	$2,486.19	$620.84	$497.24
54326	Reconstruction of urethra		T	0181	36.4186	$2,486.19	$620.84	$497.24
54328	Revise penis/urethra		T	0181	36.4186	$2,486.19	$620.84	$497.24
54332	Revise penis/urethra		T	0181	36.4186	$2,486.19	$620.84	$497.24
54336	Revise penis/urethra		T	0181	36.4186	$2,486.19	$620.84	$497.24
54340	Secondary urethral surgery		T	0181	36.4186	$2,486.19	$620.84	$497.24
54344	Secondary urethral surgery		T	0181	36.4186	$2,486.19	$620.84	$497.24
54348	Secondary urethral surgery		T	0181	36.4186	$2,486.19	$620.84	$497.24
54352	Reconstruct urethra/penis		T	0181	36.4186	$2,486.19	$620.84	$497.24
54360	Penis plastic surgery		T	0181	36.4186	$2,486.19	$620.84	$497.24

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
54380	Repair penis		T	0181	36.4186	$2,486.19	$620.84	$497.24
54385	Repair penis		T	0181	36.4186	$2,486.19	$620.84	$497.24
54390	Repair penis and bladder		C					
54400	Insert semi-rigid prosthesis		S	0385	102.2894	$6,982.99	.	$1,396.60
54401	Insert self-contd prosthesis		S	0386	168.1193	$11,477.00	.	$2,295.40
54405	Insert multi-comp penis pros		S	0386	168.1193	$11,477.00	.	$2,295.40
54406	Remove muti-comp penis pros		T	0181	36.4186	$2,486.19	$620.84	$497.24
54408	Repair multi-comp penis pros		T	0181	36.4186	$2,486.19	$620.84	$497.24
54410	Remove/replace penis prosth		S	0386	168.1193	$11,477.00	.	$2,295.40
54411	Remov/replc penis pros, comp		C					
54415	Remove self-contd penis pros		T	0181	36.4186	$2,486.19	$620.84	$497.24
54416	Remv/repl penis contain pros		S	0386	168.1193	$11,477.00	.	$2,295.40
54417	Remv/replc penis pros, compl		C					
54420	Revision of penis		T	0181	36.4186	$2,486.19	$620.84	$497.24
54430	Revision of penis		C					
54435	Revision of penis		T	0181	36.4186	$2,486.19	$620.84	$497.24
54440	Repair of penis		T	0181	36.4186	$2,486.19	$620.84	$497.24
54450	Preputial stretching		T	0156	3.0859	$210.67	.	$42.14
54500	Biopsy of testis		T	0037	15.764	$1,076.16	$228.76	$215.24
54505	Biopsy of testis		T	0183	23.7895	$1,624.04	.	$324.81
54512	Excise lesion testis		T	0183	23.7895	$1,624.04	.	$324.81
54520	Removal of testis		T	0183	23.7895	$1,624.04	.	$324.81
54522	Orchiectomy, partial		T	0183	23.7895	$1,624.04	.	$324.81
54530	Removal of testis		T	0154	33.368	$2,277.93	$464.85	$455.59
54535	Extensive testis surgery		T	0181	36.4186	$2,486.19	$620.84	$497.24
54550	Exploration for testis		T	0154	33.368	$2,277.93	$464.85	$455.59
54560	Exploration for testis		T	0183	23.7895	$1,624.04	.	$324.81
54600	Reduce testis torsion		T	0183	23.7895	$1,624.04	.	$324.81
54620	Suspension of testis		T	0183	23.7895	$1,624.04	.	$324.81

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
54640	Suspension of testis		T	0154	33.368	$2,277.93	$464.85	$455.59
54650	Orchiopexy (Fowler-Stephens)		C					
54660	Revision of testis		T	0183	23.7895	$1,624.04	.	$324.81
54670	Repair testis injury		T	0183	23.7895	$1,624.04	.	$324.81
54680	Relocation of testis(es)		T	0183	23.7895	$1,624.04	.	$324.81
54690	Laparoscopy, orchiectomy		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
54692	Laparoscopy, orchiopexy		T	0132	71.1086	$4,854.37	$1,226.23	$970.88
54699	Laparoscope proc, testis		T	0130	38.7195	$2,643.26	$659.53	$528.66
54700	Drainage of scrotum		T	0183	23.7895	$1,624.04	.	$324.81
54800	Biopsy of epididymis		T	0004	4.6624	$318.29	.	$63.66
54830	Remove epididymis lesion		T	0183	23.7895	$1,624.04	.	$324.81
54840	Remove epididymis lesion		T	0183	23.7895	$1,624.04	.	$324.81
54860	Removal of epididymis		T	0183	23.7895	$1,624.04	.	$324.81
54861	Removal of epididymis		T	0183	23.7895	$1,624.04	.	$324.81
54865	Explore epididymis		T	0183	23.7895	$1,624.04	.	$324.81
54900	Fusion of spermatic ducts		T	0183	23.7895	$1,624.04	.	$324.81
54901	Fusion of spermatic ducts		T	0183	23.7895	$1,624.04	.	$324.81
55000	Drainage of hydrocele		T	0004	4.6624	$318.29	.	$63.66
55040	Removal of hydrocele		T	0154	33.368	$2,277.93	$464.85	$455.59
55041	Removal of hydroceles		T	0154	33.368	$2,277.93	$464.85	$455.59
55060	Repair of hydrocele		T	0183	23.7895	$1,624.04	.	$324.81
55100	Drainage of scrotum abscess		T	0007	13.3268	$909.78	.	$181.96
55110	Explore scrotum		T	0183	23.7895	$1,624.04	.	$324.81
55120	Removal of scrotum lesion		T	0183	23.7895	$1,624.04	.	$324.81
55150	Removal of scrotum		T	0183	23.7895	$1,624.04	.	$324.81
55175	Revision of scrotum		T	0183	23.7895	$1,624.04	.	$324.81
55180	Revision of scrotum		T	0183	23.7895	$1,624.04	.	$324.81
55200	Incision of sperm duct		T	0183	23.7895	$1,624.04	.	$324.81
55250	Removal of sperm duct(s)		T	0183	23.7895	$1,624.04	.	$324.81

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
55300	Prepare, sperm duct x-ray		N					
55400	Repair of sperm duct		T	0183	23.7895	$1,624.04	.	$324.81
55450	Ligation of sperm duct		T	0183	23.7895	$1,624.04	.	$324.81
55500	Removal of hydrocele		T	0183	23.7895	$1,624.04	.	$324.81
55520	Removal of sperm cord lesion		T	0183	23.7895	$1,624.04	.	$324.81
55530	Revise spermatic cord veins		T	0183	23.7895	$1,624.04	.	$324.81
55535	Revise spermatic cord veins		T	0154	33.368	$2,277.93	$464.85	$455.59
55540	Revise hernia & sperm veins		T	0154	33.368	$2,277.93	$464.85	$455.59
55550	Laparo ligate spermatic vein		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
55559	Laparo proc, spermatic cord		T	0130	38.7195	$2,643.26	$659.53	$528.66
55600	Incise sperm duct pouch		T	0183	23.7895	$1,624.04	.	$324.81
55605	Incise sperm duct pouch		C					
55650	Remove sperm duct pouch		C					
55680	Remove sperm pouch lesion		T	0183	23.7895	$1,624.04	.	$324.81
55700	Biopsy of prostate		T	0184	13.338	$910.55	.	$182.11
55705	Biopsy of prostate		T	0184	13.338	$910.55	.	$182.11
55706	Prostate saturation sampling		T	0184	13.338	$910.55	.	$182.11
55720	Drainage of prostate abscess		T	0162	26.4198	$1,803.60	.	$360.72
55725	Drainage of prostate abscess		T	0162	26.4198	$1,803.60	.	$360.72
55801	Removal of prostate		C					
55810	Extensive prostate surgery		C					
55812	Extensive prostate surgery		C					
55815	Extensive prostate surgery		C					
55821	Removal of prostate		C					
55831	Removal of prostate		C					
55840	Extensive prostate surgery		C					
55842	Extensive prostate surgery		C					
55845	Extensive prostate surgery		C					
55860	Surgical exposure, prostate		T	0165	20.5471	$1,402.69	.	$280.54

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
55862	Extensive prostate surgery		C					
55865	Extensive prostate surgery		C					
55866	Laparo radical prostatectomy		C					
55870	Electroejaculation		T	0189	3.5572	$242.84	.	$48.57
55873	Cryoablate prostate		T	0674	116.8825	$7,979.22	.	$1,595.85
55875	Transperi needle place, pros		Q3	0163	37.4369	$2,555.70	.	$511.14
55876	Place rt device/marker, pros		X	0310	13.5651	$926.05	$325.27	$185.21
55899	Genital surgery procedure		T	0126	1.0983	$74.98	$16.21	$15.00
55920	Place needles pelvic for rt		T	0153	26.2068	$1,789.06	$368.04	$357.82
55970	Sex transformation, M to F		E					
55980	Sex transformation, F to M		E					
56405	I & D of vulva/perineum		T	0188	1.5975	$109.06	.	$21.82
56420	Drainage of gland abscess		T	0188	1.5975	$109.06	.	$21.82
56440	Surgery for vulva lesion		T	0193	20.7158	$1,414.21	.	$282.85
56441	Lysis of labial lesion(s)		T	0193	20.7158	$1,414.21	.	$282.85
56442	Hymenotomy		T	0193	20.7158	$1,414.21	.	$282.85
56501	Destroy, vulva lesions, sim		T	0017	21.8217	$1,489.70	.	$297.94
56515	Destroy vulva lesion/s compl		T	0017	21.8217	$1,489.70	.	$297.94
56605	Biopsy of vulva/perineum		T	0189	3.5572	$242.84	.	$48.57
56606	Biopsy of vulva/perineum		T	0188	1.5975	$109.06	.	$21.82
56620	Partial removal of vulva		T	0193	20.7158	$1,414.21	.	$282.85
56625	Complete removal of vulva		T	0193	20.7158	$1,414.21	.	$282.85
56630	Extensive vulva surgery		C					
56631	Extensive vulva surgery		C					
56632	Extensive vulva surgery		C					
56633	Extensive vulva surgery		C					
56634	Extensive vulva surgery		C					
56637	Extensive vulva surgery		C					
56640	Extensive vulva surgery		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
56700	Partial removal of hymen		T	0193	20.7158	$1,414.21	.	$282.85
56740	Remove vagina gland lesion		T	0193	20.7158	$1,414.21	.	$282.85
56800	Repair of vagina		T	0193	20.7158	$1,414.21	.	$282.85
56805	Repair clitoris		T	0193	20.7158	$1,414.21	.	$282.85
56810	Repair of perineum		T	0193	20.7158	$1,414.21	.	$282.85
56820	Exam of vulva w/scope		T	0188	1.5975	$109.06	.	$21.82
56821	Exam/biopsy of vulva w/scope		T	0188	1.5975	$109.06	.	$21.82
57000	Exploration of vagina		T	0193	20.7158	$1,414.21	.	$282.85
57010	Drainage of pelvic abscess		T	0193	20.7158	$1,414.21	.	$282.85
57020	Drainage of pelvic fluid		T	0192	6.7542	$461.09	.	$92.22
57022	I & d vaginal hematoma, pp		T	0007	13.3268	$909.78	.	$181.96
57023	I & d vag hematoma, non-ob		T	0008	20.2481	$1,382.28	.	$276.46
57061	Destroy vag lesions, simple		T	0193	20.7158	$1,414.21	.	$282.85
57065	Destroy vag lesions, complex		T	0193	20.7158	$1,414.21	.	$282.85
57100	Biopsy of vagina		T	0192	6.7542	$461.09	.	$92.22
57105	Biopsy of vagina		T	0193	20.7158	$1,414.21	.	$282.85
57106	Remove vagina wall, partial		T	0193	20.7158	$1,414.21	.	$282.85
57107	Remove vagina tissue, part		T	0195	35.735	$2,439.52	.	$487.91
57109	Vaginectomy partial w/nodes		T	0195	35.735	$2,439.52	.	$487.91
57110	Remove vagina wall, complete		C					
57111	Remove vagina tissue, compl		C					
57112	Vaginectomy w/nodes, compl		C					
57120	Closure of vagina		T	0195	35.735	$2,439.52	.	$487.91
57130	Remove vagina lesion		T	0193	20.7158	$1,414.21	.	$282.85
57135	Remove vagina lesion		T	0193	20.7158	$1,414.21	.	$282.85
57150	Treat vagina infection		T	0188	1.5975	$109.06	.	$21.82
57155	Insert uteri tandems/ovoids		T	0192	6.7542	$461.09	.	$92.22
57160	Insert pessary/other device		T	0188	1.5975	$109.06	.	$21.82
57170	Fitting of diaphragm/cap		T	0191	0.1514	$10.34	$2.08	$2.07

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
57180	Treat vaginal bleeding		T	0188	1.5975	$109.06	.	$21.82
57200	Repair of vagina		T	0193	20.7158	$1,414.21	.	$282.85
57210	Repair vagina/perineum		T	0193	20.7158	$1,414.21	.	$282.85
57220	Revision of urethra		T	0202	45.2093	$3,086.30	$981.50	$617.26
57230	Repair of urethral lesion		T	0195	35.735	$2,439.52	.	$487.91
57240	Repair bladder & vagina		T	0195	35.735	$2,439.52	.	$487.91
57250	Repair rectum & vagina		T	0195	35.735	$2,439.52	.	$487.91
57260	Repair of vagina		T	0195	35.735	$2,439.52	.	$487.91
57265	Extensive repair of vagina		T	0202	45.2093	$3,086.30	$981.50	$617.26
57267	Insert mesh/pelvic flr addon		T	0195	35.735	$2,439.52	.	$487.91
57268	Repair of bowel bulge		T	0195	35.735	$2,439.52	.	$487.91
57270	Repair of bowel pouch		C					
57280	Suspension of vagina		C					
57282	Colpopexy, extraperitoneal		T	0202	45.2093	$3,086.30	$981.50	$617.26
57283	Colpopexy, intraperitoneal		T	0202	45.2093	$3,086.30	$981.50	$617.26
57284	Repair paravag defect, open		T	0202	45.2093	$3,086.30	$981.50	$617.26
57285	Repair paravag defect, vag		T	0202	45.2093	$3,086.30	$981.50	$617.26
57287	Revise/remove sling repair		T	0195	35.735	$2,439.52	.	$487.91
57288	Repair bladder defect		T	0202	45.2093	$3,086.30	$981.50	$617.26
57289	Repair bladder & vagina		T	0195	35.735	$2,439.52	.	$487.91
57291	Construction of vagina		T	0195	35.735	$2,439.52	.	$487.91
57292	Construct vagina with graft		T	0195	35.735	$2,439.52	.	$487.91
57295	Revise vag graft via vagina		T	0193	20.7158	$1,414.21	.	$282.85
57296	Revise vag graft, open abd		C					
57300	Repair rectum-vagina fistula		T	0195	35.735	$2,439.52	.	$487.91
57305	Repair rectum-vagina fistula		C					
57307	Fistula repair & colostomy		C					
57308	Fistula repair, transperine		C					
57310	Repair urethrovaginal lesion		T	0202	45.2093	$3,086.30	$981.50	$617.26

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
57311	Repair urethrovaginal lesion		C					
57320	Repair bladder-vagina lesion		T	0195	35.735	$2,439.52	.	$487.91
57330	Repair bladder-vagina lesion		T	0195	35.735	$2,439.52	.	$487.91
57335	Repair vagina		T	0195	35.735	$2,439.52	.	$487.91
57400	Dilation of vagina		T	0193	20.7158	$1,414.21	.	$282.85
57410	Pelvic examination		T	0193	20.7158	$1,414.21	.	$282.85
57415	Remove vaginal foreign body		T	0193	20.7158	$1,414.21	.	$282.85
57420	Exam of vagina w/scope		T	0189	3.5572	$242.84	.	$48.57
57421	Exam/biopsy of vag w/scope		T	0189	3.5572	$242.84	.	$48.57
57423	Repair paravag defect, lap		T	0202	45.2093	$3,086.30	$981.50	$617.26
57425	Laparoscopy, surg, colpopexy		T	0130	38.7195	$2,643.26	$659.53	$528.66
57426	Revise prosth vag graft lap		T	0193	20.7158	$1,414.21	.	$282.85
57452	Exam of cervix w/scope		T	0188	1.5975	$109.06	.	$21.82
57454	Bx/curett of cervix w/scope		T	0189	3.5572	$242.84	.	$48.57
57455	Biopsy of cervix w/scope		T	0189	3.5572	$242.84	.	$48.57
57456	Endocerv curettage w/scope		T	0189	3.5572	$242.84	.	$48.57
57460	Bx of cervix w/scope, leep		T	0193	20.7158	$1,414.21	.	$282.85
57461	Conz of cervix w/scope, leep		T	0193	20.7158	$1,414.21	.	$282.85
57500	Biopsy of cervix		T	0192	6.7542	$461.09	.	$92.22
57505	Endocervical curettage		T	0192	6.7542	$461.09	.	$92.22
57510	Cauterization of cervix		T	0193	20.7158	$1,414.21	.	$282.85
57511	Cryocautery of cervix		T	0188	1.5975	$109.06	.	$21.82
57513	Laser surgery of cervix		T	0193	20.7158	$1,414.21	.	$282.85
57520	Conization of cervix		T	0193	20.7158	$1,414.21	.	$282.85
57522	Conization of cervix		T	0193	20.7158	$1,414.21	.	$282.85
57530	Removal of cervix		T	0195	35.735	$2,439.52	.	$487.91
57531	Removal of cervix, radical		C					
57540	Removal of residual cervix		C					
57545	Remove cervix/repair pelvis		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
57550	Removal of residual cervix		T	0195	35.735	$2,439.52	.	$487.91
57555	Remove cervix/repair vagina		T	0195	35.735	$2,439.52	.	$487.91
57556	Remove cervix, repair bowel		T	0202	45.2093	$3,086.30	$981.50	$617.26
57558	D&c of cervical stump		T	0193	20.7158	$1,414.21	.	$282.85
57700	Revision of cervix		T	0193	20.7158	$1,414.21	.	$282.85
57720	Revision of cervix		T	0193	20.7158	$1,414.21	.	$282.85
57800	Dilation of cervical canal		T	0193	20.7158	$1,414.21	.	$282.85
58100	Biopsy of uterus lining		T	0188	1.5975	$109.06	.	$21.82
58110	Bx done w/colposcopy add-on		N					
58120	Dilation and curettage		T	0193	20.7158	$1,414.21	.	$282.85
58140	Myomectomy abdom method		C					
58145	Myomectomy vag method		T	0195	35.735	$2,439.52	.	$487.91
58146	Myomectomy abdom complex		C					
58150	Total hysterectomy		C					
58152	Total hysterectomy		C					
58180	Partial hysterectomy		C					
58200	Extensive hysterectomy		C					
58210	Extensive hysterectomy		C					
58240	Removal of pelvis contents		C					
58260	Vaginal hysterectomy		T	0195	35.735	$2,439.52	.	$487.91
58262	Vag hyst including t/o		T	0195	35.735	$2,439.52	.	$487.91
58263	Vag hyst w/t/o & vag repair		T	0195	35.735	$2,439.52	.	$487.91
58267	Vag hyst w/urinary repair		C					
58270	Vag hyst w/enterocele repair		T	0195	35.735	$2,439.52	.	$487.91
58275	Hysterectomy/revise vagina		C					
58280	Hysterectomy/revise vagina		C					
58285	Extensive hysterectomy		C					
58290	Vag hyst complex		T	0202	45.2093	$3,086.30	$981.50	$617.26
58291	Vag hyst incl t/o, complex		T	0202	45.2093	$3,086.30	$981.50	$617.26

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
58292	Vag hyst t/o & repair, compl		T	0202	45.2093	$3,086.30	$981.50	$617.26
58293	Vag hyst w/uro repair, compl		C					
58294	Vag hyst w/enterocele, compl		T	0202	45.2093	$3,086.30	$981.50	$617.26
58300	Insert intrauterine device		E					
58301	Remove intrauterine device		T	0188	1.5975	$109.06	.	$21.82
58321	Artificial insemination		T	0189	3.5572	$242.84	.	$48.57
58322	Artificial insemination		T	0189	3.5572	$242.84	.	$48.57
58323	Sperm washing		T	0189	3.5572	$242.84	.	$48.57
58340	Catheter for hysterography		N					
58345	Reopen fallopian tube		T	0193	20.7158	$1,414.21	.	$282.85
58346	Insert heyman uteri capsule		T	0193	20.7158	$1,414.21	.	$282.85
58350	Reopen fallopian tube		T	0195	35.735	$2,439.52	.	$487.91
58353	Endometr ablate, thermal		T	0195	35.735	$2,439.52	.	$487.91
58356	Endometrial cryoablation		T	0202	45.2093	$3,086.30	$981.50	$617.26
58400	Suspension of uterus		C					
58410	Suspension of uterus		C					
58520	Repair of ruptured uterus		C					
58540	Revision of uterus		C					
58541	Lsh, uterus 250 g or less		T	0132	71.1086	$4,854.37	$1,226.23	$970.88
58542	Lsh w/t/o ut 250 g or less		T	0132	71.1086	$4,854.37	$1,226.23	$970.88
58543	Lsh uterus above 250 g		T	0132	71.1086	$4,854.37	$1,226.23	$970.88
58544	Lsh w/t/o uterus above 250 g		T	0132	71.1086	$4,854.37	$1,226.23	$970.88
58545	Laparoscopic myomectomy		T	0130	38.7195	$2,643.26	$659.53	$528.66
58546	Laparo-myomectomy, complex		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
58548	Lap radical hyst		C					
58550	Laparo-asst vag hysterectomy		T	0132	71.1086	$4,854.37	$1,226.23	$970.88
58552	Laparo-vag hyst incl t/o		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
58553	Laparo-vag hyst, complex		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
58554	Laparo-vag hyst w/t/o, compl		T	0131	48.0382	$3,279.42	$1,001.89	$655.89

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
58555	Hysteroscopy, dx, sep proc		T	0190	23.199	$1,583.73	$424.28	$316.75
58558	Hysteroscopy, biopsy		T	0190	23.199	$1,583.73	$424.28	$316.75
58559	Hysteroscopy, lysis		T	0190	23.199	$1,583.73	$424.28	$316.75
58560	Hysteroscopy, resect septum		T	0387	38.2775	$2,613.09	$655.55	$522.62
58561	Hysteroscopy, remove myoma		T	0387	38.2775	$2,613.09	$655.55	$522.62
58562	Hysteroscopy, remove fb		T	0190	23.199	$1,583.73	$424.28	$316.75
58563	Hysteroscopy, ablation		T	0387	38.2775	$2,613.09	$655.55	$522.62
58565	Hysteroscopy, sterilization		T	0202	45.2093	$3,086.30	$981.50	$617.26
58570	Tlh, uterus 250 g or less		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
58571	Tlh w/t/o 250 g or less		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
58572	Tlh, uterus over 250 g		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
58573	Tlh w/t/o uterus over 250 g		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
58578	Laparo proc, uterus		T	0130	38.7195	$2,643.26	$659.53	$528.66
58579	Hysteroscope procedure		T	0190	23.199	$1,583.73	$424.28	$316.75
58600	Division of fallopian tube		T	0195	35.735	$2,439.52	.	$487.91
58605	Division of fallopian tube		C					
58611	Ligate oviduct(s) add-on		C					
58615	Occlude fallopian tube(s)		T	0193	20.7158	$1,414.21	.	$282.85
58660	Laparoscopy, lysis		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
58661	Laparoscopy, remove adnexa		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
58662	Laparoscopy, excise lesions		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
58670	Laparoscopy, tubal cautery		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
58671	Laparoscopy, tubal block		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
58672	Laparoscopy, fimbrioplasty		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
58673	Laparoscopy, salpingostomy		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
58679	Laparo proc, oviduct-ovary		T	0130	38.7195	$2,643.26	$659.53	$528.66
58700	Removal of fallopian tube		C					
58720	Removal of ovary/tube(s)		C					
58740	Adhesiolysis tube, ovary		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
58750	Repair oviduct		C					
58752	Revise ovarian tube(s)		C					
58760	Fimbrioplasty		C					
58770	Create new tubal opening		T	0195	35.735	$2,439.52	.	$487.91
58800	Drainage of ovarian cyst(s)		T	0193	20.7158	$1,414.21	.	$282.85
58805	Drainage of ovarian cyst(s)		T	0195	35.735	$2,439.52	.	$487.91
58820	Drain ovary abscess, open		T	0195	35.735	$2,439.52	.	$487.91
58822	Drain ovary abscess, percut		C					
58823	Drain pelvic abscess, percut		T	0193	20.7158	$1,414.21	.	$282.85
58825	Transposition, ovary(s)		C					
58900	Biopsy of ovary(s)		T	0193	20.7158	$1,414.21	.	$282.85
58920	Partial removal of ovary(s)		T	0195	35.735	$2,439.52	.	$487.91
58925	Removal of ovarian cyst(s)		T	0195	35.735	$2,439.52	.	$487.91
58940	Removal of ovary(s)		C					
58943	Removal of ovary(s)		C					
58950	Resect ovarian malignancy		C					
58951	Resect ovarian malignancy		C					
58952	Resect ovarian malignancy		C					
58953	Tah, rad dissect for debulk		C					
58954	Tah rad debulk/lymph remove		C					
58956	Bso, omentectomy w/tah		C					
58957	Resect recurrent gyn mal		C					
58958	Resect recur gyn mal w/lym		C					
58960	Exploration of abdomen		C					
58970	Retrieval of oocyte		T	0189	3.5572	$242.84	.	$48.57
58974	Transfer of embryo		T	0189	3.5572	$242.84	.	$48.57
58976	Transfer of embryo		T	0189	3.5572	$242.84	.	$48.57
58999	Genital surgery procedure		T	0191	0.1514	$10.34	$2.08	$2.07
59000	Amniocentesis, diagnostic		T	0189	3.5572	$242.84	.	$48.57

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
59001	Amniocentesis, therapeutic		T	0192	6.7542	$461.09	.	$92.22
59012	Fetal cord puncture,prenatal		T	0189	3.5572	$242.84	.	$48.57
59015	Chorion biopsy		T	0189	3.5572	$242.84	.	$48.57
59020	Fetal contract stress test		T	0188	1.5975	$109.06	.	$21.82
59025	Fetal non-stress test		T	0188	1.5975	$109.06	.	$21.82
59030	Fetal scalp blood sample		T	0189	3.5572	$242.84	.	$48.57
59050	Fetal monitor w/report		M					
59051	Fetal monitor/interpret only		B					
59070	Transabdom amnioinfus w/us		T	0188	1.5975	$109.06	.	$21.82
59072	Umbilical cord occlud w/us		T	0189	3.5572	$242.84	.	$48.57
59074	Fetal fluid drainage w/us		T	0189	3.5572	$242.84	.	$48.57
59076	Fetal shunt placement, w/us		T	0189	3.5572	$242.84	.	$48.57
59100	Remove uterus lesion		T	0195	35.735	$2,439.52	.	$487.91
59120	Treat ectopic pregnancy		C					
59121	Treat ectopic pregnancy		C					
59130	Treat ectopic pregnancy		C					
59135	Treat ectopic pregnancy		C					
59136	Treat ectopic pregnancy		C					
59140	Treat ectopic pregnancy		C					
59150	Treat ectopic pregnancy		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
59151	Treat ectopic pregnancy		T	0131	48.0382	$3,279.42	$1,001.89	$655.89
59160	D & c after delivery		T	0193	20.7158	$1,414.21	.	$282.85
59200	Insert cervical dilator		T	0188	1.5975	$109.06	.	$21.82
59300	Episiotomy or vaginal repair		T	0193	20.7158	$1,414.21	.	$282.85
59320	Revision of cervix		T	0193	20.7158	$1,414.21	.	$282.85
59325	Revision of cervix		C					
59350	Repair of uterus		C					
59400	Obstetrical care		B					
59409	Obstetrical care		T	0193	20.7158	$1,414.21	.	$282.85

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
59410	Obstetrical care		B					
59412	Antepartum manipulation		T	0193	20.7158	$1,414.21	.	$282.85
59414	Deliver placenta		T	0193	20.7158	$1,414.21	.	$282.85
59425	Antepartum care only		B					
59426	Antepartum care only		B					
59430	Care after delivery		B					
59510	Cesarean delivery		B					
59514	Cesarean delivery only		C					
59515	Cesarean delivery		B					
59525	Remove uterus after cesarean		C					
59610	Vbac delivery		B					
59612	Vbac delivery only		T	0193	20.7158	$1,414.21	.	$282.85
59614	Vbac care after delivery		B					
59618	Attempted vbac delivery		B					
59620	Attempted vbac delivery only		C					
59622	Attempted vbac after care		B					
59812	Treatment of miscarriage		T	0193	20.7158	$1,414.21	.	$282.85
59820	Care of miscarriage		T	0193	20.7158	$1,414.21	.	$282.85
59821	Treatment of miscarriage		T	0193	20.7158	$1,414.21	.	$282.85
59830	Treat uterus infection		C					
59840	Abortion		T	0193	20.7158	$1,414.21	.	$282.85
59841	Abortion		T	0193	20.7158	$1,414.21	.	$282.85
59850	Abortion		C					
59851	Abortion		C					
59852	Abortion		C					
59855	Abortion		C					
59856	Abortion		C					
59857	Abortion		C					
59866	Abortion (mpr)		T	0189	3.5572	$242.84	.	$48.57

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
59870	Evacuate mole of uterus		T	0193	20.7158	$1,414.21	.	$282.85
59871	Remove cerclage suture		T	0193	20.7158	$1,414.21	.	$282.85
59897	Fetal invas px w/us		T	0191	0.1514	$10.34	$2.08	$2.07
59898	Laparo proc, ob care/deliver		T	0130	38.7195	$2,643.26	$659.53	$528.66
59899	Maternity care procedure		T	0191	0.1514	$10.34	$2.08	$2.07
60000	Drain thyroid/tongue cyst		T	0252	7.8743	$537.55	$109.16	$107.51
60100	Biopsy of thyroid		T	0004	4.6624	$318.29	.	$63.66
60200	Remove thyroid lesion		T	0114	50.9844	$3,480.55	.	$696.11
60210	Partial thyroid excision		T	0114	50.9844	$3,480.55	.	$696.11
60212	Partial thyroid excision		T	0114	50.9844	$3,480.55	.	$696.11
60220	Partial removal of thyroid		T	0114	50.9844	$3,480.55	.	$696.11
60225	Partial removal of thyroid		T	0114	50.9844	$3,480.55	.	$696.11
60240	Removal of thyroid		T	0114	50.9844	$3,480.55	.	$696.11
60252	Removal of thyroid		T	0256	44.8441	$3,061.37	.	$612.28
60254	Extensive thyroid surgery		C					
60260	Repeat thyroid surgery		T	0256	44.8441	$3,061.37	.	$612.28
60270	Removal of thyroid		C					
60271	Removal of thyroid		T	0256	44.8441	$3,061.37	.	$612.28
60280	Remove thyroid duct lesion		T	0114	50.9844	$3,480.55	.	$696.11
60281	Remove thyroid duct lesion		T	0114	50.9844	$3,480.55	.	$696.11
60300	Aspir/inj thyroid cyst		T	0004	4.6624	$318.29	.	$63.66
60500	Explore parathyroid glands		T	0256	44.8441	$3,061.37	.	$612.28
60502	Re-explore parathyroids		T	0256	44.8441	$3,061.37	.	$612.28
60505	Explore parathyroid glands		C					
60512	Autotransplant parathyroid		T	0022	24.1269	$1,647.07	$354.45	$329.42
60520	Removal of thymus gland		T	0256	44.8441	$3,061.37	.	$612.28
60521	Removal of thymus gland		C					
60522	Removal of thymus gland		C					
60540	Explore adrenal gland		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
60545	Explore adrenal gland		C					
60600	Remove carotid body lesion		C					
60605	Remove carotid body lesion		C					
60650	Laparoscopy adrenalectomy		C					
60659	Laparo proc, endocrine		T	0130	38.7195	$2,643.26	$659.53	$528.66
60699	Endocrine surgery procedure		T	0114	50.9844	$3,480.55	.	$696.11
61000	Remove cranial cavity fluid		T	0207	7.7204	$527.05	.	$105.41
61001	Remove cranial cavity fluid		T	0207	7.7204	$527.05	.	$105.41
61020	Remove brain cavity fluid		T	0207	7.7204	$527.05	.	$105.41
61026	Injection into brain canal		T	0207	7.7204	$527.05	.	$105.41
61050	Remove brain canal fluid		T	0207	7.7204	$527.05	.	$105.41
61055	Injection into brain canal		T	0207	7.7204	$527.05	.	$105.41
61070	Brain canal shunt procedure		T	0121	6.3264	$431.88	.	$86.38
61105	Twist drill hole		C					
61107	Drill skull for implantation		C					
61108	Drill skull for drainage		C					
61120	Burr hole for puncture		C					
61140	Pierce skull for biopsy		C					
61150	Pierce skull for drainage		C					
61151	Pierce skull for drainage		C					
61154	Pierce skull & remove clot		C					
61156	Pierce skull for drainage		C					
61210	Pierce skull, implant device		C					
61215	Insert brain-fluid device		T	0224	41.9698	$2,865.15	.	$573.03
61250	Pierce skull & explore		C					
61253	Pierce skull & explore		C					
61304	Open skull for exploration		C					
61305	Open skull for exploration		C					
61312	Open skull for drainage		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
61313	Open skull for drainage		C					
61314	Open skull for drainage		C					
61315	Open skull for drainage		C					
61316	Implt cran bone flap to abdo		C					
61320	Open skull for drainage		C					
61321	Open skull for drainage		C					
61322	Decompressive craniotomy		C					
61323	Decompressive lobectomy		C					
61330	Decompress eye socket		T	0256	44.8441	$3,061.37	.	$612.28
61332	Explore/biopsy eye socket		C					
61333	Explore orbit/remove lesion		C					
61334	Explore orbit/remove object		T	0256	44.8441	$3,061.37	.	$612.28
61340	Subtemporal decompression		C					
61343	Incise skull (press relief)		C					
61345	Relieve cranial pressure		C					
61440	Incise skull for surgery		C					
61450	Incise skull for surgery		C					
61458	Incise skull for brain wound		C					
61460	Incise skull for surgery		C					
61470	Incise skull for surgery		C					
61480	Incise skull for surgery		C					
61490	Incise skull for surgery		C					
61500	Removal of skull lesion		C					
61501	Remove infected skull bone		C					
61510	Removal of brain lesion		C					
61512	Remove brain lining lesion		C					
61514	Removal of brain abscess		C					
61516	Removal of brain lesion		C					
61517	Implt brain chemotx add-on		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
61518	Removal of brain lesion		C					
61519	Remove brain lining lesion		C					
61520	Removal of brain lesion		C					
61521	Removal of brain lesion		C					
61522	Removal of brain abscess		C					
61524	Removal of brain lesion		C					
61526	Removal of brain lesion		C					
61530	Removal of brain lesion		C					
61531	Implant brain electrodes		C					
61533	Implant brain electrodes		C					
61534	Removal of brain lesion		C					
61535	Remove brain electrodes		C					
61536	Removal of brain lesion		C					
61537	Removal of brain tissue		C					
61538	Removal of brain tissue		C					
61539	Removal of brain tissue		C					
61540	Removal of brain tissue		C					
61541	Incision of brain tissue		C					
61542	Removal of brain tissue		C					
61543	Removal of brain tissue		C					
61544	Remove & treat brain lesion		C					
61545	Excision of brain tumor		C					
61546	Removal of pituitary gland		C					
61548	Removal of pituitary gland		C					
61550	Release of skull seams		C					
61552	Release of skull seams		C					
61556	Incise skull/sutures		C					
61557	Incise skull/sutures		C					
61558	Excision of skull/sutures		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
61559	Excision of skull/sutures		C					
61563	Excision of skull tumor		C					
61564	Excision of skull tumor		C					
61566	Removal of brain tissue		C					
61567	Incision of brain tissue		C					
61570	Remove foreign body, brain		C					
61571	Incise skull for brain wound		C					
61575	Skull base/brainstem surgery		C					
61576	Skull base/brainstem surgery		C					
61580	Craniofacial approach, skull		C					
61581	Craniofacial approach, skull		C					
61582	Craniofacial approach, skull		C					
61583	Craniofacial approach, skull		C					
61584	Orbitocranial approach/skull		C					
61585	Orbitocranial approach/skull		C					
61586	Resect nasopharynx, skull		C					
61590	Infratemporal approach/skull		C					
61591	Infratemporal approach/skull		C					
61592	Orbitocranial approach/skull		C					
61595	Transtemporal approach/skull		C					
61596	Transcochlear approach/skull		C					
61597	Transcondylar approach/skull		C					
61598	Transpetrosal approach/skull		C					
61600	Resect/excise cranial lesion		C					
61601	Resect/excise cranial lesion		C					
61605	Resect/excise cranial lesion		C					
61606	Resect/excise cranial lesion		C					
61607	Resect/excise cranial lesion		C					
61608	Resect/excise cranial lesion		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
61609	Transect artery, sinus		C					
61610	Transect artery, sinus		C					
61611	Transect artery, sinus		C					
61612	Transect artery, sinus		C					
61613	Remove aneurysm, sinus		C					
61615	Resect/excise lesion, skull		C					
61616	Resect/excise lesion, skull		C					
61618	Repair dura		C					
61619	Repair dura		C					
61623	Endovasc tempory vessel occl		T	0082	97.8929	$6,682.85	.	$1,336.57
61624	Transcath occlusion, cns		C					
61626	Transcath occlusion, non-cns		T	0082	97.8929	$6,682.85	.	$1,336.57
61630	Intracranial angioplasty		C					
61635	Intracran angioplsty w/stent		C					
61640	Dilate ic vasospasm, init		E					
61641	Dilate ic vasospasm add-on		E					
61642	Dilate ic vasospasm add-on		E					
61680	Intracranial vessel surgery		C					
61682	Intracranial vessel surgery		C					
61684	Intracranial vessel surgery		C					
61686	Intracranial vessel surgery		C					
61690	Intracranial vessel surgery		C					
61692	Intracranial vessel surgery		C					
61697	Brain aneurysm repr, complx		C					
61698	Brain aneurysm repr, complx		C					
61700	Brain aneurysm repr, simple		C					
61702	Inner skull vessel surgery		C					
61703	Clamp neck artery		C					
61705	Revise circulation to head		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
61708	Revise circulation to head		C					
61710	Revise circulation to head		C					
61711	Fusion of skull arteries		C					
61720	Incise skull/brain surgery		T	0221	37.5345	$2,562.37	.	$512.48
61735	Incise skull/brain surgery		C					
61750	Incise skull/brain biopsy		C					
61751	Brain biopsy w/ct/mr guide		C					
61760	Implant brain electrodes		C					
61770	Incise skull for treatment		T	0221	37.5345	$2,562.37	.	$512.48
61790	Treat trigeminal nerve		T	0220	19.3535	$1,321.21	.	$264.25
61791	Treat trigeminal tract		T	0203	13.3062	$908.37	$225.43	$181.68
61795	Brain surgery using computer		N					
61796	Srs, cranial lesion simple		B					
61797	Srs, cran les simple, addl		B					
61798	Srs, cranial lesion complex		B					
61799	Srs, cran les complex, addl		B					
61800	Apply srs headframe add-on		B					
61850	Implant neuroelectrodes		C					
61860	Implant neuroelectrodes		C					
61863	Implant neuroelectrode		C					
61864	Implant neuroelectrde, addl		C					
61867	Implant neuroelectrode		C					
61868	Implant neuroelectrde, addl		C					
61870	Implant neuroelectrodes		C					
61875	Implant neuroelectrodes		C					
61880	Revise/remove neuroelectrode		T	0687	21.9323	$1,497.25	$397.37	$299.45
61885	Insrt/redo neurostim 1 array		S	0039	210.3341	$14,358.88	.	$2,871.78
61886	Implant neurostim arrays		S	0315	270.0348	$18,434.47	.	$3,686.90
61888	Revise/remove neuroreceiver		T	0688	29.5816	$2,019.45	$768.94	$403.89

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
62000	Treat skull fracture		T	0254	25.5397	$1,743.52	.	$348.71
62005	Treat skull fracture		C					
62010	Treatment of head injury		C					
62100	Repair brain fluid leakage		C					
62115	Reduction of skull defect		C					
62116	Reduction of skull defect		C					
62117	Reduction of skull defect		C					
62120	Repair skull cavity lesion		C					
62121	Incise skull repair		C					
62140	Repair of skull defect		C					
62141	Repair of skull defect		C					
62142	Remove skull plate/flap		C					
62143	Replace skull plate/flap		C					
62145	Repair of skull & brain		C					
62146	Repair of skull with graft		C					
62147	Repair of skull with graft		C					
62148	Retr bone flap to fix skull		C					
62160	Neuroendoscopy add-on		N					
62161	Dissect brain w/scope		C					
62162	Remove colloid cyst w/scope		C					
62163	Neuroendoscopy w/fb removal		C					
62164	Remove brain tumor w/scope		C					
62165	Remove pituit tumor w/scope		C					
62180	Establish brain cavity shunt		C					
62190	Establish brain cavity shunt		C					
62192	Establish brain cavity shunt		C					
62194	Replace/irrigate catheter		T	0207	7.7204	$527.05	.	$105.41
62200	Establish brain cavity shunt		C					
62201	Brain cavity shunt w/scope		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
62220	Establish brain cavity shunt		C					
62223	Establish brain cavity shunt		C					
62225	Replace/irrigate catheter		T	0427	16.3601	$1,116.85	.	$223.37
62230	Replace/revise brain shunt		T	0224	41.9698	$2,865.15	.	$573.03
62252	Csf shunt reprogram		S	0691	2.4765	$169.06	.	$33.82
62256	Remove brain cavity shunt		C					
62258	Replace brain cavity shunt		C					
62263	Epidural lysis mult sessions		T	0207	7.7204	$527.05	.	$105.41
62264	Epidural lysis on single day		T	0203	13.3062	$908.37	$225.43	$181.68
62267	Interdiscal perq aspir, dx		T	0004	4.6624	$318.29	.	$63.66
62268	Drain spinal cord cyst		T	0207	7.7204	$527.05	.	$105.41
62269	Needle biopsy, spinal cord		T	0685	9.9046	$676.16	.	$135.24
62270	Spinal fluid tap, diagnostic		T	0206	3.8796	$264.85	.	$52.97
62272	Drain cerebro spinal fluid		T	0206	3.8796	$264.85	.	$52.97
62273	Inject epidural patch	CH	T	0207	7.7204	$527.05	.	$105.41
62280	Treat spinal cord lesion		T	0207	7.7204	$527.05	.	$105.41
62281	Treat spinal cord lesion		T	0207	7.7204	$527.05	.	$105.41
62282	Treat spinal canal lesion		T	0207	7.7204	$527.05	.	$105.41
62284	Injection for myelogram		N					
62287	Percutaneous diskectomy		T	0221	37.5345	$2,562.37	.	$512.48
62290	Inject for spine disk x-ray		N					
62291	Inject for spine disk x-ray		N					
62292	Injection into disk lesion		T	0207	7.7204	$527.05	.	$105.41
62294	Injection into spinal artery		T	0207	7.7204	$527.05	.	$105.41
62310	Inject spine c/t		T	0207	7.7204	$527.05	.	$105.41
62311	Inject spine l/s (cd)		T	0207	7.7204	$527.05	.	$105.41
62318	Inject spine w/cath, c/t		T	0207	7.7204	$527.05	.	$105.41
62319	Inject spine w/cath l/s (cd)	CH	T	0203	13.3062	$908.37	$225.43	$181.68
62350	Implant spinal canal cath		T	0224	41.9698	$2,865.15	.	$573.03

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
62351	Implant spinal canal cath		T	0208	51.7137	$3,530.34	.	$706.07
62355	Remove spinal canal catheter		T	0203	13.3062	$908.37	$225.43	$181.68
62360	Insert spine infusion device		T	0224	41.9698	$2,865.15	.	$573.03
62361	Implant spine infusion pump		T	0227	194.6115	$13,285.54	.	$2,657.11
62362	Implant spine infusion pump		T	0227	194.6115	$13,285.54	.	$2,657.11
62365	Remove spine infusion device		T	0221	37.5345	$2,562.37	.	$512.48
62367	Analyze spine infusion pump		S	0691	2.4765	$169.06	.	$33.82
62368	Analyze spine infusion pump		S	0691	2.4765	$169.06	.	$33.82
63001	Removal of spinal lamina		T	0208	51.7137	$3,530.34	.	$706.07
63003	Removal of spinal lamina		T	0208	51.7137	$3,530.34	.	$706.07
63005	Removal of spinal lamina		T	0208	51.7137	$3,530.34	.	$706.07
63011	Removal of spinal lamina		T	0208	51.7137	$3,530.34	.	$706.07
63012	Removal of spinal lamina		T	0208	51.7137	$3,530.34	.	$706.07
63015	Removal of spinal lamina		T	0208	51.7137	$3,530.34	.	$706.07
63016	Removal of spinal lamina		T	0208	51.7137	$3,530.34	.	$706.07
63017	Removal of spinal lamina		T	0208	51.7137	$3,530.34	.	$706.07
63020	Neck spine disk surgery		T	0208	51.7137	$3,530.34	.	$706.07
63030	Low back disk surgery		T	0208	51.7137	$3,530.34	.	$706.07
63035	Spinal disk surgery add-on		T	0208	51.7137	$3,530.34	.	$706.07
63040	Laminotomy, single cervical		T	0208	51.7137	$3,530.34	.	$706.07
63042	Laminotomy, single lumbar		T	0208	51.7137	$3,530.34	.	$706.07
63043	Laminotomy, addl cervical		C					
63044	Laminotomy, addl lumbar		C					
63045	Removal of spinal lamina		T	0208	51.7137	$3,530.34	.	$706.07
63046	Removal of spinal lamina		T	0208	51.7137	$3,530.34	.	$706.07
63047	Removal of spinal lamina		T	0208	51.7137	$3,530.34	.	$706.07
63048	Remove spinal lamina add-on		T	0208	51.7137	$3,530.34	.	$706.07
63050	Cervical laminoplasty		C					
63051	C-laminoplasty w/graft/plate		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
63055	Decompress spinal cord		T	0208	51.7137	$3,530.34	.	$706.07
63056	Decompress spinal cord		T	0208	51.7137	$3,530.34	.	$706.07
63057	Decompress spine cord add-on		T	0208	51.7137	$3,530.34	.	$706.07
63064	Decompress spinal cord		T	0208	51.7137	$3,530.34	.	$706.07
63066	Decompress spine cord add-on		T	0208	51.7137	$3,530.34	.	$706.07
63075	Neck spine disk surgery		T	0208	51.7137	$3,530.34	.	$706.07
63076	Neck spine disk surgery		T	0208	51.7137	$3,530.34	.	$706.07
63077	Spine disk surgery, thorax		C					
63078	Spine disk surgery, thorax		C					
63081	Removal of vertebral body		C					
63082	Remove vertebral body add-on		C					
63085	Removal of vertebral body		C					
63086	Remove vertebral body add-on		C					
63087	Removal of vertebral body		C					
63088	Remove vertebral body add-on		C					
63090	Removal of vertebral body		C					
63091	Remove vertebral body add-on		C					
63101	Removal of vertebral body		C					
63102	Removal of vertebral body		C					
63103	Remove vertebral body add-on		C					
63170	Incise spinal cord tract(s)		C					
63172	Drainage of spinal cyst		C					
63173	Drainage of spinal cyst		C					
63180	Revise spinal cord ligaments		C					
63182	Revise spinal cord ligaments		C					
63185	Incise spinal column/nerves		C					
63190	Incise spinal column/nerves		C					
63191	Incise spinal column/nerves		C					
63194	Incise spinal column & cord		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
63195	Incise spinal column & cord		C					
63196	Incise spinal column & cord		C					
63197	Incise spinal column & cord		C					
63198	Incise spinal column & cord		C					
63199	Incise spinal column & cord		C					
63200	Release of spinal cord		C					
63250	Revise spinal cord vessels		C					
63251	Revise spinal cord vessels		C					
63252	Revise spinal cord vessels		C					
63265	Excise intraspinal lesion		C					
63266	Excise intraspinal lesion		C					
63267	Excise intraspinal lesion		C					
63268	Excise intraspinal lesion		C					
63270	Excise intraspinal lesion		C					
63271	Excise intraspinal lesion		C					
63272	Excise intraspinal lesion		C					
63273	Excise intraspinal lesion		C					
63275	Biopsy/excise spinal tumor		C					
63276	Biopsy/excise spinal tumor		C					
63277	Biopsy/excise spinal tumor		C					
63278	Biopsy/excise spinal tumor		C					
63280	Biopsy/excise spinal tumor		C					
63281	Biopsy/excise spinal tumor		C					
63282	Biopsy/excise spinal tumor		C					
63283	Biopsy/excise spinal tumor		C					
63285	Biopsy/excise spinal tumor		C					
63286	Biopsy/excise spinal tumor		C					
63287	Biopsy/excise spinal tumor		C					
63290	Biopsy/excise spinal tumor		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
63295	Repair of laminectomy defect		C					
63300	Removal of vertebral body		C					
63301	Removal of vertebral body		C					
63302	Removal of vertebral body		C					
63303	Removal of vertebral body		C					
63304	Removal of vertebral body		C					
63305	Removal of vertebral body		C					
63306	Removal of vertebral body		C					
63307	Removal of vertebral body		C					
63308	Remove vertebral body add-on		C					
63600	Remove spinal cord lesion		T	0220	19.3535	$1,321.21	.	$264.25
63610	Stimulation of spinal cord		T	0220	19.3535	$1,321.21	.	$264.25
63615	Remove lesion of spinal cord		T	0220	19.3535	$1,321.21	.	$264.25
63620	Srs, spinal lesion		B					
63621	Srs, spinal lesion, addl		B					
63650	Implant neuroelectrodes		S	0040	65.4002	$4,464.68	.	$892.94
63655	Implant neuroelectrodes		S	0061	88.8954	$6,068.62	.	$1,213.73
63661	Remove spine eltrd perq aray		T	0687	21.9323	$1,497.25	$397.37	$299.45
63662	Remove spine eltrd plate		T	0687	21.9323	$1,497.25	$397.37	$299.45
63663	Revise spine eltrd perq aray		T	0687	21.9323	$1,497.25	$397.37	$299.45
63664	Revise spine eltrd plate		T	0687	21.9323	$1,497.25	$397.37	$299.45
63685	Insrt/redo spine n generator		S	0039	210.3341	$14,358.88	.	$2,871.78
63688	Revise/remove neuroreceiver		T	0688	29.5816	$2,019.45	$768.94	$403.89
63700	Repair of spinal herniation		C					
63702	Repair of spinal herniation		C					
63704	Repair of spinal herniation		C					
63706	Repair of spinal herniation		C					
63707	Repair spinal fluid leakage		C					
63709	Repair spinal fluid leakage		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
63710	Graft repair of spine defect		C					
63740	Install spinal shunt		C					
63741	Install spinal shunt		T	0224	41.9698	$2,865.15	.	$573.03
63744	Revision of spinal shunt		T	0224	41.9698	$2,865.15	.	$573.03
63746	Removal of spinal shunt		T	0203	13.3062	$908.37	$225.43	$181.68
64400	N block inj, trigeminal		T	0204	2.666	$182.00	$40.13	$36.40
64402	N block inj, facial		T	0204	2.666	$182.00	$40.13	$36.40
64405	N block inj, occipital		T	0206	3.8796	$264.85	.	$52.97
64408	N block inj, vagus		T	0207	7.7204	$527.05	.	$105.41
64410	N block inj, phrenic		T	0207	7.7204	$527.05	.	$105.41
64412	N block inj, spinal accessor		T	0207	7.7204	$527.05	.	$105.41
64413	N block inj, cervical plexus		T	0206	3.8796	$264.85	.	$52.97
64415	N block inj, brachial plexus		T	0206	3.8796	$264.85	.	$52.97
64416	N block cont infuse, b plex		T	0207	7.7204	$527.05	.	$105.41
64417	N block inj, axillary		T	0206	3.8796	$264.85	.	$52.97
64418	N block inj, suprascapular		T	0206	3.8796	$264.85	.	$52.97
64420	N block inj, intercost, sng		T	0206	3.8796	$264.85	.	$52.97
64421	N block inj, intercost, mlt		T	0207	7.7204	$527.05	.	$105.41
64425	N block inj, ilio-ing/hypogi		T	0206	3.8796	$264.85	.	$52.97
64430	N block inj, pudendal		T	0207	7.7204	$527.05	.	$105.41
64435	N block inj, paracervical		T	0206	3.8796	$264.85	.	$52.97
64445	N block inj, sciatic, sng		T	0207	7.7204	$527.05	.	$105.41
64446	N blk inj, sciatic, cont inf		T	0207	7.7204	$527.05	.	$105.41
64447	N block inj fem, single		T	0206	3.8796	$264.85	.	$52.97
64448	N block inj fem, cont inf		T	0207	7.7204	$527.05	.	$105.41
64449	N block inj, lumbar plexus		T	0207	7.7204	$527.05	.	$105.41
64450	N block, other peripheral		T	0206	3.8796	$264.85	.	$52.97
64455	N block inj, plantar digit		T	0204	2.666	$182.00	$40.13	$36.40
64479	Inj foramen epidural c/t		T	0207	7.7204	$527.05	.	$105.41

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
64480	Inj foramen epidural add-on		T	0206	3.8796	$264.85	.	$52.97
64483	Inj foramen epidural l/s		T	0207	7.7204	$527.05	.	$105.41
64484	Inj foramen epidural add-on		T	0206	3.8796	$264.85	.	$52.97
64490	Inj paravert f jnt c/t 1 lev		T	0207	7.7204	$527.05	.	$105.41
64491	Inj paravert f jnt c/t 2 lev		T	0204	2.666	$182.00	$40.13	$36.40
64492	Inj paravert f jnt c/t 3 lev		T	0204	2.666	$182.00	$40.13	$36.40
64493	Inj paravert f jnt l/s 1 lev		T	0207	7.7204	$527.05	.	$105.41
64494	Inj paravert f jnt l/s 2 lev		T	0204	2.666	$182.00	$40.13	$36.40
64495	Inj paravert f jnt l/s 3 lev		T	0204	2.666	$182.00	$40.13	$36.40
64505	N block, spenopalatine gangl		T	0204	2.666	$182.00	$40.13	$36.40
64508	N block, carotid sinus s/p		T	0204	2.666	$182.00	$40.13	$36.40
64510	N block, stellate ganglion		T	0207	7.7204	$527.05	.	$105.41
64517	N block inj, hypogas plxs		T	0207	7.7204	$527.05	.	$105.41
64520	N block, lumbar/thoracic		T	0207	7.7204	$527.05	.	$105.41
64530	N block inj, celiac pelus		T	0207	7.7204	$527.05	.	$105.41
64550	Apply neurostimulator		A					
64553	Implant neuroelectrodes		S	0040	65.4002	$4,464.68	.	$892.94
64555	Implant neuroelectrodes		S	0040	65.4002	$4,464.68	.	$892.94
64560	Implant neuroelectrodes		S	0040	65.4002	$4,464.68	.	$892.94
64561	Implant neuroelectrodes		S	0040	65.4002	$4,464.68	.	$892.94
64565	Implant neuroelectrodes		S	0040	65.4002	$4,464.68	.	$892.94
64573	Implant neuroelectrodes		S	0225	212.7796	$14,525.82	.	$2,905.17
64575	Implant neuroelectrodes		S	0061	88.8954	$6,068.62	.	$1,213.73
64577	Implant neuroelectrodes		S	0061	88.8954	$6,068.62	.	$1,213.73
64580	Implant neuroelectrodes		S	0061	88.8954	$6,068.62	.	$1,213.73
64581	Implant neuroelectrodes		S	0061	88.8954	$6,068.62	.	$1,213.73
64585	Revise/remove neuroelectrode		T	0687	21.9323	$1,497.25	$397.37	$299.45
64590	Insrt/redo pn/gastr stimul		S	0039	210.3341	$14,358.88	.	$2,871.78
64595	Revise/rmv pn/gastr stimul		T	0688	29.5816	$2,019.45	$768.94	$403.89

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
64600	Injection treatment of nerve		T	0203	13.3062	$908.37	$225.43	$181.68
64605	Injection treatment of nerve		T	0220	19.3535	$1,321.21	.	$264.25
64610	Injection treatment of nerve		T	0220	19.3535	$1,321.21	.	$264.25
64612	Destroy nerve, face muscle		T	0204	2.666	$182.00	$40.13	$36.40
64613	Destroy nerve, neck muscle		T	0206	3.8796	$264.85	.	$52.97
64614	Destroy nerve, extrem musc		T	0206	3.8796	$264.85	.	$52.97
64620	Injection treatment of nerve		T	0207	7.7204	$527.05	.	$105.41
64622	Destr paravertebrl nerve l/s		T	0203	13.3062	$908.37	$225.43	$181.68
64623	Destr paravertebral n add-on		T	0207	7.7204	$527.05	.	$105.41
64626	Destr paravertebrl nerve c/t		T	0207	7.7204	$527.05	.	$105.41
64627	Destr paravertebral n add-on		T	0204	2.666	$182.00	$40.13	$36.40
64630	Injection treatment of nerve		T	0207	7.7204	$527.05	.	$105.41
64632	N block inj, common digit		T	0204	2.666	$182.00	$40.13	$36.40
64640	Injection treatment of nerve		T	0207	7.7204	$527.05	.	$105.41
64650	Chemodenerv eccrine glands		T	0204	2.666	$182.00	$40.13	$36.40
64653	Chemodenerv eccrine glands		T	0204	2.666	$182.00	$40.13	$36.40
64680	Injection treatment of nerve		T	0207	7.7204	$527.05	.	$105.41
64681	Injection treatment of nerve		T	0203	13.3062	$908.37	$225.43	$181.68
64702	Revise finger/toe nerve		T	0220	19.3535	$1,321.21	.	$264.25
64704	Revise hand/foot nerve		T	0220	19.3535	$1,321.21	.	$264.25
64708	Revise arm/leg nerve		T	0220	19.3535	$1,321.21	.	$264.25
64712	Revision of sciatic nerve		T	0220	19.3535	$1,321.21	.	$264.25
64713	Revision of arm nerve(s)		T	0220	19.3535	$1,321.21	.	$264.25
64714	Revise low back nerve(s)		T	0220	19.3535	$1,321.21	.	$264.25
64716	Revision of cranial nerve		T	0220	19.3535	$1,321.21	.	$264.25
64718	Revise ulnar nerve at elbow		T	0220	19.3535	$1,321.21	.	$264.25
64719	Revise ulnar nerve at wrist		T	0220	19.3535	$1,321.21	.	$264.25
64721	Carpal tunnel surgery		T	0220	19.3535	$1,321.21	.	$264.25
64722	Relieve pressure on nerve(s)		T	0220	19.3535	$1,321.21	.	$264.25

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
64726	Release foot/toe nerve		T	0220	19.3535	$1,321.21	.	$264.25
64727	Internal nerve revision		T	0220	19.3535	$1,321.21	.	$264.25
64732	Incision of brow nerve		T	0220	19.3535	$1,321.21	.	$264.25
64734	Incision of cheek nerve		T	0220	19.3535	$1,321.21	.	$264.25
64736	Incision of chin nerve		T	0220	19.3535	$1,321.21	.	$264.25
64738	Incision of jaw nerve		T	0220	19.3535	$1,321.21	.	$264.25
64740	Incision of tongue nerve		T	0220	19.3535	$1,321.21	.	$264.25
64742	Incision of facial nerve		T	0220	19.3535	$1,321.21	.	$264.25
64744	Incise nerve, back of head		T	0220	19.3535	$1,321.21	.	$264.25
64746	Incise diaphragm nerve		T	0220	19.3535	$1,321.21	.	$264.25
64752	Incision of vagus nerve		C					
64755	Incision of stomach nerves		C					
64760	Incision of vagus nerve		C					
64761	Incision of pelvis nerve		T	0220	19.3535	$1,321.21	.	$264.25
64763	Incise hip/thigh nerve		T	0220	19.3535	$1,321.21	.	$264.25
64766	Incise hip/thigh nerve		T	0221	37.5345	$2,562.37	.	$512.48
64771	Sever cranial nerve		T	0220	19.3535	$1,321.21	.	$264.25
64772	Incision of spinal nerve		T	0220	19.3535	$1,321.21	.	$264.25
64774	Remove skin nerve lesion		T	0220	19.3535	$1,321.21	.	$264.25
64776	Remove digit nerve lesion		T	0220	19.3535	$1,321.21	.	$264.25
64778	Digit nerve surgery add-on		T	0220	19.3535	$1,321.21	.	$264.25
64782	Remove limb nerve lesion		T	0220	19.3535	$1,321.21	.	$264.25
64783	Limb nerve surgery add-on		T	0220	19.3535	$1,321.21	.	$264.25
64784	Remove nerve lesion		T	0220	19.3535	$1,321.21	.	$264.25
64786	Remove sciatic nerve lesion		T	0221	37.5345	$2,562.37	.	$512.48
64787	Implant nerve end		T	0220	19.3535	$1,321.21	.	$264.25
64788	Remove skin nerve lesion		T	0220	19.3535	$1,321.21	.	$264.25
64790	Removal of nerve lesion		T	0220	19.3535	$1,321.21	.	$264.25
64792	Removal of nerve lesion		T	0221	37.5345	$2,562.37	.	$512.48

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
64795	Biopsy of nerve		T	0220	19.3535	$1,321.21	.	$264.25
64802	Remove sympathetic nerves		T	0220	19.3535	$1,321.21	.	$264.25
64804	Remove sympathetic nerves		T	0220	19.3535	$1,321.21	.	$264.25
64809	Remove sympathetic nerves		C					
64818	Remove sympathetic nerves		C					
64820	Remove sympathetic nerves		T	0220	19.3535	$1,321.21	.	$264.25
64821	Remove sympathetic nerves		T	0054	29.8184	$2,035.61	.	$407.13
64822	Remove sympathetic nerves		T	0054	29.8184	$2,035.61	.	$407.13
64823	Remove sympathetic nerves		T	0054	29.8184	$2,035.61	.	$407.13
64831	Repair of digit nerve		T	0221	37.5345	$2,562.37	.	$512.48
64832	Repair nerve add-on		T	0221	37.5345	$2,562.37	.	$512.48
64834	Repair of hand or foot nerve		T	0221	37.5345	$2,562.37	.	$512.48
64835	Repair of hand or foot nerve		T	0221	37.5345	$2,562.37	.	$512.48
64836	Repair of hand or foot nerve		T	0221	37.5345	$2,562.37	.	$512.48
64837	Repair nerve add-on		T	0221	37.5345	$2,562.37	.	$512.48
64840	Repair of leg nerve		T	0221	37.5345	$2,562.37	.	$512.48
64856	Repair/transpose nerve		T	0221	37.5345	$2,562.37	.	$512.48
64857	Repair arm/leg nerve		T	0221	37.5345	$2,562.37	.	$512.48
64858	Repair sciatic nerve		T	0221	37.5345	$2,562.37	.	$512.48
64859	Nerve surgery		T	0221	37.5345	$2,562.37	.	$512.48
64861	Repair of arm nerves		T	0221	37.5345	$2,562.37	.	$512.48
64862	Repair of low back nerves		T	0221	37.5345	$2,562.37	.	$512.48
64864	Repair of facial nerve		T	0221	37.5345	$2,562.37	.	$512.48
64865	Repair of facial nerve		T	0221	37.5345	$2,562.37	.	$512.48
64866	Fusion of facial/other nerve		C					
64868	Fusion of facial/other nerve		C					
64870	Fusion of facial/other nerve		T	0221	37.5345	$2,562.37	.	$512.48
64872	Subsequent repair of nerve		T	0221	37.5345	$2,562.37	.	$512.48
64874	Repair & revise nerve add-on		T	0221	37.5345	$2,562.37	.	$512.48

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
64876	Repair nerve/shorten bone		T	0221	37.5345	$2,562.37	.	$512.48
64885	Nerve graft, head or neck		T	0221	37.5345	$2,562.37	.	$512.48
64886	Nerve graft, head or neck		T	0221	37.5345	$2,562.37	.	$512.48
64890	Nerve graft, hand or foot		T	0221	37.5345	$2,562.37	.	$512.48
64891	Nerve graft, hand or foot		T	0221	37.5345	$2,562.37	.	$512.48
64892	Nerve graft, arm or leg		T	0221	37.5345	$2,562.37	.	$512.48
64893	Nerve graft, arm or leg		T	0221	37.5345	$2,562.37	.	$512.48
64895	Nerve graft, hand or foot		T	0221	37.5345	$2,562.37	.	$512.48
64896	Nerve graft, hand or foot		T	0221	37.5345	$2,562.37	.	$512.48
64897	Nerve graft, arm or leg		T	0221	37.5345	$2,562.37	.	$512.48
64898	Nerve graft, arm or leg		T	0221	37.5345	$2,562.37	.	$512.48
64901	Nerve graft add-on		T	0221	37.5345	$2,562.37	.	$512.48
64902	Nerve graft add-on		T	0221	37.5345	$2,562.37	.	$512.48
64905	Nerve pedicle transfer		T	0221	37.5345	$2,562.37	.	$512.48
64907	Nerve pedicle transfer		T	0221	37.5345	$2,562.37	.	$512.48
64910	Nerve repair w/allograft		T	0221	37.5345	$2,562.37	.	$512.48
64911	Neurorraphy w/vein autograft		T	0221	37.5345	$2,562.37	.	$512.48
64999	Nervous system surgery		T	0204	2.666	$182.00	$40.13	$36.40
65091	Revise eye		T	0242	39.3413	$2,685.71	$597.36	$537.15
65093	Revise eye with implant		T	0242	39.3413	$2,685.71	$597.36	$537.15
65101	Removal of eye		T	0242	39.3413	$2,685.71	$597.36	$537.15
65103	Remove eye/insert implant		T	0242	39.3413	$2,685.71	$597.36	$537.15
65105	Remove eye/attach implant		T	0242	39.3413	$2,685.71	$597.36	$537.15
65110	Removal of eye		T	0242	39.3413	$2,685.71	$597.36	$537.15
65112	Remove eye/revise socket		T	0242	39.3413	$2,685.71	$597.36	$537.15
65114	Remove eye/revise socket		T	0242	39.3413	$2,685.71	$597.36	$537.15
65125	Revise ocular implant		T	0241	26.8719	$1,834.46	$383.45	$366.90
65130	Insert ocular implant		T	0241	26.8719	$1,834.46	$383.45	$366.90
65135	Insert ocular implant		T	0241	26.8719	$1,834.46	$383.45	$366.90

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
65140	Attach ocular implant		T	0242	39.3413	$2,685.71	$597.36	$537.15
65150	Revise ocular implant		T	0241	26.8719	$1,834.46	$383.45	$366.90
65155	Reinsert ocular implant		T	0242	39.3413	$2,685.71	$597.36	$537.15
65175	Removal of ocular implant		T	0240	19.9889	$1,364.58	$296.20	$272.92
65205	Remove foreign body from eye		S	0698	0.9316	$63.60	.	$12.72
65210	Remove foreign body from eye		S	0698	0.9316	$63.60	.	$12.72
65220	Remove foreign body from eye		S	0698	0.9316	$63.60	.	$12.72
65222	Remove foreign body from eye		S	0698	0.9316	$63.60	.	$12.72
65235	Remove foreign body from eye		T	0233	17.0898	$1,166.67	$263.12	$233.34
65260	Remove foreign body from eye		T	0235	5.2921	$361.28	.	$72.26
65265	Remove foreign body from eye		T	0237	23.2772	$1,589.06	.	$317.82
65270	Repair of eye wound		T	0240	19.9889	$1,364.58	$296.20	$272.92
65272	Repair of eye wound		T	0234	24.5236	$1,674.15	$511.31	$334.83
65273	Repair of eye wound		C					
65275	Repair of eye wound		T	0234	24.5236	$1,674.15	$511.31	$334.83
65280	Repair of eye wound		T	0237	23.2772	$1,589.06	.	$317.82
65285	Repair of eye wound		T	0672	40.6474	$2,774.88	.	$554.98
65286	Repair of eye wound	CH	T	0255	7.8769	$537.73	$129.50	$107.55
65290	Repair of eye socket wound		T	0243	25.315	$1,728.18	$416.98	$345.64
65400	Removal of eye lesion		T	0233	17.0898	$1,166.67	$263.12	$233.34
65410	Biopsy of cornea		T	0233	17.0898	$1,166.67	$263.12	$233.34
65420	Removal of eye lesion		T	0233	17.0898	$1,166.67	$263.12	$233.34
65426	Removal of eye lesion		T	0234	24.5236	$1,674.15	$511.31	$334.83
65430	Corneal smear		S	0698	0.9316	$63.60	.	$12.72
65435	Curette/treat cornea		T	0239	7.783	$531.32	.	$106.27
65436	Curette/treat cornea		T	0233	17.0898	$1,166.67	$263.12	$233.34
65450	Treatment of corneal lesion		S	0231	2.2924	$156.50	.	$31.30
65600	Revision of cornea		T	0240	19.9889	$1,364.58	$296.20	$272.92
65710	Corneal transplant		T	0244	39.038	$2,665.01	$803.26	$533.01

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
65730	Corneal transplant		T	0244	39.038	$2,665.01	$803.26	$533.01
65750	Corneal transplant		T	0244	39.038	$2,665.01	$803.26	$533.01
65755	Corneal transplant		T	0244	39.038	$2,665.01	$803.26	$533.01
65756	Corneal trnspl, endothelial		T	0244	39.038	$2,665.01	$803.26	$533.01
65757	Prep corneal endo allograft		N					
65760	Revision of cornea		E					
65765	Revision of cornea		E					
65767	Corneal tissue transplant		E					
65770	Revise cornea with implant		T	0293	113.4961	$7,748.04	.	$1,549.61
65771	Radial keratotomy		E					
65772	Correction of astigmatism		T	0233	17.0898	$1,166.67	$263.12	$233.34
65775	Correction of astigmatism		T	0233	17.0898	$1,166.67	$263.12	$233.34
65780	Ocular reconst, transplant		T	0244	39.038	$2,665.01	$803.26	$533.01
65781	Ocular reconst, transplant		T	0244	39.038	$2,665.01	$803.26	$533.01
65782	Ocular reconst, transplant		T	0244	39.038	$2,665.01	$803.26	$533.01
65800	Drainage of eye	CH	T	0255	7.8769	$537.73	$129.50	$107.55
65805	Drainage of eye		T	0233	17.0898	$1,166.67	$263.12	$233.34
65810	Drainage of eye		T	0234	24.5236	$1,674.15	$511.31	$334.83
65815	Drainage of eye		T	0234	24.5236	$1,674.15	$511.31	$334.83
65820	Relieve inner eye pressure	CH	T	0234	24.5236	$1,674.15	$511.31	$334.83
65850	Incision of eye		T	0234	24.5236	$1,674.15	$511.31	$334.83
65855	Laser surgery of eye		T	0247	5.5659	$379.97	$104.31	$76.00
65860	Incise inner eye adhesions		T	0247	5.5659	$379.97	$104.31	$76.00
65865	Incise inner eye adhesions		T	0233	17.0898	$1,166.67	$263.12	$233.34
65870	Incise inner eye adhesions		T	0234	24.5236	$1,674.15	$511.31	$334.83
65875	Incise inner eye adhesions		T	0234	24.5236	$1,674.15	$511.31	$334.83
65880	Incise inner eye adhesions		T	0233	17.0898	$1,166.67	$263.12	$233.34
65900	Remove eye lesion	CH	T	0232	2.4827	$169.49	$40.82	$33.90
65920	Remove implant of eye		T	0234	24.5236	$1,674.15	$511.31	$334.83

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
65930	Remove blood clot from eye		T	0234	24.5236	$1,674.15	$511.31	$334.83
66020	Injection treatment of eye		T	0233	17.0898	$1,166.67	$263.12	$233.34
66030	Injection treatment of eye	CH	T	0233	17.0898	$1,166.67	$263.12	$233.34
66130	Remove eye lesion		T	0234	24.5236	$1,674.15	$511.31	$334.83
66150	Glaucoma surgery		T	0234	24.5236	$1,674.15	$511.31	$334.83
66155	Glaucoma surgery		T	0234	24.5236	$1,674.15	$511.31	$334.83
66160	Glaucoma surgery		T	0234	24.5236	$1,674.15	$511.31	$334.83
66165	Glaucoma surgery		T	0234	24.5236	$1,674.15	$511.31	$334.83
66170	Glaucoma surgery		T	0234	24.5236	$1,674.15	$511.31	$334.83
66172	Incision of eye		T	0234	24.5236	$1,674.15	$511.31	$334.83
66180	Implant eye shunt		T	0673	44.5131	$3,038.78	$649.56	$607.76
66185	Revise eye shunt		T	0234	24.5236	$1,674.15	$511.31	$334.83
66220	Repair eye lesion		T	0672	40.6474	$2,774.88	.	$554.98
66225	Repair/graft eye lesion		T	0673	44.5131	$3,038.78	$649.56	$607.76
66250	Follow-up surgery of eye		T	0233	17.0898	$1,166.67	$263.12	$233.34
66500	Incision of iris		T	0232	2.4827	$169.49	$40.82	$33.90
66505	Incision of iris	CH	T	0255	7.8769	$537.73	$129.50	$107.55
66600	Remove iris and lesion		T	0234	24.5236	$1,674.15	$511.31	$334.83
66605	Removal of iris		T	0234	24.5236	$1,674.15	$511.31	$334.83
66625	Removal of iris	CH	T	0255	7.8769	$537.73	$129.50	$107.55
66630	Removal of iris		T	0234	24.5236	$1,674.15	$511.31	$334.83
66635	Removal of iris		T	0234	24.5236	$1,674.15	$511.31	$334.83
66680	Repair iris & ciliary body		T	0234	24.5236	$1,674.15	$511.31	$334.83
66682	Repair iris & ciliary body		T	0234	24.5236	$1,674.15	$511.31	$334.83
66700	Destruction, ciliary body		T	0233	17.0898	$1,166.67	$263.12	$233.34
66710	Ciliary transscleral therapy		T	0233	17.0898	$1,166.67	$263.12	$233.34
66711	Ciliary endoscopic ablation		T	0233	17.0898	$1,166.67	$263.12	$233.34
66720	Destruction, ciliary body		T	0233	17.0898	$1,166.67	$263.12	$233.34
66740	Destruction, ciliary body		T	0234	24.5236	$1,674.15	$511.31	$334.83

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
66761	Revision of iris		T	0247	5.5659	$379.97	$104.31	$76.00
66762	Revision of iris		T	0247	5.5659	$379.97	$104.31	$76.00
66770	Removal of inner eye lesion		T	0247	5.5659	$379.97	$104.31	$76.00
66820	Incision, secondary cataract	CH	T	0255	7.8769	$537.73	$129.50	$107.55
66821	After cataract laser surgery		T	0247	5.5659	$379.97	$104.31	$76.00
66825	Reposition intraocular lens		T	0234	24.5236	$1,674.15	$511.31	$334.83
66830	Removal of lens lesion	CH	T	0255	7.8769	$537.73	$129.50	$107.55
66840	Removal of lens material		T	0245	14.3198	$977.57	$196.91	$195.52
66850	Removal of lens material		T	0249	31.0191	$2,117.58	$516.99	$423.52
66852	Removal of lens material		T	0249	31.0191	$2,117.58	$516.99	$423.52
66920	Extraction of lens		T	0249	31.0191	$2,117.58	$516.99	$423.52
66930	Extraction of lens		T	0249	31.0191	$2,117.58	$516.99	$423.52
66940	Extraction of lens		T	0245	14.3198	$977.57	$196.91	$195.52
66982	Cataract surgery, complex		T	0246	24.7788	$1,691.57	$495.96	$338.32
66983	Cataract surg w/iol, 1 stage		T	0246	24.7788	$1,691.57	$495.96	$338.32
66984	Cataract surg w/iol, 1 stage		T	0246	24.7788	$1,691.57	$495.96	$338.32
66985	Insert lens prosthesis		T	0246	24.7788	$1,691.57	$495.96	$338.32
66986	Exchange lens prosthesis		T	0246	24.7788	$1,691.57	$495.96	$338.32
66990	Ophthalmic endoscope add-on		N					
66999	Eye surgery procedure		T	0232	2.4827	$169.49	$40.82	$33.90
67005	Partial removal of eye fluid		T	0237	23.2772	$1,589.06	.	$317.82
67010	Partial removal of eye fluid		T	0672	40.6474	$2,774.88	.	$554.98
67015	Release of eye fluid		T	0672	40.6474	$2,774.88	.	$554.98
67025	Replace eye fluid	CH	T	0672	40.6474	$2,774.88	.	$554.98
67027	Implant eye drug system		T	0672	40.6474	$2,774.88	.	$554.98
67028	Injection eye drug		T	0238	3.1607	$215.77	.	$43.16
67030	Incise inner eye strands		T	0237	23.2772	$1,589.06	.	$317.82
67031	Laser surgery, eye strands		T	0247	5.5659	$379.97	$104.31	$76.00
67036	Removal of inner eye fluid		T	0672	40.6474	$2,774.88	.	$554.98

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
67039	Laser treatment of retina		T	0672	40.6474	$2,774.88	.	$554.98
67040	Laser treatment of retina		T	0672	40.6474	$2,774.88	.	$554.98
67041	Vit for macular pucker		T	0672	40.6474	$2,774.88	.	$554.98
67042	Vit for macular hole		T	0672	40.6474	$2,774.88	.	$554.98
67043	Vit for membrane dissect		T	0672	40.6474	$2,774.88	.	$554.98
67101	Repair detached retina		T	0237	23.2772	$1,589.06	.	$317.82
67105	Repair detached retina		T	0247	5.5659	$379.97	$104.31	$76.00
67107	Repair detached retina		T	0672	40.6474	$2,774.88	.	$554.98
67108	Repair detached retina		T	0672	40.6474	$2,774.88	.	$554.98
67110	Repair detached retina		T	0237	23.2772	$1,589.06	.	$317.82
67112	Rerepair detached retina		T	0672	40.6474	$2,774.88	.	$554.98
67113	Repair retinal detach, cplx		T	0672	40.6474	$2,774.88	.	$554.98
67115	Release encircling material		T	0237	23.2772	$1,589.06	.	$317.82
67120	Remove eye implant material		T	0237	23.2772	$1,589.06	.	$317.82
67121	Remove eye implant material	CH	T	0672	40.6474	$2,774.88	.	$554.98
67141	Treatment of retina		T	0235	5.2921	$361.28	.	$72.26
67145	Treatment of retina		T	0247	5.5659	$379.97	$104.31	$76.00
67208	Treatment of retinal lesion		T	0235	5.2921	$361.28	.	$72.26
67210	Treatment of retinal lesion		T	0247	5.5659	$379.97	$104.31	$76.00
67218	Treatment of retinal lesion		T	0237	23.2772	$1,589.06	.	$317.82
67220	Treatment of choroid lesion		T	0235	5.2921	$361.28	.	$72.26
67221	Ocular photodynamic ther		T	0235	5.2921	$361.28	.	$72.26
67225	Eye photodynamic ther add-on		T	0235	5.2921	$361.28	.	$72.26
67227	Treatment of retinal lesion		T	0237	23.2772	$1,589.06	.	$317.82
67228	Treatment of retinal lesion		T	0247	5.5659	$379.97	$104.31	$76.00
67229	Tr retinal les preterm inf		T	0247	5.5659	$379.97	$104.31	$76.00
67250	Reinforce eye wall		T	0240	19.9889	$1,364.58	$296.20	$272.92
67255	Reinforce/graft eye wall		T	0237	23.2772	$1,589.06	.	$317.82
67299	Eye surgery procedure		T	0235	5.2921	$361.28	.	$72.26

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
67311	Revise eye muscle		T	0243	25.315	$1,728.18	$416.98	$345.64
67312	Revise two eye muscles		T	0243	25.315	$1,728.18	$416.98	$345.64
67314	Revise eye muscle		T	0243	25.315	$1,728.18	$416.98	$345.64
67316	Revise two eye muscles		T	0243	25.315	$1,728.18	$416.98	$345.64
67318	Revise eye muscle(s)		T	0243	25.315	$1,728.18	$416.98	$345.64
67320	Revise eye muscle(s) add-on		T	0243	25.315	$1,728.18	$416.98	$345.64
67331	Eye surgery follow-up add-on		T	0243	25.315	$1,728.18	$416.98	$345.64
67332	Rerevise eye muscles add-on		T	0243	25.315	$1,728.18	$416.98	$345.64
67334	Revise eye muscle w/suture		T	0243	25.315	$1,728.18	$416.98	$345.64
67335	Eye suture during surgery		T	0243	25.315	$1,728.18	$416.98	$345.64
67340	Revise eye muscle add-on		T	0243	25.315	$1,728.18	$416.98	$345.64
67343	Release eye tissue		T	0243	25.315	$1,728.18	$416.98	$345.64
67345	Destroy nerve of eye muscle		T	0238	3.1607	$215.77	.	$43.16
67346	Biopsy, eye muscle		T	0699	16.6419	$1,136.09	.	$227.22
67399	Eye muscle surgery procedure		T	0243	25.315	$1,728.18	$416.98	$345.64
67400	Explore/biopsy eye socket		T	0240	19.9889	$1,364.58	$296.20	$272.92
67405	Explore/drain eye socket		T	0241	26.8719	$1,834.46	$383.45	$366.90
67412	Explore/treat eye socket		T	0240	19.9889	$1,364.58	$296.20	$272.92
67413	Explore/treat eye socket		T	0241	26.8719	$1,834.46	$383.45	$366.90
67414	Explr/decompress eye socket		T	0242	39.3413	$2,685.71	$597.36	$537.15
67415	Aspiration, orbital contents		T	0240	19.9889	$1,364.58	$296.20	$272.92
67420	Explore/treat eye socket		T	0242	39.3413	$2,685.71	$597.36	$537.15
67430	Explore/treat eye socket		T	0242	39.3413	$2,685.71	$597.36	$537.15
67440	Explore/drain eye socket		T	0242	39.3413	$2,685.71	$597.36	$537.15
67445	Explr/decompress eye socket		T	0242	39.3413	$2,685.71	$597.36	$537.15
67450	Explore/biopsy eye socket		T	0242	39.3413	$2,685.71	$597.36	$537.15
67500	Inject/treat eye socket		S	0231	2.2924	$156.50	.	$31.30
67505	Inject/treat eye socket		T	0238	3.1607	$215.77	.	$43.16
67515	Inject/treat eye socket		T	0238	3.1607	$215.77	.	$43.16

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
67550	Insert eye socket implant		T	0242	39.3413	$2,685.71	$597.36	$537.15
67560	Revise eye socket implant		T	0241	26.8719	$1,834.46	$383.45	$366.90
67570	Decompress optic nerve		T	0242	39.3413	$2,685.71	$597.36	$537.15
67599	Orbit surgery procedure		T	0238	3.1607	$215.77	.	$43.16
67700	Drainage of eyelid abscess		T	0238	3.1607	$215.77	.	$43.16
67710	Incision of eyelid		T	0239	7.783	$531.32	.	$106.27
67715	Incision of eyelid fold		T	0240	19.9889	$1,364.58	$296.20	$272.92
67800	Remove eyelid lesion		T	0238	3.1607	$215.77	.	$43.16
67801	Remove eyelid lesions		T	0239	7.783	$531.32	.	$106.27
67805	Remove eyelid lesions		T	0238	3.1607	$215.77	.	$43.16
67808	Remove eyelid lesion(s)		T	0240	19.9889	$1,364.58	$296.20	$272.92
67810	Biopsy of eyelid		T	0238	3.1607	$215.77	.	$43.16
67820	Revise eyelashes		S	0698	0.9316	$63.60	.	$12.72
67825	Revise eyelashes		T	0238	3.1607	$215.77	.	$43.16
67830	Revise eyelashes		T	0239	7.783	$531.32	.	$106.27
67835	Revise eyelashes		T	0240	19.9889	$1,364.58	$296.20	$272.92
67840	Remove eyelid lesion		T	0239	7.783	$531.32	.	$106.27
67850	Treat eyelid lesion		T	0239	7.783	$531.32	.	$106.27
67875	Closure of eyelid by suture		T	0239	7.783	$531.32	.	$106.27
67880	Revision of eyelid		T	0233	17.0898	$1,166.67	$263.12	$233.34
67882	Revision of eyelid		T	0240	19.9889	$1,364.58	$296.20	$272.92
67900	Repair brow defect		T	0241	26.8719	$1,834.46	$383.45	$366.90
67901	Repair eyelid defect		T	0240	19.9889	$1,364.58	$296.20	$272.92
67902	Repair eyelid defect		T	0241	26.8719	$1,834.46	$383.45	$366.90
67903	Repair eyelid defect		T	0240	19.9889	$1,364.58	$296.20	$272.92
67904	Repair eyelid defect		T	0240	19.9889	$1,364.58	$296.20	$272.92
67906	Repair eyelid defect		T	0240	19.9889	$1,364.58	$296.20	$272.92
67908	Repair eyelid defect		T	0240	19.9889	$1,364.58	$296.20	$272.92
67909	Revise eyelid defect		T	0240	19.9889	$1,364.58	$296.20	$272.92

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
67911	Revise eyelid defect		T	0240	19.9889	$1,364.58	$296.20	$272.92
67912	Correction eyelid w/implant		T	0240	19.9889	$1,364.58	$296.20	$272.92
67914	Repair eyelid defect		T	0240	19.9889	$1,364.58	$296.20	$272.92
67915	Repair eyelid defect		T	0240	19.9889	$1,364.58	$296.20	$272.92
67916	Repair eyelid defect		T	0240	19.9889	$1,364.58	$296.20	$272.92
67917	Repair eyelid defect		T	0240	19.9889	$1,364.58	$296.20	$272.92
67921	Repair eyelid defect		T	0240	19.9889	$1,364.58	$296.20	$272.92
67922	Repair eyelid defect		T	0240	19.9889	$1,364.58	$296.20	$272.92
67923	Repair eyelid defect		T	0240	19.9889	$1,364.58	$296.20	$272.92
67924	Repair eyelid defect		T	0240	19.9889	$1,364.58	$296.20	$272.92
67930	Repair eyelid wound		T	0240	19.9889	$1,364.58	$296.20	$272.92
67935	Repair eyelid wound		T	0240	19.9889	$1,364.58	$296.20	$272.92
67938	Remove eyelid foreign body		S	0231	2.2924	$156.50	.	$31.30
67950	Revision of eyelid		T	0240	19.9889	$1,364.58	$296.20	$272.92
67961	Revision of eyelid		T	0240	19.9889	$1,364.58	$296.20	$272.92
67966	Revision of eyelid		T	0240	19.9889	$1,364.58	$296.20	$272.92
67971	Reconstruction of eyelid		T	0240	19.9889	$1,364.58	$296.20	$272.92
67973	Reconstruction of eyelid		T	0241	26.8719	$1,834.46	$383.45	$366.90
67974	Reconstruction of eyelid		T	0240	19.9889	$1,364.58	$296.20	$272.92
67975	Reconstruction of eyelid		T	0240	19.9889	$1,364.58	$296.20	$272.92
67999	Revision of eyelid		T	0238	3.1607	$215.77	.	$43.16
68020	Incise/drain eyelid lining		T	0238	3.1607	$215.77	.	$43.16
68040	Treatment of eyelid lesions		S	0698	0.9316	$63.60	.	$12.72
68100	Biopsy of eyelid lining	CH	T	0255	7.8769	$537.73	$129.50	$107.55
68110	Remove eyelid lining lesion		T	0699	16.6419	$1,136.09	.	$227.22
68115	Remove eyelid lining lesion		T	0240	19.9889	$1,364.58	$296.20	$272.92
68130	Remove eyelid lining lesion		T	0233	17.0898	$1,166.67	$263.12	$233.34
68135	Remove eyelid lining lesion		T	0239	7.783	$531.32	.	$106.27
68200	Treat eyelid by injection		S	0698	0.9316	$63.60	.	$12.72

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
68320	Revise/graft eyelid lining		T	0241	26.8719	$1,834.46	$383.45	$366.90
68325	Revise/graft eyelid lining		T	0241	26.8719	$1,834.46	$383.45	$366.90
68326	Revise/graft eyelid lining		T	0240	19.9889	$1,364.58	$296.20	$272.92
68328	Revise/graft eyelid lining		T	0241	26.8719	$1,834.46	$383.45	$366.90
68330	Revise eyelid lining		T	0234	24.5236	$1,674.15	$511.31	$334.83
68335	Revise/graft eyelid lining		T	0241	26.8719	$1,834.46	$383.45	$366.90
68340	Separate eyelid adhesions		T	0240	19.9889	$1,364.58	$296.20	$272.92
68360	Revise eyelid lining		T	0234	24.5236	$1,674.15	$511.31	$334.83
68362	Revise eyelid lining		T	0234	24.5236	$1,674.15	$511.31	$334.83
68371	Harvest eye tissue, alograft		T	0233	17.0898	$1,166.67	$263.12	$233.34
68399	Eyelid lining surgery		T	0238	3.1607	$215.77	.	$43.16
68400	Incise/drain tear gland		T	0238	3.1607	$215.77	.	$43.16
68420	Incise/drain tear sac		T	0240	19.9889	$1,364.58	$296.20	$272.92
68440	Incise tear duct opening		T	0238	3.1607	$215.77	.	$43.16
68500	Removal of tear gland		T	0241	26.8719	$1,834.46	$383.45	$366.90
68505	Partial removal, tear gland		T	0241	26.8719	$1,834.46	$383.45	$366.90
68510	Biopsy of tear gland		T	0240	19.9889	$1,364.58	$296.20	$272.92
68520	Removal of tear sac		T	0241	26.8719	$1,834.46	$383.45	$366.90
68525	Biopsy of tear sac		T	0240	19.9889	$1,364.58	$296.20	$272.92
68530	Clearance of tear duct		T	0238	3.1607	$215.77	.	$43.16
68540	Remove tear gland lesion		T	0240	19.9889	$1,364.58	$296.20	$272.92
68550	Remove tear gland lesion		T	0241	26.8719	$1,834.46	$383.45	$366.90
68700	Repair tear ducts		T	0240	19.9889	$1,364.58	$296.20	$272.92
68705	Revise tear duct opening		T	0238	3.1607	$215.77	.	$43.16
68720	Create tear sac drain		T	0241	26.8719	$1,834.46	$383.45	$366.90
68745	Create tear duct drain		T	0241	26.8719	$1,834.46	$383.45	$366.90
68750	Create tear duct drain		T	0241	26.8719	$1,834.46	$383.45	$366.90
68760	Close tear duct opening		T	0238	3.1607	$215.77	.	$43.16
68761	Close tear duct opening		T	0238	3.1607	$215.77	.	$43.16

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
68770	Close tear system fistula		T	0241	26.8719	$1,834.46	$383.45	$366.90
68801	Dilate tear duct opening		S	0698	0.9316	$63.60	.	$12.72
68810	Probe nasolacrimal duct		T	0238	3.1607	$215.77	.	$43.16
68811	Probe nasolacrimal duct		T	0240	19.9889	$1,364.58	$296.20	$272.92
68815	Probe nasolacrimal duct		T	0240	19.9889	$1,364.58	$296.20	$272.92
68816	Probe nl duct w/balloon		T	0240	19.9889	$1,364.58	$296.20	$272.92
68840	Explore/irrigate tear ducts		S	0231	2.2924	$156.50	.	$31.30
68850	Injection for tear sac x-ray		N					
68899	Tear duct system surgery		T	0238	3.1607	$215.77	.	$43.16
69000	Drain external ear lesion		T	0006	1.4939	$101.98	.	$20.40
69005	Drain external ear lesion		T	0008	20.2481	$1,382.28	.	$276.46
69020	Drain outer ear canal lesion		T	0006	1.4939	$101.98	.	$20.40
69090	Pierce earlobes		E					
69100	Biopsy of external ear		T	0251	3.4369	$234.63	.	$46.93
69105	Biopsy of external ear canal		T	0253	17.4151	$1,188.88	$282.29	$237.78
69110	Remove external ear, partial		T	0021	18.2223	$1,243.98	.	$248.80
69120	Removal of external ear		T	0254	25.5397	$1,743.52	.	$348.71
69140	Remove ear canal lesion(s)		T	0254	25.5397	$1,743.52	.	$348.71
69145	Remove ear canal lesion(s)		T	0021	18.2223	$1,243.98	.	$248.80
69150	Extensive ear canal surgery		T	0252	7.8743	$537.55	$109.16	$107.51
69155	Extensive ear/neck surgery		C					
69200	Clear outer ear canal		X	0340	0.6899	$47.10	.	$9.42
69205	Clear outer ear canal		T	0022	24.1269	$1,647.07	$354.45	$329.42
69210	Remove impacted ear wax		X	0340	0.6899	$47.10	.	$9.42
69220	Clean out mastoid cavity		T	0013	0.8782	$59.95	.	$11.99
69222	Clean out mastoid cavity		T	0253	17.4151	$1,188.88	$282.29	$237.78
69300	Revise external ear		T	0254	25.5397	$1,743.52	.	$348.71
69310	Rebuild outer ear canal		T	0256	44.8441	$3,061.37	.	$612.28
69320	Rebuild outer ear canal		T	0256	44.8441	$3,061.37	.	$612.28

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
69399	Outer ear surgery procedure		T	0250	1.1743	$80.17	$25.10	$16.04
69400	Inflate middle ear canal		T	0251	3.4369	$234.63	.	$46.93
69401	Inflate middle ear canal		T	0251	3.4369	$234.63	.	$46.93
69405	Catheterize middle ear canal		T	0252	7.8743	$537.55	$109.16	$107.51
69420	Incision of eardrum		T	0251	3.4369	$234.63	.	$46.93
69421	Incision of eardrum		T	0253	17.4151	$1,188.88	$282.29	$237.78
69424	Remove ventilating tube		T	0253	17.4151	$1,188.88	$282.29	$237.78
69433	Create eardrum opening		T	0252	7.8743	$537.55	$109.16	$107.51
69436	Create eardrum opening		T	0253	17.4151	$1,188.88	$282.29	$237.78
69440	Exploration of middle ear		T	0254	25.5397	$1,743.52	.	$348.71
69450	Eardrum revision		T	0256	44.8441	$3,061.37	.	$612.28
69501	Mastoidectomy		T	0256	44.8441	$3,061.37	.	$612.28
69502	Mastoidectomy		T	0254	25.5397	$1,743.52	.	$348.71
69505	Remove mastoid structures		T	0256	44.8441	$3,061.37	.	$612.28
69511	Extensive mastoid surgery		T	0256	44.8441	$3,061.37	.	$612.28
69530	Extensive mastoid surgery		T	0256	44.8441	$3,061.37	.	$612.28
69535	Remove part of temporal bone		C					
69540	Remove ear lesion		T	0253	17.4151	$1,188.88	$282.29	$237.78
69550	Remove ear lesion		T	0256	44.8441	$3,061.37	.	$612.28
69552	Remove ear lesion		T	0256	44.8441	$3,061.37	.	$612.28
69554	Remove ear lesion		C					
69601	Mastoid surgery revision		T	0256	44.8441	$3,061.37	.	$612.28
69602	Mastoid surgery revision		T	0256	44.8441	$3,061.37	.	$612.28
69603	Mastoid surgery revision		T	0256	44.8441	$3,061.37	.	$612.28
69604	Mastoid surgery revision		T	0256	44.8441	$3,061.37	.	$612.28
69605	Mastoid surgery revision		T	0256	44.8441	$3,061.37	.	$612.28
69610	Repair of eardrum		T	0254	25.5397	$1,743.52	.	$348.71
69620	Repair of eardrum		T	0254	25.5397	$1,743.52	.	$348.71
69631	Repair eardrum structures		T	0256	44.8441	$3,061.37	.	$612.28

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
69632	Rebuild eardrum structures		T	0256	44.8441	$3,061.37	.	$612.28
69633	Rebuild eardrum structures		T	0256	44.8441	$3,061.37	.	$612.28
69635	Repair eardrum structures		T	0256	44.8441	$3,061.37	.	$612.28
69636	Rebuild eardrum structures		T	0256	44.8441	$3,061.37	.	$612.28
69637	Rebuild eardrum structures		T	0256	44.8441	$3,061.37	.	$612.28
69641	Revise middle ear & mastoid		T	0256	44.8441	$3,061.37	.	$612.28
69642	Revise middle ear & mastoid		T	0256	44.8441	$3,061.37	.	$612.28
69643	Revise middle ear & mastoid		T	0256	44.8441	$3,061.37	.	$612.28
69644	Revise middle ear & mastoid		T	0256	44.8441	$3,061.37	.	$612.28
69645	Revise middle ear & mastoid		T	0256	44.8441	$3,061.37	.	$612.28
69646	Revise middle ear & mastoid		T	0256	44.8441	$3,061.37	.	$612.28
69650	Release middle ear bone		T	0254	25.5397	$1,743.52	.	$348.71
69660	Revise middle ear bone		T	0256	44.8441	$3,061.37	.	$612.28
69661	Revise middle ear bone		T	0256	44.8441	$3,061.37	.	$612.28
69662	Revise middle ear bone		T	0256	44.8441	$3,061.37	.	$612.28
69666	Repair middle ear structures		T	0256	44.8441	$3,061.37	.	$612.28
69667	Repair middle ear structures		T	0256	44.8441	$3,061.37	.	$612.28
69670	Remove mastoid air cells		T	0256	44.8441	$3,061.37	.	$612.28
69676	Remove middle ear nerve		T	0256	44.8441	$3,061.37	.	$612.28
69700	Close mastoid fistula		T	0256	44.8441	$3,061.37	.	$612.28
69710	Implant/replace hearing aid		E					
69711	Remove/repair hearing aid		T	0256	44.8441	$3,061.37	.	$612.28
69714	Implant temple bone w/stimul		T	0425	122.1766	$8,340.63	.	$1,668.13
69715	Temple bne implnt w/stimulat		T	0425	122.1766	$8,340.63	.	$1,668.13
69717	Temple bone implant revision		T	0425	122.1766	$8,340.63	.	$1,668.13
69718	Revise temple bone implant		T	0425	122.1766	$8,340.63	.	$1,668.13
69720	Release facial nerve		T	0256	44.8441	$3,061.37	.	$612.28
69725	Release facial nerve		T	0256	44.8441	$3,061.37	.	$612.28
69740	Repair facial nerve		T	0256	44.8441	$3,061.37	.	$612.28

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
69745	Repair facial nerve		T	0256	44.8441	$3,061.37	.	$612.28
69799	Middle ear surgery procedure		T	0250	1.1743	$80.17	$25.10	$16.04
69801	Incise inner ear		T	0254	25.5397	$1,743.52	.	$348.71
69802	Incise inner ear		T	0254	25.5397	$1,743.52	.	$348.71
69805	Explore inner ear		T	0256	44.8441	$3,061.37	.	$612.28
69806	Explore inner ear		T	0256	44.8441	$3,061.37	.	$612.28
69820	Establish inner ear window		T	0256	44.8441	$3,061.37	.	$612.28
69840	Revise inner ear window		T	0256	44.8441	$3,061.37	.	$612.28
69905	Remove inner ear		T	0256	44.8441	$3,061.37	.	$612.28
69910	Remove inner ear & mastoid		T	0256	44.8441	$3,061.37	.	$612.28
69915	Incise inner ear nerve		T	0256	44.8441	$3,061.37	.	$612.28
69930	Implant cochlear device		T	0259	454.7997	$31,047.81	$8,543.66	$6,209.57
69949	Inner ear surgery procedure		T	0250	1.1743	$80.17	$25.10	$16.04
69950	Incise inner ear nerve		C					
69955	Release facial nerve		T	0256	44.8441	$3,061.37	.	$612.28
69960	Release inner ear canal		T	0256	44.8441	$3,061.37	.	$612.28
69970	Remove inner ear lesion		T	0256	44.8441	$3,061.37	.	$612.28
69979	Temporal bone surgery		T	0250	1.1743	$80.17	$25.10	$16.04
69990	Microsurgery add-on		N					
70010	Contrast x-ray of brain		Q2	0274	7.4103	$505.88	.	$101.18
70015	Contrast x-ray of brain		Q2	0274	7.4103	$505.88	.	$101.18
70030	X-ray eye for foreign body		X	0260	0.6683	$45.62	.	$9.13
70100	X-ray exam of jaw		X	0260	0.6683	$45.62	.	$9.13
70110	X-ray exam of jaw		X	0260	0.6683	$45.62	.	$9.13
70120	X-ray exam of mastoids		X	0260	0.6683	$45.62	.	$9.13
70130	X-ray exam of mastoids		X	0260	0.6683	$45.62	.	$9.13
70134	X-ray exam of middle ear		X	0261	1.1314	$77.24	.	$15.45
70140	X-ray exam of facial bones		X	0260	0.6683	$45.62	.	$9.13
70150	X-ray exam of facial bones		X	0260	0.6683	$45.62	.	$9.13

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
70160	X-ray exam of nasal bones		X	0260	0.6683	$45.62	.	$9.13
70170	X-ray exam of tear duct		Q2	0263	3.3875	$231.25	.	$46.25
70190	X-ray exam of eye sockets		X	0260	0.6683	$45.62	.	$9.13
70200	X-ray exam of eye sockets		X	0260	0.6683	$45.62	.	$9.13
70210	X-ray exam of sinuses		X	0260	0.6683	$45.62	.	$9.13
70220	X-ray exam of sinuses		X	0260	0.6683	$45.62	.	$9.13
70240	X-ray exam, pituitary saddle		X	0260	0.6683	$45.62	.	$9.13
70250	X-ray exam of skull		X	0260	0.6683	$45.62	.	$9.13
70260	X-ray exam of skull		X	0261	1.1314	$77.24	.	$15.45
70300	X-ray exam of teeth		X	0262	0.4853	$33.13	.	$6.63
70310	X-ray exam of teeth		X	0262	0.4853	$33.13	.	$6.63
70320	Full mouth x-ray of teeth		X	0262	0.4853	$33.13	.	$6.63
70328	X-ray exam of jaw joint		X	0260	0.6683	$45.62	.	$9.13
70330	X-ray exam of jaw joints		X	0260	0.6683	$45.62	.	$9.13
70332	X-ray exam of jaw joint		Q2	0275	4.0041	$273.35	$68.90	$54.67
70336	Magnetic image, jaw joint		Q3	0336	5.1052	$348.52	$137.34	$69.71
70350	X-ray head for orthodontia		X	0260	0.6683	$45.62	.	$9.13
70355	Panoramic x-ray of jaws	CH	X	0262	0.4853	$33.13	.	$6.63
70360	X-ray exam of neck		X	0260	0.6683	$45.62	.	$9.13
70370	Throat x-ray & fluoroscopy		X	0272	1.2472	$85.14	$31.07	$17.03
70371	Speech evaluation, complex		X	0272	1.2472	$85.14	$31.07	$17.03
70373	Contrast x-ray of larynx		Q2	0263	3.3875	$231.25	.	$46.25
70380	X-ray exam of salivary gland		X	0260	0.6683	$45.62	.	$9.13
70390	X-ray exam of salivary duct		Q2	0263	3.3875	$231.25	.	$46.25
70450	Ct head/brain w/o dye		Q3	0332	2.8569	$195.03	$75.24	$39.01
70460	Ct head/brain w/dye		Q3	0283	4.412	$301.19	$96.62	$60.24
70470	Ct head/brain w/o & w/dye		Q3	0333	4.8922	$333.98	$116.13	$66.80
70480	Ct orbit/ear/fossa w/o dye		Q3	0332	2.8569	$195.03	$75.24	$39.01
70481	Ct orbit/ear/fossa w/dye		Q3	0283	4.412	$301.19	$96.62	$60.24

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
70482	Ct orbit/ear/fossa w/o&w/dye		Q3	0333	4.8922	$333.98	$116.13	$66.80
70486	Ct maxillofacial w/o dye		Q3	0332	2.8569	$195.03	$75.24	$39.01
70487	Ct maxillofacial w/dye		Q3	0283	4.412	$301.19	$96.62	$60.24
70488	Ct maxillofacial w/o & w/dye		Q3	0333	4.8922	$333.98	$116.13	$66.80
70490	Ct soft tissue neck w/o dye		Q3	0332	2.8569	$195.03	$75.24	$39.01
70491	Ct soft tissue neck w/dye		Q3	0283	4.412	$301.19	$96.62	$60.24
70492	Ct sft tsue nck w/o & w/dye		Q3	0333	4.8922	$333.98	$116.13	$66.80
70496	Ct angiography, head		Q3	0662	5.0605	$345.47	$114.75	$69.10
70498	Ct angiography, neck		Q3	0662	5.0605	$345.47	$114.75	$69.10
70540	Mri orbit/face/neck w/o dye		Q3	0336	5.1052	$348.52	$137.34	$69.71
70542	Mri orbit/face/neck w/dye		Q3	0284	6.4555	$440.70	$146.85	$88.14
70543	Mri orbt/fac/nck w/o & w/dye		Q3	0337	7.9271	$541.16	$197.83	$108.24
70544	Mr angiography head w/o dye		Q3	0336	5.1052	$348.52	$137.34	$69.71
70545	Mr angiography head w/dye		Q3	0284	6.4555	$440.70	$146.85	$88.14
70546	Mr angiograph head w/o&w/dye		Q3	0337	7.9271	$541.16	$197.83	$108.24
70547	Mr angiography neck w/o dye		Q3	0336	5.1052	$348.52	$137.34	$69.71
70548	Mr angiography neck w/dye		Q3	0284	6.4555	$440.70	$146.85	$88.14
70549	Mr angiograph neck w/o&w/dye		Q3	0337	7.9271	$541.16	$197.83	$108.24
70551	Mri brain w/o dye		Q3	0336	5.1052	$348.52	$137.34	$69.71
70552	Mri brain w/dye		Q3	0284	6.4555	$440.70	$146.85	$88.14
70553	Mri brain w/o & w/dye		Q3	0337	7.9271	$541.16	$197.83	$108.24
70554	Fmri brain by tech		Q3	0336	5.1052	$348.52	$137.34	$69.71
70555	Fmri brain by phys/psych		S	0336	5.1052	$348.52	$137.34	$69.71
70557	Mri brain w/o dye		S	0336	5.1052	$348.52	$137.34	$69.71
70558	Mri brain w/dye		S	0284	6.4555	$440.70	$146.85	$88.14
70559	Mri brain w/o & w/dye		S	0337	7.9271	$541.16	$197.83	$108.24
71010	Chest x-ray		X	0260	0.6683	$45.62	.	$9.13
71015	Chest x-ray		X	0260	0.6683	$45.62	.	$9.13
71020	Chest x-ray		X	0260	0.6683	$45.62	.	$9.13

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
71021	Chest x-ray		X	0260	0.6683	$45.62	.	$9.13
71022	Chest x-ray		X	0260	0.6683	$45.62	.	$9.13
71023	Chest x-ray and fluoroscopy		X	0272	1.2472	$85.14	$31.07	$17.03
71030	Chest x-ray		X	0260	0.6683	$45.62	.	$9.13
71034	Chest x-ray and fluoroscopy		X	0272	1.2472	$85.14	$31.07	$17.03
71035	Chest x-ray		X	0260	0.6683	$45.62	.	$9.13
71040	Contrast x-ray of bronchi		Q2	0263	3.3875	$231.25	.	$46.25
71060	Contrast x-ray of bronchi		Q2	0263	3.3875	$231.25	.	$46.25
71090	X-ray & pacemaker insertion		N					
71100	X-ray exam of ribs		X	0260	0.6683	$45.62	.	$9.13
71101	X-ray exam of ribs/chest		X	0260	0.6683	$45.62	.	$9.13
71110	X-ray exam of ribs		X	0260	0.6683	$45.62	.	$9.13
71111	X-ray exam of ribs/chest		X	0261	1.1314	$77.24	.	$15.45
71120	X-ray exam of breastbone		X	0260	0.6683	$45.62	.	$9.13
71130	X-ray exam of breastbone		X	0260	0.6683	$45.62	.	$9.13
71250	Ct thorax w/o dye		Q3	0332	2.8569	$195.03	$75.24	$39.01
71260	Ct thorax w/dye		Q3	0283	4.412	$301.19	$96.62	$60.24
71270	Ct thorax w/o & w/dye		Q3	0333	4.8922	$333.98	$116.13	$66.80
71275	Ct angiography, chest		Q3	0662	5.0605	$345.47	$114.75	$69.10
71550	Mri chest w/o dye		Q3	0336	5.1052	$348.52	$137.34	$69.71
71551	Mri chest w/dye		Q3	0284	6.4555	$440.70	$146.85	$88.14
71552	Mri chest w/o & w/dye		Q3	0337	7.9271	$541.16	$197.83	$108.24
71555	Mri angio chest w or w/o dye		B					
72010	X-ray exam of spine		X	0261	1.1314	$77.24	.	$15.45
72020	X-ray exam of spine		X	0260	0.6683	$45.62	.	$9.13
72040	X-ray exam of neck spine		X	0260	0.6683	$45.62	.	$9.13
72050	X-ray exam of neck spine		X	0261	1.1314	$77.24	.	$15.45
72052	X-ray exam of neck spine		X	0261	1.1314	$77.24	.	$15.45
72069	X-ray exam of trunk spine		X	0260	0.6683	$45.62	.	$9.13

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
72070	X-ray exam of thoracic spine		X	0260	0.6683	$45.62	.	$9.13
72072	X-ray exam of thoracic spine		X	0260	0.6683	$45.62	.	$9.13
72074	X-ray exam of thoracic spine		X	0260	0.6683	$45.62	.	$9.13
72080	X-ray exam of trunk spine		X	0260	0.6683	$45.62	.	$9.13
72090	X-ray exam of trunk spine		X	0261	1.1314	$77.24	.	$15.45
72100	X-ray exam of lower spine		X	0260	0.6683	$45.62	.	$9.13
72110	X-ray exam of lower spine		X	0261	1.1314	$77.24	.	$15.45
72114	X-ray exam of lower spine		X	0261	1.1314	$77.24	.	$15.45
72120	X-ray exam of lower spine	CH	X	0260	0.6683	$45.62	.	$9.13
72125	Ct neck spine w/o dye		Q3	0332	2.8569	$195.03	$75.24	$39.01
72126	Ct neck spine w/dye		Q3	0283	4.412	$301.19	$96.62	$60.24
72127	Ct neck spine w/o & w/dye		Q3	0333	4.8922	$333.98	$116.13	$66.80
72128	Ct chest spine w/o dye		Q3	0332	2.8569	$195.03	$75.24	$39.01
72129	Ct chest spine w/dye		Q3	0283	4.412	$301.19	$96.62	$60.24
72130	Ct chest spine w/o & w/dye		Q3	0333	4.8922	$333.98	$116.13	$66.80
72131	Ct lumbar spine w/o dye		Q3	0332	2.8569	$195.03	$75.24	$39.01
72132	Ct lumbar spine w/dye		Q3	0283	4.412	$301.19	$96.62	$60.24
72133	Ct lumbar spine w/o & w/dye		Q3	0333	4.8922	$333.98	$116.13	$66.80
72141	Mri neck spine w/o dye		Q3	0336	5.1052	$348.52	$137.34	$69.71
72142	Mri neck spine w/dye		Q3	0284	6.4555	$440.70	$146.85	$88.14
72146	Mri chest spine w/o dye		Q3	0336	5.1052	$348.52	$137.34	$69.71
72147	Mri chest spine w/dye		Q3	0284	6.4555	$440.70	$146.85	$88.14
72148	Mri lumbar spine w/o dye		Q3	0336	5.1052	$348.52	$137.34	$69.71
72149	Mri lumbar spine w/dye		Q3	0284	6.4555	$440.70	$146.85	$88.14
72156	Mri neck spine w/o & w/dye		Q3	0337	7.9271	$541.16	$197.83	$108.24
72157	Mri chest spine w/o & w/dye		Q3	0337	7.9271	$541.16	$197.83	$108.24
72158	Mri lumbar spine w/o & w/dye		Q3	0337	7.9271	$541.16	$197.83	$108.24
72159	Mr angio spine w/o&w/dye		E					
72170	X-ray exam of pelvis		X	0260	0.6683	$45.62	.	$9.13

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
72190	X-ray exam of pelvis		X	0260	0.6683	$45.62	.	$9.13
72191	Ct angiograph pelv w/o&w/dye		Q3	0662	5.0605	$345.47	$114.75	$69.10
72192	Ct pelvis w/o dye		Q3	0332	2.8569	$195.03	$75.24	$39.01
72193	Ct pelvis w/dye		Q3	0283	4.412	$301.19	$96.62	$60.24
72194	Ct pelvis w/o & w/dye		Q3	0333	4.8922	$333.98	$116.13	$66.80
72195	Mri pelvis w/o dye		Q3	0336	5.1052	$348.52	$137.34	$69.71
72196	Mri pelvis w/dye		Q3	0284	6.4555	$440.70	$146.85	$88.14
72197	Mri pelvis w/o & w/dye		Q3	0337	7.9271	$541.16	$197.83	$108.24
72198	Mr angio pelvis w/o & w/dye		B					
72200	X-ray exam sacroiliac joints		X	0260	0.6683	$45.62	.	$9.13
72202	X-ray exam sacroiliac joints		X	0260	0.6683	$45.62	.	$9.13
72220	X-ray exam of tailbone		X	0260	0.6683	$45.62	.	$9.13
72240	Contrast x-ray of neck spine		Q2	0274	7.4103	$505.88	.	$101.18
72255	Contrast x-ray, thorax spine		Q2	0274	7.4103	$505.88	.	$101.18
72265	Contrast x-ray, lower spine		Q2	0274	7.4103	$505.88	.	$101.18
72270	Contrast x-ray, spine		Q2	0274	7.4103	$505.88	.	$101.18
72275	Epidurography		N					
72285	X-ray c/t spine disk		Q2	0388	24.9242	$1,701.50	.	$340.30
72291	Perq verte/sacroplsty, fluor		N					
72292	Perq verte/sacroplsty, ct		N					
72295	X-ray of lower spine disk		Q2	0388	24.9242	$1,701.50	.	$340.30
73000	X-ray exam of collar bone		X	0260	0.6683	$45.62	.	$9.13
73010	X-ray exam of shoulder blade		X	0260	0.6683	$45.62	.	$9.13
73020	X-ray exam of shoulder		X	0260	0.6683	$45.62	.	$9.13
73030	X-ray exam of shoulder		X	0260	0.6683	$45.62	.	$9.13
73040	Contrast x-ray of shoulder		Q2	0275	4.0041	$273.35	$68.90	$54.67
73050	X-ray exam of shoulders		X	0260	0.6683	$45.62	.	$9.13
73060	X-ray exam of humerus		X	0260	0.6683	$45.62	.	$9.13
73070	X-ray exam of elbow		X	0260	0.6683	$45.62	.	$9.13

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
73080	X-ray exam of elbow		X	0260	0.6683	$45.62	.	$9.13
73085	Contrast x-ray of elbow		Q2	0275	4.0041	$273.35	$68.90	$54.67
73090	X-ray exam of forearm		X	0260	0.6683	$45.62	.	$9.13
73092	X-ray exam of arm, infant		X	0260	0.6683	$45.62	.	$9.13
73100	X-ray exam of wrist		X	0260	0.6683	$45.62	.	$9.13
73110	X-ray exam of wrist		X	0260	0.6683	$45.62	.	$9.13
73115	Contrast x-ray of wrist		Q2	0275	4.0041	$273.35	$68.90	$54.67
73120	X-ray exam of hand		X	0260	0.6683	$45.62	.	$9.13
73130	X-ray exam of hand		X	0260	0.6683	$45.62	.	$9.13
73140	X-ray exam of finger(s)		X	0260	0.6683	$45.62	.	$9.13
73200	Ct upper extremity w/o dye		Q3	0332	2.8569	$195.03	$75.24	$39.01
73201	Ct upper extremity w/dye		Q3	0283	4.412	$301.19	$96.62	$60.24
73202	Ct uppr extremity w/o&w/dye		Q3	0333	4.8922	$333.98	$116.13	$66.80
73206	Ct angio upr extrm w/o&w/dye		Q3	0662	5.0605	$345.47	$114.75	$69.10
73218	Mri upper extremity w/o dye		Q3	0336	5.1052	$348.52	$137.34	$69.71
73219	Mri upper extremity w/dye		Q3	0284	6.4555	$440.70	$146.85	$88.14
73220	Mri uppr extremity w/o&w/dye		Q3	0337	7.9271	$541.16	$197.83	$108.24
73221	Mri joint upr extrem w/o dye		Q3	0336	5.1052	$348.52	$137.34	$69.71
73222	Mri joint upr extrem w/dye		Q3	0284	6.4555	$440.70	$146.85	$88.14
73223	Mri joint upr extr w/o&w/dye		Q3	0337	7.9271	$541.16	$197.83	$108.24
73225	Mr angio upr extr w/o&w/dye		E					
73500	X-ray exam of hip		X	0260	0.6683	$45.62	.	$9.13
73510	X-ray exam of hip		X	0260	0.6683	$45.62	.	$9.13
73520	X-ray exam of hips	CH	X	0260	0.6683	$45.62	.	$9.13
73525	Contrast x-ray of hip		Q2	0275	4.0041	$273.35	$68.90	$54.67
73530	X-ray exam of hip		N					
73540	X-ray exam of pelvis & hips		X	0260	0.6683	$45.62	.	$9.13
73542	X-ray exam, sacroiliac joint		Q2	0275	4.0041	$273.35	$68.90	$54.67
73550	X-ray exam of thigh		X	0260	0.6683	$45.62	.	$9.13

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
73560	X-ray exam of knee, 1 or 2		X	0260	0.6683	$45.62	.	$9.13
73562	X-ray exam of knee, 3		X	0260	0.6683	$45.62	.	$9.13
73564	X-ray exam, knee, 4 or more		X	0260	0.6683	$45.62	.	$9.13
73565	X-ray exam of knees		X	0260	0.6683	$45.62	.	$9.13
73580	Contrast x-ray of knee joint		Q2	0275	4.0041	$273.35	$68.90	$54.67
73590	X-ray exam of lower leg		X	0260	0.6683	$45.62	.	$9.13
73592	X-ray exam of leg, infant		X	0260	0.6683	$45.62	.	$9.13
73600	X-ray exam of ankle		X	0260	0.6683	$45.62	.	$9.13
73610	X-ray exam of ankle		X	0260	0.6683	$45.62	.	$9.13
73615	Contrast x-ray of ankle		Q2	0275	4.0041	$273.35	$68.90	$54.67
73620	X-ray exam of foot		X	0260	0.6683	$45.62	.	$9.13
73630	X-ray exam of foot		X	0260	0.6683	$45.62	.	$9.13
73650	X-ray exam of heel		X	0260	0.6683	$45.62	.	$9.13
73660	X-ray exam of toe(s)		X	0260	0.6683	$45.62	.	$9.13
73700	Ct lower extremity w/o dye		Q3	0332	2.8569	$195.03	$75.24	$39.01
73701	Ct lower extremity w/dye		Q3	0283	4.412	$301.19	$96.62	$60.24
73702	Ct lwr extremity w/o&w/dye		Q3	0333	4.8922	$333.98	$116.13	$66.80
73706	Ct angio lwr extr w/o&w/dye		Q3	0662	5.0605	$345.47	$114.75	$69.10
73718	Mri lower extremity w/o dye		Q3	0336	5.1052	$348.52	$137.34	$69.71
73719	Mri lower extremity w/dye		Q3	0284	6.4555	$440.70	$146.85	$88.14
73720	Mri lwr extremity w/o&w/dye		Q3	0337	7.9271	$541.16	$197.83	$108.24
73721	Mri jnt of lwr extre w/o dye		Q3	0336	5.1052	$348.52	$137.34	$69.71
73722	Mri joint of lwr extr w/dye		Q3	0284	6.4555	$440.70	$146.85	$88.14
73723	Mri joint lwr extr w/o&w/dye		Q3	0337	7.9271	$541.16	$197.83	$108.24
73725	Mr ang lwr ext w or w/o dye		B					
74000	X-ray exam of abdomen		X	0260	0.6683	$45.62	.	$9.13
74010	X-ray exam of abdomen		X	0260	0.6683	$45.62	.	$9.13
74020	X-ray exam of abdomen		X	0260	0.6683	$45.62	.	$9.13
74022	X-ray exam series, abdomen		X	0261	1.1314	$77.24	.	$15.45

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
74150	Ct abdomen w/o dye		Q3	0332	2.8569	$195.03	$75.24	$39.01
74160	Ct abdomen w/dye		Q3	0283	4.412	$301.19	$96.62	$60.24
74170	Ct abdomen w/o & w/dye		Q3	0333	4.8922	$333.98	$116.13	$66.80
74175	Ct angio abdom w/o & w/dye		Q3	0662	5.0605	$345.47	$114.75	$69.10
74181	Mri abdomen w/o dye		Q3	0336	5.1052	$348.52	$137.34	$69.71
74182	Mri abdomen w/dye		Q3	0284	6.4555	$440.70	$146.85	$88.14
74183	Mri abdomen w/o & w/dye		Q3	0337	7.9271	$541.16	$197.83	$108.24
74185	Mri angio, abdom w orw/o dye		B					
74190	X-ray exam of peritoneum		Q2	0263	3.3875	$231.25	.	$46.25
74210	Contrst x-ray exam of throat		S	0276	1.289	$88.00	$34.66	$17.60
74220	Contrast x-ray, esophagus		S	0276	1.289	$88.00	$34.66	$17.60
74230	Cine/vid x-ray, throat/esoph		S	0276	1.289	$88.00	$34.66	$17.60
74235	Remove esophagus obstruction		N					
74240	X-ray exam, upper gi tract		S	0276	1.289	$88.00	$34.66	$17.60
74241	X-ray exam, upper gi tract		S	0276	1.289	$88.00	$34.66	$17.60
74245	X-ray exam, upper gi tract		S	0277	2.0916	$142.79	$53.90	$28.56
74246	Contrst x-ray uppr gi tract		S	0276	1.289	$88.00	$34.66	$17.60
74247	Contrst x-ray uppr gi tract		S	0276	1.289	$88.00	$34.66	$17.60
74249	Contrst x-ray uppr gi tract		S	0277	2.0916	$142.79	$53.90	$28.56
74250	X-ray exam of small bowel		S	0276	1.289	$88.00	$34.66	$17.60
74251	X-ray exam of small bowel		S	0277	2.0916	$142.79	$53.90	$28.56
74260	X-ray exam of small bowel		S	0276	1.289	$88.00	$34.66	$17.60
74261	Ct colonography, w/o dye		Q3	0332	2.8569	$195.03	$75.24	$39.01
74262	Ct colonography, w/dye		Q3	0283	4.412	$301.19	$96.62	$60.24
74263	Ct colonography, screen		E					
74270	Contrast x-ray exam of colon		S	0276	1.289	$88.00	$34.66	$17.60
74280	Contrast x-ray exam of colon		S	0277	2.0916	$142.79	$53.90	$28.56
74283	Contrast x-ray exam of colon		S	0276	1.289	$88.00	$34.66	$17.60
74290	Contrast x-ray, gallbladder		S	0276	1.289	$88.00	$34.66	$17.60

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
74291	Contrast x-rays, gallbladder		S	0276	1.289	$88.00	$34.66	$17.60
74300	X-ray bile ducts/pancreas		N					
74301	X-rays at surgery add-on		N					
74305	X-ray bile ducts/pancreas		Q2	0263	3.3875	$231.25	.	$46.25
74320	Contrast x-ray of bile ducts		Q2	0317	5.982	$408.37	.	$81.68
74327	X-ray bile stone removal		N					
74328	X-ray bile duct endoscopy		N					
74329	X-ray for pancreas endoscopy		N					
74330	X-ray bile/panc endoscopy		N					
74340	X-ray guide for GI tube		N					
74355	X-ray guide, intestinal tube		N					
74360	X-ray guide, GI dilation		N					
74363	X-ray, bile duct dilation		N					
74400	Contrst x-ray, urinary tract		S	0278	2.591	$176.88	$58.44	$35.38
74410	Contrst x-ray, urinary tract		S	0278	2.591	$176.88	$58.44	$35.38
74415	Contrst x-ray, urinary tract		S	0278	2.591	$176.88	$58.44	$35.38
74420	Contrst x-ray, urinary tract		S	0278	2.591	$176.88	$58.44	$35.38
74425	Contrst x-ray, urinary tract		Q2	0278	2.591	$176.88	$58.44	$35.38
74430	Contrast x-ray, bladder		Q2	0278	2.591	$176.88	$58.44	$35.38
74440	X-ray, male genital tract		Q2	0278	2.591	$176.88	$58.44	$35.38
74445	X-ray exam of penis		Q2	0278	2.591	$176.88	$58.44	$35.38
74450	X-ray, urethra/bladder		Q2	0278	2.591	$176.88	$58.44	$35.38
74455	X-ray, urethra/bladder		Q2	0278	2.591	$176.88	$58.44	$35.38
74470	X-ray exam of kidney lesion		Q2	0263	3.3875	$231.25	.	$46.25
74475	X-ray control, cath insert		Q2	0161	17.7215	$1,209.79	.	$241.96
74480	X-ray control, cath insert		Q2	0161	17.7215	$1,209.79	.	$241.96
74485	X-ray guide, GU dilation		Q2	0161	17.7215	$1,209.79	.	$241.96
74710	X-ray measurement of pelvis		X	0261	1.1314	$77.24	.	$15.45
74740	X-ray, female genital tract		Q2	0263	3.3875	$231.25	.	$46.25

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
74742	X-ray, fallopian tube		N					
74775	X-ray exam of perineum		S	0278	2.591	$176.88	$58.44	$35.38
75557	Cardiac mri for morph		Q3	0336	5.1052	$348.52	$137.34	$69.71
75559	Cardiac mri w/stress img		Q3	0336	5.1052	$348.52	$137.34	$69.71
75561	Cardiac mri for morph w/dye		Q3	0337	7.9271	$541.16	$197.83	$108.24
75563	Card mri w/stress img & dye		Q3	0337	7.9271	$541.16	$197.83	$108.24
75565	Card mri vel flw map add-on		N					
75571	Ct hrt w/o dye w/ca test		X	0340	0.6899	$47.10	.	$9.42
75572	Ct hrt w/3d image		S	0383	3.7795	$258.02	.	$51.61
75573	Ct hrt w/3d image, congen		S	0383	3.7795	$258.02	.	$51.61
75574	Ct angio hrt w/3d image		S	0383	3.7795	$258.02	.	$51.61
75600	Contrast x-ray exam of aorta		Q2	0279	29.7399	$2,030.25	.	$406.05
75605	Contrast x-ray exam of aorta		Q2	0279	29.7399	$2,030.25	.	$406.05
75625	Contrast x-ray exam of aorta		Q2	0279	29.7399	$2,030.25	.	$406.05
75630	X-ray aorta, leg arteries		Q2	0279	29.7399	$2,030.25	.	$406.05
75635	Ct angio abdominal arteries		Q2	0662	5.0605	$345.47	$114.75	$69.10
75650	Artery x-rays, head & neck		Q2	0280	48.7134	$3,325.52	.	$665.11
75658	Artery x-rays, arm		Q2	0279	29.7399	$2,030.25	.	$406.05
75660	Artery x-rays, head & neck		Q2	0280	48.7134	$3,325.52	.	$665.11
75662	Artery x-rays, head & neck		Q2	0280	48.7134	$3,325.52	.	$665.11
75665	Artery x-rays, head & neck		Q2	0279	29.7399	$2,030.25	.	$406.05
75671	Artery x-rays, head & neck		Q2	0280	48.7134	$3,325.52	.	$665.11
75676	Artery x-rays, neck		Q2	0279	29.7399	$2,030.25	.	$406.05
75680	Artery x-rays, neck		Q2	0279	29.7399	$2,030.25	.	$406.05
75685	Artery x-rays, spine		Q2	0279	29.7399	$2,030.25	.	$406.05
75705	Artery x-rays, spine		Q2	0279	29.7399	$2,030.25	.	$406.05
75710	Artery x-rays, arm/leg		Q2	0279	29.7399	$2,030.25	.	$406.05
75716	Artery x-rays, arms/legs		Q2	0279	29.7399	$2,030.25	.	$406.05
75722	Artery x-rays, kidney		Q2	0279	29.7399	$2,030.25	.	$406.05

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
75724	Artery x-rays, kidneys		Q2	0279	29.7399	$2,030.25	.	$406.05
75726	Artery x-rays, abdomen		Q2	0279	29.7399	$2,030.25	.	$406.05
75731	Artery x-rays, adrenal gland		Q2	0279	29.7399	$2,030.25	.	$406.05
75733	Artery x-rays, adrenals		Q2	0279	29.7399	$2,030.25	.	$406.05
75736	Artery x-rays, pelvis		Q2	0279	29.7399	$2,030.25	.	$406.05
75741	Artery x-rays, lung		Q2	0279	29.7399	$2,030.25	.	$406.05
75743	Artery x-rays, lungs		Q2	0279	29.7399	$2,030.25	.	$406.05
75746	Artery x-rays, lung		Q2	0668	10.6287	$725.59	.	$145.12
75756	Artery x-rays, chest		Q2	0668	10.6287	$725.59	.	$145.12
75774	Artery x-ray, each vessel		N					
75791	Av dialysis shunt imaging		Q2	0676	2.3844	$162.78	.	$32.56
75801	Lymph vessel x-ray, arm/leg		Q2	0317	5.982	$408.37	.	$81.68
75803	Lymph vessel x-ray,arms/legs		Q2	0317	5.982	$408.37	.	$81.68
75805	Lymph vessel x-ray, trunk		Q2	0317	5.982	$408.37	.	$81.68
75807	Lymph vessel x-ray, trunk		Q2	0317	5.982	$408.37	.	$81.68
75809	Nonvascular shunt, x-ray		Q2	0261	1.1314	$77.24	.	$15.45
75810	Vein x-ray, spleen/liver		Q2	0279	29.7399	$2,030.25	.	$406.05
75820	Vein x-ray, arm/leg		Q2	0668	10.6287	$725.59	.	$145.12
75822	Vein x-ray, arms/legs		Q2	0668	10.6287	$725.59	.	$145.12
75825	Vein x-ray, trunk		Q2	0279	29.7399	$2,030.25	.	$406.05
75827	Vein x-ray, chest		Q2	0668	10.6287	$725.59	.	$145.12
75831	Vein x-ray, kidney		Q2	0279	29.7399	$2,030.25	.	$406.05
75833	Vein x-ray, kidneys		Q2	0279	29.7399	$2,030.25	.	$406.05
75840	Vein x-ray, adrenal gland		Q2	0279	29.7399	$2,030.25	.	$406.05
75842	Vein x-ray, adrenal glands		Q2	0279	29.7399	$2,030.25	.	$406.05
75860	Vein x-ray, neck		Q2	0668	10.6287	$725.59	.	$145.12
75870	Vein x-ray, skull		Q2	0668	10.6287	$725.59	.	$145.12
75872	Vein x-ray, skull		Q2	0668	10.6287	$725.59	.	$145.12
75880	Vein x-ray, eye socket		Q2	0668	10.6287	$725.59	.	$145.12

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
75885	Vein x-ray, liver		Q2	0279	29.7399	$2,030.25	.	$406.05
75887	Vein x-ray, liver		Q2	0668	10.6287	$725.59	.	$145.12
75889	Vein x-ray, liver		Q2	0279	29.7399	$2,030.25	.	$406.05
75891	Vein x-ray, liver		Q2	0279	29.7399	$2,030.25	.	$406.05
75893	Venous sampling by catheter		Q2	0279	29.7399	$2,030.25	.	$406.05
75894	X-rays, transcath therapy		N					
75896	X-rays, transcath therapy		N					
75898	Follow-up angiography		Q1	0261	1.1314	$77.24	.	$15.45
75900	Intravascular cath exchange		C					
75901	Remove cva device obstruct		N					
75902	Remove cva lumen obstruct		N					
75940	X-ray placement, vein filter		N					
75945	Intravascular us		Q2	0267	2.2748	$155.29	$60.50	$31.06
75946	Intravascular us add-on		N					
75952	Endovasc repair abdom aorta		C					
75953	Abdom aneurysm endovas rpr		C					
75954	Iliac aneurysm endovas rpr		C					
75956	Xray, endovasc thor ao repr		C					
75957	Xray, endovasc thor ao repr		C					
75958	Xray, place prox ext thor ao		C					
75959	Xray, place dist ext thor ao		C					
75960	Transcath iv stent rs&i		N					
75961	Retrieval, broken catheter		N					
75962	Repair arterial blockage		Q2	0083	52.1947	$3,563.18	.	$712.64
75964	Repair artery blockage, each		N					
75966	Repair arterial blockage		Q2	0083	52.1947	$3,563.18	.	$712.64
75968	Repair artery blockage, each		N					
75970	Vascular biopsy		N					
75978	Repair venous blockage		Q2	0093	36.5266	$2,493.56	.	$498.72

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
75980	Contrast xray exam bile duct		N					
75982	Contrast xray exam bile duct		N					
75984	Xray control catheter change		N					
75989	Abscess drainage under x-ray		N					
75992	Atherectomy, x-ray exam		N					
75993	Atherectomy, x-ray exam		N					
75994	Atherectomy, x-ray exam		N					
75995	Atherectomy, x-ray exam		N					
75996	Atherectomy, x-ray exam		N					
76000	Fluoroscope examination		Q1	0272	1.2472	$85.14	$31.07	$17.03
76001	Fluoroscope exam, extensive		N					
76010	X-ray, nose to rectum		X	0260	0.6683	$45.62	.	$9.13
76080	X-ray exam of fistula		Q2	0263	3.3875	$231.25	.	$46.25
76098	X-ray exam, breast specimen		Q2	0317	5.982	$408.37	.	$81.68
76100	X-ray exam of body section		X	0261	1.1314	$77.24	.	$15.45
76101	Complex body section x-ray		X	0263	3.3875	$231.25	.	$46.25
76102	Complex body section x-rays		X	0263	3.3875	$231.25	.	$46.25
76120	Cine/video x-rays		X	0272	1.2472	$85.14	$31.07	$17.03
76125	Cine/video x-rays add-on		N					
76140	X-ray consultation		E					
76150	X-ray exam, dry process		X	0260	0.6683	$45.62	.	$9.13
76350	Special x-ray contrast study		N					
76376	3d render w/o postprocess		N					
76377	3d rendering w/postprocess		N					
76380	CAT scan follow-up study		S	0282	1.7637	$120.40	$37.80	$24.08
76390	Mr spectroscopy		E					
76496	Fluoroscopic procedure		X	0272	1.2472	$85.14	$31.07	$17.03
76497	Ct procedure		S	0282	1.7637	$120.40	$37.80	$24.08
76498	Mri procedure		S	0336	5.1052	$348.52	$137.34	$69.71

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
76499	Radiographic procedure		X	0260	0.6683	$45.62	.	$9.13
76506	Echo exam of head		S	0265	0.9262	$63.23	$22.28	$12.65
76510	Ophth us, b & quant a		T	0232	2.4827	$169.49	$40.82	$33.90
76511	Ophth us, quant a only		S	0266	1.4262	$97.36	$37.53	$19.48
76512	Ophth us, b w/non-quant a		S	0266	1.4262	$97.36	$37.53	$19.48
76513	Echo exam of eye, water bath		S	0266	1.4262	$97.36	$37.53	$19.48
76514	Echo exam of eye, thickness		X	0035	0.2446	$16.70	.	$3.34
76516	Echo exam of eye		S	0265	0.9262	$63.23	$22.28	$12.65
76519	Echo exam of eye		S	0266	1.4262	$97.36	$37.53	$19.48
76529	Echo exam of eye		S	0265	0.9262	$63.23	$22.28	$12.65
76536	Us exam of head and neck		S	0266	1.4262	$97.36	$37.53	$19.48
76604	Us exam, chest		Q3	0265	0.9262	$63.23	$22.28	$12.65
76645	Us exam, breast(s)		S	0265	0.9262	$63.23	$22.28	$12.65
76700	Us exam, abdom, complete		Q3	0266	1.4262	$97.36	$37.53	$19.48
76705	Echo exam of abdomen		Q3	0266	1.4262	$97.36	$37.53	$19.48
76770	Us exam abdo back wall, comp		Q3	0266	1.4262	$97.36	$37.53	$19.48
76775	Us exam abdo back wall, lim		Q3	0266	1.4262	$97.36	$37.53	$19.48
76776	Us exam k transpl w/doppler		Q3	0266	1.4262	$97.36	$37.53	$19.48
76800	Us exam, spinal canal		S	0266	1.4262	$97.36	$37.53	$19.48
76801	Ob us < 14 wks, single fetus		S	0266	1.4262	$97.36	$37.53	$19.48
76802	Ob us < 14 wks, addl fetus		S	0265	0.9262	$63.23	$22.28	$12.65
76805	Ob us >/= 14 wks, sngl fetus		S	0266	1.4262	$97.36	$37.53	$19.48
76810	Ob us >/= 14 wks, addl fetus		S	0266	1.4262	$97.36	$37.53	$19.48
76811	Ob us, detailed, sngl fetus		S	0267	2.2748	$155.29	$60.50	$31.06
76812	Ob us, detailed, addl fetus		S	0265	0.9262	$63.23	$22.28	$12.65
76813	Ob us nuchal meas, 1 gest		S	0265	0.9262	$63.23	$22.28	$12.65
76814	Ob us nuchal meas, add-on		S	0265	0.9262	$63.23	$22.28	$12.65
76815	Ob us, limited, fetus(s)		S	0265	0.9262	$63.23	$22.28	$12.65
76816	Ob us, follow-up, per fetus		S	0265	0.9262	$63.23	$22.28	$12.65

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
76817	Transvaginal us, obstetric		S	0265	0.9262	$63.23	$22.28	$12.65
76818	Fetal biophys profile w/nst		S	0266	1.4262	$97.36	$37.53	$19.48
76819	Fetal biophys profil w/o nst		S	0266	1.4262	$97.36	$37.53	$19.48
76820	Umbilical artery echo		S	0265	0.9262	$63.23	$22.28	$12.65
76821	Middle cerebral artery echo		S	0265	0.9262	$63.23	$22.28	$12.65
76825	Echo exam of fetal heart		S	0270	8.1944	$559.41	$132.96	$111.89
76826	Echo exam of fetal heart		S	0269	5.7019	$389.25	.	$77.85
76827	Echo exam of fetal heart		S	0265	0.9262	$63.23	$22.28	$12.65
76828	Echo exam of fetal heart		S	0265	0.9262	$63.23	$22.28	$12.65
76830	Transvaginal us, non-ob		S	0266	1.4262	$97.36	$37.53	$19.48
76831	Echo exam, uterus		Q3	0267	2.2748	$155.29	$60.50	$31.06
76856	Us exam, pelvic, complete		Q3	0266	1.4262	$97.36	$37.53	$19.48
76857	Us exam, pelvic, limited		Q3	0265	0.9262	$63.23	$22.28	$12.65
76870	Us exam, scrotum		Q3	0266	1.4262	$97.36	$37.53	$19.48
76872	Us, transrectal		S	0266	1.4262	$97.36	$37.53	$19.48
76873	Echograp trans r, pros study		S	0266	1.4262	$97.36	$37.53	$19.48
76880	Us exam, extremity		S	0266	1.4262	$97.36	$37.53	$19.48
76885	Us exam infant hips, dynamic		S	0265	0.9262	$63.23	$22.28	$12.65
76886	Us exam infant hips, static		S	0265	0.9262	$63.23	$22.28	$12.65
76930	Echo guide, cardiocentesis		N					
76932	Echo guide for heart biopsy		N					
76936	Echo guide for artery repair		S	0096	1.571	$107.25	$37.13	$21.45
76937	Us guide, vascular access		N					
76940	Us guide, tissue ablation		N					
76941	Echo guide for transfusion		N					
76942	Echo guide for biopsy		N					
76945	Echo guide, villus sampling		N					
76946	Echo guide for amniocentesis		N					
76948	Echo guide, ova aspiration		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
76950	Echo guidance radiotherapy		N					
76965	Echo guidance radiotherapy		N					
76970	Ultrasound exam follow-up		S	0265	0.9262	$63.23	$22.28	$12.65
76975	GI endoscopic ultrasound		Q2	0267	2.2748	$155.29	$60.50	$31.06
76977	Us bone density measure		X	0340	0.6899	$47.10		
76998	Us guide, intraop		N					
76999	Echo examination procedure		S	0265	0.9262	$63.23	$22.28	$12.65
77001	Fluoroguide for vein device		N					
77002	Needle localization by xray		N					
77003	Fluoroguide for spine inject		N					
77011	Ct scan for localization		N					
77012	Ct scan for needle biopsy		N					
77013	Ct guide for tissue ablation		N					
77014	Ct scan for therapy guide		N					
77021	Mr guidance for needle place		N					
77022	Mri for tissue ablation		N					
77031	Stereotact guide for brst bx		N					
77032	Guidance for needle, breast		N					
77051	Computer dx mammogram add-on		A					
77052	Comp screen mammogram add-on		A					
77053	X-ray of mammary duct		Q2	0263	3.3875	$231.25	.	$46.25
77054	X-ray of mammary ducts		Q2	0263	3.3875	$231.25	.	$46.25
77055	Mammogram, one breast		A					
77056	Mammogram, both breasts		A					
77057	Mammogram, screening		A					
77058	Mri, one breast		B					
77059	Mri, both breasts		B					
77071	X-ray stress view		X	0260	0.6683	$45.62	.	$9.13
77072	X-rays for bone age		X	0260	0.6683	$45.62	.	$9.13

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
77073	X-rays, bone length studies		X	0260	0.6683	$45.62	.	$9.13
77074	X-rays, bone survey, limited		X	0261	1.1314	$77.24	.	$15.45
77075	X-rays, bone survey complete		X	0261	1.1314	$77.24	.	$15.45
77076	X-rays, bone survey, infant		X	0261	1.1314	$77.24	.	$15.45
77077	Joint survey, single view		X	0260	0.6683	$45.62	.	$9.13
77078	Ct bone density, axial		S	0288	1.0562	$72.10	$28.51	$14.42
77079	Ct bone density, peripheral		S	0282	1.7637	$120.40	$37.80	$24.08
77080	Dxa bone density, axial		S	0288	1.0562	$72.10	$28.51	$14.42
77081	Dxa bone density/peripheral		S	0665	0.4667	$31.86	$11.60	$6.38
77082	Dxa bone density, vert fx		X	0260	0.6683	$45.62	.	$9.13
77083	Radiographic absorptiometry		X	0261	1.1314	$77.24	.	$15.45
77084	Magnetic image, bone marrow		S	0336	5.1052	$348.52	$137.34	$69.71
77261	Radiation therapy planning		B					
77262	Radiation therapy planning		B					
77263	Radiation therapy planning		B					
77280	Set radiation therapy field		X	0304	1.5401	$105.14	$34.63	$21.03
77285	Set radiation therapy field		X	0305	4.0762	$278.27	$91.38	$55.66
77290	Set radiation therapy field		X	0305	4.0762	$278.27	$91.38	$55.66
77295	Set radiation therapy field		X	0310	13.5651	$926.05	$325.27	$185.21
77299	Radiation therapy planning		X	0304	1.5401	$105.14	$34.63	$21.03
77300	Radiation therapy dose plan		X	0304	1.5401	$105.14	$34.63	$21.03
77301	Radiotherapy dose plan, imrt		X	0310	13.5651	$926.05	$325.27	$185.21
77305	Teletx isodose plan simple		X	0304	1.5401	$105.14	$34.63	$21.03
77310	Teletx isodose plan intermed		X	0304	1.5401	$105.14	$34.63	$21.03
77315	Teletx isodose plan complex		X	0305	4.0762	$278.27	$91.38	$55.66
77321	Special teletx port plan		X	0305	4.0762	$278.27	$91.38	$55.66
77326	Brachytx isodose calc simp		X	0304	1.5401	$105.14	$34.63	$21.03
77327	Brachytx isodose calc interm		X	0305	4.0762	$278.27	$91.38	$55.66
77328	Brachytx isodose plan compl		X	0305	4.0762	$278.27	$91.38	$55.66

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
77331	Special radiation dosimetry		X	0304	1.5401	$105.14	$34.63	$21.03
77332	Radiation treatment aid(s)		X	0303	2.9021	$198.12	$66.95	$39.63
77333	Radiation treatment aid(s)		X	0303	2.9021	$198.12	$66.95	$39.63
77334	Radiation treatment aid(s)		X	0303	2.9021	$198.12	$66.95	$39.63
77336	Radiation physics consult		X	0304	1.5401	$105.14	$34.63	$21.03
77338	Design mlc device for imrt		X	0303	2.9021	$198.12	$66.95	$39.63
77370	Radiation physics consult		X	0304	1.5401	$105.14	$34.63	$21.03
77371	Srs, multisource		S	0127	105.7702	$7,220.61	.	$1,444.13
77372	Srs, linear based		B					
77373	Sbrt delivery		B					
77399	External radiation dosimetry		X	0304	1.5401	$105.14	$34.63	$21.03
77401	Radiation treatment delivery		S	0300	1.4418	$98.43	.	$19.69
77402	Radiation treatment delivery		S	0300	1.4418	$98.43	.	$19.69
77403	Radiation treatment delivery		S	0300	1.4418	$98.43	.	$19.69
77404	Radiation treatment delivery		S	0300	1.4418	$98.43	.	$19.69
77406	Radiation treatment delivery	CH	S	0300	1.4418	$98.43	.	$19.69
77407	Radiation treatment delivery		S	0300	1.4418	$98.43	.	$19.69
77408	Radiation treatment delivery		S	0300	1.4418	$98.43	.	$19.69
77409	Radiation treatment delivery		S	0300	1.4418	$98.43	.	$19.69
77411	Radiation treatment delivery		S	0301	2.3741	$162.07	.	$32.42
77412	Radiation treatment delivery		S	0301	2.3741	$162.07	.	$32.42
77413	Radiation treatment delivery		S	0301	2.3741	$162.07	.	$32.42
77414	Radiation treatment delivery		S	0301	2.3741	$162.07	.	$32.42
77416	Radiation treatment delivery		S	0301	2.3741	$162.07	.	$32.42
77417	Radiology port film(s)		N					
77418	Radiation tx delivery, imrt		S	0412	6.4458	$440.04	.	$88.01
77421	Stereoscopic x-ray guidance		N					
77422	Neutron beam tx, simple		S	0301	2.3741	$162.07	.	$32.42
77423	Neutron beam tx, complex		S	0301	2.3741	$162.07	.	$32.42

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
77427	Radiation tx management, x5		B					
77431	Radiation therapy management		B					
77432	Stereotactic radiation trmt		B					
77435	Sbrt management		N					
77470	Special radiation treatment		S	0299	5.7142	$390.09	.	$78.02
77499	Radiation therapy management		B					
77520	Proton trmt, simple w/o comp		S	0664	13.2159	$902.21	.	$180.45
77522	Proton trmt, simple w/comp		S	0664	13.2159	$902.21	.	$180.45
77523	Proton trmt, intermediate		S	0667	17.2884	$1,180.23	.	$236.05
77525	Proton treatment, complex		S	0667	17.2884	$1,180.23	.	$236.05
77600	Hyperthermia treatment		S	0299	5.7142	$390.09	.	$78.02
77605	Hyperthermia treatment		S	0299	5.7142	$390.09	.	$78.02
77610	Hyperthermia treatment		S	0299	5.7142	$390.09	.	$78.02
77615	Hyperthermia treatment		S	0299	5.7142	$390.09	.	$78.02
77620	Hyperthermia treatment		S	0299	5.7142	$390.09	.	$78.02
77750	Infuse radioactive materials		S	0301	2.3741	$162.07	.	$32.42
77761	Apply intrcav radiat simple		S	0312	5.0976	$348.00	.	$69.60
77762	Apply intrcav radiat interm		S	0312	5.0976	$348.00	.	$69.60
77763	Apply intrcav radiat compl		S	0312	5.0976	$348.00	.	$69.60
77776	Apply interstit radiat simpl		S	0312	5.0976	$348.00	.	$69.60
77777	Apply interstit radiat inter		S	0312	5.0976	$348.00	.	$69.60
77778	Apply interstit radiat compl		Q3	0651	14.3321	$978.41	.	$195.69
77785	Hdr brachytx, 1 channel		S	0313	10.4062	$710.40	$268.63	$142.08
77786	Hdr brachytx, 2-12 channel		S	0313	10.4062	$710.40	$268.63	$142.08
77787	Hdr brachytx over 12 chan		S	0313	10.4062	$710.40	$268.63	$142.08
77789	Apply surface radiation		S	0300	1.4418	$98.43	.	$19.69
77790	Radiation handling		N					
77799	Radium/radioisotope therapy		S	0312	5.0976	$348.00	.	$69.60
78000	Thyroid, single uptake		S	0389	1.577	$107.66	$28.71	$21.54

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
78001	Thyroid, multiple uptakes		S	0389	1.577	$107.66	$28.71	$21.54
78003	Thyroid suppress/stimul		S	0389	1.577	$107.66	$28.71	$21.54
78006	Thyroid imaging with uptake		S	0391	3.2886	$224.50	$65.96	$44.90
78007	Thyroid image, mult uptakes		S	0391	3.2886	$224.50	$65.96	$44.90
78010	Thyroid imaging		S	0390	2.0375	$139.09	$49.95	$27.82
78011	Thyroid imaging with flow		S	0390	2.0375	$139.09	$49.95	$27.82
78015	Thyroid met imaging		S	0406	4.2872	$292.67	$88.01	$58.54
78016	Thyroid met imaging/studies		S	0406	4.2872	$292.67	$88.01	$58.54
78018	Thyroid met imaging, body		S	0406	4.2872	$292.67	$88.01	$58.54
78020	Thyroid met uptake		N					
78070	Parathyroid nuclear imaging		S	0391	3.2886	$224.50	$65.96	$44.90
78075	Adrenal nuclear imaging		S	0408	12.6011	$860.24	.	$172.05
78099	Endocrine nuclear procedure		S	0390	2.0375	$139.09	$49.95	$27.82
78102	Bone marrow imaging, ltd		S	0400	3.7861	$258.47	$91.52	$51.70
78103	Bone marrow imaging, mult		S	0400	3.7861	$258.47	$91.52	$51.70
78104	Bone marrow imaging, body		S	0400	3.7861	$258.47	$91.52	$51.70
78110	Plasma volume, single		S	0393	5.877	$401.21	.	$80.25
78111	Plasma volume, multiple		S	0393	5.877	$401.21	.	$80.25
78120	Red cell mass, single		S	0393	5.877	$401.21	.	$80.25
78121	Red cell mass, multiple		S	0393	5.877	$401.21	.	$80.25
78122	Blood volume		S	0393	5.877	$401.21	.	$80.25
78130	Red cell survival study		S	0393	5.877	$401.21	.	$80.25
78135	Red cell survival kinetics		S	0393	5.877	$401.21	.	$80.25
78140	Red cell sequestration		S	0393	5.877	$401.21	.	$80.25
78185	Spleen imaging		S	0400	3.7861	$258.47	$91.52	$51.70
78190	Platelet survival, kinetics		S	0392	2.6029	$177.69	$43.31	$35.54
78191	Platelet survival		S	0392	2.6029	$177.69	$43.31	$35.54
78195	Lymph system imaging		S	0400	3.7861	$258.47	$91.52	$51.70
78199	Blood/lymph nuclear exam		S	0400	3.7861	$258.47	$91.52	$51.70

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
78201	Liver imaging		S	0394	4.2112	$287.49	$98.44	$57.50
78202	Liver imaging with flow		S	0394	4.2112	$287.49	$98.44	$57.50
78205	Liver imaging (3D)		S	0394	4.2112	$287.49	$98.44	$57.50
78206	Liver image (3d) with flow		S	0394	4.2112	$287.49	$98.44	$57.50
78215	Liver and spleen imaging		S	0394	4.2112	$287.49	$98.44	$57.50
78216	Liver & spleen image/flow		S	0394	4.2112	$287.49	$98.44	$57.50
78220	Liver function study		S	0394	4.2112	$287.49	$98.44	$57.50
78223	Hepatobiliary imaging		S	0394	4.2112	$287.49	$98.44	$57.50
78230	Salivary gland imaging		S	0395	3.6081	$246.31	$89.56	$49.27
78231	Serial salivary imaging		S	0395	3.6081	$246.31	$89.56	$49.27
78232	Salivary gland function exam		S	0395	3.6081	$246.31	$89.56	$49.27
78258	Esophageal motility study		S	0395	3.6081	$246.31	$89.56	$49.27
78261	Gastric mucosa imaging		S	0395	3.6081	$246.31	$89.56	$49.27
78262	Gastroesophageal reflux exam		S	0395	3.6081	$246.31	$89.56	$49.27
78264	Gastric emptying study		S	0395	3.6081	$246.31	$89.56	$49.27
78267	Breath tst attain/anal c-14		A					
78268	Breath test analysis, c-14		A					
78270	Vit B-12 absorption exam		S	0392	2.6029	$177.69	$43.31	$35.54
78271	Vit b-12 absrp exam, int fac		S	0392	2.6029	$177.69	$43.31	$35.54
78272	Vit B-12 absorp, combined		S	0392	2.6029	$177.69	$43.31	$35.54
78278	Acute GI blood loss imaging		S	0395	3.6081	$246.31	$89.56	$49.27
78282	GI protein loss exam		S	0395	3.6081	$246.31	$89.56	$49.27
78290	Meckels divert exam		S	0395	3.6081	$246.31	$89.56	$49.27
78291	Leveen/shunt patency exam		S	0395	3.6081	$246.31	$89.56	$49.27
78299	GI nuclear procedure		S	0395	3.6081	$246.31	$89.56	$49.27
78300	Bone imaging, limited area		S	0396	3.6637	$250.11	$95.02	$50.03
78305	Bone imaging, multiple areas		S	0396	3.6637	$250.11	$95.02	$50.03
78306	Bone imaging, whole body		S	0396	3.6637	$250.11	$95.02	$50.03
78315	Bone imaging, 3 phase		S	0396	3.6637	$250.11	$95.02	$50.03

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
78320	Bone imaging (3D)		S	0396	3.6637	$250.11	$95.02	$50.03
78350	Bone mineral, single photon		E					
78351	Bone mineral, dual photon		E					
78399	Musculoskeletal nuclear exam		S	0396	3.6637	$250.11	$95.02	$50.03
78414	Non-imaging heart function		S	0398	4.3724	$298.49	$95.61	$59.70
78428	Cardiac shunt imaging		S	0398	4.3724	$298.49	$95.61	$59.70
78445	Vascular flow imaging		S	0397	3.5928	$245.27	.	$49.06
78451	Ht muscle image spect, sing		S	0377	11.2555	$768.38	.	$153.68
78452	Ht muscle image spect, mult		S	0377	11.2555	$768.38	.	$153.68
78453	Ht muscle image,planar,sing		S	0377	11.2555	$768.38	.	$153.68
78454	Ht musc image, planar, mult		S	0377	11.2555	$768.38	.	$153.68
78456	Acute venous thrombus image		S	0397	3.5928	$245.27	.	$49.06
78457	Venous thrombosis imaging		S	0397	3.5928	$245.27	.	$49.06
78458	Ven thrombosis images, bilat		S	0397	3.5928	$245.27	.	$49.06
78459	Heart muscle imaging (PET)		S	0307	16.1009	$1,099.16	.	$219.84
78466	Heart infarct image		S	0398	4.3724	$298.49	$95.61	$59.70
78468	Heart infarct image (ef)		S	0398	4.3724	$298.49	$95.61	$59.70
78469	Heart infarct image (3D)		S	0398	4.3724	$298.49	$95.61	$59.70
78472	Gated heart, planar, single		S	0398	4.3724	$298.49	$95.61	$59.70
78473	Gated heart, multiple		S	0398	4.3724	$298.49	$95.61	$59.70
78481	Heart first pass, single		S	0398	4.3724	$298.49	$95.61	$59.70
78483	Heart first pass, multiple		S	0398	4.3724	$298.49	$95.61	$59.70
78491	Heart image (pet), single		S	0307	16.1009	$1,099.16	.	$219.84
78492	Heart image (pet), multiple		S	0307	16.1009	$1,099.16	.	$219.84
78494	Heart image, spect		S	0398	4.3724	$298.49	$95.61	$59.70
78496	Heart first pass add-on		N					
78499	Cardiovascular nuclear exam		S	0398	4.3724	$298.49	$95.61	$59.70
78580	Lung perfusion imaging		S	0401	2.9903	$204.14	$73.80	$40.83
78584	Lung V/Q image single breath		S	0378	4.7678	$325.48	$124.64	$65.10

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
78585	Lung V/Q imaging		S	0378	4.7678	$325.48	$124.64	$65.10
78586	Aerosol lung image, single		S	0401	2.9903	$204.14	$73.80	$40.83
78587	Aerosol lung image, multiple		S	0401	2.9903	$204.14	$73.80	$40.83
78588	Perfusion lung image		S	0378	4.7678	$325.48	$124.64	$65.10
78591	Vent image, 1 breath, 1 proj		S	0401	2.9903	$204.14	$73.80	$40.83
78593	Vent image, 1 proj, gas		S	0401	2.9903	$204.14	$73.80	$40.83
78594	Vent image, mult proj, gas		S	0401	2.9903	$204.14	$73.80	$40.83
78596	Lung differential function		S	0378	4.7678	$325.48	$124.64	$65.10
78599	Respiratory nuclear exam		S	0401	2.9903	$204.14	$73.80	$40.83
78600	Brain image < 4 views		S	0403	3.4106	$232.83	$72.42	$46.57
78601	Brain image w/flow < 4 views		S	0402	9.085	$620.21	.	$124.05
78605	Brain image 4+ views		S	0403	3.4106	$232.83	$72.42	$46.57
78606	Brain image w/flow 4 + views		S	0402	9.085	$620.21	.	$124.05
78607	Brain imaging (3D)		S	0402	9.085	$620.21	.	$124.05
78608	Brain imaging (PET)		S	0308	15.3994	$1,051.27	.	$210.26
78609	Brain imaging (PET)		E					
78610	Brain flow imaging only		S	0403	3.4106	$232.83	$72.42	$46.57
78630	Cerebrospinal fluid scan		S	0402	9.085	$620.21	.	$124.05
78635	CSF ventriculography		S	0402	9.085	$620.21	.	$124.05
78645	CSF shunt evaluation		S	0403	3.4106	$232.83	$72.42	$46.57
78647	Cerebrospinal fluid scan		S	0402	9.085	$620.21	.	$124.05
78650	CSF leakage imaging		S	0402	9.085	$620.21	.	$124.05
78660	Nuclear exam of tear flow		S	0403	3.4106	$232.83	$72.42	$46.57
78699	Nervous system nuclear exam		S	0403	3.4106	$232.83	$72.42	$46.57
78700	Kidney imaging, morphol		S	0404	4.7288	$322.82	$82.54	$64.57
78701	Kidney imaging with flow		S	0404	4.7288	$322.82	$82.54	$64.57
78707	K flow/funct image w/o drug		S	0404	4.7288	$322.82	$82.54	$64.57
78708	K flow/funct image w/drug		S	0404	4.7288	$322.82	$82.54	$64.57
78709	K flow/funct image, multiple		S	0404	4.7288	$322.82	$82.54	$64.57

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
78710	Kidney imaging (3D)		S	0404	4.7288	$322.82	$82.54	$64.57
78725	Kidney function study		S	0392	2.6029	$177.69	$43.31	$35.54
78730	Urinary bladder retention		S	0389	1.577	$107.66	$28.71	$21.54
78740	Ureteral reflux study		S	0404	4.7288	$322.82	$82.54	$64.57
78761	Testicular imaging w/flow		S	0404	4.7288	$322.82	$82.54	$64.57
78799	Genitourinary nuclear exam		S	0404	4.7288	$322.82	$82.54	$64.57
78800	Tumor imaging, limited area		S	0406	4.2872	$292.67	$88.01	$58.54
78801	Tumor imaging, mult areas		S	0414	7.1451	$487.77	.	$97.56
78802	Tumor imaging, whole body		S	0414	7.1451	$487.77	.	$97.56
78803	Tumor imaging (3D)		S	0414	7.1451	$487.77	.	$97.56
78804	Tumor imaging, whole body		S	0408	12.6011	$860.24	.	$172.05
78805	Abscess imaging, ltd area		S	0414	7.1451	$487.77	.	$97.56
78806	Abscess imaging, whole body		S	0414	7.1451	$487.77	.	$97.56
78807	Nuclear localization/abscess		S	0406	4.2872	$292.67	$88.01	$58.54
78808	Iv inj ra drug dx study		Q1	0392	2.6029	$177.69	$43.31	$35.54
78811	Pet image, ltd area		S	0308	15.3994	$1,051.27	.	$210.26
78812	Pet image, skull-thigh		S	0308	15.3994	$1,051.27	.	$210.26
78813	Pet image, full body		S	0308	15.3994	$1,051.27	.	$210.26
78814	Pet image w/ct, lmtd		S	0308	15.3994	$1,051.27	.	$210.26
78815	Pet image w/ct, skull-thigh		S	0308	15.3994	$1,051.27	.	$210.26
78816	Pet image w/ct, full body		S	0308	15.3994	$1,051.27	.	$210.26
78999	Nuclear diagnostic exam		S	0389	1.577	$107.66	$28.71	$21.54
79005	Nuclear rx, oral admin		S	0407	3.2871	$224.40	$78.13	$44.88
79101	Nuclear rx, iv admin		S	0407	3.2871	$224.40	$78.13	$44.88
79200	Nuclear rx, intracav admin		S	0413	5.1912	$354.39	.	$70.88
79300	Nuclr rx, interstit colloid		S	0407	3.2871	$224.40	$78.13	$44.88
79403	Hematopoietic nuclear tx		S	0413	5.1912	$354.39	.	$70.88
79440	Nuclear rx, intra-articular		S	0413	5.1912	$354.39	.	$70.88
79445	Nuclear rx, intra-arterial		S	0407	3.2871	$224.40	$78.13	$44.88

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
79999	Nuclear medicine therapy		S	0407	3.2871	$224.40	$78.13	$44.88
80047	Metabolic panel ionized ca		A					
80048	Metabolic panel total ca		A					
80050	General health panel		E					
80051	Electrolyte panel		A					
80053	Comprehen metabolic panel		A					
80055	Obstetric panel		E					
80061	Lipid panel		A					
80069	Renal function panel		A					
80074	Acute hepatitis panel		A					
80076	Hepatic function panel		A					
80100	Drug screen, qualitate/multi		A					
80101	Drug screen, single		E					
80102	Drug confirmation		A					
80103	Drug analysis, tissue prep		N					
80150	Assay of amikacin		A					
80152	Assay of amitriptyline		A					
80154	Assay of benzodiazepines		A					
80156	Assay, carbamazepine, total		A					
80157	Assay, carbamazepine, free		A					
80158	Assay of cyclosporine		A					
80160	Assay of desipramine		A					
80162	Assay of digoxin		A					
80164	Assay, dipropylacetic acid		A					
80166	Assay of doxepin		A					
80168	Assay of ethosuximide		A					
80170	Assay of gentamicin		A					
80172	Assay of gold		A					
80173	Assay of haloperidol		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
80174	Assay of imipramine		A					
80176	Assay of lidocaine		A					
80178	Assay of lithium		A					
80182	Assay of nortriptyline		A					
80184	Assay of phenobarbital		A					
80185	Assay of phenytoin, total		A					
80186	Assay of phenytoin, free		A					
80188	Assay of primidone		A					
80190	Assay of procainamide		A					
80192	Assay of procainamide		A					
80194	Assay of quinidine		A					
80195	Assay of sirolimus		A					
80196	Assay of salicylate		A					
80197	Assay of tacrolimus		A					
80198	Assay of theophylline		A					
80200	Assay of tobramycin		A					
80201	Assay of topiramate		A					
80202	Assay of vancomycin		A					
80299	Quantitative assay, drug		A					
80400	Acth stimulation panel		A					
80402	Acth stimulation panel		A					
80406	Acth stimulation panel		A					
80408	Aldosterone suppression eval		A					
80410	Calcitonin stimul panel		A					
80412	CRH stimulation panel		A					
80414	Testosterone response		A					
80415	Estradiol response panel		A					
80416	Renin stimulation panel		A					
80417	Renin stimulation panel		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
80418	Pituitary evaluation panel		A					
80420	Dexamethasone panel		A					
80422	Glucagon tolerance panel		A					
80424	Glucagon tolerance panel		A					
80426	Gonadotropin hormone panel		A					
80428	Growth hormone panel		A					
80430	Growth hormone panel		A					
80432	Insulin suppression panel		A					
80434	Insulin tolerance panel		A					
80435	Insulin tolerance panel		A					
80436	Metyrapone panel		A					
80438	TRH stimulation panel		A					
80439	TRH stimulation panel		A					
80440	TRH stimulation panel		A					
80500	Lab pathology consultation		X	0433	0.2465	$16.83	$5.17	$3.37
80502	Lab pathology consultation		X	0342	0.1596	$10.90	.	$2.18
81000	Urinalysis, nonauto w/scope		A					
81001	Urinalysis, auto w/scope		A					
81002	Urinalysis nonauto w/o scope		A					
81003	Urinalysis, auto, w/o scope		A					
81005	Urinalysis		A					
81007	Urine screen for bacteria		A					
81015	Microscopic exam of urine		A					
81020	Urinalysis, glass test		A					
81025	Urine pregnancy test		A					
81050	Urinalysis, volume measure		A					
81099	Urinalysis test procedure		A					
82000	Assay of blood acetaldehyde		A					
82003	Assay of acetaminophen		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
82009	Test for acetone/ketones		A					
82010	Acetone assay		A					
82013	Acetylcholinesterase assay		A					
82016	Acylcarnitines, qual		A					
82017	Acylcarnitines, quant		A					
82024	Assay of acth		A					
82030	Assay of adp & amp		A					
82040	Assay of serum albumin		A					
82042	Assay of urine albumin		A					
82043	Microalbumin, quantitative		A					
82044	Microalbumin, semiquant		A					
82045	Albumin, ischemia modified		A					
82055	Assay of ethanol		A					
82075	Assay of breath ethanol		A					
82085	Assay of aldolase		A					
82088	Assay of aldosterone		A					
82101	Assay of urine alkaloids		A					
82103	Alpha-1-antitrypsin, total		A					
82104	Alpha-1-antitrypsin, pheno		A					
82105	Alpha-fetoprotein, serum		A					
82106	Alpha-fetoprotein, amniotic		A					
82107	Alpha-fetoprotein l3		A					
82108	Assay of aluminum		A					
82120	Amines, vaginal fluid qual		A					
82127	Amino acid, single qual		A					
82128	Amino acids, mult qual		A					
82131	Amino acids, single quant		A					
82135	Assay, aminolevulinic acid		A					
82136	Amino acids, quant, 2-5		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
82139	Amino acids, quan, 6 or more		A					
82140	Assay of ammonia		A					
82143	Amniotic fluid scan		A					
82145	Assay of amphetamines		A					
82150	Assay of amylase		A					
82154	Androstanediol glucuronide		A					
82157	Assay of androstenedione		A					
82160	Assay of androsterone		A					
82163	Assay of angiotensin II		A					
82164	Angiotensin I enzyme test		A					
82172	Assay of apolipoprotein		A					
82175	Assay of arsenic		A					
82180	Assay of ascorbic acid		A					
82190	Atomic absorption		A					
82205	Assay of barbiturates		A					
82232	Assay of beta-2 protein		A					
82239	Bile acids, total		A					
82240	Bile acids, cholylglycine		A					
82247	Bilirubin, total		A					
82248	Bilirubin, direct		A					
82252	Fecal bilirubin test		A					
82261	Assay of biotinidase		A					
82270	Occult blood, feces		A					
82271	Occult blood, other sources		A					
82272	Occult bld feces, 1-3 tests		A					
82274	Assay test for blood, fecal		A					
82286	Assay of bradykinin		A					
82300	Assay of cadmium		A					
82306	Vitamin d, 25 hydroxy		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
82308	Assay of calcitonin		A					
82310	Assay of calcium		A					
82330	Assay of calcium		A					
82331	Calcium infusion test		A					
82340	Assay of calcium in urine		A					
82355	Calculus analysis, qual		A					
82360	Calculus assay, quant		A					
82365	Calculus spectroscopy		A					
82370	X-ray assay, calculus		A					
82373	Assay, c-d transfer measure		A					
82374	Assay, blood carbon dioxide		A					
82375	Assay, carboxyhb, quant		A					
82376	Assay, carboxyhb, qual		A					
82378	Carcinoembryonic antigen		A					
82379	Assay of carnitine		A					
82380	Assay of carotene		A					
82382	Assay, urine catecholamines		A					
82383	Assay, blood catecholamines		A					
82384	Assay, three catecholamines		A					
82387	Assay of cathepsin-d		A					
82390	Assay of ceruloplasmin		A					
82397	Chemiluminescent assay		A					
82415	Assay of chloramphenicol		A					
82435	Assay of blood chloride		A					
82436	Assay of urine chloride		A					
82438	Assay, other fluid chlorides		A					
82441	Test for chlorohydrocarbons		A					
82465	Assay, bld/serum cholesterol		A					
82480	Assay, serum cholinesterase		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
82482	Assay, rbc cholinesterase		A					
82485	Assay, chondroitin sulfate		A					
82486	Gas/liquid chromatography		A					
82487	Paper chromatography		A					
82488	Paper chromatography		A					
82489	Thin layer chromatography		A					
82491	Chromotography, quant, sing		A					
82492	Chromotography, quant, mult		A					
82495	Assay of chromium		A					
82507	Assay of citrate		A					
82520	Assay of cocaine		A					
82523	Collagen crosslinks		A					
82525	Assay of copper		A					
82528	Assay of corticosterone		A					
82530	Cortisol, free		A					
82533	Total cortisol		A					
82540	Assay of creatine		A					
82541	Column chromotography, qual		A					
82542	Column chromotography, quant		A					
82543	Column chromotograph/isotope		A					
82544	Column chromotograph/isotope		A					
82550	Assay of ck (cpk)		A					
82552	Assay of cpk in blood		A					
82553	Creatine, MB fraction		A					
82554	Creatine, isoforms		A					
82565	Assay of creatinine		A					
82570	Assay of urine creatinine		A					
82575	Creatinine clearance test		A					
82585	Assay of cryofibrinogen		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
82595	Assay of cryoglobulin		A					
82600	Assay of cyanide		A					
82607	Vitamin B-12		A					
82608	B-12 binding capacity		A					
82610	Cystatin c		A					
82615	Test for urine cystines		A					
82626	Dehydroepiandrosterone		A					
82627	Dehydroepiandrosterone		A					
82633	Desoxycorticosterone		A					
82634	Deoxycortisol		A					
82638	Assay of dibucaine number		A					
82646	Assay of dihydrocodeinone		A					
82649	Assay of dihydromorphinone		A					
82651	Assay of dihydrotestosterone		A					
82652	Vit d 1, 25-dihydroxy		A					
82654	Assay of dimethadione		A					
82656	Pancreatic elastase, fecal		A					
82657	Enzyme cell activity		A					
82658	Enzyme cell activity, ra		A					
82664	Electrophoretic test		A					
82666	Assay of epiandrosterone		A					
82668	Assay of erythropoietin		A					
82670	Assay of estradiol		A					
82671	Assay of estrogens		A					
82672	Assay of estrogen		A					
82677	Assay of estriol		A					
82679	Assay of estrone		A					
82690	Assay of ethchlorvynol		A					
82693	Assay of ethylene glycol		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
82696	Assay of etiocholanolone		A					
82705	Fats/lipids, feces, qual		A					
82710	Fats/lipids, feces, quant		A					
82715	Assay of fecal fat		A					
82725	Assay of blood fatty acids		A					
82726	Long chain fatty acids		A					
82728	Assay of ferritin		A					
82731	Assay of fetal fibronectin		A					
82735	Assay of fluoride		A					
82742	Assay of flurazepam		A					
82746	Blood folic acid serum		A					
82747	Assay of folic acid, rbc		A					
82757	Assay of semen fructose		A					
82759	Assay of rbc galactokinase		A					
82760	Assay of galactose		A					
82775	Assay galactose transferase		A					
82776	Galactose transferase test		A					
82784	Assay, iga/igd/igg/igm each		A					
82785	Assay of ige		A					
82787	Igg 1, 2, 3 or 4, each		A					
82800	Blood pH		A					
82803	Blood gases: pH, pO2 & pCO2		A					
82805	Blood gases w/02 saturation		A					
82810	Blood gases, O2 sat only		A					
82820	Hemoglobin-oxygen affinity		A					
82926	Assay of gastric acid		A					
82928	Assay of gastric acid		A					
82938	Gastrin test		A					
82941	Assay of gastrin		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
82943	Assay of glucagon		A					
82945	Glucose other fluid		A					
82946	Glucagon tolerance test		A					
82947	Assay, glucose, blood quant		A					
82948	Reagent strip/blood glucose		A					
82950	Glucose test		A					
82951	Glucose tolerance test (GTT)		A					
82952	GTT-added samples		A					
82953	Glucose-tolbutamide test		A					
82955	Assay of g6pd enzyme		A					
82960	Test for G6PD enzyme		A					
82962	Glucose blood test		A					
82963	Assay of glucosidase		A					
82965	Assay of gdh enzyme		A					
82975	Assay of glutamine		A					
82977	Assay of GGT		A					
82978	Assay of glutathione		A					
82979	Assay, rbc glutathione		A					
82980	Assay of glutethimide		A					
82985	Glycated protein		A					
83001	Gonadotropin (FSH)		A					
83002	Gonadotropin (LH)		A					
83003	Assay, growth hormone (hgh)		A					
83008	Assay of guanosine		A					
83009	H pylori (c-13), blood		A					
83010	Assay of haptoglobin, quant		A					
83012	Assay of haptoglobins		A					
83013	H pylori (c-13), breath		A					
83014	H pylori drug admin		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
83015	Heavy metal screen		A					
83018	Quantitative screen, metals		A					
83020	Hemoglobin electrophoresis		A					
83021	Hemoglobin chromotography		A					
83026	Hemoglobin, copper sulfate		A					
83030	Fetal hemoglobin, chemical		A					
83033	Fetal hemoglobin assay, qual		A					
83036	Glycosylated hemoglobin test		A					
83037	Glycosylated hb, home device		A					
83045	Blood methemoglobin test		A					
83050	Blood methemoglobin assay		A					
83051	Assay of plasma hemoglobin		A					
83055	Blood sulfhemoglobin test		A					
83060	Blood sulfhemoglobin assay		A					
83065	Assay of hemoglobin heat		A					
83068	Hemoglobin stability screen		A					
83069	Assay of urine hemoglobin		A					
83070	Assay of hemosiderin, qual		A					
83071	Assay of hemosiderin, quant		A					
83080	Assay of b hexosaminidase		A					
83088	Assay of histamine		A					
83090	Assay of homocystine		A					
83150	Assay of for hva		A					
83491	Assay of corticosteroids		A					
83497	Assay of 5-hiaa		A					
83498	Assay of progesterone		A					
83499	Assay of progesterone		A					
83500	Assay, free hydroxyproline		A					
83505	Assay, total hydroxyproline		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
83516	Immunoassay, nonantibody		A					
83518	Immunoassay, dipstick		A					
83519	Ria nonantibody		A					
83520	Immunoassay quant nos nonab		A					
83525	Assay of insulin		A					
83527	Assay of insulin		A					
83528	Assay of intrinsic factor		A					
83540	Assay of iron		A					
83550	Iron binding test		A					
83570	Assay of idh enzyme		A					
83582	Assay of ketogenic steroids		A					
83586	Assay 17- ketosteroids		A					
83593	Fractionation, ketosteroids		A					
83605	Assay of lactic acid		A					
83615	Lactate (LD) (LDH) enzyme		A					
83625	Assay of ldh enzymes		A					
83630	Lactoferrin, fecal (qual)		A					
83631	Lactoferrin, fecal (quant)		A					
83632	Placental lactogen		A					
83633	Test urine for lactose		A					
83634	Assay of urine for lactose		A					
83655	Assay of lead		A					
83661	L/s ratio, fetal lung		A					
83662	Foam stability, fetal lung		A					
83663	Fluoro polarize, fetal lung		A					
83664	Lamellar bdy, fetal lung		A					
83670	Assay of lap enzyme		A					
83690	Assay of lipase		A					
83695	Assay of lipoprotein(a)		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
83698	Assay lipoprotein pla2		A					
83700	Lipopro bld, electrophoretic		A					
83701	Lipoprotein bld, hr fraction		A					
83704	Lipoprotein, bld, by nmr		A					
83718	Assay of lipoprotein		A					
83719	Assay of blood lipoprotein		A					
83721	Assay of blood lipoprotein		A					
83727	Assay of lrh hormone		A					
83735	Assay of magnesium		A					
83775	Assay of md enzyme		A					
83785	Assay of manganese		A					
83788	Mass spectrometry qual		A					
83789	Mass spectrometry quant		A					
83805	Assay of meprobamate		A					
83825	Assay of mercury		A					
83835	Assay of metanephrines		A					
83840	Assay of methadone		A					
83857	Assay of methemalbumin		A					
83858	Assay of methsuximide		A					
83864	Mucopolysaccharides		A					
83866	Mucopolysaccharides screen		A					
83872	Assay synovial fluid mucin		A					
83873	Assay of csf protein		A					
83874	Assay of myoglobin		A					
83876	Assay, myeloperoxidase		A					
83880	Natriuretic peptide		A					
83883	Assay, nephelometry not spec		A					
83885	Assay of nickel		A					
83887	Assay of nicotine		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
83890	Molecule isolate		A					
83891	Molecule isolate nucleic		A					
83892	Molecular diagnostics		A					
83893	Molecule dot/slot/blot		A					
83894	Molecule gel electrophor		A					
83896	Molecular diagnostics		A					
83897	Molecule nucleic transfer		A					
83898	Molecule nucleic ampli, each		A					
83900	Molecule nucleic ampli 2 seq		A					
83901	Molecule nucleic ampli addon		A					
83902	Molecular diagnostics		A					
83903	Molecule mutation scan		A					
83904	Molecule mutation identify		A					
83905	Molecule mutation identify		A					
83906	Molecule mutation identify		A					
83907	Lyse cells for nucleic ext		A					
83908	Nucleic acid, signal ampli		A					
83909	Nucleic acid, high resolute		A					
83912	Genetic examination		A					
83913	Molecular, rna stabilization		A					
83914	Mutation ident ola/sbce/aspe		A					
83915	Assay of nucleotidase		A					
83916	Oligoclonal bands		A					
83918	Organic acids, total, quant		A					
83919	Organic acids, qual, each		A					
83921	Organic acid, single, quant		A					
83925	Assay of opiates		A					
83930	Assay of blood osmolality		A					
83935	Assay of urine osmolality		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
83937	Assay of osteocalcin		A					
83945	Assay of oxalate		A					
83950	Oncoprotein, her-2/neu		A					
83951	Oncoprotein, dcp		A					
83970	Assay of parathormone		A					
83986	Assay ph body fluid nos		A					
83987	Exhaled breath condensate		A					
83992	Assay for phencyclidine		A					
83993	Assay for calprotectin fecal		A					
84022	Assay of phenothiazine		A					
84030	Assay of blood pku		A					
84035	Assay of phenylketones		A					
84060	Assay acid phosphatase		A					
84061	Phosphatase, forensic exam		A					
84066	Assay prostate phosphatase		A					
84075	Assay alkaline phosphatase		A					
84078	Assay alkaline phosphatase		A					
84080	Assay alkaline phosphatases		A					
84081	Amniotic fluid enzyme test		A					
84085	Assay of rbc pg6d enzyme		A					
84087	Assay phosphohexose enzymes		A					
84100	Assay of phosphorus		A					
84105	Assay of urine phosphorus		A					
84106	Test for porphobilinogen		A					
84110	Assay of porphobilinogen		A					
84119	Test urine for porphyrins		A					
84120	Assay of urine porphyrins		A					
84126	Assay of feces porphyrins		A					
84127	Assay of feces porphyrins		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
84132	Assay of serum potassium		A					
84133	Assay of urine potassium		A					
84134	Assay of prealbumin		A					
84135	Assay of pregnanediol		A					
84138	Assay of pregnanetriol		A					
84140	Assay of pregnenolone		A					
84143	Assay of 17-hydroxypregneno		A					
84144	Assay of progesterone		A					
84145	Procalcitonin (pct)		A					
84146	Assay of prolactin		A					
84150	Assay of prostaglandin		A					
84152	Assay of psa, complexed		A					
84153	Assay of psa, total		A					
84154	Assay of psa, free		A					
84155	Assay of protein, serum		A					
84156	Assay of protein, urine		A					
84157	Assay of protein, other		A					
84160	Assay of protein, any source		A					
84163	Pappa, serum		A					
84165	Protein e-phoresis, serum		A					
84166	Protein e-phoresis/urine/csf		A					
84181	Western blot test		A					
84182	Protein, western blot test		A					
84202	Assay RBC protoporphyrin		A					
84203	Test RBC protoporphyrin		A					
84206	Assay of proinsulin		A					
84207	Assay of vitamin b-6		A					
84210	Assay of pyruvate		A					
84220	Assay of pyruvate kinase		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
84228	Assay of quinine		A					
84233	Assay of estrogen		A					
84234	Assay of progesterone		A					
84235	Assay of endocrine hormone		A					
84238	Assay, nonendocrine receptor		A					
84244	Assay of renin		A					
84252	Assay of vitamin b-2		A					
84255	Assay of selenium		A					
84260	Assay of serotonin		A					
84270	Assay of sex hormone globul		A					
84275	Assay of sialic acid		A					
84285	Assay of silica		A					
84295	Assay of serum sodium		A					
84300	Assay of urine sodium		A					
84302	Assay of sweat sodium		A					
84305	Assay of somatomedin		A					
84307	Assay of somatostatin		A					
84311	Spectrophotometry		A					
84315	Body fluid specific gravity		A					
84375	Chromatogram assay, sugars		A					
84376	Sugars, single, qual		A					
84377	Sugars, multiple, qual		A					
84378	Sugars, single, quant		A					
84379	Sugars multiple quant		A					
84392	Assay of urine sulfate		A					
84402	Assay of testosterone		A					
84403	Assay of total testosterone		A					
84425	Assay of vitamin b-1		A					
84430	Assay of thiocyanate		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
84431	Thromboxane, urine		A					
84432	Assay of thyroglobulin		A					
84436	Assay of total thyroxine		A					
84437	Assay of neonatal thyroxine		A					
84439	Assay of free thyroxine		A					
84442	Assay of thyroid activity		A					
84443	Assay thyroid stim hormone		A					
84445	Assay of tsi		A					
84446	Assay of vitamin e		A					
84449	Assay of transcortin		A					
84450	Transferase (AST) (SGOT)		A					
84460	Alanine amino (ALT) (SGPT)		A					
84466	Assay of transferrin		A					
84478	Assay of triglycerides		A					
84479	Assay of thyroid (t3 or t4)		A					
84480	Assay, triiodothyronine (t3)		A					
84481	Free assay (FT-3)		A					
84482	T3 reverse		A					
84484	Assay of troponin, quant		A					
84485	Assay duodenal fluid trypsin		A					
84488	Test feces for trypsin		A					
84490	Assay of feces for trypsin		A					
84510	Assay of tyrosine		A					
84512	Assay of troponin, qual		A					
84520	Assay of urea nitrogen		A					
84525	Urea nitrogen semi-quant		A					
84540	Assay of urine/urea-n		A					
84545	Urea-N clearance test		A					
84550	Assay of blood/uric acid		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
84560	Assay of urine/uric acid		A					
84577	Assay of feces/urobilinogen		A					
84578	Test urine urobilinogen		A					
84580	Assay of urine urobilinogen		A					
84583	Assay of urine urobilinogen		A					
84585	Assay of urine vma		A					
84586	Assay of vip		A					
84588	Assay of vasopressin		A					
84590	Assay of vitamin a		A					
84591	Assay of nos vitamin		A					
84597	Assay of vitamin k		A					
84600	Assay of volatiles		A					
84620	Xylose tolerance test		A					
84630	Assay of zinc		A					
84681	Assay of c-peptide		A					
84702	Chorionic gonadotropin test		A					
84703	Chorionic gonadotropin assay		A					
84704	Hcg, free betachain test		A					
84830	Ovulation tests		A					
84999	Clinical chemistry test		A					
85002	Bleeding time test		A					
85004	Automated diff wbc count		A					
85007	Bl smear w/diff wbc count		A					
85008	Bl smear w/o diff wbc count		A					
85009	Manual diff wbc count b-coat		A					
85013	Spun microhematocrit		A					
85014	Hematocrit		A					
85018	Hemoglobin		A					
85025	Complete cbc w/auto diff wbc		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
85027	Complete cbc, automated		A					
85032	Manual cell count, each		A					
85041	Automated rbc count		A					
85044	Manual reticulocyte count		A					
85045	Automated reticulocyte count		A					
85046	Reticyte/hgb concentrate		A					
85048	Automated leukocyte count		A					
85049	Automated platelet count		A					
85055	Reticulated platelet assay		A					
85060	Blood smear interpretation		B					
85097	Bone marrow interpretation		X	0343	0.5351	$36.53	$10.84	$7.31
85130	Chromogenic substrate assay		A					
85170	Blood clot retraction		A					
85175	Blood clot lysis time		A					
85210	Blood clot factor II test		A					
85220	Blood clot factor V test		A					
85230	Blood clot factor VII test		A					
85240	Blood clot factor VIII test		A					
85244	Blood clot factor VIII test		A					
85245	Blood clot factor VIII test		A					
85246	Blood clot factor VIII test		A					
85247	Blood clot factor VIII test		A					
85250	Blood clot factor IX test		A					
85260	Blood clot factor X test		A					
85270	Blood clot factor XI test		A					
85280	Blood clot factor XII test		A					
85290	Blood clot factor XIII test		A					
85291	Blood clot factor XIII test		A					
85292	Blood clot factor assay		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
85293	Blood clot factor assay		A					
85300	Antithrombin III test		A					
85301	Antithrombin III test		A					
85302	Blood clot inhibitor antigen		A					
85303	Blood clot inhibitor test		A					
85305	Blood clot inhibitor assay		A					
85306	Blood clot inhibitor test		A					
85307	Assay activated protein c		A					
85335	Factor inhibitor test		A					
85337	Thrombomodulin		A					
85345	Coagulation time		A					
85347	Coagulation time		A					
85348	Coagulation time		A					
85360	Euglobulin lysis		A					
85362	Fibrin degradation products		A					
85366	Fibrinogen test		A					
85370	Fibrinogen test		A					
85378	Fibrin degrade, semiquant		A					
85379	Fibrin degradation, quant		A					
85380	Fibrin degradation, vte		A					
85384	Fibrinogen		A					
85385	Fibrinogen		A					
85390	Fibrinolysins screen		A					
85396	Clotting assay, whole blood		N					
85397	Clotting funct activity		A					
85400	Fibrinolytic plasmin		A					
85410	Fibrinolytic antiplasmin		A					
85415	Fibrinolytic plasminogen		A					
85420	Fibrinolytic plasminogen		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
85421	Fibrinolytic plasminogen		A					
85441	Heinz bodies, direct		A					
85445	Heinz bodies, induced		A					
85460	Hemoglobin, fetal		A					
85461	Hemoglobin, fetal		A					
85475	Hemolysin		A					
85520	Heparin assay		A					
85525	Heparin neutralization		A					
85530	Heparin-protamine tolerance		A					
85536	Iron stain peripheral blood		A					
85540	Wbc alkaline phosphatase		A					
85547	RBC mechanical fragility		A					
85549	Muramidase		A					
85555	RBC osmotic fragility		A					
85557	RBC osmotic fragility		A					
85576	Blood platelet aggregation		A					
85597	Platelet neutralization		A					
85610	Prothrombin time		A					
85611	Prothrombin test		A					
85612	Viper venom prothrombin time		A					
85613	Russell viper venom, diluted		A					
85635	Reptilase test		A					
85651	Rbc sed rate, nonautomated		A					
85652	Rbc sed rate, automated		A					
85660	RBC sickle cell test		A					
85670	Thrombin time, plasma		A					
85675	Thrombin time, titer		A					
85705	Thromboplastin inhibition		A					
85730	Thromboplastin time, partial		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
85732	Thromboplastin time, partial		A					
85810	Blood viscosity examination		A					
85999	Hematology procedure		A					
86000	Agglutinins, febrile		A					
86001	Allergen specific igg		A					
86003	Allergen specific IgE		A					
86005	Allergen specific IgE		A					
86021	WBC antibody identification		A					
86022	Platelet antibodies		A					
86023	Immunoglobulin assay		A					
86038	Antinuclear antibodies		A					
86039	Antinuclear antibodies (ANA)		A					
86060	Antistreptolysin o, titer		A					
86063	Antistreptolysin o, screen		A					
86077	Physician blood bank service		X	0433	0.2465	$16.83	$5.17	$3.37
86078	Physician blood bank service		X	0343	0.5351	$36.53	$10.84	$7.31
86079	Physician blood bank service		X	0433	0.2465	$16.83	$5.17	$3.37
86140	C-reactive protein		A					
86141	C-reactive protein, hs		A					
86146	Glycoprotein antibody		A					
86147	Cardiolipin antibody		A					
86148	Phospholipid antibody		A					
86155	Chemotaxis assay		A					
86156	Cold agglutinin, screen		A					
86157	Cold agglutinin, titer		A					
86160	Complement, antigen		A					
86161	Complement/function activity		A					
86162	Complement, total (CH50)		A					
86171	Complement fixation, each		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
86185	Counterimmunoelectrophoresis		A					
86200	Ccp antibody		A					
86215	Deoxyribonuclease, antibody		A					
86225	DNA antibody		A					
86226	DNA antibody, single strand		A					
86235	Nuclear antigen antibody		A					
86243	Fc receptor		A					
86255	Fluorescent antibody, screen		A					
86256	Fluorescent antibody, titer		A					
86277	Growth hormone antibody		A					
86280	Hemagglutination inhibition		A					
86294	Immunoassay, tumor, qual		A					
86300	Immunoassay, tumor, ca 15-3		A					
86301	Immunoassay, tumor, ca 19-9		A					
86304	Immunoassay, tumor, ca 125		A					
86305	Human epididymis protein 4		A					
86308	Heterophile antibodies		A					
86309	Heterophile antibodies		A					
86310	Heterophile antibodies		A					
86316	Immunoassay, tumor other		A					
86317	Immunoassay,infectious agent		A					
86318	Immunoassay,infectious agent		A					
86320	Serum immunoelectrophoresis		A					
86325	Other immunoelectrophoresis		A					
86327	Immunoelectrophoresis assay		A					
86329	Immunodiffusion		A					
86331	Immunodiffusion ouchterlony		A					
86332	Immune complex assay		A					
86334	Immunofix e-phoresis, serum		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
86335	Immunfix e-phorsis/urine/csf		A					
86336	Inhibin A		A					
86337	Insulin antibodies		A					
86340	Intrinsic factor antibody		A					
86341	Islet cell antibody		A					
86343	Leukocyte histamine release		A					
86344	Leukocyte phagocytosis		A					
86352	Cell function assay w/stim		A					
86353	Lymphocyte transformation		A					
86355	B cells, total count		A					
86356	Mononuclear cell antigen		A					
86357	Nk cells, total count		A					
86359	T cells, total count		A					
86360	T cell, absolute count/ratio		A					
86361	T cell, absolute count		A					
86367	Stem cells, total count		A					
86376	Microsomal antibody		A					
86378	Migration inhibitory factor		A					
86382	Neutralization test, viral		A					
86384	Nitroblue tetrazolium dye		A					
86403	Particle agglutination test		A					
86406	Particle agglutination test		A					
86430	Rheumatoid factor test		A					
86431	Rheumatoid factor, quant		A					
86480	Tb test, cell immun measure		A					
86485	Skin test, candida		X	0341	0.0804	$5.49	$2.09	$1.10
86486	Skin test, nos antigen		X	0341	0.0804	$5.49	$2.09	$1.10
86490	Coccidioidomycosis skin test		X	0341	0.0804	$5.49	$2.09	$1.10
86510	Histoplasmosis skin test		X	0341	0.0804	$5.49	$2.09	$1.10

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
86580	TB intradermal test		X	0341	0.0804	$5.49	$2.09	$1.10
86590	Streptokinase, antibody		A					
86592	Syphilis test non-trep qual		A					
86593	Syphilis test non-trep quant		A					
86602	Antinomyces antibody		A					
86603	Adenovirus antibody		A					
86606	Aspergillus antibody		A					
86609	Bacterium antibody		A					
86611	Bartonella antibody		A					
86612	Blastomyces antibody		A					
86615	Bordetella antibody		A					
86617	Lyme disease antibody		A					
86618	Lyme disease antibody		A					
86619	Borrelia antibody		A					
86622	Brucella antibody		A					
86625	Campylobacter antibody		A					
86628	Candida antibody		A					
86631	Chlamydia antibody		A					
86632	Chlamydia igm antibody		A					
86635	Coccidioides antibody		A					
86638	Q fever antibody		A					
86641	Cryptococcus antibody		A					
86644	CMV antibody		A					
86645	CMV antibody, IgM		A					
86648	Diphtheria antibody		A					
86651	Encephalitis antibody		A					
86652	Encephalitis antibody		A					
86653	Encephalitis antibody		A					
86654	Encephalitis antibody		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
86658	Enterovirus antibody		A					
86663	Epstein-barr antibody		A					
86664	Epstein-barr antibody		A					
86665	Epstein-barr antibody		A					
86666	Ehrlichia antibody		A					
86668	Francisella tularensis		A					
86671	Fungus antibody		A					
86674	Giardia lamblia antibody		A					
86677	Helicobacter pylori		A					
86682	Helminth antibody		A					
86684	Hemophilus influenza		A					
86687	Htlv-i antibody		A					
86688	Htlv-ii antibody		A					
86689	HTLV/HIV confirmatory test		A					
86692	Hepatitis, delta agent		A					
86694	Herpes simplex test		A					
86695	Herpes simplex test		A					
86696	Herpes simplex type 2		A					
86698	Histoplasma		A					
86701	HIV-1		A					
86702	HIV-2		A					
86703	HIV-1/HIV-2, single assay		A					
86704	Hep b core antibody, total		A					
86705	Hep b core antibody, igm		A					
86706	Hep b surface antibody		A					
86707	Hep be antibody		A					
86708	Hep a antibody, total		A					
86709	Hep a antibody, igm		A					
86710	Influenza virus antibody		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
86713	Legionella antibody		A					
86717	Leishmania antibody		A					
86720	Leptospira antibody		A					
86723	Listeria monocytogenes ab		A					
86727	Lymph choriomeningitis ab		A					
86729	Lympho venereum antibody		A					
86732	Mucormycosis antibody		A					
86735	Mumps antibody		A					
86738	Mycoplasma antibody		A					
86741	Neisseria meningitidis		A					
86744	Nocardia antibody		A					
86747	Parvovirus antibody		A					
86750	Malaria antibody		A					
86753	Protozoa antibody nos		A					
86756	Respiratory virus antibody		A					
86757	Rickettsia antibody		A					
86759	Rotavirus antibody		A					
86762	Rubella antibody		A					
86765	Rubeola antibody		A					
86768	Salmonella antibody		A					
86771	Shigella antibody		A					
86774	Tetanus antibody		A					
86777	Toxoplasma antibody		A					
86778	Toxoplasma antibody, igm		A					
86780	Treponema pallidum		A					
86784	Trichinella antibody		A					
86787	Varicella-zoster antibody		A					
86788	West nile virus ab, igm		A					
86789	West nile virus antibody		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
86790	Virus antibody nos		A					
86793	Yersinia antibody		A					
86800	Thyroglobulin antibody		A					
86803	Hepatitis c ab test		A					
86804	Hep c ab test, confirm		A					
86805	Lymphocytotoxicity assay		A					
86806	Lymphocytotoxicity assay		A					
86807	Cytotoxic antibody screening		A					
86808	Cytotoxic antibody screening		A					
86812	HLA typing, A, B, or C		A					
86813	HLA typing, A, B, or C		A					
86816	HLA typing, DR/DQ		A					
86817	HLA typing, DR/DQ		A					
86821	Lymphocyte culture, mixed		A					
86822	Lymphocyte culture, primed		A					
86825	Hla x-match, non-cytotoxic		A					
86826	Hla x-match, non-cyt add-on		A					
86849	Immunology procedure		A					
86850	RBC antibody screen		X	0345	0.2168	$14.80	.	$2.96
86860	RBC antibody elution		X	0346	0.3619	$24.71	.	$4.95
86870	RBC antibody identification		X	0346	0.3619	$24.71	.	$4.95
86880	Coombs test, direct		X	0409	0.1134	$7.74	$2.18	$1.55
86885	Coombs test, indirect, qual		X	0409	0.1134	$7.74	$2.18	$1.55
86886	Coombs test, indirect, titer		X	0409	0.1134	$7.74	$2.18	$1.55
86890	Autologous blood process		X	0347	0.6903	$47.12	$9.43	$9.43
86891	Autologous blood, op salvage		X	0345	0.2168	$14.80	.	$2.96
86900	Blood typing, ABO		X	0409	0.1134	$7.74	$2.18	$1.55
86901	Blood typing, Rh (D)		X	0409	0.1134	$7.74	$2.18	$1.55
86903	Blood typing, antigen screen		X	0345	0.2168	$14.80	.	$2.96

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
86904	Blood typing, patient serum		X	0345	0.2168	$14.80	.	$2.96
86905	Blood typing, RBC antigens		X	0345	0.2168	$14.80	.	$2.96
86906	Blood typing, Rh phenotype		X	0345	0.2168	$14.80	.	$2.96
86910	Blood typing, paternity test		E					
86911	Blood typing, antigen system		E					
86920	Compatibility test, spin		X	0345	0.2168	$14.80	.	$2.96
86921	Compatibility test, incubate		X	0345	0.2168	$14.80	.	$2.96
86922	Compatibility test, antiglob		X	0346	0.3619	$24.71	.	$4.95
86923	Compatibility test, electric		X	0345	0.2168	$14.80	.	$2.96
86927	Plasma, fresh frozen		X	0345	0.2168	$14.80	.	$2.96
86930	Frozen blood prep		X	0347	0.6903	$47.12	$9.43	$9.43
86931	Frozen blood thaw		X	0347	0.6903	$47.12	$9.43	$9.43
86932	Frozen blood freeze/thaw		X	0347	0.6903	$47.12	$9.43	$9.43
86940	Hemolysins/agglutinins, auto		A					
86941	Hemolysins/agglutinins		A					
86945	Blood product/irradiation		X	0345	0.2168	$14.80	.	$2.96
86950	Leukacyte transfusion		X	0345	0.2168	$14.80	.	$2.96
86960	Vol reduction of blood/prod		X	0345	0.2168	$14.80	.	$2.96
86965	Pooling blood platelets		X	0346	0.3619	$24.71	.	$4.95
86970	RBC pretreatment		X	0345	0.2168	$14.80	.	$2.96
86971	RBC pretreatment		X	0345	0.2168	$14.80	.	$2.96
86972	RBC pretreatment		X	0345	0.2168	$14.80	.	$2.96
86975	RBC pretreatment, serum		X	0346	0.3619	$24.71	.	$4.95
86976	RBC pretreatment, serum		X	0345	0.2168	$14.80	.	$2.96
86977	RBC pretreatment, serum		X	0347	0.6903	$47.12	$9.43	$9.43
86978	RBC pretreatment, serum		X	0346	0.3619	$24.71	.	$4.95
86985	Split blood or products		X	0345	0.2168	$14.80	.	$2.96
86999	Transfusion procedure		X	0345	0.2168	$14.80	.	$2.96
87001	Small animal inoculation		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
87003	Small animal inoculation		A					
87015	Specimen concentration		A					
87040	Blood culture for bacteria		A					
87045	Feces culture, bacteria		A					
87046	Stool cultr, bacteria, each		A					
87070	Culture, bacteria, other		A					
87071	Culture bacteri aerobic othr		A					
87073	Culture bacteria anaerobic		A					
87075	Cultr bacteria, except blood		A					
87076	Culture anaerobe ident, each		A					
87077	Culture aerobic identify		A					
87081	Culture screen only		A					
87084	Culture of specimen by kit		A					
87086	Urine culture/colony count		A					
87088	Urine bacteria culture		A					
87101	Skin fungi culture		A					
87102	Fungus isolation culture		A					
87103	Blood fungus culture		A					
87106	Fungi identification, yeast		A					
87107	Fungi identification, mold		A					
87109	Mycoplasma		A					
87110	Chlamydia culture		A					
87116	Mycobacteria culture		A					
87118	Mycobacteric identification		A					
87140	Culture type immunofluoresc		A					
87143	Culture typing, glc/hplc		A					
87147	Culture type, immunologic		A					
87149	Dna/rna direct probe		A					
87150	Dna/rna, amplified probe		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
87152	Culture type pulse field gel		A					
87153	Dna/rna sequencing		A					
87158	Culture typing, added method		A					
87164	Dark field examination		A					
87166	Dark field examination		A					
87168	Macroscopic exam arthropod		A					
87169	Macroscopic exam parasite		A					
87172	Pinworm exam		A					
87176	Tissue homogenization, cultr		A					
87177	Ova and parasites smears		A					
87181	Microbe susceptible, diffuse		A					
87184	Microbe susceptible, disk		A					
87185	Microbe susceptible, enzyme		A					
87186	Microbe susceptible, mic		A					
87187	Microbe susceptible, mlc		A					
87188	Microbe suscept, macrobroth		A					
87190	Microbe suscept, mycobacteri		A					
87197	Bactericidal level, serum		A					
87205	Smear, gram stain		A					
87206	Smear, fluorescent/acid stai		A					
87207	Smear, special stain		A					
87209	Smear, complex stain		A					
87210	Smear, wet mount, saline/ink		A					
87220	Tissue exam for fungi		A					
87230	Assay, toxin or antitoxin		A					
87250	Virus inoculate, eggs/animal		A					
87252	Virus inoculation, tissue		A					
87253	Virus inoculate tissue, addl		A					
87254	Virus inoculation, shell via		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
87255	Genet virus isolate, hsv		A					
87260	Adenovirus ag, if		A					
87265	Pertussis ag, if		A					
87267	Enterovirus antibody, dfa		A					
87269	Giardia ag, if		A					
87270	Chlamydia trachomatis ag, if		A					
87271	Cytomegalovirus dfa		A					
87272	Cryptosporidium ag, if		A					
87273	Herpes simplex 2, ag, if		A					
87274	Herpes simplex 1, ag, if		A					
87275	Influenza b, ag, if		A					
87276	Influenza a, ag, if		A					
87277	Legionella micdadei, ag, if		A					
87278	Legion pneumophilia ag, if		A					
87279	Parainfluenza, ag, if		A					
87280	Respiratory syncytial ag, if		A					
87281	Pneumocystis carinii, ag, if		A					
87283	Rubeola, ag, if		A					
87285	Treponema pallidum, ag, if		A					
87290	Varicella zoster, ag, if		A					
87299	Antibody detection, nos, if		A					
87300	Ag detection, polyval, if		A					
87301	Adenovirus ag, eia		A					
87305	Aspergillus ag, eia		A					
87320	Chylmd trach ag, eia		A					
87324	Clostridium ag, eia		A					
87327	Cryptococcus neoform ag, eia		A					
87328	Cryptosporidium ag, eia		A					
87329	Giardia ag, eia		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
87332	Cytomegalovirus ag, eia		A					
87335	E coli 0157 ag, eia		A					
87336	Entamoeb hist dispr, ag, eia		A					
87337	Entamoeb hist group, ag, eia		A					
87338	Hpylori, stool, eia		A					
87339	H pylori ag, eia		A					
87340	Hepatitis b surface ag, eia		A					
87341	Hepatitis b surface, ag, eia		A					
87350	Hepatitis be ag, eia		A					
87380	Hepatitis delta ag, eia		A					
87385	Histoplasma capsul ag, eia		A					
87390	Hiv-1 ag, eia		A					
87391	Hiv-2 ag, eia		A					
87400	Influenza a/b, ag, eia		A					
87420	Resp syncytial ag, eia		A					
87425	Rotavirus ag, eia		A					
87427	Shiga-like toxin ag, eia		A					
87430	Strep a ag, eia		A					
87449	Ag detect nos, eia, mult		A					
87450	Ag detect nos, eia, single		A					
87451	Ag detect polyval, eia, mult		A					
87470	Bartonella, dna, dir probe		A					
87471	Bartonella, dna, amp probe		A					
87472	Bartonella, dna, quant		A					
87475	Lyme dis, dna, dir probe		A					
87476	Lyme dis, dna, amp probe		A					
87477	Lyme dis, dna, quant		A					
87480	Candida, dna, dir probe		A					
87481	Candida, dna, amp probe		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
87482	Candida, dna, quant		A					
87485	Chylmd pneum, dna, dir probe		A					
87486	Chylmd pneum, dna, amp probe		A					
87487	Chylmd pneum, dna, quant		A					
87490	Chylmd trach, dna, dir probe		A					
87491	Chylmd trach, dna, amp probe		A					
87492	Chylmd trach, dna, quant		A					
87493	C diff amplified probe		A					
87495	Cytomeg, dna, dir probe		A					
87496	Cytomeg, dna, amp probe		A					
87497	Cytomeg, dna, quant		A					
87498	Enterovirus, dna, amp probe		A					
87500	Vanomycin, dna, amp probe		A					
87510	Gardner vag, dna, dir probe		A					
87511	Gardner vag, dna, amp probe		A					
87512	Gardner vag, dna, quant		A					
87515	Hepatitis b, dna, dir probe		A					
87516	Hepatitis b, dna, amp probe		A					
87517	Hepatitis b, dna, quant		A					
87520	Hepatitis c, rna, dir probe		A					
87521	Hepatitis c, rna, amp probe		A					
87522	Hepatitis c, rna, quant		A					
87525	Hepatitis g, dna, dir probe		A					
87526	Hepatitis g, dna, amp probe		A					
87527	Hepatitis g, dna, quant		A					
87528	Hsv, dna, dir probe		A					
87529	Hsv, dna, amp probe		A					
87530	Hsv, dna, quant		A					
87531	Hhv-6, dna, dir probe		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
87532	Hhv-6, dna, amp probe		A					
87533	Hhv-6, dna, quant		A					
87534	Hiv-1, dna, dir probe		A					
87535	Hiv-1, dna, amp probe		A					
87536	Hiv-1, dna, quant		A					
87537	Hiv-2, dna, dir probe		A					
87538	Hiv-2, dna, amp probe		A					
87539	Hiv-2, dna, quant		A					
87540	Legion pneumo, dna, dir prob		A					
87541	Legion pneumo, dna, amp prob		A					
87542	Legion pneumo, dna, quant		A					
87550	Mycobacteria, dna, dir probe		A					
87551	Mycobacteria, dna, amp probe		A					
87552	Mycobacteria, dna, quant		A					
87555	M.tuberculo, dna, dir probe		A					
87556	M.tuberculo, dna, amp probe		A					
87557	M.tuberculo, dna, quant		A					
87560	M.avium-intra, dna, dir prob		A					
87561	M.avium-intra, dna, amp prob		A					
87562	M.avium-intra, dna, quant		A					
87580	M.pneumon, dna, dir probe		A					
87581	M.pneumon, dna, amp probe		A					
87582	M.pneumon, dna, quant		A					
87590	N.gonorrhoeae, dna, dir prob		A					
87591	N.gonorrhoeae, dna, amp prob		A					
87592	N.gonorrhoeae, dna, quant		A					
87620	Hpv, dna, dir probe		A					
87621	Hpv, dna, amp probe		A					
87622	Hpv, dna, quant		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
87640	Staph a, dna, amp probe		A					
87641	Mr-staph, dna, amp probe		A					
87650	Strep a, dna, dir probe		A					
87651	Strep a, dna, amp probe		A					
87652	Strep a, dna, quant		A					
87653	Strep b, dna, amp probe		A					
87660	Trichomonas vagin, dir probe		A					
87797	Detect agent nos, dna, dir		A					
87798	Detect agent nos, dna, amp		A					
87799	Detect agent nos, dna, quant		A					
87800	Detect agnt mult, dna, direc		A					
87801	Detect agnt mult, dna, ampli		A					
87802	Strep b assay w/optic		A					
87803	Clostridium toxin a w/optic		A					
87804	Influenza assay w/optic		A					
87807	Rsv assay w/optic		A					
87808	Trichomonas assay w/optic		A					
87809	Adenovirus assay w/optic		A					
87810	Chylmd trach assay w/optic		A					
87850	N. gonorrhoeae assay w/optic		A					
87880	Strep a assay w/optic		A					
87899	Agent nos assay w/optic		A					
87900	Phenotype, infect agent drug		A					
87901	Genotype, dna, hiv reverse t		A					
87902	Genotype, dna, hepatitis C		A					
87903	Phenotype, dna hiv w/culture		A					
87904	Phenotype, dna hiv w/clt add		A					
87905	Sialidase enzyme assay		A					
87999	Microbiology procedure		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
88000	Autopsy (necropsy), gross		E					
88005	Autopsy (necropsy), gross		E					
88007	Autopsy (necropsy), gross		E					
88012	Autopsy (necropsy), gross		E					
88014	Autopsy (necropsy), gross		E					
88016	Autopsy (necropsy), gross		E					
88020	Autopsy (necropsy), complete		E					
88025	Autopsy (necropsy), complete		E					
88027	Autopsy (necropsy), complete		E					
88028	Autopsy (necropsy), complete		E					
88029	Autopsy (necropsy), complete		E					
88036	Limited autopsy		E					
88037	Limited autopsy		E					
88040	Forensic autopsy (necropsy)		E					
88045	Coroners autopsy (necropsy)		E					
88099	Necropsy (autopsy) procedure		E					
88104	Cytopath fl nongyn, smears		X	0433	0.2465	$16.83	$5.17	$3.37
88106	Cytopath fl nongyn, filter		X	0433	0.2465	$16.83	$5.17	$3.37
88107	Cytopath fl nongyn, sm/fltr		X	0343	0.5351	$36.53	$10.84	$7.31
88108	Cytopath, concentrate tech		X	0433	0.2465	$16.83	$5.17	$3.37
88112	Cytopath, cell enhance tech		X	0343	0.5351	$36.53	$10.84	$7.31
88125	Forensic cytopathology		X	0433	0.2465	$16.83	$5.17	$3.37
88130	Sex chromatin identification		A					
88140	Sex chromatin identification		A					
88141	Cytopath, c/v, interpret		N					
88142	Cytopath, c/v, thin layer		A					
88143	Cytopath c/v thin layer redo		A					
88147	Cytopath, c/v, automated		A					
88148	Cytopath, c/v, auto rescreen		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
88150	Cytopath, c/v, manual		A					
88152	Cytopath, c/v, auto redo		A					
88153	Cytopath, c/v, redo		A					
88154	Cytopath, c/v, select		A					
88155	Cytopath, c/v, index add-on		A					
88160	Cytopath smear, other source		X	0433	0.2465	$16.83	$5.17	$3.37
88161	Cytopath smear, other source		X	0433	0.2465	$16.83	$5.17	$3.37
88162	Cytopath smear, other source		X	0343	0.5351	$36.53	$10.84	$7.31
88164	Cytopath tbs, c/v, manual		A					
88165	Cytopath tbs, c/v, redo		A					
88166	Cytopath tbs, c/v, auto redo		A					
88167	Cytopath tbs, c/v, select		A					
88172	Cytopathology eval of fna		X	0343	0.5351	$36.53	$10.84	$7.31
88173	Cytopath eval, fna, report		X	0343	0.5351	$36.53	$10.84	$7.31
88174	Cytopath, c/v auto, in fluid		A					
88175	Cytopath c/v auto fluid redo		A					
88182	Cell marker study		X	0343	0.5351	$36.53	$10.84	$7.31
88184	Flowcytometry/ tc, 1 marker		X	0433	0.2465	$16.83	$5.17	$3.37
88185	Flowcytometry/tc, add-on		X	0433	0.2465	$16.83	$5.17	$3.37
88187	Flowcytometry/read, 2-8		X	0342	0.1596	$10.90	.	$2.18
88188	Flowcytometry/read, 9-15		X	0343	0.5351	$36.53	$10.84	$7.31
88189	Flowcytometry/read, 16 & >		X	0343	0.5351	$36.53	$10.84	$7.31
88199	Cytopathology procedure		X	0342	0.1596	$10.90	.	$2.18
88230	Tissue culture, lymphocyte		A					
88233	Tissue culture, skin/biopsy		A					
88235	Tissue culture, placenta		A					
88237	Tissue culture, bone marrow		A					
88239	Tissue culture, tumor		A					
88240	Cell cryopreserve/storage		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
88241	Frozen cell preparation		A					
88245	Chromosome analysis, 20-25		A					
88248	Chromosome analysis, 50-100		A					
88249	Chromosome analysis, 100		A					
88261	Chromosome analysis, 5		A					
88262	Chromosome analysis, 15-20		A					
88263	Chromosome analysis, 45		A					
88264	Chromosome analysis, 20-25		A					
88267	Chromosome analys, placenta		A					
88269	Chromosome analys, amniotic		A					
88271	Cytogenetics, dna probe		A					
88272	Cytogenetics, 3-5		A					
88273	Cytogenetics, 10-30		A					
88274	Cytogenetics, 25-99		A					
88275	Cytogenetics, 100-300		A					
88280	Chromosome karyotype study		A					
88283	Chromosome banding study		A					
88285	Chromosome count, additional		A					
88289	Chromosome study, additional		A					
88291	Cyto/molecular report		M					
88299	Cytogenetic study		X	0342	0.1596	$10.90	.	$2.18
88300	Surgical path, gross		X	0433	0.2465	$16.83	$5.17	$3.37
88302	Tissue exam by pathologist		X	0433	0.2465	$16.83	$5.17	$3.37
88304	Tissue exam by pathologist		X	0343	0.5351	$36.53	$10.84	$7.31
88305	Tissue exam by pathologist		X	0343	0.5351	$36.53	$10.84	$7.31
88307	Tissue exam by pathologist		X	0344	0.8227	$56.16	$15.56	$11.24
88309	Tissue exam by pathologist		X	0344	0.8227	$56.16	$15.56	$11.24
88311	Decalcify tissue		X	0342	0.1596	$10.90	.	$2.18
88312	Special stains group 1		X	0433	0.2465	$16.83	$5.17	$3.37

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
88313	Special stains group 2		X	0433	0.2465	$16.83	$5.17	$3.37
88314	Histochemical stain add-on		X	0433	0.2465	$16.83	$5.17	$3.37
88318	Chemical histochemistry		X	0433	0.2465	$16.83	$5.17	$3.37
88319	Enzyme histochemistry		X	0344	0.8227	$56.16	$15.56	$11.24
88321	Microslide consultation		X	0433	0.2465	$16.83	$5.17	$3.37
88323	Microslide consultation		X	0343	0.5351	$36.53	$10.84	$7.31
88325	Comprehensive review of data		X	0344	0.8227	$56.16	$15.56	$11.24
88329	Path consult introp		X	0433	0.2465	$16.83	$5.17	$3.37
88331	Path consult intraop, 1 bloc		X	0343	0.5351	$36.53	$10.84	$7.31
88332	Path consult intraop, addl		X	0433	0.2465	$16.83	$5.17	$3.37
88333	Intraop cyto path consult, 1		X	0433	0.2465	$16.83	$5.17	$3.37
88334	Intraop cyto path consult, 2		X	0433	0.2465	$16.83	$5.17	$3.37
88342	Immunohistochemistry		X	0343	0.5351	$36.53	$10.84	$7.31
88346	Immunofluorescent study		X	0343	0.5351	$36.53	$10.84	$7.31
88347	Immunofluorescent study		X	0343	0.5351	$36.53	$10.84	$7.31
88348	Electron microscopy		X	0661	2.3687	$161.70	.	$32.34
88349	Scanning electron microscopy		X	0661	2.3687	$161.70	.	$32.34
88355	Analysis, skeletal muscle		X	0343	0.5351	$36.53	$10.84	$7.31
88356	Analysis, nerve		X	0344	0.8227	$56.16	$15.56	$11.24
88358	Analysis, tumor		X	0343	0.5351	$36.53	$10.84	$7.31
88360	Tumor immunohistochem/manual		X	0343	0.5351	$36.53	$10.84	$7.31
88361	Tumor immunohistochem/comput		X	0344	0.8227	$56.16	$15.56	$11.24
88362	Nerve teasing preparations		X	0344	0.8227	$56.16	$15.56	$11.24
88365	Insitu hybridization (fish)		X	0344	0.8227	$56.16	$15.56	$11.24
88367	Insitu hybridization, auto		X	0344	0.8227	$56.16	$15.56	$11.24
88368	Insitu hybridization, manual		X	0344	0.8227	$56.16	$15.56	$11.24
88371	Protein, western blot tissue		A					
88372	Protein analysis w/probe		A					
88380	Microdissection, laser		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
88381	Microdissection, manual		N					
88384	Eval molecular probes, 11-50		X	0433	0.2465	$16.83	$5.17	$3.37
88385	Eval molecul probes, 51-250		X	0343	0.5351	$36.53	$10.84	$7.31
88386	Eval molecul probes, 251-500		X	0344	0.8227	$56.16	$15.56	$11.24
88387	Tiss exam molecular study		N					
88388	Tiss ex molecul study add-on		N					
88399	Surgical pathology procedure		X	0342	0.1596	$10.90	.	$2.18
88720	Bilirubin total transcut		A					
88738	Hgb quant transcutaneous		A					
88740	Transcutaneous carboxyhb		A					
88741	Transcutaneous methb		A					
89049	Chct for mal hyperthermia		X	0342	0.1596	$10.90	.	$2.18
89050	Body fluid cell count		A					
89051	Body fluid cell count		A					
89055	Leukocyte assessment, fecal		A					
89060	Exam,synovial fluid crystals		A					
89100	Sample intestinal contents		X	0360	1.7011	$116.13	$33.88	$23.23
89105	Sample intestinal contents		X	0360	1.7011	$116.13	$33.88	$23.23
89125	Specimen fat stain		A					
89130	Sample stomach contents		X	0360	1.7011	$116.13	$33.88	$23.23
89132	Sample stomach contents		X	0360	1.7011	$116.13	$33.88	$23.23
89135	Sample stomach contents		X	0360	1.7011	$116.13	$33.88	$23.23
89136	Sample stomach contents		X	0360	1.7011	$116.13	$33.88	$23.23
89140	Sample stomach contents		X	0360	1.7011	$116.13	$33.88	$23.23
89141	Sample stomach contents		X	0360	1.7011	$116.13	$33.88	$23.23
89160	Exam feces for meat fibers		A					
89190	Nasal smear for eosinophils		A					
89220	Sputum specimen collection		X	0433	0.2465	$16.83	$5.17	$3.37
89225	Starch granules, feces		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
89230	Collect sweat for test		X	0343	0.5351	$36.53	$10.84	$7.31
89235	Water load test		A					
89240	Pathology lab procedure		X	0342	0.1596	$10.90	.	$2.18
89250	Cultr oocyte/embryo <4 days		X	0344	0.8227	$56.16	$15.56	$11.24
89251	Cultr oocyte/embryo <4 days		X	0344	0.8227	$56.16	$15.56	$11.24
89253	Embryo hatching		X	0344	0.8227	$56.16	$15.56	$11.24
89254	Oocyte identification		X	0344	0.8227	$56.16	$15.56	$11.24
89255	Prepare embryo for transfer		X	0344	0.8227	$56.16	$15.56	$11.24
89257	Sperm identification		X	0344	0.8227	$56.16	$15.56	$11.24
89258	Cryopreservation; embryo(s)		X	0344	0.8227	$56.16	$15.56	$11.24
89259	Cryopreservation, sperm		X	0344	0.8227	$56.16	$15.56	$11.24
89260	Sperm isolation, simple		X	0344	0.8227	$56.16	$15.56	$11.24
89261	Sperm isolation, complex		X	0344	0.8227	$56.16	$15.56	$11.24
89264	Identify sperm tissue		X	0344	0.8227	$56.16	$15.56	$11.24
89268	Insemination of oocytes		X	0344	0.8227	$56.16	$15.56	$11.24
89272	Extended culture of oocytes		X	0344	0.8227	$56.16	$15.56	$11.24
89280	Assist oocyte fertilization		X	0344	0.8227	$56.16	$15.56	$11.24
89281	Assist oocyte fertilization		X	0344	0.8227	$56.16	$15.56	$11.24
89290	Biopsy, oocyte polar body		X	0344	0.8227	$56.16	$15.56	$11.24
89291	Biopsy, oocyte polar body		X	0344	0.8227	$56.16	$15.56	$11.24
89300	Semen analysis w/huhner		A					
89310	Semen analysis w/count		A					
89320	Semen anal vol/count/mot		A					
89321	Semen anal, sperm detection		A					
89322	Semen anal, strict criteria		A					
89325	Sperm antibody test		A					
89329	Sperm evaluation test		A					
89330	Evaluation, cervical mucus		A					
89331	Retrograde ejaculation anal		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
89335	Cryopreserve testicular tiss		X	0344	0.8227	$56.16	$15.56	$11.24
89342	Storage/year; embryo(s)		X	0344	0.8227	$56.16	$15.56	$11.24
89343	Storage/year; sperm/semen		X	0344	0.8227	$56.16	$15.56	$11.24
89344	Storage/year; reprod tissue		X	0344	0.8227	$56.16	$15.56	$11.24
89346	Storage/year; oocyte(s)		X	0344	0.8227	$56.16	$15.56	$11.24
89352	Thawing cryopresrved; embryo		X	0344	0.8227	$56.16	$15.56	$11.24
89353	Thawing cryopresrved; sperm		X	0344	0.8227	$56.16	$15.56	$11.24
89354	Thaw cryoprsvrd; reprod tiss		X	0344	0.8227	$56.16	$15.56	$11.24
89356	Thawing cryopresrved; oocyte		X	0344	0.8227	$56.16	$15.56	$11.24
89398	Unlisted reprod med lab proc		X	0342	0.1596	$10.90	.	$2.18
90281	Human ig, im		E					
90283	Human ig, iv		E					
90284	Human ig, sc		E					
90287	Botulinum antitoxin		E					
90288	Botulism ig, iv		E					
90291	Cmv ig, iv		E					
90296	Diphtheria antitoxin		E					
90371	Hep b ig, im		K	1630		$115.97	.	$23.20
90375	Rabies ig, im/sc		K	9133		$139.75	.	$27.95
90376	Rabies ig, heat treated		K	9134		$152.38	.	$30.48
90378	Rsv, mab, im, 50mg		K	9003		$510.69	.	$102.14
90384	Rh ig, full-dose, im		E					
90385	Rh ig, minidose, im		N					
90386	Rh ig, iv		E					
90389	Tetanus ig, im		E					
90393	Vaccina ig, im		E					
90396	Varicella-zoster ig, im		K	9135		$147.58	.	$29.52
90399	Immune globulin		E					
90465	Immune admin 1 inj, < 8 yrs		B					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
90466	Immune admin addl inj, < 8 y		B					
90467	Immune admin o or n, < 8 yrs		B					
90468	Immune admin o/n, addl < 8 y		B					
90470	Immune admin H1N1 im/nasal		E					
90471	Immunization admin		S	0436	0.3853	$26.30	.	$5.26
90472	Immunization admin, each add		S	0436	0.3853	$26.30	.	$5.26
90473	Immune admin oral/nasal		S	0436	0.3853	$26.30	.	$5.26
90474	Immune admin oral/nasal addl		S	0436	0.3853	$26.30	.	$5.26
90476	Adenovirus vaccine, type 4		K	1254		$173.84	.	$34.77
90477	Adenovirus vaccine, type 7		E					
90581	Anthrax vaccine, sc		E					
90585	Bcg vaccine, percut		K	9137		$109.47	.	$21.90
90586	Bcg vaccine, intravesical		B					
90632	Hep a vaccine, adult im		N					
90633	Hep a vacc, ped/adol, 2 dose		N					
90634	Hep a vacc, ped/adol, 3 dose		N					
90636	Hep a/hep b vacc, adult im		N					
90644	HIB/men/tt vaccine, im		E					
90645	Hib vaccine, hboc, im		N					
90646	Hib vaccine, prp-d, im		N					
90647	Hib vaccine, prp-omp, im		N					
90648	Hib vaccine, prp-t, im		N					
90649	Hpv vaccine 4 valent, im		M					
90650	Hpv vaccine 2 valent, im		M					
90655	Flu vaccine no preserv 6-35m		L					
90656	Flu vaccine no preserv 3 & >		L					
90657	Flu vaccine, 3 yrs, im		L					
90658	Flu vaccine, 3 yrs & >, im		L					
90660	Flu vaccine, nasal		L					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
90661	Flu vacc cell cult prsv free		E					
90662	Flu vacc prsv free inc antig		E					
90663	Flu vacc pandemic H1N1		E					
90665	Lyme disease vaccine, im	CH	N					
90669	Pneumococcal vacc, 7 val im		L					
90670	Pneumococcal vacc, 13 val im	CH	L					
90675	Rabies vaccine, im		K	9139		$181.27	.	$36.26
90676	Rabies vaccine, id		K	9140		$98.12	.	$19.63
90680	Rotovirus vacc 3 dose, oral		K	1255		$73.76	.	$14.76
90681	Rotavirus vacc 2 dose oral		K	1239		$102.50	.	$20.50
90690	Typhoid vaccine, oral		N					
90691	Typhoid vaccine, im		N					
90692	Typhoid vaccine, h-p, sc/id		N					
90693	Typhoid vaccine, akd, sc		B					
90696	Dtap-ipv vacc 4-6 yr im		N					
90698	Dtap-hib-ip vaccine, im		N					
90700	Dtap vaccine, < 7 yrs, im		N					
90701	Dtp vaccine, im		N					
90702	Dt vaccine < 7, im		N					
90703	Tetanus vaccine, im		N					
90704	Mumps vaccine, sc		N					
90705	Measles vaccine, sc		N					
90706	Rubella vaccine, sc		N					
90707	Mmr vaccine, sc		N					
90708	Measles-rubella vaccine, sc		N					
90710	Mmrv vaccine, sc		N					
90712	Oral poliovirus vaccine		N					
90713	Poliovirus, ipv, sc/im		N					
90714	Td vaccine no prsrv >/= 7 im		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
90715	Tdap vaccine >7 im		N					
90716	Chicken pox vaccine, sc		M					
90717	Yellow fever vaccine, sc		N					
90718	Td vaccine > 7, im		N					
90719	Diphtheria vaccine, im		N					
90720	Dtp/hib vaccine, im		N					
90721	Dtap/hib vaccine, im		N					
90723	Dtap-hep b-ipv vaccine, im		E					
90725	Cholera vaccine, injectable		K	1271		$103.90	.	$20.78
90727	Plague vaccine, im		E					
90732	Pneumococcal vaccine		L					
90733	Meningococcal vaccine, sc		K	9143		$103.41	.	$20.69
90734	Meningococcal vaccine, im		K	9145		$103.41	.	$20.69
90735	Encephalitis vaccine, sc		K	9144		$102.08	.	$20.42
90736	Zoster vacc, sc		M					
90738	Inactivated je vacc im		M					
90740	Hepb vacc, ill pat 3 dose im		F					
90743	Hep b vacc, adol, 2 dose, im		F					
90744	Hepb vacc ped/adol 3 dose im		F					
90746	Hep b vaccine, adult, im		F					
90747	Hepb vacc, ill pat 4 dose im		F					
90748	Hep b/hib vaccine, im		E					
90749	Vaccine toxoid		N					
90801	Psy dx interview		Q3	0323	1.6309	$111.34	.	$22.27
90802	Intac psy dx interview		Q3	0323	1.6309	$111.34	.	$22.27
90804	Psytx, office, 20-30 min		Q3	0322	1.1744	$80.17	.	$16.04
90805	Psytx, off, 20-30 min w/e&m		Q3	0322	1.1744	$80.17	.	$16.04
90806	Psytx, off, 45-50 min		Q3	0323	1.6309	$111.34	.	$22.27
90807	Psytx, off, 45-50 min w/e&m		Q3	0323	1.6309	$111.34	.	$22.27

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
90808	Psytx, office, 75-80 min		Q3	0323	1.6309	$111.34	.	$22.27
90809	Psytx, off, 75-80, w/e&m		Q3	0323	1.6309	$111.34	.	$22.27
90810	Intac psytx, off, 20-30 min		Q3	0322	1.1744	$80.17	.	$16.04
90811	Intac psytx, 20-30, w/e&m		Q3	0322	1.1744	$80.17	.	$16.04
90812	Intac psytx, off, 45-50 min		Q3	0323	1.6309	$111.34	.	$22.27
90813	Intac psytx, 45-50 min w/e&m		Q3	0323	1.6309	$111.34	.	$22.27
90814	Intac psytx, off, 75-80 min		Q3	0323	1.6309	$111.34	.	$22.27
90815	Intac psytx, 75-80 w/e&m		Q3	0323	1.6309	$111.34	.	$22.27
90816	Psytx, hosp, 20-30 min		P					
90817	Psytx, hosp, 20-30 min w/e&m		P					
90818	Psytx, hosp, 45-50 min		P					
90819	Psytx, hosp, 45-50 min w/e&m		P					
90821	Psytx, hosp, 75-80 min		P					
90822	Psytx, hosp, 75-80 min w/e&m		P					
90823	Intac psytx, hosp, 20-30 min		P					
90824	Intac psytx, hsp 20-30 w/e&m		P					
90826	Intac psytx, hosp, 45-50 min		P					
90827	Intac psytx, hsp 45-50 w/e&m		P					
90828	Intac psytx, hosp, 75-80 min		P					
90829	Intac psytx, hsp 75-80 w/e&m		P					
90845	Psychoanalysis		Q3	0323	1.6309	$111.34	.	$22.27
90846	Family psytx w/o patient		Q3	0324	1.8392	$125.56	.	$25.12
90847	Family psytx w/patient		Q3	0324	1.8392	$125.56	.	$25.12
90849	Multiple family group psytx		Q3	0325	0.788	$53.79	$11.47	$10.76
90853	Group psychotherapy		Q3	0325	0.788	$53.79	$11.47	$10.76
90857	Intac group psytx		Q3	0325	0.788	$53.79	$11.47	$10.76
90862	Medication management	CH	Q3	0605	1.0573	$72.18	.	$14.44
90865	Narcosynthesis		Q3	0323	1.6309	$111.34	.	$22.27
90870	Electroconvulsive therapy		S	0320	6.0291	$411.59	.	$82.32

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
90875	Psychophysiological therapy		E					
90876	Psychophysiological therapy		E					
90880	Hypnotherapy		Q3	0323	1.6309	$111.34	.	$22.27
90882	Environmental manipulation		E					
90885	Psy evaluation of records		N					
90887	Consultation with family		N					
90889	Preparation of report		N					
90899	Psychiatric service/therapy		Q3	0322	1.1744	$80.17	.	$16.04
90901	Biofeedback train, any meth		A					
90911	Biofeedback peri/uro/rectal		T	0126	1.0983	$74.98	$16.21	$15.00
90935	Hemodialysis, one evaluation		S	0170	7.0059	$478.27	.	$95.66
90937	Hemodialysis, repeated eval		B					
90940	Hemodialysis access study		N					
90945	Dialysis, one evaluation		V	0608	2.4657	$168.33	.	$33.67
90947	Dialysis, repeated eval		B					
90951	Esrd serv, 4 visits p mo, <2		M					
90952	Esrd serv, 2-3 vsts p mo, <2		M					
90953	Esrd serv, 1 visit p mo, <2		M					
90954	Esrd serv, 4 vsts p mo, 2-11		M					
90955	Esrd srv 2-3 vsts p mo, 2-11		M					
90956	Esrd srv, 1 visit p mo, 2-11		M					
90957	Esrd srv, 4 vsts p mo, 12-19		M					
90958	Esrd srv 2-3 vsts p mo 12-19		M					
90959	Esrd serv, 1 vst p mo, 12-19		M					
90960	Esrd srv, 4 visits p mo, 20+		M					
90961	Esrd srv, 2-3 vsts p mo, 20+		M					
90962	Esrd serv, 1 visit p mo, 20+		M					
90963	Esrd home pt, serv p mo, <2		M					
90964	Esrd home pt serv p mo, 2-11		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
90965	Esrd home pt serv p mo 12-19		M					
90966	Esrd home pt, serv p mo, 20+		M					
90967	Esrd home pt serv p day, <2		M					
90968	Esrd home pt srv p day, 2-11		M					
90969	Esrd home pt srv p day 12-19		M					
90970	Esrd home pt serv p day, 20+		M					
90989	Dialysis training, complete		B					
90993	Dialysis training, incompl		B					
90997	Hemoperfusion		B					
90999	Dialysis procedure		B					
91000	Esophageal intubation		X	0361	4.0753	$278.21	$83.23	$55.65
91010	Esophagus motility study		X	0361	4.0753	$278.21	$83.23	$55.65
91011	Esophagus motility study		X	0361	4.0753	$278.21	$83.23	$55.65
91012	Esophagus motility study		X	0361	4.0753	$278.21	$83.23	$55.65
91020	Gastric motility studies		X	0361	4.0753	$278.21	$83.23	$55.65
91022	Duodenal motility study		X	0361	4.0753	$278.21	$83.23	$55.65
91030	Acid perfusion of esophagus		X	0361	4.0753	$278.21	$83.23	$55.65
91034	Gastroesophageal reflux test		X	0361	4.0753	$278.21	$83.23	$55.65
91035	G-esoph reflx tst w/electrod		X	0361	4.0753	$278.21	$83.23	$55.65
91037	Esoph imped function test	CH	X	0360	1.7011	$116.13	$33.88	$23.23
91038	Esoph imped funct test > 1h		X	0361	4.0753	$278.21	$83.23	$55.65
91040	Esoph balloon distension tst		X	0360	1.7011	$116.13	$33.88	$23.23
91052	Gastric analysis test		X	0361	4.0753	$278.21	$83.23	$55.65
91055	Gastric intubation for smear		X	0360	1.7011	$116.13	$33.88	$23.23
91065	Breath hydrogen test		X	0360	1.7011	$116.13	$33.88	$23.23
91105	Gastric intubation treatment	CH	T	0250	1.1743	$80.17	$25.10	$16.04
91110	Gi tract capsule endoscopy		T	0142	10.1443	$692.52	$152.78	$138.51
91111	Esophageal capsule endoscopy		T	0141	8.8811	$606.29	$143.38	$121.26
91120	Rectal sensation test		T	0126	1.0983	$74.98	$16.21	$15.00

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
91122	Anal pressure record		T	0156	3.0859	$210.67	.	$42.14
91123	Irrigate fecal impaction		N					
91132	Electrogastrography		X	0360	1.7011	$116.13	$33.88	$23.23
91133	Electrogastrography w/test		X	0360	1.7011	$116.13	$33.88	$23.23
91299	Gastroenterology procedure		X	0360	1.7011	$116.13	$33.88	$23.23
92002	Eye exam, new patient		V	0606	1.365	$93.18	.	$18.64
92004	Eye exam, new patient		V	0606	1.365	$93.18	.	$18.64
92012	Eye exam established pat	CH	V	0605	1.0573	$72.18	.	$14.44
92014	Eye exam & treatment		V	0605	1.0573	$72.18	.	$14.44
92015	Refraction		E					
92018	New eye exam & treatment		T	0699	16.6419	$1,136.09	.	$227.22
92019	Eye exam & treatment		T	0699	16.6419	$1,136.09	.	$227.22
92020	Special eye evaluation		S	0230	0.5913	$40.37	.	$8.08
92025	Corneal topography		S	0698	0.9316	$63.60	.	$12.72
92060	Special eye evaluation		S	0698	0.9316	$63.60	.	$12.72
92065	Orthoptic/pleoptic training		S	0698	0.9316	$63.60	.	$12.72
92070	Fitting of contact lens		N					
92081	Visual field examination(s)		S	0230	0.5913	$40.37	.	$8.08
92082	Visual field examination(s)		S	0698	0.9316	$63.60	.	$12.72
92083	Visual field examination(s)		S	0698	0.9316	$63.60	.	$12.72
92100	Serial tonometry exam(s)		N					
92120	Tonography & eye evaluation		S	0698	0.9316	$63.60	.	$12.72
92130	Water provocation tonography		S	0230	0.5913	$40.37	.	$8.08
92135	Ophth dx imaging post seg		S	0230	0.5913	$40.37	.	$8.08
92136	Ophthalmic biometry		S	0698	0.9316	$63.60	.	$12.72
92140	Glaucoma provocative tests		S	0230	0.5913	$40.37	.	$8.08
92225	Special eye exam, initial		S	0230	0.5913	$40.37	.	$8.08
92226	Special eye exam, subsequent		S	0698	0.9316	$63.60	.	$12.72
92230	Eye exam with photos		S	0231	2.2924	$156.50	.	$31.30

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
92235	Eye exam with photos		S	0231	2.2924	$156.50	.	$31.30
92240	Icg angiography		S	0231	2.2924	$156.50	.	$31.30
92250	Eye exam with photos		S	0698	0.9316	$63.60	.	$12.72
92260	Ophthalmoscopy/dynamometry		S	0230	0.5913	$40.37	.	$8.08
92265	Eye muscle evaluation		S	0698	0.9316	$63.60	.	$12.72
92270	Electro-oculography		S	0230	0.5913	$40.37	.	$8.08
92275	Electroretinography		S	0231	2.2924	$156.50	.	$31.30
92283	Color vision examination		S	0230	0.5913	$40.37	.	$8.08
92284	Dark adaptation eye exam		S	0698	0.9316	$63.60	.	$12.72
92285	Eye photography		S	0698	0.9316	$63.60	.	$12.72
92286	Internal eye photography		S	0231	2.2924	$156.50	.	$31.30
92287	Internal eye photography		S	0231	2.2924	$156.50	.	$31.30
92310	Contact lens fitting		E					
92311	Contact lens fitting		S	0698	0.9316	$63.60	.	$12.72
92312	Contact lens fitting		S	0698	0.9316	$63.60	.	$12.72
92313	Contact lens fitting		S	0230	0.5913	$40.37	.	$8.08
92314	Prescription of contact lens		E					
92315	Prescription of contact lens		S	0230	0.5913	$40.37	.	$8.08
92316	Prescription of contact lens		S	0698	0.9316	$63.60	.	$12.72
92317	Prescription of contact lens		S	0230	0.5913	$40.37	.	$8.08
92325	Modification of contact lens		S	0230	0.5913	$40.37	.	$8.08
92326	Replacement of contact lens		S	0698	0.9316	$63.60	.	$12.72
92340	Fitting of spectacles		E					
92341	Fitting of spectacles		E					
92342	Fitting of spectacles		E					
92352	Special spectacles fitting		S	0698	0.9316	$63.60	.	$12.72
92353	Special spectacles fitting		S	0230	0.5913	$40.37	.	$8.08
92354	Special spectacles fitting		S	0230	0.5913	$40.37	.	$8.08
92355	Special spectacles fitting		S	0230	0.5913	$40.37	.	$8.08

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
92358	Eye prosthesis service		S	0230	0.5913	$40.37	.	$8.08
92370	Repair & adjust spectacles		E					
92371	Repair & adjust spectacles		S	0230	0.5913	$40.37	.	$8.08
92499	Eye service or procedure		S	0230	0.5913	$40.37	.	$8.08
92502	Ear and throat examination		T	0251	3.4369	$234.63	.	$46.93
92504	Ear microscopy examination		N					
92506	Speech/hearing evaluation		A					
92507	Speech/hearing therapy		A					
92508	Speech/hearing therapy		A					
92511	Nasopharyngoscopy		T	0071	0.9225	$62.98	.	$12.60
92512	Nasal function studies		X	0363	0.8721	$59.54	$16.71	$11.91
92516	Facial nerve function test		X	0660	1.4013	$95.66	$25.67	$19.14
92520	Laryngeal function studies		X	0660	1.4013	$95.66	$25.67	$19.14
92526	Oral function therapy		A					
92531	Spontaneous nystagmus study		N					
92532	Positional nystagmus test		N					
92533	Caloric vestibular test		N					
92534	Optokinetic nystagmus test		N					
92540	Basic vestibular evaluation		X	0660	1.4013	$95.66	$25.67	$19.14
92541	Spontaneous nystagmus test		X	0363	0.8721	$59.54	$16.71	$11.91
92542	Positional nystagmus test		X	0363	0.8721	$59.54	$16.71	$11.91
92543	Caloric vestibular test		X	0660	1.4013	$95.66	$25.67	$19.14
92544	Optokinetic nystagmus test		X	0363	0.8721	$59.54	$16.71	$11.91
92545	Oscillating tracking test		X	0363	0.8721	$59.54	$16.71	$11.91
92546	Sinusoidal rotational test		X	0660	1.4013	$95.66	$25.67	$19.14
92547	Supplemental electrical test		N					
92548	Posturography		X	0660	1.4013	$95.66	$25.67	$19.14
92550	Tympanometry & reflex thresh		X	0364	0.4612	$31.48	$7.03	$6.30
92551	Pure tone hearing test, air		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
92552	Pure tone audiometry, air		X	0364	0.4612	$31.48	$7.03	$6.30
92553	Audiometry, air & bone		X	0365	1.2498	$85.32	$18.52	$17.07
92555	Speech threshold audiometry		X	0364	0.4612	$31.48	$7.03	$6.30
92556	Speech audiometry, complete		X	0364	0.4612	$31.48	$7.03	$6.30
92557	Comprehensive hearing test		X	0365	1.2498	$85.32	$18.52	$17.07
92559	Group audiometric testing		E					
92560	Bekesy audiometry, screen		E					
92561	Bekesy audiometry, diagnosis		X	0364	0.4612	$31.48	$7.03	$6.30
92562	Loudness balance test		X	0364	0.4612	$31.48	$7.03	$6.30
92563	Tone decay hearing test		X	0364	0.4612	$31.48	$7.03	$6.30
92564	Sisi hearing test		X	0364	0.4612	$31.48	$7.03	$6.30
92565	Stenger test, pure tone		X	0364	0.4612	$31.48	$7.03	$6.30
92567	Tympanometry		X	0364	0.4612	$31.48	$7.03	$6.30
92568	Acoustic refl threshold tst		X	0364	0.4612	$31.48	$7.03	$6.30
92570	Acoustic immittance testing		X	0364	0.4612	$31.48	$7.03	$6.30
92571	Filtered speech hearing test		X	0364	0.4612	$31.48	$7.03	$6.30
92572	Staggered spondaic word test		X	0366	1.5786	$107.77	$24.61	$21.56
92575	Sensorineural acuity test		X	0364	0.4612	$31.48	$7.03	$6.30
92576	Synthetic sentence test		X	0364	0.4612	$31.48	$7.03	$6.30
92577	Stenger test, speech		X	0366	1.5786	$107.77	$24.61	$21.56
92579	Visual audiometry (vra)		X	0365	1.2498	$85.32	$18.52	$17.07
92582	Conditioning play audiometry		X	0365	1.2498	$85.32	$18.52	$17.07
92583	Select picture audiometry		X	0364	0.4612	$31.48	$7.03	$6.30
92584	Electrocochleography		S	0216	2.7192	$185.63	.	$37.13
92585	Auditor evoke potent, compre		S	0216	2.7192	$185.63	.	$37.13
92586	Auditor evoke potent, limit		S	0218	1.1923	$81.39	.	$16.28
92587	Evoked auditory test		X	0363	0.8721	$59.54	$16.71	$11.91
92588	Evoked auditory test		X	0363	0.8721	$59.54	$16.71	$11.91
92590	Hearing aid exam, one ear		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
92591	Hearing aid exam, both ears		E					
92592	Hearing aid check, one ear		E					
92593	Hearing aid check, both ears		E					
92594	Electro hearng aid test, one		E					
92595	Electro hearng aid tst, both		E					
92596	Ear protector evaluation		X	0364	0.4612	$31.48	$7.03	$6.30
92597	Oral speech device eval		A					
92601	Cochlear implt f/up exam < 7		X	0366	1.5786	$107.77	$24.61	$21.56
92602	Reprogram cochlear implt < 7		X	0366	1.5786	$107.77	$24.61	$21.56
92603	Cochlear implt f/up exam 7 >		X	0366	1.5786	$107.77	$24.61	$21.56
92604	Reprogram cochlear implt 7 >		X	0366	1.5786	$107.77	$24.61	$21.56
92605	Eval for nonspeech device rx		A					
92606	Non-speech device service		A					
92607	Ex for speech device rx, 1hr		A					
92608	Ex for speech device rx addl		A					
92609	Use of speech device service		A					
92610	Evaluate swallowing function		A					
92611	Motion fluoroscopy/swallow		A					
92612	Endoscopy swallow tst (fees)		A					
92613	Endoscopy swallow tst (fees)		B					
92614	Laryngoscopic sensory test		A					
92615	Eval laryngoscopy sense tst		E					
92616	Fees w/laryngeal sense test		A					
92617	Interprt fees/laryngeal test		E					
92620	Auditory function, 60 min		X	0365	1.2498	$85.32	$18.52	$17.07
92621	Auditory function, + 15 min		N					
92625	Tinnitus assessment		X	0365	1.2498	$85.32	$18.52	$17.07
92626	Eval aud rehab status		X	0366	1.5786	$107.77	$24.61	$21.56
92627	Eval aud status rehab add-on		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
92630	Aud rehab pre-ling hear loss		E					
92633	Aud rehab postling hear loss		E					
92640	Aud brainstem implt programg		X	0365	1.2498	$85.32	$18.52	$17.07
92700	Ent procedure/service		X	0364	0.4612	$31.48	$7.03	$6.30
92950	Heart/lung resuscitation cpr		S	0094	2.4281	$165.76	$46.29	$33.16
92953	Temporary external pacing		S	0094	2.4281	$165.76	$46.29	$33.16
92960	Cardioversion electric, ext		S	0679	5.4877	$374.63	$95.30	$74.93
92961	Cardioversion, electric, int		S	0679	5.4877	$374.63	$95.30	$74.93
92970	Cardioassist, internal		C					
92971	Cardioassist, external		C					
92973	Percut coronary thrombectomy		T	0088	41.8116	$2,854.35	$655.22	$570.87
92974	Cath place, cardio brachytx		T	0103	19.1796	$1,309.33	.	$261.87
92975	Dissolve clot, heart vessel		C					
92977	Dissolve clot, heart vessel		T	0676	2.3844	$162.78	.	$32.56
92978	Intravasc us, heart add-on		N					
92979	Intravasc us, heart add-on		N					
92980	Insert intracoronary stent		T	0104	81.9089	$5,591.67	.	$1,118.34
92981	Insert intracoronary stent		T	0104	81.9089	$5,591.67	.	$1,118.34
92982	Coronary artery dilation		T	0083	52.1947	$3,563.18	.	$712.64
92984	Coronary artery dilation		T	0083	52.1947	$3,563.18	.	$712.64
92986	Revision of aortic valve		T	0083	52.1947	$3,563.18	.	$712.64
92987	Revision of mitral valve		T	0083	52.1947	$3,563.18	.	$712.64
92990	Revision of pulmonary valve		T	0083	52.1947	$3,563.18	.	$712.64
92992	Revision of heart chamber		C					
92993	Revision of heart chamber		C					
92995	Coronary atherectomy		T	0082	97.8929	$6,682.85	.	$1,336.57
92996	Coronary atherectomy add-on		T	0082	97.8929	$6,682.85	.	$1,336.57
92997	Pul art balloon repr, percut		T	0083	52.1947	$3,563.18	.	$712.64
92998	Pul art balloon repr, percut		T	0083	52.1947	$3,563.18	.	$712.64

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
93000	Electrocardiogram, complete		M					
93005	Electrocardiogram, tracing		S	0099	0.3998	$27.29	.	$5.46
93010	Electrocardiogram report		B					
93012	Transmission of ecg		N					
93014	Report on transmitted ecg		B					
93015	Cardiovascular stress test		B					
93016	Cardiovascular stress test		B					
93017	Cardiovascular stress test		X	0100	2.6301	$179.55	$41.44	$35.91
93018	Cardiovascular stress test		B					
93024	Cardiac drug stress test		X	0100	2.6301	$179.55	$41.44	$35.91
93025	Microvolt t-wave assess		X	0100	2.6301	$179.55	$41.44	$35.91
93040	Rhythm ECG with report		B					
93041	Rhythm ECG, tracing		X	0035	0.2446	$16.70	.	$3.34
93042	Rhythm ECG, report		B					
93224	ECG monitor/report, 24 hrs		M					
93225	ECG monitor/record, 24 hrs		S	0097	0.9646	$65.85	$23.66	$13.17
93226	ECG monitor/report, 24 hrs		S	0097	0.9646	$65.85	$23.66	$13.17
93227	ECG monitor/review, 24 hrs		M					
93228	Remote 30 day ecg rev/report		M					
93229	Remote 30 day ecg tech supp		S	0209	11.462	$782.48	$268.73	$156.50
93230	ECG monitor/report, 24 hrs		M					
93231	Ecg monitor/record, 24 hrs		S	0097	0.9646	$65.85	$23.66	$13.17
93232	ECG monitor/report, 24 hrs		S	0097	0.9646	$65.85	$23.66	$13.17
93233	ECG monitor/review, 24 hrs		M					
93235	ECG monitor/report, 24 hrs		M					
93236	ECG monitor/report, 24 hrs		S	0097	0.9646	$65.85	$23.66	$13.17
93237	ECG monitor/review, 24 hrs		M					
93268	ECG record/review		M					
93270	ECG recording		S	0097	0.9646	$65.85	$23.66	$13.17

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
93271	Ecg/monitoring and analysis		S	0692	1.6175	$110.42	.	$22.09
93272	Ecg/review, interpret only		M					
93278	ECG/signal-averaged		X	0035	0.2446	$16.70	.	$3.34
93279	Pm device progr eval, sngl		S	0690	0.5225	$35.67	$8.67	$7.14
93280	Pm device progr eval, dual		S	0690	0.5225	$35.67	$8.67	$7.14
93281	Pm device progr eval, multi		S	0690	0.5225	$35.67	$8.67	$7.14
93282	Icd device prog eval, 1 sngl	CH	S	0690	0.5225	$35.67	$8.67	$7.14
93283	Icd device progr eval, dual	CH	S	0690	0.5225	$35.67	$8.67	$7.14
93284	Icd device progr eval, mult	CH	S	0690	0.5225	$35.67	$8.67	$7.14
93285	Ilr device eval progr		S	0690	0.5225	$35.67	$8.67	$7.14
93286	Pre-op pm device eval		N					
93287	Pre-op icd device eval		N					
93288	Pm device eval in person		S	0690	0.5225	$35.67	$8.67	$7.14
93289	Icd device interrogate	CH	S	0690	0.5225	$35.67	$8.67	$7.14
93290	Icm device eval	CH	X	0035	0.2446	$16.70	.	$3.34
93291	Ilr device interrogate		S	0690	0.5225	$35.67	$8.67	$7.14
93292	Wcd device interrogate	CH	S	0690	0.5225	$35.67	$8.67	$7.14
93293	Pm phone r-strip device eval	CH	S	0690	0.5225	$35.67	$8.67	$7.14
93294	Pm device interrogate remote		M					
93295	Icd device interrogat remote		M					
93296	Pm/icd remote tech serv	CH	S	0690	0.5225	$35.67	$8.67	$7.14
93297	Icm device interrogat remote		M					
93298	Ilr device interrogat remote		M					
93299	Icm/ilr remote tech serv	CH	S	0691	2.4765	$169.06	.	$33.82
93303	Echo transthoracic		S	0270	8.1944	$559.41	$132.96	$111.89
93304	Echo transthoracic		S	0269	5.7019	$389.25	.	$77.85
93306	Tte w/doppler, complete		S	0269	5.7019	$389.25	.	$77.85
93307	Tte w/o doppler, complete	CH	S	0269	5.7019	$389.25	.	$77.85
93308	Tte, f-up or lmtd		S	0697	3.163	$215.93	.	$43.19

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
93312	Echo transesophageal		S	0270	8.1944	$559.41	$132.96	$111.89
93313	Echo transesophageal		S	0269	5.7019	$389.25	.	$77.85
93314	Echo transesophageal		N					
93315	Echo transesophageal		S	0270	8.1944	$559.41	$132.96	$111.89
93316	Echo transesophageal		S	0270	8.1944	$559.41	$132.96	$111.89
93317	Echo transesophageal		N					
93318	Echo transesophageal intraop		S	0270	8.1944	$559.41	$132.96	$111.89
93320	Doppler echo exam, heart		N					
93321	Doppler echo exam, heart		N					
93325	Doppler color flow add-on		N					
93350	Stress tte only		S	0269	5.7019	$389.25	.	$77.85
93351	Stress tte complete		S	0270	8.1944	$559.41	$132.96	$111.89
93352	Admin ecg contrast agent		M					
93501	Right heart catheterization		T	0080	39.8374	$2,719.58	$838.92	$543.92
93503	Insert/place heart catheter		T	0103	19.1796	$1,309.33	.	$261.87
93505	Biopsy of heart lining		T	0103	19.1796	$1,309.33	.	$261.87
93508	Cath placement, angiography		T	0080	39.8374	$2,719.58	$838.92	$543.92
93510	Left heart catheterization		T	0080	39.8374	$2,719.58	$838.92	$543.92
93511	Left heart catheterization		T	0080	39.8374	$2,719.58	$838.92	$543.92
93514	Left heart catheterization		T	0080	39.8374	$2,719.58	$838.92	$543.92
93524	Left heart catheterization		T	0080	39.8374	$2,719.58	$838.92	$543.92
93526	Rt & Lt heart catheters		T	0080	39.8374	$2,719.58	$838.92	$543.92
93527	Rt & Lt heart catheters		T	0080	39.8374	$2,719.58	$838.92	$543.92
93528	Rt & Lt heart catheters		T	0080	39.8374	$2,719.58	$838.92	$543.92
93529	Rt, lt heart catheterization		T	0080	39.8374	$2,719.58	$838.92	$543.92
93530	Rt heart cath, congenital		T	0080	39.8374	$2,719.58	$838.92	$543.92
93531	R & l heart cath, congenital		T	0080	39.8374	$2,719.58	$838.92	$543.92
93532	R & l heart cath, congenital		T	0080	39.8374	$2,719.58	$838.92	$543.92
93533	R & l heart cath, congenital		T	0080	39.8374	$2,719.58	$838.92	$543.92

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
93539	Injection, cardiac cath		N					
93540	Injection, cardiac cath		N					
93541	Injection for lung angiogram		N					
93542	Injection for heart x-rays		N					
93543	Injection for heart x-rays		N					
93544	Injection for aortography		N					
93545	Inject for coronary x-rays		N					
93555	Imaging, cardiac cath		N					
93556	Imaging, cardiac cath		N					
93561	Cardiac output measurement		N					
93562	Cardiac output measurement		N					
93571	Heart flow reserve measure		N					
93572	Heart flow reserve measure		N					
93580	Transcath closure of asd		T	0434	158.2753	$10,804.98	.	$2,161.00
93581	Transcath closure of vsd		T	0434	158.2753	$10,804.98	.	$2,161.00
93600	Bundle of His recording		S	0084	10.1429	$692.43	.	$138.49
93602	Intra-atrial recording		S	0084	10.1429	$692.43	.	$138.49
93603	Right ventricular recording		S	0084	10.1429	$692.43	.	$138.49
93609	Map tachycardia, add-on		N					
93610	Intra-atrial pacing		S	0084	10.1429	$692.43	.	$138.49
93612	Intraventricular pacing		S	0084	10.1429	$692.43	.	$138.49
93613	Electrophys map 3d, add-on		N					
93615	Esophageal recording		S	0084	10.1429	$692.43	.	$138.49
93616	Esophageal recording		S	0084	10.1429	$692.43	.	$138.49
93618	Heart rhythm pacing		S	0084	10.1429	$692.43	.	$138.49
93619	Electrophysiology evaluation		Q3	0085	53.4167	$3,646.60	.	$729.32
93620	Electrophysiology evaluation		Q3	0085	53.4167	$3,646.60	.	$729.32
93621	Electrophysiology evaluation		N					
93622	Electrophysiology evaluation		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
93623	Stimulation, pacing heart		N					
93624	Electrophysiologic study		T	0085	53.4167	$3,646.60	.	$729.32
93631	Heart pacing, mapping		N					
93640	Evaluation heart device		N					
93641	Electrophysiology evaluation		N					
93642	Electrophysiology evaluation		S	0084	10.1429	$692.43	.	$138.49
93650	Ablate heart dysrhythm focus		Q3	0085	53.4167	$3,646.60	.	$729.32
93651	Ablate heart dysrhythm focus		Q3	0086	116.6136	$7,960.86	.	$1,592.18
93652	Ablate heart dysrhythm focus		Q3	0086	116.6136	$7,960.86	.	$1,592.18
93660	Tilt table evaluation		S	0101	4.359	$297.58	$100.24	$59.52
93662	Intracardiac ecg (ice)		N					
93668	Peripheral vascular rehab		E					
93701	Bioimpedance, cv analysis		S	0099	0.3998	$27.29	.	$5.46
93720	Total body plethysmography		B					
93721	Plethysmography tracing		X	0368	0.8679	$59.25	$20.93	$11.85
93722	Plethysmography report		B					
93724	Analyze pacemaker system		S	0690	0.5225	$35.67	$8.67	$7.14
93740	Temperature gradient studies		X	0368	0.8679	$59.25	$20.93	$11.85
93745	Set-up cardiovert-defibrill	CH	S	0690	0.5225	$35.67	$8.67	$7.14
93750	Interrogation vad, in person		S	0692	1.6175	$110.42	.	$22.09
93770	Measure venous pressure		N					
93784	Ambulatory BP monitoring		E					
93786	Ambulatory BP recording		S	0097	0.9646	$65.85	$23.66	$13.17
93788	Ambulatory BP analysis		S	0097	0.9646	$65.85	$23.66	$13.17
93790	Review/report BP recording		M					
93797	Cardiac rehab		S	0095	0.5678	$38.76	$13.86	$7.76
93798	Cardiac rehab/monitor		S	0095	0.5678	$38.76	$13.86	$7.76
93799	Cardiovascular procedure		S	0097	0.9646	$65.85	$23.66	$13.17
93875	Extracranial study		S	0096	1.571	$107.25	$37.13	$21.45

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
93880	Extracranial study		S	0267	2.2748	$155.29	$60.50	$31.06
93882	Extracranial study		S	0267	2.2748	$155.29	$60.50	$31.06
93886	Intracranial study		S	0267	2.2748	$155.29	$60.50	$31.06
93888	Intracranial study		S	0265	0.9262	$63.23	$22.28	$12.65
93890	Tcd, vasoreactivity study		S	0266	1.4262	$97.36	$37.53	$19.48
93892	Tcd, emboli detect w/o inj		S	0266	1.4262	$97.36	$37.53	$19.48
93893	Tcd, emboli detect w/inj		S	0266	1.4262	$97.36	$37.53	$19.48
93922	Extremity study		S	0097	0.9646	$65.85	$23.66	$13.17
93923	Extremity study		S	0096	1.571	$107.25	$37.13	$21.45
93924	Extremity study		S	0096	1.571	$107.25	$37.13	$21.45
93925	Lower extremity study		S	0267	2.2748	$155.29	$60.50	$31.06
93926	Lower extremity study		S	0266	1.4262	$97.36	$37.53	$19.48
93930	Upper extremity study		S	0267	2.2748	$155.29	$60.50	$31.06
93931	Upper extremity study		S	0266	1.4262	$97.36	$37.53	$19.48
93965	Extremity study		S	0096	1.571	$107.25	$37.13	$21.45
93970	Extremity study		S	0267	2.2748	$155.29	$60.50	$31.06
93971	Extremity study		S	0266	1.4262	$97.36	$37.53	$19.48
93975	Vascular study		S	0267	2.2748	$155.29	$60.50	$31.06
93976	Vascular study		S	0267	2.2748	$155.29	$60.50	$31.06
93978	Vascular study		S	0267	2.2748	$155.29	$60.50	$31.06
93979	Vascular study		S	0266	1.4262	$97.36	$37.53	$19.48
93980	Penile vascular study		S	0267	2.2748	$155.29	$60.50	$31.06
93981	Penile vascular study		S	0267	2.2748	$155.29	$60.50	$31.06
93982	Aneurysm pressure sens study		S	0097	0.9646	$65.85	$23.66	$13.17
93990	Doppler flow testing		S	0266	1.4262	$97.36	$37.53	$19.48
94002	Vent mgmt inpat, init day		S	0079	2.8784	$196.50	.	$39.30
94003	Vent mgmt inpat, subq day		S	0079	2.8784	$196.50	.	$39.30
94004	Vent mgmt nf per day		B					
94005	Home vent mgmt supervision		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
94010	Breathing capacity test		X	0368	0.8679	$59.25	$20.93	$11.85
94011	Up to 2 yrs old, spirometry		X	0368	0.8679	$59.25	$20.93	$11.85
94012	= 2 yrs, spiromtry w/dilator		X	0368	0.8679	$59.25	$20.93	$11.85
94013	= 2 yrs, lung volumes		X	0369	3.0374	$207.35	$42.19	$41.47
94014	Patient recorded spirometry		X	0367	0.5872	$40.09	$13.75	$8.02
94015	Patient recorded spirometry		X	0367	0.5872	$40.09	$13.75	$8.02
94016	Review patient spirometry		A					
94060	Evaluation of wheezing		S	0078	1.4237	$97.19	.	$19.44
94070	Evaluation of wheezing		X	0369	3.0374	$207.35	$42.19	$41.47
94150	Vital capacity test		X	0367	0.5872	$40.09	$13.75	$8.02
94200	Lung function test (MBC/MVV)		X	0367	0.5872	$40.09	$13.75	$8.02
94240	Residual lung capacity		X	0368	0.8679	$59.25	$20.93	$11.85
94250	Expired gas collection	CH	X	0367	0.5872	$40.09	$13.75	$8.02
94260	Thoracic gas volume		X	0368	0.8679	$59.25	$20.93	$11.85
94350	Lung nitrogen washout curve		X	0368	0.8679	$59.25	$20.93	$11.85
94360	Measure airflow resistance		X	0367	0.5872	$40.09	$13.75	$8.02
94370	Breath airway closing volume		X	0035	0.2446	$16.70	.	$3.34
94375	Respiratory flow volume loop		X	0368	0.8679	$59.25	$20.93	$11.85
94400	CO2 breathing response curve		X	0367	0.5872	$40.09	$13.75	$8.02
94450	Hypoxia response curve		X	0368	0.8679	$59.25	$20.93	$11.85
94452	Hast w/report		X	0368	0.8679	$59.25	$20.93	$11.85
94453	Hast w/oxygen titrate		X	0368	0.8679	$59.25	$20.93	$11.85
94610	Surfactant admin thru tube		S	0077	0.418	$28.54	$7.74	$5.71
94620	Pulmonary stress test/simple		X	0368	0.8679	$59.25	$20.93	$11.85
94621	Pulm stress test/complex		X	0369	3.0374	$207.35	$42.19	$41.47
94640	Airway inhalation treatment		S	0077	0.418	$28.54	$7.74	$5.71
94642	Aerosol inhalation treatment		S	0078	1.4237	$97.19	.	$19.44
94644	Cbt, 1st hour		X	0340	0.6899	$47.10	.	$9.42
94645	Cbt, each addl hour		X	0340	0.6899	$47.10	.	$9.42

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
94660	Pos airway pressure, CPAP		S	0078	1.4237	$97.19	.	$19.44
94662	Neg press ventilation, cnp		S	0079	2.8784	$196.50	.	$39.30
94664	Evaluate pt use of inhaler		S	0077	0.418	$28.54	$7.74	$5.71
94667	Chest wall manipulation		S	0077	0.418	$28.54	$7.74	$5.71
94668	Chest wall manipulation		S	0077	0.418	$28.54	$7.74	$5.71
94680	Exhaled air analysis, o2	CH	X	0368	0.8679	$59.25	$20.93	$11.85
94681	Exhaled air analysis, o2/co2		X	0368	0.8679	$59.25	$20.93	$11.85
94690	Exhaled air analysis		X	0367	0.5872	$40.09	$13.75	$8.02
94720	Monoxide diffusing capacity		X	0368	0.8679	$59.25	$20.93	$11.85
94725	Membrane diffusion capacity		X	0368	0.8679	$59.25	$20.93	$11.85
94750	Pulmonary compliance study		X	0367	0.5872	$40.09	$13.75	$8.02
94760	Measure blood oxygen level		N					
94761	Measure blood oxygen level		N					
94762	Measure blood oxygen level		Q1	0097	0.9646	$65.85	$23.66	$13.17
94770	Exhaled carbon dioxide test	CH	X	0368	0.8679	$59.25	$20.93	$11.85
94772	Breath recording, infant		X	0369	3.0374	$207.35	$42.19	$41.47
94774	Ped home apnea rec, compl		B					
94775	Ped home apnea rec, hk-up		S	0097	0.9646	$65.85	$23.66	$13.17
94776	Ped home apnea rec, downld		S	0097	0.9646	$65.85	$23.66	$13.17
94777	Ped home apnea rec, report		B					
94799	Pulmonary service/procedure		X	0367	0.5872	$40.09	$13.75	$8.02
95004	Percut allergy skin tests		X	0381	0.4215	$28.77	.	$5.76
95010	Percut allergy titrate test		X	0381	0.4215	$28.77	.	$5.76
95012	Exhaled nitric oxide meas		X	0367	0.5872	$40.09	$13.75	$8.02
95015	Id allergy titrate-drug/bug		X	0381	0.4215	$28.77	.	$5.76
95024	Id allergy test, drug/bug		X	0381	0.4215	$28.77	.	$5.76
95027	Id allergy titrate-airborne		X	0381	0.4215	$28.77	.	$5.76
95028	Id allergy test-delayed type		X	0381	0.4215	$28.77	.	$5.76
95044	Allergy patch tests		X	0381	0.4215	$28.77	.	$5.76

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
95052	Photo patch test		X	0381	0.4215	$28.77	.	$5.76
95056	Photosensitivity tests		X	0370	1.4793	$100.99	.	$20.20
95060	Eye allergy tests		X	0370	1.4793	$100.99	.	$20.20
95065	Nose allergy test		X	0381	0.4215	$28.77	.	$5.76
95070	Bronchial allergy tests		X	0369	3.0374	$207.35	$42.19	$41.47
95071	Bronchial allergy tests		X	0369	3.0374	$207.35	$42.19	$41.47
95075	Ingestion challenge test		X	0361	4.0753	$278.21	$83.23	$55.65
95115	Immunotherapy, one injection		S	0436	0.3853	$26.30	.	$5.26
95117	Immunotherapy injections		S	0436	0.3853	$26.30	.	$5.26
95120	Immunotherapy, one injection		E					
95125	Immunotherapy, many antigens		E					
95130	Immunotherapy, insect venom		E					
95131	Immunotherapy, insect venoms		E					
95132	Immunotherapy, insect venoms		E					
95133	Immunotherapy, insect venoms		E					
95134	Immunotherapy, insect venoms		E					
95144	Antigen therapy services		S	0437	0.5491	$37.49	.	$7.50
95145	Antigen therapy services		S	0437	0.5491	$37.49	.	$7.50
95146	Antigen therapy services		S	0438	1.1156	$76.16	.	$15.24
95147	Antigen therapy services		S	0438	1.1156	$76.16	.	$15.24
95148	Antigen therapy services		S	0437	0.5491	$37.49	.	$7.50
95149	Antigen therapy services		S	0437	0.5491	$37.49	.	$7.50
95165	Antigen therapy services		S	0436	0.3853	$26.30	.	$5.26
95170	Antigen therapy services		S	0437	0.5491	$37.49	.	$7.50
95180	Rapid desensitization		X	0370	1.4793	$100.99	.	$20.20
95199	Allergy immunology services		X	0381	0.4215	$28.77	.	$5.76
95250	Glucose monitoring, cont		V	0607	1.7939	$122.46	.	$24.50
95251	Gluc monitor, cont, phys i&r		B					
95803	Actigraphy testing		S	0218	1.1923	$81.39	.	$16.28

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
95805	Multiple sleep latency test		S	0209	11.462	$782.48	$268.73	$156.50
95806	Sleep study unatt&resp efft		S	0213	2.4455	$166.95	$53.58	$33.39
95807	Sleep study, attended		S	0209	11.462	$782.48	$268.73	$156.50
95808	Polysomnography, 1-3		S	0209	11.462	$782.48	$268.73	$156.50
95810	Polysomnography, 4 or more		S	0209	11.462	$782.48	$268.73	$156.50
95811	Polysomnography w/cpap		S	0209	11.462	$782.48	$268.73	$156.50
95812	Eeg, 41-60 minutes		S	0213	2.4455	$166.95	$53.58	$33.39
95813	Eeg, over 1 hour		S	0213	2.4455	$166.95	$53.58	$33.39
95816	Eeg, awake and drowsy		S	0213	2.4455	$166.95	$53.58	$33.39
95819	Eeg, awake and asleep		S	0213	2.4455	$166.95	$53.58	$33.39
95822	Eeg, coma or sleep only		S	0213	2.4455	$166.95	$53.58	$33.39
95824	Eeg, cerebral death only		S	0216	2.7192	$185.63	.	$37.13
95827	Eeg, all night recording		S	0213	2.4455	$166.95	$53.58	$33.39
95829	Surgery electrocorticogram		N					
95830	Insert electrodes for EEG		B					
95831	Limb muscle testing, manual		A					
95832	Hand muscle testing, manual		A					
95833	Body muscle testing, manual		A					
95834	Body muscle testing, manual		A					
95851	Range of motion measurements		A					
95852	Range of motion measurements		A					
95857	Tensilon test		S	0218	1.1923	$81.39	.	$16.28
95860	Muscle test, one limb		S	0218	1.1923	$81.39	.	$16.28
95861	Muscle test, 2 limbs		S	0218	1.1923	$81.39	.	$16.28
95863	Muscle test, 3 limbs		S	0218	1.1923	$81.39	.	$16.28
95864	Muscle test, 4 limbs		S	0218	1.1923	$81.39	.	$16.28
95865	Muscle test, larynx		S	0218	1.1923	$81.39	.	$16.28
95866	Muscle test, hemidiaphragm		S	0218	1.1923	$81.39	.	$16.28
95867	Muscle test cran nerv unilat		S	0218	1.1923	$81.39	.	$16.28

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
95868	Muscle test cran nerve bilat		S	0218	1.1923	$81.39	.	$16.28
95869	Muscle test, thor paraspinal		S	0215	0.6295	$42.97	.	$8.60
95870	Muscle test, nonparaspinal		S	0215	0.6295	$42.97	.	$8.60
95872	Muscle test, one fiber		S	0218	1.1923	$81.39	.	$16.28
95873	Guide nerv destr, elec stim		N					
95874	Guide nerv destr, needle emg		N					
95875	Limb exercise test	CH	S	0218	1.1923	$81.39	.	$16.28
95900	Motor nerve conduction test		S	0215	0.6295	$42.97	.	$8.60
95903	Motor nerve conduction test		S	0215	0.6295	$42.97	.	$8.60
95904	Sense nerve conduction test		S	0215	0.6295	$42.97	.	$8.60
95905	Motor/sens nrve conduct test		S	0215	0.6295	$42.97	.	$8.60
95920	Intraop nerve test add-on		N					
95921	Autonomic nerv function test		S	0218	1.1923	$81.39	.	$16.28
95922	Autonomic nerv function test	CH	S	0218	1.1923	$81.39	.	$16.28
95923	Autonomic nerv function test		S	0218	1.1923	$81.39	.	$16.28
95925	Somatosensory testing		S	0216	2.7192	$185.63	.	$37.13
95926	Somatosensory testing		S	0216	2.7192	$185.63	.	$37.13
95927	Somatosensory testing		S	0216	2.7192	$185.63	.	$37.13
95928	C motor evoked, uppr limbs		S	0218	1.1923	$81.39	.	$16.28
95929	C motor evoked, lwr limbs		S	0218	1.1923	$81.39	.	$16.28
95930	Visual evoked potential test		S	0216	2.7192	$185.63	.	$37.13
95933	Blink reflex test		S	0215	0.6295	$42.97	.	$8.60
95934	H-reflex test		S	0215	0.6295	$42.97	.	$8.60
95936	H-reflex test		S	0215	0.6295	$42.97	.	$8.60
95937	Neuromuscular junction test		S	0218	1.1923	$81.39	.	$16.28
95950	Ambulatory eeg monitoring		S	0209	11.462	$782.48	$268.73	$156.50
95951	EEG monitoring/videorecord		S	0209	11.462	$782.48	$268.73	$156.50
95953	EEG monitoring/computer		S	0209	11.462	$782.48	$268.73	$156.50
95954	EEG monitoring/giving drugs		S	0218	1.1923	$81.39	.	$16.28

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
95955	EEG during surgery		N					
95956	Eeg monitoring, cable/radio		S	0209	11.462	$782.48	$268.73	$156.50
95957	EEG digital analysis		N					
95958	EEG monitoring/function test		S	0213	2.4455	$166.95	$53.58	$33.39
95961	Electrode stimulation, brain		S	0216	2.7192	$185.63	.	$37.13
95962	Electrode stim, brain add-on		S	0216	2.7192	$185.63	.	$37.13
95965	Meg, spontaneous		S	0067	50.0116	$3,414.14	.	$682.83
95966	Meg, evoked, single		S	0065	13.7821	$940.86	.	$188.18
95967	Meg, evoked, each addl		S	0065	13.7821	$940.86	.	$188.18
95970	Analyze neurostim, no prog		S	0218	1.1923	$81.39	.	$16.28
95971	Analyze neurostim, simple		S	0692	1.6175	$110.42	.	$22.09
95972	Analyze neurostim, complex		S	0692	1.6175	$110.42	.	$22.09
95973	Analyze neurostim, complex		S	0692	1.6175	$110.42	.	$22.09
95974	Cranial neurostim, complex		S	0692	1.6175	$110.42	.	$22.09
95975	Cranial neurostim, complex		S	0692	1.6175	$110.42	.	$22.09
95978	Analyze neurostim brain/1h		S	0692	1.6175	$110.42	.	$22.09
95979	Analyz neurostim brain addon		S	0692	1.6175	$110.42	.	$22.09
95980	Io anal gast n-stim init		N					
95981	Io anal gast n-stim subsq		S	0218	1.1923	$81.39	.	$16.28
95982	Io ga n-stim subsq w/reprog		S	0692	1.6175	$110.42	.	$22.09
95990	Spin/brain pump refil & main		S	0439	1.8498	$126.28	.	$25.26
95991	Spin/brain pump refil & main		S	0439	1.8498	$126.28	.	$25.26
95992	Canalith repositioning proc	CH	A					
95999	Neurological procedure		S	0215	0.6295	$42.97	.	$8.60
96000	Motion analysis, video/3d		S	0216	2.7192	$185.63	.	$37.13
96001	Motion test w/ft press meas		S	0216	2.7192	$185.63	.	$37.13
96002	Dynamic surface emg		S	0218	1.1923	$81.39	.	$16.28
96003	Dynamic fine wire emg	CH	S	0218	1.1923	$81.39	.	$16.28
96004	Phys review of motion tests		B					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
96020	Functional brain mapping		N					
96040	Genetic counseling, 30 min		B					
96101	Psycho testing by psych/phys		Q3	0382	2.5561	$174.50	.	$34.90
96102	Psycho testing by technician		Q3	0382	2.5561	$174.50	.	$34.90
96103	Psycho testing admin by comp		Q3	0373	1.1738	$80.13	.	$16.03
96105	Assessment of aphasia		A					
96110	Developmental test, lim		Q3	0373	1.1738	$80.13	.	$16.03
96111	Developmental test, extend		Q3	0373	1.1738	$80.13	.	$16.03
96116	Neurobehavioral status exam		Q3	0382	2.5561	$174.50	.	$34.90
96118	Neuropsych tst by psych/phys		Q3	0382	2.5561	$174.50	.	$34.90
96119	Neuropsych testing by tec		Q3	0382	2.5561	$174.50	.	$34.90
96120	Neuropsych tst admin w/comp		Q3	0382	2.5561	$174.50	.	$34.90
96125	Cognitive test by hc pro		A					
96150	Assess hlth/behave, init		Q3	0432	0.4597	$31.38	.	$6.28
96151	Assess hlth/behave, subseq		Q3	0432	0.4597	$31.38	.	$6.28
96152	Intervene hlth/behave, indiv		Q3	0432	0.4597	$31.38	.	$6.28
96153	Intervene hlth/behave, group		Q3	0432	0.4597	$31.38	.	$6.28
96154	Interv hlth/behav, fam w/pt		Q3	0432	0.4597	$31.38	.	$6.28
96155	Interv hlth/behav fam no pt		E					
96360	Hydration iv infusion, init		S	0438	1.1156	$76.16	.	$15.24
96361	Hydrate iv infusion, add-on		S	0436	0.3853	$26.30	.	$5.26
96365	Ther/proph/diag iv inf, init		S	0439	1.8498	$126.28	.	$25.26
96366	Ther/proph/diag iv inf addon		S	0436	0.3853	$26.30	.	$5.26
96367	Tx/proph/dg addl seq iv inf		S	0437	0.5491	$37.49	.	$7.50
96368	Ther/diag concurrent inf		N					
96369	Sc ther infusion, up to 1 hr		S	0439	1.8498	$126.28	.	$25.26
96370	Sc ther infusion, addl hr		S	0437	0.5491	$37.49	.	$7.50
96371	Sc ther infusion, reset pump		S	0436	0.3853	$26.30	.	$5.26
96372	Ther/proph/diag inj, sc/im		S	0436	0.3853	$26.30	.	$5.26

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
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96373	Ther/proph/diag inj, ia		S	0437	0.5491	$37.49	.	$7.50
96374	Ther/proph/diag inj, iv push		S	0437	0.5491	$37.49	.	$7.50
96375	Tx/pro/dx inj new drug addon		S	0437	0.5491	$37.49	.	$7.50
96376	Tx/pro/dx inj new drug adon		N					
96379	Ther/prop/diag inj/inf proc		S	0436	0.3853	$26.30	.	$5.26
96401	Chemo, anti-neopl, sq/im		S	0437	0.5491	$37.49	.	$7.50
96402	Chemo hormon antineopl sq/im		S	0437	0.5491	$37.49	.	$7.50
96405	Chemo intralesional, up to 7		S	0437	0.5491	$37.49	.	$7.50
96406	Chemo intralesional over 7		S	0439	1.8498	$126.28	.	$25.26
96409	Chemo, iv push, sngl drug		S	0439	1.8498	$126.28	.	$25.26
96411	Chemo, iv push, addl drug		S	0438	1.1156	$76.16	.	$15.24
96413	Chemo, iv infusion, 1 hr		S	0440	2.9855	$203.81	.	$40.77
96415	Chemo, iv infusion, addl hr		S	0437	0.5491	$37.49	.	$7.50
96416	Chemo prolong infuse w/pump		S	0440	2.9855	$203.81	.	$40.77
96417	Chemo iv infus each addl seq		S	0438	1.1156	$76.16	.	$15.24
96420	Chemo, ia, push tecnique		S	0438	1.1156	$76.16	.	$15.24
96422	Chemo ia infusion up to 1 hr		S	0440	2.9855	$203.81	.	$40.77
96423	Chemo ia infuse each addl hr		S	0438	1.1156	$76.16	.	$15.24
96425	Chemotherapy,infusion method		S	0440	2.9855	$203.81	.	$40.77
96440	Chemotherapy, intracavitary		S	0439	1.8498	$126.28	.	$25.26
96445	Chemotherapy, intracavitary		S	0440	2.9855	$203.81	.	$40.77
96450	Chemotherapy, into CNS		S	0440	2.9855	$203.81	.	$40.77
96521	Refill/maint, portable pump		S	0439	1.8498	$126.28	.	$25.26
96522	Refill/maint pump/resvr syst		S	0439	1.8498	$126.28	.	$25.26
96523	Irrig drug delivery device		Q1	0624	0.6338	$43.27	$12.65	$8.66
96542	Chemotherapy injection		S	0438	1.1156	$76.16	.	$15.24
96549	Chemotherapy, unspecified		S	0436	0.3853	$26.30	.	$5.26
96567	Photodynamic tx, skin	CH	T	0015	1.5303	$104.47	.	$20.90
96570	Photodynmc tx, 30 min add-on		T	0015	1.5303	$104.47	.	$20.90

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HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
96571	Photodynamic tx, addl 15 min		T	0015	1.5303	$104.47	.	$20.90
96900	Ultraviolet light therapy		S	0001	0.5422	$37.01	.	$7.41
96902	Trichogram		N					
96904	Whole body photography		N					
96910	Photochemotherapy with UV-B		S	0001	0.5422	$37.01	.	$7.41
96912	Photochemotherapy with UV-A		S	0001	0.5422	$37.01	.	$7.41
96913	Photochemotherapy, UV-A or B		S	0683	2.8503	$194.58	.	$38.92
96920	Laser tx, skin < 250 sq cm		T	0015	1.5303	$104.47	.	$20.90
96921	Laser tx, skin 250-500 sq cm		T	0015	1.5303	$104.47	.	$20.90
96922	Laser tx, skin > 500 sq cm		T	0015	1.5303	$104.47	.	$20.90
96999	Dermatological procedure		T	0012	0.4253	$29.03	.	$5.81
97001	Pt evaluation		A					
97002	Pt re-evaluation		A					
97003	Ot evaluation		A					
97004	Ot re-evaluation		A					
97005	Athletic train eval		E					
97006	Athletic train reeval		E					
97010	Hot or cold packs therapy		A					
97012	Mechanical traction therapy		A					
97014	Electric stimulation therapy		E					
97016	Vasopneumatic device therapy		A					
97018	Paraffin bath therapy		A					
97022	Whirlpool therapy		A					
97024	Diathermy eg, microwave		A					
97026	Infrared therapy		A					
97028	Ultraviolet therapy		A					
97032	Electrical stimulation		A					
97033	Electric current therapy		A					
97034	Contrast bath therapy		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
97035	Ultrasound therapy		A					
97036	Hydrotherapy		A					
97039	Physical therapy treatment		A					
97110	Therapeutic exercises		A					
97112	Neuromuscular reeducation		A					
97113	Aquatic therapy/exercises		A					
97116	Gait training therapy		A					
97124	Massage therapy		A					
97139	Physical medicine procedure		A					
97140	Manual therapy		A					
97150	Group therapeutic procedures		A					
97530	Therapeutic activities		A					
97532	Cognitive skills development		A					
97533	Sensory integration		A					
97535	Self care mngment training		A					
97537	Community/work reintegration		A					
97542	Wheelchair mngment training		A					
97545	Work hardening		A					
97546	Work hardening add-on		A					
97597	Active wound care/20 cm or <		T	0015	1.5303	$104.47	.	$20.90
97598	Active wound care > 20 cm		T	0015	1.5303	$104.47	.	$20.90
97602	Wound(s) care non-selective		T	0013	0.8782	$59.95	.	$11.99
97605	Neg press wound tx, < 50 cm		T	0013	0.8782	$59.95	.	$11.99
97606	Neg press wound tx, > 50 cm		T	0015	1.5303	$104.47	.	$20.90
97750	Physical performance test		A					
97755	Assistive technology assess		A					
97760	Orthotic mgmt and training		A					
97761	Prosthetic training		A					
97762	C/o for orthotic/prosth use		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
97799	Physical medicine procedure		A					
97802	Medical nutrition, indiv, in		A					
97803	Med nutrition, indiv, subseq		A					
97804	Medical nutrition, group		A					
97810	Acupunct w/o stimul 15 min		E					
97811	Acupunct w/o stimul addl 15m		E					
97813	Acupunct w/stimul 15 min		E					
97814	Acupunct w/stimul addl 15m		E					
98925	Osteopathic manipulation		S	0060	0.3636	$24.82	.	$4.97
98926	Osteopathic manipulation		S	0060	0.3636	$24.82	.	$4.97
98927	Osteopathic manipulation		S	0060	0.3636	$24.82	.	$4.97
98928	Osteopathic manipulation		S	0060	0.3636	$24.82	.	$4.97
98929	Osteopathic manipulation		S	0060	0.3636	$24.82	.	$4.97
98940	Chiropractic manipulation		S	0060	0.3636	$24.82	.	$4.97
98941	Chiropractic manipulation		S	0060	0.3636	$24.82	.	$4.97
98942	Chiropractic manipulation		S	0060	0.3636	$24.82	.	$4.97
98943	Chiropractic manipulation		E					
98960	Self-mgmt educ & train, 1 pt		E					
98961	Self-mgmt educ/train, 2-4 pt		E					
98962	Self-mgmt educ/train, 5-8 pt		E					
98966	Hc pro phone call 5-10 min		E					
98967	Hc pro phone call 11-20 min		E					
98968	Hc pro phone call 21-30 min		E					
98969	Online service by hc pro		E					
99000	Specimen handling		E					
99001	Specimen handling		E					
99002	Device handling		B					
99024	Postop follow-up visit		B					
99026	In-hospital on call service		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
99027	Out-of-hosp on call service		E					
99050	Medical services after hrs		B					
99051	Med serv, eve/wkend/holiday		B					
99053	Med serv 10pm-8am, 24 hr fac		B					
99056	Med service out of office		B					
99058	Office emergency care		B					
99060	Out of office emerg med serv		B					
99070	Special supplies		B					
99071	Patient education materials		B					
99075	Medical testimony		E					
99078	Group health education		N					
99080	Special reports or forms		B					
99082	Unusual physician travel		B					
99090	Computer data analysis		B					
99091	Collect/review data from pt		N					
99100	Special anesthesia service		B					
99116	Anesthesia with hypothermia		B					
99135	Special anesthesia procedure		B					
99140	Emergency anesthesia		B					
99143	Mod cs by same phys, < 5 yrs		N					
99144	Mod cs by same phys, 5 yrs +		N					
99145	Mod cs by same phys add-on		N					
99148	Mod cs diff phys < 5 yrs		N					
99149	Mod cs diff phys 5 yrs +		N					
99150	Mod cs diff phys add-on		N					
99170	Anogenital exam, child		T	0191	0.1514	$10.34	$2.08	$2.07
99172	Ocular function screen		E					
99173	Visual acuity screen		E					
99174	Ocular photoscreening		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
99175	Induction of vomiting		N					
99183	Hyperbaric oxygen therapy		B					
99190	Special pump services		C					
99191	Special pump services		C					
99192	Special pump services		C					
99195	Phlebotomy		X	0624	0.6338	$43.27	$12.65	$8.66
99199	Special service/proc/report		B					
99201	Office/outpatient visit, new		V	0604	0.7431	$50.73	.	$10.15
99202	Office/outpatient visit, new		V	0605	1.0573	$72.18	.	$14.44
99203	Office/outpatient visit, new		V	0606	1.365	$93.18	.	$18.64
99204	Office/outpatient visit, new		V	0607	1.7939	$122.46	.	$24.50
99205	Office/outpatient visit, new		Q3	0608	2.4657	$168.33	.	$33.67
99211	Office/outpatient visit, est		V	0604	0.7431	$50.73	.	$10.15
99212	Office/outpatient visit, est		V	0605	1.0573	$72.18	.	$14.44
99213	Office/outpatient visit, est		V	0605	1.0573	$72.18	.	$14.44
99214	Office/outpatient visit, est		V	0606	1.365	$93.18	.	$18.64
99215	Office/outpatient visit, est		Q3	0607	1.7939	$122.46	.	$24.50
99217	Observation care discharge		B					
99218	Observation care		B					
99219	Observation care		B					
99220	Observation care		B					
99221	Initial hospital care		B					
99222	Initial hospital care		B					
99223	Initial hospital care		B					
99231	Subsequent hospital care		B					
99232	Subsequent hospital care		B					
99233	Subsequent hospital care		B					
99234	Observ/hosp same date		B					
99235	Observ/hosp same date		B					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
99236	Observ/hosp same date		B					
99238	Hospital discharge day		B					
99239	Hospital discharge day		B					
99241	Office consultation		E					
99242	Office consultation		E					
99243	Office consultation		E					
99244	Office consultation		E					
99245	Office consultation		E					
99251	Inpatient consultation		E					
99252	Inpatient consultation		E					
99253	Inpatient consultation		E					
99254	Inpatient consultation		E					
99255	Inpatient consultation		E					
99281	Emergency dept visit		V	0609	0.7735	$52.80	$12.64	$10.56
99282	Emergency dept visit		V	0613	1.315	$89.77	$21.06	$17.96
99283	Emergency dept visit		V	0614	2.1031	$143.57	$34.50	$28.72
99284	Emergency dept visit		Q3	0615	3.3549	$229.03	$48.49	$45.81
99285	Emergency dept visit		Q3	0616	4.9888	$340.57	$72.86	$68.12
99288	Direct advanced life support		B					
99291	Critical care, first hour		Q3	0617	7.7626	$529.93	$111.59	$105.99
99292	Critical care, addl 30 min		N					
99304	Nursing facility care, init		B					
99305	Nursing facility care, init		B					
99306	Nursing facility care, init		B					
99307	Nursing fac care, subseq		B					
99308	Nursing fac care, subseq		B					
99309	Nursing fac care, subseq		B					
99310	Nursing fac care, subseq		B					
99315	Nursing fac discharge day		B					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
99316	Nursing fac discharge day		B					
99318	Annual nursing fac assessmnt		B					
99324	Domicil/r-home visit new pat		B					
99325	Domicil/r-home visit new pat		B					
99326	Domicil/r-home visit new pat		B					
99327	Domicil/r-home visit new pat		B					
99328	Domicil/r-home visit new pat		B					
99334	Domicil/r-home visit est pat		B					
99335	Domicil/r-home visit est pat		B					
99336	Domicil/r-home visit est pat		B					
99337	Domicil/r-home visit est pat		B					
99339	Domicil/r-home care supervis		B					
99340	Domicil/r-home care supervis		B					
99341	Home visit, new patient		B					
99342	Home visit, new patient		B					
99343	Home visit, new patient		B					
99344	Home visit, new patient		B					
99345	Home visit, new patient		B					
99347	Home visit, est patient		B					
99348	Home visit, est patient		B					
99349	Home visit, est patient		B					
99350	Home visit, est patient		B					
99354	Prolonged service, office		N					
99355	Prolonged service, office		N					
99356	Prolonged service, inpatient		C					
99357	Prolonged service, inpatient		C					
99358	Prolong service w/o contact		N					
99359	Prolong serv w/o contact add		N					
99360	Physician standby services		B					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
99363	Anticoag mgmt, init		B					
99364	Anticoag mgmt, subseq		B					
99366	Team conf w/pat by hc pro		N					
99367	Team conf w/o pat by phys		N					
99368	Team conf w/o pat by hc pro		N					
99374	Home health care supervision		B					
99375	Home health care supervision		E					
99377	Hospice care supervision		B					
99378	Hospice care supervision		E					
99379	Nursing fac care supervision		B					
99380	Nursing fac care supervision		B					
99381	Init pm e/m, new pat, inf		E					
99382	Init pm e/m, new pat 1-4 yrs		E					
99383	Prev visit, new, age 5-11		E					
99384	Prev visit, new, age 12-17		E					
99385	Prev visit, new, age 18-39		E					
99386	Prev visit, new, age 40-64		E					
99387	Init pm e/m, new pat 65+ yrs		E					
99391	Per pm reeval, est pat, inf		E					
99392	Prev visit, est, age 1-4		E					
99393	Prev visit, est, age 5-11		E					
99394	Prev visit, est, age 12-17		E					
99395	Prev visit, est, age 18-39		E					
99396	Prev visit, est, age 40-64		E					
99397	Per pm reeval est pat 65+ yr		E					
99401	Preventive counseling, indiv		E					
99402	Preventive counseling, indiv		E					
99403	Preventive counseling, indiv		E					
99404	Preventive counseling, indiv		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
99406	Behav chng smoking 3-10 min		X	0031	0.3066	$20.93	.	$4.19
99407	Behav chng smoking > 10 min		X	0031	0.3066	$20.93	.	$4.19
99408	Audit/dast, 15-30 min		E					
99409	Audit/dast, over 30 min		E					
99411	Preventive counseling, group		E					
99412	Preventive counseling, group		E					
99420	Health risk assessment test		E					
99429	Unlisted preventive service		E					
99441	Phone e/m by phys 5-10 min		E					
99442	Phone e/m by phys 11-20 min		E					
99443	Phone e/m by phys 21-30 min		E					
99444	Online e/m by phys		E					
99450	Basic life disability exam		E					
99455	Work related disability exam		B					
99456	Disability examination		B					
99460	Init nb em per day, hosp		V	0605	1.0573	$72.18	.	$14.44
99461	Init nb em per day, non-fac		M					
99462	Sbsq nb em per day, hosp		C					
99463	Same day nb discharge		V	0605	1.0573	$72.18	.	$14.44
99464	Attendance at delivery		N					
99465	Nb resuscitation		S	0094	2.4281	$165.76	$46.29	$33.16
99466	Ped crit care transport		N					
99467	Ped crit care transport addl		N					
99468	Neonate crit care, initial		C					
99469	Neonate crit care, subsq		C					
99471	Ped critical care, initial		C					
99472	Ped critical care, subsq		C					
99475	Ped crit care age 2-5, init		C					
99476	Ped crit care age 2-5, subsq		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
99477	Init day hosp neonate care		C					
99478	Ic, lbw inf < 1500 gm subsq		C					
99479	Ic lbw inf 1500-2500 g subsq		C					
99480	Ic inf pbw 2501-5000 g subsq		C					
99499	Unlisted e&m service		B					
99500	Home visit, prenatal		E					
99501	Home visit, postnatal		E					
99502	Home visit, nb care		E					
99503	Home visit, resp therapy		E					
99504	Home visit mech ventilator		E					
99505	Home visit, stoma care		E					
99506	Home visit, im injection		E					
99507	Home visit, cath maintain		E					
99509	Home visit day life activity		E					
99510	Home visit, sing/m/fam couns		E					
99511	Home visit, fecal/enema mgmt		E					
99512	Home visit for hemodialysis		E					
99600	Home visit nos		E					
99601	Home infusion/visit, 2 hrs		E					
99602	Home infusion, each addtl hr		E					
99605	Mtms by pharm, np, 15 min		E					
99606	Mtms by pharm, est, 15 min		E					
99607	Mtms by pharm, addl 15 min		E					
0001F	Heart failure composite		M					
0005F	Osteoarthritis composite		M					
0012F	Cap bacterial assess		M					
0014F	Comp preop assess cat surg		M					
0015F	Melan follow-up complete		M					
0016T	Thermotx choroid vasc lesion		T	0235	5.2921	$361.28	.	$72.26

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0017T	Photocoagulat macular drusen		T	0235	5.2921	$361.28	.	$72.26
0019T	Extracorp shock wv tx,ms nos		A					
0030T	Antiprothrombin antibody		A					
0042T	Ct perfusion w/contrast, cbf		N					
0048T	Implant ventricular device		C					
0050T	Removal circulation assist		C					
0051T	Implant total heart system		C					
0052T	Replace component heart syst		C					
0053T	Replace component heart syst		C					
0054T	Bone surgery using computer		N					
0055T	Bone surgery using computer		N					
0071T	U/s leiomyomata ablate <200		S	0067	50.0116	$3,414.14	.	$682.83
0072T	U/s leiomyomata ablate >200		S	0067	50.0116	$3,414.14	.	$682.83
0073T	Delivery, comp imrt		S	0412	6.4458	$440.04	.	$88.01
0075T	Perq stent/chest vert art		C					
0076T	S&i stent/chest vert art		C					
0078T	Endovasc aort repr w/device		C					
0079T	Endovasc visc extnsn repr		C					
0080T	Endovasc aort repr rad s&i		C					
0081T	Endovasc visc extnsn s&i		C					
0085T	Breath test heart reject		E					
0092T	Artific disc addl		C					
0095T	Artific diskectomy addl		C					
0098T	Rev artific disc addl		C					
0099T	Implant corneal ring		T	0233	17.0898	$1,166.67	$263.12	$233.34
0100T	Prosth retina receive&gen		T	0672	40.6474	$2,774.88	.	$554.98
0101T	Extracorp shockwv tx,hi enrg		T	0050	32.4253	$2,213.58	.	$442.72
0102T	Extracorp shockwv tx,anesth		T	0050	32.4253	$2,213.58	.	$442.72
0103T	Holotranscobalamin		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0104T	At rest cardio gas rebreathe		A					
0105T	Exerc cardio gas rebreathe		A					
0106T	Touch quant sensory test		X	0341	0.0804	$5.49	$2.09	$1.10
0107T	Vibrate quant sensory test		X	0341	0.0804	$5.49	$2.09	$1.10
0108T	Cool quant sensory test		X	0341	0.0804	$5.49	$2.09	$1.10
0109T	Heat quant sensory test		X	0341	0.0804	$5.49	$2.09	$1.10
0110T	Nos quant sensory test		X	0341	0.0804	$5.49	$2.09	$1.10
0111T	Rbc membranes fatty acids		A					
0123T	Scleral fistulization		T	0234	24.5236	$1,674.15	$511.31	$334.83
0124T	Conjunctival drug placement		T	0232	2.4827	$169.49	$40.82	$33.90
0126T	Chd risk imt study		Q1	0340	0.6899	$47.10	.	$9.42
0130T	Chron care drug investigatn		B					
0140T	Exhaled breath condensate ph		A					
0141T	Perq islet transplant		E					
0142T	Open islet transplant		E					
0143T	Laparoscopic islet transplnt		E					
0155T	Lap impl gast curve electrd		T	0130	38.7195	$2,643.26	$659.53	$528.66
0156T	Lap remv gast curve electrd		T	0130	38.7195	$2,643.26	$659.53	$528.66
0157T	Open impl gast curve electrd		C					
0158T	Open remv gast curve electrd		C					
0159T	Cad breast mri		N					
0160T	Tcranial magn stim tx plan		S	0216	2.7192	$185.63	.	$37.13
0161T	Tcranial magn stim tx deliv		S	0216	2.7192	$185.63	.	$37.13
0163T	Lumb artif diskectomy addl		C					
0164T	Remove lumb artif disc addl		C					
0165T	Revise lumb artif disc addl		C					
0166T	Tcath vsd close w/o bypass		C					
0167T	Tcath vsd close w bypass		C					
0168T	Rhinophototx light app bilat		T	0251	3.4369	$234.63	.	$46.93

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0169T	Place stereo cath brain		C					
0171T	Lumbar spine proces distract		T	0052	88.5249	$6,043.33	.	$1,208.67
0172T	Lumbar spine process addl		T	0052	88.5249	$6,043.33	.	$1,208.67
0173T	Iop monit io pressure		N					
0174T	Cad cxr with interp		N					
0175T	Cad cxr remote		N					
0176T	Aqu canal dilat w/o retent		T	0673	44.5131	$3,038.78	$649.56	$607.76
0177T	Aqu canal dilat w retent		T	0673	44.5131	$3,038.78	$649.56	$607.76
0178T	64 lead ecg w i&r		B					
0179T	64 lead ecg w tracing		X	0100	2.6301	$179.55	$41.44	$35.91
0180T	64 lead ecg w i&r only		B					
0181T	Corneal hysteresis		S	0230	0.5913	$40.37	.	$8.08
0182T	Hdr elect brachytherapy		S	0313	10.4062	$710.40	$268.63	$142.08
0183T	Wound ultrasound	CH	T	0015	1.5303	$104.47	.	$20.90
0184T	Exc rectal tumor endoscopic		C					
0185T	Comptr probability analysis		N					
0186T	Suprachoroidal drug delivery		T	0237	23.2772	$1,589.06	.	$317.82
0187T	Ophthalmic dx image anterior		S	0230	0.5913	$40.37	.	$8.08
0188T	Videoconf crit care 74 min		M					
0189T	Videoconf crit care addl 30		M					
0190T	Place intraoc radiation src		T	0237	23.2772	$1,589.06	.	$317.82
0191T	Insert ant segment drain int		T	0234	24.5236	$1,674.15	$511.31	$334.83
0192T	Insert ant segment drain ext		T	0673	44.5131	$3,038.78	$649.56	$607.76
0193T	Rf bladder neck microremodel		T	0165	20.5471	$1,402.69	.	$280.54
0195T	Arthrod presac interbody		C					
0196T	Arthrod presac interbody eac		C					
0197T	Intrafraction track motion		N					
0198T	Ocular blood flow measure		S	0230	0.5913	$40.37	.	$8.08
0199T	Physiologic tremor record		S	0215	0.6295	$42.97	.	$8.60

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0200T	Perq sacral augmt unilat inj		T	0049	23.2249	$1,585.49	.	$317.10
0201T	Perq sacral augmt bilat inj		T	0050	32.4253	$2,213.58	.	$442.72
0202T	Post vert arthrplst 1 lumbar		C					
0203T	Unattend sleep study w/time		S	0213	2.4455	$166.95	$53.58	$33.39
0204T	Unattended sleep study		S	0213	2.4455	$166.95	$53.58	$33.39
0205T	Inirs each vessel add-on		N					
0206T	Remote algorithm analys ecg		Q1	0340	0.6899	$47.10	.	$9.42
0207T	Clear eyelid gland w/heat		S	0230	0.5913	$40.37	.	$8.08
0208T	Automated audiometry air		X	0035	0.2446	$16.70	.	$3.34
0209T	Auto audiometry air/bone		X	0035	0.2446	$16.70	.	$3.34
0210T	Auto audiometry sp thresh		X	0035	0.2446	$16.70	.	$3.34
0211T	Auto audiometry sp thresh		X	0035	0.2446	$16.70	.	$3.34
0212T	Comprehen auto audiometry		X	0364	0.4612	$31.48	$7.03	$6.30
0213T	Us facet jt inj cerv/t 1 lev		T	0207	7.7204	$527.05	.	$105.41
0214T	Us facet jt inj cerv/t 2 lev		T	0204	2.666	$182.00	$40.13	$36.40
0215T	Us facet jt inj cerv/t 3 lev		T	0204	2.666	$182.00	$40.13	$36.40
0216T	Us facet jt inj ls 1 level		T	0207	7.7204	$527.05	.	$105.41
0217T	Us facet jt inj ls 2 level		T	0204	2.666	$182.00	$40.13	$36.40
0218T	Us facet jt inj ls 3 level		T	0204	2.666	$182.00	$40.13	$36.40
0219T	Fuse spine facet jt cerv		C					
0220T	Fuse spine facet jt thor		C					
0221T	Fuse spine facet jt lumbar		T	0050	32.4253	$2,213.58	.	$442.72
0222T	Fuse spine facet jt add seg		T	0050	32.4253	$2,213.58	.	$442.72
0500F	Initial prenatal care visit		M					
0501F	Prenatal flow sheet		M					
0502F	Subsequent prenatal care		M					
0503F	Postpartum care visit		M					
0505F	Hemodialysis plan docd		M					
0507F	Periton dialysis plan docd		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0509F	Urine incon plan docd		M					
0513F	Elev bp plan of care docd		M					
0514F	Care plan hgb docd esa pt		M					
0516F	Anemia plan of care docd		M					
0517F	Glaucoma plan of care docd		M					
0518F	Fall plan of care docd		M					
0519F	Pland chemo docd b/4 txmnt		M					
0520F	Rad dos limts b/4 3d rad		M					
0521F	Plan of care 4 pain docd		M					
0525F	Initial visit for episode		M					
0526F	Subs visit for episode		M					
0528F	Rcmnd flw-up 10 yrs docd		E					
0529F	Intrvl 3+yrs pts clnscp docd		M					
0535F	Dyspnea mngmnt plan docd		E					
0540F	Gluco mngmnt plan docd		M					
0545F	Follow up care plan mdd docd		E					
0575F	HIV rna plan care docd		M					
1000F	Tobacco use assessed		M					
1002F	Assess anginal symptom/level		M					
1003F	Level of activity assess		M					
1004F	Clin symp vol ovrld assess		M					
1005F	Asthma symptoms evaluate		M					
1006F	Osteoarthritis assess		M					
1007F	Anti-inflm/anlgsc otc assess		M					
1008F	Gi/renal risk assess		M					
1015F	Copd symptoms assess		M					
1018F	Assess dyspnea not present		M					
1019F	Assess dyspnea present		M					
1022F	Pneumo imm status assess		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
1026F	Co-morbid condition assess		M					
1030F	Influenza imm status assess		M					
1034F	Current tobacco smoker		M					
1035F	Smokeless tobacco user		M					
1036F	Tobacco non-user		M					
1038F	Persistent asthma		M					
1039F	Intermittent asthma		M					
1040F	Dsm-ivtm info mdd docd		M					
1050F	History of mole changes		M					
1055F	Visual funct status assess		M					
1060F	Doc perm/cont/parox atr fib		M					
1061F	Doc lack perm+cont+parox fib		M					
1065F	Ischm stroke symp lt3 hrsb/4		M					
1066F	Ischm stroke symp ge3 hrsb/4		M					
1070F	Alarm symp assessed-absent		M					
1071F	Alarm symp assessed-1+ prsnt		M					
1090F	Pres/absn urine incon assess		M					
1091F	Urine incon characterized		M					
1100F	Ptfalls assess-docd ge2+/yr		M					
1101F	Pt falls assess-docd le1/yr		M					
1110F	Pt lft inpt fac w/in 60 days		M					
1111F	Dschrg med/current med merge		M					
1116F	Auric/peri pain assessed		M					
1118F	GERD symps assessed 12 month		M					
1119F	Init eval for condition		M					
1121F	Subs eval for condition		M					
1123F	Acp discuss/dscn mkr docd		M					
1124F	Acp discuss-no dscnmkr docd		M					
1125F	Amnt pain noted pain prsnt		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
1126F	Amnt pain noted none prsnt		M					
1130F	Bk pain + fxn assessed		M					
1134F	Epsd bk pain for =< 6 wks		M					
1135F	Epsd bk pain for > 6 wks		M					
1136F	Epsd bk pain for <= 12 wks		M					
1137F	Epsd bk pain for > 12 wks		M					
1150F	Doc pt rsk death w/in 1yr		E					
1151F	Doc no pt rsk death w/in 1yr		E					
1152F	Doc advncd dis comfort 1st		E					
1153F	Doc advncd dis cmfrt not 1st		E					
1157F	Advnc care plan in rcrd		E					
1158F	Advnc care plan tlk docd		M					
1159F	Med list docd in rcrd		E					
1160F	Rvw meds by rx/dr in rcrd		E					
1170F	Fxnl status assessed		M					
1180F	Thromboemb risk assessed		E					
1200F	Seizure type(s)+ frq docd		E					
1205F	EPI etiol synd rvwd and docd		E					
1220F	Pt screened for depression		M					
2000F	Blood pressure measure		M					
2001F	Weight record		M					
2002F	Clin sign vol ovrld assess		M					
2004F	Initial exam involved joints		M					
2010F	Vital signs recorded		M					
2014F	Mental status assess		M					
2018F	Hydration status assess		M					
2019F	Dilated macul exam done		M					
2020F	Dilated fundus eval done		M					
2021F	Dilat macul+ exam done		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
2022F	Dil retina exam interp rev		M					
2024F	7 field photo interp doc rev		M					
2026F	Eye image valid to dx rev		M					
2027F	Optic nerve head eval done		M					
2028F	Foot exam performed		M					
2029F	Complete phys skin exam done		M					
2030F	H2o stat docd, normal		M					
2031F	H2o stat docd, dehydrated		M					
2035F	Tymp memb motion examd		M					
2040F	Bk pn xm on init visit date		M					
2044F	Doc mntl tst b/4 bk trxmnt		M					
2050F	Wound char size etc docd		E					
2060F	Pt talk eval hlthwkr re mdd		E					
3006F	Cxr doc rev		M					
3008F	Body mass index docd		E					
3011F	Lipid panel doc rev		M					
3014F	Screen mammo doc rev		M					
3015F	Cerv cancer screen docd		E					
3016F	Pt scrnd unhlthy OH use		M					
3017F	Colorectal ca screen doc rev		M					
3018F	Pre-prxd rsk et al docd		E					
3020F	Lvf assess		M					
3021F	Lvef mod/sever deprs syst		M					
3022F	Lvef >=40% systolic		M					
3023F	Spirom doc rev		M					
3025F	Spirom fev/fvc<70% w copd		M					
3027F	Spirom fev/fvc>=70%/w/o copd		M					
3028F	O2 saturation doc rev		M					
3035F	O2 saturation<=88% /pao<=55		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
3037F	O2 saturation> 88% /pao>55		M					
3038F	Pulm fx w/in 12 mon b/4 surg		E					
3040F	Fev<40% predicted value		M					
3042F	Fev>=40% predicted value		M					
3044F	Hg a1c level lt 7.0%		M					
3045F	Hg a1c level 7.0-9.0%		M					
3046F	Hemoglobin a1c level > 9.0%		M					
3048F	Ldl-c <100 mg/dl		M					
3049F	Ldl-c 100-129 mg/dl		M					
3050F	Ldl-c >= 130 mg/dl		M					
3060F	Pos microalbuminuria rev		M					
3061F	Neg microalbuminuria rev		M					
3062F	Pos macroalbuminuria rev		M					
3066F	Nephropathy doc tx		M					
3072F	Low risk for retinopathy		M					
3073F	Pre-surg eye measures docd		M					
3074F	Syst bp lt 130 mm hg		M					
3075F	Syst bp ge 130 - 139mm hg		M					
3077F	Syst bp >= 140 mm hg6 it		M					
3078F	Diast bp < 80 mm hg		M					
3079F	Diast bp 80-89 mm hg		M					
3080F	Diast bp >= 90 mm hg		M					
3082F	Kt/v lt1.2		M					
3083F	Kt/v ge 1.2 and <1.7		M					
3084F	Kt/v ge 1.7		M					
3085F	Suicide risk assessed		M					
3088F	MDD, mild		M					
3089F	MDD, moderate		M					
3090F	MDD, severe; w/o psych		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
3091F	Mdd, severe; w/ psych		M					
3092F	MDD, in remission		M					
3093F	Doc new diag 1st/addl mdd		M					
3095F	Central dexa results docd		M					
3096F	Central dexa ordered		M					
3100F	Image test ref carot diam		M					
3110F	Doc pres/absn hmrhg/lesion		M					
3111F	Ct/mri brain done w/in 24hrs		M					
3112F	Ct/Mri brain done gt 24 hrs		M					
3120F	12-lead ecg performed		M					
3130F	Upper gi endoscopy performed		M					
3132F	Doc ref upper gi endoscopy		M					
3140F	Upper gi endo shows barrtts		M					
3141F	Upper gi endo not barrtts		M					
3142F	Barium swallow test ordered		M					
3150F	Forceps esoph biopsy done		M					
3155F	Cytogen test marrow b/4 tx		M					
3160F	Doc fe+ stores b/4 epo thx		M					
3170F	Flow cyto done b/4 tx		M					
3200F	Barium swallow test not req		M					
3210F	Grp a strep test performed		M					
3215F	Pt immunity to hep a docd		M					
3216F	Pt immunity to hep b docd		M					
3218F	Rna tstng hep c docd-done		M					
3220F	Hep c quant rna tstng docd		M					
3230F	Note hring tst w/in 6 mon		M					
3250F	Nonprim loc anat bx site tum		M					
3260F	Pt cat/pn cat/hist grd docd		M					
3265F	Rna tstng hepc vir ord/docd		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
3266F	Hepc gn tstng docd b/4txmnt		M					
3268F	Psa/t/glsc docd b/4 txmnt		M					
3269F	Bone scn b/4 txmnt/aftr Dx		M					
3270F	No bone scn b/4 txmnt/aftrDx		M					
3271F	Low risk prostate cancer		M					
3272F	Med risk prostate cancer		M					
3273F	High risk prostate cancer		M					
3274F	Prost Cncr rsk not lw/md/hgh		M					
3278F	Serum lvls CA/iPTH/lpd ord		M					
3279F	Hgb lvl >/= 13 g/dl		M					
3280F	Hgb lvl 11-12.9 g/dL		M					
3281F	Hgb lvl < 11 g/dl		M					
3284F	IOP down>=15% of pre-svc lvl		M					
3285F	IOP down <15% of pre-svc lvl		M					
3288F	Fall risk assessment docd		M					
3290F	Pt=D(Rh)- and unsensitized		M					
3291F	Pt=d(rh)+ or sensitized		M					
3292F	Hiv tstng asked/docd/revwd		M					
3293F	Abo rh blood typing docd		E					
3294F	Grp b strep screening docd		E					
3300F	AJCC stage docd b/4 thxpy		M					
3301F	Cancer stage docd metast		M					
3315F	Er+ or pr+ breast cancer		M					
3316F	ER- or PR- breast cancer		M					
3317F	Path rpt malig cancer docd		M					
3318F	Path rpt malig cancer docd		M					
3319F	X-ray/ct/ultrsnd et al ord		M					
3320F	No xray/ct/ et al ordd		M					
3321F	AJCC cncr 0/IA melan docd		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
3322F	Melan >AJCC stage 0 or IA		E					
3323F	Clin node stgng docdb/4 surg		M					
3324F	Mri ct scan ord rvwd rqstd		E					
3325F	Preop asses 4 cataract surg		M					
3328F	Prfrmnc docd 2 wks b/4 surg		E					
3330F	Imaging study ordered (bkp)		M					
3331F	Bk imaging tst not ordered		M					
3340F	Mammo assess inc xray docd		M					
3341F	Mammo assess negative docd		M					
3342F	Mammo assess bengn docd		M					
3343F	Mammo probably bengn docd		M					
3344F	Mammo assess susp, docd		M					
3345F	Mammo assess hghlymalig doc		M					
3350F	Mammo bx proven malig docd		M					
3351F	Neg scrn dep symp by deptool		E					
3352F	No sig dep symp by dep tool		E					
3353F	Mild-mod dep symp by deptool		E					
3354F	Clin sig dep sym by dep tool		E					
3370F	AJCC brst cncr stage 0 docd		M					
3372F	Ajcc brst cncr stage 1+docd		M					
3374F	Ajcc brst cncr stage 1+docd		M					
3376F	AJCC brstcncr stage 2 docd		M					
3378F	AJCC brstcncr stage 3 docd		M					
3380F	AJCC brstcncr stage 4 docd		M					
3382F	AJCC cln cncr stage 0 docd		M					
3384F	AJCC cln cncr stage 1 docd		M					
3386F	AJCC cln cncr stage 2 docd		M					
3388F	AJCC cln cncr stage 3 docd		M					
3390F	AJCC cln cncr stage 4 docd		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
3450F	Dyspnea scrnd, no-mild dysp		E					
3451F	Dyspnea scrnd mod-high dysp		E					
3452F	Dyspnea not screened		E					
3455F	TB scrng done-interpd 6mon		M					
3470F	RA disease activity, low		M					
3471F	RA disease activity, mod		M					
3472F	RA disease activity, high		M					
3475F	Disease progn RA poor docd		M					
3476F	Disease progn RA good docd		M					
3490F	History - AIDS-defining cond		M					
3491F	HIV unsure baby of HIV+moms		E					
3492F	History cd4+ cell count <350		M					
3493F	No hist cd4+cell cnt<350		M					
3494F	CD4+cell count <200cells/mm3		M					
3495F	Cd4+cell cnt 200-499 cells		M					
3496F	Cd4+ cell count =500 cells		M					
3497F	CD4+ cell percentage <15%		E					
3498F	CD4+ cell percentage >=15%		E					
3500F	Cd4+cell cnt/% docd as done		M					
3502F	HIV rna vrl ld <lmts quantif		M					
3503F	HIV rna vrl ldnot<lmts quntf		M					
3510F	Doc tb scrng-rslts interpd		E					
3511F	Chlmyd/gonrh tsts docd done		M					
3512F	Syph scrng docd as done		M					
3513F	Hep B scrng docd as done		E					
3514F	Hep C scrng docd as done		E					
3515F	Pt has docd immun to hep C		E					
3550F	Low rsk thromboembolism		E					
3551F	Intrmed rsk thromboembolism		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
3552F	Hgh risk for thromboembolism		E					
3555F	Pt inr measurement performed		E					
3570F	Rprt bone scint xref w xray		M					
3572F	Pt consid poss risk fx		E					
3573F	Pt not consid poss risk fx		E					
3650F	Eeg ordered rvwd reqstd		E					
4000F	Tobacco use txmnt counseling		M					
4001F	Tobacco use txmnt, pharmacol		M					
4002F	Statin therapy, rx		M					
4003F	Pt ed write/oral, pts w/ hf		M					
4004F	Pt tobacco use done rcvd tlk		E					
4005F	Pharm thx for op rxd		M					
4006F	Beta-blocker therapy rx		M					
4009F	Ace/arb inhibitor therapy rx		M					
4011F	Oral antiplatelet therapy rx		M					
4012F	Warfarin therapy rx		M					
4014F	Written discharge instr prvd		M					
4015F	Persist asthma medicine ctrl		M					
4016F	Anti-inflm/anlgsc agent rx		M					
4017F	Gi prophylaxis for nsaid rx		M					
4018F	Therapy exercise joint rx		M					
4019F	Doc recpt counsl vit d/calc+		M					
4025F	Inhaled bronchodilator rx		M					
4030F	Oxygen therapy rx		M					
4033F	Pulmonary rehab rec		M					
4035F	Influenza imm rec		M					
4037F	Influenza imm order/admin		M					
4040F	Pneumoc vac/admin/rcvd		M					
4041F	Doc order cefazolin/cefurox		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
4042F	Doc antibio not given		M					
4043F	Doc order given stop antibio		M					
4044F	Doc order given vte prophylx		M					
4045F	Empiric antibiotic rx		M					
4046F	Doc antibio given b/4 surg		M					
4047F	Doc antibio given b/4 surg		M					
4048F	Doc antibio given b/4 surg		M					
4049F	Doc order given stop antibio		M					
4050F	Ht care plan doc		M					
4051F	Referred for an AV fistula		M					
4052F	Hemodialysis via AV fistula		M					
4053F	Hemodialysis via AV graft		M					
4054F	Hemodialysis via catheter		M					
4055F	Pt rcvng periton dialysis		M					
4056F	Approp oral rehyd recommd		M					
4058F	Ped gastro ed given, caregvr		M					
4060F	Psych svcs provided		M					
4062F	Pt referral psych docd		M					
4063F	Antidepres rxthxpy not rxd		E					
4064F	Antidepressant rx		M					
4065F	Antipsychotic rx		M					
4066F	ECT provided		M					
4067F	Pt referral for ect docd		M					
4070F	Dvt prophylx recvd day 2		M					
4073F	Oral antiplat thx rx dischrg		M					
4075F	Anticoag thx rx at dischrg		M					
4077F	Doc t-pa admin considered		M					
4079F	Doc rehab svcs considered		M					
4084F	Aspirin recvd w/in 24 hrs		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
4090F	Pt rcvng epo thxpy		M					
4095F	Pt not rcvng epo thxpy		M					
4100F	Biphos thxpy vein ord/recvd		M					
4110F	Int mam art used for cabg		M					
4115F	Beta blckr admin w/in 24 hrs		M					
4120F	Antibiot rxd/given		M					
4124F	Antibiot not rxd/given		M					
4130F	Topical prep rx aoe		M					
4131F	Syst antimicrobial thx rx		M					
4132F	No syst antimicrobial thx rx		M					
4133F	Antihist/decong rx/recom		M					
4134F	No antihist/decong rx/recom		M					
4135F	Systemic corticosteroids rx		M					
4136F	Syst corticosteroids not rx		M					
4148F	Hep A vac injxn admin/recvd		M					
4149F	Hep B vac injxn admin/recvd		M					
4150F	Pt recvng antivir txmnt hepc		M					
4151F	Pt not recvng antiv hep c		M					
4153F	Combo pegintf/rib rx		M					
4155F	Hep A vac series prev recvd		M					
4157F	Hep B vac series prev recvd		M					
4158F	Pt edu re alcoh drnkng done		M					
4159F	Contrcp talk b/4 antiv txmnt		M					
4163F	Pt couns 4 txmnt opt prost		M					
4164F	Adjv hrmnl thxpy rxd		M					
4165F	3d-crt/imrt) received		M					
4167F	Hd bed tilted 1st day vent		M					
4168F	Pt care icu&vent w/in 24hrs		M					
4169F	No pt care ICU/vent in 24hrs		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
4171F	Pt rcvng esa thxpy		M					
4172F	Pt not rcvng esa thxpy		M					
4174F	Couns potent glauc impct		M					
4175F	Vis of >= 20/40 w/in 90 days		M					
4176F	Talk re uv light pt/crgvr		M					
4177F	Talk pt/crgvr re areds prev		M					
4178F	Antid glbln rcvd w/in 26wks		M					
4179F	Tamoxifen/AI prescribed		M					
4180F	Adjv thxpyrxd/rcvd stg3a-c		M					
4181F	Conformal radn thxpy rcvd		M					
4182F	No conformal radn thxpy		M					
4185F	Continuous ppi or h2ra rcvd		M					
4186F	No cont ppi or h2ra rcvd		M					
4187F	Anti rheum drugthxpyrxd/gvn		M					
4188F	Approp ACE/ARB tstng done		M					
4189F	Approp digoxin tstng done		M					
4190F	Approp diuretic tstng done		M					
4191F	Approp anticonvuls tstng		M					
4192F	Pt not rcvng glucoco thxpy		M					
4193F	Pt rcvng<10mg daily predniso		M					
4194F	Pt rec>=10mg prednison qd		M					
4195F	Pt rcvng anti-rheum thxpy RA		M					
4196F	Ptnot rcvng anti-rhm thxpyRA		M					
4200F	External beam to prost only		M					
4201F	Extrnl beam other than prost		M					
4210F	ACE/ARB thxpy for >= 6 mons		M					
4220F	Digoxin thxpy for >= 6 mons		M					
4221F	Diuretic thxpy for >= 6 mons		M					
4230F	Anticonv thxpy for >= 6 mons		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
4240F	Instr xrcz 4bk pn >12 weeks		M					
4242F	Sprvsd xrcz bk pn >12 weeks		M					
4245F	Pt instr nrml lifest		M					
4248F	Pt instr-no bd rest>= 4 days		M					
4250F	Wrmng 4 surg - normothermia		M					
4255F	Anesth >= 60 min as docd		M					
4256F	Anesth < 60 min as docd		M					
4260F	Wound srfc culturetech used		E					
4261F	Tech other than surfc cultr		E					
4265F	Wet-dry dressings Rx-recmd		E					
4266F	No wet-dry drssings Rx-recmd		E					
4267F	Comprssion thxpy prescribed		M					
4268F	Pt ed re comp thxpy rcvd		E					
4269F	Appropos mthd offloading Rxd		E					
4270F	Pt rcvng anti r-viral thxpy		M					
4271F	Pt rcvng anti r-viral thxpy		M					
4274F	Flu immuno admind rcvd		M					
4275F	Hep b vac inj admin/ rcvd		E					
4276F	Potent antivir thxpy Rxd		M					
4279F	PCP prophylaxis Rxd		E					
4280F	PCP prophylax Rxd 3mon low %		M					
4290F	Pt scrned for inj drug use		M					
4293F	Pt scrnd - hgh-rsk sex behav		M					
4300F	Pt rcvng warf thxpy		E					
4301F	Pt not rcvng warf thxpy		E					
4305F	Pt ed re ft care inspct rcvd		E					
4306F	Pt tlk psych & Rx opd addic		E					
4320F	Pt talk psychsoc+rx oh dpnd		E					
4330F	Cnslng epi spec sfty issues		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
4340F	Cnslng chldbrng+ women epi		E					
5005F	Pt counsld on exam for moles		M					
5010F	Macul+ fndngs to dr mng dm		M					
5015F	Doc fx & test/txmnt for op		M					
5020F	Txmnts 2 main Dr by 1 mon		E					
5050F	Plan 2 main dr by 1 month		M					
5060F	Fndngs mammo 2pt w/in 3 days		M					
5062F	Doc f2fmammo fndng in 5 days		M					
5100F	Rsk fx ref w/n 24 hrs x-ray		E					
5200F	Eval appros surg thxpy epi		E					
6005F	Care level rationale doc		M					
6010F	Dysphag test done b/4 eating		M					
6015F	Dysphag test done b/4 eating		M					
6020F	Npo (nothing-mouth) ordered		M					
6030F	Max sterile barriers follwd		M					
6040F	Appro rad ds dvcs techs docd		M					
6045F	Radxps in end rprt4fluro pxd		M					
6070F	Pt asked/cnsld aed effects		E					
7010F	Pt info into recall system		M					
7020F	Mammo assess cat in dbase		M					
7025F	Pt infosys alarm 4 nxt mammo		M					
A0021	Outside state ambulance serv		E					
A0080	Noninterest escort in non er		E					
A0090	Interest escort in non er		E					
A0100	Nonemergency transport taxi		E					
A0110	Nonemergency transport bus		E					
A0120	Noner transport mini-bus		E					
A0130	Noner transport wheelch van		E					
A0140	Nonemergency transport air		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A0160	Noner transport case worker		E					
A0170	Transport parking fees/tolls		E					
A0180	Noner transport lodgng recip		E					
A0190	Noner transport meals recip		E					
A0200	Noner transport lodgng escrt		E					
A0210	Noner transport meals escort		E					
A0225	Neonatal emergency transport		E					
A0380	Basic life support mileage		E					
A0382	Basic support routine suppls		A					
A0384	Bls defibrillation supplies		A					
A0390	Advanced life support mileag		E					
A0392	Als defibrillation supplies		A					
A0394	Als IV drug therapy supplies		A					
A0396	Als esophageal intub suppls		A					
A0398	Als routine disposble suppls		A					
A0420	Ambulance waiting 1/2 hr		A					
A0422	Ambulance 02 life sustaining		A					
A0424	Extra ambulance attendant		A					
A0425	Ground mileage		A					
A0426	Als 1		A					
A0427	ALS1-emergency		A					
A0428	bls		A					
A0429	BLS-emergency		A					
A0430	Fixed wing air transport		A					
A0431	Rotary wing air transport		A					
A0432	PI volunteer ambulance co		A					
A0433	als 2		A					
A0434	Specialty care transport		A					
A0435	Fixed wing air mileage		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A0436	Rotary wing air mileage		A					
A0888	Noncovered ambulance mileage		E					
A0998	Ambulance response/treatment		E					
A0999	Unlisted ambulance service		A					
A4206	1 CC sterile syringe&needle		E					
A4207	2 CC sterile syringe&needle		E					
A4208	3 CC sterile syringe&needle		E					
A4209	5+ CC sterile syringe&needle		E					
A4210	Nonneedle injection device		E					
A4211	Supp for self-adm injections		E					
A4212	Non coring needle or stylet		B					
A4213	20+ CC syringe only		E					
A4215	Sterile needle		E					
A4216	Sterile water/saline, 10 ml		A					
A4217	Sterile water/saline, 500 ml		A					
A4218	Sterile saline or water		N					
A4220	Infusion pump refill kit		N					
A4221	Maint drug infus cath per wk		Y					
A4222	Infusion supplies with pump		Y					
A4223	Infusion supplies w/o pump		E					
A4230	Infus insulin pump non needl		N					
A4231	Infusion insulin pump needle		N					
A4232	Syringe w/needle insulin 3cc		E					
A4233	Alkalin batt for glucose mon		Y					
A4234	J-cell batt for glucose mon		Y					
A4235	Lithium batt for glucose mon		Y					
A4236	Silvr oxide batt glucose mon		Y					
A4244	Alcohol or peroxide per pint		E					
A4245	Alcohol wipes per box		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A4246	Betadine/phisohex solution		E					
A4247	Betadine/iodine swabs/wipes		E					
A4248	Chlorhexidine antisept		N					
A4250	Urine reagent strips/tablets		E					
A4252	Blood ketone test or strip		E					
A4253	Blood glucose/reagent strips		Y					
A4255	Glucose monitor platforms		Y					
A4256	Calibrator solution/chips		Y					
A4257	Replace Lensshield Cartridge		Y					
A4258	Lancet device each		Y					
A4259	Lancets per box		Y					
A4261	Cervical cap contraceptive		E					
A4262	Temporary tear duct plug		N					
A4263	Permanent tear duct plug		N					
A4264	Intratubal occlusion device		E					
A4265	Paraffin		Y					
A4266	Diaphragm		E					
A4267	Male condom		E					
A4268	Female condom		E					
A4269	Spermicide		E					
A4270	Disposable endoscope sheath		N					
A4280	Brst prsths adhsv attchmnt		A					
A4281	Replacement breastpump tube		E					
A4282	Replacement breastpump adpt		E					
A4283	Replacement breastpump cap		E					
A4284	Replcmnt breast pump shield		E					
A4285	Replcmnt breast pump bottle		E					
A4286	Replcmnt breastpump lok ring		E					
A4290	Sacral nerve stim test lead		B					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A4300	Cath impl vasc access portal		N					
A4301	Implantable access syst perc		N					
A4305	Drug delivery system >=50 ML		N					
A4306	Drug delivery system <=50 ml		N					
A4310	Insert tray w/o bag/cath		A					
A4311	Catheter w/o bag 2-way latex		A					
A4312	Cath w/o bag 2-way silicone		A					
A4313	Catheter w/bag 3-way		A					
A4314	Cath w/drainage 2-way latex		A					
A4315	Cath w/drainage 2-way silcne		A					
A4316	Cath w/drainage 3-way		A					
A4320	Irrigation tray		A					
A4321	Cath therapeutic irrig agent		A					
A4322	Irrigation syringe		A					
A4326	Male external catheter		A					
A4327	Fem urinary collect dev cup		A					
A4328	Fem urinary collect pouch		A					
A4330	Stool collection pouch		A					
A4331	Extension drainage tubing		A					
A4332	Lube sterile packet		A					
A4333	Urinary cath anchor device		A					
A4334	Urinary cath leg strap		A					
A4335	Incontinence supply		A					
A4336	Urethral insert		A					
A4338	Indwelling catheter latex		A					
A4340	Indwelling catheter special		A					
A4344	Cath indw foley 2 way silicn		A					
A4346	Cath indw foley 3 way		A					
A4349	Disposable male external cat		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A4351	Straight tip urine catheter		A					
A4352	Coude tip urinary catheter		A					
A4353	Intermittent urinary cath		A					
A4354	Cath insertion tray w/bag		A					
A4355	Bladder irrigation tubing		A					
A4356	Ext ureth clmp or compr dvc		A					
A4357	Bedside drainage bag		A					
A4358	Urinary leg or abdomen bag		A					
A4360	Disposable ext urethral dev		A					
A4361	Ostomy face plate		A					
A4362	Solid skin barrier		A					
A4363	Ostomy clamp, replacement		A					
A4364	Adhesive, liquid or equal		A					
A4366	Ostomy vent		A					
A4367	Ostomy belt		A					
A4368	Ostomy filter		A					
A4369	Skin barrier liquid per oz		A					
A4371	Skin barrier powder per oz		A					
A4372	Skin barrier solid 4x4 equiv		A					
A4373	Skin barrier with flange		A					
A4375	Drainable plastic pch w fcpl		A					
A4376	Drainable rubber pch w fcplt		A					
A4377	Drainable plstic pch w/o fp		A					
A4378	Drainable rubber pch w/o fp		A					
A4379	Urinary plastic pouch w fcpl		A					
A4380	Urinary rubber pouch w fcplt		A					
A4381	Urinary plastic pouch w/o fp		A					
A4382	Urinary hvy plstc pch w/o fp		A					
A4383	Urinary rubber pouch w/o fp		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A4384	Ostomy faceplt/silicone ring		A					
A4385	Ost skn barrier sld ext wear		A					
A4387	Ost clsd pouch w att st barr		A					
A4388	Drainable pch w ex wear barr		A					
A4389	Drainable pch w st wear barr		A					
A4390	Drainable pch ex wear convex		A					
A4391	Urinary pouch w ex wear barr		A					
A4392	Urinary pouch w st wear barr		A					
A4393	Urine pch w ex wear bar conv		A					
A4394	Ostomy pouch liq deodorant		A					
A4395	Ostomy pouch solid deodorant		A					
A4396	Peristomal hernia supprt blt		A					
A4397	Irrigation supply sleeve		A					
A4398	Ostomy irrigation bag		A					
A4399	Ostomy irrig cone/cath w brs		A					
A4400	Ostomy irrigation set		A					
A4402	Lubricant per ounce		A					
A4404	Ostomy ring each		A					
A4405	Nonpectin based ostomy paste		A					
A4406	Pectin based ostomy paste		A					
A4407	Ext wear ost skn barr <=4sq"		A					
A4408	Ext wear ost skn barr >4sq"		A					
A4409	Ost skn barr convex <=4 sq i		A					
A4410	Ost skn barr extnd >4 sq		A					
A4411	Ost skn barr extnd =4sq		A					
A4412	Ost pouch drain high output		A					
A4413	2 pc drainable ost pouch		A					
A4414	Ost sknbar w/o conv<=4 sq in		A					
A4415	Ost skn barr w/o conv >4 sqi		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A4416	Ost pch clsd w barrier/filtr		A					
A4417	Ost pch w bar/bltinconv/fltr		A					
A4418	Ost pch clsd w/o bar w filtr		A					
A4419	Ost pch for bar w flange/flt		A					
A4420	Ost pch clsd for bar w lk fl		A					
A4421	Ostomy supply misc		E					
A4422	Ost pouch absorbent material		A					
A4423	Ost pch for bar w lk fl/fltr		A					
A4424	Ost pch drain w bar & filter		A					
A4425	Ost pch drain for barrier fl		A					
A4426	Ost pch drain 2 piece system		A					
A4427	Ost pch drain/barr lk flng/f		A					
A4428	Urine ost pouch w faucet/tap		A					
A4429	Urine ost pouch w bltinconv		A					
A4430	Ost urine pch w b/bltin conv		A					
A4431	Ost pch urine w barrier/tapv		A					
A4432	Os pch urine w bar/fange/tap		A					
A4433	Urine ost pch bar w lock fln		A					
A4434	Ost pch urine w lock flng/ft		A					
A4450	Non-waterproof tape		A					
A4452	Waterproof tape		A					
A4455	Adhesive remover per ounce		A					
A4456	Adhesive remover, wipes		A					
A4458	Reusable enema bag		E					
A4461	Surgicl dress hold non-reuse		A					
A4463	Surgical dress holder reuse		A					
A4465	Non-elastic extremity binder		N					
A4466	Elastic garment/covering		E					
A4470	Gravlee jet washer		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A4480	Vabra aspirator		N					
A4481	Tracheostoma filter		A					
A4483	Moisture exchanger		A					
A4490	Above knee surgical stocking		E					
A4495	Thigh length surg stocking		E					
A4500	Below knee surgical stocking		E					
A4510	Full length surg stocking		E					
A4520	Incontinence garment anytype		E					
A4550	Surgical trays		B					
A4554	Disposable underpads		E					
A4556	Electrodes, pair		Y					
A4557	Lead wires, pair		Y					
A4558	Conductive gel or paste		Y					
A4559	Coupling gel or paste		Y					
A4561	Pessary rubber, any type		N					
A4562	Pessary, non rubber,any type		N					
A4565	Slings		N					
A4570	Splint		E					
A4575	Hyperbaric o2 chamber disps		E					
A4580	Cast supplies (plaster)		E					
A4590	Special casting material		E					
A4595	TENS suppl 2 lead per month		Y					
A4600	Sleeve, inter limb comp dev		Y					
A4601	Lith ion batt, non-pros use		Y					
A4604	Tubing with heating element		Y					
A4605	Trach suction cath close sys		Y					
A4606	Oxygen probe used w oximeter		A					
A4608	Transtracheal oxygen cath		Y					
A4611	Heavy duty battery		Y					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A4612	Battery cables		Y					
A4613	Battery charger		Y					
A4614	Hand-held PEFR meter		Y					
A4615	Cannula nasal		Y					
A4616	Tubing (oxygen) per foot		Y					
A4617	Mouth piece		Y					
A4618	Breathing circuits		Y					
A4619	Face tent		Y					
A4620	Variable concentration mask		Y					
A4623	Tracheostomy inner cannula		A					
A4624	Tracheal suction tube		Y					
A4625	Trach care kit for new trach		A					
A4626	Tracheostomy cleaning brush		A					
A4627	Spacer bag/reservoir		E					
A4628	Oropharyngeal suction cath		Y					
A4629	Tracheostomy care kit		A					
A4630	Repl bat t.e.n.s. own by pt		Y					
A4633	Uvl replacement bulb		Y					
A4634	Replacement bulb th lightbox		A					
A4635	Underarm crutch pad		Y					
A4636	Handgrip for cane etc		Y					
A4637	Repl tip cane/crutch/walker		Y					
A4638	Repl batt pulse gen sys		Y					
A4639	Infrared ht sys replcmnt pad		Y					
A4640	Alternating pressure pad		Y					
A4641	Radiopharm dx agent noc		N					
A4642	In111 satumomab		N					
A4648	Implantable tissue marker		N					
A4649	Surgical supplies		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A4650	Implant radiation dosimeter		N					
A4651	Calibrated microcap tube		A					
A4652	Microcapillary tube sealant		A					
A4653	PD catheter anchor belt		A					
A4657	Syringe w/wo needle		N					
A4660	Sphyg/bp app w cuff and stet		N					
A4663	Dialysis blood pressure cuff		N					
A4670	Automatic bp monitor, dial		E					
A4671	Disposable cycler set		B					
A4672	Drainage ext line, dialysis		B					
A4673	Ext line w easy lock connect		B					
A4674	Chem/antisept solution, 8oz		B					
A4680	Activated carbon filter, ea		N					
A4690	Dialyzer, each		N					
A4706	Bicarbonate conc sol per gal		N					
A4707	Bicarbonate conc pow per pac		N					
A4708	Acetate conc sol per gallon		N					
A4709	Acid conc sol per gallon		N					
A4714	Treated water per gallon		N					
A4719	"Y set" tubing		N					
A4720	Dialysat sol fld vol > 249cc		N					
A4721	Dialysat sol fld vol > 999cc		N					
A4722	Dialys sol fld vol > 1999cc		N					
A4723	Dialys sol fld vol > 2999cc		N					
A4724	Dialys sol fld vol > 3999cc		N					
A4725	Dialys sol fld vol > 4999cc		N					
A4726	Dialys sol fld vol > 5999cc		N					
A4728	Dialysate solution, non-dex		B					
A4730	Fistula cannulation set, ea		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A4736	Topical anesthetic, per gram		N					
A4737	Inj anesthetic per 10 ml		N					
A4740	Shunt accessory		N					
A4750	Art or venous blood tubing		N					
A4755	Comb art/venous blood tubing		N					
A4760	Dialysate sol test kit, each		N					
A4765	Dialysate conc pow per pack		N					
A4766	Dialysate conc sol add 10 ml		N					
A4770	Blood collection tube/vacuum		N					
A4771	Serum clotting time tube		N					
A4772	Blood glucose test strips		N					
A4773	Occult blood test strips		N					
A4774	Ammonia test strips		N					
A4802	Protamine sulfate per 50 mg		N					
A4860	Disposable catheter tips		N					
A4870	Plumb/elec wk hm hemo equip		N					
A4890	Repair/maint cont hemo equip		N					
A4911	Drain bag/bottle		N					
A4913	Misc dialysis supplies noc		N					
A4918	Venous pressure clamp		N					
A4927	Non-sterile gloves		N					
A4928	Surgical mask		N					
A4929	Tourniquet for dialysis, ea		N					
A4930	Sterile, gloves per pair		N					
A4931	Reusable oral thermometer		N					
A4932	Reusable rectal thermometer		E					
A5051	Pouch clsd w barr attached		A					
A5052	Clsd ostomy pouch w/o barr		A					
A5053	Clsd ostomy pouch faceplate		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A5054	Clsd ostomy pouch w/flange		A					
A5055	Stoma cap		A					
A5061	Pouch drainable w barrier at		A					
A5062	Drnble ostomy pouch w/o barr		A					
A5063	Drain ostomy pouch w/flange		A					
A5071	Urinary pouch w/barrier		A					
A5072	Urinary pouch w/o barrier		A					
A5073	Urinary pouch on barr w/flng		A					
A5081	Continent stoma plug		A					
A5082	Continent stoma catheter		A					
A5083	Stoma absorptive cover		A					
A5093	Ostomy accessory convex inse		A					
A5102	Bedside drain btl w/wo tube		A					
A5105	Urinary suspensory		A					
A5112	Urinary leg bag		A					
A5113	Latex leg strap		A					
A5114	Foam/fabric leg strap		A					
A5120	Skin barrier, wipe or swab		A					
A5121	Solid skin barrier 6x6		A					
A5122	Solid skin barrier 8x8		A					
A5126	Disk/foam pad +or- adhesive		A					
A5131	Appliance cleaner		A					
A5200	Percutaneous catheter anchor		A					
A5500	Diab shoe for density insert		Y					
A5501	Diabetic custom molded shoe		Y					
A5503	Diabetic shoe w/roller/rockr		Y					
A5504	Diabetic shoe with wedge		Y					
A5505	Diab shoe w/metatarsal bar		Y					
A5506	Diabetic shoe w/off set heel		Y					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A5507	Modification diabetic shoe		Y					
A5508	Diabetic deluxe shoe		Y					
A5510	Compression form shoe insert		E					
A5512	Multi den insert direct form		Y					
A5513	Multi den insert custom mold		Y					
A6000	Wound warming wound cover		E					
A6010	Collagen based wound filler		A					
A6011	Collagen gel/paste wound fil		A					
A6021	Collagen dressing <=16 sq in		A					
A6022	Collagen drsg>16<=48 sq in		A					
A6023	Collagen dressing >48 sq in		A					
A6024	Collagen dsg wound filler		A					
A6025	Silicone gel sheet, each		E					
A6154	Wound pouch each		A					
A6196	Alginate dressing <=16 sq in		A					
A6197	Alginate drsg >16 <=48 sq in		A					
A6198	alginate dressing > 48 sq in		A					
A6199	Alginate drsg wound filler		A					
A6203	Composite drsg <= 16 sq in		A					
A6204	Composite drsg >16<=48 sq in		A					
A6205	Composite drsg > 48 sq in		A					
A6206	Contact layer <= 16 sq in		A					
A6207	Contact layer >16<= 48 sq in		A					
A6208	Contact layer > 48 sq in		A					
A6209	Foam drsg <=16 sq in w/o bdr		A					
A6210	Foam drg >16<=48 sq in w/o b		A					
A6211	Foam drg > 48 sq in w/o brdr		A					
A6212	Foam drg <=16 sq in w/border		A					
A6213	Foam drg >16<=48 sq in w/bdr		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A6214	Foam drg > 48 sq in w/border		A					
A6215	Foam dressing wound filler		A					
A6216	Non-sterile gauze<=16 sq in		A					
A6217	Non-sterile gauze>16<=48 sq		A					
A6218	Non-sterile gauze > 48 sq in		A					
A6219	Gauze <= 16 sq in w/border		A					
A6220	Gauze >16 <=48 sq in w/bordr		A					
A6221	Gauze > 48 sq in w/border		A					
A6222	Gauze <=16 in no w/sal w/o b		A					
A6223	Gauze >16<=48 no w/sal w/o b		A					
A6224	Gauze > 48 in no w/sal w/o b		A					
A6228	Gauze <= 16 sq in water/sal		A					
A6229	Gauze >16<=48 sq in watr/sal		A					
A6230	Gauze > 48 sq in water/salne		A					
A6231	Hydrogel dsg<=16 sq in		A					
A6232	Hydrogel dsg>16<=48 sq in		A					
A6233	Hydrogel dressing >48 sq in		A					
A6234	Hydrocolld drg <=16 w/o bdr		A					
A6235	Hydrocolld drg >16<=48 w/o b		A					
A6236	Hydrocolld drg > 48 in w/o b		A					
A6237	Hydrocolld drg <=16 in w/bdr		A					
A6238	Hydrocolld drg >16<=48 w/bdr		A					
A6239	Hydrocolld drg > 48 in w/bdr		A					
A6240	Hydrocolld drg filler paste		A					
A6241	Hydrocolloid drg filler dry		A					
A6242	Hydrogel drg <=16 in w/o bdr		A					
A6243	Hydrogel drg >16<=48 w/o bdr		A					
A6244	Hydrogel drg >48 in w/o bdr		A					
A6245	Hydrogel drg <= 16 in w/bdr		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A6246	Hydrogel drg >16<=48 in w/b		A					
A6247	Hydrogel drg > 48 sq in w/b		A					
A6248	Hydrogel drsg gel filler		A					
A6250	Skin seal protect moisturizr		A					
A6251	Absorpt drg <=16 sq in w/o b		A					
A6252	Absorpt drg >16 <=48 w/o bdr		A					
A6253	Absorpt drg > 48 sq in w/o b		A					
A6254	Absorpt drg <=16 sq in w/bdr		A					
A6255	Absorpt drg >16<=48 in w/bdr		A					
A6256	Absorpt drg > 48 sq in w/bdr		A					
A6257	Transparent film <= 16 sq in		A					
A6258	Transparent film >16<=48 in		A					
A6259	Transparent film > 48 sq in		A					
A6260	Wound cleanser any type/size		A					
A6261	Wound filler gel/paste /oz		A					
A6262	Wound filler dry form / gram		A					
A6266	Impreg gauze no h20/sal/yard		A					
A6402	Sterile gauze <= 16 sq in		A					
A6403	Sterile gauze>16 <= 48 sq in		A					
A6404	Sterile gauze > 48 sq in		A					
A6407	Packing strips, non-impreg		A					
A6410	Sterile eye pad		A					
A6411	Non-sterile eye pad		A					
A6412	Occlusive eye patch		E					
A6413	Adhesive bandage, first-aid		E					
A6441	Pad band w>=3" <5"/yd		A					
A6442	Conform band n/s w<3"/yd		A					
A6443	Conform band n/s w>=3"<5"/yd		A					
A6444	Conform band n/s w>=5"/yd		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A6445	Conform band s w <3"/yd		A					
A6446	Conform band s w>=3" <5"/yd		A					
A6447	Conform band s w >=5"/yd		A					
A6448	Lt compres band <3"/yd		A					
A6449	Lt compres band >=3" <5"/yd		A					
A6450	Lt compres band >=5"/yd		A					
A6451	Mod compres band w>=3"<5"/yd		A					
A6452	High compres band w>=3"<5"yd		A					
A6453	Self-adher band w <3"/yd		A					
A6454	Self-adher band w>=3" <5"/yd		A					
A6455	Self-adher band >=5"/yd		A					
A6456	Zinc paste band w >=3"<5"/yd		A					
A6457	Tubular dressing		A					
A6501	Compres burngarment bodysuit		A					
A6502	Compres burngarment chinstrp		A					
A6503	Compres burngarment facehood		A					
A6504	Cmprsburngarment glove-wrist		A					
A6505	Cmprsburngarment glove-elbow		A					
A6506	Cmprsburngrmnt glove-axilla		A					
A6507	Cmprs burngarment foot-knee		A					
A6508	Cmprs burngarment foot-thigh		A					
A6509	Compres burn garment jacket		A					
A6510	Compres burn garment leotard		A					
A6511	Compres burn garment panty		A					
A6512	Compres burn garment, noc		A					
A6513	Compress burn mask face/neck		B					
A6530	Compression stocking BK18-30		E					
A6531	Compression stocking BK30-40		A					
A6532	Compression stocking BK40-50		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A6533	Gc stocking thighlngth 18-30		E					
A6534	Gc stocking thighlngth 30-40		E					
A6535	Gc stocking thighlngth 40-50		E					
A6536	Gc stocking full lngth 18-30		E					
A6537	Gc stocking full lngth 30-40		E					
A6538	Gc stocking full lngth 40-50		E					
A6539	Gc stocking waistlngth 18-30		E					
A6540	Gc stocking waistlngth 30-40		E					
A6541	Gc stocking waistlngth 40-50		E					
A6544	Gc stocking garter belt		E					
A6545	Grad comp non-elastic BK		A					
A6549	G compression stocking		E					
A6550	Neg pres wound ther drsg set		Y					
A7000	Disposable canister for pump		Y					
A7001	Nondisposable pump canister		Y					
A7002	Tubing used w suction pump		Y					
A7003	Nebulizer administration set		Y					
A7004	Disposable nebulizer sml vol		Y					
A7005	Nondisposable nebulizer set		Y					
A7006	Filtered nebulizer admin set		Y					
A7007	Lg vol nebulizer disposable		Y					
A7008	Disposable nebulizer prefill		Y					
A7009	Nebulizer reservoir bottle		Y					
A7010	Disposable corrugated tubing		Y					
A7011	Nondispos corrugated tubing		Y					
A7012	Nebulizer water collec devic		Y					
A7013	Disposable compressor filter		Y					
A7014	Compressor nondispos filter		Y					
A7015	Aerosol mask used w nebulize		Y					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A7016	Nebulizer dome & mouthpiece		Y					
A7017	Nebulizer not used w oxygen		Y					
A7018	Water distilled w/nebulizer		Y					
A7025	Replace chest compress vest		Y					
A7026	Replace chst cmprss sys hose		Y					
A7027	Combination oral/nasal mask		Y					
A7028	Repl oral cushion combo mask		Y					
A7029	Repl nasal pillow comb mask		Y					
A7030	CPAP full face mask		Y					
A7031	Replacement facemask interfa		Y					
A7032	Replacement nasal cushion		Y					
A7033	Replacement nasal pillows		Y					
A7034	Nasal application device		Y					
A7035	Pos airway press headgear		Y					
A7036	Pos airway press chinstrap		Y					
A7037	Pos airway pressure tubing		Y					
A7038	Pos airway pressure filter		Y					
A7039	Filter, non disposable w pap		Y					
A7040	One way chest drain valve		A					
A7041	Water seal drain container		A					
A7042	Implanted pleural catheter		N					
A7043	Vacuum drainagebottle/tubing		A					
A7044	PAP oral interface		Y					
A7045	Repl exhalation port for PAP		Y					
A7046	Repl water chamber, PAP dev		Y					
A7501	Tracheostoma valve w diaphra		A					
A7502	Replacement diaphragm/fplate		A					
A7503	HMES filter holder or cap		A					
A7504	Tracheostoma HMES filter		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A7505	HMES or trach valve housing		A					
A7506	HMES/trachvalve adhesivedisk		A					
A7507	Integrated filter & holder		A					
A7508	Housing & Integrated Adhesiv		A					
A7509	Heat & moisture exchange sys		A					
A7520	Trach/laryn tube non-cuffed		A					
A7521	Trach/laryn tube cuffed		A					
A7522	Trach/laryn tube stainless		A					
A7523	Tracheostomy shower protect		A					
A7524	Tracheostoma stent/stud/bttn		A					
A7525	Tracheostomy mask		A					
A7526	Tracheostomy tube collar		A					
A7527	Trach/laryn tube plug/stop		A					
A8000	Soft protect helmet prefab		Y					
A8001	Hard protect helmet prefab		Y					
A8002	Soft protect helmet custom		Y					
A8003	Hard protect helmet custom		Y					
A8004	Repl soft interface, helmet		Y					
A9150	Misc/exper non-prescript dru		B					
A9152	Single vitamin nos		E					
A9153	Multi-vitamin nos		E					
A9155	Artificial saliva		B					
A9180	Lice treatment, topical		E					
A9270	Non-covered item or service		E					
A9274	Ext amb insulin delivery sys		E					
A9275	Disp home glucose monitor		E					
A9276	Disposable sensor, CGM sys		E					
A9277	External transmitter, CGM		E					
A9278	External receiver, CGM sys		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A9279	Monitoring feature/deviceNOC		E					
A9280	Alert device, noc		E					
A9281	Reaching/grabbing device		E					
A9282	Wig any type		E					
A9283	Foot press off load supp dev		E					
A9284	Non-electronic spirometer		N					
A9300	Exercise equipment		E					
A9500	Tc99m sestamibi		N					
A9501	Technetium TC-99m teboroxime		N					
A9502	Tc99m tetrofosmin		N					
A9503	Tc99m medronate		N					
A9504	Tc99m apcitide		N					
A9505	TL201 thallium		N					
A9507	In111 capromab		N					
A9508	I131 iodobenguate, dx		N					
A9509	Iodine I-123 sod iodide mil		N					
A9510	Tc99m disofenin		N					
A9512	Tc99m pertechnetate		N					
A9516	Iodine I-123 sod iodide mic		N					
A9517	I131 iodide cap, rx		K	1064		$18.20	.	$3.64
A9521	Tc99m exametazime		N					
A9524	I131 serum albumin, dx		N					
A9526	Nitrogen N-13 ammonia		N					
A9527	Iodine I-125 sodium iodide		U	2632	0.3077	$21.01	.	$4.21
A9528	Iodine I-131 iodide cap, dx		N					
A9529	I131 iodide sol, dx		N					
A9530	I131 iodide sol, rx		K	1150		$13.72	.	$2.75
A9531	I131 max 100uCi		N					
A9532	I125 serum albumin, dx		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A9536	Tc99m depreotide		N					
A9537	Tc99m mebrofenin		N					
A9538	Tc99m pyrophosphate		N					
A9539	Tc99m pentetate		N					
A9540	Tc99m MAA		N					
A9541	Tc99m sulfur colloid		N					
A9542	In111 ibritumomab, dx		N					
A9543	Y90 ibritumomab, rx		K	1643		$31,434.63	.	$6,286.93
A9544	I131 tositumomab, dx		N					
A9545	I131 tositumomab, rx		K	1645		$23,132.09	.	$4,626.42
A9546	Co57/58		N					
A9547	In111 oxyquinoline		N					
A9548	In111 pentetate		N					
A9550	Tc99m gluceptate		N					
A9551	Tc99m succimer		N					
A9552	F18 fdg		N					
A9553	Cr51 chromate		N					
A9554	I125 iothalamate, dx		N					
A9555	Rb82 rubidium		N					
A9556	Ga67 gallium		N					
A9557	Tc99m bicisate		N					
A9558	Xe133 xenon 10mci		N					
A9559	Co57 cyano		N					
A9560	Tc99m labeled rbc		N					
A9561	Tc99m oxidronate		N					
A9562	Tc99m mertiatide		N					
A9563	P32 Na phosphate		K	1675		$196.49	.	$39.30
A9564	P32 chromic phosphate		K	1676		$113.44	.	$22.69
A9566	Tc99m fanolesomab		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
A9567	Technetium TC-99m aerosol		N					
A9568	Technetium tc99m arcitumomab		N					
A9569	Technetium TC-99m auto WBC		N					
A9570	Indium In-111 auto WBC		N					
A9571	Indium IN-111 auto platelet		N					
A9572	Indium In-111 pentetreotide		N					
A9576	Inj prohance multipack		N					
A9577	Inj multihance		N					
A9578	Inj multihance multipack		N					
A9579	Gad-base MR contrast NOS,1ml		N					
A9580	Sodium fluoride F-18		N					
A9581	Gadoxetate disodium inj	CH	N					
A9582	Iodine I-123 iobenguane		G	9247		$2,282.67		
A9583	Gadofosveset trisodium inj		G	1299		$12.89		
A9600	Sr89 strontium		K	0701		$805.83	.	$161.17
A9604	Sm 153 lexidronam		K	1295		$5,613.99	.	$1,122.80
A9698	Non-rad contrast materialNOC		N					
A9699	Radiopharm rx agent noc		N					
A9700	Echocardiography Contrast		B					
A9900	Supply/accessory/service		Y					
A9901	Delivery/set up/dispensing		A					
A9999	DME supply or accessory, nos		Y					
B4034	Enter feed supkit syr by day		Y					
B4035	Enteral feed supp pump per d		Y					
B4036	Enteral feed sup kit grav by		Y					
B4081	Enteral ng tubing w/ stylet		Y					
B4082	Enteral ng tubing w/o stylet		Y					
B4083	Enteral stomach tube levine		Y					
B4087	Gastro/jejuno tube, std		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
B4088	Gastro/jejuno tube, low-pro		A					
B4100	Food thickener oral		E					
B4102	EF adult fluids and electro		Y					
B4103	EF ped fluid and electrolyte		Y					
B4104	Additive for enteral formula		E					
B4149	EF blenderized foods		Y					
B4150	EF complet w/intact nutrient		Y					
B4152	EF calorie dense>/=1.5Kcal		Y					
B4153	EF hydrolyzed/amino acids		Y					
B4154	EF spec metabolic noninherit		Y					
B4155	EF incomplete/modular		Y					
B4157	EF special metabolic inherit		Y					
B4158	EF ped complete intact nut		Y					
B4159	EF ped complete soy based		Y					
B4160	EF ped caloric dense>/=0.7kc		Y					
B4161	EF ped hydrolyzed/amino acid		Y					
B4162	EF ped specmetabolic inherit		Y					
B4164	Parenteral 50% dextrose solu		Y					
B4168	Parenteral sol amino acid 3.		Y					
B4172	Parenteral sol amino acid 5.		Y					
B4176	Parenteral sol amino acid 7-		Y					
B4178	Parenteral sol amino acid >		Y					
B4180	Parenteral sol carb > 50%		Y					
B4185	Parenteral sol 10 gm lipids		B					
B4189	Parenteral sol amino acid &		Y					
B4193	Parenteral sol 52-73 gm prot		Y					
B4197	Parenteral sol 74-100 gm pro		Y					
B4199	Parenteral sol > 100gm prote		Y					
B4216	Parenteral nutrition additiv		Y					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
B4220	Parenteral supply kit premix		Y					
B4222	Parenteral supply kit homemi		Y					
B4224	Parenteral administration ki		Y					
B5000	Parenteral sol renal-amirosy		Y					
B5100	Parenteral sol hepatic-fream		Y					
B5200	Parenteral sol stres-brnch c		Y					
B9000	Enter infusion pump w/o alrm		Y					
B9002	Enteral infusion pump w/ ala		Y					
B9004	Parenteral infus pump portab		Y					
B9006	Parenteral infus pump statio		Y					
B9998	Enteral supp not otherwise c		Y					
B9999	Parenteral supp not othrws c		Y					
C1300	HYPERBARIC Oxygen		S	0659	1.565	$106.84	.	$21.37
C1713	Anchor/screw bn/bn,tis/bn		N					
C1714	Cath, trans atherectomy, dir		N					
C1715	Brachytherapy needle		N					
C1716	Brachytx, non-str, Gold-198		U	1716	2.7019	$184.45	.	$36.89
C1717	Brachytx, non-str,HDR Ir-192		U	1717	3.2259	$220.22	.	$44.05
C1719	Brachytx, NS, Non-HDRIr-192		U	1719	0.3366	$22.98	.	$4.60
C1721	AICD, dual chamber		N					
C1722	AICD, single chamber		N					
C1724	Cath, trans atherec,rotation		N					
C1725	Cath, translumin non-laser		N					
C1726	Cath, bal dil, non-vascular		N					
C1727	Cath, bal tis dis, non-vas		N					
C1728	Cath, brachytx seed adm		N					
C1729	Cath, drainage		N					
C1730	Cath, EP, 19 or few elect		N					
C1731	Cath, EP, 20 or more elec		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
C1732	Cath, EP, diag/abl, 3D/vect		N					
C1733	Cath, EP, othr than cool-tip		N					
C1750	Cath, hemodialysis,long-term		N					
C1751	Cath, inf, per/cent/midline		N					
C1752	Cath,hemodialysis,short-term		N					
C1753	Cath, intravas ultrasound		N					
C1754	Catheter, intradiscal		N					
C1755	Catheter, intraspinal		N					
C1756	Cath, pacing, transesoph		N					
C1757	Cath, thrombectomy/embolect		N					
C1758	Catheter, ureteral		N					
C1759	Cath, intra echocardiography		N					
C1760	Closure dev, vasc		N					
C1762	Conn tiss, human(inc fascia)		N					
C1763	Conn tiss, non-human		N					
C1764	Event recorder, cardiac		N					
C1765	Adhesion barrier		N					
C1766	Intro/sheath,strble,non-peel		N					
C1767	Generator, neuro non-recharg		N					
C1768	Graft, vascular		N					
C1769	Guide wire		N					
C1770	Imaging coil, MR, insertable		N					
C1771	Rep dev, urinary, w/sling		N					
C1772	Infusion pump, programmable		N					
C1773	Ret dev, insertable		N					
C1776	Joint device (implantable)		N					
C1777	Lead, AICD, endo single coil		N					
C1778	Lead, neurostimulator		N					
C1779	Lead, pmkr, transvenous VDD		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
C1780	Lens, intraocular (new tech)		N					
C1781	Mesh (implantable)		N					
C1782	Morcellator		N					
C1783	Ocular imp, aqueous drain de		N					
C1784	Ocular dev, intraop, det ret		N					
C1785	Pmkr, dual, rate-resp		N					
C1786	Pmkr, single, rate-resp		N					
C1787	Patient progr, neurostim		N					
C1788	Port, indwelling, imp		N					
C1789	Prosthesis, breast, imp		N					
C1813	Prosthesis, penile, inflatab		N					
C1814	Retinal tamp, silicone oil		N					
C1815	Pros, urinary sph, imp		N					
C1816	Receiver/transmitter, neuro		N					
C1817	Septal defect imp sys		N					
C1818	Integrated keratoprosthesis		N					
C1819	Tissue localization-excision		N					
C1820	Generator neuro rechg bat sy		N					
C1821	Interspinous implant		N					
C1874	Stent, coated/cov w/del sys		N					
C1875	Stent, coated/cov w/o del sy		N					
C1876	Stent, non-coa/non-cov w/del		N					
C1877	Stent, non-coat/cov w/o del		N					
C1878	Matrl for vocal cord		N					
C1879	Tissue marker, implantable		N					
C1880	Vena cava filter		N					
C1881	Dialysis access system		N					
C1882	AICD, other than sing/dual		N					
C1883	Adapt/ext, pacing/neuro lead		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
C1884	Embolization Protect syst		N					
C1885	Cath, translumin angio laser		N					
C1887	Catheter, guiding		N					
C1888	Endovas non-cardiac abl cath		N					
C1891	Infusion pump,non-prog, perm		N					
C1892	Intro/sheath,fixed,peel-away		N					
C1893	Intro/sheath, fixed,non-peel		N					
C1894	Intro/sheath, non-laser		N					
C1895	Lead, AICD, endo dual coil		N					
C1896	Lead, AICD, non sing/dual		N					
C1897	Lead, neurostim test kit		N					
C1898	Lead, pmkr, other than trans		N					
C1899	Lead, pmkr/AICD combination		N					
C1900	Lead, coronary venous		N					
C2614	Probe, perc lumb disc		N					
C2615	Sealant, pulmonary, liquid		N					
C2616	Brachytx, non-str,Yttrium-90		U	2616	245.7374	$16,775.76	.	$3,355.16
C2617	Stent, non-cor, tem w/o del		N					
C2618	Probe, cryoablation		N					
C2619	Pmkr, dual, non rate-resp		N					
C2620	Pmkr, single, non rate-resp		N					
C2621	Pmkr, other than sing/dual		N					
C2622	Prosthesis, penile, non-inf		N					
C2625	Stent, non-cor, tem w/del sy		N					
C2626	Infusion pump, non-prog,temp		N					
C2627	Cath, suprapubic/cystoscopic		N					
C2628	Catheter, occlusion		N					
C2629	Intro/sheath, laser		N					
C2630	Cath, EP, cool-tip		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
C2631	Rep dev, urinary, w/o sling		N					
C2634	Brachytx, non-str, HA, I-125		U	2634	0.7596	$51.86	.	$10.38
C2635	Brachytx, non-str, HA, P-103		U	2635	0.4337	$29.61	.	$5.93
C2636	Brachy linear, non-str,P-103		U	2636	0.528	$36.04	.	$7.21
C2637	Brachy,non-str,Ytterbium-169		B					
C2638	Brachytx, stranded, I-125		U	2638	0.5662	$38.65	.	$7.73
C2639	Brachytx, non-stranded,I-125		U	2639	0.5292	$36.13	.	$7.23
C2640	Brachytx, stranded, P-103		U	2640	0.9334	$63.72	.	$12.75
C2641	Brachytx, non-stranded,P-103		U	2641	0.9135	$62.36	.	$12.48
C2642	Brachytx, stranded, C-131		U	2642	1.6774	$114.51	.	$22.91
C2643	Brachytx, non-stranded,C-131		U	2643	0.9143	$62.42	.	$12.49
C2698	Brachytx, stranded, NOS		U	2698	0.5662	$38.65	.	$7.73
C2699	Brachytx, non-stranded, NOS		U	2699	0.3366	$22.98	.	$4.60
C8900	MRA w/cont, abd		Q3	0284	6.4555	$440.70	$146.85	$88.14
C8901	MRA w/o cont, abd		Q3	0336	5.1052	$348.52	$137.34	$69.71
C8902	MRA w/o fol w/cont, abd		Q3	0337	7.9271	$541.16	$197.83	$108.24
C8903	MRI w/cont, breast, uni		Q3	0284	6.4555	$440.70	$146.85	$88.14
C8904	MRI w/o cont, breast, uni		Q3	0336	5.1052	$348.52	$137.34	$69.71
C8905	MRI w/o fol w/cont, brst, un		Q3	0337	7.9271	$541.16	$197.83	$108.24
C8906	MRI w/cont, breast, bi		Q3	0284	6.4555	$440.70	$146.85	$88.14
C8907	MRI w/o cont, breast, bi		Q3	0336	5.1052	$348.52	$137.34	$69.71
C8908	MRI w/o fol w/cont, breast,		Q3	0337	7.9271	$541.16	$197.83	$108.24
C8909	MRA w/cont, chest		Q3	0284	6.4555	$440.70	$146.85	$88.14
C8910	MRA w/o cont, chest		Q3	0336	5.1052	$348.52	$137.34	$69.71
C8911	MRA w/o fol w/cont, chest		Q3	0337	7.9271	$541.16	$197.83	$108.24
C8912	MRA w/cont, lwr ext		Q3	0284	6.4555	$440.70	$146.85	$88.14
C8913	MRA w/o cont, lwr ext		Q3	0336	5.1052	$348.52	$137.34	$69.71
C8914	MRA w/o fol w/cont, lwr ext		Q3	0337	7.9271	$541.16	$197.83	$108.24
C8918	MRA w/cont, pelvis		Q3	0284	6.4555	$440.70	$146.85	$88.14

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
C8919	MRA w/o cont, pelvis		Q3	0336	5.1052	$348.52	$137.34	$69.71
C8920	MRA w/o fol w/cont, pelvis		Q3	0337	7.9271	$541.16	$197.83	$108.24
C8921	TTE w or w/o fol w/cont, com		S	0128	7.1663	$489.22	$162.90	$97.85
C8922	TTE w or w/o fol w/cont, f/u		S	0128	7.1663	$489.22	$162.90	$97.85
C8923	2D TTE w or w/o fol w/con,co		S	0128	7.1663	$489.22	$162.90	$97.85
C8924	2D TTE w or w/o fol w/con,fu		S	0128	7.1663	$489.22	$162.90	$97.85
C8925	2D TEE w or w/o fol w/con,in		S	0128	7.1663	$489.22	$162.90	$97.85
C8926	TEE w or w/o fol w/cont,cong		S	0128	7.1663	$489.22	$162.90	$97.85
C8927	TEE w or w/o fol w/cont, mon		S	0128	7.1663	$489.22	$162.90	$97.85
C8928	TTE w or w/o fol w/con,stres		S	0128	7.1663	$489.22	$162.90	$97.85
C8929	TTE w or wo fol wcon,Doppler		S	0128	7.1663	$489.22	$162.90	$97.85
C8930	TTE w or w/o contr, cont ECG		S	0128	7.1663	$489.22	$162.90	$97.85
C8957	Prolonged IV inf, req pump		S	0440	2.9855	$203.81	.	$40.77
C9113	Inj pantoprazole sodium, via		N					
C9121	Injection, argatroban		K	9121		$18.39	.	$3.68
C9248	Inj, clevidipine butyrate	CH	K	9248		$2.98	.	$0.60
C9250	Artiss fibrin sealant		G	9250		$136.64	.	$27.33
C9254	Injection, lacosamide		K	9254		$0.18	.	$0.04
C9255	Paliperidone palmitate inj		G	9255		$6.54	.	$1.31
C9256	Dexamethasone intravitreal		G	9256		$196.10	.	$39.22
C9257	Bevacizumab injection		K	1281		$1.44	.	$0.29
C9258	Telavancin injection		G	9258		$0.21	.	$0.05
C9259	Pralatrexate injection		G	9259		$165.63	.	$33.13
C9260	Ofatumumab injection		G	9260		$46.64	.	$9.33
C9261	Ustekinumab injection		G	9261		$107.43	.	$21.49
C9262	Fludarabine phosphate, oral		G	9262		$81.77	.	$16.36
C9263	Ecallantide injection		G	9263		$280.90	.	$56.18
C9352	Neuragen nerve guide, per cm		N					
C9353	Neurawrap nerve protector,cm		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
C9354	Veritas collagen matrix, cm2		N					
C9355	Neuromatrix nerve cuff, cm		N					
C9356	TenoGlide tendon prot, cm2	CH	N					
C9358	SurgiMend, fetal	CH	K	9358		$10.67	.	$2.14
C9359	Implnt,bon void filler-putty	CH	N					
C9360	SurgiMend, neonatal		G	9360		$11.24	.	$2.25
C9361	NeuroMend nerve wrap		G	9361		$265.18		
C9362	Implnt,bon void filler-strip		G	9362		$50.88		
C9363	Integra Meshed Bil Wound Mat		G	9363		$17.88	.	$3.58
C9364	Porcine implant, Permacol		G	9364		$17.67		
C9399	Unclassified drugs or biolog		A					
C9716	Radiofrequency energy to anu		T	0150	32.6184	$2,226.76	.	$445.36
C9724	EPS gast cardia plic		T	0422	16.3107	$1,113.48	$271.47	$222.70
C9725	Place endorectal app		T	0148	6.2678	$427.88	.	$85.58
C9726	Rxt breast appl place/remov		T	0028	25.7651	$1,758.91	.	$351.79
C9727	Insert palate implants		T	0252	7.8743	$537.55	$109.16	$107.51
C9728	Place device/marker, non pro		X	0310	13.5651	$926.05	$325.27	$185.21
C9898	Inpnt stay radiolabeled item		N					
C9899	Inpt implant pros dev,no cov		A					
D0120	Periodic oral evaluation		E					
D0140	Limit oral eval problm focus		E					
D0145	Oral evaluation, pt < 3yrs		E					
D0150	Comprehensve oral evaluation		S	0330	9.9085	$676.42	.	$135.29
D0160	Extensv oral eval prob focus		E					
D0170	Re-eval,est pt,problem focus		E					
D0180	Comp periodontal evaluation		E					
D0210	Intraor complete film series		E					
D0220	Intraoral periapical first f		E					
D0230	Intraoral periapical ea add		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D0240	Intraoral occlusal film		S	0330	9.9085	$676.42	.	$135.29
D0250	Extraoral first film		S	0330	9.9085	$676.42	.	$135.29
D0260	Extraoral ea additional film		S	0330	9.9085	$676.42	.	$135.29
D0270	Dental bitewing single film		S	0330	9.9085	$676.42	.	$135.29
D0272	Dental bitewings two films		S	0330	9.9085	$676.42	.	$135.29
D0273	Bitewings - three films		E					
D0274	Dental bitewings four films		S	0330	9.9085	$676.42	.	$135.29
D0277	Vert bitewings-sev to eight		S	0330	9.9085	$676.42	.	$135.29
D0290	Dental film skull/facial bon		E					
D0310	Dental saliography		E					
D0320	Dental tmj arthrogram incl i		E					
D0321	Dental other tmj films		E					
D0322	Dental tomographic survey		E					
D0330	Dental panoramic film		E					
D0340	Dental cephalometric film		E					
D0350	Oral/facial photo images		E					
D0360	Cone beam ct		E					
D0362	Cone beam, two dimensional		E					
D0363	Cone beam, three dimensional		E					
D0415	Collection of microorganisms		E					
D0416	Viral culture		B					
D0417	Collect & prep saliva sample		E					
D0418	Analysis of saliva sample		E					
D0421	Gen tst suscept oral disease		B					
D0425	Caries susceptibility test		E					
D0431	Diag tst detect mucos abnorm		B					
D0460	Pulp vitality test		S	0330	9.9085	$676.42	.	$135.29
D0470	Diagnostic casts		E					
D0472	Gross exam, prep & report		B					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D0473	Micro exam, prep & report		B					
D0474	Micro w exam of surg margins		B					
D0475	Decalcification procedure		B					
D0476	Spec stains for microorganis		B					
D0477	Spec stains not for microorg		B					
D0478	Immunohistochemical stains		B					
D0479	Tissue in-situ hybridization		B					
D0480	Cytopath smear prep & report		B					
D0481	Electron microscopy diagnost		B					
D0482	Direct immunofluorescence		B					
D0483	Indirect immunofluorescence		B					
D0484	Consult slides prep elsewher		B					
D0485	Consult inc prep of slides		B					
D0486	Accession of brush biopsy		E					
D0502	Other oral pathology procedu		B					
D0999	Unspecified diagnostic proce		B					
D1110	Dental prophylaxis adult		E					
D1120	Dental prophylaxis child		E					
D1203	Topical app fluoride child		E					
D1204	Topical app fluoride adult		E					
D1206	Topical fluoride varnish		E					
D1310	Nutri counsel-control caries		E					
D1320	Tobacco counseling		E					
D1330	Oral hygiene instruction		E					
D1351	Dental sealant per tooth		E					
D1510	Space maintainer fxd unilat		S	0330	9.9085	$676.42	.	$135.29
D1515	Fixed bilat space maintainer		S	0330	9.9085	$676.42	.	$135.29
D1520	Remove unilat space maintain		S	0330	9.9085	$676.42	.	$135.29
D1525	Remove bilat space maintain		S	0330	9.9085	$676.42	.	$135.29

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D1550	Recement space maintainer		S	0330	9.9085	$676.42	.	$135.29
D1555	Remove fix space maintainer		E					
D2140	Amalgam one surface permanen		E					
D2150	Amalgam two surfaces permane		E					
D2160	Amalgam three surfaces perma		E					
D2161	Amalgam 4 or > surfaces perm		E					
D2330	Resin one surface-anterior		E					
D2331	Resin two surfaces-anterior		E					
D2332	Resin three surfaces-anterio		E					
D2335	Resin 4/> surf or w incis an		E					
D2390	Ant resin-based cmpst crown		E					
D2391	Post 1 srfc resinbased cmpst		E					
D2392	Post 2 srfc resinbased cmpst		E					
D2393	Post 3 srfc resinbased cmpst		E					
D2394	Post >=4srfc resinbase cmpst		E					
D2410	Dental gold foil one surface		E					
D2420	Dental gold foil two surface		E					
D2430	Dental gold foil three surfa		E					
D2510	Dental inlay metalic 1 surf		E					
D2520	Dental inlay metallic 2 surf		E					
D2530	Dental inlay metl 3/more sur		E					
D2542	Dental onlay metallic 2 surf		E					
D2543	Dental onlay metallic 3 surf		E					
D2544	Dental onlay metl 4/more sur		E					
D2610	Inlay porcelain/ceramic 1 su		E					
D2620	Inlay porcelain/ceramic 2 su		E					
D2630	Dental onlay porc 3/more sur		E					
D2642	Dental onlay porcelin 2 surf		E					
D2643	Dental onlay porcelin 3 surf		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D2644	Dental onlay porc 4/more sur		E					
D2650	Inlay composite/resin one su		E					
D2651	Inlay composite/resin two su		E					
D2652	Dental inlay resin 3/mre sur		E					
D2662	Dental onlay resin 2 surface		E					
D2663	Dental onlay resin 3 surface		E					
D2664	Dental onlay resin 4/mre sur		E					
D2710	Crown resin-based indirect		E					
D2712	Crown 3/4 resin-based compos		E					
D2720	Crown resin w/ high noble me		E					
D2721	Crown resin w/ base metal		E					
D2722	Crown resin w/ noble metal		E					
D2740	Crown porcelain/ceramic subs		E					
D2750	Crown porcelain w/ h noble m		E					
D2751	Crown porcelain fused base m		E					
D2752	Crown porcelain w/ noble met		E					
D2780	Crown 3/4 cast hi noble met		E					
D2781	Crown 3/4 cast base metal		E					
D2782	Crown 3/4 cast noble metal		E					
D2783	Crown 3/4 porcelain/ceramic		E					
D2790	Crown full cast high noble m		E					
D2791	Crown full cast base metal		E					
D2792	Crown full cast noble metal		E					
D2794	Crown-titanium		E					
D2799	Provisional crown		E					
D2910	Recement inlay onlay or part		E					
D2915	Recement cast or prefab post		E					
D2920	Dental recement crown		E					
D2930	Prefab stnlss steel crwn pri		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D2931	Prefab stnlss steel crown pe		E					
D2932	Prefabricated resin crown		E					
D2933	Prefab stainless steel crown		E					
D2934	Prefab steel crown primary		E					
D2940	Dental sedative filling		E					
D2950	Core build-up incl any pins		E					
D2951	Tooth pin retention		E					
D2952	Post and core cast + crown		E					
D2953	Each addtnl cast post		E					
D2954	Prefab post/core + crown		E					
D2955	Post removal		E					
D2957	Each addtnl prefab post		E					
D2960	Laminate labial veneer		E					
D2961	Lab labial veneer resin		E					
D2962	Lab labial veneer porcelain		E					
D2970	Temp crown (fractured tooth)		E					
D2971	Add proc construct new crown		E					
D2975	Coping		E					
D2980	Crown repair		E					
D2999	Dental unspec restorative pr		S	0330	9.9085	$676.42	.	$135.29
D3110	Pulp cap direct		E					
D3120	Pulp cap indirect		E					
D3220	Therapeutic pulpotomy		E					
D3221	Gross pulpal debridement		E					
D3222	Part pulp for apexogenesis		E					
D3230	Pulpal therapy anterior prim		E					
D3240	Pulpal therapy posterior pri		E					
D3310	End thxpy, anterior tooth		E					
D3320	End thxpy, bicuspid tooth		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D3330	End thxpy, molar		E					
D3331	Non-surg tx root canal obs		E					
D3332	Incomplete endodontic tx		E					
D3333	Internal root repair		E					
D3346	Retreat root canal anterior		E					
D3347	Retreat root canal bicuspid		E					
D3348	Retreat root canal molar		E					
D3351	Apexification/recalc initial		E					
D3352	Apexification/recalc interim		E					
D3353	Apexification/recalc final		E					
D3410	Apicoect/perirad surg anter		E					
D3421	Root surgery bicuspid		E					
D3425	Root surgery molar		E					
D3426	Root surgery ea add root		E					
D3430	Retrograde filling		E					
D3450	Root amputation		E					
D3460	Endodontic endosseous implan		S	0330	9.9085	$676.42	.	$135.29
D3470	Intentional replantation		E					
D3910	Isolation- tooth w rubb dam		E					
D3920	Tooth splitting		E					
D3950	Canal prep/fitting of dowel		E					
D3999	Endodontic procedure		S	0330	9.9085	$676.42	.	$135.29
D4210	Gingivectomy/plasty per quad		E					
D4211	Gingivectomy/plasty per toot		E					
D4230	Ana crown exp 4 or> per quad		E					
D4231	Ana crown exp 1-3 per quad		E					
D4240	Gingival flap proc w/ planin		E					
D4241	Gngvl flap w rootplan 1-3 th		E					
D4245	Apically positioned flap		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D4249	Crown lengthen hard tissue		E					
D4260	Osseous surgery per quadrant		S	0330	9.9085	$676.42	.	$135.29
D4261	Osseous surgl-3teethperquad		E					
D4263	Bone replce graft first site		S	0330	9.9085	$676.42	.	$135.29
D4264	Bone replce graft each add		S	0330	9.9085	$676.42	.	$135.29
D4265	Bio mtrls to aid soft/os reg		E					
D4266	Guided tiss regen resorble		E					
D4267	Guided tiss regen nonresorb		E					
D4268	Surgical revision procedure		S	0330	9.9085	$676.42	.	$135.29
D4270	Pedicle soft tissue graft pr		S	0330	9.9085	$676.42	.	$135.29
D4271	Free soft tissue graft proc		S	0330	9.9085	$676.42	.	$135.29
D4273	Subepithelial tissue graft		S	0330	9.9085	$676.42	.	$135.29
D4274	Distal/proximal wedge proc		E					
D4275	Soft tissue allograft		E					
D4276	Con tissue w dble ped graft		E					
D4320	Provision splnt intracoronal		E					
D4321	Provisional splint extracoro		E					
D4341	Periodontal scaling & root		E					
D4342	Periodontal scaling 1-3teeth		E					
D4355	Full mouth debridement		S	0330	9.9085	$676.42	.	$135.29
D4381	Localized delivery antimicro		S	0330	9.9085	$676.42	.	$135.29
D4910	Periodontal maint procedures		E					
D4920	Unscheduled dressing change		E					
D4999	Unspecified periodontal proc		E					
D5110	Dentures complete maxillary		E					
D5120	Dentures complete mandible		E					
D5130	Dentures immediat maxillary		E					
D5140	Dentures immediat mandible		E					
D5211	Dentures maxill part resin		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D5212	Dentures mand part resin		E					
D5213	Dentures maxill part metal		E					
D5214	Dentures mandibl part metal		E					
D5225	Maxillary part denture flex		E					
D5226	Mandibular part denture flex		E					
D5281	Removable partial denture		E					
D5410	Dentures adjust cmplt maxil		E					
D5411	Dentures adjust cmplt mand		E					
D5421	Dentures adjust part maxill		E					
D5422	Dentures adjust part mandbl		E					
D5510	Dentur repr broken compl bas		E					
D5520	Replace denture teeth complt		E					
D5610	Dentures repair resin base		E					
D5620	Rep part denture cast frame		E					
D5630	Rep partial denture clasp		E					
D5640	Replace part denture teeth		E					
D5650	Add tooth to partial denture		E					
D5660	Add clasp to partial denture		E					
D5670	Replc tth&acrlc on mtl frmwk		E					
D5671	Replc tth&acrlc mandibular		E					
D5710	Dentures rebase cmplt maxil		E					
D5711	Dentures rebase cmplt mand		E					
D5720	Dentures rebase part maxill		E					
D5721	Dentures rebase part mandbl		E					
D5730	Denture reln cmplt maxil ch		E					
D5731	Denture reln cmplt mand chr		E					
D5740	Denture reln part maxil chr		E					
D5741	Denture reln part mand chr		E					
D5750	Denture reln cmplt max lab		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D5751	Denture reln cmplt mand lab		E					
D5760	Denture reln part maxil lab		E					
D5761	Denture reln part mand lab		E					
D5810	Denture interm cmplt maxill		E					
D5811	Denture interm cmplt mandbl		E					
D5820	Denture interm part maxill		E					
D5821	Denture interm part mandbl		E					
D5850	Denture tiss conditn maxill		E					
D5851	Denture tiss condtin mandbl		E					
D5860	Overdenture complete		E					
D5861	Overdenture partial		E					
D5862	Precision attachment		E					
D5867	Replacement of precision att		E					
D5875	Prosthesis modification		E					
D5899	Removable prosthodontic proc		E					
D5911	Facial moulage sectional		S	0330	9.9085	$676.42	.	$135.29
D5912	Facial moulage complete		S	0330	9.9085	$676.42	.	$135.29
D5913	Nasal prosthesis		E					
D5914	Auricular prosthesis		E					
D5915	Orbital prosthesis		E					
D5916	Ocular prosthesis		E					
D5919	Facial prosthesis		E					
D5922	Nasal septal prosthesis		E					
D5923	Ocular prosthesis interim		E					
D5924	Cranial prosthesis		E					
D5925	Facial augmentation implant		E					
D5926	Replacement nasal prosthesis		E					
D5927	Auricular replacement		E					
D5928	Orbital replacement		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D5929	Facial replacement		E					
D5931	Surgical obturator		E					
D5932	Postsurgical obturator		E					
D5933	Refitting of obturator		E					
D5934	Mandibular flange prosthesis		E					
D5935	Mandibular denture prosth		E					
D5936	Temp obturator prosthesis		E					
D5937	Trismus appliance		E					
D5951	Feeding aid		E					
D5952	Pediatric speech aid		E					
D5953	Adult speech aid		E					
D5954	Superimposed prosthesis		E					
D5955	Palatal lift prosthesis		E					
D5958	Intraoral con def inter plt		E					
D5959	Intraoral con def mod palat		E					
D5960	Modify speech aid prosthesis		E					
D5982	Surgical stent		E					
D5983	Radiation applicator		S	0330	9.9085	$676.42	.	$135.29
D5984	Radiation shield		S	0330	9.9085	$676.42	.	$135.29
D5985	Radiation cone locator		S	0330	9.9085	$676.42	.	$135.29
D5986	Fluoride applicator		E					
D5987	Commissure splint		S	0330	9.9085	$676.42	.	$135.29
D5988	Surgical splint		E					
D5991	Topical medicament carrier		E					
D5999	Maxillofacial prosthesis		E					
D6010	Odontics endosteal implant		E					
D6012	Endosteal implant		E					
D6040	Odontics eposteal implant		E					
D6050	Odontics transosteal implnt		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D6053	Implnt/abtmnt spprt remv dnt		E					
D6054	Implnt/abtmnt spprt remvprtl		E					
D6055	Implant connecting bar		E					
D6056	Prefabricated abutment		E					
D6057	Custom abutment		E					
D6058	Abutment supported crown		E					
D6059	Abutment supported mtl crown		E					
D6060	Abutment supported mtl crown		E					
D6061	Abutment supported mtl crown		E					
D6062	Abutment supported mtl crown		E					
D6063	Abutment supported mtl crown		E					
D6064	Abutment supported mtl crown		E					
D6065	Implant supported crown		E					
D6066	Implant supported mtl crown		E					
D6067	Implant supported mtl crown		E					
D6068	Abutment supported retainer		E					
D6069	Abutment supported retainer		E					
D6070	Abutment supported retainer		E					
D6071	Abutment supported retainer		E					
D6072	Abutment supported retainer		E					
D6073	Abutment supported retainer		E					
D6074	Abutment supported retainer		E					
D6075	Implant supported retainer		E					
D6076	Implant supported retainer		E					
D6077	Implant supported retainer		E					
D6078	Implnt/abut suprtd fixd dent		E					
D6079	Implnt/abut suprtd fixd dent		E					
D6080	Implant maintenance		E					
D6090	Repair implant		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D6091	Repl semi/precision attach		E					
D6092	Recement supp crown		E					
D6093	Recement supp part denture		E					
D6094	Abut support crown titanium		E					
D6095	Odontics repr abutment		E					
D6100	Removal of implant		E					
D6190	Radio/surgical implant index		E					
D6194	Abut support retainer titani		E					
D6199	Implant procedure		E					
D6205	Pontic-indirect resin based		E					
D6210	Prosthodont high noble metal		E					
D6211	Bridge base metal cast		E					
D6212	Bridge noble metal cast		E					
D6214	Pontic titanium		E					
D6240	Bridge porcelain high noble		E					
D6241	Bridge porcelain base metal		E					
D6242	Bridge porcelain nobel metal		E					
D6245	Bridge porcelain/ceramic		E					
D6250	Bridge resin w/high noble		E					
D6251	Bridge resin base metal		E					
D6252	Bridge resin w/noble metal		E					
D6253	Provisional pontic		E					
D6545	Dental retainr cast metl		E					
D6548	Porcelain/ceramic retainer		E					
D6600	Porcelain/ceramic inlay 2srf		E					
D6601	Porc/ceram inlay >= 3 surfac		E					
D6602	Cst hgh nble mtl inlay 2 srf		E					
D6603	Cst hgh nble mtl inlay >=3sr		E					
D6604	Cst bse mtl inlay 2 surfaces		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D6605	Cst bse mtl inlay >= 3 surfa		E					
D6606	Cast noble metal inlay 2 sur		E					
D6607	Cst noble mtl inlay >=3 surf		E					
D6608	Onlay porc/crmc 2 surfaces		E					
D6609	Onlay porc/crmc >=3 surfaces		E					
D6610	Onlay cst hgh nbl mtl 2 srfc		E					
D6611	Onlay cst hgh nbl mtl >=3srf		E					
D6612	Onlay cst base mtl 2 surface		E					
D6613	Onlay cst base mtl >=3 surfa		E					
D6614	Onlay cst nbl mtl 2 surfaces		E					
D6615	Onlay cst nbl mtl >=3 surfac		E					
D6624	Inlay titanium		E					
D6634	Onlay titanium		E					
D6710	Crown-indirect resin based		E					
D6720	Retain crown resin w hi nble		E					
D6721	Crown resin w/base metal		E					
D6722	Crown resin w/noble metal		E					
D6740	Crown porcelain/ceramic		E					
D6750	Crown porcelain high noble		E					
D6751	Crown porcelain base metal		E					
D6752	Crown porcelain noble metal		E					
D6780	Crown 3/4 high noble metal		E					
D6781	Crown 3/4 cast based metal		E					
D6782	Crown 3/4 cast noble metal		E					
D6783	Crown 3/4 porcelain/ceramic		E					
D6790	Crown full high noble metal		E					
D6791	Crown full base metal cast		E					
D6792	Crown full noble metal cast		E					
D6793	Provisional retainer crown		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D6794	Crown titanium		E					
D6920	Dental connector bar		S	0330	9.9085	$676.42	.	$135.29
D6930	Dental recement bridge		E					
D6940	Stress breaker		E					
D6950	Precision attachment		E					
D6970	Post & core plus retainer		E					
D6972	Prefab post & core plus reta		E					
D6973	Core build up for retainer		E					
D6975	Coping metal		E					
D6976	Each addtnl cast post		E					
D6977	Each addtl prefab post		E					
D6980	Bridge repair		E					
D6985	Pediatric partial denture fx		E					
D6999	Fixed prosthodontic proc		E					
D7111	Extraction coronal remnants		S	0330	9.9085	$676.42	.	$135.29
D7140	Extraction erupted tooth/exr		S	0330	9.9085	$676.42	.	$135.29
D7210	Rem imp tooth w mucoper flp		S	0330	9.9085	$676.42	.	$135.29
D7220	Impact tooth remov soft tiss		S	0330	9.9085	$676.42	.	$135.29
D7230	Impact tooth remov part bony		S	0330	9.9085	$676.42	.	$135.29
D7240	Impact tooth remov comp bony		S	0330	9.9085	$676.42	.	$135.29
D7241	Impact tooth rem bony w/comp		S	0330	9.9085	$676.42	.	$135.29
D7250	Tooth root removal		S	0330	9.9085	$676.42	.	$135.29
D7260	Oral antral fistula closure		S	0330	9.9085	$676.42	.	$135.29
D7261	Primary closure sinus perf		S	0330	9.9085	$676.42	.	$135.29
D7270	Tooth reimplantation		E					
D7272	Tooth transplantation		E					
D7280	Exposure impact tooth orthod		E					
D7282	Mobilize erupted/malpos toot		E					
D7283	Place device impacted tooth		B					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D7285	Biopsy of oral tissue hard		E					
D7286	Biopsy of oral tissue soft		E					
D7287	Exfoliative cytolog collect		E					
D7288	Brush biopsy		B					
D7290	Repositioning of teeth		E					
D7291	Transseptal fiberotomy		S	0330	9.9085	$676.42	.	$135.29
D7292	Screw retained plate		E					
D7293	Temp anchorage dev w flap		E					
D7294	Temp anchorage dev w/o flap		E					
D7310	Alveoplasty w/ extraction		E					
D7311	Alveoloplasty w/extract 1-3		E					
D7320	Alveoplasty w/o extraction		E					
D7321	Alveoloplasty not w/extracts		B					
D7340	Vestibuloplasty ridge extens		E					
D7350	Vestibuloplasty exten graft		E					
D7410	Rad exc lesion up to 1.25 cm		E					
D7411	Excision benign lesion>1.25c		E					
D7412	Excision benign lesion compl		E					
D7413	Excision malig lesion<=1.25c		E					
D7414	Excision malig lesion>1.25cm		E					
D7415	Excision malig les complicat		E					
D7440	Malig tumor exc to 1.25 cm		E					
D7441	Malig tumor > 1.25 cm		E					
D7450	Rem odontogen cyst to 1.25cm		E					
D7451	Rem odontogen cyst > 1.25 cm		E					
D7460	Rem nonodonto cyst to 1.25cm		E					
D7461	Rem nonodonto cyst > 1.25 cm		E					
D7465	Lesion destruction		E					
D7471	Rem exostosis any site		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D7472	Removal of torus palatinus		E					
D7473	Remove torus mandibularis		E					
D7485	Surg reduct osseoustuberosit		E					
D7490	Maxilla or mandible resectio		E					
D7510	I&d absc intraoral soft tiss		E					
D7511	Incision/drain abscess intra		B					
D7520	I&d abscess extraoral		E					
D7521	Incision/drain abscess extra		B					
D7530	Removal fb skin/areolar tiss		E					
D7540	Removal of fb reaction		E					
D7550	Removal of sloughed off bone		E					
D7560	Maxillary sinusotomy		E					
D7610	Maxilla open reduct simple		E					
D7620	Clsd reduct simpl maxilla fx		E					
D7630	Open red simpl mandible fx		E					
D7640	Clsd red simpl mandible fx		E					
D7650	Open red simp malar/zygom fx		E					
D7660	Clsd red simp malar/zygom fx		E					
D7670	Closd rductn splint alveolus		E					
D7671	Alveolus open reduction		E					
D7680	Reduct simple facial bone fx		E					
D7710	Maxilla open reduct compound		E					
D7720	Clsd reduct compd maxilla fx		E					
D7730	Open reduct compd mandble fx		E					
D7740	Clsd reduct compd mandble fx		E					
D7750	Open red comp malar/zygma fx		E					
D7760	Clsd red comp malar/zygma fx		E					
D7770	Open reduc compd alveolus fx		E					
D7771	Alveolus clsd reduc stblz te		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D7780	Reduct compnd facial bone fx		E					
D7810	Tmj open reduct-dislocation		E					
D7820	Closed tmp manipulation		E					
D7830	Tmj manipulation under anest		E					
D7840	Removal of tmj condyle		E					
D7850	Tmj meniscectomy		E					
D7852	Tmj repair of joint disc		E					
D7854	Tmj excisn of joint membrane		E					
D7856	Tmj cutting of a muscle		E					
D7858	Tmj reconstruction		E					
D7860	Tmj cutting into joint		E					
D7865	Tmj reshaping components		E					
D7870	Tmj aspiration joint fluid		E					
D7871	Lysis + lavage w catheters		E					
D7872	Tmj diagnostic arthroscopy		E					
D7873	Tmj arthroscopy lysis adhesn		E					
D7874	Tmj arthroscopy disc reposit		E					
D7875	Tmj arthroscopy synovectomy		E					
D7876	Tmj arthroscopy discectomy		E					
D7877	Tmj arthroscopy debridement		E					
D7880	Occlusal orthotic appliance		E					
D7899	Tmj unspecified therapy		E					
D7910	Dent sutur recent wnd to 5cm		E					
D7911	Dental suture wound to 5 cm		E					
D7912	Suture complicate wnd > 5 cm		E					
D7920	Dental skin graft		E					
D7940	Reshaping bone orthognathic		S	0330	9.9085	$676.42	.	$135.29
D7941	Bone cutting ramus closed		E					
D7943	Cutting ramus open w/graft		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D7944	Bone cutting segmented		E					
D7945	Bone cutting body mandible		E					
D7946	Reconstruction maxilla total		E					
D7947	Reconstruct maxilla segment		E					
D7948	Reconstruct midface no graft		E					
D7949	Reconstruct midface w/graft		E					
D7950	Mandible graft		E					
D7951	Sinus aug w bone/bone sup		E					
D7953	Bone replacement graft		E					
D7955	Repair maxillofacial defects		E					
D7960	Frenulectomy/frenulotomy		E					
D7963	Frenuloplasty		E					
D7970	Excision hyperplastic tissue		E					
D7971	Excision pericoronal gingiva		E					
D7972	Surg redct fibrous tuberosit		E					
D7980	Sialolithotomy		E					
D7981	Excision of salivary gland		E					
D7982	Sialodochoplasty		E					
D7983	Closure of salivary fistula		E					
D7990	Emergency tracheotomy		E					
D7991	Dental coronoidectomy		E					
D7995	Synthetic graft facial bones		E					
D7996	Implant mandible for augment		E					
D7997	Appliance removal		E					
D7998	Intraoral place of fix dev		E					
D7999	Oral surgery procedure		E					
D8010	Limited dental tx primary		E					
D8020	Limited dental tx transition		E					
D8030	Limited dental tx adolescent		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D8040	Limited dental tx adult		E					
D8050	Intercep dental tx primary		E					
D8060	Intercep dental tx transitn		E					
D8070	Compre dental tx transition		E					
D8080	Compre dental tx adolescent		E					
D8090	Compre dental tx adult		E					
D8210	Orthodontic rem appliance tx		E					
D8220	Fixed appliance therapy habt		E					
D8660	Preorthodontic tx visit		E					
D8670	Periodic orthodontc tx visit		E					
D8680	Orthodontic retention		E					
D8690	Orthodontic treatment		E					
D8691	Repair ortho appliance		E					
D8692	Replacement retainer		E					
D8693	Rebond/cement/repair retain		E					
D8999	Orthodontic procedure		E					
D9110	Tx dental pain minor proc		N					
D9120	Fix partial denture section		E					
D9210	Dent anesthesia w/o surgery		E					
D9211	Regional block anesthesia		E					
D9212	Trigeminal block anesthesia		E					
D9215	Local anesthesia		E					
D9220	General anesthesia		E					
D9221	General anesthesia ea ad 15m		E					
D9230	Analgesia		N					
D9241	Intravenous sedation		E					
D9242	IV sedation ea ad 30 m		E					
D9248	Sedation (non-iv)		N					
D9310	Dental consultation		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
D9410	Dental house call		E					
D9420	Hospital call		E					
D9430	Office visit during hours		E					
D9440	Office visit after hours		E					
D9450	Case presentation tx plan		E					
D9610	Dent therapeutic drug inject		E					
D9612	Thera par drugs 2 or > admin		E					
D9630	Other drugs/medicaments		S	0330	9.9085	$676.42	.	$135.29
D9910	Dent appl desensitizing med		E					
D9911	Appl desensitizing resin		E					
D9920	Behavior management		E					
D9930	Treatment of complications		S	0330	9.9085	$676.42	.	$135.29
D9940	Dental occlusal guard		S	0330	9.9085	$676.42	.	$135.29
D9941	Fabrication athletic guard		E					
D9942	Repair/reline occlusal guard		E					
D9950	Occlusion analysis		S	0330	9.9085	$676.42	.	$135.29
D9951	Limited occlusal adjustment		S	0330	9.9085	$676.42	.	$135.29
D9952	Complete occlusal adjustment		S	0330	9.9085	$676.42	.	$135.29
D9970	Enamel microabrasion		E					
D9971	Odontoplasty 1-2 teeth		E					
D9972	Extrnl bleaching per arch		E					
D9973	Extrnl bleaching per tooth		E					
D9974	Intrnl bleaching per tooth		E					
D9999	Adjunctive procedure		E					
E0100	Cane adjust/fixed with tip		Y					
E0105	Cane adjust/fixed quad/3 pro		Y					
E0110	Crutch forearm pair		Y					
E0111	Crutch forearm each		Y					
E0112	Crutch underarm pair wood		Y					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E0113	Crutch underarm each wood		Y					
E0114	Crutch underarm pair no wood		Y					
E0116	Crutch underarm each no wood		Y					
E0117	Underarm springassist crutch		Y					
E0118	Crutch substitute		E					
E0130	Walker rigid adjust/fixed ht		Y					
E0135	Walker folding adjust/fixed		Y					
E0140	Walker w trunk support		Y					
E0141	Rigid wheeled walker adj/fix		Y					
E0143	Walker folding wheeled w/o s		Y					
E0144	Enclosed walker w rear seat		Y					
E0147	Walker variable wheel resist		Y					
E0148	Heavyduty walker no wheels		Y					
E0149	Heavy duty wheeled walker		Y					
E0153	Forearm crutch platform atta		Y					
E0154	Walker platform attachment		Y					
E0155	Walker wheel attachment,pair		Y					
E0156	Walker seat attachment		Y					
E0157	Walker crutch attachment		Y					
E0158	Walker leg extenders set of4		Y					
E0159	Brake for wheeled walker		Y					
E0160	Sitz type bath or equipment		Y					
E0161	Sitz bath/equipment w/faucet		Y					
E0162	Sitz bath chair		Y					
E0163	Commode chair with fixed arm		Y					
E0165	Commode chair with detacharm		Y					
E0167	Commode chair pail or pan		Y					
E0168	Heavyduty/wide commode chair		Y					
E0170	Commode chair electric		Y					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E0171	Commode chair non-electric		Y					
E0172	Seat lift mechanism toilet		E					
E0175	Commode chair foot rest		Y					
E0181	Press pad alternating w/ pum		Y					
E0182	Replace pump, alt press pad		Y					
E0184	Dry pressure mattress		Y					
E0185	Gel pressure mattress pad		Y					
E0186	Air pressure mattress		Y					
E0187	Water pressure mattress		Y					
E0188	Synthetic sheepskin pad		Y					
E0189	Lambswool sheepskin pad		Y					
E0190	Positioning cushion		E					
E0191	Protector heel or elbow		Y					
E0193	Powered air flotation bed		Y					
E0194	Air fluidized bed		Y					
E0196	Gel pressure mattress		Y					
E0197	Air pressure pad for mattres		Y					
E0198	Water pressure pad for mattr		Y					
E0199	Dry pressure pad for mattres		Y					
E0200	Heat lamp without stand		Y					
E0202	Phototherapy light w/ photom		Y					
E0203	Therapeutic lightbox tabletp		E					
E0205	Heat lamp with stand		Y					
E0210	Electric heat pad standard		Y					
E0215	Electric heat pad moist		Y					
E0217	Water circ heat pad w pump		Y					
E0218	Water circ cold pad w pump		Y					
E0220	Hot water bottle		Y					
E0221	Infrared heating pad system		Y					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E0225	Hydrocollator unit		Y					
E0230	Ice cap or collar		Y					
E0231	Wound warming device		E					
E0232	Warming card for NWT		E					
E0235	Paraffin bath unit portable		Y					
E0236	Pump for water circulating p		Y					
E0238	Heat pad non-electric moist		Y					
E0239	Hydrocollator unit portable		Y					
E0240	Bath/shower chair		E					
E0241	Bath tub wall rail		E					
E0242	Bath tub rail floor		E					
E0243	Toilet rail		E					
E0244	Toilet seat raised		E					
E0245	Tub stool or bench		E					
E0246	Transfer tub rail attachment		E					
E0247	Trans bench w/wo comm open		E					
E0248	HDtrans bench w/wo comm open		E					
E0249	Pad water circulating heat u		Y					
E0250	Hosp bed fixed ht w/ mattres		Y					
E0251	Hosp bed fixd ht w/o mattres		Y					
E0255	Hospital bed var ht w/ mattr		Y					
E0256	Hospital bed var ht w/o matt		Y					
E0260	Hosp bed semi-electr w/ matt		Y					
E0261	Hosp bed semi-electr w/o mat		Y					
E0265	Hosp bed total electr w/ mat		Y					
E0266	Hosp bed total elec w/o matt		Y					
E0270	Hospital bed institutional t		E					
E0271	Mattress innerspring		Y					
E0272	Mattress foam rubber		Y					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E0273	Bed board		E					
E0274	Over-bed table		E					
E0275	Bed pan standard		Y					
E0276	Bed pan fracture		Y					
E0277	Powered pres-redu air mattrs		Y					
E0280	Bed cradle		Y					
E0290	Hosp bed fx ht w/o rails w/m		Y					
E0291	Hosp bed fx ht w/o rail w/o		Y					
E0292	Hosp bed var ht w/o rail w/o		Y					
E0293	Hosp bed var ht w/o rail w/		Y					
E0294	Hosp bed semi-elect w/ mattr		Y					
E0295	Hosp bed semi-elect w/o matt		Y					
E0296	Hosp bed total elect w/ matt		Y					
E0297	Hosp bed total elect w/o mat		Y					
E0300	Enclosed ped crib hosp grade		Y					
E0301	HD hosp bed, 350-600 lbs		Y					
E0302	Ex hd hosp bed > 600 lbs		Y					
E0303	Hosp bed hvy dty xtra wide		Y					
E0304	Hosp bed xtra hvy dty x wide		Y					
E0305	Rails bed side half length		Y					
E0310	Rails bed side full length		Y					
E0315	Bed accessory brd/tbl/supprt		E					
E0316	Bed safety enclosure		Y					
E0325	Urinal male jug-type		Y					
E0326	Urinal female jug-type		Y					
E0328	Ped hospital bed, manual		Y					
E0329	Ped hospital bed semi/elect		Y					
E0350	Control unit bowel system		E					
E0352	Disposable pack w/bowel syst		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E0370	Air elevator for heel		E					
E0371	Nonpower mattress overlay		Y					
E0372	Powered air mattress overlay		Y					
E0373	Nonpowered pressure mattress		Y					
E0424	Stationary compressed gas 02		Y					
E0425	Gas system stationary compre		E					
E0430	Oxygen system gas portable		E					
E0431	Portable gaseous 02		Y					
E0433	Portable liquid oxygen sys		Y					
E0434	Portable liquid 02		Y					
E0435	Oxygen system liquid portabl		E					
E0439	Stationary liquid 02		Y					
E0440	Oxygen system liquid station		E					
E0441	Stationary O2 contents, gas		Y					
E0442	Stationary O2 contents, liq		Y					
E0443	Portable 02 contents, gas		Y					
E0444	Portable 02 contents, liquid		Y					
E0445	Oximeter non-invasive		N					
E0450	Vol control vent invasiv int		Y					
E0455	Oxygen tent excl croup/ped t		Y					
E0457	Chest shell		Y					
E0459	Chest wrap		Y					
E0460	Neg press vent portabl/statn		Y					
E0461	Vol control vent noninv int		Y					
E0462	Rocking bed w/ or w/o side r		Y					
E0463	Press supp vent invasive int		Y					
E0464	Press supp vent noninv int		Y					
E0470	RAD w/o backup non-inv intfc		Y					
E0471	RAD w/backup non inv intrfc		Y					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E0472	RAD w backup invasive intrfc		Y					
E0480	Percussor elect/pneum home m		Y					
E0481	Intrpulmnry percuss vent sys		E					
E0482	Cough stimulating device		Y					
E0483	Chest compression gen system		Y					
E0484	Non-elec oscillatory pep dvc		Y					
E0485	Oral device/appliance prefab		Y					
E0486	Oral device/appliance cusfab		Y					
E0487	Electronic spirometer		N					
E0500	Ippb all types		Y					
E0550	Humidif extens supple w ippb		Y					
E0555	Humidifier for use w/ regula		Y					
E0560	Humidifier supplemental w/ i		Y					
E0561	Humidifier nonheated w PAP		Y					
E0562	Humidifier heated used w PAP		Y					
E0565	Compressor air power source		Y					
E0570	Nebulizer with compression		Y					
E0571	Aerosol compressor for svneb		Y					
E0572	Aerosol compressor adjust pr		Y					
E0574	Ultrasonic generator w svneb		Y					
E0575	Nebulizer ultrasonic		Y					
E0580	Nebulizer for use w/ regulat		Y					
E0585	Nebulizer w/ compressor & he		Y					
E0600	Suction pump portab hom modl		Y					
E0601	Cont airway pressure device		Y					
E0602	Manual breast pump		Y					
E0603	Electric breast pump		N					
E0604	Hosp grade elec breast pump		A					
E0605	Vaporizer room type		Y					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E0606	Drainage board postural		Y					
E0607	Blood glucose monitor home		Y					
E0610	Pacemaker monitr audible/vis		Y					
E0615	Pacemaker monitr digital/vis		Y					
E0616	Cardiac event recorder		N					
E0617	Automatic ext defibrillator		Y					
E0618	Apnea monitor		Y					
E0619	Apnea monitor w recorder		Y					
E0620	Cap bld skin piercing laser		Y					
E0621	Patient lift sling or seat		Y					
E0625	Patient lift bathroom or toi		E					
E0627	Seat lift incorp lift-chair		Y					
E0628	Seat lift for pt furn-electr		Y					
E0629	Seat lift for pt furn-non-el		Y					
E0630	Patient lift hydraulic		Y					
E0635	Patient lift electric		Y					
E0636	PT support & positioning sys		Y					
E0637	Combination sit to stand sys		E					
E0638	Standing frame sys		E					
E0639	Moveable patient lift system		E					
E0640	Fixed patient lift system		E					
E0641	Multi-position stnd fram sys		E					
E0642	Dynamic standing frame		E					
E0650	Pneuma compresor non-segment		Y					
E0651	Pneum compressor segmental		Y					
E0652	Pneum compres w/cal pressure		Y					
E0655	Pneumatic appliance half arm		Y					
E0656	Segmental pneumatic trunk		Y					
E0657	Segmental pneumatic chest		Y					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E0660	Pneumatic appliance full leg		Y					
E0665	Pneumatic appliance full arm		Y					
E0666	Pneumatic appliance half leg		Y					
E0667	Seg pneumatic appl full leg		Y					
E0668	Seg pneumatic appl full arm		Y					
E0669	Seg pneumatic appli half leg		Y					
E0671	Pressure pneum appl full leg		Y					
E0672	Pressure pneum appl full arm		Y					
E0673	Pressure pneum appl half leg		Y					
E0675	Pneumatic compression device		Y					
E0676	Inter limb compress dev NOS		Y					
E0691	Uvl pnl 2 sq ft or less		Y					
E0692	Uvl sys panel 4 ft		Y					
E0693	Uvl sys panel 6 ft		Y					
E0694	Uvl md cabinet sys 6 ft		Y					
E0700	Safety equipment		E					
E0705	Transfer device		B					
E0710	Restraints any type		E					
E0720	Tens two lead		Y					
E0730	Tens four lead		Y					
E0731	Conductive garment for tens/		Y					
E0740	Incontinence treatment systm		Y					
E0744	Neuromuscular stim for scoli		Y					
E0745	Neuromuscular stim for shock		Y					
E0746	Electromyograph biofeedback		N					
E0747	Elec osteogen stim not spine		Y					
E0748	Elec osteogen stim spinal		Y					
E0749	Elec osteogen stim implanted		N					
E0755	Electronic salivary reflex s		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E0760	Osteogen ultrasound stimltor		Y					
E0761	Nontherm electromgntc device		E					
E0762	Trans elec jt stim dev sys		B					
E0764	Functional neuromuscularstim		Y					
E0765	Nerve stimulator for tx n&v		Y					
E0769	Electric wound treatment dev		B					
E0770	Functional electric stim NOS		Y					
E0776	Iv pole		Y					
E0779	Amb infusion pump mechanical		Y					
E0780	Mech amb infusion pump <8hrs		Y					
E0781	External ambulatory infus pu		Y					
E0782	Non-programble infusion pump		N					
E0783	Programmable infusion pump		N					
E0784	Ext amb infusn pump insulin		Y					
E0785	Replacement impl pump cathet		N					
E0786	Implantable pump replacement		N					
E0791	Parenteral infusion pump sta		Y					
E0830	Ambulatory traction device		N					
E0840	Tract frame attach headboard		Y					
E0849	Cervical pneum trac equip		Y					
E0850	Traction stand free standing		Y					
E0855	Cervical traction equipment		Y					
E0856	Cervic collar w air bladder		Y					
E0860	Tract equip cervical tract		Y					
E0870	Tract frame attach footboard		Y					
E0880	Trac stand free stand extrem		Y					
E0890	Traction frame attach pelvic		Y					
E0900	Trac stand free stand pelvic		Y					
E0910	Trapeze bar attached to bed		Y					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E0911	HD trapeze bar attach to bed		Y					
E0912	HD trapeze bar free standing		Y					
E0920	Fracture frame attached to b		Y					
E0930	Fracture frame free standing		Y					
E0935	Cont pas motion exercise dev		Y					
E0936	CPM device, other than knee		E					
E0940	Trapeze bar free standing		Y					
E0941	Gravity assisted traction de		Y					
E0942	Cervical head harness/halter		Y					
E0944	Pelvic belt/harness/boot		Y					
E0945	Belt/harness extremity		Y					
E0946	Fracture frame dual w cross		Y					
E0947	Fracture frame attachmnts pe		Y					
E0948	Fracture frame attachmnts ce		Y					
E0950	Tray		Y					
E0951	Loop heel		Y					
E0952	Toe loop/holder, each		Y					
E0955	Cushioned headrest		Y					
E0956	W/c lateral trunk/hip suppor		Y					
E0957	W/c medial thigh support		Y					
E0958	Whlchr att- conv 1 arm drive		Y					
E0959	Amputee adapter		B					
E0960	W/c shoulder harness/straps		Y					
E0961	Wheelchair brake extension		B					
E0966	Wheelchair head rest extensi		B					
E0967	Manual wc hand rim w project		Y					
E0968	Wheelchair commode seat		Y					
E0969	Wheelchair narrowing device		Y					
E0970	Wheelchair no. 2 footplates		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E0971	Wheelchair anti-tipping devi		B					
E0973	W/Ch access det adj armrest		B					
E0974	W/Ch access anti-rollback		B					
E0978	W/C acc,saf belt pelv strap		B					
E0980	Wheelchair safety vest		Y					
E0981	Seat upholstery, replacement		Y					
E0982	Back upholstery, replacement		Y					
E0983	Add pwr joystick		Y					
E0984	Add pwr tiller		Y					
E0985	W/c seat lift mechanism		Y					
E0986	Man w/c push-rim pow assist		Y					
E0990	Wheelchair elevating leg res		B					
E0992	Wheelchair solid seat insert		B					
E0994	Wheelchair arm rest		Y					
E0995	Wheelchair calf rest		B					
E1002	Pwr seat tilt		Y					
E1003	Pwr seat recline		Y					
E1004	Pwr seat recline mech		Y					
E1005	Pwr seat recline pwr		Y					
E1006	Pwr seat combo w/o shear		Y					
E1007	Pwr seat combo w/shear		Y					
E1008	Pwr seat combo pwr shear		Y					
E1009	Add mech leg elevation		Y					
E1010	Add pwr leg elevation		Y					
E1011	Ped wc modify width adjustm		Y					
E1014	Reclining back add ped w/c		Y					
E1015	Shock absorber for man w/c		Y					
E1016	Shock absorber for power w/c		Y					
E1017	HD shck absrbr for hd man wc		Y					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E1018	HD shck absrber for hd powwc		Y					
E1020	Residual limb support system		Y					
E1028	W/c manual swingaway		Y					
E1029	W/c vent tray fixed		Y					
E1030	W/c vent tray gimbaled		Y					
E1031	Rollabout chair with casters		Y					
E1035	Patient transfer system <300		Y					
E1036	Patient transfer system >300		Y					
E1037	Transport chair, ped size		Y					
E1038	Transport chair pt wt<=300lb		Y					
E1039	Transport chair pt wt >300lb		Y					
E1050	Whelchr fxd full length arms		Y					
E1060	Wheelchair detachable arms		Y					
E1070	Wheelchair detachable foot r		Y					
E1083	Hemi-wheelchair fixed arms		Y					
E1084	Hemi-wheelchair detachable a		Y					
E1085	Hemi-wheelchair fixed arms		E					
E1086	Hemi-wheelchair detachable a		E					
E1087	Wheelchair lightwt fixed arm		Y					
E1088	Wheelchair lightweight det a		Y					
E1089	Wheelchair lightwt fixed arm		E					
E1090	Wheelchair lightweight det a		E					
E1092	Wheelchair wide w/ leg rests		Y					
E1093	Wheelchair wide w/ foot rest		Y					
E1100	Whchr s-recl fxd arm leg res		Y					
E1110	Wheelchair semi-recl detach		Y					
E1130	Whlchr stand fxd arm ft rest		E					
E1140	Wheelchair standard detach a		E					
E1150	Wheelchair standard w/ leg r		Y					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E1160	Wheelchair fixed arms		Y					
E1161	Manual adult wc w tiltinspac		Y					
E1170	Whlchr ampu fxd arm leg rest		Y					
E1171	Wheelchair amputee w/o leg r		Y					
E1172	Wheelchair amputee detach ar		Y					
E1180	Wheelchair amputee w/ foot r		Y					
E1190	Wheelchair amputee w/ leg re		Y					
E1195	Wheelchair amputee heavy dut		Y					
E1200	Wheelchair amputee fixed arm		Y					
E1220	Whlchr special size/constrc		Y					
E1221	Wheelchair spec size w foot		Y					
E1222	Wheelchair spec size w/ leg		Y					
E1223	Wheelchair spec size w foot		Y					
E1224	Wheelchair spec size w/ leg		Y					
E1225	Manual semi-reclining back		Y					
E1226	Manual fully reclining back		B					
E1227	Wheelchair spec sz spec ht a		Y					
E1228	Wheelchair spec sz spec ht b		Y					
E1229	Pediatric wheelchair NOS		Y					
E1230	Power operated vehicle		Y					
E1231	Rigid ped w/c tilt-in-space		Y					
E1232	Folding ped wc tilt-in-space		Y					
E1233	Rig ped wc tltnspc w/o seat		Y					
E1234	Fld ped wc tltnspc w/o seat		Y					
E1235	Rigid ped wc adjustable		Y					
E1236	Folding ped wc adjustable		Y					
E1237	Rgd ped wc adjstabl w/o seat		Y					
E1238	Fld ped wc adjstabl w/o seat		Y					
E1239	Ped power wheelchair NOS		Y					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E1240	Whchr litwt det arm leg rest		Y					
E1250	Wheelchair lightwt fixed arm		E					
E1260	Wheelchair lightwt foot rest		E					
E1270	Wheelchair lightweight leg r		Y					
E1280	Whchr h-duty det arm leg res		Y					
E1285	Wheelchair heavy duty fixed		E					
E1290	Wheelchair hvy duty detach a		E					
E1295	Wheelchair heavy duty fixed		Y					
E1296	Wheelchair special seat heig		Y					
E1297	Wheelchair special seat dept		Y					
E1298	Wheelchair spec seat depth/w		Y					
E1300	Whirlpool portable		E					
E1310	Whirlpool non-portable		Y					
E1353	Oxygen supplies regulator		Y					
E1354	Wheeled cart, port cyl/conc		Y					
E1355	Oxygen supplies stand/rack		Y					
E1356	Batt pack/cart, port conc		Y					
E1357	Battery charger, port conc		Y					
E1358	DC power adapter, port conc		Y					
E1372	Oxy suppl heater for nebuliz		Y					
E1390	Oxygen concentrator		Y					
E1391	Oxygen concentrator, dual		Y					
E1392	Portable oxygen concentrator		Y					
E1399	Durable medical equipment mi		Y					
E1405	O2/water vapor enrich w/heat		Y					
E1406	O2/water vapor enrich w/o he		Y					
E1500	Centrifuge		A					
E1510	Kidney dialysate delivry sys		A					
E1520	Heparin infusion pump		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E1530	Replacement air bubble detec		A					
E1540	Replacement pressure alarm		A					
E1550	Bath conductivity meter		A					
E1560	Replace blood leak detector		A					
E1570	Adjustable chair for esrd pt		A					
E1575	Transducer protect/fld bar		A					
E1580	Unipuncture control system		A					
E1590	Hemodialysis machine		A					
E1592	Auto interm peritoneal dialy		A					
E1594	Cycler dialysis machine		A					
E1600	Deli/install chrg hemo equip		A					
E1610	Reverse osmosis h2o puri sys		A					
E1615	Deionizer H2O puri system		A					
E1620	Replacement blood pump		A					
E1625	Water softening system		A					
E1630	Reciprocating peritoneal dia		A					
E1632	Wearable artificial kidney		A					
E1634	Peritoneal dialysis clamp		B					
E1635	Compact travel hemodialyzer		A					
E1636	Sorbent cartridges per 10		A					
E1637	Hemostats for dialysis, each		A					
E1639	Dialysis scale		A					
E1699	Dialysis equipment noc		A					
E1700	Jaw motion rehab system		Y					
E1701	Repl cushions for jaw motion		Y					
E1702	Repl measr scales jaw motion		Y					
E1800	Adjust elbow ext/flex device		Y					
E1801	SPS elbow device		Y					
E1802	Adjst forearm pro/sup device		Y					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E1805	Adjust wrist ext/flex device		Y					
E1806	SPS wrist device		Y					
E1810	Adjust knee ext/flex device		Y					
E1811	SPS knee device		Y					
E1812	Knee ext/flex w act res ctrl		Y					
E1815	Adjust ankle ext/flex device		Y					
E1816	SPS ankle device		Y					
E1818	SPS forearm device		Y					
E1820	Soft interface material		Y					
E1821	Replacement interface SPSD		Y					
E1825	Adjust finger ext/flex devc		Y					
E1830	Adjust toe ext/flex device		Y					
E1840	Adj shoulder ext/flex device		Y					
E1841	Static str shldr dev rom adj		Y					
E1902	AAC non-electronic board		Y					
E2000	Gastric suction pump hme mdl		Y					
E2100	Bld glucose monitor w voice		Y					
E2101	Bld glucose monitor w lance		Y					
E2120	Pulse gen sys tx endolymp fl		Y					
E2201	Man w/ch acc seat w>=20"<24"		Y					
E2202	Seat width 24-27 in		Y					
E2203	Frame depth less than 22 in		Y					
E2204	Frame depth 22 to 25 in		Y					
E2205	Manual wc accessory, handrim		Y					
E2206	Complete wheel lock assembly		Y					
E2207	Crutch and cane holder		Y					
E2208	Cylinder tank carrier		Y					
E2209	Arm trough each		Y					
E2210	Wheelchair bearings		Y					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E2211	Pneumatic propulsion tire		Y					
E2212	Pneumatic prop tire tube		Y					
E2213	Pneumatic prop tire insert		Y					
E2214	Pneumatic caster tire each		Y					
E2215	Pneumatic caster tire tube		Y					
E2216	Foam filled propulsion tire		Y					
E2217	Foam filled caster tire each		Y					
E2218	Foam propulsion tire each		Y					
E2219	Foam caster tire any size ea		Y					
E2220	Solid propulsion tire each		Y					
E2221	Solid caster tire each		Y					
E2222	Solid caster integrated whl		Y					
E2224	Propulsion whl excludes tire		Y					
E2225	Caster wheel excludes tire		Y					
E2226	Caster fork replacement only		Y					
E2227	Gear reduction drive wheel		Y					
E2228	Mwc acc, wheelchair brake		Y					
E2230	Manual standing system		E					
E2231	Solid seat support base		Y					
E2291	Planar back for ped size wc		Y					
E2292	Planar seat for ped size wc		Y					
E2293	Contour back for ped size wc		Y					
E2294	Contour seat for ped size wc		Y					
E2295	Ped dynamic seating frame		Y					
E2300	Pwr seat elevation sys		Y					
E2301	Pwr standing		Y					
E2310	Electro connect btw control		Y					
E2311	Electro connect btw 2 sys		Y					
E2312	Mini-prop remote joystick		Y					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E2313	PWC harness, expand control		Y					
E2321	Hand interface joystick		Y					
E2322	Mult mech switches		Y					
E2323	Special joystick handle		Y					
E2324	Chin cup interface		Y					
E2325	Sip and puff interface		Y					
E2326	Breath tube kit		Y					
E2327	Head control interface mech		Y					
E2328	Head/extremity control inter		Y					
E2329	Head control nonproportional		Y					
E2330	Head control proximity switc		Y					
E2331	Attendant control		Y					
E2340	W/c wdth 20-23 in seat frame		Y					
E2341	W/c wdth 24-27 in seat frame		Y					
E2342	W/c dpth 20-21 in seat frame		Y					
E2343	W/c dpth 22-25 in seat frame		Y					
E2351	Electronic SGD interface		Y					
E2360	22nf nonsealed leadacid		Y					
E2361	22nf sealed leadacid battery		Y					
E2362	Gr24 nonsealed leadacid		Y					
E2363	Gr24 sealed leadacid battery		Y					
E2364	U1nonsealed leadacid battery		Y					
E2365	U1 sealed leadacid battery		Y					
E2366	Battery charger, single mode		Y					
E2367	Battery charger, dual mode		Y					
E2368	Power wc motor replacement		Y					
E2369	Pwr wc gear box replacement		Y					
E2370	Pwr wc motor/gear box combo		Y					
E2371	Gr27 sealed leadacid battery		Y					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E2372	Gr27 non-sealed leadacid		Y					
E2373	Hand/chin ctrl spec joystick		Y					
E2374	Hand/chin ctrl std joystick		Y					
E2375	Non-expandable controller		Y					
E2376	Expandable controller, repl		Y					
E2377	Expandable controller, initl		Y					
E2381	Pneum drive wheel tire		Y					
E2382	Tube, pneum wheel drive tire		Y					
E2383	Insert, pneum wheel drive		Y					
E2384	Pneumatic caster tire		Y					
E2385	Tube, pneumatic caster tire		Y					
E2386	Foam filled drive wheel tire		Y					
E2387	Foam filled caster tire		Y					
E2388	Foam drive wheel tire		Y					
E2389	Foam caster tire		Y					
E2390	Solid drive wheel tire		Y					
E2391	Solid caster tire		Y					
E2392	Solid caster tire, integrate		Y					
E2394	Drive wheel excludes tire		Y					
E2395	Caster wheel excludes tire		Y					
E2396	Caster fork		Y					
E2397	Pwc acc, lith-based battery		Y					
E2402	Neg press wound therapy pump		Y					
E2500	SGD digitized pre-rec <=8min		Y					
E2502	SGD prerec msg >8min <=20min		Y					
E2504	SGD prerec msg>20min <=40min		Y					
E2506	SGD prerec msg > 40 min		Y					
E2508	SGD spelling phys contact		Y					
E2510	SGD w multi methods msg/accs		Y					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
E2511	SGD sftwre prgrm for PC/PDA		Y					
E2512	SGD accessory, mounting sys		Y					
E2599	SGD accessory noc		Y					
E2601	Gen w/c cushion wdth < 22 in		Y					
E2602	Gen w/c cushion wdth >=22 in		Y					
E2603	Skin protect wc cus wd <22in		Y					
E2604	Skin protect wc cus wd>=22in		Y					
E2605	Position wc cush wdth <22 in		Y					
E2606	Position wc cush wdth>=22 in		Y					
E2607	Skin pro/pos wc cus wd <22in		Y					
E2608	Skin pro/pos wc cus wd>=22in		Y					
E2609	Custom fabricate w/c cushion		Y					
E2610	Powered w/c cushion		B					
E2611	Gen use back cush wdth <22in		Y					
E2612	Gen use back cush wdth>=22in		Y					
E2613	Position back cush wd <22in		Y					
E2614	Position back cush wd>=22in		Y					
E2615	Pos back post/lat wdth <22in		Y					
E2616	Pos back post/lat wdth>=22in		Y					
E2617	Custom fab w/c back cushion		Y					
E2619	Replace cover w/c seat cush		Y					
E2620	WC planar back cush wd <22in		Y					
E2621	WC planar back cush wd>=22in		Y					
E8000	Posterior gait trainer		E					
E8001	Upright gait trainer		E					
E8002	Anterior gait trainer		E					
G0008	Admin influenza virus vac		S	0350	0.3853	$26.30		
G0009	Admin pneumococcal vaccine		S	0350	0.3853	$26.30		
G0010	Admin hepatitis b vaccine		B					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G0027	Semen analysis		A					
G0101	CA screen;pelvic/breast exam		V	0604	0.7431	$50.73		
G0102	Prostate ca screening; dre		N					
G0103	PSA screening		A					
G0104	CA screen;flexi sigmoidscope		S	0159	5.1653	$352.62		
G0105	Colorectal scrn; hi risk ind		T	0158	8.2505	$563.24		
G0106	Colon CA screen;barium enema		S	0157	1.322	$90.25	.	$18.05
G0108	Diab manage trn per indiv		A					
G0109	Diab manage trn ind/group		A					
G0117	Glaucoma scrn hgh risk direc		S	0698	0.9316	$63.60	.	$12.72
G0118	Glaucoma scrn hgh risk direc		S	0230	0.5913	$40.37	.	$8.08
G0120	Colon ca scrn; barium enema		S	0157	1.322	$90.25	.	$18.05
G0121	Colon ca scrn not hi rsk ind		T	0158	8.2505	$563.24		
G0122	Colon ca scrn; barium enema		E					
G0123	Screen cerv/vag thin layer		A					
G0124	Screen c/v thin layer by MD		B					
G0127	Trim nail(s)		T	0012	0.4253	$29.03	.	$5.81
G0128	CORF skilled nursing service		B					
G0129	Partial hosp prog service		P					
G0130	Single energy x-ray study		X	0260	0.6683	$45.62		
G0141	Scr c/v cyto,autosys and md		B					
G0143	Scr c/v cyto,thinlayer,rescr		A					
G0144	Scr c/v cyto,thinlayer,rescr		A					
G0145	Scr c/v cyto,thinlayer,rescr		A					
G0147	Scr c/v cyto, automated sys		A					
G0148	Scr c/v cyto, autosys, rescr		A					
G0151	HHCP-serv of pt,ea 15 min		B					
G0152	HHCP-serv of ot,ea 15 min		B					
G0153	HHCP-svs of s/l path,ea 15mn		B					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G0154	HHCP-svs of rn,ea 15 min		B					
G0155	HHCP-svs of csw,ea 15 min		B					
G0156	HHCP-svs of aide,ea 15 min		B					
G0166	Extrnl counterpulse, per tx		T	0678	1.4509	$99.05	.	$19.81
G0168	Wound closure by adhesive		B					
G0173	Linear acc stereo radsur com		S	0067	50.0116	$3,414.14	.	$682.83
G0175	OPPS Service,sched team conf		V	0607	1.7939	$122.46	.	$24.50
G0176	OPPS/PHP;activity therapy		P					
G0177	OPPS/PHP; train & educ serv		N					
G0179	MD recertification HHA PT		M					
G0180	MD certification HHA patient		M					
G0181	Home health care supervision		M					
G0182	Hospice care supervision		M					
G0186	Dstry eye lesn,fdr vssl tech		T	0235	5.2921	$361.28	.	$72.26
G0202	Screeningmammographydigital		A					
G0204	Diagnosticmammographydigital		A					
G0206	Diagnosticmammographydigital		A					
G0219	PET img wholbod melano nonco		E					
G0235	PET not otherwise specified		E					
G0237	Therapeutic procd strg endur		S	0077	0.418	$28.54	$7.74	$5.71
G0238	Oth resp proc, indiv		S	0077	0.418	$28.54	$7.74	$5.71
G0239	Oth resp proc, group		S	0077	0.418	$28.54	$7.74	$5.71
G0245	Initial foot exam pt lops		V	0604	0.7431	$50.73	.	$10.15
G0246	Followup eval of foot pt lop		V	0605	1.0573	$72.18	.	$14.44
G0247	Routine footcare pt w lops		T	0013	0.8782	$59.95	.	$11.99
G0248	Demonstrate use home inr mon		V	0607	1.7939	$122.46	.	$24.50
G0249	Provide INR test mater/equip		V	0607	1.7939	$122.46	.	$24.50
G0250	MD INR test revie inter mgmt		M					
G0251	Linear acc based stero radio		S	0065	13.7821	$940.86	.	$188.18

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G0252	PET imaging initial dx		E					
G0255	Current percep threshold tst		E					
G0257	Unsched dialysis ESRD pt hos		S	0170	7.0059	$478.27	.	$95.66
G0259	Inject for sacroiliac joint		N					
G0260	Inj for sacroiliac jt anesth		T	0207	7.7204	$527.05	.	$105.41
G0268	Removal of impacted wax md		N					
G0269	Occlusive device in vein art		N					
G0270	MNT subs tx for change dx		A					
G0271	Group MNT 2 or more 30 mins		A					
G0275	Renal angio, cardiac cath		N					
G0278	Iliac art angio,cardiac cath		N					
G0281	Elec stim unattend for press		A					
G0282	Elect stim wound care not pd		E					
G0283	Elec stim other than wound		A					
G0288	Recon, CTA for surg plan		N					
G0289	Arthro, loose body + chondro		N					
G0290	Drug-eluting stents, single		T	0656	104.6619	$7,144.95	.	$1,428.99
G0291	Drug-eluting stents,each add		T	0656	104.6619	$7,144.95	.	$1,428.99
G0293	Non-cov surg proc,clin trial		X	0340	0.6899	$47.10	.	$9.42
G0294	Non-cov proc, clinical trial		X	0340	0.6899	$47.10	.	$9.42
G0295	Electromagnetic therapy onc		E					
G0302	Pre-op service LVRS complete		S	0209	11.462	$782.48	$268.73	$156.50
G0303	Pre-op service LVRS 10-15dos		S	0209	11.462	$782.48	$268.73	$156.50
G0304	Pre-op service LVRS 1-9 dos		S	0213	2.4455	$166.95	$53.58	$33.39
G0305	Post op service LVRS min 6		S	0213	2.4455	$166.95	$53.58	$33.39
G0306	CBC/diffwbc w/o platelet		A					
G0307	CBC without platelet		A					
G0328	Fecal blood scrn immunoassay		A					
G0329	Electromagntic tx for ulcers		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G0333	Dispense fee initial 30 day		M					
G0337	Hospice evaluation preelecti		B					
G0339	Robot lin-radsurg com, first		S	0067	50.0116	$3,414.14	.	$682.83
G0340	Robt lin-radsurg fractx 2-5		S	0066	36.858	$2,516.19	.	$503.24
G0341	Percutaneous islet celltrans		C					
G0342	Laparoscopy islet cell trans		C					
G0343	Laparotomy islet cell transp		C					
G0364	Bone marrow aspirate &biopsy		X	0340	0.6899	$47.10	.	$9.42
G0365	Vessel mapping hemo access		S	0267	2.2748	$155.29	$60.50	$31.06
G0372	MD service required for PMD		M					
G0378	Hospital observation per hr		N					
G0379	Direct refer hospital observ		Q3	0604	0.7431	$50.73	.	$10.15
G0380	Lev 1 hosp type B ED visit		V	0626	0.625	$42.67	.	$8.54
G0381	Lev 2 hosp type B ED visit		V	0627	0.9279	$63.34	.	$12.67
G0382	Lev 3 hosp type B ED visit		V	0628	1.4941	$102.00	.	$20.40
G0383	Lev 4 hosp type B ED visit		V	0629	2.4251	$165.55	.	$33.11
G0384	Lev 5 hosp type B ED visit		Q3	0630	3.8788	$264.79	.	$52.96
G0389	Ultrasound exam AAA screen		S	0266	1.4262	$97.36		
G0390	Trauma Respons w/hosp criti		S	0618	13.999	$955.67	.	$191.14
G0396	Alcohol/subs interv 15-30mn		S	0432	0.4597	$31.38	.	$6.28
G0397	Alcohol/subs interv >30 min		S	0432	0.4597	$31.38	.	$6.28
G0398	Home sleep test/type 2 Porta		S	0213	2.4455	$166.95	$53.58	$33.39
G0399	Home sleep test/type 3 Porta		S	0213	2.4455	$166.95	$53.58	$33.39
G0400	Home sleep test/type 4 Porta		S	0213	2.4455	$166.95	$53.58	$33.39
G0402	Initial preventive exam		V	0606	1.365	$93.18		
G0403	EKG for initial prevent exam		M					
G0404	EKG tracing for initial prev		S	0099	0.3998	$27.29	.	$5.46
G0405	EKG interpret & report preve		B					
G0406	Telhealth inpt consult 15min		C					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G0407	Telheath inpt consult 25min		C					
G0408	Telhealth inpt consult 35min		C					
G0409	CORF related serv 15 mins ea		M					
G0410	Grp psych partial hosp 45-50		P					
G0411	Inter active grp psych parti		P					
G0412	Open tx iliac spine uni/bil		C					
G0413	Pelvic ring fracture uni/bil		T	0050	32.4253	$2,213.58	.	$442.72
G0414	Pelvic ring fx treat int fix		C					
G0415	Open tx post pelvic fxcture		C					
G0416	Sat biopsy prostate 1-20 spc	CH	X	0661	2.3687	$161.70	.	$32.34
G0417	Sat biopsy prostate 21-40	CH	S	1506		$450.00	.	$90.00
G0418	Sat biopsy prostate 41-60		S	1511		$950.00	.	$190.00
G0419	Sat biopsy prostate: >60		S	1513		$1,150.00	.	$230.00
G0420	Ed svc CKD ind per session		A					
G0421	Ed svc CKD grp per session		A					
G0422	Intens cardiac rehab w/exerc		S	0095	0.5678	$38.76	$13.86	$7.76
G0423	Intens cardiac rehab no exer		S	0095	0.5678	$38.76	$13.86	$7.76
G0424	Pulmonary rehab w exer		S	0102	0.9754	$66.59	.	$13.32
G0425	Inpt telehealth consult 30m		C					
G0426	Inpt telehealth consult 50m		C					
G0427	Inpt telehealth con 70/>m		C					
G0430	Drug screen multi class		A					
G0431	Drug screen single class		A					
G0432	EIA HIV-1/HIV-2 screen		A					
G0433	ELISA HIV-1/HIV-2 screen		A					
G0435	Oral HIV-1/HIV-2 screen		A					
G3001	Admin + supply, tositumomab		S	0442	31.989	$2,183.79	.	$436.76
G8006	AMI pt recd aspirin at arriv		M					
G8007	AMI pt did not receiv aspiri		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G8008	AMI pt ineligible for aspiri		M					
G8009	AMI pt recd Bblock at arr		M					
G8010	AMI pt did not rec bblock		M					
G8011	AMI pt inelig Bbloc at arriv		M					
G8012	Pneum pt recv antibiotic 4 h		M					
G8013	Pneum pt w/o antibiotic 4 hr		M					
G8014	Pneum pt not elig antibiotic		M					
G8015	Diabetic pt w/ HBA1c>9%		M					
G8016	Diabetic pt w/ HBA1c<or=9%		M					
G8017	DM pt inelig for HBA1c measu		M					
G8018	Care not provided for HbA1c		M					
G8019	Diabetic pt w/LDL>= 100mg/dl		M					
G8020	Diab pt w/LDL< 100mg/dl		M					
G8021	Diab pt inelig for LDL meas		M					
G8022	Care not provided for LDL		M					
G8023	DM pt w BP>=140/80		M					
G8024	Diabetic pt wBP<140/80		M					
G8025	Diabetic pt inelig for BP me		M					
G8026	Diabet pt w no care re BP me		M					
G8027	HF p w/LVSD on ACE-I/ARB		M					
G8028	HF pt w/LVSD not on ACE-I/AR		M					
G8029	HF pt not elig for ACE-I/ARB		M					
G8030	HF pt w/LVSD on Bblocker		M					
G8031	HF pt w/LVSD not on Bblocker		M					
G8032	HF pt not elig for Bblocker		M					
G8033	PMI-CAD pt on Bblocker		M					
G8034	PMI-CAD pt not on Bblocker		M					
G8035	PMI-CAD pt inelig Bblocker		M					
G8036	AMI-CAD pt doc on antiplatel		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G8037	AMI-CAD pt not docu on antip		M					
G8038	AMI-CAD inelig antiplate mea		M					
G8039	CAD pt w/LDL>100mg/dl		M					
G8040	CAD pt w/LDL<or=100mg/dl		M					
G8041	CAD pt not eligible for LDL		M					
G8051	Osteoporosis assess		M					
G8052	Osteopor pt not assess		M					
G8053	Pt inelig for osteopor meas		M					
G8054	Falls assess not docum 12 mo		M					
G8055	Falls assess w/ 12 mon		M					
G8056	Not elig for falls assessmen		M					
G8057	Hearing assess receive		M					
G8058	Pt w/o hearing assess		M					
G8059	Pt inelig for hearing assess		M					
G8060	Urinary incont pt assess		M					
G8061	Pt not assess for urinary in		M					
G8062	Pt not elig for urinary inco		M					
G8075	ESRD pt w/ dialy of URR>=65%		M					
G8076	ESRD pt w/ dialy of URR<65%		M					
G8077	ESRD pt not elig for URR/KtV		M					
G8078	ESRD pt w/Hct>or=33		M					
G8079	ESRD pt w/Hct<33		M					
G8080	ESRD pt inelig for HCT/Hgb		M					
G8081	ESRD pt w/ auto AV fistula		M					
G8082	ESRD pt w other fistula		M					
G8085	ESRD PT inelig auto AV FISTU		M					
G8093	COPD pt rec smoking cessat		M					
G8094	COPD pt w/o smoke cessat int		M					
G8099	Osteopo pt given Ca+VitD sup		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G8100	Osteop pt inelig for Ca+VitD		M					
G8103	New dx osteo pt w/antiresorp		M					
G8104	Osteo pt inelig for antireso		M					
G8106	Bone dens meas test perf		M					
G8107	Bone dens meas test inelig		M					
G8108	Pt receiv influenza vacc		M					
G8109	Pt w/o influenza vacc		M					
G8110	Pt inelig for influenza vacc		M					
G8111	Pt receiv mammogram		M					
G8112	Pt not doc mammogram		M					
G8113	Pt ineligible mammography		M					
G8114	Care not provided for mamogr		M					
G8115	Pt receiv pneumo vacc		M					
G8116	Pt did not rec pneumo vacc		M					
G8117	Pt was inelig for pneumo vac		M					
G8126	Pt treat w/antidepress12wks		M					
G8127	Pt not treat w/antidepres12w		M					
G8128	Pt inelig for antidepres med		M					
G8129	Pt treat w/antidepres for 6m		M					
G8130	Pt not treat w/antidepres 6m		M					
G8131	Pt inelig for antidepres med		M					
G8152	Pt w/AB 1 hr prior to incisi		M					
G8153	Pt not doc for AB 1 hr prior		M					
G8154	Pt ineligi for AB therapy		M					
G8155	Pt recd thromboemb prophylax		M					
G8156	Pt did not rec thromboembo		M					
G8157	Pt ineligi for thrombolism		M					
G8159	Pt w/CABG w/o IMA		M					
G8162	Iso CABG pt w/o preop Bblock		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G8164	Iso CABG pt w/prolng intub		M					
G8165	Iso CABG pt w/o prolng intub		M					
G8166	Iso CABG req surg rexpo		M					
G8167	Iso CABG w/o surg explo		M					
G8170	CEA/ext bypass pt on aspirin		M					
G8171	Pt w/carot endarct/ext bypas		M					
G8172	CEA/ext bypass pt not on asp		M					
G8182	CAD pt care not prov LDL		M					
G8183	HF/atrial fib pt on warfarin		M					
G8184	HF/atrial fib pt inelig warf		M					
G8185	Osteoarth pt w/ assess pain		M					
G8186	Osteoarth pt inelig assess		M					
G8193	Antibio not doc prior surg		M					
G8196	Antibio not docum prior surg		M					
G8200	Cefazolin not docum prophy		M					
G8204	MD not doc order to d/c anti		M					
G8209	Clinician did not doc		M					
G8214	Clini not doc order VTE		M					
G8217	Pt not received DVT proph		M					
G8219	Received DVT proph day 2		M					
G8220	Pt not rec DVT proph day 2		M					
G8221	Pt inelig for DVT proph		M					
G8223	Pt not doc for presc antipla		M					
G8226	Pt no prescr anticoa at D/C		M					
G8231	Pt not doc for admin t-PA		M					
G8234	Pt not doc dysphagia screen		M					
G8238	Pt not doc to rec rehab serv		M					
G8240	Inter carotid stenosis30-99%		M					
G8243	Pt not doc MRI/CT w/o lesion		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G8246	Pt inelig hx w new/chg mole		M					
G8248	Pt w/one alarm symp not doc		M					
G8251	Pt not doc w/Barretts, endo		M					
G8254	Pt w/no doc order for barium		M					
G8257	Pt not doc rev meds D/C		M					
G8260	Pt not doc to have dec maker		M					
G8263	Pt not doc assess urinary in		M					
G8266	Pt not doc charc urin incon		M					
G8268	Pt not doc rec care urin inc		M					
G8271	Pt no doc screen fall		M					
G8274	Clini not doc pres/abs alarm		M					
G8276	Pt not doc mole change		M					
G8279	Pt not doc rec PE		M					
G8282	Pt not doc to rec couns		M					
G8285	Pt did not rec pres osteo		M					
G8289	Pt not doc rec Ca/Vit D		M					
G8293	COPD pt w/o spir results		M					
G8296	COPD pt not doc bronch ther		M					
G8298	Pt doc optic nerve eval		M					
G8299	Pt not doc optic nerv eval		M					
G8302	Pt doc w/ target IOP		M					
G8303	Pt not doc w/ IOP		M					
G8304	Clin doc pt inelig IOP		M					
G8305	Clin not prov care POAG		M					
G8306	POAG w/ IOP rec care plan		M					
G8307	POAG w/ IOP no care plan		M					
G8308	POAG w/ IOP not doc plan		M					
G8310	Pt not doc rec antiox		M					
G8314	Pt not doc to rec mac exam		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G8318	Pt doc not have visual func		M					
G8322	Pt not doc pre axial leng		M					
G8326	Pt not doc rec fundus exam		M					
G8330	Pt not doc rec dilated mac		M					
G8334	Doc of macular not giv MD		M					
G8338	Clin not doc pt test osteo		M					
G8341	Pt not doc for DEXA		M					
G8345	Pt not doc have DEXA		M					
G8351	Pt not doc ECG		M					
G8354	Pt not rec aspirin prior ER		M					
G8357	Pt not doc to have ECG		M					
G8360	Pt not doc vital signs recor		M					
G8362	Pt not doc 02 SAT assess		M					
G8365	Pt not doc mental status		M					
G8367	Pt not doc have empiric AB		M					
G8370	Asthma pt w survey not docum		M					
G8371	Chemother not rec stg3 colon		M					
G8372	Chemother rec stg3 colon ca		M					
G8373	Chemo plan documen prior che		M					
G8374	Chemo plan not doc prior che		M					
G8375	CLL pt w/o doc flow cytometr		M					
G8376	Brst ca pt inelig tamoxifen		M					
G8377	MD doc colon ca pt inelig ch		M					
G8378	MD doc pt inelig radiation		M					
G8379	Doc radiat tx recom 12mo ov		M					
G8380	Pt w stgIC-3Brst ca not rec		M					
G8381	Pt w stgIC-3Brst ca rec tam		M					
G8382	MM pt w/o doc IV bisphophon		M					
G8383	No doc radiation rec 12mo ov		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G8384	Base cytogen test MDS notper		M					
G8385	Diabet pt no do Hgb A1c 12m		M					
G8386	Diabet pt nodoc LDLiprotei		M					
G8387	ESRD pt w Hct/Hgb not docume		M					
G8388	ESRD pt w URR/Ktv notdoc eli		M					
G8389	MDS pt no doc FE st prio EPO		M					
G8390	Diabetic w/o document BP 12m		M					
G8391	Pt w asthma no doc med or tx		M					
G8395	LVEF>=40% doc normal or mild		M					
G8396	LVEF not performed		M					
G8397	Dil macula/fundus exam/w doc		M					
G8398	Dil macular/fundus not perfo		M					
G8399	Pt w/DXA document or order		M					
G8400	Pt w/DXA no document or orde		M					
G8401	Pt inelig osteo screen measu		M					
G8402	Smoke preven interven counse		M					
G8403	Smoke preven nocounsel		M					
G8404	Low extemity neur exam docum		M					
G8405	Low extemity neur not perfor		M					
G8406	Pt inelig lower extrem neuro		M					
G8407	ABI documented		M					
G8408	ABI not documented		M					
G8409	Pt inelig for ABI measure		M					
G8410	Eval on foot documented		M					
G8415	Eval on foot not performed		M					
G8416	Pt inelig footwear evaluatio		M					
G8417	Calc BMI abv up param f/u		M					
G8418	Calc BMI blw low param f/u		M					
G8419	Calc BMI out nrm param nof/u		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G8420	Calc BMI norm parameters		M					
G8421	BMI not calculated		M					
G8422	Pt inelig BMI calculation		M					
G8423	Pt screen flu vac & counsel		M					
G8424	Flu vaccine not screen		M					
G8425	Flu vaccine screen not curre		M					
G8426	Pt not approp screen & counc		M					
G8427	Doc meds verified w/pt or re		M					
G8428	Meds document w/o verifica		M					
G8429	Incomplete doc pt on meds		M					
G8430	Pt inelig med check		M					
G8431	Pos clin depres scrn f/u doc		M					
G8432	Clin depression screen not d		M					
G8433	Pt inelig; scrn clin dep		M					
G8434	Cognitive impairment screen		M					
G8435	Cognitive screen not documen		M					
G8436	Pt inelig for cognitive impa		M					
G8437	Care plan develop & document		M					
G8438	Pt inelig for devlp care pln		M					
G8439	Care plan develp & not docum		M					
G8440	Pain assess f/u pln document		M					
G8441	No document of pain assess		M					
G8442	Pt inelig pain assessment		M					
G8443	Prescription by E-Prescrib s		M					
G8445	Prescrip not gen at encounte		M					
G8446	Some prescrib print or call		M					
G8447	Pt vis doc use CCHIT cer EHR		M					
G8448	Pt vis doc w/non-CCHIT EHR		M					
G8449	Pt not doc w/EMR due to syst		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G8450	Beta-bloc rx pt w/abn lvef		M					
G8451	Pt w/abn lvef inelig b-bloc		M					
G8452	Pt w/abn lvef b-bloc no rx		M					
G8453	Tob use cess int counsel		M					
G8454	Tob use cess int no counsel		M					
G8455	Current tobacco smoker		M					
G8456	Current smkless tobacco user		M					
G8457	Cur tobacco non-user		M					
G8458	Pt inelig geno no antvir tx		M					
G8459	Doc pt rec antivir treat		M					
G8460	Pt inelig RNA no antvir tx		M					
G8461	Pt rec antivir treat hep c		M					
G8462	Pt inelig couns no antvir tx		M					
G8463	Pt rec antiviral treat doc		M					
G8464	Pt inelig; lo to no dter rsk		M					
G8465	High risk recurrence pro ca		M					
G8466	Pt inelig suic; MDD remis		M					
G8467	New dx init/rec episode MDD		M					
G8468	ACE/ARB rx pt w/abn lvef		M					
G8469	Pt w/abn lvef inelig ACE/ARB		M					
G8470	Pt w/ normal lvef		M					
G8471	LVEF not performed/doc		M					
G8472	ACE/ARB no rx pt w/abn lvef		M					
G8473	ACE/ARB thxpy rx'd		M					
G8474	ACE/ARB not rx'd; doc reas		M					
G8475	ACE/ARB thxpy not rx'd		M					
G8476	BP sys <130 and dias <80		M					
G8477	BP sys>=130 and/or dias >=80		M					
G8478	BP not performed/doc		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G8479	MD rx'd ACE/ARB thxpy		M					
G8480	Pt inelig ACE/ARB thxpy		M					
G8481	MD not rx'd ACE/ARB thxpy		M					
G8482	Flu immunize order/admin		M					
G8483	Flu imm no ord/admin doc rea		M					
G8484	Flu immunize no order/admin		M					
G8485	Report, Diabetes measures		M					
G8486	Report, Prev Care Measures		M					
G8487	Report CKD Measures		M					
G8488	Report ESRD Measures		M					
G8489	CAD measures grp		M					
G8490	RA measures grp		M					
G8491	HIV/AIDS measures grp		M					
G8492	Periop Care measures grp		M					
G8493	Back pain measures grp		M					
G8494	DM meas qual act perform		M					
G8495	CKD meas qual act perform		M					
G8496	Prev Care MG qual act perfrm		M					
G8497	CABG meas qual act perform		M					
G8498	CAD meas qual act perform		M					
G8499	RA meas qual act perform		M					
G8500	HIV meas qual act perform		M					
G8501	Perio meas qual act perform		M					
G8502	Back Pain MG qual act perfrm		M					
G8506	Pt rec ACE/ARB		M					
G8507	Pt inelig pt verif meds		M					
G8508	Pt inelig; pain asses no f/u		M					
G8509	Pain assess no f/u pln doc		M					
G8510	Pt inelig neg scrn depres		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G8511	Clin depres scrn no f/u doc		M					
G8518	Clin stg b/f lun/eso ca surg		M					
G8519	Pt in; clin ca stg b/f surg		M					
G8520	Clin stg b/f surg not doc		M					
G8524	Patch closure conv CEA		M					
G8525	No patch closure CEA		M					
G8526	No patch closure conv CEA		M					
G8530	Auto AV fistula recd		M					
G8531	Pt inelig; auto AV fistula		M					
G8532	No auto AV fistula; no reas		M					
G8534	Doc elder mal scrn f/u plan		M					
G8535	Pt inelig no eld mal scrn		M					
G8536	No doc elder mal scrn		M					
G8537	Pt inelig eldmal scrn no f/u		M					
G8538	Eld mal scrn no f/u pln		M					
G8539	Cur funct assess & care pln		M					
G8540	Pt inelig funct assess		M					
G8541	No doc cur funct assess		M					
G8542	Pt inelig func asses no pln		M					
G8543	Cur funct asses; no care pln		M					
G8544	CABG measures grp		M					
G8545	HepC measures grp		M					
G8546	CAP measures grp		M					
G8547	IVD measures grp		M					
G8548	HF measures grp		M					
G8549	HepC MG qual act perform		M					
G8550	CAP MG qual act perform		M					
G8551	HF MG qual act perform		M					
G8552	IVD MG qual act perform		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G8553	1 Rx via qualified eRx sys		M					
G8556	Ref to doc otolog eval		M					
G8557	Pt inelig ref otolog eval		M					
G8558	No ref to doc otolog eval		M					
G8559	Pt ref doc oto eval		M					
G8560	Pt hx act drain prev 90 days		M					
G8561	Pt inelig for ref oto eval		M					
G8562	Pt no hx act drain 90 d		M					
G8563	Pt no ref oto reas no spec		M					
G8564	Pt ref oto eval		M					
G8565	Ver doc hear loss		M					
G8566	Pt inelig ref oto eval		M					
G8567	Pt no doc hear loss		M					
G8568	Pt no ref otolo no spec		M					
G8569	Prol intubation req		M					
G8570	No prol intub req		M					
G8571	Ster wd ifx 30 d postop		M					
G8572	No ster wd ifx		M					
G8573	Stk/CVA CABG		M					
G8574	No strk/CVA CABG		M					
G8575	Postop ren insuf		M					
G8576	No postop ren insuf		M					
G8577	Reop req bld grft oth		M					
G8578	No reop req bld grft oth		M					
G8579	Antplt med disch		M					
G8580	Antplt med contraind		M					
G8581	no antplt med disch		M					
G8582	Bblock disch		M					
G8583	Bblock contraind		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G8584	No bblock disch		M					
G8585	Antilipid treat disch		M					
G8586	Antlip disch contra		M					
G8587	No antlipid treat disch		M					
G8588	Sys BP <140		M					
G8589	Sys BP >= 140		M					
G8590	Dia BP < 90		M					
G8591	Dia BP >= 90		M					
G8592	No BP measure		M					
G8593	Lipid pn results		M					
G8594	No lipid prof perf		M					
G8595	Ldl < 100		M					
G8596	No LDL perf		M					
G8597	Ldl >= 100		M					
G8598	Asp therp used		M					
G8599	No asp therp used		M					
G8600	tPA initi w/in 3 hrs		M					
G8601	No elig tPA init w/in 3 hrs		M					
G8602	No tPA init w/in 3 hrs		M					
G8603	Spok lang comp score		M					
G8604	No high score spok lang		M					
G8605	No spok lang comp score		M					
G8606	Attention score		M					
G8607	No high score attention		M					
G8608	No attention score		M					
G8609	Memory score		M					
G8610	No high score memory		M					
G8611	No memory score		M					
G8612	Moto speech score		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G8613	No high score moto speech		M					
G8614	No moto speech score		M					
G8615	Reading score		M					
G8616	No high score reading		M					
G8617	No reading score		M					
G8618	Spok lang exp score		M					
G8619	No high score spok lang exp		M					
G8620	No spok lang exp score		M					
G8621	Writing score		M					
G8622	No high score writing		M					
G8623	No writing score		M					
G8624	Swallowing score		M					
G8625	No high score swallowing		M					
G8626	No swallowing score		M					
G8627	Surg proc w/in 30 days		M					
G8628	No surg proc w/in 30 days		M					
G9001	MCCD, initial rate		B					
G9002	MCCD,maintenance rate		B					
G9003	MCCD, risk adj hi, initial		B					
G9004	MCCD, risk adj lo, initial		B					
G9005	MCCD, risk adj, maintenance		B					
G9006	MCCD, Home monitoring		B					
G9007	MCCD, sch team conf		B					
G9008	Mccd,phys coor-care ovrsght		B					
G9009	MCCD, risk adj, level 3		B					
G9010	MCCD, risk adj, level 4		B					
G9011	MCCD, risk adj, level 5		B					
G9012	Other Specified Case Mgmt		B					
G9013	ESRD demo bundle level I		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G9014	ESRD demo bundle-level II		E					
G9016	Demo-smoking cessation coun		E					
G9017	Amantadine HCL 100mg oral		A					
G9018	Zanamivir,inhalation pwd 10m		A					
G9019	Oseltamivir phosphate 75mg		A					
G9020	Rimantadine HCL 100mg oral		A					
G9033	Amantadine HCL oral brand		A					
G9034	Zanamivir, inh pwdr, brand		A					
G9035	Oseltamivir phosp, brand		A					
G9036	Rimantadine HCL, brand		A					
G9041	Low vision rehab occupationa		A					
G9042	Low vision rehab orient/mobi		A					
G9043	Low vision lowvision therapi		A					
G9044	Low vision rehabilate teache		A					
G9050	Oncology work-up evaluation		E					
G9051	Oncology tx decision-mgmt		E					
G9052	Onc surveillance for disease		E					
G9053	Onc expectant management pt		E					
G9054	Onc supervision palliative		E					
G9055	Onc visit unspecified NOS		E					
G9056	Onc prac mgmt adheres guide		E					
G9057	Onc pract mgmt differs trial		E					
G9058	Onc prac mgmt disagree w/gui		E					
G9059	Onc prac mgmt pt opt alterna		E					
G9060	Onc prac mgmt dif pt comorb		E					
G9061	Onc prac cond noadd by guide		E					
G9062	Onc prac guide differs nos		E					
G9063	Onc dx nsclc stgI no progres		M					
G9064	Onc dx nsclc stg2 no progres		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G9065	Onc dx nsclc stg3A no progre		M					
G9066	Onc dx nsclc stg3B-4 metasta		M					
G9067	Onc dx nsclc dx unknown nos		M					
G9068	Onc dx sclc/nsclc limited		M					
G9069	Onc dx sclc/nsclc ext at dx		M					
G9070	Onc dx sclc/nsclc ext unknwn		M					
G9071	Onc dx brst stg1-2B HR,nopro		M					
G9072	Onc dx brst stg1-2 noprogres		M					
G9073	Onc dx brst stg3-HR, no pro		M					
G9074	Onc dx brst stg3-noprogress		M					
G9075	Onc dx brst metastic/ recur		M					
G9077	Onc dx prostate T1no progres		M					
G9078	Onc dx prostate T2no progres		M					
G9079	Onc dx prostate T3b-T4noprog		M					
G9080	Onc dx prostate w/rise PSA		M					
G9083	Onc dx prostate unknwn nos		M					
G9084	Onc dx colon t1-3,n1-2,no pr		M					
G9085	Onc dx colon T4, N0 w/o prog		M					
G9086	Onc dx colon T1-4 no dx prog		M					
G9087	Onc dx colon metas evid dx		M					
G9088	Onc dx colon metas noevid dx		M					
G9089	Onc dx colon extent unknown		M					
G9090	Onc dx rectal T1-2 no progr		M					
G9091	Onc dx rectal T3 N0 no prog		M					
G9092	Onc dx rectal T1-3,N1-2noprg		M					
G9093	Onc dx rectal T4,N,M0 no prg		M					
G9094	Onc dx rectal M1 w/mets prog		M					
G9095	Onc dx rectal extent unknwn		M					
G9096	Onc dx esophag T1-T3 noprog		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G9097	Onc dx esophageal T4 no prog		M					
G9098	Onc dx esophageal mets recur		M					
G9099	Onc dx esophageal unknown		M					
G9100	Onc dx gastric no recurrence		M					
G9101	Onc dx gastric p R1-R2noprog		M					
G9102	Onc dx gastric unresectable		M					
G9103	Onc dx gastric recurrent		M					
G9104	Onc dx gastric unknown NOS		M					
G9105	Onc dx pancreatc p R0 res no		M					
G9106	Onc dx pancreatc p R1/R2 no		M					
G9107	Onc dx pancreatic unresectab		M					
G9108	Onc dx pancreatic unknwn NOS		M					
G9109	Onc dx head/neck T1-T2no prg		M					
G9110	Onc dx head/neck T3-4 noprog		M					
G9111	Onc dx head/neck M1 mets rec		M					
G9112	Onc dx head/neck ext unknown		M					
G9113	Onc dx ovarian stg1A-B no pr		M					
G9114	Onc dx ovarian stg1A-B or 2		M					
G9115	Onc dx ovarian stg3/4 noprog		M					
G9116	Onc dx ovarian recurrence		M					
G9117	Onc dx ovarian unknown NOS		M					
G9123	Onc dx CML chronic phase		M					
G9124	Onc dx CML acceler phase		M					
G9125	Onc dx CML blast phase		M					
G9126	Onc dx CML remission		M					
G9128	Onc dx multi myeloma stage I		M					
G9129	Onc dx mult myeloma stg2 hig		M					
G9130	Onc dx multi myeloma unknown		M					
G9131	Onc dx brst unknown NOS		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
G9132	Onc dx prostate mets no cast		M					
G9133	Onc dx prostate clinical met		M					
G9134	Onc NHLstg 1-2 no relap no		M					
G9135	Onc dx NHL stg 3-4 not relap		M					
G9136	Onc dx NHL trans to lg Bcell		M					
G9137	Onc dx NHL relapse/refractor		M					
G9138	Onc dx NHL stg unknown		M					
G9139	Onc dx CML dx status unknown		M					
G9140	Frontier extended stay demo		A					
G9141	Influenza A H1N1,admin w cou		S	0350	0.3853	$26.30		
G9142	Influenza A H1N1, vaccine		E					
G9143	Warfarin respon genetic test		A					
G9147	Outpt IV insulin tx any mea		E					
J0120	Tetracyclin injection		N					
J0128	Abarelix injection		E					
J0129	Abatacept injection		K	9230		$19.96	.	$4.00
J0130	Abciximab injection		K	1605		$462.83	.	$92.57
J0132	Acetylcysteine injection		K	1272		$2.45	.	$0.49
J0133	Acyclovir injection		N					
J0135	Adalimumab injection		K	1083		$374.48	.	$74.90
J0150	Injection adenosine 6 MG	CH	N					
J0152	Adenosine injection		K	0917		$82.72	.	$16.55
J0170	Adrenalin epinephrin inject		N					
J0180	Agalsidase beta injection		K	9208		$136.24	.	$27.25
J0190	Inj biperiden lactate/5 mg	CH	E					
J0200	Alatrofloxacin mesylate		N					
J0205	Alglucerase injection		K	0900		$41.98	.	$8.40
J0207	Amifostine		K	7000		$327.97	.	$65.60
J0210	Methyldopate hcl injection		K	2210		$36.34	.	$7.27

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J0215	Alefacept		K	1633		$30.63	.	$6.13
J0220	Alglucosidase alfa injection		K	9234		$127.08	.	$25.42
J0256	Alpha 1 proteinase inhibitor		K	0901		$3.77	.	$0.76
J0270	Alprostadil for injection		B					
J0275	Alprostadil urethral suppos		B					
J0278	Amikacin sulfate injection		N					
J0280	Aminophyllin 250 MG inj		N					
J0282	Amiodarone HCl		N					
J0285	Amphotericin B		N					
J0287	Amphotericin b lipid complex		K	9024		$9.84	.	$1.97
J0288	Ampho b cholesteryl sulfate		K	0735		$14.00	.	$2.80
J0289	Amphotericin b liposome inj		K	0736		$15.78	.	$3.16
J0290	Ampicillin 500 MG inj		N					
J0295	Ampicillin sodium per 1.5 gm		N					
J0300	Amobarbital 125 MG inj		N					
J0330	Succinycholine chloride inj		N					
J0348	Anidulafungin injection	CH	N					
J0350	Injection anistreplase 30 u		E					
J0360	Hydralazine hcl injection		N					
J0364	Apomorphine hydrochloride		N					
J0365	Aprotonin, 10,000 kiu	CH	N					
J0380	Inj metaraminol bitartrate		N					
J0390	Chloroquine injection		N					
J0395	Arbutamine hcl injection		E					
J0400	Aripiprazole injection		N					
J0456	Azithromycin		N					
J0461	Atropine sulfate injection		N					
J0470	Dimecaprol injection	CH	N					
J0475	Baclofen 10 MG injection		K	9032		$203.89	.	$40.78

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J0476	Baclofen intrathecal trial		K	1631		$73.50	.	$14.70
J0480	Basiliximab		K	1683		$1,755.73	.	$351.15
J0500	Dicyclomine injection		N					
J0515	Inj benztropine mesylate	CH	K	1302		$42.16	.	$8.44
J0520	Bethanechol chloride inject		N					
J0559	PenG benzathine/procaine inj		N					
J0560	Penicillin g benzathine inj		N					
J0570	Penicillin g benzathine inj		N					
J0580	Penicillin g benzathine inj		N					
J0583	Bivalirudin		K	3041		$2.41	.	$0.49
J0585	Injection,onabotulinumtoxinA		K	0902		$5.49	.	$1.10
J0586	AbobotulinumtoxinA		K	1289		$7.71	.	$1.55
J0587	Inj, rimabotulinumtoxinB		K	9018		$10.58	.	$2.12
J0592	Buprenorphine hydrochloride		N					
J0594	Busulfan injection		K	1178		$14.45	.	$2.89
J0595	Butorphanol tartrate 1 mg		N					
J0598	C1 esterase inhibitor inj		G	9251		$42.75	.	$8.55
J0600	Edetate calcium disodium inj		K	1274		$197.37	.	$39.48
J0610	Calcium gluconate injection		N					
J0620	Calcium glycer & lact/10 ML		N					
J0630	Calcitonin salmon injection		K	1220		$49.26	.	$9.86
J0636	Inj calcitriol per 0.1 mcg		N					
J0637	Caspofungin acetate		K	9019		$11.59	.	$2.32
J0640	Leucovorin calcium injection		N					
J0641	Levoleucovorin injection		G	1236		$0.78	.	$0.16
J0670	Inj mepivacaine HCL/10 ml		N					
J0690	Cefazolin sodium injection		N					
J0692	Cefepime HCl for injection		N					
J0694	Cefoxitin sodium injection		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J0696	Ceftriaxone sodium injection		N					
J0697	Sterile cefuroxime injection		N					
J0698	Cefotaxime sodium injection		N					
J0702	Betamethasone acet&sod phosp		N					
J0704	Betamethasone sod phosp/4 MG		N					
J0706	Caffeine citrate injection		N					
J0710	Cephapirin sodium injection		N					
J0713	Inj ceftazidime per 500 mg		N					
J0715	Ceftizoxime sodium / 500 MG		N					
J0718	Certolizumab pegol inj		G	9249		$3.78	.	$0.76
J0720	Chloramphenicol sodium injec		N					
J0725	Chorionic gonadotropin/1000u		N					
J0735	Clonidine hydrochloride		K	0935		$98.64	.	$19.73
J0740	Cidofovir injection		K	9033		$761.10	.	$152.22
J0743	Cilastatin sodium injection		N					
J0744	Ciprofloxacin iv		N					
J0745	Inj codeine phosphate /30 MG		N					
J0760	Colchicine injection		N					
J0770	Colistimethate sodium inj		N					
J0780	Prochlorperazine injection		N					
J0795	Corticorelin ovine triflutal		K	1684		$4.48	.	$0.90
J0800	Corticotropin injection		K	1280		$2,441.70	.	$488.34
J0833	Cosyntropin injection NOS		K	0835		$73.19	.	$14.64
J0834	Cosyntropin cortrosyn inj		K	1298		$90.95	.	$18.19
J0850	Cytomegalovirus imm IV /vial		K	0903		$878.82	.	$175.77
J0878	Daptomycin injection		K	9124		$0.43	.	$0.09
J0881	Darbepoetin alfa, non-esrd		K	1685		$2.88	.	$0.58
J0882	Darbepoetin alfa, esrd use		A					
J0885	Epoetin alfa, non-esrd		K	1686		$9.44	.	$1.89

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J0886	Epoetin alfa 1000 units ESRD		A					
J0894	Decitabine injection		K	9231		$29.65	.	$5.93
J0895	Deferoxamine mesylate inj		N					
J0900	Testosterone enanthate inj		N					
J0945	Brompheniramine maleate inj		K	1256		$9.24	.	$1.85
J0970	Estradiol valerate injection		N					
J1000	Depo-estradiol cypionate inj		N					
J1020	Methylprednisolone 20 MG inj		N					
J1030	Methylprednisolone 40 MG inj		N					
J1040	Methylprednisolone 80 MG inj		N					
J1051	Medroxyprogesterone inj		N					
J1055	Medrxyprogester acetate inj		E					
J1056	MA/EC contraceptiveinjection		E					
J1060	Testosterone cypionate 1 ML		N					
J1070	Testosterone cypionat 100 MG		N					
J1080	Testosterone cypionat 200 MG		N					
J1094	Inj dexamethasone acetate		N					
J1100	Dexamethasone sodium phos		N					
J1110	Inj dihydroergotamine mesylt		N					
J1120	Acetazolamid sodium injectio		N					
J1160	Digoxin injection		N					
J1162	Digoxin immune fab (ovine)		K	1687		$487.78	.	$97.56
J1165	Phenytoin sodium injection		N					
J1170	Hydromorphone injection		N					
J1180	Dyphylline injection		N					
J1190	Dexrazoxane HCl injection		K	0726		$261.24	.	$52.25
J1200	Diphenhydramine hcl injectio		N					
J1205	Chlorothiazide sodium inj		K	0747		$352.37	.	$70.48
J1212	Dimethyl sulfoxide 50% 50 ML		K	1221		$69.98	.	$14.00

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J1230	Methadone injection		N					
J1240	Dimenhydrinate injection		N					
J1245	Dipyridamole injection		N					
J1250	Inj dobutamine HCL/250 mg		N					
J1260	Dolasetron mesylate		N					
J1265	Dopamine injection		N					
J1267	Doripenem injection	CH	N					
J1270	Injection, doxercalciferol		N					
J1300	Eculizumab injection		K	9236		$182.61	.	$36.53
J1320	Amitriptyline injection		N					
J1324	Enfuvirtide injection	CH	N					
J1325	Epoprostenol injection		N					
J1327	Eptifibatide injection		K	1607		$19.00	.	$3.80
J1330	Ergonovine maleate injection		N					
J1335	Ertapenem injection		N					
J1364	Erythro lactobionate /500 MG		N					
J1380	Estradiol valerate 10 MG inj		N					
J1390	Estradiol valerate 20 MG inj		N					
J1410	Inj estrogen conjugate 25 MG		K	9038		$88.68	.	$17.74
J1430	Ethanolamine oleate 100 mg		K	1688		$149.97	.	$30.00
J1435	Injection estrone per 1 MG	CH	E					
J1436	Etidronate disodium inj	CH	N					
J1438	Etanercept injection		K	1608		$191.55	.	$38.31
J1440	Filgrastim 300 mcg injection		K	0728		$223.05	.	$44.61
J1441	Filgrastim 480 mcg injection		K	7049		$348.68	.	$69.74
J1450	Fluconazole		N					
J1451	Fomepizole, 15 mg		K	1689		$7.64	.	$1.53
J1452	Intraocular Fomivirsen na		E					
J1453	Fosaprepitant injection	CH	K	9242		$1.62	.	$0.33

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J1455	Foscarnet sodium injection		N					
J1457	Gallium nitrate injection		K	0878		$2.03	.	$0.41
J1458	Galsulfase injection		K	9224		$339.90	.	$67.98
J1459	Inj IVIG privigen 500 mg	CH	K	1214		35.10	.	$7.02
J1460	Gamma globulin 1 CC inj		K	3043		$16.03	.	$3.21
J1470	Gamma globulin 2 CC inj		K	1282		$32.07	.	$6.42
J1480	Gamma globulin 3 CC inj		K	1283		$48.10	.	$9.62
J1490	Gamma globulin 4 CC inj		K	0904		$64.13	.	$12.83
J1500	Gamma globulin 5 CC inj		K	1284		$80.16	.	$16.04
J1510	Gamma globulin 6 CC inj		K	0920		$96.23	.	$19.25
J1520	Gamma globulin 7 CC inj		K	0921		$112.17	.	$22.44
J1530	Gamma globulin 8 CC inj		K	0922		$128.27	.	$25.66
J1540	Gamma globulin 9 CC inj		K	0923		$160.34	.	$32.07
J1550	Gamma globulin 10 CC inj		K	0924		$160.34	.	$32.07
J1560	Gamma globulin > 10 CC inj		K	0933		$160.34	.	$32.07
J1561	Gamunex injection		K	0948		$37.63	.	$7.53
J1562	Vivaglobin, inj		K	1275		$7.20	.	$1.44
J1566	Immune globulin, powder		K	2731		$30.86	.	$6.18
J1568	Octagam injection		K	0943		$37.69	.	$7.54
J1569	Gammagard liquid injection		K	0944		$38.53	.	$7.71
J1570	Ganciclovir sodium injection		N					
J1571	Hepagam b im injection	CH	K	0946		$50.63	.	$10.13
J1572	Flebogamma injection		K	0947		$37.01	.	$7.41
J1573	Hepagam b intravenous, inj	CH	K	1138		$50.63	.	$10.13
J1580	Garamycin gentamicin inj		N					
J1590	Gatifloxacin injection		N					
J1595	Injection glatiramer acetate		K	1015		$82.34	.	$16.47
J1600	Gold sodium thiomaleate inj		N					
J1610	Glucagon hydrochloride/1 MG		K	9042		$81.41	.	$16.29

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J1620	Gonadorelin hydroch/ 100 mcg	CH	N					
J1626	Granisetron hcl injection		N					
J1630	Haloperidol injection		N					
J1631	Haloperidol decanoate inj		N					
J1640	Hemin, 1 mg		K	1690		$8.18	.	$1.64
J1642	Inj heparin sodium per 10 u		N					
J1644	Inj heparin sodium per 1000u		N					
J1645	Dalteparin sodium		N					
J1650	Inj enoxaparin sodium		N					
J1652	Fondaparinux sodium	CH	N					
J1655	Tinzaparin sodium injection		N					
J1670	Tetanus immune globulin inj		K	1670		$136.81	.	$27.37
J1675	Histrelin acetate		B					
J1680	Human fibrinogen conc inj		G	1290		$72.89	.	$14.58
J1700	Hydrocortisone acetate inj		N					
J1710	Hydrocortisone sodium ph inj		N					
J1720	Hydrocortisone sodium succ i		N					
J1730	Diazoxide injection		K	1740		$114.32	.	$22.87
J1740	Ibandronate sodium injection		K	9229		$141.39	.	$28.28
J1742	Ibutilide fumarate injection		K	9044		$416.61	.	$83.33
J1743	Idursulfase injection		K	9232		$455.03	.	$91.01
J1745	Infliximab injection		K	7043		$58.74	.	$11.75
J1750	Inj iron dextran		K	1237		$12.63	.	$2.53
J1756	Iron sucrose injection		K	9046		$0.37	.	$0.08
J1785	Injection imiglucerase /unit		K	0916		$4.20	.	$0.84
J1790	Droperidol injection		N					
J1800	Propranolol injection		N					
J1810	Droperidol/fentanyl inj		E					
J1815	Insulin injection		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J1817	Insulin for insulin pump use	CH	N					
J1825	Interferon beta-1a		E					
J1830	Interferon beta-1b / .25 MG		K	0910		$176.67	.	$35.34
J1835	Itraconazole injection	CH	K	1303		$42.28	.	$8.46
J1840	Kanamycin sulfate 500 MG inj		N					
J1850	Kanamycin sulfate 75 MG inj		N					
J1885	Ketorolac tromethamine inj		N					
J1890	Cephalothin sodium injection		N					
J1930	Lanreotide injection		K	9237		$29.30	.	$5.86
J1931	Laronidase injection		K	9209		$25.56	.	$5.12
J1940	Furosemide injection		N					
J1945	Lepirudin		K	1693		$234.37	.	$46.88
J1950	Leuprolide acetate /3.75 MG		K	0800		$516.09	.	$103.22
J1953	Levetiracetam injection	CH	N					
J1955	Inj levocarnitine per 1 gm		B					
J1956	Levofloxacin injection		N					
J1960	Levorphanol tartrate inj		N					
J1980	Hyoscyamine sulfate inj		N					
J1990	Chlordiazepoxide injection		N					
J2001	Lidocaine injection		N					
J2010	Lincomycin injection		N					
J2020	Linezolid injection		K	9001		$32.57	.	$6.52
J2060	Lorazepam injection		N					
J2150	Mannitol injection		N					
J2170	Mecasermin injection	CH	K	1308		$125.21	.	$25.05
J2175	Meperidine hydrochl /100 MG		N					
J2180	Meperidine/promethazine inj		N					
J2185	Meropenem		N					
J2210	Methylergonovin maleate inj		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J2248	Micafungin sodium injection		K	9227		$1.10	.	$0.22
J2250	Inj midazolam hydrochloride		N					
J2260	Inj milrinone lactate / 5 MG		N					
J2270	Morphine sulfate injection		N					
J2271	Morphine so4 injection 100mg		N					
J2275	Morphine sulfate injection		N					
J2278	Ziconotide injection		K	1694		$6.50	.	$1.30
J2280	Inj, moxifloxacin 100 mg		N					
J2300	Inj nalbuphine hydrochloride		N					
J2310	Inj naloxone hydrochloride		N					
J2315	Naltrexone, depot form		K	0759		$2.43	.	$0.49
J2320	Nandrolone decanoate 50 MG		K	1285		$7.08	.	$1.42
J2321	Nandrolone decanoate 100 MG		K	1260		$71.34	.	$14.27
J2322	Nandrolone decanoate 200 MG		K	1286		$43.59	.	$8.72
J2323	Natalizumab injection		K	9126		$7.97	.	$1.60
J2325	Nesiritide injection		K	1695		$38.37	.	$7.68
J2353	Octreotide injection, depot		K	1207		$109.01	.	$21.81
J2354	Octreotide inj, non-depot		N					
J2355	Oprelvekin injection		K	7011		$245.08	.	$49.02
J2357	Omalizumab injection		K	9300		$19.77	.	$3.96
J2360	Orphenadrine injection		N					
J2370	Phenylephrine hcl injection		N					
J2400	Chloroprocaine hcl injection		N					
J2405	Ondansetron hcl injection		N					
J2410	Oxymorphone hcl injection		N					
J2425	Palifermin injection		K	1696		$11.34	.	$2.27
J2430	Pamidronate disodium /30 MG	CH	N					
J2440	Papaverin hcl injection		N					
J2460	Oxytetracycline injection		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J2469	Palonosetron hcl		K	9210		$17.62	.	$3.53
J2501	Paricalcitol		N					
J2503	Pegaptanib sodium injection		K	1697		$1,030.34	.	$206.07
J2504	Pegademase bovine, 25 iu		K	1739		$247.34	.	$49.47
J2505	Injection, pegfilgrastim 6mg		K	9119		$2,432.50	.	$486.50
J2510	Penicillin g procaine inj		N					
J2513	Pentastarch 10% solution		K	1222		$161.82	.	$32.37
J2515	Pentobarbital sodium inj		N					
J2540	Penicillin g potassium inj		N					
J2543	Piperacillin/tazobactam		N					
J2545	Pentamidine non-comp unit		B					
J2550	Promethazine hcl injection		N					
J2560	Phenobarbital sodium inj		N					
J2562	Plerixafor injection		G	9252		$268.58	.	$53.72
J2590	Oxytocin injection		N					
J2597	Inj desmopressin acetate		N					
J2650	Prednisolone acetate inj		N					
J2670	Totazoline hcl injection		N					
J2675	Inj progesterone per 50 MG		N					
J2680	Fluphenazine decanoate 25 MG		N					
J2690	Procainamide hcl injection		N					
J2700	Oxacillin sodium injeciton		N					
J2710	Neostigmine methylslfte inj		N					
J2720	Inj protamine sulfate/10 MG		N					
J2724	Protein c concentrate		K	1139		$12.19	.	$2.44
J2725	Inj protirelin per 250 mcg		N					
J2730	Pralidoxime chloride inj		K	1023		$90.79	.	$18.16
J2760	Phentolaine mesylate inj		N					
J2765	Metoclopramide hcl injection		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J2770	Quinupristin/dalfopristin		K	2770		$147.06	.	$29.42
J2778	Ranibizumab injection		K	9233		$404.70	.	$80.94
J2780	Ranitidine hydrochloride inj		N					
J2783	Rasburicase		K	0738		$172.53	.	$34.51
J2785	Regadenoson injection	CH	K	9244		$50.73	.	$10.15
J2788	Rho d immune globulin 50 mcg		K	9023		$25.14	.	$5.03
J2790	Rho d immune globulin inj		K	0884		$77.47	.	$15.50
J2791	Rhophylac injection		K	0945		$5.21	.	$1.05
J2792	Rho(D) immune globulin h, sd		K	1609		$18.55	.	$3.71
J2793	Rilonacept injection		K	1291		$24.09	.	$4.82
J2794	Risperidone, long acting		K	9125		$5.06	.	$1.02
J2795	Ropivacaine HCl injection		N					
J2796	Romiplostim injection	CH	K	9245		$44.18	.	$8.84
J2800	Methocarbamol injection		N					
J2805	Sincalide injection		N					
J2810	Inj theophylline per 40 MG		N					
J2820	Sargramostim injection		K	0731		$25.25	.	$5.05
J2850	Inj secretin synthetic human		K	1700		$20.31	.	$4.07
J2910	Aurothioglucose injeciton		N					
J2916	Na ferric gluconate complex		N					
J2920	Methylprednisolone injection		N					
J2930	Methylprednisolone injection		N					
J2940	Somatrem injection	CH	N					
J2941	Somatropin injection		K	7034		$55.46	.	$11.10
J2950	Promazine hcl injection		N					
J2993	Reteplase injection		K	9005		$1,555.98	.	$311.20
J2995	Inj streptokinase /250000 IU		K	1226		$32.12	.	$6.43
J2997	Alteplase recombinant		K	7048		$37.35	.	$7.47
J3000	Streptomycin injection		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J3010	Fentanyl citrate injeciton		N					
J3030	Sumatriptan succinate / 6 MG	CH	N					
J3070	Pentazocine injection		N					
J3101	Tenecteplase injection		K	9002		$46.74	.	$9.35
J3105	Terbutaline sulfate inj		N					
J3110	Teriparatide injection		B					
J3120	Testosterone enanthate inj		N					
J3130	Testosterone enanthate inj		N					
J3140	Testosterone suspension inj		N					
J3150	Testosteron propionate inj		N					
J3230	Chlorpromazine hcl injection		N					
J3240	Thyrotropin injection		K	9108		$1,053.42	.	$210.69
J3243	Tigecycline injection		K	9228		$1.16	.	$0.24
J3246	Tirofiban HCl		K	7041		$7.39	.	$1.48
J3250	Trimethobenzamide hcl inj		N					
J3260	Tobramycin sulfate injection		N					
J3265	Injection torsemide 10 mg/ml		N					
J3280	Thiethylperazine maleate inj		N					
J3285	Treprostinil injection		K	1701		$55.88	.	$11.18
J3300	Triamcinolone A inj PRS-free		K	1253		$3.21	.	$0.65
J3301	Triamcinolone acet inj NOS		N					
J3302	Triamcinolone diacetate inj		N					
J3303	Triamcinolone hexacetonl inj		N					
J3305	Inj trimetrexate glucoronate	CH	N					
J3310	Perphenazine injeciton	CH	K	1304		$29.11	.	$5.83
J3315	Triptorelin pamoate		K	9122		$164.10	.	$32.82
J3320	Spectinomycn di-hcl inj	CH	E					
J3350	Urea injection	CH	K	1306		$83.87	.	$16.78
J3355	Urofollitropin, 75 iu		K	1741		$60.01	.	$12.01

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J3360	Diazepam injection		N					
J3364	Urokinase 5000 IU injection		N					
J3365	Urokinase 250,000 IU inj		K	7036		$457.73	.	$91.55
J3370	Vancomycin hcl injection		N					
J3396	Verteporfin injection		K	1203		$9.50	.	$1.90
J3400	Triflupromazine hcl inj	CH	E					
J3410	Hydroxyzine hcl injection		N					
J3411	Thiamine hcl 100 mg		N					
J3415	Pyridoxine hcl 100 mg		N					
J3420	Vitamin b12 injection		N					
J3430	Vitamin k phytonadione inj		N					
J3465	Injection, voriconazole		K	1052		$5.82	.	$1.17
J3470	Hyaluronidase injection		N					
J3471	Ovine, up to 999 USP units		N					
J3472	Ovine, 1000 USP units		N					
J3473	Hyaluronidase recombinant		N					
J3475	Inj magnesium sulfate		N					
J3480	Inj potassium chloride		N					
J3485	Zidovudine		N					
J3486	Ziprasidone mesylate		N					
J3487	Zoledronic acid		K	9115		$221.12	.	$44.23
J3488	Reclast injection		K	0951		$222.92	.	$44.59
J3490	Drugs unclassified injection		N					
J3520	Edetate disodium per 150 mg		E					
J3530	Nasal vaccine inhalation		N					
J3535	Metered dose inhaler drug		E					
J3570	Laetrile amygdalin vit B17		E					
J3590	Unclassified biologics		N					
J7030	Normal saline solution infus		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J7040	Normal saline solution infus		N					
J7042	5% dextrose/normal saline		N					
J7050	Normal saline solution infus		N					
J7060	5% dextrose/water		N					
J7070	D5w infusion		N					
J7100	Dextran 40 infusion		N					
J7110	Dextran 75 infusion		N					
J7120	Ringers lactate infusion		N					
J7130	Hypertonic saline solution		N					
J7185	Xyntha inj		K	1268		$1.08	.	$0.22
J7186	Antihemophilic viii/vwf comp		K	1213		$0.92	.	$0.19
J7187	Humate-P, inj		K	1704		$0.88	.	$0.18
J7189	Factor viia		K	1705		$1.36	.	$0.28
J7190	Factor viii		K	0925		$0.87	.	$0.18
J7191	Factor VIII (porcine)		K	1279		$8.21	.	$1.65
J7192	Factor viii recombinant NOS		K	0927		$1.09	.	$0.22
J7193	Factor IX non-recombinant		K	0931		$0.91	.	$0.19
J7194	Factor ix complex		K	0928		$0.88	.	$0.18
J7195	Factor IX recombinant		K	0932		$1.11	.	$0.23
J7197	Antithrombin iii injection		K	1263		$2.31	.	$0.47
J7198	Anti-inhibitor		K	0929		$1.55	.	$0.31
J7199	Hemophilia clot factor noc		B					
J7300	Intraut copper contraceptive		E					
J7302	Levonorgestrel iu contracept		E					
J7303	Contraceptive vaginal ring		E					
J7304	Contraceptive hormone patch		E					
J7306	Levonorgestrel implant sys		E					
J7307	Etonogestrel implant system		E					
J7308	Aminolevulinic acid hcl top		K	7308		$134.54	.	$26.91

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J7310	Ganciclovir long act implant		K	0913		$16,960.00	.	$3,392.00
J7311	Fluocinolone acetonide implt		K	9225		$19,345.00	.	$3,869.00
J7321	Hyalgan/supartz inj per dose		K	0873		$91.96	.	$18.40
J7323	Euflexxa inj per dose		K	0875		$113.79	.	$22.76
J7324	Orthovisc inj per dose		K	0877		$176.70	.	$35.34
J7325	Synvisc or Synvisc-One		K	0874		$11.78	.	$2.36
J7330	Cultured chondrocytes implnt		B					
J7500	Azathioprine oral 50mg		N					
J7501	Azathioprine parenteral		K	0887		$96.29	.	$19.26
J7502	Cyclosporine oral 100 mg	CH	N					
J7504	Lymphocyte immune globulin		K	0890		$487.88	.	$97.58
J7505	Monoclonal antibodies		K	7038		$1,133.50	.	$226.70
J7506	Prednisone oral		N					
J7507	Tacrolimus oral per 1 MG	CH	N					
J7509	Methylprednisolone oral		N					
J7510	Prednisolone oral per 5 mg		N					
J7511	Antithymocyte globuln rabbit		K	9104		$386.48	.	$77.30
J7513	Daclizumab, parenteral		K	1612		$351.10	.	$70.22
J7515	Cyclosporine oral 25 mg	CH	N					
J7516	Cyclosporin parenteral 250mg	CH	N					
J7517	Mycophenolate mofetil oral	CH	N					
J7518	Mycophenolic acid		N					
J7520	Sirolimus, oral	CH	N					
J7525	Tacrolimus injection		K	9006		$139.41	.	$27.89
J7599	Immunosuppressive drug noc		N					
J7604	Acetylcysteine comp unit		M					
J7605	Arformoterol non-comp unit		M					
J7606	Formoterol fumarate, inh		M					
J7607	Levalbuterol comp con		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J7608	Acetylcysteine non-comp unit		M					
J7609	Albuterol comp unit		M					
J7610	Albuterol comp con		M					
J7611	Albuterol non-comp con		M					
J7612	Levalbuterol non-comp con		M					
J7613	Albuterol non-comp unit		M					
J7614	Levalbuterol non-comp unit		M					
J7615	Levalbuterol comp unit		M					
J7620	Albuterol ipratrop non-comp		M					
J7622	Beclomethasone comp unit		M					
J7624	Betamethasone comp unit		M					
J7626	Budesonide non-comp unit		M					
J7627	Budesonide comp unit		M					
J7628	Bitolterol mesylate comp con		M					
J7629	Bitolterol mesylate comp unt		M					
J7631	Cromolyn sodium noncomp unit		M					
J7632	Cromolyn sodium comp unit		M					
J7633	Budesonide non-comp con		M					
J7634	Budesonide comp con		M					
J7635	Atropine comp con		M					
J7636	Atropine comp unit		M					
J7637	Dexamethasone comp con		M					
J7638	Dexamethasone comp unit		M					
J7639	Dornase alfa non-comp unit		M					
J7640	Formoterol comp unit		E					
J7641	Flunisolide comp unit		M					
J7642	Glycopyrrolate comp con		M					
J7643	Glycopyrrolate comp unit		M					
J7644	Ipratropium bromide non-comp		M					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J7645	Ipratropium bromide comp		M					
J7647	Isoetharine comp con		M					
J7648	Isoetharine non-comp con		M					
J7649	Isoetharine non-comp unit		M					
J7650	Isoetharine comp unit		M					
J7657	Isoproterenol comp con		M					
J7658	Isoproterenol non-comp con		M					
J7659	Isoproterenol non-comp unit		M					
J7660	Isoproterenol comp unit		M					
J7667	Metaproterenol comp con		M					
J7668	Metaproterenol non-comp con		M					
J7669	Metaproterenol non-comp unit		M					
J7670	Metaproterenol comp unit		M					
J7674	Methacholine chloride, neb		N					
J7676	Pentamidine comp unit dose		M					
J7680	Terbutaline sulf comp con		M					
J7681	Terbutaline sulf comp unit		M					
J7682	Tobramycin non-comp unit		M					
J7683	Triamcinolone comp con		M					
J7684	Triamcinolone comp unit		M					
J7685	Tobramycin comp unit		M					
J7699	Inhalation solution for DME		M					
J7799	Non-inhalation drug for DME		N					
J8498	Antiemetic rectal/supp NOS		B					
J8499	Oral prescrip drug non chemo		E					
J8501	Oral aprepitant		K	0868		$5.67	.	$1.14
J8510	Oral busulfan	CH	K	1307		$3.65	.	$0.73
J8515	Cabergoline, oral 0.25mg		E					
J8520	Capecitabine, oral, 150 mg		K	7042		$6.28	.	$1.26

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J8521	Capecitabine, oral, 500 mg		K	0934		$20.66	.	$4.14
J8530	Cyclophosphamide oral 25 MG		N					
J8540	Oral dexamethasone		N					
J8560	Etoposide oral 50 MG		K	0802		$28.26	.	$5.66
J8565	Gefitinib oral		E					
J8597	Antiemetic drug oral NOS		N					
J8600	Melphalan oral 2 MG		N					
J8610	Methotrexate oral 2.5 MG		N					
J8650	Nabilone oral		N					
J8700	Temozolomide		K	1086		$8.83	.	$1.77
J8705	Topotecan oral		G	1238		$74.66	.	$14.94
J8999	Oral prescription drug chemo		B					
J9000	Doxorubicin hcl injection		N					
J9001	Doxorubicin hcl liposome inj		K	7046		$472.01	.	$94.41
J9010	Alemtuzumab injection		K	9110		$578.02	.	$115.61
J9015	Aldesleukin injection		K	0807		$844.43	.	$168.89
J9017	Arsenic trioxide injection		K	9012		$37.43	.	$7.49
J9020	Asparaginase injection		K	0814		$60.94	.	$12.19
J9025	Azacitidine injection		K	1709		$4.99	.	$1.00
J9027	Clofarabine injection		K	1710		$116.49	.	$23.30
J9031	Bcg live intravesical vac		K	0809		$121.25	.	$24.25
J9033	Bendamustine injection	CH	K	9243		$18.47	.	$3.70
J9035	Bevacizumab injection		K	9214		$57.57	.	$11.52
J9040	Bleomycin sulfate injection		N					
J9041	Bortezomib injection		K	9207		$38.24	.	$7.65
J9045	Carboplatin injection		N					
J9050	Carmustine injection		K	0812		$176.41	.	$35.29
J9055	Cetuximab injection		K	9215		$49.73	.	$9.95
J9060	Cisplatin 10 MG injection		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J9062	Cisplatin 50 MG injection		N					
J9065	Inj cladribine per 1 MG		K	0858		$28.22	.	$5.65
J9070	Cyclophosphamide 100 MG inj		N					
J9080	Cyclophosphamide 200 MG inj		N					
J9090	Cyclophosphamide 500 MG inj		N					
J9091	Cyclophosphamide 1.0 grm inj		N					
J9092	Cyclophosphamide 2.0 grm inj		N					
J9093	Cyclophosphamide lyophilized		N					
J9094	Cyclophosphamide lyophilized		N					
J9095	Cyclophosphamide lyophilized		N					
J9096	Cyclophosphamide lyophilized		N					
J9097	Cyclophosphamide lyophilized		N					
J9098	Cytarabine liposome inj		K	1166		$488.90	.	$97.78
J9100	Cytarabine hcl 100 MG inj		N					
J9110	Cytarabine hcl 500 MG inj		N					
J9120	Dactinomycin injection		K	0752		$570.53	.	$114.11
J9130	Dacarbazine 100 mg inj		N					
J9140	Dacarbazine 200 MG inj		N					
J9150	Daunorubicin injection		K	0820		$19.46	.	$3.90
J9151	Daunorubicin citrate inj		K	0821		$56.31	.	$11.27
J9155	Degarelix injection		G	1296		$2.60	.	$0.52
J9160	Denileukin diftitox inj		K	1084		$1,494.82	.	$298.97
J9165	Diethylstilbestrol injection	CH	N					
J9171	Docetaxel injection		K	0823		$17.86	.	$3.58
J9175	Elliotts b solution per ml		N					
J9178	Inj, epirubicin hcl, 2 mg		K	1167		$2.48	.	$0.50
J9181	Etoposide injection		N					
J9185	Fludarabine phosphate inj		K	0842		$205.81	.	$41.17
J9190	Fluorouracil injection		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J9200	Floxuridine injection		K	0827		$42.99	.	$8.60
J9201	Gemcitabine hcl injection		K	0828		$145.10	.	$29.02
J9202	Goserelin acetate implant		K	0810		$195.23	.	$39.05
J9206	Irinotecan injection		K	0830		$9.15	.	$1.83
J9207	Ixabepilone injection	CH	K	9240		$63.74	.	$12.75
J9208	Ifosfomide injection		K	0831		$30.76	.	$6.16
J9209	Mesna injection	CH	N					
J9211	Idarubicin hcl injection		K	0832		$63.57	.	$12.72
J9212	Interferon alfacon-1 inj		K	1266		$4.80	.	$0.96
J9213	Interferon alfa-2a inj	CH	N					
J9214	Interferon alfa-2b inj		K	0836		$15.84	.	$3.17
J9215	Interferon alfa-n3 inj		K	0865		$18.23	.	$3.65
J9216	Interferon gamma 1-b inj		K	0838		$430.93	.	$86.19
J9217	Leuprolide acetate suspnsion		K	9217		$220.41	.	$44.09
J9218	Leuprolide acetate injeciton		K	0861		$4.27	.	$0.86
J9219	Leuprolide acetate implant		K	7051		$4,819.82	.	$963.97
J9225	Vantas implant	CH	K	1711		$1,515.25	.	$303.05
J9226	Supprelin LA implant	CH	K	1142		$14,990.44	.	$2,998.09
J9230	Mechlorethamine hcl inj		K	0751		$154.50	.	$30.90
J9245	Inj melphalan hydrochl 50 MG		K	0840		$1,500.32	.	$300.07
J9250	Methotrexate sodium inj		N					
J9260	Methotrexate sodium inj		N					
J9261	Nelarabine injection		K	0825		$105.91	.	$21.19
J9263	Oxaliplatin		K	1738		$6.83	.	$1.37
J9264	Paclitaxel protein bound		K	1712		$9.43	.	$1.89
J9265	Paclitaxel injection	CH	K	1309		$11.46	.	$2.30
J9266	Pegaspargase injection		K	0843		$2,747.44	.	$549.49
J9268	Pentostatin injection		K	0844		$1,246.38	.	$249.28
J9270	Plicamycin (mithramycin) inj		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
J9280	Mitomycin 5 MG inj		K	1232		$20.35	.	$4.07
J9290	Mitomycin 20 MG inj		K	1233		$81.44	.	$16.29
J9291	Mitomycin 40 MG inj		K	1234		$162.86	.	$32.58
J9293	Mitoxantrone hydrochl / 5 MG		K	0864		$45.26	.	$9.06
J9300	Gemtuzumab ozogamicin inj		K	9004		$2,687.21	.	$537.45
J9303	Panitumumab injection		K	9235		$87.24	.	$17.45
J9305	Pemetrexed injection		K	9213		$50.63	.	$10.13
J9310	Rituximab injection		K	0849		$578.40	.	$115.68
J9320	Streptozocin injection		K	0850		$282.86	.	$56.58
J9328	Temozolomide injection		G	9253		$4.90	.	$0.98
J9330	Temsirolimus injection		K	1168		$49.83	.	$9.97
J9340	Thiotepa injection		K	0851		$113.52	.	$22.71
J9350	Topotecan injection		K	0852		$1,058.90	.	$211.78
J9355	Trastuzumab injection		K	1613		$66.41	.	$13.29
J9357	Valrubicin injection		K	1235		$960.22	.	$192.05
J9360	Vinblastine sulfate inj		N					
J9370	Vincristine sulfate 1 MG inj		N					
J9375	Vincristine sulfate 2 MG inj		N					
J9380	Vincristine sulfate 5 MG inj		N					
J9390	Vinorelbine tartrate inj		N					
J9395	Injection, Fulvestrant		K	9120		$82.22	.	$16.45
J9600	Porfimer sodium injection		K	0856		$2,934.28	.	$586.86
J9999	Chemotherapy drug		N					
K0001	Standard wheelchair		Y					
K0002	Stnd hemi (low seat) whlchr		Y					
K0003	Lightweight wheelchair		Y					
K0004	High strength ltwt whlchr		Y					
K0005	Ultralightweight wheelchair		Y					
K0006	Heavy duty wheelchair		Y					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
K0007	Extra heavy duty wheelchair		Y					
K0009	Other manual wheelchair/base		Y					
K0010	Stnd wt frame power whlchr		Y					
K0011	Stnd wt pwr whlchr w control		Y					
K0012	Ltwt portbl power whlchr		Y					
K0014	Other power whlchr base		Y					
K0015	Detach non-adjus hght armrst		Y					
K0017	Detach adjust armrest base		Y					
K0018	Detach adjust armrst upper		Y					
K0019	Arm pad each		Y					
K0020	Fixed adjust armrest pair		Y					
K0037	High mount flip-up footrest		Y					
K0038	Leg strap each		Y					
K0039	Leg strap h style each		Y					
K0040	Adjustable angle footplate		Y					
K0041	Large size footplate each		Y					
K0042	Standard size footplate each		Y					
K0043	Ftrst lower extension tube		Y					
K0044	Ftrst upper hanger bracket		Y					
K0045	Footrest complete assembly		Y					
K0046	Elevat legrst low extension		Y					
K0047	Elevat legrst up hangr brack		Y					
K0050	Ratchet assembly		Y					
K0051	Cam relese assem ftrst/lgrst		Y					
K0052	Swingaway detach footrest		Y					
K0053	Elevate footrest articulate		Y					
K0056	Seat ht <17 or >=21 ltwt wc		Y					
K0065	Spoke protectors		Y					
K0069	Rear whl complete solid tire		Y					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
K0070	Rear whl compl pneum tire		Y					
K0071	Front castr compl pneum tire		Y					
K0072	Frnt cstr cmpl sem-pneum tir		Y					
K0073	Caster pin lock each		Y					
K0077	Front caster assem complete		Y					
K0098	Drive belt power wheelchair		Y					
K0105	Iv hanger		Y					
K0108	W/c component-accessory NOS		Y					
K0195	Elevating whlchair leg rests		Y					
K0455	Pump uninterrupted infusion		Y					
K0462	Temporary replacement eqpmnt		Y					
K0552	Supply/ext inf pump syr type		Y					
K0601	Repl batt silver oxide 1.5 v		Y					
K0602	Repl batt silver oxide 3 v		Y					
K0603	Repl batt alkaline 1.5 v		Y					
K0604	Repl batt lithium 3.6 v		Y					
K0605	Repl batt lithium 4.5 v		Y					
K0606	AED garment w elec analysis		Y					
K0607	Repl batt for AED		Y					
K0608	Repl garment for AED		Y					
K0609	Repl electrode for AED		Y					
K0669	Seat/back cus no sadmerc ver		Y					
K0672	Removable soft interface LE		A					
K0730	Ctrl dose inh drug deliv sys		Y					
K0733	12-24hr sealed lead acid		Y					
K0734	Adj skin pro w/c cus wd<22in		Y					
K0735	Adj skin pro wc cus wd>=22in		Y					
K0736	Adj skin pro/pos wc cus<22in		Y					
K0737	Adj skin pro/pos wc cus>=22"		Y					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
K0738	Portable gas oxygen system		Y					
K0739	Repair/svc DME non-oxygen eq		Y					
K0740	Repair/svc oxygen equipment		E					
K0800	POV group 1 std up to 300lbs		Y					
K0801	POV group 1 hd 301-450 lbs		Y					
K0802	POV group 1 vhd 451-600 lbs		Y					
K0806	POV group 2 std up to 300lbs		Y					
K0807	POV group 2 hd 301-450 lbs		Y					
K0808	POV group 2 vhd 451-600 lbs		Y					
K0812	Power operated vehicle NOC		Y					
K0813	PWC gp 1 std port seat/back		Y					
K0814	PWC gp 1 std port cap chair		Y					
K0815	PWC gp 1 std seat/back		Y					
K0816	PWC gp 1 std cap chair		Y					
K0820	PWC gp 2 std port seat/back		Y					
K0821	PWC gp 2 std port cap chair		Y					
K0822	PWC gp 2 std seat/back		Y					
K0823	PWC gp 2 std cap chair		Y					
K0824	PWC gp 2 hd seat/back		Y					
K0825	PWC gp 2 hd cap chair		Y					
K0826	PWC gp 2 vhd seat/back		Y					
K0827	PWC gp vhd cap chair		Y					
K0828	PWC gp 2 xtra hd seat/back		Y					
K0829	PWC gp 2 xtra hd cap chair		Y					
K0830	PWC gp2 std seat elevate s/b		Y					
K0831	PWC gp2 std seat elevate cap		Y					
K0835	PWC gp2 std sing pow opt s/b		Y					
K0836	PWC gp2 std sing pow opt cap		Y					
K0837	PWC gp 2 hd sing pow opt s/b		Y					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
K0838	PWC gp 2 hd sing pow opt cap		Y					
K0839	PWC gp2 vhd sing pow opt s/b		Y					
K0840	PWC gp2 xhd sing pow opt s/b		Y					
K0841	PWC gp2 std mult pow opt s/b		Y					
K0842	PWC gp2 std mult pow opt cap		Y					
K0843	PWC gp2 hd mult pow opt s/b		Y					
K0848	PWC gp 3 std seat/back		Y					
K0849	PWC gp 3 std cap chair		Y					
K0850	PWC gp 3 hd seat/back		Y					
K0851	PWC gp 3 hd cap chair		Y					
K0852	PWC gp 3 vhd seat/back		Y					
K0853	PWC gp 3 vhd cap chair		Y					
K0854	PWC gp 3 xhd seat/back		Y					
K0855	PWC gp 3 xhd cap chair		Y					
K0856	PWC gp3 std sing pow opt s/b		Y					
K0857	PWC gp3 std sing pow opt cap		Y					
K0858	PWC gp3 hd sing pow opt s/b		Y					
K0859	PWC gp3 hd sing pow opt cap		Y					
K0860	PWC gp3 vhd sing pow opt s/b		Y					
K0861	PWC gp3 std mult pow opt s/b		Y					
K0862	PWC gp3 hd mult pow opt s/b		Y					
K0863	PWC gp3 vhd mult pow opt s/b		Y					
K0864	PWC gp3 xhd mult pow opt s/b		Y					
K0868	PWC gp 4 std seat/back		Y					
K0869	PWC gp 4 std cap chair		Y					
K0870	PWC gp 4 hd seat/back		Y					
K0871	PWC gp 4 vhd seat/back		Y					
K0877	PWC gp4 std sing pow opt s/b		Y					
K0878	PWC gp4 std sing pow opt cap		Y					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
K0879	PWC gp4 hd sing pow opt s/b		Y					
K0880	PWC gp4 vhd sing pow opt s/b		Y					
K0884	PWC gp4 std mult pow opt s/b		Y					
K0885	PWC gp4 std mult pow opt cap		Y					
K0886	PWC gp4 hd mult pow s/b		Y					
K0890	PWC gp5 ped sing pow opt s/b		Y					
K0891	PWC gp5 ped mult pow opt s/b		Y					
K0898	Power wheelchair NOC		Y					
K0899	Pow mobil dev no SADMERC		Y					
L0112	Cranial cervical orthosis		A					
L0113	Cranial cervical torticollis		A					
L0120	Cerv flexible non-adjustable		A					
L0130	Flex thermoplastic collar mo		A					
L0140	Cervical semi-rigid adjustab		A					
L0150	Cerv semi-rig adj molded chn		A					
L0160	Cerv semi-rig wire occ/mand		A					
L0170	Cervical collar molded to pt		A					
L0172	Cerv col thermplas foam 2 pi		A					
L0174	Cerv col foam 2 piece w thor		A					
L0180	Cer post col occ/man sup adj		A					
L0190	Cerv collar supp adj cerv ba		A					
L0200	Cerv col supp adj bar & thor		A					
L0220	Thor rib belt custom fabrica		A					
L0430	Dewall posture protector		A					
L0450	TLSO flex prefab thoracic		A					
L0452	tlso flex custom fab thoraci		A					
L0454	TLSO flex prefab sacrococ-T9		A					
L0456	TLSO flex prefab		A					
L0458	TLSO 2Mod symphis-xipho pre		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L0460	TLSO2Mod symphysis-stern pre		A					
L0462	TLSO 3Mod sacro-scap pre		A					
L0464	TLSO 4Mod sacro-scap pre		A					
L0466	TLSO rigid frame pre soft ap		A					
L0468	TLSO rigid frame prefab pelv		A					
L0470	TLSO rigid frame pre subclav		A					
L0472	TLSO rigid frame hyperex pre		A					
L0480	TLSO rigid plastic custom fa		A					
L0482	TLSO rigid lined custom fab		A					
L0484	TLSO rigid plastic cust fab		A					
L0486	TLSO rigidlined cust fab two		A					
L0488	TLSO rigid lined pre one pie		A					
L0490	TLSO rigid plastic pre one		A					
L0491	TLSO 2 piece rigid shell		A					
L0492	TLSO 3 piece rigid shell		A					
L0621	SIO flex pelvisacral prefab		A					
L0622	SIO flex pelvisacral custom		A					
L0623	SIO panel prefab		A					
L0624	SIO panel custom		A					
L0625	LO flexibl L1-below L5 pre		A					
L0626	LO sag stays/panels pre-fab		A					
L0627	LO sagitt rigid panel prefab		A					
L0628	LO flex w/o rigid stays pre		A					
L0629	LSO flex w/rigid stays cust		A					
L0630	LSO post rigid panel pre		A					
L0631	LSO sag-coro rigid frame pre		A					
L0632	LSO sag rigid frame cust		A					
L0633	LSO flexion control prefab		A					
L0634	LSO flexion control custom		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L0635	LSO sagit rigid panel prefab		A					
L0636	LSO sagittal rigid panel cus		A					
L0637	LSO sag-coronal panel prefab		A					
L0638	LSO sag-coronal panel custom		A					
L0639	LSO s/c shell/panel prefab		A					
L0640	LSO s/c shell/panel custom		A					
L0700	Ctlso a-p-l control molded		A					
L0710	Ctlso a-p-l control w/ inter		A					
L0810	Halo cervical into jckt vest		A					
L0820	Halo cervical into body jack		A					
L0830	Halo cerv into milwaukee typ		A					
L0859	MRI compatible system		A					
L0861	Halo repl liner/interface		A					
L0970	Tlso corset front		A					
L0972	Lso corset front		A					
L0974	Tlso full corset		A					
L0976	Lso full corset		A					
L0978	Axillary crutch extension		A					
L0980	Peroneal straps pair		A					
L0982	Stocking supp grips set of f		A					
L0984	Protective body sock each		A					
L0999	Add to spinal orthosis NOS		A					
L1000	Ctlso milwauke initial model		A					
L1001	CTLSO infant immobilizer		A					
L1005	Tension based scoliosis orth		A					
L1010	Ctlso axilla sling		A					
L1020	Kyphosis pad		A					
L1025	Kyphosis pad floating		A					
L1030	Lumbar bolster pad		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L1040	Lumbar or lumbar rib pad		A					
L1050	Sternal pad		A					
L1060	Thoracic pad		A					
L1070	Trapezius sling		A					
L1080	Outrigger		A					
L1085	Outrigger bil w/ vert extens		A					
L1090	Lumbar sling		A					
L1100	Ring flange plastic/leather		A					
L1110	Ring flange plas/leather mol		A					
L1120	Covers for upright each		A					
L1200	Furnsh initial orthosis only		A					
L1210	Lateral thoracic extension		A					
L1220	Anterior thoracic extension		A					
L1230	Milwaukee type superstructur		A					
L1240	Lumbar derotation pad		A					
L1250	Anterior asis pad		A					
L1260	Anterior thoracic derotation		A					
L1270	Abdominal pad		A					
L1280	Rib gusset (elastic) each		A					
L1290	Lateral trochanteric pad		A					
L1300	Body jacket mold to patient		A					
L1310	Post-operative body jacket		A					
L1499	Spinal orthosis NOS		A					
L1500	Thkao mobility frame		A					
L1510	Thkao standing frame		A					
L1520	Thkao swivel walker		A					
L1600	Abduct hip flex frejka w cvr		A					
L1610	Abduct hip flex frejka covr		A					
L1620	Abduct hip flex pavlik harne		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L1630	Abduct control hip semi-flex		A					
L1640	Pelv band/spread bar thigh c		A					
L1650	HO abduction hip adjustable		A					
L1652	HO bi thighcuffs w sprdr bar		A					
L1660	HO abduction static plastic		A					
L1680	Pelvic & hip control thigh c		A					
L1685	Post-op hip abduct custom fa		A					
L1686	HO post-op hip abduction		A					
L1690	Combination bilateral HO		A					
L1700	Leg perthes orth toronto typ		A					
L1710	Legg perthes orth newington		A					
L1720	Legg perthes orthosis trilat		A					
L1730	Legg perthes orth scottish r		A					
L1755	Legg perthes patten bottom t		A					
L1810	Ko elastic with joints		A					
L1820	Ko elas w/ condyle pads & jo		A					
L1830	Ko immobilizer canvas longit		A					
L1831	Knee orth pos locking joint		A					
L1832	KO adj jnt pos rigid support		A					
L1834	Ko w/0 joint rigid molded to		A					
L1836	Rigid KO wo joints		A					
L1840	Ko derot ant cruciate custom		A					
L1843	KO single upright custom fit		A					
L1844	Ko w/adj jt rot cntrl molded		A					
L1845	Ko w/ adj flex/ext rotat cus		A					
L1846	Ko w adj flex/ext rotat mold		A					
L1847	KO adjustable w air chambers		A					
L1850	Ko swedish type		A					
L1860	Ko supracondylar socket mold		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L1900	Afo sprng wir drsflx calf bd		A					
L1902	Afo ankle gauntlet		A					
L1904	Afo molded ankle gauntlet		A					
L1906	Afo multiligamentus ankle su		A					
L1907	AFO supramalleolar custom		A					
L1910	Afo sing bar clasp attach sh		A					
L1920	Afo sing upright w/ adjust s		A					
L1930	Afo plastic		A					
L1932	Afo rig ant tib prefab TCF/=		A					
L1940	Afo molded to patient plasti		A					
L1945	Afo molded plas rig ant tib		A					
L1950	Afo spiral molded to pt plas		A					
L1951	AFO spiral prefabricated		A					
L1960	Afo pos solid ank plastic mo		A					
L1970	Afo plastic molded w/ankle j		A					
L1971	AFO w/ankle joint, prefab		A					
L1980	Afo sing solid stirrup calf		A					
L1990	Afo doub solid stirrup calf		A					
L2000	Kafo sing fre stirr thi/calf		A					
L2005	KAFO sng/dbl mechanical act		A					
L2010	Kafo sng solid stirrup w/o j		A					
L2020	Kafo dbl solid stirrup band/		A					
L2030	Kafo dbl solid stirrup w/o j		A					
L2034	KAFO pla sin up w/wo k/a cus		A					
L2035	KAFO plastic pediatric size		A					
L2036	Kafo plas doub free knee mol		A					
L2037	Kafo plas sing free knee mol		A					
L2038	Kafo w/o joint multi-axis an		A					
L2040	Hkafo torsion bil rot straps		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L2050	Hkafo torsion cable hip pelv		A					
L2060	Hkafo torsion ball bearing j		A					
L2070	Hkafo torsion unilat rot str		A					
L2080	Hkafo unilat torsion cable		A					
L2090	Hkafo unilat torsion ball br		A					
L2106	Afo tib fx cast plaster mold		A					
L2108	Afo tib fx cast molded to pt		A					
L2112	Afo tibial fracture soft		A					
L2114	Afo tib fx semi-rigid		A					
L2116	Afo tibial fracture rigid		A					
L2126	Kafo fem fx cast thermoplas		A					
L2128	Kafo fem fx cast molded to p		A					
L2132	Kafo femoral fx cast soft		A					
L2134	Kafo fem fx cast semi-rigid		A					
L2136	Kafo femoral fx cast rigid		A					
L2180	Plas shoe insert w ank joint		A					
L2182	Drop lock knee		A					
L2184	Limited motion knee joint		A					
L2186	Adj motion knee jnt lerman t		A					
L2188	Quadrilateral brim		A					
L2190	Waist belt		A					
L2192	Pelvic band & belt thigh fla		A					
L2200	Limited ankle motion ea jnt		A					
L2210	Dorsiflexion assist each joi		A					
L2220	Dorsi & plantar flex ass/res		A					
L2230	Split flat caliper stirr & p		A					
L2232	Rocker bottom, contact AFO		A					
L2240	Round caliper and plate atta		A					
L2250	Foot plate molded stirrup at		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L2260	Reinforced solid stirrup		A					
L2265	Long tongue stirrup		A					
L2270	Varus/valgus strap padded/li		A					
L2275	Plastic mod low ext pad/line		A					
L2280	Molded inner boot		A					
L2300	Abduction bar jointed adjust		A					
L2310	Abduction bar-straight		A					
L2320	Non-molded lacer		A					
L2330	Lacer molded to patient mode		A					
L2335	Anterior swing band		A					
L2340	Pre-tibial shell molded to p		A					
L2350	Prosthetic type socket molde		A					
L2360	Extended steel shank		A					
L2370	Patten bottom		A					
L2375	Torsion ank & half solid sti		A					
L2380	Torsion straight knee joint		A					
L2385	Straight knee joint heavy du		A					
L2387	Add LE poly knee custom KAFO		A					
L2390	Offset knee joint each		A					
L2395	Offset knee joint heavy duty		A					
L2397	Suspension sleeve lower ext		A					
L2405	Knee joint drop lock ea jnt		A					
L2415	Knee joint cam lock each joi		A					
L2425	Knee disc/dial lock/adj flex		A					
L2430	Knee jnt ratchet lock ea jnt		A					
L2492	Knee lift loop drop lock rin		A					
L2500	Thi/glut/ischia wgt bearing		A					
L2510	Th/wght bear quad-lat brim m		A					
L2520	Th/wght bear quad-lat brim c		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L2525	Th/wght bear nar m-l brim mo		A					
L2526	Th/wght bear nar m-l brim cu		A					
L2530	Thigh/wght bear lacer non-mo		A					
L2540	Thigh/wght bear lacer molded		A					
L2550	Thigh/wght bear high roll cu		A					
L2570	Hip clevis type 2 posit jnt		A					
L2580	Pelvic control pelvic sling		A					
L2600	Hip clevis/thrust bearing fr		A					
L2610	Hip clevis/thrust bearing lo		A					
L2620	Pelvic control hip heavy dut		A					
L2622	Hip joint adjustable flexion		A					
L2624	Hip adj flex ext abduct cont		A					
L2627	Plastic mold recipro hip & c		A					
L2628	Metal frame recipro hip & ca		A					
L2630	Pelvic control band & belt u		A					
L2640	Pelvic control band & belt b		A					
L2650	Pelv & thor control gluteal		A					
L2660	Thoracic control thoracic ba		A					
L2670	Thorac cont paraspinal uprig		A					
L2680	Thorac cont lat support upri		A					
L2750	Plating chrome/nickel pr bar		A					
L2755	Carbon graphite lamination		A					
L2760	Extension per extension per		A					
L2768	Ortho sidebar disconnect		A					
L2780	Non-corrosive finish		A					
L2785	Drop lock retainer each		A					
L2795	Knee control full kneecap		A					
L2800	Knee cap medial or lateral p		A					
L2810	Knee control condylar pad		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L2820	Soft interface below knee se		A					
L2830	Soft interface above knee se		A					
L2840	Tibial length sock fx or equ		A					
L2850	Femoral lgth sock fx or equa		A					
L2861	Torsion mechanism knee/ankle		E					
L2999	Lower extremity orthosis NOS		A					
L3000	Ft insert ucb berkeley shell		A					
L3001	Foot insert remov molded spe		A					
L3002	Foot insert plastazote or eq		A					
L3003	Foot insert silicone gel eac		A					
L3010	Foot longitudinal arch suppo		A					
L3020	Foot longitud/metatarsal sup		A					
L3030	Foot arch support remov prem		A					
L3031	Foot lamin/prepreg composite		A					
L3040	Ft arch suprt premold longit		A					
L3050	Foot arch supp premold metat		A					
L3060	Foot arch supp longitud/meta		A					
L3070	Arch suprt att to sho longit		A					
L3080	Arch supp att to shoe metata		A					
L3090	Arch supp att to shoe long/m		A					
L3100	Hallus-valgus nght dynamic s		A					
L3140	Abduction rotation bar shoe		A					
L3150	Abduct rotation bar w/o shoe		A					
L3160	Shoe styled positioning dev		A					
L3170	Foot plastic heel stabilizer		A					
L3201	Oxford w supinat/pronat inf		A					
L3202	Oxford w/ supinat/pronator c		A					
L3203	Oxford w/ supinator/pronator		A					
L3204	Hightop w/ supp/pronator inf		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L3206	Hightop w/ supp/pronator chi		A					
L3207	Hightop w/ supp/pronator jun		A					
L3208	Surgical boot each infant		A					
L3209	Surgical boot each child		A					
L3211	Surgical boot each junior		A					
L3212	Benesch boot pair infant		A					
L3213	Benesch boot pair child		A					
L3214	Benesch boot pair junior		A					
L3215	Orthopedic ftwear ladies oxf		E					
L3216	Orthoped ladies shoes dpth i		E					
L3217	Ladies shoes hightop depth i		E					
L3219	Orthopedic mens shoes oxford		E					
L3221	Orthopedic mens shoes dpth i		E					
L3222	Mens shoes hightop depth inl		E					
L3224	Woman's shoe oxford brace		A					
L3225	Man's shoe oxford brace		A					
L3230	Custom shoes depth inlay		A					
L3250	Custom mold shoe remov prost		A					
L3251	Shoe molded to pt silicone s		A					
L3252	Shoe molded plastazote cust		A					
L3253	Shoe molded plastazote cust		A					
L3254	Orth foot non-stndard size/w		A					
L3255	Orth foot non-standard size/		A					
L3257	Orth foot add charge split s		A					
L3260	Ambulatory surgical boot eac		E					
L3265	Plastazote sandal each		A					
L3300	Sho lift taper to metatarsal		A					
L3310	Shoe lift elev heel/sole neo		A					
L3320	Shoe lift elev heel/sole cor		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L3330	Lifts elevation metal extens		A					
L3332	Shoe lifts tapered to one-ha		A					
L3334	Shoe lifts elevation heel /i		A					
L3340	Shoe wedge sach		A					
L3350	Shoe heel wedge		A					
L3360	Shoe sole wedge outside sole		A					
L3370	Shoe sole wedge between sole		A					
L3380	Shoe clubfoot wedge		A					
L3390	Shoe outflare wedge		A					
L3400	Shoe metatarsal bar wedge ro		A					
L3410	Shoe metatarsal bar between		A					
L3420	Full sole/heel wedge btween		A					
L3430	Sho heel count plast reinfor		A					
L3440	Heel leather reinforced		A					
L3450	Shoe heel sach cushion type		A					
L3455	Shoe heel new leather standa		A					
L3460	Shoe heel new rubber standar		A					
L3465	Shoe heel thomas with wedge		A					
L3470	Shoe heel thomas extend to b		A					
L3480	Shoe heel pad & depress for		A					
L3485	Shoe heel pad removable for		A					
L3500	Ortho shoe add leather insol		A					
L3510	Orthopedic shoe add rub insl		A					
L3520	O shoe add felt w leath insl		A					
L3530	Ortho shoe add half sole		A					
L3540	Ortho shoe add full sole		A					
L3550	O shoe add standard toe tap		A					
L3560	O shoe add horseshoe toe tap		A					
L3570	O shoe add instep extension		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L3580	O shoe add instep velcro clo		A					
L3590	O shoe convert to sof counte		A					
L3595	Ortho shoe add march bar		A					
L3600	Trans shoe calip plate exist		A					
L3610	Trans shoe caliper plate new		A					
L3620	Trans shoe solid stirrup exi		A					
L3630	Trans shoe solid stirrup new		A					
L3640	Shoe dennis browne splint bo		A					
L3649	Orthopedic shoe modifica NOS		A					
L3650	Shlder fig 8 abduct restrain		A					
L3660	Abduct restrainer canvas&web		A					
L3670	Acromio/clavicular canvas&we		A					
L3671	SO cap design w/o jnts CF		A					
L3672	SO airplane w/o jnts CF		A					
L3673	SO airplane w/joint CF		A					
L3675	Canvas vest SO		A					
L3677	SO hard plastic stabilizer		E					
L3702	EO w/o joints CF		A					
L3710	Elbow elastic with metal joi		A					
L3720	Forearm/arm cuffs free motio		A					
L3730	Forearm/arm cuffs ext/flex a		A					
L3740	Cuffs adj lock w/ active con		A					
L3760	EO withjoint, Prefabricated		A					
L3762	Rigid EO wo joints		A					
L3763	EWHO rigid w/o jnts CF		A					
L3764	EWHO w/joint(s) CF		A					
L3765	EWHFO rigid w/o jnts CF		A					
L3766	EWHFO w/joint(s) CF		A					
L3806	WHFO w/joint(s) custom fab		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L3807	WHFO,no joint, prefabricated		A					
L3808	WHFO, rigid w/o joints		A					
L3891	Torsion mechanism wrist/elbo		E					
L3900	Hinge extension/flex wrist/f		A					
L3901	Hinge ext/flex wrist finger		A					
L3904	Whfo electric custom fitted		A					
L3905	WHO w/nontorsion jnt(s) CF		A					
L3906	WHO w/o joints CF		A					
L3908	Wrist cock-up non-molded		A					
L3912	Flex glove w/elastic finger		A					
L3913	HFO w/o joints CF		A					
L3915	WHO w nontor jnt(s) prefab		A					
L3917	Prefab metacarpl fx orthosis		A					
L3919	HO w/o joints CF		A					
L3921	HFO w/joint(s) CF		A					
L3923	HFO w/o joints PF		A					
L3925	FO pip/dip with joint/spring		A					
L3927	FO pip/dip w/o joint/spring		A					
L3929	HFO nontorsion joint, prefab		A					
L3931	WHFO nontorsion joint prefab		A					
L3933	FO w/o joints CF		A					
L3935	FO nontorsion joint CF		A					
L3956	Add joint upper ext orthosis		A					
L3960	Sewho airplan desig abdu pos		A					
L3961	SEWHO cap design w/o jnts CF		A					
L3962	Sewho erbs palsey design abd		A					
L3964	Seo mobile arm sup att to wc		Y					
L3965	Arm supp att to wc rancho ty		Y					
L3966	Mobile arm supports reclinin		Y					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L3967	SEWHO airplane w/o jnts CF		A					
L3968	Friction dampening arm supp		Y					
L3969	Monosuspension arm/hand supp		Y					
L3970	Elevat proximal arm support		Y					
L3971	SEWHO cap design w/jnt(s) CF		A					
L3972	Offset/lat rocker arm w/ ela		Y					
L3973	SEWHO airplane w/jnt(s) CF		A					
L3974	Mobile arm support supinator		Y					
L3975	SEWHFO cap design w/o jnt CF		A					
L3976	SEWHFO airplane w/o jnts CF		A					
L3977	SEWHFO cap desgn w/jnt(s) CF		A					
L3978	SEWHFO airplane w/jnt(s) CF		A					
L3980	Upp ext fx orthosis humeral		A					
L3982	Upper ext fx orthosis rad/ul		A					
L3984	Upper ext fx orthosis wrist		A					
L3995	Sock fracture or equal each		A					
L3999	Upper limb orthosis NOS		A					
L4000	Repl girdle milwaukee orth		A					
L4002	Replace strap, any orthosis		A					
L4010	Replace trilateral socket br		A					
L4020	Replace quadlat socket brim		A					
L4030	Replace socket brim cust fit		A					
L4040	Replace molded thigh lacer		A					
L4045	Replace non-molded thigh lac		A					
L4050	Replace molded calf lacer		A					
L4055	Replace non-molded calf lace		A					
L4060	Replace high roll cuff		A					
L4070	Replace prox & dist upright		A					
L4080	Repl met band kafo-afo prox		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L4090	Repl met band kafo-afo calf/		A					
L4100	Repl leath cuff kafo prox th		A					
L4110	Repl leath cuff kafo-afo cal		A					
L4130	Replace pretibial shell		A					
L4205	Ortho dvc repair per 15 min		A					
L4210	Orth dev repair/repl minor p		A					
L4350	Ankle control orthosi prefab		A					
L4360	Pneumati walking boot prefab		A					
L4370	Pneumatic full leg splint		A					
L4380	Pneumatic knee splint		A					
L4386	Non-pneum walk boot prefab		A					
L4392	Replace AFO soft interface		A					
L4394	Replace foot drop spint		A					
L4396	Static AFO		A					
L4398	Foot drop splint recumbent		A					
L5000	Sho insert w arch toe filler		A					
L5010	Mold socket ank hgt w/ toe f		A					
L5020	Tibial tubercle hgt w/ toe f		A					
L5050	Ank symes mold sckt sach ft		A					
L5060	Symes met fr leath socket ar		A					
L5100	Molded socket shin sach foot		A					
L5105	Plast socket jts/thgh lacer		A					
L5150	Mold sckt ext knee shin sach		A					
L5160	Mold socket bent knee shin s		A					
L5200	Kne sing axis fric shin sach		A					
L5210	No knee/ankle joints w/ ft b		A					
L5220	No knee joint with artic ali		A					
L5230	Fem focal defic constant fri		A					
L5250	Hip canad sing axi cons fric		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L5270	Tilt table locking hip sing		A					
L5280	Hemipelvect canad sing axis		A					
L5301	BK mold socket SACH ft endo		A					
L5311	Knee disart, SACH ft, endo		A					
L5321	AK open end SACH		A					
L5331	Hip disart canadian SACH ft		A					
L5341	Hemipelvectomy canadian SACH		A					
L5400	Postop dress & 1 cast chg bk		A					
L5410	Postop dsg bk ea add cast ch		A					
L5420	Postop dsg & 1 cast chg ak/d		A					
L5430	Postop dsg ak ea add cast ch		A					
L5450	Postop app non-wgt bear dsg		A					
L5460	Postop app non-wgt bear dsg		A					
L5500	Init bk ptb plaster direct		A					
L5505	Init ak ischal plstr direct		A					
L5510	Prep BK ptb plaster molded		A					
L5520	Perp BK ptb thermopls direct		A					
L5530	Prep BK ptb thermopls molded		A					
L5535	Prep BK ptb open end socket		A					
L5540	Prep BK ptb laminated socket		A					
L5560	Prep AK ischial plast molded		A					
L5570	Prep AK ischial direct form		A					
L5580	Prep AK ischial thermo mold		A					
L5585	Prep AK ischial open end		A					
L5590	Prep AK ischial laminated		A					
L5595	Hip disartic sach thermopls		A					
L5600	Hip disart sach laminat mold		A					
L5610	Above knee hydracadence		A					
L5611	Ak 4 bar link w/fric swing		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L5613	Ak 4 bar ling w/hydraul swig		A					
L5614	4-bar link above knee w/swng		A					
L5616	Ak univ multiplex sys frict		A					
L5617	AK/BK self-aligning unit ea		A					
L5618	Test socket symes		A					
L5620	Test socket below knee		A					
L5622	Test socket knee disarticula		A					
L5624	Test socket above knee		A					
L5626	Test socket hip disarticulat		A					
L5628	Test socket hemipelvectomy		A					
L5629	Below knee acrylic socket		A					
L5630	Syme typ expandabl wall sckt		A					
L5631	Ak/knee disartic acrylic soc		A					
L5632	Symes type ptb brim design s		A					
L5634	Symes type poster opening so		A					
L5636	Symes type medial opening so		A					
L5637	Below knee total contact		A					
L5638	Below knee leather socket		A					
L5639	Below knee wood socket		A					
L5640	Knee disarticulat leather so		A					
L5642	Above knee leather socket		A					
L5643	Hip flex inner socket ext fr		A					
L5644	Above knee wood socket		A					
L5645	Bk flex inner socket ext fra		A					
L5646	Below knee cushion socket		A					
L5647	Below knee suction socket		A					
L5648	Above knee cushion socket		A					
L5649	Isch containmt/narrow m-l so		A					
L5650	Tot contact ak/knee disart s		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L5651	Ak flex inner socket ext fra		A					
L5652	Suction susp ak/knee disart		A					
L5653	Knee disart expand wall sock		A					
L5654	Socket insert symes		A					
L5655	Socket insert below knee		A					
L5656	Socket insert knee articulat		A					
L5658	Socket insert above knee		A					
L5661	Multi-durometer symes		A					
L5665	Multi-durometer below knee		A					
L5666	Below knee cuff suspension		A					
L5668	Socket insert w/o lock lower		A					
L5670	Bk molded supracondylar susp		A					
L5671	BK/AK locking mechanism		A					
L5672	Bk removable medial brim sus		A					
L5673	Socket insert w lock mech		A					
L5676	Bk knee joints single axis p		A					
L5677	Bk knee joints polycentric p		A					
L5678	Bk joint covers pair		A					
L5679	Socket insert w/o lock mech		A					
L5680	Bk thigh lacer non-molded		A					
L5681	Intl custm cong/latyp insert		A					
L5682	Bk thigh lacer glut/ischia m		A					
L5683	Initial custom socket insert		A					
L5684	Bk fork strap		A					
L5685	Below knee sus/seal sleeve		A					
L5686	Bk back check		A					
L5688	Bk waist belt webbing		A					
L5690	Bk waist belt padded and lin		A					
L5692	Ak pelvic control belt light		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L5694	Ak pelvic control belt pad/l		A					
L5695	Ak sleeve susp neoprene/equa		A					
L5696	Ak/knee disartic pelvic join		A					
L5697	Ak/knee disartic pelvic band		A					
L5698	Ak/knee disartic silesian ba		A					
L5699	Shoulder harness		A					
L5700	Replace socket below knee		A					
L5701	Replace socket above knee		A					
L5702	Replace socket hip		A					
L5703	Symes ankle w/o (SACH) foot		A					
L5704	Custom shape cover BK		A					
L5705	Custom shape cover AK		A					
L5706	Custom shape cvr knee disart		A					
L5707	Custom shape cvr hip disart		A					
L5710	Kne-shin exo sng axi mnl loc		A					
L5711	Knee-shin exo mnl lock ultra		A					
L5712	Knee-shin exo frict swg & st		A					
L5714	Knee-shin exo variable frict		A					
L5716	Knee-shin exo mech stance ph		A					
L5718	Knee-shin exo frct swg & sta		A					
L5722	Knee-shin pneum swg frct exo		A					
L5724	Knee-shin exo fluid swing ph		A					
L5726	Knee-shin ext jnts fld swg e		A					
L5728	Knee-shin fluid swg & stance		A					
L5780	Knee-shin pneum/hydra pneum		A					
L5781	Lower limb pros vacuum pump		A					
L5782	HD low limb pros vacuum pump		A					
L5785	Exoskeletal bk ultralt mater		A					
L5790	Exoskeletal ak ultra-light m		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L5795	Exoskel hip ultra-light mate		A					
L5810	Endoskel knee-shin mnl lock		A					
L5811	Endo knee-shin mnl lck ultra		A					
L5812	Endo knee-shin frct swg & st		A					
L5814	Endo knee-shin hydral swg ph		A					
L5816	Endo knee-shin polyc mch sta		A					
L5818	Endo knee-shin frct swg & st		A					
L5822	Endo knee-shin pneum swg frc		A					
L5824	Endo knee-shin fluid swing p		A					
L5826	Miniature knee joint		A					
L5828	Endo knee-shin fluid swg/sta		A					
L5830	Endo knee-shin pneum/swg pha		A					
L5840	Multi-axial knee/shin system		A					
L5845	Knee-shin sys stance flexion		A					
L5848	Knee-shin sys hydraul stance		A					
L5850	Endo ak/hip knee extens assi		A					
L5855	Mech hip extension assist		A					
L5856	Elec knee-shin swing/stance		A					
L5857	Elec knee-shin swing only		A					
L5858	Stance phase only		A					
L5910	Endo below knee alignable sy		A					
L5920	Endo ak/hip alignable system		A					
L5925	Above knee manual lock		A					
L5930	High activity knee frame		A					
L5940	Endo bk ultra-light material		A					
L5950	Endo ak ultra-light material		A					
L5960	Endo hip ultra-light materia		A					
L5962	Below knee flex cover system		A					
L5964	Above knee flex cover system		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L5966	Hip flexible cover system		A					
L5968	Multiaxial ankle w dorsiflex		A					
L5970	Foot external keel sach foot		A					
L5971	SACH foot, replacement		A					
L5972	Flexible keel foot		A					
L5973	Ank-foot sys dors-plant flex		A					
L5974	Foot single axis ankle/foot		A					
L5975	Combo ankle/foot prosthesis		A					
L5976	Energy storing foot		A					
L5978	Ft prosth multiaxial ankl/ft		A					
L5979	Multi-axial ankle/ft prosth		A					
L5980	Flex foot system		A					
L5981	Flex-walk sys low ext prosth		A					
L5982	Exoskeletal axial rotation u		A					
L5984	Endoskeletal axial rotation		A					
L5985	Lwr ext dynamic prosth pylon		A					
L5986	Multi-axial rotation unit		A					
L5987	Shank ft w vert load pylon		A					
L5988	Vertical shock reducing pylo		A					
L5990	User adjustable heel height		A					
L5999	Lowr extremity prosthes NOS		A					
L6000	Par hand robin-aids thum rem		A					
L6010	Hand robin-aids little/ring		A					
L6020	Part hand robin-aids no fing		A					
L6025	Part hand disart myoelectric		A					
L6050	Wrst MLd sck flx hng tri pad		A					
L6055	Wrst mold sock w/exp interfa		A					
L6100	Elb mold sock flex hinge pad		A					
L6110	Elbow mold sock suspension t		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L6120	Elbow mold doub splt soc ste		A					
L6130	Elbow stump activated lock h		A					
L6200	Elbow mold outsid lock hinge		A					
L6205	Elbow molded w/ expand inter		A					
L6250	Elbow inter loc elbow forarm		A					
L6300	Shlder disart int lock elbow		A					
L6310	Shoulder passive restor comp		A					
L6320	Shoulder passive restor cap		A					
L6350	Thoracic intern lock elbow		A					
L6360	Thoracic passive restor comp		A					
L6370	Thoracic passive restor cap		A					
L6380	Postop dsg cast chg wrst/elb		A					
L6382	Postop dsg cast chg elb dis/		A					
L6384	Postop dsg cast chg shlder/t		A					
L6386	Postop ea cast chg & realign		A					
L6388	Postop applicat rigid dsg on		A					
L6400	Below elbow prosth tiss shap		A					
L6450	Elb disart prosth tiss shap		A					
L6500	Above elbow prosth tiss shap		A					
L6550	Shldr disar prosth tiss shap		A					
L6570	Scap thorac prosth tiss shap		A					
L6580	Wrist/elbow bowden cable mol		A					
L6582	Wrist/elbow bowden cbl dir f		A					
L6584	Elbow fair lead cable molded		A					
L6586	Elbow fair lead cable dir fo		A					
L6588	Shdr fair lead cable molded		A					
L6590	Shdr fair lead cable direct		A					
L6600	Polycentric hinge pair		A					
L6605	Single pivot hinge pair		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L6610	Flexible metal hinge pair		A					
L6611	Additional switch, ext power		A					
L6615	Disconnect locking wrist uni		A					
L6616	Disconnect insert locking wr		A					
L6620	Flexion/extension wrist unit		A					
L6621	Flex/ext wrist w/wo friction		A					
L6623	Spring-ass rot wrst w/ latch		A					
L6624	Flex/ext/rotation wrist unit		A					
L6625	Rotation wrst w/ cable lock		A					
L6628	Quick disconn hook adapter o		A					
L6629	Lamination collar w/ couplin		A					
L6630	Stainless steel any wrist		A					
L6632	Latex suspension sleeve each		A					
L6635	Lift assist for elbow		A					
L6637	Nudge control elbow lock		A					
L6638	Elec lock on manual pw elbow		A					
L6640	Shoulder abduction joint pai		A					
L6641	Excursion amplifier pulley t		A					
L6642	Excursion amplifier lever ty		A					
L6645	Shoulder flexion-abduction j		A					
L6646	Multipo locking shoulder jnt		A					
L6647	Shoulder lock actuator		A					
L6648	Ext pwrd shlder lock/unlock		A					
L6650	Shoulder universal joint		A					
L6655	Standard control cable extra		A					
L6660	Heavy duty control cable		A					
L6665	Teflon or equal cable lining		A					
L6670	Hook to hand cable adapter		A					
L6672	Harness chest/shlder saddle		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L6675	Harness figure of 8 sing con		A					
L6676	Harness figure of 8 dual con		A					
L6677	UE triple control harness		A					
L6680	Test sock wrist disart/bel e		A					
L6682	Test sock elbw disart/above		A					
L6684	Test socket shldr disart/tho		A					
L6686	Suction socket		A					
L6687	Frame typ socket bel elbow/w		A					
L6688	Frame typ sock above elb/dis		A					
L6689	Frame typ socket shoulder di		A					
L6690	Frame typ sock interscap-tho		A					
L6691	Removable insert each		A					
L6692	Silicone gel insert or equal		A					
L6693	Lockingelbow forearm cntrbal		A					
L6694	Elbow socket ins use w/lock		A					
L6695	Elbow socket ins use w/o lck		A					
L6696	Cus elbo skt in for con/atyp		A					
L6697	Cus elbo skt in not con/atyp		A					
L6698	Below/above elbow lock mech		A					
L6703	Term dev, passive hand mitt		A					
L6704	Term dev, sport/rec/work att		A					
L6706	Term dev mech hook vol open		A					
L6707	Term dev mech hook vol close		A					
L6708	Term dev mech hand vol open		A					
L6709	Term dev mech hand vol close		A					
L6711	Ped term dev, hook, vol open		A					
L6712	Ped term dev, hook, vol clos		A					
L6713	Ped term dev, hand, vol open		A					
L6714	Ped term dev, hand, vol clos		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L6721	Hook/hand, hvy dty, vol open		A					
L6722	Hook/hand, hvy dty, vol clos		A					
L6805	Term dev modifier wrist unit		A					
L6810	Term dev precision pinch dev		A					
L6881	Term dev auto grasp feature		A					
L6882	Microprocessor control uplmb		A					
L6883	Replc sockt below e/w disa		A					
L6884	Replc sockt above elbow disa		A					
L6885	Replc sockt shldr dis/interc		A					
L6890	Prefab glove for term device		A					
L6895	Custom glove for term device		A					
L6900	Hand restorat thumb/1 finger		A					
L6905	Hand restoration multiple fi		A					
L6910	Hand restoration no fingers		A					
L6915	Hand restoration replacmnt g		A					
L6920	Wrist disarticul switch ctrl		A					
L6925	Wrist disart myoelectronic c		A					
L6930	Below elbow switch control		A					
L6935	Below elbow myoelectronic ct		A					
L6940	Elbow disarticulation switch		A					
L6945	Elbow disart myoelectronic c		A					
L6950	Above elbow switch control		A					
L6955	Above elbow myoelectronic ct		A					
L6960	Shldr disartic switch contro		A					
L6965	Shldr disartic myoelectronic		A					
L6970	Interscapular-thor switch ct		A					
L6975	Interscap-thor myoelectronic		A					
L7007	Adult electric hand		A					
L7008	Pediatric electric hand		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L7009	Adult electric hook		A					
L7040	Prehensile actuator		A					
L7045	Pediatric electric hook		A					
L7170	Electronic elbow hosmer swit		A					
L7180	Electronic elbow sequential		A					
L7181	Electronic elbo simultaneous		A					
L7185	Electron elbow adolescent sw		A					
L7186	Electron elbow child switch		A					
L7190	Elbow adolescent myoelectron		A					
L7191	Elbow child myoelectronic ct		A					
L7260	Electron wrist rotator otto		A					
L7261	Electron wrist rotator utah		A					
L7266	Servo control steeper or equ		A					
L7272	Analogue control unb or equa		A					
L7274	Proportional ctl 12 volt uta		A					
L7360	Six volt bat otto bock/eq ea		A					
L7362	Battery chrgr six volt otto		A					
L7364	Twelve volt battery utah/equ		A					
L7366	Battery chrgr 12 volt utah/e		A					
L7367	Replacemnt lithium ionbatter		A					
L7368	Lithium ion battery charger		A					
L7400	Add UE prost be/wd, ultlite		A					
L7401	Add UE prost a/e ultlite mat		A					
L7402	Add UE prost s/d ultlite mat		A					
L7403	Add UE prost b/e acrylic		A					
L7404	Add UE prost a/e acrylic		A					
L7405	Add UE prost s/d acrylic		A					
L7499	Upper extremity prosthes NOS		A					
L7500	Prosthetic dvc repair hourly		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L7510	Prosthetic device repair rep		A					
L7520	Repair prosthesis per 15 min		A					
L7600	Prosthetic donning sleeve		E					
L7900	Male vacuum erection system		A					
L8000	Mastectomy bra		A					
L8001	Breast prosthesis bra & form		A					
L8002	Brst prsth bra & bilat form		A					
L8010	Mastectomy sleeve		A					
L8015	Ext breastprosthesis garment		A					
L8020	Mastectomy form		A					
L8030	Breast prosthes w/o adhesive		A					
L8031	Breast prosthesis w adhesive		A					
L8032	Reusable nipple prosthesis		A					
L8035	Custom breast prosthesis		A					
L8039	Breast prosthesis NOS		A					
L8040	Nasal prosthesis		A					
L8041	Midfacial prosthesis		A					
L8042	Orbital prosthesis		A					
L8043	Upper facial prosthesis		A					
L8044	Hemi-facial prosthesis		A					
L8045	Auricular prosthesis		A					
L8046	Partial facial prosthesis		A					
L8047	Nasal septal prosthesis		A					
L8048	Unspec maxillofacial prosth		A					
L8049	Repair maxillofacial prosth		A					
L8300	Truss single w/ standard pad		A					
L8310	Truss double w/ standard pad		A					
L8320	Truss addition to std pad wa		A					
L8330	Truss add to std pad scrotal		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L8400	Sheath below knee		A					
L8410	Sheath above knee		A					
L8415	Sheath upper limb		A					
L8417	Pros sheath/sock w gel cushn		A					
L8420	Prosthetic sock multi ply BK		A					
L8430	Prosthetic sock multi ply AK		A					
L8435	Pros sock multi ply upper lm		A					
L8440	Shrinker below knee		A					
L8460	Shrinker above knee		A					
L8465	Shrinker upper limb		A					
L8470	Pros sock single ply BK		A					
L8480	Pros sock single ply AK		A					
L8485	Pros sock single ply upper l		A					
L8499	Unlisted misc prosthetic ser		A					
L8500	Artificial larynx		A					
L8501	Tracheostomy speaking valve		A					
L8505	Artificial larynx, accessory		A					
L8507	Trach-esoph voice pros pt in		A					
L8509	Trach-esoph voice pros md in		A					
L8510	Voice amplifier		A					
L8511	Indwelling trach insert		A					
L8512	Gel cap for trach voice pros		A					
L8513	Trach pros cleaning device		A					
L8514	Repl trach puncture dilator		A					
L8515	Gel cap app device for trach		A					
L8600	Implant breast silicone/eq		N					
L8603	Collagen imp urinary 2.5 ml		N					
L8604	Dextranomer/hyaluronic acid		N					
L8606	Synthetic implnt urinary 1ml		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L8609	Artificial cornea		N					
L8610	Ocular implant		N					
L8612	Aqueous shunt prosthesis		N					
L8613	Ossicular implant		N					
L8614	Cochlear device		N					
L8615	Coch implant headset replace		A					
L8616	Coch implant microphone repl		A					
L8617	Coch implant trans coil repl		A					
L8618	Coch implant tran cable repl		A					
L8619	Coch imp ext proc/contr rplc		A					
L8621	Repl zinc air battery		A					
L8622	Repl alkaline battery		A					
L8623	Lith ion batt CID,non-earlvl		A					
L8624	Lith ion batt CID, ear level		A					
L8627	CID ext speech process repl		A					
L8628	CID ext controller repl		A					
L8629	CID transmit coil and cable		A					
L8630	Metacarpophalangeal implant		N					
L8631	MCP joint repl 2 pc or more		N					
L8641	Metatarsal joint implant		N					
L8642	Hallux implant		N					
L8658	Interphalangeal joint spacer		N					
L8659	Interphalangeal joint repl		N					
L8670	Vascular graft, synthetic		N					
L8680	Implt neurostim elctr each		N					
L8681	Pt prgrm for implt neurostim		A					
L8682	Implt neurostim radiofq rec		N					
L8683	Radiofq trsmtr for implt neu		A					
L8684	Radiof trsmtr implt scrl neu		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
L8685	Implt nrostm pls gen sng rec		N					
L8686	Implt nrostm pls gen sng non		N					
L8687	Implt nrostm pls gen dua rec		N					
L8688	Implt nrostm pls gen dua non		N					
L8689	External recharg sys intern		A					
L8690	Aud osseo dev, int/ext comp		N					
L8691	Osseointegrated snd proc rpl		A					
L8692	Non-osseointegrated snd proc		E					
L8695	External recharg sys extern		A					
L8699	Prosthetic implant NOS		N					
L9900	O&P supply/accessory/service		N					
M0064	Visit for drug monitoring		Q3	0607	1.7939	$122.46	.	$24.50
M0075	Cellular therapy		E					
M0076	Prolotherapy		E					
M0100	Intragastric hypothermia		E					
M0300	IV chelationtherapy		E					
M0301	Fabric wrapping of aneurysm		E					
P2028	Cephalin floculation test		A					
P2029	Congo red blood test		A					
P2031	Hair analysis		E					
P2033	Blood thymol turbidity		A					
P2038	Blood mucoprotein		A					
P3000	Screen pap by tech w md supv		A					
P3001	Screening pap smear by phys		B					
P7001	Culture bacterial urine		E					
P9010	Whole blood for transfusion		R	0950	2.9637	$202.32	.	$40.47
P9011	Blood split unit		R	0967	2.9552	$201.74	.	$40.35
P9012	Cryoprecipitate each unit		R	0952	0.7391	$50.46	.	$10.10
P9016	RBC leukocytes reduced		R	0954	2.7694	$189.06	.	$37.82

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
P9017	Plasma 1 donor frz w/in 8 hr		R	9508	1.1671	$79.67	.	$15.94
P9019	Platelets, each unit		R	0957	1.0506	$71.72	.	$14.35
P9020	Plaelet rich plasma unit		R	0958	2.052	$140.08	.	$28.02
P9021	Red blood cells unit		R	0959	2.186	$149.23	.	$29.85
P9022	Washed red blood cells unit		R	0960	4.3079	$294.09	.	$58.82
P9023	Frozen plasma, pooled, sd		R	0949	0.8126	$55.47	.	$11.10
P9031	Platelets leukocytes reduced		R	1013	1.5839	$108.13	.	$21.63
P9032	Platelets, irradiated		R	9500	2.2804	$155.68	.	$31.14
P9033	Platelets leukoreduced irrad		R	0968	2.0209	$137.96	.	$27.60
P9034	Platelets, pheresis		R	9507	6.5766	$448.96	.	$89.80
P9035	Platelet pheres leukoreduced		R	9501	7.7397	$528.37	.	$105.68
P9036	Platelet pheresis irradiated		R	9502	6.8837	$469.93	.	$93.99
P9037	Plate pheres leukoredu irrad		R	1019	9.6439	$658.36	.	$131.68
P9038	RBC irradiated		R	9505	3.162	$215.86	.	$43.18
P9039	RBC deglycerolized		R	9504	5.1865	$354.07	.	$70.82
P9040	RBC leukoreduced irradiated		R	0969	3.6796	$251.20	.	$50.24
P9041	Albumin (human),5%, 50ml		K	0961		$16.89	.	$3.38
P9043	Plasma protein fract,5%,50ml		R	0956	0.3751	$25.61	.	$5.13
P9044	Cryoprecipitatereducedplasma		R	1009	1.1663	$79.62	.	$15.93
P9045	Albumin (human), 5%, 250 ml		K	0963		$60.58	.	$12.12
P9046	Albumin (human), 25%, 20 ml		K	0964		$25.67	.	$5.14
P9047	Albumin (human), 25%, 50ml		K	0965		$62.05	.	$12.41
P9048	Plasmaprotein fract,5%,250ml		R	0966	1.6989	$115.98	.	$23.20
P9050	Granulocytes, pheresis unit		R	9506	23.7666	$1,622.47	.	$324.50
P9051	Blood, l/r, cmv-neg		R	1010	2.76	$188.42	.	$37.69
P9052	Platelets, hla-m, l/r, unit		R	1011	10.5854	$722.63	.	$144.53
P9053	Plt, pher, l/r cmv-neg, irr		R	1020	8.5688	$584.97	.	$117.00
P9054	Blood, l/r, froz/degly/wash		R	1016	1.4749	$100.69	.	$20.14
P9055	Plt, aph/pher, l/r, cmv-neg		R	1017	6.2876	$429.24	.	$85.85

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
P9056	Blood, l/r, irradiated		R	1018	2.4465	$167.02	.	$33.41
P9057	RBC, frz/deg/wsh, l/r, irrad		R	1021	4.1093	$280.53	.	$56.11
P9058	RBC, l/r, cmv-neg, irrad		R	1022	4.387	$299.49	.	$59.90
P9059	Plasma, frz between 8-24hour		R	0955	1.0672	$72.85	.	$14.57
P9060	Fr frz plasma donor retested		R	9503	0.9734	$66.45	.	$13.29
P9603	One-way allow prorated miles		A					
P9604	One-way allow prorated trip		A					
P9612	Catheterize for urine spec		A					
P9615	Urine specimen collect mult		N					
Q0035	Cardiokymography		X	0100	2.6301	$179.55	$41.44	$35.91
Q0081	Infusion ther other than che		B					
Q0083	Chemo by other than infusion		B					
Q0084	Chemotherapy by infusion		B					
Q0085	Chemo by both infusion and o		B					
Q0091	Obtaining screen pap smear		T	0191	0.1514	$10.34		
Q0092	Set up port xray equipment		N					
Q0111	Wet mounts/ w preparations		A					
Q0112	Potassium hydroxide preps		A					
Q0113	Pinworm examinations		A					
Q0114	Fern test		A					
Q0115	Post-coital mucous exam		A					
Q0138	Ferumoxytol, non-esrd		G	1297		$0.82	.	$0.17
Q0139	Ferumoxytol, esrd use		A					
Q0144	Azithromycin dihydrate, oral		E					
Q0163	Diphenhydramine HCl 50mg		N					
Q0164	Prochlorperazine maleate 5mg		N					
Q0165	Prochlorperazine maleate10mg		N					
Q0166	Granisetron hcl 1 mg oral		N					
Q0167	Dronabinol 2.5mg oral		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
Q0168	Dronabinol 5mg oral		N					
Q0169	Promethazine HCl 12.5mg oral		N					
Q0170	Promethazine HCl 25 mg oral		N					
Q0171	Chlorpromazine HCl 10mg oral		N					
Q0172	Chlorpromazine HCl 25mg oral		N					
Q0173	Trimethobenzamide HCl 250mg		N					
Q0174	Thiethylperazine maleate10mg	CH	E					
Q0175	Perphenazine 4mg oral		N					
Q0176	Perphenazine 8mg oral		N					
Q0177	Hydroxyzine pamoate 25mg		N					
Q0178	Hydroxyzine pamoate 50mg		N					
Q0179	Ondansetron hcl 8 mg oral		N					
Q0180	Dolasetron mesylate oral		N					
Q0181	Unspecified oral anti-emetic		E					
Q0480	Driver pneumatic vad, rep		A					
Q0481	Microprcsr cu elec vad, rep		A					
Q0482	Microprcsr cu combo vad, rep		A					
Q0483	Monitor elec vad, rep		A					
Q0484	Monitor elec or comb vad rep		A					
Q0485	Monitor cable elec vad, rep		A					
Q0486	Mon cable elec/pneum vad rep		A					
Q0487	Leads any type vad, rep only		A					
Q0488	Pwr pack base elec vad, rep		A					
Q0489	Pwr pck base combo vad, rep		A					
Q0490	Emr pwr source elec vad, rep		A					
Q0491	Emr pwr source combo vad rep		A					
Q0492	Emr pwr cbl elec vad, rep		A					
Q0493	Emr pwr cbl combo vad, rep		A					
Q0494	Emr hd pmp elec/combo, rep		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
Q0495	Charger elec/combo vad, rep		A					
Q0496	Battery elec/combo vad, rep		A					
Q0497	Bat clps elec/comb vad, rep		A					
Q0498	Holster elec/combo vad, rep		A					
Q0499	Belt/vest elec/combo vad rep		A					
Q0500	Filters elec/combo vad, rep		A					
Q0501	Shwr cov elec/combo vad, rep		A					
Q0502	Mobility cart pneum vad, rep		A					
Q0503	Battery pneum vad replacemnt		A					
Q0504	Pwr adpt pneum vad, rep veh		A					
Q0505	Miscl supply/accessory vad		A					
Q0506	Lith-ion batt elec/pneum VAD		A					
Q0510	Dispens fee immunosupressive		B					
Q0511	Sup fee antiem,antica,immuno		B					
Q0512	Px sup fee anti-can sub pres		B					
Q0513	Disp fee inhal drugs/30 days		B					
Q0514	Disp fee inhal drugs/90 days		B					
Q0515	Sermorelin acetate injection		K	3050		$1.80	.	$0.36
Q1003	Ntiol category 3		N					
Q1004	Ntiol category 4		E					
Q1005	Ntiol category 5		E					
Q2004	Bladder calculi irrig sol	CH	N					
Q2009	Fosphenytoin inj PE		N					
Q2017	Teniposide, 50 mg		K	7035		$324.55	.	$64.91
Q3001	Brachytherapy Radioelements		B					
Q3014	Telehealth facility fee		A					
Q3025	IM inj interferon beta 1-a		K	9022		$193.93	.	$38.79
Q3026	Subc inj interferon beta-1a		E					
Q3031	Collagen skin test		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
Q4001	Cast sup body cast plaster		B					
Q4002	Cast sup body cast fiberglas		B					
Q4003	Cast sup shoulder cast plstr		B					
Q4004	Cast sup shoulder cast fbrgl		B					
Q4005	Cast sup long arm adult plst		B					
Q4006	Cast sup long arm adult fbrg		B					
Q4007	Cast sup long arm ped plster		B					
Q4008	Cast sup long arm ped fbrgls		B					
Q4009	Cast sup sht arm adult plstr		B					
Q4010	Cast sup sht arm adult fbrgl		B					
Q4011	Cast sup sht arm ped plaster		B					
Q4012	Cast sup sht arm ped fbrglas		B					
Q4013	Cast sup gauntlet plaster		B					
Q4014	Cast sup gauntlet fiberglass		B					
Q4015	Cast sup gauntlet ped plster		B					
Q4016	Cast sup gauntlet ped fbrgls		B					
Q4017	Cast sup lng arm splint plst		B					
Q4018	Cast sup lng arm splint fbrg		B					
Q4019	Cast sup lng arm splnt ped p		B					
Q4020	Cast sup lng arm splnt ped f		B					
Q4021	Cast sup sht arm splint plst		B					
Q4022	Cast sup sht arm splint fbrg		B					
Q4023	Cast sup sht arm splnt ped p		B					
Q4024	Cast sup sht arm splnt ped f		B					
Q4025	Cast sup hip spica plaster		B					
Q4026	Cast sup hip spica fiberglas		B					
Q4027	Cast sup hip spica ped plstr		B					
Q4028	Cast sup hip spica ped fbrgl		B					
Q4029	Cast sup long leg plaster		B					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
Q4030	Cast sup long leg fiberglass		B					
Q4031	Cast sup lng leg ped plaster		B					
Q4032	Cast sup lng leg ped fbrgls		B					
Q4033	Cast sup lng leg cylinder pl		B					
Q4034	Cast sup lng leg cylinder fb		B					
Q4035	Cast sup lngleg cylndr ped p		B					
Q4036	Cast sup lngleg cylndr ped f		B					
Q4037	Cast sup shrt leg plaster		B					
Q4038	Cast sup shrt leg fiberglass		B					
Q4039	Cast sup shrt leg ped plster		B					
Q4040	Cast sup shrt leg ped fbrgls		B					
Q4041	Cast sup lng leg splnt plstr		B					
Q4042	Cast sup lng leg splnt fbrgl		B					
Q4043	Cast sup lng leg splnt ped p		B					
Q4044	Cast sup lng leg splnt ped f		B					
Q4045	Cast sup sht leg splnt plstr		B					
Q4046	Cast sup sht leg splnt fbrgl		B					
Q4047	Cast sup sht leg splnt ped p		B					
Q4048	Cast sup sht leg splnt ped f		B					
Q4049	Finger splint, static		B					
Q4050	Cast supplies unlisted		B					
Q4051	Splint supplies misc		B					
Q4074	Iloprost non-comp unit dose		Y					
Q4081	Epoetin alfa, 100 units ESRD		A					
Q4082	Drug/bio NOC part B drug CAP		B					
Q4100	Skin substitute, NOS		N					
Q4101	Apligraf skin sub		K	1240		$32.71	.	$6.55
Q4102	Oasis wound matrix skin sub		K	1241		$4.62	.	$0.93
Q4103	Oasis burn matrix skin sub		K	1242		$4.62	.	$0.93

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
Q4104	Integra BMWD skin sub		K	1243		$14.84	.	$2.97
Q4105	Integra DRT skin sub		K	1244		$10.00	.	$2.00
Q4106	Dermagraft skin sub		K	1245		$40.10	.	$8.02
Q4107	Graftjacket skin sub		K	1246		$92.04	.	$18.41
Q4108	Integra matrix skin sub		K	1247		$17.99	.	$3.60
Q4109	Tissuemend skin sub		N					
Q4110	Primatrix skin sub		K	1248		$34.35	.	$6.87
Q4111	Gammagraft skin sub		K	1252		$7.40	.	$1.48
Q4112	Cymetra allograft		K	1249		$342.34	.	$68.47
Q4113	Graftjacket express allograf		K	1250		$342.34	.	$68.47
Q4114	Integra flowable wound matri	CH	K	1251		$914.43	.	$182.89
Q4115	Alloskin skin sub		K	1287		$7.34	.	$1.47
Q4116	Alloderm skin sub		K	1270		$32.57	.	$6.52
Q5001	Hospice in patient home		B					
Q5002	Hospice in assisted living		B					
Q5003	Hospice in LT/non-skilled NF		B					
Q5004	Hospice in SNF		B					
Q5005	Hospice, inpatient hospital		B					
Q5006	Hospice in hospice facility		B					
Q5007	Hospice in LTCH		B					
Q5008	Hospice in inpatient psych		B					
Q5009	Hospice care, NOS		B					
Q9951	LOCM >= 400 mg/ml iodine,1ml		N					
Q9953	Inj Fe-based MR contrast,1ml		N					
Q9954	Oral MR contrast, 100 ml		N					
Q9955	Inj perflexane lip micros,ml		N					
Q9956	Inj octafluoropropane mic,ml		N					
Q9957	Inj perflutren lip micros,ml		N					
Q9958	HOCM <=149 mg/ml iodine, 1ml		N					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
Q9959	HOCM 150-199mg/ml iodine,1ml		N					
Q9960	HOCM 200-249mg/ml iodine,1ml		N					
Q9961	HOCM 250-299mg/ml iodine,1ml		N					
Q9962	HOCM 300-349mg/ml iodine,1ml		N					
Q9963	HOCM 350-399mg/ml iodine,1ml		N					
Q9964	HOCM>= 400mg/ml iodine, 1ml		N					
Q9965	LOCM 100-199mg/ml iodine,1ml		N					
Q9966	LOCM 200-299mg/ml iodine,1ml		N					
Q9967	LOCM 300-399mg/ml iodine,1ml		N					
Q9968	Visualization adjunct		K	1288		$1.82	.	$0.37
R0070	Transport portable x-ray		B					
R0075	Transport port x-ray multipl		B					
R0076	Transport portable EKG		B					
V2020	Vision svcs frames purchases		A					
V2025	Eyeglasses delux frames		E					
V2100	Lens spher single plano 4.00		A					
V2101	Single visn sphere 4.12-7.00		A					
V2102	Singl visn sphere 7.12-20.00		A					
V2103	Spherocylindr 4.00d/12-2.00d		A					
V2104	Spherocylindr 4.00d/2.12-4d		A					
V2105	Spherocylinder 4.00d/4.25-6d		A					
V2106	Spherocylinder 4.00d/>6.00d		A					
V2107	Spherocylinder 4.25d/12-2d		A					
V2108	Spherocylinder 4.25d/2.12-4d		A					
V2109	Spherocylinder 4.25d/4.25-6d		A					
V2110	Spherocylinder 4.25d/over 6d		A					
V2111	Spherocylindr 7.25d/.25-2.25		A					
V2112	Spherocylindr 7.25d/2.25-4d		A					
V2113	Spherocylindr 7.25d/4.25-6d		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
V2114	Spherocylinder over 12.00d		A					
V2115	Lens lenticular bifocal		A					
V2118	Lens aniseikonic single		A					
V2121	Lenticular lens, single		A					
V2199	Lens single vision not oth c		A					
V2200	Lens spher bifoc plano 4.00d		A					
V2201	Lens sphere bifocal 4.12-7.0		A					
V2202	Lens sphere bifocal 7.12-20.		A					
V2203	Lens sphcyl bifocal 4.00d/.1		A					
V2204	Lens sphcy bifocal 4.00d/2.1		A					
V2205	Lens sphcy bifocal 4.00d/4.2		A					
V2206	Lens sphcy bifocal 4.00d/ove		A					
V2207	Lens sphcy bifocal 4.25-7d/.		A					
V2208	Lens sphcy bifocal 4.25-7/2.		A					
V2209	Lens sphcy bifocal 4.25-7/4.		A					
V2210	Lens sphcy bifocal 4.25-7/ov		A					
V2211	Lens sphcy bifo 7.25-12/.25-		A					
V2212	Lens sphcyl bifo 7.25-12/2.2		A					
V2213	Lens sphcyl bifo 7.25-12/4.2		A					
V2214	Lens sphcyl bifocal over 12.		A					
V2215	Lens lenticular bifocal		A					
V2218	Lens aniseikonic bifocal		A					
V2219	Lens bifocal seg width over		A					
V2220	Lens bifocal add over 3.25d		A					
V2221	Lenticular lens, bifocal		A					
V2299	Lens bifocal speciality		A					
V2300	Lens sphere trifocal 4.00d		A					
V2301	Lens sphere trifocal 4.12-7.		A					
V2302	Lens sphere trifocal 7.12-20		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
V2303	Lens sphcy trifocal 4.0/.12-		A					
V2304	Lens sphcy trifocal 4.0/2.25		A					
V2305	Lens sphcy trifocal 4.0/4.25		A					
V2306	Lens sphcyl trifocal 4.00/>6		A					
V2307	Lens sphcy trifocal 4.25-7/.		A					
V2308	Lens sphc trifocal 4.25-7/2.		A					
V2309	Lens sphc trifocal 4.25-7/4.		A					
V2310	Lens sphc trifocal 4.25-7/>6		A					
V2311	Lens sphc trifo 7.25-12/.25-		A					
V2312	Lens sphc trifo 7.25-12/2.25		A					
V2313	Lens sphc trifo 7.25-12/4.25		A					
V2314	Lens sphcyl trifocal over 12		A					
V2315	Lens lenticular trifocal		A					
V2318	Lens aniseikonic trifocal		A					
V2319	Lens trifocal seg width > 28		A					
V2320	Lens trifocal add over 3.25d		A					
V2321	Lenticular lens, trifocal		A					
V2399	Lens trifocal speciality		A					
V2410	Lens variab asphericity sing		A					
V2430	Lens variable asphericity bi		A					
V2499	Variable asphericity lens		A					
V2500	Contact lens pmma spherical		A					
V2501	Cntct lens pmma-toric/prism		A					
V2502	Contact lens pmma bifocal		A					
V2503	Cntct lens pmma color vision		A					
V2510	Cntct gas permeable sphericl		A					
V2511	Cntct toric prism ballast		A					
V2512	Cntct lens gas permbl bifocl		A					
V2513	Contact lens extended wear		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
V2520	Contact lens hydrophilic		A					
V2521	Cntct lens hydrophilic toric		A					
V2522	Cntct lens hydrophil bifocl		A					
V2523	Cntct lens hydrophil extend		A					
V2530	Contact lens gas impermeable		A					
V2531	Contact lens gas permeable		A					
V2599	Contact lens/es other type		A					
V2600	Hand held low vision aids		A					
V2610	Single lens spectacle mount		A					
V2615	Telescop/othr compound lens		A					
V2623	Plastic eye prosth custom		A					
V2624	Polishing artifical eye		A					
V2625	Enlargemnt of eye prosthesis		A					
V2626	Reduction of eye prosthesis		A					
V2627	Scleral cover shell		A					
V2628	Fabrication & fitting		A					
V2629	Prosthetic eye other type		A					
V2630	Anter chamber intraocul lens		N					
V2631	Iris support intraoclr lens		N					
V2632	Post chmbr intraocular lens		N					
V2700	Balance lens		A					
V2702	Deluxe lens feature		E					
V2710	Glass/plastic slab off prism		A					
V2715	Prism lens/es		A					
V2718	Fresnell prism press-on lens		A					
V2730	Special base curve		A					
V2744	Tint photochromatic lens/es		A					
V2745	Tint, any color/solid/grad		A					
V2750	Anti-reflective coating		A					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
V2755	UV lens/es		A					
V2756	Eye glass case		E					
V2760	Scratch resistant coating		A					
V2761	Mirror coating		B					
V2762	Polarization, any lens		A					
V2770	Occluder lens/es		A					
V2780	Oversize lens/es		A					
V2781	Progressive lens per lens		B					
V2782	Lens, 1.54-1.65 p/1.60-1.79g		A					
V2783	Lens, >= 1.66 p/>=1.80 g		A					
V2784	Lens polycarb or equal		A					
V2785	Corneal tissue processing		F					
V2786	Occupational multifocal lens		A					
V2787	Astigmatism-correct function		E					
V2788	Presbyopia-correct function		E					
V2790	Amniotic membrane		N					
V2797	Vis item/svc in other code		A					
V2799	Miscellaneous vision service		A					
V5008	Hearing screening		E					
V5010	Assessment for hearing aid		E					
V5011	Hearing aid fitting/checking		E					
V5014	Hearing aid repair/modifying		E					
V5020	Conformity evaluation		E					
V5030	Body-worn hearing aid air		E					
V5040	Body-worn hearing aid bone		E					
V5050	Hearing aid monaural in ear		E					
V5060	Behind ear hearing aid		E					
V5070	Glasses air conduction		E					
V5080	Glasses bone conduction		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
V5090	Hearing aid dispensing fee		E					
V5095	Implant mid ear hearing pros		E					
V5100	Body-worn bilat hearing aid		E					
V5110	Hearing aid dispensing fee		E					
V5120	Body-worn binaur hearing aid		E					
V5130	In ear binaural hearing aid		E					
V5140	Behind ear binaur hearing ai		E					
V5150	Glasses binaural hearing aid		E					
V5160	Dispensing fee binaural		E					
V5170	Within ear cros hearing aid		E					
V5180	Behind ear cros hearing aid		E					
V5190	Glasses cros hearing aid		E					
V5200	Cros hearing aid dispens fee		E					
V5210	In ear bicros hearing aid		E					
V5220	Behind ear bicros hearing ai		E					
V5230	Glasses bicros hearing aid		E					
V5240	Dispensing fee bicros		E					
V5241	Dispensing fee, monaural		E					
V5242	Hearing aid, monaural, cic		E					
V5243	Hearing aid, monaural, itc		E					
V5244	Hearing aid, prog, mon, cic		E					
V5245	Hearing aid, prog, mon, itc		E					
V5246	Hearing aid, prog, mon, ite		E					
V5247	Hearing aid, prog, mon, bte		E					
V5248	Hearing aid, binaural, cic		E					
V5249	Hearing aid, binaural, itc		E					
V5250	Hearing aid, prog, bin, cic		E					
V5251	Hearing aid, prog, bin, itc		E					
V5252	Hearing aid, prog, bin, ite		E					

Addendum B.-Proposed OPPS Payment by HCPCS Code for CY 2011								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
V5253	Hearing aid, prog, bin, bte		E					
V5254	Hearing id, digit, mon, cic		E					
V5255	Hearing aid, digit, mon, itc		E					
V5256	Hearing aid, digit, mon, ite		E					
V5257	Hearing aid, digit, mon, bte		E					
V5258	Hearing aid, digit, bin, cic		E					
V5259	Hearing aid, digit, bin, itc		E					
V5260	Hearing aid, digit, bin, ite		E					
V5261	Hearing aid, digit, bin, bte		E					
V5262	Hearing aid, disp, monaural		E					
V5263	Hearing aid, disp, binaural		E					
V5264	Ear mold/insert		E					
V5265	Ear mold/insert, disp		E					
V5266	Battery for hearing device		E					
V5267	Hearing aid supply/accessory		E					
V5268	ALD Telephone Amplifier		E					
V5269	Alerting device, any type		E					
V5270	ALD, TV amplifier, any type		E					
V5271	ALD, TV caption decoder		E					
V5272	Tdd		E					
V5273	ALD for cochlear implant		E					
V5274	ALD unspecified		E					
V5275	Ear impression		E					
V5298	Hearing aid noc		E					
V5299	Hearing service		B					
V5336	Repair communication device		E					
V5362	Speech screening		E					
V5363	Language screening		E					
V5364	Dysphagia screening		E					

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)					
HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
0042T	Ct perfusion w/contrast, cbf		N1		
0073T	Delivery, comp imrt		Z2	5.8592	$245.49
0126T	Chd risk imt study		N1		
0159T	Cad breast mri		N1		
0174T	Cad cxr with interp		N1		
0175T	Cad cxr remote		N1		
0182T	Hdr elect brachytherapy		Z2	9.4592	$396.32
0185T	Comptr probability analysis		N1		
70010	Contrast x-ray of brain		N1		
70015	Contrast x-ray of brain		N1		
70030	X-ray eye for foreign body		Z3		$14.24
70100	X-ray exam of jaw		Z3		$16.94
70110	X-ray exam of jaw		Z3		$19.15
70120	X-ray exam of mastoids		Z3		$18.17
70130	X-ray exam of mastoids		Z2	0.6075	$25.45
70134	X-ray exam of middle ear		Z3		$20.87
70140	X-ray exam of facial bones		Z3		$14.49
70150	X-ray exam of facial bones	CH	Z3		$21.11
70160	X-ray exam of nasal bones		Z3		$17.19
70170	X-ray exam of tear duct		N1		
70190	X-ray exam of eye sockets		Z3		$17.92
70200	X-ray exam of eye sockets	CH	Z3		$21.36
70210	X-ray exam of sinuses		Z3		$15.47
70220	X-ray exam of sinuses		Z3		$18.91
70240	X-ray exam, pituitary saddle		Z3		$14.24
70250	X-ray exam of skull		Z3		$17.68
70260	X-ray exam of skull		Z3		$21.85
70300	X-ray exam of teeth		Z3		$6.14
70310	X-ray exam of teeth		Z2	0.4411	$18.48
70320	Full mouth x-ray of teeth		Z2	0.4411	$18.48
70328	X-ray exam of jaw joint		Z3		$15.22
70330	X-ray exam of jaw joints	CH	Z3		$25.29
70332	X-ray exam of jaw joint		N1		
70336	Magnetic image, jaw joint		Z2	4.6406	$194.43
70350	X-ray head for orthodontia		Z3		$8.35

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
70355	Panoramic x-ray of jaws		Z3		$7.86
70360	X-ray exam of neck		Z3		$13.26
70370	Throat x-ray & fluoroscopy	CH	Z3		$46.16
70371	Speech evaluation, complex	CH	Z3		$37.56
70373	Contrast x-ray of larynx		N1		
70380	X-ray exam of salivary gland	CH	Z3		$21.36
70390	X-ray exam of salivary duct		N1		
70450	Ct head/brain w/o dye		Z2	2.5969	$108.80
70460	Ct head/brain w/dye	CH	Z3		$141.91
70470	Ct head/brain w/o & w/dye	CH	Z3		$174.81
70480	Ct orbit/ear/fossa w/o dye		Z2	2.5969	$108.80
70481	Ct orbit/ear/fossa w/dye		Z2	4.0105	$168.03
70482	Ct orbit/ear/fossa w/o&w/dye		Z2	4.447	$186.32
70486	Ct maxillofacial w/o dye		Z2	2.5969	$108.80
70487	Ct maxillofacial w/dye		Z2	4.0105	$168.03
70488	Ct maxillofacial w/o & w/dye		Z2	4.447	$186.32
70490	Ct soft tissue neck w/o dye		Z2	2.5969	$108.80
70491	Ct soft tissue neck w/dye		Z2	4.0105	$168.03
70492	Ct sft tsue nck w/o & w/dye		Z2	4.447	$186.32
70496	Ct angiography, head		Z2	4.6	$192.73
70498	Ct angiography, neck		Z2	4.6	$192.73
70540	Mri orbit/face/neck w/o dye		Z2	4.6406	$194.43
70542	Mri orbit/face/neck w/dye		Z2	5.868	$245.86
70543	Mri orbt/fac/nck w/o & w/dye		Z2	7.2057	$301.90
70544	Mr angiography head w/o dye		Z2	4.6406	$194.43
70545	Mr angiography head w/dye		Z2	5.868	$245.86
70546	Mr angiograph head w/o&w/dye		Z2	7.2057	$301.90
70547	Mr angiography neck w/o dye		Z2	4.6406	$194.43
70548	Mr angiography neck w/dye		Z2	5.868	$245.86
70549	Mr angiograph neck w/o&w/dye		Z2	7.2057	$301.90
70551	Mri brain w/o dye		Z2	4.6406	$194.43
70552	Mri brain w/dye		Z2	5.868	$245.86
70553	Mri brain w/o & w/dye		Z2	7.2057	$301.90
70554	Fmri brain by tech		Z2	4.6406	$194.43
70555	Fmri brain by phys/psych		Z2	4.6406	$194.43
70557	Mri brain w/o dye		Z2	4.6406	$194.43
70558	Mri brain w/dye		Z2	5.868	$245.86
70559	Mri brain w/o & w/dye		Z2	7.2057	$301.90
71010	Chest x-ray		Z3		$10.31
71015	Chest x-ray		Z3		$13.75

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
71020	Chest x-ray		Z3		$13.99
71021	Chest x-ray		Z3		$17.68
71022	Chest x-ray	CH	Z3		$22.10
71023	Chest x-ray and fluoroscopy		Z3		$35.60
71030	Chest x-ray	CH	Z3		$21.61
71034	Chest x-ray and fluoroscopy	CH	Z3		$46.40
71035	Chest x-ray		Z3		$18.41
71040	Contrast x-ray of bronchi		N1		
71060	Contrast x-ray of bronchi		N1		
71090	X-ray & pacemaker insertion		N1		
71100	X-ray exam of ribs		Z3		$15.22
71101	X-ray exam of ribs/chest		Z3		$18.41
71110	X-ray exam of ribs		Z3		$19.40
71111	X-ray exam of ribs/chest		Z3		$26.27
71120	X-ray exam of breastbone		Z3		$15.47
71130	X-ray exam of breastbone		Z3		$18.66
71250	Ct thorax w/o dye		Z2	2.5969	$108.80
71260	Ct thorax w/dye		Z2	4.0105	$168.03
71270	Ct thorax w/o & w/dye		Z2	4.447	$186.32
71275	Ct angiography, chest		Z2	4.6	$192.73
71550	Mri chest w/o dye		Z2	4.6406	$194.43
71551	Mri chest w/dye		Z2	5.868	$245.86
71552	Mri chest w/o & w/dye		Z2	7.2057	$301.90
72010	X-ray exam of spine	CH	Z3		$36.58
72020	X-ray exam of spine		Z3		$11.29
72040	X-ray exam of neck spine		Z3		$19.15
72050	X-ray exam of neck spine		Z3		$26.03
72052	X-ray exam of neck spine	CH	Z3		$34.37
72069	X-ray exam of trunk spine		Z3		$17.92
72070	X-ray exam of thoracic spine		Z3		$15.96
72072	X-ray exam of thoracic spine		Z3		$18.91
72074	X-ray exam of thoracic spine	CH	Z3		$23.57
72080	X-ray exam of trunk spine		Z3		$17.43
72090	X-ray exam of trunk spine		Z3		$24.31
72100	X-ray exam of lower spine		Z3		$20.38
72110	X-ray exam of lower spine		Z3		$27.99
72114	X-ray exam of lower spine	CH	Z3		$39.28
72120	X-ray exam of lower spine	CH	Z2	0.6075	$25.45
72125	Ct neck spine w/o dye		Z2	2.5969	$108.80
72126	Ct neck spine w/dye		Z2	4.0105	$168.03

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
72127	Ct neck spine w/o & w/dye		Z2	4.447	$186.32
72128	Ct chest spine w/o dye		Z2	2.5969	$108.80
72129	Ct chest spine w/dye		Z2	4.0105	$168.03
72130	Ct chest spine w/o & w/dye		Z2	4.447	$186.32
72131	Ct lumbar spine w/o dye		Z2	2.5969	$108.80
72132	Ct lumbar spine w/dye		Z2	4.0105	$168.03
72133	Ct lumbar spine w/o & w/dye		Z2	4.447	$186.32
72141	Mri neck spine w/o dye		Z2	4.6406	$194.43
72142	Mri neck spine w/dye		Z2	5.868	$245.86
72146	Mri chest spine w/o dye		Z2	4.6406	$194.43
72147	Mri chest spine w/dye		Z2	5.868	$245.86
72148	Mri lumbar spine w/o dye		Z2	4.6406	$194.43
72149	Mri lumbar spine w/dye		Z2	5.868	$245.86
72156	Mri neck spine w/o & w/dye		Z2	7.2057	$301.90
72157	Mri chest spine w/o & w/dye		Z2	7.2057	$301.90
72158	Mri lumbar spine w/o & w/dye		Z2	7.2057	$301.90
72170	X-ray exam of pelvis		Z3		$12.52
72190	X-ray exam of pelvis	CH	Z3		$21.61
72191	Ct angiograph pelv w/o&w/dye		Z2	4.6	$192.73
72192	Ct pelvis w/o dye		Z2	2.5969	$108.80
72193	Ct pelvis w/dye	CH	Z3		$167.20
72194	Ct pelvis w/o & w/dye		Z2	4.447	$186.32
72195	Mri pelvis w/o dye		Z2	4.6406	$194.43
72196	Mri pelvis w/dye		Z2	5.868	$245.86
72197	Mri pelvis w/o & w/dye		Z2	7.2057	$301.90
72200	X-ray exam sacroiliac joints		Z3		$14.73
72202	X-ray exam sacroiliac joints		Z3		$17.68
72220	X-ray exam of tailbone		Z3		$14.49
72240	Contrast x-ray of neck spine		N1		
72255	Contrast x-ray, thorax spine		N1		
72265	Contrast x-ray, lower spine		N1		
72270	Contrast x-ray, spine		N1		
72275	Epidurography		N1		
72285	X-ray c/t spine disk		N1		
72291	Perq verte/sacroplsty, fluor		N1		
72292	Perq verte/sacroplsty, ct		N1		
72295	X-ray of lower spine disk		N1		
73000	X-ray exam of collar bone		Z3		$14.24
73010	X-ray exam of shoulder blade		Z3		$14.98
73020	X-ray exam of shoulder		Z3		$11.29

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
73030	X-ray exam of shoulder		Z3		$14.73
73040	Contrast x-ray of shoulder		N1		
73050	X-ray exam of shoulders		Z3		$19.40
73060	X-ray exam of humerus		Z3		$14.49
73070	X-ray exam of elbow		Z3		$14.49
73080	X-ray exam of elbow		Z3		$18.91
73085	Contrast x-ray of elbow		N1		
73090	X-ray exam of forearm		Z3		$13.99
73092	X-ray exam of arm, infant		Z3		$15.96
73100	X-ray exam of wrist		Z3		$15.47
73110	X-ray exam of wrist		Z3		$19.40
73115	Contrast x-ray of wrist		N1		
73120	X-ray exam of hand		Z3		$13.75
73130	X-ray exam of hand		Z3		$16.45
73140	X-ray exam of finger(s)		Z3		$17.43
73200	Ct upper extremity w/o dye		Z2	2.5969	$108.80
73201	Ct upper extremity w/dye		Z2	4.0105	$168.03
73202	Ct uppr extremity w/o&w/dye		Z2	4.447	$186.32
73206	Ct angio upr extrm w/o&w/dye		Z2	4.6	$192.73
73218	Mri upper extremity w/o dye		Z2	4.6406	$194.43
73219	Mri upper extremity w/dye		Z2	5.868	$245.86
73220	Mri uppr extremity w/o&w/dye		Z2	7.2057	$301.90
73221	Mri joint upr extrem w/o dye		Z2	4.6406	$194.43
73222	Mri joint upr extrem w/dye		Z2	5.868	$245.86
73223	Mri joint upr extr w/o&w/dye		Z2	7.2057	$301.90
73500	X-ray exam of hip		Z3		$12.28
73510	X-ray exam of hip		Z3		$19.15
73520	X-ray exam of hips		Z3		$19.40
73525	Contrast x-ray of hip		N1		
73530	X-ray exam of hip		N1		
73540	X-ray exam of pelvis & hips		Z3		$21.11
73542	X-ray exam, sacroiliac joint		N1		
73550	X-ray exam of thigh		Z3		$13.75
73560	X-ray exam of knee, 1 or 2		Z3		$14.73
73562	X-ray exam of knee, 3		Z3		$18.66
73564	X-ray exam, knee, 4 or more	CH	Z3		$21.36
73565	X-ray exam of knees		Z3		$16.94
73580	Contrast x-ray of knee joint		N1		
73590	X-ray exam of lower leg		Z3		$13.50
73592	X-ray exam of leg, infant		Z3		$16.20

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HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
73600	X-ray exam of ankle		Z3		$14.24
73610	X-ray exam of ankle		Z3		$16.94
73615	Contrast x-ray of ankle		N1		
73620	X-ray exam of foot		Z3		$13.75
73630	X-ray exam of foot		Z3		$16.70
73650	X-ray exam of heel		Z3		$13.99
73660	X-ray exam of toe(s)		Z3		$15.96
73700	Ct lower extremity w/o dye		Z2	2.5969	$108.80
73701	Ct lower extremity w/dye		Z2	4.0105	$168.03
73702	Ct lwr extremity w/o&w/dye		Z2	4.447	$186.32
73706	Ct angio lwr extr w/o&w/dye		Z2	4.6	$192.73
73718	Mri lower extremity w/o dye		Z2	4.6406	$194.43
73719	Mri lower extremity w/dye		Z2	5.868	$245.86
73720	Mri lwr extremity w/o&w/dye		Z2	7.2057	$301.90
73721	Mri jnt of lwr extre w/o dye		Z2	4.6406	$194.43
73722	Mri joint of lwr extr w/dye		Z2	5.868	$245.86
73723	Mri joint lwr extr w/o&w/dye		Z2	7.2057	$301.90
74000	X-ray exam of abdomen		Z3		$11.29
74010	X-ray exam of abdomen		Z3		$18.91
74020	X-ray exam of abdomen		Z3		$18.91
74022	X-ray exam series, abdomen		Z3		$22.83
74150	Ct abdomen w/o dye		Z2	2.5969	$108.80
74160	Ct abdomen w/dye		Z2	4.0105	$168.03
74170	Ct abdomen w/o & w/dye		Z2	4.447	$186.32
74175	Ct angio abdom w/o & w/dye		Z2	4.6	$192.73
74181	Mri abdomen w/o dye		Z2	4.6406	$194.43
74182	Mri abdomen w/dye		Z2	5.868	$245.86
74183	Mri abdomen w/o & w/dye		Z2	7.2057	$301.90
74190	X-ray exam of peritoneum		N1		
74210	Contrst x-ray exam of throat	CH	Z3		$42.47
74220	Contrast x-ray, esophagus	CH	Z3		$47.39
74230	Cine/vid x-ray, throat/esoph	CH	Z3		$45.67
74235	Remove esophagus obstruction		N1		
74240	X-ray exam, upper gi tract		Z2	1.1717	$49.09
74241	X-ray exam, upper gi tract		Z2	1.1717	$49.09
74245	X-ray exam, upper gi tract		Z2	1.9013	$79.66
74246	Contrst x-ray uppr gi tract		Z2	1.1717	$49.09
74247	Contrst x-ray uppr gi tract		Z2	1.1717	$49.09
74249	Contrst x-ray uppr gi tract		Z2	1.9013	$79.66
74250	X-ray exam of small bowel		Z2	1.1717	$49.09

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HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
74251	X-ray exam of small bowel		Z2	1.9013	$79.66
74260	X-ray exam of small bowel		Z2	1.1717	$49.09
74261	Ct colonography, w/o dye		Z2	2.5969	$108.80
74262	Ct colonography, w/dye		Z2	4.0105	$168.03
74270	Contrast x-ray exam of colon		Z2	1.1717	$49.09
74280	Contrast x-ray exam of colon		Z2	1.9013	$79.66
74283	Contrast x-ray exam of colon		Z2	1.1717	$49.09
74290	Contrast x-ray, gallbladder		Z3		$36.83
74291	Contrast x-rays, gallbladder		Z3		$38.06
74300	X-ray bile ducts/pancreas		N1		
74301	X-rays at surgery add-on		N1		
74305	X-ray bile ducts/pancreas		N1		
74320	Contrast x-ray of bile ducts		N1		
74327	X-ray bile stone removal		N1		
74328	X-ray bile duct endoscopy		N1		
74329	X-ray for pancreas endoscopy		N1		
74330	X-ray bile/panc endoscopy		N1		
74340	X-ray guide for GI tube		N1		
74355	X-ray guide, intestinal tube		N1		
74360	X-ray guide, GI dilation		N1		
74363	X-ray, bile duct dilation		N1		
74400	Contrst x-ray, urinary tract		Z3		$61.63
74410	Contrst x-ray, urinary tract		Z3		$64.08
74415	Contrst x-ray, urinary tract	CH	Z3		$79.06
74420	Contrst x-ray, urinary tract		Z2	2.3552	$98.68
74425	Contrst x-ray, urinary tract		N1		
74430	Contrast x-ray, bladder		N1		
74440	X-ray, male genital tract		N1		
74445	X-ray exam of penis		N1		
74450	X-ray, urethra/bladder		N1		
74455	X-ray, urethra/bladder		N1		
74470	X-ray exam of kidney lesion		N1		
74475	X-ray control, cath insert		N1		
74480	X-ray control, cath insert		N1		
74485	X-ray guide, GU dilation		N1		
74710	X-ray measurement of pelvis		Z3		$16.20
74740	X-ray, female genital tract		N1		
74742	X-ray, fallopian tube		N1		
74775	X-ray exam of perineum		Z2	2.3552	$98.68
75557	Cardiac mri for morph		Z2	4.6406	$194.43

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HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
75559	Cardiac mri w/stress img		Z2	4.6406	$194.43
75561	Cardiac mri for morph w/dye		Z2	7.2057	$301.90
75563	Card mri w/stress img & dye		Z2	7.2057	$301.90
75565	Card mri vel flw map add-on		N1		
75571	Ct hrt w/o dye w/ca test		Z2	0.6271	$26.27
75572	Ct hrt w/3d image		Z2	3.4356	$143.94
75573	Ct hrt w/3d image, congen		Z2	3.4356	$143.94
75574	Ct angio hrt w/3d image		Z2	3.4356	$143.94
75600	Contrast x-ray exam of aorta		N1		
75605	Contrast x-ray exam of aorta		N1		
75625	Contrast x-ray exam of aorta		N1		
75630	X-ray aorta, leg arteries		N1		
75635	Ct angio abdominal arteries		N1		
75650	Artery x-rays, head & neck		N1		
75658	Artery x-rays, arm		N1		
75660	Artery x-rays, head & neck		N1		
75662	Artery x-rays, head & neck		N1		
75665	Artery x-rays, head & neck		N1		
75671	Artery x-rays, head & neck		N1		
75676	Artery x-rays, neck		N1		
75680	Artery x-rays, neck		N1		
75685	Artery x-rays, spine		N1		
75705	Artery x-rays, spine		N1		
75710	Artery x-rays, arm/leg		N1		
75716	Artery x-rays, arms/legs		N1		
75722	Artery x-rays, kidney		N1		
75724	Artery x-rays, kidneys		N1		
75726	Artery x-rays, abdomen		N1		
75731	Artery x-rays, adrenal gland		N1		
75733	Artery x-rays, adrenals		N1		
75736	Artery x-rays, pelvis		N1		
75741	Artery x-rays, lung		N1		
75743	Artery x-rays, lungs		N1		
75746	Artery x-rays, lung		N1		
75756	Artery x-rays, chest		N1		
75774	Artery x-ray, each vessel		N1		
75791	Av dialysis shunt imaging		N1		
75801	Lymph vessel x-ray, arm/leg		N1		
75803	Lymph vessel x-ray,arms/legs		N1		
75805	Lymph vessel x-ray, trunk		N1		

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HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
75807	Lymph vessel x-ray, trunk		N1		
75809	Nonvascular shunt, x-ray		N1		
75810	Vein x-ray, spleen/liver		N1		
75820	Vein x-ray, arm/leg		N1		
75822	Vein x-ray, arms/legs		N1		
75825	Vein x-ray, trunk		N1		
75827	Vein x-ray, chest		N1		
75831	Vein x-ray, kidney		N1		
75833	Vein x-ray, kidneys		N1		
75840	Vein x-ray, adrenal gland		N1		
75842	Vein x-ray, adrenal glands		N1		
75860	Vein x-ray, neck		N1		
75870	Vein x-ray, skull		N1		
75872	Vein x-ray, skull		N1		
75880	Vein x-ray, eye socket		N1		
75885	Vein x-ray, liver		N1		
75887	Vein x-ray, liver		N1		
75889	Vein x-ray, liver		N1		
75891	Vein x-ray, liver		N1		
75893	Venous sampling by catheter		N1		
75894	X-rays, transcath therapy		N1		
75896	X-rays, transcath therapy		N1		
75898	Follow-up angiography		N1		
75901	Remove cva device obstruct		N1		
75902	Remove cva lumen obstruct		N1		
75940	X-ray placement, vein filter		N1		
75945	Intravascular us		N1		
75946	Intravascular us add-on		N1		
75960	Transcath iv stent rs&i		N1		
75961	Retrieval, broken catheter		N1		
75962	Repair arterial blockage		N1		
75964	Repair artery blockage, each		N1		
75966	Repair arterial blockage		N1		
75968	Repair artery blockage, each		N1		
75970	Vascular biopsy		N1		
75978	Repair venous blockage		N1		
75980	Contrast xray exam bile duct		N1		
75982	Contrast xray exam bile duct		N1		
75984	Xray control catheter change		N1		
75989	Abscess drainage under x-ray		N1		

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HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
75992	Atherectomy, x-ray exam		N1		
75993	Atherectomy, x-ray exam		N1		
75994	Atherectomy, x-ray exam		N1		
75995	Atherectomy, x-ray exam		N1		
75996	Atherectomy, x-ray exam		N1		
76000	Fluoroscope examination		N1		
76001	Fluoroscope exam, extensive		N1		
76010	X-ray, nose to rectum		Z3		$13.01
76080	X-ray exam of fistula		N1		
76098	X-ray exam, breast specimen		N1		
76100	X-ray exam of body section		Z2	1.0284	$43.09
76101	Complex body section x-ray	CH	Z3		$101.89
76102	Complex body section x-rays		Z2	3.0792	$129.01
76120	Cine/video x-rays	CH	Z3		$41.00
76125	Cine/video x-rays add-on		N1		
76150	X-ray exam, dry process		Z3		$14.98
76350	Special x-ray contrast study		N1		
76376	3d render w/o postprocess		N1		
76377	3d rendering w/postprocess		N1		
76380	CAT scan follow-up study		Z2	1.6032	$67.17
76496	Fluoroscopic procedure		Z2	1.1337	$47.50
76497	Ct procedure		Z2	1.6032	$67.17
76498	Mri procedure		Z2	4.6406	$194.43
76499	Radiographic procedure		Z2	0.6075	$25.45
76506	Echo exam of head		Z2	0.8419	$35.27
76510	Ophth us, b & quant a		Z3		$53.03
76511	Ophth us, quant a only		Z3		$34.62
76512	Ophth us, b w/non-quant a		Z3		$28.73
76513	Echo exam of eye, water bath		Z3		$38.55
76514	Echo exam of eye, thickness		Z3		$2.95
76516	Echo exam of eye	CH	Z3		$30.44
76519	Echo exam of eye		Z3		$33.88
76529	Echo exam of eye	CH	Z3		$29.71
76536	Us exam of head and neck		Z2	1.2964	$54.32
76604	Us exam, chest		Z2	0.8419	$35.27
76645	Us exam, breast(s)		Z2	0.8419	$35.27
76700	Us exam, abdom, complete		Z2	1.2964	$54.32
76705	Echo exam of abdomen		Z2	1.2964	$54.32
76770	Us exam abdo back wall, comp		Z2	1.2964	$54.32
76775	Us exam abdo back wall, lim		Z2	1.2964	$54.32

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HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
76776	Us exam k transpl w/doppler		Z2	1.2964	$54.32
76800	Us exam, spinal canal		Z2	1.2964	$54.32
76801	Ob us < 14 wks, single fetus		Z2	1.2964	$54.32
76802	Ob us < 14 wks, addl fetus		Z3		$20.38
76805	Ob us >/= 14 wks, sngl fetus		Z2	1.2964	$54.32
76810	Ob us >/= 14 wks, addl fetus		Z3		$34.86
76811	Ob us, detailed, sngl fetus	CH	Z3		$70.71
76812	Ob us, detailed, addl fetus		Z2	0.8419	$35.27
76813	Ob us nuchal meas, 1 gest		Z2	0.8419	$35.27
76814	Ob us nuchal meas, add-on		Z3		$22.83
76815	Ob us, limited, fetus(s)		Z2	0.8419	$35.27
76816	Ob us, follow-up, per fetus		Z2	0.8419	$35.27
76817	Transvaginal us, obstetric		Z2	0.8419	$35.27
76818	Fetal biophys profile w/nst	CH	Z3		$50.09
76819	Fetal biophys profil w/o nst		Z3		$38.06
76820	Umbilical artery echo		Z3		$15.71
76821	Middle cerebral artery echo		Z2	0.8419	$35.27
76825	Echo exam of fetal heart		Z3		$96.24
76826	Echo exam of fetal heart		Z3		$59.91
76827	Echo exam of fetal heart	CH	Z3		$27.01
76828	Echo exam of fetal heart		Z3		$14.98
76830	Transvaginal us, non-ob		Z2	1.2964	$54.32
76831	Echo exam, uterus		Z3		$63.59
76856	Us exam, pelvic, complete		Z2	1.2964	$54.32
76857	Us exam, pelvic, limited		Z2	0.8419	$35.27
76870	Us exam, scrotum		Z2	1.2964	$54.32
76872	Us, transrectal		Z2	1.2964	$54.32
76873	Echograp trans r, pros study		Z2	1.2964	$54.32
76880	Us exam, extremity		Z2	1.2964	$54.32
76885	Us exam infant hips, dynamic		Z2	0.8419	$35.27
76886	Us exam infant hips, static		Z2	0.8419	$35.27
76930	Echo guide, cardiocentesis		N1		
76932	Echo guide for heart biopsy		N1		
76936	Echo guide for artery repair		Z2	1.428	$59.83
76937	Us guide, vascular access		N1		
76940	Us guide, tissue ablation		N1		
76941	Echo guide for transfusion		N1		
76942	Echo guide for biopsy		N1		
76945	Echo guide, villus sampling		N1		
76946	Echo guide for amniocentesis		N1		

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76948	Echo guide, ova aspiration		N1		
76950	Echo guidance radiotherapy		N1		
76965	Echo guidance radiotherapy		N1		
76970	Ultrasound exam follow-up		Z2	0.8419	$35.27
76975	GI endoscopic ultrasound		N1		
76977**	Us bone density measure		Z3		$5.40
76998	Us guide, intraop		N1		
76999	Echo examination procedure		Z2	0.8419	$35.27
77001	Fluoroguide for vein device		N1		
77002	Needle localization by xray		N1		
77003	Fluoroguide for spine inject		N1		
77011	Ct scan for localization		N1		
77012	Ct scan for needle biopsy		N1		
77013	Ct guide for tissue ablation		N1		
77014	Ct scan for therapy guide		N1		
77021	Mr guidance for needle place		N1		
77022	Mri for tissue ablation		N1		
77031	Stereotact guide for brst bx		N1		
77032	Guidance for needle, breast		N1		
77053	X-ray of mammary duct		N1		
77054	X-ray of mammary ducts		N1		
77071	X-ray stress view		Z3		$21.61
77072	X-rays for bone age		Z3		$9.82
77073	X-rays, bone length studies		Z3		$16.94
77074	X-rays, bone survey, limited		Z3		$33.15
77075	X-rays, bone survey complete		Z2	1.0284	$43.09
77076	X-rays, bone survey, infant		Z2	1.0284	$43.09
77077	Joint survey, single view		Z3		$18.17
77078**	Ct bone density, axial		Z2	0.9601	$40.23
77079**	Ct bone density, peripheral		Z3		$28.23
77080**	Dxa bone density, axial		Z2	0.9601	$40.23
77081**	Dxa bone density/peripheral	CH	Z3		$13.50
77082	Dxa bone density, vert fx		Z3		$19.89
77083**	Radiographic absorptiometry		Z3		$10.80
77084	Magnetic image, bone marrow		Z2	4.6406	$194.43
77280	Set radiation therapy field		Z2	1.4	$58.66
77285	Set radiation therapy field		Z2	3.7053	$155.24
77290	Set radiation therapy field		Z2	3.7053	$155.24
77295	Set radiation therapy field		Z3		$242.57
77299	Radiation therapy planning		Z2	1.4	$58.66

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HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
77300	Radiation therapy dose plan		Z3		$27.99
77301	Radiotherapy dose plan, imrt		Z2	12.3307	$516.63
77305	Teletx isodose plan simple		Z3		$22.59
77310	Teletx isodose plan intermed		Z3		$29.95
77315	Teletx isodose plan complex		Z3		$46.89
77321	Special teletx port plan		Z3		$43.21
77326	Brachytx isodose calc simp		Z2	1.4	$58.66
77327	Brachytx isodose calc interm		Z3		$98.45
77328	Brachytx isodose plan compl	CH	Z3		$125.22
77331	Special radiation dosimetry		Z3		$13.99
77332	Radiation treatment aid(s)		Z3		$37.32
77333	Radiation treatment aid(s)		Z3		$12.52
77334	Radiation treatment aid(s)		Z3		$66.54
77336	Radiation physics consult		Z3		$37.81
77338	Design mlc device for imrt		Z2	2.638	$110.53
77370	Radiation physics consult		Z2	1.4	$58.66
77371	Srs, multisource		Z2	96.1451	$4,028.29
77399	External radiation dosimetry		Z2	1.4	$58.66
77401	Radiation treatment delivery		Z3		$18.17
77402	Radiation treatment delivery		Z2	1.3106	$54.91
77403	Radiation treatment delivery		Z2	1.3106	$54.91
77404	Radiation treatment delivery		Z2	1.3106	$54.91
77406	Radiation treatment delivery		Z2	1.3106	$54.91
77407	Radiation treatment delivery		Z2	1.3106	$54.91
77408	Radiation treatment delivery		Z2	1.3106	$54.91
77409	Radiation treatment delivery		Z2	1.3106	$54.91
77411	Radiation treatment delivery		Z2	2.1581	$90.42
77412	Radiation treatment delivery		Z2	2.1581	$90.42
77413	Radiation treatment delivery		Z2	2.1581	$90.42
77414	Radiation treatment delivery		Z2	2.1581	$90.42
77416	Radiation treatment delivery		Z2	2.1581	$90.42
77417	Radiology port film(s)		N1		
77418	Radiation tx delivery, imrt		Z2	5.8592	$245.49
77421	Stereoscopic x-ray guidance		N1		
77422	Neutron beam tx, simple		Z2	2.1581	$90.42
77423	Neutron beam tx, complex		Z2	2.1581	$90.42
77435	Sbrt management		N1		
77470	Special radiation treatment		Z3		$70.22
77520	Proton trmt, simple w/o comp		Z2	12.0133	$503.33
77522	Proton trmt, simple w/comp		Z2	12.0133	$503.33

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77523	Proton trmt, intermediate		Z2	15.7152	$658.44
77525	Proton treatment, complex		Z2	15.7152	$658.44
77600	Hyperthermia treatment		Z2	5.1942	$217.63
77605	Hyperthermia treatment		Z2	5.1942	$217.63
77610	Hyperthermia treatment		Z2	5.1942	$217.63
77615	Hyperthermia treatment		Z2	5.1942	$217.63
77620	Hyperthermia treatment		Z2	5.1942	$217.63
77750	Infuse radioactive materials	CH	Z3		$73.66
77761	Apply intrcav radiat simple		Z3		$127.67
77762	Apply intrcav radiat interm	CH	Z3		$149.03
77763	Apply intrcav radiat compl	CH	Z3		$192.98
77776	Apply interstit radiat simpl		Z3		$133.56
77777	Apply interstit radiat inter	CH	Z3		$145.10
77778	Apply interstit radiat compl		Z3		$197.89
77785	Hdr brachytx, 1 channel		Z3		$108.03
77786	Hdr brachytx, 2-12 channel		Z3		$297.32
77787	Hdr brachytx over 12 chan		Z2	9.4592	$396.32
77789	Apply surface radiation		Z3		$39.04
77790	Radiation handling		N1		
77799	Radium/radioisotope therapy		Z2	4.6337	$194.14
78000	Thyroid, single uptake		Z3		$43.70
78001	Thyroid, multiple uptakes	CH	Z3		$55.24
78003	Thyroid suppress/stimul		Z3		$44.68
78006	Thyroid imaging with uptake		Z2	2.9893	$125.25
78007	Thyroid image, mult uptakes		Z3		$118.10
78010	Thyroid imaging		Z2	1.8521	$77.60
78011	Thyroid imaging with flow		Z2	1.8521	$77.60
78015	Thyroid met imaging		Z3		$127.67
78016	Thyroid met imaging/studies		Z2	3.8971	$163.28
78018	Thyroid met imaging, body		Z2	3.8971	$163.28
78020	Thyroid met uptake		N1		
78070	Parathyroid nuclear imaging		Z3		$87.41
78075	Adrenal nuclear imaging		Z3		$273.51
78099	Endocrine nuclear procedure		Z2	1.8521	$77.60
78102	Bone marrow imaging, ltd		Z3		$97.47
78103	Bone marrow imaging, mult	CH	Z3		$128.16
78104	Bone marrow imaging, body		Z2	3.4416	$144.20
78110	Plasma volume, single		Z3		$50.82
78111	Plasma volume, multiple		Z3		$54.26
78120	Red cell mass, single		Z3		$52.79

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78121	Red cell mass, multiple		Z3		$58.92
78122	Blood volume		Z3		$63.59
78130	Red cell survival study		Z3		$86.18
78135	Red cell survival kinetics	CH	Z3		$218.27
78140	Red cell sequestration		Z3		$75.62
78185	Spleen imaging	CH	Z3		$126.44
78190	Platelet survival, kinetics		Z2	2.366	$99.13
78191	Platelet survival		Z2	2.366	$99.13
78195	Lymph system imaging		Z2	3.4416	$144.20
78199	Blood/lymph nuclear exam		Z2	3.4416	$144.20
78201	Liver imaging		Z3		$114.66
78202	Liver imaging with flow		Z3		$125.22
78205	Liver imaging (3D)	CH	Z3		$135.04
78206	Liver image (3d) with flow		Z2	3.828	$160.39
78215	Liver and spleen imaging		Z3		$117.11
78216	Liver & spleen image/flow		Z3		$71.69
78220	Liver function study		Z3		$79.06
78223	Hepatobiliary imaging		Z2	3.828	$160.39
78230	Salivary gland imaging		Z3		$99.93
78231	Serial salivary imaging		Z3		$71.94
78232	Salivary gland function exam		Z3		$67.03
78258	Esophageal motility study	CH	Z3		$134.05
78261	Gastric mucosa imaging		Z2	3.2798	$137.42
78262	Gastroesophageal reflux exam		Z2	3.2798	$137.42
78264	Gastric emptying study		Z2	3.2798	$137.42
78270	Vit B-12 absorption exam		Z3		$50.09
78271	Vit b-12 absrp exam, int fac		Z3		$53.52
78272	Vit B-12 absorp, combined		Z3		$54.26
78278	Acute GI blood loss imaging		Z2	3.2798	$137.42
78282	GI protein loss exam		Z2	3.2798	$137.42
78290	Meckels divert exam		Z2	3.2798	$137.42
78291	Leveen/shunt patency exam		Z2	3.2798	$137.42
78299	GI nuclear procedure		Z2	3.2798	$137.42
78300	Bone imaging, limited area		Z3		$101.40
78305	Bone imaging, multiple areas	CH	Z3		$134.05
78306	Bone imaging, whole body		Z2	3.3303	$139.53
78315	Bone imaging, 3 phase		Z2	3.3303	$139.53
78320	Bone imaging (3D)	CH	Z3		$135.53
78399	Musculoskeletal nuclear exam		Z2	3.3303	$139.53
78414	Non-imaging heart function		Z2	3.9745	$166.52

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78428	Cardiac shunt imaging		Z3		$109.26
78445	Vascular flow imaging	CH	Z3		$103.36
78451	Ht muscle image spect, sing		Z3		$194.21
78452	Ht muscle image spect, mult		Z3		$283.58
78453	Ht muscle image,planar,sing		Z3		$170.15
78454	Ht musc image, planar, mult		Z3		$247.98
78456	Acute venous thrombus image		Z2	3.2659	$136.83
78457	Venous thrombosis imaging	CH	Z3		$111.22
78458	Ven thrombosis images, bilat	CH	Z3		$107.78
78459	Heart muscle imaging (PET)		Z2	14.6357	$613.21
78466	Heart infarct image		Z3		$102.63
78468	Heart infarct image (ef)		Z3		$126.20
78469	Heart infarct image (3D)	CH	Z3		$148.29
78472	Gated heart, planar, single	CH	Z3		$142.89
78473	Gated heart, multiple		Z2	3.9745	$166.52
78481	Heart first pass, single		Z3		$113.68
78483	Heart first pass, multiple	CH	Z3		$152.96
78491	Heart image (pet), single		Z2	14.6357	$613.21
78492	Heart image (pet), multiple		Z2	14.6357	$613.21
78494	Heart image, spect	CH	Z3		$147.07
78496	Heart first pass add-on		N1		
78499	Cardiovascular nuclear exam		Z2	3.9745	$166.52
78580	Lung perfusion imaging		Z2	2.7182	$113.89
78584	Lung V/Q image single breath		Z3		$71.94
78585	Lung V/Q imaging		Z2	4.3339	$181.58
78586	Aerosol lung image, single	CH	Z3		$102.38
78587	Aerosol lung image, multiple		Z2	2.7182	$113.89
78588	Perfusion lung image		Z2	4.3339	$181.58
78591	Vent image, 1 breath, 1 proj	CH	Z3		$103.85
78593	Vent image, 1 proj, gas		Z2	2.7182	$113.89
78594	Vent image, mult proj, gas		Z2	2.7182	$113.89
78596	Lung differential function		Z2	4.3339	$181.58
78599	Respiratory nuclear exam		Z2	2.7182	$113.89
78600	Brain image < 4 views	CH	Z3		$109.99
78601	Brain image w/flow < 4 views		Z3		$131.35
78605	Brain image 4+ views	CH	Z3		$118.83
78606	Brain image w/flow 4 + views		Z3		$204.76
78607	Brain imaging (3D)		Z3		$213.11
78608	Brain imaging (PET)		Z2	13.9981	$586.49
78610	Brain flow imaging only	CH	Z3		$113.43

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
78630	Cerebrospinal fluid scan		Z3		$211.88
78635	CSF ventriculography		Z3		$203.05
78645	CSF shunt evaluation		Z2	3.1002	$129.89
78647	Cerebrospinal fluid scan		Z3		$213.11
78650	CSF leakage imaging		Z3		$209.67
78660	Nuclear exam of tear flow	CH	Z3		$105.33
78699	Nervous system nuclear exam		Z2	3.1002	$129.89
78700	Kidney imaging, morphol		Z3		$107.54
78701	Kidney imaging with flow		Z3		$131.84
78707	K flow/funct image w/o drug		Z3		$133.56
78708	K flow/funct image w/drug		Z3		$84.46
78709	K flow/funct image, multiple		Z2	4.2985	$180.10
78710	Kidney imaging (3D)		Z3		$134.30
78725	Kidney function study		Z3		$58.43
78730	Urinary bladder retention		Z3		$47.14
78740	Ureteral reflux study		Z3		$135.77
78761	Testicular imaging w/flow		Z3		$124.48
78799	Genitourinary nuclear exam		Z2	4.2985	$180.10
78800	Tumor imaging, limited area		Z3		$108.03
78801	Tumor imaging, mult areas		Z3		$149.77
78802	Tumor imaging, whole body		Z3		$199.61
78803	Tumor imaging (3D)		Z3		$209.43
78804	Tumor imaging, whole body		Z3		$370.49
78805	Abscess imaging, ltd area		Z3		$103.85
78806	Abscess imaging, whole body		Z3		$207.46
78807	Nuclear localization/abscess		Z2	3.8971	$163.28
78808	Iv inj ra drug dx study		N1		
78811	Pet image, ltd area		Z2	13.9981	$586.49
78812	Pet image, skull-thigh		Z2	13.9981	$586.49
78813	Pet image, full body		Z2	13.9981	$586.49
78814	Pet image w/ct, lmtd		Z2	13.9981	$586.49
78815	Pet image w/ct, skull-thigh		Z2	13.9981	$586.49
78816	Pet image w/ct, full body		Z2	13.9981	$586.49
78999	Nuclear diagnostic exam		Z2	1.4335	$60.06
79005	Nuclear rx, oral admin		Z3		$38.55
79101	Nuclear rx, iv admin		Z3		$41.98
79200	Nuclear rx, intracav admin		Z3		$47.39
79300	Nuclr rx, interstit colloid		Z2	2.988	$125.19
79403	Hematopoietic nuclear tx		Z3		$65.55
79440	Nuclear rx, intra-articular		Z3		$40.02

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HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
79445	Nuclear rx, intra-arterial		Z2	2.988	$125.19
79999	Nuclear medicine therapy		Z2	2.988	$125.19
90371	Hep b ig, im		K2		$115.97
90375	Rabies ig, im/sc		K2		$139.75
90376	Rabies ig, heat treated		K2		$152.38
90378	Rsv, mab, im, 50mg		K2		$510.69
90385	Rh ig, minidose, im		N1		
90396	Varicella-zoster ig, im		K2		$147.58
90476	Adenovirus vaccine, type 4		K2		$173.84
90585	Bcg vaccine, percut		K2		$109.47
90632	Hep a vaccine, adult im		N1		
90633	Hep a vacc, ped/adol, 2 dose		N1		
90634	Hep a vacc, ped/adol, 3 dose		N1		
90636	Hep a/hep b vacc, adult im		N1		
90645	Hib vaccine, hboc, im		N1		
90646	Hib vaccine, prp-d, im		N1		
90647	Hib vaccine, prp-omp, im		N1		
90648	Hib vaccine, prp-t, im		N1		
90655**	Flu vaccine no preserv 6-35m		L1		
90656**	Flu vaccine no preserv 3 & >		L1		
90657**	Flu vaccine, 3 yrs, im		L1		
90658**	Flu vaccine, 3 yrs & >, im		L1		
90660**	Flu vaccine, nasal		L1		
90665	Lyme disease vaccine, im	CH	N1		
90669**	Pneumococcal vacc, 7 val im		L1		
90670**	Pneumococcal vacc, 13 val im	CH	L1		
90675	Rabies vaccine, im		K2		$181.27
90676	Rabies vaccine, id		K2		$98.12
90680	Rotovirus vacc 3 dose, oral		K2		$73.76
90681	Rotavirus vacc 2 dose oral		K2		$102.50
90690	Typhoid vaccine, oral		N1		
90691	Typhoid vaccine, im		N1		
90692	Typhoid vaccine, h-p, sc/id		N1		
90696	Dtap-ipv vacc 4-6 yr im		N1		
90698	Dtap-hib-ip vaccine, im		N1		
90700	Dtap vaccine, < 7 yrs, im		N1		
90701	Dtp vaccine, im		N1		
90702	Dt vaccine < 7, im		N1		
90703	Tetanus vaccine, im		N1		
90704	Mumps vaccine, sc		N1		

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HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
90705	Measles vaccine, sc		N1		
90706	Rubella vaccine, sc		N1		
90707	Mmr vaccine, sc		N1		
90708	Measles-rubella vaccine, sc		N1		
90710	Mmrv vaccine, sc		N1		
90712	Oral poliovirus vaccine		N1		
90713	Poliovirus, ipv, sc/im		N1		
90714	Td vaccine no prsrv >/= 7 im		N1		
90715	Tdap vaccine >7 im		N1		
90717	Yellow fever vaccine, sc		N1		
90718	Td vaccine > 7, im		N1		
90719	Diphtheria vaccine, im		N1		
90720	Dtp/hib vaccine, im		N1		
90721	Dtap/hib vaccine, im		N1		
90725	Cholera vaccine, injectable		K2		$103.90
90732**	Pneumococcal vaccine		L1		
90733	Meningococcal vaccine, sc		K2		$103.41
90734	Meningococcal vaccine, im		K2		$103.41
90735	Encephalitis vaccine, sc		K2		$102.08
90740**	Hepb vacc, ill pat 3 dose im		F4		
90743**	Hep b vacc, adol, 2 dose, im		F4		
90744**	Hepb vacc ped/adol 3 dose im		F4		
90746**	Hep b vaccine, adult, im		F4		
90747**	Hepb vacc, ill pat 4 dose im		F4		
90749	Vaccine toxoid		N1		
A4218	Sterile saline or water		N1		
A4220	Infusion pump refill kit		N1		
A4248	Chlorhexidine antisept		N1		
A4262	Temporary tear duct plug		N1		
A4263	Permanent tear duct plug		N1		
A4270	Disposable endoscope sheath		N1		
A4300	Cath impl vasc access portal		N1		
A4301	Implantable access syst perc		N1		
A4305	Drug delivery system >=50 ML		N1		
A4306	Drug delivery system <=50 ml		N1		
A4641	Radiopharm dx agent noc		N1		
A4642	In111 satumomab		N1		
A4648	Implantable tissue marker		N1		
A4650	Implant radiation dosimeter		N1		
A9500	Tc99m sestamibi		N1		

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HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
A9501	Technetium TC-99m teboroxime		N1		
A9502	Tc99m tetrofosmin		N1		
A9503	Tc99m medronate		N1		
A9504	Tc99m apcitide		N1		
A9505	TL201 thallium		N1		
A9507	In111 capromab		N1		
A9508	I131 iodobenguate, dx		N1		
A9509	Iodine I-123 sod iodide mil		N1		
A9510	Tc99m disofenin		N1		
A9512	Tc99m pertechnetate		N1		
A9516	Iodine I-123 sod iodide mic		N1		
A9521	Tc99m exametazime		N1		
A9524	I131 serum albumin, dx		N1		
A9526	Nitrogen N-13 ammonia		N1		
A9527	Iodine I-125 sodium iodide		H2		$21.01
A9528	Iodine I-131 iodide cap, dx		N1		
A9529	I131 iodide sol, dx		N1		
A9531	I131 max 100uCi		N1		
A9532	I125 serum albumin, dx		N1		
A9536	Tc99m depreotide		N1		
A9537	Tc99m mebrofenin		N1		
A9538	Tc99m pyrophosphate		N1		
A9539	Tc99m pentetate		N1		
A9540	Tc99m MAA		N1		
A9541	Tc99m sulfur colloid		N1		
A9542	In111 ibritumomab, dx		N1		
A9544	I131 tositumomab, dx		N1		
A9546	Co57/58		N1		
A9547	In111 oxyquinoline		N1		
A9548	In111 pentetate		N1		
A9550	Tc99m gluceptate		N1		
A9551	Tc99m succimer		N1		
A9552	F18 fdg		N1		
A9553	Cr51 chromate		N1		
A9554	I125 iothalamate, dx		N1		
A9555	Rb82 rubidium		N1		
A9556	Ga67 gallium		N1		
A9557	Tc99m bicisate		N1		
A9558	Xe133 xenon 10mci		N1		
A9559	Co57 cyano		N1		

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HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
A9560	Tc99m labeled rbc		N1		
A9561	Tc99m oxidronate		N1		
A9562	Tc99m mertiatide		N1		
A9566	Tc99m fanolesomab		N1		
A9567	Technetium TC-99m aerosol		N1		
A9568	Technetium tc99m arcitumomab		N1		
A9569	Technetium TC-99m auto WBC		N1		
A9570	Indium In-111 auto WBC		N1		
A9571	Indium IN-111 auto platelet		N1		
A9572	Indium In-111 pentetreotide		N1		
A9576	Inj prohance multipack		N1		
A9577	Inj multihance		N1		
A9578	Inj multihance multipack		N1		
A9579	Gad-base MR contrast NOS,1ml		N1		
A9580	Sodium fluoride F-18		N1		
A9581	Gadoxetate disodium inj	CH	N1		
A9582	Iodine I-123 iobenguane		K2		$2,282.67
A9583	Gadofosveset trisodium inj		K2		$12.89
A9698	Non-rad contrast materialNOC		N1		
C1713	Anchor/screw bn/bn,tis/bn		N1		
C1714	Cath, trans atherectomy, dir		N1		
C1715	Brachytherapy needle		N1		
C1716	Brachytx, non-str, Gold-198		H2		$184.45
C1717	Brachytx, non-str,HDR Ir-192		H2		$220.22
C1719	Brachytx, NS, Non-HDRIr-192		H2		$22.98
C1721	AICD, dual chamber		N1		
C1722	AICD, single chamber		N1		
C1724	Cath, trans atherec,rotation		N1		
C1725	Cath, translumin non-laser		N1		
C1726	Cath, bal dil, non-vascular		N1		
C1727	Cath, bal tis dis, non-vas		N1		
C1728	Cath, brachytx seed adm		N1		
C1729	Cath, drainage		N1		
C1730	Cath, EP, 19 or few elect		N1		
C1731	Cath, EP, 20 or more elec		N1		
C1732	Cath, EP, diag/abl, 3D/vect		N1		
C1733	Cath, EP, othr than cool-tip		N1		
C1750	Cath, hemodialysis,long-term		N1		
C1751	Cath, inf, per/cent/midline		N1		
C1752	Cath,hemodialysis,short-term		N1		

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HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
C1753	Cath, intravas ultrasound		N1		
C1754	Catheter, intradiscal		N1		
C1755	Catheter, intraspinal		N1		
C1756	Cath, pacing, transesoph		N1		
C1757	Cath, thrombectomy/embolect		N1		
C1758	Catheter, ureteral		N1		
C1759	Cath, intra echocardiography		N1		
C1760	Closure dev, vasc		N1		
C1762	Conn tiss, human(inc fascia)		N1		
C1763	Conn tiss, non-human		N1		
C1764	Event recorder, cardiac		N1		
C1765	Adhesion barrier		N1		
C1766	Intro/sheath,strble,non-peel		N1		
C1767	Generator, neuro non-recharg		N1		
C1768	Graft, vascular		N1		
C1769	Guide wire		N1		
C1770	Imaging coil, MR, insertable		N1		
C1771	Rep dev, urinary, w/sling		N1		
C1772	Infusion pump, programmable		N1		
C1773	Ret dev, insertable		N1		
C1776	Joint device (implantable)		N1		
C1777	Lead, AICD, endo single coil		N1		
C1778	Lead, neurostimulator		N1		
C1779	Lead, pmkr, transvenous VDD		N1		
C1780	Lens, intraocular (new tech)		N1		
C1781	Mesh (implantable)		N1		
C1782	Morcellator		N1		
C1783	Ocular imp, aqueous drain de		N1		
C1784	Ocular dev, intraop, det ret		N1		
C1785	Pmkr, dual, rate-resp		N1		
C1786	Pmkr, single, rate-resp		N1		
C1787	Patient progr, neurostim		N1		
C1788	Port, indwelling, imp		N1		
C1789	Prosthesis, breast, imp		N1		
C1813	Prosthesis, penile, inflatab		N1		
C1814	Retinal tamp, silicone oil		N1		
C1815	Pros, urinary sph, imp		N1		
C1816	Receiver/transmitter, neuro		N1		
C1817	Septal defect imp sys		N1		
C1818	Integrated keratoprosthesis		N1		

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HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
C1819	Tissue localization-excision		N1		
C1820	Generator neuro rechg bat sy		N1		
C1821	Interspinous implant		N1		
C1874	Stent, coated/cov w/del sys		N1		
C1875	Stent, coated/cov w/o del sy		N1		
C1876	Stent, non-coa/non-cov w/del		N1		
C1877	Stent, non-coat/cov w/o del		N1		
C1878	Matrl for vocal cord		N1		
C1879	Tissue marker, implantable		N1		
C1880	Vena cava filter		N1		
C1881	Dialysis access system		N1		
C1882	AICD, other than sing/dual		N1		
C1883	Adapt/ext, pacing/neuro lead		N1		
C1884	Embolization Protect syst		N1		
C1885	Cath, translumin angio laser		N1		
C1887	Catheter, guiding		N1		
C1888	Endovas non-cardiac abl cath		N1		
C1891	Infusion pump,non-prog, perm		N1		
C1892	Intro/sheath,fixed,peel-away		N1		
C1893	Intro/sheath, fixed,non-peel		N1		
C1894	Intro/sheath, non-laser		N1		
C1895	Lead, AICD, endo dual coil		N1		
C1896	Lead, AICD, non sing/dual		N1		
C1897	Lead, neurostim test kit		N1		
C1898	Lead, pmkr, other than trans		N1		
C1899	Lead, pmkr/AICD combination		N1		
C1900	Lead, coronary venous		N1		
C2614	Probe, perc lumb disc		N1		
C2615	Sealant, pulmonary, liquid		N1		
C2616	Brachytx, non-str,Yttrium-90		H2		$16,775.76
C2617	Stent, non-cor, tem w/o del		N1		
C2618	Probe, cryoablation		N1		
C2619	Pmkr, dual, non rate-resp		N1		
C2620	Pmkr, single, non rate-resp		N1		
C2621	Pmkr, other than sing/dual		N1		
C2622	Prosthesis, penile, non-inf		N1		
C2625	Stent, non-cor, tem w/del sy		N1		
C2626	Infusion pump, non-prog,temp		N1		
C2627	Cath, suprapubic/cystoscopic		N1		
C2628	Catheter, occlusion		N1		

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HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
C2629	Intro/sheath, laser		N1		
C2630	Cath, EP, cool-tip		N1		
C2631	Rep dev, urinary, w/o sling		N1		
C2634	Brachytx, non-str, HA, I-125		H2		$51.86
C2635	Brachytx, non-str, HA, P-103		H2		$29.61
C2636	Brachy linear, non-str,P-103		H2		$36.04
C2638	Brachytx, stranded, I-125		H2		$38.65
C2639	Brachytx, non-stranded,I-125		H2		$36.13
C2640	Brachytx, stranded, P-103		H2		$63.72
C2641	Brachytx, non-stranded,P-103		H2		$62.36
C2642	Brachytx, stranded, C-131		H2		$114.51
C2643	Brachytx, non-stranded,C-131		H2		$62.42
C2698	Brachytx, stranded, NOS		H2		$38.65
C2699	Brachytx, non-stranded, NOS		H2		$22.98
C8900	MRA w/cont, abd		Z2	5.868	$245.86
C8901	MRA w/o cont, abd		Z2	4.6406	$194.43
C8902	MRA w/o fol w/cont, abd		Z2	7.2057	$301.90
C8903	MRI w/cont, breast, uni		Z2	5.868	$245.86
C8904	MRI w/o cont, breast, uni		Z2	4.6406	$194.43
C8905	MRI w/o fol w/cont, brst, un		Z2	7.2057	$301.90
C8906	MRI w/cont, breast, bi		Z2	5.868	$245.86
C8907	MRI w/o cont, breast, bi		Z2	4.6406	$194.43
C8908	MRI w/o fol w/cont, breast,		Z2	7.2057	$301.90
C8909	MRA w/cont, chest		Z2	5.868	$245.86
C8910	MRA w/o cont, chest		Z2	4.6406	$194.43
C8911	MRA w/o fol w/cont, chest		Z2	7.2057	$301.90
C8912	MRA w/cont, lwr ext		Z2	5.868	$245.86
C8913	MRA w/o cont, lwr ext		Z2	4.6406	$194.43
C8914	MRA w/o fol w/cont, lwr ext		Z2	7.2057	$301.90
C8918	MRA w/cont, pelvis		Z2	5.868	$245.86
C8919	MRA w/o cont, pelvis		Z2	4.6406	$194.43
C8920	MRA w/o fol w/cont, pelvis		Z2	7.2057	$301.90
C9113	Inj pantoprazole sodium, via		N1		
C9121	Injection, argatroban		K2		$18.39
C9248	Inj, clevidipine butyrate		K2		$2.98
C9250	Artiss fibrin sealant		K2		$136.64
C9254	Injection, lacosamide		K2		$0.18
C9255	Paliperidone palmitate inj		K2		$6.54
C9256	Dexamethasone intravitreal		K2		$196.10
C9257	Bevacizumab injection		K2		$1.44

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HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
C9258	Telavancin injection		K2		$0.21
C9259	Pralatrexate injection		K2		$165.63
C9260	Ofatumumab injection		K2		$46.64
C9261	Ustekinumab injection		K2		$107.43
C9262	Fludarabine phosphate, oral		K2		$81.77
C9263	Ecallantide injection		K2		$280.90
C9352	Neuragen nerve guide, per cm		N1		
C9353	Neurawrap nerve protector,cm		N1		
C9354	Veritas collagen matrix, cm2		N1		
C9355	Neuromatrix nerve cuff, cm		N1		
C9356	TenoGlide tendon prot, cm2	CH	N1		
C9358	SurgiMend, fetal		K2		$10.67
C9359	Implnt,bon void filler-putty	CH	N1		
C9360	SurgiMend, neonatal		K2		$11.24
C9361	NeuroMend nerve wrap		K2		$265.18
C9362	Implnt,bon void filler-strip		K2		$50.88
C9363	Integra Meshed Bil Wound Mat		K2		$17.88
C9364	Porcine implant, Permacol		K2		$17.67
C9399	Unclassified drugs or biolog		K7		
E0616	Cardiac event recorder		N1		
E0749	Elec osteogen stim implanted		N1		
E0782	Non-programble infusion pump		N1		
E0783	Programmable infusion pump		N1		
E0785	Replacement impl pump cathet		N1		
E0786	Implantable pump replacement		N1		
G0130**	Single energy x-ray study		Z3		$15.71
G0173	Linear acc stereo radsur com		Z2	45.4605	$1,904.70
G0251	Linear acc based stero radio		Z2	12.5279	$524.89
G0288	Recon, CTA for surg plan		N1		
G0339	Robot lin-radsurg com, first		Z2	45.4605	$1,904.70
G0340	Robt lin-radsurg fractx 2-5		Z2	33.5039	$1,403.75
J0120	Tetracyclin injection		N1		
J0129	Abatacept injection		K2		$19.96
J0130	Abciximab injection		K2		$462.83
J0132	Acetylcysteine injection		K2		$2.45
J0133	Acyclovir injection		N1		
J0135	Adalimumab injection		K2		$374.48
J0150	Injection adenosine 6 MG	CH	N1		
J0152	Adenosine injection		K2		$82.72
J0170	Adrenalin epinephrin inject		N1		

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HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
J0180	Agalsidase beta injection		K2		$136.24
J0200	Alatrofloxacin mesylate		N1		
J0205	Alglucerase injection		K2		$41.98
J0207	Amifostine		K2		$327.97
J0210	Methyldopate hcl injection		K2		$36.34
J0215	Alefacept		K2		$30.63
J0220	Alglucosidase alfa injection		K2		$127.08
J0256	Alpha 1 proteinase inhibitor		K2		$3.77
J0278	Amikacin sulfate injection		N1		
J0280	Aminophyllin 250 MG inj		N1		
J0282	Amiodarone HCl		N1		
J0285	Amphotericin B		N1		
J0287	Amphotericin b lipid complex		K2		$9.84
J0288	Ampho b cholesteryl sulfate		K2		$14.00
J0289	Amphotericin b liposome inj		K2		$15.78
J0290	Ampicillin 500 MG inj		N1		
J0295	Ampicillin sodium per 1.5 gm		N1		
J0300	Amobarbital 125 MG inj		N1		
J0330	Succinycholine chloride inj		N1		
J0348	Anidulafungin injection	CH	N1		
J0360	Hydralazine hcl injection		N1		
J0364	Apomorphine hydrochloride		N1		
J0365	Aprotonin, 10,000 kiu	CH	N1		
J0380	Inj metaraminol bitartrate		N1		
J0390	Chloroquine injection		N1		
J0400	Aripiprazole injection		N1		
J0456	Azithromycin		N1		
J0461	Atropine sulfate injection		N1		
J0470	Dimecaprol injection	CH	N1		
J0475	Baclofen 10 MG injection		K2		$203.89
J0476	Baclofen intrathecal trial		K2		$73.50
J0480	Basiliximab		K2		$1,755.73
J0500	Dicyclomine injection		N1		
J0515	Inj benztropine mesylate	CH	K2		$42.16
J0520	Bethanechol chloride inject		N1		
J0559	PenG benzathine/procaine inj		N1		
J0560	Penicillin g benzathine inj		N1		
J0570	Penicillin g benzathine inj		N1		
J0580	Penicillin g benzathine inj		N1		
J0583	Bivalirudin		K2		$2.41

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HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
J0585	Injection,onabotulinumtoxinA		K2		$5.49
J0586	AbobotulinumtoxintypeA		K2		$7.71
J0587	Inj. rimabotulinumtoxinB		K2		$10.58
J0592	Buprenorphine hydrochloride		N1		
J0594	Busulfan injection		K2		$14.45
J0595	Butorphanol tartrate 1 mg		N1		
J0598	C1 esterase inhibitor inj		K2		$42.75
J0600	Edetate calcium disodium inj		K2		$197.37
J0610	Calcium gluconate injection		N1		
J0620	Calcium glycer & lact/10 ML		N1		
J0630	Calcitonin salmon injection		K2		$49.26
J0636	Inj calcitriol per 0.1 mcg		N1		
J0637	Caspofungin acetate		K2		$11.59
J0640	Leucovorin calcium injection		N1		
J0641	Levoleucovorin injection		K2		$0.78
J0670	Inj mepivacaine HCL/10 ml		N1		
J0690	Cefazolin sodium injection		N1		
J0692	Cefepime HCl for injection		N1		
J0694	Cefoxitin sodium injection		N1		
J0696	Ceftriaxone sodium injection		N1		
J0697	Sterile cefuroxime injection		N1		
J0698	Cefotaxime sodium injection		N1		
J0702	Betamethasone acet&sod phosp		N1		
J0704	Betamethasone sod phosp/4 MG		N1		
J0706	Caffeine citrate injection		N1		
J0710	Cephapirin sodium injection		N1		
J0713	Inj ceftazidime per 500 mg		N1		
J0715	Ceftizoxime sodium / 500 MG		N1		
J0718	Certolizumab pegol inj		K2		$3.78
J0720	Chloramphenicol sodium injec		N1		
J0725	Chorionic gonadotropin/1000u		N1		
J0735	Clonidine hydrochloride		K2		$98.64
J0740	Cidofovir injection		K2		$761.10
J0743	Cilastatin sodium injection		N1		
J0744	Ciprofloxacin iv		N1		
J0745	Inj codeine phosphate /30 MG		N1		
J0760	Colchicine injection		N1		
J0770	Colistimethate sodium inj		N1		
J0780	Prochlorperazine injection		N1		
J0795	Corticorelin ovine triflutal		K2		$4.48

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HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
J0800	Corticotropin injection		K2		$2,441.70
J0833	Cosyntropin injection NOS		K2		$73.19
J0834	Cosyntropin cortrosyn inj		K2		$90.95
J0850	Cytomegalovirus imm IV /vial		K2		$878.82
J0878	Daptomycin injection		K2		$0.43
J0881	Darbepoetin alfa, non-esrd		K2		$2.88
J0885	Epoetin alfa, non-esrd		K2		$9.44
J0894	Decitabine injection		K2		$29.65
J0895	Deferoxamine mesylate inj		N1		
J0900	Testosterone enanthate inj		N1		
J0945	Brompheniramine maleate inj		K2		$9.24
J0970	Estradiol valerate injection		N1		
J1000	Depo-estradiol cypionate inj		N1		
J1020	Methylprednisolone 20 MG inj		N1		
J1030	Methylprednisolone 40 MG inj		N1		
J1040	Methylprednisolone 80 MG inj		N1		
J1051	Medroxyprogesterone inj		N1		
J1060	Testosterone cypionate 1 ML		N1		
J1070	Testosterone cypionat 100 MG		N1		
J1080	Testosterone cypionat 200 MG		N1		
J1094	Inj dexamethasone acetate		N1		
J1100	Dexamethasone sodium phos		N1		
J1110	Inj dihydroergotamine mesylt		N1		
J1120	Acetazolamid sodium injectio		N1		
J1160	Digoxin injection		N1		
J1162	Digoxin immune fab (ovine)		K2		$487.78
J1165	Phenytoin sodium injection		N1		
J1170	Hydromorphone injection		N1		
J1180	Dyphylline injection		N1		
J1190	Dexrazoxane HCl injection		K2		$261.24
J1200	Diphenhydramine hcl injectio		N1		
J1205	Chlorothiazide sodium inj		K2		$352.37
J1212	Dimethyl sulfoxide 50% 50 ML		K2		$69.98
J1230	Methadone injection		N1		
J1240	Dimenhydrinate injection		N1		
J1245	Dipyridamole injection		N1		
J1250	Inj dobutamine HCL/250 mg		N1		
J1260	Dolasetron mesylate		N1		
J1265	Dopamine injection		N1		
J1267	Doripenem injection	CH	N1		

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HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
J1270	Injection, doxercalciferol		N1		
J1300	Eculizumab injection		K2		$182.61
J1320	Amitriptyline injection		N1		
J1324	Enfuvirtide injection	CH	N1		
J1325	Epoprostenol injection		N1		
J1327	Eptifibatide injection		K2		$19.00
J1330	Ergonovine maleate injection		N1		
J1335	Ertapenem injection		N1		
J1364	Erythro lactobionate /500 MG		N1		
J1380	Estradiol valerate 10 MG inj		N1		
J1390	Estradiol valerate 20 MG inj		N1		
J1410	Inj estrogen conjugate 25 MG		K2		$88.68
J1430	Ethanolamine oleate 100 mg		K2		$149.97
J1436	Etidronate disodium inj	CH	N1		
J1438	Etanercept injection		K2		$191.55
J1440	Filgrastim 300 mcg injection		K2		$223.05
J1441	Filgrastim 480 mcg injection		K2		$348.68
J1450	Fluconazole		N1		
J1451	Fomepizole, 15 mg		K2		$7.64
J1453	Fosaprepitant injection		K2		$1.62
J1455	Foscarnet sodium injection		N1		
J1457	Gallium nitrate injection		K2		$2.03
J1458	Galsulfase injection		K2		$339.90
J1459	Inj IVIG privigen 500 mg		K2		$35.10
J1460	Gamma globulin 1 CC inj		K2		$16.03
J1470	Gamma globulin 2 CC inj		K2		$32.07
J1480	Gamma globulin 3 CC inj		K2		$48.10
J1490	Gamma globulin 4 CC inj		K2		$64.13
J1500	Gamma globulin 5 CC inj		K2		$80.16
J1510	Gamma globulin 6 CC inj		K2		$96.23
J1520	Gamma globulin 7 CC inj		K2		$112.17
J1530	Gamma globulin 8 CC inj		K2		$128.27
J1540	Gamma globulin 9 CC inj		K2		$160.34
J1550	Gamma globulin 10 CC inj		K2		$160.34
J1560	Gamma globulin > 10 CC inj		K2		$160.34
J1561	Gamunex injection		K2		$37.63
J1562	Vivaglobin, inj		K2		$7.20
J1566	Immune globulin, powder		K2		$30.86
J1568	Octagam injection		K2		$37.69
J1569	Gammagard liquid injection		K2		$38.53

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HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
J1570	Ganciclovir sodium injection		N1		
J1571	Hepagam b im injection		K2		$50.63
J1572	Flebogamma injection		K2		$37.01
J1573	Hepagam b intravenous, inj		K2		$50.63
J1580	Garamycin gentamicin inj		N1		
J1590	Gatifloxacin injection		N1		
J1595	Injection glatiramer acetate		K2		$82.34
J1600	Gold sodium thiomaleate inj		N1		
J1610	Glucagon hydrochloride/1 MG		K2		$81.41
J1620	Gonadorelin hydroch/ 100 mcg	CH	N1		
J1626	Granisetron hcl injection		N1		
J1630	Haloperidol injection		N1		
J1631	Haloperidol decanoate inj		N1		
J1640	Hemin, 1 mg		K2		$8.18
J1642	Inj heparin sodium per 10 u		N1		
J1644	Inj heparin sodium per 1000u		N1		
J1645	Dalteparin sodium		N1		
J1650	Inj enoxaparin sodium		N1		
J1652	Fondaparinux sodium	CH	N1		
J1655	Tinzaparin sodium injection		N1		
J1670	Tetanus immune globulin inj		K2		$136.81
J1680	Human fibrinogen conc inj		K2		$72.89
J1700	Hydrocortisone acetate inj		N1		
J1710	Hydrocortisone sodium ph inj		N1		
J1720	Hydrocortisone sodium succ i		N1		
J1730	Diazoxide injection		K2		$114.32
J1740	Ibandronate sodium injection		K2		$141.39
J1742	Ibutilide fumarate injection		K2		$416.61
J1743	Idursulfase injection		K2		$455.03
J1745	Infliximab injection		K2		$58.74
J1750	Inj iron dextran		K2		$12.63
J1756	Iron sucrose injection		K2		$0.37
J1785	Injection imiglucerase /unit		K2		$4.20
J1790	Droperidol injection		N1		
J1800	Propranolol injection		N1		
J1815	Insulin injection		N1		
J1817	Insulin for insulin pump use	CH	N1		
J1830	Interferon beta-1b / .25 MG		K2		$176.67
J1835	Itraconazole injection	CH	K2		$42.28
J1840	Kanamycin sulfate 500 MG inj		N1		

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HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
J1850	Kanamycin sulfate 75 MG inj		N1		
J1885	Ketorolac tromethamine inj		N1		
J1890	Cephalothin sodium injection		N1		
J1930	Lanreotide injection		K2		$29.30
J1931	Laronidase injection		K2		$25.56
J1940	Furosemide injection		N1		
J1945	Lepirudin		K2		$234.37
J1950	Leuprolide acetate /3.75 MG		K2		$516.09
J1953	Levetiracetam injection	CH	N1		
J1956	Levofloxacin injection		N1		
J1960	Levorphanol tartrate inj		N1		
J1980	Hyoscyamine sulfate inj		N1		
J1990	Chlordiazepoxide injection		N1		
J2001	Lidocaine injection		N1		
J2010	Lincomycin injection		N1		
J2020	Linezolid injection		K2		$32.57
J2060	Lorazepam injection		N1		
J2150	Mannitol injection		N1		
J2170	Mecasermin injection	CH	K2		$125.21
J2175	Meperidine hydrochl /100 MG		N1		
J2180	Meperidine/promethazine inj		N1		
J2185	Meropenem		N1		
J2210	Methylergonovin maleate inj		N1		
J2248	Micafungin sodium injection		K2		$1.10
J2250	Inj midazolam hydrochloride		N1		
J2260	Inj milrinone lactate / 5 MG		N1		
J2270	Morphine sulfate injection		N1		
J2271	Morphine so4 injection 100mg		N1		
J2275	Morphine sulfate injection		N1		
J2278	Ziconotide injection		K2		$6.50
J2280	Inj, moxifloxacin 100 mg		N1		
J2300	Inj nalbuphine hydrochloride		N1		
J2310	Inj naloxone hydrochloride		N1		
J2315	Naltrexone, depot form		K2		$2.43
J2320	Nandrolone decanoate 50 MG		K2		$7.08
J2321	Nandrolone decanoate 100 MG		K2		$71.34
J2322	Nandrolone decanoate 200 MG		K2		$43.59
J2323	Natalizumab injection		K2		$7.97
J2325	Nesiritide injection		K2		$38.37
J2353	Octreotide injection, depot		K2		$109.01

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HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
J2354	Octreotide inj, non-depot		N1		
J2355	Oprelvekin injection		K2		$245.08
J2357	Omalizumab injection		K2		$19.77
J2360	Orphenadrine injection		N1		
J2370	Phenylephrine hcl injection		N1		
J2400	Chloroprocaine hcl injection		N1		
J2405	Ondansetron hcl injection		N1		
J2410	Oxymorphone hcl injection		N1		
J2425	Palifermin injection		K2		$11.34
J2430	Pamidronate disodium /30 MG	CH	N1		
J2440	Papaverin hcl injection		N1		
J2469	Palonosetron hcl		K2		$17.62
J2501	Paricalcitol		N1		
J2503	Pegaptanib sodium injection		K2		$1,030.34
J2504	Pegademase bovine, 25 iu		K2		$247.34
J2505	Injection, pegfilgrastim 6mg		K2		$2,432.50
J2510	Penicillin g procaine inj		N1		
J2513	Pentastarch 10% solution		K2		$161.82
J2515	Pentobarbital sodium inj		N1		
J2540	Penicillin g potassium inj		N1		
J2543	Piperacillin/tazobactam		N1		
J2550	Promethazine hcl injection		N1		
J2560	Phenobarbital sodium inj		N1		
J2562	Plerixafor injection		K2		$268.58
J2590	Oxytocin injection		N1		
J2597	Inj desmopressin acetate		N1		
J2650	Prednisolone acetate inj		N1		
J2670	Totazoline hcl injection		N1		
J2675	Inj progesterone per 50 MG		N1		
J2680	Fluphenazine decanoate 25 MG		N1		
J2690	Procainamide hcl injection		N1		
J2700	Oxacillin sodium injeciton		N1		
J2710	Neostigmine methylslfte inj		N1		
J2720	Inj protamine sulfate/10 MG		N1		
J2724	Protein c concentrate		K2		$12.19
J2725	Inj protirelin per 250 mcg		N1		
J2730	Pralidoxime chloride inj		K2		$90.79
J2760	Phentolaine mesylate inj		N1		
J2765	Metoclopramide hcl injection		N1		
J2770	Quinupristin/dalfopristin		K2		$147.06

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HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
J2778	Ranibizumab injection		K2		$404.70
J2780	Ranitidine hydrochloride inj		N1		
J2783	Rasburicase		K2		$172.53
J2785	Regadenoson injection		K2		$50.73
J2788	Rho d immune globulin 50 mcg		K2		$25.14
J2790	Rho d immune globulin inj		K2		$77.47
J2791	Rhophylac injection		K2		$5.21
J2792	Rho(D) immune globulin h, sd		K2		$18.55
J2793	Rilonacept injection		K2		$24.09
J2794	Risperidone, long acting		K2		$5.06
J2795	Ropivacaine HCl injection		N1		
J2796	Romiplostim injection		K2		$44.18
J2800	Methocarbamol injection		N1		
J2805	Sincalide injection		N1		
J2810	Inj theophylline per 40 MG		N1		
J2820	Sargramostim injection		K2		$25.25
J2850	Inj secretin synthetic human		K2		$20.31
J2910	Aurothioglucose injeciton		N1		
J2916	Na ferric gluconate complex		N1		
J2920	Methylprednisolone injection		N1		
J2930	Methylprednisolone injection		N1		
J2940	Somatrem injection	CH	N1		
J2941	Somatropin injection		K2		$55.46
J2950	Promazine hcl injection		N1		
J2993	Reteplase injection		K2		$1,555.98
J2995	Inj streptokinase /250000 IU		K2		$32.12
J2997	Alteplase recombinant		K2		$37.35
J3000	Streptomycin injection		N1		
J3010	Fentanyl citrate injeciton		N1		
J3030	Sumatriptan succinate / 6 MG	CH	N1		
J3070	Pentazocine injection		N1		
J3101	Tenecteplase injection		K2		$46.74
J3105	Terbutaline sulfate inj		N1		
J3120	Testosterone enanthate inj		N1		
J3130	Testosterone enanthate inj		N1		
J3140	Testosterone suspension inj		N1		
J3150	Testosteron propionate inj		N1		
J3230	Chlorpromazine hcl injection		N1		
J3240	Thyrotropin injection		K2		$1,053.42
J3243	Tigecycline injection		K2		$1.16

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HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
J3246	Tirofiban HCl		K2		$7.39
J3250	Trimethobenzamide hcl inj		N1		
J3260	Tobramycin sulfate injection		N1		
J3265	Injection torsemide 10 mg/ml		N1		
J3280	Thiethylperazine maleate inj		N1		
J3285	Treprostinil injection		K2		$55.88
J3300	Triamcinolone A inj PRS-free		K2		$3.21
J3301	Triamcinolone acet inj NOS		N1		
J3302	Triamcinolone diacetate inj		N1		
J3303	Triamcinolone hexacetonl inj		N1		
J3305	Inj trimetrexate glucoronate	CH	N1		
J3310	Perphenazine injeciton	CH	K2		$29.11
J3315	Triptorelin pamoate		K2		$164.10
J3350	Urea injection	CH	K2		$83.87
J3355	Urofollitropin, 75 iu		K2		$60.01
J3360	Diazepam injection		N1		
J3364	Urokinase 5000 IU injection		N1		
J3365	Urokinase 250,000 IU inj		K2		$457.73
J3370	Vancomycin hcl injection		N1		
J3396	Verteporfin injection		K2		$9.50
J3410	Hydroxyzine hcl injection		N1		
J3411	Thiamine hcl 100 mg		N1		
J3415	Pyridoxine hcl 100 mg		N1		
J3420	Vitamin b12 injection		N1		
J3430	Vitamin k phytonadione inj		N1		
J3465	Injection, voriconazole		K2		$5.82
J3470	Hyaluronidase injection		N1		
J3471	Ovine, up to 999 USP units		N1		
J3472	Ovine, 1000 USP units		N1		
J3473	Hyaluronidase recombinant		N1		
J3475	Inj magnesium sulfate		N1		
J3480	Inj potassium chloride		N1		
J3485	Zidovudine		N1		
J3486	Ziprasidone mesylate		N1		
J3487	Zoledronic acid		K2		$221.12
J3488	Reclast injection		K2		$222.92
J3490	Drugs unclassified injection		N1		
J3530	Nasal vaccine inhalation		N1		
J3590	Unclassified biologics		N1		
J7030	Normal saline solution infus		N1		

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
J7040	Normal saline solution infus		N1		
J7042	5% dextrose/normal saline		N1		
J7050	Normal saline solution infus		N1		
J7060	5% dextrose/water		N1		
J7070	D5w infusion		N1		
J7100	Dextran 40 infusion		N1		
J7110	Dextran 75 infusion		N1		
J7120	Ringers lactate infusion		N1		
J7130	Hypertonic saline solution		N1		
J7185	Xyntha inj		K2		$1.08
J7186	Antihemophilic viii/vwf comp		K2		$0.92
J7187	Humate-P, inj		K2		$0.88
J7189	Factor viia		K2		$1.36
J7190	Factor viii		K2		$0.87
J7191	Factor VIII (porcine)		K2		$8.21
J7192	Factor viii recombinant NOS		K2		$1.09
J7193	Factor IX non-recombinant		K2		$0.91
J7194	Factor ix complex		K2		$0.88
J7195	Factor IX recombinant		K2		$1.11
J7197	Antithrombin iii injection		K2		$2.31
J7198	Anti-inhibitor		K2		$1.55
J7308	Aminolevulinic acid hcl top		K2		$134.54
J7310	Ganciclovir long act implant		K2		$16,960.00
J7311	Fluocinolone acetonide implt		K2		$19,345.00
J7321	Hyalgan/supartz inj per dose		K2		$91.96
J7323	Euflexxa inj per dose		K2		$113.79
J7324	Orthovisc inj per dose		K2		$176.70
J7325	Synvisc or Synvisc-One		K2		$11.78
J7500	Azathioprine oral 50mg		N1		
J7501	Azathioprine parenteral		K2		$96.29
J7502	Cyclosporine oral 100 mg	CH	N1		
J7504	Lymphocyte immune globulin		K2		$487.88
J7505	Monoclonal antibodies		K2		$1,133.50
J7506	Prednisone oral		N1		
J7507	Tacrolimus oral per 1 MG	CH	N1		
J7509	Methylprednisolone oral		N1		
J7510	Prednisolone oral per 5 mg		N1		
J7511	Antithymocyte globuln rabbit		K2		$386.48
J7513	Daclizumab, parenteral		K2		$351.10
J7515	Cyclosporine oral 25 mg	CH	N1		

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
J7516	Cyclosporin parenteral 250mg	CH	N1		
J7517	Mycophenolate mofetil oral	CH	N1		
J7518	Mycophenolic acid		N1		
J7520	Sirolimus, oral	CH	N1		
J7525	Tacrolimus injection		K2		$139.41
J7599	Immunosuppressive drug noc		N1		
J7674	Methacholine chloride, neb		N1		
J7799	Non-inhalation drug for DME		N1		
J8501	Oral aprepitant		K2		$5.67
J8510	Oral busulfan	CH	K2		$3.65
J8520	Capecitabine, oral, 150 mg		K2		$6.28
J8521	Capecitabine, oral, 500 mg		K2		$20.66
J8530	Cyclophosphamide oral 25 MG		N1		
J8540	Oral dexamethasone		N1		
J8560	Etoposide oral 50 MG		K2		$28.26
J8597	Antiemetic drug oral NOS		N1		
J8600	Melphalan oral 2 MG		N1		
J8610	Methotrexate oral 2.5 MG		N1		
J8650	Nabilone oral		N1		
J8700	Temozolomide		K2		$8.83
J8705	Topotecan oral		K2		$74.66
J9000	Doxorubicin hcl injection		N1		
J9001	Doxorubicin hcl liposome inj		K2		$472.01
J9010	Alemtuzumab injection		K2		$578.02
J9015	Aldesleukin injection		K2		$844.43
J9017	Arsenic trioxide injection		K2		$37.43
J9020	Asparaginase injection		K2		$60.94
J9025	Azacitidine injection		K2		$4.99
J9027	Clofarabine injection		K2		$116.49
J9031	Bcg live intravesical vac		K2		$121.25
J9033	Bendamustine injection		K2		$18.47
J9035	Bevacizumab injection		K2		$57.57
J9040	Bleomycin sulfate injection		N1		
J9041	Bortezomib injection		K2		$38.24
J9045	Carboplatin injection		N1		
J9050	Carmustine injection		K2		$176.41
J9055	Cetuximab injection		K2		$49.73
J9060	Cisplatin 10 MG injection		N1		
J9062	Cisplatin 50 MG injection		N1		
J9065	Inj cladribine per 1 MG		K2		$28.22

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
J9070	Cyclophosphamide 100 MG inj		N1		
J9080	Cyclophosphamide 200 MG inj		N1		
J9090	Cyclophosphamide 500 MG inj		N1		
J9091	Cyclophosphamide 1.0 grm inj		N1		
J9092	Cyclophosphamide 2.0 grm inj		N1		
J9093	Cyclophosphamide lyophilized		N1		
J9094	Cyclophosphamide lyophilized		N1		
J9095	Cyclophosphamide lyophilized		N1		
J9096	Cyclophosphamide lyophilized		N1		
J9097	Cyclophosphamide lyophilized		N1		
J9098	Cytarabine liposome inj		K2		$488.90
J9100	Cytarabine hcl 100 MG inj		N1		
J9110	Cytarabine hcl 500 MG inj		N1		
J9120	Dactinomycin injection		K2		$570.53
J9130	Dacarbazine 100 mg inj		N1		
J9140	Dacarbazine 200 MG inj		N1		
J9150	Daunorubicin injection		K2		$19.46
J9151	Daunorubicin citrate inj		K2		$56.31
J9155	Degarelix injection		K2		$2.60
J9160	Denileukin diftitox inj		K2		$1,494.82
J9165	Diethylstilbestrol injection	CH	N1		
J9171	Docetaxel injection		K2		$17.86
J9175	Elliotts b solution per ml		N1		
J9178	Inj, epirubicin hcl, 2 mg		K2		$2.48
J9181	Etoposide injection		N1		
J9185	Fludarabine phosphate inj		K2		$205.81
J9190	Fluorouracil injection		N1		
J9200	Floxuridine injection		K2		$42.99
J9201	Gemcitabine hcl injection		K2		$145.10
J9202	Goserelin acetate implant		K2		$195.23
J9206	Irinotecan injection		K2		$9.15
J9207	Ixabepilone injection		K2		$63.74
J9208	Ifosfomide injection		K2		$30.76
J9209	Mesna injection	CH	N1		
J9211	Idarubicin hcl injection		K2		$63.57
J9212	Interferon alfacon-1 inj		K2		$4.80
J9213	Interferon alfa-2a inj	CH	N1		
J9214	Interferon alfa-2b inj		K2		$15.84
J9215	Interferon alfa-n3 inj		K2		$18.23
J9216	Interferon gamma 1-b inj		K2		$430.93

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
J9217	Leuprolide acetate suspnsion		K2		$220.41
J9218	Leuprolide acetate injeciton		K2		$4.27
J9219	Leuprolide acetate implant		K2		$4,819.82
J9225	Vantas implant		K2		$1,515.25
J9226	Supprelin LA implant		K2		$14,990.44
J9230	Mechlorethamine hcl inj		K2		$154.50
J9245	Inj melphalan hydrochl 50 MG		K2		$1,500.32
J9250	Methotrexate sodium inj		N1		
J9260	Methotrexate sodium inj		N1		
J9261	Nelarabine injection		K2		$105.91
J9263	Oxaliplatin		K2		$6.83
J9264	Paclitaxel protein bound		K2		$9.43
J9265	Paclitaxel injection	CH	K2		$11.46
J9266	Pegaspargase injection		K2		$2,747.44
J9268	Pentostatin injection		K2		$1,246.38
J9270	Plicamycin (mithramycin) inj		N1		
J9280	Mitomycin 5 MG inj		K2		$20.35
J9290	Mitomycin 20 MG inj		K2		$81.44
J9291	Mitomycin 40 MG inj		K2		$162.86
J9293	Mitoxantrone hydrochl / 5 MG		K2		$45.26
J9300	Gemtuzumab ozogamicin inj		K2		$2,687.21
J9303	Panitumumab injection		K2		$87.24
J9305	Pemetrexed injection		K2		$50.63
J9310	Rituximab injection		K2		$578.40
J9320	Streptozocin injection		K2		$282.86
J9328	Temozolomide injection		K2		$4.90
J9330	Temsirolimus injection		K2		$49.83
J9340	Thiotepa injection		K2		$113.52
J9350	Topotecan injection		K2		$1,058.90
J9355	Trastuzumab injection		K2		$66.41
J9357	Valrubicin injection		K2		$960.22
J9360	Vinblastine sulfate inj		N1		
J9370	Vincristine sulfate 1 MG inj		N1		
J9375	Vincristine sulfate 2 MG inj		N1		
J9380	Vincristine sulfate 5 MG inj		N1		
J9390	Vinorelbine tartrate inj		N1		
J9395	Injection, Fulvestrant		K2		$82.22
J9600	Porfimer sodium injection		K2		$2,934.28
J9999	Chemotherapy drug		N1		
L8600	Implant breast silicone/eq		N1		

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
L8603	Collagen imp urinary 2.5 ml		N1		
L8604	Dextranomer/hyaluronic acid		N1		
L8606	Synthetic implnt urinary 1ml		N1		
L8609	Artificial cornea		N1		
L8610	Ocular implant		N1		
L8612	Aqueous shunt prosthesis		N1		
L8613	Ossicular implant		N1		
L8614	Cochlear device		N1		
L8630	Metacarpophalangeal implant		N1		
L8631	MCP joint repl 2 pc or more		N1		
L8641	Metatarsal joint implant		N1		
L8642	Hallux implant		N1		
L8658	Interphalangeal joint spacer		N1		
L8659	Interphalangeal joint repl		N1		
L8670	Vascular graft, synthetic		N1		
L8682	Implt neurostim radiofq rec		N1		
L8690	Aud osseo dev, int/ext comp		N1		
L8699	Prosthetic implant NOS		N1		
P9041	Albumin (human),5%, 50ml		K2		$16.89
P9045	Albumin (human), 5%, 250 ml		K2		$60.58
P9046	Albumin (human), 25%, 20 ml		K2		$25.67
P9047	Albumin (human), 25%, 50ml		K2		$62.05
Q0138	Ferumoxytol, non-esrd		K2		$0.82
Q0163	Diphenhydramine HCl 50mg		N1		
Q0164	Prochlorperazine maleate 5mg		N1		
Q0166	Granisetron hcl 1 mg oral		N1		
Q0167	Dronabinol 2.5mg oral		N1		
Q0169	Promethazine HCl 12.5mg oral		N1		
Q0171	Chlorpromazine HCl 10mg oral		N1		
Q0173	Trimethobenzamide HCl 250mg		N1		
Q0175	Perphenazine 4mg oral		N1		
Q0177	Hydroxyzine pamoate 25mg		N1		
Q0179	Ondansetron hcl 8 mg oral		N1		
Q0180	Dolasetron mesylate oral		N1		
Q0515	Sermorelin acetate injection		K2		$1.80
Q1003	Ntiol category 3		L6		$50.00
Q2004	Bladder calculi irrig sol	CH	N1		
Q2009	Fosphenytoin inj PE		N1		
Q2017	Teniposide, 50 mg		K2		$324.55
Q3025	IM inj interferon beta 1-a		K2		$193.93

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)					
HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
Q4100	Skin substitute, NOS		N1		
Q4101	Apligraf skin sub		K2		$32.71
Q4102	Oasis wound matrix skin sub		K2		$4.62
Q4103	Oasis burn matrix skin sub		K2		$4.62
Q4104	Integra BMWD skin sub		K2		$14.84
Q4105	Integra DRT skin sub		K2		$10.00
Q4106	Dermagraft skin sub		K2		$40.10
Q4107	Graftjacket skin sub		K2		$92.04
Q4108	Integra matrix skin sub		K2		$17.99
Q4109	Tissuemend skin sub		N1		
Q4110	Primatrix skin sub		K2		$34.35
Q4111	Gammagraft skin sub		K2		$7.40
Q4112	Cymetra allograft		K2		$342.34
Q4113	Graftjacket express allograf		K2		$342.34
Q4114	Integra flowable wound matri		K2		$914.43
Q4115	Alloskin skin sub		K2		$7.34
Q4116	Alloderm skin sub		K2		$32.57
Q9951	LOCM >= 400 mg/ml iodine,1ml		N1		
Q9953	Inj Fe-based MR contrast,1ml		N1		
Q9954	Oral MR contrast, 100 ml		N1		
Q9955	Inj perflexane lip micros,ml		N1		
Q9956	Inj octafluoropropane mic,ml		N1		
Q9957	Inj perflutren lip micros,ml		N1		
Q9958	HOCM <=149 mg/ml iodine, 1ml		N1		
Q9959	HOCM 150-199mg/ml iodine,1ml		N1		
Q9960	HOCM 200-249mg/ml iodine,1ml		N1		
Q9961	HOCM 250-299mg/ml iodine,1ml		N1		
Q9962	HOCM 300-349mg/ml iodine,1ml		N1		
Q9963	HOCM 350-399mg/ml iodine,1ml		N1		
Q9964	HOCM>= 400mg/ml iodine, 1ml		N1		
Q9965	LOCM 100-199mg/ml iodine,1ml		N1		
Q9966	LOCM 200-299mg/ml iodine,1ml		N1		
Q9967	LOCM 300-399mg/ml iodine,1ml		N1		
Q9968	Visualization adjunct		K2		$1.82
V2630	Anter chamber intraocul lens		N1		
V2631	Iris support intraoclr lens		N1		
V2632	Post chmbr intraocular lens		N1		
V2785	Corneal tissue processing		F4		
V2790	Amniotic membrane		N1		

ADDENDUM BB.—PROPOSED ASC COVERED ANCILLARY SERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2011 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS Code	Short Descriptor	CY 2011 Comment Indicator	CY 2011 Payment Indicator	CY 2011 Payment Weight	CY 2011 Payment
NOTE 1: The Medicare program payment is 80 percent of the total payment amount and beneficiary coinsurance is 20 percent of the total payment amount. Section 4104 of the Affordable Care Act (ACA) waives coinsurance for most preventive services, identified with a double asterisk (**).					
NOTE 2: Payment indicators for radiology services (Z2, Z3) are based on a comparison of the final rates according to the ASC standard ratesetting methodology and the MPFS. At the time we compiled this addenda, current law requires a negative update to the MPFS payment rates for CY 2011. For a discussion of those rates, we refer readers to the CY 2011 MPFS proposed rule.					
**: Defined as a preventive service with $0 proposed coinsurance as required by section 4104 of the Affordable Care Act (ACA).					

ADDENDUM D1.—PROPOSED OPPS PAYMENT STUATS INDICATORS FOR CY 2011

ADDENDUM D1.—PROPOSED OPPS PAYMENT STATUS INDICATORS FOR CY 2011		
Indicator	**Item/Code/Service**	**OPPS Payment Status**
A	Services furnished to a hospital outpatient that are paid under a fee schedule or payment system other than OPPS, for example: • Ambulance Services • Clinical Diagnostic Laboratory Services • Non-Implantable Prosthetic and Orthotic Devices • EPO for ESRD Patients • Physical, Occupational, and Speech Therapy • Routine Dialysis Services for ESRD Patients Provided in a Certified Dialysis Unit of a Hospital • Diagnostic Mammography • Screening Mammography	Not paid under OPPS. Paid by fiscal intermediaries/MACs under a fee schedule or payment system other than OPPS. Not subject to deductible or coinsurance. Not subject to deductible.
B	Codes that are not recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x).	Not paid under OPPS. • May be paid by fiscal intermediaries/MACs when submitted on a different bill type, for example, 75x (CORF), but not paid under OPPS. • An alternate code that is recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x) may be available.
C	Inpatient Procedures	Not paid under OPPS. Admit patient. Bill as inpatient.

ADDENDUM D1.—PROPOSED OPPS PAYMENT STATUS INDICATORS FOR CY 2011		
Indicator	**Item/Code/Service**	**OPPS Payment Status**
D	Discontinued Codes	Not paid under OPPS or any other Medicare payment system.
E	Items, Codes, and Services: • That are not covered by any Medicare outpatient benefit based on statutory exclusion. • That are not covered by any Medicare outpatient benefit for reasons other than statutory exclusion. • That are not recognized by Medicare for outpatient claims but for which an alternate code for the same item or service may be available. • For which separate payment is not provided on outpatient claims.	Not paid by Medicare when submitted on outpatient claims (any outpatient bill type).
F	Corneal Tissue Acquisition; Certain CRNA Services and Hepatitis B Vaccines	Not paid under OPPS. Paid at reasonable cost.
G	Pass-Through Drugs and Biologicals	Paid under OPPS; separate APC payment.
H	Pass-Through Device Categories	Separate cost-based pass-through payment; not subject to copayment.
K	Nonpass-Through Drugs and Nonimplantable Biologicals, Including Therapeutic Radiopharmaceuticals	Paid under OPPS; separate APC payment.
L	Influenza Vaccine; Pneumococcal Pneumonia Vaccine	Not paid under OPPS. Paid at reasonable cost; not subject to deductible or coinsurance.
M	Items and Services Not Billable to the Fiscal Intermediary/MAC	Not paid under OPPS.
N	Items and Services Packaged into APC Rates	Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment.
P	Partial Hospitalization	Paid under OPPS; per diem APC payment.

ADDENDUM D1.—PROPOSED OPPS PAYMENT STATUS INDICATORS FOR CY 2011

Indicator	Item/Code/Service	OPPS Payment Status
Q1	STVX-Packaged Codes	Paid under OPPS; Addendum B displays APC assignments when services are separately payable. (1) Packaged APC payment if billed on the same date of service as a HCPCS code assigned status indicator "S," "T," "V," or "X." (2) In all other circumstances, payment is made through a separate APC payment.
Q2	T-Packaged Codes	Paid under OPPS; Addendum B displays APC assignments when services are separately payable. (1) Packaged APC payment if billed on the same date of service as a HCPCS code assigned status indicator "T." (2) In all other circumstances, payment is made through a separate APC payment.
Q3	Codes That May Be Paid Through a Composite APC	Paid under OPPS; Addendum B displays APC assignments when services are separately payable. Addendum M displays composite APC assignments when codes are paid through a composite APC. (1) Composite APC payment based on OPPS composite-specific payment criteria. Payment is packaged into a single payment for specific combinations of service. (2) In all other circumstances, payment is made through a separate APC payment or packaged into payment for other services.
R	Blood and Blood Products	Paid under OPPS; separate APC payment.
S	Significant Procedure, Not Discounted When Multiple	Paid under OPPS; separate APC payment.
T	Significant Procedure, Multiple Reduction Applies	Paid under OPPS; separate APC payment.
U	Brachytherapy Sources	Paid under OPPS; separate APC payment.
V	Clinic or Emergency Department Visit	Paid under OPPS; separate APC payment.

ADDENDUM D1.—PROPOSED OPPS PAYMENT STATUS INDICATORS FOR CY 2011

Indicator	Item/Code/Service	OPPS Payment Status
X	Ancillary Services	Paid under OPPS; separate APC payment.
Y	Non-Implantable Durable Medical Equipment	Not paid under OPPS. All institutional providers other than home health agencies bill to DMERC.

ADDENDUM DD1.—PROPOSED ASC PAYMENT INDICATORS FOR CY 2011

ADDENDUM DD1.—PROPOSED ASC PAYMENT INDICATORS FOR CY 2011	
Indicator	**Payment Indicator Definition**
A2	Surgical procedure on ASC list in CY 2007; payment based on OPPS relative payment weight.
D5	Deleted/discontinued code; no payment made.
F4	Corneal tissue acquisition, hepatitis B vaccine; paid at reasonable cost.
G2	Non office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight.
H2	Brachytherapy source paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate.
H8	Device-intensive procedure on ASC list in CY 2007; paid at adjusted rate.
J7	OPPS pass-through device paid separately when provided integral to a surgical procedure on ASC list; payment contractor-priced.
J8	Device-intensive procedure added to ASC list in CY 2008 or later; paid at adjusted rate.
K2	Drugs and biologicals paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate.
K7	Unclassified drugs and biologicals; payment contractor-priced.
L1	Influenza vaccine; pneumococcal vaccine. Packaged item/service; no separate payment made.
L6	New Technology Intraocular Lens (NTIOL); special payment.
N1	Packaged service/item; no separate payment made.
P2	Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on OPPS relative payment weight.
P3	Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on MPFS nonfacility PE RVUs.
R2	Office-based surgical procedure added to ASC list in CY 2008 or later without MPFS nonfacility PE RVUs; payment based on OPPS relative payment weight.
Z2	Radiology service paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS relative payment weight.
Z3	Radiology service paid separately when provided integral to a surgical procedure on ASC list; payment based on MPFS nonfacility PE RVUs.

ADDENDUM D2.—PROPOSED OPPS COMMENT INDICATORS FOR CY 2011

ADDENDUM D2.—PROPOSED OPPS COMMENT INDICATORS FOR CY 2011	
Comment Indicator	**Descriptor**
NI	New code for the next calendar year or existing code with substantial revision to its code descriptor in the next calendar year as compared to current calendar year, interim APC assignment; comments will be accepted on the interim APC assignment for the new code.
CH	Active HCPCS code in current year and next calendar year, status indicator and/or APC assignment has changed; or active HCPCS code that will be discontinued at the end of the current calendar year.

ADDENDUM DD2.—PROPOSED ASC COMMENT INDICATORS FOR CY 2011

ADDENDUM DD2.—PROPOSED ASC COMMENT INDICATORS FOR CY 2011	
CI	**Comment Indicator Meanings**
CH	Active HCPCS code in current year and next calendar year, payment indicator assignment has changed; or active HCPCS code that is newly recognized as payable in ASC; or active HCPCS code that is discontinued at the end of the current calendar year.
NI	New code, interim payment indicator assignment; comments will be accepted on the interim payment assignment for the new code.

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
00176	Anesth, pharyngeal surgery	C	
00192	Anesth, facial bone surgery	C	
00211	Anesth, cran surg, hemotoma	C	
00214	Anesth, skull drainage	C	
00215	Anesth, skull repair/fract	C	
00452	Anesth, surgery of shoulder	C	
00474	Anesth, surgery of rib(s)	C	
00524	Anesth, chest drainage	C	
00540	Anesth, chest surgery	C	
00542	Anesth, release of lung	C	
00546	Anesth, lung,chest wall surg	C	
00560	Anesth, heart surg w/o pump	C	
00561	Anesth, heart surg < age 1	C	
00562	Anesth hrt surg w/pmp age 1+	C	
00567	Anesth, cabg w/pump	C	
00580	Anesth, heart/lung transplnt	C	
00604	Anesth, sitting procedure	C	
00622	Anesth, removal of nerves	C	
00632	Anesth, removal of nerves	C	
00670	Anesth, spine, cord surgery	C	
00792	Anesth, hemorr/excise liver	C	
00794	Anesth, pancreas removal	C	
00796	Anesth, for liver transplant	C	
00802	Anesth, fat layer removal	C	
00844	Anesth, pelvis surgery	C	
00846	Anesth, hysterectomy	C	
00848	Anesth, pelvic organ surg	C	
00864	Anesth, removal of bladder	C	
00865	Anesth, removal of prostate	C	
00866	Anesth, removal of adrenal	C	
00868	Anesth, kidney transplant	C	
00882	Anesth, major vein ligation	C	
00904	Anesth, perineal surgery	C	
00908	Anesth, removal of prostate	C	
00932	Anesth, amputation of penis	C	
00934	Anesth, penis, nodes removal	C	
00936	Anesth, penis, nodes removal	C	
00944	Anesth, vaginal hysterectomy	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011

HCPCS Code	Short Descriptor	SI	CI
01140	Anesth, amputation at pelvis	C	
01150	Anesth, pelvic tumor surgery	C	
01212	Anesth, hip disarticulation	C	
01214	Anesth, hip arthroplasty	C	
01232	Anesth, amputation of femur	C	
01234	Anesth, radical femur surg	C	
01272	Anesth, femoral artery surg	C	
01274	Anesth, femoral embolectomy	C	
01402	Anesth, knee arthroplasty	C	
01404	Anesth, amputation at knee	C	
01442	Anesth, knee artery surg	C	
01444	Anesth, knee artery repair	C	
01486	Anesth, ankle replacement	C	
01502	Anesth, lwr leg embolectomy	C	
01634	Anesth, shoulder joint amput	C	
01636	Anesth, forequarter amput	C	
01638	Anesth, shoulder replacement	C	
01652	Anesth, shoulder vessel surg	C	
01654	Anesth, shoulder vessel surg	C	
01656	Anesth, arm-leg vessel surg	C	
01756	Anesth, radical humerus surg	C	
01990	Support for organ donor	C	
11004	Debride genitalia & perineum	C	
11005	Debride abdom wall	C	
11006	Debride genit/per/abdom wall	C	
11008	Remove mesh from abd wall	C	
15756	Free myo/skin flap microvasc	C	
15757	Free skin flap, microvasc	C	
15758	Free fascial flap, microvasc	C	
16036	Escharotomy; addl incision	C	
19271	Revision of chest wall	C	
19272	Extensive chest wall surgery	C	
19305	Mast, radical	C	
19306	Mast, rad, urban type	C	
19361	Breast reconstr w/lat flap	C	
19364	Breast reconstruction	C	
19367	Breast reconstruction	C	
19368	Breast reconstruction	C	
19369	Breast reconstruction	C	
20661	Application of head brace	C	
20664	Halo brace application	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
20802	Replantation, arm, complete	C	
20805	Replant forearm, complete	C	
20808	Replantation hand, complete	C	
20816	Replantation digit, complete	C	
20824	Replantation thumb, complete	C	
20827	Replantation thumb, complete	C	
20838	Replantation foot, complete	C	
20930	Sp bone algrft morsel add-on	C	
20931	Sp bone algrft struct add-on	C	
20936	Sp bone agrft local add-on	C	
20937	Sp bone agrft morsel add-on	C	
20938	Sp bone agrft struct add-on	C	
20955	Fibula bone graft, microvasc	C	
20956	Iliac bone graft, microvasc	C	
20957	Mt bone graft, microvasc	C	
20962	Other bone graft, microvasc	C	
20969	Bone/skin graft, microvasc	C	
20970	Bone/skin graft, iliac crest	C	
21045	Extensive jaw surgery	C	
21141	Reconstruct midface, lefort	C	
21142	Reconstruct midface, lefort	C	
21143	Reconstruct midface, lefort	C	
21145	Reconstruct midface, lefort	C	
21146	Reconstruct midface, lefort	C	
21147	Reconstruct midface, lefort	C	
21151	Reconstruct midface, lefort	C	
21154	Reconstruct midface, lefort	C	
21155	Reconstruct midface, lefort	C	
21159	Reconstruct midface, lefort	C	
21160	Reconstruct midface, lefort	C	
21179	Reconstruct entire forehead	C	
21180	Reconstruct entire forehead	C	
21182	Reconstruct cranial bone	C	
21183	Reconstruct cranial bone	C	
21184	Reconstruct cranial bone	C	
21188	Reconstruction of midface	C	
21194	Reconst lwr jaw w/graft	C	
21196	Reconst lwr jaw w/fixation	C	
21247	Reconstruct lower jaw bone	C	
21255	Reconstruct lower jaw bone	C	
21268	Revise eye sockets	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
21343	Treatment of sinus fracture	C	
21344	Treatment of sinus fracture	C	
21346	Treat nose/jaw fracture	C	
21347	Treat nose/jaw fracture	C	
21348	Treat nose/jaw fracture	C	
21366	Treat cheek bone fracture	C	
21422	Treat mouth roof fracture	C	
21423	Treat mouth roof fracture	C	
21431	Treat craniofacial fracture	C	
21432	Treat craniofacial fracture	C	
21433	Treat craniofacial fracture	C	
21435	Treat craniofacial fracture	C	
21436	Treat craniofacial fracture	C	
21510	Drainage of bone lesion	C	
21615	Removal of rib	C	
21616	Removal of rib and nerves	C	
21620	Partial removal of sternum	C	
21627	Sternal debridement	C	
21630	Extensive sternum surgery	C	
21632	Extensive sternum surgery	C	
21705	Revision of neck muscle/rib	C	
21740	Reconstruction of sternum	C	
21750	Repair of sternum separation	C	
21810	Treatment of rib fracture(s)	C	
21825	Treat sternum fracture	C	
22010	I&d, p-spine, c/t/cerv-thor	C	
22015	I&d, p-spine, l/s/ls	C	
22110	Remove part of neck vertebra	C	
22112	Remove part, thorax vertebra	C	
22114	Remove part, lumbar vertebra	C	
22116	Remove extra spine segment	C	
22206	Cut spine 3 col, thor	C	
22207	Cut spine 3 col, lumb	C	
22208	Cut spine 3 col, addl seg	C	
22210	Revision of neck spine	C	
22212	Revision of thorax spine	C	
22214	Revision of lumbar spine	C	
22216	Revise, extra spine segment	C	
22220	Revision of neck spine	C	
22224	Revision of lumbar spine	C	
22226	Revise, extra spine segment	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
22318	Treat odontoid fx w/o graft	C	
22319	Treat odontoid fx w/graft	C	
22325	Treat spine fracture	C	
22326	Treat neck spine fracture	C	
22327	Treat thorax spine fracture	C	
22328	Treat each add spine fx	C	
22532	Lat thorax spine fusion	C	
22533	Lat lumbar spine fusion	C	
22534	Lat thor/lumb, addl seg	C	
22548	Neck spine fusion	C	
22554	Neck spine fusion	C	
22556	Thorax spine fusion	C	
22558	Lumbar spine fusion	C	
22585	Additional spinal fusion	C	
22590	Spine & skull spinal fusion	C	
22595	Neck spinal fusion	C	
22600	Neck spine fusion	C	
22610	Thorax spine fusion	C	
22630	Lumbar spine fusion	C	
22632	Spine fusion, extra segment	C	
22800	Fusion of spine	C	
22802	Fusion of spine	C	
22804	Fusion of spine	C	
22808	Fusion of spine	C	
22810	Fusion of spine	C	
22812	Fusion of spine	C	
22818	Kyphectomy, 1-2 segments	C	
22819	Kyphectomy, 3 or more	C	
22830	Exploration of spinal fusion	C	
22840	Insert spine fixation device	C	
22841	Insert spine fixation device	C	
22842	Insert spine fixation device	C	
22843	Insert spine fixation device	C	
22844	Insert spine fixation device	C	
22845	Insert spine fixation device	C	
22846	Insert spine fixation device	C	
22847	Insert spine fixation device	C	
22848	Insert pelv fixation device	C	
22849	Reinsert spinal fixation	C	
22850	Remove spine fixation device	C	
22852	Remove spine fixation device	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
22855	Remove spine fixation device	C	
22856	Cerv artific diskectomy	C	
22857	Lumbar artif diskectomy	C	
22861	Revise cerv artific disc	C	
22862	Revise lumbar artif disc	C	
22864	Remove cerv artif disc	C	
22865	Remove lumb artif disc	C	
23200	Resect clavicle tumor	C	
23210	Resect scapula tumor	C	
23220	Resect prox humerus tumor	C	
23332	Remove shoulder foreign body	C	
23472	Reconstruct shoulder joint	C	
23900	Amputation of arm & girdle	C	
23920	Amputation at shoulder joint	C	
24900	Amputation of upper arm	C	
24920	Amputation of upper arm	C	
24930	Amputation follow-up surgery	C	
24931	Amputate upper arm & implant	C	
24940	Revision of upper arm	C	
25900	Amputation of forearm	C	
25905	Amputation of forearm	C	
25915	Amputation of forearm	C	
25920	Amputate hand at wrist	C	
25924	Amputation follow-up surgery	C	
25927	Amputation of hand	C	
26551	Great toe-hand transfer	C	
26553	Single transfer, toe-hand	C	
26554	Double transfer, toe-hand	C	
26556	Toe joint transfer	C	
26992	Drainage of bone lesion	C	
27005	Incision of hip tendon	C	
27025	Incision of hip/thigh fascia	C	
27030	Drainage of hip joint	C	
27036	Excision of hip joint/muscle	C	
27054	Removal of hip joint lining	C	
27070	Partial removal of hip bone	C	
27071	Partial removal of hip bone	C	
27075	Resect hip tumor	C	
27076	Resect hip tum incl acetabul	C	
27077	Resect hip tum w/innom bone	C	
27078	Rsect hip tum incl femur	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
27090	Removal of hip prosthesis	C	
27091	Removal of hip prosthesis	C	
27120	Reconstruction of hip socket	C	
27122	Reconstruction of hip socket	C	
27125	Partial hip replacement	C	
27130	Total hip arthroplasty	C	
27132	Total hip arthroplasty	C	
27134	Revise hip joint replacement	C	
27137	Revise hip joint replacement	C	
27138	Revise hip joint replacement	C	
27140	Transplant femur ridge	C	
27146	Incision of hip bone	C	
27147	Revision of hip bone	C	
27151	Incision of hip bones	C	
27156	Revision of hip bones	C	
27158	Revision of pelvis	C	
27161	Incision of neck of femur	C	
27165	Incision/fixation of femur	C	
27170	Repair/graft femur head/neck	C	
27175	Treat slipped epiphysis	C	
27176	Treat slipped epiphysis	C	
27177	Treat slipped epiphysis	C	
27178	Treat slipped epiphysis	C	
27181	Treat slipped epiphysis	C	
27185	Revision of femur epiphysis	C	
27187	Reinforce hip bones	C	
27222	Treat hip socket fracture	C	
27226	Treat hip wall fracture	C	
27227	Treat hip fracture(s)	C	
27228	Treat hip fracture(s)	C	
27232	Treat thigh fracture	C	
27236	Treat thigh fracture	C	
27240	Treat thigh fracture	C	
27244	Treat thigh fracture	C	
27245	Treat thigh fracture	C	
27248	Treat thigh fracture	C	
27253	Treat hip dislocation	C	
27254	Treat hip dislocation	C	
27258	Treat hip dislocation	C	
27259	Treat hip dislocation	C	
27268	Cltx thigh fx w/mnpj	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
27269	Optx thigh fx	C	
27280	Fusion of sacroiliac joint	C	
27282	Fusion of pubic bones	C	
27284	Fusion of hip joint	C	
27286	Fusion of hip joint	C	
27290	Amputation of leg at hip	C	
27295	Amputation of leg at hip	C	
27303	Drainage of bone lesion	C	
27365	Resect femur/knee tumor	C	
27445	Revision of knee joint	C	
27447	Total knee arthroplasty	C	
27448	Incision of thigh	C	
27450	Incision of thigh	C	
27454	Realignment of thigh bone	C	
27455	Realignment of knee	C	
27457	Realignment of knee	C	
27465	Shortening of thigh bone	C	
27466	Lengthening of thigh bone	C	
27468	Shorten/lengthen thighs	C	
27470	Repair of thigh	C	
27472	Repair/graft of thigh	C	
27477	Surgery to stop leg growth	C	
27485	Surgery to stop leg growth	C	
27486	Revise/replace knee joint	C	
27487	Revise/replace knee joint	C	
27488	Removal of knee prosthesis	C	
27495	Reinforce thigh	C	
27506	Treatment of thigh fracture	C	
27507	Treatment of thigh fracture	C	
27511	Treatment of thigh fracture	C	
27513	Treatment of thigh fracture	C	
27514	Treatment of thigh fracture	C	
27519	Treat thigh fx growth plate	C	
27535	Treat knee fracture	C	
27536	Treat knee fracture	C	
27540	Treat knee fracture	C	
27556	Treat knee dislocation	C	
27557	Treat knee dislocation	C	
27558	Treat knee dislocation	C	
27580	Fusion of knee	C	
27590	Amputate leg at thigh	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
27591	Amputate leg at thigh	C	
27592	Amputate leg at thigh	C	
27596	Amputation follow-up surgery	C	
27598	Amputate lower leg at knee	C	
27645	Resect tibia tumor	C	
27646	Resect fibula tumor	C	
27702	Reconstruct ankle joint	C	
27703	Reconstruction, ankle joint	C	
27712	Realignment of lower leg	C	
27715	Revision of lower leg	C	
27724	Repair/graft of tibia	C	
27725	Repair of lower leg	C	
27727	Repair of lower leg	C	
27880	Amputation of lower leg	C	
27881	Amputation of lower leg	C	
27882	Amputation of lower leg	C	
27886	Amputation follow-up surgery	C	
27888	Amputation of foot at ankle	C	
28800	Amputation of midfoot	C	
31225	Removal of upper jaw	C	
31230	Removal of upper jaw	C	
31290	Nasal/sinus endoscopy, surg	C	
31291	Nasal/sinus endoscopy, surg	C	
31360	Removal of larynx	C	
31365	Removal of larynx	C	
31367	Partial removal of larynx	C	
31368	Partial removal of larynx	C	
31370	Partial removal of larynx	C	
31375	Partial removal of larynx	C	
31380	Partial removal of larynx	C	
31382	Partial removal of larynx	C	
31390	Removal of larynx & pharynx	C	
31395	Reconstruct larynx & pharynx	C	
31584	Treat larynx fracture	C	
31587	Revision of larynx	C	
31725	Clearance of airways	C	
31760	Repair of windpipe	C	
31766	Reconstruction of windpipe	C	
31770	Repair/graft of bronchus	C	
31775	Reconstruct bronchus	C	
31780	Reconstruct windpipe	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
31781	Reconstruct windpipe	C	
31786	Remove windpipe lesion	C	
31800	Repair of windpipe injury	C	
31805	Repair of windpipe injury	C	
32035	Exploration of chest	C	
32036	Exploration of chest	C	
32095	Biopsy through chest wall	C	
32100	Exploration/biopsy of chest	C	
32110	Explore/repair chest	C	
32120	Re-exploration of chest	C	
32124	Explore chest free adhesions	C	
32140	Removal of lung lesion(s)	C	
32141	Remove/treat lung lesions	C	
32150	Removal of lung lesion(s)	C	
32151	Remove lung foreign body	C	
32160	Open chest heart massage	C	
32200	Drain, open, lung lesion	C	
32215	Treat chest lining	C	
32220	Release of lung	C	
32225	Partial release of lung	C	
32310	Removal of chest lining	C	
32320	Free/remove chest lining	C	
32402	Open biopsy chest lining	C	
32440	Removal of lung	C	
32442	Sleeve pneumonectomy	C	
32445	Removal of lung	C	
32480	Partial removal of lung	C	
32482	Bilobectomy	C	
32484	Segmentectomy	C	
32486	Sleeve lobectomy	C	
32488	Completion pneumonectomy	C	
32491	Lung volume reduction	C	
32500	Partial removal of lung	C	
32501	Repair bronchus add-on	C	
32503	Resect apical lung tumor	C	
32504	Resect apical lung tum/chest	C	
32540	Removal of lung lesion	C	
32650	Thoracoscopy, surgical	C	
32651	Thoracoscopy, surgical	C	
32652	Thoracoscopy, surgical	C	
32653	Thoracoscopy, surgical	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
32654	Thoracoscopy, surgical	C	
32655	Thoracoscopy, surgical	C	
32656	Thoracoscopy, surgical	C	
32657	Thoracoscopy, surgical	C	
32658	Thoracoscopy, surgical	C	
32659	Thoracoscopy, surgical	C	
32660	Thoracoscopy, surgical	C	
32661	Thoracoscopy, surgical	C	
32662	Thoracoscopy, surgical	C	
32663	Thoracoscopy, surgical	C	
32664	Thoracoscopy, surgical	C	
32665	Thoracoscopy, surgical	C	
32800	Repair lung hernia	C	
32810	Close chest after drainage	C	
32815	Close bronchial fistula	C	
32820	Reconstruct injured chest	C	
32850	Donor pneumonectomy	C	
32851	Lung transplant, single	C	
32852	Lung transplant with bypass	C	
32853	Lung transplant, double	C	
32854	Lung transplant with bypass	C	
32855	Prepare donor lung, single	C	
32856	Prepare donor lung, double	C	
32900	Removal of rib(s)	C	
32905	Revise & repair chest wall	C	
32906	Revise & repair chest wall	C	
32940	Revision of lung	C	
32997	Total lung lavage	C	
33015	Incision of heart sac	C	
33020	Incision of heart sac	C	
33025	Incision of heart sac	C	
33030	Partial removal of heart sac	C	
33031	Partial removal of heart sac	C	
33050	Removal of heart sac lesion	C	
33120	Removal of heart lesion	C	
33130	Removal of heart lesion	C	
33140	Heart revascularize (tmr)	C	
33141	Heart tmr w/other procedure	C	
33202	Insert epicard eltrd, open	C	
33203	Insert epicard eltrd, endo	C	
33236	Remove electrode/thoracotomy	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
33237	Remove electrode/thoracotomy	C	
33238	Remove electrode/thoracotomy	C	
33243	Remove eltrd/thoracotomy	C	
33250	Ablate heart dysrhythm focus	C	
33251	Ablate heart dysrhythm focus	C	
33254	Ablate atria, lmtd	C	
33255	Ablate atria w/o bypass, ext	C	
33256	Ablate atria w/bypass, exten	C	
33257	Ablate atria, lmtd, add-on	C	
33258	Ablate atria, x10sv, add-on	C	
33259	Ablate atria w/bypass add-on	C	
33261	Ablate heart dysrhythm focus	C	
33265	Ablate atria, lmtd, endo	C	
33266	Ablate atria, x10sv, endo	C	
33300	Repair of heart wound	C	
33305	Repair of heart wound	C	
33310	Exploratory heart surgery	C	
33315	Exploratory heart surgery	C	
33320	Repair major blood vessel(s)	C	
33321	Repair major vessel	C	
33322	Repair major blood vessel(s)	C	
33330	Insert major vessel graft	C	
33332	Insert major vessel graft	C	
33335	Insert major vessel graft	C	
33400	Repair of aortic valve	C	
33401	Valvuloplasty, open	C	
33403	Valvuloplasty, w/cp bypass	C	
33404	Prepare heart-aorta conduit	C	
33405	Replacement of aortic valve	C	
33406	Replacement of aortic valve	C	
33410	Replacement of aortic valve	C	
33411	Replacement of aortic valve	C	
33412	Replacement of aortic valve	C	
33413	Replacement of aortic valve	C	
33414	Repair of aortic valve	C	
33415	Revision, subvalvular tissue	C	
33416	Revise ventricle muscle	C	
33417	Repair of aortic valve	C	
33420	Revision of mitral valve	C	
33422	Revision of mitral valve	C	
33425	Repair of mitral valve	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
33426	Repair of mitral valve	C	
33427	Repair of mitral valve	C	
33430	Replacement of mitral valve	C	
33460	Revision of tricuspid valve	C	
33463	Valvuloplasty, tricuspid	C	
33464	Valvuloplasty, tricuspid	C	
33465	Replace tricuspid valve	C	
33468	Revision of tricuspid valve	C	
33470	Revision of pulmonary valve	C	
33471	Valvotomy, pulmonary valve	C	
33472	Revision of pulmonary valve	C	
33474	Revision of pulmonary valve	C	
33475	Replacement, pulmonary valve	C	
33476	Revision of heart chamber	C	
33478	Revision of heart chamber	C	
33496	Repair, prosth valve clot	C	
33500	Repair heart vessel fistula	C	
33501	Repair heart vessel fistula	C	
33502	Coronary artery correction	C	
33503	Coronary artery graft	C	
33504	Coronary artery graft	C	
33505	Repair artery w/tunnel	C	
33506	Repair artery, translocation	C	
33507	Repair art, intramural	C	
33510	CABG, vein, single	C	
33511	CABG, vein, two	C	
33512	CABG, vein, three	C	
33513	CABG, vein, four	C	
33514	CABG, vein, five	C	
33516	Cabg, vein, six or more	C	
33517	CABG, artery-vein, single	C	
33518	CABG, artery-vein, two	C	
33519	CABG, artery-vein, three	C	
33521	CABG, artery-vein, four	C	
33522	CABG, artery-vein, five	C	
33523	Cabg, art-vein, six or more	C	
33530	Coronary artery, bypass/reop	C	
33533	CABG, arterial, single	C	
33534	CABG, arterial, two	C	
33535	CABG, arterial, three	C	
33536	Cabg, arterial, four or more	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
33542	Removal of heart lesion	C	
33545	Repair of heart damage	C	
33548	Restore/remodel, ventricle	C	
33572	Open coronary endarterectomy	C	
33600	Closure of valve	C	
33602	Closure of valve	C	
33606	Anastomosis/artery-aorta	C	
33608	Repair anomaly w/conduit	C	
33610	Repair by enlargement	C	
33611	Repair double ventricle	C	
33612	Repair double ventricle	C	
33615	Repair, modified fontan	C	
33617	Repair single ventricle	C	
33619	Repair single ventricle	C	
33641	Repair heart septum defect	C	
33645	Revision of heart veins	C	
33647	Repair heart septum defects	C	
33660	Repair of heart defects	C	
33665	Repair of heart defects	C	
33670	Repair of heart chambers	C	
33675	Close mult vsd	C	
33676	Close mult vsd w/resection	C	
33677	Cl mult vsd w/rem pul band	C	
33681	Repair heart septum defect	C	
33684	Repair heart septum defect	C	
33688	Repair heart septum defect	C	
33690	Reinforce pulmonary artery	C	
33692	Repair of heart defects	C	
33694	Repair of heart defects	C	
33697	Repair of heart defects	C	
33702	Repair of heart defects	C	
33710	Repair of heart defects	C	
33720	Repair of heart defect	C	
33722	Repair of heart defect	C	
33724	Repair venous anomaly	C	
33726	Repair pul venous stenosis	C	
33730	Repair heart-vein defect(s)	C	
33732	Repair heart-vein defect	C	
33735	Revision of heart chamber	C	
33736	Revision of heart chamber	C	
33737	Revision of heart chamber	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
33750	Major vessel shunt	C	
33755	Major vessel shunt	C	
33762	Major vessel shunt	C	
33764	Major vessel shunt & graft	C	
33766	Major vessel shunt	C	
33767	Major vessel shunt	C	
33768	Cavopulmonary shunting	C	
33770	Repair great vessels defect	C	
33771	Repair great vessels defect	C	
33774	Repair great vessels defect	C	
33775	Repair great vessels defect	C	
33776	Repair great vessels defect	C	
33777	Repair great vessels defect	C	
33778	Repair great vessels defect	C	
33779	Repair great vessels defect	C	
33780	Repair great vessels defect	C	
33781	Repair great vessels defect	C	
33782	Nikaidoh proc	C	
33783	Nikaidoh proc w/ostia implt	C	
33786	Repair arterial trunk	C	
33788	Revision of pulmonary artery	C	
33800	Aortic suspension	C	
33802	Repair vessel defect	C	
33803	Repair vessel defect	C	
33813	Repair septal defect	C	
33814	Repair septal defect	C	
33820	Revise major vessel	C	
33822	Revise major vessel	C	
33824	Revise major vessel	C	
33840	Remove aorta constriction	C	
33845	Remove aorta constriction	C	
33851	Remove aorta constriction	C	
33852	Repair septal defect	C	
33853	Repair septal defect	C	
33860	Ascending aortic graft	C	
33861	Ascending aortic graft	C	
33863	Ascending aortic graft	C	
33864	Ascending aortic graft	C	
33870	Transverse aortic arch graft	C	
33875	Thoracic aortic graft	C	
33877	Thoracoabdominal graft	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
33880	Endovasc taa repr incl subcl	C	
33881	Endovasc taa repr w/o subcl	C	
33883	Insert endovasc prosth, taa	C	
33884	Endovasc prosth, taa, add-on	C	
33886	Endovasc prosth, delayed	C	
33889	Artery transpose/endovas taa	C	
33891	Car-car bp grft/endovas taa	C	
33910	Remove lung artery emboli	C	
33915	Remove lung artery emboli	C	
33916	Surgery of great vessel	C	
33917	Repair pulmonary artery	C	
33920	Repair pulmonary atresia	C	
33922	Transect pulmonary artery	C	
33924	Remove pulmonary shunt	C	
33925	Rpr pul art unifocal w/o cpb	C	
33926	Repr pul art, unifocal w/cpb	C	
33930	Removal of donor heart/lung	C	
33933	Prepare donor heart/lung	C	
33935	Transplantation, heart/lung	C	
33940	Removal of donor heart	C	
33944	Prepare donor heart	C	
33945	Transplantation of heart	C	
33960	External circulation assist	C	
33961	External circulation assist	C	
33967	Insert ia percut device	C	
33968	Remove aortic assist device	C	
33970	Aortic circulation assist	C	
33971	Aortic circulation assist	C	
33973	Insert balloon device	C	
33974	Remove intra-aortic balloon	C	
33975	Implant ventricular device	C	
33976	Implant ventricular device	C	
33977	Remove ventricular device	C	
33978	Remove ventricular device	C	
33979	Insert intracorporeal device	C	
33980	Remove intracorporeal device	C	
33981	Replace vad pump ext	C	
33982	Replace vad intra w/o bp	C	
33983	Replace vad intra w/bp	C	
34001	Removal of artery clot	C	
34051	Removal of artery clot	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
34151	Removal of artery clot	C	
34401	Removal of vein clot	C	
34451	Removal of vein clot	C	
34502	Reconstruct vena cava	C	
34800	Endovas aaa repr w/sm tube	C	
34802	Endovas aaa repr w/2-p part	C	
34803	Endovas aaa repr w/3-p part	C	
34804	Endovas aaa repr w/1-p part	C	
34805	Endovas aaa repr w/long tube	C	
34806	Aneurysm press sensor add-on	C	
34808	Endovas iliac a device addon	C	
34812	Xpose for endoprosth, femorl	C	
34813	Femoral endovas graft add-on	C	
34820	Xpose for endoprosth, iliac	C	
34825	Endovasc extend prosth, init	C	
34826	Endovasc exten prosth, addl	C	
34830	Open aortic tube prosth repr	C	
34831	Open aortoiliac prosth repr	C	
34832	Open aortofemor prosth repr	C	
34833	Xpose for endoprosth, iliac	C	
34834	Xpose, endoprosth, brachial	C	
34900	Endovasc iliac repr w/graft	C	
35001	Repair defect of artery	C	
35002	Repair artery rupture, neck	C	
35005	Repair defect of artery	C	
35013	Repair artery rupture, arm	C	
35021	Repair defect of artery	C	
35022	Repair artery rupture, chest	C	
35045	Repair defect of arm artery	C	
35081	Repair defect of artery	C	
35082	Repair artery rupture, aorta	C	
35091	Repair defect of artery	C	
35092	Repair artery rupture, aorta	C	
35102	Repair defect of artery	C	
35103	Repair artery rupture, groin	C	
35111	Repair defect of artery	C	
35112	Repair artery rupture,spleen	C	
35121	Repair defect of artery	C	
35122	Repair artery rupture, belly	C	
35131	Repair defect of artery	C	
35132	Repair artery rupture, groin	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
35141	Repair defect of artery	C	
35142	Repair artery rupture, thigh	C	
35151	Repair defect of artery	C	
35152	Repair artery rupture, knee	C	
35182	Repair blood vessel lesion	C	
35189	Repair blood vessel lesion	C	
35211	Repair blood vessel lesion	C	
35216	Repair blood vessel lesion	C	
35221	Repair blood vessel lesion	C	
35241	Repair blood vessel lesion	C	
35246	Repair blood vessel lesion	C	
35251	Repair blood vessel lesion	C	
35271	Repair blood vessel lesion	C	
35276	Repair blood vessel lesion	C	
35281	Repair blood vessel lesion	C	
35301	Rechanneling of artery	C	
35302	Rechanneling of artery	C	
35303	Rechanneling of artery	C	
35304	Rechanneling of artery	C	
35305	Rechanneling of artery	C	
35306	Rechanneling of artery	C	
35311	Rechanneling of artery	C	
35331	Rechanneling of artery	C	
35341	Rechanneling of artery	C	
35351	Rechanneling of artery	C	
35355	Rechanneling of artery	C	
35361	Rechanneling of artery	C	
35363	Rechanneling of artery	C	
35371	Rechanneling of artery	C	
35372	Rechanneling of artery	C	
35390	Reoperation, carotid add-on	C	
35400	Angioscopy	C	
35450	Repair arterial blockage	C	
35452	Repair arterial blockage	C	
35454	Repair arterial blockage	C	
35456	Repair arterial blockage	C	
35480	Atherectomy, open	C	
35481	Atherectomy, open	C	
35482	Atherectomy, open	C	
35483	Atherectomy, open	C	
35501	Artery bypass graft	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
35506	Artery bypass graft	C	
35508	Artery bypass graft	C	
35509	Artery bypass graft	C	
35510	Artery bypass graft	C	
35511	Artery bypass graft	C	
35512	Artery bypass graft	C	
35515	Artery bypass graft	C	
35516	Artery bypass graft	C	
35518	Artery bypass graft	C	
35521	Artery bypass graft	C	
35522	Artery bypass graft	C	
35523	Artery bypass graft	C	
35525	Artery bypass graft	C	
35526	Artery bypass graft	C	
35531	Artery bypass graft	C	
35533	Artery bypass graft	C	
35535	Artery bypass graft	C	
35536	Artery bypass graft	C	
35537	Artery bypass graft	C	
35538	Artery bypass graft	C	
35539	Artery bypass graft	C	
35540	Artery bypass graft	C	
35548	Artery bypass graft	C	
35549	Artery bypass graft	C	
35551	Artery bypass graft	C	
35556	Artery bypass graft	C	
35558	Artery bypass graft	C	
35560	Artery bypass graft	C	
35563	Artery bypass graft	C	
35565	Artery bypass graft	C	
35566	Artery bypass graft	C	
35570	Artery bypass graft	C	
35571	Artery bypass graft	C	
35583	Vein bypass graft	C	
35585	Vein bypass graft	C	
35587	Vein bypass graft	C	
35600	Harvest art for cabg add-on	C	
35601	Artery bypass graft	C	
35606	Artery bypass graft	C	
35612	Artery bypass graft	C	
35616	Artery bypass graft	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
35621	Artery bypass graft	C	
35623	Bypass graft, not vein	C	
35626	Artery bypass graft	C	
35631	Artery bypass graft	C	
35632	Artery bypass graft	C	
35633	Artery bypass graft	C	
35634	Artery bypass graft	C	
35636	Artery bypass graft	C	
35637	Artery bypass graft	C	
35638	Artery bypass graft	C	
35642	Artery bypass graft	C	
35645	Artery bypass graft	C	
35646	Artery bypass graft	C	
35647	Artery bypass graft	C	
35650	Artery bypass graft	C	
35651	Artery bypass graft	C	
35654	Artery bypass graft	C	
35656	Artery bypass graft	C	
35661	Artery bypass graft	C	
35663	Artery bypass graft	C	
35665	Artery bypass graft	C	
35666	Artery bypass graft	C	
35671	Artery bypass graft	C	
35681	Composite bypass graft	C	
35682	Composite bypass graft	C	
35683	Composite bypass graft	C	
35691	Arterial transposition	C	
35693	Arterial transposition	C	
35694	Arterial transposition	C	
35695	Arterial transposition	C	
35697	Reimplant artery each	C	
35700	Reoperation, bypass graft	C	
35701	Exploration, carotid artery	C	
35721	Exploration, femoral artery	C	
35741	Exploration popliteal artery	C	
35800	Explore neck vessels	C	
35820	Explore chest vessels	C	
35840	Explore abdominal vessels	C	
35870	Repair vessel graft defect	C	
35901	Excision, graft, neck	C	
35905	Excision, graft, thorax	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
35907	Excision, graft, abdomen	C	
36660	Insertion catheter, artery	C	
36822	Insertion of cannula(s)	C	
36823	Insertion of cannula(s)	C	
37140	Revision of circulation	C	
37145	Revision of circulation	C	
37160	Revision of circulation	C	
37180	Revision of circulation	C	
37181	Splice spleen/kidney veins	C	
37182	Insert hepatic shunt (tips)	C	
37215	Transcath stent, cca w/eps	C	
37616	Ligation of chest artery	C	
37617	Ligation of abdomen artery	C	
37618	Ligation of extremity artery	C	
37660	Revision of major vein	C	
37788	Revascularization, penis	C	
38100	Removal of spleen, total	C	
38101	Removal of spleen, partial	C	
38102	Removal of spleen, total	C	
38115	Repair of ruptured spleen	C	
38380	Thoracic duct procedure	C	
38381	Thoracic duct procedure	C	
38382	Thoracic duct procedure	C	
38562	Removal, pelvic lymph nodes	C	
38564	Removal, abdomen lymph nodes	C	
38724	Removal of lymph nodes, neck	C	
38746	Remove thoracic lymph nodes	C	
38747	Remove abdominal lymph nodes	C	
38765	Remove groin lymph nodes	C	
38770	Remove pelvis lymph nodes	C	
38780	Remove abdomen lymph nodes	C	
39000	Exploration of chest	C	
39010	Exploration of chest	C	
39200	Removal chest lesion	C	
39220	Removal chest lesion	C	
39499	Chest procedure	C	
39501	Repair diaphragm laceration	C	
39502	Repair paraesophageal hernia	C	
39503	Repair of diaphragm hernia	C	
39520	Repair of diaphragm hernia	C	
39530	Repair of diaphragm hernia	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
39531	Repair of diaphragm hernia	C	
39540	Repair of diaphragm hernia	C	
39541	Repair of diaphragm hernia	C	
39545	Revision of diaphragm	C	
39560	Resect diaphragm, simple	C	
39561	Resect diaphragm, complex	C	
39599	Diaphragm surgery procedure	C	
41130	Partial removal of tongue	C	
41135	Tongue and neck surgery	C	
41140	Removal of tongue	C	
41145	Tongue removal, neck surgery	C	
41150	Tongue, mouth, jaw surgery	C	
41153	Tongue, mouth, neck surgery	C	
41155	Tongue, jaw, & neck surgery	C	
42426	Excise parotid gland/lesion	C	
42845	Extensive surgery of throat	C	
42894	Revision of pharyngeal walls	C	
42953	Repair throat, esophagus	C	
42961	Control throat bleeding	C	
42971	Control nose/throat bleeding	C	
43045	Incision of esophagus	C	
43100	Excision of esophagus lesion	C	
43101	Excision of esophagus lesion	C	
43107	Removal of esophagus	C	
43108	Removal of esophagus	C	
43112	Removal of esophagus	C	
43113	Removal of esophagus	C	
43116	Partial removal of esophagus	C	
43117	Partial removal of esophagus	C	
43118	Partial removal of esophagus	C	
43121	Partial removal of esophagus	C	
43122	Partial removal of esophagus	C	
43123	Partial removal of esophagus	C	
43124	Removal of esophagus	C	
43135	Removal of esophagus pouch	C	
43279	Lap myotomy, heller	C	
43281	Lap paraesophag hern repair	C	
43282	Lap paraesoph her rpr w/mesh	C	
43300	Repair of esophagus	C	
43305	Repair esophagus and fistula	C	
43310	Repair of esophagus	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
43312	Repair esophagus and fistula	C	
43313	Esophagoplasty congenital	C	
43314	Tracheo-esophagoplasty cong	C	
43320	Fuse esophagus & stomach	C	
43324	Revise esophagus & stomach	C	
43325	Revise esophagus & stomach	C	
43326	Revise esophagus & stomach	C	
43330	Repair of esophagus	C	
43331	Repair of esophagus	C	
43340	Fuse esophagus & intestine	C	
43341	Fuse esophagus & intestine	C	
43350	Surgical opening, esophagus	C	
43351	Surgical opening, esophagus	C	
43352	Surgical opening, esophagus	C	
43360	Gastrointestinal repair	C	
43361	Gastrointestinal repair	C	
43400	Ligate esophagus veins	C	
43401	Esophagus surgery for veins	C	
43405	Ligate/staple esophagus	C	
43410	Repair esophagus wound	C	
43415	Repair esophagus wound	C	
43425	Repair esophagus opening	C	
43460	Pressure treatment esophagus	C	
43496	Free jejunum flap, microvasc	C	
43500	Surgical opening of stomach	C	
43501	Surgical repair of stomach	C	
43502	Surgical repair of stomach	C	
43520	Incision of pyloric muscle	C	
43605	Biopsy of stomach	C	
43610	Excision of stomach lesion	C	
43611	Excision of stomach lesion	C	
43620	Removal of stomach	C	
43621	Removal of stomach	C	
43622	Removal of stomach	C	
43631	Removal of stomach, partial	C	
43632	Removal of stomach, partial	C	
43633	Removal of stomach, partial	C	
43634	Removal of stomach, partial	C	
43635	Removal of stomach, partial	C	
43640	Vagotomy & pylorus repair	C	
43641	Vagotomy & pylorus repair	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
43644	Lap gastric bypass/roux-en-y	C	
43645	Lap gastr bypass incl smll i	C	
43770	Lap place gastr adj device	C	
43771	Lap revise gastr adj device	C	
43772	Lap rmvl gastr adj device	C	
43773	Lap replace gastr adj device	C	
43774	Lap rmvl gastr adj all parts	C	
43775	Lap sleeve gastrectomy	C	
43800	Reconstruction of pylorus	C	
43810	Fusion of stomach and bowel	C	
43820	Fusion of stomach and bowel	C	
43825	Fusion of stomach and bowel	C	
43832	Place gastrostomy tube	C	
43840	Repair of stomach lesion	C	
43843	Gastroplasty w/o v-band	C	
43845	Gastroplasty duodenal switch	C	
43846	Gastric bypass for obesity	C	
43847	Gastric bypass incl small i	C	
43848	Revision gastroplasty	C	
43850	Revise stomach-bowel fusion	C	
43855	Revise stomach-bowel fusion	C	
43860	Revise stomach-bowel fusion	C	
43865	Revise stomach-bowel fusion	C	
43880	Repair stomach-bowel fistula	C	
43881	Impl/redo electrd, antrum	C	
43882	Revise/remove electrd antrum	C	
44005	Freeing of bowel adhesion	C	
44010	Incision of small bowel	C	
44015	Insert needle cath bowel	C	
44020	Explore small intestine	C	
44021	Decompress small bowel	C	
44025	Incision of large bowel	C	
44050	Reduce bowel obstruction	C	
44055	Correct malrotation of bowel	C	
44110	Excise intestine lesion(s)	C	
44111	Excision of bowel lesion(s)	C	
44120	Removal of small intestine	C	
44121	Removal of small intestine	C	
44125	Removal of small intestine	C	
44126	Enterectomy w/o taper, cong	C	
44127	Enterectomy w/taper, cong	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
44128	Enterectomy cong, add-on	C	
44130	Bowel to bowel fusion	C	
44132	Enterectomy, cadaver donor	C	
44133	Enterectomy, live donor	C	
44135	Intestine transplnt, cadaver	C	
44136	Intestine transplant, live	C	
44137	Remove intestinal allograft	C	
44139	Mobilization of colon	C	
44140	Partial removal of colon	C	
44141	Partial removal of colon	C	
44143	Partial removal of colon	C	
44144	Partial removal of colon	C	
44145	Partial removal of colon	C	
44146	Partial removal of colon	C	
44147	Partial removal of colon	C	
44150	Removal of colon	C	
44151	Removal of colon/ileostomy	C	
44155	Removal of colon/ileostomy	C	
44156	Removal of colon/ileostomy	C	
44157	Colectomy w/ileoanal anast	C	
44158	Colectomy w/neo-rectum pouch	C	
44160	Removal of colon	C	
44187	Lap, ileo/jejuno-stomy	C	
44188	Lap, colostomy	C	
44202	Lap, enterectomy	C	
44203	Lap resect s/intestine, addl	C	
44204	Laparo partial colectomy	C	
44205	Lap colectomy part w/ileum	C	
44210	Laparo total proctocolectomy	C	
44211	Lap colectomy w/proctectomy	C	
44212	Laparo total proctocolectomy	C	
44227	Lap, close enterostomy	C	
44300	Open bowel to skin	C	
44310	Ileostomy/jejunostomy	C	
44314	Revision of ileostomy	C	
44316	Devise bowel pouch	C	
44320	Colostomy	C	
44322	Colostomy with biopsies	C	
44345	Revision of colostomy	C	
44346	Revision of colostomy	C	
44602	Suture, small intestine	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
44603	Suture, small intestine	C	
44604	Suture, large intestine	C	
44605	Repair of bowel lesion	C	
44615	Intestinal stricturoplasty	C	
44620	Repair bowel opening	C	
44625	Repair bowel opening	C	
44626	Repair bowel opening	C	
44640	Repair bowel-skin fistula	C	
44650	Repair bowel fistula	C	
44660	Repair bowel-bladder fistula	C	
44661	Repair bowel-bladder fistula	C	
44680	Surgical revision, intestine	C	
44700	Suspend bowel w/prosthesis	C	
44715	Prepare donor intestine	C	
44720	Prep donor intestine/venous	C	
44721	Prep donor intestine/artery	C	
44800	Excision of bowel pouch	C	
44820	Excision of mesentery lesion	C	
44850	Repair of mesentery	C	
44899	Bowel surgery procedure	C	
44900	Drain app abscess, open	C	
44960	Appendectomy	C	
45110	Removal of rectum	C	
45111	Partial removal of rectum	C	
45112	Removal of rectum	C	
45113	Partial proctectomy	C	
45114	Partial removal of rectum	C	
45116	Partial removal of rectum	C	
45119	Remove rectum w/reservoir	C	
45120	Removal of rectum	C	
45121	Removal of rectum and colon	C	
45123	Partial proctectomy	C	
45126	Pelvic exenteration	C	
45130	Excision of rectal prolapse	C	
45135	Excision of rectal prolapse	C	
45136	Excise ileoanal reservior	C	
45395	Lap, removal of rectum	C	
45397	Lap, remove rectum w/pouch	C	
45400	Laparoscopic proc	C	
45402	Lap proctopexy w/sig resect	C	
45540	Correct rectal prolapse	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
45550	Repair rectum/remove sigmoid	C	
45562	Exploration/repair of rectum	C	
45563	Exploration/repair of rectum	C	
45800	Repair rect/bladder fistula	C	
45805	Repair fistula w/colostomy	C	
45820	Repair rectourethral fistula	C	
45825	Repair fistula w/colostomy	C	
46705	Repair of anal stricture	C	
46710	Repr per/vag pouch sngl proc	C	
46712	Repr per/vag pouch dbl proc	C	
46715	Rep perf anoper fistu	C	
46716	Rep perf anoper/vestib fistu	C	
46730	Construction of absent anus	C	
46735	Construction of absent anus	C	
46740	Construction of absent anus	C	
46742	Repair of imperforated anus	C	
46744	Repair of cloacal anomaly	C	
46746	Repair of cloacal anomaly	C	
46748	Repair of cloacal anomaly	C	
46751	Repair of anal sphincter	C	
47010	Open drainage, liver lesion	C	
47015	Inject/aspirate liver cyst	C	
47100	Wedge biopsy of liver	C	
47120	Partial removal of liver	C	
47122	Extensive removal of liver	C	
47125	Partial removal of liver	C	
47130	Partial removal of liver	C	
47133	Removal of donor liver	C	
47135	Transplantation of liver	C	
47136	Transplantation of liver	C	
47140	Partial removal, donor liver	C	
47141	Partial removal, donor liver	C	
47142	Partial removal, donor liver	C	
47143	Prep donor liver, whole	C	
47144	Prep donor liver, 3-segment	C	
47145	Prep donor liver, lobe split	C	
47146	Prep donor liver/venous	C	
47147	Prep donor liver/arterial	C	
47300	Surgery for liver lesion	C	
47350	Repair liver wound	C	
47360	Repair liver wound	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
47361	Repair liver wound	C	
47362	Repair liver wound	C	
47380	Open ablate liver tumor rf	C	
47381	Open ablate liver tumor cryo	C	
47400	Incision of liver duct	C	
47420	Incision of bile duct	C	
47425	Incision of bile duct	C	
47460	Incise bile duct sphincter	C	
47480	Incision of gallbladder	C	
47550	Bile duct endoscopy add-on	C	
47570	Laparo cholecystoenterostomy	C	
47600	Removal of gallbladder	C	
47605	Removal of gallbladder	C	
47610	Removal of gallbladder	C	
47612	Removal of gallbladder	C	
47620	Removal of gallbladder	C	
47700	Exploration of bile ducts	C	
47701	Bile duct revision	C	
47711	Excision of bile duct tumor	C	
47712	Excision of bile duct tumor	C	
47715	Excision of bile duct cyst	C	
47720	Fuse gallbladder & bowel	C	
47721	Fuse upper gi structures	C	
47740	Fuse gallbladder & bowel	C	
47741	Fuse gallbladder & bowel	C	
47760	Fuse bile ducts and bowel	C	
47765	Fuse liver ducts & bowel	C	
47780	Fuse bile ducts and bowel	C	
47785	Fuse bile ducts and bowel	C	
47800	Reconstruction of bile ducts	C	
47801	Placement, bile duct support	C	
47802	Fuse liver duct & intestine	C	
47900	Suture bile duct injury	C	
48000	Drainage of abdomen	C	
48001	Placement of drain, pancreas	C	
48020	Removal of pancreatic stone	C	
48100	Biopsy of pancreas, open	C	
48105	Resect/debride pancreas	C	
48120	Removal of pancreas lesion	C	
48140	Partial removal of pancreas	C	
48145	Partial removal of pancreas	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
48146	Pancreatectomy	C	
48148	Removal of pancreatic duct	C	
48150	Partial removal of pancreas	C	
48152	Pancreatectomy	C	
48153	Pancreatectomy	C	
48154	Pancreatectomy	C	
48155	Removal of pancreas	C	
48400	Injection, intraop add-on	C	
48500	Surgery of pancreatic cyst	C	
48510	Drain pancreatic pseudocyst	C	
48520	Fuse pancreas cyst and bowel	C	
48540	Fuse pancreas cyst and bowel	C	
48545	Pancreatorrhaphy	C	
48547	Duodenal exclusion	C	
48548	Fuse pancreas and bowel	C	
48551	Prep donor pancreas	C	
48552	Prep donor pancreas/venous	C	
48554	Transpl allograft pancreas	C	
48556	Removal, allograft pancreas	C	
49000	Exploration of abdomen	C	
49002	Reopening of abdomen	C	
49010	Exploration behind abdomen	C	
49020	Drain abdominal abscess	C	
49040	Drain, open, abdom abscess	C	
49060	Drain, open, retrop abscess	C	
49062	Drain to peritoneal cavity	C	
49203	Exc abd tum 5 cm or less	C	
49204	Exc abd tum over 5 cm	C	
49205	Exc abd tum over 10 cm	C	
49215	Excise sacral spine tumor	C	
49220	Multiple surgery, abdomen	C	
49255	Removal of omentum	C	
49425	Insert abdomen-venous drain	C	
49428	Ligation of shunt	C	
49605	Repair umbilical lesion	C	
49606	Repair umbilical lesion	C	
49610	Repair umbilical lesion	C	
49611	Repair umbilical lesion	C	
49900	Repair of abdominal wall	C	
49904	Omental flap, extra-abdom	C	
49905	Omental flap, intra-abdom	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
49906	Free omental flap, microvasc	C	
50010	Exploration of kidney	C	
50040	Drainage of kidney	C	
50045	Exploration of kidney	C	
50060	Removal of kidney stone	C	
50065	Incision of kidney	C	
50070	Incision of kidney	C	
50075	Removal of kidney stone	C	
50100	Revise kidney blood vessels	C	
50120	Exploration of kidney	C	
50125	Explore and drain kidney	C	
50130	Removal of kidney stone	C	
50135	Exploration of kidney	C	
50205	Renal biopsy open	C	
50220	Remove kidney, open	C	
50225	Removal kidney open, complex	C	
50230	Removal kidney open, radical	C	
50234	Removal of kidney & ureter	C	
50236	Removal of kidney & ureter	C	
50240	Partial removal of kidney	C	
50250	Cryoablate renal mass open	C	
50280	Removal of kidney lesion	C	
50290	Removal of kidney lesion	C	
50300	Remove cadaver donor kidney	C	
50320	Remove kidney, living donor	C	
50323	Prep cadaver renal allograft	C	
50325	Prep donor renal graft	C	
50327	Prep renal graft/venous	C	
50328	Prep renal graft/arterial	C	
50329	Prep renal graft/ureteral	C	
50340	Removal of kidney	C	
50360	Transplantation of kidney	C	
50365	Transplantation of kidney	C	
50370	Remove transplanted kidney	C	
50380	Reimplantation of kidney	C	
50400	Revision of kidney/ureter	C	
50405	Revision of kidney/ureter	C	
50500	Repair of kidney wound	C	
50520	Close kidney-skin fistula	C	
50525	Repair renal-abdomen fistula	C	
50526	Repair renal-abdomen fistula	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
50540	Revision of horseshoe kidney	C	
50545	Laparo radical nephrectomy	C	
50546	Laparoscopic nephrectomy	C	
50547	Laparo removal donor kidney	C	
50548	Laparo remove w/ureter	C	
50600	Exploration of ureter	C	
50605	Insert ureteral support	C	
50610	Removal of ureter stone	C	
50620	Removal of ureter stone	C	
50630	Removal of ureter stone	C	
50650	Removal of ureter	C	
50660	Removal of ureter	C	
50700	Revision of ureter	C	
50715	Release of ureter	C	
50722	Release of ureter	C	
50725	Release/revise ureter	C	
50728	Revise ureter	C	
50740	Fusion of ureter & kidney	C	
50750	Fusion of ureter & kidney	C	
50760	Fusion of ureters	C	
50770	Splicing of ureters	C	
50780	Reimplant ureter in bladder	C	
50782	Reimplant ureter in bladder	C	
50783	Reimplant ureter in bladder	C	
50785	Reimplant ureter in bladder	C	
50800	Implant ureter in bowel	C	
50810	Fusion of ureter & bowel	C	
50815	Urine shunt to intestine	C	
50820	Construct bowel bladder	C	
50825	Construct bowel bladder	C	
50830	Revise urine flow	C	
50840	Replace ureter by bowel	C	
50845	Appendico-vesicostomy	C	
50860	Transplant ureter to skin	C	
50900	Repair of ureter	C	
50920	Closure ureter/skin fistula	C	
50930	Closure ureter/bowel fistula	C	
50940	Release of ureter	C	
51525	Removal of bladder lesion	C	
51530	Removal of bladder lesion	C	
51550	Partial removal of bladder	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
51555	Partial removal of bladder	C	
51565	Revise bladder & ureter(s)	C	
51570	Removal of bladder	C	
51575	Removal of bladder & nodes	C	
51580	Remove bladder/revise tract	C	
51585	Removal of bladder & nodes	C	
51590	Remove bladder/revise tract	C	
51595	Remove bladder/revise tract	C	
51596	Remove bladder/create pouch	C	
51597	Removal of pelvic structures	C	
51800	Revision of bladder/urethra	C	
51820	Revision of urinary tract	C	
51840	Attach bladder/urethra	C	
51841	Attach bladder/urethra	C	
51865	Repair of bladder wound	C	
51900	Repair bladder/vagina lesion	C	
51920	Close bladder-uterus fistula	C	
51925	Hysterectomy/bladder repair	C	
51940	Correction of bladder defect	C	
51960	Revision of bladder & bowel	C	
51980	Construct bladder opening	C	
53415	Reconstruction of urethra	C	
53448	Remov/replc ur sphinctr comp	C	
54125	Removal of penis	C	
54130	Remove penis & nodes	C	
54135	Remove penis & nodes	C	
54390	Repair penis and bladder	C	
54411	Remov/replc penis pros, comp	C	
54417	Remv/replc penis pros, compl	C	
54430	Revision of penis	C	
54650	Orchiopexy (Fowler-Stephens)	C	
55605	Incise sperm duct pouch	C	
55650	Remove sperm duct pouch	C	
55801	Removal of prostate	C	
55810	Extensive prostate surgery	C	
55812	Extensive prostate surgery	C	
55815	Extensive prostate surgery	C	
55821	Removal of prostate	C	
55831	Removal of prostate	C	
55840	Extensive prostate surgery	C	
55842	Extensive prostate surgery	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
55845	Extensive prostate surgery	C	
55862	Extensive prostate surgery	C	
55865	Extensive prostate surgery	C	
55866	Laparo radical prostatectomy	C	
56630	Extensive vulva surgery	C	
56631	Extensive vulva surgery	C	
56632	Extensive vulva surgery	C	
56633	Extensive vulva surgery	C	
56634	Extensive vulva surgery	C	
56637	Extensive vulva surgery	C	
56640	Extensive vulva surgery	C	
57110	Remove vagina wall, complete	C	
57111	Remove vagina tissue, compl	C	
57112	Vaginectomy w/nodes, compl	C	
57270	Repair of bowel pouch	C	
57280	Suspension of vagina	C	
57296	Revise vag graft, open abd	C	
57305	Repair rectum-vagina fistula	C	
57307	Fistula repair & colostomy	C	
57308	Fistula repair, transperine	C	
57311	Repair urethrovaginal lesion	C	
57531	Removal of cervix, radical	C	
57540	Removal of residual cervix	C	
57545	Remove cervix/repair pelvis	C	
58140	Myomectomy abdom method	C	
58146	Myomectomy abdom complex	C	
58150	Total hysterectomy	C	
58152	Total hysterectomy	C	
58180	Partial hysterectomy	C	
58200	Extensive hysterectomy	C	
58210	Extensive hysterectomy	C	
58240	Removal of pelvis contents	C	
58267	Vag hyst w/urinary repair	C	
58275	Hysterectomy/revise vagina	C	
58280	Hysterectomy/revise vagina	C	
58285	Extensive hysterectomy	C	
58293	Vag hyst w/uro repair, compl	C	
58400	Suspension of uterus	C	
58410	Suspension of uterus	C	
58520	Repair of ruptured uterus	C	
58540	Revision of uterus	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
58548	Lap radical hyst	C	
58605	Division of fallopian tube	C	
58611	Ligate oviduct(s) add-on	C	
58700	Removal of fallopian tube	C	
58720	Removal of ovary/tube(s)	C	
58740	Adhesiolysis tube, ovary	C	
58750	Repair oviduct	C	
58752	Revise ovarian tube(s)	C	
58760	Fimbrioplasty	C	
58822	Drain ovary abscess, percut	C	
58825	Transposition, ovary(s)	C	
58940	Removal of ovary(s)	C	
58943	Removal of ovary(s)	C	
58950	Resect ovarian malignancy	C	
58951	Resect ovarian malignancy	C	
58952	Resect ovarian malignancy	C	
58953	Tah, rad dissect for debulk	C	
58954	Tah rad debulk/lymph remove	C	
58956	Bso, omentectomy w/tah	C	
58957	Resect recurrent gyn mal	C	
58958	Resect recur gyn mal w/lym	C	
58960	Exploration of abdomen	C	
59120	Treat ectopic pregnancy	C	
59121	Treat ectopic pregnancy	C	
59130	Treat ectopic pregnancy	C	
59135	Treat ectopic pregnancy	C	
59136	Treat ectopic pregnancy	C	
59140	Treat ectopic pregnancy	C	
59325	Revision of cervix	C	
59350	Repair of uterus	C	
59514	Cesarean delivery only	C	
59525	Remove uterus after cesarean	C	
59620	Attempted vbac delivery only	C	
59830	Treat uterus infection	C	
59850	Abortion	C	
59851	Abortion	C	
59852	Abortion	C	
59855	Abortion	C	
59856	Abortion	C	
59857	Abortion	C	
60254	Extensive thyroid surgery	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011

HCPCS Code	Short Descriptor	SI	CI
60270	Removal of thyroid	C	
60505	Explore parathyroid glands	C	
60521	Removal of thymus gland	C	
60522	Removal of thymus gland	C	
60540	Explore adrenal gland	C	
60545	Explore adrenal gland	C	
60600	Remove carotid body lesion	C	
60605	Remove carotid body lesion	C	
60650	Laparoscopy adrenalectomy	C	
61105	Twist drill hole	C	
61107	Drill skull for implantation	C	
61108	Drill skull for drainage	C	
61120	Burr hole for puncture	C	
61140	Pierce skull for biopsy	C	
61150	Pierce skull for drainage	C	
61151	Pierce skull for drainage	C	
61154	Pierce skull & remove clot	C	
61156	Pierce skull for drainage	C	
61210	Pierce skull, implant device	C	
61250	Pierce skull & explore	C	
61253	Pierce skull & explore	C	
61304	Open skull for exploration	C	
61305	Open skull for exploration	C	
61312	Open skull for drainage	C	
61313	Open skull for drainage	C	
61314	Open skull for drainage	C	
61315	Open skull for drainage	C	
61316	Implt cran bone flap to abdo	C	
61320	Open skull for drainage	C	
61321	Open skull for drainage	C	
61322	Decompressive craniotomy	C	
61323	Decompressive lobectomy	C	
61332	Explore/biopsy eye socket	C	
61333	Explore orbit/remove lesion	C	
61340	Subtemporal decompression	C	
61343	Incise skull (press relief)	C	
61345	Relieve cranial pressure	C	
61440	Incise skull for surgery	C	
61450	Incise skull for surgery	C	
61458	Incise skull for brain wound	C	
61460	Incise skull for surgery	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011

HCPCS Code	Short Descriptor	SI	CI
61470	Incise skull for surgery	C	
61480	Incise skull for surgery	C	
61490	Incise skull for surgery	C	
61500	Removal of skull lesion	C	
61501	Remove infected skull bone	C	
61510	Removal of brain lesion	C	
61512	Remove brain lining lesion	C	
61514	Removal of brain abscess	C	
61516	Removal of brain lesion	C	
61517	Implt brain chemotx add-on	C	
61518	Removal of brain lesion	C	
61519	Remove brain lining lesion	C	
61520	Removal of brain lesion	C	
61521	Removal of brain lesion	C	
61522	Removal of brain abscess	C	
61524	Removal of brain lesion	C	
61526	Removal of brain lesion	C	
61530	Removal of brain lesion	C	
61531	Implant brain electrodes	C	
61533	Implant brain electrodes	C	
61534	Removal of brain lesion	C	
61535	Remove brain electrodes	C	
61536	Removal of brain lesion	C	
61537	Removal of brain tissue	C	
61538	Removal of brain tissue	C	
61539	Removal of brain tissue	C	
61540	Removal of brain tissue	C	
61541	Incision of brain tissue	C	
61542	Removal of brain tissue	C	
61543	Removal of brain tissue	C	
61544	Remove & treat brain lesion	C	
61545	Excision of brain tumor	C	
61546	Removal of pituitary gland	C	
61548	Removal of pituitary gland	C	
61550	Release of skull seams	C	
61552	Release of skull seams	C	
61556	Incise skull/sutures	C	
61557	Incise skull/sutures	C	
61558	Excision of skull/sutures	C	
61559	Excision of skull/sutures	C	
61563	Excision of skull tumor	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
61564	Excision of skull tumor	C	
61566	Removal of brain tissue	C	
61567	Incision of brain tissue	C	
61570	Remove foreign body, brain	C	
61571	Incise skull for brain wound	C	
61575	Skull base/brainstem surgery	C	
61576	Skull base/brainstem surgery	C	
61580	Craniofacial approach, skull	C	
61581	Craniofacial approach, skull	C	
61582	Craniofacial approach, skull	C	
61583	Craniofacial approach, skull	C	
61584	Orbitocranial approach/skull	C	
61585	Orbitocranial approach/skull	C	
61586	Resect nasopharynx, skull	C	
61590	Infratemporal approach/skull	C	
61591	Infratemporal approach/skull	C	
61592	Orbitocranial approach/skull	C	
61595	Transtemporal approach/skull	C	
61596	Transcochlear approach/skull	C	
61597	Transcondylar approach/skull	C	
61598	Transpetrosal approach/skull	C	
61600	Resect/excise cranial lesion	C	
61601	Resect/excise cranial lesion	C	
61605	Resect/excise cranial lesion	C	
61606	Resect/excise cranial lesion	C	
61607	Resect/excise cranial lesion	C	
61608	Resect/excise cranial lesion	C	
61609	Transect artery, sinus	C	
61610	Transect artery, sinus	C	
61611	Transect artery, sinus	C	
61612	Transect artery, sinus	C	
61613	Remove aneurysm, sinus	C	
61615	Resect/excise lesion, skull	C	
61616	Resect/excise lesion, skull	C	
61618	Repair dura	C	
61619	Repair dura	C	
61624	Transcath occlusion, cns	C	
61630	Intracranial angioplasty	C	
61635	Intracran angioplsty w/stent	C	
61680	Intracranial vessel surgery	C	
61682	Intracranial vessel surgery	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
61684	Intracranial vessel surgery	C	
61686	Intracranial vessel surgery	C	
61690	Intracranial vessel surgery	C	
61692	Intracranial vessel surgery	C	
61697	Brain aneurysm repr, complx	C	
61698	Brain aneurysm repr, complx	C	
61700	Brain aneurysm repr, simple	C	
61702	Inner skull vessel surgery	C	
61703	Clamp neck artery	C	
61705	Revise circulation to head	C	
61708	Revise circulation to head	C	
61710	Revise circulation to head	C	
61711	Fusion of skull arteries	C	
61735	Incise skull/brain surgery	C	
61750	Incise skull/brain biopsy	C	
61751	Brain biopsy w/ct/mr guide	C	
61760	Implant brain electrodes	C	
61850	Implant neuroelectrodes	C	
61860	Implant neuroelectrodes	C	
61863	Implant neuroelectrode	C	
61864	Implant neuroelectrde, addl	C	
61867	Implant neuroelectrode	C	
61868	Implant neuroelectrde, addl	C	
61870	Implant neuroelectrodes	C	
61875	Implant neuroelectrodes	C	
62005	Treat skull fracture	C	
62010	Treatment of head injury	C	
62100	Repair brain fluid leakage	C	
62115	Reduction of skull defect	C	
62116	Reduction of skull defect	C	
62117	Reduction of skull defect	C	
62120	Repair skull cavity lesion	C	
62121	Incise skull repair	C	
62140	Repair of skull defect	C	
62141	Repair of skull defect	C	
62142	Remove skull plate/flap	C	
62143	Replace skull plate/flap	C	
62145	Repair of skull & brain	C	
62146	Repair of skull with graft	C	
62147	Repair of skull with graft	C	
62148	Retr bone flap to fix skull	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
62161	Dissect brain w/scope	C	
62162	Remove colloid cyst w/scope	C	
62163	Neuroendoscopy w/fb removal	C	
62164	Remove brain tumor w/scope	C	
62165	Remove pituit tumor w/scope	C	
62180	Establish brain cavity shunt	C	
62190	Establish brain cavity shunt	C	
62192	Establish brain cavity shunt	C	
62200	Establish brain cavity shunt	C	
62201	Brain cavity shunt w/scope	C	
62220	Establish brain cavity shunt	C	
62223	Establish brain cavity shunt	C	
62256	Remove brain cavity shunt	C	
62258	Replace brain cavity shunt	C	
63043	Laminotomy, addl cervical	C	
63044	Laminotomy, addl lumbar	C	
63050	Cervical laminoplasty	C	
63051	C-laminoplasty w/graft/plate	C	
63077	Spine disk surgery, thorax	C	
63078	Spine disk surgery, thorax	C	
63081	Removal of vertebral body	C	
63082	Remove vertebral body add-on	C	
63085	Removal of vertebral body	C	
63086	Remove vertebral body add-on	C	
63087	Removal of vertebral body	C	
63088	Remove vertebral body add-on	C	
63090	Removal of vertebral body	C	
63091	Remove vertebral body add-on	C	
63101	Removal of vertebral body	C	
63102	Removal of vertebral body	C	
63103	Remove vertebral body add-on	C	
63170	Incise spinal cord tract(s)	C	
63172	Drainage of spinal cyst	C	
63173	Drainage of spinal cyst	C	
63180	Revise spinal cord ligaments	C	
63182	Revise spinal cord ligaments	C	
63185	Incise spinal column/nerves	C	
63190	Incise spinal column/nerves	C	
63191	Incise spinal column/nerves	C	
63194	Incise spinal column & cord	C	
63195	Incise spinal column & cord	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
63196	Incise spinal column & cord	C	
63197	Incise spinal column & cord	C	
63198	Incise spinal column & cord	C	
63199	Incise spinal column & cord	C	
63200	Release of spinal cord	C	
63250	Revise spinal cord vessels	C	
63251	Revise spinal cord vessels	C	
63252	Revise spinal cord vessels	C	
63265	Excise intraspinal lesion	C	
63266	Excise intraspinal lesion	C	
63267	Excise intraspinal lesion	C	
63268	Excise intraspinal lesion	C	
63270	Excise intraspinal lesion	C	
63271	Excise intraspinal lesion	C	
63272	Excise intraspinal lesion	C	
63273	Excise intraspinal lesion	C	
63275	Biopsy/excise spinal tumor	C	
63276	Biopsy/excise spinal tumor	C	
63277	Biopsy/excise spinal tumor	C	
63278	Biopsy/excise spinal tumor	C	
63280	Biopsy/excise spinal tumor	C	
63281	Biopsy/excise spinal tumor	C	
63282	Biopsy/excise spinal tumor	C	
63283	Biopsy/excise spinal tumor	C	
63285	Biopsy/excise spinal tumor	C	
63286	Biopsy/excise spinal tumor	C	
63287	Biopsy/excise spinal tumor	C	
63290	Biopsy/excise spinal tumor	C	
63295	Repair of laminectomy defect	C	
63300	Removal of vertebral body	C	
63301	Removal of vertebral body	C	
63302	Removal of vertebral body	C	
63303	Removal of vertebral body	C	
63304	Removal of vertebral body	C	
63305	Removal of vertebral body	C	
63306	Removal of vertebral body	C	
63307	Removal of vertebral body	C	
63308	Remove vertebral body add-on	C	
63700	Repair of spinal herniation	C	
63702	Repair of spinal herniation	C	
63704	Repair of spinal herniation	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
63706	Repair of spinal herniation	C	
63707	Repair spinal fluid leakage	C	
63709	Repair spinal fluid leakage	C	
63710	Graft repair of spine defect	C	
63740	Install spinal shunt	C	
64752	Incision of vagus nerve	C	
64755	Incision of stomach nerves	C	
64760	Incision of vagus nerve	C	
64809	Remove sympathetic nerves	C	
64818	Remove sympathetic nerves	C	
64866	Fusion of facial/other nerve	C	
64868	Fusion of facial/other nerve	C	
65273	Repair of eye wound	C	
69155	Extensive ear/neck surgery	C	
69535	Remove part of temporal bone	C	
69554	Remove ear lesion	C	
69950	Incise inner ear nerve	C	
75900	Intravascular cath exchange	C	
75952	Endovasc repair abdom aorta	C	
75953	Abdom aneurysm endovas rpr	C	
75954	Iliac aneurysm endovas rpr	C	
75956	Xray, endovasc thor ao repr	C	
75957	Xray, endovasc thor ao repr	C	
75958	Xray, place prox ext thor ao	C	
75959	Xray, place dist ext thor ao	C	
92970	Cardioassist, internal	C	
92971	Cardioassist, external	C	
92975	Dissolve clot, heart vessel	C	
92992	Revision of heart chamber	C	
92993	Revision of heart chamber	C	
99190	Special pump services	C	
99191	Special pump services	C	
99192	Special pump services	C	
99356	Prolonged service, inpatient	C	
99357	Prolonged service, inpatient	C	
99462	Sbsq nb em per day, hosp	C	
99468	Neonate crit care, initial	C	
99469	Neonate crit care, subsq	C	
99471	Ped critical care, initial	C	
99472	Ped critical care, subsq	C	
99475	Ped crit care age 2-5, init	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
99476	Ped crit care age 2-5, subsq	C	
99477	Init day hosp neonate care	C	
99478	Ic, lbw inf < 1500 gm subsq	C	
99479	Ic lbw inf 1500-2500 g subsq	C	
99480	Ic inf pbw 2501-5000 g subsq	C	
0048T	Implant ventricular device	C	
0050T	Removal circulation assist	C	
0051T	Implant total heart system	C	
0052T	Replace component heart syst	C	
0053T	Replace component heart syst	C	
0075T	Perq stent/chest vert art	C	
0076T	S&i stent/chest vert art	C	
0078T	Endovasc aort repr w/device	C	
0079T	Endovasc visc extnsn repr	C	
0080T	Endovasc aort repr rad s&i	C	
0081T	Endovasc visc extnsn s&i	C	
0092T	Artific disc addl	C	
0095T	Artific diskectomy addl	C	
0098T	Rev artific disc addl	C	
0157T	Open impl gast curve electrd	C	
0158T	Open remv gast curve electrd	C	
0163T	Lumb artif diskectomy addl	C	
0164T	Remove lumb artif disc addl	C	
0165T	Revise lumb artif disc addl	C	
0166T	Tcath vsd close w/o bypass	C	
0167T	Tcath vsd close w bypass	C	
0169T	Place stereo cath brain	C	
0184T	Exc rectal tumor endoscopic	C	
0195T	Arthrod presac interbody	C	
0196T	Arthrod presac interbody eac	C	
0202T	Post vert arthrplst 1 lumbar	C	
0219T	Fuse spine facet jt cerv	C	
0220T	Fuse spine facet jt thor	C	
G0341	Percutaneous islet celltrans	C	
G0342	Laparoscopy islet cell trans	C	
G0343	Laparotomy islet cell transp	C	
G0406	Telhealth inpt consult 15min	C	
G0407	Telheath inpt consult 25min	C	
G0408	Telhealth inpt consult 35min	C	
G0412	Open tx iliac spine uni/bil	C	
G0414	Pelvic ring fx treat int fix	C	

ADDENDUM E.—PROPOSED HCPCS CODES THAT WOULD BE PAID ONLY AS INPATIENT PROCEDURES FOR CY 2011			
HCPCS Code	Short Descriptor	SI	CI
G0415	Open tx post pelvic fxcture	C	
G0425	Inpt telehealth consult 30m	C	
G0426	Inpt telehealth consult 50m	C	
G0427	Inpt telehealth con 70/>m	C	

ADDENDUM L.—PROPOSED CY 2011 OPPS OUT-MIGRATION ADJUSTMENT

ADDENDUM L.—PROPOSED CY 2011 OPPS OUT-MIGRATION ADJUSTMENT				
Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
010005	*	0.0315	MARSHALL	01470
010008		0.0336	CRENSHAW	01200
010010		0.0315	MARSHALL	01470
010012		0.0168	DE KALB	01240
010015		0.0055	CLARKE	01120
010021		0.0052	DALE	01220
010022	*	0.0695	CHEROKEE	01090
010025	*	0.0389	CHAMBERS	01080
010027		0.0026	COFFEE	01150
010029	*	0.0504	LEE	01400
010032		0.0315	RANDOLPH	01550
010035	*	0.0226	CULLMAN	01210
010040		0.0061	ETOWAH	01270
010045		0.0178	FAYETTE	01280
010046	*	0.0061	ETOWAH	01270
010047		0.0245	BUTLER	01060
010049		0.0026	COFFEE	01150
010052	*	0.0245	TALLAPOOSA	01610
010059	*	0.0071	LAWRENCE	01390
010061	*	0.0552	JACKSON	01350
010065	*	0.0245	TALLAPOOSA	01610
010083	*	0.0152	BALDWIN	01010
010091		0.0055	CLARKE	01120

ADDENDUM L.—PROPOSED CY 2011 OPPS OUT-MIGRATION ADJUSTMENT				
Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
010100	*	0.0152	BALDWIN	01010
010101	*	0.0190	TALLADEGA	01600
010109		0.0405	PICKENS	01530
010110		0.0415	BULLOCK	01050
010125		0.0429	WINSTON	01660
010128		0.0055	CLARKE	01120
010129		0.0152	BALDWIN	01010
010138		0.0101	SUMTER	01590
010143	*	0.0226	CULLMAN	01210
010150		0.0245	BUTLER	01060
010158	*	0.0103	FRANKLIN	01290
010164	*	0.0190	TALLADEGA	01600
013027		0.0152	BALDWIN	01010
013032		0.0061	ETOWAH	01270
014006		0.0061	ETOWAH	01270
030067		0.0328	LAPAZ	03055
040014	*	0.0158	WHITE	04720
040019		0.0242	ST. FRANCIS	04610
040039	*	0.0055	GREENE	04270
040047		0.0037	RANDOLPH	04600
040067		0.0045	COLUMBIA	04130
040071	*	0.0067	JEFFERSON	04340
040076	*	0.0975	HOT SPRING	04290
040081		0.0398	PIKE	04540
042007		0.0067	JEFFERSON	04340
042011		0.0158	WHITE	04720
050002	*	0.0056	ALAMEDA	05000
050007		0.0234	SAN MATEO	05510
050009	*	0.0174	NAPA	05380
050013	*	0.0174	NAPA	05380
050014	*	0.0138	AMADOR	05020
050042	*	0.0196	TEHAMA	05620
050043	*	0.0056	ALAMEDA	05000
050069	*	0.0013	ORANGE	05400
050070		0.0234	SAN MATEO	05510
050073	*	0.0297	SOLANO	05580

ADDENDUM L.—PROPOSED CY 2011 OPPS OUT-MIGRATION ADJUSTMENT				
Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
050075	*	0.0056	ALAMEDA	05000
050089	*	0.0011	SAN BERNARDINO	05460
050099	*	0.0011	SAN BERNARDINO	05460
050101	*	0.0297	SOLANO	05580
050113		0.0234	SAN MATEO	05510
050129	*	0.0011	SAN BERNARDINO	05460
050133		0.0165	YUBA	05680
050140	*	0.0011	SAN BERNARDINO	05460
050150	*	0.0318	NEVADA	05390
050168	*	0.0013	ORANGE	05400
050173	*	0.0013	ORANGE	05400
050193	*	0.0013	ORANGE	05400
050195	*	0.0056	ALAMEDA	05000
050197	*	0.0234	SAN MATEO	05510
050211	*	0.0056	ALAMEDA	05000
050224	*	0.0013	ORANGE	05400
050226	*	0.0013	ORANGE	05400
050230	*	0.0013	ORANGE	05400
050245	*	0.0011	SAN BERNARDINO	05460
050264	*	0.0056	ALAMEDA	05000
050272	*	0.0011	SAN BERNARDINO	05460
050279	*	0.0011	SAN BERNARDINO	05460
050283	*	0.0056	ALAMEDA	05000
050289		0.0234	SAN MATEO	05510
050298		0.0011	SAN BERNARDINO	05460
050300	*	0.0011	SAN BERNARDINO	05460
050305	*	0.0056	ALAMEDA	05000
050320	*	0.0056	ALAMEDA	05000
050327	*	0.0011	SAN BERNARDINO	05460
050348	*	0.0013	ORANGE	05400
050366	*	0.0050	CALAVERAS	05040
050367	*	0.0297	SOLANO	05580
050426	*	0.0013	ORANGE	05400
050488	*	0.0056	ALAMEDA	05000
050512	*	0.0056	ALAMEDA	05000
050517	*	0.0011	SAN BERNARDINO	05460

ADDENDUM L.—PROPOSED CY 2011 OPPS OUT-MIGRATION ADJUSTMENT				
Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
050526	*	0.0013	ORANGE	05400
050541	*	0.0234	SAN MATEO	05510
050543	*	0.0013	ORANGE	05400
050548	*	0.0013	ORANGE	05400
050551	*	0.0013	ORANGE	05400
050567	*	0.0013	ORANGE	05400
050570	*	0.0013	ORANGE	05400
050580	*	0.0013	ORANGE	05400
050586	*	0.0011	SAN BERNARDINO	05460
050589	*	0.0013	ORANGE	05400
050603	*	0.0013	ORANGE	05400
050609	*	0.0013	ORANGE	05400
050618	*	0.0011	SAN BERNARDINO	05460
050667	*	0.0174	NAPA	05380
050678	*	0.0013	ORANGE	05400
050680	*	0.0297	SOLANO	05580
050693	*	0.0013	ORANGE	05400
050744	*	0.0013	ORANGE	05400
050745	*	0.0013	ORANGE	05400
050746	*	0.0013	ORANGE	05400
050747	*	0.0013	ORANGE	05400
050754		0.0234	SAN MATEO	05510
050758	*	0.0011	SAN BERNARDINO	05460
052034		0.0056	ALAMEDA	05000
052035		0.0013	ORANGE	05400
052037		0.0011	SAN BERNARDINO	05460
052039		0.0013	ORANGE	05400
052040		0.0011	SAN BERNARDINO	05460
052053		0.0013	ORANGE	05400
053034		0.0013	ORANGE	05400
053037		0.0011	SAN BERNARDINO	05460
053301		0.0056	ALAMEDA	05000
053304		0.0013	ORANGE	05400
053306		0.0013	ORANGE	05400
053308		0.0013	ORANGE	05400
054074		0.0297	SOLANO	05580

ADDENDUM L.—PROPOSED CY 2011 OPPS OUT-MIGRATION ADJUSTMENT				
Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
054093		0.0011	SAN BERNARDINO	05460
054110		0.0056	ALAMEDA	05000
054111		0.0011	SAN BERNARDINO	05460
054122		0.0174	NAPA	05380
054135		0.0013	ORANGE	05400
054141		0.0297	SOLANO	05580
054146		0.0056	ALAMEDA	05000
060001	*	0.0096	WELD	06610
060003	*	0.0101	BOULDER	06060
060027	*	0.0101	BOULDER	06060
060103	*	0.0101	BOULDER	06060
060116	*	0.0101	BOULDER	06060
060121	*	0.0096	WELD	06610
063033		0.0096	WELD	06610
064007		0.0101	BOULDER	06060
070003	*	0.0020	WINDHAM	07070
070004	*	0.0134	LITCHFIELD	07020
070011	*	0.0134	LITCHFIELD	07020
070015	*	0.0134	LITCHFIELD	07020
070020		0.0101	MIDDLESEX	07030
070021	*	0.0020	WINDHAM	07070
073026		0.0020	WINDHAM	07070
074003		0.0101	MIDDLESEX	07030
074007		0.0101	MIDDLESEX	07030
080001		0.0044	NEW CASTLE	08010
080003		0.0044	NEW CASTLE	08010
082000		0.0044	NEW CASTLE	08010
083300		0.0044	NEW CASTLE	08010
084001		0.0044	NEW CASTLE	08010
084002		0.0044	NEW CASTLE	08010
084003		0.0044	NEW CASTLE	08010
090001		0.0033	THE DISTRICT	09000
090003		0.0033	THE DISTRICT	09000
090004	*	0.0033	THE DISTRICT	09000
090005		0.0033	THE DISTRICT	09000
090006		0.0033	THE DISTRICT	09000

ADDENDUM L.—PROPOSED CY 2011 OPPS OUT-MIGRATION ADJUSTMENT				
Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
090008		0.0033	THE DISTRICT	09000
090011		0.0033	THE DISTRICT	09000
092002		0.0033	THE DISTRICT	09000
092003		0.0033	THE DISTRICT	09000
093025		0.0033	THE DISTRICT	09000
093300		0.0033	THE DISTRICT	09000
094001		0.0033	THE DISTRICT	09000
094004		0.0033	THE DISTRICT	09000
100014	*	0.0055	VOLUSIA	10630
100017	*	0.0055	VOLUSIA	10630
100023	*	0.0031	CITRUS	10080
100045	*	0.0055	VOLUSIA	10630
100047	*	0.0028	CHARLOTTE	10070
100068	*	0.0055	VOLUSIA	10630
100072	*	0.0055	VOLUSIA	10630
100077	*	0.0028	CHARLOTTE	10070
100081	*	0.0022	WALTON	10650
100118	*	0.0251	FLAGLER	10170
100139	*	0.0006	LEVY	10370
100232	*	0.0068	PUTNAM	10530
100236	*	0.0028	CHARLOTTE	10070
100249	*	0.0031	CITRUS	10080
100252	*	0.0258	OKEECHOBEE	10460
100290	*	0.0338	SUMTER	10590
100292	*	0.0022	WALTON	10650
110023	*	0.0277	GORDON	11500
110040	*	0.1172	JACKSON	11610
110041	*	0.0768	HABERSHAM	11540
110100		0.0810	JEFFERSON	11620
110101		0.0068	COOK	11311
110142		0.0193	EVANS	11441
110146	*	0.0364	CAMDEN	11170
110150	*	0.0190	BALDWIN	11030
110187	*	0.0792	LUMPKIN	11701
110189	*	0.0043	FANNIN	11450
110190	*	0.0094	MACON	11710

ADDENDUM L.—PROPOSED CY 2011 OPPS OUT-MIGRATION ADJUSTMENT				
Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
110205		0.0466	GILMER	11471
114018		0.0190	BALDWIN	11030
130003	*	0.0165	NEZ PERCE	13340
130024		0.0688	BONNER	13080
130049	*	0.0365	KOOTENAI	13270
130066		0.0365	KOOTENAI	13270
130067	*	0.1032	BINGHAM	13050
132001		0.0365	KOOTENAI	13270
134010		0.1032	BINGHAM	13050
140001		0.0321	FULTON	14370
140026		0.0296	LA SALLE	14580
140043	*	0.0038	WHITESIDE	14988
140058	*	0.0119	MORGAN	14770
140110	*	0.0296	LA SALLE	14580
140116	*	0.0014	MC HENRY	14640
140160	*	0.0316	STEPHENSON	14970
140161	*	0.0178	LIVINGSTON	14610
140167	*	0.0768	IROQUOIS	14460
140176	*	0.0014	MC HENRY	14640
140234		0.0296	LA SALLE	14580
150022		0.0251	MONTGOMERY	15530
150030	*	0.0242	HENRY	15320
150072		0.0092	CASS	15080
150076	*	0.0297	MARSHALL	15490
150088	*	0.0038	MADISON	15470
150091	*	0.0089	HUNTINGTON	15340
150102	*	0.0174	STARKE	15740
150113	*	0.0038	MADISON	15470
150133	*	0.0212	KOSCIUSKO	15420
150146	*	0.0087	NOBLE	15560
153040		0.0297	MARSHALL	15490
154014		0.0212	KOSCIUSKO	15420
154035		0.0092	CASS	15080
154047		0.0297	MARSHALL	15490
160013		0.0187	MUSCATINE	16690
160030		0.0013	STORY	16840

ADDENDUM L.—PROPOSED CY 2011 OPPS OUT-MIGRATION ADJUSTMENT				
Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
160032		0.0341	JASPER	16490
160080	*	0.0019	CLINTON	16220
170137	*	0.0421	DOUGLAS	17220
170150		0.0143	COWLEY	17170
180012	*	0.0089	HARDIN	18460
180017	*	0.0092	BARREN	18040
180049	*	0.0329	MADISON	18750
180064		0.0211	MONTGOMERY	18860
180066		0.0517	LOGAN	18700
180070		0.0121	GRAYSON	18420
180079		0.0174	HARRISON	18480
183028		0.0089	HARDIN	18460
184012		0.0089	HARDIN	18460
190003	*	0.0061	IBERIA	19220
190015	*	0.0238	TANGIPAHOA	19520
190017	*	0.0134	ST. LANDRY	19480
190034		0.0135	VERMILION	19560
190044		0.0185	ACADIA	19000
190050		0.0056	BEAUREGARD	19050
190053		0.0102	JEFFRSON DAVIS	19260
190054		0.0061	IBERIA	19220
190078		0.0134	ST. LANDRY	19480
190086	*	0.0038	LINCOLN	19300
190088		0.0281	WEBSTER	19590
190099		0.0105	AVOYELLES	19040
190106	*	0.0081	ALLEN	19010
190116		0.0052	MOREHOUSE	19330
190133		0.0081	ALLEN	19010
190140		0.0021	FRANKLIN	19200
190144	*	0.0281	WEBSTER	19590
190145		0.0050	LA SALLE	19290
190184		0.0075	CALDWELL	19100
190190	*	0.0075	CALDWELL	19100
190191		0.0134	ST. LANDRY	19480
190246		0.0075	CALDWELL	19100
190257	*	0.0038	LINCOLN	19300

ADDENDUM L.—PROPOSED CY 2011 OPPS OUT-MIGRATION ADJUSTMENT				
Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
192022		0.0038	LINCOLN	19300
192026		0.0281	WEBSTER	19590
192034		0.0134	ST. LANDRY	19480
192036		0.0238	TANGIPAHOA	19520
192040		0.0238	TANGIPAHOA	19520
192050		0.0185	ACADIA	19000
193036		0.0134	ST. LANDRY	19480
193044		0.0238	TANGIPAHOA	19520
193047		0.0135	VERMILION	19560
193049		0.0135	VERMILION	19560
193055		0.0075	CALDWELL	19100
193058		0.0052	MOREHOUSE	19330
193063		0.0238	TANGIPAHOA	19520
193067		0.0102	JEFFRSON DAVIS	19260
193068		0.0238	TANGIPAHOA	19520
193069		0.0052	MOREHOUSE	19330
193073		0.0134	ST. LANDRY	19480
193079		0.0238	TANGIPAHOA	19520
193081		0.0185	ACADIA	19000
193088		0.0185	ACADIA	19000
193091		0.0061	IBERIA	19220
194047		0.0281	WEBSTER	19590
194065		0.0038	LINCOLN	19300
194075		0.0102	JEFFRSON DAVIS	19260
194077		0.0038	LINCOLN	19300
194081		0.0056	BEAUREGARD	19050
194082		0.0102	JEFFRSON DAVIS	19260
194083		0.0052	MOREHOUSE	19330
194085		0.0185	ACADIA	19000
194087		0.0038	LINCOLN	19300
194091		0.0238	TANGIPAHOA	19520
194092		0.0021	FRANKLIN	19200
194095		0.0134	ST. LANDRY	19480
194097		0.0134	ST. LANDRY	19480
200024	*	0.0130	ANDROSCOGGIN	20000
200032		0.0367	OXFORD	20080

ADDENDUM L.—PROPOSED CY 2011 OPPS OUT-MIGRATION ADJUSTMENT				
Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
200034	*	0.0130	ANDROSCOGGIN	20000
200050	*	0.0170	HANCOCK	20040
210001		0.0110	WASHINGTON	21210
210023		0.0038	ANNE ARUNDEL	21010
210028		0.0383	ST. MARYS	21180
210043		0.0038	ANNE ARUNDEL	21010
210061		0.0188	WORCESTER	21230
212002		0.0110	WASHINGTON	21210
214001		0.0038	ANNE ARUNDEL	21010
214003		0.0110	WASHINGTON	21210
214015		0.0188	WORCESTER	21230
220001	*	0.0072	WORCESTER	22170
220002	*	0.0446	MIDDLESEX	22090
220010	*	0.0310	ESSEX	22040
220011	*	0.0446	MIDDLESEX	22090
220019	*	0.0072	WORCESTER	22170
220025	*	0.0072	WORCESTER	22170
220029	*	0.0310	ESSEX	22040
220033	*	0.0310	ESSEX	22040
220035	*	0.0310	ESSEX	22040
220049	*	0.0446	MIDDLESEX	22090
220058	*	0.0072	WORCESTER	22170
220062	*	0.0072	WORCESTER	22170
220063	*	0.0446	MIDDLESEX	22090
220070	*	0.0446	MIDDLESEX	22090
220080	*	0.0310	ESSEX	22040
220082	*	0.0446	MIDDLESEX	22090
220084	*	0.0446	MIDDLESEX	22090
220090	*	0.0072	WORCESTER	22170
220095	*	0.0072	WORCESTER	22170
220098	*	0.0446	MIDDLESEX	22090
220101	*	0.0446	MIDDLESEX	22090
220105	*	0.0446	MIDDLESEX	22090
220163	*	0.0072	WORCESTER	22170
220171	*	0.0446	MIDDLESEX	22090
220174	*	0.0310	ESSEX	22040

ADDENDUM L.—PROPOSED CY 2011 OPPS OUT-MIGRATION ADJUSTMENT				
Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
220175	*	0.0446	MIDDLESEX	22090
220176	*	0.0072	WORCESTER	22170
222000		0.0446	MIDDLESEX	22090
222003		0.0446	MIDDLESEX	22090
222024		0.0446	MIDDLESEX	22090
222026		0.0310	ESSEX	22040
222044		0.0310	ESSEX	22040
222047		0.0310	ESSEX	22040
222048		0.0072	WORCESTER	22170
223026		0.0446	MIDDLESEX	22090
223028		0.0310	ESSEX	22040
223029		0.0072	WORCESTER	22170
223033		0.0072	WORCESTER	22170
224007		0.0446	MIDDLESEX	22090
224026		0.0072	WORCESTER	22170
224032		0.0072	WORCESTER	22170
224033		0.0310	ESSEX	22040
224038		0.0446	MIDDLESEX	22090
224039		0.0310	ESSEX	22040
230002	*	0.0043	WAYNE	23810
230003	*	0.0314	OTTAWA	23690
230005		0.0488	LENAWEE	23450
230013	*	0.0021	OAKLAND	23620
230015		0.0314	ST. JOSEPH	23740
230019	*	0.0021	OAKLAND	23620
230020	*	0.0043	WAYNE	23810
230021	*	0.0159	BERRIEN	23100
230022	*	0.0213	BRANCH	23110
230024	*	0.0043	WAYNE	23810
230029	*	0.0021	OAKLAND	23620
230035	*	0.0143	MONTCALM	23580
230037	*	0.0235	HILLSDALE	23290
230041		0.0052	BAY	23080
230047	*	0.0017	MACOMB	23490
230053	*	0.0043	WAYNE	23810
230071	*	0.0021	OAKLAND	23620

ADDENDUM L.—PROPOSED CY 2011 OPPS OUT-MIGRATION ADJUSTMENT				
Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
230072	*	0.0314	OTTAWA	23690
230075		0.0067	CALHOUN	23120
230078	*	0.0159	BERRIEN	23100
230089	*	0.0043	WAYNE	23810
230092		0.0205	JACKSON	23370
230093		0.0088	MECOSTA	23530
230096	*	0.0314	ST. JOSEPH	23740
230099	*	0.0074	MONROE	23570
230104	*	0.0043	WAYNE	23810
230121	*	0.0922	SHIAWASSEE	23770
230130	*	0.0021	OAKLAND	23620
230135	*	0.0043	WAYNE	23810
230142	*	0.0043	WAYNE	23810
230146	*	0.0043	WAYNE	23810
230151	*	0.0021	OAKLAND	23620
230165	*	0.0043	WAYNE	23810
230174	*	0.0314	OTTAWA	23690
230176	*	0.0043	WAYNE	23810
230195	*	0.0017	MACOMB	23490
230204	*	0.0017	MACOMB	23490
230207	*	0.0021	OAKLAND	23620
230208	*	0.0143	MONTCALM	23580
230217		0.0067	CALHOUN	23120
230222	*	0.0098	MIDLAND	23550
230227	*	0.0017	MACOMB	23490
230244	*	0.0043	WAYNE	23810
230254	*	0.0021	OAKLAND	23620
230257	*	0.0017	MACOMB	23490
230264	*	0.0017	MACOMB	23490
230269	*	0.0021	OAKLAND	23620
230270	*	0.0043	WAYNE	23810
230273	*	0.0043	WAYNE	23810
230277	*	0.0021	OAKLAND	23620
230297	*	0.0043	WAYNE	23810
230301	*	0.0021	OAKLAND	23620
230302	*	0.0021	OAKLAND	23620

ADDENDUM L.—PROPOSED CY 2011 OPPS OUT-MIGRATION ADJUSTMENT				
Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
232019		0.0043	WAYNE	23810
232020		0.0052	BAY	23080
232023		0.0017	MACOMB	23490
232025		0.0159	BERRIEN	23100
232027		0.0043	WAYNE	23810
232028		0.0067	CALHOUN	23120
232030		0.0021	OAKLAND	23620
232031		0.0043	WAYNE	23810
232032		0.0043	WAYNE	23810
232036		0.0205	JACKSON	23370
232038		0.0043	WAYNE	23810
233025		0.0067	CALHOUN	23120
233027		0.0043	WAYNE	23810
233028		0.0021	OAKLAND	23620
233300		0.0043	WAYNE	23810
234011		0.0021	OAKLAND	23620
234021		0.0017	MACOMB	23490
234023		0.0021	OAKLAND	23620
234028		0.0043	WAYNE	23810
234034		0.0043	WAYNE	23810
234035		0.0043	WAYNE	23810
234038		0.0043	WAYNE	23810
234039		0.0017	MACOMB	23490
240018		0.0923	GOODHUE	24240
240044		0.0733	WINONA	24840
240064		0.0212	ITASCA	24300
240069	*	0.0312	STEELE	24730
240071	*	0.0404	RICE	24650
240101		0.0145	BECKER	24020
240117		0.0615	MOWER	24490
240211		0.1004	PINE	24570
250023	*	0.0722	PEARL RIVER	25540
250040	*	0.0225	JACKSON	25290
250117	*	0.0722	PEARL RIVER	25540
250128		0.0419	PANOLA	25530
250162		0.0011	HANCOCK	25220

ADDENDUM L.—PROPOSED CY 2011 OPPS OUT-MIGRATION ADJUSTMENT				
Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
252011		0.0419	PANOLA	25530
260059		0.0032	LACLEDE	26520
260064		0.0040	AUDRAIN	26030
260097		0.0362	JOHNSON	26500
260116	*	0.0095	ST. FRANCOIS	26930
260160		0.0144	STODDARD	26985
260163		0.0095	ST. FRANCOIS	26930
264005		0.0095	ST. FRANCOIS	26930
280077	*	0.0085	DODGE	28260
290002	*	0.0150	LYON	29090
300011	*	0.0049	HILLSBOROUGH	30050
300012	*	0.0049	HILLSBOROUGH	30050
300017	*	0.0075	ROCKINGHAM	30070
300020	*	0.0049	HILLSBOROUGH	30050
300023	*	0.0075	ROCKINGHAM	30070
300029	*	0.0075	ROCKINGHAM	30070
300034	*	0.0049	HILLSBOROUGH	30050
303026		0.0075	ROCKINGHAM	30070
304001		0.0075	ROCKINGHAM	30070
310002	*	0.0312	ESSEX	31200
310009	*	0.0312	ESSEX	31200
310015	*	0.0199	MORRIS	31300
310017	*	0.0199	MORRIS	31300
310038	*	0.0232	MIDDLESEX	31270
310039	*	0.0232	MIDDLESEX	31270
310050	*	0.0199	MORRIS	31300
310054	*	0.0312	ESSEX	31200
310070	*	0.0232	MIDDLESEX	31270
310076	*	0.0312	ESSEX	31200
310083	*	0.0312	ESSEX	31200
310096	*	0.0312	ESSEX	31200
310108	*	0.0232	MIDDLESEX	31270
310119	*	0.0312	ESSEX	31200
312018		0.0232	MIDDLESEX	31270
312020		0.0199	MORRIS	31300
313025		0.0312	ESSEX	31200

ADDENDUM L.—PROPOSED CY 2011 OPPS OUT-MIGRATION ADJUSTMENT				
Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
313300		0.0232	MIDDLESEX	31270
314010		0.0312	ESSEX	31200
314011		0.0232	MIDDLESEX	31270
314016		0.0199	MORRIS	31300
314020		0.0312	ESSEX	31200
320003	*	0.0480	SAN MIGUEL	32230
320011		0.0337	RIO ARRIBA	32190
323025		0.0480	SAN MIGUEL	32230
330004	*	0.0908	ULSTER	33740
330008	*	0.0064	WYOMING	33900
330010		0.0060	MONTGOMERY	33380
330027	*	0.0196	NASSAU	33400
330033		0.0179	CHENANGO	33080
330047		0.0060	MONTGOMERY	33380
330073	*	0.0078	GENESEE	33290
330094	*	0.0540	COLUMBIA	33200
330103		0.0136	CATTARAUGUS	33040
330106	*	0.0196	NASSAU	33400
330126	*	0.0488	ORANGE	33540
330132		0.0136	CATTARAUGUS	33040
330135		0.0488	ORANGE	33540
330144		0.0056	STEUBEN	33690
330151		0.0056	STEUBEN	33690
330167	*	0.0196	NASSAU	33400
330175		0.0222	CORTLAND	33210
330181	*	0.0196	NASSAU	33400
330182	*	0.0196	NASSAU	33400
330198	*	0.0196	NASSAU	33400
330205		0.0488	ORANGE	33540
330222		0.0016	SARATOGA	33640
330224	*	0.0908	ULSTER	33740
330225	*	0.0196	NASSAU	33400
330235	*	0.0246	CAYUGA	33050
330259	*	0.0196	NASSAU	33400
330264		0.0488	ORANGE	33540
330276		0.0032	FULTON	33280

ADDENDUM L.—PROPOSED CY 2011 OPPS OUT-MIGRATION ADJUSTMENT				
Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
330277	*	0.0056	STEUBEN	33690
330331	*	0.0196	NASSAU	33400
330332	*	0.0196	NASSAU	33400
330372	*	0.0196	NASSAU	33400
330386	*	0.0820	SULLIVAN	33710
334017		0.0488	ORANGE	33540
334049		0.0016	SARATOGA	33640
334061		0.0488	ORANGE	33540
340020		0.0163	LEE	34520
340021	*	0.0143	CLEVELAND	34220
340024		0.0143	SAMPSON	34810
340027	*	0.0164	LENOIR	34530
340037	*	0.0143	CLEVELAND	34220
340038		0.0329	BEAUFORT	34060
340039	*	0.0091	IREDELL	34480
340068	*	0.0102	COLUMBUS	34230
340070	*	0.0289	ALAMANCE	34000
340071	*	0.0261	HARNETT	34420
340085	*	0.0270	DAVIDSON	34280
340096	*	0.0270	DAVIDSON	34280
340126	*	0.0130	WILSON	34970
340129	*	0.0091	IREDELL	34480
340133		0.0260	MARTIN	34580
340144	*	0.0091	IREDELL	34480
340145	*	0.0305	LINCOLN	34540
340151		0.0084	HALIFAX	34410
360002		0.0101	ASHLAND	36020
360010	*	0.0023	TUSCARAWAS	36800
360013	*	0.0143	SHELBY	36760
360025	*	0.0065	ERIE	36220
360036	*	0.0164	WAYNE	36860
360040		0.0456	KNOX	36430
360044		0.0134	DARKE	36190
360055	*	0.0011	TRUMBULL	36790
360065	*	0.0061	HURON	36400
360070		0.0005	STARK	36770

ADDENDUM L.—PROPOSED CY 2011 OPPS OUT-MIGRATION ADJUSTMENT				
Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
360071		0.0069	VAN WERT	36820
360084		0.0005	STARK	36770
360086	*	0.0086	CLARK	36110
360096		0.0023	COLUMBIANA	36140
360107		0.0170	SANDUSKY	36730
360125	*	0.0106	ASHTABULA	36030
360131		0.0005	STARK	36770
360151		0.0005	STARK	36770
360156		0.0170	SANDUSKY	36730
360161		0.0011	TRUMBULL	36790
360175	*	0.0200	CLINTON	36130
360185	*	0.0023	COLUMBIANA	36140
360245	*	0.0106	ASHTABULA	36030
360355		0.0086	CLARK	36110
362016		0.0005	STARK	36770
362032		0.0005	STARK	36770
363026		0.0011	TRUMBULL	36790
364031		0.0005	STARK	36770
364040		0.0086	CLARK	36110
364043		0.0069	VAN WERT	36820
370014	*	0.0170	BRYAN	37060
370015	*	0.0390	MAYES	37480
370023		0.0072	STEPHENS	37680
370065		0.0102	CRAIG	37170
370149	*	0.0242	POTTAWATOMIE	37620
370156		0.0097	GARVIN	37240
370169		0.0173	MCINTOSH	37450
370214		0.0097	GARVIN	37240
372019		0.0242	POTTAWATOMIE	37620
380022	*	0.0126	LINN	38210
390008		0.0014	LAWRENCE	39450
390016	*	0.0014	LAWRENCE	39450
390030	*	0.0147	SCHUYLKILL	39650
390031	*	0.0147	SCHUYLKILL	39650
390039		0.0037	SOMERSET	39680
390044	*	0.0250	BERKS	39110

ADDENDUM L.—PROPOSED CY 2011 OPPS OUT-MIGRATION ADJUSTMENT				
Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
390052		0.0020	CLEARFIELD	39230
390056		0.0020	HUNTINGDON	39380
390065	*	0.0471	ADAMS	39000
390066	*	0.0274	LEBANON	39460
390086	*	0.0020	CLEARFIELD	39230
390096	*	0.0250	BERKS	39110
390110	*	0.0002	CAMBRIA	39160
390112		0.0037	SOMERSET	39680
390117		0.0001	BEDFORD	39100
390130	*	0.0002	CAMBRIA	39160
390138	*	0.0208	FRANKLIN	39350
390150		0.0006	GREENE	39370
390151	*	0.0208	FRANKLIN	39350
390162	*	0.0217	NORTHAMPTON	39590
390173		0.0037	INDIANA	39390
390183	*	0.0147	SCHUYLKILL	39650
390201		0.0951	MONROE	39550
390313	*	0.0147	SCHUYLKILL	39650
390316	*	0.0250	BERKS	39110
392030		0.0471	ADAMS	39000
392031		0.0002	CAMBRIA	39160
392034		0.0217	NORTHAMPTON	39590
393026		0.0250	BERKS	39110
393050		0.0217	NORTHAMPTON	39590
394014		0.0250	BERKS	39110
394020		0.0274	LEBANON	39460
394052		0.0250	BERKS	39110
420002		0.0001	YORK	42450
420005		0.0012	DILLON	42160
420007	*	0.0030	SPARTANBURG	42410
420019		0.0169	CHESTER	42110
420020	*	0.0008	GEORGETOWN	42210
420027	*	0.0231	ANDERSON	42030
420030	*	0.0148	COLLETON	42140
420036	*	0.0075	LANCASTER	42280
420039	*	0.0110	UNION	42430

ADDENDUM L.—PROPOSED CY 2011 OPPS OUT-MIGRATION ADJUSTMENT				
Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
420043		0.0152	CHEROKEE	42100
420053		0.0103	NEWBERRY	42350
420054		0.0002	MARLBORO	42340
420055		0.0028	MARION	42330
420062		0.0125	CHESTERFIELD	42120
420068	*	0.0068	ORANGEBURG	42370
420069	*	0.0005	CLARENDON	42130
420070	*	0.0051	SUMTER	42420
420082		0.0002	AIKEN	42010
420083	*	0.0030	SPARTANBURG	42410
420098		0.0008	GEORGETOWN	42210
422004		0.0030	SPARTANBURG	42410
423028		0.0001	YORK	42450
423029		0.0231	ANDERSON	42030
424011		0.0231	ANDERSON	42030
430048		0.0355	LAWRENCE	43400
430094		0.0355	LAWRENCE	43400
440007		0.0171	COFFEE	44150
440008		0.0262	HENDERSON	44380
440012		0.0009	SULLIVAN	44810
440016		0.0084	CARROLL	44080
440017		0.0009	SULLIVAN	44810
440025	*	0.0009	GREENE	44290
440035	*	0.0287	MONTGOMERY	44620
440047		0.0197	GIBSON	44260
440050		0.0009	GREENE	44290
440051		0.0048	MC NAIRY	44540
440060		0.0197	GIBSON	44260
440063		0.0033	WASHINGTON	44890
440070		0.0063	DECATUR	44190
440105		0.0033	WASHINGTON	44890
440109		0.0041	HARDIN	44350
440115		0.0197	GIBSON	44260
440137		0.0578	BEDFORD	44010
440144	*	0.0171	COFFEE	44150
440148		0.0232	DE KALB	44200

ADDENDUM L.—PROPOSED CY 2011 OPPS OUT-MIGRATION ADJUSTMENT				
Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
440174	*	0.0232	HAYWOOD	44370
440176		0.0009	SULLIVAN	44810
440181		0.0296	HARDEMAN	44340
440182		0.0084	CARROLL	44080
440184		0.0033	WASHINGTON	44890
440185	*	0.0234	BRADLEY	44050
442016		0.0009	SULLIVAN	44810
443027		0.0009	SULLIVAN	44810
444006		0.0033	WASHINGTON	44890
444008		0.0296	HARDEMAN	44340
450032	*	0.0216	HARRISON	45620
450039	*	0.0049	TARRANT	45910
450052	*	0.0330	BOSQUE	45160
450064	*	0.0049	TARRANT	45910
450087	*	0.0049	TARRANT	45910
450090		0.0699	COOKE	45340
450099	*	0.0084	GRAY	45563
450135	*	0.0049	TARRANT	45910
450137	*	0.0049	TARRANT	45910
450144	*	0.0446	ANDREWS	45010
450163		0.0115	KLEBERG	45743
450192		0.0314	HILL	45651
450194		0.0052	CHEROKEE	45281
450210		0.0128	PANOLA	45842
450224	*	0.0055	WOOD	45974
450236		0.0418	HOPKINS	45654
450270		0.0314	HILL	45651
450283	*	0.0415	VAN ZANDT	45947
450347	*	0.0395	WALKER	45949
450348	*	0.0093	FALLS	45500
450370	*	0.0250	COLORADO	45312
450389	*	0.0405	HENDERSON	45640
450395		0.0470	POLK	45850
450419	*	0.0049	TARRANT	45910
450438	*	0.0250	COLORADO	45312
450451		0.0522	SOMERVELL	45893

ADDENDUM L.—PROPOSED CY 2011 OPPS OUT-MIGRATION ADJUSTMENT				
Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
450460		0.0055	TYLER	45942
450497		0.0511	MONTAGUE	45800
450539		0.0138	HALE	45582
450547	*	0.0055	WOOD	45974
450563	*	0.0049	TARRANT	45910
450565	*	0.0509	PALO PINTO	45841
450573		0.0131	JASPER	45690
450596	*	0.0724	HOOD	45653
450597		0.0003	DE WITT	45420
450615		0.0033	CASS	45260
450639	*	0.0049	TARRANT	45910
450641		0.0511	MONTAGUE	45800
450672	*	0.0049	TARRANT	45910
450675	*	0.0049	TARRANT	45910
450677	*	0.0049	TARRANT	45910
450698		0.0262	LAMB	45751
450747	*	0.0031	ANDERSON	45000
450755		0.0571	HOCKLEY	45652
450770	*	0.0218	MILAM	45795
450779	*	0.0049	TARRANT	45910
450813		0.0031	ANDERSON	45000
450872	*	0.0049	TARRANT	45910
450880	*	0.0049	TARRANT	45910
450886	*	0.0049	TARRANT	45910
450888		0.0049	TARRANT	45910
452018		0.0049	TARRANT	45910
452019		0.0049	TARRANT	45910
452028		0.0049	TARRANT	45910
452088		0.0049	TARRANT	45910
452099		0.0049	TARRANT	45910
452110		0.0049	TARRANT	45910
453040		0.0049	TARRANT	45910
453041		0.0049	TARRANT	45910
453042		0.0049	TARRANT	45910
453089		0.0031	ANDERSON	45000
453094		0.0049	TARRANT	45910

ADDENDUM L.—PROPOSED CY 2011 OPPS OUT-MIGRATION ADJUSTMENT				
Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
453300		0.0049	TARRANT	45910
453303		0.0049	TARRANT	45910
454009		0.0052	CHEROKEE	45281
454012		0.0049	TARRANT	45910
454051		0.0049	TARRANT	45910
454052		0.0049	TARRANT	45910
454061		0.0049	TARRANT	45910
454072		0.0049	TARRANT	45910
454086		0.0049	TARRANT	45910
454101		0.0138	HALE	45582
460001		0.0001	UTAH	46240
460013		0.0001	UTAH	46240
460017		0.0229	BOX ELDER	46010
460023		0.0001	UTAH	46240
460039	*	0.0229	BOX ELDER	46010
460043		0.0001	UTAH	46240
460052		0.0001	UTAH	46240
462005		0.0001	UTAH	46240
490002		0.0003	RUSSELL	49830
490019	*	0.1041	CULPEPER	49230
490038		0.0003	SMYTH	49860
490084		0.0237	ESSEX	49280
490105		0.0003	SMYTH	49860
490110		0.0176	MONTGOMERY	49600
494029		0.0003	SMYTH	49860
500003	*	0.0270	SKAGIT	50280
500007	*	0.0270	SKAGIT	50280
500019		0.0166	LEWIS	50200
500024		0.0064	THURSTON	50330
500039	*	0.0182	KITSAP	50170
500041	*	0.0055	COWLITZ	50070
500139		0.0064	THURSTON	50330
500143		0.0064	THURSTON	50330
510012		0.0110	MASON	51260
510018	*	0.0107	JACKSON	51170
510047	*	0.0234	MARION	51240

ADDENDUM L.—PROPOSED CY 2011 OPPS OUT-MIGRATION ADJUSTMENT				
Provider Number	Reclassified for FY 2011	Out-Migration Adjustment	Qualifying County Name	County Code
520009		0.0027	OUTAGAMIE	52430
520028	*	0.0473	GREEN	52220
520035		0.0111	SHEBOYGAN	52580
520044		0.0111	SHEBOYGAN	52580
520045		0.0022	WINNEBAGO	52690
520048		0.0022	WINNEBAGO	52690
520057		0.0296	SAUK	52550
520071	*	0.0332	JEFFERSON	52270
520076	*	0.0275	DODGE	52130
520088		0.0084	FOND DU LAC	52190
520095	*	0.0296	SAUK	52550
520102	*	0.0714	WALWORTH	52630
520116	*	0.0332	JEFFERSON	52270
520160		0.0027	OUTAGAMIE	52430
520198		0.0022	WINNEBAGO	52690
523302		0.0022	WINNEBAGO	52690
524002		0.0022	WINNEBAGO	52690
524025		0.0084	FOND DU LAC	52190
673035		0.0049	TARRANT	45910

* Asterisk indicates hospitals that have already been reclassified under section 1886(d)(10) of the Act or redesignated under section 1886(d)(8)(B) of the Act for CY 2011.

ADDENDUM M.—PROPOSED HCPCS CODES FOR ASSIGNMENT TO OPPS COMPOSITE APCs FOR CY 2011

ADDENDUM M.—PROPOSED HCPCS CODES FOR ASSIGNMENT TO OPPS COMPOSITE APCs FOR CY 2011					
HCPCS Code	Short Descriptor	CI	SI	Single Code APC Assignment	Composite APC Assignment
90801	Psy dx interview		Q3	0323	0034
90802	Intac psy dx interview		Q3	0323	0034
90804	Psytx, office, 20-30 min		Q3	0322	0034
90805	Psytx, off, 20-30 min w/e&m		Q3	0322	0034
90806	Psytx, off, 45-50 min		Q3	0323	0034
90807	Psytx, off, 45-50 min w/e&m		Q3	0323	0034
90808	Psytx, office, 75-80 min		Q3	0323	0034
90809	Psytx, off, 75-80, w/e&m		Q3	0323	0034
90810	Intac psytx, off, 20-30 min		Q3	0322	0034
90811	Intac psytx, 20-30, w/e&m		Q3	0322	0034
90812	Intac psytx, off, 45-50 min		Q3	0323	0034
90813	Intac psytx, 45-50 min w/e&m		Q3	0323	0034
90814	Intac psytx, off, 75-80 min		Q3	0323	0034
90815	Intac psytx, 75-80 w/e&m		Q3	0323	0034
90845	Psychoanalysis		Q3	0323	0034
90846	Family psytx w/o patient		Q3	0324	0034
90847	Family psytx w/patient		Q3	0324	0034
90849	Multiple family group psytx		Q3	0325	0034
90853	Group psychotherapy		Q3	0325	0034
90857	Intac group psytx		Q3	0325	0034
90862	Medication management	CH	Q3	0605	0034
90865	Narcosynthesis		Q3	0323	0034
90880	Hypnotherapy		Q3	0323	0034
90899	Psychiatric service/therapy		Q3	0322	0034
96101	Psycho testing by psych/phys		Q3	0382	0034
96102	Psycho testing by technician		Q3	0382	0034
96103	Psycho testing admin by comp		Q3	0373	0034
96110	Developmental test, lim		Q3	0373	0034
96111	Developmental test, extend		Q3	0373	0034
96116	Neurobehavioral status exam		Q3	0382	0034
96118	Neuropsych tst by psych/phys		Q3	0382	0034
96119	Neuropsych testing by tec		Q3	0382	0034
96120	Neuropsych tst admin w/comp		Q3	0382	0034
96150	Assess hlth/behave, init		Q3	0432	0034
96151	Assess hlth/behave, subseq		Q3	0432	0034
96152	Intervene hlth/behave, indiv		Q3	0432	0034
96153	Intervene hlth/behave, group		Q3	0432	0034

ADDENDUM M.—PROPOSED HCPCS CODES FOR ASSIGNMENT TO OPPS COMPOSITE APCs FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	Single Code APC Assignment	Composite APC Assignment
96154	Interv hlth/behav, fam w/pt		Q3	0432	0034
M0064	Visit for drug monitoring		Q3	0607	0034
93619	Electrophysiology evaluation		Q3	0085	8000
93620	Electrophysiology evaluation		Q3	0085	8000
93650	Ablate heart dysrhythm focus		Q3	0085	8000
93651	Ablate heart dysrhythm focus		Q3	0086	8000
93652	Ablate heart dysrhythm focus		Q3	0086	8000
55875	Transperi needle place, pros		Q3	0163	8001
77778	Apply interstit radiat compl		Q3	0651	8001
99205	Office/outpatient visit, new		Q3	0608	8002
99215	Office/outpatient visit, est		Q3	0607	8002
G0379	Direct refer hospital observ		Q3	0604	8002
99284	Emergency dept visit		Q3	0615	8003
99285	Emergency dept visit		Q3	0616	8003
99291	Critical care, first hour		Q3	0617	8003
G0384	Lev 5 hosp type B ED visit		Q3	0630	8003
76604	Us exam, chest		Q3	0265	8004
76700	Us exam, abdom, complete		Q3	0266	8004
76705	Echo exam of abdomen		Q3	0266	8004
76770	Us exam abdo back wall, comp		Q3	0266	8004
76775	Us exam abdo back wall, lim		Q3	0266	8004
76776	Us exam k transpl w/doppler		Q3	0266	8004
76831	Echo exam, uterus		Q3	0267	8004
76856	Us exam, pelvic, complete		Q3	0266	8004
76857	Us exam, pelvic, limited		Q3	0265	8004
76870	Us exam, scrotum		Q3	0266	8004
70450	Ct head/brain w/o dye		Q3	0332	8005 or 8006
70480	Ct orbit/ear/fossa w/o dye		Q3	0332	8005 or 8006
70486	Ct maxillofacial w/o dye		Q3	0332	8005 or 8006
70490	Ct soft tissue neck w/o dye		Q3	0332	8005 or 8006
71250	Ct thorax w/o dye		Q3	0332	8005 or 8006
72125	Ct neck spine w/o dye		Q3	0332	8005 or 8006
72128	Ct chest spine w/o dye		Q3	0332	8005 or 8006
72131	Ct lumbar spine w/o dye		Q3	0332	8005 or 8006

ADDENDUM M.—PROPOSED HCPCS CODES FOR ASSIGNMENT TO OPPS COMPOSITE APCs FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	Single Code APC Assignment	Composite APC Assignment
72192	Ct pelvis w/o dye		Q3	0332	8005 or 8006
73200	Ct upper extremity w/o dye		Q3	0332	8005 or 8006
73700	Ct lower extremity w/o dye		Q3	0332	8005 or 8006
74150	Ct abdomen w/o dye		Q3	0332	8005 or 8006
74261	Ct colonography, w/o dye		Q3	0332	8005 or 8006
70460	Ct head/brain w/dye		Q3	0283	8006
70470	Ct head/brain w/o & w/dye		Q3	0333	8006
70481	Ct orbit/ear/fossa w/dye		Q3	0283	8006
70482	Ct orbit/ear/fossa w/o&w/dye		Q3	0333	8006
70487	Ct maxillofacial w/dye		Q3	0283	8006
70488	Ct maxillofacial w/o & w/dye		Q3	0333	8006
70491	Ct soft tissue neck w/dye		Q3	0283	8006
70492	Ct sft tsue nck w/o & w/dye		Q3	0333	8006
70496	Ct angiography, head		Q3	0662	8006
70498	Ct angiography, neck		Q3	0662	8006
71260	Ct thorax w/dye		Q3	0283	8006
71270	Ct thorax w/o & w/dye		Q3	0333	8006
71275	Ct angiography, chest		Q3	0662	8006
72126	Ct neck spine w/dye		Q3	0283	8006
72127	Ct neck spine w/o & w/dye		Q3	0333	8006
72129	Ct chest spine w/dye		Q3	0283	8006
72130	Ct chest spine w/o & w/dye		Q3	0333	8006
72132	Ct lumbar spine w/dye		Q3	0283	8006
72133	Ct lumbar spine w/o & w/dye		Q3	0333	8006
72191	Ct angiograph pelv w/o&w/dye		Q3	0662	8006
72193	Ct pelvis w/dye		Q3	0283	8006
72194	Ct pelvis w/o & w/dye		Q3	0333	8006
73201	Ct upper extremity w/dye		Q3	0283	8006
73202	Ct uppr extremity w/o&w/dye		Q3	0333	8006
73206	Ct angio upr extrm w/o&w/dye		Q3	0662	8006
73701	Ct lower extremity w/dye		Q3	0283	8006
73702	Ct lwr extremity w/o&w/dye		Q3	0333	8006
73706	Ct angio lwr extr w/o&w/dye		Q3	0662	8006
74160	Ct abdomen w/dye		Q3	0283	8006
74170	Ct abdomen w/o & w/dye		Q3	0333	8006
74175	Ct angio abdom w/o & w/dye		Q3	0662	8006

ADDENDUM M.—PROPOSED HCPCS CODES FOR ASSIGNMENT TO OPPS COMPOSITE APCs FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	Single Code APC Assignment	Composite APC Assignment
74262	Ct colonography, w/dye		Q3	0283	8006
75635	Ct angio abdominal arteries		Q3	0662	8006
70336	Magnetic image, jaw joint		Q3	0336	8007 or 8008
70540	Mri orbit/face/neck w/o dye		Q3	0336	8007 or 8008
70544	Mr angiography head w/o dye		Q3	0336	8007 or 8008
70547	Mr angiography neck w/o dye		Q3	0336	8007 or 8008
70551	Mri brain w/o dye		Q3	0336	8007 or 8008
70554	Fmri brain by tech		Q3	0336	8007 or 8008
71550	Mri chest w/o dye		Q3	0336	8007 or 8008
72141	Mri neck spine w/o dye		Q3	0336	8007 or 8008
72146	Mri chest spine w/o dye		Q3	0336	8007 or 8008
72148	Mri lumbar spine w/o dye		Q3	0336	8007 or 8008
72195	Mri pelvis w/o dye		Q3	0336	8007 or 8008
73218	Mri upper extremity w/o dye		Q3	0336	8007 or 8008
73221	Mri joint upr extrem w/o dye		Q3	0336	8007 or 8008
73718	Mri lower extremity w/o dye		Q3	0336	8007 or 8008
73721	Mri jnt of lwr extre w/o dye		Q3	0336	8007 or 8008
74181	Mri abdomen w/o dye		Q3	0336	8007 or 8008
75557	Cardiac mri for morph		Q3	0336	8007 or 8008
75559	Cardiac mri w/stress img		Q3	0336	8007 or 8008
C8901	MRA w/o cont, abd		Q3	0336	8007 or 8008
C8904	MRI w/o cont, breast, uni		Q3	0336	8007 or 8008
C8907	MRI w/o cont, breast, bi		Q3	0336	8007 or 8008
C8910	MRA w/o cont, chest		Q3	0336	8007 or

ADDENDUM M.—PROPOSED HCPCS CODES FOR ASSIGNMENT TO OPPS COMPOSITE APCs FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	Single Code APC Assignment	Composite APC Assignment
					8008
C8913	MRA w/o cont, lwr ext		Q3	0336	8007 or 8008
C8919	MRA w/o cont, pelvis		Q3	0336	8007 or 8008
70542	Mri orbit/face/neck w/dye		Q3	0284	8008
70543	Mri orbt/fac/nck w/o & w/dye		Q3	0337	8008
70545	Mr angiography head w/dye		Q3	0284	8008
70546	Mr angiograph head w/o&w/dye		Q3	0337	8008
70548	Mr angiography neck w/dye		Q3	0284	8008
70549	Mr angiograph neck w/o&w/dye		Q3	0337	8008
70552	Mri brain w/dye		Q3	0284	8008
70553	Mri brain w/o & w/dye		Q3	0337	8008
71551	Mri chest w/dye		Q3	0284	8008
71552	Mri chest w/o & w/dye		Q3	0337	8008
72142	Mri neck spine w/dye		Q3	0284	8008
72147	Mri chest spine w/dye		Q3	0284	8008
72149	Mri lumbar spine w/dye		Q3	0284	8008
72156	Mri neck spine w/o & w/dye		Q3	0337	8008
72157	Mri chest spine w/o & w/dye		Q3	0337	8008
72158	Mri lumbar spine w/o & w/dye		Q3	0337	8008
72196	Mri pelvis w/dye		Q3	0284	8008
72197	Mri pelvis w/o & w/dye		Q3	0337	8008
73219	Mri upper extremity w/dye		Q3	0284	8008
73220	Mri uppr extremity w/o&w/dye		Q3	0337	8008
73222	Mri joint upr extrem w/dye		Q3	0284	8008
73223	Mri joint upr extr w/o&w/dye		Q3	0337	8008
73719	Mri lower extremity w/dye		Q3	0284	8008
73720	Mri lwr extremity w/o&w/dye		Q3	0337	8008
73722	Mri joint of lwr extr w/dye		Q3	0284	8008
73723	Mri joint lwr extr w/o&w/dye		Q3	0337	8008
74182	Mri abdomen w/dye		Q3	0284	8008
74183	Mri abdomen w/o & w/dye		Q3	0337	8008
75561	Cardiac mri for morph w/dye		Q3	0337	8008
75563	Card mri w/stress img & dye		Q3	0337	8008
C8900	MRA w/cont, abd		Q3	0284	8008
C8902	MRA w/o fol w/cont, abd		Q3	0337	8008
C8903	MRI w/cont, breast, uni		Q3	0284	8008
C8905	MRI w/o fol w/cont, brst, un		Q3	0337	8008
C8906	MRI w/cont, breast, bi		Q3	0284	8008

ADDENDUM M.—PROPOSED HCPCS CODES FOR ASSIGNMENT TO OPPS COMPOSITE APCs FOR CY 2011

HCPCS Code	Short Descriptor	CI	SI	Single Code APC Assignment	Composite APC Assignment
C8908	MRI w/o fol w/cont, breast,		Q3	0337	8008
C8909	MRA w/cont, chest		Q3	0284	8008
C8911	MRA w/o fol w/cont, chest		Q3	0337	8008
C8912	MRA w/cont, lwr ext		Q3	0284	8008
C8914	MRA w/o fol w/cont, lwr ext		Q3	0337	8008
C8918	MRA w/cont, pelvis		Q3	0284	8008
C8920	MRA w/o fol w/cont, pelvis		Q3	0337	8008

[FR Doc. 2010–16448 Filed 7–2–10; 2:30 pm]
BILLING CODE 4120–01–P

Federal Register

Tuesday,
August 3, 2010

Part III

The President

Proclamation 8544—45th Anniversary of Medicare and Medicaid

Federal Register
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Presidential Documents

Title 3—

The President

Proclamation 8544 of July 30, 2010

45th Anniversary of Medicare and Medicaid

By the President of the United States of America

A Proclamation

When President Lyndon B. Johnson signed Medicare and Medicaid into law on July 30, 1965, millions of Americans and about half our Nation's seniors lacked health care coverage, unable to afford basic health care services or weather a medical emergency. The signing of Medicare forged a promise with older Americans—that those who have contributed a lifetime to our national life and economy can enjoy their golden years with peace of mind and the security of reliable medical insurance. Medicaid created an essential partnership between the Federal Government and the States to provide a basic health care safety net for some of the most vulnerable Americans: low-income children, parents, seniors, and people with disabilities. Forty-five years later, we must ensure this inviolable trust between America and its citizens remains stronger than ever.

Medicare and Medicaid support longer, healthier lives and economic security for some of the neediest among us. Since their expansion in 1972, Medicare and Medicaid have covered millions of people with disabilities, protecting individuals who otherwise might not have access to affordable health coverage. Today, Medicare provides over 47 million Americans with dependable medical insurance, and is the largest health care provider in our Nation. State Medicaid programs provide health and long-term care coverage to more than 56 million low-income Americans. With too many communities stricken by the economic crisis, Medicaid provides a critical support for those struggling to raise healthy families or cope with illness or injury. No American should be one illness away from financial ruin, and we must continue to keep Medicare and Medicaid strong for the millions of beneficiaries who rely on these vital safety nets.

Medicare is not simply an entitlement program that starts at age 65—it is earned over a lifetime. The health care reforms in the landmark Affordable Care Act (ACA) renew and strengthen our pledge to America's seniors and families, ensuring Medicare and Medicaid will be there when they need it. Guaranteed Medicare benefits will not change, and participants will see greater savings, improved quality, and increased accountability in their health care coverage.

My Administration is taking steps to extend the life of the Medicare trust fund and to slow the growth of Medicare costs. The ACA helps accomplish this by addressing overpayments to insurance companies that operate Medicare Advantage plans; aggressively fighting waste, fraud, and abuse; and better coordinating the care of individuals with chronic conditions. The ACA also helps seniors and people with disabilities in Medicare who fall in the Part D coverage gap for prescription drug costs, or the "donut hole," and Medicare beneficiaries who reach the donut hole this year are receiving a $250 rebate. Additionally, beneficiaries will see 50 percent discounts on brand name drugs in the coverage gap starting next year, and an end of the coverage gap altogether by 2020. To encourage health maintenance, the ACA enables Medicare to provide a free annual physical examination and other effective preventative care services, like certain colorectal cancer screenings and mammograms, with no co-pays or deductibles. Through focus

on preventative care, increased efficiencies, and better management, the ACA is modernizing the health care system to make it work better for older Americans.

As President, I will protect the promise of Medicare and Medicaid, and make sure they continue to be strong and solvent for our children and grandchildren. As we celebrate the 45th anniversary of these critical programs, we reflect on a moment when our Nation made an enduring commitment to care for those who have given the most to our society, and those living in poverty. Let us continue protecting Medicare and Medicaid so older Americans can age with dignity, and so all Americans can live longer, healthier, and happier lives.

NOW, THEREFORE, I, BARACK OBAMA, President of the United States of America, by virtue of the authority vested in me by the Constitution and the laws of the United States, do hereby proclaim July 30, 2010, as the 45th Anniversary of Medicare and Medicaid. I call upon all Americans to observe this day with appropriate ceremonies and activities that recognize the vital safety net that Medicare and Medicaid provide for millions of Americans.

IN WITNESS WHEREOF, I have hereunto set my hand this thirtieth day of July, in the year of our Lord two thousand ten, and of the Independence of the United States of America the two hundred and thirty-fifth.

[FR Doc. 2010–19202
Filed 8–2–10; 11:15 am]
Billing code 3195–W0–P

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Federal Register

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The text of laws is not published in the **Federal Register** but may be ordered in ''slip law'' (individual pamphlet) form from the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402 (phone, 202–512–1808). The text will also be made available on the Internet from GPO Access at *http://www.gpoaccess.gov/plaws/index.html*. Some laws may not yet be available.

H.R. 725/P.L. 111–211
To protect Indian arts and crafts through the improvement of applicable criminal proceedings, and for other purposes. (July 29, 2010; 124 Stat. 2258)

H.R. 4899/P.L. 111–212
Supplemental Appropriations Act, 2010 (July 29, 2010; 124 Stat. 2302)

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