

DEPARTMENT OF HEALTH AND HUMAN SERVICES**Centers for Medicare & Medicaid Services****42 CFR Parts 419 and 485**

[CMS-1501-FC]

RIN 0938-AN46

Medicare Program; Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2006 Payment Rates**AGENCY:** Centers for Medicare & Medicaid Services (CMS), HHS.**ACTION:** Final rule with comment period.

SUMMARY: This final rule with comment period revises the Medicare hospital outpatient prospective payment system to implement applicable statutory requirements and changes arising from our continuing experience with this system and to implement certain related provisions of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003. In addition, the final rule with comment period describes changes to the amounts and factors used to determine the payment rates for Medicare hospital outpatient services paid under the prospective payment system. This final rule with comment period also changes the requirement for physician oversight of mid-level practitioners in critical access hospitals (CAHs).

In this final rule with comment period, we also are responding to public comments received on the November 15, 2004, final rule with comment period pertaining to the ambulatory payment classification (APC) group assignment of Healthcare Common Procedure Coding System (HCPCS) codes identified in Addendum B of that rule with the new interim (NI) comment indicator. These changes are applicable to services furnished on or after January 1, 2006.

DATES: *Effective Date:* This final rule with comment period is effective on January 1, 2006.

Comment Date: We will consider comments on the payment classification assigned to HCPCS codes identified in Addendum B with the NI comment code and other areas specified through the preamble if we receive them at the appropriate address, as provided below, no later than 5 p.m. on January 9, 2006.

ADDRESSES: In commenting, please refer to file code CMS-1501-FC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

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

1. *Electronically.* You may submit electronic comments on specific issues in this final rule with comment period to <http://www.cms.hhs.gov/regulations/ecomments>. (Attachments should be in Microsoft Word, WordPerfect, or Excel; however, we prefer Microsoft Word).

2. *By regular mail.* You may mail written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-1501-FC, P.O. Box 8016, Baltimore, MD 21244-8018.

3. *By express or overnight mail.* You may send written comments (one original and two copies) to the following address ONLY:

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-1501-FC, Mail Stop C4-26-05, 7500 Security Boulevard, Baltimore, MD 21244-1850.

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

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

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

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. CMS posts all electronic comments received before the close of the comment period on its public Web site as soon as possible after they have been received. Hard copy comments received timely will be available for public inspection as they are received,

generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244-1850, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1-800-743-3951.

Requirements for Issuance of Regulations: Section 902 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Pub. L. 108-173, amended section 1871(a) of the Act and requires the Secretary, in consultation with the Director of the Office of Management and Budget, to establish and publish timelines for the publication of Medicare final regulations based on the previous publication of a Medicare proposed or interim final regulation. Section 902 of Pub. L. 108-173 also states that the timelines for these regulations may vary but shall not exceed 3 years after publication of the preceding proposed or interim final regulation except under exceptional circumstances.

This final rule with comment period finalizes provisions set forth in the CY 2006 OPPA proposed rule (70 FR 42674, July 25, 2005). In addition, this final rule has been published within the 3-year time limit imposed by section 902 of Pub. L. 108-173. This final rule also finalizes the November 15, 2004 final rule with comment period (69 FR 65681) to address public comments pertaining to the APC group assignment of HCPCS codes identified in Addendum B of that rule with the NI comment indicator. Again, we finalized the rule within the 3-year timeframe imposed under section 902 of Pub. L. 108-173. Therefore, we believe that the final rule is in accordance with the Congress' intent to ensure timely publication of final regulations.

FOR FURTHER INFORMATION, CONTACT:

Rebecca Kane, (410) 786-0378, Outpatient prospective payment issues and Suzanne Asplen, (410) 786-4558, Partial hospitalization and community mental health centers issues.

SUPPLEMENTARY INFORMATION:**Electronic Access**

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

ACEP American College of Emergency Physicians
 AHA American Hospital Association
 AHIMA American Health Information Management Association
 AMA American Medical Association
 APC Ambulatory payment classification
 AMP Average manufacturer price
 ASP Average sales price
 ASC Ambulatory surgical center
 AWP Average wholesale price
 BBA Balanced Budget Act of 1997, Pub. L. 105–33
 BIPA Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Pub. L. 106–554
 BBRA Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, Pub. L. 106–113
 CAH Critical access hospital
 CBSA Core-Based Statistical Areas
 CCR (Cost center specific) Cost-to-charge ratio
 CMHC Community mental health center
 CMS Centers for Medicare & Medicaid Services (formerly known as the Health Care Financing Administration)
 CNS Clinical nurse specialist
 CORF Comprehensive outpatient rehabilitation facility
 CPT [Physicians'] Current Procedural Terminology, Fourth Edition, 2005, copyrighted by the American Medical Association
 CRNA Certified registered nurse anesthetist
 CY Calendar year
 DMEPOS Durable medical equipment, prosthetics, orthotics, and supplies
 DMERC Durable medical equipment regional carrier
 DRGY Diagnosis-related group
 DSH Disproportionate share hospital
 EACH Essential Access Community Hospital
 E/M Evaluation and management
 EPO Erythropoietin
 ESRD End-stage renal disease
 FACA Federal Advisory Committee Act, Pub. L. 92–463
 FDA Food and Drug Administration
 FI Fiscal intermediary
 FSS Federal Supply Schedule
 FY Federal fiscal year
 GAO Government Accountability Office
 HCPCS Healthcare Common Procedure Coding System
 HCRIS Hospital Cost Report Information System
 HHA Home health agency
 HIPAA Health Insurance Portability and Accountability Act of 1996, Pub. L. 104–191
 ICD–9–CM International Classification of Diseases, Ninth Edition, Clinical Modification
 IME Indirect medical education
 IPPS (Hospital) Inpatient prospective payment system
 IVIG Intravenous immune globulin
 LTC Long-term care
 MedPAC Medicare Payment Advisory Commission

MDH Medicare-dependent hospital
 MMA Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108–173
 MSA Metropolitan Statistical Area
 NCCI National Correct Coding Initiative
 NCD National Coverage Determination
 NP Nurse practitioner
 OCE Outpatient Code Editor
 OMB Office of Management and Budget
 OPD (Hospital) Outpatient department
 OPPTS (Hospital) Outpatient prospective payment system
 PA Physician assistant
 PHP Partial hospitalization program
 PM Program memorandum
 PPI Producer Price Index
 PPS Prospective payment system
 PPV Pneumococcal pneumonia (virus)
 PRA Paperwork Reduction Act
 QIO Quality Improvement Organization
 RFA Regulatory Flexibility Act
 RRC Rural referral center
 SBA Small Business Administration
 SCH Sole community hospital
 SDP Single drug pricer
 SI Status indicator
 TEFRA Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97–248
 TOPS Transitional outpatient payments
 USPDI United States Pharmacopoeia Drug Information

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I. Background

A. Legislative and Regulatory Authority for the Hospital Outpatient Prospective Payment System

When the Medicare statute was originally enacted, Medicare payment for hospital outpatient services was

based on hospital-specific costs. In an effort to ensure that Medicare and its beneficiaries pay appropriately for services and to encourage more efficient delivery of care, the Congress mandated replacement of the reasonable cost-based payment methodology with a prospective payment system (PPS). The Balanced Budget Act of 1997 (BBA) (Pub. L. 105–33), enacted on August 5, 1997, added section 1833(t) to the Social Security Act (the Act) authorizing implementation of a PPS for hospital outpatient services. The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106–113), enacted on November 29, 1999, made major changes that affected the hospital outpatient PPS (OPSS). The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (Pub. L. 106–554), enacted on December 21, 2000, made further changes in the OPSS. Section 1833(t) of the Act was also amended by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Pub. L. 108–173, enacted on December 8, 2003. (Discussion of provisions related specifically to the CY 2006 OPSS is included in sections II.C., II.F., II.G., and V.B.3.a.(2) of this final rule with comment period.) The OPSS was first implemented for services furnished on or after August 1, 2000. Implementing regulations for the OPSS are located at 42 CFR Part 419.

Under the OPSS, we pay for hospital outpatient services on a rate-per-service basis that varies according to the ambulatory payment classification (APC) group to which the service is assigned. We use Healthcare Common Procedure Coding System (HCPCS) codes (which include certain Current Procedural Terminology (CPT) codes) and descriptors to identify and group the services within each APC group. The OPSS includes payment for most hospital outpatient services, except those identified in section I.B. of this final rule with comment period. Section 1833(t)(1)(B)(ii) of the Act provides for Medicare payment under the OPSS for certain services designated by the Secretary that are furnished to inpatients who have exhausted their Part A benefits or who are otherwise not in a covered Part A stay. Section 611 of Pub. L. 108–173 provided for Medicare coverage of an initial preventive physical examination, subject to the applicable deductible and coinsurance, as an outpatient department service, payable under the OPSS. In addition, the OPSS includes payment for partial hospitalization services furnished by

community mental health centers (CMHCs).

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

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

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

B. Excluded OPSS Services and Hospitals

Section 1833(t)(1)(B)(i) of the Act authorizes the Secretary to designate the hospital outpatient services that are paid under the OPSS. While most hospital outpatient services are payable under the OPSS, section 1833(t)(1)(B)(iv) of the Act excluded payment for ambulance, physical and occupational therapy, and speech-

language pathology services, for which payment is made under a fee schedule. Section 614 of Pub. L. 108–173 amended section 1833(t)(1)(B)(iv) of the Act to exclude OPPS payment for screening and diagnostic mammography services. The Secretary exercised the broad authority granted under the statute to exclude from the OPPS those services that are paid under fee schedules or other payment systems. Such excluded services include, for example, the professional services of physicians and nonphysician practitioners paid under the Medicare Physician Fee Schedule (MPFS); laboratory services paid under the clinical diagnostic laboratory fee schedule; services for beneficiaries with end-stage renal disease (ESRD) that are paid under the ESRD composite rate; services and procedures that require an inpatient stay that are paid under the hospital inpatient prospective payment system (IPPS); and certain services furnished to inpatients of hospitals that do not submit claims for outpatient services under Medicare Part B. We set forth the services that are excluded from payment under the OPPS in § 419.22 of the regulations.

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

C. Prior Rulemaking

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

changes to the OPPS, we refer readers to these **Federal Register** final rules.¹

On November 15, 2004, we published in the **Federal Register** a final rule with comment period (69 FR 65681) that revised the OPPS to update the payment weights and conversion factor for services payable under the calendar year (CY) 2005 OPPS on the basis of claims data from January 1, 2003 through December 31, 2003, and to implement certain provisions of Pub. L. 108–173. In addition, we responded to public comments received on the January 6, 2004 interim final rule with comment period relating to Pub. L. 108–173 provisions that were effective January 1, 2004, and finalized those policies. Further, we responded to public comments received on the November 7, 2003 final rule with comment period pertaining to the APC assignment of HCPCS codes identified in Addendum B of that rule with the NI comment indicator; and public comments received on the August 16, 2004 OPPS proposed rule (69 FR 50448).

Subsequent to publishing the November 15, 2004 final rule with comment period, we published a correction of final rule with comment period on December 30, 2004 (69 FR 78315). This document corrected technical errors that appeared in the November 15, 2004 final rule with comment period. It also provided additional information about the CY 2005 wage indices for the OPPS that was not published in the November 15, 2004 final rule with comment period.

D. APC Advisory Panel

1. Authority of the APC Panel

Section 1833(t)(9)(A) of the Act, as amended by section 201(h) of the BBRA of 1999, requires that we consult with an outside panel of experts to review the clinical integrity of the payment groups and weights under the OPPS. The Advisory Panel on Ambulatory Payment Classification (APC) Groups (the APC Panel), discussed under section I.D.2. of this preamble, fulfills this requirement. The Act further specifies that the APC Panel will act in an advisory capacity.

¹ Interim final rule with comment period, August 3, 2000 (65 FR 47670); interim final rule with comment period, November 13, 2000 (65 FR 67798); final rule and interim final rule with comment period, November 2, 2001 (66 FR 55850 and 55857); final rule, November 30, 2001 (66 FR 59856); final rule, December 31, 2001 (66 FR 67494); final rule, March 1, 2002 (67 FR 9556); final rule, November 1, 2002 (67 FR 66718); final rule with comment period, November 7, 2003 (68 FR 63398); correction of the November 7, 2003 final rule with comment period, December 31, 2003 (68 FR 75442); interim final rule with comment period, January 6, 2004 (69 FR 820); and final rule with comment period, November 15, 2004 (69 FR 65681).

This expert panel, which may be composed of up to 15 representatives of hospitals and other Medicare providers subject to the OPPS (currently employed full-time and in their respective areas of expertise), reviews and advises CMS about the clinical integrity of the APC groups and their weights. For purposes of this Panel, consultants or independent contractors are not considered to be full-time employees. The APC Panel is not restricted to using our data and may use data collected or developed by organizations outside the Department in conducting its review.

2. Establishment of the APC Panel

On November 21, 2000, the Secretary originally signed the charter establishing the APC Panel. The APC Panel is technical in nature and is governed by the provisions of the Federal Advisory Committee Act (FACA), as amended (Pub. L. 92–463). Since its initial chartering, the Secretary has twice renewed the APC Panel's charter: on November 1, 2002, and on November 1, 2004. The renewed charter indicates that the APC Panel continues to be technical in nature; is governed by the provisions of FACA with a Designated Federal Official (DFO) to oversee the day-to-day administration of the FACA requirements and to provide to the Committee Management Officer all committee reports for forwarding to the Library of Congress; may convene up to three meetings per year; and is chaired by a Federal official who also serves as a CMS medical officer.

Originally, in establishing the APC Panel, we solicited members in a notice published in the **Federal Register** on December 5, 2000 (65 FR 75943). We received applications from more than 115 individuals who nominated either colleagues or themselves. After carefully reviewing the applications, we chose 15 highly qualified individuals to serve on the APC Panel. Because four APC Panel members' terms of office expired on March 31, 2004, we published a **Federal Register** notice on January 23, 2004 (69 FR 3370) that solicited nominations for APC Panel membership. From the 24 nominations that we received, we chose four new members. Six members' terms expired on March 31, 2005; therefore, a **Federal Register** notice was published on February 25, 2005, requesting nominations to the APC Panel. We received only 13 nominations before the nomination period closed on March 15, 2005. Consequently, we extended the deadline for nominations to May 9, 2005, and announced the extension in the **Federal Register** on April 8, 2005 (70 FR 18028). From a total of 26 nominees from the two notices, we

chose 6 new members who were announced in the **Federal Register** on August 26, 2005 (70 FR 50358). The entire APC Panel membership and information pertaining to it, including **Federal Register** notices, meeting dates, agenda topics, and meeting reports are identified on the CMS Web site: <http://www.cms.hhs.gov/faca/apc/apcmem.asp>.

3. APC Panel Meetings and Organizational Structure

The APC Panel first met on February 27, February 28, and March 1, 2001. Since that initial meeting, the APC Panel has held seven subsequent meetings. The most recent meeting took place on August 17 and 18, 2005, which was announced in the meeting notice published on July 8, 2005 (70 FR 39514). Prior to each of these biennial meetings, we published a notice in the **Federal Register** to announce each meeting and, when necessary, to solicit and announce nominations for APC Panel membership. For a more detailed discussion about these announcements, refer to the following **Federal Register** notices: December 5, 2000 (65 FR 75943), December 14, 2001 (66 FR 64838), December 27, 2002 (67 FR 79107), July 25, 2003 (68 FR 44089), December 24, 2003 (68 FR 74621), August 5, 2004 (69 FR 47446), December 30, 2004 (69 FR 78464), and July 8, 2005 (70 FR 39514).

During these meetings, the APC Panel established its operational structure that, in part, includes the use of three subcommittees to facilitate its required APC review process. Currently, the three subcommittees are the Data Subcommittee, the Observation Subcommittee, and the Packaging Subcommittee. The Data Subcommittee is responsible for studying the data issues confronting the APC Panel and for recommending viable options for resolving them. This subcommittee was initially established on April 23, 2001, as the Research Subcommittee and reestablished as the Data Subcommittee on April 13, 2004, February 11, 2005, and August 15, 2005. The Observation Subcommittee, which was established on June 24, 2003, and reestablished with new members on March 8, 2004, February 11, 2005, and August 15, 2005, reviews and makes recommendations to the APC Panel on all issues pertaining to observation services paid under the OPSS, such as coding and operational issues. The Packaging Subcommittee, which was established on March 8, 2004, and reestablished with new members on February 11, 2005, and August 15, 2005, studies and makes recommendations on issues pertaining

to services that are not separately payable under the OPSS but are bundled or packaged APC payments. Each of these subcommittees was established by a majority vote of the APC Panel during a scheduled APC Panel meeting. All subcommittee recommendations are discussed and voted upon by the full APC Panel.

For a detailed discussion of the APC Panel meetings, refer to the hospital OPSS final rules cited in section I.C. of this preamble. Full discussion of the recommendations resulting from the APC Panel's February 2005 and August 2005 meetings are included in the sections of this preamble that are specific to each recommendation.

E. Provisions of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 That Will Be Implemented in CY 2006

On December 8, 2003, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Pub. L. 108-173, was enacted. Pub. L. 108-173 made changes to the Act relating to the Medicare OPSS. In the January 6, 2004 interim final rule with comment period and the November 15, 2004 final rule with comment period, we implemented provisions of Pub. L. 108-173 relating to the OPSS that were effective for CY 2004 and CY 2005, respectively. Provisions of Pub. L. 108-173 that were implemented in CY 2004 or CY 2005, and that are continuing in CY 2006, are discussed throughout this final rule with comment period. Moreover, in this final rule with comment period, we finalize our proposal to implement the following provisions of Pub. L. 108-173 that affect the OPSS beginning in CY 2006:

1. Hold Harmless Provisions

Section 411 of Pub. L. 108-173 amended section 1833(t)(7)(D)(i) of the Act and extended the hold harmless provision for small rural hospitals having 100 or fewer beds through December 31, 2005. Section 411 of Pub. L. 108-173 further amended section 1833(t)(7) of the Act to provide that hold harmless transitional corridor payments shall apply through December 31, 2005 to sole community hospitals (SCHs) (as defined in section 1886(d)(5)(D)(iii) of the Act) located in a rural area. In accordance with these provisions, effective January 1, 2006, we proposed to discontinue transitional corridor payments for small rural hospitals having 100 or fewer beds and for SCHs located in a rural area.

2. Study and Authorization of Adjustment for Rural Hospitals

Section 411(b) of Pub. L. 108-173 added a new paragraph (13) to section 1833(t) of the Act to authorize an "Adjustment for Rural Hospitals." This provision requires us to conduct a study to determine if costs incurred by hospitals located in rural areas by APCs exceed those costs incurred by hospitals located in urban areas. This provision further requires us to provide for an appropriate adjustment by January 1, 2006, if we find that the costs incurred by hospitals located in rural areas exceed those costs incurred by hospitals located in urban areas. In accordance with these provisions, effective January 1, 2006, as we proposed, we are implementing an adjustment for rural sole community hospitals (SCHs), as discussed below.

3. Payment for "Specified Covered Outpatient Drugs"

Section 621(a)(1) of Pub. L. 108-173 added section 1833(t)(14) to the Act that specifies payments for certain "specified covered outpatient drugs" beginning in 2006. Specifically, section 1833(t)(14)(A)(iii)(I) of the Act states that such payment shall be equal to what we determine to be the average acquisition cost for the drug, taking into account hospital acquisition cost survey data furnished by the Government Accountability Office (GAO). Section 1833(t)(14)(A)(iii)(II) of the Act further notes that if hospital acquisition cost data are not available, payment for specified covered outpatient drugs shall equal the average price for the drug established under section 1842(o), section 1847(A), or section 1847(B) of the Act as calculated and adjusted by the Secretary as necessary. Both payment approaches are subject to adjustments under section 1833(t)(14)(E) of the Act as discussed below.

4. Adjustment in Payment Rates for "Specified Covered Outpatient Drugs" for Overhead Costs

Section 621(a)(1) of Pub. L. 108-173 added section 1833(t)(14)(E) to the Act. Section 1833(t)(14)(E)(ii) of the Act authorizes us to make an adjustment to payments for "specified covered outpatient drugs" to take into account overhead and related expenses such as pharmacy services and handling costs, based on recommendations contained in a report prepared by the Medicare Payment Advisory Commission (MedPAC).

5. Budget Neutrality Adjustment

Section 621(a)(1) of Pub. L. 108-173 amended the Act by adding section

1833(t)(14)(H), which requires that additional expenditures resulting from adjustments in APC payment rates for specified covered outpatient drugs be taken into account beginning in CY 2006 and continuing in subsequent years, in establishing the OPSS conversion, weighting, and other adjustment factors.

F. CMS' Commitment to New Technologies

As we indicated in the CY 2006 proposed rule, CMS is committed to ensuring that Medicare beneficiaries will have timely access to new medical treatments and technologies that are well-evaluated and demonstrated to be effective. We launched the Council on Technology and Innovation (CTI) to provide the Agency with improved methods for developing practical information about the clinical benefits of new medical technologies to result in faster and more efficient coverage and payment of these medical technologies. The CTI supports CMS efforts to develop better evidence on the safety, effectiveness, and cost of new and approved technologies to help promote their more effective use.

We want to provide doctors and patients with better information about the benefits of new medical treatments or technologies, or both, especially compared to other treatment options. We also want beneficiaries to have access to valuable new medical innovations as quickly and efficiently as possible. We note there are a number of payment mechanisms in the OPSS and the IPPS designed to achieve appropriate payment of promising new technologies. In the OPSS, qualifying new medical devices may be paid on a cost basis by means of transitional pass-through payments, in addition to the APC payments for the procedures which utilize the devices. In addition, qualifying new services may be assigned for payment to New Technology APCs or, if appropriate, to regular clinical APCs. In the IPPS, qualifying new technologies may receive add-on payments to the standard diagnosis-related group (DRG) payments. We also note that collaborative efforts are underway to facilitate coordination between the Food and Drug Administration (FDA) and CMS with regard to streamlining the CMS coverage process by which new technologies come to the marketplace.

To promote timely access to new medical treatments and technologies, in the CY 2006 OPSS proposed rule, we proposed enhancements to both the OPSS pass-through payment criteria for devices as discussed in section IV.D.2.

of that rule and the qualifying process for assignment of new services to New Technology APCs or regular clinical APCs discussed in section III.C.3. of that rule. In the CY 2006 OPSS proposed rule, we proposed to make device pass-through eligibility available to a broader range of qualifying devices. We also proposed to change the application and review process for assignment of new services to New Technology APCs to promote thoughtful review of the coding, clinical use and efficacy of new services by the wider medical community, encouraging appropriate dissemination of new technologies.

We received a large number of public comments generally supporting our commitment to new technologies. Many of these comments in support of this commitment were stated in the context of our proposals to enhance the OPSS pass-through payment criteria for devices or the application requirements for assignment of a service to a New Technology APC. Specific comments are addressed in those respective sections.

G. Summary of the Provisions of the CY 2006 OPSS Proposed Rule

On July 25, 2005, we published a proposed rule in the **Federal Register** (70 FR 42674) that set forth proposed changes to the Medicare hospital OPSS for CY 2006 to implement statutory requirements and changes arising from our continuing experience with the system, to implement provisions of Pub. L. 108-173 specified in sections II.C., II.F., II.G., and V.B.3.a.(2) of this preamble, and to change the requirement for physician oversight of nonphysician practitioners in CAHs that will be effective for services furnished on or after January 1, 2006. Subsequent to publishing the proposed rule, we published a correction of the proposed rule on August 26, 2005 (70 FR 50679) that corrected technical errors that appeared in the proposed rule. The following is a summary of the major changes included in the CY 2006 OPSS proposed rule that we proposed to make:

1. Updates to Payments for CY 2006

In the proposed rule, we set forth—

- The methodology used to recalculate the proposed APC relative payment weights and the proposed recalibration of the relative payment weights for CY 2006.

- The proposed payment for partial hospitalization, including the proposed separate threshold for outlier payments for CMHCs.

- The proposed update to the conversion factor used to determine

payment rates under the OPSS for CY 2006.

- The proposed retention of our current policy to apply the IPPS wage indices to wage adjust the APC median costs in determining the OPSS payment rate and the copayment standardized amount for CY 2006.

- The proposed update of statewide average default cost-to-charge ratios.

- Proposed changes relating to the expiring hold harmless payment provision.

- Proposed changes to payment for rural SCHs for CY 2006.

- Proposed changes in the way we calculate hospital outpatient outlier payments for CY 2006.

- Calculation of the proposed national unadjusted Medicare OPSS payment.

- The proposed beneficiary copayment for OPSS services for CY 2006.

2. Ambulatory Payment Classification (APC) Group Policies

In the proposed rule, we discussed establishing a number of new APCs and making changes to the assignment of HCPCS codes under a number of existing APCs based on our analyses of Medicare claims data and recommendations of the APC Panel. We also discussed the application of the 2 times rule and proposed exceptions to it; proposed changes for specific APCs; the proposed refinement of the New Technology cost bands; the proposed movement of procedures from the New Technology APCs; and the proposed additions of new procedure codes to the APC groups.

3. Payment Changes for Devices

In the proposed rule, we discussed proposed changes to the device-dependent APCs, to related regulations under §§ 419.66(b)(3) and 419.66(c)(1), and to the pass-through payment for three categories of devices.

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

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

5. Estimate of Transitional Pass-Through Spending in CY 2006 for Drugs, Biologicals, and Devices

In the proposed rule, we discussed the proposed methodology for estimating total pass-through spending and whether there should be a pro rata reduction for transitional pass-through drugs, biologicals, radiopharmaceuticals, and categories of devices for CY 2006.

6. Brachytherapy Payment Changes

In the proposed rule, we included a discussion of our proposal concerning coding and payment for the sources of brachytherapy.

7. Coding and Payment for Drug Administration

In the proposed rule, we discussed our proposed coding and payment changes for drug administration services.

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

In the proposed rule, we discussed our proposal for developing coding guidelines for evaluation and management services.

9. Payment for Blood and Blood Products

In the proposed rule, we discussed our proposed payment changes for blood and blood products.

10. Payment for Observation Services

In the proposed rule, we discussed our proposed criteria and coding changes for observation services.

11. Procedures That Will Be Paid Only as Inpatient Services

In the proposed rule, we discussed the procedures that we proposed to remove from the inpatient list and assign to APCs.

12. Indicator Assignments

In the proposed rule, we discussed proposed changes to the list of status indicators assigned to APCs and presented our comment indicators that we proposed to use in this final rule with comment period.

13. Nonrecurring Policy Changes

In the proposed rule, we discussed proposed changes in payments for multiple diagnostic imaging procedures and proposed changes in payment policy for interrupted procedures.

14. OPSS Policy and Payment Recommendations

In the proposed rule, we addressed recommendations made by MedPAC, the APC Panel, and the GAO regarding the OPSS for CY 2006.

15. Physician Oversight in Critical Access Hospitals

In the proposed rule, we discussed physician oversight for services provided by nonphysician practitioners such as physician assistants, nurse practitioners, and clinical nurse specialists in CAHs.

H. Public Comments Received on the CY 2006 OPSS Proposed Rule

We received over 1,000 timely pieces of correspondence containing multiple comments on the CY 2006 OPSS proposed rule. Summaries of the public comments and our responses to those comments are set forth in the various sections under the appropriate headings.

Comment: One commenter objected to the short time between the end of the comment period and the effective date of the final rule. The commenter stated that the brief time period gives inadequate time for systems and software changes. The commenter asked that the proposed rule be published July 1 and that the final rule be published no later than October 1 of each year. The commenter indicated that hospitals need the extra month to implement the OPSS because it is much more complex for hospitals to implement than the IPPS.

Response: We understand the commenter's concern about the difficulty of implementing the annual OPSS update in 60 days. We do our best to issue the proposed rule and the final rule as promptly as possible and to make all of the supporting documentation available on the CMS Web site as soon as we can. However, factors such as the use of the most recent claims data and cost report data on which we base the proposed and final rates delay the issuance of the proposed rule and the final rule. Hospital delays in submission of hospital bills are an important factor in timing of the OPSS updates as well, because we want to use as many claims as possible in setting the OPSS rates. Moreover, we cannot issue the final rule until the HCPCS code files for the forthcoming year are final because we assign a status indicator to each HCPCS code in the OPSS OCE. The HCPCS files are not final until they are published in October.

Comment: Commenters asked that CMS include an indirect medical education adjustment in the OPSS because it is the only major Medicare payment system that does not include a teaching adjustment. One commenter asked that CMS conduct a study to determine the special roles and costs related to medical education and the appropriateness of including a teaching hospital adjustment.

Response: We have not developed an indirect medical education add-on payment made under the OPSS because the statute does not provide for this adjustment, and we are not convinced that it would be appropriate in a budget-

neutral payment system where such changes would result in reduced payments to all other hospitals. Moreover, in the final rule, we have developed payment weights that we believe resolve many of the public concerns regarding appropriate payments for new technology services and device-dependent procedures, which we believe are furnished largely by teaching hospitals. In addition, the application of the wage index adjustment to 60 percent of the APC payment package (especially for APCs into which expensive devices are packaged) tends to benefit teaching hospitals, which are predominantly located in high-cost areas. These and other payment changes should help ensure equitable payment for all hospitals within the constraints of the statute.

I. Public Comments Received on the November 15, 2004 Final Rule With Comment Period

We received approximately 55 timely pieces of correspondence on the November 5, 2004 final rule with comment period, some of which contained multiple comments on the APC assignment of HCPCS codes identified with the NI comment indicator in Addendum B of that final rule with comment period and on the surgical insertion and implantation device criterion. Summaries of those public comments and our responses to those comments are set forth in the various sections under the appropriate headings.

II. Updates Affecting Payments for CY 2006

A. Recalibration of APC Relative Weights for CY 2006

1. Database Construction

a. Database Source and Methodology. Section 1833(t)(9)(A) of the Act requires that the Secretary review and revise the relative payment weights for APCs at least annually. In the April 7, 2000 OPSS final rule (65 FR 18482), we explained in detail how we calculated the relative payment weights that were implemented on August 1, 2000, for each APC group. Except for some reweighting due to a small number of APC changes, these relative payment weights continued to be in effect for CY 2001. This policy is discussed in the November 13, 2000 interim final rule (65 FR 67824 through 67827).

In the CY 2005 OPSS proposed rule (70 FR 42680), we proposed to use the same basic methodology that we described in the April 7, 2000 final rule to recalibrate the APC relative payment

weights for services furnished on or after January 1, 2006, and before January 1, 2007. That is, we would recalibrate the relative payment weights for each APC based on claims and cost report data for outpatient services. We proposed to use the most recent available data to construct the database for calculating APC group weights. For the purpose of recalibrating APC relative payment weights for CY 2006, we used approximately 137 million final action claims for hospital OPD services furnished on or after January 1, 2004, and before January 1, 2005. Of the 137 million final action claims for services provided in hospital outpatient settings, 109 million claims were of the type of bill potentially appropriate for use in setting rates for OPPS services (but did not necessarily contain services payable under the OPPS). Of the 109 million claims, we were able to use 52.7 million whole claims to set the proposed OPPS APC relative weights for CY 2006 OPPS. From the 52.7 million whole claims, we created 87.9 million single records, of which 54.9 million were "pseudo" single claims (created from multiple procedure claims using the process we discuss in this section).

As we proposed, the final APC relative weights and payments for CY 2006 in Addenda A and B to this final rule with comment period were calculated using claims from this period that had been processed before June 30, 2005, and continue to be based on the median hospital costs for services in the APC groups. We selected claims for services paid under the OPPS and matched these claims to the most recent cost report filed by the individual hospitals represented in our claims data.

We received numerous public comments concerning our proposed data source and methodology for recalibrating the APC relative weights for CY 2006. A summary of the comments and our responses are discussed below.

Comment: Commenters stated that many APC rates fluctuate dramatically, and the instability in the system makes it very hard for hospitals to budget and plan services from year to year. Among the services identified as issues of specific concern were clinic visits, application of brachytherapy sources, drugs and biologicals, and device-intensive APCs. Some commenters recommended that CMS limit increases and decreases for all APCs to no more than a 5-percent shift (increase or decrease) from one year to another. Commenters emphasized that fluctuations in payment rates for device-dependent procedures from year to year impact manufacturers' abilities to

contract effectively with hospitals to provide a stable purchasing environment and, thereby, impede innovation and adversely impact beneficiaries.

Response: We understand the commenters' concerns about the need for sufficient stability in the OPPS so that hospitals can plan and budget. We have given this issue much consideration. We recognize that reliance on single procedure claims may result in fewer claims for some services than for others. For example, median costs for services such as office visits, for which the volume of single bills is very high, would generally be more stable than the median costs for services for which we have very few single procedure claims. We will continue to explore changes we could effectuate to enable us to use even more claims on the premise that using more claims data will enhance stability.

However, we note that the statutory design of the OPPS and the rapid evolution in the delivery of outpatient hospital services include many elements that may be responsible for some of the fluctuation in rates from year to year. For example, the "2 times rule" imposed by the law requires the movement of some procedures from one APC to another each year. Moreover, the OPPS is based on procedure coding for which there are hundreds of changes each year. In addition, the entry of new technology into a budget neutral payment system results in a shift of funds away from previously existing services to provide payments for new services. These systemic factors are valid reflections of the changes in services in the outpatient department, and shifts in payment legitimately mirror those changes.

Comment: Commenters stated that the entire OPPS is underfunded because it pays only 87 percent of the costs of services to Medicare beneficiaries. One commenter indicated that the underfunding of services to Medicare patients is particularly severe for disproportionate share hospitals and hospitals with level I trauma centers and, therefore, will inhibit access to care for Medicare beneficiaries and other individuals.

Response: Our early analyses indicated that the OPPS was, in its inception, based on payment that was less than cost due to statutory reductions in payment for hospital outpatient costs prior to the enactment of the BBA, which authorized the current OPPS. Certain fundamental statutory features of the OPPS dictate such a finding. For example, the base amounts upon which the OPPS was

established, the rules concerning budget neutrality, and subsequent out-year adjustments such as annual reductions in coinsurance and adjustments to outlier and pass-through payment allocations are established in statute and, as such, would require legislation to amend.

Comment: Commenters supported use of the most recent claims data for recalibrating the APC relative weights but in many cases wanted CMS to adjust the claims data for particular services of interest to them in ways that will result in higher payment for those specified services. Other commenters supported use of proprietary, confidential external data in lieu of claims data to set the median costs on which the rates are based for selected services because they believe that the use of claims data results in median costs that are less than the costs of the services being furnished. Some commenters asked CMS to establish a representative sample of hospitals from which data would be collected for use in place of claims data or to validate the data derived from claims.

Response: We believe that, in a budget neutral relative payment system such as the OPPS, it is important that the relative weights be based on a uniform source of data processed in a standardized way. We believe that Medicare claims data are the most uniform data source available to us. Moreover, the weights derived from such a system are the vehicles for distributing Medicare payments for outpatient hospital services fairly among all hospitals that furnish outpatient hospital services to Medicare beneficiaries. We are committed to using claims data in a uniform manner, to the maximum extent possible, to develop the relative weights from which payment rates are calculated. We do not see a compelling need to use external data to set or adjust median costs for device-dependent APCs for the CY 2006 OPPS. Therefore, for the CY 2006 OPPS, we have not substituted external data for Medicare claims data for the purpose of setting the median costs on which the relative weights are based.

After carefully considering all comments received, we are finalizing our data source and methodology for the recalibration of CY 2006 APC relative weights as proposed without modification.

b. Use of Single and Multiple Procedure Claims. For CY 2006, we proposed to continue to use single procedure claims to set the medians on which the APC relative payment weights would be based. As noted in the November 15, 2004 final rule with

comment period, we have received many requests asking that we ensure that the data from claims that contain charges for multiple procedures are included in the data from which we calculate the relative payment weights (69 FR 65730 through 65731). Requesters believe that relying solely on single procedure claims to recalibrate APC relative payment weights fails to take into account data for many frequently performed procedures, particularly those commonly performed in combination with other procedures. They believe that, by depending upon single procedure claims, we base relative payment weights on the least costly services, thereby introducing downward bias to the medians on which the weights are based.

We agree that, optimally, it is desirable to use the data from as many claims as possible to recalibrate the APC relative payment weights, including those with multiple procedures. We generally use single procedure claims to set the median costs for APCs because we are, so far, unable to ensure that packaged costs can be appropriately allocated across multiple procedures performed on the same date of service. However, by bypassing specified codes that we believe do not have significant packaged costs, we are able to use more data from multiple procedure claims. In many cases, this enables us to create multiple "pseudo" single claims from claims that, as submitted, contained multiple separately paid procedures on the same claim. We have used the date of service on the claims and a list of codes to be bypassed to create "pseudo" single claims from multiple procedure claims the same as we did in recalibrating the CY 2005 APC relative payment weights. We refer to these newly created single procedure claims as "pseudo" singles because they were submitted by providers as multiple procedure claims.

For CY 2003, we created "pseudo" single claims by bypassing HCPCS codes 93005 (Electrocardiogram, tracing), 71010 (Chest x-ray), and 71020 (Chest x-ray) on a submitted claim. However, we did not use claims data for the bypassed codes in the creation of the median costs for the APCs to which these three codes were assigned because the level of packaging that would have remained on the claim after we selected the bypass code was not apparent and, therefore, it was difficult to determine if the medians for these codes would be correct.

For CY 2004, we created "pseudo" single claims by bypassing these three codes and also by bypassing an additional 269 HCPCS codes in APCs.

We selected these codes based on a clinical review of the services and because it was presumed that these codes had only very limited packaging and could appropriately be bypassed for the purpose of creating "pseudo" single claims. The APCs to which these codes were assigned were varied and included mammography, cardiac rehabilitation, and Level I plain film x-rays. To derive more "pseudo" single claims, we also split the claims where there were dates of service for revenue code charges on that claim that could be matched to a single procedure code on the claim on the same date.

As in CY 2003, we did not include the claims data for the bypassed codes in the creation of the APCs to which the 269 codes were assigned because, again, we had not established that such an approach was appropriate and would aid in accurately estimating the median costs for those APCs. For CY 2004, from about 16.3 million otherwise unusable claims, we used about 9.5 million multiple procedure claims to create about 27 million "pseudo" single claims. For CY 2005, we identified 383 bypass codes and from approximately 24 million otherwise unusable claims, we used about 18 million multiple procedure claims to create about 52 million "pseudo" single claims.

For CY 2006, we proposed to continue using date of service matching as a tool for creation of "pseudo" single claims and to continue the use of a bypass list to create "pseudo" single claims. The process we proposed for CY 2006 OPSS resulted in our being able to use some part of 90 percent of the total claims that are eligible for use in OPSS rate-setting and modeling in developing this final rule with comment period. This process enabled us to use, for CY 2006, 88 million single bills for rate-setting; 55 million "pseudo" singles and 34 million "natural" single bills (bills that were submitted containing only one separately payable major HCPCS code). (These numbers do not sum to 88 million because more than 800,000 single bills were removed when we trimmed at the HCPCS level at ± 3 standard deviations from the geometric mean.)

We proposed to bypass the 404 codes identified in Table 1 of the proposed rule (70 FR 42682) to create new single claims and to use the line-item costs associated with the bypass codes on these claims in the creation of the median costs for the APCs into which they are assigned. Of the codes on that list, 385 were used for bypass in CY 2005. For CY 2006, we proposed to continue the use of the codes on the CY 2005 OPSS bypass list and expand it by

adding those codes that, using data presented to the APC Panel at its February 2005 meeting, met the same empirical criteria as those used in CY 2005 to create the bypass list. Our examination of the data against the criteria for inclusion on the bypass list, as discussed below for the addition of new codes, shows that the empirically selected codes used for bypass for the CY 2005 OPSS generally continue to meet the criteria or come very close to meeting the criteria, and we have received no comments against bypassing them.

As we proposed, in this final rule with comment period, we used the following empirical criteria that were developed by reviewing the frequency and magnitude of packaging in the single claims for payable codes other than drugs and biologicals. We assumed that the representation of packaging on the single claims for any given code is comparable to packaging for that code in the multiple claims:

- There were 100 or more single claims for the code. This number of single claims ensured that observed outcomes were sufficiently representative of packaging that might occur in the multiple claims.
- Five percent or fewer of the single claims for the code had packaged costs on that single claim for the code. This criterion results in limiting the amount of packaging being redistributed to the payable procedure remaining on the claim after the bypass code is removed and ensures that the costs associated with the bypass code represent the cost of the bypassed service.
- The median cost of packaging observed in the single claim was equal to or less than \$50. This limits the amount of error in redistributed costs.
- The code is not a code for an unlisted service.

As stated in the proposed rule (70 FR 42681), we also added to the bypass list three codes (CPT codes 51701, 51702, and 51703 for bladder catheterization) which do not meet these criteria. These codes have been packaged and have never been paid separately. For that reason, when these were the only services provided to the beneficiary, no payment was made to the hospital. The APC Panel's Packaging Subcommittee recommended that we make separate payment when they are the only service on the claim. See section II.A.4. of this preamble for further discussion of our policy to pay these services separately. We added these codes to the bypass list because changing them from packaged to separately paid would result in a reduction of the number of single bills on which we could base median costs

for other major separately paid procedures that are billed on the same claim with these procedure codes. Single bills which contain other procedures would become multiple procedure claims when these bladder catheterization codes were converted from packaged to separately paid status.

As explained in the CY 2006 proposed rule (70 FR 42682), we examined the packaging on the single procedure claims in the CY 2004 data for these codes. We found that none of these three codes met the empirical standards for the bypass list. However, we believe that when these services are performed on the same date as another separately paid procedure, any packaging that appears on the claim would appropriately be associated with the other procedures and not with these codes. Therefore, we believe that bypassing them does not adversely affect the medians for other procedures. Moreover, future separate payment for these codes does not harm the hospitals that furnish these services, in view of the historical absence of separate payment for them under the OPPS in the past. Hence, we proposed to pay separately for these codes and to add them to the bypass list for the CY 2006 OPPS.

In the CY 2006 proposed rule, we specifically invited public comments on the proposed "pseudo" single process, including the bypass list and the criteria. A summary of the many comments we received and our responses follow:

Comment: Some commenters supported use of multiple procedure claims through application of the bypass list and date of service stratification. Other commenters stated that these processes may result in more claims but not necessarily better data for rate-

setting. Many commenters objected to the use of single procedure claims as the basis for setting the relative weights because they believed that using single procedure claims limits the claims data to the simplest and least costly cases. They proposed CPT code or APC specific strategies for using multiple procedure claims in ways that would apply only to the services of interest to them that could not be generalized across multiple procedure claims for all services. The commenters indicated that the use of single procedure claims greatly limits the number of claims that are used for setting median costs and weights, and that the OPPS relative weights would be greatly improved if we could use all of the claims data. They indicated that the use of single procedure claims causes medians to be set based on incorrectly coded claims for the many add-on codes that can only be billed properly when they are billed with the base code to which they are attached. In addition, they indicated that many services are so routinely furnished in combination with other services that use of single procedure claims will never result in appropriate median costs for these procedures.

Response: We share the commenters' desire to use as much claims data as possible to set the relative weights for the OPPS services. We continue to explore ways to use more data from multiple procedure claims. Specifically, we are looking at the extent to which the many add-on codes (codes that are reported for services furnished only as an adjunct to another service) can be packaged to create more single claims. We are also exploring strategies for using data from correctly coded multiple procedure claims containing both base and add-on codes to ascertain

the incremental costs of the add-on services. We also expect to explore other generally applicable strategies, such as apportioning packaging based on submitted charges that would enable us to use multiple procedure claims.

We are disinclined to focus on service-specific strategies for using multiple procedure claims because those that have been suggested to us are not generally applicable to multiple procedure claims across all services, but rather are focused on increasing the median costs of particular services to the exclusion of all other services. As we indicated above, we believe that it is important in a relative weight system that, to the maximum extent possible, the same claims and the same processing rules apply to all services so that the resulting relative weights are uniformly created and serve all hospitals fairly.

Comment: One commenter asked why only some of the office visit and consultation services are included in the bypass list (for example, CPT codes 99213 and 99214 are on the list) but CPT codes 99211, 99212 and 99215 are not. The commenter believed that the cited unlisted codes should also be on the list. Other commenters did not believe that CPT codes 99213 and 99214 met the criteria for inclusion as bypass codes and believed that they should be removed from the list.

Response: We have included below data calculated from the APC Panel data for use in setting the bypass list for the CY 2006 proposed rule and this final rule with comment period. These data show that CPT codes 99213 and 99214 meet the criteria for inclusion as bypass codes, and that CPT codes 99211, 99212 and 99215 exceed the 5-percent limit for single bills containing packaging:

| HCPSCS | Short descriptor | Median amount of packaging on single bills | Percent of single bills for the code containing packaging |
|-------------|------------------------------------|--|---|
| 99211 | Office/outpatient visit, est | \$11.98 | 6.15 |
| 99212 | Office/outpatient visit, est | 10.88 | 5.43 |
| 99213 | Office/outpatient visit, est | 11.72 | 3.87 |
| 99214 | Office/outpatient visit, est | 12.76 | 3.63 |
| 00215 | Office/outpatient visit, est | 12.76 | 8.62 |

Comment: Commenters supported the use of the bypass list but were concerned that the inclusion of services on the bypass list may systematically result in lower costs for the procedures that are included on the list than if they had not been included on the list.

Response: We established the bypass list criteria for the purpose of limiting

any potential adverse impact on the medians for the services on the bypass list. We believe that the requirement that a code cannot be placed on the bypass list if more than 5 percent of the single bills for that code contain packaging or if the median packaging for the code exceeds \$50, is a strong deterrent to systematic reduction of

medians for services on the bypass list. We have received no comments on the appropriateness or inappropriateness of the bypass criteria, and thus, we have not changed them for the CY 2006 OPPS.

Comment: Commenters asked CMS to carefully consider the impact of add-on codes on the creation of multiple

procedure claims and urged CMS to not disqualify a claim because of the presence of an add-on code that is packaged. In the case of add-on codes that are separately paid, one commenter urged CMS to apportion the packaged charges between the base code and the add-on code so that the data from the multiple procedure claim can be used. Some commenters asked CMS to place all add-on codes, both packaged and separately paid, on the bypass list to create more single procedure claims.

Response: The presence of an add-on code with a status indicator of "N" because it is a packaged service does not currently disqualify the claim as a multiple procedure claim. The claim is considered to be a single procedure claim and the cost of the packaged add-on code is treated like any other packaged drug, device, or supply or other packaged cost. However, the presence of an add-on code that is separately paid but not on the bypass list does currently cause the claim to be a multiple procedure claim that is not used because of the difficulties in determining how to apportion the packaging on the claim between the two separately paid procedure codes.

We disagree that all add-on codes could safely be added to the bypass list. Many add-on codes use significant resources that are reported as packaged charges in support of the add-on code. For example, CPT code 33225 (Left ventricular lead add-on) requires more than an hour of additional operating room time and also requires a device with significant cost when the service is

furnished in conjunction with a base service. If we were to include CPT code 33225 on the bypass list, only the line-item charge for the CPT code would be attributed to the procedure code. Neither the device cost (which is packaged), nor the share of other costs attributable to the service (for example, drugs, supplies, and extended operating room time) would be attributed to CPT code 33225. They would both be packaged into the base code. The single procedure claims for CPT code 33225 would not reflect the costs of the device or extended operating room time. In addition, the single procedure claims for the base code would reflect packaging that is not properly associated with that procedure.

However, we recognize that the add-on codes present a significant data problem because they can never be correctly billed unless they are also billed on the same claim with a base code to which they add services. We are undertaking a study of add-on codes to determine whether there are add-on codes that are now separately paid that should become packaged, and thus would provide more single procedure claims. With respect to the add-on codes for which packaging is not appropriate, we will be exploring methods that would enable us to systematically calculate valid median costs for the add-on codes from multiple procedure claims and thus create a more robust set of valid claims for rate-setting. We anticipate working with the APC Panel members on this issue.

Comment: Commenters asked CMS to assign a flag to claims that became pseudo singles in the claims included in the public use files so that it would be easier for commenters to model future proposed policies.

Response: The public use files (the limited data set and the beneficiary encrypted data set) contain claims as submitted to CMS. Therefore, to flag the pseudo single claims in the public use file is not possible because the pseudo single claims may be part, but not all, of the submitted claim. Even if we did flag the claim, the user would still have to replicate the process to create pseudo single claims. We note that we have greatly increased the information we issued regarding how we process the claims to acquire the median costs, and we understand that outside replication of our medians has improved.

Comment: Commenters asked whether CMS disregards line item charges for drugs, biologicals, and radiopharmaceutical agents and items with status indicators "K" and "G" for purposes of creating pseudo singles claims.

Response: The presence on a claim of a code and charge for a drug, biological, or radiopharmaceutical agent, whether separately paid or packaged, has no impact on determining whether the claim is a single procedure claim.

After carefully considering all public comments received, we are adopting as final the proposed "pseudo" single process and the bypass codes listed in Table 1 without modification.

BILLING CODE 4120-01-P

**Table 1.--CY 2006 HCPCS Bypass Codes for Creating
“Pseudo” Single Claims for Calculating Median Costs**

| HCPCS Code | Short Description | Status Indicator |
|-------------------|----------------------------------|-------------------------|
| 11056* | Trim skin lesions, 2 to 4 | T |
| 11057* | Trim skin lesions, over 4 | T |
| 11719 | Trim nail(s) | T |
| 11720 | Debride nail, 1-5 | T |
| 11721 | Debride nail, 6 or more | T |
| 17003* | Destroy lesions, 2-14 | T |
| 31231* | Nasal endoscopy, dx | T |
| 31579 | Diagnostic laryngoscopy | T |
| 51701* | Insert bladder catheter | X |
| 51702* | Insert temp bladder catheter | X |
| 51703* | Insert bladder catheter, complex | X |
| 51798* | Us urine capacity measure | X |
| 54240 | Penis study | T |
| 67820* | Revise eyelashes | S |
| 70030* | X-ray eye for foreign body | X |
| 70100 | X-ray exam of jaw | X |
| 70110 | X-ray exam of jaw | X |
| 70130 | X-ray exam of mastoids | X |
| 70140 | X-ray exam of facial bones | X |
| 70150 | X-ray exam of facial bones | X |
| 70160 | X-ray exam of nasal bones | X |
| 70200 | X-ray exam of eye sockets | X |
| 70210 | X-ray exam of sinuses | X |
| 70220 | X-ray exam of sinuses | X |
| 70250 | X-ray exam of skull | X |
| 70260 | X-ray exam of skull | X |
| 70328 | X-ray exam of jaw joint | X |
| 70330 | X-ray exam of jaw joints | X |
| 70336* | Magnetic image, jaw joint | S |
| 70355 | Panoramic x-ray of jaws | X |
| 70360 | X-ray exam of neck | X |
| 70370* | Throat x-ray & fluoroscopy | X |
| 70371 | Speech evaluation, complex | X |
| 70450 | Ct head/brain w/o dye | S |
| 70480 | Ct orbit/ear/fossa w/o dye | S |
| 70486 | Ct maxillofacial w/o dye | S |
| 70544 | Mr angiography head w/o dye | S |
| 70551* | Mri brain w/o dye | S |
| 71010 | Chest x-ray | X |
| 71015 | Chest x-ray | X |
| 71020 | Chest x-ray | X |

| HCPCS Code | Short Description | Status Indicator |
|-------------------|------------------------------|-------------------------|
| 71021 | Chest x-ray | X |
| 71022 | Chest x-ray | X |
| 71023* | Chest x-ray and fluoroscopy | X |
| 71030 | Chest x-ray | X |
| 71034 | Chest x-ray and fluoroscopy | X |
| 71090 | X-ray & pacemaker insertion | X |
| 71100 | X-ray exam of ribs | X |
| 71101 | X-ray exam of ribs/chest | X |
| 71110 | X-ray exam of ribs | X |
| 71111 | X-ray exam of ribs/ chest | X |
| 71120 | X-ray exam of breastbone | X |
| 71130 | X-ray exam of breastbone | X |
| 71250 | Ct thorax w/o dye | S |
| 72040 | X-ray exam of neck spine | X |
| 72050 | X-ray exam of neck spine | X |
| 72052 | X-ray exam of neck spine | X |
| 72069* | X-ray exam of trunk spine | X |
| 72070 | X-ray exam of thoracic spine | X |
| 72072 | X-ray exam of thoracic spine | X |
| 72074 | X-ray exam of thoracic spine | X |
| 72080 | X-ray exam of trunk spine | X |
| 72090 | X-ray exam of trunk spine | X |
| 72100 | X-ray exam of lower spine | X |
| 72110 | X-ray exam of lower spine | X |
| 72114 | X-ray exam of lower spine | X |
| 72120 | X-ray exam of lower spine | X |
| 72125 | Ct neck spine w/o dye | S |
| 72128* | Ct chest spine w/o dye | S |
| 72141 | Mri neck spine w/o dye | S |
| 72146 | Mri chest spine w/o dye | S |
| 72148 | Mri lumbar spine w/o dye | S |
| 72170 | X-ray exam of pelvis | X |
| 72190 | X-ray exam of pelvis | X |
| 72192 | Ct pelvis w/o dye | S |
| 72220 | X-ray exam of tailbone | X |
| 73000 | X-ray exam of collar bone | X |
| 73010 | X-ray exam of shoulder blade | X |
| 73020 | X-ray exam of shoulder | X |
| 73030 | X-ray exam of shoulder | X |
| 73050 | X-ray exam of shoulders | X |
| 73060 | X-ray exam of humerus | X |
| 73070 | X-ray exam of elbow | X |
| 73080 | X-ray exam of elbow | X |
| 73090 | X-ray exam of forearm | X |
| 73100 | X-ray exam of wrist | X |

| HCPSC Code | Short Description | Status Indicator |
|-------------------|------------------------------|-------------------------|
| 73110 | X-ray exam of wrist | X |
| 73120 | X-ray exam of hand | X |
| 73130 | X-ray exam of hand | X |
| 73140 | X-ray exam of finger(s) | X |
| 73218 | Mri upper extremity w/o dye | S |
| 73221 | Mri joint upr extrem w/o dye | S |
| 73510 | X-ray exam of hip | X |
| 73520 | X-ray exam of hips | X |
| 73540 | X-ray exam of pelvis & hips | X |
| 73550 | X-ray exam of thigh | X |
| 73560 | X-ray exam of knee, 1 or 2 | X |
| 73562 | X-ray exam of knee, 3 | X |
| 73564 | X-ray exam, knee, 4 or more | X |
| 73565 | X-ray exam of knees | X |
| 73590 | X-ray exam of lower leg | X |
| 73600 | X-ray exam of ankle | X |
| 73610 | X-ray exam of ankle | X |
| 73620 | X-ray exam of foot | X |
| 73630 | X-ray exam of foot | X |
| 73650 | X-ray exam of heel | X |
| 73660 | X-ray exam of toe(s) | X |
| 73700 | Ct lower extremity w/o dye | S |
| 73718* | Mri lower extremity w/o dye | S |
| 73721 | Mri jnt of lwr extre w/o dye | S |
| 74000 | X-ray exam of abdomen | X |
| 74010* | X-ray exam of abdomen | X |
| 74210 | Contrst x-ray exam of throat | S |
| 74220 | Contrast x-ray, esophagus | S |
| 74230 | Cine/vid x-ray, throat/esoph | S |
| 74235 | Remove esophagus obstruction | S |
| 74240 | X-ray exam, upper gi tract | S |
| 74245 | X-ray exam, upper gi tract | S |
| 74246 | Contrst x-ray uppr gi tract | S |
| 74247 | Contrst x-ray uppr gi tract | S |
| 74249 | Contrst x-ray uppr gi tract | S |
| 74250 | X-ray exam of small bowel | S |
| 74300 | X-ray bile ducts/pancreas | X |
| 74301 | X-rays at surgery add-on | X |
| 74305 | X-ray bile ducts/pancreas | X |
| 74327 | X-ray bile stone removal | S |
| 74340 | X-ray guide for GI tube | X |
| 74350 | X-ray guide, stomach tube | X |
| 74355 | X-ray guide, intestinal tube | X |
| 74360 | X-ray guide, GI dilation | S |
| 74363 | X-ray, bile duct dilation | S |

| HCPCS Code | Short Description | Status Indicator |
|-------------------|------------------------------|-------------------------|
| 74475 | X-ray control, cath insert | S |
| 74480 | X-ray control, cath insert | S |
| 74485 | X-ray guide, GU dilation | S |
| 74742 | X-ray, fallopian tube | X |
| 75894 | X-rays, transcath therapy | S |
| 75898 | Follow-up angiography | X |
| 75901 | Remove cva device obstruct | X |
| 75902 | Remove cva lumen obstruct | X |
| 75945 | Intravascular us | S |
| 75946 | Intravascular us add-on | S |
| 75960 | Transcatheter intro, stent | S |
| 75961 | Retrieval, broken catheter | S |
| 75962 | Repair arterial blockage | S |
| 75964 | Repair artery blockage, each | S |
| 75966 | Repair arterial blockage | S |
| 75968 | Repair artery blockage, each | S |
| 75970 | Vascular biopsy | S |
| 75978 | Repair venous blockage | S |
| 75980 | Contrast xray exam bile duct | S |
| 75982 | Contrast xray exam bile duct | S |
| 75984 | Xray control catheter change | X |
| 75992 | Atherectomy, x-ray exam | S |
| 75993 | Atherectomy, x-ray exam | S |
| 75994 | Atherectomy, x-ray exam | S |
| 75995 | Atherectomy, x-ray exam | S |
| 75996 | Atherectomy, x-ray exam | S |
| 76012 | Percut vertebroplasty fluor | S |
| 76013 | Percut vertebroplasty, ct | S |
| 76040 | X-rays, bone evaluation | X |
| 76061 | X-rays, bone survey | X |
| 76062 | X-rays, bone survey | X |
| 76066 | Joint survey, single view | X |
| 76070* | CT scan, bone density study | S |
| 76075 | Dexa, axial skeleton study | S |
| 76076 | Dexa, peripheral study | S |
| 76078 | Radiographic absorptiometry | X |
| 76095 | Stereotactic breast biopsy | T |
| 76096 | X-ray of needle wire, breast | X |
| 76100 | X-ray exam of body section | X |
| 76101 | Complex body section x-ray | X |
| 76360 | Ct scan for needle biopsy | S |
| 76380 | CAT scan follow-up study | S |
| 76393 | Mr guidance for needle place | S |
| 76511 | Echo exam of eye | S |
| 76512 | Echo exam of eye | S |

| HCPCS Code | Short Description | Status Indicator |
|-------------------|------------------------------|-------------------------|
| 76516 | Echo exam of eye | S |
| 76519 | Echo exam of eye | S |
| 76536 | Us exam of head and neck | S |
| 76645 | Us exam, breast(s) | S |
| 76700 | Us exam, abdom, complete | S |
| 76705 | Echo exam of abdomen | S |
| 76770 | Us exam abdo back wall, comp | S |
| 76775 | Us exam abdo back wall, lim | S |
| 76778* | Us exam kidney transplant | S |
| 76801* | Ob us < 14 wks, single fetus | S |
| 76811* | Ob us, detailed, snl fetus | S |
| 76817* | Transvaginal us, obstetric | S |
| 76830 | Transvaginal us, non-ob | S |
| 76856 | Us exam, pelvic, complete | S |
| 76857 | Us exam, pelvic, limited | S |
| 76870 | Us exam, scrotum | S |
| 76880 | Us exam, extremity | S |
| 76941 | Echo guide for transfusion | S |
| 76945 | Echo guide, villus sampling | S |
| 76946 | Echo guide for amniocentesis | S |
| 76948 | Echo guide, ova aspiration | S |
| 76950* | Echo guidance radiotherapy | S |
| 76970* | Ultrasound exam follow-up | S |
| 76977 | Us bone density measure | X |
| 77280 | Set radiation therapy field | X |
| 77285 | Set radiation therapy field | X |
| 77295* | Set radiation therapy field | X |
| 77300 | Radiation therapy dose plan | X |
| 77301 | Radiotherapy dose plan, imrt | X |
| 77315 | Teletx isodose plan complex | X |
| 77326 | Radiation therapy dose plan | X |
| 77327 | Brachytx isodose calc interm | X |
| 77328 | Brachytx isodose plan compl | X |
| 77331 | Special radiation dosimetry | X |
| 77332 | Radiation treatment aid(s) | X |
| 77333 | Radiation treatment aid(s) | X |
| 77334 | Radiation treatment aid(s) | X |
| 77336 | Radiation physics consult | X |
| 77370 | Radiation physics consult | X |
| 77402* | Radiation treatment delivery | S |
| 77403 | Radiation treatment delivery | S |
| 77404* | Radiation treatment delivery | S |
| 77408* | Radiation treatment delivery | S |
| 77409 | Radiation treatment delivery | S |
| 77411 | Radiation treatment delivery | S |

| HCPCS Code | Short Description | Status Indicator |
|-------------------|------------------------------|-------------------------|
| 77412 | Radiation treatment delivery | S |
| 77413 | Radiation treatment delivery | S |
| 77414 | Radiation treatment delivery | S |
| 77416 | Radiation treatment delivery | S |
| 77417 | Radiology port film(s) | X |
| 77418 | Radiation tx delivery, imrt | S |
| 77470 | Special radiation treatment | S |
| 78350 | Bone mineral, single photon | X |
| 80502 | Lab pathology consultation | X |
| 85060 | Blood smear interpretation | X |
| 86585 | TB tine test | X |
| 86850 | RBC antibody screen | X |
| 86870 | RBC antibody identification | X |
| 86880 | Coombs test, direct | X |
| 86885 | Coombs test, indirect, qual | X |
| 86886 | Coombs test, indirect, titer | X |
| 86890 | Autologous blood process | X |
| 86900 | Blood typing, ABO | X |
| 86901 | Blood typing, Rh (D) | X |
| 86905 | Blood typing, RBC antigens | X |
| 86906 | Blood typing, Rh phenotype | X |
| 86930 | Frozen blood prep | X |
| 86970 | RBC pretreatment | X |
| 88104 | Cytopathology, fluids | X |
| 88106 | Cytopathology, fluids | X |
| 88107 | Cytopathology, fluids | X |
| 88108 | Cytopath, concentrate tech | X |
| 88160 | Cytopath smear, other source | X |
| 88161 | Cytopath smear, other source | X |
| 88172 | Cytopathology eval of fna | X |
| 88182 | Cell marker study | X |
| 88300 | Surgical path, gross | X |
| 88304 | Tissue exam by pathologist | X |
| 88305 | Tissue exam by pathologist | X |
| 88311 | Decalcify tissue | X |
| 88312 | Special stains | X |
| 88313 | Special stains | X |
| 88321 | Microslide consultation | X |
| 88323 | Microslide consultation | X |
| 88325 | Comprehensive review of data | X |
| 88331 | Path consult intraop, 1 bloc | X |
| 88342 | Immunohistochemistry | X |
| 88346 | Immunofluorescent study | X |
| 88347 | Immunofluorescent study | X |
| 90801 | Psy dx interview | S |

| HCPCS Code | Short Description | Status Indicator |
|-------------------|------------------------------|-------------------------|
| 90804* | Psytx, office, 20-30 min | S |
| 90805 | Psytx, off, 20-30 min w/e&m | S |
| 90806 | Psytx, off, 45-50 min | S |
| 90807 | Psytx, off, 45-50 min w/e&m | S |
| 90808 | Psytx, office, 75-80 min | S |
| 90809 | Psytx, off, 75-80, w/e&m | S |
| 90810 | Intac psytx, off, 20-30 min | S |
| 90818 | Psytx, hosp, 45-50 min | S |
| 90826 | Intac psytx, hosp, 45-50 min | S |
| 90845 | Psychoanalysis | S |
| 90846 | Family psytx w/o patient | S |
| 90847 | Family psytx w/patient | S |
| 90853 | Group psychotherapy | S |
| 90857 | Intac group psytx | S |
| 90862 | Medication management | X |
| 92002 | Eye exam, new patient | V |
| 92004 | Eye exam, new patient | V |
| 92012 | Eye exam established pat | V |
| 92014 | Eye exam & treatment | V |
| 92020* | Special eye evaluation | S |
| 92081* | Visual field examination(s) | S |
| 92082 | Visual field examination(s) | S |
| 92083 | Visual field examination(s) | S |
| 92135 | Ophthalmic dx imaging | S |
| 92136 | Ophthalmic biometry | S |
| 92225 | Special eye exam, initial | S |
| 92226 | Special eye exam, subsequent | S |
| 92230 | Eye exam with photos | T |
| 92250 | Eye exam with photos | S |
| 92275 | Electroretinography | S |
| 92285 | Eye photography | S |
| 92286 | Internal eye photography | S |
| 92520 | Laryngeal function studies | X |
| 92541* | Spontaneous nystagmus test | X |
| 92546 | Sinusoidal rotational test | X |
| 92548 | Posturography | X |
| 92552 | Pure tone audiometry, air | X |
| 92553 | Audiometry, air & bone | X |
| 92555 | Speech threshold audiometry | X |
| 92556 | Speech audiometry, complete | X |
| 92557* | Comprehensive hearing test | X |
| 92567 | Tympanometry | X |
| 92582 | Conditioning play audiometry | X |
| 92585 | Auditor evoke potent, compre | S |
| 92604* | Reprogram cochlear implt 7 > | X |

| HCPCS Code | Short Description | Status Indicator |
|-------------------|------------------------------|-------------------------|
| 93005 | Electrocardiogram, tracing | S |
| 93225 | ECG monitor/record, 24 hrs | X |
| 93226 | ECG monitor/report, 24 hrs | X |
| 93231 | Ecg monitor/record, 24 hrs | X |
| 93232 | ECG monitor/report, 24 hrs | X |
| 93236 | ECG monitor/report, 24 hrs | X |
| 93270 | ECG recording | X |
| 93278 | ECG/signal-averaged | S |
| 93303 | Echo transthoracic | S |
| 93307 | Echo exam of heart | S |
| 93320 | Doppler echo exam, heart | S |
| 93731 | Analyze pacemaker system | S |
| 93732* | Analyze pacemaker system | S |
| 93733 | Telephone analy, pacemaker | S |
| 93734 | Analyze pacemaker system | S |
| 93735* | Analyze pacemaker system | S |
| 93736 | Telephonic analy, pacemaker | S |
| 93741* | Analyze ht pace device sngl | S |
| 93743 | Analyze ht pace device dual | S |
| 93797 | Cardiac rehab | S |
| 93798 | Cardiac rehab/monitor | S |
| 93875 | Extracranial study | S |
| 93880 | Extracranial study | S |
| 93882 | Extracranial study | S |
| 93886 | Intracranial study | S |
| 93888 | Intracranial study | S |
| 93922 | Extremity study | S |
| 93923 | Extremity study | S |
| 93924 | Extremity study | S |
| 93925 | Lower extremity study | S |
| 93926 | Lower extremity study | S |
| 93930* | Upper extremity study | S |
| 93931 | Upper extremity study | S |
| 93965 | Extremity study | S |
| 93970 | Extremity study | S |
| 93971 | Extremity study | S |
| 93975 | Vascular study | S |
| 93976 | Vascular study | S |
| 93978 | Vascular study | S |
| 93979 | Vascular study | S |
| 93990 | Doppler flow testing | S |
| 94015 | Patient recorded spirometry | X |
| 95115 | Immunotherapy, one injection | X |
| 95117* | Immunotherapy injections | X |
| 95165 | Antigen therapy services | X |

| HCPCS Code | Short Description | Status Indicator |
|------------|------------------------------|------------------|
| 95805 | Multiple sleep latency test | S |
| 95806* | Sleep study, unattended | S |
| 95807 | Sleep study, attended | S |
| 95812 | Electroencephalogram (EEG) | S |
| 95813 | Eeg, over 1 hour | S |
| 95816 | Electroencephalogram (EEG) | S |
| 95819 | Electroencephalogram (EEG) | S |
| 95822 | Sleep electroencephalogram | S |
| 95864 | Muscle test, 4 limbs | S |
| 95867* | Muscle test, head or neck | S |
| 95872 | Muscle test, one fiber | S |
| 95900 | Motor nerve conduction test | S |
| 95921 | Autonomic nerv function test | S |
| 95925* | Somatosensory testing | S |
| 95926 | Somatosensory testing | S |
| 95930 | Visual evoked potential test | S |
| 95937 | Neuromuscular junction test | S |
| 95950 | Ambulatory eeg monitoring | S |
| 95953 | EEG monitoring/computer | S |
| 95970* | Analyze neurostim, no prog | S |
| 95972* | Analyze neurostim, complex | S |
| 95974* | Cranial neurostim, complex | S |
| 96000 | Motion analysis, video/3d | S |
| 96100 | Psychological testing | X |
| 96115 | Neurobehavior status exam | X |
| 96117* | Neuropsych test battery | X |
| 96900 | Ultraviolet light therapy | S |
| 96910 | Photochemotherapy with UV-B | S |
| 96912 | Photochemotherapy with UV-A | S |
| 96913 | Photochemotherapy, UV-A or B | S |
| 98925* | Osteopathic manipulation | S |
| 98940 | Chiropractic manipulation | S |
| 99213 | Office/outpatient visit, est | V |
| 99214 | Office/outpatient visit, est | V |
| 99241 | Office consultation | V |
| 99242* | Office consultation | V |
| 99243 | Office consultation | V |
| 99244 | Office consultation | V |
| 99245 | Office consultation | V |
| 99273 | Confirmatory consultation | V |
| 99274 | Confirmatory consultation | V |
| 99275 | Confirmatory consultation | V |
| D0473 | Micro exam, prep & report | S |
| G0101 | CA screen;pelvic/breast exam | V |
| G0127 | Trim nail(s) | T |
| G0166 | Extrnl counterpulse, per tx | T |
| G0175 | OPPS Service,sched team conf | V |
| Q0091 | Obtaining screen pap smear | T |

HCPCS codes shown with an asterisk are bypass codes added to the list for CY 2006.

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2. Calculation of Median Costs for CY 2006

In this section of the preamble, we discuss the use of claims to calculate the OPSS payment rates for CY 2006. The hospital outpatient prospective payment page on the CMS Web site on which this final rule with comment period is posted provides an accounting of claims used in the development of the final rates: <http://www.cms.hhs.gov/providers/hopps>. The accounting of claims used in the development of this final rule with comment period is included on the Web site under supplemental materials for the CY 2006 final rule with comment period. That accounting provides additional detail regarding the number of claims derived at each stage of the process. In addition, below we discuss the files of claims that comprise the data sets that are available for purchase under a CMS data user contract. Our CMS Web site, <http://www.cms.hhs.gov/providers/hopps>, includes information about purchasing the following two OPSS data files: "OPSS Limited Data Set" and "OPSS Identifiable Data Set."

As we proposed, we used the following methodology to establish the relative weights to be used in calculating the OPSS payment rates for CY 2006 shown in Addendum A and in Addendum B to this final rule with comment period. This methodology is as follows:

We used outpatient claims for the full CY 2004 to set the relative weights for CY 2006. To begin the calculation of the relative weights for CY 2006, we pulled all claims for outpatient services furnished in CY 2004 from the national claims history file. This is not the population of claims paid under the OPSS, but all outpatient claims (including, for example, CAH claims, and hospital claims for clinical laboratory services for persons who are neither inpatients nor outpatients of the hospital).

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

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

2 and 3 comprise the 109 million claims that contain hospital bill types paid under the OPSS.

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

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

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

For the cost-to-charge ratio (CCR) calculation process, we used the same approach as we used in developing the final APC rates for CY 2005 (69 FR 65744). That is, we first limited the population of cost reports to only those for hospitals that filed outpatient claims in CY 2004 before determining whether the CCRs for such hospitals were valid. This initial limitation changed the distribution of CCRs used during the trimming process discussed below.

We then calculated the CCRs at a departmental level and overall for each hospital for which we had claims data. We did this using hospital-specific data from the Healthcare Cost Report Information System (HCRIS). We used the most recent available cost report data, in most cases, cost reports for CY 2002 or CY 2003. For this final rule with comment period, we used the most recent cost report available, whether submitted or settled. If the most recent available cost report was submitted but not settled, we looked at the last settled cost report to determine the ratio of submitted to settled cost, and we then adjusted the most recent available submitted but not settled cost report using that ratio.

The overall hospital-specific CCR is the total of costs and charges in those cost centers where we believe that a significant portion of the costs and charges are for services paid under the OPSS. We have included the list of the cost centers that we use in our overall CCR calculation on our Web site along with our cost center to revenue code crosswalk, which we discuss below. We do not include the costs and charges generated by nursing schools or paramedical education programs in our cost and charge totals.

We then flagged CAH claims, which are not paid under the OPSS, and claims from hospitals with invalid CCRs. The latter included claims from hospitals without a CCR; those from hospitals paid an all-inclusive rate; those from

hospitals with obviously erroneous CCRs (greater than 90 or less than .0001); and those from hospitals with CCRs that were identified as outliers (3 standard deviations from the geometric mean after removing error CCRs). In addition, we trimmed the CCRs at the departmental level by removing the CCRs for each cost center as outliers if they exceeded ± 3 standard deviations of the geometric mean. This is the same methodology that we used in developing the final CY 2005 CCRs. For CY 2006, as proposed, we trimmed at the departmental CCR level to eliminate aberrant CCRs that, if found in high volume hospitals, could skew the medians. We used a four-tiered hierarchy of cost center CCRs to match a cost center to a revenue code, with the top tier being the most common cost center and the last tier being the default CCR. If a hospital's departmental CCR was deleted by trimming, we set the departmental CCR for that cost center to "missing," so that another departmental CCR in the revenue center hierarchy could apply. If no other departmental CCR could apply to the revenue code on the claim, we used the hospital's overall CCR for the revenue code in question. The hierarchy of CCRs is available for inspection and comment at the CMS Web site: <http://www.cms.hhs.gov/providers/hopps/default.asp>.

We then converted the charges on the claim by applying the CCR that we believed was best suited to the revenue code indicated on the line with the charge. Table 2 of the proposed rule (70 FR 42690) contained a list of the allowed revenue codes. Revenue codes not included in Table 2 are those not allowed under the OPSS because their services cannot be paid under the OPSS (for example, inpatient room and board charges) and, thus charges with those revenue codes were not packaged for creation of the OPSS median costs. If a hospital did not have a CCR that was appropriate to the revenue code reported for a line-item charge (for example, a visit reported under the clinic revenue code, but the hospital did not have a clinic cost center), we applied the hospital-specific overall CCR, except as discussed in section X. of this preamble for calculation of costs for blood.

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

We identified claims with condition code 41 as partial hospitalization services of CMHCs and moved them to

another file. These claims were combined with the 76X claims identified previously to calculate the partial hospitalization per diem rate.

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

We next copied line-item costs for drugs, blood, and devices (the lines stay on the claim, but are copied off onto another file) to a separate file. No claims were deleted when we copied these lines onto another file. These line-items are used to calculate the per unit median for drugs, radiopharmaceutical agents, and blood and blood products. The line-item costs were also used to calculate the per administration cost of drugs, biologicals (other than blood and blood products), and radiopharmaceutical agents.

We then divided the remaining claims into five groups.

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

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

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

4. *Multiple Minor Claims:* Claims with multiple HCPCS codes that are not separately payable without examining dates of service. For example, pathology codes are not used unless the pathology service is the single code on the bill or unless the pathology code is on a separate date of service from the other procedure on the claim. The multiple minor file has claims with multiple occurrences of pathology codes, with packaged costs that cannot be appropriately allocated across the multiple pathology codes. However, by matching dates of service for the code and the reported costs through the "pseudo" single creation process discussed earlier, a claim with multiple pathology codes may become several "pseudo" single claims with a unique

pathology code and its associated costs on each day. These "pseudo" singles for the pathology codes would then be considered a separately payable code and would be used the same as claims in the single major claim file.

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

We note that the claims listed in numbers 1, 2, 3, and 4 above are included in the data files that can be purchased as described above.

We set aside the single minor claims and the non-OPPS claims (numbers 3 and 5 above) because we did not use either in calculating median cost. We then examined the multiple major and multiple minor claims (numbers 2 and 4 above) to determine if we could convert any of them to single major claims using the process described previously. We first grouped items on the claims by date of service. If each major procedure on the claim had a different date of service and if the line-items for packaged HCPCS and packaged revenue codes had dates of service, we split the claim into multiple "pseudo" single claims based on the date of service.

After those single claims were created, we used the list of "bypass codes" listed in Table 1 of the proposed rule and this final rule with comment period to remove separately payable procedures that we determined contain limited costs or no packaged costs from a multiple procedure bill. A discussion of the creation of the list of bypass codes used for the creation of "pseudo" single claims is contained in section II.A.1.b. of this preamble.

When one of the two separately payable procedures on a multiple procedure claim was on the bypass code list, we split the claim into two single procedure claims records. The single procedure claim record that contained the bypass code did not retain packaged services. The single procedure claim record that contained the other separately payable procedure (but no bypass code) retained the packaged revenue code charges and the packaged HCPCS charges. This enables us to use a claim that would otherwise be a multiple procedure claim and could not be used.

We excluded those claims that we were not able to convert to singles even after applying both of the techniques for creation of "pseudo" singles. We then packaged the costs of packaged HCPCS codes (codes with status indicator "N"

listed in Addendum B to this final rule with comment period) and packaged revenue codes into the cost of the single major procedure remaining on the claim. The list of packaged revenue codes is shown below in Table 2. These are the same as those published in Table 2 of the proposed rule (70 FR 42690).

After removing claims for hospitals with error CCRs, claims without HCPCS codes, claims for immunizations not covered under the OPPS, and claims for services not paid under the OPPS, 58.4 million claims were left. Of these million claims, we were able to use some portion of 52.7 million whole claims (90.24 percent of the potentially usable claims) to create the 88 million single and "pseudo" single claims for use in the CY 2006 median payment rate-setting.

We also excluded (1) claims that had zero costs after summing all costs on the claim and (2) claims containing token charges (charges of less than \$1.01) or for which intermediary systems had allocated charges as if the charges were submitted on the claim. We deleted claims containing token charges because we do not believe that a charge of less than \$1.01 would yield a cost that would be valid to set weights for a significant separately paid service. Moreover, effective for services furnished on or after July 1, 2004, the OCE assigns payment flag number 3 to claims on which hospitals submitted token charges for a service with status indicator "S" or "T" (a major separately paid service under OPPS) for which the intermediary is required to allocate the sum of charges for services with a status indicator equaling "S" or "T" based on the weight for the APC to which each code is assigned. We do not believe that these charges, which were token charges as submitted by the hospital, are valid reflections of hospital resources. Therefore, we deleted these claims.

For the remaining claims, we then wage adjusted 60 percent of the cost of the claim (which we have previously determined to be the labor-related portion), as has been our policy since the initial implementation of the OPPS, to adjust for geographic variation in labor-related costs. We made this adjustment by determining the wage index that applied to the hospital that furnished the service and dividing the cost for the separately paid HCPCS code furnished by the hospital by that wage index. As has been our policy since the inception of the OPPS, we use the pre-reclassified wage indices for standardization because we believe that they better reflect the true costs of items and services in the area in which the hospital is located than the post-

reclassification wage indices, and would result in the most accurate adjusted median costs.

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

A detailed discussion of the medians for blood and blood products is included in section X. of this preamble. A discussion of the medians for APCs that require one or more devices when the service is performed is included in section IV.A. of this preamble. A discussion of the median for observation services is included in section XI. of this preamble and a discussion of the median for partial hospitalization is included below in section II.B. of this preamble.

We received a number of public comments concerning our proposed data processes for calculating the CY 2006 OPPS relative weights and median costs. A summary of the comments and our responses follow:

Comment: Commenters stated that the proposed rule did not provide adequate information for hospitals to evaluate the impact of each of the proposed policy changes independently or in combination. They requested that CMS provide a public use file that shows the impact of each individual proposed change in methodology so that providers can determine how the changes would affect their own operations and provide a basis for comments.

Response: We currently provide provider-specific tables that we understand are very accurate in

estimating the payments individual hospitals will receive. While we wish to make available to the public as much hospital-specific information as possible, there are limits to the resources available to us to provide hospital-specific information. Generally, we provide a broad range of information to the public. We make available our claims data in the form of both a limited data set and a beneficiary encrypted data set for use by the public, including hospitals. In addition, in both the OPSS proposed and final rules each year, we give a detailed description of how we process the paid claims to derive the median costs and how we create relative weights from the median costs. Many different organizations with a broad range of divergent interests currently use this information provided to the public to generate extraordinarily detailed reports and data of interest to them. As this is public information, we would expect that hospital associations and hospitals could do the same, either directly or using alternative sources to determine the impact of various policy options.

Comment: One commenter strongly opposed the requirement that all OPSS encounters furnished on the same day must be billed on a single claim. Some commenters believed that this increases the number of claims that cannot be used for ratesetting by creating multiple procedure claims and creates a needless burden on hospitals to ensure that all encounters on the same date of service are billed on the same claim.

Response: We agree and we have revised our policy governing how services on the same date of service must be billed. See Change Request 4047, Transmittal 711, dated October 14, 2005 for a complete discussion of our current policy. Under this change in policy, there are instances where nonrepetitive OPSS services that are furnished on the same date of service may be billed on different claims as long as all charges that pertain to each service are also reported on the same claim as the HCPCS code that describes that service. We emphasize that it is vitally important to us that all of the charges that pertain to a separately paid service be included on the same claim with the service being billed so that the claim will accurately reflect the full cost of the service. If, for example, charges for a packaged drug, recovery room time, and sterile supplies that were used in providing a surgical service are not included on the claim with the HCPCS code and line-item charge for the use of the operating room for the surgical procedure, those charges for drugs, recovery room, and supplies will not be

packaged with the charge for the OR time for the surgical procedure and that claim will incorrectly and inadvertently lower the median cost for that surgical procedure. This is especially the case if the service is a low volume service. Also, this revised billing policy cannot apply to services for which we use claim-specific OCE logic to determine payments, such as drug administration and observation services, because the OCE claim-by-claim logic cannot function properly if all services provided by a hospital that are related to the services subject to the OCE logic are not reported on the same claim.

Comment: One commenter supported deletion of claims with token or nominal charges (for example, a very small charge such as \$1) but was concerned about exclusion of claims containing multiple surgical or cardiac catheterization services because such exclusions may significantly reduce the number of claims used for rate-setting. The commenter noted that CMS has long permitted hospitals to show a token charge on the line-item with separately paid procedures when they were performed at the same session as a surgical procedure for which a charge is shown as operating room time. Another commenter wanted claims that contain a single payable APC line to be included even if there are token charges on other nonpayable lines on the claim.

Response: The submission of claims for multiple separately paid procedures with the same date of service on which there is a charge for operating room time for one of the HCPCS codes and token charges on the lines for the other separately paid HCPCS codes reflects a difficulty with using multiple procedure claims. (For example, a claim contains three separately paid surgical services, with a charge of \$2,000 for one and charges of \$1 for each of the others, plus a single charge each for drugs, sterile supplies, and recovery room time.) We note if we were to use such claims and allocate packaging to each separately paid procedure (on some basis yet to be determined) and then divide the claim into multiple claims, we would be using claims records that would contain nothing but packaged costs and a token charge for some of those services. Similarly, if we were to focus solely on the procedure with the line charge of \$2,000 and attribute all the packaging to it, we would be overstating the packaging for that service because some of it rightfully belongs with the other two separately paid procedures for which there was a token charge. We acknowledge the commenters' concern and we will continue to pursue an

appropriate way to allocate the costs on these types of claims.

After carefully reviewing all public comments received, we are finalizing the process for calculating median costs and the list of packaged services shown in Table 2 for OPPS services furnished on or after January 1, 2006, as proposed

without modification. Table 2 contains the list of packaged services by revenue code that we used in developing the APC relative weights listed in Addenda A and B of this final rule with comment period.

We note that comments and responses regarding aspects of median cost and

relative weight calculations specific to particular services or particular categories of services are also found in specifically identified sections of this preamble.

BILLING CODE 4120-01-C

Table 2.--CY 2006 Packaged Services by Revenue Code

| Revenue Code | Description |
|---------------------|--|
| 250 | PHARMACY |
| 251 | GENERIC |
| 252 | NONGENERIC |
| 254 | PHARMACY INCIDENT TO OTHER DIAGNOSTIC |
| 255 | PHARMACY INCIDENT TO RADIOLOGY |
| 257 | NONPRESCRIPTION DRUGS |
| 258 | IV SOLUTIONS |
| 259 | OTHER PHARMACY |
| 260 | IV THERAPY, GENERAL CLASS |
| 262 | IV THERAPY/PHARMACY SERVICES |
| 263 | SUPPLY/DELIVERY |
| 264 | IV THERAPY/SUPPLIES |
| 269 | OTHER IV THERAPY |
| 270 | M&S SUPPLIES |
| 271 | NONSTERILE SUPPLIES |
| 272 | STERILE SUPPLIES |
| 274 | PROSTHETIC/ORTHOTIC DEVICES |
| 275 | PACEMAKER DRUG |
| 276 | INTRAOCULAR LENS SOURCE DRUG |
| 278 | OTHER IMPLANTS |
| 279 | OTHER M&S SUPPLIES |
| 280 | ONCOLOGY |
| 289 | OTHER ONCOLOGY |
| 290 | DURABLE MEDICAL EQUIPMENT |
| 343 | DIAGNOSTIC RADIOPHARMS |
| 344 | THERAPEUTIC RADIOPHARMS |
| 370 | ANESTHESIA |
| 371 | ANESTHESIA INCIDENT TO RADIOLOGY |
| 372 | ANESTHESIA INCIDENT TO OTHER DIAGNOSTIC |
| 379 | OTHER ANESTHESIA |
| 390 | BLOOD STORAGE AND PROCESSING |
| 399 | OTHER BLOOD STORAGE AND PROCESSING |
| 560 | MEDICAL SOCIAL SERVICES |
| 569 | OTHER MEDICAL SOCIAL SERVICES |
| 621 | SUPPLIES INCIDENT TO RADIOLOGY |
| 622 | SUPPLIES INCIDENT TO OTHER DIAGNOSTIC |
| 624 | INVESTIGATIONAL DEVICE (IDE) |
| 630 | DRUGS REQUIRING SPECIFIC IDENTIFICATION, GENERAL CLASS |
| 631 | SINGLE SOURCE |
| 632 | MULTIPLE |
| 633 | RESTRICTIVE PRESCRIPTION |
| 681 | TRAUMA RESPONSE, LEVEL I |
| 682 | TRAUMA RESPONSE, LEVEL II |
| 683 | TRAUMA RESPONSE, LEVEL III |
| 684 | TRAUMA RESPONSE, LEVEL IV |
| 689 | TRAUMA RESPONSE, OTHER |
| 700 | CAST ROOM |
| 709 | OTHER CAST ROOM |
| 710 | RECOVERY ROOM |
| 719 | OTHER RECOVERY ROOM |
| 720 | LABOR ROOM |
| 721 | LABOR |
| 762 | OBSERVATION ROOM |
| 810 | ORGAN ACQUISITION |
| 819 | OTHER ORGAN ACQUISITION |
| 942 | EDUCATION/TRAINING |

BILLING CODE 4120-01-P

3. Calculation of Scaled OPPS Payment Weights

Using the median APC costs discussed previously, we calculated the final relative payment weights for each APC for CY 2006 shown in Addenda A and B to this final rule with comment period. As in prior years, we scaled all the relative payment weights to APC 0601 (Mid Level Clinic Visit) because it is one of the most frequently performed services in the hospital outpatient setting. We assigned APC 0601 a relative payment weight of 1.00 and divided the median cost for each APC by the median cost for APC 0601 to derive the relative payment weight for each APC. Using CY 2004 data, the median cost for APC 0601 is \$60.19 for CY 2006.

Section 1833(t)(9)(B) of the Act requires that APC reclassification and recalibration changes, wage index changes, and other adjustments be made in a manner that assures that aggregate payments under the OPPS for CY 2006 are neither greater than nor less than the aggregate payments that would have been made without the changes. To comply with this requirement concerning the APC changes, we compared aggregate payments using the CY 2005 relative weights to aggregate payments using the CY 2006 final relative weights. Based on this comparison, we adjusted the relative weights for purposes of budget neutrality. The unscaled relative payment weights were adjusted by 1.012508103 for budget neutrality. The final relative payment weights are listed in Addenda A and B to this final rule with comment period. The final relative payment weights incorporate the recalibration adjustments discussed in sections II.A.1. and 2. of this preamble.

Section 1833(t)(14)(H) of the Act, as added by section 621(a)(1) of Pub. L. 108-173, states that "Additional expenditures resulting from this paragraph shall not be taken into account in establishing the conversion factor, weighting and other adjustment factors for 2004 and 2005 under paragraph (9) but shall be taken into account for subsequent years." Section 1833(t)(14) of the Act provides the payment rates for certain "specified covered outpatient drugs." Therefore, the cost of those specified covered outpatient drugs (as discussed in section V. of this preamble) is included in the budget neutrality calculations for CY 2006 OPPS.

Under section 1833(t)(16)(C) of the Act, as added by section 621(b)(1) of Pub. L. 108-173, payment for devices of brachytherapy consisting of a seed or

seeds (or radioactive source) is to be made at charges adjusted to cost for services furnished on or after January 1, 2004, and before January 1, 2006. As we stated in our January 6, 2004 interim final rule, charges for the brachytherapy sources will not be used in determining outlier payments and payments for these items will be excluded from budget neutrality calculations for the CY 2006 OPPS. (We provide a discussion of brachytherapy payment issues at section VII. of this final rule with comment period.)

Comment: One commenter indicated that CMS should convene a panel to look at additional data submission requirements that the panel believes would greatly enhance both the reliability of the data and its subsequent use for ratesetting. Specifically, the commenter urged CMS to consider whether to require hospitals to identify the APCs that apply to multiple procedure claims or develop a system that groups multiple procedure claims in a fashion that is analogous to the inpatient prospective payment system.

Response: We fail to understand how hospital reporting of the APCs that apply to services on claims would resolve the issue of how to distribute packaged costs, such as drugs and recovery room time, among multiple procedures billed on the same claim. Therefore, we do not support imposing this reporting burden on hospitals. With respect to grouping procedures into combination APCs for purposes of dealing effectively with services that commonly appear in specific combinations together on claims, we proposed creation of combination APCs for the CY 2004 OPPS to deal with very frequent combinations of services. While we chose not to implement this approach for the CY 2004 OPPS, largely in response to public comments, we have not ruled out such an approach in the future as a way to effectively calculate median costs and set payment rates for services for which the norm is provision in combinations with other services.

4. Changes to Packaged Services

a. Background. Payments for packaged services under the OPPS are bundled into the payments providers receive for separately payable services provided on the same day. Packaged services are identified by the status indicator "N." Hospitals include charges for packaged services on their claims, and the costs associated with these packaged services are then bundled into the costs for separately payable procedures on the claims for purposes of median cost calculations.

Hospitals may use CPT codes to report any packaged services that were performed, consistent with CPT coding guidelines.

As a result of requests from the public, a Packaging Subcommittee to the APC Panel was established to review all the procedural CPT codes with a status indicator of "N." Providers have often suggested that many packaged services could be provided alone, without any other separately payable services on the claim, and requested that these codes not be assigned status indicator "N." As stated in the proposed rule, the Packaging Subcommittee reviewed every code that was packaged in the CY 2004 OPPS (70 FR 42691). Based on comments we have received and their own expert judgment, the subcommittee identified a set of packaged codes that are often provided separately and subsequently reviewed utilization and median cost data for these codes. One of the main criteria utilized by the Packaging Subcommittee to determine whether a code should become unpackaged was how likely it was for the code to be billed without any other separately payable services on the claim. Another criterion used to determine whether a code should become unpackaged was how likely it was for the costs of the packaged code to be appropriately mapped to the separately payable codes with which it was performed. The Packaging Subcommittee also examined median costs from hospital claims for packaged services.

The Packaging Subcommittee identified areas for change for some packaged CPT codes that they believed could frequently be provided to patients as the sole service on a given date and that required significant hospital resources as determined from hospital claims data. During the February 2005 meeting, the APC Panel accepted the report of the Packaging Subcommittee and recommended:

(1) That packaged codes be reviewed by the Panel individually.

(2) That the Packaging Subcommittee continue to meet throughout the year to discuss problematic packaged codes.

(3) That CMS assign a modifier to CPT codes 36540 (Collect blood, venous device); 36600 (Withdrawal of arterial blood); and 51701 (Insertion of non-indwelling bladder catheter), for use when there are no other separately payable codes on the claim. The modifier would flag the OCE to assign payment to the claim.

(4) That CMS maintain the current packaged status indicator for CPT code 76937 (Ultrasound guidance for vascular access).

(5) That CMS change the status indicators for CPT immunization administration codes 90471 and 90472 to allow separate payment and ensure consistency with other injection codes.

(6) That CMS gather more data on CPT code 94762 (Overnight pulse oximetry) to determine how often this code is billed without any other separately payable codes and whether it is performed more frequently alone in rural settings than other settings.

(7) No changes to the packaged status of CPT codes 77790 (Radiation source handling) and 94760 and 94761 (both codes are for procedures to measure blood oxygen levels).

(8) That CMS provide education and consistent guidelines to providers and fiscal intermediaries on correct billing for packaged codes in general, and in particular for CPT codes 36540, 36600, 51701, and the recommended modifier, if approved.

(9) That the Packaging Subcommittee review CPT codes 42550 (Injection for salivary x-ray) and 38792 (Sentinel node imaging).

(10) That CPT code 97602 (Nonselective wound care) be referred to the Physician Payment Group within CMS for evaluation of its bundled status as it relates to services provided under the OPSS and that the Physician Payment Group report its conclusions back to the Panel.

In addition, during its August 2005 meeting, the APC Panel accepted the report of the Packaging Subcommittee and made the following recommendations:

(1) No change to the CY 2005 status indicator of 76937 (N-packaged), ultrasound guidance for vascular access, but requested that CMS collect available hospital claims data on that code for further consideration by the Packaging Subcommittee at the next available meeting.

(2) No change to the CY 2005 status indicator of CPT code 38792 (N-packaged), sentinel node identification, but requested that CMS collect available hospital claims data on that code for further consideration by the Packaging Subcommittee by the next scheduled meeting.

(3) No change to the CY 2005 status indicator of CPT code 42550 (N-packaged), injection for salivary x-ray.

(4) That CMS collect additional data on CPT code 36500, venous catheterization for selective blood organ sampling, and the corresponding radiological supervision and interpretation code, 75893, including a list of other codes with which these codes are most frequently billed, for

consideration by the Packaging Subcommittee.

(5) No change to the CY 2005 status indicator of CPT code 0069T (N-packaged), acoustic heart sound services.

(6) That CMS collect additional data on CPT 94762, overnight pulse oximetry, including a list of other codes with which this code is most frequently billed, for consideration by the Packaging Subcommittee.

b. Responses to the APC Panel Recommendations

For CY 2006, we proposed to maintain CPT codes 36540 (Collect blood venous device) and 36600 (Withdrawal of arterial blood) as packaged services and not adopt the APC Panel's recommendation to assign a modifier to the codes. We noted in our proposed rule that CPT code 36540 was also bundled under the Medicare Physician Fee Schedule (MPFS), and our data demonstrated that the service was generally billed with other separately payable services (70 FR 42691). We also had relatively few single claims for CPT code 36600, compared to the procedure's overall frequency. Both of these codes had relatively low hospital resource utilization. As these procedures were almost always provided with other separately payable services, hospitals' payments for those other services included the costs of CPT codes 36540 and 36600. With respect to the APC Panel's recommendation that the OPSS make payment for one of these services if the code had a modifier appended signifying that it was the only service provided on a day, there is currently no appropriate CPT modifier that could be appended to signal this circumstance. A new HCPCS modifier would not be appropriate because the packaged codes recommended by the APC Panel for separate payment when billed alone are CPT codes.

We received a few public comments concerning this proposal.

Comment: Commenters stated that CPT 36540 should not be assigned status indicator "N" because drawing blood for laboratory work from a venous access device requires that a registered nurse assess the patient and then use a sterile kit to perform the blood draw. They objected to having to report an E/M visit code in order to receive payment for the service when it is the only service provided. The commenters requested that CMS assign the proposed status indicator "Q" for CPT code 36540 so that the OPSS could make payment when it is the only service provided. Similarly, at least one commenter asked

that CMS assign the "Q" status indicator to CPT code 36600.

Response: We continue to believe that the services described by CPT codes 36540 and 36600 are almost always provided in conjunction with other separately payable services in the hospital outpatient department setting. Our data do not support making these services separately payable. We proposed the new "Q" status indicator for services that may be separately payable or packaged depending on special circumstances for CY 2006 only for observation services. Codes assigned this status indicator will require the application of OCE logic to determine the codes' payment status and identify separate payment if appropriate, and then application of the same logic in our data processing to develop median costs for those services for future OPSS updates. We seek to gain some experience with such logic in the OCE and our data processing for observation services prior to considering any expansion of the use of status indicator "Q." Use of the "Q" modifier for procedures that are sometimes packaged would require ongoing maintenance of a list of codes for which this status indicator may be used and their APC assignments if separately paid, as well as additional claims and data processing activities.

After carefully reviewing all comments received, for CY 2006 we are adopting as final without modification our proposal to retain CPT codes 36540 and 36600 as packaged services and not adopt the APC Panel's recommendation to assign a modifier for use when the services are provided with no other separately payable services on the same day.

For CY 2006, we proposed to pay separately for CPT code 51701 (Insertion of non-indwelling bladder catheter), and to map it to APC 0340 (Minor Ancillary Procedures), with status indicator "X", and a median cost of \$39.00. The APC Panel recommended that we pay separately for this code only when there are no other separately payable services on the claim. However, we proposed to pay separately for this code every time it is billed. We believed that it was more appropriate to make payment for each procedure, rather than increase hospitals' administrative burden by requiring specific coding changes to indicate that there were no other separately payable procedures on the claim. Based on our review of the data, the cost for this procedure was not insignificant, and the volume of single and multiple claims was modest. When we reviewed related codes, including CPT code 51702 (Insertion of temporary

indwelling bladder catheter, simple) and CPT code 51703 (Insertion of temporary indwelling bladder catheter, complicated), we noted that these codes also had substantial median costs and a moderate volume of single claims. Therefore, for CY 2006, we proposed to pay separately for CPT codes 51702 and 51703, mapping them to APC 0340 with a median cost of \$39.00 and APC 0164 (Level I Urinary and Anal Procedures) with a median cost of \$72.00, respectively. We proposed that CPT codes 51701, 51702, and 51703 be placed on the bypass list, as discussed in section II.A.1.b. of this final rule with comment period.

The comments we received supported our proposal. Accordingly, we are finalizing our proposal to pay separately for CPT codes 51701 and 51702, and to assign them to APC 0340 with status indicator "X," and a median cost of \$36.00 for CY 2006. We are also finalizing our proposal to pay separately for CPT code 51703, and to assign it to APC 0164 with status indicator "T," and a median cost of \$69.00 for CY 2006.

For CY 2006, we proposed to accept the APC Panel recommendation that CPT code 76937 (Ultrasound guidance for vascular access) remain packaged. We were concerned that there might be unnecessary overuse of this procedure if it were separately payable. In addition, we believed that the service would always be provided with another separately payable procedure, so its costs would be appropriately bundled with the definitive vascular access service. As stated in the CY 2005 final rule with comment period (69 FR 65697), CMS and the Packaging Subcommittee reviewed CY 2004 claims data for CPT code 76937 and determined that this code should remain packaged.

We received several public comments in response to our proposal.

Comment: A few commenters requested that some radiologic guidance codes, such as CPT code 76937 for ultrasound guidance for vascular access and CPT code 75998 for fluoroscopic guidance for central venous access device placement, become separately payable instead of packaged. The commenters stated that each guidance code could be reported with several separately payable procedure codes, thereby skewing the median costs for the procedures and not providing appropriate payment for the procedures when radiologic guidance was used. In addition, one commenter expressed concern that the codes have been packaged due to concern over unnecessary utilization. The commenter stated that an audit is a more

appropriate way to prevent unnecessary utilization. In addition, the commenters cited a finding published in a June 2001 report by the Agency for Healthcare Research and Quality, that use of ultrasound guidance reduces relative risk for complications during a central venous catheter insertion by 78 percent, as a reason that separate payment should be made for CPT code 76937. The commenters also stated that assignment of packaged status to these codes conflicts with CMS' policy as stated in its CY 2003 OPSS final rule, to pay separately for all radiology guidance codes.

Response: OPSS hospital claims data reveal that out of the total instances of CPT code 76937 appearing on claims used for setting payment rates for CY 2006, CPT code 76937 was billed with four separately payable codes for insertion of central venous access devices 84 percent of the time. This indicates, as might be expected, that the costs for CPT code 76937 are typically packaged into four CPT codes, 36556, 36558, 36561, and 36569, the most commonly billed codes under the OPSS for vascular access device insertion. The data for CPT code 75998 reveal similar patterns of utilization and packaging. Of the total instances of CPT code 75998 appearing on claims used for setting payment rates for CY 2006, code 75998 was billed with the same four separately payable codes for insertion of central venous access devices 70 percent of the time. This indicates that the costs for fluoroscopic guidance for central venous access device placement are typically packaged into the same CPT codes as the costs for ultrasound guidance for vascular access. Of single claims used for setting payment rates for CY 2006 for those four CPT codes describing the insertion of vascular access devices, ultrasound guidance was reported from 16 to 34 percent of the time, and fluoroscopic guidance was billed from 29 to 52 percent of the time. For the same four CPT codes, one or more forms of guidance (fluoroscopic and/or ultrasound) were reported on 41 to 64 percent of the single claims utilized for rate-setting. Thus, overall for these vascular access device insertion services, guidance was used in at least 41 percent of the single claim cases, a very significant proportion of the time. If anything, this percentage may underestimate the utilization of guidance for the insertion of vascular access devices, as we have been told that hospitals may not always code separately for packaged services for which no separate payment is made.

Hospital claims data from CY 2004 yield a median cost of \$61.00 for

ultrasound guidance and \$73.00 for fluoroscopic guidance for vascular access. The costs for these guidance procedures are relatively low compared with the CY 2006 payment rates for the separately payable services they most frequently accompany, which range from almost \$500 to about \$1,600. We note that, in general, our payment rates for vascular access device services for CY 2006 are significantly greater than our CY 2005 payment rates for the same services because more specific CY 2004 data available for CPT codes that were new in CY 2004 permitted us to reconfigure the APCs containing vascular access device procedures to improve clinical and resource coherence. In addition, our hospital claims data demonstrate that in CY 2004 guidance services were used frequently for the insertion of vascular access devices, and we have no evidence that patients lacked appropriate access to guidance services necessary for the safe insertion of vascular access devices in the hospital outpatient setting. We believe the increased CY 2006 payment rates for insertion of vascular access devices should result in preservation of appropriate access to medically reasonable and necessary ultrasound and fluoroscopic guidance procedures used to facilitate the insertion of the devices.

If we were to unpackage CPT codes 76937 and 75998, single bills available to develop median costs for vascular access device insertion services would be significantly reduced. In addition, separate payment for an ancillary guidance service always performed in conjunction with other separately payable services could lead to overutilization of the ancillary service, for which payment is more appropriately bundled into the prospectively established payment for the procedure to insert the vascular access device. Our statement regarding paying separately for radiology guidance services in the CY 2003 final rule with comment period was made in the context of our explanation regarding our decision to unpackage certain radiology guidance procedures that had first been packaged for CY 2002, and does not necessarily apply to all radiology guidance services. As for all HCPCS codes, we will continue to evaluate each service, including radiology guidance services, for its most appropriate OPSS payment status, including packaged versus separately payable designation, on a case-by-case basis according to the clinical and resource characteristics of the procedure and the other services with which it would likely be billed.

We will share the CY 2004 and early CY 2005 hospital claims data concerning these vascular access guidance services with the APC Panel Packaging Subcommittee, as recommended by the APC Panel, for their review prior to the next biannual APC Panel meeting.

After carefully considering the public comments received, we are adopting as final without modification our proposal to accept the APC Panel's recommendation that CPT code 76937 remains a packaged service for CY 2006. In addition, we are finalizing our proposal to continue to package CPT code 75998 for CY 2006.

We refer the reader to section VIII. of this preamble on drug administration regarding the APC Panel's recommendation concerning CPT codes 90471 and 90472.

For CY 2006, we proposed to accept the APC Panel recommendation to gather data and review CPT code 94762 to determine how often this code was billed without any other separately payable codes on the same date of service and whether it was performed more frequently alone in rural settings than other settings. During the August 2005 APC Panel meeting, we presented data to the APC Panel regarding CPT code 94762. CY 2004 OPSS hospital claims data indicated at that time that CPT code 94762 was billed only 1,145 times without any separately payable codes on the claim, which was only 1.5 percent of all units of code 94762 billed. Fifty-two percent of the 1,145 single occurrences of CPT code 94762 were provided by rural hospitals. Fifty-two percent was particularly high considering that, when reviewing both single and multiple procedure claims, the data indicated that CPT code 94762 was provided by rural hospitals only 12 percent of the time. The data revealed that rural hospitals were more likely than urban hospitals to bill CPT code 94762 without any separately payable codes on the claim. For purposes of this analysis, a rural hospital was defined as any hospital that is considered rural for payment purposes. In general, this included geographically rural providers as well as providers that were reclassified to rural areas for wage index classification.

We recognize that the data used in the analysis are somewhat limited. Because CPT 94762 is a packaged code and does not receive separate payment, it is possible that an unknown number of hospitals chose not to submit claims to CMS when CPT code 94762 was provided without other separately payable services on their claims.

Comment: Several comments requested that CMS change the status indicator for CPT code 94762 from "N" to "X" and that the service be assigned to APC 0369, (Level III Pulmonary Tests). They stated that because noninvasive ear or pulse oximetry for oxygen saturation, by continuous overnight monitoring, is a prerequisite for providing the medical necessity for home oxygen therapy, this is often the only service provided to beneficiaries during their hospital outpatient visits. The commenters stated that no E/M service is necessary and that it should be possible to receive payment for CPT code 94762 when it is the only service provided.

Response: We continue to believe that the packaged status of CPT code 94762 is appropriate. As discussed during the August 2005 APC Panel meeting, our data do not support separate payment for this service because 98.5 percent of the time, it is provided with separately payable services, and is rarely the only service provided in hospital settings on a single date of service to a Medicare beneficiary.

After carefully considering the public comments received, for CY 2006 we are accepting the APC Panel's recommendations to retain as a packaged service CPT code 94762. We will share the CY 2004 and early CY 2005 hospital claims data concerning CPT code 94762 with the APC Panel Packaging Subcommittee as recommended by the APC Panel, for its review during the next biannual APC Panel meeting.

For CY 2006, we proposed to accept the APC Panel recommendations that CPT codes 77790 (Radiation handling), 94760 (Pulse oximetry for oxygen saturation, single determination), and 94761 (Pulse oximetry for oxygen saturation, multiple determinations) remain packaged. We state our belief that CPT code 77790 was integral to the provision of brachytherapy and should always be billed on the same day with brachytherapy sources and their loading, ensuring that the provider would receive appropriate payment for the radiation source handling bundled with the payment for the brachytherapy service. The small number of single claims for this code in our data verified that this code was rarely billed alone without other payable services on the claim, and those few single claims might be miscoded claims. Our data review of CPT codes 94760 and 94761 revealed that these codes had low resource utilization, and were most frequently provided with other services. Similar to CPT code 77790, there were many fewer single claims for CPT codes

94760 and 94761 than multiple procedure claims that included CPT codes 94760 and 94761. CPT codes 94760 and 94761 describe services that were very commonly performed in the hospital outpatient setting, and unpackaging these codes would likely significantly decrease the number of single claims available for use in calculating median costs for other services.

We did not receive any public comments concerning our proposal. Therefore, for CY 2006 we are finalizing, without modification, our proposal to accept the APC Panel's recommendations to retain as packaged services CPT codes 77790, 94760, and 94761.

For CY 2006, we proposed to accept the APC Panel recommendation to gather data and review CPT codes 42550 (injection for salivary x-ray), and 38792 (sentinel node identification) with the Packaging Subcommittee. In the proposed rule, we stated that this would include analyzing single and multiple procedure claims volume and resource utilization data, and reviewing those studies with the Packaging Subcommittee. During the August 2005 APC Panel meeting, the Panel recommended that we continue to package CPT codes 42550 and 38792 for CY 2006. We believed that CPT code 42550 was appropriately packaged, as were other injection codes that were integral to the provision of some separately payable procedures. In addition, we agreed with the APC Panel that CPT code 38792 was appropriately packaged because we believed that it would almost always be provided with other separately payable procedures on the same date of service, such as nuclear medicine services or surgical procedures.

We received a few public comments regarding our proposal to retain as packaged CPT code 38792.

Comment: The commenters stated that CPT 38792 is sometimes the only service provided in the hospital outpatient department, and that separate payment under the OPSS should be allowed. They stated that there are instances in which the injection for the X-ray is provided in the hospital outpatient department, and then the beneficiary goes to a different setting outside the hospital for the surgery. The commenters requested that CMS assign the proposed "Q" status indicator to this procedure code to make separate payment possible under the OPSS.

Response: We believe that the most appropriate course of action with regard to CPT code 38792 is to retain its packaged status and to collect

additional data and, as recommended by the APC Panel, to then present those data to the Packaging Subcommittee during our next meeting with them. Based on our CY 2004 claims data, we had only four single claims for CPT code 38792. We continue to believe that payment for the injection service is most appropriately packaged with other separately payable services provided on the same date of service, most likely imaging or surgical procedures.

After carefully reviewing and considering the public comments received for CY 2006, we are accepting the APC Panel's recommendations to retain as packaged services CPT codes 38792 and 42550. Payment for those injection services is most appropriately bundled with the payments for other separately payable services provided on the same day.

We will share the CY 2004 and early CY 2005 hospital claims data concerning CPT 38792 with the APC Panel Packaging Subcommittee as recommended by the APC Panel, for its review during the next biannual APC Panel meeting.

As we proposed, we referred CPT code 97602 (Nonselective wound care) for MPFS evaluation of its bundled status as CPT code 97602 relates to services provided under the OPPS.

We received several public comments concerning our proposed treatment of CPT code 97602 for CY 2006, with assignment of status indicator "A." Those comments and others related to wound care services are addressed in section III.D.5.j. of this preamble.

During the August 2005 APC Panel meeting, the Panel recommended that CMS collect additional data on CPT code 36500 (Venous catheterization for selective blood organ sampling) and the corresponding radiological supervision and interpretation code, 75893. We received several clinical scenarios from a provider, indicating that CPT codes 36500 and 75893, both packaged services, were frequently provided on a claim without any separately payable codes. In those cases, the provider did not receive any payment. We believed it was unlikely that these two procedures would be reported without any other separately payable codes on the claim. Our early review of several clinical scenarios revealed that other separately payable codes would likely be provided on the same claim.

We received one comment in response to our proposal to retain packaged status for CPT codes 36500 and 75893.

Comment: One commenter requested that CMS allow separate payment for CPT codes 36500 and 75893 when these

services are the only services on the claim. The commenter stated that there are many times that these are the only procedures performed during a hospital outpatient encounter.

Response: Our data do not support separate payment for these procedures at this time. After considering the comment and the APC Panel's recommendation, we will collect and review additional data to determine which codes are most frequently billed on claims with CPT codes 36500 and 75893. We will share the CY 2004 and early CY 2005 hospital claims data for these venous catheterization and radiological supervision services as recommended by the APC Panel, for its review prior to the next biannual APC Panel meeting.

During the August 2005 APC Panel meeting, the Panel recommended that CMS maintain the packaged status of CPT 0069T (Acoustic heart sound recording and computer analysis only). This code is indicated as an add-on code to an electrocardiography service, according to the American Medical Association's CY 2005 CPT book. Therefore, we believed this code was appropriately packaged because it was integrally related to the provision of electrocardiography, and should never be performed alone.

We received several comments regarding CPT 0069T in response to the code's new interim designation in the CY 2005 final rule with comment period and to our proposal for CY 2006.

Comment: Several commenters requested that CMS change the status indicator for CPT code 0069T (Acoustic heart sound recording and computer analysis only). The commenters requested that CMS assign the procedure to APC 0099 with an "S" status indicator rather than "N," as was the CY 2005 and proposed CY 2006 status indicator for code 0069T. The commenters indicated that the test's status as a packaged procedure results in inequitable payment to hospitals. They stated that the cost of an EKG with the acoustic heart sound recording is \$55, whereas the cost of an EKG without such recording is only \$31. They added that because CMS has packaged the procedure, the hospital is underpaid by \$24 for each test it performs.

Response: It is our understanding that the acoustic heart sound recording and analysis is intended for a specific, targeted group of patients to enhance the provider's ability to diagnose heart failure. The technology always is performed in conjunction with an EKG and as such is ideal for packaging. It is up to hospitals to increase their charges to reflect the additional costs for those

EKGs that include the acoustic heart sound recording. If the hospital uses the test according to the manufacturer's guidelines, the costs will be distributed over the large number of EKGs that are performed in the hospital outpatient department and, over time, the additional costs will be recognized in the OPPS rates as increased payments for other services provided on the same day, likely EKGs. We are accepting the Panel's recommendation that we maintain the packaged status of CPT code 0069T for CY 2006. We will review claims data as they become available for the CY 2007 OPPS update.

We also received several comments that requested status indicator changes for other CPT codes, not previously brought before the Packaging Subcommittee.

Comment: Commenters suggested that the following packaged procedures should be made separately payable: CPT code 96523 (Irrigation of implanted venous access device for drug delivery systems (new code for CY 2006)); CPT code 76001 (Fluoroscopy, physician time more than one hour); CPT code 76003 (Fluoroscopic guidance for needle placement); CPT code 76005 (Fluoroscopic guidance and location of needle or catheter tip); CPT code 74328 (Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation); CPT code 74329 (Endoscopic catheterization of the pancreatic ductal system, radiological supervision and interpretation); CPT code 74330 (Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation); HCPCS code P9612 (Catheterization for collection of specimen); and HCPCS code G0269 (Placement of occlusive device into either a venous or arterial access site, post surgical or interventional procedure).

Response: We believe that the commenters' suggestions bear closer examination. We will not make any changes to the packaged status of these services at this time. Rather, we will collect data related to the costs and utilization of these services for presentation to the Packaging Subcommittee of the APC Panel. We note that the status indicator of CPT code 96523, a new CPT code for CY 2006, is subject to comment in this final rule with comment period. We will discuss with the Packaging Subcommittee, on an ongoing basis, packaged procedures for which status indicator changes have been suggested by the public. The ongoing process allows members some additional time to

consider the issues we bring to them prior to the twice yearly meetings where the subcommittee makes its recommendations to the full APC Panel.

Additional issues and new data concerning the packaging status of codes will be shared with the APC Panel Packaging Subcommittee for its consideration as information becomes available. We continue to encourage submission of common clinical scenarios involving currently packaged HCPCS codes to the Packaging Subcommittee for its ongoing review. Additional detailed suggestions for the Packaging Subcommittee should be submitted to APCPanel@cms.hhs.gov, with "Packaging Subcommittee" in the subject line.

B. Payment for Partial Hospitalization

1. Background

Partial hospitalization is an intensive outpatient program of psychiatric services provided to patients as an alternative to inpatient psychiatric care for beneficiaries who have an acute mental illness. A partial hospitalization program (PHP) may be provided by a hospital to its outpatients or by a Medicare-certified CMHC. Section 1833(t)(1)(B)(i) of the Act provides the Secretary with the authority to designate the hospital outpatient services to be covered under the OPSS. Section 419.21(c) of the Medicare regulations that implement this provision specifies that payments under the OPSS will be made for partial hospitalization services furnished by CMHCs. Section 1883(t)(2)(C) of the Act requires that we establish relative payment weights based on median (or mean, at the election of the Secretary) hospital costs determined by 1996 claims data and data from the most recent available cost reports. Payment to providers under the OPSS for PHPs represents the provider's overhead costs associated with the program. Because a day of care is the unit that defines the structure and scheduling of partial hospitalization services, we established a per diem payment methodology for the PHP APC, effective for services furnished on or after August 1, 2000. For a detailed discussion, refer to the April 7, 2000 OPSS final rule (65 FR 18452).

2. PHP APC Update for CY 2006

To calculate the final CY 2006 PHP per diem payment, we initially used the same methodology that was used to compute the CY 2005 PHP per diem payment. For CY 2005, the per diem amount was based on 12 months of hospital and CMHC PHP claims data (for services furnished from January 1,

2003 through December 31, 2003). We used data from all hospital bills reporting condition code 41, which identifies the claim as partial hospitalization, and all bills from CMHCs because CMHCs are Medicare providers only for the purpose of providing partial hospitalization services. We used CCRs from the most recently available hospital and CMHC cost reports to convert each provider's line-item charges as reported on bills, to estimate the provider's cost for a day of PHP services. Per diem costs were then computed by summing the line-item costs on each bill and dividing by the number of days on the bill.

In a Program Memorandum issued on January 17, 2003 (Transmittal A-03-004), we directed fiscal intermediaries to recalculate hospital and CMHC CCRs using the most recently settled cost reports by April 30, 2003. Following the initial update of CCRs, fiscal intermediaries were further instructed to continue to update a provider's CCR and enter revised CCRs into the outpatient provider specific file. Therefore, for CMHCs, we used CCRs from the outpatient provider specific file.

Historically, the median per diem cost for CMHCs has greatly exceeded the median per diem cost for hospital-based PHPs and has fluctuated significantly from year to year while the median per diem cost for hospital-based PHPs has remained relatively constant (\$200-\$225). We believe that CMHCs may have increased and decreased their charges in response to Medicare payment policies. As discussed in more detail in the next section and in the final rule establishing the CY 2004 OPSS (68 FR 63470), we believe that some CMHCs manipulated their charges in order to inappropriately receive outlier payments.

In the CY 2003 update, the difference in median per diem cost for CMHCs and hospital-based PHPs was so great, \$685 for CMHCs and \$225 for hospital-based PHPs, that we applied an adjustment factor of .583 to CMHC costs to account for the difference between "as submitted" and "final settled" cost reports. By doing so, the CMHC median per diem cost was reduced to \$384, resulting in a combined hospital-based and CMHC PHP median per diem cost of \$273. As with all APCs in the OPSS, the median cost for each APC was scaled to be relative to the cost of a mid-level office visit and the conversion factor was applied. The resulting per diem rate for PHP for CY 2003 was \$240.03.

In the CY 2004 OPSS update, the median per diem cost for CMHCs grew to \$1038, while the median per diem

cost for hospital-based PHPs was again \$225. After applying the .583 adjustment factor to the median CMHC per diem cost, the median CMHC per diem cost was \$605. Since the CMHC median per diem cost exceeded the average per diem cost of inpatient psychiatric care, we proposed a per diem rate for CY 2004 based solely on hospital-based PHP data. The proposed PHP per diem for CY 2004, after scaling, was \$208.95. However, by the time we published the OPSS final rule with comment period for CY 2004, we had received updated CCRs for CMHCs. Using the updated CCRs significantly lowered the CMHC median per diem cost to \$440. As a result, we determined that the higher per diem cost for CMHCs was not due to the difference between "as submitted" and "final settled" cost reports, but were the result of excessive increases in charges which may have been done in order to receive higher outlier payments. Therefore, in calculating the PHP median per diem cost for CY 2004, we did not apply the .583 adjustment factor to CMHC costs to compute the PHP APC. Using the updated CCRs for CMHCs, the combined hospital-based and CMHC median per diem cost for PHP was \$303. After scaling, we established the CY 2004 PHP APC of \$286.82.

Then, in the CY 2005 OPSS update, the CMHC median per diem cost was \$310 and the hospital-based PHP median per diem cost was \$215. No adjustments were determined to be necessary and, after scaling, the combined median per diem cost of \$289 was reduced to \$281.33. We believed that the reduction in the CMHC median per diem cost indicated that the use of updated CCRs had accounted for the previous increase in CMHC charges, and represented a more accurate estimate of CMHC per diem costs for PHP.

As discussed in the proposed rule (70 FR 42693), for CY 2006, we analyzed 12 months of data for hospital and CMHC PHP claims for services furnished between January 1, 2004, and December 31, 2004. The data indicated that the median per diem cost for CMHCs had dropped to \$143, while the median per diem cost for hospital-based PHPs was \$209. It appears that CMHCs significantly reduced their charges in CY 2004 compared to CY 2003. The average charge per day for CMHCs in CY 2003 was \$1,184 and in CY 2004, the CMHC average charge per day dropped to \$765. We have determined that a combination of lower charges and slightly lower CCRs for CMHCs resulted in a significant decline in the CMHC median per diem cost.

Following the methodology used for the CY 2005 OPPS update, the combined hospital-based and CMHC median per diem cost would be \$149, a decrease of 48 percent compared to the CY 2005 combined median per diem amount. We believed that after scaling this amount to the cost of a mid-level office visit, the resulting APC rate would be too low to cover the per diem cost for all PHPs.

As stated in the proposed rule (70 FR 42693), we considered three alternatives to our update methodology for the PHP APC for CY 2006 that would mitigate this drastic reduction in payment for PHP. One alternative was to base the PHP APC on hospital-based PHP data alone. The median per diem cost of hospital-based PHPs has remained in the \$200–225 range over the last 5 years, while the median per diem cost for CMHC PHPs has fluctuated significantly from a high of \$1,037 to a low of \$143. Under this alternative, we would have used \$209, the median per diem cost for hospital-based PHPs during CY 2004 to establish the PHP APC for CY 2006. However, we believed using this amount would also result in an unacceptable drop in Medicare payments for all PHPs in CY 2006 compared to payments in CY 2005.

The second alternative we considered was to apply a different trimming methodology to CMHC costs in an effort to eliminate the effect of data for those CMHCs that appeared to have excessively increased their charges in order to receive outlier payments. We compared CMHC per diem costs in CY 2003 to CMHC per diem costs in CY 2004 and determined the percentage change. Initially, we trimmed CMHCs claims where the CMHC's per diem costs changed by 50 percent or more from CY 2003 to CY 2004. After combining the remaining CMHC claims with the hospital-based PHP claims, we calculated a median per diem cost of \$160.75. We then analyzed the resulting median per diem cost if we trimmed CMHC claims where the difference in CMHC per diem costs from 2003 to 2004 was 25 percent. This trimming approach resulted in a combined CMHC and hospital-based PHP median per diem cost of \$176. We also trimmed the CMHC claims from the CY 2003 data to see how trimming aberrant data would have affected the combined hospital/CMHC median per diem cost. We found that trimming the claims from the CMHCs with a 25 percent difference in per diem cost from CY 2003 to CY 2004 reduced the \$289 median per diem cost to \$218.

We believe it is important to eliminate aberrant data and we believe trimming

certain CMHC data will provide an incentive for CMHCs to stabilize their charges so that we can use their data in future updates of the PHP APC. However, we believe that the trimming methods described above will also result in an unacceptably large decrease in payment. In addition, the trimming method we used was based on percentage change in cost per day, and may not have identified all the CMHCs that may have manipulated their charges in order to receive more outlier payments, for example, CMHCs with high charges and no reduction in charges compared to CY 2003.

Although we prefer to use both CMHC and hospital data to establish the PHP APC, as stated in the proposed rule (70 FR 42693) we continue to be concerned about the volatility of the CMHC data. The analyses we conducted for the proposed rule seem to indicate that eliminating aberrant CMHC data results in a median per diem cost more in line with hospital data. We stated in the proposed rule that we would continue to analyze the CMHC data in developing payment rates, and cautioned that we may use only hospital data in the future if the data continue to be unstable.

In the proposed rule, we stated that we considered a third alternative that would lessen the PHP payment reduction for CY 2006, yet provide an adequate payment amount to promote access to the partial hospitalization benefit for Medicare beneficiaries (70 FR 42694). Using this approach, for CY 2006, we proposed to apply a 15-percent reduction in the combined hospital-based and CMHC median per diem cost that was used to establish the CY 2005 PHP APC. We scaled that amount relative to the cost of a mid-level office visit to establish the PHP APC for CY 2006. We believed a reduction in the CY 2005 median per diem cost would strike an appropriate balance between using the best available data and providing adequate payment for a program that often spans 5–6 hours a day. We believed 15 percent was an appropriate reduction because it recognizes decreases in median per diem costs in both the hospital data and the CMHC data, and also reduces the risk of any adverse impact on access to these services that might result from a large single-year rate reduction. However, we proposed that the reduction in payments for PHP be a transitional measure, and proposed to continue to monitor CMHC costs and charges for these services and work with CMHCs to improve their reporting so that payments can be calculated based on better empirical data, consistent with

the approach we have used to calculate payments in other areas of the OPPS.

We received 58 public comments in response to this proposal. A summary of the comments is provided below along with our responses.

Comment: In general, the commenters expressed concern that a reduction in the PHP rate of 15 percent would lead to the closure of many PHPs and that limited access to this crucial service would result in more costly inpatient hospital care as the only alternative. CMHCs commented that their costs are higher than hospitals', with most in the \$300 to \$400 range. Another commenter indicated that a per diem rate of \$300 to \$350 was more appropriate than our proposed amount.

A few commenters also suggested alternatives such as including prior years' CMHC data trended forward based on medical inflation, using a rolling-average or maintaining the CY 2005 payment rate for PHP services furnished in CY 2006.

Response: For the final rule, we analyzed 12 months of more current data for hospital and CMHC PHP claims for services furnished between January 1, 2004 and December 31, 2004. This claims data is more current in that it includes claims paid through June 30, 2005. We also used the most currently available cost-to-charge ratios to estimate costs. Using this updated data, we recreated the analysis performed for this year's proposed rule to determine if the significant factors we used in determining the proposed PHP rate had changed. The median per diem cost for CMHCs increased slightly to \$154, while the median per diem cost for hospital-based PHPs decreased slightly to \$201. The CY 2004 average charge per day for CMHCs was \$760 similar to the figure noted in the proposed rule (\$765) but still significantly lower than what is noted for CY 2003 (\$1,184). We continue to believe that a combination of reduced charges and slightly lower CCRs for CMHCs resulted in a significant decline in the CMHC median per diem cost between CY 2003 and CY 2004.

Following the methodology used for the CY 2005 OPPS update, the combined hospital-based and CMHC median per diem cost would be \$161, a decrease of 44 percent compared to the CY 2005 combined median per diem amount. While this figure is somewhat higher than the \$149 combined median in the proposed rule, we believe that this amount is still too low to cover the cost for all PHPs.

As we did in the proposed rule, we again considered three alternatives to our update methodology for the PHP

APC for CY 2006 that would mitigate the payment differences for PHP services. The first alternative was to base the PHP APC on hospital-based PHP data alone. Using the most recent years available data, the median per diem cost of hospital-based PHPs for CY 2004 is \$201, somewhat less than the \$209 median per diem cost of hospital-based PHP using the proposed rule CY 2004 data. We continue to believe that using \$201 would be too low for all PHPs in CY 2006. However, we do believe the decrease from \$209 to \$201 from the proposed rule to this final rule with comment continues the trend in lower per diem costs for hospital-based PHPs.

The second alternative we considered was to apply the same trimming methodology noted in the proposed rule to CMHC costs in an effort to eliminate the effect of data for those CMHCs that appeared to have excessively increased their charges in order to receive outlier payments. Again, using the most recent available data, we compared CMHC per diem costs in CY 2003 to CMHC per diem cost in CY 2004 and determined the percentage change. Initially, we trimmed CMHC claims where the CMHC's per diem costs changed by 50 percent or more from CY 2003 to CY 2004. After combining the remaining CMHC claims with the hospital-based PHP claims, we calculated a median per diem cost of \$165, slightly more than noted in the proposed rule. Again, this approach still produced a per diem cost we believe is too low. We then trimmed CMHC claims where the difference in CMHC per diem costs from 2003 to 2004 were 25 percent or more. This trimming variant produced a CMHC median per diem cost of \$172 for CY 2004.

We continue to believe that trimming certain aberrant CMHC data will provide an incentive for CMHCs to stabilize their charges so that we can use their data in future updates of the PHP APC. However, the two trimming methods described above produce median per diem costs that we believe are too low for the CY 2006 PHP APC rate.

The CY 2004 claims data coincides with the effective date of the separate CMHC outlier threshold policy which became effective January 1, 2004. We believe that this policy may have, in part, contributed to the rapid decreases in CMHC's per diem charges in CY 2004. If so, we may see charges stabilize in the CY 2005 claims data which would enable us to use the CMHC data to compute the CY 2007 rate.

We proposed a 15 percent reduction to the combined hospital-based and CMHC median per diem cost for CY

2006. We have conducted further analysis of more complete CY 2004 claims data combined with more recently available cost-to-charge ratios. The newer data continue to produce a combined hospital-based and CMHC median per diem cost that is an unacceptable decrease from CY 2005 PHP APC rate. We continue to believe that 15 percent is an appropriate reduction because it recognizes decreases in median per diem costs in the hospital data and the CMHC data, and also reduces the risk of adverse impact on access to these services that might result from a large single-year rate reduction.

To apply this methodology, we reduce \$289 (the CY 2005 combined hospital-based and CMHC median per diem cost) by 15 percent, resulting in a combined median per diem cost of \$245.65. After scaling, the resulting APC final rate for PHP of \$246.04 for CY 2006, of which \$49.21 is the beneficiary's coinsurance.

Comment: A few commenters stated that CMHC facility costs increased in virtually every area including salaries, benefits, supplies, insurance, dietary support, transportation, communications and administrative support and that they experienced overall increases in expenses of more than 5 percent in most areas. These commenters requested that CMS increase the per diem rate paid for PHP services consistent with the inflation rate for the medical industry. Another commenter suggested we use inpatient costs per day as the basis for the PHP median per diem cost. This commenter suggested that CMS develop an adjustment factor relative to the inpatient psychiatric facility prospective payment system per diem base rate to form the basis for the PHP per diem rate.

Response: The statute does not provide for the update strategies suggested by these commenters and is specific as to the update methodology.

Comment: A few commenters indicated that the methodology used to compute the PHP APC distorts per diem costs because the claims include non-paid days.

Response: If a provider has charges on a bill for which they do not receive payment, this will be reflected in that provider's cost-to-charge ratio. This lower cost-to-charge ratio will be applied to the larger charges and will result in the appropriate cost per diem.

Comment: A few commenters stated that they are unable to collect coinsurance from their patients, that Medicaid cuts have made it more difficult to stay viable, and that the proposed rate reduction would cause PHP programs to close.

Response: The Medicare bad debt policy and Medicaid payment policies are beyond the scope of the July 25, 2005 OPPS proposed rule. We note the bad debt policy can be located in the Medicare Provider Reimbursement Manual, Pub. 15, Chapter 3 or through the following link: http://www.cms.hhs.gov/manuals/pub151/PUB_15_1.asp.

Comment: With respect to the methodology used to establish the PHP APC amount, commenters expressed concern that data from settled cost reports fails to include costs reversed on appeal and that there are inherent problems in using claims data from a different time period like available cost-to-charge ratios on settled cost reports.

These commenters also stated that this can only artificially lower the actual median costs. The commenters claim that when cost reports are settled, generally 2 years or more after the actual year of services, they have operated on actual revenues of 80 percent of the per diem.

Response: We use the best available data in computing the APCs. With respect to PHP services, we specifically issued a Program Memorandum on January 17, 2003 directing FIs to update the cost-to-charge ratios on an on-going basis whenever a more recent full year cost report is available. In this way, we hoped to minimize the time lag between the cost-to-charge ratios and claims data.

Comment: One commenter related that administrative costs for CMHCs continue to be a major impediment to operating PHPs for Medicare beneficiaries. Medicare does not cover transportation to and from programs and does not cover meals. Almost all programs offer transportation because in most cases Medicare beneficiaries with serious mental illnesses would not be able to access these programs without the transportation.

Response: The services that are covered as part of a PHP are specified in section 1861(ff) of the Act. Meals and transportation are specifically excluded under section 1861(ff)(2)(I) of the Act.

Comment: Several commenters simply summed the payment rates for three Group Therapy Sessions (APC 0325) and one Extended Individual Therapy Session (APC 0323) and requested that amount as the minimum for a day of PHP. These same commenters then questioned why the per diem amount is considerably less than the combined cost of these services.

Response: We do not believe this is an appropriate comparison. It is important to note that the APC services cited by

the commenter (APC 0325 and APC 0323) are not PHP services, but rather single outpatient therapeutic sessions. PHP is a complete program of services with efficiencies and economies of scale provided in contrast to individual psychotherapy services. We also believe that the commenters used only the median cost from single bills, for example, where group psychotherapy was the only service furnished. As stated earlier, we used data from PHP programs (both hospitals and CMHCs) to determine the median cost of a day of PHP. PHP is a complete program of services with efficiencies and economies of scale provided in contrast to individual psychotherapy services.

The PHP APC (0033) reflects the program of services provided in that it consists of the cost of all services provided each day and does not reflect a sole service. Although we require that each PHP day include a psychotherapy service, we do not specify the specific mix of other services provided and have focused our analysis on the cost per day rather than the cost of each service furnished within the day.

Comment: One commenter requested that the same provisions given to rural hospital outpatient departments also be given to rural CMHCs.

Response: We believe the commenter may be referring to the statutory hold harmless provisions. Section 1833(t)(7)(D) of the Act authorizes such payments, on a permanent basis, for children's hospitals and cancer hospitals and, through CY 2005, for rural hospitals having 100 or fewer beds and sole community hospitals in rural areas. Section 1866(t)(7)(D) of the Act does not authorize hold harmless payments to CMHC providers.

Comment: We received several comments from CMHCs stating that their costs are higher as hospitals can share and spread their costs to other departments. These commenters also indicated that the CMHC patient acuity level is more intense than the hospital patients as hospital outpatient departments need only provide 1 or 2 therapies, yet still receive the full per diem.

Response: By definition, a PHP bill must have at least 3 partial hospitalization HCPCS codes for each day of service, one of which must be a psychotherapy HCPCS code (other than brief psychotherapy). This requirement is applied to all partial hospitalization bills, whether provided in an outpatient hospital department or in a CMHC. Therefore, hospital outpatient departments must provide the same level of program intensity and must provide for the same level of patient

acuity as CMHCs in order to receive payment.

Comment: A few commenters requested that CMS revise the CMHC cost report form (CMS-2088) to include a field which allows the CMHC to report its Medicare PHP days. They also recommended that we revise settlement worksheet D on the CMS-2088 to include new fields that display the Medicare PHP cost per day and separate PHP reimbursement between outlier and non-outlier reimbursement (since the current cost report form commingles both types of reimbursement). Finally, the commenters recommended that we revise the CMHC Provider Statistical & Reimbursement Report Type: 76P to include a field which reports actual paid Medicare PHP days.

Response: We appreciate the commenters suggestions for improving the Medicare cost report for CMHCs. We plan to explore these and other modifications to improve CMHC cost reporting so that we may use CMHC data in future ratesetting.

Comment: A few commenters stated that hospitals that offer partial hospitalization services should not be penalized for the instability in data reporting that stems from CMHCs.

Response: We believe hospitals-based PHPs have actually benefited from our combining hospital and CMHC data to compute the PHP APC rate. The median calculated from hospital outpatient department PHPs has consistently been far less than the median amount that is computed for CMHCs.

Comment: One commenter who represents CMHCs expressed frustration over several unsuccessful attempts at becoming a member of the APC panel.

Response: The qualifications and selection of the APC Panel members is outside the scope of this regulation. We refer the commenter to <http://www.cms.hhs.gov/faca/apc/default.asp> for information on the APC panel.

3. Separate Threshold for Outlier Payments to CMHCs

In the November 7, 2003 final rule with comment period (68 FR 63469), we indicated that, given the difference in PHP charges between hospitals and CMHCs, we did not believe it was appropriate to make outlier payments to CMHCs using the outlier percentage target amount and threshold established for hospitals. There was a significant difference in the amount of outlier payments made to hospitals and CMHCs for PHP. Further analysis indicated the use of OPPS outlier payments for CMHCs was contrary to the intent of the general OPPS outlier policy. Therefore, for CYs 2004 and 2005, we established

a separate outlier threshold for CMHCs. We designated a portion of the estimated 2.0 percent outlier target amount specifically for CMHCs, consistent with the percentage of projected payments to CMHCs under the OPPS in each of those years, excluding outlier payments.

As stated in the November 15, 2004 final rule with comment period, CMHCs were projected to receive 0.6 percent of the estimated total OPPS payments in CY 2005 (69 FR 65848). The CY 2005 CMHC outlier threshold is met when the cost of furnishing services by a CMHC exceeds 3.5 times the PHP APC payment amount. The current outlier payment percentage is 50 percent of the amount of costs in excess of the threshold.

CMS and the Office of the Inspector General are continuing to monitor the excessive outlier payments to CMHCs. As previously stated, we used CY 2004 claims data to calculate the CY 2006 per diem payment. These data show the effect of the separate outlier threshold for CMHCs that was effective January 1, 2004. During CY 2004, the separate outlier threshold for CMHCs resulted in \$1.8 million in outlier payments to CMHCs, within the 2.0 percent of total OPPS payments identified for CMHCs. In contrast, for CY 2003, more than \$30 million was paid to CMHCs in outlier payments. We believe this difference in outlier payments indicates that the separate outlier threshold for CMHCs has been successful in keeping outlier payments to CMHCs in line with the percentage of OPPS payments made to CMHCs.

In the proposed rule, CMHCs were projected to receive 0.6 percent of the estimated total OPPS payments in CY 2006. As noted in section II.H. of this preamble, for CY 2006, we proposed to set the target for hospital outpatient outlier payments at 1.0 percent of total OPPS payments. We also proposed allocate a portion of that 1.0 percent, 0.6 percent (or 0.006 percent of total OPPS payments), to CMHCs for PHP services. As discussed in section II.G. below, we proposed to set a dollar threshold in addition to an APC multiplier threshold for hospital OPPS outlier payments. However, because PHP is the only APC for which CMHCs may receive payment under the OPPS, we would not expect to redirect outlier payments by imposing a dollar threshold. Therefore, we did not set a dollar threshold for CMHC outliers. We proposed to set the outlier threshold for CMHCs for CY 2006 at 3.45 percent times the APC payment amount and the CY 2006 outlier payment percentage applicable to costs in excess of the threshold at 50 percent. As we did with the hospital

outlier threshold, we used hospital charge inflation factor to inflate charges to CY 2006.

We received no comments on our proposal. As discussed in section II.H, using more recent data for this final rule, we set the target for hospital outpatient outlier payments at 1.0 percent of total OPPS payments. We also allocate a portion of that 1.0 percent, 0.6 percent (or 0.006 percent of total OPPS payments), to CMHCs for PHP services. As we proposed, we set a dollar threshold in addition to an APC multiplier threshold for hospital OPPS outlier payments. However, because PHP is the only APC for which CMHCs may receive payment under the OPPS, we would not expect to redirect outlier payments by imposing a dollar threshold. Therefore, we did not set a dollar threshold for CMHC outliers. For CY 2006, we set the outlier threshold for CMHCs at 3.40 percent times the APC payment amount and the CY 2006 outlier payment percentage applicable to costs in excess of the threshold at 50 percent. As we did with the hospital outlier threshold, we used hospital charge inflation factor to inflate charges to CY 2006.

C. Conversion Factor Update for CY 2006

Section 1833(t)(3)(C)(ii) of the Act requires us to update the conversion factor used to determine payment rates under the OPPS on an annual basis. Section 1833(t)(3)(C)(iv) of the Act provides that, for CY 2006, the update is equal to the hospital inpatient market basket percentage increase applicable to hospital discharges under section 1886(b)(3)(B)(iii) of the Act.

The forecast of the hospital market basket increase for FY 2006 published in the IPPS final rule on August 12, 2005, is 3.7 percent (70 FR 47392), rather than the 3.2 percent forecast published in the IPPS proposed rule on May 4, 2005 (70 FR 23384) and referenced in the CY 2006 OPPS proposed rule. To set the OPPS proposed conversion factor for CY 2006, we increased the CY 2005 conversion factor of \$56.983, as specified in the November 15, 2004 final rule with comment period (69 FR 65842), by 3.7 percent.

In accordance with section 1833(t)(9)(B) of the Act, we further adjusted the conversion factor for CY 2005 to ensure that the revisions we are making to our updates by means of the wage index are made on a budget neutral basis. We calculated a budget neutrality factor of 1.001485209 for wage index changes by comparing total payments from our simulation model

using the FY 2006 IPPS final wage index values to those payments using the current (FY 2005) IPPS wage index values. In addition, to accommodate the rural adjustment discussed in section II.G. of this preamble, we calculated a budget neutrality factor of 0.99614506 by comparing payments with the rural adjustment to those without. For CY 2006, we estimate that allowed pass-through spending will equal approximately \$45.5 million, which represents 0.17 percent of total OPPS projected spending for CY 2006. The conversion factor is also adjusted by the difference between the 2.0 percent pass-through set-aside and the 0.17 percent estimate of pass-through spending. Finally, decreasing payments for outliers to 1.0 percent of total payments, as proposed, returned 1.0 percent to the conversion factor.

The market basket increase update factor of 3.7 percent for CY 2006, the required wage index budget neutrality adjustment of approximately 1.001485209, the return of 1.0 percent in total payments from a reduced outlier target, the return of 1.83 percent of the pass-through set-aside, and the adjustment for the rural payment adjustment of 0.99614506 result in a conversion factor for CY 2006 of \$59.511.

We received several public comments on the proposed conversion factor update for CY 2006.

Comment: Several commenters requested CMS to revise the market basket update included in the final OPPS rule to include a 3.7 percent market basket update, consistent with the IPPS final rule.

Response: We have used a 3.7 percent market basket increase update factor in our conversion factor calculation for the CY 2006 OPPS update.

Comment: One commenter suggested that CMS increase total payments to hospitals by 3.2 percent and not the 1.9 percent total payment increase indicated in the regulatory impact analysis section of the proposed rule.

Response: The 1.9 percent reported in column 6 of Table 33 in the regulatory analysis section of the proposed rule is not the 3.2 percent that appears in column 5 because it models all payments to hospitals. The 1.9 percent reflects the loss of payment for drugs outside of OPPS authorized by Pub. L. 108-173, that expires in CY 2006. The statute requires CMS to take into account, for purposes of establishing a budget neutral CY 2006 update, the additional costs associated with payments for specified covered outpatient drugs. The regulatory impact analysis accompanying this final rule

with comment period demonstrates a similar loss. The market basket increase update factor of 3.7 percent is offset by the drug payments in CY 2006 that were made outside the system in CY 2005, to result in an overall increase of 2.2 percent.

Accordingly, we are finalizing the conversion factor update for CY 2006 of \$59.511.

D. Wage Index Changes for CY 2006

Section 1833(t)(2)(D) of the Act requires the Secretary to determine a wage adjustment factor to adjust, for geographic wage differences, the portion of the OPPS payment rate and the copayment standardized amount attributable to labor and labor-related cost. This adjustment must be made in a budget neutral manner. As we have done in prior years, we proposed to adopt the IPPS wage indices and extend these wage indices to TEFRA hospitals that participate in the OPPS but not the IPPS.

As discussed in section II.A. of this preamble, we standardize 60 percent of estimated costs (labor-related costs) for geographic area wage variation using the IPPS wage indices that are calculated prior to adjustments for reclassification to remove the effects of differences in area wage levels in determining the OPPS payment rate and the copayment standardized amount.

As published in the original OPPS April 7, 2000 final rule (65 FR 18545), OPPS has consistently adopted the final IPPS wage indices as the wage indices for adjusting the OPPS standard payment amounts for labor market differences. As initially explained in the September 8, 1998 OPPS proposed rule, we believed and continue to believe that using the IPPS wage index as the source of an adjustment factor for OPPS is reasonable and logical, given the inseparable, subordinate status of the hospital outpatient within the hospital overall. In accordance with section 1886(d)(3)(E) of the Act, the IPPS wage index is updated annually. In the CY 2006 OPPS proposed rule, in accordance with our established policy, we proposed to use the FY 2006 final version of these wage indices with any corrections posted on the CMS Web site, to determine the wage adjustments for the OPPS payment rate and copayment standardized amount that we will publish in our final rule for CY 2006.

We note that the FY 2006 IPPS wage indices continue to reflect a number of changes implemented in FY 2005 as a result of the new OMB standards for defining geographic statistical areas, the implementation of an occupational mix adjustment as part of the wage index,

and new wage adjustments provided for under Pub. L. 108–173. The following is a brief summary of the proposed changes in the FY 2005 IPPS wage indices, continued for FY 2006, and any adjustments that we are applying to the OPSS for CY 2006. We refer the reader to the FY 2006 IPPS final rule (70 FR 47363 through 47387, August 12, 2005) for a detailed discussion of the changes to the wage indices. In this final rule with comment period, we are not reprinting the FY 2006 IPPS wage indices referenced in the discussion below, with the exception of the out-migration wage adjustment table (Addendum L of this final rule with comment period). We refer readers to the CMS Web site for the OPSS at <http://www.cms.hhs.gov/providers/hops>. At this Web site, the reader will find a link to the FY 2006 IPPS wage indices tables and any corrections made to them.

1. The continued use of the new Core Based Statistical Areas (CBSAs) issued by the Office of Management and Budget (OMB) as revised standards for designating geographical statistical areas based on the 2000 Census data, to define labor market areas for hospitals for purposes of the IPPS wage index. The OMB revised standards were published in the **Federal Register** on December 27, 2000 (65 FR 82235), and OMB announced the new CBSAs on June 6, 2003, through an OMB bulletin. In the FY 2005 hospital IPPS final rule, CMS adopted the new OMB definitions for wage index purposes. In the FY 2006 IPPS final rule, we again stated that hospitals located in MSAs will be urban and hospitals that are located in Micropolitan Areas or Outside CBSAs will be rural. To help alleviate the decreased payments for previously urban hospitals that became rural under the new MSA definitions, we allowed these hospitals to maintain their assignment to the MSA where they previously had been located for the 3-year period from FY 2005 through FY 2007. To be consistent with IPPS, we will continue the policy we began in CY 2005 of applying the same criterion to TEFRA hospitals paid under the OPSS but not under the IPPS and to maintain that MSA designation for determining a wage index for the specified period. Beginning in FY 2008, these hospitals will receive their statewide rural wage index, although those hospitals paid under the IPPS will be eligible to apply for reclassification. In addition to this “hold harmless” provision, the FY 2005 IPPS final rule implemented a 1-year transition for hospitals that experienced a decrease in their FY 2005 wage index

compared to their FY 2004 wage index due solely to the changes in labor market definitions. These hospitals received 50 percent of their wage indices based on the new MSA configurations and 50 percent based on the FY 2004 labor market areas. In the FY 2006 IPPS final rule, we discussed the cessation of the 1-year transition and announced that hospitals will receive 100 percent of their wage index based upon the new CBSA configurations beginning in FY 2006. Again, for the sake of consistency with IPPS, TEFRA hospitals will receive 100 percent of their wage index based upon the new CBSA configurations beginning in CY 2006.

2. We are applying the occupational mix adjustment for FY 2006 IPPS to 10 percent of the average hourly wage and leave 90 percent of the average hourly wage unadjusted for occupational mix. As noted in the FY 2006 IPPS final rule, we are, essentially, using the same CMS Wage Index Occupational Mix Survey and Bureau of Labor Statistics data to calculate the adjustment. Because there are no significant differences between the FY 2005 and the FY 2006 occupational mix survey data and results, we believe it is appropriate to adopt the IPPS rule and apply the same occupational mix adjustment to 10 percent of the FY 2006 wage index.

3. The reclassifications of hospitals to geographic areas for purposes of the wage index. For purposes of the OPSS wage index, we are adopting all of the IPPS reclassifications for FY 2006, including reclassifications that the Medicare Geographic Classification Review Board (MGCRB) approved under the one-time appeal process for hospitals under section 508 of Pub. L. 108–173. We note that section 508 reclassifications will terminate March 31, 2007.

4. We are continuing to apply an adjustment to the wage index to reflect the “out-migration” of hospital employees who reside in one county but commute to work in a different county with a higher wage index, in accordance with section 505 of Pub. L. 108–173 (FY 2006 IPPS final rule (70 FR 47383 and 47384, August 12, 2005)). Hospitals paid under the IPPS located in the qualifying section 505 “out-migration” counties receive a wage index increase unless they have already been reclassified under section 1886(d)(10) of the Act, redesignated under section 1886(d)(8)(B) of the Act, or reclassified under section 508. As discussed in the FY 2006 IPPS final rule, we finalized our policy that reclassified hospitals not receive the out-migration adjustment unless they waive their reclassified

status. For OPSS purposes, we are continuing our policy from CY 2005 to apply the same 505 criterion to TEFRA hospitals paid under the OPSS but not paid under the IPPS. Because TEFRA hospitals cannot reclassify under sections 1886(d)(8) and 1886(d)(10) of the Act or section 508, they are eligible for the out-migration adjustment. Therefore, TEFRA hospitals located in a qualifying section 505 county will also receive an increase to their wage index under OPSS. Addendum L to this final rule with comment period lists all hospitals that will receive an out-migration adjustment to their wage index in 2006 including TEFRA hospitals that will receive an out-migration adjustment under this OPSS final rule with comment period. (See also Table 4J of the Addendum to the FY 2006 IPPS final rule).

We used the final FY 2006 IPPS indices to adjust the payment rates and coinsurance amounts that are included in this OPSS final rule with comment period for CY 2006. With the exception of reclassifications resulting from the implementation of the one-time appeal process under section 508 of Pub. L. 108–173, all changes to the wage index resulting from geographic labor market area reclassifications or other adjustments must be incorporated in a budget neutral manner. Accordingly, in calculating the OPSS budget neutrality estimates for CY 2006, we have included the wage index changes that result from MGCRB reclassifications, implementation of section 505 of Pub. L. 108–173, and other refinements made in the FY 2006 IPPS final rule, such as the hold harmless provision for hospitals changing status from urban to rural under the new CBSA geographic statistical area definitions. However, section 508 set aside \$900 million to implement the section 508 reclassifications. We considered the increased Medicare payments that the section 508 reclassifications would create in both the IPPS and OPSS when we determined the impact of the one-time appeal process. Because the increased OPSS payments already counted against the \$900 million limit, we did not consider these reclassifications when we calculated the OPSS budget neutrality adjustment.

We received two public comments on the application of the FY 2006 IPPS wage indices under the OPSS.

Comment: One commenter supported our proposal to extend the IPPS wage indices to OPSS because this simplifies payment for hospitals.

One commenter suggested that OPSS use different labor share percentages for hospitals with a wage index below 1.0

and hospitals with a wage index above 1.0. The commenter specifically cited the requirement in Pub. L. 108–173 that IPPS use a larger labor share percentage for hospitals with wage indexes over 1.0 and a relatively smaller labor share percentage for hospitals with wage indexes less than 1.0. This commenter specifically requested that CMS use a labor share of 50 percent for hospitals with wage indexes less than 1.0.

Response: Section 403 of Pub. L. 108–173 requires that IPPS hospitals be paid using a labor-related share of 62 percent unless this labor-related share would result in lower payments than would otherwise be made. Unlike IPPS, OPSS has no mandate to reduce the labor-related share. The OPSS labor-related share was determined through regression analyses conducted for the initial OPSS proposed rule (63 FR 47581, September 8, 1998). Those analyses identified 60 percent as the appropriate labor share for outpatient services. We confirmed that this labor-related share is still appropriate during our regression analysis for the payment adjustment for rural hospitals in this final rule. In these regression equations, the coefficient of the hospital wage index is the estimated percentage change in unit costs attributable to a 1 unit percent increase in the wage index, which is an estimate of the share of outpatient unit costs attributable to labor. Both Table 5 and Table 6 in section II.G. of this preamble indicate a coefficient of 63 percent for the wage index. In light of both analyses, we believe that the current 60 percent labor-related share remains appropriate for OPSS payment purposes.

After carefully considering the public comments received, we are finalizing our wage index adjustment policy for

CY 2006 OPSS as proposed without modification.

E. Statewide Average Default Cost-to-Charge Ratios (CCRs)

CMS uses CCRs to determine outlier payments, payments for pass-through devices, and monthly interim transitional corridor payments under the OPSS. Some hospitals do not have a valid CCR. These hospitals include, but are not limited to, hospitals that are new and have not yet submitted a cost report, hospitals that have a CCR that falls outside predetermined floor and ceiling thresholds for a valid CCR, or hospitals that have recently given up their all-inclusive rate status. Last year, we updated the default urban and rural CCRs for CY 2005 in our final rule, published on November 15, 2004 (69 FR 65821 through 65825). As we proposed, in this final rule with comment period, we have updated the default ratios using the most recent cost report data for CY 2006.

We calculated the statewide default CCRs using the same CCRs that we use to adjust charges to costs on claims data. Table 3 of the proposed rule (70 FR 42696) listed the proposed CY 2006 default urban and rural CCRs by State. These CCRs are the ratio of total costs to total charges from each provider's most recently submitted cost report, for those cost centers relevant to outpatient services. We also adjusted these ratios to reflect final settled status by applying the differential between settled to submitted costs and charges from the most recent pair of settled to submitted cost reports.

For the proposed rule, 80.79 percent of the submitted cost reports represented data for CY 2003. We have since updated the cost report data we use to calculate cost to charge ratios

with additional submitted cost reports for CY 2004. For the final rule, 51.66 percent, the majority of the submitted reports utilized in the default ratio calculation, were for CY 2003. We only used valid CCRs to calculate these default ratios. That is, we removed the CCRs for all-inclusive hospitals, CAHs, and hospitals in Guam and the U.S. Virgin Islands because these entities are not paid under the OPSS, or in the case of all-inclusive hospitals, because their CCRs are suspect. We further identified and removed any obvious error CCRs and trimmed any outliers. We limited the hospitals used in the calculation of the default CCRs to those hospitals that billed for services under the OPSS during CY 2003.

Finally, we calculated an overall average CCR, weighted by a measure of volume for CY 2003, for each State except Maryland. This measure of volume is the total lines on claims and is the same one that we use in our impact tables. For Maryland, we used an overall weighted average CCR for all hospitals in the Nation as a substitute for Maryland CCRs, which appeared in Table 3. Very few providers in Maryland are eligible to receive payment under the OPSS, which limits the data available to calculate an accurate and representative CCR. The overall decrease in default statewide CCRs can be attributed to the general decline in the ratio between costs and charges widely observed in the cost report data.

We did not receive any public comments concerning the proposed statewide average default CCRs. Therefore, we are finalizing them as shown in Table 3 below for OPSS services furnished on or after January 1, 2006.

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Table 3.--Statewide Average Cost-to-Charge Ratios (CCRs)

| State | Urban/Rural | Previous Default CCR | Default CCR |
|----------------------|-------------|----------------------|-------------|
| ALABAMA | RURAL | 0.31552 | 0.23418 |
| ALABAMA | URBAN | 0.2986 | 0.21741 |
| ALASKA | RURAL | 0.59388 | 0.54605 |
| ALASKA | URBAN | 0.38555 | 0.39832 |
| ARIZONA | RURAL | 0.39748 | 0.30658 |
| ARIZONA | URBAN | 0.30922 | 0.24132 |
| ARKANSAS | RURAL | 0.35936 | 0.29108 |
| ARKANSAS | URBAN | 0.38278 | 0.27611 |
| CALIFORNIA | RURAL | 0.40335 | 0.26409 |
| CALIFORNIA | URBAN | 0.32427 | 0.22126 |
| COLORADO | RURAL | 0.51041 | 0.39223 |
| COLORADO | URBAN | 0.41863 | 0.28236 |
| CONNECTICUT | RURAL | 0.42702 | 0.38081 |
| CONNECTICUT | URBAN | 0.46592 | 0.38571 |
| DELAWARE | RURAL | 0.36289 | 0.35359 |
| DELAWARE | URBAN | 0.45061 | 0.42436 |
| DISTRICT OF COLUMBIA | URBAN | 0.3869 | 0.34874 |
| FLORIDA | RURAL | 0.31782 | 0.22179 |
| FLORIDA | URBAN | 0.28363 | 0.20998 |
| GEORGIA | RURAL | 0.39829 | 0.30927 |
| GEORGIA | URBAN | 0.40262 | 0.29195 |
| HAWAII | RURAL | 0.4442 | 0.34871 |
| HAWAII | URBAN | 0.34815 | 0.32641 |
| IDAHO | RURAL | 0.49682 | 0.41757 |
| IDAHO | URBAN | 0.51942 | 0.46269 |
| ILLINOIS | RURAL | 0.41825 | 0.31279 |
| ILLINOIS | URBAN | 0.36825 | 0.27474 |
| INDIANA | RURAL | 0.44596 | 0.35138 |
| INDIANA | URBAN | 0.44205 | 0.3498 |
| IOWA | RURAL | 0.50166 | 0.40375 |
| IOWA | URBAN | 0.46963 | 0.34645 |
| KANSAS | RURAL | 0.48065 | 0.34407 |
| KANSAS | URBAN | 0.34698 | 0.26461 |
| KENTUCKY | RURAL | 0.36987 | 0.28358 |
| KENTUCKY | URBAN | 0.37381 | 0.29116 |
| LOUISIANA | RURAL | 0.34317 | 0.27617 |
| LOUISIANA | URBAN | 0.34357 | 0.25738 |
| MAINE | RURAL | 0.47857 | 0.385 |
| MAINE | URBAN | 0.54084 | 0.43839 |
| MARYLAND | RURAL | 0.7038 | 0.3362 |
| MARYLAND | URBAN | 0.68104 | 0.30235 |
| MASSACHUSETTS | URBAN | 0.44439 | 0.34321 |
| MICHIGAN | RURAL | 0.4489 | 0.36976 |
| MICHIGAN | URBAN | 0.41143 | 0.33319 |
| MINNESOTA | RURAL | 0.48514 | 0.46788 |
| MINNESOTA | URBAN | 0.45259 | 0.34301 |
| MISSISSIPPI | RURAL | 0.34264 | 0.28672 |
| MISSISSIPPI | URBAN | 0.37097 | 0.25325 |
| MISSOURI | RURAL | 0.42187 | 0.30823 |
| MISSOURI | URBAN | 0.38128 | 0.2907 |
| MONTANA | RURAL | 0.51173 | 0.45445 |
| MONTANA | URBAN | 0.49396 | 0.41281 |
| NEBRASKA | RURAL | 0.49386 | 0.39625 |
| NEBRASKA | URBAN | 0.42043 | 0.29024 |
| NEVADA | RURAL | 0.42878 | 0.46867 |
| NEVADA | URBAN | 0.22854 | 0.21197 |
| NEW HAMPSHIRE | RURAL | 0.50083 | 0.37552 |
| NEW HAMPSHIRE | URBAN | 0.39954 | 0.32278 |
| NEW JERSEY | URBAN | 0.49024 | 0.28231 |
| NEW MEXICO | RURAL | 0.44932 | 0.29838 |
| NEW MEXICO | URBAN | 0.50857 | 0.37082 |
| NEW YORK | RURAL | 0.52062 | 0.43021 |
| NEW YORK | URBAN | 0.54625 | 0.41179 |
| NORTH CAROLINA | RURAL | 0.37776 | 0.32018 |

| State | Urban/Rural | Previous Default CCR | Default CCR |
|----------------|-------------|----------------------|-------------|
| NORTH CAROLINA | URBAN | 0.42726 | 0.35682 |
| NORTH DAKOTA | RURAL | 0.52829 | 0.37434 |
| NORTH DAKOTA | URBAN | 0.47341 | 0.36945 |
| OHIO | RURAL | 0.42562 | 0.38349 |
| OHIO | URBAN | 0.42718 | 0.30535 |
| OKLAHOMA | RURAL | 0.40628 | 0.31287 |
| OKLAHOMA | URBAN | 0.36264 | 0.27113 |
| OREGON | RURAL | 0.47915 | 0.38707 |
| OREGON | URBAN | 0.49958 | 0.3986 |
| PENNSYLVANIA | RURAL | 0.40582 | 0.32748 |
| PENNSYLVANIA | URBAN | 0.33807 | 0.25961 |
| PUERTO RICO | URBAN | 0.42208 | 0.42501 |
| RHODE ISLAND | URBAN | 0.4393 | 0.30402 |
| SOUTH CAROLINA | RURAL | 0.35996 | 0.25726 |
| SOUTH CAROLINA | URBAN | 0.36961 | 0.25645 |
| SOUTH DAKOTA | RURAL | 0.49599 | 0.37687 |
| SOUTH DAKOTA | URBAN | 0.44259 | 0.31324 |
| TENNESSEE | RURAL | 0.36663 | 0.28343 |
| TENNESSEE | URBAN | 0.36464 | 0.2595 |
| TEXAS | RURAL | 0.41763 | 0.30769 |
| TEXAS | URBAN | 0.33611 | 0.27468 |
| UTAH | RURAL | 0.49748 | 0.47797 |
| UTAH | URBAN | 0.46733 | 0.43421 |
| VERMONT | RURAL | 0.47278 | 0.44428 |
| VERMONT | URBAN | 0.54533 | 0.39407 |
| VIRGINIA | RURAL | 0.39408 | 0.29042 |
| VIRGINIA | URBAN | 0.38604 | 0.2976 |
| WASHINGTON | RURAL | 0.54246 | 0.40571 |
| WASHINGTON | URBAN | 0.54658 | 0.381 |
| WEST VIRGINIA | RURAL | 0.42671 | 0.32565 |
| WEST VIRGINIA | URBAN | 0.45616 | 0.38024 |
| WISCONSIN | RURAL | 0.50126 | 0.39136 |
| WISCONSIN | URBAN | 0.46268 | 0.3672 |
| WYOMING | RURAL | 0.54596 | 0.4687 |
| WYOMING | URBAN | 0.41265 | 0.38414 |

BILLING CODE 4120-01-P*F. Expiring Hold Harmless Provision for Transitional Corridor Payments for Certain Rural Hospitals*

When the OPPS was implemented, every provider was eligible to receive an additional payment adjustment (transitional corridor payment) if the payments it received for covered OPD services under the OPPS were less than the payments it would have received for the same services under the prior

reasonable cost-based system (section 1833(t)(7) of the Act). Section 1833(t)(7) of the Act provides that the transitional corridor payments are temporary payments for most providers, with two exceptions, to ease their transition from the prior reasonable cost-based payment system to the OPPS system. Cancer hospitals and children's hospitals receive the transitional corridor payments on a permanent basis. Section 1833(t)(7)(D)(i) of the Act originally

provided for transitional corridor payments to rural hospitals with 100 or fewer beds for covered OPD services furnished before January 1, 2004. However, section 411 of Pub. L. 108-173 amended section 1833(t)(7)(D)(i) of the Act to extend these payments through December 31, 2005, for rural hospitals with 100 or fewer beds. Section 411 also extended the transitional corridor payments to SCHs located in rural areas for services

furnished during the period that begins with the provider's first cost reporting period beginning on or after January 1, 2004, and ends on December 31, 2005. Accordingly, the authority for making transitional corridor payments under section 1833(t)(7)(D)(i) of the Act, as amended by section 411 of Pub. L. 108-173, will expire for rural hospitals having 100 or fewer beds and SCHs located in rural areas on December 31, 2005. For CY 2006, transitional corridor payments will continue to be available to cancer and children's hospitals. (We note that the succeeding section II.G. of this preamble discusses an additional provision of section 411 of Pub. L. 108-173 that related to a study to determine appropriate adjustment to payments for rural hospitals under the OPSS beginning January 2006.)

We received four public comments concerning this hold harmless policy.

Comment: The commenters expressed concern about the impact that the expiration of the transitional corridor hold harmless payments would have on small rural hospitals because these are vulnerable facilities that provide important access to care in their communities.

One commenter recommended that the provision be expanded to permanently extend the hold harmless payments to small rural hospitals and rural SCHs, as is currently the case for cancer hospitals and children's hospitals. Two commenters referenced efforts by a large hospital association to work with Congress on legislation to provide for this expansion.

Response: We appreciate the comments that were submitted and we have carefully reviewed each of them. As the commenters acknowledge, section 1833(t)(7)(D) of the Act, as amended by section 411 of Pub. L. 108-173, provides that OPSS transitional corridor payments will expire for rural hospitals having 100 or fewer beds and SCHs located in rural areas on December 31, 2005. Therefore, we are providing for the termination of these payments in this final rule with comment period. However, as noted in section II.G. of this final rule with comment period, we are providing a 7.1 percent adjustment for rural sole community hospitals in accordance with section 411 of Pub. L. 108-173.

G. Adjustment for Rural Hospitals

Section 411 of Pub. L. 108-173 added a new paragraph (13) to section 1833(t) of the Act. New section 1833(t)(13)(A) specifically instructs the Secretary to conduct a study to determine if rural hospital outpatient costs exceed urban hospital outpatient costs. Moreover,

under new section 1833(t)(13)(B) of the Act, the Secretary is given authorization to provide an appropriate adjustment to rural hospitals by January 1, 2006, if rural hospital costs are determined to be greater than urban hospital costs.

As described in our CY 2006 OPSS proposed rule, we used regression analysis to study the differences in outpatient cost per unit between rural and urban hospitals because we believed that a simple comparison of unit costs would not capture the myriad of factors that contribute to observed costs, including labor supply, complexity, and volume of services. For this final rule with comment period, we reran these regression analyses that we conducted in the proposed rule and conducted additional analyses in response to issues raised in public comments.

For this final rule with comment period, our regression analysis included all 4,088 hospitals billing under OPSS for which we could model accurate cost per unit estimates. For each hospital, total outpatient costs and descriptive information were derived from a more complete set of CY 2004 Medicare claims than was used in the analysis for the proposed rule and the hospital's most recently submitted cost report. The description of claims used, our methodology for creating costs from charges, and a description of the specific hospitals included in our modeling are discussed in section II. A. of this preamble. We excluded separately payable drugs and biologicals, services receiving pass-through payments, and any service paid under a separate payment system from our analysis. We excluded the 49 hospitals in Puerto Rico because their wage indices and unit costs are so different that they would have skewed results. Finally, we excluded facilities whose unit outpatient costs were outside of 3 standard deviations from the geometric mean unit outpatient cost.

We calculated the total unit outpatient cost for each hospital by dividing total outpatient cost by the total number of APC units discounted for the joint performance of multiple surgical procedures. (See section II.G.1. below for a definition of discounted units.) As in the analysis for the proposed rule, we modeled both explanatory and payment regression models. In an "explanatory model" approach, all variables that are hypothesized to be important determinants of cost are included in the cost regression, whether or not they are going to be used as payment adjustments. We used the explanatory regression models to assess which class

of rural hospitals, if any, is significantly more costly than urban hospitals. In a "payment model" approach, the only independent variables included in the cost regression are those variables considered for payment adjustments. We used the payment model to determine the amount of the adjustment for any class of hospitals identified as significantly more costly in the explanatory model. The regression equations for both models were specified in double logarithmic form. The dependent variable in the explanatory regression equation was unit outpatient cost. The dependent variable in the payment regressions was standardized unit outpatient costs, that is, unit outpatient costs adjusted to reflect unit payment by dividing through by the provider's service-mix index which was adjusted by the provider's wage index. The service-mix index is a measure of the resource intensity of services provided by each hospital. Both regression equation models included quantitative independent variables transformed into natural logarithms and categorical independent variables. Categorical independent (dummy) variables included hospital characteristics such as rural location or type of hospital (short stay or specialty hospital). In regression analysis, dummy variables capture the difference in means of the dependent variable in the class of hospitals of interest and all other hospitals, holding all other variables in the equation constant.

1. Factors Contributing to Unit Cost Differences Between Rural Hospitals and Urban Hospitals and Associated Explanatory Variables

For this final rule with comment period, we retained the same set of explanatory variables as used in the regression analysis for the proposed rule because we believe that these variables capture the most important factors contributing to differences in unit costs between rural and urban hospitals.

- First, unit outpatient costs are expected to vary directly with the prices of inputs used to produce outpatient services, especially labor. Wage rates tend to be lower in rural areas than in urban areas. We used the OPSS hospital wage index for CY 2006 as our measure of relative differences in labor input costs.

- Second, there may be economies of scale in producing outpatient services, which imply that unit costs will vary inversely with the volume of outpatient services provided. We used the total number of discounted units as our indicator of volume. Discounted units

are the total number of units after we adjust for the multiple procedure reduction of 50 percent that applies to payment for surgical services when two surgical procedures are performed during the same operative session. For example, if a procedure is paid at 100 percent of payment 1,000 times and the same procedure is paid at 50 percent of payment 100 times, the discounted units for that procedure equal 1,050 units (the sum of 1,000 units at full payment plus 100 units at 50 percent payment).

- Third, independent of the volume of outpatient services, hospitals that provide more complex outpatient services are expected to have higher unit costs than hospitals with less complex service-mixes. Typically, greater complexity involves a combination of higher equipment and labor costs. Rural hospitals usually have less volume and perform less complex services than urban hospitals. We used a service-mix index defined as the ratio of the number of discounted units weighted by APC relative weights divided by the number of unweighted discounted units as our measure of complexity. The service-mix index reflects the average APC weight of each facility's outpatient services. From our analysis, we also believe that the

number of beds captures variation in unit costs attributable to the additional complexity of services performed by a hospital that is not explained by their service mix index.

- Fourth, the size of a hospital may influence the volume and service-mix of outpatient services. Large hospitals generally provide a wider range of more complex services than do small hospitals. Large hospitals may also have larger volumes in ancillary departments that are shared between outpatient and inpatient services, and as a result, benefit from greater economies of scale than do small hospitals. Rural hospitals tend to be smaller than urban hospitals. Our primary measure of outpatient volume is discounted units of APCs, which only reflects the volume of Medicare services paid under the outpatient PPS. This measure does not include the inpatient utilization of shared ancillary departments or non-Medicare outpatient services. For all of these reasons, it seems appropriate to include a broader measure of facility size in the explanatory regression model. Therefore, as explained below, we used the total number of facility beds to measure facility size. Unit outpatient costs may be positively or negatively related to facility size depending on whether complexity

effects, noted above, or scale economies are more important.

- In addition to the above factors, we included additional categorical variables to indicate the types of specialty hospitals that participate in OPPS, specifically cancer, children's, long-term care, rehabilitation, and psychiatric hospitals because we do not believe that the costs, volume, and service-mix associated with these hospitals looks like the costs, volume, and service mix of a typical OPPS provider.

- Finally, we included several categorical variables for rural/urban location and type of rural hospital to capture variation unexplained by the other independent variables in the model. Urban hospitals are the reference group for all of the different types of hospitals examined included in the regressions equations below. Table 4 provides descriptive statistics for the dependent variables and key independent variables by urban and rural status. Without controlling for the other influences on per unit cost, rural hospitals have a lower cost per unit than urban hospitals. However, when standardized for the service-mix wage indices, average unit costs are nearly identical between urban and rural hospitals.

TABLE 4.—MEANS AND STANDARD DEVIATIONS (IN PARENTHESIS) FOR KEY VARIABLES BY RURAL AND URBAN LOCATION

| Variable | Rural | | Urban | |
|---|----------|--------------------|----------|--------------------|
| | Means | Standard Deviation | Means | Standard Deviation |
| Unit Outpatient Cost | \$157.57 | (\$64.94) | \$188.76 | (\$93.53) |
| Standardized Unit Outpatient Cost | \$75.51 | (\$55.70) | \$73.54 | (\$40.98) |
| Wage Index | 0.8807 | (0.1012) | 1.0212 | (0.1479) |
| Service-Mix Index | 2.3636 | (0.9357) | 2.7544 | (1.6037) |
| Outpatient Volume | 21,021 | (21,770) | 38,469 | (46,925) |
| Beds | 78 | (56) | 196 | (170) |
| Number of Hospitals | 1,206 | | 2,882 | |

2. Results

For this final rule with comment period, we began our analysis by rerunning the regression models that we had examined for the proposed rule. As a group, all rural hospitals continue to demonstrate weak evidence of slightly higher unit costs than urban hospitals, after controlling for labor input prices, service-mix complexity, volume, facility size, and type of hospital. In the explanatory model, regressing unit costs on all of the independent variables discussed above, the coefficient for the rural categorical variable was 0.024 (p=0.0613). If the unit costs of rural hospitals are the same as the unit costs of urban hospitals, the probability of

observing a value as extreme as or more extreme than 2.4 percent would be approximately 6 percent or less. This suggests that rural hospitals are approximately 2.4 percent more costly than urban hospitals after accounting for the impact of other explanatory variables. This is the same coefficient observed in the regression analyses for the proposed rule. The results of this regression appear in Table 5. This regression demonstrated reasonably good explanatory power with an adjusted R2 of 0.54 (rounded). Adjusted R2 is the percentage of variation in the dependent variable explained by the independent variables and is a standard measure of how well the regression

model fits the data. The regression coefficients of the key explanatory variables all move in the expected direction: positive for the wage index, indicating that rural hospitals can be expected to have lower unit outpatient costs because they tend to be located in areas with lower wage rates; positive for the outpatient service-mix index, consistent with the hypothesis that rural hospitals' less complex outpatient service-mixes result in lower unit costs than those of the typical urban hospital; negative for outpatient service volume, implying that, on average, rural hospitals' lower service volumes are a source of higher unit cost compared to urban hospitals; and positive for the

facility size variable (beds), suggesting that facility size is more reflective of complexity than any economies of scale.

The payment regression that accompanies this explanatory model

indicates an adjustment for all rural hospitals of 4.3 percent.

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Table 5.--Regression Results for Unit Outpatient Cost: Rural Versus Urban

| Variable | Explanatory | | | Payment | | |
|--------------------------|------------------------|----------------------|----------------------|------------------------|----------------------|----------------------|
| | Regression Coefficient | t Value ¹ | p Value ² | Regression Coefficient | t Value ¹ | p Value ² |
| Intercept | 4.96886 | 127.93 | <.0001 | 4.22095 | 664.32 | <0.0001 |
| Wage Index | 0.62958 | 17.53 | <.0001 | | | |
| Service-Mix Index | 0.73528 | 59.98 | <.0001 | | | |
| Outpatient Volume | -0.07419 | -16.66 | <.0001 | | | |
| Beds | 0.04851 | 6.80 | <.0001 | | | |
| All Rural Hospitals | 0.02394 | 1.87 | 0.0613 | 0.04212 | 3.60 | 0.0003 |
| Children's Hospitals | 0.02866 | 0.60 | 0.5483 | | | |
| Psychiatric Hospitals | -0.48134 | -16.85 | <.0001 | | | |
| Long-Term Care Hospitals | -0.12577 | -4.21 | <.0001 | | | |
| Rehabilitation Hospitals | -0.30148 | -9.57 | <.0001 | | | |
| Cancer Hospitals | 0.31344 | 3.50 | 0.0005 | | | |
| | | | | | | |
| Adj. R2 ³ | 0.5383 | | | | | |

NOTE: Coefficients of all quantitative variables are elasticities since both the dependent variable, unit outpatient cost, and all quantitative independent variables were in natural logarithms. To calculate percentage differences for categorical variables, their coefficients must be raised to the power, e, the base of natural logarithms.

¹A t value is an indicator of our degree of confidence that the regression coefficient is different from zero, taking into account the statistical variability of the estimated coefficient.

²A p value is the probability of observing the specific t value when the estimated coefficient is zero. The t values greater than 2 and less than -2 indicate a probability less than 5 percent, p-value<0.05, that the estimated coefficient is zero.

³ Adjusted R2 is the percentage of variation in the dependent variable explained by the independent variables and is a standard measure of how well the regression model fits the data. No adjusted R2 is reported for the payment regression because the purpose of this model is not to explain all variation in the dependent variable but to determine the amount of the payment adjustment. The dependent variable reflects unit payment not unit cost.

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As we did for our proposed rule, we divided rural hospitals into categories that reflected their eligibility for the expiring hold harmless provision under section 1833(t)(7)(D) of the Act in order to determine whether the small difference in costs was uniform across classes of rural hospitals or whether all of the variation was attributable to a specific type of rural hospitals. Specifically, we divided rural hospitals into rural SCHs, rural hospitals with 100 or fewer beds that are not rural SCHs, and other rural hospitals. The first two categories of rural hospitals are currently eligible for payments under the expiring hold harmless provision.

As indicated in the proposed rule, we found that rural SCHs demonstrated significantly higher cost per unit than

urban hospitals after controlling for labor input prices, service-mix complexity, volume, facility size, and type of hospital. The results of this regression appear in Table 6. With the exception of the new rural variables, the independent variables have the same sign and significance as in Table 5. Rural SCHs have a positive and significant coefficient. The rural SCH variable has an explanatory regression coefficient of 0.06044 and an observed probability of 0.0003. If the unit costs of rural SCHs are the same as those of urban hospitals, the probability of observing a value as extreme or more extreme than 6.2 percent would be less than 0.1 percent. This is sufficient evidence to accept that rural SCHs are more costly than urban hospitals, holding all other variables constant.

Notably, we observe no significant difference between all small rural hospitals with 100 or fewer beds and urban hospitals or between other rural hospitals and urban hospitals. In the explanatory regression presented in Table 6, the dummy variable for small rural hospitals has an observed coefficient of 0.01203 and an associated probability of 0.4748. If the unit costs of small rural hospitals are the same as those of urban hospitals, the probability of observing a value as extreme or more extreme than 1.2 percent would be less than 50 percent. With such a high probability, there is insufficient evidence to conclude that rural hospitals with 100 or fewer beds are more costly than urban hospitals, holding all other variables constant. The results are almost identical when

volume and facility size are not included in the equation. Finally, the dummy variable for other rural hospitals has an observed coefficient of -0.01646 and an associated probability of 0.4545 . If the unit costs of other rural hospitals are the same as those of urban hospitals,

the probability of observing a value as extreme or more extreme than -1.7 percent would be less than 50 percent. These results are also present when facility size and volume are not included in the equation. As with small rural hospitals, this is insufficient

evidence to conclude that other rural hospitals are more costly than urban hospitals. Further, for this group of rural hospitals, the coefficient is negative, indicating lower cost per unit.

Table 6.--Regression Results for Unit Outpatient Cost: Rural Sole Community Hospitals

| Variable | Explanatory | | | Payment | | |
|-----------------------------|------------------------|----------------------|----------------------|------------------------|----------------------|----------------------|
| | Regression Coefficient | t Value ¹ | p Value ² | Regression Coefficient | t Value ¹ | p Value ² |
| Intercept | 4.95656 | 124.68 | <.0001 | 4.22555 | 745.89 | <.0001 |
| Wage Index | 0.62700 | 17.45 | <.0001 | -- | -- | -- |
| Service-Mix Index | 0.73640 | 59.60 | <.0001 | -- | -- | -- |
| Outpatient Volume | -0.07424 | -16.69 | <.0001 | -- | -- | -- |
| Beds | 0.05079 | 6.98 | <.0001 | -- | -- | -- |
| Rural SCH | 0.06044 | 3.61 | 0.0003 | 0.06865 | 4.09 | <.0001 |
| Small Rural Hospitals | 0.01203 | 0.71 | 0.4748 | -- | -- | -- |
| Other Rural Hospitals | -0.01646 | -0.75 | 0.4545 | -- | -- | -- |
| Children's Hospitals | 0.02882 | 0.60 | 0.5456 | -- | -- | -- |
| Psychiatric Hospitals | -0.47873 | -16.76 | <.0001 | -- | -- | -- |
| Long-Term Care Hospitals | -0.12229 | -4.09 | <.0001 | -- | -- | -- |
| Rehabilitation Hospitals | -0.29848 | -9.47 | <.0001 | -- | -- | -- |
| Cancer Hospitals | 0.31883 | 3.57 | 0.0004 | -- | -- | -- |
| R ² ³ | 0.5394 | | | -- | -- | -- |

NOTE: Coefficients of all quantitative variables are elasticities since both the dependent variables, unit outpatient cost, and all quantitative independent variables were in natural logarithms. To calculate percentage differences for categorical variables, their coefficients must be raised to the power, e , the base of natural logarithms.

¹A t value is an indicator of our degree of confidence that the regression coefficient is different from zero, taking into account the statistical variability of the estimated coefficient.

²A p value is the probability of observing the specific t value when the estimated coefficient is zero. The t values greater than 2 and less than -2 indicate a probability less than 5 percent, p-value <0.05 , that the estimated coefficient is zero.

³ Adjusted R² is the percentage of variation in the dependent variable explained by the independent variables and is a standard measure of how well the regression model fits the data. No adjusted R² is reported for the payment regression because the purpose of this model is not to explain all variation in the dependent variable but to determine the amount of the payment adjustment. The dependent variable reflects unit payment not unit cost.

Based on the above analysis, we continue to believe that a payment adjustment for rural SCHs is warranted. The accompanying payment regression, also appearing in Table 6, indicates a cost impact of 7.1 percent. Thus, in accordance with the authority provided in section 1833(t)(13)(B) of the Act, as added by section 411 of Pub. L. 108-173, we are implementing a 7.1 percent payment increase for rural SCHs for CY 2006. This adjustment will apply to all services and procedures paid under the OPSS, excluding drugs, biologicals, and services paid under the pass-through payment policy. As stated in the proposed rule, this adjustment is budget

neutral, and will be applied before calculating outliers and coinsurance. We will not reestablish the adjustment amount on an annual basis, but we may review the adjustment in the future, and if appropriate, may revise the adjustment. Additional descriptive statistics are available on the CMS Web site.

We received 19 public comments concerning these results.

Comment: Several commenters supported our proposed payment increased for rural SCHs of 6.6 percent.

Response: We appreciate the commenters' support. As we discussed above, based on our most recent

analysis, we are implementing an adjustment of 7.1 percent in this final rule with comment period. We believe that an adjustment at this level remains consistent with the views expressed by the commenters.

Comment: Several commenters expressed concern that the regression analysis, as presented, does not separately set out the regression results for rural hospitals with 100 or fewer beds that are not rural SCHs. They indicate that, while CMS stated that this class of hospitals did not demonstrate significance in the explanatory regression analyses, it did not definitively display these results. The

commenters highlighted the importance of showing these results because these are the facilities that will be losing their hold harmless protection in CY 2006. One of the commenters cited MedPAC's 2005 Report to Congress, which noted that previous MedPAC research indicated higher costs for low-volume hospitals which are predominantly rural. The commenters urged CMS to specifically report the regression results with small rural hospitals with 100 or fewer beds identified separately.

Response: We agree with the commenters that we should identify small rural hospitals with 100 or fewer beds separately in the analysis. The results in Table 6 demonstrate that small rural hospitals with 100 or fewer beds do not appear to have unit costs different from those of urban hospitals after controlling for other contributors to unit cost, including volume.

Comment: Several commenters requested clarification on the definition of rural in order to assess which hospitals would be eligible for the rural adjustment. The commenters asked: Would a SCH located in a rural area that has been reclassified for wage index purposes into an urban area be eligible for the SCH adjustment? Would a SCH located in an urban area that has been reclassified for wage index purposes into a rural area be eligible for the SCH adjustment?

Response: SCHs will be considered rural for the rural adjustment, and for purposes of the OPPS rural adjustment only, under section 1833(t)(13)(B) of the Act if a hospital is geographically located in a rural area or has been reclassified to a rural area for wage index purposes. Therefore, a SCH located in a rural area that has been reclassified for wage index purposes into an urban area will be eligible for the adjustment, regardless of whether the SCH has been reclassified to an urban area for wage index purposes. In addition, a SCH located in an urban area that has been reclassified for wage index purposes into a rural area also will be eligible for the adjustment. New § 419.43(g)(1)(ii) of the regulations, which we are finalizing in this final rule with comment period, will provide that an SCH is eligible for the adjustment if the hospital is "located in a rural area as defined in § 412.64(b) of this chapter or is treated as being located in a rural area under § 412.103." To clarify the text in response to the comments received, we are referencing § 412.103 in the final regulation text instead of the reference to section 1886(d)(8)(E) of the Act. This definition of a "SCH located in a rural area" only will apply for the

purposes of the rural adjustment in this rule.

Comment: One commenter asked if rural SCHs that are participating in the Rural Community Hospital Demonstration Program would be eligible for the rural adjustment.

Response: Rural SCHs participating in the Rural Community Hospital Demonstration Program are eligible to receive this rural adjustment. The Rural Community Hospital Demonstration Program, authorized under section 410A of Pub. L. 108-173, assesses whether rural hospitals will benefit from cost-based reimbursement and is limited to payment for inpatient services. Although SCHs participating in the demonstration program are not eligible to receive traditional SCH payments made under the IPPS, these hospitals retain their SCH status.

Comment: Several commenters requested clarification of whether CMS intends to make this adjustment available beyond CY 2006, and whether it intends to reestablish the adjustment amount on an annual basis.

Response: We will not reestablish the adjustment amount on an annual basis, but we may review the adjustment in the future and, if appropriate, revise the adjustment.

Comment: A few commenters requested that CMS extend the rural adjustment to CMHCs or make some other special allowance or provision for their rural location.

Response: Section 1833(t)(13)(A) of the Act limits the scope of this analysis and any adjustment to comparing rural and urban hospitals costs.

Comment: Several commenters requested that CMS extend the proposed rural adjustment to all SCHs, not just rural hospitals, under its equitable adjustment authority in section 1833(t)(2)(E) of the Act. The commenters described the necessary access to services that urban SCHs provide and highlighted that both urban and rural SCHs have been recognized for special protections by Congress in other payment systems because they are the sole source of inpatient hospital services reasonably available to Medicare beneficiaries.

One commenter used the public use file that CMS provided on its Web site and conducted detailed analyses to assess the appropriateness of an adjustment for urban SCHs. The commenter compared urban SCHs, rural SCHs, other urban hospitals, and other rural hospitals on the number of beds, their service mix, and wage index. The commenter also conducted regression analysis. The first model the commenter examined included a variable for rural

location and a variable for SCH status in addition to the other variables used in CMS' explanatory model. The commenter reported that the SCH variable is significant, suggesting that SCHs are more costly than other non-SCHs controlling for rural or urban status. The commenter concluded that the results indicated SCHs are significantly more costly than hospitals that are not SCHs and that geographic location does not influence this finding.

The same commenter also examined an explanatory model that resembled CMS' explanatory model. The commenter indicated that this model included separate variables for urban SCHs, rural SCHs, and all other rural hospitals in order to isolate the unit cost differences between urban SCHs and other hospitals. The commenter reported that, in this model, the unit costs of urban SCHs were not significantly different from urban, non-SCH unit costs. With regard to this last finding, the commenter suggested that the lack of significance is less important than the comparability in the magnitude of the coefficient for rural and urban SCHs, and that both types of hospitals have coefficients at 6 percent. Finally, the commenter examined the significance of the rural indicator in an explanatory regression model conducted only with SCH hospitals. Within this population, the commenter reported that all explanatory variables are statistically significant, except an indicator for rural status, and suggested that this finding further supports extending the adjustment to urban SCHs. The commenter concluded by requesting that CMS repeat its regression to confirm that SCH status, and not geographic location, is indicative of higher costs, and if it finds this to be true, to appropriately adjust for higher costs.

Response: We do not believe it is sufficient to confirm that all SCHs are significantly more costly than non-SCHs, as the commenter demonstrated in its first regression model because the statutory authority for this adjustment is to be based upon the comparison between urban and rural hospitals. The regression model that includes a variable for SCH status and a variable for rural location only confirms that all SCHs have higher costs than hospitals that are not SCHs and that, having controlled for SCH status, rural and urban hospitals are not different. Rural SCHs comprise 90 percent of all SCH, and are the basis for the observed significance on the SCH variable. Notwithstanding the mandate for this rural adjustment, we believe that urban SCHs would have to demonstrate strong

empirical evidence that they are significantly more costly than other urban hospitals. We do not find the strong empirical evidence supporting an adjustment for urban SCHs, as we do for rural SCHs.

In many respects, urban SCHs look like urban hospitals on some of the key variables presented in Table 4. Urban SCHs have a mean cost per unit of \$183.89, and urban hospitals have a mean cost per unit of \$188.76. Urban SCHs have a mean standardized unit cost of \$74.01, and all urban hospitals have a mean standardized cost of \$73.54. Finally, urban SCHs have a mean volume of 36,714, and urban hospitals have a mean volume of 38,469. Similar to the commenter, we also ran an explanatory regression analysis that included urban SCHs as a separate class of hospitals in addition to rural SCHs, small rural hospitals, and other rural hospitals. In these results, the coefficient associated with urban SCHs was 0.05960 and the associated probability was 0.1624. If the unit costs of urban SCHs are the same as those of urban hospitals, the probability of observing a value as extreme or more extreme than 6.1 percent would be less than 20 percent. We acknowledge the commenter's statement that the size of the coefficient on the urban SCH dummy variable is comparable to that on the dummy variable for rural SCHs. However, we do not believe that the size of the coefficient is sufficient evidence. The lack of significance associated with such a large coefficient is attributable to the much higher standard error accompanying urban SCHs compared to rural SCHs. Higher standard error indicates that there is large variability in unit costs for urban SCHs after controlling for all other variables in the equation. Some urban SCHs may have unit costs as high as rural SCHs, but clearly many do not. We believe that this observation accounts for the lack of significance on the rural variable in the commenter's regression analyses, which was limited to the population of SCHs.

Comment: One commenter requested that CMS examine whether the outpatient costs of Medicare-Dependent Small Rural Hospitals (MDHs), a subgroup of rural hospitals, are higher than urban hospitals' outpatient costs, and provide an adjustment to payments if appropriate.

Response: We did not find any evidence that rural MDHs are more costly than urban hospitals. We ran an explanatory regression analysis that included rural MDHs as a separate class of small rural hospitals from other small rural hospitals because 90 percent of rural MDHs were also small rural

hospitals. We also included all of the other variables in Table 6 above, including rural SCHs and other rural hospitals. In these results, the coefficient associated with rural MDHs was -0.01955 , with an associated probability of 0.4438. If the unit costs of MDHs are the same as those of urban hospitals, the probability of observing a value as extreme or more extreme than 2 percent would be less than 50 percent.

Comment: One commenter argued that CMS excluded variables from the regression model that control for "financial pressure" and "market structure." The commenter argued that higher costs can be the result of inefficient operations as much as they could also be the result of higher input costs created by rural location, and that measures of financial pressure or market structure would capture any variation in unit cost attributable to a lack of local competition. The commenter suggested that SCHs may be inefficient because they already have special payment status under the IPPS and the OPSS. Finally, the commenter suggested that, because beneficiaries' access to care is the central objective of any payment policy, CMS should consider a low-volume adjustment that better captures higher costs that the hospital cannot control. At the same time, the commenter acknowledged that section 1833(t)(13)(A) of the Act specifically requires an analysis of urban and rural costs.

Response: While it is not inappropriate to include additional variables in the explanatory regression analysis, we first note that section 1833(t)(13)(A) of the Act specifically calls a determination of whether costs faced by rural hospitals are higher than those faced by urban hospitals. For this reason, we believe that the model in Table 6 ably controls for scale efficiencies in a comparison of urban and rural costs. Our adjusted R² of 54 percent also demonstrates a relatively good fit. We acknowledge that some of the SCHs eligible for the adjustment may also be more costly because of inefficiencies due to limited competition or because they currently receive special payment status under the IPPS and the OPSS. However, we also agree with the commenter that beneficiary access is an important goal. We believe that the current model is sufficiently robust to identify hospitals with significantly higher costs such that payment under the OPSS alone might impact beneficiary access. The SCH status of these hospitals suggests that they are important to beneficiary access. Rural SCHs receive their designation because they are the only, or one of a

few, sources of care for beneficiaries. For example, these hospitals may be the only immediately available source of emergency services for Medicare beneficiaries.

In accordance with the authority provided in section 1833(t)(13)(B) of the Act, as added by section 411 of Pub. L. 108-173, we are finalizing our policy by including a payment adjustment for rural SCHs of 7.1 percent and finalizing the regulation text at § 419.43(g) as noted above.

H. Hospital Outpatient Outlier Payments

Currently, the OPSS pays outlier payments on a service-by-service basis. For CY 2005, the outlier threshold is met when the cost of furnishing a service or procedure by a hospital exceeds 1.75 times the APC payment amount and exceeds the APC payment rate plus a \$1,175 fixed-dollar threshold. We introduced a fixed-dollar threshold in CY 2005 in addition to the traditional multiple threshold in order to better target outliers to those high cost and complex procedures where a very costly service could present a hospital with significant financial loss. If a provider meets both of these conditions, the multiple threshold and the fixed-dollar threshold, the outlier payment is calculated as 50 percent of the amount by which the cost of furnishing the service exceeds 1.75 times the APC payment rate. For a discussion on CMHC outliers, see section II.B.3. of this final rule with comment period.

As explained in our CY 2005 final rule with comment period (69 FR 65844), we set our projected target for aggregate outlier payments at 2.0 percent of aggregate total payments under the OPSS. Our outlier thresholds were set so that estimated CY 2005 aggregate outlier payments would equal 2.0 percent of aggregate total payments under the OPSS.

For CY 2006, we proposed to set our projected target for aggregate outlier payments at 1.0 percent of aggregate total payments under the OPSS. A portion of that 1.0 percent, an amount equal to 0.6 percent of outlier payments, would be allocated to CMHCs for partial hospitalization program service outliers. In support of this decision, we cited MedPAC's March 2004 Report to Congress, in which MedPAC recommended that Congress pursue the statutory change needed to eliminate the outlier policy under the OPSS. We specifically highlighted several of the reasons given by MedPAC for the elimination of the outlier policy because they are equally applicable to any

reduction in the size of the percentage of OPPS payments dedicated to outlier payments. One of MedPAC's arguments included the very narrow definition of many APCs with limited packaging frequently resulting in multiple service payments for any given claim. In addition, we noted that outlier policies are susceptible to "gaming" through charge inflation and that the OPPS is the only ambulatory payment system with an outlier policy. Finally, we cited MedPAC's observation that the distribution of outlier payments benefits some hospital groups more than others.

In order to ensure that estimated CY 2006 aggregate outlier payments would equal 1.0 percent of estimated aggregate total payments under the OPPS, we proposed that the outlier threshold be modified so that outlier payments are triggered when the cost of furnishing a service or procedure by a hospital exceeds 1.75 times the APC payment amount and exceeds the APC payment rate plus a \$1,575 fixed-dollar threshold. Ultimately, we chose to modify the fixed dollar threshold to target 1.0 percent of estimated aggregate total payment under the OPPS and not to modify the current 1.75 multiple in order to further our policy of targeting outlier payments to complex and expensive procedures with sufficient variability to pose a financial risk for hospitals. We note that modifying the multiple threshold would have done less to target outlier payments to complex and expensive procedures.

We calculated the fixed-dollar threshold for the proposed rule using the same methodology as we did in CY 2005. The claims that we use to model each OPPS lag by 2 years. For this final rule with comment period, we used CY 2004 claims to model the CY 2006 payment system. In order to estimate CY 2006 outlier payments for the proposed rule, we inflated the charges on the CY 2004 claims using the same inflation factor of 1.0865 that we used to estimate the IPPS fixed-dollar outlier threshold for the IPPS FY 2006 proposed rule. For 2 years, the inflation factor is 1.1804. The methodology for determining this charge inflation factor was discussed at length in the IPPS proposed rule (70 FR 47493, August 12, 2005). As we stated in our final rule for 2005, we believe that the use of this charge inflation factor is appropriate for OPPS because, with the exception of the routine service cost centers, hospitals use the same cost centers to capture costs and charges across inpatient and outpatient services (69 FR 65845, November 15, 2004). As also noted in the IPPS final rule, we believe that a charge inflation factor is more appropriate than an adjustment to

costs because this methodology closely captures how actual outlier payments are made and calculated (70 FR 47495, August 12, 2005). We then applied the overall cost-to-charge ratio (CCR) that we calculate from each Hospital's Cost Report (CMS-2552-96) as part of our process for estimating median APC costs. The calculation of this overall CCR is discussed in greater detail in section II.A. of this preamble. We estimated outlier payments using these costs for several different fixed-dollar thresholds, holding the 1.75 multiple constant until the aggregated outlier payments equaled 1.0 percent of aggregated total payments under the OPPS. In addition, for CY 2006, we proposed an outlier threshold for CMHCs of 3.45 times the APC payment rate.

For this final rule with comment period, we recalculated the fixed-dollar threshold in light of updated claims data, a revised charge inflation estimate, and more timely CCRs. As in the proposed rule, we did not change the multiple threshold of 1.75 times the APC payment rate, but concentrated on adjusting the fixed-dollar threshold. We again used the same inflation factor that we used to estimate the IPPS fixed-dollar threshold. Because the charge inflation factor for the IPPS was revised to 14.94 percent for 2 years in the IPPS FY 2006 final rule (70 FR 47493, August 12, 2005), we inflated charges on all CY 2004 OPPS claims by 1.1494.

We then applied the hospital specific overall CCR which we calculated for purposes of our APC cost estimation. We simulated aggregated outlier payments using these costs for several different fixed dollar thresholds holding the 1.75 multiple constant until the total outlier payments equaled 1.0 percent of aggregated total OPPS payments. We estimate that a threshold of \$1,250 combined with the multiple threshold of 1.75 times the APC payment rate will allocate 1.0 percent of aggregated total OPPS payments to outlier payments. We used a lower charge inflation factor of 14.94 percent to increase charges to reflect 2006 dollars. The proposed fixed dollar threshold declined to \$1,250 from \$1,575 in the proposed rule primarily because we used the lower charge inflation factor of 1.1494.

The following is an example of an outlier calculation for CY 2006 under our final policy. A hospital charges \$26,000 for a procedure. The APC payment for the procedure is \$3,000, including a rural adjustment, if applicable. Using the provider's CCR of 0.30, the estimated cost to the hospital is \$7,800. To determine whether this provider is eligible for outlier payments

for this procedure, the provider must determine whether the cost for the service exceeds both the APC outlier cost threshold ($1.75 \times \text{APC payment}$) and the fixed-dollar threshold ($\$1,250 + \text{APC payment}$). In this example, the provider meets both criteria:

- (1) \$7,800 exceeds \$5,250 ($1.75 \times \$3,000$)
- (2) \$7,800 exceeds \$4,250 ($\$1,250 + \$3,000$)

To calculate the outlier payment, which is 50 percent of the amount by which the cost of furnishing the service exceeds 1.75 times the APC rate, subtract \$5,250 ($1.75 \times \$3,000$) from \$7,800 (resulting in \$2,550). The provider is eligible for 50 percent of the difference, in this case \$1,275 ($\$2,550 / 2$). The formula is $(\text{cost} - (1.75 \times \text{APC payment rate})) / 2$.

For CMHCs, in CY 2005, the outlier threshold is met when the cost of furnishing a service or procedure by a CMHC exceeds 3.5 times the APC payment rate. If a CMHC provider meets this condition, the outlier payment is calculated as 50 percent of the amount by which the cost exceeds 3.5 times the APC payment rate. For this final rule with comment period, updated data reduces the multiple outlier threshold for CMHCs to 3.4. The outlier threshold for a CMHC is met when the cost of furnishing a service or procedure by a CMHC exceeds 3.4 times the APC payment rate. If a CMHC provider meets this condition, the outlier payment is calculated as 50 percent of the amount by which the cost exceeds 3.4 times the APC payment rate.

We received 25 public comments concerning our proposed outlier policy. *Comment:* One commenter supported CMS' decision to reduce the percentage of total payments set aside for outlier payments from 2.0 percent to 1.0 percent.

Response: We appreciate the commenter's support. Although the fixed-dollar threshold has changed due to more accurate data than in the proposed rule, we do not believe that this change would impact the views expressed by the commenter.

Comment: Several commenters expressed concern that, in light of an increase in the threshold from \$1,175 to \$1,575, CMS may have set the threshold for outlier payments too high. They requested clarification as to how CMS determined that a \$400 increase in the fixed-dollar threshold was appropriate and how the \$1,575 fixed-dollar threshold was calculated. The commenters specifically noted that in the IPPS final rule CMS reduced the charge inflation factor used to set the fixed-dollar threshold from 18.04

percent to 14.94 percent, and suggested that CMS make a similar adjustment to the OPPS methodology.

Response: As discussed above, for the proposed rule, we used a charge inflation factor of 1.1804 to inflate the charges on CY 2004 claims to CY 2006 dollars. We then applied the overall CCR that we calculate as part of our APC median estimation process to those inflated charges to estimate costs. We compared these estimated costs to 1.75 times the proposed APC payment amount and to the APC payment amount plus a number of fixed-dollar thresholds until we identified a threshold that produced total outlier payments equal to 1.0 percent of total aggregated OPPS payments. This methodology increased the fixed-dollar threshold by \$400.

We repeated the same estimation process for this final rule, using a complete set of CY 2004 claims, the updated charge inflation estimate of 14.94 percent from the IPPS final rule, as requested by commenters, and each hospital's overall CCR, as calculated for our APC median setting process. The final fixed dollar threshold for OPPS 2006 is \$1,250 plus the APC payment rate, and the final multiple threshold is 1.75 times the APC payment rate.

Comment: Commenters expressed concern that CMS has never reported the actual amount of outlier payments for the OPPS made in past years. They noted that CMS routinely reports prior year outlier payments for the IPPS. The commenters also expressed concern that CMS may not spend the percentage of total aggregated OPPS payment set aside each year for outlier payments. One commenter hypothesized that outlier payments had been underspent in previous years, and that the proposed reduction in outlier payments was designed to realign the policy with actual payment. The commenters urged CMS to publish data on actual outlier payments made in CY 2004 and prior years in the final rule. They also recommended that actual outlier payments for CY 2005 OPPS be reported as soon as CMS is able to obtain accurate data and that CMS continue to report these data in the future.

Response: As we have stated in prior rules (see for example 69 FR 65847, November 15, 2004), we have not provided aggregate outlier payments for past years because we do not use those estimates to set the outlier thresholds and because we make outpatient claims available. However, we understand that providers might wish to know this information, especially in light of recent changes in the OPPS outlier policy. In the final set of CY 2004 OPPS claims,

aggregated outlier payments were 2.5 percent of aggregated total OPPS payments. In the final set of CY 2003 OPPS claims, aggregated outlier payments were 3.1 percent of aggregated total OPPS payments. For both years, the estimated outlier payments were set at 2 percent of total aggregated OPPS payments. At this time, we cannot make accurate estimates about aggregated total outlier payments for CY 2005, but we intend to provide this information in our proposed rule for CY 2007. We intend to continue reporting the percentage of total payments made in outlier payments for the most recent and complete set of claims in future rules. We note above our reasons for proposing to reduce the projected target percent of total aggregated OPPS payments attributable to outlier payments.

Comment: Several commenters suggested that CMS did not provide sufficient analytic support to justify a reduction in outlier payments from 2.0 percent to 1.0 percent, relying only on MedPAC's recommendations. The commenters urged CMS not to change its outlier policy or to delay implementation until greater technical analyses could be conducted. One commenter suggested that, without CMS' technical analyses, stakeholders cannot conduct their own analyses. The commenters frequently questioned our reference to the March 2004 MedPAC Report to Congress and stated that outlier payments are not evenly distributed among hospitals as justification for reducing the percentage of total payments dedicated to outlier payments. They noted that differences in outlier payments would be expected for hospitals serving different populations. Several commenters cited the continued instability in rates as a reason for continuing at 2.0 percent. One commenter specifically hypothesizes that instability in payment rates may be attributable to a lack of stability in unit costs, suggesting a continued need for outlier payments. Another commenter acknowledged that the variability in costs for APCs was clearly less than that for DRGs, but that the current policy of setting aside two percent of total payments, already accounted for this difference.

Response: Our decision to reduce the projected target amount of total payments set aside for outlier payments is based on the technical analyses that MedPAC conducted in its March 2004 Report to Congress demonstrating that the CY 2004 OPPS outlier policy was ineffective at addressing complex cases of financial risk and on the arguments that MedPAC made against outlier

payments. As noted above, MedPAC argued that the fairly narrow definition of the APC groups makes outlier payments less necessary for the OPPS, that the limited packaging in OPPS frequently resulting in multiple service payments for any given claim, and that the susceptibility to "gaming" through charge inflation continues. MedPAC's 2004 Report to Congress also suggested that our outlier policy could be redistributing outlier payments among hospitals based on cost structures or charging patterns rather than differences in case-mix. We agree with the commenters that an unequal distribution of outlier payments according to differences in case mix is appropriate, the concern is that different case mix does not account for outlier payment distributions.

We do not believe that the moderate fluctuation in APC payment rates that continues to be present in the OPPS is an adequate argument against reducing the percentage of aggregated total OPPS payments set aside for outlier payments for several reasons: changes in payment rates appropriately reflect changes in costs, the variability of costs is less for complex and expensive procedures, and outlier payments in OPPS target services not cases. As discussed in section II.A. of this preamble, we believe that the moderate changes in the payment rates remaining after the system has been operating for several years is, in large part, a function of the small APC group size and service basis. The small group size of the APCs makes changes in service costs more transparent than if groups were larger. Aggregation generally reduces variation. Changes in payment rates from year to year appropriately reflect true changes in the cost of a specific service. Changes in cost and charging patterns captured in a provider's cost report will lead to changes in the median cost of services from year to year. In addition, we are required to adjust the APCs each year to ensure that groups are comparable with "respect to the use of resources." The "2 times" rule requires that the highest median cost for an item or service within the group not be greater than two times the lowest median cost. The "2 times" rule specifically limits the amount of variability of unit costs in any group, forcing the APC payment rates to reflect changes in costs. It embeds some fluctuation into APC payment rates, but also reduces the need for an expansive outlier policy.

The observed variability in unit costs is greater for low cost and simple procedures and smaller for complex, expensive procedures. In its 2004 Report to Congress, MedPAC found that

the highest variability in estimated costs was associated with the lowest cost items. This observation continues to be true in the CY 2004 claims. On average, HCPCS codes with low median costs demonstrate greater variability, as measured by the coefficient of variation, than HCPCS codes with high median costs. The coefficient of variation is the percent of the standard deviation accounted for by the mean and enables a relative comparison of variation across groups. This trend also is evident in the APC coefficient of variation. The bottom 50 percent of APCs arrayed by median costs have an average coefficient of variation of 82 percent, whereas the top 50 percent of APCs, arrayed by median cost, have an average coefficient of variation of 63 percent.

Finally, OPSS outlier payments are targeted to services, rather than cases. Unlike the IPPS, outlier payments are not for extremely costly patients but extremely costly services. In many cases, an extremely costly case in the outpatient setting may not warrant an outlier payment because no specific service was excessively costly. The small number of services included in any APC group means that the provider will receive payment for most services billed on a claim. Reducing total outlier payments to 1.0 percent of total OPSS payments effectively raises the payment for all other services because the foregone 1.0 percent of total spending is returned to the conversion factor. We acknowledge the comment stating that the comparative difference in cost variability between the IPPS and the OPSS is already accounted for in the difference between the 5 to 6 percent estimated outlier target under IPPS and the 2 percent projected outlier estimate under OPSS. However, we believe that setting total outlier payments at 1.0 percent of total aggregated OPSS payments sets aside an appropriate amount of dollars for unexpected and costly services.

Comment: One commenter indicated concern that CMS proposed an additional change to the outlier payments before having one year of experience with the fixed-dollar threshold introduced in CY 2005.

Response: We do not believe that these two policies are related. The amount of total aggregated OPSS payments set aside for outlier payments is an entirely different policy from the manner in which those payments are distributed to hospitals. We did not institute the fixed-dollar threshold to reduce outlier payments, but rather to target payments to expensive and costly cases. The fixed-dollar threshold will

continue to have this effect within a smaller amount of outlier payments.

Comment: Several commenters suggested that CMS did not sufficiently demonstrate the impact on hospitals of reducing the percentage of estimated total payments dedicated to outlier payments 2.0 percent to 1.0 percent and requested this analysis. The commenters expressed concern that hospitals providing sophisticated and expensive technologies to very sick patients would be placed at greater risk of financial loss. Most of the commenters suggested that the reduction in the outlier percentage be delayed until CMS can fully evaluate the impact, while other commenters simply urged for a return to the 2-percent target amount.

Response: For the proposed rule, we did not include a specific analysis of the redistributive impact of outliers because the fixed-dollar threshold policy did not change, only the aggregate amount of dollars paid. We did include outlier payments in our impact tables, and we made the amount of outlier payment estimated for each hospital available on our Web site. However, we appreciate commenters' desire to more fully view the impact of the outlier policy. For this final rule with comment period, we have provided a separate table in our regulatory impact analysis, section XIX of this preamble, showing the differences in total aggregated OPSS payment for CY 2006 attributable to the change in the outlier policy. We estimate that no class of hospital will experience more than a 1 percent change in total payments due to outlier payments and many classes of hospitals receive greater payments.

Comment: Several commenters suggested that CMS pay outlier claims at the same rate at which inpatient outlier claims are paid, that is, 80 percent of cost. Various rationales were provided, including consistency with the IPPS, ensuring that hospitals can recoup the variable costs of providing expensive care, and improving the adequacy of payments.

Response: We believe that the payment percentage of 50 percent is appropriate for the OPSS because, in general, a costly OPSS service poses less of a financial risk for hospitals than a costly case under the IPPS. If we did increase the payment percentage to 80 percent, we would have to compensate elsewhere to maintain the 1.0 percent set aside for outlier payments, probably by raising the fixed-dollar threshold. Changing the payment percentage to 80 percent would merely concentrate a more generous outlier payment on a much smaller number of extremely costly services each year.

Comment: One commenter recommended a new methodology for estimating the fixed-dollar outlier threshold for both the OPSS and the IPPS. The commenter suggested that, in addition to inflating charges from CY 2004 to CY 2006, CMS also should adjust CCRs to reflect proportionally slower inflation in costs. The commenter believed that this would result in deflating overall CCRs. The commenter specifically recommended that CMS update the CCRs for the OPSS to the latest available hospital-specific data.

Response: We agree with the commenter that the CCRs that we use to set the outlier thresholds should be as recent as possible. We also believe that these CCRs should reflect, as closely as possible, the actual CCRs that the fiscal intermediary will use to determine outlier payments in CY 2006. As we did for the IPPS final rule (70 FR 47493, August 12, 2005), we used the overall CCRs from the most recent provider-specific file, in this case, the July 2005 OPSF, to estimate costs from inflated charges on CY 2004 claims. The OPSF contains CCRs from each provider's most recent tentatively settled cost report. Because of the time it takes to complete cost reports and upload them in the fiscal intermediaries' standard systems, for at least part of CY 2006, the CCRs on the OPSF are the same ones that the fiscal intermediaries will use to determine outlier payments. However, unlike the IPPS, the overall CCRs on the OPSF are higher than those that we use to estimate APC medians. The median overall CCR that we calculate from each hospital's cost report as a default CCR in estimating costs from charges in order to set relative weights is 0.305, whereas the median overall CCR on the OPSF is 0.32. Were we to use the CCRs from the OPSF, the fixed dollar threshold would increase, from \$1,250 to \$1,800.

We will consider using the CCRs found in the OPSF for the CY 2007 OPSS outlier calculations, similar to our calculations under IPPS. However, in view of the newness of a fixed-dollar threshold for OPSS outlier payments and our concern that using the OPSF CCRs for this final rule would result in an \$1,800 fixed dollar threshold that is considerably higher than the proposed threshold, we have decided to use the CCRs that we calculated for the APC median setting process for our outlier calculations as we have in past years. These CCRs are timely, as the majority of them are created from cost reports with fiscal years beginning in 2004 and 2003.

Comment: One commenter requested that CMS reverse its decision to reduce

the percentage of total payments attributable to outlier payments to 1 percent and return outlier payments to the target level of 3 percent established under the Balanced Budget Act (BBA) of 1997.

Response: For all of the reasons stated above, we do not believe that outlier payments should be increased to 3 percent of total payments. We further note that the BBA, as revised by the Balanced Budget Refinement Act (BBRA) of 1999, set an upper limit of “no more than” 3.0 percent for outlier policies, giving the Secretary the discretion to set a lower estimated target percent.

Comment: One commenter expressed concern that decreasing the outlier pool and increasing the fixed dollar threshold may encourage greater packaging in order to increase procedure charges.

Response: We do not believe that greater packaging is an issue for the OPSS outlier policy. Should providers choose to package more services into the charges for payable procedures and not report packaged services, over time, those higher costs would lead to higher payment rates for payable procedures. This would, in turn, increase the fixed dollar outlier threshold. Further, rolling the charges for packaged services into the charges for payable procedures is expected under OPSS.

Comment: One commenter requested that CMS describe the services that qualify for outlier payments.

Response: The actual services that qualify for outlier payments under the fixed dollar threshold policy introduced in CY 2005 will likely be quite similar to those receiving payments under 2005 OPSS. As noted above, at this time, we do not have a complete set of CY 2005 claims. However, in our analysis replicating the analysis done by MedPAC in its March 2004 Report to Congress, we estimate that costly services such as APC 0246 (Cataract Procedures with IOL Insert), APC 0080 (Diagnostic Cardiac Catheterization), and APC 0131 (Level II Laparoscopy) would receive a large percentage of outlier payments under the fixed-dollar threshold policy.

Accordingly, after considering the public comments received, for CY 2006, we are finalizing the OPSS outlier policy of two thresholds for hospitals of a multiple threshold of 1.75 times the APC payment amount and a fixed dollar threshold of \$1,250 plus the APC payment amount and one threshold for CMHCs of 3.4 times the APC payment amount.

I. Calculation of the National Unadjusted Medicare Payment

The basic methodology for determining prospective payment rates for OPD services under the OPSS is set forth in existing regulations at § 419.31 and § 419.32. The payment rate for services and procedures for which payment is made under the OPSS is the product of the conversion factor calculated in accordance with section II.C. of this final rule with comment period and the relative weight determined under section II.A. of this final rule with comment period. Therefore, the national unadjusted payment rate for APCs contained in Addendum A to this final rule with comment period and for HCPCS codes to which payment under the OPSS has been assigned in Addendum B to this final rule with comment period (Addendum B is provided as a convenience for readers) was calculated by multiplying the final CY 2006 scaled weight for the APC by the final CY 2006 conversion factor.

However, to determine the payment that will be made in a calendar year under the OPSS to a specific hospital for an APC for a service other than a drug, in a circumstance in which the multiple procedure discount does not apply, we take the following steps:

Step 1. Calculate 60 percent (the labor-related portion) of the national unadjusted payment rate. Since initial implementation of the OPSS, we have used 60 percent to represent our estimate of that portion of costs attributable, on average, to labor. (Refer to the April 7, 2000 final rule with comment period (65 FR 18496 through 18497) for a detailed discussion of how we derived this percentage.)

Step 2. Determine the wage index area in which the hospital is located and identify the wage index level that applies to the specific hospital. The wage index values assigned to each area reflect the new geographic statistical areas as a result of revised OMB standards (urban and rural) to which hospitals are assigned for FY 2006 under the IPPS, reclassifications through the Medicare Classification Geographic Review Board, section 1866(d)(8)(B) “Lugar” hospitals, and section 401 of Pub. L. 108–173, and the reclassifications of hospitals under the one-time appeals process under section 508 of Pub. L. 108–173. The wage index values include the occupational mix adjustment described in section II.D. of this final rule with comment period that was developed for the FY 2006 IPPS.

Step 3. Adjust the wage index of hospitals located in certain qualifying

counties that have a relatively high percentage of hospital employees who reside in the county, but who work in a different county with a higher wage index, in accordance with section 505 of Pub. L. 108–173. Addendum L contains the qualifying counties and the final wage index increase developed for the FY 2006 IPPS. This step is to be followed only if the hospital has chosen not to accept reclassification under Step 2 above.

Step 4. Multiply the applicable wage index determined under Steps 2 and 3 by the amount determined under Step 1 that represents the labor-related portion of the national unadjusted payment rate.

Step 5. Calculate 40 percent (the nonlabor-related portion) of the national unadjusted payment rate and add that amount to the resulting product of Step 4. The result is the wage index adjusted payment rate for the relevant wage index area.

Step 6. If a provider is a SCH, as defined in § 419.92, and located in a rural area, as defined in § 412.63(b), or is treated as being located in a rural area under § 412.103 of the Act, multiply the wage index adjusted payment rate by 1.071 to calculate the total payment.

We received no public comments concerning our proposal for calculating the national unadjusted Medicare payment rate. Therefore, we are adopting as final, for OPSS services furnished on or after January 1, 2006, our proposed methodology for calculating the national unadjusted Medicare payment amount.

J. Beneficiary Copayments for CY 2006

1. Background

Section 1833(t)(3)(B) of the Act requires the Secretary to set rules for determining copayment amounts to be paid by beneficiaries for covered OPD services. Section 1833(t)(8)(C)(ii) of the Act specifies that the Secretary must reduce the national unadjusted copayment amount for a covered OPD service (or group of such services) furnished in a year in a manner so that the effective copayment rate (determined on a national unadjusted basis) for that service in the year does not exceed specified percentages. For all services paid under the OPSS in CY 2006, and in calendar years thereafter, the specified percentage is 40 percent of the APC payment rate. Section 1833(t)(3)(B)(ii) of the Act provides that, for a covered OPD service (or group of such services) furnished in a year, the national unadjusted coinsurance amount cannot be less than 20 percent of the OPD fee schedule amount.

2. Copayment for CY 2006

For CY 2006, we proposed to determine copayment amounts for new and revised APCs using the same methodology that we implemented for CY 2004 (see the November 7, 2003 OPSS final rule with comment period, 68 FR 63458). We used the same methodology to determine the final unadjusted copayment amounts for services payable under the OPSS that will be effective January 1, 2006. These copayment amounts are shown in Addendum A and Addendum B of this final rule with comment period.

3. Calculation of the Unadjusted Copayment Amount for CY 2006

To calculate the unadjusted copayment amount for an APC group, take the following steps:

Step 1. Calculate the beneficiary payment percentage for the APC by dividing the APC's national unadjusted copayment by its payment rate. For example, using APC 0001, \$7.00 is 29 percent of \$23.79.

Step 2. Calculate the wage adjusted payment rate for the APC, for the provider in question, as indicated in section II.I. of this preamble.

Step 3. Multiply the percentage calculated in Step 1 by the payment rate calculated in Step 2. The result is the wage-adjusted copayment amount for the APC.

We received two public comments concerning our proposed methodology for calculating the beneficiary unadjusted copayment amount.

Comment: One commenter recommended that CMS maintain the coinsurance amount above 40 percent of the APC payment amount as the proposed payment rate for CY 2006 is

lower than the CY 2005 payment rate when adjusted for inflation.

Response: We appreciate the commenter's recommendation but note that the statute does not provide for this. Section 1833(t)(8)(C)(ii) of the Act specifies that the Secretary must reduce the national unadjusted copayment amount for a covered OPD service (or group of such services) furnished in a year in a manner so that the effective copayment rate (determined on a national unadjusted basis) for that service in the year does not exceed specified percentages. For all services paid under the OPSS in CY 2006, and in calendar years thereafter, that specified percentage is 40 percent of the APC payment rate.

Comment: One commenter objected to beneficiaries being liable for more than 20 percent of the Medicare payment rate for services paid under the OPSS. The commenter acknowledged that the law limits the copayment for a single service to the amount of the inpatient deductible, but objected to there being no limit to the amount of coinsurance that a beneficiary can incur per year or even for a single outpatient encounter. The commenter acknowledged that the amount of beneficiary copayment liability is set in statute but urged CMS to work with Congress to restore beneficiary coinsurance of hospital outpatient services to the level it views as appropriate.

Response: As the commenter indicated, the level of beneficiary coinsurance is set based on specific statutory criteria.

Comment: One commenter recommended that CMS work with Congress to restore the beneficiary coinsurance for hospital outpatient

services to the appropriate level. By "appropriate," we assume the commenter means that coinsurance for all OPSS services should be 20 percent, which is the coinsurance rate for other services paid under Medicare Part B.

Response: We appreciate the commenter's recommendation and will take it into consideration. However, until the statute at section 1833(t)(8)(C)(ii) of the Act is revised, the Secretary must adhere to the current requirements of the law, which caps the beneficiary coinsurance payment at 40 percent of the APC payment rate. In addition, the law requires that the coinsurance amount be no less than 20 percent of the APC rate.

Accordingly, we are adopting as final, for OPSS services furnished on or after January 1, 2006, our proposed methodology for calculating the beneficiary unadjusted copayment amount.

III. Ambulatory Payment Classification (APC) Group Policies

A. Introduction

1. Treatment of New HCPCS Codes Discussed in the CY 2006 OPSS Proposed Rule

During the second quarter of CY 2005, we created 11 HCPCS codes that were not addressed in the November 15, 2004 final rule with comment period that updated the CY 2005 OPSS. (Table 14 of the CY 2006 OPSS proposed rule.) We have designated the payment status of those codes and added them to the April update of the CY 2005 OPSS (Transmittal 514). In the proposed rule, we also solicited public comments on the proposed APC assignments of these services.

TABLE 7.—NEW HCPCS CODES IMPLEMENTED IN APRIL 2005

| HCPCS code | Description |
|-------------|---|
| C9127 | Injection, paclitaxel protein-bound particles, per 1 mg. |
| C9128 | Injection, pegaptamib sodium, per 0.3 mg. |
| C9223 | Injection, adenosine for therapeutic or diagnostic use, 6 mg (not to be used to report any adenosine phosphate compounds, instead use A9270). |
| C9440 | Vinorelbine tartrate, brand name, per 10 mg. |
| C9723 | Dynamic infrared blood perfusion imaging (DIRI). |
| C9724 | Endoscopic full-thickness plication in the gastric cardia using endoscopic plication system (EPS); includes endoscopy. |
| Q4079 | Injection, natalizumab, 1 mg. |
| Q9941 | Injection, Immune Globulin, Intravenous, Lyophilized, 1 g. |
| Q9942 | Injection, Immune Globulin, Intravenous, Lyophilized, 10 mg. |
| Q9943 | Injection, Immune Globulin, Intravenous, Non-Lyophilized, 1 g. |
| Q9944 | Injection, Immune Globulin, Intravenous, Non-Lyophilized, 10 mg. |

Further, consistent with our annual APC updating policy, we proposed to assign the new HCPCS codes for CY 2006 to the appropriate APCs and

incorporate them into our final rule with comment period for CY 2006.

We did not receive any public comments on the new procedural C codes, their status indicators, or their

APC assignments for the two new OPSS procedures (C9723 and C9724) implemented in April 2005. Therefore, we are adopting as final our proposal to assign these HCPCS codes C9723 and

C9724 for CY 2006 to the appropriate APCs, as shown in Addendum B of this final rule with comment period, without modification.

We received a number of public comments related to drugs described by new HCPCS codes implemented in April 2005 in the OPSS; specifically, HCPCS codes C9127, C9128, C9223, C9440, Q4079, Q9941, Q9942, Q9943, and Q9944. See section V. of this preamble (Payment Changes for Drugs, Biologicals, and Radiopharmaceutical Agents) for a discussion of these comments, including comment summaries, our responses and a description of our final OPSS payment policies. In addition, our final payment policy for CY 2006 is included in Addendum B of this final rule with comment period.

2. Treatment of New CY 2006 HCPCS Codes

In the proposed rule, we proposed that we would assign new HCPCS codes for CY 2006 to appropriate APCs and/or status indicators and that we would implement them in our final rule. However, we received some comments regarding individual new HCPCS codes that commenters expect to be implemented for the first time in the CY 2006 OPSS. We do not specifically respond to those comments in this final rule. We could not discuss APC and/or status indicator assignments for new CY 2006 HCPCS codes in the proposed rule because the new CY 2006 HCPCS codes were not available when we issued the proposed rule. Rather, as has been our practice in the past, we implement new HCPCS codes in the OPSS final rule, at which time we invite public comment about our treatment of the new codes. We subsequently respond to those comments in the final rule for the following year's OPSS update.

New 2006 HCPCS codes are designated in Addendum B with Comment Indicator "NI." The status indicator and/or APC assignments for all HCPCS codes flagged with Comment Indicator "NI", which are new 2006 HCPCS codes, are subject to public comment.

3. Treatment of New Mid-Year Category III CPT Codes

Twice each year, the AMA issues Category III CPT codes, which the AMA defines as temporary codes for emerging technology, services, and procedures. The AMA established these codes to allow collection of data specific to the service described by the code which otherwise could only be reported using a Category I CPT unlisted code. The AMA releases Category III CPT codes in

January, for implementation beginning the following July, and in July, for implementation beginning the following January. In the past, CMS has treated new Category III CPT codes implemented in July of the previous year or January of the OPSS update year in the same manner that new Category I CPT codes and new Level II HCPCS codes implemented in January of the OPSS update year are treated; that is, we provide APC and/or status indicator assignments in the final rule updating the OPSS for the following calendar year. New Category I and Category III CPT codes, as well as new Level II HCPCS codes, are flagged with Comment Indicator "NI" in Addendum B of the final rule to indicate that we are assigning them an interim payment status which is subject to public comment following publication of the final rule that implements the annual OPSS update.

We are concerned that not recognizing for 6 months (from July to January) the Category III codes that the AMA releases each January for implementation in July may hinder timely collection of data pertinent to the services described by the codes. Moreover, delay in recognizing these codes could inhibit access to the services they describe because of provider reluctance to furnish a service that defaults to the OPSS payment assigned to unlisted codes. Also, we have on occasion found redundancy between Category III CPT codes and some of the C-codes, which are only payable under the OPSS and created by us in response to applications for New Technology services. Therefore, beginning in CY 2006, we are modifying this process and recognizing Category III CPT codes that are released by the AMA in January to be effective beginning July of the same calendar year in which they are issued, rather than deferring recognition of those codes to the following calendar year update of the OPSS. Adopting this approach means that new Category III CPT codes will be recognized under the OPSS biannually rather than annually.

Some of the new Category III CPT codes may describe services that our medical advisors determine to be similar in clinical characteristics and resource use to HCPCS codes in an existing APC. In these instances, we may assign the Category III CPT code to the appropriate clinical APC. Other Category III CPT codes may describe services that our medical advisors determine are not compatible with an existing clinical APC, yet are appropriately provided in the hospital outpatient setting. In these cases, we may assign the Category III CPT code to

what we estimate is an appropriately priced New Technology APC. In other cases, we may assign a Category III CPT code one of several non-separately payable status indicators, including N, C, B, or E, which we feel is appropriate for the specific code. We expect that we will already have received applications for New Technology status for some of the services described by new Category III CPT codes, which may assist us in determining appropriate APC assignments. If the AMA establishes a Category III CPT code for a service for which an application has been submitted to CMS for New Technology status, CMS may not have to issue a temporary Level II HCPCS code to describe the service, as has often been the case in the past when Category III CPT codes were only recognized by the OPSS on an annual basis.

Therefore, beginning in July 2006, CMS will implement in the regular quarterly update of the OPSS the Category III CPT codes that the AMA releases in January 2006 for implementation in July 2006. CMS will implement in the January 2007 update of the OPSS the Category III CPT codes that the AMA releases in July 2006, and so forth.

B. Variations Within APCs

1. Background

Section 1833(t)(2)(A) of the Act requires the Secretary to develop a classification system for covered hospital outpatient services. Section 1833(t)(2)(B) provides that this classification system may be composed of groups of services, so that services within each group are comparable clinically and with respect to the use of resources. In accordance with these provisions, we developed a grouping classification system, referred to as the Ambulatory Payment Classification Groups (or APCs), as set forth in § 419.31 of the regulations. We use Level I and Level II HCPCS codes and descriptors to identify and group the services within each APC. The APCs are organized such that each group is homogeneous both clinically and in terms of resource use. Using this classification system, we have established distinct groups of surgical, diagnostic, partial hospitalization services, and medical visits. We also have developed separate APC groups for certain medical devices, drugs, biologicals, radiopharmaceuticals, and brachytherapy devices.

We have packaged into each procedure or service within an APC group the cost associated with those items or services that are directly related

and integral to performing a procedure or furnishing a service. Therefore, we do not make separate payment for packaged items or services. For example, packaged items and services include: use of an operating, treatment, or procedure room; use of a recovery room; use of an observation bed; anesthesia; medical/surgical supplies; pharmaceuticals (other than those for which separate payment may be allowed under the provisions discussed in section V of this preamble); and incidental services such as venipuncture. Our packaging methodology is discussed in section II.A. of this final rule with comment period.

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

Section 1833(t)(9)(A) of the Act requires the Secretary to review the components of the OPSS not less than annually and to revise the groups and relative payment weights and make other adjustments to take into account changes in medical practice, changes in technology, and the addition of new services, new cost data, and other relevant information and factors. Section 1833(t)(9)(A) of the Act, as amended by section 201(h) of the BBRA of 1999, also requires the Secretary, beginning in CY 2001, to consult with an outside panel of experts to review the APC groups and the relative payment weights (the APC Panel recommendations for CY 2006 OPSS and our responses to them are discussed in sections III.B. and III.C.4. of this preamble).

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

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

2. Application of the 2 Times Rule

In accordance with section 1833(t)(2) of the Act and § 419.31 of the regulations, we annually review the items and services within an APC group to determine, with respect to comparability of the use of resources, if the median of the highest cost item or service within an APC group is more than 2 times greater than the median of the lowest cost item or service within that same group ("2 times rule"). We make exceptions to this limit on the variation of costs within each APC group in unusual cases such as low-volume items and services. The statute provides no exception in the case of a drug or biological that has been designated as an orphan drug under section 526 of the Federal Food, Drug, and Cosmetic Act because these drugs are assigned to individual APCs.

During the APC Panel's February 2005 meeting, we presented median cost and utilization data for the period of January 1, 2004, through September 30, 2004, concerning a number of APCs that violated the 2 times rule and asked the APC Panel for its recommendation. After carefully considering the information and data we presented, the APC Panel recommended moving a total of 65 HCPCS codes from their currently assigned APCs to different APCs to resolve the 2 times rule violations. Of the 65 HCPCS code reassignments recommended by the APC Panel, we concurred with 58 of the recommended reassignments. Therefore, we proposed to reassign the HCPCS codes as indicated in Table 7 of the proposed rule (70 FR 42703).

The seven HCPCS code movements that the APC Panel recommended, but upon further review we proposed not to accept, are discussed below. We include in our discussion the assignments we also proposed and the final assignments for CY 2006.

a. APC 0146: Level I Sigmoidoscopy, APC 0147: Level II Sigmoidoscopy, APC 0428: Level III Sigmoidoscopy. APCs 0146 and 0147 were exceptions to the 2 times rule in CY 2005. At the time of the proposed rule, our analysis of those two APCs based on partial year CY 2004 data revealed greater violations of the 2 times rule and changing relative frequencies of simple and complex procedures in these two APCs. Thus, for CY 2006 the APC Panel assisted us in reconfiguring these two APCs into three related APCs to resolve the two times violations and improve their clinical and resource homogeneity based on the partial CY 2004 hospital claims data and

to remove these APCs from the list of exceptions. The APC Panel recommended maintaining CPT codes 45303 (Proctosigmoidoscopy, rigid; with dilation) and 45305 (Proctosigmoidoscopy, rigid; with biopsy, single or multiple) in APC 0146 because the median cost for these codes appeared too high, and they believed that the CY 2004 claims were aberrant. In addition, the APC Panel recommended that CMS move CPT code 45309 (Proctosigmoidoscopy, rigid; with removal of single tumor, polyp, or other lesion by snare technique) from APC 0147 and assign it to a new proposed APC 0428. Based on the results of our review of several years of claims data and our study of hospital resource homogeneity, we disagreed that those claims data were aberrant. We proposed to move CPT codes 45303 and 45305 to APC 0147 and to keep CPT 45309 in APC 0147, to resolve the 2 times rule violation.

We received no public comments concerning our proposed APC assignments for CPT codes 45303, 45305 and 45309 and are making final our proposal, without modification.

b. APC 0342: Level I Pathology, APC 0433: Level II Pathology, APC 0343: Level III Pathology. To resolve a 2 times rule violation, the APC Panel recommended moving CPT codes 88108 (Cytopathology, concentration technique, smears and interpretation) and 88112 (Cytopathology, selective cellular enhancement technique with interpretation, except vaginal or cervical) from APC 0343 to a proposed new APC 0433. The APC Panel also recommended moving CPT codes 88319 (Determinative histochemistry or cytochemistry to identify enzyme constituents) and 88321 (Consultation and report on referred slides prepared elsewhere) from APC 0342 to a proposed new APC 0433. Based on the results of our review of several years of hospital claims data and our study of hospital resource homogeneity, we proposed a different way to resolve the 2 times rule violation. We proposed to place CPT codes 88319 and 88112 in APC 0343 and to place CPT codes 88108 and 88321 in new APC 0433.

We received no public comments concerning our proposal.

We will finalize, without modification our proposal to assign CPT codes 88112 and 88319 to APC 0343 and to assign CPT codes 88108 and 88321 to new APC 0433.

c. Other Comments on the Proposed List of APC Assignments to Address 2 Times Violations. We received a few comments concerning our proposed reassignments for several of the other

HCPCS codes (for example, CPT codes 57155, 75790, and 88187) indicated in Table 7 of the proposed rule (70 FR 42703) and the responses are included in clinically relevant sections, elsewhere in this preamble.

After carefully reviewing our final data and all comments received concerning our proposed assignments of the 58 HCPCS codes, we are finalizing those assignments as proposed.

3. Exceptions to the 2 Times Rule

As discussed earlier, we may make exceptions to the 2 times limit on the variation of costs within each APC group in unusual cases such as low-volume items and services. At the time of the proposed rule, taking into account the APC changes that we proposed for CY 2006 based on the APC Panel recommendations discussed in section III.B.1. of this preamble and the use of CY 2004 claims data to calculate the median costs of procedures classified in the APCs, we reviewed all the APCs to determine which APCs would not satisfy the 2 times rule criteria. We used the following criteria to decide whether to propose exceptions to the 2 times rule for affected APCs:

- Resource homogeneity
- Clinical homogeneity
- Hospital concentration
- Frequency of service (volume)

- Opportunity for upcoding and code fragments.

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

Table 8 published in the proposed rule (70 FR 42705) listed the APCs that we proposed to exempt from the 2 times rule based on the criteria cited above. For cases in which a recommendation by the APC Panel appeared to result in or allow a violation of the 2 times rule, we generally accepted the APC Panel's recommendation because those recommendations were based on explicit consideration of resource use, clinical homogeneity, hospital specialization, and the quality of the data used to determine the APC payment rates that we proposed for CY 2006. The median costs for hospital outpatient services for these and all other APCs can be found on the CMS Web site: <http://www.cms.hhs.gov>.

We received a number of comments about some of the procedures assigned to APCs that we proposed to make exempt from the 2 times rule for CY 2006. Those discussions are elsewhere in the preamble, in sections related to the types of procedures that were the subject of the comments.

For the proposed rule the listed exceptions to the 2 times rule were

based on data from January 1, 2004 through September 30, 2004. For this final rule with comment period, we used data from January 1, 2004 through December 31, 2004. Thus, after responding to all of the comments on the proposed rule and making changes to APCs based on those comments, we analyzed the full CY 2004 data to identify APCs with 2 times rule violations.

Based on those final data, we found that there were 41 APCs with 2 times violations. We were able to remedy two violations of the 2 times rule that appeared in the final data for APC 0363 (Level I Otorhinolaryngologic Function Tests) and APC 0010, (Level I Destruction of Lesion). We moved CPT code 92588 (Evoked otoacoustic emissions; comprehensive or diagnostic evaluation) from APC 0363 to APC 0660 (Level II Otorhinolaryngologic Function Tests) to address a 2-times violation in APC 0363. We applied the criteria as described earlier to finalize the APCs that are exceptions to the 2 times rule for CY 2006.

Listed below in Table 8 is the final revised list of APCs that are exceptions to the 2 times rule for CY 2006.

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Table 8.--APC Exceptions to the 2 Times Rule For CY 2006

| APC | APC Description |
|------------|--|
| 0004 | Level I Needle Biopsy/ Aspiration Except Bone Marrow |
| 0010 | Level I Destruction of Lesion |
| 0019 | Level I Excision/ Biopsy |
| 0024 | Level I Skin Repair |
| 0043 | Closed Treatment Fracture Finger/Toe/Trunk |
| 0046 | Open/Percutaneous Treatment Fracture or Dislocation |
| 0047 | Arthroplasty without Prosthesis |
| 0060 | Manipulation Therapy |
| 0081 | Non-Coronary Angioplasty or Atherectomy |
| 0093 | Vascular Reconstruction/Fistula Repair without Device |
| 0099 | Electrocardiograms |
| 0105 | Revision/Removal of Pacemakers, AICD, or Vascular |
| 0120 | Infusion Therapy Except Chemotherapy |
| 0140 | Esophageal Dilation without Endoscopy |
| 0141 | Level I Upper GI Procedures |
| 0148 | Level I Anal/Rectal Procedures |
| 0164 | Level I Urinary and Anal Procedures |
| 0191 | Level I Female Reproductive Proc |
| 0203 | Level IV Nerve Injections |
| 0204 | Level I Nerve Injections |
| 0235 | Level I Posterior Segment Eye Procedures |
| 0245 | Level I Cataract Procedures without IOL Insert |
| 0251 | Level I ENT Procedures |
| 0252 | Level II ENT Procedures |
| 0262 | Plain Film of Teeth |
| 0274 | Myelography |
| 0297 | Level II Therapeutic Radiologic Procedures |
| 0303 | Treatment Device Construction |
| 0312 | Radioelement Applications |
| 0314 | Hyperthermic Therapies |
| 0325 | Group Psychotherapy |
| 0330 | Dental Procedures |
| 0341 | Skin Tests |
| 0353 | Level II Injections |
| 0397 | Vascular Imaging |
| 0409 | Red Blood Cell Tests |
| 0432 | Health and Behavior Services |
| 0600 | Low Level Clinic Visits |
| 0664 | Level I Proton Beam Radiation Therapy |
| 0688 | Revision/Removal of Neurostimulator Pulse Generator Receiver |

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C. New Technology APCs

1. Introduction

In the November 30, 2001 final rule (66 FR 59903), we finalized changes to the time period a service was eligible for payment under a New Technology APC. Beginning in CY 2002, we retain services within New Technology APC groups until we gather sufficient claims data to enable us to assign the service to a clinically appropriate APC. This policy allows us to move a service from a New Technology APC in less than 2 years if sufficient data are available. It also allows us to retain a service in a New Technology APC for more than 3 years if sufficient data upon which to base a decision for reassignment have not been collected.

Every year we receive many requests for higher payment amounts for specific procedures under the OPSS because they require the use of expensive equipment. We are taking this opportunity to respond in general to the issue of hospitals' capital expenditures as they relate to the OPSS and Medicare.

Under the OPSS, our goal is to make payments that are appropriate for the services that are necessary for treatment of Medicare beneficiaries. The OPSS and most other Medicare payment systems are budget neutral and so, although we do not pay full hospital costs for procedures, we believe that our payment rates generally reflect the costs that are associated with providing care to Medicare beneficiaries in cost-efficient settings. Further, we believe that our rates are adequate to assure access to services for most beneficiaries.

For many emerging technologies there is a transitional period during which utilization may be low, often because providers are first learning about the techniques and their clinical utility. Quite often, the requests for higher payment amounts are for new procedures in that transitional phase. The requests, and their accompanying estimates for expected Medicare beneficiary or total patient utilization, often reflect very low rates of patient use, resulting in high per use costs for which requestors believe Medicare should make full payment. Medicare does not, and we believe should not, assume responsibility for more than its share of the costs of procedures based on Medicare beneficiary projected utilization and does not set its payment rates based on initial projections of low utilization for services that require expensive capital equipment. For the OPSS, we rely on hospitals to make

their business decisions regarding acquisition of high cost capital equipment taking into consideration their knowledge about their entire patient base (Medicare beneficiaries included) and an understanding of Medicare's and other payors' payment policies.

As stated earlier, in a budget neutral environment we do not make payments that fully cover hospitals' costs, including those for the purchase and maintenance of capital equipment. We rely on providers to make their decisions regarding the acquisition of high cost equipment with the understanding that the Medicare program must be careful to establish its initial payment rates for new services that lack hospital claims data based on realistic utilization projections for all such services delivered in cost efficient hospital outpatient settings. As the OPSS acquires claims data regarding hospital costs associated with new procedures, we will regularly examine the claims data and any available new information regarding the clinical aspects of new procedures to confirm that our OPSS payments remain appropriate for procedures as they transition into mainstream medical practice.

2. Refinement of New Technology Cost Bands

In the November 7, 2003 final rule with comment period, we last restructured the New Technology APC groups to make the cost intervals more consistent across payment levels (68 FR 63416). We established payment levels in \$50, \$100, and \$500 intervals and expanded the number of New Technology APCs. We also retained two parallel sets of New Technology APCs, one set with a status indicator of "S" (Significant Procedure, Not Discounted When Multiple) and the other set with a status indicator of "T" (Significant Procedures, Multiple Reduction Applies). We did this restructuring because the number of procedures assigned to New Technology APCs had increased, and narrower cost bands were necessary to avoid significant payment inaccuracies for new technology services. Therefore, we dedicated two new series of APCs to the restructured New Technology APCs, which allowed us to narrow the cost bands and afforded us the flexibility to create additional bands as future needs dictated.

As the number of procedures that qualify for placement in the New Technology APCs has continued to

increase over the past 2 years, we recognized that the \$0 to \$50 cost band represented by "S" status APC 1501 (New Technology, Level I, \$0-\$50) and "T" status APC 1538 (New Technology, Level I, \$0-\$50) spanned too broad of a cost interval to accurately represent the lower costs of an ever-increasing number of procedures that are appropriate for New Technology APC assignment. Therefore, we proposed to refine this cost band to five \$10 increments, resulting in the creation of an additional 10 New Technology APCs to accommodate the two parallel sets of New Technology APCs, one set with a status indicator of "S" and the other set with a status indicator of "T." We also proposed to eliminate the two \$0 to \$50 cost band New Technology APCs 1501 and 1538, so that the cost bands of all New Technology APCs would continue to be mutually exclusive. Table 9 published in the proposed rule (70 FR 42706) contained a listing of the 10 additional New Technology APCs that we proposed for CY 2006.

As we explained in the November 30, 2001 final rule (66 FR 59897), we generally keep a procedure in the New Technology APC to which it is initially assigned until we have collected data sufficient to enable us to move the procedure to a clinically appropriate APC. However, in cases where we find that our original New Technology APC assignment was based on inaccurate or inadequate information, or where the New Technology APCs are restructured, we may, based on more recent resource utilization information (including claims data) or the availability of refined New Technology APC bands, reassign the procedure or service to a different New Technology APC that most appropriately reflects its cost. Therefore, we proposed to discontinue New Technology APCs 1501 and 1538, and reassign the procedures currently assigned to them to proposed New Technology APCs 1491 through 1500. Table 10 published in our proposed rule (70 FR 42707) summarized these proposed New Technology APC reassignments.

We received no public comments in response to our proposed refinement of the New Technology APC cost bands. Therefore, for CY 2006, we are finalizing our proposal to discontinue New Technology APCs 1501 and 1538, and reassign the procedures currently assigned to them to New Technology APCs 1491 through 1500. Table 9 lists the final New Technology APCs 1491 through 1500 for CY 2006.

TABLE 9.—NEW TECHNOLOGY APCs FOR CY 2006

| APC | Descriptor | Status Indicator | Final CY 2006 payment rate |
|------------|---|------------------|----------------------------|
| 1491 | New Technology—Level IA (\$0–\$10) | S | \$5 |
| 1492 | New Technology—Level IB (\$10–\$20) | S | 15 |
| 1493 | New Technology—Level IC (\$20–\$30) | S | 25 |
| 1494 | New Technology—Level ID (\$30–\$40) | S | 35 |
| 1495 | New Technology—Level IE (\$40–\$50) | S | 45 |
| 1496 | New Technology—Level IA (\$0–\$10) | T | 5 |
| 1497 | New Technology—Level IB (\$10–\$20) | T | 15 |
| 1498 | New Technology—Level IC (\$20–\$30) | T | 25 |
| 1499 | New Technology—Level ID (\$30–\$40) | T | 35 |
| 1500 | New Technology—Level IE (\$40–\$50) | T | 45 |

3. Requirements for Assigning Services to New Technology APCs

In the April 7, 2000, final rule (65 FR 18477), we created a set of New Technology APCs to pay for certain new technology services under the OPPS. We described a group of criteria for use in determining whether a service is eligible for assignment to a New Technology APC. We subsequently modified this set of criteria in our November 30, 2001, final rule (66 FR 59897 to 59901), effective January 1, 2002. These modifications were based on changes in the data (we were no longer required to use CY 1996 data to set payment rates) and on our continuing experience with the assignment of services to New Technology APCs.

In the course of reviewing applications for New Technology APC assignments under the OPPS, we have encountered many situations in which there is extremely limited clinical experience with new technology services regarding their use and efficacy in the typical Medicare population. In some cases, there has been ambiguity regarding how the new technology services fit within the standard coding framework for established procedures, and there may be no specific coding available for the new technology services in other settings or for use by other payers. Nevertheless, applicants requesting assignment of services to New Technology APCs request that we provide billing and payment mechanisms under the OPPS for the new technology services through the establishment of codes, descriptors, and payment rates. As stated in section I.F. of this preamble, we remain committed to the overarching goal of ensuring that Medicare beneficiaries have timely access to the most effective new medical treatments and technologies in clinically appropriate settings. In the CY 2006 proposed rule, we indicated that we believed that our current New Technology APC assignment process

helps to assure such access, and that an enhancement to the New Technology APC application process might further encourage appropriate dissemination of and Medicare beneficiary access to new technology services.

We are interested in promoting review of the coding, clinical use, and efficacy of new technology services by the greater medical community through our New Technology APC application and review process for the OPPS. Therefore, in addition to our current informational requirements at the time of application, we proposed to require that an application for a code for a new technology service be submitted to the American Medical Association’s (AMA’s) CPT Editorial Panel before we accept a New Technology APC application for review. In making this proposal, we specifically indicated that we would not change our current criteria for assignment of a service to a New Technology APC. Rather, the intent of the proposed new requirement was to encourage timely review of a new service or procedure by the wider medical community as CMS is reviewing it for possible new coding and assignment to a New Technology APC under the OPPS. The AMA’s CPT Editorial Panel has only one CPT code application that is used by applicants requesting consideration for either Category I or III codes. We indicated that we would accept either a Category I or Category III code application to the CPT Editorial Panel. The application requests relevant clinical information regarding new services, including their appropriate use and the patient populations expected to benefit from the services, which would provide us with useful additional information. CPT code applications are reviewed by the CPT Editorial Panel, whose members bring diverse clinical expertise to that review. In the proposed rule, we indicated our belief that consideration by the CPT Editorial Panel might facilitate appropriate dissemination of the new

technology services across delivery settings and bring to light other needed coding changes or clarifications. We further proposed that a copy of the submitted CPT application be filed with us as part of the application for a New Technology APC assignment under the OPPS, along with CPT’s letter acknowledging or accepting the coding application. We reminded the public that we do not consider an application complete until all informational requirements are provided. In addition, we reminded the public that when we assign a new service a HCPCS code and provide for payment under the OPPS, these actions do not imply coverage by the Medicare program, but indicate only how the procedure or service may be paid if covered by the program. Fiscal intermediaries must determine whether a service meets all program requirements for coverage, for example, that it is reasonable and necessary to treat the beneficiary’s condition and whether it is excluded from payment. CMS may also make National Coverage Determinations (NCDs) on new technology procedures.

We received a large number of public comments concerning our proposal.

Comment: Many commenters suggested that the AMA CPT Editorial Panel may not be the most appropriate forum for a federally mandated decision. Some of these commenters pointed out that meetings of the panel and the considerations on which it bases decisions are not open to the public. Other commenters questioned whether there is an inherent conflict in the proposal, as CMS and the AMA are distinctly separate organizations with different objectives and constituencies, so that it may not be in the interest of Medicare beneficiaries to tie CMS policy to proceedings of the AMA. Other commenters suggested that even the requirement that the AMA acknowledge receipt of the coding application suggests that the AMA has potential “veto” power over CMS authority and

may thus constitute an unlawful delegation of federal decision making.

Response: We wish to clarify that it was not our proposal to rely upon the decisions of the CPT Editorial Panel. Nor did we propose to adopt the objectives or policies of the AMA or the CPT Editorial Panel. Rather, we proposed only to require initiation of the process for obtaining a CPT code in order to foster the common objective of appropriately recognizing new technology services and properly coding those services. Under our proposal, we would continue to make determinations about the need for new HCPCS codes and about appropriate assignments to New Technology APCs to establish payment rates completely independently of the CPT Editorial Panel. We also proposed only that the applicant show us a letter of acknowledgement or receipt from the AMA, not that the AMA would send us such a letter or withhold such a letter as a way to exercise veto power.

Comment: One commenter stated that while it is possible for manufacturers to file CPT applications to the AMA, the AMA has usually discouraged this practice and specialty societies have been slow to support CPT applications not vetted through them. Another commenter indicated that manufacturers are often not in receipt of letters from the AMA indicating receipt of a CPT coding application, and hence may not be able to provide these letters with their application for New Technology APC assignment. Other commenters claimed that if a manufacturer waits to gather clinical and utilization information sufficient to support a Category I code, the application may no longer meet CMS's definition of "truly new" and may be ineligible for a New Technology APC assignment.

Response: Our proposal did not specifically require that manufacturers submit applications to the CPT Editorial Panel. In fact, we specifically proposed only that such an application "be submitted," and did not stipulate the identity of the applicant. In addition, we were not proposing to require that manufacturers provide us with copies of letters they had received directly from the AMA. We understand, however, that manufacturers ordinarily work in concert with the actual applicants for new CPT codes, and expect that it is reasonable for a manufacturer to be able to obtain such a letter. We also specifically required only the initiation of the application process, not the receipt of a positive (or negative) decision by the CPT Editorial Panel, in order to prevent the process from

delaying our decision beyond the point at which a New Technology APC assignment is appropriate. Our proposal was meant only to encourage the appropriate dissemination of information, data collection, and review by the wider medical community concerning new technologies. Finally, it is worth emphasizing that while our objective is to consider for assignment to New Technology APCs services that represent technologies that are "truly new," for designation under the OPPS we specifically rely on our criteria which require that a service or procedure not be described by any existing HCPCS code or combination of codes, that it cannot be adequately represented in the claims data being used for the most current annual OPPS update, and that there is no appropriate clinical APC for its assignment. We do not believe that our proposal to require initiation of the CPT application process would result in delays beyond the point at which these criteria could still be met.

Comment: One commenter stated that there are only three submission deadlines per year for CPT applications, which do not comport to the quarterly schedule for filing New Technology applications to CMS.

Response: The filing dates for New Technology applications are informational dates published on our website as reference points for application receipt related to the earliest date for adding a new code for an approved service to a New Technology APC, that is, the beginning of the following quarter. The actual dates for adding new services, if approved, are often later than the next quarter, depending on specific issues related to comprehensive evaluation of a specific application, which often involves requests for additional information.

Comment: One commenter recommended as an alternative that CMS create codes for qualifying services and assign them to a New Technology APC and stipulate that those applicants must apply to the CPT Editorial Panel for a new code within one year.

Response: We do not believe that it would be advisable to accept this recommendation. First, we do not have a policy of making contingent approvals for payment. All requirements for Medicare payment must be met at the time a code and payment rate are established. In addition, this recommendation would require establishing a mechanism to monitor compliance with the condition of approval. Finally, the necessity of withdrawing some HCPCS codes from coding and payment because of non-

compliance has great potential for causing confusion among providers.

Comment: One commenter stated that our concern about limited experience with new technologies in the Medicare population is more appropriately related to coverage of new procedures, rather than to coding issues. Assignment of a service to a New Technology APC is meant to create a mechanism for gathering utilization data, and does not guarantee coverage and payment of a technology. Coverage for new technologies remains the discretion of Medicare contractors, unless CMS makes a national coverage determination. This commenter claimed that the proposal to require a CPT coding application implies that CMS would be effectively removing the Medicare contractors from the coverage decision-making process.

Response: We do not believe that our proposal would have the effect of removing Medicare contractors from the process of making coverage decisions, or otherwise usurp the role of the coverage decision-making process. Rather, the proposal would serve merely to promote evaluation of new services by the wider medical community, so that the results of this evaluation could serve to assist in broader distribution of new clinical information, establishment of appropriate standard coding, and wider dissemination of promising technologies. Even when the CPT Editorial Panel establishes a new code, Medicare contractors have discretion to make local coverage decisions, and CMS retains the right to make national coverage determinations with regard to the procedure or service.

Comment: Some commenters indicated that there are unique payment concerns related to applying for a Category III CPT code, asserting that many Medicare contractors view Category III CPT codes as an indication that a technology is experimental or investigational. One commenter provided as an example a proposed and final policy of one CMS contractor not to cover any technologies described by Category III CPT codes, "since these codes have been created to track new, unproven therapies and tests." Another commenter claimed that assignment of a Category III CPT code often results in non-coverage decisions by both local carriers and fiscal intermediaries.

Response: The example provided by commenters about the implications of Category III CPT codes for coverage decisions by Medicare contractors appears to be relevant outside the context of the OPPS, mainly within the physician payment context. We have been unable to identify any fiscal

intermediary that has adopted any such broad noncoverage policy regarding Category III CPT codes.

Comment: One group of commenters urged us not to adopt the proposed requirement that a CPT application submission to the AMA's CPT Editorial Panel be required before we accept a New Technology APC application for review. These commenters asserted that a CPT coding application, in and of itself, will not provide us with input from the greater medical community, unless we wait until the CPT Editorial Panel has made a coding decision and that decision has been made public. Because of the timing of the CPT code review process, it is not reasonable for CMS to wait until the CPT Editorial Panel has made a public coding decision, which can take 6–12 months for an internal decision, and 6–24 months before publishing a coding decision for a Category I code. These commenters also believed that this requirement would delay access to new services, asserting that applying for a CPT code is a lengthy process and involves months of gathering information on the technology and its use, working with relevant specialty societies to obtain support for a new code and to develop a clinical vignette, and consulting within the CPT Editorial Panel. In order to obtain a Category I code, the new technology must have widespread usage across the country and in multiple locations, and its efficacy must be documented in U.S. peer-reviewed journal articles. Other commenters stated that a number of issues regarding the CPT coding process make our proposal impractical, in addition to the lack of a guaranteed timely review by the CPT Editorial Panel. The AMA does not have "official" evidence and utilization thresholds for coding applications. However, commenters indicated that physician specialty societies often require certain thresholds of utilization or clinical evidence be met before a Category I CPT application for a new service is submitted, and there is considerable variation in such thresholds among the specialty societies. If a manufacturer submits an application without society support or before there is widespread utilization, the application is more likely to be denied or assigned a Category III CPT code, even if that was not requested. Some commenters indicated that there are payment concerns in applying for a Category III CPT code, asserting that most private payers view Category III CPT codes as indication that a technology is experimental or

investigational, and therefore refuse to cover procedures or services described by Category III CPT codes. These commenters asserted that because of the risk of non-coverage of Category III CPT codes, manufacturers may forego applying for New Technology APC assignments, or will be hesitant to apply for both a New Technology APC assignment and CPT code simultaneously. Without unique service codes, it will be more difficult for CMS to track new services and eventually to assign them to clinically appropriate APCs. The result will be fewer New Technology APC applications, and less beneficiary access to new technologies. A few commenters asserted that little would be gained by the mere filing of a CPT application without a coding determination from the CPT Editorial Panel, because the information in both applications is similar. One commenter suggested that if there is information from the CPT application that CMS requires to evaluate the New Technology APC application, we should add such questions to our application.

In lieu of using the CPT coding process to encourage review by the wider medical community, a few commenters recommend that CMS appoint a standing advisory committee of clinical representatives, or another independent group of medical experts from specialties and hospitals, to review New Technology APC applications and provide input to CMS. Other commenters also suggested that we convene an independent group of medical experts to assist in the review of applications as necessary.

A number of other commenters, principally from hospitals and hospital associations, supported our proposal to require a CPT application prior to our consideration of a New Technology APC application because they favored less ambiguity in the coding framework. Some of these commenters said that there is a proliferation of C-codes and G-codes, which are burdensome to hospitals as such codes are often not recognized by other payers, and our proposal will minimize the need for expedited issuance of C-codes or G-codes. They asserted that hospitals would benefit by reduced duplication of codes for services recognized by Medicare and other payers. Other commenters claimed that the correct process for coding new services is to start by way of the CPT Editorial Panel review process rather than the New Technology APC application process. Other commenters also supported the requirement on the grounds that the CPT review process is rigorous, including input by physician specialty

societies, which indicates the level of acceptance of a new technology in the medical community, relevant to the OPSS because physicians perform new technology procedures in the hospital setting. One commenter indicated that there may be specific occasions when it is necessary to submit applications to the CPT Editorial Panel and CMS simultaneously. Another commenter requested that we recognize potential delays resulting from this additional step and expedite our review of New Technology APC applications. Finally, one commenter indicated appreciation of the reasons for the proposal, but asked that this new requirement remain as stated, that an application needs to be submitted to the AMA CPT Editorial Panel, but that it did not necessarily need to be reviewed and processed by the CPT Editorial Panel prior to CMS's consideration of the New Technology APC application.

Response: In light of the strong division among the commenters on the merits of our proposal to require that a CPT coding request be submitted prior to submission of a New Technology APC application, we have decided not to adopt this proposal at this time. Many of the comments reflect confusion about the specifics of the proposal. Therefore, we are concerned that, because the commenters did not understand some specifics of this proposal during their review of the CY 2006 proposed rule, we may similarly not be in a position to understand all the implications of the concerns noted by the commenters. In particular, we did not intend to tie our decision-making regarding applications for New Technology APC assignment to the CPT Editorial Panel process, but wished to promote review of the coding, clinical use, and efficacy of new technology services by the wider medical community to facilitate the swift spread of promising new technologies into medical practice.

While we are deferring our proposal, we continue to believe that timely review of potential new services by the wider medical community is valuable, given our experience that many services that have requested OPSS coding and assignment to a New Technology APC have demonstrated limited clinical efficacy. We also continue to believe that new technology services deserve timely standard and comprehensive coding established through the CPT Editorial Panel review process to permit appropriate payment and data collection regarding their utilization patterns and clinical outcomes. We also do not agree with many of the criticisms directed against the proposal. For example, as stated previously, we do not agree that

our proposal to have applicants file a CPT coding request before submission of a New Technology APC application would make the CPT coding process a Federal decisionmaking forum. This is because we would not require a decision to be made by the CPT Editorial Panel. However, in light of the numerous and considered comments opposed to the proposal, we are not proceeding with it at this time.

At the same time, we remain committed to the general goal of promoting review of the coding, clinical use, and efficacy of new technology services by the wider medical community. We continue to believe that such broad and early review of new technology procedures would enhance our ability to make appropriate initial and subsequent decisions on assignments of new services to New Technology APCs and would facilitate the more rapid dissemination of promising new technologies to all service settings and appropriate patient populations. Therefore, we will continue to study how to best achieve these goals of timely review of new technologies by the general medical community to validate their clinical worth and distinctiveness in comparison with existing services and to promote more rapid dissemination of effective new procedures throughout standard medical practice. In doing so, we will continue to consider whether the proposal we advanced would serve that goal. We would specifically welcome further input on this proposal or alternatives to it. We may reintroduce this proposal or advance alternative approaches at a later date.

As a preliminary matter, we are not inclined to accept one alternative recommended by some commenters. Specifically, we are not inclined to establish a standing advisory committee to provide input on New Technology applications to the OPPS, as some have suggested. A standing committee involving outside experts would add additional review time that would impede upon our application process, as well as prevent us from evaluating New Technology applications for addition to the OPPS on a quarterly basis, as appropriate. We prefer to maintain the flexibility that our current process provides. In addition, the specific medical expertise required to evaluate new technologies would likely vary widely from application to application. This factor would render consultation with a standing advisory committee with fairly stable membership more difficult to maintain.

4. New Technology Services

a. Ablation of Bone Tumors

Comment: One commenter requested that we reassign CPT code 20982 (Ablation, bone tumor(s) (eg, osteoid osteoma, metastasis) radiofrequency, percutaneous, including computed tomographic guidance) from New Technology Level XX, APC 1557 to New Technology Level XXII, APC 1559. The commenter stated that the procedure has been in New Technology APC 1557 for 2 years, and that the payment rate for that APC is not adequate to cover the hospitals' costs. The commenter asserted that assignment to that APC was based on inadequate information. The commenter used physician practice expense data to estimate costs to perform the ablation procedure, and stated that the costs far surpass the OPPS payment amount, largely due to the high cost of the necessary radiofrequency probe. Further, the commenter added that its analysis found that 2 of the 16 single claims CMS used to calculate the median cost for CPT code 20982 for the proposed rule were inaccurate because no charge for the ablation device, as indicated by the absence of a separate supply charge, was included. The commenter believed that those two claims had a significant effect on the median cost for CPT code 20982, because of the small number of claims for the procedure. The commenters' analysis further showed that the median cost for these procedures was \$2,156 based on 14 claims that included a supply charge.

Response: As we have stated in this preamble, we are committed to relying on our claims data for making APC assignments as much as possible. While we appreciate the external data provided by the commenter regarding the costs of supplies associated with the practice expense inputs for the Medicare Physician Fee Schedule, that payment system utilizes a different methodology for establishing payment for services that is not directly applicable to payment rates under the OPPS. In the case of CPT code 20982, we believe that our hospital claims data are adequate to support our proposal to maintain the service in New Technology APC 1557 for CY 2006. CPT code 20982 was a new code for CY 2004 so we have 1 year of hospital data for this procedure. For CPT code 20982, we have 17 single claims from CY 2004 with a procedure-specific median cost of \$1,578. As we do not require that hospitals bill a separate supply charge for the probe that is used for this service because there is no specific device C-code available, we have no reason to

believe that claims for CPT code 20982 without a separate supply charge do not contain charges for all costs associated with the procedure. The catheter charges may be wrapped into the charge for the procedure itself. The code-specific median indicates that even the current New Technology APC payment at \$1,850 may be too high, but given the information provided by the commenter and the relatively low number of CY 2004 claims available for calculating the median cost for CPT code 20982, we are finalizing our proposal for CY 2006 and are retaining CPT code 20982 for at least 1 more year in New Technology APC 1557.

b. Breast Brachytherapy

Comment: In response to the November 15, 2004 final rule with comment period (69 FR 65682), one commenter applauded our assignment of CPT codes 19296 (Placement of radiotherapy afterloading balloon catheter into the breast for interstitial radioelement application) and 19298 (Placement of radiotherapy afterloading balloon catheters, multiple tube and button type, into the breast for interstitial radioelement application) to New Technology APC 1524 (Level XIV \$3000–\$3500), and CPT code 19297 (Placement of radiotherapy afterloading balloon catheter into the breast for interstitial radioelement application; concurrent with partial mastectomy) to New Technology APC 1523 (Level XXIII \$2500–\$3000) for CY 2005. The commenter stated that these payment amounts adequately cover the costs of the applicator devices involved in the procedures.

Response: We agree with the commenter's acknowledgement that the payment amounts that we assigned to CPT codes 19296, 19297, and 19298 for CY 2005 adequately cover the resource costs associated with these procedures. Therefore, for CY 2006, we are maintaining CPT codes 19296 and 19298 in New Technology APC 1524 and CPT code 19297 in New Technology APC 1523.

c. Enteryx Procedure

A new CPT code, 0133T (Upper gastrointestinal endoscopy, including esophagus, stomach, and either the duodenum and/or jejunum as appropriate, with injection of implant material into and along the muscle of the lower esophageal sphincter (e.g., for treatment of gastroesophageal reflux disease)), was created for implementation January 1, 2006 to describe the procedure currently coded under the OPPS as HCPCS code C9704 (Injection or insertion of inert substance

for submucosal/intramuscular injections(s) into the upper gastrointestinal tract, under fluoroscopic guidance). For CY 2005, C9704 was assigned to New Technology APC 1556, with a payment rate of \$1,750. As discussed below, we determined an appropriate APC assignment for this procedure for CY 2006. However, in the period between publication of the proposed rule and the end of the comment period, the product manufacturer recalled this product and the Food and Drug Administration has warned physicians about the danger of its use.

In our analyses to determine the most appropriate APC assignment for the new CPT code, we found that the most accurate payment will be made by retaining the procedure's current APC assignment. We did not automatically assign CPT code 0133T to APC 1556 because that CPT code explicitly includes the endoscopy that is integral to the service, whereas the current C-code does not. For that reason we calculated the claims-based median cost for the procedure by using single claims for HCPCS code C9704, on the premise that if the procedure required endoscopy and the endoscopy was not separately billed then the endoscopy charges were reflected in the charges for HCPCS code C9704 as well as claims for HCPCS code C9704 that had a charge for an endoscopy included to assure us that we were capturing the charges for the entire procedure from as many claims as possible. Thus, to determine an appropriate APC placement for CPT code 0133T we analyzed all single claims for HCPCS code C9704, as well as claims that had HCPCS code C9704 combined with either CPT code 43234 (Upper gastrointestinal endoscopy, simple primary examination (e.g., with small diameter flexible endoscope)), or CPT code 43235 (Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/ or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing).

The median cost from these claims which would crosswalk to the new CPT code is \$1,660. Therefore, we believe that it is still appropriate to retain the procedure, coded for CY 2006 as CPT code 0133T, in New Technology APC 1556 rather than assigning it to a different New Technology APC or a clinical APC at this time. We will be deleting HCPCS code C9704. As with all procedures assigned to New Technology APCs, we will reevaluate it for next year to determine whether assignment to a clinical APC is more appropriate.

d. Extracorporeal Shock Wave Treatment

Comment: Several commenters to both the November 15, 2004 final rule with comment period and to our July 25, 2005 proposed rule opposed our placement of new HCPCS codes for high energy Extracorporeal Shock Wave Therapy (ESWT) services into New Technology APC 1547. In response to a New Technology application for ESWT, we created new codes for high energy ESWT for chronic lateral epicondylitis (C9720-tennis elbow) and for chronic plantar fasciitis (C9721) effective January 1, 2005, and placed them into New Technology APC 1547, with a payment rate of \$850 for CY 2005. A number of commenters requested that these ESWT services be placed in New Technology APC 1559, which has a payment rate of \$2,250. A manufacturer of ESWT equipment, who commented, cited our regulations (42 CFR § 419.31) in stating that APC groups "must be" comparable in terms of clinical use and resources required. This commenter, as well as another manufacturer, claimed that New Technology APC 1547 does not cover the costs of the ESWT procedures for chronic lateral epicondylitis and for chronic plantar fasciitis. The commenters provided their estimated costs of the procedure at about \$2,300 per service for both clinical indications. One commenter also indicated that it understood that the AMA's CPT Editorial Panel intended to issue new codes for the two high energy ESWT services beginning in CY 2006. It stated that when these new CPT codes become effective, providers and payers will be faced with two different sets of codes for high energy ESWT, the CPT codes and the HCPCS C-codes, and this will cause difficulties with provider billing and reimbursement.

Commenting parties expressed their belief that our placement of ESWT did not cover the costs of ESWT for plantar fasciitis, claiming that the ESWT equipment costs between \$250,000 and \$400,000 for each unit, varying by manufacturer, and summarizing other additional costs, such as those for an annual maintenance contract, a specialized technician, and anesthesia, along with a specialized transport vehicle for the ESWT equipment. Commenters asserted that high energy ESWT is comparable to the resource costs of services in Level II Foot Musculoskeletal Procedures, APC 0056 with a CY 2005 payment rate of \$2,380.72, except that ESWT includes the capital costs for the equipment, transport vehicle, and technician mentioned earlier. The commenters also

stated that high energy ESWT has a similar technology and cost structure, including technological devices, maintenance contracts, and specialized technical personnel, to extracorporeal shock wave lithotripsy, for the fragmentation of kidney stones. These commenters proposed that high energy ESWT be placed in APC 1559. One hospital indicated that its average cost for ESWT is \$2,100. Another commenter who compared high energy ESWT with lithotripsy stated that if we wished to compare ESWT with the costs of other procedures, then we should use lithotripsy, which also employs high energy extracorporeal shock waves, but for the treatment of kidney stones. The commenter claimed that many of the other costs associated with the two procedures were similar as well, with the exception of an imaging component used with lithotripsy. The commenter noted that lithotripsy's APC assignment, APC 0169, has a payment rate close to that of New Technology APC 1559. Another commenter, commenting only on HCPCS code C9721, recommended that high energy ESWT for treatment of chronic plantar fasciitis be placed in either clinical APC 0055 (Level I Foot Musculoskeletal Procedures) or APC 0056 (Level II Foot Musculoskeletal Procedures), claiming that it fits most closely clinically to procedures in APC 0055, and that high energy ESWT is more homogeneous to either APC 0055 or 0056 clinically and economically than to its assigned New Technology APC. The commenter also stated that any new CPT code beginning in CY 2006 for high energy ESWT for chronic plantar fasciitis should replace HCPCS code C9721 and should be placed in APC 0055 or 0056.

Response: When we determine that a new service is eligible for placement into a New Technology APC, we then perform our own cost analysis and cost estimate, in addition to taking the projected costs submitted in a New Technology APC application into consideration. As we stated in our November 30, 2001 final rule (66 FR 59900) concerning placement of new services into APCs, " * * * we will not limit our determination of the cost of the procedure to information submitted by the applicant. Our staff will obtain information on cost from other appropriate sources before making a determination of the cost of the procedure to hospitals." We compared the necessary hospital resources such as procedure room time, personnel, anesthesia and other resources of the ESWT procedure to various other procedures for which we have historical

hospital claims data. Additionally, we took into consideration projected costs submitted in the New Technology APC application, including the capital costs and equipment utilization assumptions, concluding that HCPCS codes C9720 and C9721 should be assigned to New Technology APC 1547. New Technology APCs, by their very definition, do not contain services that are clinically homogeneous, but instead, based solely on hospital resource considerations, the services have estimated costs that place them into the same New Technology payment band. In contrast, services assigned to the same clinical APC are homogeneous with respect to both their clinical characteristics and hospital resource utilization.

There are new CPT codes for CY 2006 that describe high energy ESWT services, and hospitals providing these services in CY 2006 will use the CPT codes to report them instead of the two predecessor C codes. In particular, CPT code 0102T (Extracorporeal shock wave, high energy, performed by a physician, requiring anesthesia other than local, involving lateral humeral epicondyle) will replace HCPCS code C9720. In addition, CPT code 28890 (Extracorporeal shock wave, high energy, performed by a physician, requiring anesthesia other than local, including ultrasound guidance, involving the plantar fascia) will replace HCPCS code C9721. We have closely reviewed the hospital cost information provided by the commenters, along with our CY 2004 hospital claims data for other outpatient hospital services. We are not confident yet, in the absence of hospital claims data for the predecessor C codes or the new CPT codes, that we can appropriately place CPT codes 0102T and 28890 in clinical APCs where they would share clinical and resource homogeneity with other services. Therefore, for CY 2006 we are assigning CPT codes 0102T and 28890 to New Technology APC 1547 with a payment rate of \$850. We believe that the payment rate is appropriate based on all cost and utilization information available to us regarding high energy ESWT and other services provided in a hospital outpatient setting.

Comment: One commenter, the applicant for assignment of high energy ESWT to a New Technology APC, claimed that our assignment of ESWT to a New Technology APC violates the Administrative Procedure Act (APA). The commenter asserted that the OPSS proposed rule published August 16, 2004 (69 FR 50448) failed to mention ESWT or its placement in an APC. Moreover, the commenter claimed that our lack of discussion of our

methodology made proper comments difficult if not impossible. The commenting party claimed that finalizing a rule without explanation is unlawful. The commenter furthermore claimed that the placement of ESWT in APC 1547 was arbitrary, capricious, and in excess of statutory authority in violation of the Administrative Procedure Act. The commenter claimed that it appeared that CMS ignored the applicant's data that it submitted regarding resource use, instead comparing the resource costs for ESWT with entirely different procedures, resulting in inaccurate conclusions regarding the costs of ESWT services. Moreover, the commenter claimed that we have improperly classified ESWT into the same APC as endoscopic epidural lysis, which it claims violated the statutory requirement to group procedures based on both costs and clinical and resource comparability.

Response: We disagree that our assignment of ESWT to New Technology APC 1547 was arbitrary, capricious, and in violation of the APA or the Medicare statute. As stated in our response above, we perform our own cost analysis and estimate the cost of any eligible new service, while taking the projected hospital costs submitted in the New Technology APC application into consideration. As we have indicated above, our November 30, 2001 final rule concerning placement of new services into APCs states that we do not limit our determination of the cost of the procedure to information submitted by the applicant. We obtain information on costs from other appropriate sources before making a determination of the cost of the procedure to hospitals. In the case of the ESWT procedures, our clinical review team of physicians compared the resources such as procedure room time, anesthesia, and other resources of the ESWT procedure to the resources of various other outpatient hospital procedures for which we have historical hospital claims data. We believe that our claims data on other procedures in terms of hospital resource use yield relevant cost information for use in developing cost estimates for new procedures without a claims history. As explained above, we took the New Technology APC applicant's costs into account as we reviewed its projected hospital costs thoroughly and, in particular, utilized information regarding expected service frequency, capital equipment, and other costs in our total cost estimate for the procedures. As discussed earlier, assignment to a New Technology APC does not imply clinical homogeneity

with other services assigned to the same New Technology APC. We also note that we could not have included these two C-codes in the proposed rule for CY 2005, since we had not yet completed our evaluation of the New Technology APC application and rendered a decision until well after that proposed rule was published. As we have announced numerous times elsewhere, we will add New Technology service codes and assign their payment rates in our quarterly updates, where applicable and available, to facilitate timely integration of new codes into the OPSS. The timing of the ESWT procedures decision made the addition of the codes and payment rates coincident with our CY 2005 final rule publication. In order to have provided a discussion of the codes in a proposed rule, implementation of the codes would have been delayed a full year.

e. GreenLight Laser

During the August 2005 APC Panel meeting, the Panel recommended accepting CMS' proposed creation of APC 0429 for CY 2006 and the inclusion of HCPCS C9713, which describes use of the GreenLight Laser System, in this APC. We received several public comments concerning the reassignment of HCPCS codes C9713, 52647, 52648, 50080, and 50081 to APC 0429.

Comment: Several commenters requested that CMS maintain HCPCS code C9713 in its New Technology APC for one more year, which would give hospitals more time to learn how to correctly code for this service. The commenters stated that our proposed reassignment of the procedure to a clinical APC was premature because the decision was based on only 9 months of claims data. They suggested that many hospitals may not even have known about the new HCPCS code C9713 because it was not implemented until April 5, 2004, and, therefore, CMS received even fewer correctly coded claims than the true number of outpatient hospital services actually described by HCPCS code C9713 that were performed on Medicare beneficiaries during the 9 month period.

The commenters pointed out that there is evidence that hospitals have not been using the HCPCS code properly and reminded us that some members of the APC Panel stated that their hospitals were not coding these procedures correctly.

The commenters stated that the short period of time for collection of claims data and the low median cost calculated for HCPCS code C9713 based on those claims support their conjecture that the claims are not correct, and that the

procedure should remain in its CY 2005 New Technology APC for at least one more year to allow for collection of more accurate claims data.

Response: For CY 2006, CPT revised the descriptors of two procedure codes for prostate laser procedures described by CPT codes 52647 and 52648. The revised CPT code descriptors are as follows: 52647 (Laser coagulation of prostate, including control of postoperative bleeding, complete (vasotomy, meatotomy, cystourethroscopy, urethral calibration and /or dilation, and internal urethrotomy are included if performed); and 52648 (Laser vaporization of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation internal urethrotomy and transurethral resection of prostate are included if performed). These descriptors for the CPT codes will be implemented on January 1, 2006. Our policy in the OPSS is to maintain only one HCPCS code that describes a specific procedure, and to the extent possible adopt CPT coding for services provided under the OPSS. In this case we determined, based on our review of the new descriptors, that procedures reported using HCPCS code C9713 in CY 2005 could be appropriately billed with CPT codes for CY 2006.

We also concluded that the resource use and clinical aspects of the laser vaporization procedure reported with HCPCS code C9713 and of the prostate procedures reported using CPT codes 52647 and 52648 prior to revision were so similar that it was appropriate to move, as proposed, the CY 2004 hospital claims data for HCPCS code C9713 to APC 0429 to contribute to the APC's median cost calculation for CY 2006. In addition, there was no reason to postpone adoption of the revised CPT codes for use in the OPSS. Although we had less than a full year of hospital claims data available for HCPCS code C9713, we had well over 1,600 single claims upon which to calculate median costs for the procedure, and those claims data confirmed the resource similarity of this service to the services coded by CPT codes 52647 and 52648. The medians for these three procedures only range from \$2,475 to \$2,602 and the clinical indications for the procedures are also similar. For CY 2006 we are adopting the newly available revised CPT codes for reporting the procedure previously described by HCPCS code C9713 and deleting HCPCS code C9713, effective January 1, 2006.

Creation of a new Level V APC 0042 for Cystourethroscopy and Other

Genitourinary Procedures, the level to which we assigned the CY 2004 data for the prostate laser procedures described by HCPCS code C9713 and CPT codes 52647 and 52648, along with cost data for two other procedures also reassigned to that APC, resulted in tighter median cost distributions within all levels of the APCs for cystourethroscopy and other genitourinary procedures. We are confident in the median costs for all of these prostate procedures because we have over 1,000 single claims for each of those procedures.

Although HCPCS code C9713 was placed in a New Technology APC for only one year, assignment to an appropriate clinical APC is always our goal for procedures that spend time assigned to New Technology APCs. In this case, the creation of a Category I CPT code that describes the procedure reported by HCPCS code C9713 during CY 2004 and CY 2005 in the OPSS occurred more quickly than is often the case. We believe that the procedure's assignment with similar procedures to a new clinical APC is appropriate and will result in accurate payment. Also, we expect that adoption of a revised CPT code for reporting the noncontact laser vaporization of the prostate procedure will reduce hospitals' administrative burden as they will be able report CPT codes for prostate services provided in CY 2006, rather than C-codes specific to the OPSS.

After carefully considering all comments we received, we are finalizing, without modification, our proposal to assign CPT codes 52647, 52648, 50080, and 50081 to new APC 0429, Level V Cystourethroscopy and Other Genitourinary Procedures. The CY 2004 hospital claims data for HCPCS code C9713 have been assigned to APC 0429 for purposes of establishing the final CY 2006 payment rate for that APC.

f. Magnetoencephalography (MEG)

We proposed to reassign MEG procedures to clinical APC 0043, using CY 2004 claims data to establish median costs on which payments would be based.

We received a number of public comments concerning the reassignment of CPT codes 95965, 95966, 95967.

Comment: A number of commenters addressed our proposal to assign magnetoencephalography (MEG) procedures to APC 0430. There are three MEG procedures affected by our proposal: CPT code 95965, MEG recording and analysis for spontaneous brain magnetic activity; CPT code 95966, MEG for evoked magnetic fields, single modality; and CPT code 95967,

MEG for evoked magnetic fields, each additional modality to be listed separately in addition to CPT code 95965 for primary procedure. Each of those procedures is currently assigned to a separate New Technology APC, and the commenters believed that they should remain in those APCs for CY 2006. The commenters believed that assignment to APC 0430 was inappropriate because the proposed payment level of \$674 was inadequate to cover the costs of the procedures and because the procedures should not be assigned to only one level as their required hospital resources differ significantly.

The commenters stated that the median costs based on CMS' hospital claims data are erroneous because hospitals are not providing accurate charges for the procedures. Further, they stated that our data did not represent the true costs of the procedures because MEG procedures are performed on very few Medicare patients.

In addition to the written comments we received on our proposed rule, hospital and manufacturer representatives made presentations to the APC Panel during its August 2005 meeting. At that time, the Panel recommended that CMS retain the MEG procedures in their current New Technology APCs and that we collect more external data and provide a detailed review of the data for the Panel's consideration at its next meeting.

Response: The MEG procedures have been assigned to New Technology APCs for 4 years. In CY 2002, all three services were assigned a payment rate of \$150 in a single New Technology APC. As these CPT codes were new for CY 2002 and, therefore, first open to comment in the CY 2002 final rule, we received several comments regarding the costs of the services. For CY 2003, all three services were assigned to higher paying New Technology APCs, with a rate of \$2,250 for CPT code 95965, \$1,375 for CPT code 95966, and \$875 for CPT code 95967. For CY 2004 and CY 2005, the procedures were again assigned to higher paying New Technology APCs, with CPT code 95965 moving to a rate of \$5,250; CPT code 95966 to a rate of \$1,450; and CPT code 95967 to a rate of \$950.

For CY 2006, we proposed to assign these procedures to one new clinical APC because assignment to New Technology APCs is generally temporary while we are gathering hospitals claims data, and we now have 3 years of data upon which to base clinical APC assignments. Over the entire 3-year period, the median costs

for all 3 services, especially CPT code 95965, have generally been far less than the OPSS payment rates. In fact, the CY 2005 median cost (based on CY 2003 claims data) for CPT code 95965 was only 16 percent of the payment rate, and for CY 2006 the median cost (based on CY 2004 claims) was only 12 percent of the rate.

These procedures are rarely performed on Medicare beneficiaries and, therefore, we have a small number of claims now and have no expectation that the volume will increase. Patients targeted for MEG investigation procedures are typically between 17 and 32 years old. Furthermore, industry expectations are that the technology's growth will be in installations outside of hospitals. Nevertheless, almost all services with ongoing expectations of low volume for Medicare beneficiaries, including obstetrical services, reside in clinical APCs, not New Technology APCs. From CY 2003 claims data we were able to use 20 of the 21 claims submitted for CPT code 95965, 7 of the 7 claims submitted for CPT code 95966, and 4 of the 6 submitted for CPT code 95967 to calculate median costs of the procedures. For CY 2006 based on CY 2004 hospital claims data, we were able to use 10 of the 10 claims submitted for CPT code 95965 and 3 of the 4 submitted for CPT code 95966, while we had no claims for CPT code 95967.

In contrast to the comments, we are committed to relying increasingly on those data, especially in a case like this where the few hospitals that offer this technology have been billing these procedures for at least four years and the technology is no longer new. However, we also are sensitive to the potential access effects of relying on a low volume of claims to establish payment rates, as well as to the APC Panel's recommendation regarding these procedures as noted by the commenters. Therefore, for CY 2006 we considered charge and cost information provided to us during the comment period in addition to our claims data. A commenter provided total charge information billed to multiple payers, including Medicare, for MEG services from one hospital which showed charges of about \$10,500. Also included in the information we received during the comment period were cost estimates

for the procedures from various sources, and the estimates of costs varied considerably. For example, we were provided with estimates of hospital costs per case for CPT code 95965 that ranged from \$8,321 to \$4,054. We believe that some of that variation may be due to differences in the number of cases used in amortization estimates, as the costs of the equipment used in MEG procedures are significant. However, the fact that volume varies from one provider to another does not mean that we will base our payments on the high cost per case that results from allocating costs over only a few cases. In the case of MEG, we are especially sensitive to this given the very low level of Medicare beneficiary participation in the technology because of the clinical circumstances in which MEG services are typically provided. The OPSS payment rates for services need to make appropriate payments for the services provided to Medicare beneficiaries, recognizing that, as a budget neutral payment system, the OPSS does not pay the full hospital costs of services. We expect that our payment rates generally will reflect the costs that are associated with providing care to Medicare beneficiaries in cost-efficient settings.

We agree with the APC Panel and the commenters that there are no currently existing clinical APCs containing other services where MEG services could be appropriately assigned, based on clinical and resource homogeneity with other OPSS services. We carefully considered our claims data, information provided by commenters, and the APC Panel recommendation that we retain the MEG procedures in New Technology APCs. As a result of this analysis, we determined that using a 50/50 blend of the code-specific median costs from our most recent CY 2004 hospital claims data and the CY 2005 code-specific payment amounts as the basis for assignment of the procedures for CY 2006 would be one way to recognize both the current payment rates for the procedures, which were originally based on the theoretical costs to hospitals of providing MEG services, and the median costs based upon our hospital claims data regarding actual MEG services provided to Medicare beneficiaries by hospitals. Accordingly, for CY 2006, because we are not fully

confident in our claims data for MEG procedures and there are no clinical APCs containing other services that share clinical and hospital resource characteristics with MEG procedures, we believe that it is most appropriate to place MEG services in New Technology APCs for CY 2006 to accommodate these adjusted costs. We agree with the commenters that these APCs should be "S" status so no multiple procedure reduction will apply, as we are determining an adjusted cost for each specific MEG service. For CPT codes 95965 and 95966, we averaged the services' median costs from CY 2004 claims data with their CY 2005 payment rates to determine adjusted costs for the procedures and, therefore, their appropriate New Technology APC assignments. There were no CY 2004 claims for CPT code 95967, and thus, no median cost to use for such an adjustment. For that procedure, we based the New Technology APC assignment on the historical relationship (66 percent in CY 2005) between the New Technology APC payment for that procedure and the New Technology APC payment for CPT code 95966, the code to which CPT code 95967 is an add-on. We used 66 percent of our CY 2006 payment rate for CPT code 95966 to determine the adjusted cost of CPT code 95967 and establish the New Technology payment amount for CPT code 95967 for CY 2006. The table below provides the CY 2006 payment rates and the resulting APC assignments for MEG services.

As suggested by the APC Panel, we will continue to study the APC assignments for these procedures over the coming year and invite members of the public to submit any information they believe will be helpful to us. We have given these procedures special consideration through this adjustment methodology for CY 2006 to help assure that Medicare beneficiaries have appropriate access to MEG services. With an additional year of data and improved consistency of billing by hospitals providing MEG services, we are hopeful that the claims-based median costs of these services in future years will more consistently and appropriately reflect hospitals' costs of providing MEG procedures.

TABLE 10.—CY 2006 APC ASSIGNMENTS FOR MEG SERVICES

| CPT | CY 2006 median cost | CY 2005 payment | Adjusted cost | CY 2006 payment amount/APC |
|-------------|---------------------|-----------------|---------------|----------------------------|
| 95965 | \$644.71 | \$5,250 | \$2,947.35 | \$2,750/1523 |
| 95966 | 1,013.34 | 1,450 | 1,231.67 | 1,250/1514 |
| 95967 | N/A | 950 | 818.97 | 850/1510 |

g. Positron Emission Tomography (PET) Scans

(1) Nonmyocardial PET Scans

Positron emission tomography (PET) serves an important role in the clinical care of many Medicare beneficiaries. As stated in the November 15, 2004 final rule with comment period (69 FR 65716), we believe there are sufficient claims data to assign nonmyocardial PET scans to a single clinical APC. However, to minimize any potential impact that a payment reduction resulting from this move might have had on beneficiary access to this technology, we set the CY 2005 OPPTS payment for nonmyocardial PET scans based on a 50/50 blend of their CY 2005 median cost and the payment rate of the CY

2004 New Technology APC to which they were assigned. Therefore, nonmyocardial PET scans were assigned to New Technology APC 1513 (New Technology—Level XIV (\$1,000–\$1,200) for a blended payment rate of \$1,150 in CY 2005.

At the February 2005 APC Panel meeting, the Panel agreed with a presenter's assertion that the resource costs associated with nonmyocardial PET scans are similar to the costs associated with myocardial PET scans, and recommended that myocardial PET scans be placed in the same New Technology APC 1513 in which the nonmyocardial PET scans currently reside. Furthermore, presenters at the February 2005 APC Panel meeting expressed concern that movement of nonmyocardial PET scans from their

New Technology APC to lower paying clinical APC 0285 could impede beneficiary access to this technology, similar to concerns articulated by commenters in previous years.

As a result of a recent Medicare national coverage determination (Publication 100–3, Medicare Claims Processing Manual section 220.6), effective January 28, 2005, we discontinued the PET G-codes listed in Table 10, and activated the CPT codes listed below in Table 11 for myocardial and nonmyocardial PET scans and concurrent PET/CT scans for anatomical localization. These lists of codes along with claims processing instructions, are provided in Change Request 3756, Transmittal 514, Publication 100–04, Medicare Claims Processing Manual.

Table 11.--HCPCS Codes for PET Services Not Valid for Medicare for Dates of Service on or after January 28, 2005

| HCPCS Code | HCPCS Code | HCPCS Code | HCPCS Code |
|------------|------------|------------|------------|
| G0030 | G0042 | G0215 | G0228 |
| G0031 | G0043 | G0216 | G0229 |
| G0032 | G0044 | G0217 | G0230 |
| G0033 | G0045 | G0218 | G0231 |
| G0034 | G0046 | G0220 | G0232 |
| G0035 | G0047 | G0221 | G0233 |
| G0036 | G0125 | G0222 | G0234 |
| G0037 | G0210 | G0223 | G0253 |
| G0038 | G0211 | G0224 | G0254 |
| G0039 | G0212 | G0225 | G0296 |
| G0040 | G0213 | G0226 | G0336 |
| G0041 | G0214 | G0227 | |

TABLE 12.—CPT CODES FOR COVERED PET SCAN INDICATIONS EFFECTIVE FOR DATES OF SERVICE ON OR AFTER JANUARY 28, 2005

| CPT code | Description |
|-------------|--|
| 78459 | Myocardial imaging, positron emission tomography (PET), metabolic evaluation. |
| 78491 | Myocardial imaging, positron emission tomography (PET), perfusion, single study at rest or stress. |
| 78492 | Myocardial imaging, positron emission tomography (PET), perfusion, multiple studies at rest and/or stress. |
| 78608 | Brain imaging, positron emission tomography (PET); metabolic evaluation. |
| 78811 | Tumor imaging, positron emission tomography (PET); limited area (e.g., chest, head/neck). |
| 78812 | Tumor imaging, positron emission tomography (PET); skull base to mid thigh. |
| 78813 | Tumor imaging, positron emission tomography (PET); whole body. |
| 78814 | Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; limited area (e.g., chest, head/neck). |
| 78815 | Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; skull base to mid thigh. |
| 78816 | Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; whole body. |

In the CY 2006 OPPTS proposed rule, we proposed to maintain CPT codes 78608, 78609, 78811, 78812, and 78813

for nonmyocardial PET scans in New Technology APC 1513 (New Technology—Level XIII, \$1,100–\$1,200)

at a payment rate of \$1,150, the same APC placement as their predecessor G-codes, to ensure continuing beneficiary

access to this technology. We also proposed to maintain CPT codes 78814, 78815, and 78816, which describe concurrent PET/CT scans for anatomical localization, in New Technology APC 1514 (New Technology—Level XIV, \$1,200–\$1,300) at a payment rate of \$1,250, based on input claiming that the costs associated with PET/CT technology are higher than the costs of PET technology alone.

Comment: Several commenters to the November 15, 2004 final rule with comment period (69 FR 65682) urged that we replace the G-codes for PET procedures with the established CPT codes for PET scans, while commenters to the July 25, 2005 proposed rule (70 FR 42674) applauded our transition to the CPT codes for PET scans. These commenters stated that movement to the established CPT codes for PET scans would greatly reduce the burden on hospitals of tracking and billing the G codes which are not recognized by other payors, and would allow for more uniform hospital billing of these scans. Furthermore, while a few commenters urged that we increase the payment for PET scans, the majority of commenters supported our proposal to maintain nonmyocardial PET scans in New Technology APC 1513 (paying \$1,150), consistent with the payment level under their predecessor G-codes. Commenters stated that hospital claims data do not accurately reflect the costs of providing these services, and beneficiary access to this technology would be threatened if hospital claims data alone were used to set the CY 2006 payment rates.

Response: We agree with commenters that movement from the G-codes to the established CPT codes for PET scans allows for more uniform billing of these scans. Furthermore, we concur, in general, with commenters' recommendations that the payment levels under the established CPT codes for PET scans be consistent with the payment levels under their predecessor G-codes. Therefore, we are maintaining newly established CPT codes 78608, 78811, 78812, and 78813 for nonmyocardial PET scans in New Technology APC 1513 (New Technology—Level XIII, \$1,100–\$1,200) at a payment rate of \$1,150. In addition, for myocardial PET scans we are assigning CPT codes 78459 and 78491 to newly established APC 0306 (Myocardial Positron Emission Tomography (PET) imaging, single study, metabolic evaluation) and CPT code 78492 to newly established APC 0307 (Myocardial Positron Emission Tomography (PET) imaging, multiple studies), where the APC medians have been calculated based on data from their

predecessor G-codes, as discussed in more detail below. However, we are changing the status indicator for CPT code 78609 (Brain imaging, PET; perfusion evaluation) from "S" (separately paid under the OPPS) to "E" (not paid under the OPPS) retroactive to January 28, 2005, as historically there has been and currently there remains no coverage for this service under the Medicare program.

Comment: Numerous comments applauded our recognition of the newly established CPT codes for concurrent PET/CT scans and acknowledgement of the clinical usefulness of concurrent PET/CT scans for attenuation correction and anatomical localization in the management of patients with cancer. However, several commenters expressed concern that the proposed assignment of PET/CT scans (CPT codes 78814, 78815, and 78816) to New Technology APC 1514 (paying \$1,250) may not adequately cover the costs of providing PET/CT services. These commenters explained that hospitals incur more capital and maintenance costs with PET/CT than with conventional PET. For instance, a large trade association commented that a new PET/CT scanner costs approximately \$1.8 million, compared to \$1.2 million for a conventional PET scanner. Another commenter quoted annual maintenance costs of approximately \$240,000 for a new PET/CT scanner, compared to \$120,000 for a conventional PET scanner. These commenters asserted that the proposed payment rate for PET/CT scans does not recognize the additional diagnostic benefits provided by concurrent PET/CT scans over traditional diagnostic PET and CT scans. These commenters further explained that the CT scan performed during a PET/CT is not limited to one part of the body but includes the entire area imaged by the PET scan and, therefore, is more efficient than performing one PET scan plus several separate CT scans for different regions of the body. Several commenters recommended that we assign the newly established CPT codes for PET/CT scans (CPT codes 78814, 78815, and 78816) to New Technology APC 1519 (paying \$1,750) based on external data and an economic analysis submitted by one of the commenters, which reported the costs of providing a PET/CT scan at approximately \$1,717. In contrast, a leading mobile provider of PET/CT scans reported an average cost of \$1,485 for providing a PET/CT scan, which included FDG, mileage to sites, technologists, supplies, equipment maintenance, and scheduling.

Response: While we acknowledge that concurrent PET/CT scans for

attenuation correction and anatomical localization in the management of patients with cancer may be clinically useful, we have received no convincing data that support the assignment of PET/CT scans (CPT codes 78814, 78815, and 78816) to an APC paying higher than \$1,250. The external data and economic analysis submitted by one of the commenters failed to meet the criterion for consideration of external data that we proposed in our August 12, 2003 proposed rule (68 FR 47987) and finalized in our November 7, 2003 final rule (68 FR 63424). The external data and analysis was not provided with the level of detail that would have allowed us to verify the claims data nor to have adjusted the claims data should we have determined an adjustment was necessary. Furthermore, one commenter reported an average cost of \$1,485 for providing a PET/CT scan, which included FDG, among other related costs. Considering that FDG will be paid separately at charges adjusted to cost for CY 2006 (estimated typically to be about \$250), the payment rate of \$1,250 for PET/CT scans (not including FDG) adequately covers the cost of \$1,485 that this commenter reported for providing PET/CT scans (including FDG). While we acknowledge that PET/CT scanners may be more costly to purchase and maintain than dedicated PET scanners, a PET/CT scanner is versatile and may also be used to perform individual CT scans, thereby potentially expanding its use if PET/CT scan demand is limited. Therefore, for CY 2006, we are maintaining CPT codes 78814, 78815, and 78816, which describe concurrent PET/CT scans for attenuation correction and anatomical localization, in New Technology APC 1514 (New Technology—Level XIV, \$1,200–\$1,300) at a payment rate of \$1,250.

Comment: One commenter expressed concern that the proposed payment rate of \$1,250 for a PET/CT scan may not cover the costs of a diagnostic CT when performed in conjunction with a PET/CT scan. The commenter stated that although many of the technical resources for acquiring diagnostic CT data when performed as a single acquisition with a PET/CT scan are the same as for the CT for attenuation correction and anatomical localization, the initial capital costs are greater for a PET/CT scanner capable of performing a diagnostic CT. In addition, there are added costs for acquiring the diagnostic CT data such as for the contrast agent and appropriate personnel. This commenter expressed interest in a continued dialogue with CMS on the issue of appropriate payment for the

technical costs of performing a diagnostic CT acquired simultaneously with a PET/CT scan.

Response: We appreciate the commenter's concerns regarding appropriate billing and OPPS payment for a PET scan with CT for attenuation correction and anatomical localization and a diagnostic CT scan performed as a single acquisition. We will consider this issue should we issue more specific hospital billing guidance regarding various combinations of medically reasonable and necessary PET and CT scans.

(2) Myocardial PET Scans

Comment: Two commenters to the November 15, 2004 final rule with comment period (69 FR 65682) urged CMS to delete HCPCS code G0230 (PET imaging, metabolic assessment for myocardial viability following inconclusive SPECT study) and recognize CPT code 78459 (myocardial imaging, positron emission tomography, metabolic evaluation) by changing its status indicator from "B" to "S."

Response: As a result of a recent Medicare national coverage determination Publication 100–3, Medicare Claims Processing Manual section 220.6), effective January 28, 2005, we discontinued HCPCS code G0230 and activated CPT code 78459, changing its status indicator from "B" to "S." For CY 2006, we are maintaining CPT code 78459 as the active code for billing "myocardial imaging, positron emission tomography, metabolic evaluation."

Comment: Several commenters to the November 15, 2004 final rule with comment period (69 FR 65682) and the CY 2006 OPPS proposed rule (70 FR 42674) stated that the payment rate for APC 0285 does not accurately reflect the costs associated with performing multiple studies of PET myocardial perfusion imaging. They noted that, as configured, APC 0285 violated the two times rule for CY 2005 and was proposed as an exception to the two times rule for CY 2006. These commenters suggested that CMS split myocardial PET scans into two APCs to distinguish the resource consumption differences between single-study and multiple-study PET imaging.

Response: We agree with commenters that the significant cost differences between single study and multiple studies myocardial PET imaging services reflected in our historical hospital claims data for the G-code myocardial PET scan services support the splitting of APC 0285 into two myocardial PET scan APCs for more accurate rate-setting for these services

for CY 2006. Furthermore, the splitting of APC 0285 resolves the two times violation that occurred in the CY 2006 proposed rule configuration of APC 0285. Therefore, we are assigning single-study myocardial PET imaging procedures and metabolic evaluation of myocardial PET imaging to APC 0306 (Myocardial Positron Emission Tomography (PET) imaging, single study, metabolic evaluation) with a median cost of \$800, based on the CY 2004 hospital claims data for the predecessor G-codes that have been replaced with CPT codes 78459 and 78491. In addition, we are assigning multiple-study myocardial PET imaging procedures to APC 0307 (Myocardial Positron Emission Tomography (PET) imaging, multiple studies) with a median cost of \$2,482, based on the CY 2004 hospital claims data for the predecessor G-codes that have been replaced with CPT code 78492.

Comment: One commenter explained that myocardial PET perfusion studies may be performed with or without gating similar to myocardial SPECT procedures. However, for myocardial PET perfusion studies, there are no additional codes to describe gating; therefore, the provider receives the same payment regardless of having performed a gated study versus a non-gated study. The commenter requested that the payment rate for myocardial PET perfusion studies be adjusted to assure proper payment for gated studies.

Response: While we recognize that the CPT codes describing myocardial PET scans make no distinction between gated and non-gated studies, we received numerous comments urging that we discontinue the G-codes for PET scans and recognize these CPT codes for PET scans. Furthermore, the splitting of the myocardial PET scans into two APCs to distinguish single-study imaging from multiple-study imaging, as discussed in detail above, may improve payment for certain gated studies that involve multiple studies and address the commenter's concern for adequate payment for gated studies.

h. Proton Beam Treatment

In the CY 2005 OPPS proposed rule (69 FR 50467), we proposed to reassign CPT codes 77523 (Proton treatment delivery, intermediate) and 77525 (Proton treatment delivery, complex) from New Technology APC 1511 (New Technology, Level XI, \$900–\$1,000) to clinical APC 0419 (Proton Beam Therapy, Level II). In response to this proposal, we received numerous comments urging that we maintain CPT codes 77523 and 77525 in New Technology APC 1511 at a payment rate

of \$950 for CY 2005, arguing that the proposed payment rate of \$678 for CY 2005 would halt diffusion of this technology and negatively impact patient access to this cancer treatment. Commenters explained that the low volume of claims submitted by only two facilities provided volatile and insufficient data for movement into the proposed clinical APC 0419. They further explained that the extraordinary capital expense of between \$70 and \$125 million and high operating costs of a proton beam facility necessitate adequate payment for this service to protect the financial viability of this emerging technology.

In the November 15, 2004 final rule with comment period (69 FR 65719 through 65720), we considered the concerns expressed by numerous commenters that patient access to proton beam therapy might be impeded by a significant reduction in OPPS payment. Therefore, we set the CY 2005 payment rate for CPT codes 77523 and 77525 by calculating a 50/50 blend of the median cost for intermediate and complex proton beam therapies of \$690 derived from CY 2003 claims and the CY 2004 New Technology payment rate of \$950. We used the result of this calculation (\$820) to assign intermediate and complex proton beam therapies (CPT codes 77523 and 77525) to New Technology APC 1510 (New Technology—Level X (\$800–\$900) for a blended payment rate of \$850 for CY 2005.

Our examination of the CY 2004 claims data has revealed a second year of a stable, albeit modest, number of claims on which to set the CY 2006 payment rates for CPT codes 77523 and 77525. However, unlike the median of \$690 for the proposed CY 2005 Level II proton beam radiation therapy clinical APC containing CPT codes 77523 and 77525 derived from the CY 2003 claims data, the median for a comparable Level II proton beam radiation therapy clinical APC was \$934 derived from partial CY 2004 claims data at the time of development of the CY 2006 proposed rule. This more recent median appears to more accurately reflect the significant capital expense and high operating costs of a proton beam therapy facility, and supports patient access to proton beam therapy. Therefore, we proposed to move CPT codes 77523 and 77525 from New Technology APC 1510 to clinical APC 0667 (Level II Proton Beam Radiation Therapy) based on a median cost of \$934 for CY 2006.

Comment: Numerous commenters applauded our proposal to reassign CPT codes 77523 (Proton treatment delivery, intermediate) and 77525 (Proton

treatment delivery, complex) from New Technology APC 1510 (New Technology—Level X (\$800–\$900) to clinical APC 0667 (Level II Proton Beam Radiation Therapy), setting payment on the median cost of \$1,133 derived from the CY 2004 claims, an increase from the median cost of \$934 in the proposed rule. Commenters also supported our proposal to maintain CPT codes 77520 (Proton treatment delivery; simple, without compensation) and 77522 (Proton treatment delivery; simple, with compensation) in APC 0664 (Level I Proton Beam Radiation Therapy), setting the payment on the median cost of \$947 derived from the full year CY 2004 claims. Commenters stated that these proposed payments more accurately reflect the significant capital expense and operating costs of a proton beam therapy center. Commenters also were pleased with our proposal to maintain separate APCs for distinguishing simple from intermediate and complex proton beam therapies, stating that the distinction is necessary to differentiate between the resource demands of the different treatment levels. Commenters urged CMS to continue protecting beneficiary access to this technology, especially during this early stage of clinical adoption to ensure economic viability of both existing facilities and those in various stages of construction and development.

Response: We agree with commenters that the CY 2004 median cost data for proton beam therapy services more accurately reflect the significant capital expense and high operating costs of a proton beam therapy facility. Furthermore, our reassignment of CPT codes 77523 and 77525 from New Technology APC 1510 to clinical APC 0667 based on the improved median cost data and stable frequency is consistent with our policy of transitioning New Technology services into a clinically appropriate APC with payment based on median cost data once the data for these services become sufficiently stable to protect patient access to such services. Therefore, we are finalizing our proposal to reassign intermediate and complex proton beam therapy services (CPT codes 77523 and 77525) from New Technology APC 1510 to clinical APC 0667, and to maintain simple proton beam therapy services (CPT codes 77520 and 77522) in APC 0664 for CY 2006.

i. Smoking Cessation Counseling

Comment: Two commenters expressed concern about our proposal to move smoking cessation HCPCS codes G0375 (Smoking and tobacco-use cessation counseling visit; 3–10

minutes) and G0376 (Smoking and tobacco-use cessation counseling visit; greater than 10 minutes) from their current New Technology APC 1501 (Level I, \$0–\$50) with a payment rate of \$25, to New Technology APC 1491 (Level IA, \$0–\$10) with a payment rate of \$5. Both commenters contended that the current payment rate of \$25 is not sufficient to cover resources associated with this type of visit. Both commenters expressed the conviction that, once claims data reflecting the costs of the service become available, it would become clear that a payment rate closer to \$52 is warranted. One commenter urged us to maintain these codes in their current New Technology APC until provider claims data become available. The other commenter took the position that placement in a New Technology APC is not appropriate, as the services could reasonably be placed in an existing clinical APC. Specifically, this commenter recommended that HCPCS codes G0375 and G0376 be assigned immediately to APC 0600 (Low Level Clinic Visits), which the commenter considers appropriate in terms of resource costs and clinical characteristics. Finally, both commenters pointed out that there was an inconsistency in our tables in the proposed rule with regard to the APC assignments of codes G0375 and G0376. Specifically, Table 10 in the proposed rule (70 FR 42706) showed HCPCS code G0375 assigned to New Technology APC 1491 (with a payment rate of \$5), while HCPCS code G0376 was assigned to New Technology APC 1492 (with a payment rate of \$15). However, Addendum B of the proposed rule (70 FR 42936) showed both HCPCS codes G0375 and G0376 assigned to New Technology APC 1491 (with a payment rate of \$5).

Response: We thank the commenters for bringing to our attention a typographical error that appeared in Table 10 of the proposed rule (70 FR 42706). This error did not come to our attention in time for correction. Our intent, as indicated in Addendum B, was to assign both HCPCS codes G0375 and G0376 to APC 1491 (with a payment rate of \$5). We regret the error. We do not agree with the commenter who suggested that it is appropriate at this time to remove HCPCS codes G0375 and G0376 from assignment to a New Technology APC and to assign them to clinical APC 0600 (Low Level Clinic Visits). One purpose of assignment to a New Technology APC is to provide an opportunity to collect claims data from our system, in order to allow for the ultimate placement of a code in the

most appropriate clinical APC in terms of hospital resource requirements. At this time, we lack any data that would justify placing these codes in the clinical APC recommended by the commenter or in any other clinical APC. We believe that these smoking cessation services, because they are so specifically defined with respect to coding and coverage, may not require similar hospital resources as those required of other services assigned to APC 0600. As two specific G-codes were developed for these new smoking cessation services, the specific services likely bear little clinical resemblance to many of the evaluation and management services assigned to APC 0600, whose median cost currently reflects CY 2004 claims from hospitals. We also cannot agree with the commenter recommending placement of these codes in one or more higher-paying New Technology APCs. Our proposal to reassign these codes from their current New Technology APC 1501 (with a payment rate of \$25) to New Technology APC 1491 (with a payment rate of \$5) was based on our assessment that the hospital facility resources required for this service are likely to be very limited. At the time of activation of these new G-codes in CY 2005, New Technology APC 1501 was the New Technology APC applicable to new OPSS services with expected hospital costs of between \$0 and \$50. As we proposed to refine the New Technology cost bands for CY 2006 and are finalizing that proposal in this final rule, we believe that for CY 2006 assignment of the smoking cessation G-codes to New Technology APC 1491 now more appropriately reflects the hospital resources required for these services. Therefore, for CY 2006, we are finalizing that proposal in this final rule. However, for CY 2007 rate-setting, we will reassess the APC placement of these codes in light of the available partial year CY 2005 hospital claims data.

j. Stereoscopic Kv X-ray

Comment: A number of commenters addressed our creation of a new code for stereoscopic kilovolt x-ray imaging, HCPCS code C9722 (Stereoscopic kilovolt x-ray imaging with infrared tracking for localization of target volume), and assignment of the service to a New Technology APC. Commenters stated that the “definition,” which appears to refer to the code descriptor, combines two technologies into one HCPCS code. A commenter claimed that this descriptor excludes other superior technologies to acquire kilovolt (kV) x-ray images for localization of target volume that do not rely on infrared

tracking. Commenters asserted that the key feature of the service is the use of kV x-ray imaging for localization of target volume, while the infrared tracking feature is used for patient monitoring only to ensure immobilization, not for positioning and localization. A commenter stated that many kV x-ray systems do not use infrared tracking. The commenters, including a number of cancer centers, recommended modifying the descriptor of HCPCS code C9722 to "Stereoscopic kV x-ray imaging with or without infrared tracking for localization of target volume," claiming that this would allow hospitals equal reimbursement for providing the service regardless of the vendor from whom they bought the kV x-ray equipment. One commenter stated that the kV x-ray is part of Image Guided Radiation Therapy (IGRT), a new generation of conformal radiation therapy techniques, and that it was working with the CPT Editorial Panel to submit CPT applications for stereoscopic x-ray guidance, as well as other IGRT technologies. A commenter stated that there is a new CPT code for stereoscopic x-ray guidance effective January 1, 2006, and recommended that we crosswalk HCPCS code C9722 to the new CPT code.

Response: The AMA's CPT Editorial Panel created new CPT code 77421, "Stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy", which will be effective January 1, 2006. We will replace HCPCS code C9722 with CPT code 77421 for CY 2006, mapping the new code to the same New Technology APC as for CY 2005—APC 1502. As with the instructions embedded in the descriptor for HCPCS code C9722, CPT code 77421 should not be reported with the five G-codes for stereotactic radiosurgery treatment to be billed under the OPPS in CY 2006. As CPT code 77421 makes no reference to infrared tracking, the commenters' concerns are addressed by the use of this CPT code and its descriptor.

k. Stereotactic Radiosurgery (SRS)

In a correction to the November 7, 2003 final rule with comment period, issued on December 31, 2003 (68 FR 75442), we considered a commenter's request to combine HCPCS codes G0242 (Cobalt 60-based stereotactic radiosurgery planning) and HCPCS code G0243 (Cobalt 60-based stereotactic radiosurgery delivery) into a single procedure code in order to capture the costs of this treatment in single procedure claims because the majority of patients receive the planning and delivery of this treatment on the same

day. We responded to the commenter's request by explaining that several other commenters stated that HCPCS code G0242 was being misused to code for the planning phase of linear accelerator-based stereotactic radiosurgery planning. Because the claims data for HCPCS code G0242 represented costs for linear accelerator-based stereotactic radiosurgery planning (due to misuse of the code), in addition to Cobalt 60-based stereotactic radiosurgery planning, we were uncertain of how to combine these data with HCPCS code G0243 to determine an accurate payment rate for a combined code for planning and delivery of Cobalt 60-based stereotactic radiosurgery.

In consideration of the misuse of HCPCS code G0242 and the potential for causing greater confusion by combining HCPCS codes G0242 and G0243 into a single procedure code, for CY 2004 we created a planning code for linear accelerator-based stereotactic radiosurgery (HCPCS code G0338) to distinguish this service from Cobalt 60-based stereotactic radiosurgery planning. We maintained both HCPCS codes G0242 and G0243 for the planning and delivery of Cobalt 60-based stereotactic radiosurgery, consistent with the use of the two G-codes for planning (HCPCS code G0338) and delivery (HCPCS codes G0173, G0251, G0339, G0340, as applicable) of each type of linear accelerator-based stereotactic radiosurgery (SRS). We indicated that we intended to maintain these new codes in their current New Technology APCs until we had sufficient hospital claims data reflecting the costs of the services to consider moving them to clinical APCs.

During the February 2005 APC Panel meeting, the APC Panel discussed the clinical and resource cost similarities between planning for Cobalt 60-based and linear accelerator-based SRS. The APC Panel also discussed the use of CPT codes instead of specific G-codes to describe the services involved in SRS planning, noting the clinical similarities in radiation treatment planning regardless of the mode of treatment delivery. Acknowledging the possible need for CMS to separately track planning for SRS, the APC Panel eventually recommended that we create a single HCPCS code to encompass both Cobalt 60-based and linear accelerator-based SRS planning. However, a hospital association and other presenters at the APC Panel meeting urged that we discontinue the use of G-codes for SRS planning, and instead, recognize the current CPT codes that describe the specific component services involved in SRS planning to

reduce the burden on hospitals of maintaining duplicative codes for the same services to accommodate different payers. Lastly, one presenter urged that we combine HCPCS codes G0242 (Cobalt 60-based stereotactic radiosurgery planning) and G0243 (Cobalt 60-based stereotactic radiosurgery delivery) into a single procedure code to reflect that the majority of patients receive the planning and delivery of this treatment on the same day as a single fully integrated service.

The APC Panel recommended that we make no changes to the coding or APC placement of SRS delivery codes G0173, G0243, G0251, G0339, and G0340 for CY 2006. We first established the above full group of delivery codes in CY 2004, so we have only one year of hospital claims data reflecting costs of all of the services. In addition, presenters to the APC Panel described current ongoing deliberations amongst interested professional societies around the descriptions and coding for SRS. The APC Panel and presenters suggested that we wait for the outcome of these deliberations prior to making any significant changes to SRS delivery coding or payment rates.

In an effort to balance the recommendations of the APC Panel with the recommendations of presenters at the APC Panel meeting, in accordance with the APC Panel recommendations, we proposed to make no changes to the APC placement of the following SRS treatment delivery codes for CY 2006: HCPCS codes G0173, G0243, G0251, G0339, and G0340.

In the CY 2006 proposed rule, we acknowledged concerns expressed by some presenters urging that we discontinue the use of the G-codes for SRS planning, and instead, recognize the current CPT codes that describe the specific component services involved in SRS planning to reduce the burden on hospitals of maintaining duplicative codes for the same services to accommodate different payers. In addition, we indicated that we had no need to separately track SRS planning services, which share clinical and resource homogeneity with other radiation treatment planning services described by current CPT codes.

When HCPCS code G0242 was established for SRS planning, several radiology planning services were considered in determining its APC placement. In the November 30, 2001 final rule, in which we described our determination of the total cost for SRS planning based on our claims experience, we added together the median costs of the following CPT codes

that we found to be regularly billed with SRS delivery (CPT code 61793 in the available hospital data): 77295, 77300, 77370, and 77315. In the CY 2006 proposed rule, our examination of the costs from the CY 2004 claims data available to us at that time for the above-mentioned CPT codes closely approximated the CY 2004 median costs reported for HCPCS codes G0242 and G0338. The APC median costs for the above-mentioned CPT codes based on the CY 2004 claims data utilized for the proposed rule totaled \$1,297, while the median cost for HCPCS code G0242 was \$1,366 and the median cost for HCPCS code G0338 was \$1,100 based on the partial year CY 2004 claims data. In addition, three of the above-mentioned CPT codes were included on the proposed bypass list for CY 2006, so we did not anticipate that the billing of these codes on the same day as an SRS treatment service would cause significant problems with multiple bills for SRS services. Therefore, we proposed to discontinue HCPCS codes G0242 and G0338 for the reporting of charges for SRS planning under the OPPI, and to instruct hospitals to bill charges for SRS planning using all of the available CPT codes that most accurately reflect the services provided.

We acknowledged one APC Panel presenter's concern that the coding structure of Cobalt 60-based SRS, using either the current SRS planning G-code or the appropriate CPT codes for planning services as we proposed for CY 2006, might not necessarily reflect the same day, integrated Cobalt 60-based SRS service furnished to the majority of patients receiving Cobalt 60-based SRS. Thus, we specifically requested public comment on the clinical, administrative, or other concerns that could arise if we were to bundle Cobalt 60-based SRS planning services, currently reported using HCPCS code G0242 and proposed for CY 2006 to be billed using the appropriate CPT codes for planning services, into the Cobalt 60-based SRS treatment service, currently reported under the OPPI using HCPCS code G0243. Under such a scenario, the SRS treatment service described by HCPCS code G0243 would be placed in a higher paying New Technology APC to reflect payment for the costs of the SRS planning and delivery as an integrated service. Hospitals would be prohibited from billing other radiation planning services along with the Cobalt 60-based SRS treatment delivery code. In contrast to Cobalt 60-based SRS coding, we did not consider bundling the planning for linear accelerator-based SRS with the treatment delivery services, given the

various timeframes for planning that may occur with linear accelerator-based SRS.

As discussed in detail above, the APC Panel recommended that CMS create a single HCPCS code to encompass both Cobalt 60-based and linear accelerator-based SRS planning. Furthermore, the Panel recommended that we make no changes to the coding or APC placement of SRS treatment delivery HCPCS codes G0173, G0243, G0251, G0339, and G0340 for CY 2006.

For reasons discussed below, we are discontinuing HCPCS codes G0242 and G0338 for the reporting of charges for SRS planning under the OPPI for CY 2006, and instructing hospitals to bill charges for SRS planning, regardless of the mode of treatment delivery, using all of the available CPT codes that most accurately reflect the services provided. In addition, while we are reassigning HCPCS code G0243 to clinical APC 0127 for CY 2006, we are making no changes to the APC placement of SRS treatment delivery HCPCS codes G0173, G0251, G0339, and G0340.

We received a number of public comments on these SRS issues.

Comment: We received numerous comments supporting our proposal to discontinue HCPCS codes G0242 (Cobalt 60-based stereotactic radiosurgery planning) and G0338 (Linear accelerator-based SRS planning) for the reporting of charges for SRS planning, and to instruct hospitals to bill charges for SRS planning using available CPT codes that most accurately reflect the services provided. These commenters agreed that available CPT codes more accurately describe the services involved in SRS planning and are less administratively burdensome for providers because other payors recognize them. Some commenters urged that we retain separate codes for reporting the planning and treatment delivery of Cobalt 60-based SRS, whether through the use of existing G-codes (HCPCS codes G0242 and G0243) or through available CPT codes. Several of these commenters explained that although the planning and treatment delivery of Cobalt 60-based SRS most often occur on the same date of service, there are instances in which the planning and treatment are not delivered on the same date of service due to an unanticipated problem that arises during the planning that precludes the treatment delivery. In such instances where only planning for the Cobalt 60-based SRS is performed, commenters stated that CMS would need to clarify how providers should bill these services if separate codes are not maintained for the planning and

treatment delivery of Cobalt 60-based SRS. Commenters expressed concern that combining the planning code (HCPCS code G0242) and treatment delivery code (HCPCS code G0243) for Cobalt 60-based SRS into a single combination code would necessitate the use of a modifier when they are not performed on the same date of service and would complicate the billing of these services and increase the administrative burden on hospitals. One commenter suggested that, if we decide to maintain HCPCS code G0242 for Cobalt 60-based SRS planning rather than transition to the CPT codes, we consider placing the planning code (HCPCS code G0242) on the bypass list as an alternative solution to generating more single bills for future rate-setting, rather than combining the planning and treatment delivery codes for Cobalt 60-based SRS into a single combination code.

In contrast, a few commenters urged that we continue to recognize HCPCS codes G0242 and G0338 for the reporting of SRS planning rather than transition to the available CPT codes that describe these services. These commenters predicted that another year of stability would allow CMS to collect more reliable data for use in setting the CY 2008 payment rates for SRS planning services.

Many commenters urged that we refrain from treating various forms of SRS (i.e., Cobalt 60-based and linear accelerator-based) differently by "bundling" planning into the treatment delivery for Cobalt 60-based SRS by creating a single combination code, while "unbundling" planning and treatment delivery for linear accelerator-based SRS by paying separately for these services. These commenters asserted that the planning and treatment delivery of SRS, regardless of the form of delivery, are clinically distinct services that should be reported separately to distinguish their distinct resource requirements. One commenter refuted claims that the administration of the planning and treatment delivery of SRS on the same date of service is unique to Cobalt 60-based SRS, arguing that the planning and treatment delivery of LINAC-based SRS likewise are typically performed on the same day, and that a mere time proximity of the two services does not necessitate a single combination code for either form of SRS. Several commenters cautioned against establishing different coding schemes for various SRS services that would likely cause confusion for coders, inaccurate coding, and unreliable data for future rate setting.

Numerous other commenters urged CMS to combine the planning code (HCPCS code G0242) and treatment delivery code (HCPCS code G0243) for Cobalt 60-based SRS into a single surgical code, preferably CPT code 61793 (stereotactic radiosurgery, particle beam, gamma ray, or linear accelerator, one or more sessions), which would replace all of the SRS G codes regardless of the mode of delivery. These commenters stated that the planning and treatment delivery of Cobalt 60-based SRS are always performed on the same day and that a single combination code would be less confusing for coders, provide more accurate claims data, and result in a more appropriate payment for Cobalt 60-based SRS. While some of these commenters urged that we assign this single combination code to a higher paying New Technology APC consistent with its CY 2004 median cost data until more accurate cost data are available for determining an appropriate clinical APC, other commenters strongly opposed the designation of Cobalt 60-based SRS as a new technology service, noting that Cobalt 60-based SRS became a standard of care for treating cancer patients over two decades ago and a new technology label is no longer appropriate. Commenters stated that CMS' designation of Cobalt 60-based SRS as a new technology service has led other insurers to consider the treatment to be experimental, which frequently delays, and sometimes prevents, access to treatment for critically ill patients. These commenters urged that we assign this new combination code reflecting planning and delivery of Cobalt 60-based SRS to a surgical APC and set the payment based on the median cost calculated from the CY 2004 hospital claims data. Some of these commenters recommended that this single combination code describe all forms of SRS, while other commenters emphasized the importance of maintaining separate combination codes for Cobalt 60-based SRS and LINAC-based SRS to distinguish the significant clinical and resource cost differences associated with these services.

One commenter urged that if CMS replaces the G-codes for SRS planning with available CPT codes describing these services, we should not assign HCPCS code G0243 (Cobalt 60-based SRS treatment delivery) to a New Technology APC paying higher than its CY 2005 payment rate of \$5,250. This commenter supported our proposal to make no changes to the APC placement of SRS treatment delivery codes that describe a complete course of treatment

in one session, stating that the proposed payment of \$5,250 for all single session SRS treatment services for CY 2006 is appropriate based on the hospital resources involved in furnishing these services.

Response: We thank the many commenters for their insightful thoughts and recommendations for the reporting of hospital charges for SRS services under the OPSS for CY 2006. In recognition of the heightened level of diligence that the current coding scheme for SRS services requires of hospital coders to ensure that charges for these services are reported under the appropriate G-code, we carefully considered several options for simplifying the coding scheme for SRS services while maintaining a certain level of data specificity to reflect the differential clinical considerations and hospital resource utilization that are necessary to inform future rate setting.

First, we considered several recommendations by commenters to bundle the planning for Cobalt 60-based SRS into the treatment delivery (HCPCS code G0243) for Cobalt 60-based SRS by either establishing a single combination G-code describing both the planning and delivery of Cobalt 60-based SRS or by instructing providers to report CPT code 61793 for such services. However, we agree with the majority of commenters who expressed strong opposition to a single combination G-code or CPT code to report the planning and treatment delivery of Cobalt 60-based SRS, noting the following concerns: (1) The administrative burden on providers of maintaining duplicative codes for SRS planning to accommodate various payors (that is, G-codes for Medicare and CPT codes for non-Medicare payors); (2) the added complexity of attaching a modifier to the code for instances when planning and delivery are not provided on the same date of service because treatment does not proceed due to an unanticipated problem; (3) the confusion for coders and unreliable data that could emanate from inconsistent coding schemes for different forms of SRS (that is, Cobalt 60-based and LINAC-based SRS); and (4) the nonspecificity of the descriptor for CPT code 61793 which describes all forms of SRS treatment delivery and makes no mention of SRS planning services. We also agree with the majority of commenters who stated that the G-codes (G0242 and G0338) for SRS planning are duplicative of existing CPT codes that adequately describe such services and that are much less administratively burdensome on hospitals because they are recognized by non-Medicare payors.

Furthermore, our analysis of the CY 2004 claims data revealed that the median costs for HCPCS codes G0242 and G0338 closely approximated the sum of the median costs for the CPT codes (77295, 77300, 77315, 77370) that were most commonly billed under the OPSS for SRS planning prior to the establishment of HCPCS codes G0242 and G0338. In addition, we remind commenters that three of the above-mentioned CPT codes are included on the bypass list for CY 2006, so we do not anticipate that the billing of these codes on the same day as an SRS treatment delivery service will cause significant problems with multiple bills for SRS services, eliminating any need for recognizing a single combination G-code or CPT code which describes both planning and treatment delivery SRS services for the purpose of generating more single bills. Finally, based on additional confirmation from commenters that the similarities in clinical characteristics and resource costs associated with treatment planning for services delivering radiation, regardless of the mode of treatment delivery, dispel the need to separately track planning services for SRS, we are discontinuing HCPCS codes G0242 and G0338 for the reporting of charges for SRS planning under the OPSS for CY 2006, and instructing hospitals to bill charges for SRS planning, regardless of the mode of treatment delivery, using all of the available CPT codes that most accurately reflect the services provided.

We also agree with the majority of commenters who strongly urged that we reassign HCPCS code G0243 (Cobalt 60-based treatment delivery) from New Technology APC 1528 to a clinical APC, pointing out that Cobalt 60-based SRS became a standard of care for treating cancer patients over two decades ago and, therefore, a new technology label no longer appropriately describes the service. Furthermore, the median costs from hospital claims for HCPCS code G0243 based on a significant number of single claims each year have been quite stable over the past three years, supporting movement of this service out of a New Technology APC and into a clinical APC based on its median cost data from CY 2004. Therefore, we are reassigning HCPCS code G0243 from New Technology APC 1528 to clinical APC 0127 and setting its payment rate based on a median cost of \$7,297 for CY 2006.

Lastly, we agree with commenters who emphasized the significant clinical and resource cost differences associated with the treatment delivery of Cobalt 60-based SRS and LINAC-based SRS, and

that establishment of a single code to describe all forms of SRS treatment delivery would result in a loss of essential data specificity for determining appropriate future payment rates for these services. For instance, based on the CY 2004 claims data, the median costs for the various forms of SRS treatment delivery ranged from \$2,502 to \$7,296. These significant differences in median cost data emphasize the importance of maintaining different codes that distinguish the various forms of SRS treatment delivery for the purpose of setting the most appropriate payment rates for these services. We believe it would be premature, as well, to move the LINAC-based SRS treatment delivery procedures to clinical APCs for CY 2006 because we have only one year of claims data reflecting their current coding structure, although we have hundreds of single claims for some of the services. We will be examining our claims data carefully for the next OPBS update, because we will then have 2 years of data for these LINAC-based SRS treatment delivery services now assigned to New Technology APCs. Therefore, we are maintaining HCPCS codes G0173 and G0339 in New Technology APC 1528, HCPCS code G0251 in New Technology APC 1513, and HCPCS code G0340 in New Technology APC 1525 for CY 2006. And as mentioned elsewhere in this section, we are reassigning HCPCS code G0243 from New Technology APC 1528 to clinical APC 0127.

Comment: One commenter urged that we create a new CPT code titled "Surgeon-based Gamma Stereotactic Radiosurgery, complete course, one procedure, per lesion" to describe Cobalt 60-based SRS planning and treatment delivery and assign this CPT code to a new surgical APC titled "Surgeon-based Gamma Stereotactic Radiosurgery." This commenter recommended that we set the payment rate of this new APC based on the combined median costs from claims data for HCPCS codes G0242 and G0243.

Response: We appreciate the commenter's suggestion; however, CMS does not possess the authority to create CPT codes, which are established and maintained by the American Medical Association. Furthermore, under the OPBS, we do not label APCs according to the type of clinician delivering the service (that is, surgeon versus non-surgeon) because such categorization is irrelevant to establishing payment for hospital services billed under the OPBS. Rather, we provide titles for clinical APCs that describe the actual hospital

services assigned to the APCs for which providers should report their hospital costs and charges. In addition, as discussed above, we agree with the majority of commenters who opposed the recognition of a single combination code (that is, CPT code 61793) for the planning and delivery of Cobalt 60-based SRS services, for reasons stated previously, i.e. the administrative burden of maintaining duplicative codes, the added complexity of attaching a modifier to the code for instances when planning and delivery are not provided on the same date of service because treatment does not proceed due to an unanticipated problem, the confusion for coders and unreliable data that could emanate from inconsistent coding schemes for different forms of SRS (that is, Cobalt 60-based and LINAC-based SRS), and the nonspecificity of the descriptor for CPT code 61793 which describes all forms of SRS treatment delivery and makes no mention of SRS planning services. Therefore, as discussed elsewhere in this section, for CY 2006, we are discontinuing HCPCS code G0242 and recognizing existing CPT codes for the reporting of Cobalt 60-based SRS planning, and moving HCPCS code G0243 (Cobalt 60-based SRS treatment delivery) from New Technology APC 1528 to clinical APC 0127 based on a median cost of \$7,296.

Comment: Several commenters recommended that we make HCPCS code G0339 (Image guided, robotic, linear accelerator-based (LINAC) SRS treatment delivery, complete session, first session of fractionated treatment) a permanent code and continue to pay this service at the CY 2005 payment rate of \$5,250. These commenters also recommended that we eliminate HCPCS code G0340 (Image guided, robotic, linear accelerator-based (LINAC) SRS treatment delivery, fractionated treatment, 2nd–5th sessions) and instruct hospitals to report HCPCS code G0339 for all fractionated treatment sessions, stating that the resource costs are the same for each session regardless of the number of treatment sessions that the patient receives.

Response: We disagree with the commenters' assertions that the resource costs are the same for each session of image-guided, robotic LINAC-based SRS treatment delivery regardless of the number of treatment sessions that the patient receives. Based on CY 2004 claims data, the median cost for HCPCS code G0339 (\$4,917) was considerably higher than the median cost for HCPCS code G0340 (\$2,502), and does not support the elimination of HCPCS code G0340 or its payment at a rate

comparable to the payment rate for HCPCS code G0339. As the SRS treatment delivery G-codes are national Level II HCPCS codes that we utilize for billing SRS treatments in the OPBS, we are uncertain what changes the commenter would like us to make for the codes to be "permanent." Therefore, for CY 2006, we are maintaining HCPCS code G0339 in New Technology APC 1528, and HCPCS code G0340 in New Technology APC 1525.

Comment: One commenter urged CMS to assign HCPCS codes G0251 and G0340, for fractionated non-robotic and image-guided robotic LINAC-based SRS respectively, to the same APC, contending that these procedures involve similar resources and should be paid equally. In contrast, another commenter asserted that image-guided robotic LINAC-based SRS is substantially more resource intensive than non-robotic LINAC-based SRS, and that CMS should maintain HCPCS code G0251 in a separate APC from HCPCS code G0340 to distinguish their levels of resource requirements.

Response: We began recognizing HCPCS code G0251 to describe fractionated sessions of non-robotic LINAC-based SRS treatment delivery in CY 2004, which yielded no single procedure claims data for HCPCS code G0251 to substantiate a similarity or lack of similarity of its resource costs in comparison with HCPCS code G0340 (fractionated, 2nd–5th sessions, image-guided robotic LINAC-based SRS treatment delivery). However, the large divergence in the median cost of \$2,802 for the complete session of non-robotic LINAC-based SRS treatment delivery (HCPCS code G0173), in comparison with the median cost of \$4,917 for the complete and first fractionated sessions of image-guided robotic LINAC-based SRS treatment delivery (HCPCS code G0339), indicates that fractionated image-guided robotic LINAC-based SRS treatment delivery is likely substantially more resource intensive than fractionated non-robotic LINAC-based SRS treatment delivery. Therefore, for CY 2006, we are maintaining HCPCS code G0251 in New Technology APC 1513 and HCPCS code G0340 in New Technology APC 1525. However, for CY 2007, we will reexamine our APC placement of HCPCS codes G0251 and G0340 based on CY 2005 hospital claims data.

Comment: One commenter to the November 15, 2004 final rule with comment period (69 FR 65682) disagreed with CMS' statement that CPT codes 0082T (Stereotactic body radiation, treatment delivery, one or more treatment areas, per day) and

0083T (Stereotactic body radiation therapy, treatment management, per day) are bundled into the current G-codes for SRS treatment delivery. The commenter stated that stereotactic body radiation treatment delivery and management are new technologies and, thus, are not included in the current G-codes for SRS treatment delivery; however, the commenter provided no cost data nor any explanation as to how stereotactic body radiation treatment differs from the current procedures described by the G-codes for SRS treatment delivery. Instead, the commenter simply requested that CMS designate these new tracking codes for stereotactic body radiation treatment delivery and management as new technology services and assign these codes to a New Technology APC.

Response: We disagree with the commenter's unsubstantiated assertion that the current G-codes for SRS treatment delivery do not already describe or include some services that could also be identified as stereotactic body radiation treatment delivery and management described by CPT codes 0082T and 0083T, respectively. Furthermore, we received no evidence to support the commenter's assertion that these services represent new technologies that could not be represented in our hospital claims data. Therefore, for CY 2006, we are maintaining CPT code 0082T with a status indicator of "B" because we consider an alternate code to be available for billing this service under the OPSS. Likewise, for CY 2006, we are maintaining CPT code 0083T with a status indicator of "N", indicating that the charges for this service are packaged into the payment for other services paid separately under the OPSS.

D. APC—Specific Policies

We received many comments on our proposed changes to specific groups of services as discussed in the CY 2006 OPSS proposed rule preamble and displayed in Addendum B. We have grouped these comments, and our responses, into five general clinical categories as shown below.

We received one comment that generally addresses our APC assignment methodology.

Comment: One commenter objected to the placement of codes for unlisted services in the lowest APC that is clinically appropriate and to the lack of discussion of this policy in the CY 2006 OPSS proposed rule. The commenter asked that CMS examine claims data and match unlisted services to the diagnosis to determine if there is a more appropriate APC than the lowest level.

Response: We discussed this policy in the CY 2005 OPSS proposed rule which we published on August 16, 2004 (69 FR 50448), and we made our existing policy final in the November 15, 2004 final rule (69 FR 65682). We proposed no changes to this policy in the CY 2006 OPSS proposed rule (which we published on July 25, 2005 (70 FR 42674)) and, therefore, we have not changed the policy. The HCPCS codes for unlisted services should be used only if there is no existing code that can be used alone or with existing modifiers to report the service that was furnished. We believe that their use should be very rare. We do not believe that examination of the diagnoses on claims for unlisted procedures would enable us to properly place the codes into APCs because there are so many different types of services at different levels of resource use that could apply to a single diagnosis. There is a 2-year lag between the year of hospital claims data and the OPSS payment rates that are established based on the data. New procedure-specific HCPCS codes are developed on an annual basis, and there are continuous changes in procedures for many diagnoses as medical practice evolves. Therefore, we have no confidence that the array of unlisted services billed by hospitals, and by implication their median costs, in a given year for patients with certain diagnoses would necessarily have any relationship to unlisted services, and their median costs, billed 2 years later for patients with the same diagnoses. Moreover, placing unlisted services in the lowest level APC encourages use of existing codes where it is possible and also encourages development of new HCPCS codes for services for which codes do not exist.

1. Cardiac and Vascular Procedures

a. Acoustic Heart Sound Recording and Analysis

Comment: One commenter requested that CMS change the status indicator for CPT code 0069T (Acoustic heart sound recording and computer analysis only). The commenter requested that we assign the procedure to APC 0099 with an "S" status indicator rather than "N," as is currently assigned to CPT code 0069T. The commenter stated that the test's current status as a packaged procedure results in inequitable payment to the hospital. They stated that the cost of an EKG with the acoustic heart sounds recording is \$55 whereas, the cost of an EKG without is \$31, and that because we have packaged the procedure, the hospital is underpaid by \$24 for each test it performs.

Response: It is our understanding that the acoustic heart sound recording and analysis is intended for a specific, targeted group of patients to enhance the provider's ability to diagnose heart failure. The technology, as described by CPT code 0069T, always is performed in conjunction with an EKG and as such is ideal for packaging. It is the hospitals responsibility to increase their charges to reflect the additional costs for those EKGs that include the acoustic heart sound recording. If the hospital uses the test according to the manufacturer guidelines, the costs will be distributed over the large number of EKGs that are performed in the hospital outpatient department and, over time, the additional costs may be recognized in the OPSS rates as increased median costs for EKGs in general.

Comment: One commenter requested that CPT code 0069T (Acoustic heart sound recording and computer analysis only) become separately payable. The commenter was concerned that CMS interpreted the code to be an add-on code to an EKG procedure. The commenter clarified that CPT code 0069T is often used as a stand-alone procedure, provided without an EKG procedure.

Response: We are accepting the APC Panel's recommendations that CPT code 0069T remain packaged for CY 2006. The Panel reviewed this code and determined it to be an add-on code to an electrocardiography service, as indicated by the American Medical Association's descriptor of this code. In addition, we are concerned that there may be unnecessary utilization of this procedure if it is separately payable because it is an add-on code to EKG services, for which there were almost 6 million claims under the OPSS in CY 2004. Lastly, we continue to believe that this service is a minor procedure that may be performed quickly accompanied by an EKG and likely other separately payable services, and thus is appropriately packaged.

b. Cardiac Electrophysiologic Services (APC 0087)

Comment: Commenters objected to the decline in proposed payment rate for APC 0087 from prior years. They also objected to what they view as a two times violation in APC 0087 and asked that we move electrophysiologic "mapping" CPT codes 93609, 93613, and 93631 to APC 0086 because the CPT code median costs for these codes are much higher than the median costs for the other codes in APC 0087. They state that because "mapping" CPT codes 93609, 93613, and 93631 are billed with other cardiac electrophysiologic services

already assigned to APC 0086, then these "mapping" services should also be assigned to the same clinical APC. They also asked that we use only claims that contain the device codes required for these CPT codes in setting the median cost for the APC into which CMS places these codes.

Response: We disagree that there is a 2 times violation, under our rules, in APC 0087. The law permits an exception to the two times rule for "low volume items and services." We define any service that does not meet our test as a "significant service" to be a "low volume item or service." A significant service is a service with a single bill frequency greater than 1,000 (which no services in APC 0087 meet) or a service with a single bill frequency greater than 99 and more than 2 percent of the single bills (which no services in APC 0087 meet). Because APC 0087 does not have any codes which meet the test of being significant, all of the codes in APC 0087 are "low volume" under our definition, and there is no two times violation.

Notwithstanding the absence of a 2 times violation under our rules, we acknowledge the commenter's concerns, and we will ask for the APC Panel's views regarding the assignment of these codes to APC 0087 in preparation for the CY 2007 OPPS update. We also recognize that, for many of the procedures assigned to APC 0087, multiple procedure claims are the norm. We will also work with the APC Panel to develop potential strategies which could enable us to use more claims for rate setting for these cardiac electrophysiologic services. We disagree, however, that because the electrophysiology "mapping" codes are performed with other cardiac electrophysiology studies, the clinical and resource characteristics of the "mapping" procedures necessarily are similar to the base services provided.

See section IV.A. for our discussion of adjustments to median costs for device-dependent APCs for the CY 2006 OPPS. See Table 16 for the adjusted median cost for APC 0087 for the CY 2006 OPPS.

c. Cardioverter-Defibrillator Implantation (APC 0107, 0108)

The median costs for APC 0107 (Implantation of Cardioverter-Defibrillator) and APC 0108 (Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads and Insertion of Cardioverter-Defibrillator) have been adjusted each year since CY 2003 when pass-through payment expired for cardioverter-defibrillators, because the unadjusted medians have differed significantly from the prior year's

payment medians. Moreover, because we use single procedure claims to set the median costs, the median costs for these APCs have always been set on a relatively small number of claims as compared to the total frequency of claims for the services under the OPPS. For example, for the CY 2006 OPPS proposed rule, the unadjusted median cost for APC 0107 was set based on 445 single procedure claims, which is 5.5 percent of the 8,073 claims on which a procedure code in the APC was billed. Similarly, the unadjusted median cost for APC 0108 was set based on 520 single procedure claims, which is 8.7 percent of the 6,003 claims on which a procedure code in the APC was billed. Commenters have frequently told us that using the single procedure median costs for these APCs does not accurately reflect the costs of the procedures because claims from typical clinical circumstances involving multiple procedures, which constitute the majority of claims under these APCs, are not used to establish the medians.

At the February 2005 APC Panel meeting, the APC Panel recommended that CMS package CPT codes 93640 and 93641 (electrophysiologic evaluation at time of initial implantation or replacement of cardioverter-defibrillator leads). The APC Panel recommended that we always package the costs for these codes because the definitions of the codes state that these evaluations are done at the time of lead implantation. Therefore, CPT codes 93640 and 93641 would never be correctly reported without a code in APC 0107 or APC 0108 also being reported. In addition, when a service assigned to APC 0107 or APC 0108 is provided, we would expect that CPT codes 93640 or 93641 for electrophysiologic evaluation and testing would also be performed frequently, and CY 2004 claims data for services in APC 0107 and APC 0108 confirm this. The APC Panel believed that packaging the costs of CPT codes 93640 and 93641 would result in more single bills available for setting the median costs for APC 0107 and APC 0108, and thus would likely yield more appropriate median costs for those APCs. Those medians would then include the costs of the electrophysiologic testing commonly performed at the time of the implantable cardioverter-defibrillator (ICD) insertion.

The APC Panel further recommended that CMS treat CPT code 33241 (Subcutaneous removal of cardioverter-defibrillator) as a bypass code when the code appeared on the same claims with services assigned to APC 0107 or APC 0108. The APC Panel recommended

bypassing charges for this code only when it appeared on the same claim with codes in APC 0107 or APC 0108, because when a cardioverter defibrillator (ICD) is removed and replaced in the same operative session, it is appropriate to attribute all of the packaged costs on the claim to the implantation of the device rather than to the removal of the device. The line costs for CPT code 33241 that are removed from the claims in this case would be discarded and would not be used to set the median cost for APC 0105 (the APC in which the code is located).

We modeled the median costs that would be calculated for APCs 0107 and 0108, if we were to make the changes recommended by the APC Panel for these APCs, under four possible scenarios: (1) The cardioverter-defibrillator device is inserted without removal or testing; (2) the device is inserted and tested with no removal; (3) the device is removed and inserted but not tested; and (4) the device is removed, inserted, and tested. For each unique scenario, we then compared the sum of the unadjusted median costs, the sum of the proposed adjusted median costs and the sum of the costs that we modeled using the APC Panel recommendations. These results were shown in the proposed rule in Tables 16 and 17.

We proposed to set the medians for these APCs at 85 percent of their CY 2005 payment medians and based our modeling of the scalar and the impact analysis on that proposal, although we believed that the APC Panel recommendations have significant merit, particularly when we move to complete reliance on claims data in updating the OPPS for CY 2007. Although we proposed to adjust the median costs for these APCs in the same manner as other device-dependent APCs, we stated in the proposed rule that we will consider, based on the public comments, whether it would be appropriate to apply the multiple procedure claims methodology to these APCs for the CY 2006 OPPS. We specifically invited public comments on the APC Panel recommendations regarding packaging and bypassing services frequently performed with procedures assigned to APC 0107 and APC 0108, with the goal of increasing single bills available for rate-setting in order to improve the accuracy of median costs based upon hospital claims.

We received many public comments concerning our proposal.

Comment: Many commenters stated that the payments CMS proposed for APCs 0107 and 0108 are inadequate to cover the acquisition costs of the

devices, much less the full hospital costs of providing the services. They asserted that the proposed payments for APCs 0107 and 0108 are only 84 percent of the cost of the device alone, leaving the hospital with an out of pocket loss for the device and no payment for the service costs. They indicated that if the proposed payment rates are made final, APCs 0107 and 0108 will have incurred reductions of 20.5 percent and 29.4 percent respectively since CY 2002. They urged that CMS use external data for the device portion of the median cost or at a minimum, accept the APC Panel recommendation to set the payment rate for APCs 0107 and 0108 at no less than the CY 2005 OPPS payment rate updated by the full market basket increase. They say that beneficiary access to care will be inhibited by continued inadequate payments for these services.

Response: We have considered the comments and, as proposed, will adjust the medians for the services in APCs 0107 and 0108 under the same policy being applied to other device-dependent APCs. See section IV.A. of this preamble for our discussion of the use of external data, and requests to update the CY 2005 OPPS median costs and payment rates by the market basket for purposes of setting the CY 2006 OPPS payments. Also see section IV. A. of this preamble for our discussion of adjustments to median costs for device-dependent APCs. See Table 16 for the CY 2006 adjusted median costs for device-dependent APCs, including APCs 0107 and 0108.

Comment: One commenter supported the recommendations of the APC Panel that CMS package CPT codes 93640 and 93641 (electrophysiologic evaluation at time of initial implantation or replacement of cardioverter-defibrillator) and treat CPT code 33241 (subcutaneous removal of cardioverter-defibrillator) as a bypass code when it appears on claims with services assigned to APCs 0107 or 0108. The commenter believed that these changes would result in a more robust set of claims to be used to set the median costs for APCs 0107 and 0108. Other commenters indicate that with or without these changes, the increased volume of claims is unlikely to result in adequate median costs for these procedures.

Response: We believe that it may be appropriate to package CPT codes 93640 and 93641 into the services assigned to APCs 0107 and 0108, and that it may be appropriate to bypass CPT code 33241 only when it appears on the same claim with codes in APCs 0107 or 0108, and we will explore doing this in the future.

The APC Data Subcommittee will continue to advise us on efforts to increase the amount of usable claims data for services that very frequently are provided along with other separately payable procedures.

As noted above, consistent with payment for other device-dependent APCs, the CY 2006 OPPS payment for APCs 0107 and 0108 is set based on 90 percent of the CY 2005 OPPS adjusted median cost. See Table 16 for a complete listing of device-dependent APCs and the adjusted median costs on which the payment rates are based.

d. Endovenous Ablation (APC 0092)

Comment: One commenter addressed our final rule (November 15, 2004) regarding the APC assignment of new CPT codes 36475 (Endovenous radiofrequency ablation, first vein) and 36476 (Endovenous radiofrequency ablation, vein add-on). The commenter asserted that the assignment to APC 0092 (Level I Vascular Ligation) was inappropriate and results in payment that is inadequate to cover the costs of the procedure. The commenter recommended creation of two new APCs, Level I and Level II endovenous ablation procedures, and advocated assignment of both CPT codes 36475 and 36476 to the higher of the two levels. The commenter stated that radiofrequency (RF) ablation procedures are quite different from other vein stripping methods and require substantially more operating room time and hospital resources than do vein stripping or endovenous laser procedures.

Further, the commenter stated that our assignment of CPT codes 36475 and 36476 to APC 0092 was inconsistent with the cost data CMS analyzed for making pass-through payments for the ablation catheter (HCPCS code C1888, which expires December 31, 2005). The commenter asserted that we failed to add the costs for the ablation device into the procedure when we made the assignment to APC 0092. The commenter also stated that hospitals and the manufacturer have submitted cost information and charge data to CMS that support assignment of the procedures to an APC with a payment rate of about \$2,500.

We received one comment, from the same commenter, on our proposed rule. The commenters stated that the RF ablation procedures are more like those assigned to APC 0086, Ablate Heart Dysrhythm Focus, than those in APC 0092 (Level I Vascular Ligation). Similar to its comment on the final rule, the commenter recommended that CMS reassign CPT codes 36475 and 36476 to

a new APC with a payment amount of approximately \$2,800. The commenter also recommended that we assign new CPT codes 36478 (Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated) and 36479 (Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; second and subsequent veins treated in a single extremity, each through separate access sites) to the lower level of the two new endovascular ablation procedure APCs that they requested, with a payment rate of approximately \$2,300.

In its proposed rule comments, the commenter provided detailed information about the costs of the endovenous ablation procedures from the practice expense cost inputs for the Medicare Physician Fee Schedule. The commenter based its recommendations for OPPS payment on those data and provided prices for the RF ablation catheter (\$680) and the laser fiber kit (\$325), as well as for the capital equipment for each procedure type.

Response: Prior to the CY 2005 implementation of CPT codes 36475 and 36476 for radiofrequency ablation and CPT codes 36478 and 36479 for laser ablation, the radiofrequency ablation device used in the endovenous ablation procedure was coded using HCPCS code C1888 (Catheter, ablation, non-cardiac, endovascular) and was separately paid as a pass-through until December 31, 2004 when the pass-through status expired.

We received a significant number of bills for HCPCS code C1888 (1787 units) in CY 2004 and considered the median cost (\$636) based on those bills, along with clinical information and historical hospital claims data for other OPPS services in making the APC assignments of the new CPT codes. We assigned all RF and laser endovenous ablation procedures for the first vein and second and subsequent veins to APC 0092, status indicator "T," with other vein procedures and a CY 2005 payment rate of \$1,538. However, in response to the comment we reconsidered our decision. While there are no two times rule violations for APCs 0092 and 0091 for CY 2006, the median costs for individual procedures assigned to those APCs significantly overlap. Nevertheless, APC 0091 has a somewhat higher payment rate for CY 2006. Given the costs for the disposables and other resources used in delivery of both laser and RF endovenous ablation services, we determined that assignment to the higher paying of these APCs was a more

accurate placement than APC 0092 as we proposed. Therefore, for CY 2006, CPT codes 36475, 36476, 36478, and 36479 will be assigned to APC 0091. The "T" status of the APC should ensure appropriate payment when ablation of more than one vein is performed in an operative session. For CY 2007 we will have hospital claims data for those codes for the first time, and, with the assistance of the APC Panel, we will reconsider the APC assignments for them and the other procedures assigned to APCs 0091 and 0092 because we believe that for procedures assigned to APCs 0091 and 0092 CY 2007 APC reconfiguration may be advisable.

e. External Counterpulsation Therapy (APC 0678)

Comment: One commenter submitted comments about external counterpulsation therapy (EECP, HCPCS code G0166). The commenter requested that we base the CY 2006 payment for this procedure on the OPPS relative weight for the procedure from CY 2005. The commenter was concerned because the OPPS rate for this procedure has decreased every year since CY 2000, and they believed that the lower payments might result in diminished beneficiary access to the therapy. The commenter believed that the low costs in the GMS data may be due to hospitals filing inaccurate claims.

Response: Although the OPPS payment rate for EECP has decreased every year since CY 2000 as noted by the commenter, we are committed to relying on our hospital claims data for this APC. In addition, we note that the total numbers of OPPS claims for this service have increased over the past several years, from 26,836 in CY 2002, to 37,568 in CY 2003, and again to 40,362 in our most recent claims data for CY 2004. We have no reason to believe that Medicare beneficiaries are having trouble accessing this therapy. Hospitals have been billing Medicare for EECP since CY 2000 and so should be filing accurate bills. The procedure is in an APC that has no other procedures that can affect its median, and the median cost for the CY 2006 OPPS is based on more than 38,000 single claims. Therefore, we will finalize our proposed CY 2006 APC assignment and payment rate for APC 0678, based on our standard OPPS methodology.

f. Intracardiac Echocardiography (APC 0670)

Comment: One comment submitted comments about the APC assignment for CPT code 93662 (Intracardiac echocardiography during therapeutic/

diagnostic intervention, including imaging supervision and interpretation). The commenter objected to the procedure's assignment to APC 0670 (Level II Intravascular and Intracardiac Ultrasound and Flow Reserve) for several reasons. First among those reasons was that the procedure should not be assigned to the same APC as is CPT code 92978, Intravascular ultrasound (coronary vessel or graft) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report. The commenter stated that the two procedures are dissimilar clinically and with respect to resource consumption. The differences between the two procedures listed by the commenter were: the intracardiac echocardiography (ICE) procedure can be used to image the entire heart rather than just a coronary vessel as does the intravascular ultrasound (IVUS) procedure; ICE is closely associated with electrophysiology and interventional cardiology procedures; IVUS is an imaging technique used as an adjunct to coronary/peripheral stent deployment; IVUS catheters cost from \$500 to \$700 whereas ICE catheters cost from \$900 to \$2,800; and the mean and median costs for the procedures are very different.

Response: The ICE procedure is a CPT code "add-on," and so normally is not reported alone on OPPS bills. For that reason, only 10 of the 541 claims for the procedure were single claims that we could use to calculate its procedure-specific median cost of \$1,815. In fact, all four of the procedures assigned to APC 0670 are "add-on" codes, and two of the procedures had no single claims for CY 2004 because one of the codes, CPT code 31620 (Endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s)), was new for CY 2005 and CPT code 93571 (Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; initial vessel) was packaged under the OPPS in CY 2004 and when unpackaged for CY 2005, no single claims were available. The fourth code in APC 0670, CPT code 92978, the IVUS procedure, had a median cost of \$1,505 and 115 single claims and, therefore, had a disproportionate influence on the median cost for the APC.

We do not agree that there are no significant clinical similarities among the procedures assigned to APC 0670. These similarities include their "add-on" status and their use of intravascular

or intrabronchial catheters or wires with complex capabilities to provide clinical information, such as images or flow data. The hospital resources required for all of these services are highly related to the costs of the technologies used for the procedures. In general, our hospital claims data are quite consistent with assignment of CPT code 93662 to APC 0670 with a median cost of \$1,505 for CY 2006, along with the other services previously described. We note that our CY 2004 total claims volume for CPT code 93662 almost doubled between CY 2003 and CY 2004, providing no evidence that Medicare beneficiaries are having trouble accessing this service.

As discussed elsewhere in this preamble, we are working on alternative strategies for determining the costs for procedures that are reported as CPT "add-on" codes. When we are better able to identify those costs, we will reevaluate the assignment of the ICE and IVUS procedures. At this time, however, we believe that APC 0670 is the most appropriate assignment for CPT codes 93662 and 92978.

g. Percutaneous Thrombectomy and Thrombolysis (APC 0676)

Comment: One commenter submitted comments regarding the APC assignment for CPT code 92973, Percutaneous transluminal coronary thrombectomy and CPT code 37195 (Thrombolysis, cerebral, by intravenous infusion). The commenter stated that the payment rate for APC 0676 (Thrombolysis and Thrombectomy) was based largely on only one of the procedures assigned to the APC, CPT code 36550 (Declotting by thrombolytic agent of implanted vascular access device or catheter), and that it was inappropriately low for CPT codes 92973 and 37195. The commenter stated that the procedures coded by CPT codes 92973 and 37195 require a mechanical device costing hundreds of dollars or significant quantities of expensive lytic agents, respectively. The comment also suggested that the difficulty that CMS has in obtaining accurate cost data for these procedures is due to the fact that they are rarely reported as single claims, and that next year there will be new codes for percutaneous thrombectomy that will help to remedy that situation.

Response: For CY 2006, we proposed to retain CPT code 92973 in APC 0676 and to remove CPT code 37195 from the inpatient list and assign it to APC 0676 as well. The median cost for each of these procedures was based on one single claim each, out of 149 and 28 total claims respectively. The very low volume of single claims is expected for these two procedures because CPT code

92973 is an "add-on" code and would not be expected to be reported alone, and CPT code 37195 was on the inpatient list in CY 2004, and therefore, we do not have many outpatient hospital claims for it.

The commenter's point that the APC 0676 payment rate was based mainly on one of the other procedures assigned to that APC is correct. The procedure coded with CPT code 36550 (Dec clotting by thrombolytic agent of implanted vascular access device or catheter) had a very high volume of single claims with a procedure-specific median cost of \$128 so that its claims disproportionately influenced the APC median cost of \$135. There were 5,099 single claims for that procedure and the next highest volume of single claims in APC 0676 was only 439 claims for CPT code 37201 (Transcatheter therapy, infusion for thrombolysis other than coronary).

While we acknowledge the small number of claims for CPT code 92973, we agree with the commenter than its continued assignment to APC 0676 could lead to significant underpayment for this service that utilizes a costly catheter. Therefore, we will reassign CPT code 92973 to APC 0088 (Thrombectomy) with an APC median of \$2,171 for CY 2006, where other procedures that are more clinically and resource coherent with CPT code 92973 reside. As this service is an "add-on" code to other surgical procedures and is assigned status indicator "T," we expect that its payment rate will be reduced by 50 percent when it is correctly billed with other surgical procedures.

With respect to CPT code 37195, we will finalize its assignment to APC 0676 for CY 2006. We expect that the lytic drugs that will be administered to a patient during this procedure will generally be separately payable under the OPSS, as well as some of the other services that typically will be provided to a patient receiving cerebral thrombolysis by intravenous infusion. While we expect that performance of this procedure in the hospital outpatient setting will remain rare, we believe that APC 0676 should make appropriate payment for CPT code 37195 for CY 2006. As always, we will examine the costs from hospital claims as new data become available to ensure that the OPSS payment is appropriate.

h. Coronary Flow Reserve (APCs 0416 and 0670)

Comment: One commenter requested that CMS make permanent the revised APC 0670 (Level II Intravascular and Intracardiac Ultrasound and Flow Reserve) and new APC 0416 (Level I

Intravascular and Intracardiac Ultrasound and Flow Reserve), as presented in the November 15, 2004 final rule. In addition, the commenter requested that we reactivate discontinued HCPCS code C3556 which was used previously for three specific brands of sensors, including guidewire-mounted coronary flow reserve sensors. The commenter believed that the requirement to report HCPCS device codes for device-dependent APCs would result in inaccurate cost information for the flow reserve sensors because these devices are currently coded using HCPCS code C1769 which is also used to code all types of guidewires.

Response: We appreciate the comment concerning these new and revised APCs as we published them in the November 15, 2004 final rule. We have made those changes final.

Beginning April 1, 2001, many manufacturer and device-specific HCPCS codes established for device pass-through payment purposes were discontinued in favor of more general codes to describe categories of devices. HCPCS code C3556 was discontinued as of April 1, 2001 as part of that action. The guidewire-mounted coronary flow reserve sensors previously reported with HCPCS code C3556 were cross-walked to HCPCS code C1769, which was established for coding guidewires. The Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 required us to establish categories, or types, of devices and no longer create codes to describe each device specifically. Further, we do not create new device codes unless one is needed to support accurate payment for devices that meet our criteria for transitional pass-through payment. There is no such need in this case as the guidewire-mounted coronary flow reserve sensor received its full period of device pass-through payments.

We do not believe that use of HCPCS code C1769 will result in inaccurate cost data for coronary flow reserve measurement services. Reporting the device code on claims for device-dependent procedures is meant to ensure that the bills upon which we rely for calculation of the median costs include the device costs integral to the procedures. We base this policy on our belief that if a hospital includes the code for the device on the bill, even though there is no separate payment for the device, the bill is more likely to be an accurate and complete report of hospital charges (and thereby, costs). We expect that hospitals reporting the required guidewire device C-code along with a coronary flow reserve measurement service will provide an

appropriate charge for the device used in the procedure.

The new requirement for device coding is one technique that we believe will help us to address the ongoing problem of hospitals inadvertently failing to accurately and fully bill the charges for all hospital resources utilized to perform procedures. By requiring that the device code be on the claim, we are more confident that the device costs have been included in the hospital's bill and that we will capture accurate costs for rate setting for the procedure as a whole.

i. Vascular Access Procedures (APCs 0621, 0622, and 0623)

Many of the codes that currently describe vascular access procedures were new in the CY 2004 version of CPT and were assigned into APC groups by crosswalking the newly created CPT codes to the deleted codes' APC assignments. Although the new codes were implemented in January 2004, because of the delay between a bill being submitted to Medicare and when the bill data are viable for analysis, we did not have cost and utilization data for the new codes available for analysis until this year in preparation for the CY 2006 OPSS.

Since those original APC assignments were made, we have received requests from the public for specific APC assignment changes. We were reluctant to make changes without data to support reassignments and, therefore, made few changes to those original APC assignments.

As an outcome of an analysis of procedure-specific median costs and 2 times rule violations in preparation for the CY 2006 update of the OPSS, for the proposed rule we developed a new APC configuration for vascular access procedure codes and several other related codes. The proposed new assignments were supported by CY 2004 hospital claims data and are based on median cost and clinical considerations.

Thus, for CY 2006 we proposed to reassign many of the CPT codes that are currently in the following APCs:

- APC 0032 (Insertion of Central Venous/Arterial Catheter)
- APC 0109 (Removal of Implanted Devices)
- APC 0115 (Cannula/Access Device Procedures)
- APC 0119 (Implantation of Infusion Pump)
- APC 0124 (Revision of Implanted Infusion Pump)
- APC 0187 (Miscellaneous Placement/Repositioning)

The configuration that we proposed placed all of the procedures currently

assigned to APC 0187 into more clinically appropriate APCs. We also proposed to reassign all of the vascular access procedure codes currently assigned to any of the identified APCs to existing or newly reconfigured clinical APCs to create more clinical and median cost homogeneity. As a result of the proposed reassignments, those clinical APCs were comprised of a different mix of codes than is currently the case for the CY 2005 OPPS. There were no codes assigned to APC 0187 because the only procedures that remained in APC 0187 after reassigning the vascular access procedures as we proposed were CPT code 75940 (X-ray placement of vein filter) and CPT code 76095 (Stereotactic breast biopsy), which we reassigned to

more clinically appropriate APCs. We proposed to reassign CPT code 75940 to APC 0297 (Level II Therapeutic Radiologic Procedures) and CPT code 76095 to APC 0264 (Level II Miscellaneous Radiology Procedures).

We proposed to create three new clinical APCs, APC 0621 (Level I Vascular Access Codes), APC 0622 (Level II Vascular Access Codes), and APC 0623 (Level III Vascular Access Codes) and assign procedures to each of these based on median cost and clinical homogeneity. We also proposed to rename APCs 0109 and 0115 as follows: APC 0109 (Removal of Implanted Devices); and APC 0115 (Cannula/Access Device Procedures).

We presented this proposal to the APC Panel at its February 2005 meeting.

The APC Panel was supportive of the proposed reassignments and recommended that we make these changes. Therefore, for the stated reasons we proposed the APC modifications for CY 2006 OPPS as summarized in Table 13 of the proposed rule (70 FR 42713).

We received a few comments on our proposal.

Comment: All of the comments were supportive of our reconfiguration of the APCs and encouraged us to make the proposal final.

Response: We appreciate the commenters' support.

Therefore, we are finalizing our proposal without modification for FY 2006.

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Table 13.--Current and Final APC Assignments for Vascular Access Procedures and Related Procedures for CY 2006

| CPT Code | Descriptor | CY 2005 APC | CY 2006 APC |
|-----------------|---|--------------------|--------------------|
| APC 0621 | Level I Vascular Access Procedure | | |
| 36555 | Insertion non-tunneled cv cath | 0187 | 0621 |
| 36556 | Insertion non-tunneled cv cath | 0187 | 0621 |
| 36568 | Insert tunneled cv cath | 0187 | 0621 |
| 36569 | Insert tunneled cv cath | 0187 | 0621 |
| 36575 | Repair tunneled cv cath | 0187 | 0621 |
| 36576 | Repair tunneled cv cath | 0187 | 0621 |
| 36580 | Replace tunneled cv cath | 0187 | 0621 |
| 36584 | Replace tunneled cv cath | 0187 | 0621 |
| 36589 | Remove tunneled cv cath | 0109 | 0621 |
| 36590 | Remove tunneled cv cath | 0187 | 0621 |
| 36596 | Mech removal tunneled cv cath | 0187 | 0621 |
| 36597 | Reposition venous catheter | 0187 | 0621 |
| APC 0622 | Level II Vascular Access Procedures | | |
| 36557 | Insert tunneled cv cath | 0032 | 0622 |
| 36558 | Insert tunneled cv cath | 0032 | 0622 |
| 36578 | Replace tunneled cv cath | 0187 | 0622 |
| 36581 | Replace tunneled cv cath | 0032 | 0622 |
| 36585 | Replace tunneled cv cath | 0032 | 0622 |
| 36570 | Insert tunneled cv cath | 0032 | 0622 |
| 36571 | Insert tunneled cv cath | 0032 | 0622 |
| 36595 | Mech removal tunneled cv cath | 0187 | 0622 |
| 36262 | Removal intra-arterial inf. Pump | 0124 | 0622 |
| APC 0623 | Level III Vascular Access Procedures | | |
| 36560 | Insert tunneled cv cath | 0115 | 0623 |
| 36561 | Insert tunneled cv cath | 0115 | 0623 |
| 36563 | Insert tunneled cv cath | 0119 | 0623 |
| 36565 | Insert tunneled cv cath | 0115 | 0623 |
| 36582 | Replace tunneled cv cath | 0115 | 0623 |
| 36583 | Insertion of access device | 0119 | 0623 |
| 36640 | Insertion catheter, artery | 0032 | 0623 |
| 36260 | Insertion of infusion pump | 0119 | 0623 |
| 36261 | Revision of infusion pump | 0124 | 0623 |
| APC 0115 | Cannula/Access Device Procedures | | |
| 36835 | Artery to vein shunt | 0115 | 0115 |
| 35903 | Excision, graft, extremity | 0115 | 0115 |
| 36815 | Insertion of cannula | 0115 | 0115 |
| 36861 | Cannula declotting | 0115 | 0115 |
| 35761 | Exploration of artery/vein | 0115 | 0115 |
| 49419 | Insert abdominal cath for chemo | 0115 | 0115 |
| 36800 | Insertion of cannula | 0115 | 0115 |
| 37204 | Transcatheter occlusion | 0115 | 0115 |
| 36810 | Insertion of cannula | 0115 | 0115 |
| APC 0109 | Removal of Implanted Devices | | |
| 33284 | Remove pt-activated heart recorder | 0109 | 0109 |
| 63746 | Removal of spinal shunt | 0109 | 0109 |

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2. Radiology, Radiation Oncology, and Nuclear Medicine

a. Angiography and Venography (APCs 0279, 0280, and 0668)

Comment: One commenter supported our proposal to reassign CPT code 75790 (Angiography, arteriovenous shunt, radiological supervision and interpretation) from APC 0281 (Venography of Extremity) to APC 0279 (Level II Angiography and Venography except Extremity). However, this same commenter objected to our proposal to move CPT codes 75820 (Venography, extremity, unilateral, radiological supervision and interpretation) and 75822 (Venography, extremity, unilateral, radiological supervision and interpretation) from APC 0281 (Venography of Extremity) to APC 0668 (Level I Angiography and Venography except Extremity). The commenter contended that CPT codes 75790, 75820, and 75822 share similar clinical characteristics and resource requirements and, therefore, should be mapped to the same APC 0279. For instance, the commenter stated that all three services require the use of guidewires, catheters, local anesthetic, and contrast. Furthermore, the commenter asserted that CPT code 75822 involves a bilateral procedure which requires much higher resource costs than other services assigned to APC 0668. Lastly, the commenter stated that CPT codes 75790, 75820, and 75822 share similar clinical characteristics with CPT code 75658 (Angiography, brachial, retrograde, radiological supervision and interpretation), which currently resides in APC 0279, differing only with respect to whether a vein is accessed versus an artery in an extremity. The commenter urged that CMS reassign CPT codes 75790, 75820, and 75822 to APC 0279 for CY 2006. In addition, the commenter recommended that CMS modify the title of APC 0668 to exclude language referring to extremities based on the commenter's belief that none of the other CPT codes assigned to APC 0668 relate to extremities.

Response: Based on our analysis of our CY 2004 claims data we disagree with the commenter that services described by CPT codes 75790, 75820, and 75822 require similar hospital resources. CPT code 75790 has a median cost of \$548, based on over 18,000 single claims from CY 2004, and is assigned to APC 0279 (Level II Angiography and Venography), which has a median cost of \$517. We believe that this APC appropriately reflects the clinical and hospital resource

characteristics of CPT code 75790 and provides appropriate payment to hospitals for this service.

In contrast, CPT code 75720 has a median cost of only \$258, based on almost 3,500 single claims that represent over half of the total claims for the service. Similarly, CPT code 75722 has a median cost of \$349, based on over 2,400 claims that represent more than half of the total claims for the service. Both of these procedures are assigned to APC 0668 which has a median cost of \$375. We believe that APC 0668 appropriately reflects the clinical and hospital resource characteristics of both of these procedures. Thus, although these three codes were assigned to the same clinical APC 0281 for CY 2005, when we eliminated that APC and reassigned the three services, we were able to place them in such a way as to provide more accurate payments for each of the services.

We appreciate the commenter's drawing our attention to the phrase "Except Extremity" that remained in the APC titles for APCs 0668, 0279, and 0280 after we eliminated the CY 2005 APC for extremity venography services. For CY 2006, we have removed the phrase "Except Extremity" from the APC title for APCs 0668, 0279, and 0280, so they are now renamed Levels I, II, and III Angiography and Venography, respectively.

b. Brachytherapy (APCs 0312, 0313, and 0651)

Comment: Commenters objected to the proposed reduction in the payment rates for APCs 0312, 0313 and 0651 for the CY 2006 OPPIs. They indicated that the reductions could result in decreased access to care. They recommended that CMS use only claims on which a brachytherapy source appears with the procedure code, which they describe as "correctly coded" claims, as the basis for the median cost calculations for these APCs. They indicated that using only claims on which the brachytherapy source code was billed results in median costs that are higher than the median costs calculated using all single procedure claims. At its August 2005 meeting, the APC Panel recommended that we evaluate this proposal. The commenters also asked that CMS expand the adjustment proposed for selected device dependent APCs to APCs 0312, 0313 and 0651. They asked that CMS consider alternative methodologies to utilize single and multiple procedure claims for rate setting purposes so that more claims could be used. They also asked that CMS use external proprietary and

confidential data to determine median costs for rate-setting. They said that because brachytherapy sources are required to furnish these services, they should be treated like device dependent APCs with regard to adjustment of medians and required editing for the presence of sources on the claims.

Response: We have not accepted the commenters' recommendations to use external data for the reasons we cite in the discussion of external data in section II. of this preamble. Moreover, we have not accepted the recommendation that we use only claims that contain a brachytherapy source on the claim to calculate the median costs for APCs 0312, 0313, and 0651 because we believe that the presence of a source on the claim is not relevant, since sources are paid separately. While the median costs presented by the commenters based on claims that contain sources resulted in higher median costs, we do not see a valid reason to limit the claims to claims with sources because the presence of the source is not relevant to the median cost of the procedural APC. We have no reason to believe that the claims without sources on the claim do not contain the full charges for the procedural services furnished. We have applied adjustments to the median costs for device dependent APCs for CY 2006 because of the difficulties in ensuring device charges are fully reflected on claims for these services, thus allowing appropriate packaging of the device costs into the APC payments. This rationale does not apply to the APCs for application of brachytherapy sources, so we have not applied the device dependent APC median adjustment policy to APCs 0312, 0313, and 0651 for CY 2006.

We disagree that these services should be treated like device dependent APCs solely because they require brachytherapy sources. The critical distinction is that the APC payment for device dependent APCs includes payment for the packaged devices, while payment for these brachytherapy source application APCs is exclusive of payment for the sources, which are paid on the basis of charges reduced to cost. The editing for the presence of key devices on claims for services assigned device dependent APCs is not "correct coding" editing. Instead, the edit is made to maximize the likelihood that the charge for the principle device required to perform the service is included on the claim so that we will capture the cost of the device in setting the median cost for the APC.

Although the brachytherapy procedure comments have largely

focused on the payment for CPT code 77778, the application of the brachytherapy sources, we note that all the related procedures, such as needle or catheter use and placement, must be considered for a full analysis of payment for brachytherapy services. The brachytherapy source application service is but one component of the entire procedure. The hospital also bills for the placement of the needles or catheters, the imaging and planning services, and is paid separately for the sources at charges reduced to costs.

Because of the particularly large drop in median cost from the median based on CY 2003 data compared to the median cost based on CY 2004 claims data for APC 0651, we extensively reviewed the cost of APC 0651, which is most commonly billed for the provision of interstitial prostate brachytherapy and frequently appears on the same claim with CPT code 55859, the code for placement of needles or catheters into the prostate. Contrary to the commenters' belief that "correctly coded" claims for CPT code 77778 also contain brachytherapy sources, in most cases of prostate brachytherapy both CPT codes 55859 and 77778 are found on the same claim with a radiologic guidance code (often CPT codes 76000 or 76965) and/or with a radiation planning code (usually CPT code 77290). This results in a correctly coded claim for interstitial brachytherapy designated as a multiple procedure claim. Furthermore, these claims not only contain the two major procedures (CPT codes 55859 and 77778), but they also often contain the three ancillary procedures (CPT codes 76000, 76965 and/or 77290), which are not on the bypass list because they have packaging in excess of \$50 or they have packaging on more than 5 percent of single bills.

In our review, we identified 11,341 claims containing both CPT codes 55859 and 77778 on the same date of service. We then looked for claims in this subgroup that contained no separately paid codes other than the three ancillary services (after we applied the bypass list and removed any codes on it). This gave us 7,533 claims containing CPT codes 55859 and 77778 with no other major procedures except for the 3 ancillary services. We believe that claims with CPT codes 55859, 77778 and one or more of these 3 ancillary services represent the most typical combinations of services furnished when brachytherapy sources are applied. We then calculated two combination median costs: a combination package and combination bypass. The first combination median cost was calculated

by treating these three codes as if they were grouped into one comprehensive service by adding the costs of these codes to the costs on the claim for CPT codes 55859 and 77778 and all other packaged costs. This "combination group median" is \$3,187.86. This "combination group median" overstates the costs of CPT codes 55859 and 77778 by the extent to which the costs of the three ancillary services and the packaging that is associated with them are reflected in it. We then calculated a second combination median cost in which we treated these three ancillary codes as if they were on the bypass list by removing the line item charges for these codes and associated all packaging on the claim with CPT codes 55859 and 77778. This "combination bypass median" is \$2,968.64. This "combination bypass median" overstates the costs of CPT codes 55859 and 77778 to the extent that the packaged costs associated with the 3 ancillary services are reflected in it.

We then compared the sum of the single bill medians calculated from our OPSS stated methodology for CPT codes 55859 and 77778 to both of these combination medians. The sum of the single bill medians for these codes (without any costs from the three ancillary procedures) is \$2,662.62. We then summed the medians for CPT codes 55859, 77778, 76000, and 77290, a typical combination of codes for these services, resulting in a sum of \$2,975.50, similar in range to both the "combination group median" and the "combination bypass median."

Under our analysis, the sum of the single bill medians for insertion of needles or catheters in the prostate and the application of brachytherapy sources is well within the range of the combination medians we calculated based on the multiple procedure claims. Accordingly, we have no reason to believe that the single bill median costs for the services reported by CPT codes 55859 and 77778 do not otherwise appropriately reflect the costs for those services. Therefore, we have used the standard OPSS methodology for clinical brachytherapy services to set the payment rates for the CY 2006 OPSS.

Comment: One commenter stated that date of service stratification results in pseudo single claims for APCs 0312 and 0651 that lack packaging because all packaging on the claim has the same date of service as the other procedure on the claim (i.e. not the procedure code in APC 0312 or 0651). The commenter indicated that the median costs for these "pseudo no package" claims is significantly lower than the medians for other single procedure bills for these

services and, therefore, should be deleted from the claims used to set the median costs for these APCs.

Response: We have no basis to believe that the charges for the procedure code are not all-inclusive charges for all packaged items and services associated with the procedure when a single charge appears for a procedure code. Again, we encourage hospitals to bill all relevant HCPCS codes that appropriately reflect the services provided.

c. Computed Tomography (APCs 0283 and 0333)

Comment: One commenter supported our proposal to pay separately for low osmolar contrast material (LOCM) and most magnetic resonance contrast agents. However, the commenter expressed concern that the separate payment for these agents will not adequately compensate for the reduced payment which CMS proposed for APCs 0283 (CT with contrast) and 0333 (CT and CTA without contrast followed by contrast). The commenter stated that they did not understand CMS' rationale for proposing to reduce payments for APCs 0283 and 0333 to a level that results in an overall net loss for contrast-enhanced CT studies.

Response: We do not agree with the commenter's assertion that the proposed CY 2006 payment rates for APCs 0283 and 0333 will necessarily reduce overall payments for contrast-enhanced CT studies. First, the proposed CY 2006 payments for APCs 0283 and 0333 decreased by less than 3 percent compared to their CY 2005 payment rates. Second, our proposal to pay separately for LOCM products (HCPCS codes Q9945 through Q9951) as a result of the mean costs per day of their predecessor codes (HCPCS codes A4644 through A4646) exceeding \$50, may increase overall payments for some contrast-enhanced CT studies while decreasing overall payments for other contrast-enhanced CT studies, depending on the volume and concentration of the LOCM used. The CY 2006 final payment rates for APCs 0283 and 0333 were calculated from CY 2004 hospital claims data utilizing the standard OPSS methodology based on our comprehensive payment policies for CY 2006, which include unpackaging LOCM.

Therefore, hospital charges for LOCM in association with single claims for services assigned to APCs 0283 and 0333 were not packaged into the median cost calculations for these APCs. As a result, we would expect the APC payment rates for APCs 0283 and 0333 to decline slightly for CY 2006. For CY 2006, we are applying our standard

OPPS rate setting methodology using CY 2004 hospital claims data to set the payment rates for APCs 0283 and 0333, and are paying separately for LOCM based on the payment methodology described in section V.B.3.a.(3) of this preamble.

d. Computed Tomographic Angiography (APC 0333)

In Addendum B of the CY 2006 proposed rule (70 FR 42776), we proposed to maintain a number of imaging procedures discussed below in their CY 2005 APCs.

Comment: Several comments expressed concern that the CY 2006 proposed payment rate for Computerized Tomographic Angiography (CTA) procedures (APC 0662) continues to be lower than the proposed payment rate for conventional CT procedures. These commenters recommended that CMS set the payment rate for CTA procedures at a level equal to the payment for a CT scan (APC 0333) plus a three-dimensional image reconstruction (APC 0282) by either increasing the payment for APC 0662 or reassigning CTA procedures to an existing APC whose payment rate more closely reflects the resource costs of performing CTA procedures.

Response: As we stated in the November 15, 2004 final rule with comment period (69 FR 65722), accurate cost information about the cost of image reconstruction for CTA specifically, and for CT alone as utilized with CTA, would be required in order to implement the commenter's suggestion that we make the payment rate for CTA (APC 0662) equal to the sum of the rates for CT alone (APC 333) plus image reconstruction (APC 282). Such cost information is not available. The CY 2004 image reconstruction CPT code 76375 (coronal, sagittal, multiplanar, oblique, 3-dimensional and/or holographic reconstruction of computed tomography, magnetic resonance imaging, or other tomographic modality) is not limited to image reconstruction performed for CTA and may be used in a number of other procedures. Based on the available CPT codes for CTA, we would not expect any current utilization of CPT code 76375 to be for CTA post-image processing, unless there was no appropriate CTA code to describe the body region imaged, which we believe would rarely be the case. In addition, we would not expect our current cost data for CTA alone to necessarily reflect the resources utilized for the CT portion of CTA.

Commenters provided no evidence suggesting that Medicare beneficiaries have experienced difficulty accessing

these services in the hospital outpatient setting. To the contrary, our number of claims for CTA procedures increased steadily between CY 2002 and CY 2003 and nearly doubled from CY 2003 to CY 2004. Furthermore, we used over 50 percent (99,000 single claims out of nearly 180,000 total claims) of the CY 2004 claims for CTA procedures to calculate the CY 2006 payment rate for these services.

We now have several years of robust claims data for CTA procedures and have no reason to doubt this data. Based on the full year of CY 2004 data, the median costs for the APCs 0333 (CT) and 0662 (CTA) are about equal, and have decreased minimally from their median costs based on CY 2003 claims data. Because hospitals set their own charges for services, which we then convert to costs, we still see no reason why adding the costs for CT alone plus the costs for image reconstruction would necessarily provide a better estimate of costs for CTA than our analysis of our specific CTA claims. Furthermore, no other existing clinical APC appears to contain services that share more clinical and resource cost homogeneity with CTA procedures than APC 0662, whose median cost reflects solely the claims data from 8 CTA procedures. For this reason, we are not reassigning CTA procedures to any other clinical APC(s) for CY 2006. Instead, for CY 2006, we are applying our standard OPPS rate-setting methodology for calculating the payment rate for CTA procedures residing in APC 0662. Once again, we encourage all hospitals to take all actions necessary to ensure that they are billing accurately and including in their charges all resources utilized to deliver CTA services.

e. Computed Tomographic Guidance (APC 0332)

Comment: One commenter objected to the proposed payment rate of \$194 for CPT code 76362 (Computed tomography guidance for, and monitoring of, visceral tissue ablation), which was proposed to be assigned to APC 0332 (Computerized Axial Tomography and Computerized Angiography without Contrast) for CY 2006. The commenter said that, although CMS included only 9 single claims in the calculation of the \$371 median cost for CPT code 76362 in the proposed rule, they identified 202 single bills with a median cost of \$580 for CPT code 76362. The commenter indicated that it found that CPT code 76362 was not being treated as a major procedure in CMS' median cost calculations, and it could not determine if CMS packaged the cost for CPT code 76362 into the

payment for the other separately payable procedure on the claim. The commenter indicated that it simulated removing the exception (although they did not specify what they did) and by doing so found 202 single bills with a median cost of \$580 for the code. The commenter asked that we place CPT code 76362 in New Technology APC 1507 (Level VII \$500-\$600) so that payment would be set at \$550. The commenter also requested that CMS add CPT code 76362 to the bypass list in future years.

Response: We do not agree that CPT code 76362 would be appropriately assigned to New Technology APC 1507 because CT is not a new technology. The use of CT guidance for and monitoring of visceral tissue ablation is a more recent application of this well-established technology. We acknowledge that we have few single bills upon which to base our calculation of the median cost of this service, but this is consistent with our expectations based on the nature of the service. We believe that all correctly coded claims would also include a CPT code for the specific ablation service that was monitored using CT and billed along with CPT code 76362.

We believe that the primary costs directly attributable to CTP code 76362, as opposed to the accompanying ablation procedure, are the hospital resources required for the lengthy operation of the necessary CT scanner. In examining the clinical characteristics of the use of CT for visceral tissue ablation, we believe that the CT use time for the procedure, although variable depending on the specific ablation procedure provided, would typically be longer than the CT use time for most noncontrast CTs assigned to APC 0332.

Because the commenter indicated their comfort with CPT code 76362 being added to the bypass list, we analyzed the line item charges for all units of service of CPT code 76362 billed by hospitals in CY 2004. The median charge per unit based on over 1,000 units was \$1,165. Application of a hospital average CCR of 0.28 for the diagnostic radiology cost center to the median charge of \$1,165 for CPT code 76362 yielded a procedure-specific line item cost of approximately \$325 for this service. This is quite consistent with our final single claim median cost of \$363 based on 9 single claims.

Therefore, we are reassigning CPT code 76362 to APC 0333 (Computerized Axial Tomography and Computerized Angiography Without Contrast Followed by Contrast) with an APC median cost of \$303 for CY 2006, where

CT procedures that include both noncontrast and contrast studies in one examination session reside. We believe that, although the ablation monitoring service is not necessarily provided both without and with contrast, the longer time of use of the CT scanner for CPT code 76362 is more consistent with the scanner use time for services assigned to APC 0333. In addition, the median cost of APC 0333 is similar to the median cost of CPT code 76362 based on single claims and to the other cost estimate based on our analysis of all billed units of the code.

With respect to the commenter's data findings, CPT code 76362 is considered to be a minor procedure (notwithstanding the status indicator of "S"), because it so frequently occurs on the same claim as other separately paid procedures and is ancillary to them. As such, when a minor procedure is on the same claim as a major procedure, the claim is considered to be a single major procedure claim and the costs of the minor procedure are not used to set the median for the minor procedure, nor are they packaged into the payment for the major procedure. The only single claims that are used in the calculation of the median cost for the minor procedure code and, therefore, for the APC to which the code is assigned are single minor procedure claims which are derived from circumstances in which the minor procedure appears alone on a claim or when it appears as one of several multiple minor procedures on a claim and can be split off because the services have different dates of service.

We considered making CPT code 76362 a major procedure and adding the service to the bypass list. However, the code does not meet the empirical criteria we have established for considering new additions to the bypass list. Of the total claims for CPT code 76362, we had only 9 single procedure claims (less than the 100 required for a code to go onto the bypass list); 6 of the 9 claims (67 percent) contained packaged services (more than the 5 percent limit) that yielded a median of \$1,231 (considerably above the \$50 median limit). Hence, because the data for CPT code 76362 from CY 2004 do not meet any of the criteria for addition of the code to the bypass list, we will not convert it to a major procedure and add it to the bypass list for CY 2006. However, we will consider for CY 2007 whether we should make an exception to our empirical criteria for additions to the bypass list for services such as CPT code 76362. We will continue to develop a more appropriate median cost for the procedure and it seems plausible

that the procedure should have very little associated packaging.

f. Computerized Reconstruction (APC 0417)

Comment: One comment expressed concern about the payment rate for HCPCS code G0288 (Reconstruction, computed tomographic angiography of aorta for preoperative planning and evaluation post vascular surgery). The commenter was concerned because the proposed rule indicated that the rate for HCPCS code G0288 would decrease for CY 2006, continuing a trend of decreases that began in CY 2004. The commenter made several recommendations to CMS that it believed would help to limit the decreased rate for CY 2006 and to prevent continuation of the downward trend for coming years. The first recommendation was for CMS to mandate which revenue code hospitals are to use to report HCPCS code G0288. The commenter recommended use of revenue code 0780, Telemedicine. This was based on their finding that hospitals used 17 different revenue codes to report HCPCS code G0288. The commenter stated that more consistent use of a revenue code would alleviate the effects of providers not billing charges high enough to result in cost findings near the acquisition costs.

Next, the commenter recommended that for CY 2006, CMS use the hospital overall CCRs to calculate the median for HCPCS code G0288. The commenter believed use of the overall CCRs would increase the median for APC 0417 to approximately \$415.

Third, the commenter recommended as a fallback measure, in case the first two recommendations could not be implemented, that CMS should use the CY 2005 rate, adjusted upward in accordance with the CY 2006 conversion factor, for APC 0417 in CY 2006.

Finally, the commenter requested that the descriptor for HCPCS code G0288 be revised to read, "Three-dimensional pre-operative and post-operative computer-aided measurement planning and simulation in accordance with measurements and modeling specifications of the Society for Vascular Surgery." They stated that the revised descriptor would ensure that the code would be used more accurately.

Response: Regarding the commenter's last request, that we revise the descriptor for HCPCS code G0288, we do not believe that is necessary. HCPCS code G0288 was revised in CY 2004 to clarify that the service can be provided for both treatment planning prior to surgery and for postsurgical monitoring.

Other than this one comment, we have had no indication that there is confusion among providers about when to use the code. In addition, we generally allow hospitals to allocate their charges across revenue codes as they feel is appropriate to their specific institutional settings, and we see no reason to deviate from this policy for the service described by HCPCS code G0288. We do not understand how specifying a revenue code for reporting would necessarily ensure adequate hospital charges for the service.

In response to the commenter's recommendations regarding our hospital cost data, we conducted a detailed examination of our CY 2004 claims data and, like the commenter, found that hospitals used 17 different revenue codes to report HCPCS code G0288. However, we also found that although 8 different cost centers for HCPCS code G0288 were used in our conversion of charges to costs for the service, for 83 percent of the approximately 5,300 single bills utilized for rate setting we converted hospital charges to costs using one cost center, namely Diagnostic Radiology. Therefore, while we acknowledge that utilizing an overall hospital CCR for HCPCS code G0288 yields a higher median cost, \$335 for APC 0417 based on our analysis, as opposed to a median cost of \$235 utilizing our standard revenue code to cost center crosswalk, we do not believe that it would be appropriate to substitute specific hospital overall CCRs in our calculation of this APC's median. We utilize one hospital-specific departmental CCR for the conversion of charges to costs for most of the single claims, and we have no reason to believe that the CCR in this case is inappropriate. Also, hospitals should bill adequate and complete charges for the service to account for all of the hospital resources required.

Additionally, we see no reason to adjust the payment rate for APC 0417 to the CY 2005 rate adjusted upward in accordance with the CY 2006 conversion factor. We note that despite reductions in payment rates over the last several years, the number of total procedures billed under the OPPS for HCPCS code G0288 has continued to rise from 2,065 in CY 2002, to 4,733 in CY 2003, and most recently to 8,421 in CY 2004. We have no evidence that Medicare beneficiaries are having trouble accessing this service based on our hospital claims information. Therefore, we believe that it is appropriate for us to use our historical hospital cost data as the basis for the CY 2006 payment amount, and we are

finalizing our payment rate for APC 0417 at \$235.66 for CY 2006.

g. Diagnostic Computed Tomographic Colonography (APC 0333)

We proposed to reassign CPT 0067T (diagnostic computed tomographic colonography (CTC-Dx)) to APC 0333 (CT and CTA without contrast followed by contrast) for CY 2006.

Comment: One commenter responded to the November 15, 2004 final rule with comment period (69 FR 65682), explaining that CPT code 0067T (diagnostic computed tomographic colonography (CTC-Dx)) was established in CY 2005 to replace the previous coding scheme for CT colonography involving two computed tomography (CT) scans (i.e., abdomen and pelvis) and three-dimensional image reconstruction. Furthermore, the commenter explained that the two CT components of a CTC-Dx may be administered in a variety of ways: (1) CT without contrast, (2) CT with contrast, or (3) CT without contrast followed by a CT scan with contrast. The commenter stated that CMS' assignment of CPT code 0067T to APC 0332 (CT and CTA without contrast) for CY 2005 failed to recognize the cost differential between a CT scan and the variety of ways in which a CTC-Dx scan is administered, along with the costs associated with the three-dimensional image reconstruction. The commenter urged CMS to reconsider the APC placement of CPT code 0067T, taking into account its advantages as a less invasive and less costly alternative to a colonoscopy.

Response: Due to the recent establishment of CPT code 0067T in CY 2005, we will have no hospital claims data for determining its resource requirements until CY 2007. For CY 2005, we assigned CPT code 0067T to APC 0332 (CT and CTA without contrast) because we considered the clinical characteristics of CTC-Dx to be relatively similar to other services assigned to APC 0332. We thank the commenter for bringing to our attention the variety of ways in which a CTC-Dx can be administered, notably a CT scan without contrast followed by a CT scan with contrast. In light of this additional information, for CY 2006 we proposed to reassign CPT 0067T to APC 0333 (CT and CTA without contrast followed by contrast), where similar services reside involving a CT scan without contrast followed by a CT scan with contrast. We are finalizing our proposal to reassign CPT 0067T to APC 0333 for CY 2006. However, in preparation for CY 2007 rate setting, we will reexamine the APC placement of CPT code 0067T based on available CY 2005 hospital claims data.

h. Intensity Modulated Radiation Therapy (IMRT) (APCs 0310 and 0412)

In Addendum B of the CY 2006 proposed rule, we proposed to maintain CPT code 77301 (Radiotherapy dose plan, intensity modulated radiation therapy (IMRT)) in APC 0310 (Level III Therapeutic Radiation Treatment Preparation) based on the CY 2004 hospital claims data submitted for CPT code 77301. In addition, we proposed to maintain CPT codes 0073T (Compensator-based IMRT treatment delivery) and 77418 (Multileaf collimator-based intensity modulated treatment delivery) in APC 0412 (IMRT treatment delivery) for CY 2006.

We received several public comments related to IMRT issues.

Comment: One commenter expressed concern that the proposed payment rate for CPT code 77301 does not reflect the actual physics planning time and resources for this procedure. The commenter recommended that we take into consideration the costs associated with IMRT planning for a typical head and neck case, including the time spent by the dosimetrists, physicists, and physicians, when setting the payment for CPT code 77301.

Response: The proposed procedure-specific median cost of \$827 for CPT code 77301 was calculated using 16,417 single procedure claims out of 16,885 total claims (97 percent of the total claims). We proposed to maintain CPT code 77301 in APC 0310 (Level III Therapeutic Radiation Treatment Preparation) grouped with only one other service, CPT code 77295 (Set radiation therapy field), whose proposed median procedure-specific cost of \$844 had the effect of increasing the proposed payment for CPT code 77301 due to its significantly higher single frequency of claims used to set the payment for APC 0310. We have no reason to believe that the single procedure claims for CPT code 77301 that represent IMRT planning for head and neck treatment reflect more accurate costs and charges than those claims for CPT 77301 that represent IMRT planning for other body areas. Thus, we would have no justification for discarding such a subset of claims that appear to be accurately reported under CPT code 77301, but merely require less resource utilization for certain covered clinical indications. Rather, the high percentage of single procedure claims for this service, which remains at 97 percent for the final rule data, along with its relatively stable median cost for several years, confirms our belief that the CY 2006 median cost for CPT code 77301 accurately reflects hospitals' costs

for the service. We believe these data represent, on average, the resources consumed by hospitals for the provision of IMRT planning services. We note that the OPSS does not provide payment for physicians' professional services that may be required for procedures. Therefore, for CY 2006, we are maintaining CPT code 77301 in APC 0310 with an APC median cost of \$825, higher than the final code-specific median cost of CPT code 77301 of \$786.

Comment: In response to the November 15, 2004 final rule with comment period (69 FR 65682) and the CY 2006 OPSS proposed rule (70 FR 42674), several commenters applauded our decision to establish a national payment rate for category III CPT code 0073T for compensator-based IMRT treatment delivery. These commenters stated that our decision to pay for compensator-based IMRT treatment delivery will encourage patient access and diffusion of this cost-effective technology. Furthermore, these commenters agreed with our rationale to assign CPT codes 0073T (Compensator-based IMRT treatment delivery) and 77418 (Multileaf collimator-based IMRT treatment delivery) to the same APC 0412 (IMRT treatment delivery) for rate setting purposes, noting that the IMRT treatment delivery costs are virtually identical for both modalities. In contrast, one commenter to the November 15, 2004 final rule with comment period (69 FR 65682) was opposed to the assignment of CPT code 0073T to APC 0412. This commenter explained that CPT code 0073T was created specifically to distinguish compensator-based IMRT treatment delivery from multileaf collimator-based IMRT treatment delivery, described by CPT code 77418. The commenter believed that the assignment of CPT codes 0073T and 77418 to the same APC 0412 precludes CMS from collecting distinct claims data for each code, and urged CMS to assign CPT code 0073T to a New Technology APC and reserve APC 0412 for CPT code 77418.

Response: Our decision to place CPT codes 0073T and 77418 in the same APC 0412 supports the clinical homogeneity of APC 0412. Because we had no CY 2003 claims data for the newly established Category III CPT code 0073T, we concluded that its resource costs were likely reflected to some degree in the costs and charges reported for CPT code 77418, considering that this was the only CPT code available to providers for the billing of compensator-based IMRT treatment delivery prior to January 1, 2005. Contrary to a belief held by one of the commenters, the assignment of CPT codes 0073T and

74418 to the same APC 0412 for payment purposes does not preclude CMS from collecting distinct claims data for these two codes. Once the CY 2005 claims data for CPT code 0073T become available for setting the CY 2007 payment rate, we will reexamine the APC placement of CPT code 0073T. In the meantime, for CY 2006 we will maintain CPT codes 0073T and 77418 in the same APC 0412.

Comment: One commenter explained that, effective January 1, 2005, the descriptor for CPT code 77418 (Multileaf collimator-based intensity modulated treatment delivery) was changed to explicitly exclude compensator-based IMRT treatment delivery and a new Category III code 0073T was created to describe compensator-based IMRT delivery. This commenter requested that we either update the December 19, 2003 Medicare Program Transmittal 32 (CR 3007) or issue a new Medicare Program Transmittal to include compensator-based IMRT treatment delivery code 0073T. The commenter provided CMS with recommended language to clarify the billing of compensator-based IMRT treatment delivery under the OPSS for CY 2006.

Response: We appreciate the commenter bringing to our attention the need to update our billing guidance to reflect the newly established Category III CPT code 0073T for the billing of compensator-based IMRT treatment delivery. We thank the commenter for providing CMS with recommended language and will consider such language as we revise our guidance on the billing of compensator-based IMRT treatment delivery under the OPSS for CY 2006.

i. Kidney Imaging (APC 0267)

Comment: One commenter expressed concern that CMS's proposed reassignment of CPT code 78700 (Kidney imaging, static) from APC 0404 (Level I Renal and Genitourinary Studies) to APC 0267 (Level III Diagnostic Ultrasound) disrupts the clinical homogeneity of the two APCs. The commenter stated that the resource requirements and clinical characteristics of kidney imaging have not changed in the past year and urged CMS to maintain CPT code 78700 in APC 0404 for CY 2006.

Response: We agree with the commenter's observation that the clinical attributes of CPT code 78700 more closely resemble the services assigned to APC 0404 rather than APC 0267. Although our proposal to reassign CPT code 78700 to APC 0267 was based on its median cost data collected for the

proposed rule, the more recent median cost data from CY 2004 for CPT code 78700 do not preclude its return to APC 0404. Therefore, in the interest of preserving the clinical homogeneity of APCs 0267 and 0404, we are not adopting our proposed reassignment and will retain CPT code 78700 in APC 0404 for CY 2006.

j. Magnetic Resonance Guided Focused Ultrasound Ablation (APC 0193)

We received one public comment on the CY 2006 OPSS proposed rule concerning the APC assignments for HCPCS codes 0071T and 0072T, along with several related comments on the November 15, 2004 final rule with comment period.

Comment: Several commenters submitted comments on the November 15, 2004 final rule regarding the APC assignments of magnetic resonance guided focused ultrasound (MRgFUS) therapy for uterine fibroids. We proposed to retain magnetic resonance guided focused ultrasound (MRgFUS) procedures in APC 0193 for CY 2006. The commenters believed that the procedure's assignment to APC 0193 (Level V Female Reproductive Procedures) resulted in significant underpayment. They asserted that MRgFUS is a new technology and that CMS should assign the two Category III CPT codes to two separate New Technology APCs, based on external cost data, until adequate claims data are available upon which to base assignments to clinical APCs.

More recently, hospital and manufacturer representatives made a presentation at the August 2005 meeting of the APC Panel and also commented on our July 25, 2005 proposed rule. The Panel recommended that CMS work with stakeholders to assign CPT codes 0071T and 0072T, focused ultrasound ablation of uterine leiomyomata including magnetic resonance guidance, to an appropriate New Technology APC(s).

The procedures are coded with Category III CPT codes 0071T (Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume less than 200 cc of tissue) and 0072T (Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume greater or equal to 200 cc of tissue). These codes were new CPT codes in CY 2006. The commenters and the presenters at the APC Panel suggested that we assign CPT code 0071T to New Technology APC 1528 (Level XXV) and CPT code 0072T to New Technology APC 1532 (Level XXVI).

Response: In light of the additional information that has been presented to us, we agree that it would be more accurate to assign the two procedures to separate APCs to account for the higher level of resources required to ablate the larger growths. However, we do not agree that it is most appropriate to assign MRgFUS procedures to New Technology APCs 1528 and 1532. Although FDA approval of one specific ablation technology was relatively recent, MRgFUS therapy bears a significant relationship to technologies already in widespread use in hospitals, in particular MRI and ultrasound services. The use of focused ultrasound for thermal tissue ablation has been in development for decades, and the recent application of MRI to focused ultrasound therapy provides monitoring capabilities that may make the therapy more clinically useful. We believe that MRgFUS therapy is a new and integrated application of existing technologies (MRI and ultrasound) and, therefore, is not necessarily most accurately assigned to a New Technology APC. We believe that the technology used in this service fits as well into existing clinical APCs for female reproductive services, as do many other modalities that are currently assigned to those clinical groups. In addition, MRgFUS procedures are most often performed on younger women and are only seldom performed on Medicare beneficiaries. We believe that placing them in clinical APCs with other female reproductive procedures will enable us both to set accurate payment amounts and to maintain appropriate clinical homogeneity of the APCs.

Cost data for MRgFUS procedures provided to us for two hospitals showed high, but disparate costs. The costs per case reported by each of the hospitals were significantly different from one another and were much higher than reports of costs from other publicly available sources. We suspect that much of the variation reflects differences in capital costs and projections of utilization and procedure times, as well as in the types of personnel used to perform the procedures. We understand that the MRI equipment can also be used to perform conventional MRI procedures, and the MRI equipment costs should be allocated accordingly so that amortization of the costs will be shared by those tests. The OPSS payment rates for services need to make appropriate payments for the services to Medicare beneficiaries, recognizing that, as a budget neutral payment system, the OPSS does not pay the full hospital costs of services. We expect that our

payment rates generally will reflect the costs that are associated with providing care to Medicare beneficiaries in cost-efficient settings.

We compared the necessary hospital resources for the MRgFUS procedures, including specialized equipment, MRI/procedure room time, personnel, anesthesia and other required resources, to various other procedures for which we have historical hospital claims data. Additionally, we took into consideration projected costs for the MRgFUS procedures submitted to us, and other available information regarding the clinical characteristics and costs of those services. Upon consideration of all of the information available to us, we have determined that a higher level of payment would be more appropriate for the MRgFUS procedures. However, we are rejecting the recommendation of the APC Panel, and we will assign CPT codes 0071T and 0072T to APC 0195 (Level IX Female Reproductive Procedures) and 0202 (Level X Female Reproductive Procedures), respectively for CY 2006. These new APC assignments provide significantly higher payment rates than we proposed for these services in CY 2006. We believe that these placements in APCs 0195 and 0202 will provide appropriate payments for MRgFUS services to provide access for Medicare beneficiaries who need them.

k. Non-Imaging Nuclear Medicine Studies (APC 0389)

In Addendum B of the CY 2006 proposed rule (70 FR 42776), we proposed to maintain CPT codes 78270 (Vitamin B-12 absorption study; without intrinsic factor), 78271 (Vitamin B-12 absorption study; with intrinsic factor), and 78272 (Vitamin B-12 absorption study; with and without intrinsic factor) in APC 0389 (Non-Imaging Nuclear Medicine) for CY 2006.

We received one public comment related to the above-mentioned nuclear medicine procedures.

Comment: One commenter expressed concern that the resource requirements associated with CPT codes 78271 (Vitamin B-12 absorption study; with

intrinsic factor), and 78272 (Vitamin B-12 absorption study; with and without intrinsic factor) far exceed the median cost of APC 0389 (Non-imaging Nuclear Medicine) in which they reside. The commenter noted that the exceptionally low single claim counts for these procedures have little or no impact on the overall median cost for APC 0389 due to the thousands of other single claim counts for lower cost CPT codes that reside in APC 0389. To protect beneficiary access to these services, the commenter requested that CMS consider either freezing the payment rate for APC 0389 at its CY 2005 payment rate or buffering the proposed 12 percent decrease from its CY 2005 payment rate. The commenter noted that, in addition to underpayment for the nuclear medicine procedures, the three radiopharmaceuticals that could be used in the tests (C1079—Supply of radiopharmaceutical diagnostic imaging agent, cyanocobalamin Co-57/58, per 0.5 mCi; C9013—Supply of Co-57 cobaltous chloride, radiopharmaceutical diagnostic imaging agent; and Q3012—Supply of oral radiopharmaceutical diagnostic imaging agent, cyanocobalamin cobalt Co-57, per 0.5 mCi) were proposed to change from status indicator “K” in CY 2005 to status indicator “N” for CY 2006. The commenter was concerned that the packaging of the necessary radiopharmaceuticals, in addition to the reduced payment rate for the tests, could threaten Medicare beneficiaries’ access to these procedures.

Response: While we acknowledge the commenter’s concern that the procedure-specific median costs for CPT codes 78271 (\$244) and 78272 (\$310) appear to far exceed the median cost of APC 0389 (\$86) for CY 2006 based on the CY 2004 hospital claims data, we remind the commenter that the exceptionally low single claim counts that they brought to our attention for CPT codes 78271 (9 single claims) and 78272 (5 single claims) significantly increase the volatility of their median costs from year-to-year. Moreover, the higher CY 2005 single claim counts for

CPT codes 78271 (209 single claims) and 78272 (133 single claims) based on the CY 2003 hospital claims data yielded lower median costs for CPT codes 78271 (\$98) and 78272 (\$159). These lower median costs may have been due to separate CY 2005 payments for the required radiopharmaceuticals, in comparison with the median costs from CY 2004 claims developed based on the CY 2006 payment policy of packaging the radiopharmaceuticals.

In reviewing the claims data for all of the CPT codes assigned to APC 0389 for CY 2005, we noted that, in addition to CPT codes 78271 and 78272, several other services had consistently higher procedure-specific median costs than the CY 2006 APC median cost (\$86), including CPT code 78003 (Thyroid uptake; stimulation, suppression or discharge); CPT code 78190 (Kinetics, study or platelet survival, with or without differential organ/tissue localization); CPT code 78270 (Vitamin B-12 absorption study; without intrinsic factor); and CPT code 78191 (Platelet survival study) with median costs of \$167, \$170, \$186, and \$384, respectively. As these services were all low volume, with fewer than 100 claims each, there was no two times violation in APC 0389, despite the finding that the least expensive procedure assigned to APC 0389 had a median cost of \$76. The higher level of hospital resources required for the more costly non-imaging nuclear medicine procedures was notable.

While we will not adjust the CY 2006 median cost of APC 0389 by using its CY 2005 median cost or dampening the decline between CY 2005 and CY 2006 as suggested by the commenter, we acknowledge that the structure of the APC would benefit from reconfiguration. Therefore, we are splitting the services assigned to APC 0389 for CY 2005 into two groupings for CY 2006: APC 0389, Level I Non-Imaging Nuclear Medicine; and newly created APC 0392, Level II Non-Imaging Nuclear Medicine. The assignment of CPT codes to these two APCs is shown in Table 14 below.

TABLE 14.—ASSIGNMENT OF CPT CODES TO APCs 0389 AND 0392 FOR CY 2006

| APC 0389 | APC 0392 |
|--|---|
| 78725, Kidney function study | 78003, Thyroid, stimulation, suppression. |
| 78000, Thyroid, single uptake | 78190, Platelet survival, kinetics. |
| 78001, Thyroid, multiple uptakes | 78191, Platelet survival. |
| 78999U, Nuclear diagnostic exam | 78270, Vitamin B-12 absorption exam; without intrinsic factor. |
| | 78271, Vitamin B-12 absorption exam; with intrinsic factor. |
| | 78272, Vitamin B-12 absorption exam; with and without intrinsic factor. |

In this reconfiguration, the median cost of APC 0389 for CY 2006 is \$85, and the median cost for APC 0392 is \$209. We believe that these new APC configurations will result in more accurate payments for non-imaging nuclear medicine studies, by improving clinical and resource homogeneity within the groupings. We note that for the purposes of any studies contemplated by the commenter, different codes will be available for reporting the required radiopharmaceuticals in the CY 2006 OPPS. Specifically HCPCS code C9013 will be deleted, HCPCS code A9546 (Cobalt CO-57/58, cyanocobalamin, diagnostic, per study dose, up to 1 microcurie) will replace HCPCS code C1079, and HCPCS code A9559 (Cobalt CO-57 cyanocobalamin, oral, diagnostic, per study dose, up to 1 microcurie) will replace HCPCS code Q3012. We anticipate that these new permanent HCPCS codes for radiopharmaceuticals will simplify billing and provide more accurate hospital claims data as the basis for potential packaging determinations in future years. With the transition to these new radiopharmaceutical HCPCS codes, we will closely monitor the claims data for APCs 0389 and 0392 in the future, as any changes in the packaging status of required radiopharmaceuticals could affect the median costs of services assigned to them and alter the resource homogeneity of the groupings.

l. Therapeutic Radiation Treatment (APC 0304)

Comment: One commenter objected to our proposal to maintain CPT code 77370 (Radiation physics consult) in APC 0304 (Level I Therapeutic Radiation Treatment Preparation) for CY 2006, noting that the procedure experienced over a 50 percent decrease in its payment rate between CYs 2004 and 2005. The commenter explained that this procedure often involves a significant amount of time spent by the physics department in developing the treatment planning, immobilization, and proper beam placement for the patient. The commenter requested that CMS consider the amount of time spent by the physicists and dosimetrists in collaborating with the physician when determining the APC placement of CPT code 77370 for CY 2006.

Response: The CY 2006 median cost of \$140 for CPT code 77370 is based on 96 percent of the CY 2004 total claims (41,123 single procedure claims out of 42,753 total claims). Similarly, the CY 2005 median cost of \$136 for CPT code 77370 was based on 95 percent of the CY 2003 total claims (40,723 single

procedure claims out of 42,985 total claims). The robust claims data reported by hospitals over the past several years support the placement of CPT code 77370 in APC 0304 for CY 2006. Furthermore, the commenter provided no supporting evidence that the proposed payment of \$105 for CY 2006 would jeopardize beneficiary access to this service. Therefore, for CY 2006 we are maintaining CPT code 77370 in APC 0304.

m. Urinary Bladder Study (APC 0340)

At the February 2005 APC panel meeting, the APC Panel recommended that we move CPT code 78730 (Urinary bladder residual study) from APC 0340 (Minor Ancillary Procedures) to APC 0404 (Level I Renal and Genitourinary Studies) for CY 2006, suggesting that the CY 2003 data for CPT code 78730 may have been derived from incorrectly coded hospital claims. For reasons discussed in detail below, we are maintaining CPT code 78730 in APC 0340 for CY 2006.

We received a number of public comments related to such imaging procedures.

Comment: One commenter stated that the resource requirements of CPT code 78730 (Urinary bladder residual study) do not resemble other services assigned to APC 0340 (Minor Ancillary Procedures). The commenter explained that the high volume and low median cost data for CPT code 78730 resulted from inappropriate use of this code to report other services unrelated to nuclear medicine. The commenter noted that during the February 2005 APC Panel meeting, the APC Panel recommended that CMS move CPT code 78730 from APC 0340 to APC 0404 (Level I Renal and Genitourinary Studies), suggesting that the CY 2003 data for CPT code 78730 may have been derived from incorrectly coded hospital claims. The commenter urged CMS to recognize the full costs associated with the nuclear medicine aspects of the procedure by reassigning CPT code 78730 to APC 0404 for CY 2006.

Response: In the November 15, 2004 final rule with comment period (69 FR 65705), we noted that CPT code 78730 was originally created and valued for the MPFS as a procedure requiring the services of a nuclear medicine technician, but that the use of the code subsequently had changed to be used primarily by urologists rather than by nuclear medicine physicians. While we reassigned CPT code 78730 to APC 0340 for CY 2005 based on robust CY 2003 claims data, we solicited other physician specialties to submit resource data for us to review in the context of

our hospital claims data so that we could reexamine the appropriate APC placement of CPT code 78730 for CY 2006. While we acknowledge the commenter's repeated concern that the median cost for CPT code 78730 may reflect miscoded claims, the commenter again provided no supporting evidence of what they believe to be the true resource costs associated with CPT code 78730. If some of the reported claims data are inaccurate, we have no way to determine which claims are more or less accurate than others. Rather, a relatively stable number of single procedure claims has generated a consistent median cost for CPT code 78730 over the past four years (that is, ranging from \$39 based on the CY 2001 claims data to \$53 based on the CY 2004 claims data) and supports our assignment of CPT code 78730 to APC 0340 with an APC median cost of \$36, as opposed to APC 0404 with an APC median cost of \$217. Therefore, we are maintaining CPT code 78730 in APC 0340 for CY 2006. However, in preparation for the CY 2007 OPPS update, we will reexamine the APC placement of CPT code 78730 by reviewing any resource data submitted by commenters in the context of our CY 2005 hospital claims data. Commenters may wish to identify approaches to distinguishing correctly coded claims so that we could develop a procedure-specific median cost based on correctly coded hospital claims data. As the commenter believes the vast majority of claims for CPT code 78730 were miscoded over many years, they may wish to explore a change in the code with the AMA's CPT Editorial Panel or request their dissemination of guidance on use of the code, to clarify the code's intended use and assist providers in correctly billing for services provided.

3. Gastrointestinal and Genitourinary Procedures

a. Cystourethroscopy With Lithotripsy (APC 0163)

Comment: A few commenters requested that CMS assign CPT code 52353 (Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy) to the new APC 0429 (Level V Cystourethroscopy and other Genitourinary Procedures). The commenters stated that this procedure has been grouped into the same APC (0163, Level IV Cystourethroscopy and other Genitourinary Procedures) with many of the procedures that we reassigned into APC 0429 and that CPT code 52353 should also be assigned to that APC. They stated that the procedure described by CPT code 52353

is used for the same indications as are those in APC 0429, and that much of the same capital equipment is used to perform CPT code 52353 and those in APC 0429.

The commenters asserted that although the median cost in CMS's hospital claims data for CPT code 52353 is lower than those for procedures in APC 0429, its median cost is the highest in APC 0163 and its costs are actually higher than reflected in the claims data since hospitals are failing to report all of the costs associated with the flexible ureteroscope required for the procedure.

Based on their analysis of the proposed rule data, the commenters found that assignment of CPT code 52353 to APC 0429 would only result in small decreases in the median costs for both APCs 0163 and 0429. They estimated that the median cost for APC 0163 would drop by approximately \$19 and that the median cost for APC 0429 would decrease by approximately \$100. They stated that these drops would not represent payment disruptions for the other procedures in the APCs.

Response: The median cost for CPT code 52353, \$2,117, is the highest in APC 0163, but the procedure-specific median costs in APC 0163 vary from lowest to highest by very little. The median cost for APC 0163 is \$1,997, only \$120 lower than the code-specific median cost for CPT code 52353.

The median cost for APC 0429 is \$2,502, and the median costs of the individual procedures with more than 50 single claims assigned to that APC (representing a total of 13,200 claims) vary from \$2,475 to \$2,602, a difference of only \$127. We believe that the decrease in the APC 0429 median that would result from assignment of CPT code 52353 (14,570 claims) would unfairly disadvantage the procedures that we proposed to assign there, and that the \$100 drop that the commenters referred to as not representing payment disruptions would not be viewed similarly by hospitals billing for the procedures we proposed for assignment to APC 0429. In addition, we have no reason to doubt the accuracy of our median cost for CPT code 52353 based on thousands of CY 2004 single hospital claims, nor do we understand why hospitals would differentially not be including charges for the costs of all required equipment and supplies for this procedure on their hospital claims in comparison with their billing for other procedures. Any small underpayment that would result from the continued assignment of CPT code 52353 to APC 0163 would be less than the potential for overpayment if the code were moved to APC 0429, which

contains some procedures that have different clinical characteristics and services with higher median costs.

We will reevaluate the APC assignment for CPT code 52353 for CY 2007 and finalize our proposal, without modification, to retain it in APC 0163 for CY 2006.

b. GI Stenting (APC 0384)

Comment: Commenters, including the APC Panel, asked that we use only claims containing devices to set the APC median cost for APC 0384, or alternatively, freeze the 2006 CY OPPS payment rate at the CY 2005 OPPS payment.

Response: We considered the comments and have decided to apply the same policy to these services that we will apply to other device-dependent APCs. In the case of this APC, the median on which the CY 2006 OPPS payments will be based was calculated using claims that contain the device codes applicable to the services assigned to APC 0384. See the discussion of payment for device dependent APCs in section VI.A for our discussion of adjustments to median costs for device-dependent APCs. See Table 16 for the median cost on which the CY 2006 payment rate for APC 0384 is based.

Comment: Some commenters, including the APC Panel, recommended that we establish a separate APC for CPT codes 43268 and 43269 for endoscopic retrograde cholangiopancreatography (ERCP) services because they believed that these services use fluoroscopy while the other codes in APC 0384 do not. Other commenters opposed this change because they said that all services in APC 0384 require use of similar supplies, equipment, and fluoroscopic assistance. They indicated that the hospital resources that are required to furnish a specific GI stenting service are determined more by nuances arising from gaining access to the site at which the stent will be placed, sedating the patient, and providing fluoroscopic monitoring, than by the specific location where the stent is being placed.

Response: We did not create a new APC for ERCP-related stent procedures because those procedures are appropriately placed with the other services in APC 0384, both with respect to clinical characteristics and resources used, particularly in view of the clinical rationale provided by the commenters. In addition, the number of single claims available for establishing payment rates for APC 0384 is already relatively small. We are concerned that if we were to move the two ERCP procedures to another APC, there would be very few

single claims remaining in APC 0384 to establish that APC's median cost.

c. Insertion of Uterine Tandems and/or Vaginal Ovoids for Clinical Brachytherapy (APC 0192)

Comment: Several commenters disagreed with our proposal to reassign CPT code 57155 (Insertion of uterine tandems and/or vaginal ovoids for clinical brachytherapy) from APC 0193 (Level V Female Reproductive Procedures) to 0192 (Level IV Female Reproductive Procedures). The commenters were concerned that the reassignment would result in a 66 percent decrease in payment, and that there was no discussion of the reassignment in the proposed rule. They requested that the procedure be retained in its current CY 2005 APC assignment, and that in the future CMS discuss all changes to APC assignments in the preambles of their proposed rules. They asserted that there have been no changes in the technology or provision of these services that would justify a reduction in payment and that the dramatic decrease in payment amount proposed by CMS would have a negative effect on Medicare beneficiaries' access to this important treatment for vaginal and/or uterine cancer.

Response: The procedure described by CPT code 57155 is for the insertion of the "holders" for brachytherapy sources when brachytherapy is to be delivered to specific sites. The procedure to load the radioactive elements and the brachytherapy sources themselves are separately payable under the OPPS. CPT code 57155 was first reassigned from APC 0192 to APC 0193 for CY 2004 Hospital claims data from CY 2002, utilized for the CY 2004 OPPS update, yielded a code-specific median cost for CPT code 57155 of about \$743, based on 132 single claims. However, CY 2003 data, utilized for the CY 2005 OPPS update, provided a code-specific median for CPT code 57155 of approximately \$232 based on 350 single claims, creating a 2 times violation in APC 0193. For CY 2005, our final OPPS payment policy specifically excepted APC 0193 from the two times rule in light of this violation.

While we did not propose to reassign CPT code 57155 for the CY 2005 OPPS, we now have a second year of hospital claims data from CY 2004 that indicate that CPT code 57155 should be assigned to a lower level Female Reproductive Procedures APC. Therefore, in addendum B of the proposed rule, we proposed to reassign CPT code 57155 to APC 0193. The median cost for CPT code 57155 of \$353 based on 867 single claims is in the same range as the

medians for other procedures assigned to APC 192 for CY 2006, making it an appropriate placement for CPT code 57155. If CPT code 57155 were to be assigned to APC 0193 which has a median cost of about \$870, we would once again have to except APC 0193 from the two times rule for CY 2006. Based on stable claims data for the past 2 years and significant numbers of single bills, we used our standard OPPS methodology and the updated CY 2004 claims data to determine that hospital claims data for CPT code 57155 are accurate and appropriate to use for making the CY 2006 APC assignment for CPT code 57155. Therefore, we will finalize our proposal to assign CPT code 57155 to APC 0192.

d. Laparoscopic Ablation Procedures (APC 0131)

Comment: One commenter requested that CMS reassign CPT code 47370 (Laparoscopy, surgical; ablation of one or more liver tumor(s); radiofrequency) to APC 0132 (Level III Laparoscopy). The procedure is currently assigned to APC 0131, Level II Laparoscopy, and the commenter stated that the costs for the procedure far exceed the payment rate in that APC. The commenter analyzed OPPS claims for CYs 2002, 2003, and 2004 and found that the median cost for that procedure has been more than “two times greater than the median of the lowest cost item or service” in APC 0131 during all of those years. Further, they asserted that the procedure’s median cost is actually more similar to those of the procedures assigned to APC 0132.

Response: We examined our median cost data for the years referenced in the comment and concur with their findings that the median cost for CPT code 47370 has been notably higher than those for other procedures in APC 0131 for several years. For CY 2006, we have 28 single claims, and the procedure-specific median cost of \$5,088 is significantly higher than the median costs for most of the procedures assigned to APC 0131. The median cost for CPT code 47370 also is higher than the median costs for other procedures currently assigned to APC 0132. We believe that for purposes of clinical homogeneity, APC 0132 is the most appropriate APC assignment for the procedure but we will continue to monitor it for future APC assignment changes. For CY 2006, we will assign CPT code 47370 to APC 0132 (Level III Laparoscopy).

Comment: One commenter requested that CMS reassign CPT code 50542 (Laparoscopy, surgical; ablation of renal mass lesion(s)) to APC 0132 (Level III

Laparoscopy). The procedure is currently assigned to APC 0131 (Level II Laparoscopy), and the commenter stated that the costs for the procedure far exceed the payment rate in that APC. The commenter analyzed OPPS claims and found that two of the 11 single claims available for the proposed rule did not reflect separate charges for the ablation device and was concerned that with so few claims, these two apparently incorrect claims may have a significant effect on the median cost.

Response: We examined our median cost data for CY 2005 and CY 2006. For CY 2005, there were 11 single claims used for the final rule median and the assignment of the procedure to APC 0131 was appropriate. For CY 2006, we have 16 single claims and the median cost is significantly higher than the median costs for most of the procedures assigned to APC 131. The median cost for CPT code 50542 is \$3,940, within the range of median costs for procedures assigned to APC 0132 for CY 2006. We will assign CPT code 50542 to APC 0132 (Level III Laparoscopy) for CY 2006.

e. Plicator Procedure (APC 0422)

Comment: One commenter submitted comments about the APC assignment for new HCPCS code C9724 (EPS gastric cardia plicator) used in the treatment of gastroesophageal reflux disease (GERD). The commenter suggested that the procedure’s assignment to APC 0422 (Level II Upper GI Procedures) is inappropriate because it is a new technology and that placement violates the OPPS two times rule. The commenter recommended that we assign the procedure to an APC with a higher payment rate and suggested that we may want to create a level III upper GI procedures APC. They reported that the cost of the Plicator Procedure kit (\$1,795), in addition to the endoscopy (approximately \$460) is two times more costly than CPT 43228 (Esophagoscopy, rigid or flexible; with ablation of tumor(s), polyp(s), or other lesion(s), not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique), a high volume procedure that is also assigned to APC 0422.

Response: In April 2004, CMS received an application for this procedure to qualify for payment as a New Technology under the OPPS. In April 2005, CMS assigned it to HCPCS code C9724 and placed it in APC 0422 for payment under the OPPS. We have no claims data for the procedure due to its very recent HCPCS code assignment. We assigned it to APC 0422 because there are other endoscopic procedures for the treatment of GERD assigned to that APC and we believed, based on

specific information available to us about the plicator service and hospital cost and clinical information regarding other services payable under the OPPS, that APC 0422 was an appropriate assignment for HCPCS code C9724. We continue to believe that is the most appropriate APC placement for the procedure. We will reevaluate that assignment when we have claims data on which to base a reassignment.

We find that there is no basis for the suggestion that assignment of HCPCS code C9724 represents a two times rule violation because there are no data for HCPCS code C9724 to compare to median costs for the other significant procedures assigned to that APC.

We are finalizing our proposal to assign HCPCS code C9724 to APC 0422 for CY 2006.

f. Prostate Cryosurgery (APC 0674)

For CY 2006 OPPS, we proposed to set the payment rate for APC 0674 (Prostate Cryoablation) based on an unadjusted median cost of \$5,780. We received many public comments concerning the payment for prostate cryoablation.

Comment: Commenters objected to the proposed payment rate for cryoablation of the prostate (APC 0674) because they believed that the proposed payment was not sufficient to cover the cost of the procedure. The commenters indicated that a hospital incurs costs of greater than \$9,000 to furnish the service. Commenters furnished copies of bills, invoices and cancelled checks intended to substantiate their claims that the total costs are in excess of \$9,000 because the costs of the probes alone are no less than \$4,000. They indicated that the proposed Medicare payment rate, if implemented, would result in a shortfall of over \$3,000 per case. Commenters said that hospitals tend to under report and under charge their true costs for cryosurgery procedures, and that there are incentives to resist billing changes that would result in higher charges for the procedures. Commenters said that CMS should recalculate the median cost for APC 0674 by excluding claims that do not have a charge of at least \$6,000 under either HCPCS code C2618 or revenue codes 270, 272 or 278 because any charge for cryoablation probes less than \$6,000 would be inadequate to result in a reasonable cost for the device. Commenters indicated that, at a minimum, CMS should not set the payment rate for APC 0674 at less than the CY 2005 payment rate plus inflation.

Response: We share the commenters’ concern that these services continue to be available to Medicare beneficiaries

and we will pay APC 0674 under the general policy which we apply to device-dependent APCs. Under this general policy, we have set the median cost for APC 0674 using only claims that contain the device code for the cryoablation probes used in this service. See section IV.A. for our discussion of adjustments to median costs for device dependent APCs. See Table 16 for the adjusted median cost for APC 0674 for CY 2006.

Comment: Commenters indicated that the proposed Medicare payment rate would result in reduced or no access for Medicare beneficiaries. One commenter stated that in the past 2 years, a total of 29 hospitals either ceased performing or elected not to start a cryosurgery program due to inadequate Medicare payment. Commenters stated that inadequate payment under the OPSS would result in hospitals providing more expensive care in the inpatient setting under DRG 315 that could be much more costly to Medicare.

Response: Our review of the claims from hospitals used to set the median costs for APC 0674 shows that from CYs 2003 to 2004, the number of claims for APC 0674 grew from 1,516 to 2,328 or by 35 percent in one year. Similarly, the number of hospital providers furnishing the service grew from 222 to 317 or by 30 percent in one year. Neither the growth in the number of claims or the number of hospitals furnishing the service indicates that there is a barrier to access to care. Moreover, while 29 hospitals may have ceased performing the procedure or decided not to begin a cryosurgery program, the growth in hospitals furnishing the service from CYs 2003 to 2004 is substantial. This is particularly meaningful because the device came off of pass-through payment in CY 2004 and the payment for the device was packaged into the payment for the procedure in CY 2004, rather than being paid separately under the pass-through payment methodology. We see no reason to believe that Medicare beneficiaries have problems in accessing this service. Moreover, as commenters indicate in the discussion of calculation of payment weights, hospitals take many factors into consideration in determining whether to offer a service, only one of which is the rate of Medicare payment.

g. Stretta Procedure (APC 0422)

CPT code 43257, effective January 1, 2005, is used for esophagoscopy with delivery of thermal energy to the muscle of the lower esophageal sphincter and/or gastric cardia for the treatment of gastroesophageal reflux disease. This code describes the Stretta procedure,

including use of the Stretta System and all endoscopies associated with the Stretta procedure. Prior to CY 2005, the Stretta procedure was recognized under HCPCS code C9701 in the OPSS. For the CY 2005 OPSS, HCPCS code C9701 was deleted and CPT code 43257 was utilized for the Stretta procedure. In CY 2005, the Stretta procedure was transitioned from a New Technology APC to clinical APC 0422 (Level II Upper GI Procedures) based on several years of hospital cost data. Procedures within APC 0422 were similar to the Stretta procedure in terms of clinical characteristics and resource use.

We received several public comments in response to the CY 2005 methodology for calculating the median cost for APC 0422 set forth in our CY 2005 OPSS final rule with comment period.

Comment: Commenters objected to the APC assignment of the Stretta procedure (HCPCS code C9701 in 2003; CPT code 43257 beginning in 2004) to APC 0422. Commenters indicated that CMS should recalculate the median cost for the procedure by packaging in the costs of all endoscopies (regardless of CPT code) that were performed on the same date as the Stretta procedure and assigning the procedure to a New Technology APC based on the recalculated median cost. They said that absent this change, CMS should clarify that hospitals may bill and will be paid for each endoscopy done at the time of the Stretta procedure. Commenters asked that we make these changes effective January 1, 2005.

Response: We did not make these changes for CY 2005 because we believe that we correctly calculated the median cost for the Stretta procedure by incorporating the cost of a single endoscopy (CPT codes 43234 and 43235) when billed into the reported median cost for Stretta in the calculation of the final rule median cost for the new CPT code 43257 for CY 2005, based on the codes hospitals correctly reported in CY 2004 for the full Stretta service. Moreover, we believe that assignment of the procedure to the APC that contains similar procedures for the treatment of gastroesophageal reflux disease is appropriate. Therefore, we believe that the Stretta procedure is placed in an APC for CY 2005 which is appropriate both with regard to clinical characteristics and resource use. As the code descriptor for CPT code 43257 includes upper gastrointestinal endoscopy, we do not expect that hospitals would separately bill for each endoscopy done at the time of the Stretta procedure.

For CY 2006, we proposed to use both CY 2004 single claims for HCPCS code C9701 and multiple procedure claims containing one unit of HCPCS code C9701 and one unit of either CPT code 43234 or CPT code 43235 to calculate the Stretta procedure's contribution to the median for APC 0422. Claims reporting one endoscopy code (CPT code 43234 or CPT code 43235) along with HCPCS code C9701 were included in the proposed median calculation because, in CY 2002, CMS authorized the separate and additional billing of a single endoscopy code with HCPCS code C9701, while CPT code 43257 now includes all endoscopies performed during the procedure.

Using this proposed methodology, we calculated a median cost for CPT code 43257 (HCPCS code C9701 in the CY 2004 claims data) of \$1,669. Using these claims in the calculation of the median cost for APC 0422, we calculated a median cost of \$1,386. We proposed to use this methodology, applied to the more complete final rule with comment period claims set, to calculate the final CY 2006 OPSS median cost for APC 0422.

We received several public comments on our proposed methodology for calculating the median cost for APC 0422.

Comment: One commenter objected to the proposed payment for CPT code 43257, the Stretta procedure for the CY 2006 OPSS. The commenter indicated that the payment would create economic disincentives to the utilization of the service and might ultimately impose greater costs on Medicare and its beneficiaries. The commenter asked that CMS create a new APC to which we would assign CPT code 43257 and CPT code 0008T, and that we use a different methodology from that proposed to calculate the median cost. The commenter indicated that because CPT codes 43228 and 43830 have higher volumes but lower costs, the inclusion of them in the same APC as CPT code 43257 does not enable payment of CPT code 43257 at a level that is appropriate to pay the costs of the service. Therefore, the commenter requested that we create a new clinical APC to enable higher payment for CPT code 43257. The commenter believed that creating the new APC is analogous to what CMS proposed to do for vascular access devices for the CY 2006 OPSS.

The commenter also asked that CMS undertake special claims manipulation to establish the median cost for the new APC. The commenter's preference was that we add the median cost for CPT code 43235 to the cost of all claims for

HCPCS code C9701 (CPT code 43257 in 2005) which did not also contain at least one unit of an endoscopy code on the claim. These inflated claims costs would then be combined with all claims for HCPCS code C9701 which also contain at least one unit of an endoscopy code and with the claims for CPT code 0008T to set the median cost for the APC they wanted us to create. The commenter offered a less preferred alternative of using only claims that contained both HCPCS code C9701 and CPT codes 43234, 42235 or any other endoscopy code to calculate the median cost, which would not yield as robust a set of claims for median setting.

Response: We have not created a new APC for CPT code 43257 and CPT code 0008T, and we have kept them both in APC 0422 for the CY 2006 OPPS. The services reported by these CPT codes are clinically similar to the other procedures in APC 0422. In addition the resources used to furnish the services are very similar to the other services in APC 0442 based on hospital claims data. We see no reason to create a new APC for CPT codes 43257 and 0008T.

We also have not undertaken the special claims manipulation that the commenter requested. We do not believe that it is valid to add the median cost for an endoscopy to the costs for claims for which an endoscopy is not billed on the same claim. Similarly, we do not believe that it is valid to include all of the charges for endoscopies other than a single unit of CPT code 43234 or 43235 in the calculation of the median cost for the Stretta procedure. As the commenter indicates, endoscopy is a fundamental part of the Stretta service described by CPT code 43257. Therefore, there is every reason to believe that a hospital included all charges pertaining to the service in the charge for C9701 (the predecessor of CPT code 43257).

To set the median cost for APC 0422, we used all single procedure claims for CPT code 43257, and we also used claims with CPT code 43257 which contained one and only one unit of either CPT codes 43234 or 43235 on the same date of service. We packaged the costs of the single unit of the additional endoscopy and used these claims records in the calculation of the median cost for APC 0422.

For CY 2006 OPPS, the payment for APC 0422 is based on the median cost of \$1,434 that was derived from this process. The median for CPT code 43257 which we derived from this process is \$1,669. CPT codes 43257 and 0008T remain assigned to APC 0422.

h. Urological Stenting Procedures (APCs 0163 and 0164)

Comment: A few commenters requested reassignment of two urology procedures to newly created APC 0429 (Level V Cystourethroscopy). The commenters requested that CPT codes 0084T (Insertion of a temporary prostatic urethral stent) and 52282 (Cystourethroscopy, with insertion of urethral stent) be assigned to the new APC.

CPT 52282 is currently assigned to APC 0163 (Level IV Cystourethroscopy and other Genitourinary Procedures) and the commenters stated that it is neither clinically similar to the other procedures in that APC nor is it similar in terms of hospital resources. Those commenters also stated that CPT code 0084T is better suited for assignment to APC 0429 than to APC 0164 (Level I Urinary and Anal Procedures), to which it is currently assigned.

The commenters requested that if we do not reassign CPT codes 52282 and 0084T to APC 0429, that we at least move CPT code 52282 to APC 0385 (Level I Prosthetic Urological Procedures), where it was assigned for CY 2004. They stated that CMS moved it from APC 0385 for CY 2005 because CMS determined that the urethral stent being implanted was not a prosthetic device, a decision with which they strongly disagree. They asserted that the urethral stent, like collagen implants injected into the urethra and other devices, meets the Medicare definition of a prosthetic device and should be assigned to an APC in line with that designation.

Response: Based on careful examination of the claims data and the comments, we continue to find that assignment for these procedures to APCs 0163 and 0164 is appropriate. The median cost for CPT code 52282, \$1,955, is considered within the range of median costs for the other procedures assigned to APC 0163. The APC median cost is \$1,997, and the narrow procedure-specific range of median costs within the APC is \$1,730 to \$2,117. In contrast, the median cost for APC 0385, \$4,384, is more than twice that of the median cost of CPT code 52282. In addition, the median cost for APC 0429 of \$2,501 is significantly higher than the median cost for CPT code 52282.

While APC 0385 (Level I Prosthetic Urological Procedures), as its title suggests, was established as an APC for some urological procedures requiring prosthetics, it is not required that all procedures utilizing urological prosthetics be assigned to an APC with

“prosthetic” in the title. Instead, urological procedures that do, or do not, utilize prosthetics, like other services paid under the OPPS, are assigned to APCs based on clinical and resource homogeneity with other services in those clinical APCs. CPT code 52282 for cystourethroscopy with insertion of a urethral stent shares common clinical characteristics with other cystourethroscopy services also assigned to APC 0163. Therefore, we continue to believe that APC 0163 is the most appropriate APC assignment for CPT code 52282 for CY 2006.

In addition, we have no claims data for CPT code 0084T because it was a new code for CY 2005. We assigned it to APC 0164 based on available information regarding the specific service, as well as clinical and cost information for other hospital services payable under the OPPS. *CPT Changes: An Insider's View 2005*, describes CPT code 0084T as the prepping of a patient for a typical sterile urethral device insertion procedure, followed by activities to select and deploy the stent in the prostatic urethra, and assessment of the patient's ability to void prior to discharge from the clinic. As stated earlier, we based our assignment for CPT code 0084T on the expected clinical and hospital resource characteristics of the service, rather than on whether or not the procedure required a prosthetic. Procedures utilizing urological prosthetics do not necessarily show the most clinical and resource compatibility with other services assigned to APCs with prosthetic urological procedures in their APC titles, as such individual procedures may exhibit a wide range of clinical and cost differences. We assigned CPT code 0084T to a clinical APC that includes other urinary and anal procedures. We do not agree that its assignment to APC 0429, the highest level cystourethroscopy APC that contains complex laser prostate and percutaneous nephrostolithotomy procedures with a median cost of \$2,502, is an appropriate placement for CPT code 0084T for CY 2006. We continue to believe that APC 0164 is the most appropriate APC assignment for CPT code 0084T for CY 2006. We will have CY 2005 claims data for CPT code 0084T and will reassess its APC assignment based on those data for the CY 2007 OPPS update.

We are finalizing, without modification, our proposal to retain CPT code 52282 in APC 0163 and CPT code 0084T in APC 0164 for CY 2006.

4. Other Surgical Services

a. Excision-Malignant Lesions (APCs 0019 and 0020)

Comment: One commenter submitted comments regarding CPT codes 11620 (Excision, malignant lesion, excised diameter 0.5 cm or less) and the code 11621 (excised diameter 0.6 to 1.0 cm). The commenter, representing a hospital, stated that there appeared to be an error in the placement of CPT code 11620 in APC 0020 (Level II Excision/Biopsy) and CPT code 11621 in APC 0019 (Level I Excision/Biopsy) because CPT code 11621 is the more invasive procedure of the two, yet it had been placed in an APC with a lower payment rate for CY 2006.

Response: This is not an error. APCs are arranged based on a combination of considerations, including clinical homogeneity and median costs from hospital claims data reflecting hospital resources used. We have several hundred single claims for CY 2003 and CY 2004 for each of the services. Our data for these years consistently show that CPT code 11621 was performed almost twice as often as CPT code 11620, but it also had a consistently lower median cost, reflecting less hospital resources required for the excision of a larger lesion in comparison with a smaller lesion. Based on CY 2004 hospital claims data, CPT code 11621 has a median cost of about \$314 based on 659 single claims and is appropriately assigned to APC 0019, with a median cost of about \$247. To place CPT code 11621 in APC 0020 (median cost of about \$413) would create a significant overpayment. Conversely, CY 2004 claims data reveal a median cost of about \$511 for CPT code 11620, based on 347 single claims, and therefore, the code is appropriately placed in APC 0020.

There could be many reasons why the hospital claims data reflect greater resource utilization for the procedure that the commenter believes is "less invasive," such as different supplies or equipment used for smaller excisions or variations in surgical techniques and related procedural times depending on the size of the lesion. We feel confident that our stable median cost data accurately reflect that the hospital resources are greater for the excision procedure described by CPT code 11620, and therefore, will finalize our proposed CY 2006 APC assignments for CPT code 11620 in APC 0020 and for CPT code 11621 in APC 0019.

b. External Fixation (APCs 0046 and 0050)

Comment: One commenter suggested that the current configuration of APC 0046 (Open/Percutaneous Treatment Fracture or Dislocation) significantly underpays procedures that involve external fixation devices. The commenter gave several recommendations on ways to realign the procedures. First, they recommended that CMS distinguish procedures that involve external fixation devices by allowing hospitals to bill either CPT code 20690 (Application of a uniplane, unilateral, external fixation system) or CPT code 20692 (Application of multiplane, unilateral, external fixation system) together with a fracture procedure code, and that these combinations of codes would be placed in a new APC specifically for "fracture procedures with fixation devices." The commenter reasoned that establishing one or two new APCs for these procedures when billed together would eliminate the ongoing two times rule violation, preserve clinical homogeneity, and more appropriately reimburse hospitals. Second, if CMS were to establish two new APCs, one should be for lower extremity fractures and the second should include upper extremity fractures.

Response: CPT codes 20690 and 20692 are currently in APC 0050, and no changes were proposed for the CY 2006 OPSS. There are no 2 times violations in the APC in which they are located, and each of these codes represents 1 percent or less of the total volume in the APC. Therefore, we see no reason to create a new APC for these codes as we believe APC 0050 provides appropriate payment to hospitals when services described by CPT codes 20690 and 20692 are provided and billed in accordance with correct coding guidelines. However, the CPT codes for treatment of a fracture often include "with" or "without fixation" in the definition of the code. Where fixation is included in the definition of the code, it would be miscoding to also report 20690 or 20692; these codes should be reported if, and only if, fixation is not included in the CPT code for treatment of the fracture. Providers should review the CPT instructions and look to the AMA's guidance on coding if they have questions about when these codes should be reported.

We do acknowledge, however, that we have excepted APC 0046 from the two times rule for several years, as we will again for CY 2006. This is a large APC to which many procedures are assigned, and the median costs of the significant

procedures in this APC range from a low of about \$1,231 to a high of approximately \$3,460. We will ask the APC Panel at its next biannual meeting to consider whether this APC could be reconfigured to improve its clinical and resource homogeneity.

c. Intradiscal Annuloplasty (APC 0203)

Comment: During the August 2005 meeting of the APC Panel, there was one presentation by a provider in support of a higher payment amount for intradiscal annuloplasty procedures. The presenter provided clinical and cost information to the Panel and stated that the procedures' current assignments to APC 0203 (Level IV Nerve Injections) did not describe the clinical features or hospital resources associated with CPT codes 0062T (Percutaneous intradiscal annuloplasty, any method, unilateral or bilateral including fluoroscopic guidance; single level) and 0063T (Percutaneous intradiscal annuloplasty, any method, unilateral or bilateral including fluoroscopic guidance; one or more additional levels). Further, the presenter suggested that a more appropriate APC assignment that would achieve more clinical and hospital resource homogeneity would be either APC 0050 (Level II Musculoskeletal Procedures except Hand and Foot), or APC 0051 (Level III Musculoskeletal Procedures except Hand and Foot). The APC Panel agreed with the presenter and recommended that CMS assign the procedure to either APC 0050 or 0051.

Commenters on our proposed rule also requested that CMS assign CPT codes 0062T and 0063T to an APC that more accurately reflects the level of the procedures' resource use. The commenters also suggested that placement in either APC 0050 or 0051 would be the most appropriate from both clinical and payment aspects. They, like the presenter to the APC Panel, believed that a musculoskeletal APC was a more clinically accurate description of the procedure than its CY 2005 assignment with nerve injections in APC 0203.

Response: CPT codes 0062T and 0063T were new for January 2005. Thus, we had no hospital claims data upon which to base our APC assignment of these procedures, and we were interested in the additional information that was provided to us for our CY 2006 update to the OPSS. Commenters indicated that performance of the procedures requires a single use electrothermal catheter that costs more than \$1,000 and operating room time of one hour. In addition, other more costly capital equipment is required in comparison with procedures assigned to

APC 0203. The presenter to the APC Panel stated that the procedure costs range from \$4,000 to about \$7,000.

We found the information provided in the APC Panel presentation and the public comments to the proposed rule, in addition to the APC Panel's recommendation and historical hospital claims data regarding other services payable under the OPPS, to be convincing in favor of assignment of this procedure to APC 0050, with an APC median cost of \$1,423 for CY 2006. We agree that placement in APC 0050 will result in more accurate payment and more APC clinical homogeneity for the procedure. For our CY 2007 update, we will have hospital claims data for the procedure and we will reevaluate the assignment.

d. Kyphoplasty (APC 0051)

Comment: Two commenters on the November 15, 2004 final rule with comment period (69 FR 65681), a device manufacturer and an orthopedic surgeon, commended CMS for creating C-codes (HCPCS codes C9718 Kyphoplasty, one vertebral body, unilateral or bilateral injection; and C9719, Kyphoplasty, each additional vertebral body) for this procedure in the hospital outpatient setting. The commenters stated, however, that placement in APC 0051, Level III Musculoskeletal Procedures Except Hand and Foot, (CY 2005 payment rate of \$2,043) does not appropriately reflect the hospital resources used in performing these procedures, and that these assignments violate the two times rule because the resources associated with kyphoplasty are more than two times the cost of the resources for procedures in APC 0051. Both commenters recommended that kyphoplasty procedures be placed in APC 0425, Level II Arthroplasty with Prosthesis, at a CY 2005 payment rate of \$5,562 in order to better reflect the clinical features and resources needed to perform the procedures. One commenter alternatively suggested creating a new APC solely for kyphoplasty.

Additionally, these two commenters also submitted new comments to the July 25, 2005 proposed rule containing new recommendations pertaining to the same issues. The commenters recommended that CMS either reassign kyphoplasty procedures to APC 0681 (Knee Arthroplasty) with a payment rate of \$8,103 or create a new APC for kyphoplasty titled "Vertebral spinal augmentation and stabilization using balloon inflation" with a payment rate of \$8,750. They also repeated their prior recommendation to place kyphoplasty

services in APC 0425; however, one commenter suggested that this should only be a "stop gap measure" for one year until CMS can gather claims data. This commenter also recommended that if the CPT codes for kyphoplasty have a status indicator of "T," they should then be placed in the same APC, as the add-on code would be subject to the multiple procedure reduction. The commenters reasoned that movement to a new APC would better reflect the clinical resources used and referenced outside data showing hospital median charges that range from \$4,500 to \$41,000, with an average charge of approximately \$15,700.

A third individual commenter representing a hospital recommended that CMS either increase reimbursement for kyphoplasty, or change its status indicator to "C" to be more consistent with InterQual "Guidelines for Surgery and Procedures in the Inpatient Setting" and the Ingenix Cross Coder.

Response: For CY 2005, CMS created two C-codes for the kyphoplasty procedure: C9718 Kyphoplasty, one vertebral body, unilateral or bilateral injection and HCPCS code C9719 Kyphoplasty, one vertebral body, unilateral or bilateral injection; each additional vertebral body (List separately in addition to code for primary procedure). These procedures were placed in APC 0051 with a "T" status indicator because we believed that this APC was appropriate for these procedures in terms of clinical characteristics and resource costs.

Though we do not yet have claims data, we have been told that a bone biopsy is performed more than half the time in addition to the kyphoplasty procedure. For CY 2005, under the OPPS the bone biopsy could be billed separately along with one or more of the kyphoplasty C-codes. The typical deep bone biopsy code used for a vertebral body procedure, CPT code 20225, was assigned to APC 0020 (Level II Excision/Biopsy), which had a "T" status indicator and a payment rate of \$434 for CY 2005. Both the biopsy and kyphoplasty procedures had a status indicator of "T"; therefore, when performed together the hospital would receive fifty percent of the payment rate for the bone biopsy (\$217). We have been told that hospitals typically also bill one or more fluoroscopy codes for necessary guidance, such as CPT codes 76003 (Fluoroscopic guidance for needle placement), or 76005 (Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinal diagnosis or therapeutic injection procedures, including neurolytic agent destruction), along with the kyphoplasty

procedure, and we note that these fluoroscopic services were packaged for CY 2005. Thus, for CY 2005 payment to a hospital providing a single level kyphoplasty procedure and billing packaged fluoroscopic guidance that was also accompanied by a bone biopsy would be about \$2,260.

For CY 2006, several new CPT codes were created to describe the kyphoplasty procedure. These codes are:

- CPT 22523—Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (e.g., kyphoplasty); thoracic
- CPT 22524—Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (e.g., kyphoplasty); lumbar
- CPT 22525—Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (e.g., kyphoplasty); each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)

CPT codes 22523 and 22524 generally correspond to C code C9718, and CPT code 22525 generally corresponds to C code C9719. We will be deleting the two kyphoplasty C-codes for CY 2006, and hospitals will use the appropriate CPT codes to bill for kyphoplasty services. The new CPT codes include a bone biopsy when performed so hospitals will no longer separately bill CPT code 20225 when a bone biopsy accompanies a kyphoplasty procedure.

CPT code 76012 (Radiological supervision and interpretation, percutaneous vertebroplasty or vertebral augmentation including cavity creation, per vertebral body; under fluoroscopic guidance) for fluoroscopic guidance also has changed in definition for CY 2006 to include specific reference to vertebral augmentation including cavity creation, which is characteristic of the kyphoplasty procedure. For CY 2006, hospitals using fluoroscopic guidance for kyphoplasty would bill CPT code 76012, which has a status indicator S and is assigned to APC 0274 for calendar year CY 2006 with a payment rate of \$173.53. Thus, while a hospital providing a kyphoplasty service in CY 2006 will no longer receive separate payment under the OPPS for an accompanying bone biopsy, hospitals

will be able to bill for and receive separate payment for necessary fluoroscopic guidance. Thus, if there were no change for CY 2006 in the assignment of kyphoplasty services to APC 0051, as they were initially placed for CY 2005, payment to a hospital providing a single level kyphoplasty procedure and billing separately payable fluoroscopic guidance that was also accompanied by a bone biopsy would be about \$2,352.

Based on modifications in coding associated with the change from C-codes to new CPT codes and additional clinical and hospital resource information, we believe it is appropriate to move the kyphoplasty procedures from APC 0051 to another APC for CY 2006. As we originally developed C-codes for outpatient hospital billing of kyphoplasty services after extensive clinical review, we do not agree with one commenter that kyphoplasty should be placed on the OPPS inpatient list. In addition, as kyphoplasty procedures do not entail implantation of a prosthesis, we do not agree with the commenters that kyphoplasty is comparable to services that require a prosthesis and, therefore, we will not place the new CPT codes in APC 0425 (Level II Arthroplasty with prosthesis). We also will not place the new CPT codes in APC 0681 (Knee arthroplasty) because we do not believe that the services are clinically coherent with knee arthroscopy procedures, and because we do not believe that resources required for kyphoplasty warrant that level of payment. We also will not create a separate APC solely for kyphoplasty procedures because we have no claims data from CY 2004 upon which to base a calculation of median cost for such an APC.

After considering the additional comments submitted, we have decided to place CPT codes 22523, 22524, and 22525 in APC 0052 (Level IV Musculoskeletal Procedures Except Hand and Foot) for CY 2006, based on clinical and resource compatibility with other procedures assigned to that APC. We agree with the commenters that the initial level procedures and the add-on code for each additional level should be assigned to the same "T" status APC. Although we received outside data on hospital charges and costs for this procedure, the data that was presented to us was highly variable in terms of charges and presented cost data for only one hospital. We will examine the median costs from hospital claims data for these services when it becomes available for the CY 2007 OPPS update.

e. Neurostimulator Electrode Implantation (APCs 0040 and 0225)

Comment: Commenters, including the APC Panel, recommended that the services currently assigned to APCs 0040 (percutaneous implantation of neurostimulators electrodes, excluding cranial nerve) and 0225 (implantation of neurostimulators electrodes, cranial nerve) be reorganized into three APCs, based on clinically coherent groupings of percutaneous, laminectomy or incision, and cranial neurostimulator electrode implantation. They indicated that such a realignment would enhance clinical and cost congruence of the procedure groupings. Other commenters objected to the reassignment of CPT code 63655 from APC 0225 to APC 0040.

Response: We agree with the proposal for creation of a new neurostimulator electrode implantation APC and have made the change. CPT codes 63655 (from APC 0225), 64575 (from APC 0040), 64577 (from APC 0225), 64580 (from APC 0225) and 64581 (from APC 0040) have been reassigned to newly created APC 0061 (Laminectomy or incision for implantation of neurostimulators electrodes, excluding cranial nerve).

See section IV. A. for our discussion of adjustments to median costs for device-dependent APCs. See Table 16 for the adjusted median costs for APCs 0040, 0225 and 0061 for CY 2006.

f. Neurostimulator Generator Implantation (APC 0222)

Comment: Commenters indicated that the proposed payment for neurostimulator generator implantation is inadequate and that CMS should use external data to set the payment rates. They explained that if payment rates were not increased, providers would cease providing the services. They asked that CMS set the median cost at the CY 2005 OPPS payment median inflated by the market basket.

Response: The proposed payment for APC 0222 (Implantation of neurological device) was based on a median cost that was set at 85 percent of the CY 2005 payment median. As with some other device-dependent APCs, the median cost on which the CY 2006 OPPS payment rate will be based will be set at 90 percent of the CY 2005 OPPS payment median. See the discussion of device-dependent APCs in section IV.A of this preamble.

Comment: Commenters objected to the payment for rechargeable neurostimulators under APC 0222 because they said that the payment rate for APC 0222 is inadequate for the

payment of nonrechargeable devices, and that hospitals will not permit implantation of the rechargeable neurostimulators for this inadequate payment. They stated that CMS recognized the need for additional payment for rechargeable neurostimulators when it provided a new technology add-on payment under the IPPS for 2006, and that CMS should create a new category for rechargeable neurostimulators and should grant pass-through status for rechargeable neurostimulators for the CY 2006 OPPS.

Response: CMS does not announce decisions regarding pass-through status in regulations. There are many new items and services that fall under existing categories and pass-through status for each is determined on the merits of the specific application. When and if pass-through status for rechargeable neurostimulators is granted, it will be implemented through the OCE with creation of an appropriate category and status indicator assignment. Additions to the items qualifying for pass-through status are announced in quarterly updates of the OPPS claims processing and billing instructions sent to our contractors and posted on the CMS Web site.

g. Thoracentesis/Lavage (APC 0070)

Comment: One commenter said that CPT code 32019 (Insert pleural catheter) should be assigned to APC 0652 (Insertion of intraperitoneal catheters) because the clinical and resource characteristics of APC 0652 are more appropriate to CPT code 32019 than are the characteristics of APC 0070, the code's placement for CY 2005. The commenter indicated that APC 0070 is not an appropriate placement for CPT code 32019 because it is not like CPT code 32020 (tube thoracostomy with or without water seal) to which it is often compared and is assigned to APC 0070. The commenter stated that CPT code 32020 is a short term procedure, typically done at bedside with a single percutaneous incision, and uses a catheter with a simpler and different design. The commenter stated that CPT code 32019 is a long term procedure, typically done in a treatment room, using multiple incisions and subcutaneous tunneling, and a catheter with a more complex design. The commenter did not specifically describe the clinical or resource characteristics of APC 0652 that justify the conclusion that CPT code 32019 is more appropriately placed in APC 0652.

Response: We agree that the procedure reported by CPT code 32019 is likely more resource intensive than CPT code 32020 and other higher

volume codes in APC 0070. Therefore, we are reassigning CPT code 32019 to APC 0427 (level III tube changes and repositioning) for the CY 2006. We do not agree that it is necessarily similar in resource use to the insertion of intraperitoneal catheter or cannula procedures currently assigned to APC 0652. We will examine the claims data for this code and review that decision when there are claims data for the code, which was new for CY 2004 and for which no cost data are available for use in the CY 2006 OPPS.

5. Other Services

a. Allergy Testing (APC 0370)

A number of providers have expressed confusion related to the reporting of units for allergy testing described by CPT codes 95004 through 95078. Most of the CPT codes in the code range are assigned to APC 0370 (Allergy Tests) for the CY 2005 OPPS. Nine of those CPT codes instruct providers to specify the number of tests or use the singular word “test” in their descriptors, while five of them do not contain such an instruction or do not contain “tests” or “testing” in their descriptors. Some providers have stated that the lack of clarity related to the reporting of units has resulted in erroneous reporting of charges for multiple allergy tests under one unit (that is, “per visit”) for the CPT codes that instruct providers to specify the number of tests.

In light of the variable hospital billing that may be inconsistent with the CPT code descriptors, we carefully examined the CY 2004 single and multiple procedure claims data for the allergy test codes that reside in APC 0370 to set the CY 2006 payment rates. Our examination of the CY 2004 claims data revealed that many of the services for which providers billed multiple units of an allergy test reported a consistent charge for each unit. Conversely, some providers that billed only a single unit

of an allergy test reported a charge many times greater than the “per test” charge reported by providers billing multiple units of an allergy test.

Our analysis of the claims data appeared to validate reports made by a number of providers that the charges reported on many of the single procedure claims represent a “per visit” charge, rather than a “per test” charge, including claims for the allergy test codes that instruct providers to specify the number of tests. Because the OPPS relies only on these single procedure claims in establishing payment rates, we believed that this inaccurate coding would have resulted in an inflated CY 2006 median cost for services that were in the CY 2005 configuration of APC 0370.

Therefore, we proposed to move the allergy test CPT codes that instruct providers to specify the number of tests or use the singular word “test” in their descriptors from APC 0370 to proposed APC 0381 (Single Allergy Tests) for CY 2006. We proposed to calculate a “per unit” median cost for proposed APC 0381 using a total of 306 claims containing multiple units or multiple occurrences of a single CPT code. Packaging on the claims was allocated equally to each unit of the CPT code. Using this “per unit” methodology, we proposed a median cost for APC 0381 of \$11 for CY 2006. Because we believed the single procedure claims for the codes remaining in APC 0370 reflected accurate coding of these services, we proposed to use the standard OPPS methodology to calculate the median for APC 0370. Table 12 as published in the proposed rule (70 FR 42711) listed the proposed assignment of CPT codes to APC 0370 and proposed APC 0381 for CY 2006.

We received one public comment concerning our proposed policy changes for allergy test procedures.

Comment: One commenter supported our proposal to move the allergy test

CPT codes into two APC configurations to differentiate between CPT codes that represent “per visit” and “per test” services.

Response: We agree with the commenter that differentiating single allergy tests (“per test”) from multiple allergy tests (“per visit”) by assigning these services to two different APCs provides hospital coders with better clarity for billing these services and more accurately places these tests with like services sharing similar resource costs. Therefore, for CY 2006, we are finalizing our proposal to assign single allergy tests to newly established APC 0381 and maintaining multiple allergy tests in APC 0370. We expect that the improved clinical and resource homogeneity of these APCs, along with improved hospital coding of these services, will result in more accurate claims data for setting the CY 2008 payment rates for these services. In the meantime, for CY 2006, we are finalizing our proposal to calculate a “per unit” median cost for APC 0381 using a total of 340 claims containing multiple units or multiple occurrences of a single CPT code. Using this “per unit” methodology, we are setting the payment rate for APC 0381 based on a median cost of \$11 for CY 2006. Because we believe the single procedure claims for the codes remaining in APC 0370 reflect accurate coding of these services, we are finalizing our proposal to use the standard OPPS methodology to calculate the median for APC 0370. Table 15 lists the assignment of CPT codes to APCs 0370 and 0381 for CY 2006. We will be providing billing guidance to hospitals in CY 2006 clarifying the billing of allergy testing services under the OPPS that should be reported with charges per test rather than per visit, so that the accuracy of hospital claims data improves and allows us in the future to calculate median costs for both APCs 0370 and 0381 using our standard OPPS process.

TABLE 15.—ASSIGNMENT OF CPT CODES TO APC 0370 AND APC 0381 FOR CY 2006

| APC 0370 | APC 0381 |
|--|---|
| 95056, Photosensitivity tests | 95004, Percutaneous allergy skin tests. |
| 95060, Eye allergy tests | 95010, Percutaneous allergy titrate test. |
| 95078, Provocative testing | 95015, Intradermal allergy titrate-drug/bug. |
| 95180, Rapid desensitization | 95024, Intradermal allergy test, drug/bug. |
| 95199U, Unlisted allergy/clinical immunologic service or procedure | 95027, Intradermal allergy titrate-airborne. |
| | 95028, Intradermal allergy test-delayed type. |
| | 95044, Allergy patch tests. |
| | 95052, Photo patch test. |
| | 95065, Nose allergy test. |

b. Apheresis (APC 0112)

Comment: Several commenters commended our proposal to reassign CPT code 36515 (Therapeutic apheresis; with extracorporeal immunoadsorption and plasma reinfusion) from APC 0111 (Blood product exchange) to APC 0112 (Apheresis, Photopheresis, and Plasmapheresis) for CY 2006. These commenters stated that the resource requirements and the clinical characteristics of CPT code 36515 more closely resemble the services assigned to APC 0112. However, these commenters expressed concern that the proposed 25 percent reduction in payment for APC 0112 (from \$2,127 in CY 2005 to \$1,590 proposed for CY 2006) will not cover the costs associated with the disposable supplies, specially trained medical staff, and equipment used in conjunction with the services assigned to APC 0112 and described by CPT codes 36515, 36516 (Therapeutic apheresis; with extracorporeal selective adsorption or selective filtration and plasma reinfusion), and 36522 (Photopheresis, extracorporeal). For example, commenters explained that the cost of the disposable supplies alone for CPT codes 36515 and 36516 nearly equals the proposed payment for APC 0112. One commenter provided practice expense information from the Medicare Physician Fee Schedule to substantiate supply costs of over \$1,400 for CPT codes 36515 and 36516 and over \$900 for CPT code 36522. Many commenters alleged that over half the hospitals reporting claims for CPT codes 36515 and 36516 in CY 2004 did not fully reflect the costs of the disposables in their charges for the procedure. Some of these commenters stated that hospitals that charge separately for the disposables are likely to charge more accurately for the full procedure than hospitals that bundle the entire costs of the disposable supplies into their charge for the procedure. These commenters urged that CMS set the payment rate for APC 0112 based only on claims where separate charges for supplies have been identified. Other commenters recommended that we exclude the CY 2004 claims data for CPT codes 36515 and 36516 and set the payment rate for APC 0112 based solely on the claims for CPT code 36522, whose proposed CPT code median cost appeared to be accurate to the majority of commenters. In addition, several commenters urged that we reexamine our calculation of the median cost for APC 0112 for errors in the computation, due to their observation that the proposed median cost of APC 0112 was significantly lower than the proposed median cost for

CPT code 36522, which comprised 83 percent of the single claims used to set the proposed payment rate for APC 0112.

One commenter noted that CPT code 36516 is utilized for billing LDL-apheresis treatments, and expressed concern that only 40 percent of the CY 2004 claims used to calculate the proposed payment for CPT code 36516 actually reported diagnoses consistent with LDL-apheresis treatments on the claim. This commenter provided a list of hospitals which the commenter believed to be misreporting CPT code 36516, based on the commenter's experience as a distributor and knowledge of the market, and requested that we exclude the claims for CPT codes 36515 and 36516 submitted by these providers when calculating the payment rate for APC 0112. Another commenter provided a detailed analysis of the claims for CPT codes 36515, 36516, and 36522 that we used to calculate the proposed payment rate for APC 0112. Based on this claims analysis, of the 24 providers that billed CPT code 36515, 29 percent reported costs for the entire procedure at or below \$170, and 67 percent reported medical supply costs at or below \$1,412. The commenter also noted that nearly half of the single claims for CPT code 36515 were not billed with ICD-9 codes that supported the medical necessity of protein A column apheresis, leading the commenter to conclude that such providers were miscoding the services they performed. For instance, the commenter suspected that several hospitals may have incorrectly billed CPT code 36515 when reporting the collection of venous blood by venipuncture (CPT code 36415) based on the charges reported by these hospitals matching a typical charge for venipuncture. Further claims analysis also revealed that, of the 46 providers that billed CPT code 36516, 63 percent reported medical supply costs at or below \$1,485. Furthermore, the commenters said that only 44 percent of the single claims for CPT code 36516 were billed with ICD-9 diagnosis codes that supported the medical necessity of LDL-apheresis. The commenter concluded that the underreporting of costs and assignment of inappropriate ICD-9 diagnosis codes to claims reporting CPT codes 36515 and 36516 were strong indicators that many providers failed to include the charges for medical supplies on the claims for CPT codes 36515 and 36516 or miscoded the services they provided.

Several commenters suggested that because the procedures assigned to APC 0112 utilize device systems to modify or

selectively remove agents from the blood, these services should be treated in a manner similar to either device dependent APCs or blood and blood products. For instance, commenters recommended that we apply the same methodology to APC 0112 as we proposed to apply to blood and blood products, limiting the decrease in median cost to 10 percent on the basis that the services assigned to APC 0112 could be considered closely related to blood and blood products.

Alternatively, these commenters suggested that we should consider treating APC 0112 as a device dependent APC, limiting the decrease in median cost to 15 percent on the basis that the device systems are integral to the procedures assigned to APC 0112 and comprise a significant cost component of these procedures. One of these commenters urged that we add APC 0112 to the list of device dependent APCs, and set the payment floor at 100 percent of the CY 2005 payment rate plus the market basket update for all device dependent APCs.

Response: We appreciate commenters' concerns that we use accurate and complete claims data to develop the median cost to set the payment rate for APC 0112 for CY 2006. In response to requests by several commenters that we reexamine our calculation of the median cost for APC 0112, we closely studied the single claims charge and cost distributions for CPT codes 36515, 36516, and 36522, those single claims we used to set the payment rate for APC 0112. First, we noted that we had 4,828 single bills drawn from a total of 6,071 bills for services in APC 0112, allowing us to use approximately 80 percent of all claims in establishing the median cost for APC 0112. This large percentage of single bills held true for each of the 3 CPT codes assigned to the APC as well. The availability of almost 5,000 single bills for rate setting, a 15 percent increase over the number of single bills available for the CY 2005 OPPI update, increases our confidence in the accuracy of the median cost of APC 0112 calculated for CY 2006.

Next, we confirmed that we made no errors in the calculation of the APC median cost. The apparent inconsistency between the relatively high median cost of CPT code 36522, which provided the majority of single claims for APC 0112, and the relatively lower APC median cost was explained by the observed distribution of costs of single claims for all of the services assigned to APC 0112. Almost half of the costs of single claims for CPT code 36522 are closer to the APC median. The cost of single claims for CPT code

36522 at the 45th percentile is \$1,597.45. We applied all of our usual processes, including standard trimming, to the calculation of the APC median cost.

In our analysis of the distributions of costs from claims for all three CPT codes assigned to APC 0112, we observed that CPT code 36515, in particular, had some claims with very low costs of less than \$200 up through the 50th percentile of claims costs. While, in the commenters' opinions, claims with even higher costs could not have represented the full costs of the procedures, we were not confident that we had reason to exclude claims with higher costs in calculating the median cost of APC 0112. Therefore, we identified 12 hospital providers submitting claims for CPT code 36515 with the lowest fifteen percent of costs and then recalculated the median cost for APC 0112, excluding all claims for CPT code 36515 reported by these 12 providers. We found essentially no change in the median cost of APC 0112 in this recalculation, as compared with its median cost based on all single claims.

Because commenters suggested that we set the APC median cost using only claims with medical supply revenue code charges, we proceeded to analyze all single claims for APC 0112 for the presence of separate line item charges under revenue codes 270 (Medical/Surgical Supplies) and 272 (Sterile Supplies) that could most likely represent separate charges for the costly disposables that commenters indicated are required for all 3 CPT codes assigned to the APC. The median cost for claims with medical supply revenue code charges is higher, at \$2,800, compared with the median cost for claims without medical supply revenue code charges, \$1,400. However, we do not believe it is appropriate to subset the claims based on the presence of medical supply revenue code charges for calculating the median APC cost for several reasons. First, we noted that between 80 and 90 percent of the single claims for each CPT code and, consequently, of all single bills used to estimate the median cost for APC 0112 did not have separate charges under one of the two specified revenue codes. This is fully consistent with our past guidance to hospitals that it is appropriate to bundle the costs of all supplies (excluding implantable devices with active device codes) into the line item charges for the procedures with which they were used. For those claims billed with charges in the 270 and 272 medical supply revenue codes, we observed that the specific median cost

associated with those revenue codes was only \$349. Because this median cost is well below the approximately \$900–1,400 cost commenters expected for the disposable supplies, we are not convinced that the bills with separate revenue code charges are truly more reflective of the full costs of the apheresis procedures. Finally, we observed that there were actually higher total costs in the distribution of those claims without separate billing of revenue code charges, up to \$12,296 in comparison with a maximum of \$10,131 for those claims with separate revenue code charges. Considering the small percentage of providers reporting separate supply charges for CPT codes 36515, 36516, and 36522 under revenue codes 0270 and 0272, and the low median cost for such revenue code charges, the majority of providers appear more likely to have included their disposable supply charges in their overall charges for the procedures rather than to have reported such charges under a supply revenue code. We have no reason to believe, based on our analysis, that the claims with separate charges for supplies are more correctly coded or more accurately reflective of the costs of services assigned to APC 0112.

In conclusion, we are not making any adjustments to our standard processes for developing APC median costs for CY 2006 for APC 0112. We will not screen claims for the presence of specified diagnoses that the commenters feel are appropriately treated with these procedures and assume that all other claims are miscoded. The three services treat a number of different medical conditions, and while there are some local coverage policies for the procedures, it would be difficult to identify the correct ICD-9 diagnosis coding for those claims reflecting all of the cases of appropriate utilization of these services. We are not calculating the payment rate for APC 0112 based solely on those claims where separate charges for supplies have been identified. Although we recognize that some of the charges reported for CPT codes 36515 and 36516 in particular are unexpectedly low, we disagree with those commenters who asserted that the hospital claims data for CPT codes 36515 and 36516 are flawed to the extent that would justify discarding all such claims and basing the payment rate for APC 0112 solely on claims for CPT code 36522. We will not exclude all claims for two of the three procedures assigned to APC 112 to calculate the APC's median cost, because we believe that the APC median cost should reflect

the variable costs of all services assigned to it. Consistent with details provided in the comments, we do not believe that the costs of procedures described by CPT codes 36515, 36516, and 36522 are the same, as the services are each provided using very specific disposable supplies for patients with different clinical conditions. In addition, we do not agree with those commenters who argued that the services described by CPT codes 36515, 36516, and 36522 should be treated in a manner similar to either device dependent APCs or blood and blood products by mitigating their payment reductions. We do not consider a procedure requiring a disposable supply to be a device dependent APC, which utilizes implantable devices. In addition, we do not believe that the data concerns regarding these procedures that treat the blood are similar to the supply and availability challenges associated with maintaining the nation's blood supply. Therefore, for CY 2006, we are applying our standard OPPS rate-setting methodology to all single claims for APC 0112, setting the payment rate for APC 0112 based on a median cost of \$1,568.

c. Audiology (APCs 0364, 0365, and 0366)

Comment: One commenter, an association representing audiologists, requested more detailed explanation for several proposed movements of CPT codes among APCs. We proposed for CY 2006 to make the following APC migrations: CPT codes 92533 (audiometry, air & bone) and 92572 (staggered spondaic word test) from APC 0364 to APC 0365; CPT code 92561 (Bekeasy audiometry, diagnosis) from APC 0365 to APC 0364; and CPT code 92577 (Stenger test, speech) from APC 0365 to APC 0366. The commenter did not object to the changes.

Response: With respect to proposed APC reassignments of services that are not specifically discussed in the proposed rule, in general we proposed changes to improve the clinical and resource homogeneity of the involved APCs, and, in particular, to address violations of the two times rule resulting from variable median costs.

In this instance, CPT code 92561 was moved from the Level II Audiometry APC to the Level I Audiometry APC because the data from CY 2004 hospital claims showed that the code-specific median cost of \$19 for CPT code 92561 was most compatible with the median cost of APC 0364, at \$27. To leave the code in APC 0365 would create a significant overpayment, and there was another clinically appropriate APC

available. A similar rationale applied to CPT code 92577, whose code-specific median cost of \$108 was more coherent with the median cost of APC 0366 (Level III Audiometry) of \$100 than the median cost of the Level II APC at \$80. While we excepted APC 0364, the CY 2005 APC assignment for CPT code 92553, from the two times rule for CY 2005, we proposed to move CPT code 92553 to APC 0365 for CY 2006 to eliminate our need to except APC 0364 from the two times rule for CY 2006. When compared with the median costs of other procedures in APC 0365, the median cost of CPT code 92553 of \$43 was reasonably consistent with the median costs of other codes assigned to APC 0365 and to the overall APC median cost of \$71. Due to this code's significant volume of single claims and stable median costs, we believed that it was appropriate to propose its reassignment based on both clinical and hospital resource considerations. We are finalizing our APC assignments for CPT codes 92561, 92577, and 92553 as proposed for CY 2006.

We proposed to move CPT code 92572 (staggered spondaic word test) from APC 0364 to APC 0365 for CY 2006 because we believed that its resource requirements, as reflected in hospital claims data, were more consistent with other services assigned to APC 0365 than to procedures assigned to APC 0364. CY 2003 hospital claims data for CPT code 92572 revealed a median cost of about \$100 based on 19 single claims. CY 2004 claims data, based on 10 single claims, yielded a median cost of about \$167. Although the median does not appear to be as stable for this code as the others discussed nor is the volume of claims large, upon review of final CY 2004 hospital claims data in response to this comment and examination of the clinical characteristics of the service, we believe that CPT code 92572 is most appropriately assigned to APC 0366 for CY 2006. Therefore, we will not finalize our proposal to move CPT code 92572 to APC 0365, but will instead reassign the service to APC 0366 for the CY 2006 OPPS.

d. Bone Marrow Harvesting (APC 0111)

Comment: Several commenters stated that the proposed payment of \$735 for CPT code 38230 (Bone marrow harvesting for transplantation) does not adequately cover the costs of providing this service. These commenters called our attention to the large difference in the proposed median cost of \$1,209 for CPT code 38230 and the proposed median cost of \$747 for APC 0111, where CPT code 38230 resides.

Commenters also noted the volatility of the CPT code median as a result of the extremely low frequency of 9 claims, noting that the costs of these claims ranged from \$140 to \$66,770. Commenters strongly urged CMS to reassign CPT code 38230 from APC 0111 (Blood product exchange) to APC 0123 (Bone marrow harvesting and bone marrow/stem cell transplant) to more accurately reflect the high cost of this procedure and to improve the clinical homogeneity of the two APCs, stating that the APC title for APC 0123 is more applicable to CPT code 38230 than the title of APC 0111.

Response: Hospitals have reported a consistently low median costs for CPT code 38230 for the past several years, prompting us to reassign this service to a lower paying APC, from APC 0123 to APC 0111, for CY 2005. However, closer analysis of this code-specific low median cost leads us to suspect that a number of providers are likely billing this code for services that are not described by CPT code 38230, bone marrow harvesting for transplantation. Considering the typical clinical characteristics of the service, we would expect the costs of the necessary hospital resources to more closely approximate the median costs of services assigned to APC 0123 for CY 2006. Therefore, we will return CPT code 38230 to APC 0123 for CY 2006. However, we will reevaluate the appropriateness of this APC assignment during the OPPS update for CY 2007. In the meantime, we advise providers to exercise greater care when reporting CPT code 38230 to ensure that this code is billed correctly only for services described by the CPT code and that all costs associated with providing the bone marrow harvesting procedure are included in charges on the claims for the service.

e. Computer Assisted Navigational Procedures

Comment: Two commenters expressed concern about computer assisted navigation for orthopedic procedures (CPT codes 0054T, 0055T, and 0056T). Both commenters were concerned that CMS had not assigned these procedures to an APC for OPPS payment, but instead had proposed their status indicators as "B" while another computer assisted navigational procedure, CPT code 61795 (Stereotactic computer assisted volumetric (navigational) procedure, intracranial, extracranial, or spinal), had previously been assigned status indicator "S" in APC 302 (Level III Radiation Therapy). Both commenters recommended that orthopedic computer assisted

navigational procedures should be assigned to APC 0302 with the other computer assisted navigational procedures, or alternatively each procedure (CPT codes 61795, 0054T, 0055T, and 0056T) should be placed in a new clinical APC with a payment rate equaling the payment rate of APC 0302.

Response: We agree with the commenters that these computer assisted navigational procedures share a common technological theme in their clinical use during surgical procedures and may use comparable hospital resources. We, therefore, will place CPT codes 0054T, 0055T, and 0056T in APC 0302 with CPT 61795 for CY 2006. We will also give APC 0302 a new name, "Computer Assisted Navigational Procedures," because the APC contains only these four services and is thus most appropriately described by that title.

f. Hyperbaric Oxygen Therapy (APC 0659)

When hyperbaric oxygen therapy (HBOT) is prescribed for promoting the healing of chronic wounds, it typically is prescribed on average for 90 minutes, which would be billed using multiple units of HBOT to achieve full body hyperbaric oxygen therapy. In addition to the therapeutic time spent at full hyperbaric oxygen pressure, treatment involves additional time for achieving full pressure (descent), providing air breaks to prevent neurological and other complications from occurring during the course of treatment, and returning the patient to atmospheric pressure (ascent). The OPPS recognizes HCPCS code C1300 (Hyperbaric oxygen under pressure, full body chamber, per 30 minute interval) for HBOT provided in the hospital outpatient setting.

We explained in the August 16, 2004 proposed rule (69 FR 50495) that our CY 2003 claims data revealed that many providers were improperly reporting charges for 90 to 120 minutes under only one unit rather than three or four units of HBOT. This inaccurate coding resulted in an inflated median cost of \$177.96 for HBOT, derived using single service claims and "pseudo" single service claims. Because of these single claims coding anomalies, we proposed to calculate a "per unit" median cost for APC 0659, using only multiple units or multiple occurrences of HBOT, excluding claims with only one unit of HBOT and excluding packaged costs. To convert HBOT charges to costs, we used the CCR from the respiratory therapy cost center when available; otherwise, we used the hospital's overall CCR. Using this "per unit" methodology, we proposed a median cost for APC 0659 of \$82.91 for CY 2005.

In the November 15, 2004 final rule with comment period (69 FR 65758), we agreed with commenters that there was sufficient evidence that the CCR for HBOT was not reflected solely in the respiratory therapy cost center; rather, the CCR for HBOT was reflected in a variety of cost centers. Therefore, we calculated a “per unit” median cost of \$93.26 for HBOT, using only multiple units or multiple occurrences of HBOT and each hospital’s overall CCR.

Our examination of the CY 2004 single procedure claims filed for HCPCS code C1300 revealed similar coding anomalies to those encountered in the CY 2003 single procedure claims data. Therefore, for CY 2006 rate-setting, we recalculated a “per unit” median cost for HCPCS code C1300 using only multiple units or multiple occurrences of HBOT and each hospital’s overall CCR, which is the same methodology we used for setting the CY 2005 payment rate for HBOT. Excluding claims with only one unit of HBOT, we used a total of 41,152 claims to calculate the proposed median for APC 0659 for CY 2006. Applying the methodology described above, we proposed a median cost for APC 0659 of \$93.37 for CY 2006.

We received several public comments concerning our proposed APC payment for HBOT.

Comment: Several commenters approved of our decision to rely on each hospital’s overall CCR rather than the respiratory therapy CCR in our calculation of HBOT median costs. However, the commenters noted that most hospitals providing HBOT services report the costs and charges associated with providing this service on a separate line of their cost report. These commenters further encouraged us to use the CCR specific to HBOT for hospitals that report HBOT separately. They also asked CMS to encourage hospitals not reporting costs and charges for HBOT separately, to do so in the future.

Response: Unfortunately, the Healthcare Cost Report Information System (HCRIS), the electronic database of the Hospital Cost Report (CMS–2552–96) that we use to estimate costs from charges, rolls up costs and charges on each hospital’s cost report into a standard list of cost centers. Because HBOT is not included on the standard list of cost centers, CMS does not have readily available information about the specific costs and charges that each institution garners in providing HBOT services. Until last year, we had hypothesized that most hospitals providing HBOT services reported the costs and charges for those services as

a separate line item in their respiratory therapy cost center. Commenters convinced us that hospitals did not report their HBOT costs and charges in a uniform location on their cost report. In the final rule for CY 2005, we used the overall CCR for each hospital rather than the respiratory therapy CCR to calculate the median cost for HBOT (APC 0659). While we could encourage hospitals to report their costs and charges for HBOT separately, at this time extra effort by hospitals would not allow us to improve the accuracy of our HBOT median cost calculation because we lose line-item specificity when the data is entered into HCRIS.

Comment: One commenter commissioned a study to analyze our rate-setting methodology and conducted an independent survey of hospitals that provide HBOT services. Surveys conducted in CYs 2004 and 2005 asked all hospitals providing HBOT services to identify the standard cost center associated with the line on their cost report where the hospital reports costs and charges for HBOT: 206 hospitals, or 44 percent of all hospitals providing HBOT services, responded to one of the surveys. The commenter believes that the survey results are generalizable to all hospitals providing HBOT services because the demographics of those hospitals not responding to the surveys are comparable to those responding to the surveys. For each of the responding hospitals, the survey results provided the standard cost center on each hospital cost report. The study calculated an HBOT CCR for each hospital based on the costs and charges in the associated standard cost center, not just the costs and charges for HBOT. On the basis of these results, the study then generalized an HBOT CCR to the 56 percent of hospitals not responding to the surveys. Specifically, the study simulated HBOT CCRs for each of the non-responding hospitals by applying a methodology that generalized to the non-responding hospitals HBOT-specific findings from similar hospitals. The study results led the commenter to conclude that the proposed median cost of \$93.37 was too low, and that a more accurate estimate of median cost per unit is \$118.94. On the basis of this analysis the commenter requested that CMS use the median cost of \$118.94 to set the payment rate for APC 0659. The commenter noted that APC 0659, where the HCPCS code for HBOT (C1300) is assigned, is unusual as it is one of only a few APCs that contain only one HCPCS code. They concluded that as no averaging of the costs of services occurs, any changes in the median cost for

C1300 in APC 0659 have a particularly great impact on the APC median, as compared to changes in the median cost for a procedure assigned to an APC to which multiple services are assigned.

Response: We receive many submissions of external data from commenters supporting their requests for higher median cost estimates for specific procedures. In many cases, submitted data have not met the minimum standards required for setting payment rates. We have previously provided preferred characteristics of external data to be submitted in comments regarding devices (68 FR 47987). While we have not specifically provided criteria for non-device external data, the subset of our published characteristics that could be applicable to a service such as HBOT include the public availability of the data, its representativeness of a diverse group of hospitals both by location and type, and its identification of its data sources. As part of the CY 2005 study, hospitals gave their consent for their identification and cost report information to be made public, an essential characteristic of data submitted as part of a public comment. The submitted HBOT CY 2005 survey data represent a varied group of 120 hospitals, both by location and type of hospital, as well as 31 percent of the population of total hospitals providing HBOT services according to CY 2004 hospital claims. Inclusion of HBOT survey data from the CY 2004 survey increases the response rate to 44 percent. The survey results provide us with the specific standard cost center in which costs and charges for HBOT are located for the responding hospitals, allowing us to relate the HBOT charge data to cost-to-charge information provided in hospital cost reports for these hospitals. We are appreciative of this study in that it provides us with some useful information as we examine our payment for HBOT services.

These survey results based on this modest response may, therefore, be representative of the 464 hospitals that submitted HBOT claims to the OPSS in CY 2004. However, only a small minority of OPSS hospitals actually provides HBOT services, and there is such significant regional variation in the frequency of billing of hospital outpatient HBOT services that it is unlikely to be fully explained by the different health characteristics of regional populations. We understand that HBOT may also be provided in freestanding centers, and the business decisions around its location may depend upon the local healthcare infrastructure. Therefore, while the

responding hospitals may be similar to the non-responding hospitals with respect to hospital category and geographic location, we are not confident that these characteristics alone signify that the minority of responding hospitals is truly reflective of the relatively small number of OPSS providers billing for HBOT. In addition, we are not certain that comparability of hospitals with respect to their category and geographic location is related to individual hospital decisions about where to include HBOT costs and charges on their Medicare cost reports. Therefore, we are not convinced that it would be appropriate to generalize these HBOT cost center findings to non-responding hospitals to calculate an adjusted payment rate for HBOT.

In addition to our concern about generalizability based on the methodology discussed above, we have several additional reservations about employing the approach recommended by the commenter without the benefit of additional comment from other parties. First, employing this approach may establish an important precedent, which may well be cited by other commenters concerned with the median costs of other services. The OPSS is a prospective payment system that relies upon the coherent grouping of services that share clinical as well as resource utilization characteristics and the packaging of many ancillary services to determine payments. We are concerned that differentially employing methods that depend on additional external collection of information from hospitals may have unintended and potentially negative consequences in a payment system based on averages and relative values. It stands to reason that, as in the case of HBOT, commenters will only submit special surveys and proposals to refine rate-setting when they have at least a strong reason to believe that such customized methods will increase the rates for the specific services in which they are interested. In a budget-neutral payment system based on relative weights, this poses the risk that using this specific external information for select services will actually distort the process of establishing the relative weights in favor of some services but to the disadvantage of other services where such information is not available or not as potentially influential based on the APC assignments of those services. In a relative system such as the OPSS, it may be more important to employ a consistent set of data than to adopt specially "enhanced" data and methods for some services, but not for all services generally. Indeed, a consistent data set

may be more likely to yield accurate relative values than a mixed data set consisting of both values calculated from hospital claims data and values determined by enhanced methods.

Lastly, our capacity to review, evaluate, and adapt special approaches to increase payment levels for individual services in the OPSS is necessarily limited. Based on all of our concerns previously discussed, it is consequently important that we obtain some idea of the extent of other possible requests for use of special methods and non-claims based data to increase payment levels for particular services or groups of services before setting such a precedent for one specific OPSS service, where there appear to be no pressing access concerns based on our OPSS payment rates to date. Our hospital claims data reveal steadily increasing frequencies of HBOT claims, from 101,843 services in CY 2002, to 188,604 services in CY 2003, and once again to 242,558 services in CY 2004. This more than doubling of HBOT services in hospital outpatient departments over a 2-year time period indicates that Medicare beneficiaries are unlikely to be experiencing difficulty in accessing medically necessary HBOT services in the context of the OPSS payment rates for HBOT.

Before we engage in further rulemaking, we therefore specifically invite input on other situations where special approaches may be appropriate and where high quality external data might be made available. We are interested in the possible merits of these other approaches and in potential criteria that we might use to assess when a special methodology should be employed. We believe these comments can help us to develop options for consideration for the CY 2007 OPSS update. In the meantime, we intend to continue our efforts to improve the precision of the OPSS relative weights by increasing our use of multiple procedure claims and refining our cost estimation process.

While we solicit additional public comment on this subject matter, for CY 2006 rate-setting we are finalizing our proposal to recalculate a "per unit" median cost for HCPCS code C1300 using only multiple units or multiple occurrences of HBOT and each hospital's overall CCR, which is the same methodology we used for setting the CY 2005 payment rate for HBOT. Excluding claims with only one unit of HBOT, we used a total of 47,101 claims to calculate the final median cost for APC 0659 for CY 2006. Applying the methodology described above, we are setting the final payment rate for APC

0659 based on a median cost of \$90.09 for CY 2006.

Comment: One commenter pointed out that they had difficulty replicating CMS's median cost estimate, in part because the public dataset that we make available included cost data calculated with the respiratory therapy CCR, that the calculation of the "overall CCR" was not sufficiently defined in regulations to be replicated, and that using the cost centers marked with a "Y" on the "Revenue Code to Cost Center Crosswalk Description" did not yield an overall CCR comparable to the one that we used.

Response: We acknowledge the commenter's concern regarding the accessibility and quality of data available to replicate CMS's median cost calculations. While we believe that we have fulfilled our public obligation to provide access to data to support public comments, users of the data can sometimes identify improvements. We agree that the overall CCR calculation should be more transparent. We have provided additional information about this calculation both in the final rule under our discussion of APC median calculations and on our Web site. We also agree that we should have placed the hospital specific overall CCR to estimate costs for HBOT on our public use file. We will remedy this for the CY 2007 rulemaking process.

g. Ophthalmology Examinations (APC 0601)

Comment: One commenter, representing eye physicians and surgeons, agreed with our decision to exempt the APC 0235 (Level I Posterior Segment Eye Procedures) from the 2 times rule for CY 2006. The commenter also agreed with our proposal to move several other ophthalmology procedures into higher paying APC groups (CPT codes 65265, 65285, 66220, 67025, 67027, 67036, 67038, 67039, and 67121). See 70 FR 42704, July 25, 2005 for a table including the proposed changes.

However, this commenter disagreed with the proposal to move CPT codes 92004 (eye exam, new patient) and 92014 (eye exam, established patient) from APC 0602 (High Level Clinic Visits) to APC 0601 (Mid Level Clinic Visits). The commenter urged CMS to reconsider this decision and keep these codes in APC 0602.

Response: At its February 2005 meeting, the APC Panel recommended that CMS restructure APCs 0601 and 0602 to eliminate violations of the two times rule. At the time of the proposed rule for CY 2006, the available median cost data for these two codes showed

that the hospital resources for both codes were more homogenous with other services assigned to the mid level clinic visit APC 0601, as compared to services assigned to the high level clinic visit APC 0602. Keeping these codes in APC 0602 for CY 2006 would have resulted in significant overpayments for both codes based on historical hospital claims data.

We now have additional claims data, reflecting more complete median costs for both codes from CY 2004 claims. Upon review of CPT code 92004, its median cost of \$82 based on almost 21,000 single claims is more consistent with the median costs of other services assigned to APC 0602 (\$88), and assigning this code to APC 0602 for CY 2006 would not cause a two times rule violation. We, therefore we will not finalize our CY 2006 proposal to move CPT code 92004 to APC 0601, but instead we will reassign CPT code 92004 back to APC 0602 for CY 2006. However, the median cost of CPT code 92014 (\$67) based on nearly 100,000 single claims remains more consistent with the median cost of APC 0601 (\$60). Based on OPSS hospital claims data, hospitals are consistently reporting higher costs for comprehensive eye exams for new patients in comparison with comprehensive eye exams for established patients. These differences in costs likely result from the additional hospital resources required to provide eye exams to new patients, in keeping with current clinical practice. To return CPT code 92014 to APC 0602 for CY 2006 would significantly overpay comprehensive eye examinations for established patients. We therefore finalize our CY 2006 proposal to assign CPT code 92014 to APC 0601.

h. Pathology Services

Comment: One commenter supported the proposed status indicator of B for HCPCS codes D0472–D0999 because the commenter indicated that providers should bill the appropriate CPT code in place of these codes. The commenter urged CMS to require its contractors to deny claims for HCPCS codes D0472–D0999.

Response: We agree that these HCPCS codes duplicate existing CPT codes and therefore have designated them as not payable or recognized under OPSS. As a practical matter, this change in status indicator has little or no impact on providers because of this entire code series, in all of CY 2004, only 3 units of HCPCS code D0999 were billed by hospitals under OPSS. This CY 2006 final rule with comment period applies to payments under the OPSS and a comment that we should deny claims

for these codes submitted by all other providers in all other settings is outside the scope of this final rule.

Comment: One commenter objected to payment of CPT code 86586 under the OPSS and asked that we place it on the clinical laboratory fee schedule for CY 2006 because currently, the only source of payment is under the OPSS and therefore independent laboratories cannot be paid for it.

Response: We agree with this comment and we will pay for this code under the clinical lab fee schedule in CY 2006. This code will therefore not be paid under the OPSS in 2006.

Comment: One commenter objected to payment being made under the OPSS for CPT codes 80500–80502 and 88187–88189, which are for physician interpretation and report services. The commenter asked that we change their status indicators to “M” so that the codes would not be billable to a fiscal intermediary nor payable under the OPSS. The commenter believed that these services should only be paid to physicians on claims submitted by carriers.

Response: These services currently have status indicator “X” and are separately paid under OPSS. We believe that payment to hospitals is appropriate because of the resources hospitals furnish for the physician to be able to perform these services in a hospital (that is, space, computer, office supplies, medical records system).

i. Photodynamic Therapy of the Skin (APC 0013)

Comment: One commenter supported the proposed move of CPT code 96567 (Photodynamic Therapy of the Skin) from APC 0013, with a proposed payment rate of \$66, to APC 0016 with a proposed payment rate of \$153. The commenter also expressed appreciation that the drug used with this procedure (HCPCS code J7308) is paid separately and not bundled into the payment for the procedure. The commenter asked that CMS continue to monitor the median costs reported by hospitals so that Medicare beneficiaries may continue to have access to this procedure and the drug associated with the procedure.

Response: We appreciate the thoughtful comments submitted by this pharmaceutical manufacturer. We will finalize the placement of CPT code 96567 in APC 0016 as proposed. As always, we will continue to monitor claims data submitted by hospitals to ensure appropriate payment for all procedures.

j. Wound Care

As stated in the July 25, 2005 proposed rule (70 FR 42692), based upon a recommendation from the APC Panel we referred CPT code 97602 (non-selective wound care) for MPFS evaluation of its bundled status in relation to services provided under the OPSS. In the proposed rule for CY 2006, we assigned CPT code 97602 a status indicator of “A,” meaning that while it was not payable under the OPSS, it was payable under a fee schedule other than the OPSS, specifically the MPFS. We explained that, under the MPFS, the nonselective wound care services described by CPT code 97602 are “bundled” into the selective wound care debridement codes (CPT codes 97597 and 97598). Furthermore, under the MPFS, a separate payment is never made for “bundled” services and, because of this designation, the provider does not receive separate payment for furnishing non-selective wound care services described by CPT code 97602.

We received several public comments concerning our proposed treatment of CPT code 97602 under the OPSS.

Comment: Several commenters objected to our proposal to maintain a status indicator of “A” for CPT code 97602, which does not allow for separate payment under the OPSS. These commenters contended that CMS’ recognition of this code only under the MPFS as a bundled service is equivalent to CMS asking hospitals to furnish but not charge for this service. They asserted that our decision not to pay for this service under the OPSS is based on a misclassification of this code as an “always therapy” service. They further explained that registered nurses, as opposed to physical therapists, routinely perform non-selective wound care services in the hospital outpatient setting. These commenters urged CMS to acknowledge non-selective wound care as meeting the definition of covered outpatient therapeutic services under the OPSS. Two commenters requested that we assign the newly proposed status indicator “Q” to CPT code 97602 so that separate payment can be made under the OPSS when this is the only payable service provided under the OPSS. These two commenters also suggested that we pay this service at the same payment rate as services assigned to APC 0600 (Low Level Clinic Visits).

Another commenter strongly recommended that CMS also review our status indicator assignment of “A” to CPT codes 97605 (Negative pressure wound therapy; total wound(s) surface area less than or equal to 50 sq. cm.) and 97606 (Negative pressure wound

therapy; total wound(s) surface area greater than 50 sq. cm.), in addition to CPT code 97602 as mentioned by other commenters and discussed above. The commenter urged that we pay separately for these services under the OPSS, emphasizing that these codes represent comprehensive wound care management and are typically not performed with any other service. Furthermore, the commenter objected to our designation of CPT codes 97602, 97605, and 97606 as “always therapy” services, contending that these services are often performed by registered nurses and should be classified as “sometimes therapy” services and assigned a status indicator of “S” which pays separately under the OPSS. Finally, this commenter recommended that we assign CPT codes 97602, 97605, and 97606 to New Technology APC 1502 (Level II \$50–\$100) with a payment rate of \$75 for CY 2006 until we can collect hospital claims data to aid us in assigning these services to a clinical APC based on hospital median costs.

Response: We thank the commenters for their views on the classification and payment status of wound care services under the OPSS. Pursuant to a congressional mandate (Balanced Budget Act of 1997, Pub. L. 105–33) to pay for all therapy services under one prospective payment system, as provided under section 1834(k)(5) of the Act, we created a therapy code list to identify and track outpatient therapy services paid under the MPFS. We provide this list of therapy codes along with their respective designation in the Medicare Claims Processing Manual Pub. 100–04, section 20. We define an “always therapy” service as a service that must be performed by a qualified therapist under a certified therapy plan of care, and a “sometimes therapy” service as a service that may be performed by a non-therapist outside of a certified therapy plan of care. As recommended by the commenters, we have carefully reviewed our designation of CPT codes 97602, 97605, and 97606 as “always therapy” codes and our assignment of payment status indicator “A” to these codes under the OPSS. In light of the comments, we have also reexamined our classification of CPT codes 97597 (selective wound care; total wound(s) surface area less than or equal to 20 sq. cm.) and 97598 (selective wound care; total wound(s) surface area greater than 20 sq. cm.) as “sometimes therapy” codes with respect to payment under the OPSS. The past implications of designating CPT codes 97602, 97605, and 97606 as “always therapy” services, in addition to assigning these codes a

status indicator of “A” under the OPSS indicating they were to be paid off the MPFS, were that hospitals may have been unable to bill and be paid for these services when they were provided as non-therapy in the hospital outpatient setting. When some of these OPSS services were packaged under the MPFS, hospitals received no separate payment, and when other services were paid off the MPFS, the services were required to meet the criteria for therapy services. However, this requirement for payment to hospitals only as therapy services was inconsistent with Medicare’s designation of CPT codes 97597 and 97598 as “sometimes therapy” services, that could be appropriately provided either as therapy services or as non-therapy services. Therefore, for CY 2006, we are reclassifying CPT codes 97602, 97605, and 97606 as “sometimes therapy” services that may be appropriately provided either as therapy or non-therapy services, as well as maintaining our designation of CPT codes 97597 and 97598 as “sometimes therapy” services.

In order to pay hospitals accurately when delivering these “sometimes therapy” services independent of a therapy plan of care, we are establishing payment rates for CPT codes 97597, 97598, 97602, 97605, and 97606 under the OPSS when performed as non-therapy services in the hospital outpatient setting. To further clarify, hospitals will receive separate payment under the OPSS when they bill for wound care services described by CPT codes 97597, 97598, 97602, 97605, and 97606 that are furnished to hospital outpatients by non-therapists independent of a therapy plan of care. In contrast, when such services are performed by a qualified therapist under an approved therapy plan of care, providers should attach an appropriate therapy modifier (that is, GP for physical therapy, GO for occupational therapy, and GN for speech-language pathology) and/or report their charges under a therapy revenue code (that is, 420, 430, or 440) to receive payment under the MPFS. The OCE logic will either assign these services to the appropriate APC for payment under the OPSS if the services are non-therapy, or will direct contractors to the MPFS established payment rates if the services are identified on hospital claims with a therapy modifier or therapy revenue code as therapy.

Under the OPSS, we considered several options for determining the APC placement of CPT codes 97597, 97598, 97602, 97605, and 97606. As two commenters suggested, we considered placing these codes in APC 0600 (Low

Level Clinic Visits); however, we concluded that these services do not share similar enough characteristics in terms of clinical homogeneity and resource requirements to other services assigned to APC 0600. In particular, specialized supplies are likely necessary for the procedures, unlike many of the supplies used in services assigned to APC 0600. Likewise, we also considered one commenter’s recommendation to assign CPT codes 97597, 97598, 97602, 97605, and 97606 to New Technology APC 1502 with a payment rate of \$75. However, because we do not consider wound care services to be appropriately described by a new technology designation under the OPSS, nor do we expect the resource intensity of these services to approach \$75, we are not assigning these services to New Technology APC 1502. Instead, we sought to place these codes in clinical APCs with like services sharing similar resource requirements. Therefore, for CY 2006, we are assigning CPT code 97602 to APC 0340 (Minor Ancillary Procedures) because we consider the resource requirements of this service to be similar to the hospital resources necessary for many of the other minor hospital procedures assigned to this APC. While it may be that our CY 2004 hospital claims data may not reflect all claims for services that could have been described by CPT code 97602 because some hospitals may have been billing for an evaluation and management service if nonselective wound care was the only procedure provided on a day, we note that based on almost 75,000 single claims the median cost of \$42 for CPT code 97602 is very consistent with the CY 2006 median cost of \$36 for APC 0340. In addition, we are assigning CPT codes 97597 and 97605 to APC 0012 (Level I Debridement and Destruction), and CPT codes 97598 and 97606 to APC 0013 (Level II Debridement and Destruction) because we consider these services to closely resemble both the clinical characteristics and resource requirements of the other debridement services assigned to these APCs. We have listed these five codes in Addendum B with status indicator “X” for CPT code 97602 and status indicator “T” for CPT codes 97597, 97598, 97605, and 97606, along with their individual APC assignments to indicate their payment rates in common hospital outpatient circumstances where the services are provided as non-therapy. If a claim indicates, as described above, that the services are provided as therapy, the claim for such services will be paid under the MPFS.

When hospitals provide wound care services, they should bill the most appropriate CPT codes to describe those services. Hospitals should not bill for an evaluation and management service along with the wound care service unless a significant, separately identifiable evaluation and management service, correctly identified with modifier – 25 on the claim, was also provided to the patient during the same encounter. Lastly, under the OPPS we consider payment for nonselective wound care to always be included in payment for selective wound care or negative pressure wound therapy if both services are provided at the same anatomic site in one encounter. Therefore, hospitals should not bill for both services when nonselective wound care is provided with selective wound care or negative pressure wound therapy at the same anatomic site in a single encounter. Hospitals would appropriately use the – 59 modifier to indicate nonselective and selective wound care or negative pressure wound therapy services provided in a single encounter at different anatomic sites.

IV. Payment Changes for Devices

A. Device-Dependent APCs

Device-dependent APCs are populated by HCPCS codes that usually, but not always, require that a device be implanted or used to perform the procedure. For the CY 2002 OPPS, we used external data, in part, to establish the device-dependent APC medians used for weight setting. At that time, many devices were eligible for pass-through payment. For the CY 2002 OPPS, we estimated that the total amount of pass-through payments would far exceed the limit imposed by statute. To reduce the amount of a pro rata adjustment to all pass-through items, we packaged 75 percent of the cost of the devices, using external data furnished by commenters on the August 24, 2001 proposed rule and information furnished on applications for pass-through payment, into the median costs for the device-dependent APCs associated with these pass-through devices. The remaining 25 percent of the cost was considered to be pass-through payment.

In the CY 2003 OPPS, we determined APC medians for device-dependent APCs using a three-pronged approach. First, we used only claims with device codes on the claim to set the medians for these APCs. Second, we used external data, in part, to set the medians for selected device-dependent APCs by blending that external data with claims data to establish the APC medians.

Finally, we also adjusted the median for any APC (whether device-dependent or not) that declined more than 15 percent. In addition, in the CY 2003 OPPS we deleted the device codes (“C” codes) from the HCPCS file in the belief that hospitals would include the charges for the devices on their claims, notwithstanding the absence of specific codes for devices used.

In the CY 2004 OPPS, we used only claims containing device codes to set the medians for device-dependent APCs and again used external data in a 50–50 blend with claims data to adjust medians for a few device-dependent codes when it appeared that the adjustments were important to ensure access to care. However, hospital device code reporting was optional.

In the CY 2005 OPPS, which was based on CY 2003 claims data, there were no device codes on the claims and, therefore, we could not use device-coded claims in median calculations as a proxy for completeness of the coding and charges on the claims. For the CY 2005 OPPS, we adjusted device-dependent APC medians for those device-dependent APCs for which the CY 2005 OPPS payment median was less than 95 percent of the CY 2004 OPPS payment median. In these cases, the CY 2005 OPPS payment median was adjusted to 95 percent of the CY 2004 OPPS payment median. We also reinstated the device codes and made the use of the device codes mandatory where an appropriate code exists to describe a device utilized in a procedure and also implemented HCPCS code edits to facilitate complete reporting of the charges for the devices used in the procedures assigned to the device-dependent APCs.

1. Public Comments and Our Responses on the November 15, 2004 OPPS Final Rule With Comment Period

We solicited public comments concerning the methodology set forth in our CY 2005 OPPS final rule with comment period (November 15, 2004, 69 FR 65681). A summary of the comments we received and our responses follow:

Comment: One commenter asked that CMS implement device edits other than those included in Table 19 of the November 15, 2004 final rule with comment period in April 2005. The commenter asked that CMS add the following APCs to the list of device-dependent APCs and implement device editing for them using the specific device codes provided by the commenter: APC 0088 (Thrombectomy), APC 0141 (Level I Upper GI Procedures), APC 0151 (Endoscopic

Retrograde Cholangio-Pancreatography), APC 0154 (Hernia/Hydrocele Procedures), APC 0187 (Miscellaneous Placement/Repositioning), APC 0315 (Level II Implantation of Neurostimulator), APC 0415 (Level II Endoscopy Lower Airway), APC 0416 (Level I Intravascular and Intracardiac Ultrasound and Flow Reserve), and APC 0676 (Level II Thrombolysis and Thrombectomy).

Response: We implemented the device edits for device-dependent APCs in two phases for CY 2005. Those identified in Table 19 of the November 15, 2004 final rule with comment period (69 FR 65763) were implemented effective for services furnished April 1, 2005, and later. The remaining edits for device-dependent APCs were implemented effective for services furnished October 1, 2005, and later. We implemented the edits in two phases so that we could ensure that any systems issues that might arise with implementation of the first set of edits would be resolved before we implemented the remainder of the edits. We limited the edits we implemented to those for services included in the list of device-dependent APCs that we posted on the CMS Web site for public review to minimize the possibility of unintended claims processing problems. At this time, we have not expanded the scope of device-dependent APCs or the scope of the edits because of concerns raised by hospitals regarding the administrative burden that edits impose on hospitals. We will evaluate the impact of the edits on hospitals and on our claims data before we consider expanding the scope of the edits to other services such as those suggested by the commenter.

Comment: One commenter recommended that device codes C1750 (Cath, hemodialysis, long-term) and C1752 (Cath, hemodialysis, short-term) be allowed when billing for services using CPT codes 36557 (Insert tunneled cv cath), 36558 (Insert tunneled cv cath), and 36581 (Replace tunneled cv cath). The commenter further recommended that CMS allow the use of device code C1898 (Lead, pmkr, other than trans) when billing for services using CPT codes 33211 (Insertion of heart electrode), 33216 (Insert lead pace-defib, one), and 33217 (Insert lead pace-defib, dual).

Response: We agree with the commenter's recommendations and made the changes when the edits were implemented in the two phases for CY 2005 discussed above in response to the preceding comment.

Comment: One commenter recommended that device codes for

brachytherapy needles, catheters, and sources be required when providers bill for the following CPT codes for brachytherapy application: 77761, 77762, 77763, 77776, 77777, 77778, 77781, 77782, 77783, and 77784.

Numerous other commenters strongly opposed device editing for brachytherapy procedures due to the burden that it would impose on them.

Response: We did not require these edits for CY 2005. The needles and catheters that are placed for the application of brachytherapy sources are not placed when the procedures cited are performed but are generally placed in procedures that are coded separately. In the case of application of seeds for prostate brachytherapy (CPT code 77778), the needles or catheters are placed when CPT code 55859 (Percut/needle insert, pros) is performed and not as part of CPT code 77778.

Moreover, for CY 2005, sources of brachytherapy are billed and paid separately on the basis of charges reduced to cost and, therefore, are irrelevant to the calculation of a median cost for the application of the brachytherapy sources because, unlike other devices, the cost of brachytherapy sources is not packaged into the payment for the service in which the sources are required.

2. CY 2006 Proposal, APC Panel Recommendations, and Responses to Public Comments Received

In the CY 2006 OPSS proposed rule, we proposed to base the OPSS device-dependent APC medians on CY 2004 claims, the most current data available. In CY 2004, the use of device codes was optional. Thus, for the CY 2006 OPSS proposed rule, we proposed to calculate median costs for these APCs using all single bills without regard to whether there was a device code reported on the claim. We calculated median costs for this set of APCs using the standard median calculation methodology. This methodology uses single procedure claims to set the median costs for the APC. We then compared these unadjusted median costs to the adjusted median costs that we used to set the payment rates for the CY 2005 OPSS. We found that 21 APCs experienced increases in median cost compared to the CY 2005 OPSS adjusted median costs, 1 APC median was unchanged, 16 APCs experienced decreases in median costs, and 8 APCs were proposed to be reconfigured in such a way that no valid comparison was possible. Table 15 published in the CY 2005 OPSS proposed rule showed the comparison of these median costs (70 FR 42714).

As we stated previously, in CY 2004, CMS reissued HCPCS codes for devices and asked hospitals to voluntarily code devices utilized to provide services. As part of our development of the medians for this final rule with comment period, we examined CY 2004 claims that contained device codes that met our device edits, as posted on the OPSS Web site at <http://www.cms.hhs.gov/providers/hopps/default.asp>. We found that, in many cases, the number of claims that passed the device edits was quite small. To use these claims to set medians for the CY 2006 OPSS would mean that the medians for some of these APCs would be set based on very small numbers of claims, reflecting the fact that, in CY 2004 when device coding was optional under the OPSS, relatively few hospitals chose to code for devices. Therefore, we did not propose to use only claims that passed the device edits to set the median costs for device-dependent APCs for the CY 2006 OPSS.

When we considered whether to base the weights for these APCs on the unadjusted median costs, we found that, for 10 of the 38 APCs for which the APC composition is stable, basing the payment weight on the unadjusted median cost would result in a reduction of more than 15 percent in the median cost for the CY 2006 OPSS compared to the CY 2005 OPSS.

In the CY 2006 proposed rule, we stated that we fully expect to use the unadjusted median costs for device-dependent APCs as the basis of their payment weights for the CY 2007 OPSS because device coding is required for CY 2005 and device editing is being implemented in CY 2005, so that all CY 2005 claims should reflect the costs of devices used to provide services. Nevertheless, we recognized that a payment reduction of more than 15 percent from the CY 2005 OPSS to the CY 2006 OPSS may be problematic for hospitals that provide the services contained in these APCs. Therefore, for the CY 2006 OPSS, we proposed to adjust the median costs for the device-dependent APCs listed in Table 15 of the CY 2006 proposed rule (70 FR 42714) for which comparisons with prior years are valid to the higher of the CY 2006 unadjusted APC median or 85 percent of the adjusted median on which payment was based for the CY 2005 OPSS. We stated that we viewed this as a transitional step from the adjusted medians of past years to the use of unadjusted medians based solely on hospital claims data with device codes in future years.

As stated in the proposed rule (70 FR 42714), we expect that CY 2006 will be the last year in which we would make

an across-the-board adjustment to the median costs for these device-dependent APCs based on comparisons to the prior year's payment medians. We believe that mandatory reporting of device codes for services furnished in CY 2005, combined with the editing of claims for the presence of device codes, where such codes are appropriate, would result in claims data that more fully reflect the relative costs of these services and that across-the-board adjustments to median costs for these APCs would no longer be appropriate.

a. APC Panel Recommendations

In the CY 2005 proposed rule, we proposed to treat APCs 0107 and 0108 in the same manner as we proposed to treat other device-dependent APCs. We note that at its August 2005 meeting, the APC Panel recommended that CMS set the payment rates for cardioverter defibrillator APCs (APCs 0107 and 0108) at the CY 2005 payment rates plus the full market basket increase for CY 2006. We did not accept this recommendation because to do so would greatly contradict our stated policy of applying a single standardized methodology wherever possible to establish APC payment amounts that are appropriately relative to one another.

The APC Panel also recommended that CMS add APC 0416 (Level I Intravascular and Intracardiac Ultrasound and Flow Reserve) and, in particular, CPT code 37250 (Iv vs first vessel add-on) to the list of device-dependent APCs and require device editing for CPT code 37250.

We did not accept this recommendation. Many services that require devices are not included in the set of APCs to which we have given special attention as they came off pass-through status. We package the costs of relatively high cost devices into the median costs for the device-dependent APCs, and the absence of charges for these devices on claims is the reason for special treatment of the APCs in the past. The absence of charges also gives rise to our application of device editing to the services in the device-dependent APCs so that our hospital claims data are more complete for these specific services. At this time, we see no compelling reason to expand this list of device-dependent APCs. This is particularly true given that we expect that, for CY 2007, these APCs will not receive special attention as a class. However, we note that we will make case-by-case decisions regarding the adjustment of median costs where we believe that it is appropriate.

b. Public Comments Received and Our Responses

We received numerous public comments concerning our proposal. Following is a summary of those comments and our responses:

(1) Adjustment of Median Costs

Comment: Some commenters supported the proposed median cost adjustment for device-dependent APCs and supported the use of claims data to set the relative weights for the CY 2006 OPPS. However, many commenters stated that the proposed payments are inadequate to compensate hospitals for the full costs of the devices and procedures for many APCs, including, but not limited to, implantation of cochlear implants, neurostimulators, urologic prosthetics, and cardioverter defibrillators.

Commenters presented a variety of requests for revised median costs or revised payment rates. Many commenters asked that CMS accept and use external data in place of claims data and requested that CMS accept and use confidential and proprietary information that cannot be made public. Other commenters objected to the use of external data to set median costs that are the basis of the rates and to the use of any proprietary or confidential information that cannot be shared with the public. Some commenters asked CMS to substitute specific amounts they identified for the device portion of the median cost, for the full median cost, or for the payment amount for the APCs of interest to them. Commenters urged CMS to restrict the claims used to calculate the median costs for device-dependent APCs to those with specified diagnoses, or to those with specified HCPCS device codes, or with specified revenue code charges only if the charges associated with those codes exceeded amounts they recommended. Some commenters asked that CMS set the CY 2006 median cost at the CY 2005 adjusted median with an inflation adjustment for the full market basket increase for CY 2006. Other commenters asked CMS to adjust the medians to no less than 95 percent of the CY 2005 OPPS adjusted medians for all APCs, as well as for device-dependent APCs. These commenters stated that a transitional step to 85 percent was too great to prevent disruption to care.

Some commenters asked CMS to disregard requests to set the payment rates at 100 percent of the CY 2005 OPPS payment rates plus inflation for neurostimulator and cardioverter defibrillator APCs, which they stated have been given preferential treatment

over other device-dependent APCs in past years. These commenters requested that the same adjustment policy apply to all device-dependent APCs. Some commenters asked CMS to use only claims that contained appropriate device codes in the calculations of the median costs because the presence of the device code and a charge for the device are more likely to produce the best possible estimate of relative cost for the service. All commenters who addressed this general issue of device-dependent APCs supported an adjustment of some type to median costs for these high cost APCs.

Response: After considering all of the comments received, we have set the median costs for device-dependent APCs for CY 2006 at the highest of: The median cost of all single bills; the median cost calculated using only claims that contain pertinent device codes and for which the device cost is greater than \$1; or 90 percent of the payment median that was used to set the CY 2005 payment rates. We set 90 percent of the CY 2005 payment median as a floor in consideration of comments that stated that a 15-percent reduction from the CY 2005 payment median was too large of a transitional step. We also incorporated, as part of our methodology, the recommendation to base payment on medians that were calculated using only claims that passed the device edits. We believe that this policy provides a reasonable transition to full use of claims data in CY 2007, while better moderating the amount of decline from the CY 2005 OPPS payment rates. Table 16 of this final rule with comment period contains the CY 2005 payment median, the CY 2006 unadjusted single bill median, the amount represented by 90 percent of the CY 2005 payment median, the CY 2006 median calculated using only claims containing appropriate devices, and the CY 2006 adjusted median on which payment is based. As we discussed, in the CY 2006 proposed rule, we did not adjust the medians for APC 0122 (Level II Tube Changes and Repositioning), APC 0427 (Level III Tube Changes and Repositioning) APC 0166 (Level I Urethral Procedures), APC 0168 (Level II Urethral Procedures), APC 0621 (Level I Vascular Access Procedures), APC 0622 (Level II Vascular Access Procedures), and APC 0623 (Level III Vascular Access Procedures) because of substantial migration of HCPCS codes within these APCs.

We did not inflate the CY 2005 median cost or payment rate by the market basket, or substitute specific amounts derived from external studies or other external sources, as requested

by commenters, because doing so would contradict our stated policy of using claims data developed from a single source, and applying a single standardized methodology wherever possible to establish payment amounts that are appropriately relative to one another. The Medicare claims database we use contains all claims for all services paid under the OPPS for all Medicare patients (other than those in Medicare managed care programs). As such, we believe that it is the best and most reliable source for standardized utilization and cost data in the Nation with regard to Medicare outpatient hospital care. Because the OPPS is a relative weight system, we believe it is important that, to the maximum extent possible, the relative weights be calculated using standardized processes and a standardized base of claims data.

(2) Effects of Inconsistent Markup of Charges

Comment: Some commenters objected to the use of claims data because they believed the payments that result are less than the cost of the procedures and the devices due to the high markup of low cost items and services and the low markup of high cost items and services. They indicated that the use of CCRs applied to hospital charges results in median costs that are inadequate for high cost devices because the markup on high cost devices is insufficient to result in the correct costs for the devices after application of CCRs calculated from all services in the applicable departments. Commenters offered a variety of recommendations for dealing with this phenomenon that they identified as "charge compression." They suggested that CMS establish a sample of hospitals from which data would be collected for use in place of claims data or to validate the data derived from claims. They also suggested that CMS establish a new cost center solely for high cost devices and calculate an appropriate CCR for this new specialized cost center. Some of the commenters recommended that CMS conduct a study of the data of volunteer hospitals to determine an appropriate CCR for high cost devices that would be applied to all hospitals. They noted that CMS could adjust claims-based medians by substituting proprietary confidential cost data for the device portion of the median costs. They suggested that CMS could also calculate a charge decompression factor that would estimate the markup function from charges on claims and device acquisition cost data and incorporate these data into setting two CCRs: one for high cost devices and one for low cost

devices, which would be used in place of actual hospital CCRs. Lastly, the commenters also suggested that CMS could create a broad stakeholder panel to address this issue.

Other commenters stated that the use of the hospital's average CCR results in computed costs and relative weights that are more or less than specific actual costs, but that this averaging is appropriate and desirable in a PPS and should continue. They stated that the alternative is a micromanaged payment system that resembles the system that Congress discarded in favor of a bundled PPS. The commenters urged CMS to remain committed to the principles of a PPS and the use of averaging, rather than seeking to pay the actual cost for one element of costs at the expense of all other items and services, which they stated would occur as a result of the application of budget neutrality adjustments required by law. They reiterated that many factors go into the decision of what services to furnish in a hospital, and that the payment for a specific service is only one of the applicable factors.

Response: We agree that the use of the hospital's average CCR results in computed costs and relative weights that may be more or less than specific actual costs and that this averaging is appropriate and desirable in a PPS and should continue. One of the principal purposes of determining median costs for weight setting in a budget neutral payment system is to determine the appropriate relativity in resource use among services, so that the fixed amount of money can be fairly and equitably distributed among hospitals based on case-mix. We note that, in general, the median costs derived from this process may not represent the actual acquisition costs of the services being furnished, nor will they ever represent acquisition costs. They are estimated relative costs that are converted to relative weights, scaled for budget neutrality, and then multiplied by a conversion factor to result in payments that, as we have previously discussed, were designed in such a manner that they are not expected to pay the full costs of the services.

(3) Effects of Multiple Procedure Reduction

Comment: Some commenters stated that all device-dependent APCs should be assigned a status indicator of "S" (significant service, separately payable) because none of the procedures assigned to these APCs should ever be reduced when performed with another procedure. Commenters stated that much of the cost of these procedures is

a function of the cost of the device, and that the device cost remains unchanged whether the procedure in which it is required is performed with other surgical procedures or not. Commenters specifically objected to the movement of CPT code 33225 (L ventric pacing lead add-on) from New Technology APC 1525 in CY 2005 where it has a status indicator of "S" to APC 0418 (Insertion of Left Ventricular Pacing Elect) for CY 2006, in which it was proposed to have status indicator "T," because the payment for the procedure, when performed in addition to another procedure, would be reduced by 50 percent although most of the cost of the procedure is in the device, the cost of which remains fixed. Commenters also specifically objected to the assignment of status indicator "T" to APCs 0223 and 0227 because it results in a reduction in payment when services to place a catheter and implant an infusion pump are provided in the same session.

Response: We decide on a service-by-service basis whether the assignment of a status indicator "S" or "T" is appropriate. In the case of most device-dependent APCs, the service in question is never reduced because it is always the procedure with the highest payment rate (for example, cochlear implants and insertion of a cardioverter defibrillator (ICD)), and the assignment of a status indicator "T" is necessary so that the lower cost services are reduced in payment to reflect the efficiencies that occur when they are done at the same time as the highest paid procedure.

In the case of CPT code 33225 for insertion of a left ventricular pacing electrode at time of insertion of an ICD, we believe that payment at 50 percent of the payment rate for APC 0418 is appropriate for this add-on procedure based on the information furnished to us by manufacturers, hospitals, and physicians who are familiar with the service. This procedure is always done as an adjunct to insertion of a cardioverter defibrillator and a significant portion of the cost of the procedure is in the extension of operating room time and not in the cost of the device, drugs, or supplies needed to furnish the service. While CPT code 33225 is an add-on code, we discuss our ongoing exploration of possible solutions to the data challenges in developing appropriate payment rates for add-on codes in the data section (section II.A.) of this final rule with comment period. Also assigned to APC 0418 is the stand-alone procedure for insertion of the left ventricular lead, and we believe the add-on lead insertion is appropriately reduced by 50 percent in comparison with the payment rate for

the stand-alone insertion procedure. Therefore, we believe that payment at 50 percent of the amount for APC 0418 to which we proposed to assign CPT code 33225 is appropriate and, as proposed, we have moved CPT code 33225 to APC 0418 with a status indicator of "T."

When a spinal infusion pump is implanted along with an intrathecal or epidural catheter, CPT codes billed likely include those assigned to APCs 0227 and 0223, respectively. The higher paying APC 0227 for implantation of the infusion pump would receive full payment, while the catheter insertion APC 0223 would receive 50 percent of the APC payment because both APCs are assigned "T" status indicators. We believe this reduction is appropriate, as there are some efficiencies when both services are performed in a single session. In addition, we note that the CPT code for the catheter implantation includes the possibility of repositioning in its descriptor, so it is possible that this procedure may not require a new device every time it is performed. Therefore, we believe that the procedures assigned to APCs 0223 and 0227 are appropriately assigned "T" status indicators.

(4) Impact of Proposed Rates on Access to Care

Comment: Some commenters stated that under the proposed payments, Medicare beneficiaries may not get the device-related services they need because Medicare payments would be inadequate to compensate hospitals for their costs, and that hospitals would not furnish the services to Medicare beneficiaries for the rates that Medicare proposed to pay in CY 2006. They stated that hospitals will either cease providing certain services, or they will decide not to furnish them due to low Medicare payment rates.

Response: We share the commenters' concern that beneficiaries have access to all of the care they need, regardless of the type of service. As other commenters have stated, hospitals decide upon the range of services to offer based on a variety of factors, of which Medicare outpatient hospital payment is only one. We believe that the best way to ensure access to care for Medicare beneficiaries is to establish the OPPS using as many claims as possible from all hospitals so that the relative weights on which the payments are based result in the most fair and equitable distribution possible of Medicare's funding for outpatient hospital services.

We note that our regulations at 42 CFR 489.53(a)(2) state that a hospital

risks termination of its Medicare provider agreement if it treats Medicare beneficiaries differently from other similar patients in the hospital.

(5) Addition of Other APCs as Device-Dependent APCs

Comment: Some commenters asked that CMS expand the list of APCs for which medians will be adjusted to include all APCs that require the use of a device. Specifically, they requested that we apply any median adjustment for device-dependent APCs also to APC 0112 (Apheresis, Photopheresis, and Plasmapheresis), APC 0312 (Radioelement Applications), APC 0313 (Brachytherapy), and APC 0651 (Complex Interstitial Radiation Source Application). They asked that CMS set the median for all such APCs that use a device at the CY 2005 OPSS adjusted median after inflating by the full market basket increase for CY 2006. Commenters asked that CMS add APC 0416 Level I Intravascular and Intracardiac Ultrasound and Flow Reserve) and, in particular, CPT code 37250 (Iv us first vessel add-on) to the list of device-dependent APCs and require device editing for CPT code 37250. They stated that this service requires a device, that its APC should be treated like all other device-dependent APCs, and that claims for the service should be returned if they are submitted without the HCPCS code for the device so that the full cost of the device will be included on every claim.

Response: As previously stated in response to the APC Panel's recommendation on a similar issue, many services that require devices are not included in the set of APCs to which we have given special attention as they came off pass-through status. We package the costs of relatively high cost devices into the median costs for the device-dependent APCs, and the absence of charges for these devices on claims is the reason for special treatment of the APCs in the past. The absence of charges also leads to our application of device editing to the services in the device-dependent APCs so that our hospital claims data are more complete for these specific services. At this time, we see no compelling reason to expand this list of device-dependent APCs. This is particularly true given that we expect that, for CY 2007, these APCs will not receive special attention as a class. However, we note that we will make case-by-case decisions regarding the application of edits where appropriate.

(6) Instructions on Reporting Device Charges

Comment: Some commenters asked that CMS educate providers on how to report charges for devices and technologies that do not have HCPCS codes, and that CMS issue explicit instructions regarding consistent use of revenue codes for reporting charges for devices and technologies to ensure that such charges are fully reported on claims.

Response: CMS' instructions regarding the need to report device codes and charges are included in the Internet Only Manual, Claims Processing Manual 100-4, Chapter 4 (CMS Web site: <http://www.cms.hhs.gov/manuals/>). Section 61.1 of that manual provides instructions on the requirement to report the device code and directs providers to the CMS Web site for the most current list of HCPCS codes for devices and for the most recent set of procedure code to device edits. In addition, section 20.5.1 specifies revenue centers that should be used when devices are reported. As always, when devices do not have appropriate HCPCS codes for reporting, hospitals should be sure to include all charges associated with their use on claims for services with which the devices were used.

(7) Application of Wage Index to Device-Dependent APCs Containing Devices

Comment: Some commenters objected to the application of the wage index to an APC into which devices were packaged. They indicated that applying the wage index will continue to further undervalue new technology services. They asked that CMS revise its policy and apply the wage index only to the service portion of the procedure for APCs for which the device cost is more than 80 percent of the total APC payment.

Response: Whether the application of the wage index to 60 percent of the APC payment will raise or reduce the payment for the service depends on the wage index value of the area in which the hospital is located. However, while we do not believe that the application of the wage index underpays new technology items or services, we acknowledge the commenter's request, and we will consider it as we develop our policies for future updates of the OPSS.

(8) Recalls of High Cost Devices

Comment: Some commenters are concerned that claims for items subject

to a recall not be used for claims setting as there is no charge for the device on the claim, and the use of the claim could skew the median cost. These commenters also asked that CMS provide explicit guidance on how to report devices for which the provider incurred no cost due to replacement by the manufacturer under a recall of the device.

Response: The recalls of a significant number of cardioverter defibrillators and pacemakers to which the commenters referred occurred very late in CY 2004 and in CY 2005. Therefore, we believe that they have no effect on the CY 2004 claims used to set the rates for the CY 2006 OPSS. We are aware of the potential impact on data used for ratesetting for the CY 2007 OPSS and are already considering a strategy for ensuring that the CY 2005 claims data we will use for the CY 2007 OPSS will be appropriately reflective of the costs of the devices. We note that one way of doing this is to not use claims that contain device charges of \$1.01 or less in the calculation of the median costs for these APCs. In the July 2005 OPSS instruction, Change Request 3915, dated June 30, 2005, we issued interim instructions regarding how hospitals should report device codes and charges when the device was furnished without cost by the manufacturer under a recall. Specifically, we advised hospitals to report the HCPCS code for the device and a token charge of \$1.01 or less on the line with the device code. Accordingly, we will use the device code and charge combination to find these claims in the CY 2005 data.

For the future, beginning January 1, 2006, hospitals should report modifier "FB" on the claim with the device code (where there is one to report) or with the procedure code (where there is no appropriate device code) to indicate that a device used in the procedure was furnished without cost to the provider and, therefore, is not being charged to Medicare or the beneficiary. The device edits will recognize the modifier and will not return the claim to the provider as incomplete because the device code is not on the claim. CMS will issue instructions regarding use of the modifier in the January 2006 OPSS change request issuance.

(9) Separate Payment for High Cost Devices

Comment: Some commenters asked that we pay separately for high cost devices and recommended that CMS define "high cost" devices as those with a cost greater than 50 percent of the APC payment rate. They indicated that even with device editing, they do not believe

that hospitals will be diligent about reporting all of their services or setting charges that reflect the costs of the devices. They believed that separate payments for high cost devices is the only way to achieve valid cost data for devices and related services.

Response: In general, we believe that packaging the costs of items needed to furnish services into the payments for the services and the assignment of multiple services to a single APC create incentives for efficiency and for the selection of the least costly device that meets the patient's needs. Therefore, for the CY 2006 OPPS, we will continue to package payment for all devices without

pass-through status, and which are not brachytherapy sources, into the payments for the procedures that utilize them. However, we recognize that there may be valid reasons to consider whether it would be appropriate to pay separately for some high cost devices, and we will consider whether there are circumstances in which this may be appropriate in the future.

After carefully reviewing all comments received concerning our proposed median cost adjustment for device-dependent APCs for CY 2006, we have set the medians for device-dependent APCs at the highest of: the median cost of all single bills; the

median cost calculated using only claims that contain pertinent device codes and for which the device cost is greater than \$1; or 90 percent of the payment median that was used to set the CY 2005 payment rates. Table 16 below shows the adjusted median costs for the listed device-dependent APCs for which comparisons with prior years are valid to the highest of the CY 2006 unadjusted APC median, 90 percent of the adjusted median on which payment was based for the CY 2005 OPPS, or the median calculated using only claims that meet the device code edits implemented in CY 2005.

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**Table 16.--Median Cost Adjustments
for Device-Dependent APCs for CY 2006**

| APC | Description | SI | Adjusted Final 2005 OPPS Median | Unadjusted CY 2006 OPPS final rule median | Change from CY 2005 adjust to CY 2006 final unadjust | 90% of CY 2005 payment median | CY 2006 OPPS final rule median w "C" code claims only and device cost >\$1 | CY 2006 final rule total frequency (CY 2004 claims) | Adjusted final CY 2006 median |
|------|---|----|---------------------------------|---|--|-------------------------------|--|---|-------------------------------|
| 0039 | Implantation of Neurostimulator | S | \$12,878.01 | \$9,836.02 | -24% | \$11,590.21 | \$10,296.79 | 1,983 | \$11,590.21 |
| 0040 | Level I Implantation of Neurostimulator Electrodes (lost codes to APC 61 after NPRM) | S | NA | \$3,021.79 | NA | NA | \$2,991.69 | 10,671 | \$3,021.79 |
| 0061 | Level II Implantation of Neurostimulator Electrodes (created after NPRM by taking codes from APCs 40 and 225) | S | NA | \$5,552.67 | NA | NA | \$4,025.40 | 2,370 | \$5,552.67 |
| 0080 | Diagnostic Cardiac Catheterization | T | \$2,123.65 | \$2,160.24 | 2% | | \$2,149.34 | 423,665 | \$2,160.24 |
| 0081 | Non-Coronary Angioplasty or Atherectomy | T | \$1,918.04 | \$1,947.72 | 2% | | \$2,512.59 | 143,106 | \$2,512.59 |
| 0082 | Coronary Atherectomy | T | \$6,035.25 | \$4,531.43 | -25% | \$5,431.72 | \$4,899.36 | 373 | \$5,431.72 |
| 0083 | Coronary Angioplasty and Percutaneous Valvuloplasty | T | \$3,241.85 | \$2,887.41 | -11% | \$2,917.66 | \$3,285.85 | 6,072 | \$3,285.85 |
| 0085 | Level II Electrophysiologic Evaluation | T | \$2,034.82 | \$2,030.08 | 0% | | \$2,033.39 | 22,479 | \$2,033.39 |
| 0086 | Ablate Heart Dysrhythm Focus | T | \$2,637.96 | \$2,499.71 | -5% | | \$2,404.64 | 10,139 | \$2,499.71 |
| 0087 | Cardiac Electrophysiologic Recording/Mapping | T | \$2,180.19 | \$814.47 | -63% | \$1,962.17 | \$1,830.20 | 14,377 | \$1,962.17 |
| 0089 | Insertion/Replacement of Permanent Pacemaker and Electrodes | T | \$6,416.90 | \$6,307.74 | -2% | | \$6,957.99 | 4,808 | \$6,957.99 |
| 0090 | Insertion/Replacement of Pacemaker Pulse Generator | T | \$5,301.99 | \$5,362.17 | 1% | | \$4,904.18 | 6,848 | \$5,362.17 |
| 0104 | Transcatheter Placement of Intracoronary Stents | T | \$4,750.06 | \$4,510.86 | -5% | | \$4,802.39 | 8,870 | \$4,802.39 |
| 0106 | Insertion/Replacement/Repair of Pacemaker and/or Electrodes | T | \$3,229.10 | \$1,834.34 | -43% | \$2,906.19 | \$3,325.21 | 4,301 | \$3,325.21 |
| 0107 | Insertion of Cardioverter-Defibrillator | T | \$18,460.10 | \$14,062.73 | -24% | \$16,614.09 | \$15,772.87 | 9,001 | \$16,614.09 |

| APC | Description | SI | Adjusted Final 2005 OPPS Median | Unadjusted CY 2006 OPPS final rule median | Change from CY 2005 adjust to CY 2006 final unadjust | 90% of CY 2005 payment median | CY 2006 OPPS final rule median w "C" code claims only and device cost >\$1 | CY 2006 final rule total frequency (CY 2004 claims) | Adjusted final CY 2006 median |
|------|--|----|---------------------------------|---|--|-------------------------------|--|---|-------------------------------|
| 0108 | Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads | T | \$24,788.26 | \$18,699.78 | -25% | \$22,309.44 | \$21,487.56 | 6,965 | \$22,309.44 |
| 0115 | Canula/device access procedures | T | \$1,502.71 | \$1,872.60 | 25% | | \$2,198.37 | 11,055 | \$2,198.37 |
| 0202 | Level X Female Reproductive Proc | T | \$2,322.83 | \$2,396.88 | 3% | | \$2,451.09 | 16,353 | \$2,451.09 |
| 0222 | Implantation of Neurological Device | T | \$12,714.60 | \$9,739.50 | -23% | \$11,443.14 | \$10,001.56 | 6,208 | \$11,443.14 |
| 225 | Level III Neurostimulator Electrodes (lost codes to APC 61 after NPRM) | | NA | \$13,794.14 | NA | NA | \$14,912.04 | 1,021 | \$14,912.04 |
| 0227 | Implantation of Drug Infusion Device | T | \$8,806.84 | \$8,131.78 | -8% | | \$9,216.76 | 3,050 | \$9,216.76 |
| 0229 | Transcatheter Placement of Intravascular Shunts | T | \$3,638.52 | \$3,660.15 | 1% | | \$3,943.56 | 51,409 | \$3,943.56 |
| 0259 | Level VI ENT Procedures | T | \$26,006.74 | \$21,236.83 | -18% | \$23,406.07 | \$21,646.15 | 1,078 | \$23,406.07 |
| 0315 | Level II Implantation of Neurostimulator | T | \$20,633.70 | \$12,425.59 | -40% | \$18,570.33 | \$15,190.25 | 388 | \$18,570.33 |
| 0384 | GI Procedures with Stents | T | \$1,585.92 | \$1,262.06 | -20% | \$1,427.33 | \$1,598.84 | 22,357 | \$1,598.84 |
| 0385 | Level I Prosthetic Urological Procedures | S | \$4,080.56 | \$4,384.16 | 7% | | \$3,980.70 | 833 | \$4,384.16 |
| 0386 | Level II Prosthetic Urological Procedures | S | \$6,674.53 | \$7,148.86 | 7% | | \$7,545.49 | 4,982 | \$7,545.49 |
| 0418 | Left ventricular lead | T | \$4,363.37 | \$6,398.41 | 47% | | \$10,067.34 | 5,306 | \$10,067.34 |
| 0425 | Level II Arthroplasty with prosthesis | T | \$5,715.97 | \$6,017.66 | 5% | | \$6,226.13 | 959 | \$6,226.13 |
| 0648 | Breast Reconstruction with Prosthesis | T | \$2,957.76 | \$2,917.03 | -1% | | \$3,182.21 | 1,489 | \$3,182.21 |
| 0652 | Insertion of Intraperitoneal Catheters | T | \$1,626.29 | \$1,704.49 | 5% | | \$1,745.63 | 5,491 | \$1,745.63 |
| 0653 | Vascular Reconstruction/Fistula Repair with Device | T | \$1,644.53 | \$1,805.31 | 10% | | \$2,196.11 | 31,835 | \$2,196.11 |
| 0654 | Insertion/Replacement of a permanent dual chamber pacemaker | T | \$6,170.83 | \$5,908.47 | -4% | | \$6,659.66 | 22,236 | \$6,659.66 |
| 0655 | Insertion/Replacement/Conversion of a permanent dual chamber pacemaker | T | \$7,913.85 | \$7,970.77 | 1% | | \$8,134.94 | 15,112 | \$8,134.94 |
| 0656 | Transcatheter Placement of Intracoronary Drug Eluting Stents | T | \$6,156.14 | \$6,428.89 | 4% | | \$6,370.83 | 22,347 | \$6,428.89 |
| 0670 | Intravenous and Intracardiac Ultrasound | S | \$1,779.08 | \$1,505.28 | -15% | \$1,601.17 | \$1,709.36 | 5,126 | \$1,709.36 |
| 0674 | Prostate Cryoablation | T | \$6,569.33 | \$5,950.05 | -9% | | \$6,620.83 | 2,328 | \$6,620.83 |
| 0680 | Insertion of Patient Activated Event Recorders | S | \$3,744.69 | \$3,765.01 | 1% | | \$4,452.85 | 2,395 | \$4,452.85 |
| 0681 | Knee Arthroplasty | T | \$5,374.98 | \$7,993.50 | 49% | | \$8,052.87 | 728 | \$8,052.87 |

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B. Pass-Through Payments for Devices

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

Section 1833(t)(6)(B)(iii) of the Act requires that, under the OPSS, a category of devices be eligible for transitional pass-through payments for at least 2, but not more than 3 years. This period begins with the first date on which a transitional pass-through payment is made for any medical device that is described by the category. In our November 15, 2004 final rule with comment period (69 FR 65773), we specified three device categories currently in effect that would cease to be eligible for pass-through payment effective January 1, 2006.

The device category codes became effective April 1, 2001, under the provisions of the BIPA. Prior to pass-through device categories, we paid for pass-through devices under the OPSS on a brand-specific basis. All of the initial 97 category codes that were established as of April 1, 2001, have expired; 95 categories expired after CY 2002 and 2 categories expired after CY 2003. All of the categories listed in Table 17, along with their expected expiration dates, were created since we published the criteria and process for creating additional device categories for pass-through payment on November 2, 2001 (66 FR 55850 through 55857). We based the expiration dates for the category codes listed in Table 17 on the date on which a category was first eligible for pass-through payment.

There are three categories for devices that would have been eligible for pass-through payments for at least 2 years as of December 31, 2005. In the November 15, 2004 final rule with comment period, we finalized the December 31, 2005 expiration dates for these three categories—C1814 (Retinal tamponade device, silicone oil), C1818 (Integrated keratoprosthesis), and C1819 (Tissue localization excision device). Each category includes devices for which pass-through payment was first made under the OPSS in CY 2003 or CY 2004.

In the November 1, 2002 final rule, we established a policy for payment of devices included in pass-through categories that are due to expire (67 FR 66763). For CY 2003, we packaged the costs of the devices no longer eligible for pass-through payments into the costs of the procedures with which the devices were billed in CY 2001. Brachytherapy sources for other than

prostate brachytherapy, which are now separately paid in accordance with section 621(b)(2) of Pub. L. 108-173, are an exception to this established policy. For CY 2005, we continued to apply this policy, the same as we did in CYs 2003 and 2004, to categories of devices that expired on December 31, 2004.

2. Proposed and Final Policy for CY 2006

For CY 2006, we proposed to implement the final decision we made in the November 15, 2004 final rule with comment period that finalizes the expiration date for pass-through status for device categories C1814, C1818, and C1819. Therefore, as of January 1, 2006, we will discontinue pass-through payment for C1814, C1818, and C1819. In accordance with our established policy, we proposed to package the costs of the devices assigned to these three categories into the costs of the procedures with which the devices were billed in CY 2004, the year of hospital claims data used for the CY 2006 OPSS update.

We received two public comments concerning the expiration of pass-through payment for these three device categories.

Comment: One commenter recommended that CMS extend the pass-through payment for device category C1819 until December 31, 2006, rather than ending pass-through payment on December 31, 2005. The commenter expressed concern that our median cost data for the procedure codes utilizing a tissue localization excision device do not include the costs attributed to device category C1819, and that the volume of C1819 claims is not sufficient to affect the median costs for CPT codes 19125 (Excision, breast lesion) and 19160 (Removal of breast tissue).

Response: We finalized the pass-through payment for device category code C1819 in the CY 2005 final rule with comment period and responded to a similar comment in that same rule (69 FR 65773). In this CY 2006 final rule with comment period, we are merely implementing that decision effective for services furnished on or after January 1, 2006. Moreover, we believe that the device costs represented by device category code C1819 are found in our median cost data, as we have CY 2004 hospital claims billed with C1819 that have been used to establish CY 2006 payment rates. As the device median cost was only approximately \$67 and

the median cost of APC 0028 (Level I Breast Surgery), where the accompanying procedure CPT codes 19125 and 19160 mentioned in the comment reside, is over \$1,100, we anticipate that the packaging of this device will not limit appropriate access. We note that as usage of this device grows, the device costs may become more prominent contributors to the median costs of procedures utilizing the device, as long as hospitals report the device code and its associated charges on their claims.

Comment: One commenter expressed concern regarding the appropriate packaging of expiring device categories from pass-through payment for ophthalmologic devices after December 31, 2005. The commenter recommended that device category code C1814 be packaged with HCPCS codes 67036 (Removal of inner eye fluid), 67040 (Laser treatment of retina), 67108 (Repair detached retina), and 67112 (Rerepair detached retina), all of which the commenter claimed are paid under APC 0672. The commenter recommended that device category code C1818 be packaged with HCPCS code 65770 (Revise cornea with implant), which is proposed to be paid through APC 0244 (Cornea Transplant).

Response: Our policy is to package the expired device categories' costs with the costs relating to the procedure codes with which they were billed in our claims data. We will apply this policy to device category codes C1814 and C1818 as well. To the extent that the HCPCS codes reported in our claims data for the services associated with device codes C1814 and C1818 are the same as those HCPCS service codes noted in the comment, the median cost data for those HCPCS codes will include the costs associated with codes C1814 and C1818.

As indicated in the November 15, 2004 final rule with comment period, device categories C1814, C1818 and C1819 will expire from pass-through payment on December 31, 2005. We remind the public that these C-codes are still active for the billing and reporting of devices and their charges along with the HCPCS codes for the procedures with which they are used. When billing for procedures utilizing devices that have active device codes, hospitals are required to report the codes for the devices on their claims for the procedures.

TABLE 17.—LIST OF CURRENT PASS-THROUGH DEVICE CATEGORIES BY EXPIRATION DATE

| HCCPS codes | Category long descriptor | Date(s) populated | Expiration date |
|-------------|--|-------------------|-----------------|
| C1814 | Retinal tamponade device, silicone oil | 4/1/03 | 12/31/05 |
| C1818 | Integrated keratoprosthesis | 7/1/03 | 12/31/05 |
| C1819 | Tissue localization excision device | 1/1/04 | 12/31/05 |

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

1. Provisions for Reducing Transitional Pass-Through Payments to Offset Costs Packaged Into APC Groups

a. Background

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

For the CY 2002 and CY 2003 OPSS updates, to estimate the portion of each APC payment rate that could reasonably be attributed to the cost of an associated device eligible for pass-through payment, we used claims data from the period used for recalibration of the APC rates. That is, for CY 2002 OPSS updating, we used CY 2000 claims data and for CY 2003 OPSS updating, we used CY 2001 claims data. For CY 2002, we used median cost claims data based on specific revenue centers used for device related costs because C-code cost data were not available until CY 2003. For CY 2003, we calculated a median cost for every APC without packaging the costs of associated C-codes for device categories that were billed with the APC. We then calculated a median cost for every APC with the costs of the associated device category C-codes that were billed with the APC packaged into the median. Comparing the median APC cost without device packaging to the median APC cost including device packaging enabled us to determine the percentage of the median APC cost that is attributable to the associated pass-through devices. By applying those percentages to the APC payment rates, we determined the applicable amount to

be deducted from the pass-through payment, the “offset” amount. We created an offset list comprised of any APC for which the device cost was at least 1 percent of the APC’s cost.

The offset list that we have published each year is a list of offset amounts associated with those APCs with identified offset amounts developed using the methodology described above. As a rule, we do not know in advance which procedures residing in certain APCs may be billed with new device categories. Therefore, an offset amount is applied only when a new device category is billed with a HCPCS procedure code that is assigned to an APC appearing on the offset list. The list of potential offsets for CY 2005 is currently published on the CMS Web site: <http://www.cms.hhs.gov>, as “Device-Related Portions of Ambulatory Payment Classification Costs for 2005.”

For CY 2004, we modified our policy for applying offsets to device pass-through payments. Specifically, we indicated that we would apply an offset to a new device category only when we could determine that an APC contains costs associated with the device. We continued our existing methodology for determining the offset amount, described earlier. We were able to use this methodology to establish the device offset amounts for CY 2004 because providers reported device codes (C-codes) on the CY 2002 claims used for the CY 2004 OPSS update. For the CY 2005 update to the OPSS, our data consisted of CY 2003 claims that did not contain device codes and, therefore, for CY 2005 we utilized the device percentages as developed for CY 2004. In the CY 2004 OPSS update, we reviewed the device categories eligible for continuing pass-through payment in CY 2004 to determine whether the costs associated with the device categories are packaged into the existing APCs. Based on our review of the data for the device categories existing in CY 2004, we determined that there were no close or identifiable costs associated with the devices relating to the respective APCs that are normally billed with them. Therefore, for those device categories, we set the offset to \$0 for CY 2004. We continued this policy of setting offsets to \$0 for the device categories that

continued to receive pass-through payment in CY 2005.

For the CY 2006 OPSS update, CY 2004 hospital claims are available for analysis. Hospitals billed device C-codes in CY 2004 on a voluntary basis. We have reviewed our CY 2004 data, examining hospital claims for services that included device C-codes and utilizing the methodology for calculating device offsets noted above. The numbers of claims for services in many of the APCs for which we calculated device percentages using CY 2004 data were quite small. Many of these APCs already had relatively few single claims available for median calculations compared with the total bill frequencies because of our inability to use many multiple bills in establishing median costs for all APCs, and subsetting the single claims to only those including C-codes often reduced those single bills by 80 percent or more. Our claims demonstrate that relatively few hospitals specifically coded for devices utilized in CY 2004. Thus, we are not confident that CY 2004 claims reporting C-codes represent the typical costs of all hospitals providing the services. Therefore, we did not propose to use CY 2004 claims with device coding to propose CY 2006 device offset amounts. In addition, we did not propose to use the CY 2005 methodology, for which we utilized the device percentages as developed for CY 2004. Two years have passed since we developed the device offsets for CY 2004, and the device offsets originally calculated from CY 2002 hospitals’ claims data may not appropriately reflect the contributions of device costs to procedural costs in the current outpatient hospital environment. In addition, a number of the APCs on the CY 2004 and CY 2005 device offset percentage lists are either no longer in existence or have been so significantly reconfigured that the past device offsets likely do not apply.

b. Proposed and Final Policy for CY 2006

For CY 2006, we proposed to continue to review each new device category on a case-by-case basis as we have done in CY 2004 and CY 2005, to determine whether device costs associated with

the new category are packaged into the existing APC structure. If we do not determine for any new device category the device costs associated with the new category are packaged into existing APCs, we proposed to continue our current policy of setting the offset for the new category to \$0 for CY 2006. There are currently no established categories that would continue for pass-through payment in CY 2006. However, we may establish new categories in any quarter. If we create a new device category and determine that our data contain a sufficient number of claims with identifiable costs associated with the devices in any APC, we would adjust the APC payment if the offset is greater than \$0. If we determine that a device offset greater than \$0 is appropriate for any new category that we create, we proposed to announce the offset amounts in the program transmittal that announces the new category.

For CY 2006, we proposed to use available partial year or full year CY 2005 hospital claims data to calculate device percentages and potential offsets for CY 2006 applications for new device categories. Effective January 1, 2005, we require hospitals to report device C-codes and their costs when hospitals bill for services which utilize devices described by the existing C-codes. In addition, during CY 2005 we are implementing device edits for many services that require devices and for which appropriate device C-codes exist. Therefore, we expect that the number of claims, including device codes and their respective costs, will be much more robust and representative for CY 2005 than for CY 2004. We also note that offsets would not be used for any existing categories at this time. If a new device category is created for payment, for CY 2006 we proposed to examine the available CY 2005 claims data, including device costs, to determine whether device costs associated with the new category are already packaged into the existing APC structure, as indicated earlier. If we conclude that some related device costs are packaged into existing APCs, we proposed to utilize the methodology described earlier and first used for the CY 2003 OPPS to determine an appropriate device offset percentage for those APCs with which the new category would be reported.

We proposed not to publish a list of APCs with device percentages as a transitional policy for CY 2006 because of the previously discussed limitations of the CY 2004 OPPS data with respect to device costs associated with procedures. We expect to reexamine our

previous methodology for calculating the device percentages and offset amounts for the CY 2007 OPPS update, which will be based on CY 2005 hospital claims data where device C-code reporting is required.

We did not receive any public comments in response to our proposals.

Accordingly, we are finalizing our proposed policy for CY 2006 for calculating device percentages and applying offsets.

2. Criteria for Establishing New Pass-Through Device Categories

a. Surgical Insertion and Implantation Criterion

One of our criteria, as set forth in § 419.66(b)(3) of the regulations, for establishing a new category of devices for pass-through payment is that the item be surgically inserted or implanted. The criterion that a device be surgically inserted or implanted is one of our original criteria adopted when we implemented the BBRA requirement that we establish pass-through payment for devices. This criterion helps us define whether an item is a device, as distinguished from other items, such as materials and supplies. We further clarified our definition of the surgical insertion and implantation criterion in the November 13, 2000 final rule (65 FR 67805). In that rule, we stated that we consider a device to be surgically inserted or implanted if it is introduced into the human body through a surgically created incision. We also stated that we do not consider an item used to cut or otherwise create a surgical opening to be a device that is surgically inserted or implanted.

In our November 15, 2004 final rule with comment period, we responded to comments received on our CY 2005 OPPS proposed rule, which requested that we revisit our surgical insertion and implantation criterion for establishing a new device category. The commenters specifically requested that CMS eliminate the current requirement that items that are included in new pass-through device categories must be surgically inserted or implanted through a surgically created incision. The commenters expressed concern that the current requirement may prevent access to innovative and less invasive technologies, particularly in the areas of gynecologic, urologic, colorectal, and gastrointestinal procedures. These commenters asked that CMS change the surgical insertion or implantation criterion to allow pass-through payment for potential new device categories that include items introduced into the human body through a natural orifice,

as well as through a surgically created incision. Several of the commenters recommended that CMS allow the creation of a new pass-through category for items implanted or inserted through a natural orifice, as long as the other existing criteria are met.

In responding to the commenters, we stated in the November 15, 2004 final rule with comment period (69 FR 65774) that we were also interested in hearing the views of other parties and receiving additional information on these issues. While we appreciate and welcome additional comments on these issues from the medical device makers, we were also interested in hearing the views of Medicare beneficiaries, of the hospitals that are paid under the OPPS, and of physicians and other practitioners who attend to patients in the hospital outpatient setting. For that reason, we solicited additional comments on this topic within the 60-day comment period for the November 15, 2004 final rule with comment period (69 FR 65774 through 65775). In framing their comments, we asked that commenters consider the following questions specific to devices introduced into the body through natural orifices:

1. Whether orifices include those that are either naturally or surgically created, as in the case of ostomies. If you believe this includes only natural orifices, why do you distinguish between natural and surgically created orifices?

2. How would you define "new," with respect to time and to predecessor technology? What additional criteria or characteristics do you believe distinguish "new" devices that are surgically introduced through an existing orifice from older technology that also is inserted through an orifice?

3. What characteristics do you consider to distinguish a device that might be eligible for a pass-through category even if inserted through an existing orifice from materials and supplies such as sutures, clips or customized surgical kits that are used incident to a service or procedure?

4. Are there differences with respect to instruments that are seen as supplies or equipment for open procedures when those same instruments are passed through an orifice using a scope?

(1) Public Comments Received on the November 15, 2004 Final Rule With Comment Period and Our Responses

Below is a summary of the public comments we received on the four stated surgical insertion and implantation device criterion questions and our responses to them.

Comment: Most commenters generally framed their responses to the four

questions listed above. Commenters were generally in favor of modifying our surgical insertion and implantation criterion so that devices that are placed into patients without the need for a surgical incision would not be ineligible for pass-through payment, claiming that devices that are inserted through a natural orifice offer important benefits to Medicare beneficiaries, such as avoidance of more costly and more invasive surgery. One commenter stated that procedures that could be performed with minimal morbidity and on an outpatient basis are the trend for surgery and should be encouraged. Another commenter believed that our criterion of surgical insertion or implantation through a surgically created incision was ineffective as a clear and comprehensive description of surgical procedures, including endoscopic and laparoscopic procedures.

Regarding the first specific question we posed, whether devices introduced into the body through natural orifices includes orifices that are either naturally or surgically created, commenters generally stated CMS should include devices as potentially eligible for pass-through categories whether they are introduced through orifices that are either naturally or surgically created, as in the case of ostomies, if the devices meet other cost and clinical criteria, in order to encourage the development of new technologies.

Regarding the second question restated above, which asked how the public would define "new" with respect to time and to predecessor technology, some commenters stated that they believed the current clinical and cost criteria are sufficient and that no additional criteria or characteristics are needed. Several commenters indicated that the timeframe for what CMS considers "new" could be clarified so that if the device in question was not FDA approved or not used for the services in the OPD during the year of the hospital claims that provided the basis for the most recent OPPS update, it should be considered "new." Some commenters elaborated by example. They stated that if CMS changes the surgical insertion or implantation requirement to include devices inserted through natural orifices in CY 2005, devices approved by the FDA and in use in the OPD in CY 2003 or previously would not be eligible, while devices approved by FDA in CY 2004 or later and used in the OPD settings would be eligible for pass-through consideration. Another commenter stated that the definition of "new" device should include those devices that require only

an FDA investigational device exemption (IDE) clearance. The commenter further stated that these devices should be granted "new" status at the time of FDA release as an IDE. The commenter stated that if FDA required a premarket approval (PMA) for the device, a determination of newness should be made on a case-by-case basis.

Regarding the question of what characteristics distinguish a device that might be eligible for a pass-through category even if inserted through an existing orifice from materials and supplies that are used incident to a service or procedure, some commenters generally believed that the current clinical and cost criteria are sufficient to distinguish devices that might be eligible from materials and supplies. Other commenters stated that the device must be an integral part of the procedure or that it should include the characteristic of having a diagnostic or therapeutic purpose, without which the procedure could not be performed. Thus, according to these commenters, the device must function for a specific procedure, while supplies may be used for many procedures. One commenter pointed out that many devices are now implanted through the use of naturally occurring orifices or without significant incisions. This commenter indicated that the requirement of a "traditional incision" no longer serves the purpose of distinguishing between devices that are and are not implanted, or between devices and supplies and instruments. The commenter stated that retaining the requirement of a traditional incision could create incentives to use more invasive technology, if that is the technology that is eligible for pass-through payments and less invasive technology is not. The commenter suggested excluding tools and disposable supplies by excluding any item that is used primarily for the purpose of cutting or delivering an implantable device. However, the commenter recommended not reducing payment when delivery systems are packaged with the device. The commenter further recommended that the term "incision" be clearly defined to include all procedures involving the cutting, breaking, or puncturing of tissue or skin, regardless of how small that cut is, provided that the device is attached to or inserted into the body via this cut, puncture, or break. Another commenter stated that there are items included in a surgical kit that have significant cost and are single use, for example, guidewires, implying that it is

sometimes difficult to determine what a supply is.

Regarding our question about whether there are differences with respect to instruments that are seen as supplies or equipment for open procedures when those same instruments are passed through an orifice using a scope, commenters believed that the definitions of supplies and eligible devices are independent of the use of a scope during a procedure, and stated there were no distinguishing features of supplies or equipment. One commenter reiterated that the current clinical and cost criteria are sufficient to distinguish eligible devices (that is, those with "a specific therapeutic use") from materials and supplies. Commenters believed that the use of a scope should not be a factor in the distinction between devices and supplies.

One commenter urged us to consider the points that the surgical incision requirement is not mandated by statute and that CMS' criterion to limit devices to only those that are surgically inserted or implanted may have been based upon concern that less restrictive criteria would cause spending on pass-through items to exceed the pool of money set to fund the pass-through payments. The commenter indicated that this concern would no longer be valid, given the relatively few items currently paid on a pass-through basis.

Response: As we stated in the November 15, 2004 final rule, we share the view that it is important to ensure access for Medicare beneficiaries to new technologies that offer substantial clinical improvement in the treatment of their medical conditions. We also recognize that since the beginning of the OPPS, there have been beneficial advances in technologies and services for many conditions, which have both markedly altered the courses of medical care and ultimately improved the health outcomes of many beneficiaries.

We carefully considered the comments and proposed to maintain our current criterion that a device must be surgically inserted or implanted, but also proposed to modify the way we currently interpret this criterion under § 419.66(b)(3) of the regulations. We proposed to consider eligible those items that are surgically inserted or implanted either through a natural orifice or a surgically created orifice (such as through an ostomy), as well as those that are inserted or implanted through a surgically created incision. We noted that we would maintain all of our other criteria in § 419.66 of the regulations, as elaborated in our various rules, such as the November 1, 2002 final rule (67 FR 66781 through 66787).

Specifically, we noted that we would maintain the clarification made at the time we clarified the surgically inserted or implanted criterion in our August 3, 2000 interim final rule with comment period, namely, that we do not consider an item used to cut or otherwise create a surgical opening to be a device that is surgically implanted or inserted (65 FR 67805).

With this proposed revision of our definition of devices that are surgically inserted or implanted, we reminded the public that device category eligibility for transitional pass-through payment continues to depend on meeting our substantial clinical improvement criterion, where we compare the clinical outcomes of treatment options using the device to currently available treatments, including treatments using devices in existing or previously existing pass-through device categories. We expect that requested new pass-through device categories that successfully demonstrate substantial clinical improvement for Medicare beneficiaries would describe new devices, where the additional device costs would not be reflected in the hospital claims data providing the costs of treatments available during the time period used for the most recent OPPS update.

(2) Public Comments Received on the CY 2006 OPPS Proposed Rule and Our Responses

We received many comments concerning our proposals to modify the surgical insertion or implantation criterion for new pass-through device categories.

Comment: Commenters supported our proposal to modify the way we currently interpret our criterion that a device must be surgically inserted or implanted under § 419.66(b)(3) of the regulations, but suggested that CMS consider eligible those items that are surgically inserted or implanted either through a natural orifice or a surgically created orifice (such as through an ostomy), as well as items that are surgically inserted or implanted through a surgically created incision. A few commenters suggested that CMS modify the regulatory language to codify this change, by explicitly stating in § 419.66(b)(3) that the device is implanted or inserted through a natural or surgically created orifice or through a surgically created incision. These commenters made this request in the context of stating that the proposed interpretation resolves the current need to make a traditional surgical incision to insert or implant a device through an orifice for that device to be considered

eligible for a pass-through device category.

Response: We appreciate the support for our proposal to modify our interpretation of the surgical insertion or implantation criterion for pass-through payment eligibility for devices. Our current criterion is that a device must be surgically inserted or implanted, while our interpretation of this criterion up to this point has been to consider eligible only those devices that are inserted or implanted through a surgically created incision, as clarified in our August 3, 2000 interim final rule. As stated above, other clarifications in that interim final rule remain. We do not believe that it is either essential or advisable to revise the regulations. Therefore, we are not changing the current language of § 419.66(b)(3), as some commenters have suggested. However, we are adopting as final our interpretation that surgical insertion or implantation criteria include devices that are surgically inserted or implanted via a natural or surgically created orifice, as well as those devices that are inserted or implanted via a surgically created incision. We will maintain all of the other criteria in § 419.66 of the regulations, as elaborated in our various rules, such as the November 1, 2002 final rule (67 FR 66781 through 66787) and our August 3, 2000 interim final rule with comment period, namely, that we do not consider an item used to cut or otherwise create a surgical opening to be a device that is surgically implanted or inserted (65 FR 67805).

b. Existing Device Category Criterion

One of our criteria, as set forth in § 419.66(c)(1) of the regulations, to establish a new device category for pass-through payment is that the devices that would populate the category not be described by any existing or previously existing category. Commenters to our various proposed rules, as well as applicants for new device categories, have expressed concern that some of our existing and previously existing device category descriptors are overly broad, and that the category descriptors as they are currently written may preclude some new technologies from qualifying for establishment of a new device category for pass-through payment. These parties have recommended that CMS consider modifying the descriptors for existing device categories, especially when a device would otherwise meet all the other criteria for establishing a new device category to qualify for pass-through payment.

We agree that implementation of the requirement that a new device category not be described by an existing or

previously existing category merits review. Beginning with CY 2006, 3 years will have elapsed since the vast majority of the 97 initial device categories we established on April 1, 2001, will have expired: 95 categories expired after December 31, 2002, and 2 categories expired after December 31, 2003. Several additional years will have passed since those categories were first populated in CY 2000 or CY 2001. Thus, while some of the initial device category descriptors sufficed at the time they were first created, further clarification as to the types of devices that they are meant to describe is indicated. Therefore, we proposed to create an additional category for devices that meet all of the criteria required to establish a new category for pass-through payment in instances where we believe that an existing or previously existing category descriptor does not appropriately describe the new type of device. This may entail the need to clarify or refine the short or long descriptors of the previous category. We will evaluate each situation on a case-by-case basis. We proposed that any such clarification will be made prospectively from the date the new category would be made effective.

We also proposed to revise § 419.66(c)(1) of the regulations, accordingly, to reflect, as one of the criteria for establishing a device category, our determination that a device is not appropriately described by any of the existing categories or by any category previously in effect. In order to determine if a “new” device is appropriately described by an existing or previously existing category of devices, we proposed to apply two tests based upon our evaluation of information provided to us in the device category application. First, we will expect an applicant for a new device category to show that its device is not similar to devices (including related predicate devices) whose costs are reflected in the OPPS claims data in the most recent OPPS update. Second, we will require an applicant for a new device category to demonstrate that utilization of its device provides a substantial clinical improvement for Medicare beneficiaries compared with currently available treatments, including procedures utilizing devices in existing or previously existing device categories. We will consider a new device that meets both of these tests not to be appropriately described by one of the existing or previously existing pass-through device categories.

We received a large number of public comments concerning our proposal to create an additional category for devices

that meet all of the criteria required to establish a new category for pass-through payment in instances where we believe that an existing or previously existing category descriptor does not appropriately describe the new type of device.

Comment: Commenters generally supported our proposal to create an additional category for devices that meet all of the criteria required to establish a new category for pass-through payment in instances where we believe that an existing or previously existing category descriptor does not appropriately describe the new type of device, and which may entail the need to clarify or refine the short or long descriptors of the previous category. The commenters believed that CMS has sufficient documentation on devices in expired categories to differentiate those devices from new devices, as well as the authority to clarify the definitions of previously existing categories. The commenters gave examples of devices that they believe are not appropriately described by existing categories and whose descriptors are overly broad. Commenters also supported the application of the two tests that we proposed to apply in order to determine if the devices in device category applications are described by an existing or previously existing category. One commenter expressed that it would be useful for CMS to provide additional details on how we intend to evaluate whether a new technology is similar to existing technologies. Another commenter expressed concern that we have not developed standards of proof of substantial clinical improvement, which is one of the proposed tests, and encouraged CMS to develop further explanation of the substantial clinical improvement test.

Response: We appreciate the commenters' support for our proposed modification to our policy that a device may not be described by an existing or previously existing device category. Regarding the recommendations made for clarifying whether a nominated new device is similar to an existing technology, as new device applications consist of unique technologies, evaluation of what constitutes a similar technology or substantial clinical improvement is done on an individual application basis. We refer the commenters to our discussion of the substantial clinical improvement criterion that is found in our November 1, 2002 final rule (67 FR 66782–66783), which provides a list of criteria and examples of clinical outcomes that are used to determine if a request for a new category of devices meets our

substantial clinical improvement criterion.

Comment: A few commenters recommended that CMS consider pending pass-through applications in light of this modification to the existing category criterion, and that CMS make modifications to existing or previously existing categories effective January 1, 2006, where all device category criteria are met.

Response: It is our intention to evaluate pending pass-through device category applications against any changes to criteria as a result of this final rule with comment period. If any pending applications are then eligible for establishment of a new device category for pass-through payment, we will endeavor to add those for payment effective January 1, 2006. Any payment instructions would be announced in the program transmittal implementing our CY 2006 OPPS update.

Comment: In commenting on our proposal to modify the existing device category criterion for pass-through payment for devices, a number of commenters noted that rechargeable implantable pulse generator (IPG) neurostimulators should be provided with pass-through payment status, and that a new category is needed specifically for rechargeable neurostimulators. The commenters claimed that rechargeable neurostimulators have allowed a significant advance to the field of neuromodulation for the treatment of chronic intractable pain. The commenters stated there is a high degree of patient compliance with rechargeable neurostimulators, and these devices will reduce the cost of spinal cord stimulation over time by reducing the number of surgical battery replacements. A large number of commenters stated that the new class of rechargeable IPG neurostimulators meets our proposed new tests to determine if a device is described by an existing or previously existing category. The commenters requested that CMS clarify the previously existing category to state that it described nonrechargeable neurostimulators. The commenters recommended that CMS apply any revised criterion to pending applications.

Response: We note that two pass-through applications now under consideration are for devices currently described by a previously existing pass-through category. These applications are for implantable rechargeable neurostimulators. Neurostimulators are covered by a previously existing OPPS device category for pass-through payment, C1767, Generator,

neurostimulator (implantable). This same type of rechargeable device was considered for the IPPS new technology add-on payment, and passed all that payment system's criteria, including demonstrating substantial clinical improvement. Therefore, with the adoption of our proposal to clarify an existing or previously existing device category if an existing or previously existing device category does not appropriately describe a new device and the device would otherwise be eligible for a new pass-through device category, we will consider the rechargeable neurostimulator applications for pass-through payment beginning January 2006, in which case we would also consider the need to clarify or refine the description of category C1767. Any coding and payment information will be announced in the program transmittal implementing the OPPS for CY 2006. We also note that we have included an estimate for a rechargeable neurostimulator category in our pass-through spending estimate in section VI.B of this rule, should there be creation of a new device category for pass-through payment for such devices.

We are finalizing this proposal without change. We will create an additional category for devices that meet all of the criteria required to establish a new category for pass-through payment in instances where we believe that an existing or previously existing category descriptor does not appropriately describe the new type of device. This may entail the need to clarify or refine the short or long descriptors of the previous category. We will evaluate each situation on a case-by-case basis and apply the two tests described above. Any such clarification to a category descriptor will be made prospectively from the date the new category would be made effective. We are also finalizing our proposed revision of our regulations at § 419.66(c)(1) to reflect this change.

V. Payment Changes for Drugs, Biologicals, and Radiopharmaceuticals

A. Transitional Pass-Through Payment for Additional Costs of Drugs and Biologicals

1. Background

Section 1833(t)(6) of the Act provides for temporary additional payments or "transitional pass-through payments" for certain drugs and biological agents. As originally enacted by the BBRA, this provision required the Secretary to make additional payments to hospitals for current orphan drugs, as designated under section 526 of the Federal Food, Drug, and Cosmetic Act (Pub. L. 107–186); current drugs and biological agents

and brachytherapy used for the treatment of cancer; and current radiopharmaceutical drugs and biological products. For those drugs and biological agents referred to as “current,” the transitional pass-through payment began on the first date the hospital OPPS was implemented (before enactment of BIPA (Pub. L. 106–554), on December 21, 2000).

Transitional pass-through payments are also required for certain “new” drugs, devices, and biological agents that were not being paid for as a hospital OPD service as of December 31, 1996, and whose cost is “not insignificant” in relation to the OPPS payment for the procedures or services associated with the new drug, device, or biological. Under the statute, transitional pass-through payments can be made for at least 2 years but not more than 3 years. In Addenda A and B to this final rule with comment period, pass-through drugs and biological agents are identified by status indicator “G.”

The process to apply for transitional pass-through payment for eligible drugs and biological agents can be found on our CMS Web site: www.cms.hhs.gov. If we revise the application instructions in any way, we will post the revisions on our Web site and submit the changes to

the Office of Management and Budget (OMB) for approval, as required under the Paperwork Reduction Act (PRA). Notification of new drugs and biologicals application processes is generally posted on the OPSS Web site at: <http://www.cms.hhs.gov/providers/hopps>.

2. Expiration in CY 2005 of Pass-Through Status for Drugs and Biologicals

Section 1833(t)(6)(C)(i) of the Act specifies that the duration of transitional pass-through payments for drugs and biologicals must be no less than 2 years and no longer than 3 years. The drugs whose pass-through status will expire on December 31, 2005, meet that criterion. In the CY 2006 OPSS proposed rule, in Table 19 (70 FR 42722) we listed the 10 drugs and biologicals for which we proposed that pass-through status would expire on December 31, 2005.

We received one public comment concerning the proposed expiration of pass-through status for those drugs and biologicals on December 31, 2005.

Comment: One commenter noted that the proposed rule did not make clear whether drugs coming off pass-through status will be reassigned to J-codes or will continue to be listed under their C-

codes for payment purposes and requested clarification in the final rule.

Response: In order to reduce redundancy and simplify coding for drugs, biologicals, and radiopharmaceuticals under the OPSS, we are deleting the temporary C-codes for items that also have permanent HCPCS codes and are paying for those items under the permanent HCPCS codes if it is appropriate to do so. Among the items whose pass-through status will expire on December 31, 2005, are HCPCS codes C9123, C9203, C9205, C9211, and C9212, which will be deleted effective December 31, 2005. For services furnished on or after January 1, 2006, hospitals should use HCPCS code J7344 to bill for Transcyte, HCPCS code Q9955 to bill for Perflexane lipid micro, HCPCS code J9263 to bill for Oxaliplatin, and HCPCS code J0215 to bill for Alefacept. Later in the preamble, we list all of the C-codes in Table 25 that will be deleted on December 31, 2005 and replaced with other existing or new HCPCS codes in CY 2006.

For this final rule with comment period, in Table 18 below, we are specifying the drugs and biologicals for which pass-through status will expire on December 31, 2005. This listing is the same as that published in the proposed rule.

TABLE 18.—LIST OF DRUGS AND BIOLOGICALS FOR WHICH PASS-THROUGH STATUS EXPIRES DECEMBER 31, 2005

| HCPCS | APC | Short descriptor |
|-------------|------|----------------------------|
| C9123 | 9123 | Transcyte, per 247 sq cm. |
| C9203 | 9203 | Perflexane lipid micro. |
| C9205 | 9205 | Oxaliplatin. |
| C9211 | 9211 | Inj, alefacept, IV. |
| C9212 | 9212 | Inj, alefacept, IM. |
| J0180 | 9208 | Agalsidase beta injection. |
| J1931 | 9209 | Laronidase injection. |
| J2469 | 9210 | Palonosetron HCl. |
| J3486 | 9204 | Ziprasidone mesylate. |
| J9041 | 9207 | Bortezomib injection. |

3. Drugs and Biologicals With Pass-Through Status in CY 2006

In the CY 2005 OPSS proposed rule (70 FR 42722 and 42723), we proposed to continue pass-through status in CY 2006 for 14 drugs and biologicals. These items, which were listed in Table 20 of the CY 2006 OPSS proposed rule (70 FR 42723), were given pass-through status as of April 1, 2005. The APCs and HCPCS codes for drugs and biologicals that we proposed to continue with pass-through status in CY 2006 are assigned status indicator “G” in Addenda A and B of this final rule with comment period.

Section 1833(t)(6)(D)(i) of the Act sets the payment rate for pass-through

eligible drugs (assuming that no pro rata reduction in pass-through payment is necessary) as the amount determined under section 1842(o) of the Act. We note that this section of the Act also states that if a drug or biological is covered under a competitive acquisition contract under section 1847B of the Act, the payment rate is equal to the average price for the drug or biological for all competitive acquisition areas and the year established as calculated and adjusted by the Secretary. The competitive acquisition program had not been implemented at the time of issuance of the CY 2006 proposed rule. Therefore, we did not have payment rates for certain drugs and biologicals

that would be covered under this program at that time. Section 1847A of the Act, as added by section 303(c) of Pub. L. 108–173, establishes the use of the average sales price (ASP) methodology as the basis for payment of drugs and biologicals described in section 1842(o)(1)(C) of the Act and furnished on or after January 1, 2005. This payment methodology is set forth in § 419.64 of the regulations. Similar to the payment policy established for pass-through drugs and biologicals in CY 2005, we proposed to pay under the OPSS for drugs and biologicals with pass-through status in CY 2006 consistent with the provisions of section 1842(o) of the Act, as amended by

section 621 of Pub. L. 108–173, at a rate that is equivalent to the payment these drugs and biologicals would receive in the physician office setting.

Section 1833(t)(6)(D)(i) of the Act also sets the amount of additional payment for pass-through eligible drugs and biologicals (the pass-through payment amount). The pass-through payment amount is the difference between the amount authorized under section 1842(o) of the Act, and the portion of the otherwise applicable fee schedule amount (that is, the APC payment rate) that the Secretary determines is associated with the drug or biological.

In the CY 2006 OPSS proposed rule, (70 FR 42722 and 42731) we proposed to continue to make separate payment in CY 2006 for new drugs and biologicals with a HCPCS code consistent with the provisions of section 1842(o) of the Act, as amended by section 621 of Pub. L. 108–173, at a rate that is equivalent to the payment they would receive in a physician office setting, whether or not we have received a pass-through application for the item. Accordingly, in CY 2006 the pass-through payment amount would equal zero for those new drugs and biologicals that we determine have pass-through status. That is, when we subtract the amount to be paid for pass-through drugs and biologicals under section 1842(o) of the Act, as amended by section 621 of Pub. L. 108–173, from the portion of the otherwise applicable fee schedule amount or the APC payment rate associated with the drug or biological that would be the amount paid for drugs and biologicals under section 1842(o) of the Act as amended by section 621 of Pub. L. 108–173, the resulting difference is equal to zero.

We proposed to use payment rates based on the ASP data from the fourth quarter of 2004 for budget neutrality estimates, impact analyses, and to complete Addenda A and B of the proposed rule because these were the most recent numbers available to us during the development of the proposed rule. These payment rates were also the basis for drug payments in the physician office setting effective April 1, 2005. To be consistent with the ASP-based payments that would be made when these drugs and biologicals are furnished in physician offices, we stated in our proposed rule (70 FR 42722 and 42723) that we planned to make any appropriate adjustments to the amounts shown in Addenda A and B of the proposed rule when we publish our final rule and also on a quarterly basis on our Web site during CY 2006 if later quarter ASP submissions indicate that adjustments to the payment rates for

these pass-through drugs and biologicals are necessary.

In Table 20 of the proposed rule, we listed the drugs and biologicals for which we proposed that pass-through status continue in CY 2006. We assigned pass-through status to these drugs and biologicals as of April 1, 2005. Since publication of the CY 2006 OPSS proposed rule, we have approved three additional drugs and biologicals for pass-through payment beginning on or after July 1, 2005. These products are Abraxane, which has been assigned HCPCS code C9127 (Injection, Paclitaxel Protein Bound Particles, per 1 mg); Macugen, which has been assigned HCPCS code C9128 (Injection, Pegaptanib Sodium, per 0.3 mg); and Clolar, which has been assigned HCPCS code C9129 (Injection, Clofarabine, per 1 mg). (See Change Request 3915, Transmittal 599 issued on June 30, 2005.) In addition, two more products have been approved for pass-through status beginning on or after October 1, 2005. They are Retisert, which has been assigned HCPCS code C9225 (Injection, fluocinolone acetonide intravitreal implant, per 0.59 mg) and Prialat, which has been assigned HCPCS code C9226 (Injection, ziconotide for intrathecal infusion, per 5 mcg). (See Change Request 4035, Transmittal 691 issued on September 30, 2005). For CY 2006, the C-codes C9127, C9128, C9129, and C9226 have been deleted and replaced with permanent HCPCS codes J9264, J2503, J9027, and J2278, respectively. These new eligible pass-through items are listed in Table 19 below. We also have included in Addenda A and B to this final rule with comment period the CY 2006 APC payment rates for all pass-through drugs and biologicals.

We received several public comments on the proposed listing and payment rates for drugs and biologicals with pass-through status continuing in CY 2006.

Comment: A few commenters indicated that our proposal to apply the same payment methodology to pass-through drugs and to drugs that are classified as a “specified covered outpatient drug” may not appropriately recognize and pay hospitals for the additional costs that are often associated with new technologies that are given pass-through status. One commenter indicated that the proposal negated the intent of the pass-through payment, which was meant to compensate hospitals for costs not covered by existing APC payments. Commenters urged CMS to consider maintaining a differential in payment systems between innovative and older drugs in order to ensure adequate access to newer

therapies within the hospital outpatient setting. One commenter suggested that CMS consider making the pass-through payment methodology consistent with the methodology applied to new drugs in the physician office setting (that is, wholesale acquisition cost or the applicable payment methodology in effect on November 1, 2003) to distinguish and provide sufficient payment for the class of pass-through drugs in future years.

Response: Section 1833(t)(6)(D)(i) of the Act sets the additional payment amount for pass-through eligible drugs or biologicals as the difference between the amount determined under section 1842(o) of the Act and the APC payment rate determined by the Secretary associated with the drug or biological. As we explained earlier, section 1847A of the Act, as added by section 303(c) of Pub. L. 108–173, establishes the use of the ASP methodology as the basis for payment of drugs and biologicals described in section 1842(o)(1)(C) of the Act and furnished on or after January 1, 2005. Our proposal to pay for drugs and biologicals with pass-through status in CY 2006 using the ASP methodology at a rate that is equivalent to the payment these drugs and biologicals would receive in the physician office setting is consistent with the provisions of section 1842(o) of the Act, as amended by section 621 of Pub. L. 108–173. Specifically, in CY 2006, we will be paying for drugs and biologicals with pass-through status under the OPSS based on the ASP methodology and using ASP data specific to the drug or biological itself. We note that there may be certain drugs and biologicals with pass-through status that are payable under different HCPCS codes in the physician offices and outpatient departments, and for such cases, payment for the drug or biological under the OPSS will be based on the ASP data for the item described by the code that is used under the OPSS. We agree that pass-through payments are designed to recognize differences between the payment rates under the OPSS and the payment rates for certain drugs and biologicals in the physician office setting. Statutory changes in the payment methodology for pass-through drugs and biologicals mean that such cost differentials no longer exist.

We have used payment rates based on the ASP data from the second quarter of CY 2005 for budget neutrality estimates, impact analyses, and to complete Addenda A and B of this final rule with comment period because these were the most recent numbers available to us during the development of this rule. These payment rates are also the basis

for drug payments in the physician office setting effective October 1, 2005. However, the payment rates for pass-through drugs and biologicals that will be effective in the OPSS on January 1, 2006 will be based on ASP data from the third quarter of CY 2005, which will also be the basis for drug payments in physician offices as of January 1, 2006. To be consistent with the ASP-based payments that will be made when these pass-through drugs and biologicals are furnished in physician offices, we plan to make any appropriate adjustments in CY 2006 to the payment rates for these items if later quarter ASP submissions indicate that adjustments to the payment rates are necessary.

As noted earlier, section 1833(t)(6)(D)(i) of the Act also states that if a drug or biological is covered under a competitive acquisition contract under section 1847B of the Act, the payment rate is equal to the average price for the drug or biological for all competitive acquisition areas and year established as calculated and adjusted by the Secretary. The competitive acquisition program still has not been implemented with issuance of this final rule with comment period. We expect implementation by July 1, 2006. For this final rule with comment period, we do not have payment rates for certain drugs and biologicals that would be covered under this program at that time. However, when the competitive acquisition program is implemented in CY 2006, the OPSS payment rates for pass-through drugs and biologicals that will also be covered under the program will be based on the competitive acquisition program methodology in CY 2006.

We refer readers to section V.B.3.a. of this preamble for a discussion of payment policies for specified covered outpatient drugs.

Comment: The manufacturer of natalizumab (HCPCS code Q4079) supported continued pass-through status for this product, but was concerned that continuation of the 1-mg unit descriptor will create confusion among providers and inject the potential of erroneously denied or underpaid claims. The commenter indicated that a 300 mg dose of the product is always uniformly infused and urged CMS to amend the coding descriptor to reflect its clinical use.

Response: We recognize the commenter's concern. However, the National HCPCS Panel coordinates decisions regarding the descriptors of permanent HCPCS codes. Therefore, we will not respond to this comment as it is outside the scope of this rule.

Table 19 below lists the drugs and biologicals that will have pass-through status in CY 2006. Addenda A and B of this final rule with comment period list the final CY 2006 rates for these pass-through drugs and biologicals, which are based on ASP data reported by manufacturers from the second quarter of CY 2005. These items are assigned to status indicator "G."

Comment: A commenter recommended that CMS finalize the proposal to continue payment for HCPCS codes C9221 and C9222 as pass-through biologics in CY 2006 and requested that CMS confirm that the proposed payment rate of \$1,234.36 for HCPCS code C9221 reflected ASP+6 percent.

Response: We agree with the commenters that HCPCS codes C9221 and C9222 should be paid as pass-through items in CY 2006; therefore, these items are listed in Table 19 along with other drugs and biologicals that will also have pass-through status under the OPSS in CY 2006 and are also assigned to status indicator "G" in Addendum B of this final rule with comment period.

Comment: A commenter indicated that the HCPCS code C9127 (paclitaxel protein-bound particles for injectable suspension, per 1 mg) was granted pass-through status effective July 1, 2005; however, the CY 2006 proposed rule listed this code with a status indicator "K" rather than status indicator "G." The commenter requested that this code be assigned to status indicator "G" in the final rule indicating its pass-through status.

Response: In the proposed rule, we listed only the drugs and biologicals that received pass-through status as of April 1, 2005. As indicated earlier, there are additional drugs and biologicals that have been approved for pass-through status since the publication of the proposed rule, and HCPCS code C9127 is one of the drugs that received pass-through status effective July 1, 2005. We note that HCPCS code C9127 has been deleted effective December 31, 2005 and replaced with HCPCS code J9264 in CY 2006. Consequently, in this final rule we have assigned HCPCS code J9264 to status indicator "G" in Addendum B in this final rule with comment period.

Comment: Another commenter indicated that it was pleased with CMS' proposal to continue pass-through status in CY 2006 for the drug Orthovisc, which is reported under HCPCS code C9220; however, it was also concerned that once the period of eligibility for pass-through payments expired, there will not be a code corresponding to HCPCS code C9220 that will be

available for use. The commenter expressed concern about the CMS HCPCS Workgroup's preliminary recommendation to deny a unique code for Orthovisc and to include Orthovisc with other viscosupplements described by HCPCS code J7317. The commenter stated its belief that a new code is necessary and appropriate for Orthovisc under the established HCPCS process, and such a decision would recognize the unique characteristics of Orthovisc, distinguish it from other viscosupplements, allow for appropriate payment, and facilitate patient access. The commenter indicated that it resubmitted its J-code application under the new HCPCS process on December 24, 2004 and requested that CMS recognize Orthovisc as a unique product and grant it a unique HCPCS code.

Response: Effective January 1, 2006, the National HCPCS Panel has created HCPCS code J7318 (Hyaluron/derive intra-art inj) to describe all of the sodium hyaluronate products, including Orthovisc. Decisions regarding the creation of permanent HCPCS codes are coordinated by the National HCPCS Panel. Comments related to the HCPCS code creation process and decisions made by the National HCPCS Panel are outside the scope of this rule. However, we note that in CY 2006 because HCPCS code C9220 will continue to have pass-through status under the OPSS both HCPCS code C9220 and HCPCS code J7318 will be payable under the OPSS, and their payment rates will be established using the ASP data for all of the products described by these codes. Therefore, we encourage providers to continue billing for Orthovisc, which has pass-through status, using HCPCS code C9920 in order to receive appropriate payment for furnishing this drug in the hospital outpatient setting.

Comment: A few commenters requested the CMS clarify in the final rule how payment for infusion drugs administered through an item of DME, such as drugs administered through an implantable or external infusion pump, will be paid under the OPSS in CY 2006. One commenter was especially concerned about the payment rate for HCPCS code C9226 (Brand name: Prialt), which is administered through an intrathecal pump. The commenters noted CMS' statement that CY 2006 payment for drugs and biologicals under the OPSS will follow that of the physician office setting; however, CMS did not specifically state that this particular group of drugs, which are not paid under the ASP methodology, will continue to be paid at 95 percent of AWP in CY 2006. Commenters requested that CMS clarify that infusion

drugs administered through an item of DME and furnished in the hospital outpatient setting, like Prialt, will be paid at 95 percent of AWP pursuant to section 1842(o)(1)(D) of the Act. One commenter also requested that CMS clarify that Prialt is not an orphan drug.

Response: HCPCS code C9226 was approved for pass-through status effective October 1, 2005. As a pass-through drug under the OPPS, payment for Prialt was established using the ASP methodology. (See Change Request 4035, Transmittal 691 issued on September 30, 2005). As with other new drugs without ASP data, payment for Prialt was set at WAC+6% (\$32.24 per

5 mcg) effective October 1, 2005. We note that Prialt is not considered a single-indication orphan drug under OPPS. As the commenters noted, section 1842(o)(1)(D) of the Act states that drugs infused through DME are paid at 95 percent of AWP until such time as they are incorporated into the DME competitive bidding program. However, section 1842(o)(1) of the Act (which governs section 1842(o)(1)(D)) specifically states that this payment methodology only applies when a “drug or biological is not paid on a cost or prospective payment basis.” Payment for drugs under the OPPS is established on the basis of prospective rates. The

provision that requires payment for DME infusion drugs at 95 percent of AWP is therefore not applicable to Prialt or any other DME infusion drugs furnished in the hospital outpatient setting. Therefore, in CY 2006 we will continue to pay for Prialt and other non-pass-through DME infusion drugs using the ASP methodology instead of paying at 95 percent of AWP. We note that HCPCS code C9226 has been deleted effective December 31, 2005 and replaced with J2278 in CY 2006. Consequently, in this final rule, we have assigned HCPCS code J2278 to status indicator “G” in Addendum B in this final rule with comment period.

TABLE 19.—LIST OF DRUGS AND BIOLOGICALS WITH PASS-THROUGH STATUS IN CY 2006

| HCPCS Code | APC | Short descriptor |
|------------|------|-------------------------------|
| C9220 | 9220 | Sodium hyaluronate. |
| C9221 | 9221 | Graftjacket Reg Matrix. |
| C9222 | 9222 | Graftjacket SftTis. |
| C9225 | 9225 | Fluocinolone acetonide. |
| J0128 | 9216 | Abarelix injection. |
| J0878 | 9124 | Daptomycin injection. |
| J2278 | 1694 | Ziconotide injection. |
| J2357 | 9300 | Omalizumab injection. |
| J2503 | 1697 | Pegaptanib sodium injection. |
| J2783 | 0738 | Rasburicase. |
| J2794 | 9125 | Risperidone, long acting. |
| J7518 | 9219 | Mycophenolic acid. |
| J8501 | 0868 | Oral aprepitant. |
| J9027 | 1710 | Clofarabine injection. |
| J9035 | 9214 | Bevacizumab injection. |
| J9055 | 9215 | Cetuximab injection. |
| J9264 | 1712 | Paclitaxel injection. |
| J9305 | 9213 | Pemetrexed injection. |
| Q4079 | 9126 | Injection, Natalizumab, 1 mg. |

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

1. Background

Under the CY 2005 OPPS, we currently pay for drugs, biologicals including blood and blood products, and radiopharmaceuticals that do not have pass-through status in one of two ways: packaged payment and separate payment (individual APCs). We explained in the April 7, 2000 final rule (65 FR 18450) that we generally package the cost of drugs and radiopharmaceuticals into the APC payment rate for the procedure or treatment with which the products are usually furnished. Hospitals do not receive separate payment from Medicare for packaged items and supplies, and hospitals may not bill beneficiaries separately for any packaged items and supplies whose costs are recognized and paid within the national OPPS payment rate for the associated procedure or service. (Program Memorandum

Transmittal A–01–133, issued on November 20, 2001, explains in greater detail the rules regarding separate payment for packaged services.)

Packaging costs into a single aggregate payment for a service, procedure, or episode of care is a fundamental principle that distinguishes a prospective payment system from a fee schedule. In general, packaging the costs of items and services into the payment for the primary procedure or service with which they are associated encourages hospital efficiencies and also enables hospitals to manage their resources with maximum flexibility. Notwithstanding our commitment to package as many costs as possible, we are aware that packaging payments for certain drugs, biologicals, and radiopharmaceuticals, especially those that are particularly expensive or rarely used, might result in insufficient payments to hospitals, which could adversely affect beneficiary access to medically necessary services.

Section 1833(t)(16)(B) of the Act, as added by section 621(a)(1) of Pub. L. 108–173, requires that the threshold for establishing separate APCs for drugs and biologicals be set at \$50 per administration for CYs 2005 and 2006. For CY 2005, we finalized our policy to continue paying separately for drugs, biologicals, and radiopharmaceuticals whose median cost per day exceeds \$50 and packaging the costs of drugs, biologicals, and radiopharmaceuticals whose median cost per day is less than \$50 into the procedures with which they are billed. For CY 2005, we also adopted an exception policy to our packaging rule for one particular class of drugs, the oral and injectable 5HT3 forms of anti-emetic treatments (69 FR 65779 through 65780).

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

In accordance with section 1833(t)(16)(B) of the Act, for CY 2006, the threshold for establishing separate

APCs for drugs and biologicals is required to be set at \$50 per administration. Therefore, in the CY 2006 proposed rule we proposed to continue our existing policy of paying separately for drugs, biologicals, and radiopharmaceuticals whose per day cost exceeds \$50 and packaging the cost of drugs, biologicals, and radiopharmaceuticals whose per day cost is less than \$50 into the procedures with which they are billed. We also proposed to continue our policy of exempting seven oral and injectable 5HT3 anti-emetic products from our packaging rule (Table 21 of the CY 2006 OPPS proposed rule, 70 FR 42723), thereby making separate payment for all of the 5HT3 anti-emetic products. As stated in our CY 2005 final rule with comment period (69 FR 65779 through 65780), chemotherapy is very difficult for many patients to tolerate, as the side effects are often debilitating. In order for beneficiaries to achieve the maximum therapeutic benefit from chemotherapy and other therapies with side effects of nausea and vomiting, anti-emetic use is often an integral part of the treatment regimen. We want to continue to ensure that our payment rules do not impede a beneficiary's access to the particular anti-emetic that is most effective for him or her as determined by the beneficiary and his or her physician.

TABLE 20.—ANTI-EMETICS TO EXEMPT FROM \$50 PACKAGING REQUIREMENT

| HCPCS Code | Short description |
|-------------|----------------------------|
| J1260 | Dolasetron mesylate. |
| J1626 | Granisetron HCl injection. |
| J2405 | Ondansetron HCl injection. |
| J2469 | Palonosetron HCl. |
| Q0166 | Granisetron HCl 1 mg oral. |
| Q0179 | Ondansetron HCl 8 mg oral. |
| Q0180 | Dolasetron mesylate oral. |

For the CY 2006 proposed payment rates, we calculated the per day cost of all drugs, biologicals, and radiopharmaceuticals that had a HCPCS code in CY 2004 and were paid (via packaged or separate payment) under the OPPS using claims data from January 1, 2004 to December 31, 2004. In CY 2004, multisource drugs and radiopharmaceuticals had two HCPCS codes that distinguished the innovator multisource (brand) drug or radiopharmaceutical from the noninnovator multisource (generic) drug or radiopharmaceutical. We aggregated claims for both the brand and generic HCPCS codes in our packaging analysis of these multisource products. Items such as single indication orphan drugs, certain vaccines, and blood and blood

products were excluded from these calculations and our treatment of these items is discussed separately in sections V.F., V.E., and X.B., respectively, of this preamble.

In order to calculate the per day cost for drugs, biologicals, and radiopharmaceuticals to determine their packaging status in CY 2006, we proposed several changes in the methodology that was described in detail in the CY 2004 OPPS proposed rule (68 FR 47996 through 47997) and finalized in the CY 2004 final rule with comment period (68 FR 63444 through 63447). For CY 2006, to calculate the per day cost of the drugs, biologicals, and radiopharmaceuticals, our proposed methodology was the following:

Step 1. After application of the CCRs, we aggregated all line-items for a single date of service on a single claim for each product. This resulted in creation of a single line-item with the total number of units and the total cost of a drug or radiopharmaceutical given to a patient in a single day.

Step 2. We then created a separate record for each drug or radiopharmaceutical by date of service, regardless of the number of lines on which the drug or radiopharmaceutical was billed on each claim. For example, "drug X" is billed on a claim with two different dates of service, and for each date of service, the drug is billed on two line-items with a cost of \$10 and 5 units for each line-item. In this case, the computer program would create two records for this drug, and each record would have a total cost of \$20 and 10 units of the product.

Step 3. We trimmed records with unit counts per day greater or less than 3 standard deviations from the geometric mean. (This is a new step in the methodology that we proposed for CY 2006.)

Step 4. For each remaining record for a drug or radiopharmaceutical, we calculated the cost per unit of the drug. If the HCPCS descriptor for "drug X" is "per 1 mg" and one record was created for a total of 10 mg (as indicated by the total number of units for the drug on the claim for each unique date of service), the computer program divided the total cost for the record by 10 to give a per unit cost. We then weighted this unit cost by the total number of units in the record. We did this by generating a number of line-items equivalent to the number of units in that particular claim. Thus, a claim with 100 units of "drug X" and a total cost of \$200 would be given 100 line-items, each with a cost of \$2, while a claim of 50 units with a cost of \$50 would be given 50 line items, each with a cost of \$1.

Step 5. We trimmed the unit records with cost per unit greater or less than 3 standard deviations from the geometric mean.

Step 6. We aggregated the remaining unit records to determine the mean cost per unit of the drug or radiopharmaceutical.

Step 7. Using only the records that remained after records with unit counts per day greater or less than 3 standard deviations from the geometric mean were trimmed (step 3), we determined the total number of units billed for each item and the total number of unique per-day records for each item. We divided the count of the total number of units by the total number of unique per-day records for each item to calculate an average number of units per day.

Step 8. Instead of using median cost as done in previous years, we used the payment rate for each drug and biological effective April 1, 2005 for the physician office setting, which was calculated using the ASP methodology, and multiplied the payment rate by the average number of units per day for each drug or biological to arrive at its per day cost. For items that did not have an ASP-based payment rate, we used their mean unit cost derived from the CY 2004 hospital claims data to determine their per day cost. Our reasoning for using these cost data is discussed in section V.B.3.a. of this preamble.

Step 9. We packaged the items with per day cost based on the ASP methodology or mean cost less than \$50 and made items with per day cost greater than \$50 separately payable.

In the past, many commenters had alleged that hospitals do not accurately bill the number of units for drugs and radiopharmaceuticals consistent with expected appropriate clinical use. We have consistently decided not to determine whether a hospital claim reports a clinically appropriate unit dose of a drug for rate-setting purposes. Variations among patients with respect to appropriate doses, the variety of indications with different dosing regimens for some agents, and the possibility of off-label uses make it difficult to know when units are incorrectly reported. However, we believed that trimming the units would improve the accuracy of estimates by removing those records with the most extreme units, without requiring us to speculate about clinically appropriate dosing. Therefore, we believed that trimming the records with unit counts greater or less than 3 standard deviations from the geometric mean would eliminate claims from our analysis that might not appropriately

represent the actual number of units of a drug or radiopharmaceutical furnished by a hospital to a patient during a specific clinical encounter. Because it reduced extreme variation, trimming on greater or less than 3 standard deviations from the geometric mean made this trim more conservative and removed fewer records. This change in methodology gave us even greater confidence in the cost estimates we use for our packaging decisions.

We specifically requested comments on the changes that we proposed in our methodology for packaging drugs and radiopharmaceuticals. In response, we received numerous public comments on the proposed methodology.

Comment: Many commenters supported CMS' continued use of the \$50 per day cost threshold to determine whether a drug, biological, or radiopharmaceutical will be packaged or paid separately. One commenter indicated that this system allows hospital outpatient departments to have an efficient option for packaging and for collecting payments for less costly drugs. Numerous commenters also supported CMS' proposal to exempt the 5HT3 anti-emetic products from the current \$50 packaging threshold and pay for all of them separately, noting that the policy will help to ensure that Medicare beneficiaries have access to the particular anti-emetic that is most effective for them as determined by the beneficiary and his or her physician. One commenter, to the contrary, indicated that the current threshold for separate payment of radiopharmaceuticals is too high and

distorts the resource homogeneity of the nuclear medicine APCs and recommended that CMS make separate payments for all radiopharmaceuticals.

Response: We appreciate the commenters' support of our proposals for CY 2006 to establish a packaging threshold for drugs, biologicals, and radiopharmaceuticals at \$50 per day and to pay separately for the seven 5HT3 anti-emetic products. Section 1833(t)(16)(B) of the Act requires that the threshold for establishing separate APCs for drugs and biologicals be set at \$50 per administration for CY 2006. Therefore, we cannot change the threshold amount for radiopharmaceuticals, to which the policy also applies, as one of the commenters has suggested.

In determining the packaging status of drugs, biologicals, and radiopharmaceuticals for CY 2006, we calculated the per day costs of these items using the general methodology described above. However, as it is our policy to use updated data for the final rule, to determine the final per day costs of these items we used the payment rate for each drug and biological effective October 1, 2005 for the physician office setting, which was calculated using the ASP methodology, along with updated hospital claims data from CY 2004. The payment rate was multiplied by the average number of units per day for each drug or biological, which were recalculated using all of the CY 2004 hospital claims data used for this final rule with comment period, to arrive at each product's per day cost. For items that did not have an ASP-based

payment rate, we used their mean unit cost, which we also recalculated using all of the CY 2004 hospital claims data used for this final rule with comment period to determine their per day cost.

We note that there are two drugs for which we proposed to pay separately in our proposed rule that now have per day costs less than \$50 based on the updated cost and claims data. In these cases, we are applying our equitable adjustment authority to the packaging threshold according to the policy that we finalized in the CY 2005 final rule for drugs and biologicals with similar circumstances (69 FR 65780). Therefore, for CY 2006, we are applying the following policy to these drugs and biologicals:

- Drugs and biologicals that were paid separately in CY 2005, were proposed for separate payment in CY 2006, and have per day costs less than \$50 based on updated ASPs and hospital claims data used for this CY 2006 final rule with comment period will continue to receive separate payment in CY 2006.

- Those drugs and biologicals that were packaged in CY 2005, were proposed for separate payment in CY 2006, and have per day costs less than \$50 based on updated ASPs and hospital claims data used for this CY 2006 final rule with comment period will remain packaged in CY 2006.

Table 21 lists the two drugs and biologicals to which this policy will apply, along with their CYs 2005 and 2006 payment status indicators.

TABLE 21.—DRUGS AND BIOLOGICALS WITH PER DAY COSTS LESS THAN \$50 USING FINAL RULE DATA, BUT WERE PROPOSED FOR SEPARATE PAYMENT

| HCPCS | Description | CY 2005 status indicator | CY 2006 status indicator |
|-------------|-----------------------------------|--------------------------|--------------------------|
| J0580 | Penicillin g benzathine inj | N | N |
| J3350 | Urea injection | K | K |

We also note that there were several drugs, biologicals, and radiopharmaceuticals that we proposed to package in the proposed rule and that now have per day costs greater than \$50 using updated ASPs and all of the hospital claims data from CY 2004 used for this final rule with comment period. In accordance with our established policy for such cases, for CY 2006 we will pay for these drugs, biologicals, and radiopharmaceuticals separately. Table 22 lists the drugs and biologicals that were proposed as packaged items, but will be paid separately in CY 2006.

TABLE 22.—DRUGS AND BIOLOGICALS WITH PER DAY COSTS ABOVE \$50 FOR WHICH SEPARATE PAYMENT WILL BE MADE IN CY 2006

| HCPCS ¹ | Description |
|--------------------|------------------------------|
| 90665 | Lyme disease vaccine, im. |
| 90717 | Yellow fever vaccine, sc. |
| A9504 | Technetium tc 99m apcitide. |
| J0350 | Injection anistreplase 30 u. |
| J0470 | Dimecaprol injection. |
| J2700 | Oxacillin sodium injection. |
| J2910 | Aurothioglucose injection. |
| J3470 | Hyaluronidase injection. |
| J7197 | Antithrombin iii injection. |

Comment: One commenter supported the addition of "step 3" to the calculation of the per day cost methodology used to determine the packaging status of drugs, biologicals, and radiopharmaceuticals and stated that the addition of the new step will improve the accuracy of the per day cost calculation by enabling CMS to trim out very high units of service associated with very low costs that may inappropriately lower the overall median cost.

Response: We appreciate the commenter's support of the change in our methodology to determine the per

day costs of drugs, biologicals, and radiopharmaceuticals and are finalizing this change for CY 2006, along with the other proposed changes for determining per day costs of these items.

Comment: We received comments on the packaging status of one drug and several radiopharmaceuticals where the commenters indicated that the items were incorrectly packaged and should be paid separately in CY 2006. Specific items mentioned in the comments were HCPCS codes J1245, A9513, C1079, C9013, and Q3012. One commenter asserted that confusing HCPCS descriptors contributed to the submission of inaccurate claims data to CMS. This commenter also noted that the inconsistent market availability of some of these products resulted in small numbers of claims and variable cost data, which CMS used to determine the per day costs of these items. The commenters indicated that there are other products that are used for the same indication as some of these products, and also that there are clinical situations where physician would prefer to utilize one particular product over another. Therefore, commenters did not want payment rules to affect access to particular products that may be most clinically effective for patients.

Response: We understand the commenters' concerns about the packaging of these items. Based on the methodology we used to calculate per day costs of these items, as described earlier in the preamble, we determined that the per-day costs of these products were below \$50. Therefore, these items were packaged. When we recalculated the per day costs of these items using updated CY 2004 claims data and ASP-based payment rates based on data from the second quarter of CY 2005 for the final rule, we observed that the per day costs of these items remained below \$50. For radiopharmaceuticals, we recalculate their mean per day costs using updated CY 2004 claims data.

As described earlier, we applied an additional unit trimming step in the methodology to determine per day costs of items in CY 2006. We stated our belief that trimming the units would improve the accuracy of the per day cost estimates by removing those records with the most extreme units, without requiring us to speculate about clinically appropriate dosing. Therefore, we believe that the new trimming step eliminates claims from our analysis that might not appropriately represent the actual number of units of a drug or radiopharmaceutical furnished by a hospital to a patient during a specific clinical encounter. We indicated that this change in methodology gave us

even greater confidence in the cost estimates we use for our packaging decisions. Also, section 621(a)(2) of Pub. L. 108-173 requires that the threshold for establishing separate APCs for drugs and biologicals be set at \$50 per administration for CY 2006. Therefore, we cannot change the packaging threshold amount from \$50, which would be required of us if we were to pay for these items separately. For these reasons, we believe that it is appropriate for us to package these items in CY 2006 under OPSS. We expect that the modest per day costs of these packaged items will allow hospitals to make the most clinically appropriate choices of products in their care of patients, as hospitals will also bill a variety of separately payable services for the care provided.

Comment: One commenter indicated that it is operationally impossible to establish a separate process for charging anti-emetic drugs when they are used only in conjunction with chemotherapy since the majority of their surgical outpatients receive these drugs. The commenter inquired as to whether CMS could develop an edit to only pay for the anti-emetic drug when it is connected to a cancer diagnosis.

Response: We note that separate payments for these 5HT₃ injectable and oral anti-emetic drugs will be made as long as these drugs are covered by Medicare, regardless of the clinical indications for the drugs' use. The policy described above for the 5HT₃ anti-emetic drugs applies only to the packaging status of these items, not to their coverage status. Hospitals should continue billing for these injectable and oral anti-emetic drugs in accordance with existing coverage rules.

Section 1833(t)(16)(B) of the Act that requires the threshold for establishing separate APCs for drugs and biologicals to be set at \$50 per administration will expire at the end of CY 2006. Therefore, we will be evaluating other packaging thresholds for these products for the CY 2007 OPSS update. We specifically requested comments on the use of alternative thresholds for packaging drugs and radiopharmaceuticals in CY 2007.

We received a number of public comments in response to this request.

Comment: Commenters made various suggestions for establishing the packaging threshold for CY 2007. Several commenters encouraged CMS to set the packaging threshold no higher than \$50 in CY 2007 and beyond. Other commenters suggested that CMS provide separate payment for all infused and injectable drugs, regardless of their per day costs, and only continue to

package oral drugs in CY 2007. Other commenters echoed this general suggestion, but further suggested that the oral anti-emetic drugs be paid separately along with the infused and injectable drugs. One commenter stated that CMS should continue to pay separately for all drugs and biologicals that were separately paid in the past, including all therapies that had received pass-through status. Another commenter suggested that, to the extent CMS may elect to raise the packaging threshold in CY 2007 and beyond, the threshold be linked to an appropriate price indexing mechanism. In establishing the appropriate price indexing measure, the commenter urged CMS to give substantial consideration to the impact resulting from capturing more high-cost drugs in packaged payment groups, including the effect such a policy may have on beneficiary access to needed treatments, with particular focus on avoiding unintended disadvantages for newer innovator products. Other commenters suggested that CMS determine appropriate payment levels that will be sufficient to ensure patient access in its consideration of the use of alternative thresholds for packaging drugs in CY 2007, and that CMS utilize ASP data from CY 2005 to determine the appropriate parameters for a packaging threshold in CY 2007. On the other hand, MedPAC indicated that it has long been concerned about the incentives created by the unpackaging of drugs that exists in the OPSS. For example, MedPAC stated that, under the OPSS, providers have an incentive to use a higher-cost drug that is paid separately in place of a lower-cost drug that is packaged. If hospitals act on this incentive, it could raise beneficiaries' overall cost sharing, Part B premiums, and program spending. MedPAC added that setting payment rates for small packages is likely to be less accurate than setting rates for larger packages. It pointed out that, with greater packaging, variations in charging practices are more likely to balance out, leading to payment rates that, on average, are more reflective of costs.

Response: We appreciate receiving these suggestions for establishing an appropriate packaging threshold for CY 2007 and will take the recommendations into consideration as we work on our packaging proposal for the CY 2007 OPSS.

3. Payment for Drugs, Biologicals, and Radiopharmaceuticals Without Pass-Through Status That Are Not Packaged

a. Payment for Specified Covered Outpatient Drugs

(1) Background

Section 1833(t)(14) of the Act, as added by section 621(a)(1) of Pub. L. 108–173, requires special classification of certain separately paid radiopharmaceuticals, drugs, and biologicals and mandates specific payments for these items. Under section 1833(t)(14)(B)(i) of the Act, a “specified covered outpatient drug” is a covered outpatient drug, as defined in section 1927(k)(2) of the Act, for which a separate APC exists and that either is a radiopharmaceutical agent or is a drug or biological for which payment was made on a pass-through basis on or before December 31, 2002.

Under section 1833(t)(14)(B)(ii) of the Act, certain drugs and biologicals are designated as exceptions and are not included in the definition of “specified covered outpatient drugs.” These exceptions are—

- A drug or biological for which payment is first made on or after January 1, 2003, under the transitional pass-through payment provision in section 1833(t)(6) of the Act.
- A drug or biological for which a temporary HCPCS code has not been assigned.
- During CYs 2004 and 2005, an orphan drug (as designated by the Secretary).

Section 1833(t)(14)(F) of the Act defines the categories of drugs based on section 1861(t)(1) and sections 1927(k)(7)(A)(ii), (k)(7)(A)(iii), and (k)(7)(A)(iv) of the Act. The categories of drugs are “sole source drugs (includes a biological product or a single source drug),” “innovator multiple source drugs,” and “noninnovator multiple source drugs.” The definitions of these specified categories for drugs, biologicals, and radiopharmaceuticals were discussed in the January 6, 2004 OPSS interim final rule with comment period (69 FR 822), along with our use of the Medicaid average manufacturer price database to determine the appropriate classification of these products. Because of the many comments received on the January 6, 2004 interim final rule with comment period, the classification of many of the drugs, biologicals, and radiopharmaceuticals changed from that initially published. We announced these changes to the public on February 27, 2004, through Transmittal 112, Change Request 3144. We also implemented

additional classification changes through Transmittal 132 (Change Request 3154, released March 30, 2004) and Transmittal 194 (Change Request 3322, released June 4, 2004).

Section 1833(t)(14)(A) of the Act, as added by section 621(a)(1) of Pub. L. 108–173, also provides that payment for these specified covered outpatient drugs for CYs 2004 and 2005 is to be based on its “reference average wholesale price (AWP).” Section 1833(t)(14)(A)(ii) of the Act, as added by section 621(a) of Pub. L. 108–173 requires that in CY 2005—

- A sole source drug must be paid no less than 83 percent and no more than 95 percent of the reference AWP.
- An innovator multiple source drug must be paid no more than 68 percent of the reference AWP.
- A noninnovator multiple source drug must be paid no more than 46 percent of the reference AWP.

Section 1833(t)(14)(G) of the Act defines “reference AWP” as the AWP determined under section 1842(o) the Act as of May 1, 2003. We interpreted this to mean the AWP set under the CMS single drug pricer (SDP) based on prices published in the Red Book on May 1, 2003.

For CY 2005, we finalized our policy to determine the payment rates for specified covered outpatient drugs under the provisions of Pub. L. 108–173 by comparing the payment amounts calculated under the median cost methodology as done for procedural APCs to the AWP percentages specified in section 1833(t)(14)(A)(ii) of the Act.

(2) Changes for CY 2006 Related to Pub. L. 108–173

Section 1833(t)(14)(A)(iii) of the Act, as added by section 621(a)(1) of Pub. L. 108 173, requires that payment for specified covered outpatient drugs in CY 2006 be equal to the average acquisition cost for the drug for that year as determined by the Secretary subject to any adjustment for overhead costs and taking into account the hospital acquisition cost survey data collected by the Government Accountability Office (GAO) in CYs 2004 and 2005. If hospital acquisition cost data are not available, the law requires that payment be equal to payment rates established under the methodology described in section 1842(o), section 1847A, or section 1847B of the Act as calculated and adjusted by the Secretary as necessary.

(3) Data Sources Available for Setting CY 2006 Payment Rates

Section 1833(t)(14)(D) of the Act, as added by section 621(a)(1) of Pub. L. 108–173, outlines the provisions of the

hospital outpatient drug acquisition cost survey mandated for the GAO. This provision directs the GAO to collect data on hospital acquisition costs of specified covered outpatient drugs and to provide information based on these data that can be taken into consideration for setting CY 2006 payment rates for these products under the OPSS. Accordingly, the GAO conducted a survey of 1,400 acute care, Medicare-certified hospitals and requested hospitals to provide purchase prices for specified covered outpatient drugs purchased between July 1, 2003 and June 30, 2004. The survey yielded a response rate of 83 percent; 1,157 hospitals provided usable information. To ensure that its methodology for data collection and analysis was sound, the GAO consulted an advisory panel of experts in pharmaceutical economics, pharmacy, medicine, survey sampling and Medicare payment.

The GAO reported the average and median purchase prices for 55 specified covered outpatient drug categories for the period July 1, 2003 to June 30, 2004. These items represented 86 percent of Medicare spending for specified covered outpatient drugs during the first 9 months of CY 2004. The initial GAO data did not include any radiopharmaceuticals. The report noted that the purchase price information accounted for volume and other discounts provided at the time of purchase, but excluded subsequent rebates from manufacturers and payments from group purchasing organizations. The GAO survey data were available in time for consideration in the CY 2006 OPSS proposed rule.

At the time of issuance of the CY 2006 OPSS proposed rule, another available source of drug pricing information was the ASP data from the fourth quarter of CY 2004, which were used to set payment rates for drugs and biologicals in the physician office setting effective April 1, 2005. We had ASP-based prices for approximately 475 drugs and biologicals (including contrast agents) payable under the OPSS. However, we did not then have (and we still do not have) any ASP data on radiopharmaceuticals. Payments for most of the drugs and biologicals paid in the physician office setting were based on ASP+6 percent. Payments for items with no reported ASP were based on wholesale acquisition cost (WAC).

Lastly, the third source of cost data that we had at the time of issuance of the proposed rule for drugs, biologicals, and radiopharmaceuticals was the mean and median costs derived from the CY 2004 hospital claims data. In our data analysis for the proposed rule, we

compared the payment rates for drugs and biologicals using data from all three sources described above. As section 1833(t)(14)(A)(iii) of the Act clearly specifies that payment for specified covered outpatient drugs in CY 2006 be equal to the “average” acquisition cost for the drug, we limited our analysis to the mean costs of drugs determined

using the GAO acquisition cost survey and the hospital claims data, instead of using median costs. For the proposed rule, we estimated aggregate expenditures for all drugs and biologicals (excluding radiopharmaceuticals) that would be separately payable in CY 2006 and for the 55 drugs and biologicals reported by the GAO using mean costs from the

claims data, the GAO mean purchase prices, and the ASP-based payment amounts (ASP+6 percent in most cases), and calculated the equivalent average ASP-based payment rate under each of the three payment methodologies. The results which we presented in the proposed rule are shown in Table 23 below.

TABLE 23.—COMPARISON OF RELATIVE PRICING FOR OPPTS DRUGS AND BIOLOGICALS UNDER VARIOUS PAYMENT METHODOLOGIES

| Type of pricing data | Time period of pricing data | ASP equivalent (55 GAO drugs only) | ASP equivalent (all separately billable drugs) |
|----------------------------------|----------------------------------|------------------------------------|--|
| GAO mean purchase price | 12 months ending June 2004 | ASP+3% | N/A |
| ASP+6% | 4th quarter of 2004 | ASP+6% | ASP+6% |
| Mean cost from claims data | 1st 9 months of 2004 | ASP+8% | ASP+8% |

Prior to any adjustments for the differing time periods of the pricing data, the results indicated that using the GAO mean purchase prices as the basis for paying the 55 drugs and biologicals would be equivalent to paying for those drugs and biologicals, on average, at ASP+3 percent. In addition, using mean unit cost from hospital claims data to set the payment rates for the drugs and biologicals that would be separately payable in CY 2006 would be equivalent to basing their payment rates, on average, at ASP+8 percent.

In determining the payment rates for drugs and biologicals in CY 2006, we did not propose to use the GAO mean purchase prices for the 55 drugs and biologicals because the GAO data reflect hospital acquisition costs from a less recent period of time. The survey was conducted from July 1, 2003 to June 30, 2004; thus, the purchase prices are generally reflective of the time that is the midpoint of this period, which is January 1, 2004. The hospital purchase price data also do not fully account for rebates from manufacturers or payments from group purchasing organizations made to hospitals. We also noted that it would be difficult to update the GAO mean purchase prices during CY 2006 and in future years.

We also did not propose, in general, to use mean costs from CY 2004 hospital claims data to set payment rates for drugs and biologicals in CY 2006. In previous OPPTS rules, we stated that pharmacy overhead costs are captured in the pharmacy revenue cost centers and reflected in the median costs of drug administration APCs, and the payment rate we established for a drug, biological, or radiopharmaceutical APC was intended to pay only for the cost of

acquiring the item (66 FR 59896 and 67 FR 66769). However, findings from a MedPAC survey of hospital charging practices indicated that hospitals set charges for drugs, biologicals, and radiopharmaceuticals high enough to reflect their handling costs as well as their acquisition costs. Therefore, the mean costs calculated using charges from hospital claims data converted to costs are representative of hospital acquisition costs for these products, as well as their pharmacy overhead costs. For CY 2006, the statute specifies that payments for specified covered outpatient drugs are required to be equal to the “average” acquisition cost for the drug. Payments based on mean costs would represent the products’ acquisition costs plus overhead costs, instead of acquisition costs only. Therefore, at the time of issuance of the proposed rule, we determined that it would be appropriate for us to use a source of cost information other than the CY 2004 hospital claims data to set the payment rates for most drugs and biologicals in CY 2006.

Based on these considerations, we proposed to pay ASP+6 percent as the acquisition payment for separately payable drugs and biologicals in CY 2006. Given the data as described above, we determined at the time of issuance of the proposed rule that this was our best estimate of average acquisition costs for CY 2006. We noted in the proposed rule (70 FR 42726) that the comparison between the GAO purchase price data and the ASP data indicated that the GAO data, on average, were equivalent to ASP+3 percent. However, as noted earlier, we determined that this comparison was problematic for two

reasons. First, there were differences in the time periods for the two sources of data. The GAO data were from the 12 months ending June 2004, and the ASP data were from the fourth quarter of CY 2004. It could be argued that prices increased in the intervening time period. However, we determined that there was no source of reliable information on specific price changes for this time period for the drugs studied by the GAO. In the future, we will have better information on price trends for Medicare Part B drugs as more quarters of pricing information are reported under the ASP system.

We also noted that the comparison between the GAO data and the ASP data was problematic as the ASP data included rebates and other price concessions and the GAO data did not. Inclusion of these rebates and price concessions in the GAO data would decrease the GAO prices relative to the ASP prices, suggesting that ASP+6 percent may be an overestimate of hospitals’ average acquisition costs. Unfortunately, we did not have a source of information on the magnitude of the rebates and price concessions for the specific drugs in the GAO data at that time.

Therefore, we determined in the proposed rule that it was difficult to adjust the GAO prices for inflation, rebates, and price concessions to make the comparison with ASP more precise. We indicated that we would continue to examine new data to improve our future estimates of acquisition costs. In future years, our proposed pricing would be modified as appropriate to reflect the most recent data and analyses available. We also noted that, in addition to the importance of making accurate

estimates of acquisition costs for drug pricing, there were important implications for prices of other services due to the required budget neutrality of the OPSS. For example, drugs and biological prices set at ASP+3 percent instead of ASP+6 percent would have made available approximately an additional \$60 million for other items and services under the OPSS.

In the proposed rule, we also noted that ASP data are unavailable for some drugs and biologicals. For the few drugs and biologicals, other than radiopharmaceuticals as discussed later, where ASP data were unavailable, we proposed to use the mean costs from the CY 2004 hospital claims data to determine their packaging status for rate-setting. Until we received ASP data for these items, we proposed that payment would be based on their mean cost.

Our proposal used payment rates based on ASP data from the fourth quarter of CY 2004 because these were the most recent numbers available to us during the development of the proposed rule. To be consistent with the ASP-based payments that would be made when these drugs and biologicals are furnished in physician offices, we stated in our proposed rule (70 FR 42726) that we planned to make any appropriate adjustments to the amounts shown in Addenda A and B to the proposed rule for these items based on more recent ASP data from the second quarter of CY 2005, which is the basis for setting payment rates for drugs and biologicals in the physician office setting effective October 1, 2005, prior to our publication of the CY 2006 OPSS final rule, and also on a quarterly basis on our Web site during CY 2006. We noted that we would determine the packaging status of each drug or biological only once during the year during the update process. However, for the separately payable drugs and biologicals, we would update their ASP-based payment rates on a quarterly basis.

We also noted that we intend for the quarterly updates of the ASP-based payment rates for separately payable drugs and biologicals to function as future surveys of hospital acquisition cost data, as section 1833(t)(14)(D)(ii) of the Act instructs us to conduct periodic subsequent surveys to determine hospital acquisition cost for each specified covered outpatient drug.

We specifically requested comments on our proposal to pay for drugs and biologicals (including contrast agents) under the OPSS using the ASP-based methodology that is also used to set the payment rates for drugs and biologicals furnished in physician offices and the

adequacy of the payment rates to account for hospital acquisition costs of the drugs and biologicals.

During the August 2005 meeting of the APC Panel, the Panel recommended that CMS evaluate all the separately payable drug to be paid at ASP+6 percent under the OPSS and pay particular attention to those whose payments would drop or rise precipitously. We appreciate the Panel's support of our payment proposal and discuss the final CY 2006 policies for drugs and biologicals below.

We received many public comments in response to our proposal to pay for drugs and biologicals under the OPSS using the ASP methodology.

Comment: Many commenters, including national organizations representing leading pharmaceutical and biotechnology companies, hospital associations, and hospitals, supported CMS' proposal to pay for most separately payable drugs and biologicals at ASP+6 percent. These commenters stated that paying for drugs and biologicals at this rate appeared to be both a reasonable and the best available estimate of average hospital acquisition cost. One commenter stated that ASPs reported by manufacturers are as close to real-time costs as any data source CMS uses for rate-setting. Some of the commenters indicated that this policy offered hospitals the assurance that the payment rates will reflect market conditions as those rates will be updated on a quarterly basis. Other supporters of this proposal noted that the policy had the additional benefit of providing consistent payment rates under the OPSS and under Part B in the physician office setting, thus helping to avoid financial incentives for selection of sites of service. One commenter indicated that the proposed policy also offered simplicity to the OPSS, both for CMS and providers, by treating almost all separately paid drugs uniformly and noted that paying for pass-through drugs the same way as other separately payable drugs without pass-through status created appropriate incentives to provide the most effective therapies, regardless of their costs and payment amounts.

A comment from MedPAC acknowledged the problems presented by the GAO purchase price information and recognized the use of ASP data as a viable alternative. However, MedPAC indicated that a limitation of ASP data is that CMS derives ASPs from manufacturers' sales to all distribution channels, including wholesalers, group purchasing organizations, hospitals, and other providers such as physicians. Therefore, the ASPs do not specifically

reflect hospital acquisition costs. Furthermore, MedPAC indicated that reporting may not be consistent across manufacturers, and CMS may need to verify the accuracy of ASP data through confidential audits. Although MedPAC stated that it supports CMS' proposed use of ASPs, it remained concerned about the proposal to pay for most specified covered outpatient drugs at a rate of ASP+8 percent, specifically ASP+6 percent for the drug and an additional 2 percent for handling costs. MedPAC noted that CMS' analysis of hospitals' mean purchase prices for drugs studied in the GAO survey indicated that the hospitals' mean purchase prices were equivalent to ASP+3 percent. Given that average ASP values have declined in recent quarters and that the GAO's data did not fully reflect rebates, MedPAC stated that the proposed payment rates for drugs alone may be too high.

Several commenters, however, remained concerned that this proposal will result in significant reductions in payments below acquisition costs for certain types of drugs and biologicals, such as IVIG and drugs and biologicals used to treat rare disorders, and was inadequate to protect beneficiary access to these therapies. One commenter indicated that payments increased to ASP+8 percent also resulted in compensation below acquisition costs for certain products. Many of these commenters urged CMS to monitor patient access problems and take prompt steps to adjust payment rates where necessary to address such problems. Several commenters requested that CMS implement the APC Panel's recommendation to monitor for "precipitous" drops in payment rates during the transition to ASP-based payments and apply a dampening policy to the payment rates for certain drugs and biologicals. Several dampening options were suggested, such as limiting payment decreases to 15 percent from CY 2005, paying at the higher of ASP+8 percent or 90 percent of drugs' CY 2005 payment rates, and freezing payment at the CY 2005 levels. One commenter recommended that no change be made to the payment rates for drugs and biologicals from CY 2005 to CY 2006. Another commenter urged CMS to gather data on the adequacy of ASP payment over the next year and report to Congress if the agency finds that ASP is not an appropriate payment formula.

A comment from a large cancer care provider raised several issues concerning the use of ASPs. The commenter noted that the prices and discounts included in the calculation of

ASP often are not passed along to providers. The commenter added that small hospitals without purchasing power are likely to purchase drugs above ASP rates. In addition, the commenter noted that because manufacturers typically raise prices two to three times per year, the two-quarter lag in the calculation of ASP may cause hospitals to suffer losses each time they administer drugs. Another commenter questioned whether ASP could be calculated regionally instead of nationally. One commenter noted that CMS did not make clear in the proposed rule what data will be used to establish payment rates for separately payable drugs and biologicals as of January 1, 2006. The commenter indicated that ASP data for the third quarter of CY 2005 will be available on October 30, 2005 and requested that these data be used to set payment rates for the first quarter of CY 2006.

Response: We appreciate the commenters' support of our proposal to

pay for separately payable drugs and biologicals at ASP+6 percent. For this final rule with comment period, we again evaluated the three data sources that we have available to us for setting the CY 2006 payment rates for drugs and biologicals. As described in the proposed rule, these data sources are the GAO reported average and median purchase prices for 55 specified covered outpatient drug categories for the period July 1, 2003 to June 30, 2004; ASP data; and mean and median costs derived from hospital claims data used for this final rule with comment period. For this final rule with comment period, we are able to use updated ASP data from the second quarter of CY 2005, which are used to set payment rates for drugs and biologicals in the physician office setting effective October 1, 2005. We are also able to use updated claims data, reflecting all of the hospital claims data from CY 2004 and updated CCRs.

In our data analysis for this final rule with comment period, we again

compared the payment rates for drugs and biologicals using data from all three sources described above. As described in the proposed rule, we limited our analysis to the mean costs of drugs and biologicals determined using the GAO acquisition cost survey and the hospital claims data, instead of using median costs. We estimated aggregate expenditures for all drugs and biologicals (excluding radiopharmaceuticals) that would be separately payable in CY 2006 and for the 55 drugs and biologicals reported by the GAO using mean costs from the claims data, the GAO mean purchase prices, and the ASP-based payment amounts (ASP+6 percent in most cases), and then calculated the equivalent average ASP-based payment rate under each of the three payment methodologies. The results based on updated ASP and claims data are presented in Table 24 below.

TABLE 24.—COMPARISON OF RELATIVE PRICING FOR OPPTS DRUGS AND BIOLOGICALS UNDER VARIOUS PAYMENT METHODOLOGIES

| Type of pricing data | Time period of pricing data | ASP equivalent (55 GAO drugs only) | ASP equivalent (all separately billable drugs) |
|----------------------------------|----------------------------------|------------------------------------|--|
| GAO mean purchase price | 12 months ending June 2004 | ASP+4% | N/A |
| ASP+6% | 2nd quarter of 2005 | ASP+6% | ASP+6% |
| Mean cost from claims data | 12 months of 2004 | ASP+6% | ASP+6% |

Prior to any adjustments for the differing time periods of the pricing data, the results indicated that using the GAO mean purchase prices as the basis for paying the 55 drugs and biologicals would be equivalent to paying for those drugs and biologicals, on average, at ASP+4 percent. In addition, using mean unit cost from hospital claims to set the payment rates for the drugs and biologicals that would be separately payable in CY 2006 would be equivalent to basing their payment rates, on average, at ASP+6 percent. We note that these levels are slightly different from the estimates we determined for the proposed rule, where the GAO data were equivalent to ASP+3 percent and mean costs derived from the CY 2004 claims data were equivalent to ASP+8 percent, on average. (See Table 22 of the CY 2006 OPPTS proposed rule, 70 FR 42725).

We understand the concerns raised by commenters about the reductions in payment rates for certain drugs and biologicals with the transition from an AWP-based methodology to an ASP-

based methodology. However, our intent is to pay for drugs and biologicals based on their hospital acquisition costs, and we believe that market-based ASP data, which are reported by the manufacturers, better represent these costs than dampened payment rates. We also note that commenters did not present actual evidence demonstrating that access problems currently exist for some of these products. They presented anecdotal reports and results based on surveys that we can not validate. Therefore, we believe that it is still appropriate for us to base payment for these items on the ASP data.

As noted earlier and in the proposed rule, findings from a MedPAC survey of hospital charging practices indicated that hospitals set charges for drugs, biologicals, and radiopharmaceuticals high enough to reflect their pharmacy handling costs as well as their acquisition costs. Therefore, the mean costs calculated using charges from hospital claims data converted to costs are representative of hospital acquisition costs for these products, as

well as their related pharmacy overhead costs. Our calculations indicated that using mean unit costs to set the payment rates for all separately payable drugs and biologicals would be equivalent to basing their payment rates on the ASP+6 percent, on average. This result also seems to confirm MedPAC's comment that paying for the acquisition cost of drugs alone at ASP+6 percent may be too high. Because pharmacy overhead costs are already built into the charges for drugs, biologicals, and radiopharmaceuticals, our current data therefore indicate that payment for drugs and biologicals and pharmacy overhead at a combined ASP+6 percent rate would serve as the best proxy for the combined acquisition and overhead costs of each of these products.

Therefore, in this final rule with comment period for CY 2006, we are adopting a policy of paying for the acquisition and overhead costs of separately paid drugs and biologicals at a combined rate of ASP+6 percent. In other words, payment at ASP+6 percent will serve as a proxy to make

appropriate payment for both the acquisition cost and overhead cost of each of these products. We discuss in additional detail our responses regarding payments for pharmacy overhead costs later in the preamble.

As noted in the proposed rule, ASP data are unavailable for some drugs and biologicals. For these few drugs and biologicals, we used the mean costs from the CY 2004 hospital claims data to determine their packaging status for rate-setting. Until we receive ASP data for these items, payment will be based on their mean cost calculated from CY 2004 hospital claims data. The payment rates for separately payable drugs and biologicals shown in Addenda A and B to this final rule with comment period represent payments for their acquisition costs in addition to their overhead costs.

For this final rule with comment period, we are using payment rates based on ASP data from the second quarter of CY 2005 because these are the most recent numbers available for the development of this final rule. To be consistent with the ASP-based payments that would be made when these drugs and biologicals are furnished in physician offices, as proposed, we plan to make any appropriate adjustments to the amounts shown in Addenda A and B to this final rule with comment period for these items on a quarterly basis as more recent ASP data become available and post the payment rate changes on our Web site during each quarter of CY 2006.

Effective January 1, 2006, we will base payment rates for separately payable drugs and biologicals on ASP data from the third quarter of CY 2005, which will also be the basis for setting payment rates for drugs and biologicals in the physician office setting effective January 1, 2006. We discussed in the proposed rule that we would determine the packaging status of each drug or biological only once during the year during the update process; however, for the separately payable drugs and biologicals, we would update their ASP-based payment rates on a quarterly basis. Specifically, for CY 2006, the packaging status of each drug or biological has been established using the ASP data from the second quarter of CY 2005 and the appropriate packaging status indicator can be found for these items in Addendum B of this final rule with comment period. During CY 2006, we will only update quarterly the payment rates for the separately payable drugs and biologicals whose payments are based on the ASP methodology.

Comment: One commenter requested that CMS standardize the HCPCS code descriptions in Addendum B, so that the

drug names appear first (and can be sorted alphabetically), rather than using "injection" as the first word. The commenter also sought clarification on the dosage sizes of several HCPCS codes and identified HCPCS codes for drugs that the commenters believed are obsolete.

Response: We note that the HCPCS code descriptions in Addendum B of our final rule with comment period are based on the short descriptors assigned to the HCPCS codes by the National HCPCS Panel. The National HCPCS Panel also determines the units associated with the HCPCS codes. We suggest that the commenter pursue its concerns related to the HCPCS codes through the process set up by the National HCPCS Panel.

Comment: One commenter indicated that there are currently five sodium hyaluronate products approved for use in the United States that differ in terms of molecular weights, proposed biological effects, active ingredient doses per treatment, number of treatments per course, and labeling for repeated treatment courses. Because of the existing coding mechanism for these products, the commenter noted that the proposed payment rates associated with the HCPCS codes may create financial incentives for hospitals to stock and use certain products instead of choosing products based on clinical judgment and appropriate treatment for patients. The commenter expressed the belief that the dosing differences among these agents warrant the creation of specific codes for each single source product and has submitted recommendations to CMS for specific coding and nomenclature for adoption in CY 2006.

Response: We recognize the commenter's concerns about payment for these sodium hyaluronate products under the OPSS. As noted earlier, the National HCPCS Panel has created HCPCS code J7318 (Hyaluron/derive intra-art inj) to describe all of the sodium hyaluronate products effective January 1, 2006. The payment rate for HCPCS code J7318 in CY 2006 will be established using the ASP data for all of the products described by this code. HCPCS code J7318 will be used in the OPSS during CY 2006 to report the administration of all products described by that code that do not have another OPSS-specific code available due to their pass-through status.

Comment: We received many comments on the significant proposed reduction in payment rates from CY 2005 to CY 2006 for several wound care products. The products of concern are Apligraf, Dermagraft, and Orcel, which are reported by HCPCS codes C1305,

C9201, and C9200 respectively under the OPSS in CY 2005. Commenters indicated that the proposed CY 2006 payment rates for the acquisition and overhead costs of all three of these products were incorrectly based on the CY 2004 claims data, instead of ASP+8 percent as proposed for other separately payable drugs and biologicals, and they were very concerned that decreased payments will significantly underpay hospitals and jeopardize patient access to these therapies. One of the commenters stated that CMS based payment for Apligraf on mean costs derived from the CY 2004 claims data because there had been no ASP payment rate specific to HCPCS code C1305 and noted that the ASP rate for Apligraf is reported by CMS in the physician office setting under HCPCS code J7340. Other commenters raised similar concerns for Dermagraft whose ASP rate is reported in the physician office setting under HCPCS code J7342, instead of HCPCS code C9201. With respect to Orcel, one commenter stated that this product was not commercially available during CY 2004 and, as a result, neither ASP data nor hospital outpatient claims data should have existed for the product. The commenter recommended that, in the absence of either claims or ASP data, CMS should follow its payment policy for drugs and biologicals that do not have ASP data and establish the payment rate for Orcel using WAC. If WAC was not available, then CMS should set payment for Orcel at 95 percent of the May 1, 2003 AWP.

Response: We recognize the commenters' concerns about the proposed reduction in payment rates for these wound care products in CY 2006. The commenters were correct in stating that we based the payment rates for these items on their mean costs derived from the CY 2004 claims data in the proposed rule because we believed that we did not have any ASP data for these C-codes. We appreciate the commenters indicating to us that HCPCS codes C1305 and C9201 are billed using HCPCS codes J7340 and J7342, respectively, in the physician office, and the ASP data submitted for these products were associated with their permanent J-codes.

For this final rule with comment period, we reviewed the NDCs for which ASP data from the second quarter of CY 2005 were reported under HCPCS codes J7340 and J7342, and verified that these NDCs included Apligraf and Dermagraft products, respectively. Therefore, for CY 2006, we will be deleting the HCPCS code C1305 for Apligraf and HCPCS code C9201 for Dermagraft and paying for these

products using the ASPs calculated for HCPCS codes J7340 and J7342, respectively. As one of the commenters noted, ASP data are not available currently for HCPCS code C9200, which describes Orcel. Based on our review of the descriptor for HCPCS code J7340, we determined that this code appropriately describes Orcel; therefore, we will be deleting HCPCS code C9200 and paying for this product using HCPCS code J7340. Even though the calculation of the ASP-based payment rate for HCPCS code J7340 does not currently account for the ASP of Orcel, we believe that it is still appropriate for us to pay for Orcel using HCPCS code J7340 since this code appropriately describes this product. Also, once Orcel becomes available in the market and we receive ASP data for this product, the ASP-based payment rate for HCPCS code J7340 will properly reflect the market price for Orcel. We believe that this coding policy will lessen confusion for providers, enhance coding

consistency between the OPPS and physician offices, and result in appropriate payment rates for these three wound care products in CY 2006.

In addition to reviewing whether permanent HCPCS codes duplicate the three temporary C-codes describing wound care products in the CY 2005 OPPS, we also reviewed whether there are permanent HCPCS codes that currently exist or will be created in CY 2006 that describe the other C-codes for drugs, biologicals, and radiopharmaceuticals that are payable under the OPPS in CY 2005 to determine if we could streamline coding for other items as well. Based on our review, we found that there are several C-codes for drugs, biologicals, and radiopharmaceuticals that are payable under OPPS in CY 2005 that will be replaced with new permanent HCPCS codes in CY 2006. We also found that there are some C-codes that are also described by other permanent HCPCS codes that existed in CY 2005. In cases

where it is appropriate to do so, we are deleting these C-codes and replacing them with new CY 2006 HCPCS codes or existing HCPCS codes that appropriately describe products currently coded in the OPPS by the C-codes. As discussed later in the preamble, we are also deleting the C-codes that were created to represent the innovator multiple source (brand) drugs and instructing hospitals to use the HCPCS codes for noninnovator multiple source (generic) drugs to bill for both the brand and generic forms of a drug in CY 2006. Table 25 lists the C-codes that we are deleting effective December 31, 2005 and the permanent HCPCS codes that will be replacing them in CY 2006. For services furnished on or after January 1, 2006, hospitals should use replacements codes to bill for the products whose C-codes will be deleted on December 31, 2005.

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**Table 25.--List of C-codes That Will Be deleted on December 31, 2005
and Their CY 2006 Replacement Codes**

| CY 2005 HCPCS Code | CY 2005 HCPCS Description | CY 2006 Replacement HCPCS Code(s) | CY 2006 HCPCS Description |
|-----------------------------------|--------------------------------------|--|--------------------------------------|
| C1079 | CO 57/58 per 0.5 uCi | A9546 | Co57/58 |
| C1080 | I-131 tositumomab, dx | A9544 | I131 tositumomab, dx |
| C1081 | I-131 tositumomab, tx | A9545 | I131 tositumomab, rx |
| C1082 | In-111 ibritumomab tiuxetan | A9542 | In111 ibritumomab, dx |
| C1083 | Yttrium 90 ibritumomab tiuxe | A9543 | Y90 ibritumomab, rx |
| C1091 | IN111 oxyquinoline,per0.5mCi | A9547 | In111 oxyquinoline |
| C1092 | IN 111 pentetate per 0.5 mCi | A9548 | In111 pentetate |
| C1093 | TC99M fanolesomab | A9566 | Tc99m fanolesomab |
| C1122 | Tc 99M ARCITUMOMAB PER VIAL | A9549 | Tc99m arcitumomab |
| C1200 | TC 99M Sodium Glucoheptonat | A9550 | Tc99m gluceptate |
| C1201 | TC 99M SUCCIMER, PER Vial | A9551 | Tc99m succimer |
| C1305 | Apligraf | J7340 | Metabolic active D/E tissue |
| C1775 | FDG, per dose (4-40 mCi/ml) | A9552 | F18 fdg |
| C9000 | Na chromateCr51, per 0.25mCi | A9553 | Cr51 chromate |
| C9007 | Baclofen Intrathecal kit- 1am | J0476 | Baclofen intrathecal trial |
| C9008 | Baclofen Refill Kit- 500mcg | J0475 | Baclofen 10 MG injection |
| C9009 | Baclofen Refill Kit- 2000mcg | J0475 | Baclofen 10 MG injection |
| C9013 | Co 57 cobaltous chloride | A9559 | Co57 cyano |
| C9102 | 51 Na Chromate, 50mCi | A9553 | Cr51 chromate |
| C9103 | Na Iothalamate I-125, 10 uCi | A9554 | I125 iothalamate, dx |
| C9105 | Hep B imm glob, per 1 ml | 90371 | Hep b ig, im |
| C9112 | Perflutren lipid micro, | Q9957 | Inj perflutren lip |

| CY 2005 HCPCS Code | CY 2005 HCPCS Description | CY 2006 Replacement HCPCS Code(s) | CY 2006 HCPCS Description |
|-----------------------------------|--------------------------------------|--|--------------------------------------|
| | 2ml | | micros,ml |
| C9123 | Transcyte, per 247 sq cm | J7344 | Nonmetabolic active tissue |
| C9127 | Paclitaxel protein pr | J9264 | Paclitaxel injection |
| C9128 | Inj pegaptanib sodium | J2503 | Pegaptanib sodium injection |
| C9129 | Inj clofarabine | J9027 | Clofarabine injection |
| C9200 | Orcel, per 36 cm2 | J7340 | Metabolic active D/E tissue |
| C9201 | Dermagraft, per 37.5 sq cm | J7342 | Metabolically active tissue |
| C9202 | Octafluoropropane | Q9956 | Inj octafluoropropane mic,ml |
| C9203 | Perflexane lipid micro | Q9955 | Inj perflexane lip micros,ml |
| C9205 | Oxaliplatin | J9263 | Oxaliplatin |
| C9206 | Integra, per cm2 | J7343 | Nonmetabolic act d/e tissue |
| C9211 | Inj, alefacept, IV | J0215 | Alefacept |
| C9212 | Inj, alefacept, IM | J0215 | Alefacept |
| C9218 | Injection, azacitidine | J9025 | Azacitidine injection |
| C9223 | Inj adenosine, tx dx | J0150 | Injection adenosine 6 MG |
| C9223 | Inj adenosine, tx dx | J0152 | Adenosine injection |
| C9226 | Ziconotide intrathecal inf | J2278 | Ziconotide injection |
| C9400 | Thallous chloride, brand | A9505 | TL201 thallium |
| C9401 | Strontium-89 chloride,brand | A9600 | Sr89 strontium |
| C9402 | Th I131 so iodide cap, brand | A9517 | Th I131 so iodide cap millic |
| C9403 | Dx I131 so iodide cap, brand | A9528 | Iodine I-131 iodide cap, dx |
| C9404 | Dx I131 so iodide sol, brand | A9529 | I131 iodide sol, dx |
| C9405 | Th I131 so iodide sol, brand | A9530 | I131 iodide sol, rx |
| C9410 | Dexrazoxane HCl inj, brand | J1190 | Dexrazoxane HCl injection |
| C9411 | Pamidronate disodium, brand | J2430 | Pamidronate disodium /30 MG |

| CY 2005 HCPCS Code | CY 2005 HCPCS Description | CY 2006 Replacement HCPCS Code(s) | CY 2006 HCPCS Description |
|--------------------|------------------------------|-----------------------------------|------------------------------|
| C9413 | Na hyaluronate bran | J7317 | Sodium hyaluronate injection |
| C9414 | Etoposide oral, brand | J8560 | Etoposide oral 50 MG |
| C9415 | Doxorubic hcl chemo, brand | J9000 | Doxorubic hcl 10 MG vl chemo |
| C9417 | Bleomycin sulfate inj, brand | J9040 | Bleomycin sulfate injection |
| C9418 | Cisplatin inj, brand | J9060 | Cisplatin 10 MG injection |
| C9419 | Inj cladribine, brand | J9065 | Inj cladribine per 1 MG |
| C9420 | Cyclophosphamide inj, brand | J9070 | Cyclophosphamide 100 MG inj |
| C9421 | Cyclophosphamide lyo, brand | J9093 | Cyclophosphamide lyophilized |
| C9422 | Cytarabine hcl inj, brand | J9100 | Cytarabine hcl 100 MG inj |
| C9423 | Dacarbazine inj, brand | J9130 | Dacarbazine 100 mg inj |
| C9424 | Daunorubicin, brand | J9150 | Daunorubicin |
| C9425 | Etoposide inj, brand | J9181 | Etoposide 10 MG inj |
| C9426 | Floxuridine inj, brand | J9200 | Floxuridine injection |
| C9427 | Ifosfomide inj, brand | J9208 | Ifosfomide injection |
| C9428 | Mesna injection, brand | J9209 | Mesna injection |
| C9429 | Idarubicin hcl inj, brand | J9211 | Idarubicin hcl injection |
| C9430 | Leuprolide acetate bran | J9218 | Leuprolide acetate injeciton |
| C9431 | Paclitaxel inj, brand | J9265 | Paclitaxel injection |
| C9432 | Mitomycin inj, brand | J9280 | Mitomycin 5 MG inj |
| C9433 | Thiotepa inj, brand | J9340 | Thiotepa injection |
| C9435 | Gonadorelin hydroch, brand | J1620 | Gonadorelin hydroch/ 100 mcg |
| C9436 | Azathioprine parenteral,brnd | J7501 | Azathioprine parenteral |
| C9437 | Carmus bischl nitro inj | J9050 | Carmus bischl nitro inj |
| C9438 | Cyclosporine oral, brand | J7502 | Cyclosporine oral 100 mg |
| C9439 | Diethylstilbestrol injection | J9165 | Diethylstilbestrol injection |
| C9440 | Vinorelbine tar,brand | J9390 | Vinorelbine tartrate/10 mg |

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Comment: One commenter noted that CMS should confirm that payment for echocardiography contrast agents will be based on ASP+6 percent plus an appropriate amount to reflect handling (no less than two percent) so that

payment for these items is consistent with all other separately payable drugs under OPPS. A few commenters indicated that CMS should implement the new HCPCS codes for echocardiography contrast agents,

which will be effective January 1, 2006, to facilitate uniform billing for all echocardiography contrast agents across all sites of service.

Response: In CY 2005, echocardiography contrast agents are

described by three C-codes, which are HCPCS code C9112 (Perflutren lipid micro, 2ml), HCPCS code C9202 (Octafluoropropane), and HCPCS code C9203 (Perflorane lipid micro). In the proposed rule, we proposed to delete these C-codes and pay for the products using Q-codes in CY 2006. As noted in the previous response to comments, these three C-codes will be deleted as of December 31, 2005 and replaced with HCPCS codes Q9957, Q9956, and Q9955, respectively. Hospitals should use the new Q-codes in CY 2006 when billing for these echocardiography contrast agents. We also note we will be paying for the acquisition and overhead costs of these separately payable echocardiography contrast agents at a combined rate of ASP+6 percent in CY 2006.

Comment: We received many comments that expressed concerns about the proposed reductions in OPPS payment rates for intravenous immunoglobulin (IVIG) products. Commenters requested that CMS make special consideration in its payment for IVIG due to the current access problems facing patients that rely on this lifesaving therapy. Commenters indicated that payment at ASP+6 percent has not been adequate to permit the continued purchase and administration of IVIG in physician offices, infusion suites, and home care settings, resulting in a shift of care to hospitals. Consequently, hospitals have been overburdened by the increase in demand for IVIG, which has not been easily accessible. The commenters indicated that CMS' goal in setting payment rates for IVIG should be to ensure that patients have access to all brands of IVIG in all sites of care. Commenters requested that CMS use any and all authority and flexibility to address the existing payment problems that will arise if the proposed OPPS payment rates for IVIG are implemented and recommended several actions. In order of priority, commenters' recommendations were to: (1) Provide a proxy add-on payment rate for IVIG when determining the CY 2006 payment levels; (2) in the absence of a proxy add-on, apply the 15-percent dampening provision proposed for device-dependent APCs to determine the CY 2006 payment rates for IVIG; (3) establish unique HCPCS codes for each brand of IVIG and set their payment rates on the ASP data specific to each product; (4) classify IVIG as a biologic response modifier and pay its administration through a high complexity intravenous infusion APC; and (5) exclude prompt pay discounts

when calculating the ASPs for the IVIG HCPCS codes and equalize the lag time between the ASP reporting by manufacturers and CMS' posting of the ASP-based payment rates for the OPPS and Part B physician office payment rates. One commenter urged CMS to revert to the original J-codes for IVIG (J1563 and J1564) and maintain the CY 2005 payment rates. Other commenters suggested that, at minimum, CMS should continue payment for IVIG at the CY 2005 payment rates of 83 percent of AWP for 2 years, during which time CMS, consulting with Congress, manufacturers, distributors, providers, and patient groups, should conduct a study to determine the best payment methodology for IVIG with the goal of ensuring access to IVIG and continuity of care in all practice settings.

Response: As discussed earlier, we believe that ASP data are reflective of present hospital acquisition costs for separately payable drugs and biologicals under the OPPS. We believe this to be true for IVIG as well. We therefore cannot agree that it is appropriate to make adjustments to the payment rates for IVIG based on past prices, as we have more current ASP data available that reflect current market pricing for all of the brands of IVIG.

With respect to establishing brand-specific HCPCS codes for the different IVIG products, we note that the procedures for HCPCS coding specifically reject brand-specific coding, and we do not see a compelling reason to override that standard. For further discussion of HCPCS coding, see <http://www.cms.hhs.gov/medicare/hcpcs/codpayproc.asp>. Finally, we note that in CY 2006 the OPPS and physician offices will both be paid based on the most recently available quarter's ASP data, with implementation of payment rate changes in both systems on the same date. As noted earlier, effective January 1, 2006 we will base payment rates for all separately payable drugs and biologicals under the OPPS on ASP data from the third quarter of CY 2005, which will also be the basis for setting payment rates for drugs and biologicals in the physician office setting effective January 1, 2006. After considering these factors, we are finalizing our proposal to pay for IVIG under the OPPS at ASP+6 percent for CY 2006, the same payment rate as in the physician office setting.

We will, however, continue to work with the IVIG community, manufacturers, Congress, and other entities to seek better understanding of the supply and market issues influencing the current IVIG environment. We have discussed the accuracy of the ASP data with the

manufacturers and have been assured by these manufacturers that their ASPs have been developed in accordance with applicable guidance and that the resulting price reflects the current IVIG market. At the same time, the IVIG manufacturers' association, the Plasma Protein Therapeutics Association, reports that the overall supply of IVIG is adequate and has improved in the past several months. However, based on the comments received and our ongoing work with manufacturers, patient groups, and other stakeholders, we continue to be concerned about CY 2005 reports of patients experiencing difficulties in accessing timely IVIG treatments and reports of providers experiencing difficulties in obtaining adequate amounts of IVIG products on a consistent basis to meet their patients' needs in the current marketplace. Most brands of IVIG have been put on allocation by manufacturers, and some manufacturers have reported allocating products to a smaller number of distributors and reducing the size of inventories. In addition, there have been reports of diversion of products to the secondary market and secondary distributors raising prices markedly. The Secretary's Advisory Committee on Blood Safety and Availability has recommended immediate steps be taken to ensure access to IVIG so that patients' needs are being met. However, the complexity of the IVIG marketplace makes it unclear what particular systematic approaches would be most effective in addressing the many individual circumstances that have been shared with us while not exacerbating what appears to be a temporary disruption in the marketplace.

IVIG is a complicated biological product that is purified from human plasma obtained from human plasma donors. Its purification is a complex process that occurs along a very long timeline, and only a small number of manufacturers provide commercially available products. Historically, numerous factors, including decreased manufacturing capacity, increased usage, more sophisticated processing steps, and low demand for byproducts from IVIG fractionation have affected the supply of IVIG. For CY 2006, there are two HCPCS codes that describe all IVIG products, based on their lyophilized versus liquid preparation.

The recent patterns of utilization of IVIG also are unusual in comparison with most other drugs and biologicals. Different IVIG products are FDA-approved in a number of therapeutic areas for various specific conditions, which include: Anti-infective therapy (bone marrow transplant); immune

globulin replacement therapy (primary immune deficiencies and chronic lymphocytic leukemia); anti-inflammatory therapy (Kawasaki disease); and immunomodulation therapy (idiopathic thrombocytopenic purpura). IVIG therapy, which has been available for about 25 years, was initially reserved for the treatment of these FDA-approved indications. More recently, IVIG has been increasingly used off-label so that off-label uses now significantly exceed on-label uses. Many of these off-label uses are for autoimmune, neurological, or systemic inflammatory conditions. Some off-label uses of IVIG are supported by a robust evidence base, while for other medical conditions the evidence has not demonstrated that IVIG infusions are of significant therapeutic benefit. In addition, despite the growing uses of IVIG there are definite risks associated with IVIG treatment, including both early inflammatory reactions and more rare but serious renal and thromboembolic complications, as well as the inherent risk associated with receipt of any biological product even with the ongoing improvements in the safety of these types of products.

Medicare currently has one national coverage determination in place since CY 2002 regarding IVIG infusions to treat autoimmune blistering diseases, and there are numerous local coverage policies that describe Medicare coverage for specific off-label indications. In the context of these national and local coverage policies, IVIG use in hospital outpatient departments has climbed steeply over the most recent years for which data are available, from about 40,000 infusion days in CY 2002, to 60,000 days in CY 2003, and again to over 70,000 days in CY 2004. The infusion of IVIG in physician offices increased from about 2.3 million grams in CY 2003 to 4.0 million grams in CY 2004. In the face of growing demand for IVIG in the absence of significant changes in the prevalence of medical conditions for which there is high quality evidence regarding the effectiveness of IVIG therapy, we are concerned that all patients with medical need for IVIG continue to have access to this expensive and valuable therapy. Over the upcoming year, we will be using our historical claims databases to study the epidemiology of IVIG treatment of Medicare beneficiaries in outpatient settings. We expect that the health system as a whole should encourage an accountable and scientifically grounded use of IVIG, and we welcome discussions with industry, providers, and other interested entities

around efforts to ensure that IVIG is responsibly utilized for evidence-based clinical indications so that optimal benefit is obtained.

Based on the potential access concerns, the growing demand for IVIG, and the unique features of IVIG detailed above, as well as our move to an ASP payment methodology for IVIG in the OPPI for CY 2006, as we seek to gain improved understanding of the contemporary, volatile IVIG marketplace we will employ a two-pronged approach during CY 2006 to help ensure the availability of IVIG to physicians and hospital outpatient departments who care for Medicare beneficiaries and will be paid ASP+6 percent for the IVIG products.

First, in addition to ongoing monitoring and outreach activities within the Department of Health and Human Services, the Office of the Inspector General (OIG) is studying the availability and pricing of IVIG as part of its monitoring of market prices pursuant to section 1847A(d)(2)(A). We expect the OIG's work to provide a significant contribution to the analysis of the current situation with respect to the specific activities of manufacturers and distributors that may be contributing to possible access problems for IVIG as we move to the ASP payment methodology in both physician office and hospital outpatient settings. We hope to understand those particular market behaviors that may have led to such public alarm about the availability of IVIG and the adequacy of our payment rate of ASP+6 percent, concerns that have been particularly strong and persistent for IVIG in comparison with other drugs paid under the same ASP methodology.

Second, we will provide additional payment in CY 2006. Presently the IVIG marketplace is a dynamic one, where a significant portion of IVIG products previously available in CY 2005 are being discontinued and other products are expected to enter the market over the next year. In light of this temporary market instability, we understand that manufacturers have continued allocation procedures aimed at stabilizing the supply of IVIG. Even so, we understand that providers may face purchasing whichever brand of IVIG is available, even if it is not a brand the patient is known to tolerate. Many patients treated with IVIG receive regular infusions on a predictable schedule. To meet this need, hospital staff must conduct significant preadministration services prior to IVIG infusions to monitor and manage their inventory, locate available IVIG products, reschedule infusions

according to product availability and patients' needs, and implement physicians' determinations regarding whether the available formulations are appropriate for patients and whether specific dosing adjustments are required. Product-specific factors must be evaluated in light of patients' clinical indications for the IVIG infusions, their underlying medical conditions, and their past reactions to various IVIG products, and hospital staff must locate appropriate doses of IVIG products in light of these considerations. If the appropriate IVIG product formulations were more widely and reliably available, we do not believe that routine IVIG infusions would require these extensive preadministration-related services prior to each infusion.

To continue to ensure appropriate patient access to IVIG in CY 2006 during this short-term period of market instability for IVIG, beginning for dates of service on or after January 1, 2006 through December 31, 2006, we will temporarily allow a separate payment to hospitals to reflect the additional resources that are associated with locating and acquiring adequate IVIG products and preparing for an outpatient hospital infusion of IVIG in the current environment. We expect that making separate payment for these additional necessary services will help insure that hospitals are able continue to provide IVIG infusions to their patients who depend upon them. We will also provide an additional payment to physician offices for these special services, to ensure that patients continue to have access to IVIG infusions in the most medically appropriate settings, without undesirable shifts in sites of service for their care.

Because the extra hospital resources currently associated with the preadministration-related services for intravenous infusion of immunoglobulin are not accounted for in the CY 2004 hospital claims data used to establish payments rates for the CY 2006 drug administration HCPCS codes that will be billed for IVIG infusions, we are creating a temporary G-code to describe these additional preadministration services related to the intravenous infusion of immunoglobulin. We have established the following G-code for hospital outpatient billing for CY 2006:

- G0332; Preadministration-related services for intravenous infusion of immunoglobulin, per infusion encounter (This service is to be billed in conjunction with administration of immunoglobulin.)

Hospitals may bill this service once per day in association with a patient encounter for administration of IVIG, in addition to billing for the appropriate drug administration service(s) and for appropriate units of the HCPCS code that describes the IVIG product infused. In addition, hospitals may also bill for any significant and separately identifiable evaluation and management (E/M) service they perform at a level 2 through 5 in association with the infusion encounter, appending modifier -25 to the E/M service. We have established the payment level for this service in outpatient hospital departments by crosswalking it to the payment level established for the physician office for CY 2006. We believe that the hospital resources required for HCPCS code G0332 should be very similar to the practice expense for this service in the physician office, and, because no physician work is included in the physician office payment for the new service, the HCPCS code G0332 payment rates in physician office and hospital outpatient settings should be generally comparable. HCPCS code G0332 is a new service with no claims history under the OPSS and we cannot identify an appropriate clinical APC for its assignment based on considerations of clinical and resource homogeneity. Therefore, we are assigning HCPCS code G0332 to New Technology APC 1502 (status indicator "S") with a payment rate of \$75 for CY 2006, based on a direct crosswalk to the New Technology APC that corresponds with the physician office CY 2006 payment of approximately \$69.

We believe that this temporary separate payment provided through HCPCS code G0332 in CY 2006 for the physician office and hospital outpatient resources associated with additional IVIG preadministration-related services due to the present significant fluctuations in the IVIG marketplace will ensure that Medicare beneficiaries depending on IVIG experience no adverse health consequences from the market instability for IVIG products. In the meantime, we will continue to evaluate the market factors affecting the pricing and availability of IVIG products in the context of our ASP+6 percent payment methodology and our separate payment for HCPCS code G0332 in CY 2006. We expect that in CY 2006 with continued collection of updated ASP data for IVIG; improved understanding of the IVIG marketplace; more focused attention on the medical necessity of the utilization of IVIG; ongoing collaboration between CMS, the IVIG community, manufacturers, providers,

and other interested entities; and this temporary separate payment for hospital and physician office resources required for the intensive preadministration services related to IVIG infusion, the IVIG marketplace will stabilize over the upcoming year. Substantial preadministration-related services for IVIG infusions should no longer be required of physician offices and hospital outpatient departments that provide IVIG infusions to patients who need them. Therefore, this additional payment for G0332 is effective for CY 2006 only. Thus, we will be closely monitoring this issue once again in the context of our rulemaking for CY 2007.

Comment: One commenter requested that CMS provide separate payment for all magnetic resonance imaging contrast agents, including imaging agents covered by HCPCS code Q9953.

Response: In CY 2006, the HCPCS codes that will be used to describe magnetic resonance imaging contrast agents are HCPCS codes Q9952 (Inj Gad-base MR contrast, ml), Q9953 (Inj Fe-based MR contrast, ml) and Q9954 (Oral MR contrast, 100 ml). In the proposed rule, we proposed to pay separately for HCPCS code Q9952 and HCPCS code Q9954; however, we proposed to package HCPCS code Q9953 because we were not able to estimate its per administration cost. For CY 2006, we will be paying separately for HCPCS code Q9952 and HCPCS code Q9954, as proposed. Additionally, we will provide separate payment for HCPCS code Q9953 since we have now determined its per day cost to be higher than \$50 in this final rule with comment period.

Comment: One commenter indicated that WinRho SDF Liquid is a new intravenous gamma globulin product that recently received marketing clearance from the FDA, and that this product was created to replace the first generation therapy, WinRho SDF. The commenter noted that WinRho SDF Liquid does not require reconstitution, whereas WinRho SDF is a lyophilized product that requires reconstitution and is described by HCPCS code J2792. According to the commenter, if WinRho SDF Liquid is also assigned to HCPCS code J2792, then the OPSS payment in CY 2006 is likely to be below the acquisition cost of this new product. Therefore, the commenter requested that CMS establish separate codes to distinguish between the liquid and lyophilized forms of Rho D Immune Globulin.

Response: We recognize the commenter's concern about payment for this new intravenous gamma globulin product under the OPSS. The National HCPCS Panel coordinates decisions

regarding the creation of permanent HCPCS codes; therefore, comments related to the HCPCS code creation process are outside the scope of this rule.

Comment: One commenter was concerned that where the ASP information does not exist, CMS will use the CY 2004 hospital claims data, and with drug cost increases averaging 5 to 10 percent over the past two years, the payments would not be enough to cover the costs of providing these drugs.

Response: We understand the commenter's concern. However, as we stated in the proposed rule, until ASP data are available for certain drugs and biologicals, their payment rates will be based on their mean costs derived from the CY 2004 claims data. We note that with respect to items for which we currently do not have ASP data, once their ASP data become available in later quarter submissions, their payment rates under the OPSS will be adjusted so that the rates are based on the ASP methodology and set to ASP+6 percent. Therefore, we encourage the manufacturers of these drugs and biologicals to report their ASPs to CMS.

We received several public comments on the November 15, 2004 final rule with comment period concerning issues related to payment for drugs and biologicals in CY 2005. For those issues that have not already been addressed in other sections of this preamble, below is a summary of those comments and our responses.

Comment: One commenter stated that CMS incorrectly calculated a payment rate of \$6.60 per cm² for the product Integra described by HCPCS code C9206 (Collagen-Glycosaminoglycan Bilayer Matrix, per cm²) and that the payment rate was inappropriate in the OPSS setting. The commenter noted that Integra is provided in four sizes that are appropriate for different clinical needs and settings, and the payment rate set by CMS represented a single payment rate based on the cost of the largest package size used in the inpatient setting. The commenter recommended that either three additional and separate payment HCPCS codes be established for the different sizes, with payment rates established according to their different WACs, or that the payment rate for Integra be based on the costs of the smallest packaging sizes, which are the ones used in the hospital outpatient department. In addition, the commenter recommended that the unit descriptor for HCPCS code C9206 be changed to 25 cm² so that it is consistent with the descriptors of the CPT codes used with this product and also so that it is convenient and easy to apply for

hospital personnel inputting codes on claim forms.

Response: Effective January 1, 2005, HCPCS code C9206 (Collagen-Glycosaminoglycan Bilayer Matrix, per cm²) was created to describe Integra. To accommodate the different package sizes that currently exist or may enter the market in the future, our policy is to create a HCPCS code descriptor based on the lowest possible dosage or size of the product; therefore, we assigned a unit of cm² to HCPCS code C9206. The payment rate of \$6.60 per cm² for this biological was calculated using the standard methodology used to determine the payment rates for drugs and biologicals in the physician office setting, where for drugs and biologicals without an ASP, our methodology prescribes the use of the lesser of the median WAC for all sources of the generic forms of the product or the brand name product with the lowest WAC. Therefore, because Integra is a brand name product with four different package sizes and prices, we set the payment rate for HCPCS code C9206 at \$6.60, which was the lowest WAC per cm². This payment rate was in effect during the first quarter of CY 2005. We note that the payment rates for C9206 for the second quarter of CY 2005 and following quarters were based on 106 percent of its ASP, based on the ASP methodology for drugs furnished in the physician office setting on or after January 1, 2005. We note that for CY 2006, HCPCS code C9206 has been deleted and replaced with the permanent HCPCS code J7343.

Comment: One commenter requested that CMS revise the first quarter CY 2005 ASP rate for HCPCS code J0180 (Injection, agalsidase beta, 1 mg) from \$121.12 to \$121.14 because it believes that CMS made an error in the weighting of the different ASP figures provided to CMS for the two National Drug Codes for this product.

Response: The methodology used to establish the ASP-based payment rates for drugs and biologicals is discussed in the CY 2006 Medicare Physician Fee Schedule final rule. Therefore, we will not respond to this comment since it is outside the scope of this rule.

Comment: One commenter expressed concern about the creation of the new HCPCS code J3396 (Injection, verteporfin, 0.1 mg) in CY 2005 for verteporfin and the deletion of HCPCS code J3395 (Injection, verteporfin, 15 mg). The commenter stated that the new code will create confusion among providers and urged CMS to reinstate HCPCS code J3395 for use with verteporfin injections and/or to clarify and implement measures to ensure that

the change to HCPCS code J3396 will not impact providers' ability to accurately bill for their use of this medication.

Response: Decisions regarding the creation of permanent HCPCS codes are coordinated by the National HCPCS Panel. Comments related to the HCPCS code creation process and decisions made by the National HCPCS Panel are outside the scope of this rule.

In CY 2005, we applied an equitable adjustment to determine the payment rate for darbepoetin alfa (HCPCS code Q0137) pursuant to section 1833(t)(2)(E) of the Act. However, for CY 2006, we proposed to establish the payment rate for this biological using the ASP methodology. The ASP data represent market prices for this biological; therefore, we believe it is appropriate to use the ASP methodology to establish payment rates for darbepoetin alfa because this method will permit market forces to determine the appropriate payment for this biological. We specifically requested comments on the proposed payment policy for this biological.

We received several public comments on our proposal.

Comment: A number of commenters expressed concern about our proposal to establish payment for both epoetin alfa (marketed under the trade name of Procrit[®]) and darbepoetin alfa (marketed under the trade name of Aranesp[®]) using the ASP methodology. Several commenters urged CMS to implement this proposal so that a market-oriented, ASP-based payment system can function as the Pub.L. 108-173 intended without any arbitrary government interference. In addition, one of the commenters indicated that this policy would promote appropriate patient and physician choice in making health care decisions. One of the commenters supported the proposal to establish a payment rate for darbepoetin alfa using the ASP methodology and to discontinue application of an equitable adjustment to its payment rate. This commenter also stated that CMS accurately noted in the CY 2006 proposed rule that "the ASP data represent market prices for this biological," and that using the ASP methodology to establish the CY 2006 OPPS payment rate for darbepoetin alfa "will permit market forces to determine the appropriate payment for this biological." Therefore, the commenter reasoned that an equitable adjustment is not needed in CY 2006 since payments for all separately payable drugs and biologicals will be based on market prices. The commenter also provided clinical and economic data to further

support CMS' proposal not to apply an equitable adjustment to the payment rate for darbepoetin alfa in CY 2006. For example, the commenter noted that new clinical data demonstrate that darbepoetin alfa and epoetin alfa achieve comparable clinical outcomes at comparably priced doses. By applying the proposed payment rates for doses of the two drugs based on current clinical guidelines and validated randomized controlled trials, the commenter concluded that overall Medicare and beneficiary spending would decrease for similar clinical outcomes with the use of darbepoetin alfa rather than epoetin alfa. In addition, the commenter highlighted that applying an equitable adjustment to the payment rate for darbepoetin alfa in CY 2006 would, in fact, increase Medicare and beneficiary spending on darbepoetin alfa. This commenter also recommended that if CMS plans to utilize its equitable adjustment authority again, then the conversion ratio should be increased to 400:1 to reflect the results of a new clinical study that proves the clinical comparability of darbepoetin alfa and epoetin alfa at such a dosing ratio.

One commenter on this topic also provided detailed results of clinical studies that the commenter believes provide a strong rationale for continuing the equitable payment adjustment for darbepoetin alfa and demonstrate that the appropriate conversion ratio for making this adjustment is less than or equal to 260:1. The commenter stated that Medicare and beneficiary spending for these two drugs under the proposed payment policy for CY 2006 will be higher in order to achieve comparable therapeutic effects unless CMS maintains the equitable adjustment policy and re-establishes a conversion ratio that is less than or equal to 260:1.

Response: We appreciate the many thoughtful and detailed comments on our proposed CY 2006 payment rates for darbepoetin alfa and epoetin alfa. Based on our ASP market price data from the second quarter of CY 2005 for these two drugs, we observed that the payment rates for epoetin alfa and darbepoetin alfa would decrease by similar levels in CY 2006 from their current CY 2005 payment rates. Payment for epoetin alfa would decrease by 17 percent and payment for darbepoetin alfa would decrease by 18 percent. In CY 2006, if we continued the CY 2005 equitable adjustment policy of determining the payment rate for darbepoetin alfa using a conversion ratio of 330 Units of epoetin alfa to 1 microgram of darbepoetin alfa (330:1), then the payment rate for darbepoetin alfa would decrease by 17 percent, the same rate of

change as that for epoetin alfa. Following the payment methodology described earlier for separately payable drugs and biologicals where payment for their acquisition and overhead costs would be equal to ASP+6 percent in CY 2006, the payment rate for epoetin alfa would be \$9.22 per 1000 Units and the payment rate for darbepoetin alfa would be \$3.01 per microgram. However, if we applied the CY 2005 conversion ratio of 330:1, the payment rate for darbepoetin alfa would be \$3.04 per microgram.

In determining our payment policy for darbepoetin alfa in CY 2006, we reviewed the results of the many recent clinical studies that were provided in the comments. We independently assessed the methodological rigor of the study designs and the generalizability of the results of the various studies. This assessment included the appropriateness and comparability of the sizes and characteristics of the subject groups, the duration of the trials, the administered doses of the investigational agents, the drop out rates in the treatment arms, and the consideration of other possible causes of study bias. With the limitations of the studies supporting either an increase or a decrease in the conversion factor, the quality and quantity of the currently available published evidence do not provide sufficient, clear evidence to support a change in the appropriate conversion factor at this time. Methodological shortcomings included insufficient sample sizes, excessive dropout rates, inadequate study duration, and failure to adequately account for confounding effects. Some studies have yet to be published as full, peer-reviewed journal articles; abstracts do not provide sufficient detail for our review. Overall, the results of these clinical studies were not consistent or conclusive in defining a single, different conversion ratio for dosing between these two products, particularly with respect to the timing of specific doses of the two drugs required to achieve several different meaningful clinical outcomes. The results of contemporary clinical studies demonstrated that a wide range of conversion ratios could be considered, and these ratios varied by a factor of two or more depending on the specific study design, the measured clinical outcomes, and the treated patient populations. As we have noted above, the payment rate for darbepoetin alfa at ASP+6 percent (\$3.01 per microgram) is slightly lower than but consistent with the payment rate for darbepoetin alfa using the 330:1 conversion ratio (\$3.04 per microgram) that we established in CY 2005. This

conversion ratio is also well within the range of the conversion ratios that may be supported by the available clinical data. We therefore do not believe that there is sufficient clinical evidence to indicate that we should specifically employ our equitable adjustment authority to adjust the payment rate for darbepoetin alfa in CY 2006. By finalizing this payment policy specifically for the CY 2006 OPPS, based on our latest payment rate analysis and independent review of the recent clinical literature, it is not our intention to preclude the use of a conversion ratio to establish the OPPS payment rates for epoetin alfa and darbepoetin alfa in the future. Rather, as long as the market price for darbepoetin alfa is consistent with a payment rate derived using a clinically appropriate conversion ratio, invoking our equitable adjustment authority would not lead to a different result. However, we retain our authority to apply an equitable adjustment in the future to determine the payment rate for darbepoetin alfa pursuant to section 1833(t)(2)(E) of the Act. We will once again assess the need to exercise this authority when we next update the payment rates under the OPPS based on the latest available clinical evidence on the appropriate conversion ratio and based on the actual pricing experience at that time.

Effective April 1, 2005, several HCPCS codes were created to describe various concentrations of low osmolar contrast material (LOCM). These new codes are HCPCS codes Q9945 through Q9951. However, in Transmittal 514 (April 2005 Update of the OPPS), we instructed hospitals to continue reporting LOCM in CY 2005 using the existing HCPCS codes A4644, A4645, and A4646 and made Q9945 through Q9951 not payable under the OPPS. For CY 2006, we proposed to activate the new Q-codes for hospitals and discontinue the use of HCPCS codes A4644 through A4646 for billing LOCM products. We have CY 2004 hospital claims data for HCPCS codes A4644 through A4646, which show that the mean costs per day for these products are greater than \$50. Because we did not have CY 2004 hospital claims data for HCPCS codes Q9945 through Q9951, we crosswalked the cost data for the HCPCS A-codes to the new Q-codes. There is no predecessor code that crosswalks to HCPCS code Q9951 for LOCM with a concentration of 400 or greater mg/ml of iodine. Therefore, we proposed that our general payment policy of paying separately for new codes while hospital data are being collected would apply to HCPCS code Q9951. As our historical

hospital mean per day costs for the three A-codes exceeded the packaging threshold and our payment policy for new codes without predecessors applied to one of the new codes, we proposed to pay for the HCPCS codes Q9945 through Q9951 separately in CY 2006 at payment rates calculated using the ASP methodology. We noted that because the new Q-codes describing LOCM were more descriptively discriminating and had different units than the previous A-codes for LOCM, as well as widely varying ASPs, we expected that the packaging status of these Q-codes might change in future years when we have specific OPPS claims data for these new codes. We specifically invited comments on our proposed policy to pay separately for LOCM described by HCPCS codes Q9945 through Q9951 in CY 2006.

We received several public comments in response to our request.

Comment: Several commenters supported CMS' proposal to pay separately for LOCM using HCPCS codes Q9945 through Q9951, indicating that this policy will help to protect beneficiary access to the most appropriate therapies. The commenters believed that this change would promote consistency across sites of services. A comment from a manufacturer of contrast agents expressed concern about the use of the new Q-codes for LOCM and the corresponding ASP payment methodology to determine their payment rates. The commenter noted that the proposed payment rates for the contrast media codes increase as the iodine or active material concentration decreases and believed that the coding tiers adopted by CMS do not appropriately categorize the various media products. The commenter was also concerned that such a payment scheme might be a perverse incentive for hospitals to use a lower concentration LOCM in diagnostic imaging procedures in order to qualify for higher payment rates or motivate clinically unnecessary and potentially dangerous switches in contrast media selections. The commenter recommended that CMS review whether an alternative payment mechanism would be more appropriate for LOCM and proposed a revised version of the Q-code classifications for LOCM.

Response: We appreciate the commenters' support of our proposal to implement new HCPCS codes for LOCM in CY 2006 and pay for them separately. In the final rule, the payment rates for these codes are based on their market prices from the second quarter of CY 2005, and we believe that the ASP-based

rates appropriately reflect the acquisition and pharmacy overhead costs of these products under each of the HCPCS codes. Decisions regarding the creation of permanent HCPCS codes are coordinated by the National HCPCS Panel. We suggest that commenters who have concerns about the new Q-codes for LOCM should pursue appropriate changes through the process set up by the National HCPCS Panel to establish HCPCS codes.

(4) CY 2006 Proposed and Final Payment Policy for Radiopharmaceutical Agents

We do not have ASP data for radiopharmaceuticals. Therefore, for CY 2006, we proposed to calculate per day costs of radiopharmaceuticals using mean unit costs from the CY 2004 hospital claims data to determine the items' packaging status similar to the drugs and biologicals with no ASP data. In a separate report, the GAO provided CMS with hospital purchase price information for nine radiopharmaceuticals. As part of the GAO survey described earlier, the GAO surveyed 1,400 acute-care, Medicare-certified hospitals and requested hospitals to provide purchase prices for radiopharmaceuticals from July 1, 2003 to June 30, 2004. The radiopharmaceutical part of the survey yielded a response rate of 61 percent, where 808 hospitals provided usable information. The GAO reported the average and median purchase prices for nine radiopharmaceuticals for the period July 1, 2003, to June 30, 2004. These items represented 9 percent of the Medicare spending for specified covered outpatient drugs during the first 9 months of CY 2004. The report noted that the purchase price information accounted for volume and other discounts provided at the time of purchase, but excluded subsequent rebates from manufacturers and payments from group purchasing organizations.

When we examined differences between the CY 2005 payment rates for these nine radiopharmaceutical and their GAO mean purchase prices, we found that the GAO purchase prices were substantially lower for several of these agents. We also found similar patterns when we compared the CY 2005 payment rates for radiopharmaceuticals with their CY 2004 median and mean costs from hospital claims data. In the proposed rule, we indicated that our intent was to maintain consistency, whenever possible, between the payment rates for these agents from CY 2005 to CY 2006, because such rapid reductions could

adversely affect beneficiary access to services utilizing radiopharmaceuticals.

As we did not have ASPs for radiopharmaceuticals that best represent market prices, we proposed as a temporary 1-year policy for CY 2006 to pay for radiopharmaceuticals that were separately payable in CY 2006 based on the hospital's charge for each radiopharmaceutical agent adjusted to cost. As we noted in the proposed rule, MedPAC has indicated that hospitals currently include the charge for pharmacy overhead costs in their charge for the radiopharmaceutical. Therefore, we also noted in the proposed rule that paying for these items on the basis of charges converted to cost would be the best available proxy for the average acquisition cost of the radiopharmaceutical along with its handling cost until we received ASP and overhead information on these agents. We noted that we expected hospitals' different purchasing and preparation and handling practices for radiopharmaceuticals to be reflected in their charges, which would be converted to costs using hospital-specific CCRs. To better identify the separately payable radiopharmaceuticals to which this policy would apply, we proposed to assign them to status indicator "H." We specifically requested public comment on the proposed payment policy for separately payable radiopharmaceuticals in CY 2006.

We received many comments on this proposal.

Comment: Numerous commenters expressed concern about our proposal to pay for separately payable radiopharmaceuticals at hospitals' charges converted to cost in CY 2006. Most of the commenters generally supported the proposed payment methodology for radiopharmaceuticals in CY 2006. However, several of the commenters noted their belief that this methodology may trigger drastic decreases in the payment rates for certain items based on their review of hospital charge data for these agents. Some of the commenters urged CMS to consider refining the methodology for CY 2006 and offered several options. Several commenters recommended that CMS utilize hospital-specific overall CCRs, rather than departmental CCRs, indicating that overall CCRs were more reflective of hospitals' overall charges and that department-specific CCRs would fail to convert charges for radiopharmaceuticals to "average" acquisition costs, resulting in significantly lower payments than the CY 2005 levels. Some of the commenters expressed concern about

the effect of cost compression using a CCR method, stating that the proposed methodology will result in underpayment for more expensive radiopharmaceuticals. The commenters noted that because hospitals do not tend to maintain a constant CCR, as radiopharmaceutical costs increase, the differences between actual costs and the CMS derived costs increase exponentially. One commenter suggested that CMS address this issue by establishing a national and unique CCR for radiopharmaceuticals during CY 2006, which could more accurately account for radiopharmaceutical handling and overhead costs, while a few other commenters recommended that CMS facilitate hospital reporting of accurate charges for radiopharmaceuticals by clarifying exactly which cost-to-charge ratio would apply to each hospital to calculate the hospital outpatient payment for radiopharmaceuticals in CY 2006. Another commenter suggested that CMS provide a template that hospitals may use to prepare their claims for radiopharmaceuticals, including handling and other costs, and provide instructions to fiscal intermediaries regarding the implementation of this policy. One of the commenters suggested that CMS recognize the general reasonable concern regarding using the hospital-specific overall cost-to-charge methodology for highly expensive radiopharmaceuticals, and identified 19 radiopharmaceuticals with hospital acquisition costs per patient study greater than \$500, for which it recommended that CMS use external data to verify and pay based on invoice acquisition costs plus handling fees, or freeze the CY 2005 payment rates for these radiopharmaceuticals, or both. Other commenters suggested limiting decreases in payment rates for separately payable radiopharmaceuticals from CY 2005 to CY 2006, including (1) establishing a payment floor during CY 2006, based on an appropriate percentage of the CY 2005 payment rate for specific radiopharmaceuticals; (2) ensuring that the resultant payment rate for each product in CY 2006 does not fall below the level identified in the GAO data or, if GAO data were unavailable, that the payment not be less than 95 percent of the CY 2005 payment rate for the product; and (3) ensuring that payments for these products do not fall below 95 percent of their CY 2005 rates. One commenter, to the contrary, indicated that while the concerns of other commenters advocating a payment floor

under the proposed methodology for CY 2006 are understandable, CMS should not implement a floor in addition to implementing a CCR approach for payment. This commenter noted that there were variations in the cost data reported by hospitals in their charge reports, and it was important that hospitals, as well as manufacturers, be encouraged to report accurately to CMS and that setting an artificial payment floor reduces hospitals' incentives to do so. The commenter further stated that because the proposed policy already would provide hospitals with an opportunity to report charges accurately for each claim, there was no need for CMS to provide any additional safeguards to ensure sufficient payment and that hospitals would already have the ability to receive appropriate payment by reporting appropriate charges for these agents in their claims.

Lastly, several of the commenters indicated that CMS incorrectly stated that overhead costs for radiopharmaceuticals are included in the hospital charges for the radiopharmaceuticals. One commenter stated that some hospital costs associated with radiopharmaceutical purchase and use are captured in hospital charges. However, the preparation, distribution, administration, and safe disposal of radiopharmaceuticals, along with labor costs and necessary patient and hospital staff protection costs, are not uniformly and accurately reflected in hospital charges. These commenters urged CMS to provide hospital outpatient departments with clear guidance on the array of costs associated with radiopharmaceutical acquisition and handling that should be appropriately included in their charges for radiopharmaceuticals, so that payments and data in CY 2006 accurately reflect hospital acquisition and pharmacy overhead costs for each radiopharmaceutical. One commenter also noted that an additional payment for overhead and handling of radiopharmaceuticals should be made because these costs are not captured in charges for the radiopharmaceuticals.

Response: We appreciate the commenters' support of our proposed payment policy for separately payable radiopharmaceuticals in CY 2006. As recommended by several commenters, in this final rule with comment period, we are using hospital-specific overall CCRs to derive the costs of these items from the hospitals' reported charges. We acknowledge the commenters' concerns about the use of the CCRs resulting in cost compression. We believe that hospitals have the ability to set charges

for items properly so that charges converted to costs can appropriately account fully for their acquisition and overhead costs. The specific payment rates for separately payable radiopharmaceuticals are not being determined on a prospective basis in CY 2006 because hospitals will receive a newly calculated payment for each claim submitted for a separately payable radiopharmaceutical, based on the specific radiopharmaceutical charge on that claim and the applicable overall hospital CCR. Therefore, if necessary we believe that hospitals can appropriately adjust their charges for radiopharmaceuticals so that the calculated costs properly reflect their actual costs. Specifically, it is appropriate for hospitals to set charges for these agents in CY 2006 based on all costs associated with the acquisition, preparation, and handling of these products so that their payments under the OPPS can accurately reflect all of the actual costs associated with providing these products to hospital outpatients. We believe that payment for these items using charges converted to costs will be the best available proxy for the average acquisition costs of the radiopharmaceuticals along with their handling costs and that no additional dampening based on historical payment rates is necessary to pay appropriately for radiopharmaceuticals. Therefore, for CY 2006, we are finalizing the proposed policy to pay for radiopharmaceuticals that are separately payable based on the hospital's charge for each radiopharmaceutical adjusted to cost. We note that we will not be indicating exactly which cost-to-charge ratio will apply to each hospital, as the fiscal intermediaries determine those values. We also note that we have never provided such information in previous years for pass-through devices and brachytherapy sources which are also paid under the same methodology. As indicated in the proposed rule, we are assigning all radiopharmaceuticals that will be separately payable in CY 2006, to which this policy will apply, status indicator "H" in Addendum B of this final rule with comment period.

Comment: A commenter indicated that the OPPS Final Rule should reflect the use of HCPCS code A9523, rather than HCPCS code C1083, to describe the imaging agent in the Zevalin therapeutic regimen in the event that the HCPCS Committee modifies the HCPCS descriptor of HCPCS code A9523 to reflect a per dose unit.

Response: We note that HCPCS codes C1083 and A9523 will be deleted on December 31, 2005 and replaced with the new HCPCS code A9543 (Yttrium

Y-90 ibritumomab tiuxetan, therapeutic, per treatment dose, up to 40 millicuries) for services furnished on or after January 1, 2006.

Comment: One commenter recommended that HCPCS code G3001 (Administration and supply of tositumomab, 450 mg), currently applicable to both doses of the non-radioactive component of therapy and its administration, be amended to apply only to the non-radioactive component of the regimen. The commenter also recommended that hospitals should be allowed to use CPT code 90784 for the administration of the non-radioactive component of BEXXAR and HCPCS code G3001 to reflect the supply of tositumomab, thus allowing hospitals to identify the non-radioactive product accurately in their claims with a familiar product code and receive appropriate payment for the infusion of the product. Consequently, the commenter strongly urged CMS to retain HCPCS code G3001 as a product-only code, so that these facilities can continue to provide treatment to Medicare beneficiaries.

Response: As we had stated in the November 7, 2003 final rule with comment period for CY 2004 (68 FR 63443), unlabeled tositumomab is not approved as either a drug or a radiopharmaceutical, but it is a supply that is required as part of the Bexxar treatment regimen. We do not make separate payment for supplies used in services provided under the OPPS. Payments for necessary supplies are packaged into payments for the separately payable services provided by the hospital. Administration of unlabeled tositumomab is a complete service that qualifies for separate payment under its own APC. This complete service is currently described by HCPCS code G3001. Therefore, we do not agree with the commenter's recommendation that we assign a separate code to the supply of unlabeled tositumomab. Rather, we will continue to make separate payment for the administration of tositumomab, and payment for the supply of unlabeled tositumomab is packaged into the administration payment.

Comment: One commenter suggested that CMS establish HCPCS descriptors based on "per dose" units for radiopharmaceuticals, indicating that such a policy would help facilitate a smoother transition as CMS moves to establish payments for radiopharmaceuticals based on average acquisition costs and pharmacy handling APCs.

Response: For CY 2006, the National HCPCS Panel has changed the

descriptors of many of the radiopharmaceutical product to indicate per dose units. The new CY 2006 HCPCS codes and their descriptors can be found on the HCPCS Web site at <http://www.cms.hhs.gov/medicare/hcpcs/>. The payment status indicators associated with these codes can be found in Addendum B of this final rule with comment period.

Comment: One commenter suggested that CMS require hospitals to report HCPCS codes and charges for all radiopharmaceuticals to facilitate accurate data collection and help ensure that the costs and charges of radiopharmaceuticals (as well as the associated handling costs) are considered in establishing payment rates under the OPPS. Another commenter commended CMS for clarification and education provided to hospitals regarding the importance of coding and reporting charges for radiopharmaceuticals and encouraged CMS to continue to remind hospitals to report charges regardless of N, K, or H status indicators assigned to the radiopharmaceuticals, as these charges have a key role in setting future APC rates and assignment of appropriate status indicators.

Response: We will continue to strongly encourage hospitals to report charges for all drugs, biologicals, and radiopharmaceuticals using the correct HCPCS codes for the items used, including the items that have packaged status in CY 2006. We agree with the commenters, that a robust set of claims for each packaged or separately payable item paid under the OPPS aids in obtaining the most accurate data for future packaging decisions and rate-setting. In the CY 2005 final rule, we noted that, with just a very few exceptions, hospitals appeared to be reporting charges for drugs, biologicals and radiopharmaceuticals using the existing HCPCS codes, even when such items had packaged status (69 FR 65811). Therefore, we do not believe it is necessary to institute a coding requirement for drugs, biologicals, and radiopharmaceuticals in CY 2006 as we are currently doing for device category codes required to be reported when used in procedures.

Section 303(h) of Pub. L. 108-173 exempted radiopharmaceuticals from ASP pricing in the physician office setting where the fewer numbers (relative to the hospital outpatient setting) of radiopharmaceuticals are priced locally by Medicare contractors. However, the statute does not exempt radiopharmaceutical manufacturers from ASP reporting. We currently do not require reporting for

radiopharmaceuticals because we do not pay for any of the radiopharmaceuticals using the ASP methodology. However, for CY 2006, we proposed to begin collecting ASP data on all radiopharmaceuticals for purposes of ASP-based payment of radiopharmaceuticals beginning in CY 2007.

As we had stated in the November 7, 2003 final rule with comment period for CY 2004 (68 FR 42728), in the CY 2006 proposed rule we recognized that there are significant complex issues surrounding the reporting of ASPs for radiopharmaceuticals. Most radiopharmaceuticals must be compounded from a "cold kit" containing necessary nonradioactive materials for the final product to which a radioisotope is added. There are critical timing issues, given the short half-lives of many radioisotopes used for diagnostic or therapeutic purposes. Significant variations in practices exist with respect to what entity purchases the constituents and who then compounds the radiopharmaceutical to develop a final product for administration to a patient. For example, manufacturers may sell the components of a radiopharmaceutical to independent radiopharmacies. These radiopharmacies may then sell unit or multi-doses to many hospitals. However, some hospitals also may purchase the components of the radiopharmaceutical and prepare the radiopharmaceutical themselves. In some cases, hospitals may generate the radioisotope on-site, rather than purchasing it. The costs associated with acquiring the radiopharmaceutical in these instances may vary significantly. In addition, there may only be manufacturer pricing for the components. However, the price set by the manufacturer for one component of a radiopharmaceutical may not directly translate into the acquisition cost of the "complete" radiopharmaceutical, which may result from the combination of several components. In general, for drugs other than radiopharmaceuticals, the products sold by manufacturers with National Drug Codes (NDCs) correspond directly with the HCPCS codes for the products administered to patients so ASPs may be directly calculated for the HCPCS codes. In the case of radiopharmaceuticals, this 1 to 1 relationship may not hold, potentially making the calculation of ASPs for radiopharmaceuticals more complex.

In addition, some hospitals may generate their own radioisotopes, which they then use for radiopharmaceutical compounding, and they may sell these complete products to other sites. The

costs associated with this practice could be difficult to capture through ASP reporting. We invited very specific comments on these and all other relevant issues surrounding implementation of ASP reporting for radiopharmaceuticals.

We received numerous public comments on our proposal to begin collecting ASP data on all radiopharmaceuticals for purposes of ASP-based payment of radiopharmaceuticals beginning in CY 2007.

Comment: Many commenters provided detailed discussions of the policy, including practical and legal challenges related to our proposal to require ASP reporting for radiopharmaceuticals in CY 2006. Some of these commenters indicated that radiopharmaceuticals are formulated, distributed, compounded, and administered in unique distribution channels that preclude the determination of ASP relevant to a radiopharmaceutical HCPCS code by the manufacturer. Most radiopharmaceuticals are typically formed from two or more components. Thus, one manufacturer does not know if a hospital combining individual components to generate the end product, a patient dose, uses exclusively the manufacturer's raw materials, or instead combines raw materials from more than one manufacturer. In this case, the manufacturer has no way to calculate the ASP of the end product patient dose, as the manufacturer only knows the sales prices of its own components. Consequently, radiopharmaceutical manufacturers could not in good faith sign CMS required ASP-reporting certifications as they generally have no knowledge or access to end product unit prices. In addition, the components may be combined to generate a vial of radiopharmaceutical from which multiple patient doses can be drawn. Pricing for a patient unit dose would thus vary, depending on how many patient doses are drawn from a vial. Commenters also noted that a significant proportion of radiopharmaceuticals are sold as components to independent freestanding radiopharmacies or nuclear pharmacies. These radiopharmacies prepare patient unit doses, which are then purchased by hospitals. The manufacturer of the component may not know what the radiopharmacies' prices are for a final unit dose product, and may be precluded from accessing such information. Some of the commenters indicated that if ASP reporting were imposed, it might require reporting from

commercial radiopharmacies, entities that are currently not subject to ASP reporting.

Many commenters also questioned whether CMS has the legal authority to impose ASP reporting on radiopharmaceutical manufacturers and the authority to implement payment for radiopharmaceuticals based on ASP. They noted that Pub. L. 108-173 exempted radiopharmaceuticals from the ASP-based payment methodology in physician offices. One of the commenters stated that when Congress exempted radiopharmaceuticals from the Pub. L. 108-173 provision modifying Part B payments for drugs and biologicals furnished in the physician office setting, it did so because of the unique nature and complexities associated with radiopharmaceuticals rather than the unique nature of the physician office setting. Therefore, it was unlikely that Congress intended for CMS to collect ASP data for radiopharmaceuticals that would be precluded from use in a Part B radiopharmaceutical payment methodology.

Most of the commenters agreed that the variability and complexities associated with radiopharmaceuticals and their preparation make uniform application of the ASP processes to products virtually impossible for CMS. One commenter believed that it may be appropriate to pay hospitals for therapeutic radioimmunotherapies based on the same calculation for ASP as used for physician-administered pharmaceuticals. However, this commenter did not provide an opinion on the applicability of the ASP methodology for diagnostic radiopharmaceuticals. Another commenter suggested that ASP data could be adapted to the unique features of radiopharmaceuticals if CMS considered collecting ASP data from independent radiopharmacies in addition to manufacturers. The commenter noted that if CMS were to use some form of ASPs for outpatient hospital radiopharmaceutical payments, it must—(1) qualify manufacturer reporting; (2) use a weighted average that includes manufacturer and radiopharmacy ASP data; (3) work with stakeholders to determine the appropriate crosswalk between NDCs and HCPCS codes; (4) conduct surveys of the relationships between end-user acquisition costs at the HCPCS level from independent radiopharmacies and hospital radiopharmacies and the manufacturer-reported ASPs; and (5) develop a specific proposal for reporting radiopharmaceutical ASPs appropriately and allow stakeholders to

comment on the proposal before it is finalized.

Most commenters urged CMS to recognize the operational and statutory impediments to ASP reporting for radiopharmaceuticals and the inherent difficulties in establishing the OPPS payments for these products based upon any ASP methodology. Rather than attempting to determine ASP for radiopharmaceuticals based on some manipulation of a hypothetical radiopharmaceutical ASP, many commenters urged CMS to consider continuation of the CCR methodology to pay for separately payable radiopharmaceuticals using the overall hospital-specific CCRs with some refinements in CY 2007, as this policy may generate combined hospital average acquisition and overhead costs, consistent with statutory requirements. One commenter suggested that CMS consider all issues surrounding radiopharmaceutical acquisition, dispensing, and dosage before adopting any alternative payment mechanisms. Other commenters urged CMS to continue working with hospitals and manufacturers to ensure that both short-term and long-term payment methodologies for radiopharmaceuticals would sufficiently pay providers for medically necessary diagnostic tests and therapies and generate valid and reliable data to support future payment rates.

Response: We appreciate all of the comments that we received on our proposal to begin ASP reporting for radiopharmaceuticals in CY 2006. We recognize that there are many complex issues surrounding our ability to collect accurate ASP data for these agents in CY 2006. At this time, we agree with the commenters about the difficulties in translating ASP information gathered from manufacturers regarding radiopharmaceutical raw materials into individual patient doses of specific radiopharmaceuticals, as described by particular HCPCS codes. As this transitional step would be essential to any future OPPS radiopharmaceutical payment methodology based on ASP data, we are hesitant at this time to establish required ASP reporting for radiopharmaceuticals, with its accompanying administrative complexities. Therefore, in this final rule with comment period, we are not adopting our proposal to require reporting of ASP data by radiopharmaceutical manufacturers in CY 2006. Instead, we will continue to further explore the issues surrounding ASP reporting and crosswalking ASPs to patient doses of radiopharmaceuticals. In addition, we will take into consideration other

radiopharmaceutical payment alternatives to ASP reporting suggested by commenters as we develop our policies for the CY 2007 OPPS. We will continue to seek input and guidance from hospitals, radiopharmaceutical manufacturers, and other interested organizations as we contemplate alternative payment methodologies for radiopharmaceuticals.

Comment: Several commenters requested that for CY 2007 and future years CMS carefully review and analyze radiopharmaceutical costs acquired in CY 2006 and consider continuing the use of the CCR methodology for payment, along with other possible options. Some commenters suggested that CMS consider the impact to the payment system and the burden to hospitals to significantly change payment methods for radiopharmaceuticals from year to year. Other commenters encouraged CMS to work in close consultation in the future with hospitals and manufacturers to help ensure that the costs of radiopharmaceuticals are properly captured in the OPPS rates beyond CY 2006. One commenter stated that data from the GAO survey of hospital acquisition costs could be one basis for acquiring information on which national payment rates could be established. Another commenter recommended that CMS explore the possibility of treating radiotherapies such as Bexxar and Zevalin differently from traditional radiopharmaceuticals in order to preserve patient access to them.

Response: We appreciate receiving these suggestions for establishing an appropriate payment methodology for radiopharmaceuticals beyond CY 2006 and will take all of the recommendations into consideration when we start developing our payment proposal for radiopharmaceuticals for the CY 2007 OPPS. Other payment options for radiopharmaceuticals that we will also consider include basing payments on mean costs derived from hospital claims data or creating charge-based payment rates for these items. Another option would be to develop a hospital payment methodology using the invoice data submitted to carriers when radiopharmaceuticals are administered in physician offices. It is not our intention to maintain the CY 2006 methodology of paying for radiopharmaceuticals on the basis of charges converted to costs permanently. Rather, we will actively seek other sources of information on radiopharmaceutical costs that might provide a basis for payment. We

welcome suggestions about such sources of data and alternative methodologies.

We discuss in section V.B.3.a.(5) of this preamble our CY 2006 proposed payment policies for overhead costs of drugs, biologicals, and radiopharmaceuticals. In section V.D. of this preamble, we discuss the methodology that we proposed to use to determine the CY 2006 payment rates for new drugs, biologicals, and radiopharmaceuticals.

While payments for drugs, biologicals and radiopharmaceuticals are taken into account when calculating budget neutrality, we note that we proposed to pay for the acquisition costs of drugs, biologicals, and radiopharmaceuticals without scaling these payment amounts. We proposed not to scale these payments because we believed that Congress, in section 621 of Pub.L. 103–178, intended for payments for these drugs to be based on average acquisition costs. Scaling these payments would mean that they are no longer based solely on acquisition costs. Therefore, at the time of the proposed rule we believed that it was most consistent with the statute not to scale these payment rates. In section V.B.3.a.(5) of this preamble, we also discuss that we proposed to add 2 percent of the ASP to the payment rates for drugs and biologicals with rates based on the ASP methodology to provide payment to hospitals for pharmacy overhead costs associated with furnishing these products. We proposed to scale these additional payment amounts for pharmacy overhead costs. In the CY 2006 proposed rule, we specifically invited public comments on whether it was appropriate to exempt payment rates for drugs, biologicals, and radiopharmaceuticals from scaling and scale the additional payment amount for pharmacy overhead costs.

We note that further discussion of the budget neutrality implications of the various drug payment proposals that we considered is included in section XIX.C. of this preamble.

We received a few public comments on these scaling issues associated with drugs, biologicals, and radiopharmaceuticals.

Comment: MedPAC expressed concern that CMS proposed to apply budget neutrality adjustments to all APCs, while exempting payment for the acquisition costs of specified covered outpatient drugs from these adjustments. MedPAC's concern was that this policy, by reducing the payment rates for clinical APCs but not drugs, may exacerbate any existing incentives for hospitals to use separately payable products. For example, the

financial incentive to use a SCOD instead of a packaged drug would be increased by the proposed method of budget neutrality adjustment, creating higher payments for hospitals that are relatively high users of SCODs and reducing payments for low users. Another commenter supported the use of these rates for budget neutrality estimates and impact analysis.

Response: We understand MedPAC's concern about our proposal to not scale the payment rates for separately payable drugs and biologicals. The statute contains a general requirement (section 1833(t)(9)(B)) that changes to the APC relative weights, APC groups, and other adjustments "for a year may not cause the estimated amount of expenditures under this part for the year to increase or decrease." We therefore apply a budget neutrality adjustment, or scalar, to the APC relative weights to satisfy this requirement. Section 1833(t)(14)(A)(iii)(I) requires that, beginning in CY 2006, we pay for a separately payable drug on the basis of "the average acquisition cost of the drug." We believe that the best interpretation of the specific requirement that we pay for such drugs on the basis of average acquisition cost, is that these payments themselves should not be adjusted as part of meeting the statutory budget neutrality requirement. If we were to apply the budget neutrality scalar to these payments, we would no longer be paying the average acquisition cost, but rather an adjusted average acquisition cost, for separately payable drugs. For CY 2006, as described earlier, we will be paying for the acquisition and overhead costs of drugs and biologicals at ASP+6 percent, without scaling for budget neutrality. We believe that these amounts are the best proxies we have for the aggregate average acquisition and pharmacy overhead costs of drugs and biologicals. We continue to believe that not scaling these payments is most consistent with the statutory requirement of paying for the acquisition costs of drugs on the basis of average costs. Because we are no longer identifying a separate payment amount for overhead costs, we will not scale any part of the ASP+6 percent payment for drugs in order to maintain consistency with the statutory requirement to pay on the basis of average acquisition costs. It is also worth noting that the budget neutrality adjustment is not always negative. For CY 2006, for example, the budget neutrality adjustment is 1.012508103. Therefore applying the adjustment to clinical APCs but not to drug payments

does not always increase any incentive that otherwise may exist for a hospital to use a SCOD instead of a packaged drug.

(5) MedPAC Report on APC Payment Rate Adjustment for Specified Covered Outpatient Drugs

Section 1833(t)(14)(E) of the Act, as added by section 621(a)(1) of Pub. L. 108–173, required MedPAC to submit a report to the Secretary, not later than July 1, 2005, on adjusting the APC rates for specified covered outpatient drugs to take into account overhead and related expenses, such as pharmacy services and handling costs. This provision also required that the MedPAC report include the following: a description and analysis of the data available for adjusting such overhead expenses; recommendation as to whether a payment adjustment should be made; and the methodology for adjusting payment, if an adjustment is recommended. Section 1833(t)(14)(E)(ii) of the Act, as added by section 621(a)(1) of Pub. L. 108–173, authorized the Secretary to adjust the APC weights for specified covered outpatient drugs to reflect the MedPAC recommendation.

The statute mandates MedPAC to report on whether drug APC payments under the OPSS should be adjusted to account for pharmacy overhead and nuclear medicine handling costs associated with providing specified covered outpatient drugs. In creating its framework for analysis, MedPAC interviewed stakeholders, analyzed cost report data, conducted four individual hospital case studies, and received technical advice on grouping items with similar handling costs from a team of experts in hospital pharmacy, hospital finance, cost accounting, and nuclear medicine.

As we discussed in the CY 2006 OPSS proposed rule (70 FR 42728), MedPAC concluded that the handling costs for drugs, biologicals, and radiopharmaceuticals delivered in the hospital outpatient department are not insignificant, as medications typically administered in outpatient departments generally require greater pharmacy preparation time than do those provided to inpatients. MedPAC found that little information is currently available about the magnitude of these costs. According to the MedPAC analysis, hospitals historically set charges for drugs, biologicals, and radiopharmaceuticals at levels that reflected their respective handling costs, and payments covered both drug acquisition and handling. Moreover, hospitals vary considerably in their likelihood of providing specific services which utilize drugs, biologicals,

or radiopharmaceuticals with different handling costs.

As we also reported in the CY 2006 OPSS proposed rule, MedPAC developed seven drug categories for pharmacy and nuclear medicine handling costs, according to the level of resources used to prepare the products (Table 23 of the proposed rule, 70 FR 42729) Characteristics associated with the level of handling resources required included radioactivity, toxicity, mode of administration, and the need for special handling. Groupings ranged from dispensing an oral medication on the low end of relative cost to providing radiopharmaceuticals on the high end. MedPAC collected cost data from four hospitals that were then used to develop relative median costs for all categories but radiopharmaceuticals (Category 7+). The case study facilities were not able to provide sufficient cost information regarding the handling of outpatient radiopharmaceuticals to develop a cost relative for Category 7+. The MedPAC study classified about 230 different drugs, biologicals, and radiopharmaceuticals into the seven categories based on input from their expert panel and each case study facility.

In its report, MedPAC recommended the following:

- Establish separate, budget neutral payments to cover the costs hospitals incur for handling separately payable drugs, biologicals, and radiopharmaceuticals; and
- Define a set of handling fee APCs that group drugs, biologicals, and radiopharmaceuticals based on attributes of the products that affect handling costs; instruct hospitals to submit charges for these APCs; and base payment rates for the handling fee APCs on submitted charges reduced to costs.

MedPAC found some differences in the categorizations of drug and radiopharmaceutical products by different experts and across the case study sites. In the majority of cases where groupings disagreed, hospitals used different forms of the products, which were coded with the same HCPCS code. For example, a drug may be purchased as a prepackaged liquid or as a powder requiring reconstitution. Such a drug would vary in the handling resources required for its preparation and would fall into a different drug category depending on its form. In addition, the handling cost groupings may vary depending on the intended method of drug delivery, such as via intravenous push or intravenous infusion. For a number of commonly used drugs, MedPAC provided two categories in their final consensus

categorizations, with the categories 2 and 3 reported as the most frequent combination. For example, MedPAC placed HCPCS codes J1260 (Injection, dolasetron mesylate, 10 mg) and J2020 (Injection, linezolid, 200 mg) in consensus categories 2 and 3, acknowledging that the appropriate categorization could vary depending on the clinical preparation and use of the drug. We noted in the proposed rule (70 FR 42729) that we have no information regarding hospitals' frequencies of use of various forms of drugs provided in the outpatient department under the OPSS, as the case studies only included four facilities and the technical advisory committee was similarly small. Thus, in many cases it is impossible to assign a drug exclusively and appropriately to a certain overhead category that would apply to all hospital outpatient uses of the drug because of the different handling resources required to prepare different forms of the drugs.

There are over 100 separately payable drugs, biologicals, and radiopharmaceuticals that are separately payable under the OPSS but for which MedPAC provided no consensus categorizations in its 7 drug groups. In preparation for the CY 2006 proposed rule, we independently examined these products and considered the handling cost categories that could be appropriately assigned to each product as described by an individual HCPCS code. As discussed above, many of the drugs had several forms, which would place them in different handling cost groupings depending on the specific form of the drug prepared by the hospital pharmacy for a patient's treatment. In addition, as we stated in the proposed rule, we believe that hospitals may have difficulty discriminating among the seven categories for some drugs, because the applicability of a given category description to a specific clinical situation could be ambiguous. Indeed, in the MedPAC study, initially only about 80 percent of the case study pharmacists agreed with the expert panel category assignments. However, concurrence increased that percentage to almost 90 percent after discussion and review. Nevertheless, there remained a number of drugs for which differences in categorization by the case study facilities and the expert panel persisted.

In light of our concerns over our ability to appropriately assign drugs to the seven MedPAC drug categories so that the categories accurately described the drugs' attributes in all of the OPSS hospitals and the MedPAC recommendations, for CY 2006 we

proposed to establish three distinct HCPCS C-codes and three corresponding APCs for drug handling categories to differentiate overhead costs for drugs and biologicals, by combining several of the categories identified in the MedPAC report. We proposed to collapse the MedPAC categories 2, 3, and 4 into a single category described by HCPCS code CXXXX, and MedPAC categories 5 and 6 into another category described by HCPCS code CYYYY, while maintaining MedPAC category 1 as described by HCPCS code CWWWW. (Our rationale for not proposing to create an overhead payment category for radiopharmaceuticals is discussed below.) We proposed merging categories in this way generally because we believed that doing so would resolve the categorization dilemmas resulting from the most common scenarios where drugs might fall into more than one grouping and minimized the administrative burden on hospitals to determine which category applied to the handling of a drug in a specific clinical situation. In addition, these broader handling cost groupings would minimize any undesirable payment policy incentives to utilize particular forms of drugs or specific preparation methods. We proposed only to collapse those categories whose MedPAC relative weights differed by less than a factor of two, consistent with the principle outlined in section 1833(t)(2) of the Act that provides that items and services within an APC group cannot be considered comparable with respect to the use of resources if the median cost of the highest cost item or service within an APC group is more than 2 times greater than the median cost of the lowest cost item or service within that same group.

As discussed in previous final rules and in the CY 2006 OPSS proposed rule, we believed that pharmacy overhead costs are captured in the pharmacy revenue cost centers and reflected in the median cost of drug administration APCs, and the payment rate we established for a drug, biological, or radiopharmaceutical APC was intended to pay only for the cost of acquiring the item (66 FR 59896, 67 FR 66769, and 70 FR 42729 through 42730). As a MedPAC survey of hospital charging practices indicated that hospitals' charges for drugs, biologicals, and radiopharmaceuticals reflect their handling costs as well as their acquisition costs, we believed pharmacy overhead costs would be incorporated into the OPSS payment rates for drugs, biologicals, and radiopharmaceuticals if the rates were based on hospital claims

data. However, in light of our proposal to establish three distinct C-codes for drug handling categories, we also proposed to instruct hospitals to charge the appropriate pharmacy overhead C-code for overhead costs associated with each administration of each separately payable drug and biological based on the code description that best reflected the service the hospital provided to prepare the product for administration to a patient. We would collect hospital charges for these C-codes for 2 years, and consider basing payment for the corresponding drug handling APCs on the charges reduced to costs in CY 2008, similar to the payment methodology for other procedural APCs. Median hospital costs for the drug handling APCs should reflect the CY 2006 practice patterns across all OPSS hospitals of handling drugs whose preparation was described by each of the C-codes, reflecting the differential utilization of various forms of drugs and alternative methods of preparation and delivery through hospitals' billing and charges for the C-codes. Table 24 of the proposed rule (70 FR 42730) listed the drug handling categories, C-codes, and APCs we proposed for CY 2006.

We proposed these three categories because we believed that they were sufficiently distinct and reflective of the resources necessary for drug handling to permit appropriate hospital billing and to capture the varying overhead costs of the drugs and biologicals separately payable under the OPSS. We did not propose to adopt the median cost relatives reported for MedPAC's six categories (excluding radiopharmaceuticals). This was because it was very difficult to accurately crosswalk the cost relatives for the six categories to the three categories we proposed. In addition, we were not confident that the cost relatives that were based on cost data from four hospitals appropriately reflected the median relative resource costs of all hospitals that would bill these drug handling services under the OPSS. Instead, we believed it was most appropriate to collect hospital charges for the drug handling services based on attributes of the products that affected the hospital resources required for their handling, and to consider making future payments under the OPSS using the proposed C-codes based on the medians of charges converted to costs for the drug handling APC associated with each administration of a separately payable drug or biological.

For CY 2006, pursuant to section 1833(t)(14)(E)(ii) of the Act, we proposed an adjustment to cover the costs hospitals incur for handling

separately payable drugs and biologicals. As we did not have separate hospital charge data on pharmacy overhead, we proposed for CY 2006 to pay for drug and biological overhead costs based on 2 percent of the ASP. As described earlier, we estimated aggregate expenditure for all separately payable OPSS drugs and biologicals (excluding radiopharmaceuticals) using mean costs from the claims data and then determined the equivalent average ASP-based rates. Our calculations at the time of the proposed rule indicated that using mean unit costs to set the payment rates for all separately payable drugs and biologicals would be equivalent to basing their payment rates on ASP+8 percent. As noted previously, because pharmacy overhead costs are already built into the charges for drugs, biologicals, and radiopharmaceuticals as indicated by the MedPAC study described above, we believed on the basis of the data available at the time of our development of the proposed rule that payments for drugs and biologicals and overhead at a combined ASP+8 percent would serve as a proxy for representing both the acquisition and overhead cost of each of these products. Moreover, as we proposed to pay for all separately payable drugs and biologicals using the ASP methodology, where payment rates for most of these items were set at ASP+6 percent, we believed that an additional 2 percent of the ASP would provide adequate additional payment for the overhead costs of these products and be consistent with historical hospital costs for drug acquisition and handling. Even though we did not propose to scale the payment rates for drugs and biologicals based on the ASP methodology, we proposed to scale the additional payment amount of 2 percent of the ASP for pharmacy overhead costs. Therefore, for CY 2006, we proposed to pay an additional 2 percent of the ASP scaled for budget neutrality for overhead costs associated with separately payable drugs and biologicals, along with paying ASP+6 percent for the acquisition costs of the drugs and biologicals. We specifically requested public comments on this proposed policy for paying for pharmacy overhead costs in CY 2006 and on the proposed policy regarding hospital billing of drug handling charges associated with each administration of each separately payable drug or biological using the proposed C-codes.

During the August 2005 meeting of the APC Panel, the Panel made three recommendations regarding our proposals for determining and paying for overhead costs associated with

providing drugs and biologicals. The Panel recommended that CMS: (1) Reconsider carefully the proposal to pay 2 percent of ASP for hospital pharmacy overhead costs to ensure that it is in line with hospital costs and that CMS take into account external data gathered during the comment period; (2) pay for the pharmacy overhead costs of both packaged and separately paid drugs, employing a mechanism that adds only minimal additional administrative burden for hospitals; and (3) delay the implementation of the proposed codes for drug handling cost categories until January 2007 so that further data and alternative solutions for making payments to hospitals for pharmacy overhead costs can be collected, analyzed by CMS, and presented to the Panel at its winter 2006 meeting. The final CY 2006 policies on pharmacy overhead costs are discussed below.

We received many public comments concerning our proposals.

Comment: Commenters were pleased that CMS recognized that additional payments should be provided to hospitals to cover handling costs associated with administering drugs and biologicals in the hospital outpatient setting. However, many commenters were concerned that the proposed payment of 2 percent of the ASP for these costs was not adequate to ensure that hospitals would be able to continue to provide these services. Commenters indicated that these handling costs could be substantial and cited comments in the MedPAC study on pharmacy handling costs attributing 26 to 28 percent of pharmacy department costs to overhead costs. Several commenters noted that MedPAC stated in its report that pharmacy overhead costs are inconsistently reported in hospital charge data. Therefore, these commenters concluded that our analysis of the HCPCS drug charge data derived from CY 2004 provider claims is not likely to reflect pharmacy handling charges accurately and consistently. One commenter stated that an additional payment of 2 percent of ASP for drug handling is not adequate for certain drugs that have very high handling costs due to special equipment or procedures related to the drug's toxicity, or special compounding or preparation requirements. Several other commenters stated that hospitals are facing increased pharmacy handling costs and overhead expenses as a result of at least one, and possibly two, new government requirements that reflect new criteria for compounding sterile products and new procedures to ensure staff and patient safety. According to the commenters, these additional costs were

not reflected in the CY 2004 hospital claims data, and therefore were not accounted for in CMS' estimate of 2 percent of ASP for the pharmacy overhead costs of drugs and biologicals.

Commenters provided various recommendations for CMS to consider in determining appropriate payment levels for drug handling costs in CY 2006. One commenter encouraged CMS to use industry data to set an equitable payment rate for these pharmacy overhead costs instead of the percentage of ASP proposed. Another commenter recommended that CMS increase the payment for pharmacy overhead costs to more closely approximate the findings reported by MedPAC. Several commenters recommended implementing a dampening policy in CY 2006, so that drug payments are no lower than 95 percent of the CY 2005 payment levels. Another dampening policy suggested was that CMS pay for separately payable drugs and biologicals at the higher of ASP+8 percent or 90 percent of the CY 2005 payment rate. One commenter recommended that CMS consider freezing payments in CY 2006 for those drugs whose payments would decline significantly from the CY 2005 rates, particularly those drugs that may have especially complex and costly handling requirements. Some of these commenters indicated that a dampening policy would allow CMS to provide hospitals with a transition mechanism as it moved toward an ASP-based payment methodology, and at the same time provide adequate payment for these items until CMS collected sufficient pharmacy overhead charge data to establish accurate cost-based payment rates for drug handling expenses.

MedPAC expressed concern about the methodology to pay hospitals 2 percent of ASP for each separately payable drug administered because of the proportional nature of this proposal. MedPAC suggested that CMS consider another alternative because the proposed method ties payment for handling costs directly to the acquisition cost of a drug. MedPAC noted that payment for the handling cost of a particular drug could differ sharply from the handling cost hospitals actually incur; for example, a drug with a high acquisition cost does not necessarily also have high handling costs. MedPAC also expressed concern that this method of paying for pharmacy overhead could result in higher drug acquisition costs for hospitals because it gives manufacturers an incentive to increase prices. MedPAC proposed an alternative methodology under which CMS would estimate the total dollars

that should be dedicated to paying pharmacy handling costs and determine how much of the total should be allocated to groups of drugs that are similar with respect to their handling costs. MedPAC noted that 2 percent of ASP, as suggested by our analysis of the data on hospitals' acquisition and overhead costs, would be a viable basis for creating such a pool. Under the MedPAC methodology, hospitals would receive the same payment for the handling cost of each specified covered outpatient drug within the same category of handling costs, regardless of the acquisition costs of the specific drugs assigned to the category.

One commenter urged CMS to implement a pharmacy service and handling add-on of at least 8 percent of ASP, in addition to the acquisition cost payment of ASP+6 percent. The commenter used the hospital outpatient claims data to examine the percentage add-on to ASP that would be necessary to maintain aggregate payments in CY 2006 at 95 or 100 percent of the CY 2005 level. The commenter found that, to maintain payments at 95 or 100 percent of the CY 2005 levels for chemotherapy or supportive care drugs, except radiopharmaceuticals, add-on amounts of 7.6 percent of ASP or 13.3 percent of ASP, respectively, would be necessary. The commenter stated that payment at this level would be an appropriate interim measure to limit the potential decreases in drug payments until data are collected to implement a better long-term solution. Many other commenters supported this proposal to pay 8 percent of ASP for overhead costs in addition to paying ASP+6 percent for acquisition costs (for a total payment of ASP plus 14 percent for drug acquisition and overhead costs).

Another commenter recommended that CMS adopt a process similar to what it proposed to support the 2 percent payment for CY 2006 and suggested a variation to the proposed methodology. The commenter indicated that CMS could compute a reasonable estimate of handling costs by use of current claims data by first computing the mean cost of each drug and then deducting the ASP+6 percent amount. The commenter added that, after statistical outliers are excluded, CMS would have a reasonable estimate of the handling costs either by drug HCPCS code or by three categories without hospitals incurring the additional burden of billing a new handling charge. The commenter stated that CMS could then add the estimated handling costs to the drug ASP+6 percent payment to create a single payment for both the acquisition and handling costs. The

commenter indicated that this method should also be more accurate than the current proposal of 2 percent of ASP for handling costs that applies equally to all three categories. The commenter expressed concern that the proposed 2 percent of ASP for handling costs is significantly lower than the percentage indicated by both MedPAC and CMS studies. Because the drug handling cost must be paid in a budget neutral manner, the commenter questioned the adoption of an administratively burdensome process which attempted to redistribute OPSS payments for only 2 percent of drug payments. The commenter recommended that CMS withdraw its proposed billing requirement for handling charges and simply adopt the 2 percent of ASP payment method proposed for CY 2006 and future years if CMS believes that its data indicate that drug handling costs are only 2 percent of drug payments. The commenter added that submitting handling charges for the proposed C-codes would be burdensome for such a relatively small payment refinement benefit. Several other commenters believed that, while an imperfect measure, increasing payment for drug handling costs by 2 percent of ASP would be appropriate as a temporary measure.

Some commenters also indicated that CMS should work with hospital and pharmacy stakeholders to develop an approach to establish differential add-on payments for drug handling costs to account for a wide variety of drug handling categories. Lastly, one commenter noted that if CMS implements this policy, it should continue to analyze and refine payment for pharmacy overhead costs in the future to ensure that 2 percent of the ASP adjustment provides adequate payment for these services.

Response: We understand the commenters' concerns about basing the additional payment amount for overhead costs of drugs and biologicals on 2 percent of an item's ASP. We agree with MedPAC and other commenters on the proposed rule that hospital charges for drugs and biologicals are generally reflective of both their acquisition and overhead costs. MedPAC did indicate in its comments that 2 percent would be a viable basis for creating the drug overhead pool. Therefore, we are not convinced by those commenters who contended that drug overhead costs are much higher than 2 percent of ASP (for example, 25 to 30 percent of total drug costs). As described earlier, using updated CY 2004 claims data and ASP information from the second quarter of CY 2005, we determined that using

mean unit costs to set the payment rates for the drugs and biologicals that would be separately payable in CY 2006 would be equivalent to basing their payment rates, on average, at ASP+6 percent. Consequently, we believe that it is appropriate for us to base payment for average acquisition and overhead costs for separately payable drugs and biologicals on ASP+6 percent for CY 2006 because both acquisition and overhead costs are reflected in the charges submitted by hospitals for these items. We have no reason to believe that, in the aggregate, a payment rate of ASP+6 percent would be insufficient to provide combined appropriate payment for both the hospital acquisition and overhead costs related to providing drugs and biologicals to hospital outpatients.

In the light of this decision to proceed with an integrated payment of ASP+6 percent for the acquisition and overhead costs of drugs, we also are not adopting MedPAC's recommendation to create and appropriately distribute a drug overhead payment pool in this final rule with comment period. We understand MedPAC's concern that a flat percentage add-on payment for overhead costs might underpay these costs for some drugs and overpay for others. However, on the basis of our claims data, we believe that the payment rate that we are adopting will provide adequate payment for both acquisition and overhead costs in the aggregate. We also note the difficulties in determining the relative values of the separate drug handling cost categories in order to allocate spending from MedPAC's overhead drug pool. However, we will continue to study and consider this alternative as we develop our future policies on payment for drug costs in general and overhead costs in particular. As we evaluate other options for paying for drug handling costs in the future, we will also consider different methodologies that could be used to develop clinically meaningful and distinct payment levels for the diverse pharmacy overhead resources associated with administration of drugs and biologicals. We welcome comments and information about sources of data that could be useful in further developing a methodology for payment of drug overhead costs for the CY 2007 proposed rule.

Comment: Two commenters were concerned that the proposed additional payment of 2 percent of ASP did not fully cover hospital costs of procuring, storing, and furnishing clotting factors to patients with hemophilia. The commenters noted that the CY 2005 payment for a clotting factor in the

physician office setting is based on ASP+6 percent plus an additional furnishing fee to cover the costs of providing the product to Medicare beneficiaries. According to the commenters, this fee was set at \$0.14 per unit of clotting factor for CY 2005 and is required to be updated annually. The commenters also noted that an add-on payment is made to hospitals for clotting factors provided to patients in the hospital inpatient setting. They indicated that for hospital inpatient services the current additional payment for a clotting factor equals 95 percent of its AWP; however, for CY 2006, CMS proposed to set the payment rate and the furnishing fee for clotting factors used in the hospital inpatient setting at the same rate as for clotting factors provided in physician offices under Part B. The commenters argued that the hospital outpatient handling costs should not be treated differently than in the physician office because the costs of inventory, specialized refrigeration, assay management, and formulation of clotting factors are similar for all providers of these drugs and do not vary between the hospital inpatient and outpatient setting. The commenters were concerned that the proposed 2 percent of ASP did not fully cover the additional costs of furnishing clotting factors to Medicare beneficiaries in the hospital outpatient setting and urged CMS to apply the Part B furnishing fee to the hospital outpatient setting as well. One of the commenters additionally requested that CMS not include clotting factors in the collection of overhead cost data using the proposed C-codes, as CMS has already established a mechanism for calculating and updating the costs associated with providing these drugs under the Medicare Physician Fee Schedule and Inpatient Prospective Payment System, and it sought clarification in the preamble and regulatory text of the final rule on all payment provisions related to clotting factors.

Response: Section 303 of Pub. L. 108-173 established section 1847A of the Act which requires that almost all Medicare Part B drugs not paid on a cost or prospective basis be paid at 106 percent of average sales price (ASP) and provided for payment of a furnishing fee for blood clotting factors, effective January 1, 2005. In CY 2006, payment for clotting factors furnished in both the physician office setting and inpatient hospital setting will be made at ASP+6 percent plus an additional amount for the furnishing fee. We agree with the commenters' statements about the use of similar resources to furnish clotting

factors across all types of service settings and believe that it is appropriate to adopt a methodology for paying for clotting factors under the OPSS that is consistent with the methodology applied in the physician office setting and the inpatient hospital setting. Therefore, in CY 2006, we will be paying for clotting factors at ASP+6 percent in the OPSS and providing payment for the furnishing fee that will also be a part of the payment for clotting factors furnished in physician offices under Medicare Part B. This furnishing fee will be updated each calendar year based on the consumer price index, and we will update the amount appropriately each year under the OPSS. In CY 2005, the furnishing fee is \$0.14 per unit, and for CY 2006, it will be updated to \$0.146 per unit. Effective January 1, 2006, we will make payment for clotting factors at ASP+6 percent using ASP data from the third quarter of 2005 along with paying for the furnishing fee using the updated amount for CY 2006. The final CY 2006 regulations establishing the ASP methodology and the furnishing fee for blood clotting factors under Medicare Part B can be found in the CY 2006 Medicare Physician Fee Schedule final rule. We believe that this methodology will allow us to provide adequate payment for both the acquisition and overhead costs of clotting factors under the OPSS in CY 2006.

Comment: One commenter requested that CMS clarify how it will pay hospitals for the costs incurred with handling intrathecal drugs, noting that MedPAC did not discuss the handling costs of intrathecal drugs in its report on pharmacy overhead costs. The commenter noted that intrathecal drugs involve significant handling costs; therefore, CMS should ensure that intrathecal drugs are paid a sum sufficient to cover their handling costs.

Response: In CY 2006, payment for intrathecal drugs will be determined using the same ASP methodology as will be used for other separately payable drugs and biologicals, where payment for acquisition and overhead costs will be set at ASP+6 percent.

Comment: We received many comments on our proposal to implement C-codes for drug handling categories in CY 2006. Many of the commenters opposed the proposal, while other commenters supported it.

A national association of hospitals expressed strong opposition to the proposal to require hospitals to report their drug handling charges using C-codes in order for CMS to pay pharmacy overhead costs and recommended that CMS find an alternative method to

identify drug handling costs. The commenter raised several concerns regarding this proposal. For example, the commenter indicated that by proposing to require hospitals to bill a handling charge when the industry practice has been to bill a combined charge to reflect both the drug acquisition cost and handling cost is contrary to a basic, long standing tenet of the Medicare Act in 42 U.S.C. 1395 that CMS interpreted as prohibiting any interference with hospital charge structures. Also, the commenter noted that Medicare providers must have a consistent charge structure in order to prepare the Medicare cost report and to apportion costs within the Medicare cost report. The proposal to require hospitals to begin billing the drug handling charge as a separate line-item charge will present billing and payment concerns for all other payers because drug handling charges would also have to be billed also to private payers and the Medicaid program, or the provider would have to be able to generate consistent charges for proper Medicare apportionment costs. However, since most other payers do not recognize C-codes and may refuse to accept and/or pay for such handling charges, it would raise concern for a provider as to whether it must pursue collection in order to have a consistent charge structure for payment and apportionment. The commenter noted that drug handling costs are not presently billed separately by the vast majority of hospitals, and most of these hospitals do not have sophisticated cost accounting systems that would permit the determination of handling costs for each billable drug. Reporting pharmacy overhead charges with C-codes would result in a tremendous burden to hospitals, requiring the modification of their pharmacy charge masters to reduce each current drug charge to reflect only the drug acquisition cost and to remove the drug handling costs currently included in each drug line item's charge. Hospitals that do not have sophisticated cost accounting systems would have difficulty in determining the applicable amount attributable to the handling costs. The commenter indicated that even if this administratively burdensome process of billing for handling charges is adopted, CMS would still be unable to determine the drug handling costs at the individual drug level because an average pharmacy department CCR would be applied to billed charges to determine drug handling costs, and these CCRs were never intended to determine cost at the specific procedure

level, such as drug handling costs for individual drugs. The commenter also expressed concern that CMS' proposal to pay the drug handling costs only for separately payable drugs would create an additional burden for hospitals as they must identify and modify only those drug charge items that qualify for separate payment under the OPSS. Charges for packaged drugs must continue to include the overhead costs as part of the drug's line item charge or the appropriate revenue code charge. Because Medicare beneficiaries frequently require more than one drug in an outpatient encounter, it may be impossible to identify any correlation between the drug HCPCS code reported and the drug handling category HCPCS code reported. Additionally, there would be no incentives for hospitals to perform the charge master maintenance and educate pharmacy staff as neither the presence nor accuracy of the drug handling HCPCS codes will impact the proposed CY 2006 payment of drug handling costs. Another concern raised was that CMS would be able to determine appropriate payment rates for these C-codes in future years using the claims data only if hospitals can reasonably estimate their drug handling costs and if hospitals mark up their drug handling costs in line with their overall pharmacy mark-up. The last concern cited by the commenter was that there may be an issue if hospitals report the new drug handling costs separately without restructuring their existing drug charges to remove the drug handling costs already included in the drug charges.

Other commenters echoed these concerns. One commenter indicated that even though collecting charge data for handling costs may be useful for CMS, the reporting requirement would overwhelm coding and nursing staffs already challenged with the complex task of ensuring that the correct dosage of the drug is billed. Another commenter strongly opposed the use of C-codes to bill for drug handling costs because it would present an operational nightmare because every drug required "handling." The commenter, therefore, requested that CMS not implement this proposal until further assessments of the system implications associated with such a change are completed.

Several commenters raised other coding, billing, and charging issues related to this proposal. For example, commenters questioned whether CMS would expect multiple line-items to be reported per date of service if multiple drugs from the same drug handling family are provided. They also asked whether CMS would require providers

to report a single revenue code with the pharmacy handling C-codes, or would the revenue codes need to match the actual drug revenue code. The commenters urged CMS to review the coding and billing requirements necessary to implement such a mechanism correctly.

One commenter strongly opposed the proposal requiring hospitals to establish separate pharmacy overhead charges for separately payable drugs and biologicals and use the three proposed C-codes for charging these overhead costs in CY 2006. This commenter indicated that it would be extremely burdensome and difficult for hospitals to implement the proposal. The commenter also indicated that there are many complex issues and administratively burdensome aspects to adopting this proposal for charging for drug handling using these new C-codes. The commenter pointed out that even assuming that hospitals could provide differential charges, other concerns remain. For example, the commenter indicated that hospitals would have to evaluate the normal mark-up formula for all pharmacy items and deduct the handling costs for only the separately payable drugs under Medicare, while the drug handling charges for packaged drugs would remain incorporated within overall charges for those drugs. The commenter stated that because the C-codes would only be recognized by and acceptable to Medicare, but not to other payers, hospitals would have to modify their billing systems to separate out the drug handling charge from the drug charge for Medicare claims, but bill them as a single line-item for other payers. The commenter believed that there would also be confusion about how the drug handling C-codes would apply when a hospital pharmacy mixes multiple doses of a drug for a patient, and in particular the question of whether the hospital would report a single C-code for handling costs or multiple C-codes in this situation. The commenter also expressed concern that some hospitals may not be able to accommodate the proposed C-codes because drug pricing is generated through a pharmacy charging system often located outside the hospital's normal charging system. For these reasons, the commenter indicated that it is unclear how CMS would expect providers to report drug charges in the inpatient setting versus the outpatient setting because many hospitals use the same charge master for inpatient and outpatient services.

One of the commenters noted that when hospital clinic nurses and pharmacies bill for drugs, they do not view the patient-specific data to

determine if the patient has Medicare coverage and whether the drug is separately payable to make decisions about whether to report additional services. The commenter pointed out that dispensing fees vary significantly in each hospital due to variances in overhead and handling fees incurred. The commenter believed that the proposal requires more research and consideration in order to reduce the administrative burden that would be required of hospital staff and adequately capture all pharmacy overhead and handling costs incurred. This commenter supported establishing payment for pharmacy overhead costs based on the additional 2 percent of ASP added to each APC drug payment, as this method simplifies the payment mechanism.

Many commenters stated that CMS should not implement the proposed drug handling C-codes in CY 2006 and should instead study alternate mechanisms for obtaining drug handling cost data, including using the cost report to compute an average pharmacy handling percentage that may be used in the future along with the ASP+6 percent model for drug acquisition costs. Other commenters recommended that CMS work with stakeholder groups to collect additional data and develop simpler, alternative solutions for ensuring that hospitals are appropriately paid for their pharmacy overhead and drug handling costs. Some commenters stated that such approaches should incorporate the payment for drug handling directly into the payment rate for the drug itself, rather than requiring separate coding systems. One commenter suggested that CMS obtain more accurate information by surveying hospital pharmacy departments and studying data on the departmental costs of hospital pharmacies. Another commenter stated that CMS should collect data and make payments in a manner similar to the way in which data are collected and payments provided through the Quality Measurement Demonstration Project that was implemented in physicians' offices in CY 2005.

Several commenters supported our proposal to implement the C-codes for drug handling categories. They supported the development of the three proposed distinct C-codes for drug handling categories and the collection of hospital claims data over the next 2 years for use in establishing payment rates based on actual costs in CY 2008 and beyond. One of the commenters supported basing payment for these new categories in CY 2008 on a weighted average of the overhead costs for all drugs to which the categories will

apply, thus ensuring the most accurate payment level possible while meeting the objective of the proposal to streamline the overhead payment system.

A few commenters did not believe the three drug handling categories proposed were sufficient to cover the wide range of drug handling costs for all of the separately payable drugs used by hospital outpatient departments and stated that the categories proposed by MedPAC would allow greater differentiation of drug handling costs. One commenter explained that more refined categories can and should be developed and urged CMS to reevaluate the use of the MedPAC categories and to release a listing of the drugs assigned to each drug handling category for hospital review. These commenters indicated that limiting the number of categories for which hospitals report their drug handling costs would not provide accurate cost data and were concerned that CMS' descriptions of these categories did not provide sufficient clarity for hospitals to appropriately classify all of their drugs. One commenter noted that intrathecal drugs should be assigned to category three or a new overhead cost category for intrathecal drugs should be created.

MedPAC was pleased that CMS' proposed methodology to pay for overhead and handling costs beginning in CY 2008 reflected its recommendations and noted that the methodology would be similar to that used to set payment rates for procedural APCs. However, MedPAC encouraged CMS to explore whether it would be reasonable to expand the number of handling cost APCs beyond the proposed three categories after the charge data necessary to set rates for the three handling cost APCs are collected.

Several commenters supported the creation of a mechanism for hospitals to begin capturing and reporting pharmacy costs. However, they indicated that it will take hospitals considerable time and effort to develop this approach as most hospitals do not currently report pharmacy costs directly or capture these costs fully. One commenter recommended that CMS tie reporting of the new C-codes for handling fees to actual payment amounts for the services so that hospitals would have an incentive to quickly develop a mechanism to report these codes. Other commenters supported the general C-code methodology, but were concerned that there was insufficient time to properly instruct and educate hospitals on how and when to use these codes. Therefore, to ensure that the new C-codes can be used effectively, these

commenters recommended that CMS consult with hospital organizations on this issue, and after reviewing their feedback, consider delaying C-code implementation until January 1, 2007 while continuing to refine the codes and develop instructions for their use. The APC Panel also recommended that CMS delay implementation of this proposal in order to collect more data and study alternatives.

If this policy is implemented for CY 2006, some commenters suggested that CMS provide a grace period of no less than 90 days after the implementation of the CY 2006 OPSS to allow hospitals time to make necessary system changes and to educate pharmacy staff, finance staff, and coders on the required use of the drug handling C-codes. Other commenters noted that a grace period of no less than 6 months would be required after the implementation of the CY 2006 OPSS. One commenter insisted that CMS collect hospital charge data for overhead costs for 2 years to determine if the proposed 2 percent of the ASP add-on rate is adequate and consider new payment rates for these pharmacy overhead services in CY 2008.

Response: We have carefully considered all the comments and the concerns raised by the commenters. In light of the extensive operational issues related to coding, billing, and charging for C-codes for drug handling categories identified by commenters, we believe there is good reason at this time not to proceed with our proposal for CY 2006. Therefore, we are not finalizing our proposal to collect data on pharmacy overhead costs in CY 2006. Rather, we will continue to solicit input from the industry, APC Panel, and hospitals to explore alternative methodologies for capturing meaningful and complete pharmacy overhead costs, for potential use in providing appropriate payments to hospitals for such services in future updates of the OPSS. We note that for CY 2006 we are requiring specific coding for certain devices, as we require the billing of all separately payable drugs and request that hospitals report packaged drugs. We believe that hospitals can easily ascertain the acquisition costs of devices and decide on an appropriate markup that includes device handling, and these device costs (except for devices with pass-through status) are then appropriately packaged into payments for the separately payable procedures that utilize the devices. Similarly, we believe that hospitals are aware of the acquisition costs of drugs and provide an appropriate markup that includes pharmacy overhead. These billed drugs are then either separately paid at ASP+6% for CY 2006 or their

payment is packaged into payments for the separately payable procedures where the drugs are administered. However, as discussed above, hospitals do not keep track of their pharmacy overhead costs nor their device handling costs separately. Rather, these broad overhead and handling costs are typically built into the charges for the drugs or devices themselves. In many ways, the device charge reported on a claim is like the drug charge, in that both currently reflect the acquisition cost of the device or drug and the handling cost of the device or drug (special handling, storage, etc.). Just as we do not require hospitals at this time to further differentiate their device charges into acquisition and handling components, based on our review of comments to the CY 2006 proposed rule we are also not going to require hospitals for CY 2006 to separate the traditionally highly linked drug acquisition and pharmacy overhead charges.

Comment: Several commenters urged CMS to recognize that low-cost drugs and biologicals may have substantial handling costs depending on the type and volume of the drugs administered, and therefore, recommended that CMS apply additional payments to packaged drugs and biologicals, as well as to separately payable therapies. The APC Panel also recommended that CMS pay for the overhead costs of both packaged and separately paid drugs. One of the commenters suggested that the use of the proposed C-codes for drug handling categories also be extended to include packaged drugs. One commenter recommended that CMS make an add-on payment of at least \$14.80 per dose of packaged drug administered, and that CMS consider establishing a new G-code for pharmacy handling services associated with packaged drugs for this purpose. The commenter based its recommendation on an analysis of the amount of required pharmacist and pharmacy technician time, plus indirect overhead costs, associated with preparing each dose of a packaged drug. Another commenter indicated that CMS may believe that overhead costs for packaged drugs are reflected in the payments for drug administration APCs; however, the commenter did not believe that the drug administration APC payment rates are sufficient to pay providers for administration services, or the acquisition and handling costs associated with packaged drugs. In addition, one commenter indicated that CMS should ensure that the add-on payment is applied equally to all drugs,

including those on pass-through and new to the market.

One commenter strongly opposed the expansion of the drug handling C-code reporting proposal to packaged drugs, citing that this policy would exponentially increase the coding and administrative burden on hospitals due to the large number of drugs that would require special charging practices for Medicare purposes. For example, the commenter noted that hospitals generally do not provide detailed billing for drugs that are not separately paid. The commenter believed that because all drugs do not have their own unique HCPCS codes, creating new codes for all drugs would be a significant burden. The commenter added that, given the large volume of drugs used in hospital outpatient departments, expanding drug handling coding requirements to all of these drugs, regardless of their packaging status, would dramatically increase hospital administrative costs associated with this proposal. Other commenters expressed similar views.

Response: We agree with the commenters who stated that extending specific payment for handling costs to packaged drugs would impose an excessive burden on hospitals. As the commenters noted, this policy would exponentially increase the coding and administrative burden that our proposed use of C-codes would have imposed. In addition, as we have stated previously, overhead costs are built into the charges for drugs, and these charges are already accounted for in setting the weights for the procedural APCs into which some drugs are packaged. Accordingly, we believe that additional payment for overhead costs of packaged drugs would be duplicative and have not made a separate provision for additional payment.

As discussed earlier, we proposed to pay for separately payable radiopharmaceuticals based on their charges on the claims submitted by hospitals converted to costs. MedPAC found that the handling resource costs associated with radiopharmaceuticals were especially difficult to study and estimate because of the varying resource requirements for handling radiopharmaceuticals in a variety of hospital outpatient settings for different clinical uses. These various methods of preparation of radiopharmaceuticals, and the individual radiopharmaceuticals themselves, differ significantly in the costs of their handling, with substantial variation in such factors as site of preparation, personnel time, shielding, transportation, equipment, waste disposal, and regulatory compliance

requirements. However, as MedPAC also found that handling costs for drugs, biologicals, and radiopharmaceuticals were built into hospitals' charges for the products themselves, we stated in the proposed rule that we believed that the charges from hospital claims converted to costs were representative of hospital acquisition costs for these agents, as well as their overhead costs. These costs would appropriately reflect each hospital's potentially diverse patterns of acquisition or production of radiopharmaceuticals for use in the outpatient hospital setting and their related handling costs that vary across radiopharmaceutical products and the circumstances of their production and use. Therefore, we did not propose to create separate handling categories for radiopharmaceuticals for CY 2006.

We received many public comments on this radiopharmaceutical proposal.

Comment: Several commenters stated that CMS should not assume that the hospitals have incorporated handling costs in their hospital charges for radiopharmaceuticals. They indicated that there has been some ambiguity about what costs should be included in radiopharmaceutical charges, as opposed to procedure charges, and this matter is complicated by the difference in payment policies for physician offices as compared to the hospital outpatient setting. They also stated that differing payment policies and lack of clear billing instructions in the different settings contribute to uncertainty about where radiopharmaceutical costs are reported by hospitals. Commenters suggested that CMS specifically declare where the costs for radiopharmaceutical handling should reside for all delivery settings and give clear direction to providers. One commenter stated that, due to the variety of radiopharmaceuticals that can be used with the same procedure, it is most accurate to incorporate radiopharmaceutical handling costs in the charge for the radiopharmaceutical rather than in the charge for the nuclear medicine procedure.

Response: We understand the commenters' concerns. We would emphasize that, in light of the policy that we are adopting in this final rule with comment period of paying for radiopharmaceuticals based on hospitals' charges converted to costs, it is appropriate for hospitals to include all the costs associated with acquiring and handling radiopharmaceuticals in their charges for the radiopharmaceuticals.

However, because we proposed to collect ASP information for radiopharmaceuticals in CY 2006, we

requested specific comments on appropriate categories for potentially capturing radiopharmaceutical handling costs. We stated in the proposed rule that we believed that these handling costs may vary depending on many factors. We also indicated that the handling cost categories should exclude any resources associated with specific diagnostic procedures or administration codes for patient services that utilize the radiopharmaceuticals. However, the handling cost categories should include all aspects of radiopharmaceutical handling and preparation, including transportation, storage, compounding, required shielding, inventory management, revision of dosages based on patient conditions, documentation, disposal, and regulatory compliance. The MedPAC study contractor suggested a variety of discriminating factors that may be related to the magnitude of radiopharmaceutical handling costs, including the complexity of the calculations and manipulations involved with compounding, the intended use of the product for diagnostic or therapeutic purposes, the item's status as a radioimmunoconjugate or nonradioimmunoconjugate, short-lived agents produced in-house, and preparation of the radiopharmaceutical in-house versus production in a commercial radiopharmacy. We sought comments on the construction of radiopharmaceutical handling cost categories that would meaningfully reflect differences in the levels of necessary hospital resources and that could easily be understood and applied by hospitals characterizing their preparation of radiopharmaceuticals.

We received numerous public comments concerning radiopharmaceutical handling cost categories.

Comment: We received comments describing various proposals for creating radiopharmaceutical handling cost categories. One commenter recommended the creation of five handling categories for radiopharmaceuticals and assigning them G-codes, instead of C-codes as proposed, for drug handling categories. The commenter recommended this approach because G-codes are available to all insurers and would assist hospitals in more accurate, consistent, and efficient billing for radiopharmaceuticals. Another commenter suggested seven potential radiopharmaceutical handling categories for our consideration. Still another commenter proposed four categories for capturing the costs of radiopharmaceuticals. MedPAC also encouraged CMS to further study how to

best construct categories of handling cost APCs for radiopharmaceuticals, which are generally likely to require greater resources for their preparation than drugs and biologicals. One commenter recommended that all radiopharmaceuticals be paid separately. The commenter believed that because of the potential for hospitals to bill one of the radiopharmaceutical handling category codes, this policy would facilitate appropriate data gathering, recognition, and payment of handling costs for all radiopharmaceuticals.

One commenter was pleased that CMS did not intend to create C-codes for radiopharmaceutical handling costs for CY 2006. Other commenters stated that, if CMS implements its proposal to create handling cost categories for drugs and biologicals in CY 2006, it should also create handling cost categories for radiopharmaceuticals in CY 2006. These commenters added, however, if CMS delays implementation of these drug handling categories, it would be appropriate to delay the adoption of handling cost category codes for radiopharmaceuticals.

Several commenters noted that if CMS implemented specific coding for handling and overhead costs of radiopharmaceuticals in CY 2006, it would have to initiate well in advance of January 2006 an educational effort to communicate to providers the need to use the new codes and to adjust radiopharmaceutical charges during CY 2006 to accurately reflect any changes in HCPCS code descriptors, along with identification of the relevant hospital CCR appropriate for calculating radiopharmaceutical payments. Another commenter suggested that CMS advise hospitals to make timely updates in charges to ensure that they fully, accurately, and uniformly report all relevant costs for radiopharmaceuticals.

A few commenters were concerned about the usefulness of creating additional C-codes for hospitals to report radiopharmaceutical handling costs in CY 2006 for use in CY 2007 without providing any payment to hospitals for this additional work, citing that the process will place an undue administrative burden on hospitals. They recommended that CMS work with medical specialty societies and industry to develop appropriate handling cost categories for radiopharmaceuticals and establish a specific payment rate for each category to help deflect the additional costs to hospitals for this added burden and to ensure adequate data collection. In addition, the commenters asked for concurrent direction to hospitals about

including the costs of handling in their charges for radiopharmaceuticals. Another commenter recommended that CMS incorporate these added handling costs directly into the final payment rates for radiopharmaceuticals by individual HCPCS codes.

Response: As discussed earlier, we will not be implementing the C-code handling categories for drugs and biologicals in CY 2006 due to the complex operational and policy issues surrounding this proposal. We will continue to study the possibility of creating handling cost categories for radiopharmaceuticals, as well as drugs, in order to develop viable options for making accurate payments for drug and radiopharmaceutical handling costs for consideration in future updates of the OPPS. In the meantime, as discussed earlier, payment for both acquisition and handling costs of radiopharmaceuticals in CY 2006 will be made based on hospital charges for these items converted to costs using each hospital's overall CCR. This methodology will allow us to pay simultaneously for radiopharmaceutical acquisition and handling costs, without creating additional administrative burden for hospitals.

Comment: One commenter noted that CMS should include the costs associated with specially trained personnel to handle and compound radiopharmaceuticals, waste, and spoilage in its list of elements to consider including as part of radiopharmaceutical handling costs. The commenter also suggested that CMS make clear whether the radiopharmaceutical "transportation" costs should reside with the acquisition costs or with the handling costs. At present, many radiopharmaceutical invoice acquisition costs could include the "transportation" costs, therefore, the commenter cautioned CMS regarding the potential for double counting.

Response: Since in CY 2006 payment for both acquisition and handling costs of radiopharmaceuticals will be made based on hospital charges for these items converted to costs, we encourage hospitals to include in their charges the costs associated with specially trained personnel to handle and compound radiopharmaceuticals, waste, spoilage, and transportation costs as noted by the commenter. Whether hospitals associate these costs with radiopharmaceutical acquisition or handling is not significant, as both types of costs should be fully reflected in the hospitals' charges for radiopharmaceuticals.

b. Final CY 2006 Payment for Nonpass-Through Drugs, Biologicals, and Radiopharmaceuticals With HCPCS Codes, But Without OPSS Hospital Claims Data

Pub. L. 108–173 does not address the OPSS payment in CY 2005 and after for new drugs, biologicals, and radiopharmaceuticals that have assigned HCPCS codes, but that do not have a reference AWP or approval for payment as pass-through drugs or biologicals. Because there is no statutory provision that dictated payment for such drugs and biologicals in CY 2005, and because we had no hospital claims data to use in establishing a payment rate for them, we investigated several payment options for CY 2005 and discussed them in detail in the CY 2005 OPSS final rule with comment period (69 FR 65797 through 65799).

In the CY 2006 OPSS proposed rule, we proposed to use the same methodology that we used in CY 2005. That is, we proposed to pay for these new drugs and biologicals with HCPCS codes but which do not have pass-through status at a rate that is equivalent to the payment they would receive in the physician office setting, which would be established in accordance with the ASP methodology described in the CY 2006 Medicare Physician Fee Schedule final rule. As discussed in the CY 2005 final rule with comment period (69 FR 65797), new drugs, biologicals, and radiopharmaceuticals may be expensive, and we were concerned that packaging these new items might jeopardize beneficiary access to them. In addition, we did not want to delay separate payment for these items solely because a pass-through application was not submitted. We noted in the proposed rule that this payment methodology is the same as the methodology that would be used to calculate the OPSS payment amount that pass-through drugs and biologicals would be paid in CY 2006 in accordance with section 1842(o) of the Act, as amended by section 303(b) of Pub. L. 108–173, and section 1847A of the Act. Thus, we proposed to continue to treat new drugs, biologicals, and radiopharmaceuticals with established HCPCS codes the same, irrespective of whether pass-through status has been determined. We also proposed to assign status indicator “K” to HCPCS codes for new drugs and biologicals for which we have not received a pass-through application.

In the proposed rule, we stated that there were several drugs, biologicals, and radiopharmaceuticals that were payable during CY 2004 or where HCPCS codes for products were created effective January 1, 2005, for which we did not have any CY 2004 hospital claims data. In order to determine the packaging status of these items for CY 2006, in the proposed rule we calculated an estimate of the per day cost of each of these items by multiplying the payment rate for each product, as determined using the ASP methodology, by an estimated average number of units of each product that would be furnished to a patient during one administration. We proposed to package items for which we estimated the per administration cost to be less than \$50 and pay separately for items with an estimated per administration cost greater than \$50. We indicated that payment for the separately payable items would be based on rates determined using the ASP methodology established in the physician office setting. There were two codes HCPCS codes 90393 (Vaccina ig, im) and Q9953 (Inj Fe-based MR contrast, ml), for which we were not able to determine payment rates based on the ASP methodology. Because we were unable to estimate the per administration cost of these items, we proposed to package them in CY 2006. We specifically requested public comments on our proposed policy for determining the per administration cost of these drugs, biologicals, and radiopharmaceuticals that were payable under the OPSS, but did not have any CY 2004 claims data.

We received several public comments in response to our request.

Comment: One commenter supported the proposal to price drugs that have a HCPCS code but do not have pass-through status at the same rate they would be paid in the physician office setting based on the ASP methodology.

Response: We appreciate the commenter’s support. We are finalizing our proposed policy to pay for new drugs, biologicals, and radiopharmaceuticals with HCPCS codes but which do not have pass-through status at a rate that is equivalent to the payment they would receive in the physician office setting, which will be established in accordance with the ASP methodology. We are also paying separately for drugs, biologicals, and radiopharmaceuticals whose HCPCS codes will be payable for the first time

under the OPSS in CY 2006 but whose codes do not crosswalk to other HCPCS codes previously recognized under the OPSS.

In CY 2006, payment for these new drugs, biologicals, and radiopharmaceuticals will be based on ASP+6 percent. In accordance with the ASP methodology used in the physician office setting, in the absence of ASP data, we will use wholesale acquisition cost (WAC) for the product to establish the initial payment rate. We note, however, that if WAC is also unavailable, then we will calculate payment at 95 percent of the most recent AWP that we have available at the time of the development of this final rule and for the quarterly updates. We note that with respect to items for which we currently do not have ASP data, once their ASP data become available in later quarter submissions, their payment rates under the OPSS will be adjusted so that the rates are based on the ASP methodology and set to ASP+6 percent.

For this final rule with comment period, we are basing the payment rates for these items on ASP data from the second quarter of CY 2005, which are effective in the physician office setting on October 1, 2005, because these are the most recent values available for the development of this rule. To be consistent with the ASP-based payments that would be made when these drugs and biologicals are furnished in physician offices as proposed, we plan to make any appropriate adjustments to the amounts shown in Addenda A and B to this final rule with comment period for these items on a quarterly basis as more recent ASP data become available. Changes in the payment rates will be posted on our Web site during each quarter of CY 2006. Accordingly, effective January 1, 2006, we will base payment rates for all separately payable drugs and biologicals on ASP data from the third quarter of CY 2005, which will also be the basis for setting payment rates for drugs and biologicals in the physician office setting effective January 1, 2006.

For CY 2006, we will apply this policy to several drugs, biologicals, and radiopharmaceuticals that are new effective January 1, 2006 and do not have pass-through status or hospital claims data. These items are listed in Table 26 below and will be separately payable under OPSS in CY 2006, and thus, we have assigned them to status indicator “K”.

TABLE 26.—CY 2006 PAYMENT METHODOLOGY FOR NEW DRUGS, BIOLOGICALS, AND RADIOPHARMACEUTICALS WITHOUT PASS-THROUGH STATUS AND CY 2004 CLAIMS DATA

| HCPCS code | Description | APC | CY 2006 SI |
|------------|-------------------------------|------|------------|
| 90714 | Td vaccine no prsrv >= 7 im | 1634 | K |
| A9567 | Technetium TC-99m aerosol | 1679 | H |
| A9535 | Injection, methylene blue | 1640 | K |
| J0132 | Acetylcysteine injection | 1680 | K |
| J0278 | Amikacin sulfate injection | 1681 | K |
| J2425 | Palifermin injection | 1696 | K |
| J2805 | Sincalide injection | 1699 | K |
| J2850 | Inj secretin synthetic human | 1700 | K |
| J3471 | Ovine, up to 999 USP units | 1702 | K |
| J3472 | Ovine, 1000 USP units | 1703 | K |
| J7341 | Non-human, metabolic tissue | 1707 | K |
| J8540 | Oral dexamethasone | 1708 | K |
| J9225 | Histrelin implant | 1711 | K |
| Q9958 | HOCM <=149 mg/ml iodine, 1ml | 1714 | K |
| Q9960 | HOCM 200-249mg/ml iodine, 1ml | 1715 | K |
| Q9961 | HOCM 250-299mg/ml iodine, 1ml | 1734 | K |
| Q9962 | HOCM 300-349mg/ml iodine, 1ml | 1735 | K |
| Q9963 | HOCM 350-399mg/ml iodine, 1ml | 1736 | K |
| Q9964 | HOCM >= 400 mg/ml iodine, 1ml | 1737 | K |

Comment: One commenter agreed in principle with CMS' proposed methodology for determining the packaging status for drugs for which CMS did not have CY 2004 claims data. However, the commenter expressed concern about the proposal to package HCPCS code Q9953 (Inj Fe-based MR contrast, ml). The commenter noted that ASP data are available for Q9953, and the data demonstrated that the average per administration cost of Q9953 exceeded the \$50 packaging threshold. Thus, the commenter believed that HCPCS code Q9953 should be paid separately in CY 2006. The commenter indicated that the most current ASP data submission, which was submitted to CMS on July 29, 2005, showed an ASP for Feridex I.V., the product described by HCPCS code Q9953, of \$28.68 per ml. The commenter pointed out that using an average dosing of 3.5 ml per the Feridex I.V. package insert, the average cost per administration

would be \$100.39 for HCPCS code Q9953, which far exceeds the CY 2006 OPPS \$50 packaging threshold. Therefore, the commenter requested that CMS use the ASP data as reported to establish a CY 2006 OPPS payment amount for HCPCS code Q9953.

Response: Consistent with the commenter's statement, we received ASP data from the second quarter of CY 2005 for HCPCS code Q9953 after the proposed rule was issued. For this final rule with comment period, we are using updated ASP data under the methodology we proposed to determine the packaging status for items that did not have any CY 2004 hospital claims data, and our calculation of the per day cost of HCPCS code Q9953 indicated that it is higher than \$50 per day. Therefore, we will make separate payment for HCPCS code Q9953 in CY 2006 and set payment at the rate determined using the ASP methodology.

In this final rule with comment period, we are finalizing the proposed policy for determining the per administration cost of drugs, biologicals, and radiopharmaceuticals that are payable under the OPPS, but which do not have any CY 2004 claims data to determine their packaging status in CY 2006. Table 27 below lists all of the drugs and biologicals to which this policy will apply in CY 2006.

We note that in the proposed rule, we indicated that we are packaging HCPCS code 90393 (Vaccina ig, im) as we were unable to determine a payment rate for this item based on the ASP methodology; thus, we were also unable to estimate the per administration cost of this item. For this final rule with comment period, we were still not able to determine an ASP-based payment for this item to estimate its per administration cost. Therefore, we will continue to package this code in this final rule with comment period.

TABLE 27.—DRUGS, BIOLOGICALS, AND RADIOPHARMACEUTICALS WITHOUT CY 2004 CLAIMS DATA

| HCPCS code | Description | ASP-based payment rate | Est. average number of units per administration | CY 2006 SI |
|------------|-----------------------------|------------------------|---|------------|
| 90581 | Anthrax vaccine, sc | \$126.46 | 1 | K |
| C1093* | TC99M fanolesomab | 1,197.00 | 1 | H |
| C9206* | Integra, per cm2 | 10.69 | 19 | K |
| C9224 | Injection, galsulfase | 1,522.15 | 14 | K |
| J0135 | Adalimumab injection | 293.98 | 2 | K |
| J0190 | Inj biperiden lactate/5 mg | 3.14 | 1 | N |
| J0200 | Alatrofloxacin mesylate | 16.03 | 2.5 | N |
| J0288 | Ampho b cholesteryl sulfate | 12.00 | 35 | K |
| J0395 | Arbutamine HCl injection | 160.00 | 1 | K |
| J1180 | Dyphylline injection | 8.05 | 8.4 | K |
| J1457 | Gallium nitrate injection | 1.25 | 340 | K |
| J3315 | Triptorelin pamoate | 372.86 | 1 | K |

TABLE 27.—DRUGS, BIOLOGICALS, AND RADIOPHARMACEUTICALS WITHOUT CY 2004 CLAIMS DATA—Continued

| HCPCS code | Description | ASP-based payment rate | Est. average number of units per administration | CY 2006 SI |
|--------------|----------------------------------|------------------------|---|------------|
| J3530 | Nasal vaccine inhalation | 15.00 | 1 | N |
| J7350 | Injectable human tissue | 5.35 | 33 | K |
| J7674 | Methacholine chloride, neb | 0.40 | 8.875 | N |
| J9357 | Valrubicin, 200 mg | 369.60 | 4 | K |
| Q2012* | Pegademase bovine, 25 iu | 166.07 | 56 | K |
| Q2018* | Urofollitropin, 75 iu | 48.45 | 2 | K |

*For CY 2006, C1093, C9206, Q2012, and Q2018 are deleted and replaced with A9566, J7343, J2504, and J3355 respectively.

Comment: One commenter requested that CMS clarify the coding and payment policies for high osmolar contrast medium (HOCM) that will be applicable during CY 2006. The commenter supported the proposal that would allow hospitals to bill and be paid for these agents using the recently assigned HCPCS codes Q9958—Q9964 and revenue code 636. In addition, the commenter requested that HOCM agents be paid using the ASP methodology in CY 2006. The commenter noted that section 3631 of CMS' Intermediary Manual currently states that "if billing separately, hospitals use revenue code 255 for contrast material other than LOCM. To prevent confusion and the inappropriate denial of claims, the commenter further requested that CMS specify that hospitals should disregard the program manual instruction and use revenue code 636 and the Q-codes when billing for HOCM.

Response: The HCPCS codes Q9958—Q9964 for HOCM were created effective July 1, 2005. We believe that these codes should be paid separately according to the ASP methodology in CY 2006, similar to our policy of paying separately for new items in CY 2006 because these codes had no predecessor codes in the OPSS and the codes themselves will first be recognized under the OPSS in CY 2006. In this final rule with comment period, we were able to determine ASP-based payment rates for all of the HOCM codes, except HCPCS code Q9959. We were unable to identify a product that crosswalked to this code; therefore, we could not calculate an appropriate payment for this code. Therefore, we are packaging HCPCS code Q9959 in this final rule with comment period. We note that if ASP data become available in later quarter submissions for this code, then we will pay for this code separately based on an appropriate payment rate. The ASP-based payment rates for the separately payable HOCM codes that are listed in Addenda A and B of this final rule with comment period are estimates

and have not been published before as these codes are not currently separately paid in the physician office setting. In response to one of the commenter's concerns about appropriate billing for HOCM, the hospitals may wish to post their charges for HOCM on the claim with the revenue code that crosswalks to the cost center on the hospital Medicare cost report where the costs for HOCM are reported. We note that we will be closely examining hospital claims data for HOCM codes, as for all drugs, biologicals, and radiopharmaceuticals, to assess whether packaging or separate payment is appropriate for future OPSS updates.

C. Coding and Billing Changes for Specified Covered Outpatient Drugs

1. Background

As discussed in the January 6, 2004 interim final rule with comment period (69 FR 826), we instructed hospitals to bill for sole source drugs using the existing HCPCS codes, which were priced in accordance with the provisions of section 1833(t)(14)(A)(i) of the Act, as added by Pub. L. 108–173. However, at that time, the existing HCPCS codes did not allow us to differentiate payment amounts for innovator multiple source and noninnovator multiple source forms of the drug. Therefore, effective April 1, 2004, we implemented new HCPCS codes via Program Transmittal 112 (Change Request 3144, February 27, 2004) and Program Transmittal 132 (Change Request 3154, March 30, 2004) that providers were instructed to use to bill for innovator multiple source drugs in order to receive appropriate payment in accordance with section 1833(t)(14)(A)(i)(II) of the Act. We also instructed providers to continue to use the existing HCPCS codes to bill for noninnovator multiple source drugs to receive payment in accordance with section 1833(t)(14)(A)(i)(III) of the Act. These coding policies allowed hospitals to appropriately code for drugs, biologicals, and radiopharmaceuticals

based on their classification and to be paid accordingly. We continued this coding practice in CY 2005 with payment made in accordance with section 1833(t)(14)(A)(ii) of the Act.

2. CY 2006 Payment Policy

In the CY 2006 OPSS proposed rule, we proposed to base the payment rates for drugs and biologicals and their pharmacy overhead costs on the ASP methodology that is used to set payment rates for these items in the physician office setting. Under this methodology, a single payment rate for the drug is calculated by considering the prices for both the innovator multiple source (brand) and noninnovator multiple source (generic) forms of the drug. Therefore, under the OPSS, we noted in the proposed rule that we believed that there was no longer a need to differentiate between the brand and generic forms of a drug. Thus, we proposed to discontinue use of the C-codes that were created to represent the innovator multiple source drugs. In CY 2006, hospitals would use the HCPCS codes for noninnovator multiple source (generic) drugs to bill for both the brand and generic forms of a drug as they did prior to implementation of section 1833(t)(14)(A) in Pub. L. 108–173. We specifically requested comments on this proposed policy.

We received a few public comments concerning this proposal.

Comment: Several commenters supported the proposal to eliminate the use of the brand name drug C-codes in CY 2006 as there was no longer a need to distinguish between innovator (brand name) and noninnovator (generic) multiple source drugs. The commenters indicated that this policy will reduce the administrative burden of maintaining and reporting separate HCPCS codes for both generic and brand name drugs. However, some commenters pointed out that the availability of these drugs varies in the marketplace, and they asked CMS to clarify how it determines a single ASP payment for both brand and generic

drugs to ensure that the calculated APC payment accurately reflects the combined cost of both brand and generic forms of the drug. One commenter also requested that CMS clarify whether the ASP is based on the volume of brand versus generic drugs purchased by providers during a given quarter.

Response: Section 1847A(b)(3) of the Act specifies that the payment amount for multiple source drugs is the volume-weighted average of the ASPs reported by the manufacturers of the NDCs assigned to the billing HCPCS code. The computation is weighted by the number of units sold during the reporting period. As availability of products changes in the marketplace, changes in purchasing patterns will be reported in the ASP data. For further discussion of the methodology used to determine the ASP-based payment amounts, see the related "Frequently Asked Question" at <http://questions.cms.hhs.gov>. This issue is also addressed in the CY 2006 Medicare Physician Fee Schedule final rule.

For CY 2006, we are finalizing our proposal to discontinue use of the C-codes that were created to represent the innovator multiple source drugs, and note that hospitals are to use the HCPCS codes for noninnovator multiple source (generic) drugs to bill for both the brand and generic forms of a drug.

D. Payment for New Drugs, Biologicals, and Radiopharmaceuticals Before HCPCS Codes Are Assigned

1. Background

Historically, hospitals have used a HCPCS code for an unlisted or unclassified drug, biological, or radiopharmaceutical or used an appropriate revenue code to bill for drugs, biologicals, and radiopharmaceuticals furnished in the outpatient department that do not have an assigned HCPCS code. The codes for not otherwise classified drugs, biologicals, and radiopharmaceuticals are assigned packaged status under the OPSS. That is, separate payment is not made for the code, but charges for the code would be eligible for an outlier payment and, in future OPSS updates, the charges for the code are packaged with the separately payable service with which the code is reported for the same date of service.

Drugs and biologicals that are newly approved by the FDA and for which a HCPCS code has not yet been assigned by the National HCPCS Alpha-Numeric Workgroup could qualify for pass-through payment under the OPSS. An application must be submitted to CMS

in order for a drug or biological to be assigned pass-through status, a temporary C-code assigned for billing purposes, and an APC payment amount determined. Pass-through applications are reviewed on a flow basis, and payment for drugs and biologicals approved for pass-through status is implemented throughout the year as part of the quarterly updates of the OPSS.

2. CY 2006 Payment Policy

Section 1833(t)(15) of the Act, as added by section 621(a)(1) of Pub. L. 108-173, provides for payment for new drugs and biologicals until HCPCS codes are assigned under the OPSS. Under this provision, we are required to make payment for an outpatient drug or biological that is furnished as part of covered outpatient hospital services but for which a HCPCS code has not yet been assigned in an amount equal to 95 percent of AWP. This provision applies only to payments made under the OPSS on or after January 1, 2004.

As noted in the proposed rule (70 FR 42733), we initially adopted the methodology for determining payment under section 1833(t)(15) of the Act on an interim basis on May 28, 2004, via Transmittal 188, Change Request 3287, and finalized the methodology for CY 2005 in our CY 2005 OPSS final rule with comment period. In that final rule with comment period, we also expanded the methodology to include payment for new radiopharmaceuticals to which a HCPCS code is not assigned (69 FR 65804 through 65807). We instructed hospitals to bill for a drug or biological that is newly approved by the FDA by reporting the NDC for the product along with new HCPCS code C9399 (Unclassified drug or biological). When HCPCS code C9399 appears on a claim, the OCE suspends the claim for manual pricing by the fiscal intermediary. The fiscal intermediary prices the claim at 95 percent of its AWP using the Red Book or an equivalent recognized compendium, and processes the claim for payment. This approach enables hospitals to bill and receive payment for a new drug, biological, or radiopharmaceutical concurrent with its approval by the FDA. The hospital does not have to wait for the next OPSS quarterly release or for approval of a product-specific HCPCS code to receive payment for a newly approved drug, biological, or radiopharmaceutical. In addition, the hospital does not have to resubmit claims for adjustment. Hospitals discontinue billing HCPCS code C9399 and the NDC upon implementation of a HCPCS code, status indicator, and

appropriate payment amount with the next OPSS quarterly update.

For CY 2006, we proposed to continue the same methodology for paying for new drugs, biologicals, and radiopharmaceuticals without HCPCS codes. We received a few public comments in response to our proposal.

Comment: Several commenters supported CMS' proposal to pay for new drugs prior to the assignment of a HCPCS code at an amount equal to 95 percent of the drug's AWP and reiterated that the AWP should correspond to the payment rate established by the fiscal intermediaries using the Red Book or an equivalent recognized compendium. One commenter noted that this policy allows providers to receive payment for newer drugs in a timely fashion.

Response: We appreciate the commenters' support for the continuation of our policy to pay for new drugs, biologicals, and radiopharmaceuticals without HCPCS codes at 95 percent of AWP. For CY 2006, we are finalizing our proposed methodology, without modification.

E. Payment for Vaccines

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

Influenza, pneumococcal, and hepatitis B vaccines and their administration are specifically covered by Medicare under section 1861(s)(10) of the Act. For CY 2006, we proposed

to continue to pay influenza and pneumococcal vaccines at reasonable cost. However, hepatitis B vaccines have been paid under clinical APCs that also included other vaccines. For CY 2006, we proposed to pay for all hepatitis B vaccines at reasonable cost, consistent with the payment methodology for influenza and pneumococcal vaccines. Influenza and pneumococcal vaccines are exempt from coinsurance and deductible payments under sections 1833(a)(3) and 1833(b) of the Act and have been assigned status indicator "L". However, hepatitis B vaccines have no similar coinsurance or deductible exemption. Therefore, we proposed to assign these items status indicator "F".

Previously under the OPSS, separately payable vaccines other than influenza and pneumococcal were grouped into clinical APCs 0355 (Level I Immunizations) and 0356 (Level II Immunizations) for payment purposes. Payment rates for these APCs were based on the APCs' median costs, calculated from the costs of all of the vaccines grouped within the APCs. For CY 2006, we proposed to pay for each separately payable vaccine under its own APC, consistent with our policy for separately payable drugs other than vaccines, instead of aggregating them into clinical APCs with other vaccines. We believed this policy would allow us to more appropriately establish a payment rate for each separately payable vaccine based on the ASP methodology. Proposed and final policy changes to coding and payments for the administration of these vaccines are discussed in section VIII.C. of this preamble.

During the August 2005 meeting of the APC Panel, the Panel recommended that CMS change the status indicator for CPT code 90660, intranasal influenza vaccine, to "L," and that the code be reimbursed on a reasonable-cost basis. As discussed below, we accepted this recommendation.

We specifically requested comments on our proposed vaccine policies for CY 2006. We received several public comments concerning our proposal.

Comment: All commenters supported CMS' proposal to continue to pay for influenza and pneumococcal pneumonia vaccines based on reasonable cost. One commenter believed that payment based on reasonable cost helps to ensure that hospitals are adequately paid for providing these vaccines.

Response: We appreciate the commenters' continued support of our policy. We are finalizing our proposal to pay for influenza and pneumococcal pneumonia vaccines at reasonable cost

for CY 2006 in this final rule with comment period. We did not receive any comments on our proposals to also pay for Hepatitis B vaccines at reasonable cost and pay for each separately payable vaccine under its own APC. For CY 2006, we are also finalizing these two proposals.

Comment: Several commenters noted that CMS assigned CPT code 90660 (Intranasal influenza vaccine) status indicator "E," indicating that Medicare does not cover the item, does not recognize it, or does not provide separate payment for it. The commenters urged CMS to implement the APC Panel's recommendation to pay for CPT code 90660 on a reasonable cost basis and exempt this code from coinsurance and deductible, similar to all other influenza vaccines.

Response: We agree with the commenters that our proposal to pay influenza vaccines at reasonable cost should also apply to CPT code 90660. Therefore, CPT code 90660 will be paid at reasonable cost and assigned to status indicator "L" in CY 2006, similar to all other influenza vaccines.

F. Changes in Payment for Single Indication Orphan Drugs

Section 1833 (t)(1)(B)(i) of the Act gives the Secretary the authority to designate the hospital outpatient services to be covered. The Secretary has specified coverage for certain drugs as orphan drugs (section 1833(t)(14)(B)(ii)(III) of the Act, as added by section 621(a)(1) of Pub. L. 108-173). Section 1833 (t)(14)(C) of the Act, as added by section 621(a)(1) of Pub. L. 108-173, gives the Secretary the authority in CYs 2004 and 2005 to specify the amount of payment for an orphan drug that has been designated as such by the Secretary.

In the CY 2006 OPSS proposed rule (70 FR 42733), we indicated that we recognized that orphan drugs that are used solely for an orphan condition or conditions are generally expensive and, by definition, are rarely used. We believed that if the costs of these drugs were packaged into the payment for an associated procedure or visit, the payment for the procedure might be insufficient to compensate a hospital for the typically high costs of this special type of drug. Therefore, we proposed to continue paying for them separately.

In the November 1, 2002 final rule (67 FR 66772), we identified 11 single indication orphan drugs that are used solely for orphan conditions by applying the following criteria:

- The drug is designated as an orphan drug by the FDA and approved by the

FDA for treatment of only one or more orphan condition(s).

- The current United States Pharmacopoeia Drug Information (USPDI) shows that the drug has neither an approved use nor an off-label use for other than the orphan condition(s).

Eleven single indication orphan drugs were identified as having met these criteria and payments for these drugs were made outside of the OPSS on a reasonable cost basis.

In the November 7, 2003 final rule with comment period (68 FR 63452), we discontinued payment for orphan drugs on a reasonable cost basis and made separate payments for each single indication orphan drug under its own APC. Payments for the orphan drugs were made at 88 percent of the AWP listed for these drugs in the April 1, 2003 single drug pricer, unless we were presented with verifiable information that showed that our payment rate did not reflect the price that was widely available to the hospital market. For CY 2004, Ceredase (alglucerase) and Cerezyme (imiglucerase) were paid at 94 percent of the AWP because external data submitted by commenters on the August 12, 2003 proposed rule caused us to believe that payment at 88 percent of the AWP would be insufficient to ensure beneficiaries' access to these drugs.

In the December 31, 2003 correction of the November 7, 2003 final rule with comment period (68 FR 75442), we added HCPCS code J9017 (Arsenic trioxide, 1 mg) to our list of single indication orphan drugs. In the November 15, 2004 final rule with comment period (69 FR 65807), we retained the same criteria for identifying single indication orphan drugs and added two HCPCS codes to our list, HCPCS code C9218 (Injection, Azactidine, per 1 mg) and HCPCS code J9010 (Alemtuzumab, 10 mg) (69 FR 65808). As of CY 2005, the following are the 14 orphan drugs that we have identified as meeting our criteria: HCPCS code C9218 (Injection, Azactidine, per 1 mg); HCPCS code J0205 (Injection, Alglucerase, per 10 units); HCPCS code J0256 (Injection, Alpha 1-proteinase inhibitor, 10 mg); HCPCS code J9300 (Gemtuzumab ozogamicin, 5mg); HCPCS code J1785 (Injection, Imiglucerase, per unit); HCPCS code J2355 (Injection, Oprelvekin, 5 mg); HCPCS code J3240 (Injection, Thyrotropin alpha, 0.9 mg); HCPCS code J7513 (Daclizumab, parenteral, 25 mg); HCPCS code J9010 (Alemtuzumab, 10 mg); HCPCS code J9015 (Aldesleukin, per single use vial); HCPCS code J9017 (Arsenic trioxide, 1 mg); HCPCS code J9160 (Denileukin

difitox, 300 mcg); HCPCS code J9216 (Interferon, gamma 1-b, 3 million units); and HCPCS code Q2019 (Injection, Basiliximab, 20 mg).

In the November 15, 2004 final rule with comment period (69 FR 65808), we stated that had we not classified these drugs as single indication orphan drugs for payment under the OPSS, they would have met the definition of single source specified covered outpatient drugs and received lower payments, which could have impeded beneficiary access to these unique drugs dedicated to the treatment of rare diseases.

Instead, for CY 2005, under our authority at section 1833(t)(14)(C) of the Act, we set payment for all 14 single indication orphan drugs at the higher of 88 percent of the AWP or the ASP+6 percent. For CY 2005, we also updated on a quarterly basis the payment rates through comparison of the most current ASP and AWP information available to us. Given that CY 2005 was the first year of mandatory ASP reporting by manufacturers, we did not want potential significant fluctuations in the ASPs to affect payments to hospitals furnishing these drugs, which in turn might cause access problems for beneficiaries. Therefore, in the November 15, 2004 final rule, we did not implement the proposed 95 percent AWP cap on payments for single indication orphan drugs, which was described in the August 16, 2004 proposed rule (69 FR 50518), as we intended to monitor the impact of our payment policy and consider the need for a cap in future OPSS updates if appropriate (69 FR 65809).

As indicated in the proposed rule (70 FR 42734), as a part of the GAO study on hospital acquisition costs of specified covered outpatient drugs, the GAO provided the average hospital purchase prices for four orphan drugs: HCPCS code J0256 (Injection, Alpha 1-proteinase inhibitor, 10 mg), HCPCS code J1785 (Injection, Imiglucerase, per unit), HCPCS code J9160 (Denileukin difitox, 300 mcg), and HCPCS code J9010 (Alemtuzumab, 10 mg).

For alpha 1-proteinase inhibitor (HCPCS code J0256), the hospitals in the study sample represented only about 14 percent of the estimated total number of hospitals purchasing the drug. The mean hospital purchase price was about 73 percent of the payment rate based on ASP+6 percent rate and about 63 percent of the CY 2005 payment rate updated in April 2005. We noted in the proposed rule (70 FR 42734) that we believed the GAO acquisition data for alpha 1-proteinase inhibitor were likely not representative of hospital acquisition costs for the drug because

the number of hospitals providing data was so small compared to the total number of hospitals expected to utilize the drug. Furthermore, we recognized that the GAO data on hospital drug acquisition costs did not reflect the current acquisition costs experienced by hospitals but instead, relied on past cost data from late CY 2003 through early CY 2004. On the other hand, we stated that the ASP data were more current and thus were likely more reflective of hospital acquisition costs for alpha 1-proteinase inhibitor at the time of issuance of the CY 2006 proposed rule.

In contrast to the GAO data for alpha 1-proteinase inhibitor, the GAO data for imiglucerase (HCPCS code J1785) reflected hospital purchase prices from about 69 percent of the hospitals expected to utilize the drug. For this drug, the mean hospital purchase price was about 93 percent of the CY 2005 payment rate for imiglucerase updated in April 2005, which was based on ASP+6 percent rate. Thus, the ASP-based payment rate also appeared to be appropriately reflective of hospital acquisition costs for imiglucerase, and to be consistent with the GAO mean purchase price.

For denileukin difitox (HCPCS code J9160) and alemtuzumab (HCPCS code J9010), the GAO data for these drugs reflected hospital purchase prices from about 77 percent and 66 percent of the hospitals expected to acquire these drugs, respectively. The mean hospital purchase price for denileukin difitox was about 94 percent of the payment rate based on the ASP+6 percent rate and about 79 percent of the CY 2005 payment rate. As for alemtuzumab, the mean hospital purchase price was about 95 percent of the payment rate based on the ASP+6 percent rate and about 89 percent of the CY 2005 payment rate. For both of these drugs, the ASP-based payment rates also appeared to be appropriately reflective of their hospital acquisition costs, based on confirmation by the GAO average purchase price data from over two-thirds of the hospitals expected to acquire the drugs.

During the quarterly updates to payment rates for single indication orphan drugs for CY 2005, we observed significant improvement in the accuracy and consistency of manufacturers' reporting of the ASPs for these orphan drugs. Overall, we found that the ASPs as compared to the AWP were less likely to experience dramatic fluctuations in prices from quarter to quarter. We indicated in the proposed rule that we expected that as the ASP system continues to mature, manufacturers will further refine their quarterly reporting, leading to even

greater stability and accuracy in their reporting of sales prices. As the ASPs reflect the average sales prices to all purchasers, the ASP data also include drug sales to hospitals. Past commenters have indicated to us that some orphan drugs are administered principally in hospitals, and to the extent that this is true their ASPs should predominantly be based upon the sales of drugs used by hospitals. For three of the orphan drugs for which the GAO provided average purchase prices from a large percentage of hospitals expected to acquire the drugs, the GAO data were very consistent with the ASP+6 percent. For the fourth drug, the GAO mean was significantly lower than the ASP+6 percent and the confidence interval around that mean was quite tight, although only a small proportion of hospitals expected to acquire the drug reported their purchase prices. Thus, in the proposed rule, we stated that we believed that proposing to pay for orphan drugs based on an ASP methodology was appropriate for the CY 2006 OPSS and should assure patients' continued access to these orphan drugs in the hospital outpatient department. Therefore, for CY 2006, we proposed to pay for single indication orphan drugs at the ASP+6 percent.

We believed that paying for orphan drugs using the ASP methodology was consistent with our proposed general drug payment policy for other separately payable drugs and biologicals in the CY 2006 and reflected our general view that ASP-based payment rates serve as the best proxy for the average acquisition cost for these items as described in this section V. of the preamble. In addition, we proposed to pay an additional 2 percent of the ASP scaled for budget neutrality to cover the handling costs of these drugs, also consistent with our proposed general pharmacy overhead payment policy for handling costs associated with separately payable drugs and biologicals. We believed that the ASP+6 percent for orphan drugs would provide appropriate payment for hospital acquisition costs for these drugs that are administered by a relatively small number of providers, so that patients would continue to have access to orphan drugs in the hospital outpatient setting. Hospitals would also receive additional payments for costs associated with their storage, handling, and preparation of orphan drugs. We proposed to update the payment rates on a quarterly basis to reflect the most current ASPs available to us, and we also noted that appropriate adjustments to the payment amounts shown in

Addendum A and B of this final rule with comment period would be made if the ASP submissions in a later quarter indicated that adjustments to the payment rates were necessary. (70 FR 42735) These changes to the Addenda would be announced in our program instructions released on a quarterly basis and posted on our Web site at <http://www.cms.hhs.gov>.

We specifically requested comments on our proposed payment policy for single indication orphan drugs in CY 2006. We received several public comments regarding our proposal.

Comment: One commenter indicated that, under the proposed payment policy for orphan drugs, it did not anticipate access problems generally for orphan drugs that will be used in the hospital outpatient setting in CY 2006. However, the commenter also stated that orphan drugs should be given special consideration as a class and recommended that CMS adopt the definition of "orphan drugs" used in the Food, Drug, and Cosmetics Act for purposes of identifying drugs and biologicals that are treatments for rare diseases. The commenter further recommended that CMS establish an evaluation process to determine which orphan products may need special status or assistance to assure access. For example, the commenter suggested that CMS accept orphan products designated by the FDA as a valid class for initial consideration; develop prospective criteria to determine which orphan drugs should not be part of this class; work with stakeholders to identify any access problems that may occur or are likely to occur in the near future; and provide patients and pharmaceutical companies an opportunity to present data and receive a written explanation with examples before making a final decision that an orphan drug access problem exists.

Response: As we stated in the CY 2005 final rule with comment period (69 FR 65808), using the statutory authority in section 1833(t)(1)(B)(i) of the Act, which gives the Secretary broad authority to designate covered OPD services under the OPPTS, we have established criteria which distinguish single indication orphan drugs from other drugs designated as orphan drugs by the FDA under the Orphan Drug Act. Our determination to provide special payment for these drugs in previous years neither affected nor deviated from FDA's classification of any drugs as orphan drugs. The special treatment given to this subset of FDA-designated orphan drugs was intended to ensure that beneficiaries had continued access to these life-saving therapies given that

these drugs have a relatively low volume of patient use, lack any other nonorphan indication, and are typically very costly. We will consider the recommendation to establish an evaluation process to determine future changes to the OPPTS orphan drug list and the payment rates for these drugs.

Based on our analysis of the ASP rates using data from the fourth quarter of CY 2004 and the GAO reported mean purchase prices for four orphan drugs, we stated in the proposed rule (70 FR 42735) that we believed proposing to pay for orphan drugs using the ASP methodology at a payment rate of ASP+6 percent is appropriate for the CY 2006 OPPTS and should ensure patients' continued access to these orphan drugs in the hospital outpatient department. Using updated ASP data reported from the second quarter of CY 2005, we found that our current analysis is consistent with the results we found for the proposed rule. As indicated in the proposed rule, we believe that paying for orphan drugs using the ASP methodology is consistent with our CY 2006 final drug payment policy for other separately payable drugs and biologicals and reflects our general view that ASP-based payment rates serve as the best proxy for the average acquisition costs for these items as described earlier in this preamble.

Earlier in the preamble, we indicated that in CY 2006, we are basing payment for the average acquisition and overhead costs for other separately payable drugs and biologicals on ASP+6 percent because, in part, both the acquisition and pharmacy overhead costs are reflected in the charges submitted by hospitals for these items. In this final rule with comment period, we made this determination using updated ASP data, hospital claims data, and CCRs. We believe that the same observation is true for single indication orphan drugs, as we do not have any reason to believe that hospitals would include their acquisition and overhead costs in the charges for other separately payable drugs and biologicals, but would not follow the same charging practice when billing for single-indication orphan drugs. Therefore, we believe that in CY 2006, a combined payment rate of ASP+6 percent will be sufficient and appropriate for both the acquisition and overhead costs related to providing single-indication drugs to hospital outpatients. Accordingly, in this final rule with comment period, we are adopting the policy of paying for orphan drugs separately at ASP+6 percent, which represents a combined payment for the acquisition and overhead costs associated with furnishing these

products. We note that this policy will no longer differentiate how we pay for orphan drugs based on the use of the drugs because all orphan drugs, both single-indication and multi-indication, will be paid under the same methodology.

For this CY 2006 OPPTS final rule with comment period, we are using payment rates for single-indication orphan drugs based on ASP data from the second quarter of CY 2005, which are effective in the physician office setting on October 1, 2005, because these are the most recent numbers available for the development of this rule. To be consistent with the ASP-based payments that would be made when these drugs and biologicals are furnished in physician offices, as proposed, we plan to make any appropriate adjustments to the amounts shown in Addenda A and B to this final rule with comment period for these items on a quarterly basis as more recent ASP data become available. Changes in the APC payment rates for these items will be posted on our Web site during each quarter of CY 2006. Therefore, effective January 1, 2006, we will base payment rates for single-indication orphan drugs on ASP data from the third quarter of CY 2005, which will also be the basis for setting payment rates for drugs and biologicals in the physician office setting effective January 1, 2006.

Comment: One commenter indicated that payment at ASP+6 percent is inadequate for HCPCS code J9160 (Denileukin diftitox, 300 mcg) because the methodology has resulted in access issues for patients in the physician office setting, which influenced the shift of patients from physician offices to hospital outpatient sites. As CMS proposed to use the same methodology to establish payment rates in the hospital outpatient setting, the commenter is concerned that the consequence will be that patients will be left with no access to this biological. The commenter noted that the GAO data that supported the belief that the median purchase price for hospitals was almost exactly the same as the WAC price for this item for CY 2003. Therefore, the commenter recommended that CMS consider a temporary payment rate for one year that is closer to the actual hospital acquisition cost such as WAC or implement some other special methodology to ensure appropriate payment for this product in CY 2006. The commenter also indicated that an additional payment amount of 2 percent of the ASP for handling costs associated with this biological is inadequate and

requested a higher handling rate for a special class of products, like denileukin difitox, that require special handling.

Response: As we stated in the proposed rule, the GAO data for denileukin difitox reflected hospital purchase prices from about 77 percent of the hospitals expected to acquire these drugs. The mean hospital purchase price from the GAO study for denileukin difitox was about 91 percent of the ASP+6 percent payment rate based on data from the second quarter of CY 2005 and about 79 percent of the CY 2005 payment rate. We continue to believe in this final rule with comment period that the ASP-based payment rate for this drug appears to be appropriately reflective of its hospital acquisition costs, based on confirmation by the GAO average purchase price data from over three-fourths of the hospitals expected to acquire the drug. Moreover, as stated previously, we believe that like for other single-indication orphan drugs and other separately payable drugs and biologicals, a combined payment of ASP+6 percent in CY 2006 for this drug is adequate to cover both its acquisition and pharmacy overhead costs.

We received two public comments on the proposed payment rate for HCPCS code J0256.

Comment: One commenter indicated that HCPCS code J0256 described three alpha 1-augmentation therapies currently available and urged CMS to recognize the critical importance of the access issues surrounding these therapies. Therefore, the commenter recommended that in CY 2006 CMS set the payment rate for HCPCS code J0256 at the higher of the CY 2005 fourth quarter payment rate or the proposed ASP+8 percent rate. The commenter added that setting a floor should provide access to all three therapies, which is critical because there is not a sufficient supply of any of the alpha 1-proteinase inhibitors to supply all patients for whom the therapy has been prescribed. Another commenter recommended that CMS establish brand-specific codes and payment rates for the different products described by HCPCS code J0256; synchronize operationally the lag time between the manufacturers' ASP reporting and CMS' posting of the updated ASP payment rates on its Web site so that such changes are implemented at the same time for drugs paid under the OPPS and those paid under the physician fee schedule; and consider a proxy add-on payment to cover the overhead costs associated with these drugs.

Response: As discussed earlier in this preamble and noted in the proposed

rule, we believe the GAO acquisition data for alpha 1-proteinase inhibitor are likely not representative of hospital acquisition costs for the drug because the number of hospitals providing data is so small compared to the total number of hospitals expected to use the drug. Moreover, the GAO data relied on past hospital cost information from late CY 2003 through early CY 2004. As previously stated, the ASP data are more current, and thus are likely more reflective of present hospital acquisition costs for alpha 1-proteinase inhibitor. We continue to believe this to be true, and therefore, based on rationale cited above, in CY 2006, we will pay for all single-indication orphan drugs, including alpha 1-proteinase inhibitor, at a rate of ASP+6 percent for both the acquisition and overhead costs associated with these items. We find no reason to establish a payment floor for alpha 1-proteinase inhibitor that is related to the CY 2005 payment rates, when we have more current ASP data available that reflect current market prices.

With respect to establishing brand-specific HCPCS codes for the different products described by HCPCS code J0256, we suggest that the commenter pursue these changes through the process set up by the National HCPCS Panel to establish HCPCS codes. Lastly, we note that in CY 2006 there will not be a lag in the implementation of the ASP-based payment rates for the OPPS and the physician fee schedule. As noted earlier, effective January 1, 2006, we will base payment rates for single-indication orphan drugs on ASP data from the third quarter of CY 2005, which will also be the basis for setting payment rates for drugs and biologicals in the physician office setting effective January 1, 2006. We note that HCPCS codes C9128 and Q201 have been deleted effective December 31, 2005 and replaced with HCPCS codes J9025 and J0480, respectively, in CY 2006.

VI. Estimate of Transitional Pass-Through Spending in CY 2006 for Drugs, Biologicals, and Devices

A. Total Allowed Pass-Through Spending

Section 1833(t)(6)(E) of the Act limits the total projected amount of transitional pass-through payments for drugs, biologicals, radiopharmaceuticals, and categories of devices for a given year to an "applicable percentage" of projected total Medicare and beneficiary payments under the hospital OPPS. For a year before CY 2004, the applicable percentage was 2.5 percent; for CY 2005

and subsequent years, we specify the applicable percentage up to 2.0 percent.

If we estimate before the beginning of the calendar year that the total amount of pass-through payments in that year would exceed the applicable percentage, section 1833(t)(6)(E)(iii) of the Act requires a uniform reduction in the amount of each of the transitional pass-through payments made in that year to ensure that the limit is not exceeded. We make an estimate of pass-through spending to determine not only whether payments exceed the applicable percentage, but also to determine the appropriate reduction to the conversion factor for the projected level of pass-through spending in the following year.

As stated in the proposed rule, making an estimate of pass-through spending for devices in CY 2006 entails estimating spending for two groups of items (70 FR 42735). The first group consists of those items for which we have claims data for procedures that we believe used devices that were eligible for pass-through status in CY 2004 and CY 2005 and that would continue to be eligible for pass-through payment in CY 2006. The second group consists of those items for which we have no direct claims data, that is, items that became, or would become, eligible in CY 2005 and would retain pass-through status in CY 2006, as well as items that would be newly eligible for pass-through payment beginning in CY 2006.

B. Estimate of Pass-Through Spending for CY 2006

As we proposed, in this final rule with comment period, we are setting the applicable percentage cap at 2.0 percent of the total OPPS projected payments for CY 2006. As we discuss in section IV.C. of this preamble, the three remaining device categories receiving pass-through payment in CY 2005 will expire on December 31, 2005. Therefore, we estimate pass-through spending attributable to the first group of items described above to equal zero.

To estimate CY 2006 pass-through spending for device categories in the second group, that is, items for which we have no direct claims data, as we proposed, in this final rule with comment period, we used the following approach: For additional device categories that are approved for pass-through status after July 1, 2005, but before January 1, 2006, we used price information from manufacturers and volume estimates based on claims for procedures that would most likely use the devices in question because we did not have any CY 2004 claims data upon which to base a spending estimate. We projected these data forward to CY 2006

using inflation and utilization factors based on total growth in OPPS services as projected by CMS' Office of the Actuary (OACT) to estimate CY 2006 pass-through spending for this group of device categories. For device categories that become eligible for pass-through status in CY 2006, we used the same methodology. We anticipated that any new categories for January 1, 2006, would be announced after the publication of the proposed rule, but before publication of this final rule with comment period. Therefore, as indicated in the proposed rule (70 FR 42735), the estimate of pass-through spending in this final rule with comment period incorporates any pass-through spending for device categories made effective January 1, 2006, and during subsequent quarters of CY 2006.

We did not announce pass-through status for any new device categories after July 1, 2005. There is one new device category that we may add for pass-through payment as of January 1, 2006. To estimate CY 2006 pass-through spending for items for which we have no direct claims data, we are adhering to the methodology, as specified above, for estimating pass-through spending for the second group of items, with a refinement to the growth factor. That is, we are projecting forward to CY 2006 the OPPS volume of the procedure utilizing devices that could fall into the potential new device category at a higher rate of increase than the total rate of growth in OPPS services as projected by the OACT. The rate of growth of this relatively new procedure in the OPPS claims data from recent years is several times the overall growth rate of all OPPS services.

With respect to CY 2006 pass-through spending for drugs and biologicals, as we noted in the proposed rule (70 FR 42735) and as explained in section V.A.3. of this final rule with comment period, the pass-through payment amount for new drugs and biologicals that we determine have pass-through status will equal zero. Therefore, our estimate of pass-through spending for drugs and biologicals with pass-through status in CY 2006 equals zero.

In the CY 2005 final rule with comment period (69 FR 65810), we indicated that we are accepting pass-through applications for new radiopharmaceuticals that are assigned a HCPCS code on or after January 1, 2005. The pass-through amount for new radiopharmaceuticals approved for pass-through status in CY 2005 is the difference between the OPPS payment for the radiopharmaceutical, that is, the payment amount determined for the radiopharmaceutical as a sole source

specified covered drug, and the payment amount for the radiopharmaceutical under section 1842(o) of the Act. However, we have no new radiopharmaceuticals that were added for pass-through payment in CY 2005, and we have no information identifying new radiopharmaceuticals to which a HCPCS code might be assigned on or after January 1, 2006, for which pass-through status would be sought. We also have no data regarding payment for new radiopharmaceuticals with pass-through status under the methodology that we specified in the CY 2005 final rule with comment period. However, we do not believe that pass-through spending for new radiopharmaceuticals in CY 2006 will be significant enough to materially affect our estimate of total pass-through spending in CY 2006. Therefore, we are not including radiopharmaceuticals in our estimate of pass-through spending for CY 2006.

In accordance with the methodology described above and the methodology for estimating pass-through spending discussed in our proposed rule for CY 2006, we estimate that total pass-through spending for device categories that first become eligible for pass-through status during CY 2006 will equal approximately \$45.5 million, which represents 0.17 percent of total OPPS projected payments for CY 2006. This figure includes estimates for the current device categories continuing into CY 2006, which equal zero, in addition to projections for categories that first become eligible during CY 2006.

This estimate of total pass-through spending for CY 2006 is significantly lower than many previous years' estimates (except for the CY 2005 estimate, which was approximately \$23.4 million) both because of the method we used, as discussed in section V.A.3. of this preamble, for determining the amount of pass-through payment for drugs and biologicals with pass-through status, and the fact that there are no CY 2005 pass-through device categories that are being carried over to CY 2006.

Because we estimate pass-through spending in CY 2006 will not amount to 2.0 percent of total projected OPPS CY 2006 spending, we will return 1.83 percent of the pass-through pool to adjust the conversion factor, as we discuss in section II.C. of this preamble.

We received one public comment on our estimated pass-through spending for CY 2006.

Comment: One commenter commended us for returning, via an adjustment to the conversion factor, the portion of the pass-through spending

pool that exceeds the estimated amount for pass-through payments in CY 2006. The commenter indicated that this will ensure beneficiary access to basic services.

Response: We appreciate the commenter's support.

Accordingly, we are finalizing our proposed methodology for estimating CY 2006 OPPS pass-through spending for drugs, biologicals, and categories of devices with the modification as discussed above. Our adoption of this proposal as modified will return 1.83 percent of the pass-through pool to adjust the conversion factor.

VII. Brachytherapy Source Payment Changes

A. Background

Section 1833(t)(16)(C) and section 1833(t)(2)(H) of the Act, as added by sections 621(b)(1) and (b)(2) of Pub. L. 108-173, respectively, establish separate payment for devices of brachytherapy consisting of a seed or seeds (or radioactive source) based on a hospital's charges for the service, adjusted to cost. Charges for the brachytherapy devices may not be used in determining any outlier payments under the OPPS. In addition, consistent with our practice under the OPPS to exclude items paid at cost from budget neutrality consideration, these items must be excluded from budget neutrality as well. The period of payment under this provision is for brachytherapy sources furnished from January 1, 2004, through December 31, 2006.

Section 621(b)(3) of Pub. L. 108-173 requires the Government Accountability Office (GAO) to conduct a study to determine appropriate payment amounts for devices of brachytherapy, and to submit a report on its study to the Congress and the Secretary, including recommendations. As indicated in the CY 2006 proposed rule, we are awaiting the report and any recommendations on the payment of devices of brachytherapy, which would pertain to brachytherapy payments after December 31, 2006.

In the OPPS interim final rule with comment period published on January 6, 2004 (69 FR 827), we implemented sections 621(b)(1) and (b)(2)(C) of Pub. L. 108-173. In that rule, we stated that we will pay for the brachytherapy sources listed in Table 4 of the interim final rule with comment period (69 FR 828) on a cost basis, as required by the statute. Since January 1, 2004, we have used status indicator "H" to denote nonpass-through brachytherapy sources paid on a cost basis, a policy that we

finalized in the CY 2005 final rule with comment period (69 FR 65838).

As we indicated in the January 6, 2004 interim final rule with comment period, we began payment for the brachytherapy source in HCPCS code C1717 (High Dose Rate Iridium 192) based on the hospital's charge adjusted to cost beginning January 1, 2004. Prior to enactment of Pub. L. 108-173, these sources were paid as packaged services in APC 0313. As a result of the requirement under Pub. L. 108-173 to pay for HCPCS code C1717 separately, we adjusted the payment rate for APC 0313, Brachytherapy, to reflect the unpackaging of the brachytherapy source. We finalized this payment methodology in our November 15, 2004 final rule with comment period (69 FR 65839).

Section 1833(t)(2)(H) of the Act, as added by section 621(b)(2)(C) of Pub. L. 108-173, mandated the creation of separate groups of covered OPD services that classify brachytherapy devices separately from other services or groups of services. The additional groups must be created in a manner that reflects the number, isotope, and radioactive intensity of the devices of brachytherapy furnished, including separate groups for Palladium-103 and Iodine-125 devices. In accordance with this provision and based on recommendations of the APC Panel in the February 2004 meeting, we established the following two new brachytherapy source codes for CY 2005 (69 FR 65839):

- C2634 Brachytherapy source, High Activity Iodine-125, greater than 1.01 mCi (NIST), per source
- C2635 Brachytherapy source, High Activity Palladium-103, greater than 2.2 mCi (NIST), per source

In addition to adopting the APC Panel's recommendation to establish new HCPCS codes that would distinguish high activity Iodine-125 from high activity Palladium-103 on a per source basis, we adopted this policy for other brachytherapy code descriptors, as well. Therefore, beginning January 1, 2005, we included "per source" in the HCPCS code descriptors for all those brachytherapy source descriptors for which units of payment were not already delineated. Table 40 published in the November 15, 2004 final rule with comment period (69 FR 65840) included a complete listing of

the HCPCS codes, long descriptors, APC assignments, and status indicators that we used for brachytherapy sources paid under the OPSS in CY 2005 (69 FR 65840 and 65841).

Further, for CY 2005, we added the following code of linear source Palladium-103 to be paid at cost: C2636 Brachytherapy linear source, Palladium-103, per 1 mm. We had indicated in our August 16, 2004 proposed rule that we were aware of a new linear source Palladium-103, which came to our attention in CY 2003 through an application for a new device category for pass-through payment. We stated that, while we decided not to create a new category for pass-through payment, we believed that the new linear source fell under the provisions of Pub. L. 108-173. Therefore, we made final our proposal to add HCPCS code C2636 as a new brachytherapy source to be paid at cost in CY 2005.

B. Changes Related to Pub. L. 108-173

As stated in the CY 2006 OPSS proposed rule (70 FR 42736), we consistently invite the public to submit recommendations for new codes to describe brachytherapy sources in a manner reflecting the number, radioisotope, and radioactivity intensity of the sources. We request that commenters provide a detailed rationale to support recommended new codes and to send recommendations to us. We endeavor to add new brachytherapy source codes and descriptors to our systems for payment on a quarterly basis. Such recommendations should be directed to the Division of Outpatient Care, Mail Stop C4-05-17, Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244.

Prior to the publication of the CY 2006 OPSS proposed rule, we had then recently received only one such request for coding and payment of a new brachytherapy source since we added separate APC payment beginning in CY 2005 for the three brachytherapy sources discussed above. Therefore, we did not propose any coding changes to the sources of brachytherapy for CY 2006 but listed in Table 26 of the CY 2006 proposed rule (70 FR 42737) the separately payable brachytherapy sources that we proposed to continue for CY 2006. In addition, in that same proposed rule, we stated that we would

evaluate the one request that we had received for establishment of a new brachytherapy source code prior to publishing this final rule with comment period (70 FR 42736). Our decision regarding that coding request is discussed below.

At the end of May 2005, we received a recommendation for the creation of a new code and descriptor that would be used to pay separately for Ytterbium-169, a new high activity brachytherapy source for use in High Dose Rate (HDR) brachytherapy, in accordance with sections 1833(t)(16)(C) and 1833(t)(2)(H) of the Act, as added by sections 621(b)(1) and (b)(2), respectively, of Pub. L. 108-173. We evaluated this new source and agree with the recommendation to establish a new code and descriptor for Ytterbium-169, effective October 1, 2005. The new coding information was first announced in Program Transmittal 662, dated August 26, 2005, for OPSS implementation effective October 1, 2005. The new code and long descriptor are as follow:

- C2637 Brachytherapy source, Ytterbium-169, per source

This code and descriptor are also listed in Table 29 below.

We received one public comment concerning payment for brachytherapy sources.

Comment: One commenter requested CMS to identify a form of radiation therapy as utilizing a source of brachytherapy and provide a separate payment for the source.

Response: We will evaluate this request and, if warranted, establish a code, descriptor, and separate payment for a source of brachytherapy. Evaluation of potential brachytherapy sources is often complex and requires a significant evaluation period. Because this request was received as one of our comments to the proposed rule for CY 2006, we will continue to evaluate it and provide a code and descriptor, if appropriate, through one of our quarterly OPSS updates.

C. Final Policy for CY 2006

Table 28 provides a complete listing of the HCPCS codes, long descriptors, APC assignments, and status indicators that we will use for brachytherapy sources paid separately on a cost basis under the OPSS in CY 2006.

TABLE 28.— SEPARATELY PAYABLE BRACHYTHERAPY SOURCES FOR CY 2006

| HCPCS | Long descriptor | APC | APC title | New status indicator |
|-------------|--|------|---------------------------------------|----------------------|
| C1716 | Brachytherapy source, Gold 198, per source | 1716 | Brachytx source, Gold 198 | H |
| C1717 | Brachytherapy source, High Dose Rate Iridium 192, per source. | 1717 | Brachytx source, HDR Ir-192 | H |
| C1718 | Brachytherapy source, Iodine 125, per source .. | 1718 | Brachytx source, Iodine 125 | H |
| C1719 | Brachytherapy source, Non-High Dose Rate Iridium 192, per source. | 1719 | Brachytx source, Non-HDR Ir-192 | H |
| C1720 | Brachytherapy source, Palladium 103, per source. | 1720 | Brachytx source, Palladium 103 | H |
| C2616 | Brachytherapy source, Yttrium-90, per source .. | 2616 | Brachytx source, Yttrium-90 | H |
| C2632 | Brachytherapy solution, Iodine-125, per mCi | 2632 | Brachytx sol, I-125, per mCi | H |
| C2633 | Brachytherapy source, Cesium-131, per source | 2633 | Brachytx source, Cesium-131 | H |
| C2634 | Brachytherapy source, High Activity, Iodine-125, greater than 1.01 mCi (NIST), per source. | 2634 | Brachytx source, HA, I-125 | H |
| C2635 | Brachytherapy source, High Activity, Palladium-103, greater than 2.2 mCi (NIST), per source. | 2635 | Brachytx source, HA, P-103 | H |
| C2636 | Brachytherapy linear source, Palladium-103, per 1MM. | 2636 | Brachytx linear source, P-103 | H |
| C2637 | Brachytherapy source, Ytterbium-169, per source. | 2637 | Brachytx, Ytterbium-169 | H |

VIII. Coding and Payment for Drug Administration

A. Background

From the start of the OPSS until the end of CY 2004, three HCPCS codes were used to bill drug administration services provided in the hospital outpatient department:

- Q0081 (Infusion therapy, using other than chemotherapeutic drugs, per visit)
- Q0083 (Chemotherapy administration by other than infusion technique only, per visit)
- Q0084 (Chemotherapy administration by infusion technique only, per visit).

A fourth OPSS drug administration HCPCS code, Q0085 (Administration of chemotherapy by both infusion and another route, per visit) was active from the beginning of the OPSS through the end of CY 2003.

Each of these four HCPCS codes mapped to an APC (that is, Q0081 mapped to APC 0120, Q0083 mapped to APC 0116, Q0084 mapped to APC 0117, and Q0085 mapped to APC 0118), and the APC payment rates for these codes were made on a per-visit basis. The per-visit payment included payment for all hospital resources (except separately payable drugs) associated with the drug administration procedures. For CY 2004, we discontinued using HCPCS code Q0085 to identify drug administration services and moved to a combination of HCPCS codes Q0083 and Q0084 that allowed more accurate calculations when determining OPSS payment rates.

In response to comments we received concerning the available opportunities to gather additional drug administration data (and subsequently facilitate development of more accurate payment rates for drug administration services in future years) and to reduce hospital administrative burden, we proposed for the CY 2005 OPSS to change our coding and payment methodologies related to drug administration services.

After examining comments and suggestions, including recommendations of the APC Panel, we adopted a crosswalk for the CY 2005 OPSS that identified all active CY 2005 CPT drug administration codes and the corresponding OPSS Q-codes, which hospitals had previously used to report their charges for drug administration services. Hospitals were instructed to begin billing CPT codes for drug administration services in the hospital outpatient department effective January 1, 2005.

Payment rates for CY 2005 drug administration services were set using CY 2003 claims data. These data reflected per-visit costs associated with the four Q-codes listed above. To allow for the time necessary to collect data at the more specific CPT code level and to continue accurate payments based on available claims data, we used the Q-code crosswalk to map CPT drug administration codes to existing drug administration APCs. While hospitals were instructed to bill all relevant CPT codes that describe the services provided, the OCE collapsed payments for drug administration services attributed to the same APC and paid a single APC amount for those services for

each visit, unless a modifier was used to identify drug administration services provided more than once in a separate encounter on the same day.

In 2004, the CPT Editorial Panel approved several new drug administration codes and revised several existing codes for use beginning in CY 2006. Those physicians paid under the Medicare Physician Fee Schedule were given HCPCS G-codes corresponding to these expected CY 2006 CPT codes to bill for drug administration services provided in CY 2005 in the physician office setting.

B. CY 2006 Drug Administration Policy Changes

For CY 2006 OPSS billing purposes, we proposed to continue our policy of using CPT codes to bill for drug administration services provided in the hospital outpatient department, understanding that the CY 2005 CPT codes were likely going to change significantly for CY 2006. We anticipated that the CY 2005 CPT codes would no longer be active in CY 2006. Therefore, we proposed a CY 2006 crosswalk that mapped CY 2005 CPT codes to the CPT drug administration codes approved by the CPT Editorial Panel in CY 2004. Our closest proxy to the expected CY 2006 CPT codes was the set of HCPCS G-codes used in the physician office setting for CY 2005 and we used these G-codes in an extensive crosswalk (Table 27 in the proposed rule) that provided an overview of our proposed billing and payment policies for CY 2006.

The OPSS drug administration payment rates that we proposed for CY

2006 were dependent on CY 2004 data containing per-visit charges for HCPCS codes Q0081, Q0083, and Q0084. While HCPCS code Q0085 was used to inform payment rates for drug administration APCs for CY 2005, there are no data from this code to develop payment rates for drug administration APCs for CY 2006 because this code was not used in CY 2004. We proposed to map the new CY 2006 CPT codes to existing drug administration APC groups (APC 0116, APC 0117, and APC 0120) as we did in CY 2005. Again, we indicated in our proposal that hospitals would be expected to bill all relevant CPT codes for services provided, despite the per-encounter payment hospitals would receive for services billed within the same APC group without the use of a proper modifier to signify services that were provided in a separate visit on the same day.

The APC Panel approved the crosswalk presented in Table 27 of the CY 2006 OPSS proposed rule at both the February 2005 and August 2005 meetings, and further recommended that CMS evaluate hospital claims data to ensure appropriate payments for subsequent hours of infusion.

We received a number of public comments on several aspects of our proposed drug administration policy for CY 2006.

Comment: Numerous commenters generally supported our proposed policy to use CPT codes to report drug administration services in the hospital outpatient setting in CY 2006. They stated that consistent coding across sites of service reduces hospital burden by simplifying the coding process. The majority of these commenters offered support in the context of the overall principle of utilizing CPT codes when applicable in the hospital outpatient setting to bill for services under the OPSS.

Response: We agree with the commenters that consistent coding across sites of service is preferable when codes are applicable across settings. Our transition to CPT codes in CY 2005 was in response to numerous comments requesting that the OPSS recognize CPT drug administration codes to reduce the overall hospital administrative burden of billing one set of codes for Medicare and another set of codes for non-Medicare payers.

Comment: Commenters expressed concern over the complexity and specificity of the CPT codes and the billing guidelines provided by the AMA for the new CY 2006 CPT codes for drug administration. Specifically, the commenters stated that CPT code descriptions that contain “initial,”

“sequential,” or “concurrent” either did not apply or would be very difficult to correctly apply in the hospital setting due to the patient’s likelihood of receiving numerous drug administration services from multiple hospital departments during the course of a patient’s hospital outpatient encounter. The commenters recommended that CMS instruct hospitals to disregard these terms, particularly the word “initial” and the related CPT instruction to bill only one initial service when multiple intravenous injections and infusion are provided, when billing for outpatient services as these codes do not sufficiently describe the way hospital services are often provided. The commenters pointed out that because hospital outpatient charging for drug administration services currently occurs at the departmental level on a flow basis as services are provided, if hospitals were required to use the CPT codes in full accordance with the CPT instructions, extensive, disruptive, and burdensome involvement of medical records staff and coders would be required to bill for these very common hospital outpatient services.

Response: While we understand the commenters’ concerns regarding the granularity of the CY 2006 CPT codes, we do not agree that the concepts embedded in CPT codes described with the terms “initial,” “sequential,” or “concurrent,” and the accompanying expectations of differential resources required to perform those services, are inapplicable in the hospital setting. Similar to a physician office setting, we believe it is reasonable to expect that different hospital resources would be used for the first (initial) drug administration service provided to a patient in a hospital outpatient setting on a single day. For example, the first intravenous infusion provided to a hospital outpatient would generally require either the start of an intravenous line or the accessing of an indwelling catheter or port. All subsequent intravenous infusions in the hospital on the same day would likely not involve those additional resources associated with the initial infusion. We understand that the concepts associated with drug administration coding using CY 2006 CPT codes are substantially different from the principles of drug administration coding used by the OPSS in the past. However, this conceptual difference alone does not lead us to conclude that the full adoption of the CY 2006 CPT codes and their descriptors in the hospital setting is inappropriate.

While we acknowledge that hospital charging practices might need to change

with implementation of the new CY 2006 CPT codes and their descriptors, in the OPSS we originally moved to the use of CPT codes for the billing of drug administration services at the request of hospitals so they could use one standard code set for billing all payers. We would expect that hospitals would nonetheless need to implement some administrative changes for other payers who will be making payments for hospital outpatient drug administration services based on the CY 2006 CPT codes. While we do not doubt the administrative burden on hospitals associated with billing changes, we cannot and do not understand how our instructing hospitals to ignore certain concepts in the code descriptors for the new CY 2006 CPT codes would substantially reduce the administrative changes necessary for hospitals to bill the codes appropriately to other payers, in addition to Medicare.

Comment: Several commenters pointed out that if the proposed crosswalk were implemented as displayed in Table 27 of the proposed rule and no exceptions to CPT billing guidance were provided, our CY 2005 payment policy of providing separate APC payments for chemotherapy services and nonchemotherapy infusions during the same episode of care would no longer apply. The commenters believed that if our proposal is to package all subsequent hours of infusion therapy (chemotherapy and nonchemotherapy), hospitals following CPT billing guidelines would have coded only one initial code, and therefore only received one APC payment. The commenters expressed concern about this situation and stated that they did not believe it was CMS’ intent to reduce payment in this scenario.

Response: The commenters are correct in that it was not our intent to change the drug administration payment policies in place in CY 2005. We appreciate the analysis submitted by the commenters who provided us with detailed recommendations to remedy this situation.

Under CY 2006 CPT guidelines, hospitals would be required to bill one, and only one, initial service code for intravenous drug administration services (unless a modifier is used to indicate an additional episode of care on the same date of service). As many commenters noted, hospital billing personnel recently transitioned from a per-visit concept under the CY 2004 Q-codes to a per-treatment concept under CY 2005 CPT codes, and an additional transition in CY 2006 to even more complex concepts does not allow

sufficient time to properly train and educate hospital personnel regarding correct coding for drug administration.

As we considered the above comments, we developed preliminary OCE logic that would have potentially permitted some of the CY 2006 CPT codes for sequential and additional infusion services to be assigned status indicator "Q," consistent with a variable payment status. That is, under some circumstances where the sequential infusion was the same type of infusion (that is, chemotherapy or nonchemotherapy) as the initial infusion, payment for the sequential infusion would be packaged into payment for the initial drug administration service. In contrast, for situations where the sequential infusion was of a different type than the initial infusion, separate OPSS payment for the sequential infusion would be made. Thus, in order to determine the payment status of some drug administration CPT codes (packaged or separately payable), hospitals would have to be meticulous in correctly coding their claims. Therefore, only expected code pairs that had been built into OCE logic were present on claims. Otherwise, claims would have to be returned to hospitals

for correction. We grew concerned that hospitals would have an overwhelming burden not only implementing these new CPT codes in hospital software but also providing the necessary training to a variety of staff who provide and bill these high-volume drug administration services. It is our understanding that a system change this complex may have unintended consequences if implemented for January 1, 2006. One of our main concerns is that without sufficient time to train and educate staff, hospitals may experience a great number of returned claims and, therefore, experience a delay in payment for these high-volume services. We believe that the level of understanding required to properly bill for services under the CY 2006 CPT codes will require substantial hospital efforts to minimize unintentional coding errors that could lead to returned claims.

We have developed the advanced OCE logic that identifies separately payable instances of multiple drug administration services provided in the same episode of care but with only one initial CPT code. Claims not passing this extensive logic would not provide sufficient information in order to assign

APC payment to the services billed, and would subsequently result in a return of such claims to providers. We are still reviewing the future use of such logic for drug administration services under the OPSS.

Comment: Commenters provided a variety of other solutions that could permit continuation of CY 2005 OPSS drug administration payment policies while using CY 2006 CPT codes. The commenters' suggestions included reverting back to the three Q-codes (used prior to CY 2005), creating HCPCS codes to mimic the CY 2005 CPT codes, or creating a hybrid of CY 2005 and CY 2006 drug administration codes.

Response: We appreciate the many ideas discussed in the comments we received on the proposed rule, and we considered the above mentioned options in addition to many others before making our decision. However, we believe we have discussed the inherent advantages of using CPT codes, and in order to continue in our efforts to use CPT codes whenever possible, we will be adopting 20 of the 33 CY 2006 drug administration CPT codes for billing and payment purposes under the OPSS for CY 2006 (Table 29).

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Table 29.--CY 2006 OPSS Drug Administration CPT Codes

| Code | Description | Add-On | SI | APC |
|-------|---|--------|----|------|
| 90772 | Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular | -- | X | 0353 |
| 90773 | Therapeutic, prophylactic or diagnostic injection (specify substance or drug); intra-arterial | -- | X | 0359 |
| 90779 | Unlisted therapeutic, prophylactic or diagnostic intravenous or intra-arterial injection or infusion | -- | X | 0352 |
| 96401 | Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic | -- | S | 0116 |
| 96402 | Chemotherapy administration, subcutaneous or intramuscular; hormonal anti neoplastic | -- | S | 0116 |
| 96405 | Chemotherapy administration; intralesional, up to and including 7 lesions | -- | S | 0116 |
| 96406 | Chemotherapy administration; intralesional, more than 7 lesions | -- | S | 0116 |
| 96416 | Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of portable or implantable pump | -- | S | 0117 |
| 96420 | Chemotherapy administration, intra-arterial; push technique | -- | S | 0116 |
| 96422 | Chemotherapy administration, intra-arterial; infusion technique, up to one hour | -- | S | 0117 |
| 96423 | Chemotherapy administration, intra-arterial; infusion technique, each additional hour up to 8 hours (List separately in addition to code for primary procedure) | Y | N | - |
| 96425 | Chemotherapy administration, intra-arterial; infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump | -- | S | 0117 |
| 96440 | Chemotherapy administration into pleural cavity, requiring and including thoracentesis | -- | S | 0116 |
| 96445 | Chemotherapy administration into peritoneal cavity, requiring and including peritoneocentesis | -- | S | 0116 |
| 96450 | Chemotherapy administration, into CNS (eg, intrathecal), requiring and including spinal puncture | -- | S | 0116 |
| 96521 | Refilling and maintenance of portable pump | -- | T | 0125 |
| 96522 | Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (eg, intravenous, intra-arterial) | -- | T | 0125 |
| 96523 | Irrigation of implanted venous access device for drug delivery systems | -- | N | - |
| 96542 | Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir, single or multiple agents | -- | S | 0116 |
| 96549 | Unlisted chemotherapy procedure | -- | S | 0116 |

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In addition, we will not recognize under the OPSS 13 of the 33 CY 2006 CPT codes, but instead will instruct hospitals to use 6 new HCPCS C-codes for billing and payment purposes under OPSS for CY 2006 (Table 31). The C-codes generally parallel the less complex CY 2005 CPT codes for

infusions and intravenous pushes, as those codes will be deleted for the CY 2006 OPSS. We are adopting these 6 newly created C-codes in an effort to minimize the administrative burden hospitals have indicated they will face if the OPSS were to adopt all 33 of the CY 2006 drug administration CPT codes. The CY 2006 CPT drug

administration codes that we will not be using in the OPSS for CY 2006 are codes that require determinations of initial, sequential, and concurrent infusions or intravenous pushes. The C-codes will permit straightforward billing of types of infusions and intravenous pushes, for the first hour and then each additional hour of infusion or for each intravenous

push, an approach to coding that commenters indicated was consistent with current patterns of delivery and billing of drug administration services in the hospital outpatient setting. The OCE logic to determine the appropriate CY 2006 APC payments to make for a single drug administration encounter in one day or multiple separate encounters in the same day will operate as it did for CY 2005. As the C-codes are similar to the CY 2005 CPT codes, we expect that their implementation for CY 2006

billing should be clear, as hospitals have 1 year of experience already with the use of very similar codes during CY 2005.

We believe that providing hospitals with additional time to train staff on the correct billing of the CY 2006 drug administration CPT codes, combined with the opportunity for hospital staff to use these codes for non-Medicare payers during CY 2006, should allow a less burdensome transition to the remaining CPT drug administration codes in the

future. In addition, because we will have more specific drug administration median cost data for use in the CY 2007 OPSS and beyond with the first availability of CY 2005 cost data for the CPT codes for drug administration services, we anticipate that ensuring more accurate payment with respect to these remaining CPT drug administration codes may be more feasible for future OPSS updates.

TABLE 30.—CY 2006 OPSS DRUG ADMINISTRATION C-CODES

| Code | Description | Add-On | SI | APC |
|-------------|--|--------|----|------|
| C8950 | Intravenous infusion for therapy/diagnosis; up to 1 hour | | S | 0120 |
| C8951 | Intravenous infusion for therapy/diagnosis; each additional hour (List separately in addition to C8950). | Y | N | |
| C8952 | Therapeutic, prophylactic or diagnostic injection; intravenous push | | X | 0359 |
| C8953 | Chemotherapy administration, intravenous; push technique | | S | 0116 |
| C8954 | Chemotherapy administration, intravenous; infusion technique, up to one hour | | S | 0117 |
| C8955 | Chemotherapy administration, intravenous; infusion technique, each additional hour (List separately in addition to C8954). | Y | N | |

Comment: Commenters requested that CMS provide various billing and coding instructions relating to the CY 2006 CPT drug administration codes, and that CMS include more specific definitions of CPT drug administration terminology in the final rule.

Response: We appreciate the commenters' request for clarity on aspects of the proposed CY 2006 drug administration CPT codes. As we have done in the past, we will release instructions separately from this final rule with comment period that include drug administration billing and coding guidance for hospitals for CY 2006. In addition, as is our longstanding practice, we defer questions about CPT code definitions to the AMA CPT Editorial Panel members who are the creators and maintainers of CPT codes.

Comment: Several commenters requested that CMS provide explicit billing and coding instructions regarding the administration of specific drugs and agents.

Response: As stated above, we do not provide billing guidance to hospitals in

the final rule. Information for hospitals that discusses billing and coding specifics will be distributed separately via CMS transmittal following the publication of this final rule with comment period. In addition, we expect that all drug administration codes used in the CY 2006 OPSS, including the new C-codes, will conform to CPT guidance regarding under what clinical circumstances they may be appropriately billed, including instructions related to appropriate coding for the administration of certain complex biologics.

Comment: Commenters requested that a section within the AMA CPT Manual be created to identify and provide hospital-specific definitions for CPT codes that are used by the OPSS.

Response: The OPSS does not issue or maintain CPT codes. Comments regarding the AMA CPT Manual or CPT codes should be directed to the AMA.

Comment: Commenters requested that CMS create non-chemotherapy HCPCS codes similar to the CPT codes for initiation of a prolonged chemotherapy

infusion requiring a pump and pump maintenance and refilling codes so hospitals can bill for these services when provided to patients who require extended infusions of non-chemotherapy medications, including drugs for pain. They argued that the CY 2006 CPT codes for drug administration do not include appropriate codes to bill for these services, which require specific and significant hospital resources.

Response: We agree that codes for these services were needed, and we have created HCPCS codes C8956 (Refilling and maintenance of portable or implantable pump or reservoir for drug delivery for therapy/diagnosis, systemic (eg. intravenous, intra-arterial)) and C8957 (Intravenous infusion for therapy/diagnosis; initiation of prolonged infusion (more than 8 hours), requiring use of portable or implantable pump) for this purpose (Table 31).

TABLE 31.—NONCHEMOTHERAPY PROLONGED INFUSION CODES THAT REQUIRE A PUMP

| Code | Description | Add-On | SI | APC |
|-------------|---|--------|----|------|
| C8956 | Refilling and maintenance of portable or implantable pump or reservoir for drug delivery for therapy/diagnosis, systemic (eg. intravenous, intra-arterial). | | T | 0125 |
| C8957 | Intravenous infusion for therapy/diagnosis; initiation of prolonged infusion (more than 8 hours), requiring use of portable or implantable pump. | | S | 0120 |

Comment: One commenter requested that the OPSS use the information present on the claim, specifically the

pharmacy revenue code (636), to identify which payment would be best

suited for administration of that type of drug.

Response: We support minimizing the administrative burden that hospitals incur when billing for drug administration services in the outpatient department. However, we do not believe that this suggestion would yield more accurate claims data or reduce the administrative burden on hospitals to code for drug administration services. Hospitals are responsible for identifying which drug administration services are provided and establishing appropriate charges for those services, and implementing a system such as that conceived by the commenter that removes the determination from hospitals would be unproductive.

Comment: Commenters noted that CY 2006 drug administration APC payment rates are derived from CY 2004 claims data and expressed concern that these data are outdated and inaccurate.

Response: While we acknowledge the concern presented by commenters, we do not believe that our reliance on the most recent claims data available provides inaccurate payments for drug administration services provided in hospital outpatient departments. It has been the OPSS policy to set payments for drug administration services, as well as almost all other OPSS services, based on the most recent claims year data available, and we are continuing that methodology in CY 2006.

Comment: Several commenters requested that CMS implement a chemotherapy demonstration program similar to the Quality of Care Demonstration program that was instituted in the physician office setting throughout CY 2005.

Response: While we recognize the desire of the commenters to ensure beneficiary access to drug administration services by providing additional payments to hospitals for drug administration-related services, we believe that the drug administration payment methodology we are finalizing in this final rule with comment period provides accurate payments for hospital drug administration services. Further, we do not believe that there is a beneficiary access issue directly attributable to the OPSS payment policies for drug administration services.

Comment: Many commenters requested that the OPSS provide payment for additional hours of infusion, instead of packaging subsequent hours of infusion into the payment for the initial hour of infusion therapy.

Response: As discussed in the proposed rule, CY 2006 OPSS payment rates rely upon CY 2004 claims data that only has information on the three Q-

codes mapped to APCs 0116, 0117 and 0120. For CY 2006, while the codes for initial hour of infusion and subsequent hour(s) of infusion were available for hospitals to report in CY 2005, appropriate CY 2005 claims data are not available to use for ratesetting purposes for the CY 2006 OPSS. As the most recent and complete year of data available from CY 2004 reflects per-visit payment rates for drug administration services, we must continue to use both our crosswalk methodology and the OCE claims logic during CY 2006 which allows us to collect more specific drug administration cost data while continuing to make appropriate drug administration payments. Because of the descriptors of the previous drug administration Q-codes upon which CY 2006 drug administration payment rates are based, each payment for a drug administration APC in CY 2006 is necessarily a payment that reflects an "average" infusion service in CY 2004, constituting one or more hours. We appreciate hospitals' continued diligence in accurately billing for the additional hours of infusion for chemotherapy and nonchemotherapy treatments that will once again be packaged for CY 2006, as we gather additional hospital claims data to support our move to more specific payments for individual drug administration services in the future.

Comment: One commenter noted that in Addendum B, Payment Status by HCPCS Code and Related Information Calendar Year 2006, HCPCS code G0258 (IV infusion during obs stay) was incorrectly listed as payable with a status indicator of "X."

Response: We agree that HCPCS code G0258 was incorrectly listed in Addendum B of the proposed rule as having status indicator "X" rather than "B." However, HCPCS code G0258 is deleted for CY 2006; therefore, it will have no payment status in the CY 2006 OPSS.

Comment: One commenter requested that CMS not reassign CPT codes 95144 through 95165 (Antigen therapy services) to the injection APCs as listed in Addendum B of the proposed rule. Instead, the commenter suggested keeping these services within APC 0371 because of their similarity in resource use and for reasons of clinical coherence.

Response: We agree with the commenter that the median cost data available for these codes do not correspond to the expected levels of service based on the CPT code descriptors. For example, in the proposed rule, HCPCS code 95149 (Professional services for the

supervision of preparation and provision of antigens for allergen immunotherapy; five single stinging insect venoms) was mapped to APC 0352 (Level I Injections) based on a median cost of \$11.43 from 9 single claims, while HCPCS code 95146 (Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; two single stinging venoms) was mapped to APC 0359 (Level III Injections) based on a median cost of \$70.64 from 43 single claims. These unexpected median cost results may have arisen from miscoding or from the inherently high volatility in costs that may occur due to small numbers of claims. While we are unable to retain these codes in APC 0371 as recommended by the commenter due to the restructuring of the injection codes into three levels of injection APCs, we have decided to place CPT codes 95144 through 95165 in APC 0353 (Level II Injections) because we believe that the services provided by these HCPCS codes are similar to other HCPCS codes within this APC and the CY 2006 median cost for APC 0353 most closely matches the CY 2005 median cost these codes experienced in APC 0371.

C. 2006 Vaccine Administration Policy Changes

Hospitals currently use three HCPCS G-codes to indicate the administration of the following vaccines that have specific statutory coverage:

- G0008—Administration of Influenza Virus Vaccine.
- G0009—Administration of Pneumococcal Vaccine.
- G0010—Administration of Hepatitis B Vaccine.

HCPCS codes G0008 and G0009 are exempt from beneficiary coinsurance and deductible applications and, as such, payment has been made outside of the OPSS since CY 2003 based on reasonable cost. We have made payment for HCPCS code G0010 through a clinical APC (that is, APC 0355) that included vaccines along with this vaccine administration code. Additional vaccine administration codes have been packaged or not paid under the OPSS.

As stated in the CY 2006 OPSS proposed rule, we believe that HCPCS codes G0008, G0009 and G0010 are clinically similar and comparable in resource use to one another and to the administration of other immunizations and other therapeutic, prophylactic, or diagnostic injections. To that end, we concluded that the appropriate APC assignment for these vaccine administration services was newly reconfigured APC 0353 (Injection, Level

II). However, because of their statutory exemption regarding beneficiary deductible and coinsurance, for operational reasons we were unable to include HCPCS codes G0008 and G0009 in an APC with codes that did not share this exemption.

Instead of including these codes within the same APC, we proposed to map HCPCS codes G0008 and G0009 to APC 0350 (Administration of flu and PPV vaccines). As dictated by statute, HCPCS codes G0008 and G0009 would continue to be exempt from beneficiary coinsurance and deductible.

We also proposed to change the status indicator for HCPCS code G0010 from "K" (Separate APC Payment) to "B" (Not paid under OPPS; Alternate code may be available), and to change the status indicators for vaccine administration codes 90471 and 90472 from "N" (Packaged) to "X" (Separate APC Payment), in agreement with the recommendation of the APC Panel to unpackage these services. Hospitals would code for hepatitis B vaccine administration using codes 90471 or 90472 (as appropriate), and payment would be mapped to reconfigured APC 0353 (Injection, Level II) that would include other injection services that were clinically similar and comparable in resource use.

In order to pay appropriately for services that we believed were clinically similar and comparable in resource use and, barring technical restrictions, would otherwise be assigned to the same APC, we proposed to calculate a combined median cost for all services assigned to APC 0350 and APC 0353 that would then serve as the median cost for both APCs. This combined median would be calculated using charges converted to costs from claims for services in both APCs and would have the effect of making the OPPS payment rates for APC 0350 and APC 0353 identical, although beneficiary

copayment and deductible would not be applied to services in APC 0350.

Our vaccine administration proposed policy also included proposed changes to the status indicators for vaccine administration codes 90473 and 90474 from "E" (Not paid under OPPS) to "S" (Paid under OPPS) and proposed to make payments for these services when they were covered through proposed APC 1491 (New Technology—Level IA (\$0–\$10)).

Finally, we proposed to change the status indicators for the four remaining vaccine administration codes involving physician counseling (90465, 90466, 90467 and 90468) from "N" (Packaged) to "B" (Not paid under OPPS; Alternate code may be available). We proposed that hospitals providing immunization services with physician counseling would use the vaccine administration codes 90471, 90472, 90473, and 90474 to report such services, as we did not believe the provision of physician counseling would significantly affect the hospital resources required for administration of immunizations.

During its August 2005 meeting, the APC Panel made a recommendation to CMS to pay for the administration of flu vaccines similarly under the OPPS regardless of their method of administration. We agree that hospitals should always use the most specific HCPCS codes available, whose descriptors are consistent with the method of administration and type of vaccine, to bill for all vaccine administration services but, in particular, to bill for vaccine services that are congressionally exempt from deductible and coinsurance. However, we note that vaccine administration codes other than G0008 for administration of influenza virus vaccine and G0009 for administration of pneumococcal vaccine are not exempted in the OCE from charging beneficiary deductible and coinsurance and should

not be used to report these services which are exempt from copayment.

Comment: Similar to the APC Panel recommendation discussed above, commenters requested that CMS provide payment for the administration of intranasal influenza vaccine similar to payments for other methods of administration of the influenza vaccine.

Response: As stated above, vaccine administration codes other than G0008 for administration of influenza virus vaccine are not exempted in the OCE from charging beneficiary deductible and coinsurance and they should not be used to report these services which are exempt from copayment.

Comment: Numerous commenters supported our proposal to pay separately for vaccine administration services.

Response: We appreciate the commenters' support of our proposed policy and are adopting it as final in this rule.

Comment: Several commenters noted a typographical error in the CY 2006 OPPS proposed rule preamble that incorrectly listed two codes to be used for the administration of hepatitis B vaccine as codes 96471 and 96472 instead of codes 90741 and 90742.

Response: We appreciate the commenters' note, and we have corrected the error in this final rule with comment period.

After consideration of the public comments received, in this final rule with comment period, we are finalizing our proposed CY 2006 methodology to pay separately for vaccine administration services as discussed above. Table 32 below specifies the CY 2006 vaccine administration codes, their APC median costs, the status indicator assigned to each code, and the APC payment amount.

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**Table 32.--CY 2006 Vaccine Administration Codes
and CY 2006 Payment Rates**

| HCPCS | Description | CY 2005 | | CY 2006 | | |
|-------|--|---------|-----------------|---------|------|---------|
| | | SI | APC | SI | APC | Payment |
| G0008 | Influenza Vaccine Administration | L | Reasonable Cost | X | 0350 | \$23.31 |
| G0009 | Pneumococcal Vaccine Administration | L | Reasonable Cost | X | 0350 | \$23.31 |
| G0010 | Hepatitis B Vaccine Administration | K | 0355 | B | --- | --- |
| 90465 | Immunization Admin, under 8 yrs old, with counseling; first injection | N | --- | B | --- | --- |
| 90466 | Immunization Admin, under 8 yrs old, with counseling; each additional injection | N | --- | B | --- | --- |
| 90467 | Immunization Admin, under 8 yrs old, with counseling; first intranasal or oral | N | --- | B | --- | --- |
| 90468 | Immunization Admin, under 8 yrs old, with counseling; each additional intranasal or oral | N | --- | B | --- | --- |
| 90471 | Immunization Admin, one vaccine injection | N | --- | X | 0353 | \$23.31 |
| 90472 | Immunization Admin each additional vaccine injection | N | --- | X | 0353 | \$23.31 |
| 90473 | Immunization Admin, one vaccine by intranasal or oral | E | --- | S | 1491 | \$5.00 |
| 90474 | Immunization Admin, each additional vaccine by intranasal or oral | E | --- | S | 1491 | \$5.00 |

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

In the CY 2006 proposed rule (70 FR 42740), we again stated our concerns and directions for developing a set of national facility coding guidelines for emergency department and clinic visits. We noted that we intend to make available for public comment the proposed coding guidelines that we are

considering through the CMS OPPS Web site as soon as we have completed them. We also stated that we will notify the public through our listserve when these proposed guidelines become available, and instructed interested parties to subscribe to this listserve by going to the following CMS Web site: <http://www.cms.hhs.gov/medlearn/listserv.asp> and following the directions to the OPPS listserve.

We received a number of public comments on our proposal.

Comment: Several commenters expressed disappointment that CMS has not yet proposed national E/M guidelines for facilities. While the majority of commenters were pleased that CMS is continuing to develop and test draft codes and guidelines, they were concerned that the ongoing lack of uniformity places hospitals at risk for

multiple interpretations of the level of service that should be coded, and hampers CMS' ability to gather consistent, meaningful data on services provided in the emergency department and hospital clinics. One commenter emphasized that the implementation of a uniform set of national guidelines for E/M services is especially important because CMS uses the mid-level clinic visit (APC 0601) to scale the relative payment weights for all other services paid under the OPSS. A few commenters recommended that CMS implement the E/M guidelines drafted by the independent panel of experts from the AHA and the AHIMA. Two other commenters provided their own model guidelines for CMS to consider.

Several commenters reminded CMS that adoption of a new set of guidelines for E/M services will involve an enormous undertaking by large medical centers and that CMS had committed to providing a minimum of between 6 and 12 months' notice prior to implementation to allow providers adequate time to make necessary systems changes and educate their staff. The commenters also urged CMS to ensure adequate opportunity for the public to review and comment on the proposed guidelines before they are finalized.

Response: Over the past year, we have engaged a contractor to assist us with testing the validity and reliability of a slightly modified draft of the guidelines recommended by the independent Hospital Evaluation and Management Coding Panel of the AHA and AHIMA. We have contracted a study of these guidelines using a sample of hospital outpatient claims to analyze the potential financial impact of the proposed guidelines on classes of hospitals and on the OPSS, as well as the potential burden that adoption of such guidelines might impose on hospitals. Although we have made much progress in our efforts to develop a set of national facility guidelines for emergency department and clinic visits, we believe additional testing is necessary and essential to providing hospitals with the least burdensome standard for achieving uniformity and to yielding more accurate, meaningful information related to hospital resources upon which to set the OPSS payments for emergency department and clinic services. We are committed to the goal of paying appropriately under the OPSS for the costs of hospital E/M services across the levels of care. Therefore, we will continue to develop and test the draft codes and guidelines. However, we have not yet set a date for their implementation.

As stated in the CY 2006 OPSS proposed rule, we intend to make available for public comment the proposed coding guidelines that we are considering through the CMS OPSS Web site once we are satisfied with the results of the testing and have made appropriate modifications in light of these testing results. Furthermore, we will provide ample opportunity for the public to comment on such a major proposal. We will continue to be considerate of the time necessary to educate clinicians and coders on the use of the new codes and guidelines and for hospitals to modify their systems. We still anticipate providing a minimum notice of between 6 and 12 months prior to implementation of the new evaluation and management codes and guidelines.

Comment: One commenter expressed a number of concerns that the commenter believed were related to proposals on the manner in which the Medicare program uses CPT code definitions that have been adopted by the AMA as a basis to classify patients who receive emergency department services for payment purposes under the Medicare OPSS.

Response: In the CY 2006 OPSS proposed rule, we did not propose to make any changes related to the manner in which we use CPT code definitions as a basis to classify patients. We are not making any changes to our use of the CPT code definitions in this final rule with comment period. However, we remind the public that regulations implementing the HIPAA (42 CFR Parts 160 and 162) require that the HCPCS be used to report health care services, including outpatient services paid under the OPSS. The OPSS regulations at 42 CFR 419.2(a) establish HCPCS codes as the means for identifying services paid under the OPSS. The HIPAA regulations require that these codes be used in the manner described by the maintainer's guidelines. In accordance with our policy that was established in the April 7, 2000 final rule with comment period that implemented the OPSS, hospitals use internal guidelines only to distinguish among varying levels of resource intensity when determining an appropriate CPT code to bill for outpatient E/M services.

X. Payment for Blood and Blood Products

A. Background

Since the implementation of the OPSS in August 2000, separate payments have been made for blood and blood products through APCs rather than packaging

them into payments for the procedures with which they were administered. Hospital payments for the costs of blood and blood products, as well as the costs of collecting, processing, and storing blood and blood products, are made through the OPSS payments for specific blood product APCs. On April 12, 2001, CMS issued the original billing guidance for blood products to hospitals (Program Transmittal A-01-50). In response to requests for clarification of these instructions, CMS issued Transmittal 496 on March 4, 2005. The comprehensive billing guidelines in the Transmittal also addressed specific concerns and issues related to billing for blood-related services, which the public had brought to our attention.

In CY 2000, payments for blood and blood products were established based on external data provided by commenters due to limited Medicare claims data. From CY 2000 to CY 2002, payment rates for blood and blood products were updated for inflation. For CY 2003, as described in the November 1, 2002 final rule with comment period (67 FR 66773), we applied a special dampening methodology to blood and blood products that had significant reductions in payment rates from CY 2002 to CY 2003, when median costs were first calculated from hospital claims. Using the dampening methodology, we limited the decrease in payment rates for blood and blood products to approximately 15 percent. For CY 2004, as recommended by the APC Panel, we froze payment rates for blood and blood products at CY 2003 levels as we studied concerns raised by commenters and presenters at the August 2003 and February 2004 APC Panel meetings.

For CY 2005, we established new APCs that allowed each blood product to be assigned to its own separate APC, as several of the previous blood product APCs contained multiple blood products with no clinical homogeneity or whose product-specific median costs may not have been similar. Some of the blood product HCPCS codes were reassigned to the new APCs (Table 34 of the November 15, 2004 final rule with comment period (69 FR 65819)).

We also noted in the November 15, 2004 final rule with comment period that public comments on previous OPSS rules had stated that the CCRs that were used to adjust charges to costs for blood products in past years were too low. Past commenters indicated that this approach resulted in an underestimation of the true hospital costs for blood and blood products. In response to these comments and APC Panel recommendations from its

February 2004 and September 2004 meetings, we conducted a thorough analysis of the OPSS CY 2003 claims (used to calculate the CY 2005 APC payment rates) to compare CCRs between those hospitals reporting a blood-specific cost center and those hospitals defaulting to the overall hospital CCR in the conversion of their blood product charges to costs. As a result of this analysis, we observed a significant difference in CCRs utilized for conversion of blood product charges to costs for those hospitals with and without blood-specific cost centers. The median hospital blood-specific CCRs were almost two times the median overall hospital CCR. As discussed in the November 15, 2004 final rule with comment period, we applied a methodology for hospitals not reporting a blood-specific cost center, which simulated a blood-specific CCR for each hospital that we then used to convert charges to costs for blood products. Thus, we developed simulated medians for all blood and blood products based on CY 2003 hospital claims data (69 FR 65816).

For CY 2005, we also identified a subset of blood products that had less than 1,000 units billed in CY 2003. For these low-volume blood products, we based the CY 2005 payment rate on a 50/50 blend of CY 2004 product-specific OPSS median costs and the CY 2005 simulated medians based on the application of blood-specific CCRs to all claims. We were concerned that, given the low frequency in which these products were billed, a few occurrences of coding or billing errors may have led to significant variability in the median calculation. The claims data may not have captured the complete costs of these products to hospitals as fully as possible. This low-volume adjustment methodology also allowed us to further study the issues raised by commenters and by presenters at the September 2004 APC Panel meeting, without putting beneficiary access to these low-volume blood products at risk.

B. Proposed and Final Policy Changes for CY 2006

For CY 2006, we proposed to continue to make separate payments for blood and blood products under the OPSS through individual APCs for each product. We also proposed to establish payment rates for these blood and blood products by using the same simulation methodology described in the November 15, 2004 final rule with comment period (69 FR 65816), which utilized hospital-specific actual or simulated CCRs for blood cost centers to convert hospital charges to costs, with an adjustment

applied to some products. We continue to believe that using blood-specific CCRs applied to hospital claims data will result in reasonably accurate payments that more fully reflect hospitals' true costs of providing blood and blood products than our general methodology of defaulting to the overall hospital CCR when more specific CCRs are unavailable.

For blood and blood products whose CY 2006 simulated medians experienced a decrease of more than 10 percent in comparison to their CY 2005 payment medians, we proposed to limit the decrease in medians to 10 percent. Therefore, overall we proposed to base median costs for blood and blood products in CY 2006 on the greater of: (1) Simulated medians calculated using CY 2004 claims data; or (2) 90 percent of the APC payment median for CY 2005 for such products. We recognize that possible errors in hospital billing or coding for blood products in CY 2004 may have contributed to these decreases in medians. In particular, hospitals may have been uncertain about which of their many different costs for providing blood and blood products should be captured in their charges for the products, based on variations in the specific circumstances of the services they provided. In addition, the six products affected by the proposed CY 2006 adjustment policy all were relatively low volume with fewer than 7,000 units billed in CY 2004. Three of these products were affected by the low-volume payment adjustment for CY 2005 because there were less than 1,000 units billed, and their CY 2005 payment medians would have decreased without the adjustment. In the interim, as hospitals become more familiar with the comprehensive billing guidelines for blood and blood products that are described in Program Transmittal 496 (Change Request 3681 dated March 4, 2005), we acknowledge the need to protect beneficiaries' access to a safe blood supply and proposed to do so by limiting significant decreases in payment rates for blood and blood products from CY 2005 to CY 2006. We expect that our billing guidance will assist hospitals in more fully including all appropriate costs for providing blood and blood products in their charges for those products, so that our data for CY 2005, which will be used to set median costs for blood and blood products in the CY 2007 OPSS update, should more accurately capture the hospital costs associated with each different blood product.

Therefore, for CY 2006, we proposed to establish payment rates for blood and blood products under the OPSS using

the same simulation methodology described in the November 15, 2004 final rule with comment period (69 FR 65816). For blood and blood products whose CY 2006 medians would have otherwise experienced a decrease of more than 10 percent in comparison with their CY 2005 payment rates, we proposed to adjust the simulated medians by limiting their decrease to 10 percent.

At the August 2005 APC Panel meeting, the Panel recommended that CMS use its CY 2005 payment rates as the floor for its CY 2006 payment rates for all blood and blood products. Specifically, the Panel recommended that CMS should pay the greater of: (1) The simulated median costs calculated from the CY 2004 hospitals claims data; or (2) the CY 2005 APC payment medians for these products. For reasons discussed in detail below, we are not adopting the Panel's recommendation for setting the CY 2006 payment rates for blood and blood products. Instead, for CY 2006, we are setting the final median costs for blood and blood products at the greater of: (1) The simulated median costs calculated from the CY 2004 hospital claims data; or (2) 95 percent of the CY 2005 adjusted median costs for these products.

We received numerous public comments concerning our proposed payment for blood and blood products.

Comment: Numerous commenters applauded our March 2005 issuance of comprehensive billing guidelines (Program Transmittal 496) for blood and blood products, stating that the guidelines clarified many areas of confusion for providers and should result in improved hospital coding of blood and blood products. Other commenters recommended that CMS release guidance on blood and blood products on an annual basis.

Response: We appreciate the comment and expect that the billing guidance that we issued in March 2005 will result in improved hospital coding of blood and blood products. We will continue to support educational efforts by interested organizations to clarify areas of confusion and improve accuracy of billing for hospitals related to the billing of blood and blood products. In addition, we will continue to issue guidance on billing for blood and blood products to provide clarification or additional explanation as needed, based on additional questions and issues that are brought to our attention.

Comment: Numerous commenters expressed concern that the proposed payment rates for several blood products had decreased from their CY

2005 payment rates. Commenters stated that such payment declines would likely jeopardize beneficiary access to these products. Most notably, according to several organizations providing blood and blood products to hospitals, the proposed CY 2006 payment rate for leukocyte-reduced red blood cells (HCPCS code P9016), the most commonly billed blood product in the hospital outpatient setting, is significantly below hospitals' actual acquisition costs. Commenters urged CMS to set the CY 2006 payment rates for blood and blood products at the greater of: (1) The simulated medians calculated using the CY 2004 claims data; or (2) the CY 2005 APC payment medians for these products.

Response: We are displaying in Table 33 of this final rule with comment period the list of blood product HCPCS codes with their final CY 2006 adjusted median costs. Overall, median costs from CY 2005 and CY 2006 were relatively stable, with significant increases and adjusted decreases for some specific blood products. In addition, we expect that as hospitals improve their billing and coding practices, medians based on historical hospital claims data should continue to become more consistent and reflective of all hospital costs associated with providing blood products to hospital

outpatients. We agree with commenters that beneficiary access to the safest and most immediately available blood supply is critical to saving lives. In addition, we understand that, in most cases, the hospital costs related to providing blood and blood products stem mainly from the costs of processing and storing the blood. We also acknowledge that new blood testing due to technological advances and challenges associated with donor recruitment and retention may contribute to rising costs of blood and blood products. However, there may be other environmental forces, including improved efficiencies through new technologies and changes in the clinical circumstances surrounding outpatient hospital transfusions, that may reduce the costs of providing blood products. While the above-mentioned issues must all be carefully considered, we also remind commenters that the payment rates for services paid under the OPPS will naturally experience fluctuations from year to year. Such variation is inherent in any budget-neutral prospective payment system such as the OPPS, where payment rates are developed based on historical hospital claims data. However, when such fluctuations become large enough to potentially jeopardize access to services paid under the OPPS, we may

acknowledge the need to balance these payment fluctuations with protecting beneficiary access to such services by moderating abrupt payment declines that occur over a 1-year period. We were concerned that our proposed allowance of a 10 percent decrease in median costs from the CY 2005 adjusted final medial costs might affect beneficiary access to these services. Therefore, for CY 2006, for blood and blood products whose CY 2006 simulated median costs would have otherwise experienced a decrease of more than 5 percent in comparison with their CY 2005 adjusted final median costs, we are adjusting the simulated medians by limiting their decrease to 5 percent. We applied this adjustment to 11 blood and blood product APCs for CY 2006. Table 33 of this final rule with comment period contains the adjusted payment medians for CY 2006. Those CY 2006 final median costs that we adjusted by moderating their decrease to 5 percent are indicated by an asterisk in the table. In summary, for the CY 2006 OPPS, the final median costs for blood and blood products are set at the greater of: (1) the simulated median costs calculated from the CY 2004 claims data; or (2) 95 percent of the CY 2005 adjusted median costs for these products.

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Table 33.--CY 2006 Adjusted Final Median Costs for Blood and Blood Products by APC

| APC | HCPCS | Description | CY 2006 Adjusted Final Median Cost |
|-------|-------|------------------------------|------------------------------------|
| *0949 | P9023 | Frozen plasma, pooled, sd | \$76.15 |
| 0950 | P9010 | Whole blood for transfusion | \$117.91 |
| *0952 | P9012 | Cryoprecipitate each unit | \$47.10 |
| 0954 | P9016 | RBC leukocytes reduced | \$163.16 |
| 0955 | P9059 | Plasma, frz between 8-24hour | \$74.70 |
| 0956 | P9043 | Plasma protein fract,5%,50ml | \$67.94 |
| 0957 | P9019 | Platelets, each unit | \$51.50 |
| 0958 | P9020 | Plaelet rich plasma unit | \$277.42 |
| 0959 | P9021 | Red blood cells unit | \$121.48 |
| *0960 | P9022 | Washed red blood cells unit | \$189.22 |
| *0966 | P9048 | Plasmaprotein fract,5%,250ml | \$315.70 |
| 0967 | P9011 | Split unit of blood | \$82.50 |
| *0968 | P9033 | Platelets leukoreduced irrad | \$150.58 |
| 0969 | P9040 | RBC leukoreduced irradiated | \$218.04 |
| 1009 | P9044 | Cryoprecipitatereducedplasma | \$74.52 |
| 1010 | P9051 | Blood, l/r, cmv-neg | \$207.72 |
| 1011 | P9052 | Platelets, hla-m, l/r, unit | \$609.48 |
| 1013 | P9031 | Platelets leukocytes reduced | \$98.30 |
| *1016 | P9054 | Blood, l/r, froz/degly/wash | \$261.93 |
| 1017 | P9055 | Plt, aph/pher, l/r, cmv-neg | \$526.00 |
| *1018 | P9056 | Blood, l/r, irradiated | \$178.37 |
| 1019 | P9037 | Plate pheres leukoredu irrad | \$581.01 |
| 1020 | P9053 | Plt, pher, l/r cmv-neg, irr | \$654.13 |
| 1021 | P9057 | RBC, frz/deg/wsh, l/r, irrad | \$345.53 |
| *1022 | P9058 | RBC, l/r, cmv-neg, irrad | \$266.89 |
| *9500 | P9032 | Platelets, irradiated | \$86.55 |
| 9501 | P9035 | Platelet pheres leukoreduced | \$493.12 |
| *9502 | P9036 | Platelet pheresis irradiated | \$325.87 |
| 9503 | P9060 | Fr frz plasma donor retested | \$94.72 |
| 9504 | P9039 | RBC deglycerolized | \$343.44 |
| 9505 | P9038 | RBC irradiated | \$147.47 |
| *9506 | P9050 | Granulocytes, pheresis unit | \$994.64 |
| 9507 | P9034 | Platelets, pheresis | \$434.01 |
| 9508 | P9017 | Plasma 1 donor frz w/in 8 hr | \$70.40 |

The asterisk () shown in this APC column denotes the APCs with adjusted median costs for CY 2006.

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Comment: While one commenter thanked CMS for providing hospitals with detailed billing guidance for blood and blood products when furnished under the hospital outpatient setting, the commenter requested additional clarification on whether hospitals should charge inpatients, as they do outpatients, for blood administration services. The commenter explained that some hospitals do not charge inpatients separately for blood administration services; rather they consider such

services to be included in the room and board rate. The commenter urged CMS to instruct hospitals to establish a charge structure for blood transfusion and administration services that applies uniformly to both inpatients and outpatients.

Response: We appreciate the comment's recommendation. However, we do not consider the OPPS final rule, which addresses hospital outpatient payment policies, to be an appropriate forum for addressing detailed billing guidance for inpatient services. Rather,

we encourage hospitals to consult their fiscal intermediaries with any concerns related to the billing of blood transfusion and administration services to inpatients.

Comment: One commenter supported our proposal to set CY 2006 OPPS payments for blood and blood products based on hospital claims data rather than blood industry data. This commenter recommended that if CMS does consider using external data in some fashion for setting the payment rates for blood and blood products, that

CMS proceed very cautiously in considering whether to utilize blood industry data. The commenter stated that it is crucial that the external data be valid, reliable, publicly available, reflective of geographic variations in costs, and subject to audit.

Response: Although we are not using external data for setting the CY 2006 payment rates for blood and blood products, we thank the commenter for the recommended and considered caution toward using such external data in this case.

After carefully considering all comments received on our proposed CY 2006 OPPS methodology for establishing APC payment for blood and blood products, we are adopting as final our proposal with modification. To ensure beneficiaries' access to a safe blood supply, we are adopting a payment adjustment policy that will limit significant decreases in APC payment rates for blood and blood products from CY 2005 to CY 2006 by not more than 5 percent rather than 10 percent as proposed. Therefore, for the CY 2006 OPPS, the final median costs for blood and blood products are set at the greater of: (1) The simulated median costs calculated from the CY 2004 claims data; or (2) 95 percent of the CY 2005 adjusted median costs for these products, as reflected in Table 34 above.

For CY 2006, we also proposed to change the status indicator for CPT code 85060 (Blood smear, peripheral, interpretation by physician with written report) from "X" (separately paid under the OPPS) to "B" (not paid under the OPPS). When a hospital provides a physician interpretation of an abnormal peripheral blood smear interpretation for a hospital outpatient, the charge for the facility resources associated with the interpretation should be bundled into the charge reported for the ordered hematology lab service, such as CPT code 85007 (Blood count; blood smear, microscopic examination with manual differential WBC count) or CPT code 85008 (Blood count; blood smear, microscopic examination without manual differential WBC count), that are paid under the Clinical Laboratory Fee Schedule (CLFS). A physician interpretation of an abnormal peripheral blood smear is considered a routine part of the ordered hematology lab service, such as CPT codes 85007 and 85008 paid under the CLFS, so hospitals will receive duplicate payment for the facility resources associated with a physician's blood smear interpretation if we were to continue to pay separately for CPT code 85060 under the OPPS for hospital outpatients. Therefore, for CY 2006, we proposed to discontinue

payment under the OPPS for CPT code 85060 by changing its status indicator from "X" to "B."

We did not receive any public comments on this proposal. Accordingly, we are finalizing our proposal to discontinue payment under the OPPS effective for services furnished on or after January 1, 2006, for CPT code 85060 by changing its status indicator from "X" to "B."

XI. Payment for Observation Services

A. Background

Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment, before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation status is commonly assigned to patients with unexpectedly prolonged recovery after surgery and to patients who present to the emergency department and who then require a significant period of treatment or monitoring before a decision is made concerning their next placement. For a detailed discussion of the clinical and payment history of observation services under the OPPS, we refer readers to the November 1, 2002 final rule with comment period (67 FR 66794).

For a detailed discussion of our proposed changes to payments for observation services for CY 2006, we refer readers to the CY 2006 OPPS proposed rule at 70 FR 42742 through 42745. A summary of the proposed changes is included below, followed by our responses to the public comments, and our final policies for CY 2006.

B. Proposed and Final CY 2006 Coding Changes for Observation Services and Direct Admission to Observation

In response to comments received regarding the continuing administrative burden on hospitals when attempting to differentiate between packaged and separately payable observation services for purposes of billing correctly, and recommendations made by the APC Panel and participants at the February 2005 APC Panel meeting, in the CY 2006 OPPS proposed rule, we proposed two changes in observation coding and implementation of the OPPS payment policies for observation services in CY 2006. As we stated in the CY 2006 proposed rule (70 FR 42743), these administrative changes were prompted by the fact that CY 2004 hospital data do not reflect the CY 2005 policy changes implemented for separately

payable observation services. We continued to receive incomplete and unreliable data as a result of inconsistent hospital reporting, with some hospitals reporting observation services per day, and others reporting each hour of observation as one unit. The CY 2006 proposed changes were an effort to ensure more consistent hospital billing for both separately payable and packaged observation services in order to guide our future analyses of observation care and to shift the administrative burden for determining separately payable observation services from hospitals to the OCE. We do not expect to see an increase in the number of separately payable observations services as a result of these changes.

First, we proposed to discontinue HCPCS codes G0244 (Observation care by facility to patient), G0263 (Direct admission with CHF, CP, asthma), and G0264 (Assessment other than CHF, CP, asthma) and to create two new HCPCS codes to be used by hospitals to report all observation services, whether separately payable or packaged, and direct admission for observation care, whether separately payable or packaged:

- G0378—Hospital observation services, per hour (cited in the proposed rule as "GXXXX").
- G0379—Direct admission of patient for hospital observation care (cited in the proposed rule as "GYYYYY").

Second, we proposed to shift determination of whether or not observation services are separately payable under APC 0339 (Observation) from the hospital billing department to the OPPS claims processing logic. That is, hospitals would bill HCPCS code G0378 when observation services are provided to any patient admitted to "observation status," regardless of the patient's condition. In addition to the HCPCS code G0378, hospitals would bill HCPCS code G0379 when observation services are the result of a direct admission to "observation status" without an associated emergency room visit, hospital outpatient clinic visit, or critical care service on the day of or day before the observation services.

We proposed to assign both of these proposed new HCPCS codes a new status indicator "Q" (packaged service subject to separate payment based on criteria) that would trigger the OCE logic during the processing of the claim to determine if the observation service or direct admission service is packaged with the other separately payable hospital services provided, or if a separate APC payment for observation services or direct admission to observation is appropriate in accordance with the criteria discussed in section

XI.C. or XI.D. of this preamble. In addition, we proposed to change the status indicator for CPT codes 99217 through 99220 and 99234 through 99236 from “N” (packaged) to “B” (code not recognized by the OPPS). We noted we would expect hospitals to use HCPCS code G0378 to accurately report all observation services provided to beneficiaries, whether the observation would be packaged or separately payable, to assist us in developing consistent and complete hospital claims data regarding the utilization and costs of observation services. The units of service reported with HCPCS code G0378 would equal the number of hours the patient is in observation status.

Comment: Several commenters expressed support for the proposed changes and CMS’ and the APC Panel’s efforts to streamline the billing process for observation services in hospitals. Nine commenters stated that they appreciated our proposal to shift the burden of determining if observation is separately payable from the hospitals to the OCE logic.

While most of these commenters approved the proposal to use the new HCPCS code G0378 to bill for hospital observation services, two commenters believed that HCPCS code G0378 is unnecessary. They recommended that providers should use CPT evaluation and management codes for observation care, specifically CPT codes 99218, 99219, and 99220. The commenters also suggested that CMS should require hospitals to provide the hour information in the unit field and develop edits for these codes to edit for the qualifying conditions. A third commenter requested clarification on why G-codes are needed at all.

Response: We disagree with the commenters that HCPCS code G0378 is unnecessary and disagree that the requirement of reporting the code per hour could be handled in the unit field for CPT observation codes. The CPT observation codes are per day codes by CPT definition. We believe that to instruct hospitals to bill multiple units of a per day code to report the hours of observation care provided would create confusion and many variances in claims reporting resulting in poor hospital claims data. Generally, we follow CPT instructions for coding, and in this case we believe that it would be most prudent to establish a per hour G-code for observation services to facilitate ease of coding observation services and to ensure that we will be able to obtain useful and consistent data from future claims.

Comment: Five commenters sought clarification of the language in section

XI.B. of the CY 2006 proposed rule on page 70 FR 42743 where we stated that hospitals would bill HCPCS code G0378 when observation services are provided to any patient admitted to “observation status,” regardless of the patient’s status as inpatient or outpatient.

Response: We mistakenly included the word “inpatient” in this statement. The statement should instead read, “Hospitals would bill HCPCS code G0378 when observation services are provided to any patient admitted to ‘observation status’ regardless of the patient’s condition.”

Comment: One commenter notified CMS of an omission on page 70 FR 42745, under section XI.C.3.a of the CY 2006 proposed rule. The commenter pointed out that we had omitted direct admission from the bulleted list of additional hospital services.

Response: We appreciate the commenter bringing this error to our attention. The omission was inadvertent. In this final rule with comment period, we have made the appropriate change to make the policy consistent with the CY 2005 OPPS payment policy. The corrected policy reads as follows for the billing of hospital observation services:

“Additional Hospital Services:

a. The hospital must provide on the same day or the day before and report on the same claim:

- An emergency department visit (APC 0610 or 0612); or
- A clinic visit (APC 0600, 0601, or 0602); or
- Critical care (APC 0620); or
- Direct admission to observation using HCPCS code G0379.”

Comment: Many commenters expressed overall approval for our proposed policy changes concerning the new G-codes for observation services and, specifically, approval of the new HCPCS code G0379 to report direct admission to observation when a Medicare beneficiary is directly admitted into a hospital outpatient department for observation care after being seen by a physician in the community.

However, seven commenters believed that HCPCS code G0379 would be unnecessary if CMS would alter the OCE logic to look for revenue codes 45X (Emergency Department) and 516 (urgent care) on claims for observation services coded with HCPCS code G0378. They reasoned that if one of these revenue codes is not on the claim, the OCE logic should determine that the observation services billed were as a result of a direct admission to observation care.

Response: While we appreciate this suggestion and we agree that the OCE logic could recognize these revenue codes, we will implement HCPCS code G0379 as proposed. The OCE logic has no method of identifying if the direct admission to observation care service was actually provided. For example, the observation care billed with HCPCS code G0378 may have been an error in coding by a hospital, or the hospital may have failed to bill for an emergency room or clinic visit on the same day on the same claim as the observation services. Because we plan to pay separately for HCPCS code G0379 in some circumstances and the OPPS pays for services that were provided and billed with HCPCS codes on claims, the HCPCS code G0379 is necessary for billing and possible separate payment. In addition, if hospitals did not appropriately bill HCPCS code G0379 with its associated charges in cases of direct admission to observation, we would have no direct way of calculating the median cost of the direct admission to observation to facilitate analysis of its median cost in comparison with the OPPS payment rate for that service. If the observation care itself was not separately payable, and there were no other separately payable services on the claim, there would be no billed direct admission service with which to package the observation care and other packaged costs on the claim. Thus, in the absence of a code on a claim reporting a direct admission to observation services billed as HCPCS code G0379, Medicare will not use the OCE logic to infer that the patient was previously seen by a physician outside of the hospital who ordered the direct admission of the patient for observation services.

In summary, while a few commenters questioned the necessity of creating new G-codes for reporting observation services and direct admission to observation, we agree with the many commenters who encouraged us to implement the new codes and to use the OCE logic to determine when observation services are separately payable for the CY 2006 OPPS. Like those commenters, we believe that this change will both reduce the administrative burden on hospitals and will improve CMS claims data which will allow us to continue to evaluate our payment policies for observation services under the OPPS.

C. Proposed and Final Criteria for Separate Payment for Direct Admission to Observation

Through claims processing logic, we proposed to continue paying for direct

admission to observation at a rate equal to that of a Low Level Clinic Visit (APC 0600) when a Medicare beneficiary seen by a physician in the community and then is directly admitted into a hospital outpatient department for observation care that does not qualify for separate payment under APC 0339. In order to receive separate payment for a direct admission into observation (APC 0600), the claim must show:

1. Both HCPCS codes G0378 (Hourly Observation) and G0379 (Direct Admit to Observation) with the same date of service.
2. That no services with a status indicator "T" or "V" or Critical care (APC 0620) were provided on the same day of service as HCPCS code G0379.
3. The observation care does not qualify for separate payment under APC 0339.

Comment: One commenter disagreed with our proposal that no service with a status indicator of "V" (clinic or emergency department visit) can be on the claim when provided on the same day of service as HCPCS code G0379. The commenter stated that because OPSS services performed on the same date of service must be reported on the same claim, the hospital would not receive any payment for observation services for patients who receive a service in a provider-based clinic in the morning and later in the day are directly admitted to observation by their primary care practitioner for an unrelated reason. The commenter recommended that CMS eliminate the requirement that a hospital must combine separate outpatient encounters on a single claim.

Response: We appreciate the commenter's suggestion, but at this time we are not removing the requirement that services with status indicator "V" cannot be billed on the same claim with the same date of service as HCPCS code G0379 for direct admission to observation care for separate payment for HCPCS code G0379 to be made. We believe that the circumstances under which a patient would have a hospital visit (clinic or emergency room), sees a physician outside the hospital for an unrelated reason later in the same day, and then be directed on that same day to the same hospital where he or she had the first hospital visit for direct admission to observation for observation services that would be packaged (that is, not for chest pain, congestive heart failure, or asthma) but for which we would make separate payment for the direct admission to observation would be very rare. The OCE editing cannot deal with the complexity of this unusual sequence of events. Thus, if the observation services were not separately

payable in such a scenario, payment for the direct admission to observation and the accompanying observation services would be packaged with payments for the other separately payable services on the claim, including the day's earlier hospital visit if all of these services were billed on the claim.

As discussed in the data section (section II.A.) of this final rule with comment period and in Change Request 4047, issued on October 14, 2005, some nonrepetitive OPSS services provided on the same day by a hospital may be billed on different claims, provided that all charges associated with each procedure or service being reported are billed on the same claim with the HCPCS code which describes that service. We reiterate that it is vitally important that all of the charges that pertain to a nonrepetitive, separately paid procedure or service be reported on the same claim with that procedure or service. Only thus can we develop complete and accurate median costs for ratesetting purposes. We also emphasize that this relaxation of same day billing requirements for some nonrepetitive services does not apply to nonrepetitive services provided on the same day as either direct admission to observation care or observation services because the OCE claim-by-claim logic cannot function properly unless all services related to the episode of observation care, including hospital clinic visits, emergency department visits, critical care services, and "T" status procedures, are reported on the same claim. Further instruction on billing repetitive and nonrepetitive hospital services can be found in Change Request 4047 cited above.

Specifically with respect to the billing of HCPCS code G0379 for direct admission to observation care, we expect that hospitals will only bill this service if a patient is admitted directly to observation care after being seen by a physician in the community. Although our OCE logic is performed on a claim-by-claim basis, hospitals should not bill HCPCS code G0379 for direct admission to observation care on the same day as hospital clinic visits, emergency room visits, critical care services, and "T" status procedures that are related to the subsequent admission to observation care. Instead, hospitals should bill all of the services associated with the observation care, including hospital clinic visits, emergency room visits, critical care services, and "T" status procedures, on the same claim so that the OCE logic may appropriately determine the separately payable or packaged payment status of HCPCS codes G0378 and G0379.

In summary, we are implementing as final our proposed CY 2006 payment policies for observation services under the OPSS. We are also implementing the policy related to the new HCPCS code G0379 as proposed in order to continue paying for direct admission to observation at a rate equal to that of a Low Level Clinic Visit when a Medicare beneficiary is directly admitted into a hospital outpatient department for observation care that does not qualify for separate payment under APC 0339.

D. Proposed and Final Criteria for Separately Payable Observation Services (APC 0339)

For CY 2006, we proposed to continue applying the existing CY 2005 criteria (69 FR 65830), which determine if hospitals may receive separate payment for medically necessary observation care provided to a patient with congestive heart failure, chest pain, or asthma. In addition, we proposed to continue our policy of packaging payment for all other observation services into the payments for the separately payable services with which the observation service is reported. As explained previously in section XI.B. of this preamble, the only changes we proposed are related to the code hospitals will use to report observation services, and the point at which a payment determination is made. Rather than requiring the hospital to determine prior to claims submission whether patient condition and the services furnished meet the criteria for payment of APC 0339, that determination would shift to the claims processing modules installed by the fiscal intermediaries to process all OPSS bills, thereby reducing the administrative burden on hospitals.

Criteria for separate observation service payments include documentation of specific ICD-9-CM diagnostic codes; the length of time a patient is in observation status; hospital services provided before, during, and after the patient receives observation care; and ongoing physician evaluation of the patient's status.

As we stated in Program Transmittal A-02-129 released in January 2003, we will continue to update any changes in the list of ICD-9-CM codes required for payment of HCPCS code G0378 resulting from the October 1 annual update of ICD-9-CM in the October quarterly update of the OPSS. The ICD-9-CM codes for CY 2006 through October 2006 are listed in Table 35. As we proposed, below are the criteria that we will continue using in CY 2006 to determine if hospitals may receive separate OPSS payment for medically necessary observation care provided to

a patient with congestive heart failure, chest pain, or asthma.

1. Diagnosis Requirements

a. The beneficiary must have one of three medical conditions: congestive heart failure, chest pain, or asthma.

b. The hospital bill must report as the reason for visit or principal diagnosis an

appropriate ICD-9-CM code (as shown in Table 30 below) to reflect the condition.

c. The qualifying ICD-9-CM diagnosis code must be reported in Form Locator (FL) 76, Patient Reason for Visit, or FL 67, principal diagnosis, or both, in order for the hospital to receive separate payment for APC 0339. If a qualifying

ICD-9-CM diagnosis code(s) is reported in the secondary diagnosis field but is not reported in either the Patient Reason for Visit field (FL 76) or in the principal diagnosis field (FL 67), separate payment for APC 0339 will not be allowed.

BILLING CODE 4120-01-P

Table 34.--CY 2006 Eligible Diagnosis Codes for Billing Observation Services

| Required Diagnosis For: | Eligible ICD-9-CM Code | Code Descriptor |
|-------------------------|--|--|
| Chest Pain | 411.0 | Postmyocardial infarction syndrome |
| | 411.1 | Intermediate coronary syndrome |
| | 411.81 | Coronary occlusion without myocardial infarction |
| | 411.89 | Other acute ischemic heart disease |
| | 413.0 | Angina decubitus |
| | 413.1 | Prinzmetal angina |
| | 413.9 | Other and unspecified angina pectoris |
| | 786.05 | Shortness of breath |
| | 786.50 | Chest pain, unspecified |
| | 786.51 | Precordial pain |
| | 786.52 | Painful respiration |
| 786.59 | Other chest pain | |
| Asthma | 493.01 | Extrinsic asthma with status asthmaticus |
| | 493.02 | Extrinsic asthma with acute exacerbation |
| | 493.11 | Intrinsic asthma with status asthmaticus |
| | 493.12 | Intrinsic asthma with acute exacerbation |
| | 493.21 | Chronic obstructive asthma with status asthmaticus |
| | 493.22 | Chronic obstructive asthma with acute exacerbation |
| | 493.91 | Asthma, unspecified with status asthmaticus |
| 493.92 | Asthma, unspecified with acute exacerbation | |
| Heart Failure | 391.8 | Other acute rheumatic heart disease |
| | 398.91 | Rheumatic heart failure (congestive) |
| | 402.01 | Malignant hypertensive heart disease with congestive heart failure |
| | 402.11 | Benign hypertensive heart disease with congestive heart failure |
| | 402.91 | Unspecified hypertensive heart disease with congestive heart failure |
| | 404.01 | Malignant hypertensive heart and renal disease with congestive heart failure |
| | 404.03 | Malignant hypertensive heart and renal disease with congestive heart and renal failure |
| | 404.11 | Benign hypertensive heart and renal disease with congestive heart failure |
| | 404.13 | Benign hypertensive heart and renal disease with congestive heart and renal failure |
| | 404.91 | Unspecified hypertensive heart and renal disease with congestive heart failure |
| | 404.93 | Unspecified hypertensive heart and renal disease with heart and renal failure |
| | 428.0 | Congestive heart failure |
| | 428.1 | Left heart failure |
| | 428.20 | Unspecified systolic heart failure |
| | 428.21 | Acute systolic heart failure |
| | 428.22 | Chronic systolic heart failure |
| | 428.23 | Acute on chronic systolic heart failure |
| | 428.30 | Unspecified diastolic heart failure |
| | 428.31 | Acute diastolic heart failure |
| | 428.32 | Chronic diastolic heart failure |
| | 428.33 | Acute on chronic diastolic heart failure |
| | 428.40 | Unspecified combined systolic and diastolic heart failure |
| | 428.41 | Acute combined systolic and diastolic heart failure |
| 428.42 | Chronic combined systolic and diastolic heart failure | |
| 428.43 | Acute on chronic combined systolic and diastolic heart failure | |
| 428.9 | Heart failure, unspecified | |

BILLING CODE 4120-01-C

2. Observation Time

- a. Observation time must be documented in the medical record.
- b. A beneficiary's time in observation (and hospital billing) begins with the beneficiary's admission to an observation bed.
- c. A beneficiary's time in observation (and hospital billing) ends when all clinical or medical interventions have been completed, including followup care furnished by hospital staff and physicians that may take place after a physician has ordered the patient be released or admitted as an inpatient.
- d. The number of units reported with HCPCS code G0378 must equal or exceed 8 hours.

3. Additional Hospital Services

- a. The hospital must provide on the same day or the day before and report on the same claim:
 - An emergency department visit (APC 0610, 0611, or 0612) or
 - A clinic visit (APC 0600, 0601, or 0602); or
 - Critical care (APC 0620); or
 - Direct admission to observation services using HCPCS code G0379 (APC 0600).
- b. No procedure with a "T" status indicator can be reported on the same day or day before observation care is provided.

4. Physician Evaluation

- a. The beneficiary must be in the care of a physician during the period of observation, as documented in the medical record by admission, discharge, and other appropriate progress notes that are timed, written, and signed by the physician.
- b. The medical record must include documentation that the physician explicitly assessed patient risk to determine that the beneficiary would benefit from observation care.

The APC Panel met in August 2005 and made several recommendations for clarification of the observation policy, including that CMS offer further guidance regarding the definition of end-time of observation services, billing the new HCPCS G-codes in relation to the currently required evaluation and management visit codes, the typical length of observation time, and if the hospital has the ability to issue an Advance Beneficiary Notice (ABN) and under what circumstances.

We appreciate the consideration of the issues by the APC Panel and will continue to evaluate its recommendations as we gather claims data based on the new G-codes. We also

appreciate the APC Panel's concern for clear coding and billing guidance. We will provide detailed guidance regarding billing for observation services in an upcoming Internet-only manual update and "Medlearn Matters" article. For further clarification, this guidance will also include a restatement of when observation hours begin and end, and a discussion of appropriate billing of the G-codes for observation services in relationship to other services also billed by hospitals. As we have stated before in reference to the appropriate duration of observation services, we believe that in the overwhelming majority of cases, decisions can be and are routinely made in less than 48 hours, and generally in less than 24 hours, regarding whether to release a beneficiary from the hospital following resolution of the reason for the outpatient visit or whether to admit the beneficiary as an inpatient (69 FR 65830, November 15, 2004).

In response to the APC Panel's recommendation for clarification concerning if and when a hospital may issue an ABN, all hospital observation services, regardless of the duration of the observation care, that are medically reasonable and necessary are covered by Medicare, and hospitals receive OPPS payments for such observation services. We make separate payment for observation care only for the three conditions previously defined that also meet our specific criteria, and payments for all other reasonable and necessary observation services are packaged into the payments for other separately payable services provided to the patient on the same day. An ABN should not be issued in the context of reasonable and necessary observation services, whether packaged or not.

The APC Panel also recommended that CMS reevaluate expanding the list of diagnoses eligible for separate payment for observation.

We appreciate this recommendation by the APC Panel. While we believe that it is premature to expand the conditions for which we would separately pay for observation services, we believe that the coding changes we are finalizing for CY 2006 will result in more consistent and accurate hospital claims. The data gathered from these claims will allow further analysis of the appropriateness of expanding the number of separately payable conditions.

In addition, the APC Panel recommended that CMS establish a mechanism to reimburse separately for observation services when specific HCPCS codes with status indicator "T" are also on the claim with observation services on the day of or the day

preceding observation care. The APC Panel believed that sometimes observation services could be provided on the same day as "T" status procedures, but be unassociated with those procedures, as the observation care could be related to treatment of chest pain, asthma, or congestive heart failure for which we might otherwise make separate payment.

Although we appreciate the discussion of the APC Panel and this recommendation, we believe that in most cases, where observation care is billed on a claim on the same date as a "T" status procedure, the observation services are most likely related to post-procedural observation for which we do not make separate payment. As we take on the administrative responsibility for determining which observation services we will pay separately for, we have limited ability to determine the temporal order of "T" status procedures in relationship to the observation services. In addition, considering that there are over 13,000 "T" status codes paid under the OPPS, it would be an extremely large administrative burden for us to individually evaluate each "T" status code to determine if there may be an exception to the rule in some clinical circumstances, where observation care would precede or be unassociated with the "T" status procedure. We will discuss this issue again with the APC Panel in future APC Panel meetings and will examine the utilization patterns and costs of procedure-related observation services in our claims data based on the new G-code reporting of observation care.

We note, as described earlier in the context of billing HCPCS code G0379 for direct admission to observation, that through Change Request 4047 issued on October 14, 2005, we have recently relaxed our previous requirement to bill all OPPS services provided on the same day on the same claim. In the case of observation care, because of the OCE claim-by-claim logic, in order for us to make proper determinations regarding packaging or separate payment for observation services consistent with our payment policy to make separate observation payment only for the three specified medical conditions, all services associated with the observation care, including hospital clinic visits, emergency room visits, critical care services, and "T" status procedures that may have resulted in the need for observation care, must be reported on the same claim.

Comment: Several commenters requested clarification of the billing process, such as how to bill observation services when the patient is seen over

the midnight hour. Three commenters requested that CMS issue further billing guidance in the form of prompt issuance of program transmittals and manual changes, as well as a possible training package for hospitals to use when training physicians so that physicians can receive the same instructions from all facilities to which they admit patients.

Response: We appreciate these suggestions and, as stated earlier, we will provide detailed guidance regarding billing for observation services in an upcoming Internet-only manual update and "Medlearn Matters" article.

Comment: Several commenters recommended that CMS reevaluate expanding the list of diagnoses eligible for separate payment for observation. One commenter requested that CMS consider adding the following diagnoses: 466.0—Acute bronchitis; 466.11 (Acute bronchitis due to RSV); 466.19 (Acute bronchitis due to oth infects organism); 491.21 (Chr obstructive bronchitis, w acute exacerbation); 491.22 (Chr obstructive bronchitis, w acute bronchitis); and 496 (Chr obstructive pulmonary disease). The commenter stated that the current asthma diagnoses that receive separate payment include some patients with chronic obstructive pulmonary disease (COPD), but not all patients with COPD, and that physicians are frequently nonspecific when stating a diagnosis, which then leads to a wide variety of assignments of asthma and COPD codes. In addition, the commenter reasoned that the care of a patient with asthma, bronchitis, or COPD is very similar as far as the diagnostic tests performed, medications ordered, and clinical care provided.

Response: Our separately payable observation policy includes only diagnoses directly related to asthma. While we acknowledge that some of these conditions may have similar symptoms or a similar clinical course to asthma, we do not consider these diagnoses codes to represent asthma. In addition, there may be significant differences in responses to treatment for patients with these other diagnoses. Therefore, we are not adding the suggested diagnoses at this time.

Comment: One commenter requested that CMS and the APC Panel study the possible expansion of the conditions for which separate payment would be provided to include the diagnoses of febrile neutropenia, chemotherapy hypersensitivity reaction, and hypovolemia, electrolyte imbalance. Another commenter requested that CMS consider adding the diagnosis codes for

coronary artery disease as valid conditions for separate payment of observation.

Response: We appreciate the comments that we received from these commenters regarding possible additions to the list of diagnoses eligible for separate payment for observation services. Although we are not implementing in the CY 2006 OPSS the recommendations made by commenters and the APC Panel to expand separate payment for observation to include conditions in addition to congestive heart failure, asthma, and chest pain, we will continue to analyze our data based on the new G-codes and will study the feasibility and impact of such changes in eligible diagnoses as we consider future updates of the OPSS. We believe that the use of the new G-code for reporting hourly observation services should yield much more robust and reliable claims data upon which to base such further analyses.

Comment: One commenter recommended that CMS establish a mechanism to reimburse separately for observation services when specific HCPCS codes with status indicator "T" are also on the claim with observation services on the day of or the day preceding observation care. The commenter stated that the intensity and types of service for these types of procedures can be similar and that procedural complications or physician planned overnight observation can apply to status "T" procedures such as breast procedures and interventional radiology procedures. The commenter also expressed concern that patients initially in observation for chest pain may proceed to cardiac catheterization evaluations, and the current rule would seem to limit separate payment for observation services in this situation, even though the observation was for chest pain and it preceded the cardiac catheterization. The commenter requested that CMS either allow both "S" and "T" status services to be on the claim or discontinue this edit.

Response: Our changes in coding and OCE logic for CY 2006 do not affect the criteria for separately payable observation services. We do not intend to make separate payment for observation services following surgical or interventional procedures, and, in general, these services may be most readily identified by their "T" status under the OPSS. As we stated previously in response to a similar recommendation by the APC Panel, we believe that in most cases, where observation care is billed on a claim on the same date as a "T" status procedure, the observation services are most likely

related to post-procedural observation for which we do not make separate payment. We refer the readers to the previous response for further explanation.

Comment: One commenter recommended that CMS reconsider requiring hospitals to report one of the ICD-9-CM diagnosis codes designated for payment of APC 0339 as the admitting or primary diagnosis on the hospital claim. The commenter was concerned that if we restrict the position of the diagnosis code to the admitting or principal field, many claims that otherwise meet the criteria for separate payment of observation services will not be payable because coding rules and the frequency by which Medicare beneficiaries with asthma, congestive heart failure, or chest pains have other presenting signs, symptoms, and clinical conditions will result in inappropriate placement of the requisite diagnosis code. The commenter recommended that CMS accept the required diagnosis in any diagnosis field.

Response: As we stated in the CY 2005 OPSS final rule with comment period, we do not agree that this requirement will result in many claims for APC 0339 not being paid. Rather, we believe that requiring hospitals to report the signs, symptoms, and conditions that are the reason for the patient's visit will enhance coding accuracy and ensure that Medicare is paying appropriately for APC 0339 by limiting separate payment to those observation services furnished to monitor asthma, chest pain, and congestive heart failure. If we were to accept the required ICD-9-CM diagnosis code as a secondary diagnosis, we would remain concerned that we may be making separate payment for observation for conditions other than asthma, congestive heart failure, or chest pain because these conditions are reported in the secondary diagnosis field even though they are not the clinical reason that the patient is receiving observation services.

In summary, after careful consideration of the comments we received related to the criteria required for separate payment of observation services (APC 0339), we have decided to continue using the criteria as proposed for CY 2006. We will analyze the data that will be gathered through the reporting of the new HCPCS codes G0378 and G0379 to further study the implications of expanding the list of conditions eligible for separate payment for observation services. In addition, we will be issuing additional guidance for reporting and billing observation services in the form of a change request

updating the Internet-only manual and a "Medlearn Matters" article.

XII. Procedures That Will Be Paid Only as Inpatient Procedures

A. Background

Section 1833(t)(B)(i) of the Act gives the Secretary broad authority to determine the services to be covered and paid for under the OPPS. Before implementation of the OPPS in August 2000, Medicare paid reasonable costs for services provided in the outpatient department. The claims submitted were subject to medical review by the fiscal intermediaries to determine the appropriateness of providing certain services in the outpatient setting. We did not specify in regulations those services that were appropriate to provide only in the inpatient setting and that, therefore, should be payable only when provided in that setting.

In the April 7, 2000 final rule with comment period, we identified procedures that are typically provided only in an inpatient setting and, therefore, would not be paid by Medicare under the OPPS (65 FR 18455). These procedures comprise what is referred to as the "inpatient list." The inpatient list specifies those services that are only paid when provided in an inpatient setting because of the nature of the procedure, the need for at least 24 hours of postoperative recovery time or monitoring before the patient can be safely discharged, or the underlying physical condition of the patient. As we discussed in the April 7, 2000 final rule with comment period (65 FR 18455) and the November 30, 2001 final rule (66 FR 59856), we use the following criteria when reviewing procedures to determine whether or not they should be moved from the inpatient list and assigned to an APC group for payment under the OPPS:

- Most outpatient departments are equipped to provide the services to the Medicare population.
- The simplest procedure described by the code may be performed in most outpatient departments.
- The procedure is related to codes that we have already removed from the inpatient list.

In the November 1, 2002 final rule with comment period (67 FR 66792), we removed 43 procedures from the inpatient list for payment under OPPS. We also added the following criteria for use in reviewing procedures to determine whether they should be removed from the inpatient list and assigned to an APC group for payment under the OPPS:

- We have determined that the procedure is being performed in multiple hospitals on an outpatient basis; or
- We have determined that the procedure can be appropriately and safely performed in an ambulatory surgical center (ASC) and is on the list of approved ASC procedures or proposed by us for addition to the ASC list.

We believe that these additional criteria help us to identify procedures that are appropriate for removal from the inpatient list.

In the November 7, 2003 final rule with comment period (68 FR 63465), no significant changes were made to the inpatient list. In the November 15, 2004 final rule with comment period (69 FR 65834), we removed 22 procedures from the inpatient list, effective for services furnished on or after January 1, 2005.

B. Proposed and Final Changes to the Inpatient List

For CY 2006 OPPS, we used the same methodology as described in the November 15, 2004 final rule with comment period (69 FR 65837) to identify a subset of procedures currently on the inpatient list that were being widely performed on an outpatient basis. These procedures were then clinically reviewed for possible removal from the inpatient list. We solicited input from the APC Panel on the appropriateness of the removal of 26 procedures from the inpatient list at the February 2005 APC Panel meeting. The APC Panel recommended that these 26 procedures be removed from the list and further recommended that CMS consider CPT code 37183 (Remove hepatic shunt (TIPS)) for removal. We agreed with the APC Panel's recommendation that CPT code 37183 be removed from the inpatient list for CY 2006 and we proposed to remove it from the inpatient list. In addition, the APC Panel recommended that CMS review site of service data on laminectomy services, which currently have status indicator C and are on the inpatient list, to determine whether the procedures are being performed in the hospital outpatient setting with enough frequency to be assigned to APCs for payment under the OPPS.

However, subsequent to the APC Panel's February 2005 meeting, we conducted further clinical evaluations of three procedures (CPT codes 33420, 65273, and 59856) included among the 26 procedures that the APC Panel recommended for removal from the inpatient list. Upon further clinical evaluation of CPT code 33420 (Valvotomy, mitral valve; closed heart),

we found that the utilization data suggesting that this procedure is an office-based procedure were errant. Additional sources of utilization data suggested that this procedure is predominately performed on an inpatient basis. Concomitant with not meeting our criteria of being performed on an outpatient basis in multiple hospitals and not appearing on the ASC list of approved procedures, we were not compelled to support the removal of this procedure from the inpatient list. For this reason, we proposed to retain CPT code 33420 on the inpatient list for CY 2006.

CPT codes 65273 and 59856 were similarly reevaluated because of our concern with the HCPCS long descriptors for these two codes. The long descriptors for these codes are as follows: CPT code 65273 (Repair of laceration; conjunctiva, by mobilization and rearrangement, with hospitalization) and CPT code 59856 (Induced abortion, by one or more vaginal suppositories (eg, prostaglandin) with or without cervical dilation (eg, laminaria), including hospital admission and visits, delivery of fetus and secundines; with dilation and curettage and/or evacuation). The long descriptors indicate that hospital admission or hospitalization is included in the codes for these two procedures, which leads us to believe that these two procedures do not meet the established criteria for removal from the inpatient list. The same code descriptor for CPT code 65273, but without hospitalization, is assigned to CPT code 65272, which is already separately payable under the OPPS. Therefore, we proposed to retain CPT codes 65273 and 59856 on the inpatient list for CY 2006.

In addition, we proposed to remove CPT code 62160 (Neuroendoscopy) from the inpatient list. Questions about this service have been raised to us by the hospital community because CPT code 62160 is an add-on CPT code (that is, a code that is commonly performed as an "additional or supplemental" procedure to the primary procedure). Two of the separately coded services that CPT indicates are to be used with the add-on code are currently payable under the OPPS. Further clinical evaluation of this add-on procedure and its use in various sites of service leads us to believe it is appropriate for removal from the inpatient list.

Therefore, for CY 2006, we proposed to remove 25 procedures from the inpatient list and to assign 23 of these procedures to clinically appropriate APCs. We did not propose to assign two of these procedures to APC groups, that is, CPT codes 00634 (Anesthesia for

procedures in lumbar region; chemonucleolysis) and 01190 (Anesthesia for obturator neurectomy; intrapelvic) because they are anesthesia procedures for which no separate payment is made under the OPSS. Payment for these two procedures will be packaged into the procedures with which they are billed. We proposed that the changes to the inpatient list would be effective for services furnished on or after January 1, 2006.

We received numerous public comments on our proposed assignment of procedures to the inpatient list for the CY 2006 OPSS.

Comment: No commenter objected to the removal of the 25 procedures from the inpatient list. However, commenters requested that CMS eliminate the inpatient list. Among the reasons cited in the comments is that physicians are not bound by the list for payment for their professional services but are the decisionmakers regarding where a procedure is performed. The commenters stated that physicians often are unaware of the payment restrictions placed on the hospital by the inpatient list or, because their payment is unaffected by the list's constraints, may not be concerned with the hospital's payment. They pointed out that these factors make implementation and administration of the inpatient list very difficult for hospitals.

The commenters requested that if CMS does retain the list, that CMS make a strong effort to educate physicians about the hospital issues related to the inpatient list by, at a minimum, posting the inpatient list and an explanation of it on CMS' physician Web sites and on carrier Web sites.

Commenters also stated that teaching hospitals, where many of the procedures that are on the inpatient list are performed on an outpatient basis for the first time, are affected by the policy more than are nonteaching hospitals, because there is usually a significant time gap between when the services are performed safely in teaching hospital outpatient departments and "most" hospital outpatient departments. They asserted that criteria should be revised to allow a procedure to be removed from the list when it can be performed safely in a hospital outpatient department rather than based on the number of outpatient departments in which it may be safely performed.

The commenters also urged CMS to establish an appeal process in the event that the list is not eliminated. They believe that a process that would allow for case-by-case review of the documentation for inpatient procedures that were performed in the outpatient

department may serve to alleviate some hospital losses and provide information to CMS regarding procedures that may be good candidates for removal from the list.

Finally, the commenters once again stated that they strongly supported the February, 2004 APC Panel's recommendation that CMS eliminate the inpatient list.

Response: We are not eliminating the inpatient list at this time. We continue to believe that there are services that cannot be safely and effectively delivered to Medicare beneficiaries in the hospital outpatient setting. We are concerned that elimination of the inpatient list could result in unsafe or uncomfortable care for Medicare beneficiaries. Among the potential results of eliminating the list are long observation stays after some procedures and imposition of OPSS copayments, which could differ significantly from a beneficiary's inpatient cost-sharing responsibilities.

We believe that it is important for hospitals to educate physicians on Medicare services provided under the OPSS to avoid inadvertently providing services in a hospital outpatient setting that are more appropriately performed in an inpatient setting. However, we will follow up on the commenters' recommendations regarding what CMS may be able to do to supplement hospitals' physician education efforts.

Comment: Several commenters requested that CMS issue billing instructions for instances where hospitals have charges for an inpatient procedure performed in the outpatient department in addition to other services on the bill. Commenters were concerned that some fiscal intermediaries allow payment for the services other than the inpatient procedure, while other fiscal intermediaries do not. They also requested that CMS include in the proposed rule explanations for any new Category III CPT codes that CMS assigns to the inpatient list.

Response: Billing instructions are outside of the scope of the final rule, but we will look into the billing issues as suggested by the commenters. With regard to new Category III CPT codes released by the AMA on January 1 for implementation on July 1 of a given year, we refer the readers to section III.E. of this final rule for a description of our process for recognizing these codes and receiving public comments on their status under the OPSS. We will respond to those comments in the final rule, here for CY 2007. With regard to new Category III CPT codes released by the AMA on July 1 for implementation in January and new Category I CPT

codes released in the fall for implementation in January, because of the timing of the release of these codes we are unable to provide discussions of those assignments in any proposed rule. Instead, consistent with current practice, we will continue to designate these codes with comment indicator "NI" in the final rule to indicate that we are assigning them an interim payment status which is subject to public comment following publication of the final rule that implements the annual OPSS update. We believe that these processes provide ample opportunity for the public to comment regarding the assignments of new CPT codes to the inpatient list prior to our finalizing such assignments.

Comment: One commenter requested that CMS clarify that just because services are not on the inpatient list that does not mean they can only be provided in the outpatient setting.

Response: Many services payable under the OPSS may also be payable by Medicare when they are provided in other outpatient settings, including ASCs and physician offices, and in inpatient settings, depending on the clinical circumstances and health care delivery practices surrounding the care of specific Medicare beneficiaries. As we have stated previously, the OPSS inpatient list is a list of procedures that are only paid by Medicare when they are provided in an inpatient setting, and the absence of procedures from the inpatient list should not be interpreted as identifying those procedures as appropriately performed only in the outpatient setting.

Comment: Several commenters requested that CMS remove additional procedures from the inpatient list. In addition, the APC Panel recommended that CMS review site of service data on certain laminectomy services, which currently have status indicator C and are on the inpatient list, to determine whether the procedures are being performed in the hospital outpatient setting with enough frequency to be assigned to APCs for payment under the OPSS. None of the commenters provided us with specific evidence to support statements that the procedures were being performed on an outpatient basis in a safe and effective manner, nor did they suggest appropriate APC assignments for the procedures.

The commenters requested that the CPT codes for procedures shown in Table 35 below be removed from the inpatient list.

Table 35.---Public Requests for Removal of Procedures from Inpatient List

| CPT Code | Descriptor |
|----------|--|
| 22630 | Arthrodesis, posterior interbody technique, incl. laminectomy and/or diskectomy to prepare interspace, single interspace; lumbar |
| 37182 | Insertion of transvenous intrahepatic portosystemic shunt(s) (TIPS) |
| 44602 | Suture, small intestine (enterorrhaphy) for perforated ulcer, diverticulum, wound, injury or rupture; single perforation |
| 44603 | Suture, small intestine, (enterorrhaphy) for perforated ulcer, diverticulum, wound, injury or rupture; multiple perforations |
| 44604 | Suture, large intestine, (colorrhaphy) for perforated ulcer, diverticulum, wound, injury or rupture; (single or multiple perforations); without colostomy |
| 45563 | Exploration, repair, and presacral drainage for rectal injury; with colostomy |
| 49000 | Exploratory laparotomy, exploratory celiotomy with or without biopsy(s) |
| 57282 | Colpopexy, vaginal; extra-peritoneal approach |
| 57283 | Colpopexy, vaginal; intra-peritoneal approach |
| 58260 | Vaginal hysterectomy, for uterus 250 grams or less |
| 58940 | Oophorectomy, partial or total, unilateral or bilateral |
| 61624 | Transcatheter permanent occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method; central nervous system |
| 63043 | Laminotomy (hemilaminectomy), w/decompression of nerve root(s)I including partial facetectomy, foraminotomy reexploration, single interspace; each add'l cervical interspace |
| 63044 | Laminotomy (hemilaminectomy), w/decompression of nerve root(s)I including partial facetectomy, foraminotomy reexploration, each add'l lumbar interspace |
| 63050 | Laminoplasty, cervical, with decompression of the spinal cord, two or more vertebral segments |
| 63051 | Laminoplasty, cervical, with decompression of the spinal cord, two or more vertebral segments; with reconstruction of the posterior bony elements (including application of bridging bone graft and non-segmental fixation devices when performed) |
| 63075 | Diskectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophyctomy; cervical, single interspace |

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Response: We carefully evaluated each of the 17 procedures the commenters requested for deletion from the inpatient list. With the exception of one of the procedures, we found that 16 of the procedures are performed on Medicare beneficiaries more than 90 percent of the time in the inpatient setting and are associated with more than 23 hour recovery times. Some of the procedures are associated with an expectation of 4 to 5 day hospital stays. Two of the codes (63043 and 63044) are for "add-ons" to procedures that are not included on the inpatient list (63040,

Laminotomy (hemilaminectomy), with decompression of nerve root(s), including parital facetectomy, foraminotomy and/or excision of herniated intervertebral disk, reexploration, single interspace; cervical and 63042, Laminotomy (hemilaminectomy), with decompression of nerve root(s), including parital facetectomy, foraminotomy and/or excision of herniated intervertebral disk, reexploration, single interspace; lumbar). We are retaining codes 63043 and 63044 on the inpatient list because when these "add-on" services are

performed in addition to the base procedures, the resulting complete surgical sessions involve more extensive surgery, longer intraoperative times, longer recovery periods, and a higher frequency of performance in the inpatient setting, than do the base procedures alone that are not included on the inpatient list.

We will take this opportunity to remind the public that the determinations for inclusion on the inpatient list are made for the Medicare population. Thus, although some procedures may be routinely performed on an outpatient basis for younger

patients, their safe performance in the outpatient hospital setting may be much rarer for older individuals who are likely to have a number of comorbidities and slower recovery times. For procedures that are not included on the inpatient list, we rely on the practitioners' judgment to determine on

a patient-by-patient basis whether or not a particular procedure would be most appropriately performed in the inpatient setting. We believe that these 16 procedures should remain on the inpatient list for the CY 2006 OPFS. The one procedure that we believe is appropriate for deletion from the inpatient list is code 63075. We found

evidence that this procedure is being performed safely in some outpatient settings with increasing frequency. We are deleting the procedure from the inpatient list and assigning it to APC 0208 (Laminotomies and Laminectomies) for CY 2006.

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Table 36.—Procedure Codes Removed from Inpatient List and APC Assignments, Effective January 1, 2006

| HCPCS | Long Descriptor | New APC Assignment | Old Status Indicator | New Status Indicator |
|-------|---|--------------------|----------------------|----------------------|
| 00634 | ANESTHESIA FOR PROCEDURES IN LUMBAR REGION; CHEMONUCLEOLYSIS | n/a | C | N |
| 01190 | ANESTHESIA FOR OBTURATOR NEURECTOMY; INTRAPELVIC | n/a | C | N |
| 20662 | APPLICATION OF HALO, INCLUDING REMOVAL; PELVIC | 0049 | C | T |
| 20663 | APPLICATION OF HALO, INCLUDING REMOVAL; FEMORAL | 0049 | C | T |
| 20822 | REPLANTATION, DIGIT, EXCLUDING THUMB (INCLUDES DISTAL TIP TO SUBLIMIS TENDON INSERTION), COMPLETE AMPUTATION | 0054 | C | T |
| 20972 | FREE OSTEOCUTANEOUS FLAP WITH MICROVASCULAR ANASTOMOSIS; METATARSAL | 0056 | C | T |
| 20973 | FREE OSTEOCUTANEOUS FLAP WITH MICROVASCULAR ANASTOMOSIS; GREAT TOE WITH WEB SPACE | 0056 | C | T |
| 21150 | RECONSTRUCTION MIDFACE, LEFORT II; ANTERIOR INTRUSION (EG, TREACHER-COLLINS SYNDROME) | 0256 | C | T |
| 21175 | RECONSTRUCTION, BIFRONTAL, SUPERIOR-LATERAL ORBITAL RIMS AND LOWER FOREHEAD, ADVANCEMENT OR ALTERATION (EG, PLAGIOCEPHALY, TRIGONOCEPHALY, BRACHYCEPHALY), WITH OR WITHOUT GRAFTS (INCLUDES OBTAINING AUTOGRAFTS) | 0256 | C | T |
| 21195 | RECONSTRUCTION OF MANDIBULAR RAMI AND/OR BODY, SAGITTAL SPLIT; WITHOUT INTERNAL RIGID FIXATION | 0256 | C | T |
| 21408 | OPEN TREATMENT OF FRACTURE OF ORBIT, EXCEPT BLOWOUT; WITH BONE GRAFTING (INCLUDES OBTAINING GRAFT) | 0256 | C | T |
| 21495 | OPEN TREATMENT OF HYOID FRACTURE | 0253 | C | T |
| 27475 | ARREST, EPIPHYSEAL, ANY METHOD (EG, EPIPHYSIODESIS); DISTAL FEMUR | 0050 | C | T |
| 31293 | NASAL/SINUS ENDOSCOPY, SURGICAL; WITH MEDIAL ORBITAL WALL AND INFERIOR ORBITAL WALL DECOMPRESSION | 0075 | C | T |
| 31294 | NASAL/SINUS ENDOSCOPY, SURGICAL; WITH OPTIC NERVE DECOMPRESSION | 0075 | C | T |
| 36510 | CATHETERIZATION OF UMBILICAL VEIN FOR DIAGNOSIS OR THERAPY, NEWBORN | n/a | C | T |
| 37183 | REMOVE HEPATIC SHUNT (TIPS) | 0229 | C | T |
| 37195 | THROMBOLYSIS, CEREBRAL, BY INTRAVENOUS INFUSION | 0676 | C | T |
| 54560 | EXPLORATION FOR UNDESCENDED TESTIS WITH ABDOMINAL EXPLORATION | 0183 | C | T |
| 55600 | VESICULOTOMY; | 0183 | C | T |
| 59100 | HYSTEROTOMY, ABDOMINAL (EG, FOR HYDATIDIFORM MOLE, ABORTION) | 0195 | C | T |
| 61334 | EXPLORATION OF ORBIT (TRANSCRANIAL APPROACH); WITH REMOVAL OF FOREIGN BODY | 0256 | C | T |
| 62160 | NEUROENDOSCOPY | 0122 | C | T |
| 63075 | Dissectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophyctomy; cervical, single interspace | 0208 | C | T |
| 64763 | TRANSECTION OR AVULSION OF OBTURATOR NERVE, EXTRAPELVIC, WITH OR WITHOUT ADDUCTOR TENOTOMY | 0220 | C | T |
| 64766 | TRANSECTION OR AVULSION OF OBTURATOR NERVE, INTRAPELVIC, WITH OR WITHOUT ADDUCTOR TENOTOMY | 0221 | C | T |

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C. Ancillary Outpatient Services When Patient Expires (-CA Modifier)

In the November 1, 2002 final rule with comment period (67 FR 66798), we discussed the creation of a new HCPCS modifier -CA to address situations where a procedure on the OPSS inpatient list must be performed to resuscitate or stabilize a patient (whose status is that of an outpatient) with an emergent, life-threatening condition, and the patient dies before being admitted as an inpatient. In Transmittal A-02-129, issued on January 3, 2003, we instructed hospitals on the use of this modifier when submitting a claim on bill type 13x for a procedure that is on the inpatient list and assigned the payment status indicator (SI) "C." Conditions to be met for hospital payment for a claim reporting a service billed with modifier -CA include a patient with an emergent, life-threatening condition on whom a procedure on the inpatient list is performed on an emergency basis to resuscitate or stabilize the patient. For CY 2003, a single payment for otherwise payable outpatient services billed on a claim with a procedure appended with this new -CA modifier was made under APC 0977 (New Technology Level VIII, \$1,000-\$1,250), due to the lack of available claims data to establish a payment rate based on historical hospital costs.

As discussed in the November 7, 2003 final rule with comment period, we created APC 0375 to pay for services furnished on the same date as a procedure with SI "C" and billed with the modifier -CA (68 FR 63467) because we were concerned that payment under a New Technology APC would not result in an appropriate payment. Payment under a New Technology APC is a fixed amount that does not have a relative payment weight and, therefore, is not subject to recalibration based on hospital costs. In the absence of hospital claims data to determine costs, the clinical APC 0375 payment rate for CY 2004 was set at of \$1,150, which was the payment amount for the newly structured New Technology APC that replaced APC 0977.

For CY 2005, payment for otherwise payable outpatient services furnished on the same date of service that a procedure with SI "C" was performed on an emergent basis on an outpatient who died before inpatient admission and where modifier -CA was appended to the inpatient procedure continued to be made under APC 0375 (Ancillary Outpatient Services When Patient Expires) at a payment rate of \$3,217.47.

As discussed in the November 15, 2004 final rule with comment period (69 FR 65841), the payment median was set in accordance with the same methodology we followed to set payment rates for the other procedural APCs in CY 2005, based on the relative payment weight calculated for APC 0375. A review of the 18 hospital claims utilized for ratesetting revealed a reasonable mix of outpatient services that a hospital could be expected to furnish during an encounter with a patient with an emergency condition requiring immediate medical intervention, as well as a wide range of costs.

For CY 2006, we did not propose any changes to our payment policy for services billed on the same date as a "C" status procedure appended with modifier -CA. We proposed to continue to make one payment under APC 0375 for the services that meet the specific conditions discussed in previous rules for using modifier -CA, based on calculation of the relative payment weight for APC 0375, using charge data from CY 2004 claims for line items with a HCPCS code and status indicator "V," "S," "T," "X," "N," "K," "G," and "H," in addition to charges for revenue codes without a HCPCS code.

In accordance with this methodology, for the CY 2006 proposed rule, we calculated a median cost of \$2,528.61 for APC 0375 for the aggregated otherwise payable outpatient hospital services based on 300 CY 2004 hospital claims reporting modifier -CA with an inpatient procedure. These 300 claims were billed by 218 different hospital providers, each submitting between 1 and 10 claims with modifier -CA appended to a "C" status procedure. This median cost for APC 0375 is relatively consistent with the median calculated for the CY 2005 OPSS update, and, as expected, the hospital claims once again show a wide range of costs. Nevertheless, we are concerned with the very large increase in the volume of hospital claims billed with the -CA modifier from CY 2003 to CY 2004, growing from 18 to 300 claims over that 1-year time period. We acknowledge that modifier -CA was first introduced in CY 2003, and in CY 2003 and CY 2004 hospitals may have been experiencing a learning curve with respect to its appropriate use on claims for services payable under the OPSS.

However, our clinical review for the proposed rule of the 300 claims reporting modifier -CA lends some support to our early concerns regarding the increased CY 2004 modifier volume and hospitals' possible incorrect use of the modifier for services that do not meet the payment conditions we

established. Hospitals should be using this modifier only under circumstances described in section VI of Transmittal A-02-129, which provided specific billing guidance for the use of modifier -CA. In addition to expected use of the -CA modifier for exploratory laparotomies and insertions of intra-aortic balloon assist devices, other unanticipated examples of "C" status procedures reported with the -CA modifier by hospitals in CY 2004 include knee arthroplasty, thyroidectomy, repair of nonunion or malunion of the femur, and thromboendarterectomy of the carotid, vertebral, or subclavian arteries. Moreover, few of the claims also include a clinic or emergency room visit on the same date of service as the procedure appended with modifier -CA, as might be expected for some patients presenting to a hospital with serious medical conditions which require urgent interventions with inpatient procedures. We are concerned that some procedures reported by hospitals with the -CA modifier in CY 2004 may not have been provided to patients with emergent, life-threatening conditions, where the inpatient procedure was performed on an emergency basis to resuscitate or stabilize the patient. Instead, those procedures may have been provided to hospital outpatients as scheduled inpatient procedures that were not emergency interventions for patients in critical or unstable condition and such circumstances would have been inconsistent with our billing and payment rules regarding correct use of the -CA modifier to receive payment for APC 0375. In light of these claims findings and our current analysis, we will continue to closely monitor hospital use of modifier -CA, following changes in the claims volume, noting inpatient procedures to which the -CA modifier is appended, examining other services billed on the same date as the inpatient procedure, and analyzing specific hospital patterns of billing for services with modifier -CA appended, to assess whether a proposal to change our policies regarding payment for APC 0375 would be warranted in the future or whether hospitals require further education regarding correct use of the modifier -CA.

We received several public comments concerning our proposed payment for APC 0375.

Comment: A few commenters indicated that the -CA modifier policy supports an important function for hospitals and should be retained. Commenters suggested that the increased use of the modifier noted by CMS may be due to hospitals only

recently becoming aware of the relatively new modifier.

In response to CMS' question about why few of the claims with a -CA modifier included a clinic or emergency department visit on the same date of service, the commenters speculated that perhaps the beneficiary came in for a scheduled procedure but due to complications, the physician finds it necessary to provide a service that they had not otherwise intended to perform in an outpatient setting and the patient then died prior to inpatient admission.

Response: Despite the comments we received, we remain concerned that, while our billing and payment rules indicate that the inpatient procedure on the claim should be performed on an emergency basis to stabilize the patient if the modifier -CA is to be reported, on many of our claims, the -CA modifier was appended to inpatient list procedures that would likely not have been emergency resuscitative procedures. We remind hospitals to review our billing and payment rules for using the -CA modifier described in section VI. Of Transmittal A-02-129. Hospitals should limit their use of the -CA modifier to only those claims where all of the conditions outlined are met.

After careful consideration of the public comments received, we have decided that we will make no change to our -CA modifier policy at this time. We will continue to monitor the use of the modifier and will continue to encourage educational efforts by interested parties regarding appropriate use of the -CA modifier on OPPS claims.

XIII. Indicator Assignments

A. Status Indicator Assignments

The payment status indicators (SIs) that we assign to HCPCS codes and APCs under the OPPS play an important role in determining payment for services under the OPPS because they indicate whether a service represented by a HCPCS code is payable under the OPPS or another payment system and also whether particular OPPS policies apply to the code. In the CY 2006 OPPS proposed rule, we provided for CY 2006 our proposed status indicator assignments for APCs in Addendum A, for the HCPCS codes in Addendum B, and the definitions of the status indicators in Addendum D1.

Specifically, for CY 2006, we proposed to use the following status indicators in the specified manner:

- "A" to indicate services that are billable to fiscal intermediaries but are paid under some payment method other than OPPS, such as under the durable medical equipment, prosthetics,

orthotics, and supplies (DMEPOS) fee schedule or the Medicare Physician Fee Schedule. Some, but not all, of these other payment systems are identified in Addendum D1.

- "B" to indicate the services that are billable to fiscal intermediaries but are not payable under the OPPS when submitted on an outpatient hospital Part B bill type, but that may be payable by fiscal intermediaries to other provider types when submitted on an appropriate bill type.

- "C" to indicate inpatient services that are not payable under the OPPS.

- "D" to indicate a code that is discontinued, effective January 1, 2006.

- "E" to indicate items or services that are not covered by Medicare or codes that are not recognized by Medicare.

- "F" to indicate acquisition of corneal tissue which is paid on a reasonable cost basis, certain CRNA services, and hepatitis B vaccines that are paid on a reasonable cost basis.

- "G" to indicate drugs and biologicals that are paid under the OPPS transitional pass-through rules.

- "H" to indicate pass-through devices, brachytherapy sources, and separately payable radiopharmaceuticals that are paid on a cost basis.

- "K" to indicate drugs and biologicals (including blood and blood products) that are paid in separate APCs under the OPPS, but that are not paid under the OPPS transitional pass-through rules.

- "L" to indicate flu and pneumococcal immunizations that are paid at reasonable cost but to which no coinsurance or copayment apply.

- "M" to indicate services that are only billable to carriers and not to fiscal intermediaries and that are not payable under the OPPS.

- "N" to indicate services that are paid under the OPPS, but for which payment is packaged into another service or APC group.

- "P" to indicate services that are paid under the OPPS, but only in partial hospitalization programs.

- "Q" to indicate packaged services subject to separate payment under OPPS payment criteria.

- "S" to indicate significant procedures that are not discounted when multiple and that are subject to separate APC payment under the OPPS.

- "T" to indicate significant services that are paid under the OPPS and to which the multiple procedure payment discount under the OPPS applies.

- "V" to indicate medical visits (including emergency department or clinic visits) that are paid under the OPPS.

- "X" to indicate ancillary services that are paid under the OPPS.

- "Y" to indicate nonimplantable durable medical equipment that must be billed directly to the durable medical equipment regional carrier rather than to the fiscal intermediary.

We proposed the payment status indicators identified above, of which indicators "M" and "Q" are new for CY 2006, for each HCPCS code and each APC listed in Addenda A and B and we requested comments on the appropriateness of the indicators that we proposed to assign.

We received numerous comments regarding the appropriateness of the status indicator assignment for specific HCPCS codes which we discuss in other related sections of this final rule with comment period. In addition, we received several general comments regarding the payment status indicators and their proposed uses, which are discussed below.

Comment: Several commenters recommended that CMS revise the definition of status indicator "H" which had been initially used only for pass-through device categories paid on a cost basis that were not subject to coinsurance. The commenters argued that the proposed expansion of "H" to include brachytherapy sources that are paid on a cost basis and radiopharmaceuticals that we proposed to pay on a cost basis for CY 2006 is inconsistent in classification because coinsurance applies to these items.

One commenter made recommendations regarding other status indicators. For indicator "A," the commenter requested that CMS identify what fee schedule each HCPCS code is paid under. For indicator "B," the commenter recommended that if the HCPCS code was paid to physicians, the same code should be paid to hospitals. The commenter also requested that CMS revise the definition of status indicator "E" to separately identify services that were not covered by Medicare according to statute from those not covered for other reasons. Lastly, the commenter asked whether hospitals could automatically follow the language in the "C" status indicator descriptor, which states, "Not paid under the OPPS. Admit patient. Bill as inpatient."

Response: We have established specific status indicators in the OPPS for the principal purpose of making appropriate payment for services under the OPPS because we must signal the claims processing system through the OCE software as to HCPCS codes that are paid under the OPPS and those codes to which particular OPPS payment policies apply.

With respect to those HCPCS codes proposed for CY 2006 with the status indicator “H,” all of those codes have individual APC assignments that are unique. Because the APCs for these items each contain only one HCPCS code, we have chosen to associate the application of coinsurance or the lack thereof within each of these APCs in our claims processing system. Therefore, in CY 2005, the APCs for pass-through device categories do not have associated coinsurance, whereas the APCs for brachytherapy sources are subject to a 20-percent coinsurance. Similarly, for separately payable radiopharmaceuticals in CY 2006, their APCs will be subject to a 20-percent coinsurance. Therefore, we have no operational need to establish a new status indicator to separately identify the coinsurance status of HCPCS codes paid on a cost basis under the OPSS. However, we will indicate that pass-through device categories receive

separate cost-based pass-through payments that are not subject to coinsurance in the OPSS payment status description of status indicator “H” in Addendum D. We are finalizing for CY 2006 our proposed expansion of the definition of status indicator “H” to include radiopharmaceutical agents.

With respect to the comments concerning status indicators “A” and “E,” the OPSS has no administrative need to make the distinctions suggested by the commenter. Regarding HCPCS codes assigned status indicator “B,” in some cases such services may be paid to physicians and not to hospitals because the services are professional services only, not requiring hospital resources. In other cases, there may be alternate HCPCS codes that are recognized for the services under the OPSS. Therefore, we do not believe that status indicator “B” needs to be modified.

Lastly, status indicator “C” identifies services that are only paid in an

inpatient setting because of the nature of the procedures, their associated recovery times, or the physical conditions of the patients. Therefore, these services are not paid by Medicare under the OPSS. While the OPSS payment status explanation suggests what a hospital might do regarding admission and billing for such services, hospitals must follow all of their own and Medicare’s policies and procedures regarding inpatient hospital admissions and inpatient billing.

We are finalizing the definitions of status indicators “H” and “K” as noted in Table 37 below. Consequently, all pass-through device categories active in CY 2006 are assigned status indicator “H” and are not subject to coinsurance, while brachytherapy sources and radiopharmaceuticals assigned status indicator “H” will be subject to coinsurance.

TABLE 37.—CY 2006 DEFINITIONS OF STATUS INDICATORS “H” AND “K”

| Status indicator | Item/code/service | OPSS payment status |
|------------------|--|---|
| H | (1) Pass-Through Device Categories | (1) Separate cost-based pass-through payment; Not subject to coinsurance. |
| | (2) Brachytherapy Sources | (2) Separate cost-based nonpass-through payment. |
| | (3) Radiopharmaceutical Agents | (3) Separate cost-based nonpass-through payment. |
| K | Non-Pass-Through Drugs and Biologicals | Paid under OPSS; Separate APC payment. |

We are also finalizing our policy regarding status indicator “Q.” HCPCS codes with status indicator “Q” are either separately payable or packaged, depending on the specific circumstances of their billing. Addendum B displays the APC assignments of those codes with “Q” status when they are separately payable. OCE claims processing logic will be applied to codes assigned status indicator “Q” in order to determine if the service will be packaged or separately payable. In the event that a code is separately payable, the HCPCS code will receive an APC payment that corresponds to the APC listed in Addendum B, and would be subject to any discounting policies applied to that APC (identified by the APC status indicator). For CY 2006, hospital observation G-codes are assigned “Q” status; specific discussion of the payment policy applying to these services can be found in section IX. of this final rule with comment period.

B. Comment Indicators for the CY 2006 OPSS Final Rule

In the CY 2006 proposed rule, we proposed to continue to use the two comment indicators finalized in the

November 15, 2004 final rule with comment period (69 FR 65827 and 65828) to identify in this CY 2006 final rule the assignment status of a specific HCPCS code to an APC and the timeframe when comments on the HCPCS APC assignment will be accepted. The two comment indicators are listed below and in Addendum D2.

- “NF”—New code, final APC assignment; Comments were accepted on a proposed APC assignment in the Proposed Rule; APC assignment is no longer open to comment.
- “NI”—New code, interim APC assignment; Comments will be accepted on the interim APC assignment for the new code.

Comment: Several commenters expressed concern regarding changes in the proposed APC assignments for several codes (for example, CPT codes 63655 and 78700) that were not specifically addressed in the proposed rule. The commenters believed that the proposed new APC assignments for these codes were made in error.

Response: In general, changes in proposed APC assignments that were not discussed in detail in the proposed rule were made to improve clinical and resource homogeneity of the APC

groups. We noted in the proposed rule that the payment status indicators for each APC and HCPCS code in Addenda A and B are subject to comment (70 FR 42748), and included the APC assignment of all individual HCPCS codes.

Specific changes based on APC Panel recommendations are noted in the related topic sections of this final rule with comment period under section I.D. We discuss other changes throughout the final rule to address particular interests or concerns of the public. Addendum B of this final rule with comment period provides the status indicator and, where applicable, the APC assignment for those HCPCS codes that are payable under the OPSS, as well as those HCPCS codes that are being discontinued in CY 2006. To facilitate review of these changes, we are establishing new comment indicator “CH” in this final rule with comment period to designate HCPCS codes in Addendum B whose status indicator or APC assignment, or both, for the upcoming year will change from what they are in the current year:

- “CH”—Active HCPCS codes in current year and next calendar year;

status indicator and/or APC assignment have changed.

For example, in Addendum B of this final rule with comment period, the APC assignment and/or status indicator assignment for HCPCS codes flagged with comment indicator "CH" will be different for services furnished on or after January 1, 2006, than they were for services furnished on December 31, 2005. A HCPCS code showing comment indicator "CH" in Addendum B is not open to comment as they are so indicated only for the ease of the public to review the changes made from FY 2005 to CY 2006. Rather, in Addendum B of this final rule with comment period, only HCPCS codes flagged with comment indicator "NI" are subject to public comment.

XIV. Nonrecurring Policy Changes

A. Payments for Multiple Diagnostic Imaging Procedures

Currently, under the OPSS, hospitals billing for diagnostic imaging procedures receive full APC payments for each service on a claim, regardless of how many procedures are performed using a single imaging modality and whether or not contiguous areas of the body are studied in the same session. In its March 2005 Report to Congress, MedPAC recommended that the

Secretary should improve Medicare coding edits that detect unbundled diagnostic imaging services and reduce the technical component payment for multiple imaging services when they are performed on contiguous areas of the body (Recommendation 3-B). MedPAC pointed out that Medicare's payment rates are based on each service being provided independently and that the rates do not account for efficiencies that may be gained when multiple studies using the same imaging modality are performed in the same session. Further, MedPAC stated that those efficiencies are especially likely when contiguous body areas are the focus of the imaging because the patient and equipment have already been prepared for the second and subsequent procedures, potentially yielding resource savings in areas such as clerical time, technical preparation, and supplies, elements of hospital costs for imaging procedures that are reflected in APC payment rates under the OPSS.

Under the OPSS, we have a longstanding policy of reducing payment for multiple surgical procedures performed on the same patient in the same operative session (§ 419.44(a) of the regulations). In such cases, full payment is made for the procedure with the highest APC payment rate, and each subsequent

procedure is paid at 50 percent of its respective APC payment rate. In the proposed rule, we indicated that we believed that a similar policy for payment of diagnostic imaging services would be more appropriate than our current policy because it would lead to more appropriate payment for multiple imaging procedures of contiguous body areas that are performed during the same session.

In our efforts to determine whether or not such a policy would improve the accuracy of OPSS payments, in the CY 2006 OPSS proposed rule, we identified 11 "families" of imaging procedures by imaging modality (ultrasound, computerized tomography (CT) and computerized tomography angiography (CTA), magnetic resonance imaging (MRI) and magnetic resonance angiography (MRA)) and contiguous body area (for example, CT and CTA of Chest/Thorax/Abdomen/Pelvis), as displayed in Table 38. Using those families of procedures, we examined OPSS bills for CY 2004 and found that there were numerous claims reporting more than one imaging procedure within the same family provided to a beneficiary by a hospital on the same day.

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**Table 38.--Multiple Imaging Procedures Families
by Imaging Modality and Contiguous Body Area**

| Family | Imaging Modality/Contiguous Body Area |
|--|--|
| Family 1 Ultrasound (Chest/Abdomen/Pelvis - Non-Obstetrical) | |
| 76604 | Us exam, chest, b-scan |
| 76645 | Us exam, breast(s) |
| 76700 | Us exam, abdom, complete |
| 76705 | Echo exam of abdomen |
| 76770 | Us exam abdo back wall, comp |
| 76775 | Us exam abdo back wall, lim |
| 76778 | Us exam kidney transplant |
| 76830 | Transvaginal us, non-ob |
| 76831 | Echo exam, uterus |
| 76856 | Us exam, pelvic, complete |
| 76857 | Us exam, pelvic, limited |
| Family 2 CT and CTA (Chest/Thorax/Abd/Pelvis) | |
| 71250 | Ct thorax w/o dye |
| 71260 | Ct thorax w/ dye |
| 71270 | Ct thorax w/o & w/ dye |
| 72192 | Ct pelvis w/o dye |
| 72193 | Ct pelvis w/ dye |
| 72194 | Ct pelvis w/o & w/ dye |
| 74150 | Ct abdomen w/o dye |
| 74160 | Ct abdomen w/ dye |
| 74170 | Ct abdomen w/o & w/ dye |
| 71275 | Ct angiography, chest |
| 72191 | Ct angiography, pelv w/o & w/ dye |
| 74175 | Ct angiography, abdom w/o & w/ dye |
| 75635 | Ct angio abdominal arteries |
| 0067T | Ct colonography; dx |
| Family 3 CT and CTA (Head/Brain/Orbit/Maxillofacial/Neck) | |
| 70450 | Ct head/brain w/o dye |
| 70460 | Ct head/brain w/ dye |
| 70470 | Ct head/brain w/o & w/ dye |
| 70480 | Ct orbit/ear/fossa w/o dye |
| 70481 | Ct orbit/ear/fossa w/ dye |
| 70482 | Ct orbit/ear/fossa w/o & w/ dye |
| 70486 | Ct maxillofacial w/o dye |
| 70487 | Ct maxillofacial w/ dye |
| 70488 | Ct maxillofacial w/o & w/ dye |
| 70490 | Ct soft tissue neck w/o dye |
| 70491 | Ct soft tissue neck w/ dye |
| 70492 | Ct soft tissue neck w/o & w/ dye |
| 70496 | Ct angiography, head |
| 70498 | Ct angiography, neck |

| Family | Imaging Modality/Contiguous Body Area |
|--|---------------------------------------|
| Family 4 MRI and MRA (Chest/Abd/Pelvis) | |
| 71550 | Mri chest w/o dye |
| 71551 | Mri chest w/ dye |
| 71552 | Mri chest w/o & w/ dye |
| 72195 | Mri pelvis w/o dye |
| 72196 | Mri pelvis w/ dye |
| 72197 | Mri pelvis w/o &w/ dye |
| 74181 | Mri abdomen w/o dye |
| 74182 | Mri abdomen w/ dye |
| 74183 | Mri abdomen w/o and w/ dye |
| C8900 | MRA w/contrast, abdomen |
| C8901 | MRA w/o contrast, abdomen |
| C8902 | MRA w/o fol w/contrast, abd |
| C8903 | MRI w/contrast, breast, unilateral |
| C8904 | MRI w/o contrast, breast, unilateral |
| C8905 | MRI w/o fol w/contrast, breast, uni |
| C8906 | MRI w/contrast, breast, bilateral |
| C8907 | MRI w/o contrast, breast, bilateral |
| C8908 | MRI w/o fol w/contrast, breast, bilat |
| C8909 | MRA w/contrast, chest |
| C8910 | MRA w/o contrast, chest |
| C8911 | MRA w/o fol w/contrast, chest |
| C8918 | MRA w/contrast, pelvis |
| C8919 | MRA w/o contrast, pelvis |
| C8920 | MRA w/o fol w/contrast, pelvis |
| Family 5 MRI and MRA (Head/Brain/Neck) | |
| 70540 | Mri orbit/face/neck w/o dye |
| 70542 | Mri orbit/face/neck w/ dye |
| 70543 | Mri orbit/face/neck w/o & w/dye |
| 70551 | Mri brain w/o dye |
| 70552 | Mri brain w/dye |
| 70553 | Mri brain w/o & w/dye |
| 70544 | Mr angiography head w/o dye |
| 70545 | Mr angiography head w/dye |

| Family | Imaging Modality/Contiguous Body Area |
|--|---------------------------------------|
| 70546 | Mr angiography head w/o & w/dye |
| 70547 | Mr angiography neck w/o dye |
| 70548 | Mr angiography neck w/dye |
| 70549 | Mr angiography neck w/o & w/dye |
| Family 6 MRI and MRA (Spine) | |
| 72141 | Mri neck spine w/o dye |
| 72142 | Mri neck spine w/dye |
| 72146 | Mri chest spine w/o dye |
| 72147 | Mri chest spine w/dye |
| 72148 | Mri lumbar spine w/o dye |
| 72149 | Mri lumbar spine w/dye |
| 72156 | Mri neck spine w/o & w/dye |
| 72157 | Mri chest spine w/o & w/dye |
| 72158 | Mri lumbar spine w/o & w/dye |
| Family 7 CT Spine) | |
| 72125 | CT neck spine w/o dye |
| 72126 | Ct neck spine w/dye |
| 72127 | Ct neck spine w/o & w/dye |
| 72128 | Ct chest spine w/o dye |
| 72129 | Ct chest spine w/dye |
| 72130 | Ct chest spine w/o & w/dye |
| 72131 | Ct lumbar spine w/o dye |
| 72132 | Ct lumbar spine w/dye |
| 72133 | Ct lumbar spine w/o & w/dye |
| Family 8 MRI and MRA (Lower Extremities) | |
| 73718 | Mri lower extremity w/o dye |
| 73719 | Mri lower extremity w/dye |
| 73720 | Mri lower ext w/ & w/o dye |
| 73721 | Mri joint of lwr extre w/o dye |
| 73722 | Mri joint of lwr extr w/dye |
| 73723 | Mri joint of lwr extr w/o & w/dye |
| C8912 | MRA w/contrast, lwr extremity |
| C8913 | MRA w/o contrast, lwr extremity |
| C8914 | MRA w/o fol w/contrast, lwr extremity |
| Family 9 CT and CTA (Lower Extremities) | |
| 73700 | Ct lower extremity w/o dye |
| 73701 | Ct lower extremity w/dye |
| 73702 | Ct lower extremity w/o & w/dye |
| 73706 | Ct angio lower ext w/o & w/dye |
| Family 10 Mr and MRI (Upper Extremities and Joints) | |
| 73218 | Mri upper extr w/o dye |
| 73219 | Mri upper extr w/dye |
| 73220 | Mri upper extremity w/o & w/dye |
| 73221 | Mri joint upper extr w/o dye |
| 73222 | Mri joint upper extr w/dye |
| 73223 | Mri joint upper extr w/o & w/dye |
| Family 11 CT and CTA (Upper Extremities) | |
| 73200 | Ct upper extremity w/o dye |
| 73201 | Ct upper extremity w/dye |
| 73202 | Ct upper extremity w/o & w/dye |
| 73206 | Ct angio upper extr w/o & w/dye |

tomography, abdomen; without contrast material) are for studies of two adjacent body regions. Appropriate diagnostic evaluation of many constellations of patients' signs and symptoms and potentially affected organ systems may involve assessment of pathology in both the abdomen and pelvis, body areas that are anatomically and functionally closely related. Therefore, both studies are frequently performed in the same session to provide the necessary clinical information to diagnose and treat a patient. Although each procedure, by itself, entails the use of hospital resources, including certain staff, equipment, and supplies, some of those resource costs are not incurred twice when the procedures are performed in the same session and, thus we believed, should not be paid as if they were. Beginning with the beneficiary's arrival in the outpatient department, costs are incurred only once for registering the patient, taking the patient to the procedure room, positioning the patient on the table for the CT scan, among others. We proposed a reduction because we believed that reducing the payment for the second and subsequent procedures within the identified families might result in more accurate payments with respect to the hospital resources utilized for multiple imaging procedures performed in the same session.

OPPS bills do not contain detailed information on the hospitals' costs that are incurred in furnishing imaging procedures. Much of the cost is packaged and included in the overall charges for the procedures. Even if bundled costs are reported with charges on separate lines either with HCPCS codes or with revenue codes, when there are multiple procedures on the claims, it is impossible for us to accurately attribute bundled costs to each procedure. However, at the time of issuance of the proposed rule, our analysis of CY 2004 hospital claims convinced us that some discounting of multiple imaging procedures is warranted. In order to determine the level of adjustment that would be appropriate for the second and subsequent procedures performed within a family in the same session, we used the MPFS methodology and data.

Under the resource-based practice expense methodology used for Medicare payments to physicians, specific practice expense inputs of clinical labor, supplies and equipment are used to calculate "relative value units" on which physician payments are based. When multiple images are acquired in a single session, most of the clinical labor activities are not performed twice and

many of the supplies are not furnished twice. Specifically, we consider that the following clinical labor activities included in the "technical component" (TC) of the MPFS are not duplicated for subsequent procedures: Greeting, positioning and escorting the patient; providing education and obtaining consent; retrieving prior exams; setting up the IV; and preparing and cleaning the room. In addition, we consider that supplies, with the exception of film, are not duplicated for subsequent procedures. Equipment time and indirect costs are allocated based on clinical labor time in the physician payment methodology and therefore, we believe, these inputs should be reduced accordingly.

We performed analyses and found that excluding those practice expense inputs, along with the corresponding portion of equipment time and indirect costs, supported a 50-percent reduction in the payment for the TC portion of subsequent procedures. The items and services that make up hospitals' facility costs are generally very similar to those that are counted in the TC portion of the MPFS for diagnostic imaging procedures. We believed that the analytic justification for a 50-percent reduction of the TC for the second and subsequent imaging procedures using the MPFS input data also provided a basis for a similar relative reduction to payments for multiple imaging procedures performed in the hospital outpatient department. Therefore, we proposed to make a 50-percent reduction in the OPPS payments for some second and subsequent imaging procedures performed in the same session, similar to our policy of reducing payments for some second and subsequent surgical procedures.

We proposed to apply the multiple imaging procedure reduction only to individual services described by codes within one family, not across families. Reductions would apply when more than one procedure within the family is performed in the same session. For example, no reduction would apply to an MRI of the brain (CPT code 70552) in code Family 5, when performed in the same session as an MRI of the spinal canal and contents (CPT code 72142) in code Family 6. We proposed to make full payment for the procedure with the highest APC payment rate, and payment at 50 percent of the applicable APC payment rate for every additional procedure in the same family, when performed in the same session.

At its August 2005 meeting, the APC Panel heard testimony that provided evidence against proceeding with the proposal to discount for multiple

diagnostic imaging procedures at this time based on logic that efficiencies related to multiple imaging procedures were already captured in the OPPS claims data. The Panel made its recommendation that CMS should postpone implementation of the policy for a year so that we may gather more data on the implications of those changes. The Panel also recommended that CMS work with the American College of Radiology and other stakeholders in that process.

Comment: Many commenters on the proposed rule requested that we postpone implementation of the proposed discounting policy until we perform further analyses and are able to find more substantial, supporting hospital-based data. The commenters stated that our use of the MPFS data was an inappropriate basis for estimating costs and cost efficiencies in the hospital outpatient department and that a 50-percent reduction for second and subsequent services provided in the same imaging session was unwarranted. Commenters stated that the hospital cost data used by CMS to set payment rates already reflect savings due to the efficiencies of performing multiple procedures during the same session, and that the proposed policy to discount second and subsequent procedures is actually tantamount to discounting those procedures twice.

In addition, other commenters suggested that a lower percentage reduction may be more accurate. Some commenters also provided specific recommendations for modifications to the procedures included in the families eligible for discounting. One commenter indicated that CMS had failed to consider differences in patient preparation requirements for some imaging procedures that would necessitate significant additional time between the two tests, even though they are being performed during the same session. The commenters asserted that any discounting payment policy would systematically disadvantage hospitals relative to other settings for imaging services and that the negative effect on rural hospitals, who commonly lease expensive capital equipment such as MRI machines, would result in discontinuation of essential diagnostic radiology services in many areas. Finally, the commenters identified implementation issues that we had not addressed in the proposed rule, such as defining what we meant as "the same session."

Response: After careful consideration of the public comments received, the results of additional analyses of CY 2004 OPPS claims data, and the APC

Panel recommendation, we have decided not to finalize our proposal to discount for multiple diagnostic imaging procedures at this time. In calculating median costs for outpatient imaging procedures in the radiology families we proposed for discounting, for most hospitals' claims, we used a hospital-specific diagnostic radiology CCR for the conversion of charges to costs. Some hospitals reported costs and charges in nonstandard cost centers for ultrasound, CT, or MRI services, and, in general, those modality-specific CCRs were lower than their CCRs for diagnostic radiology. Those lower CCRs were not inconsistent with hospitals' experiences of particular efficiencies in providing multiple ultrasound, CT, or MRI services in a single setting, without reductions in charges for those multiple procedure sessions.

For the majority of hospitals for which we used diagnostic radiology CCRs to convert charges to costs for ultrasound, CT, and MRI procedures, we were concerned about whether these CCRs were too general and broad to reflect the efficiencies of providing multiple imaging procedures on contiguous body parts. We found that the imaging procedures we identified as eligible for the proposed payment reductions accounted for approximately half of the total OPSS charges attributed by the OPSS to hospitals' diagnostic radiology cost centers. This result suggests that costs and charges related to ultrasound, CT, and MRI services in the 11 proposed families are significant contributors from the OPSS to hospitals' diagnostic radiology cost centers; we also recognize that costs and charges are incurred in diagnostic radiology cost centers for inpatients and patients not insured by Medicare. We have no way of knowing how patterns of costs and charges for those patients contribute to hospitals' diagnostic radiology CCRs, but we have no specific reason to believe that their patterns of services would be very different than those for Medicare beneficiaries in the hospital outpatient setting. Thus, it may be correct that our median costs for imaging services in the 11 families proposed for the reduction policy reflect a reduced median based, in part, on hospitals' provision of multiple scans in one session.

Although our analyses provided no definite answer regarding whether, and by how much, the OPSS median costs for single imaging services in the 11 proposed families are reduced due to existing hospital efficiencies related to multiple services as compared with the hypothetical median costs for actual single services, our analyses do not

disprove the commenters' contentions that there are efficiencies already reflected in their hospital costs, and therefore, their CCRs and the median costs for the procedures. Further, the results of our initial analyses do support the recommendation that we should defer implementation of the proposed multiple imaging procedure reduction policy to perform additional analyses. Depending upon the results of our analyses, in a future rule we may propose revisions to the structure of our rates in order to ensure that these rates properly reflect the relative costs of initial and subsequent imaging procedures.

Comment: MedPAC expressed support of our multiple imaging discounting proposal and suggested that it would be preferable for CMS to be able to make the proposed reductions without the requirement for budget neutrality so that budget savings and lower cost sharing for beneficiaries would result. MedPAC realized that CMS is statutorily required to maintain budget neutrality in all changes made to the OPSS and, therefore, suggested that the Secretary offer a legislative proposal to Congress to allow us to capture potential savings.

Response: We appreciate MedPAC's support for our proposed policy. We are also appreciative of the preliminary work that MedPAC has provided in this area. We have carefully considered its suggestions, as well as those of other commenters, in determining whether to finalize our proposed multiple diagnostic imaging policy and will consider their suggestions regarding budget neutrality issues in our ongoing work on this issue.

Given the evidence presented by the commenters, the recommendation of the APC Panel, and our further analysis of this issue, we are convinced that additional analyses are in order. Therefore, during the coming year, we will perform analyses of relevant data to determine what, if any, changes in our median cost calculations for imaging services or discounting policies, or both, could be appropriate to enable us to make more accurate payments for diagnostic imaging services. To the extent feasible, as recommended by the APC Panel, we will look to the stakeholders in this policy for additional information and input concerning further development. As we have stated, in a future rule we may propose revisions to the structure of our rates in order to ensure that these rates properly reflect the relative costs of initial and subsequent imaging procedures.

B. Interrupted Procedure Payment Policies (Modifiers -52, -73, and -74)

1. Modifier -52

Since implementation of the OPSS in 2000, we have required hospitals to report modifiers -52, -73, and -74 to indicate procedures that were terminated before their completion. Modifier -52 indicates partial reduction or discontinuation of services that do not require anesthesia, while modifiers -73 and -74 are used for procedures requiring anesthesia, where the patient was taken to the treatment room and the procedure was discontinued before anesthesia administration or after anesthesia administration/procedure initiation, respectively. The elective cancellation of procedures is not reported. Hospitals are paid 50 percent of the APC payment for services with modifier -73 appended and 100 percent for procedures with modifier -52 or -74 reported, in accordance with § 419.44(b) of the regulations. In January 2005, we clarified, in Program Transmittal 442, the definition of anesthesia for purposes of billing for services furnished in the hospital outpatient department in the context of reporting modifiers -73 and -74. The APC Panel considered the current OPSS payment policies for interrupted procedures at its February 2005 meeting and made a number of recommendations that are addressed in the following discussion.

Current OPSS policy requires providers to use modifier -52 to indicate that a service that did not require anesthesia was partially reduced or discontinued at the physician's discretion. The physician may discontinue or cancel a procedure that is not completed in its entirety due to a number of circumstances, such as adverse patient reaction or medical judgment that completion of the full study is unnecessary. The modifier is reported most often to identify interrupted or reduced radiological and imaging procedures, and our current policy is to make full payment for procedures with a -52 modifier.

We have reconsidered our payment policy for interrupted or reduced services not requiring anesthesia and reported with a -52 modifier. At its February 2005 meeting, the APC Panel recommended continuing current OPSS payment policy at 100 percent of the APC payment for reduced services reported with modifier -52, although the APC Panel members acknowledged their limited familiarity with the specific outpatient hospital services and their clinical circumstances that would warrant the reporting of modifier -52. We examined our data to determine the

appropriateness of our current policy regarding payment for services that are reduced, and although some hospital resources are used to provide even an incomplete service, such as a radiology service, we are skeptical that it is accurate to pay the full rate for a discontinued or reduced radiological service. Compared to surgical procedures that require anesthesia, a number of general and procedure-specific supplies, and reserved procedure rooms that must be cleaned and prepared prior to performance of each specific procedure, the costs to the hospital outpatient department for the rooms and supplies typically associated with procedures not requiring anesthesia are much more limited. For example, the scheduling maintained for radiological services not requiring anesthesia generally exhibits greater flexibility than that for surgical procedures, and the procedure rooms are used for many unscheduled services that are fit in, when possible, between those that are scheduled. Consequently, we believe that the loss of revenue that may result from a surgical procedure being discontinued prior to its initiation in the procedure room is usually more substantial than that lost as the result of a discontinued service not requiring anesthesia, such as a radiology procedure. Nonetheless, under our current policy, Medicare makes the full APC payment for discontinued or reduced radiological procedures and only 50 percent of the APC payment for surgical procedures that are discontinued prior to initiation of the procedure or the administration of anesthesia.

Therefore, we proposed to pay 50 percent of the APC payment amount for a discontinued procedure that does not require anesthesia where modifier -52 is reported. We believed that this proposed payment would appropriately recognize the hospital's costs involved with the delivery of a typical reduced service, similar to our payment policies for interrupted procedures that require anesthesia.

We received many comments on our proposal to reduce by 50 percent the OPPS payment for claims for discontinued procedures reported with modifier -52.

Comment: All of the commenters requested that CMS continue to make full payment for those procedures. One argument presented by commenters was that the modifier cannot be used for elective cancellations, and that discontinuations are often associated with some unanticipated incident related to the beneficiary's clinical condition. They asserted that, in those

cases, the provider must address the beneficiary's clinical needs and because of the costs incurred as a result of those interventions, no fewer resources are used during the attempt to complete the procedure than there would have been if it had been completed without complications.

In fact, many commenters asserted that failed attempts to complete procedures often result in much higher resource use than completed, uncomplicated procedures because the procedure's discontinuation may come after many supplies and much time were expended. Further, they stated that a reduction in the OPPS payment is unfair because there are many times that no other procedures can be performed during the period that was scheduled for the incomplete procedure.

Commenters also stated that CMS does not fully understand hospital operations and urged CMS to learn more before we implement such a payment reduction policy. They stated that there was no indication in the proposed rule that CMS conducted any analysis to support the proposed reduction. They believed that CMS must perform cost analyses regarding the procedures to which the modifier is applied in order to evaluate the types of other services delivered when procedures are interrupted and the resources expended in their delivery.

Further, the commenters believed there is still confusion among providers regarding how to use the -52 modifier, and suggested that CMS review the data to evaluate the potential financial impact of the proposed policy because it may be applied disproportionately to those providers who use the modifier appropriately.

Response: We have conducted analyses of our hospital claims data to examine the usage of the -52 modifier in CY 2004. Those analyses are the basis for our determination that a reduction in the OPPS payments for interrupted procedures reported with a -52 modifier is warranted. We discovered 120,000 procedures in the CY 2004 hospital claims data with a -52 modifier appended. That level of use seemed high, and more in-depth analysis revealed that, although most of the usage was for imaging procedures, some of the services reported with the -52 modifier were unexpected and inappropriate (that is, office visit and diagnostic colonoscopy).

The results of our data analysis appear, to some degree, to conflict with much of the anecdotal information presented by the commenters. Although the commenters asserted that many times, discontinuation of procedures is

associated with emergency interventions and use of additional resources, the data did not indicate that this was likely to have been the primary reason for the procedures to which the -52 modifier was appended in CY 2004. The highest frequency use of the -52 modifier was among diagnostic imaging procedures that are typically not associated with adverse reactions (the top three procedures are imaging services without contrast), and we believe that there are some cost savings that result from not performing the entire procedure (for example, less film, less computer time, and less room time). As the claims for many of these procedures included little packaging and we found the line item charges for the services were not reduced when the -52 modifier was reported, we could generally not detect significant differences in costs for the same procedure, with and without the -52 modifier reported. However, because the line item charges for the services were typically similar for completed and interrupted procedures, we do not believe that our claims analysis had the potential to reflect any true hospital cost savings when procedures were discontinued. In general, we did not observe increased costs for claims for services reported with the -52 modifier. Further, some of the services that had the -52 modifier appended do not require significant supplies or procedure rooms, but, rather, are provided in examination rooms or other nonspecific areas of the outpatient department. Therefore, only minimal costs would be incurred by the hospital for an incomplete procedure.

Our data also indicated that the -52 modifier was often used inappropriately. For example, diagnostic colonoscopies ordinarily require anesthesia and, therefore, when discontinued, are to be reported using the -73 or -74 modifiers, rather than modifier -52. However, what we found in the hospital claims data was that diagnostic colonoscopy was the fifth most frequently reported procedure with the -52 modifier. We expect that the frequency of -52 modifier use with procedures in which anesthesia was administered will have decreased for CY 2005 as a result of our clarification regarding the use of modifiers -52, -73 and -74 published in Transmittal 442 issued in January 2005.

We have examined our data and given careful consideration to the public comments and the APC Panel's discussion and recommendations regarding OPPS payment policies for interrupted procedures. Given the nature of the procedures that were likely

reported appropriately with the -52 modifier in CY 2004, we continue to believe that there are considerable savings associated with their incomplete performance. We think that in the hospital outpatient setting, there are generally many opportunities to utilize the rooms and equipment that would otherwise be left unused as a result of discontinued procedures. We also believe that, although there may be occasional instances in which a discontinued procedure appropriately reported with the -52 modifier consumes more resources than one that is completed without interruption, those are unusual events and the vast majority of discontinued cases are significantly less costly than completed procedures. Therefore, we are finalizing our proposed policy to apply a 50 percent reduction to the APC payments for interrupted procedures reported with the -52 modifier in CY 2006.

Comment: One commenter requested that CMS give special consideration to capsule endoscopy of the esophagus if CMS makes final its proposal to reduce payment for procedures with the -52 modifier. The commenter indicated that the procedure is correctly coded using CPT 91110 (Gastrointestinal tract imaging, intraluminal (e.g., capsule endoscopy), esophagus through ileum, with physician interpretation and report), with -52 appended to indicate that the ileum was not visualized, even in cases where visualization of the ileum was not intended. The commenter stated that, although the professional component costs are reduced if the ileum is not included in the test, the technical costs of the procedure are the same whether or not the ileum is visualized.

The commenter suggested several options for accommodating the capsule endoscopy of the esophagus procedure in case CMS goes forward with the proposed -52 modifier policy. These included exempting hospitals from reporting the modifier with CPT 91110, establishing an administrative exception so that intermediaries would not reduce payment under the OPPS for the procedure, and establishing a different code for the procedure that would obviate the need for the -52 modifier.

Response: We are finalizing our proposal to reduce payments for procedures to which the -52 modifier is appended. We do not believe that exempting the capsule endoscopy procedure from the reduction policy is practical or warranted, given our consideration of specific information available to use concerning the capsule endoscopy of the esophagus procedure and hospital cost and clinical

information regarding other separately payable services under the OPPS. Moreover, even if we believed that it was appropriate, it is not feasible for us to selectively exempt individual procedures from the requirements of our OPPS payment policy for the -52 modifier, nor should providers knowingly misuse a CPT code in contradiction to CPT instructions.

While we do not establish HCPCS codes for new technology procedures that are described by existing HCPCS codes or combinations of HCPCS codes, we acknowledge that the commenter is concerned about the current CPT coding structure and its applicability to capsule endoscopy of the esophagus, along with the implications of the CY 2006 OPPS payment policy for services reported with the -52 modifier. As the AMA, through the CPT Editorial Panel, develops new CPT codes, provides coding instructions, and makes editorial changes to existing CPT codes, we encourage the commenter to bring its concerns about appropriate CPT coding for capsule endoscopy of the esophagus to the attention of the CPT Editorial Panel.

2. Modifiers -73 and -74

When a procedure requiring anesthesia is discontinued after the beneficiary was prepared for the procedure and taken to the room where it was to be performed but before the administration of anesthesia, hospitals currently report modifier -73 and receive 50 percent of the APC payment for the planned service. The APC Panel recommended that we make full APC payment for services with modifier -73 reported, because significant hospital resources were expended to prepare the patient and the treatment room or operating room for the procedure. Although the circumstances that require use of modifier -73 occur infrequently, we continue to believe that hospitals realize significant savings when procedures are discontinued prior to initiation but after the beneficiary is taken to the procedure room. We believe savings are recognized for treatment/operating room time, single use devices, drugs, equipment, supplies, and recovery room time. Thus, we believe our policy of paying 50 percent of the procedure's APC payment when modifier -73 is reported remains appropriate.

Further, in the CY 2006 proposed rule, we explored the possibility of applying a payment reduction for interrupted procedures in which anesthesia was to be used (and may have been administered) and the procedure was initiated. Currently,

those cases are reported using modifier -74, and we make the full APC payment for the planned service.

The payment policy for interrupted procedures reported with modifier -74 was originally adopted because we believed that the facility costs incurred for discontinued procedures that were initiated to some degree were as significant to the hospital provider as for a completed procedure, including resources for patient preparation, operating room use, and recovery room care. However, we had come to question that underlying assumption, especially as many surgical procedures have come to require specialized and costly devices and equipment, and our APC payments include the costs for those devices and equipment. At the time of the CY 2006 proposed rule, we expressed our belief that there may be costs that are not incurred in the event of a procedure's discontinuation, if a hospital is managing its use of devices, supplies, and equipment efficiently and conservatively. For example, the patient's recovery time may be less than the recovery time would have been for the planned procedure, because less extensive surgery was performed or costly devices planned for the procedure may not be used.

The APC Panel recommended that we continue to pay 100 percent of the procedural APC payment when modifier -74 is appended to the surgical service because, in its opinion, procedures may frequently be terminated prior to completion because the patient is experiencing adverse effects from the surgical service or the anesthesia. The APC Panel speculated that, in fact, significant additional resources could be expended in such a situation to stabilize and treat the patient if a procedure were discontinued because of patient complications. However, we believed that many of such additional services, including critical care, drugs, blood and blood products, and x-rays that may be necessary to manage and treat such patients, are separately payable under the OPPS and thus the hospital's costs need not be paid through the APC payment for the planned procedure. Because the OPPS is paying for the time in the operating room, recovery room, outpatient department staff, and supplies related to the typical procedure, it seemed that those costs might be lower in those infrequent cases when the procedure is initiated but not completed. We acknowledged that the costs on claims reporting a service with modifier -74 might be particularly diverse, depending upon the point in the procedure when the service was interrupted. Thus, in the proposed rule,

we specifically invited comment on the clinical circumstances in which modifier -74 is used in the hospital outpatient department, and the degree to which hospitals may experience cost savings in such situations where procedures are not completed. We were specifically interested in comments regarding the disposition of devices and specialized equipment that are not used because a procedure is discontinued after its initiation. In particular, we were interested in obtaining information about when during the procedure the decision to discontinue is typically made.

We received numerous public comments on the use of modifiers -73 and -74 and the associated costs of procedures billed with one of those modifiers.

Comment: A number of commenters encouraged CMS to continue to make full OPPS payments for interrupted services requiring anesthesia that were coded with the -74 modifier to indicate that the procedures were interrupted after their initiation or after the administration of anesthesia. In response to the proposed rule in which we discussed our concerns about the appropriateness of our current policy of making full payment for those discontinued procedures, the commenters provided extensive detail about the variable clinical circumstances where the -74 modifier is correctly reported and provided examples of the hospital resources required in such circumstances. They believed that the resources were definitely not reduced because, in most cases, all supplies would have been opened, the patient would continue to require recovery time, and the operative session might actually be longer than usual because of patient complications or multiple unsuccessful attempts to complete a complicated procedure.

In addition, numerous commenters recommended that CMS make full APC payments for services reported with a -73 modifier because of significant hospital resources required to prepare patients for those procedures. The commenters pointed out that the current OPPS payment policy indicates that CMS makes 50 percent of the APC payment when a -73 modifier is appended to a procedure that requires anesthesia and was interrupted after the patient was taken into the treatment room but prior to the administration of anesthesia. The commenters provided multiple examples of the types of costs incurred by hospitals in such circumstances, noting that the procedure might have been interrupted because a patient required treatment for

an evolving medical condition, requiring significant hospital resources. They added that sterile supplies may have been opened and other resources, including staff time and allocated procedure room time, used. The commenters recommended that CMS make 100 percent of the APC payment when a -73 modifier is reported with a procedure. In addition, several commenters requested that CMS modify the definition of when the -73 modifier is to be used. They indicated a preference that the modifier be used earlier, when a procedure is cancelled while a patient is still in a holding room or preoperative suite where the patient has been prepared for surgery, rather than being applicable only after the patient has been taken into the treatment room.

Response: We made no proposals to change our payment policies for procedures reported with modifiers -73 and -74 for CY 2006. We appreciate the detailed comments we received on hospitals' experiences with their use. We continue to believe that payment at 50 percent of the APC rate is appropriate for procedures reported with modifier -73, as we believe, in particular, that there are significant savings associated with decreased procedure or operating room times and markedly reduced recovery times. We do not believe it is appropriate to make procedural APC payments for services cancelled prior to a patient's entering the treatment or operating room. While specific hospital resources used in individual circumstances to prepare patients for surgery differ, in general, costs incurred in preoperative preparation are similar across surgical procedures (for example, establishment of intravenous access, pre-operative medication) and are unlikely to be closely related to the APC payments for the planned procedures. We expect that hospitals will continue to be cautious in expending resources preoperatively for procedures that may be cancelled prior to the patient entering the treatment room. Therefore, we will continue our current policy of a 50-percent reduction in the APC payment for services reported with the -73 modifier for the CY 2006 OPPS.

We also will maintain our current policy of paying 100 percent of the APC payment for procedures reported with the -74 modifier for CY 2006. We agree with the commenters that, in general, the clinical circumstances where the -74 modifier is reported may be particularly diverse and unpredictable. While we understand that any reductions in APC payments under such circumstances could pose some risk of

the OPPS making inappropriate payments for hospital resources utilized for such discontinued procedures, we remain concerned that making the full APC payment could also be inappropriate if a discontinued procedure with the -74 modifier appended was a high cost service requiring an expensive device that was not actually utilized. In the future, we may further examine our hospital claims data to analyze cost information for procedures reported with and without the -74 modifier.

We will provide billing guidance for CY 2006 regarding modifiers -52, -73, and -74 to offer hospitals additional instructions regarding the appropriate use of the three modifiers in the OPPS. Our goal is to assure that hospitals understand and report these modifiers correctly so that they receive appropriate payments for the services they provide.

XV. OPPS Policy and Payment Recommendations

A. MedPAC Recommendations

1. Report to the Congress: Medicare Payment Policy (March 2005)

The Medicare Payment Advisory Commission (MedPAC) submits reports to Congress in March and June that summarize payment policy recommendations. The March 2005 MedPAC report included the following two recommendations relating specifically to the hospital OPPS:

a. Recommendation 1: The Congress should increase payment rates for the outpatient prospective payment system by the projected increase in the hospital market basket index less 0.4 percent for calendar year 2006. A discussion regarding hospital update payments, and the effect of the market basket update in relation to other factors influencing OPPS payment rates, is included in section II.C. ("Conversion Factor Update for CY 2006") of this preamble.

b. Recommendation 2: The Congress should extend hold-harmless payments under the outpatient prospective payment system for rural sole community hospitals and other rural hospitals with 100 or fewer beds through calendar year 2006. A discussion of the expiration of the hold-harmless provision is included in section II.F. of this preamble. See also section II.G. ("Adjustment for Rural Hospitals") of this preamble for a discussion of section 411 of Pub. L. 108-173.

2. Report to the Congress: Issues in a modernized Medicare Program—Payment for Pharmacy Handling Costs in Hospital Outpatient Departments (June 2005)

A discussion of the MedPAC recommendations relating to pharmacy overhead payments in the hospital outpatient department can be found in section V. of the preamble of this final rule with comment period.

B. APC Panel Recommendations

Recommendations made by the APC Panel are discussed in sections of this preamble that correspond to topics addressed by the APC Panel. Minutes of the APC Panel's February 2005 and August 2005 meeting are available online at <http://www.cms.hhs.gov/faca/apc/default.asp>.

C. GAO Hospital Outpatient Drug Acquisition Cost Survey

A discussion of the June 30, 2005 GAO report entitled "Medicare: Drug Purchase Prices for CMS Consideration in Hospital Outpatient Rate-Setting" and section 621(a)(1) of the MMA is included in section V. of the preamble of this final rule with comment period.

XVI. Physician Oversight of Nonphysician Practitioners in Critical Access Hospitals

A. Background

Section 1820 of the Act, as amended by section 4201 of the Balanced Budget Act of 1997, Pub. L. 105–33, provides for the establishment of Medicare Rural Hospital Flexibility Programs (MRHFPs), under which individual States may designate certain facilities as critical access hospitals (CAHs). Facilities that are so designated and meet the CAH conditions of participations (COPs) under 42 CFR part 485, subpart F, will be certified as CAHs by CMS. The MRHFP replaced the Essential Access Community Hospital (EACH)/ Rural Primary Care Hospital (RPCH) program.

B. Proposed Policy Change in the Proposed Rule

Under the former EACH/RPCH program, physician oversight was required for services provided by nonphysician practitioners such as physician assistants (PAs), nurse practitioners (NPs), and clinical nurse specialists (CNSs) in a CAH. Under the MRHFP, the statute likewise requires physician oversight for nonphysician practitioners.

We note that under the EACH/RPCH program, we allowed for situations when the RPCH had an unusually high

volume of outpatients (100 or more during a 2-week period) that were treated by nonphysician practitioners. We stated that it would be sufficient for a physician to review and sign a 25-percent sample of medical records for patients cared for by a nonphysician practitioner unless State practice and laws require higher standards for physician oversight for nonphysician practitioners.

However, the current regulation does not distinguish between inpatient and outpatient physician oversight. Although the CAH CoPs at § 485.631(b)(iv) provide that a doctor of medicine or osteopathy periodically reviews and signs the records of patients cared for by NPs, CNSs, or PAs, section 1820(c)(2)(B)(iv)(III) of the Act states that CAH inpatient care provided by a PA or NP is subject to the oversight of a physician. The review of outpatient records is not addressed in the statute. Presently, for patients cared for by nonphysician practitioners, the interpretative guidelines set forth in Appendix W of the State Operations Manual (CMS Publication 7) set parameters for inpatient and outpatient physician reviews. To maintain consistency from the EACH/RPCH program to the CAH program, we indicated in the Interpretative Guidelines that CAHs with a high volume of outpatients need to have a physician review and sign a random sample of 25 percent of outpatient medical records. Therefore, the interpretative guidelines allow a physician to review and sign a 25-percent sample of outpatient records for patients under the care of a nonphysician practitioner.

Nonphysician practitioners recently brought to our attention their concerns regarding their ability to practice under their State laws governing scope of practice. Particularly, the nonphysician practitioners believe the current regulations and guidelines impede their ability to practice in CAHs. Certified nurse midwives, NPs, and CNSs disagree with the need for a physician to review records of patients that have been in their care when State law permits them to practice independently.

MedPAC, in its June 2002 Report to Congress, stated that certified nurse midwives, NPs, CNSs, and PAs are health care practitioners who furnish many of the same health care services traditionally provided by physicians, such as diagnosing illnesses, performing physical examinations, ordering and interpreting laboratory tests, and providing preventive health services. In many States, advance practice nurses are permitted to practice independently

or in collaboration with a physician. MedPAC reported that NPs have independent practice authority in 21 States, and CNSs have independent practice authority in 20 States. PAs, by law, must work under the supervision of a physician. Based on the American Medical Association's guidelines for PAs, the definition of supervision varies by State. Generally, the physician assistant is a representative of the physician, treating the patient in the style and manner developed and directed by the supervising physician.

MedPAC further reported that several studies have shown comparable patient outcomes for the services provided by physician and nonphysician practitioners. MedPAC reported that research conducted by Mundinger et al.² in 2000, Brown and Grimes³ in 1993, Ryan in 1993,⁴ and the Office of Technology Assessment⁵ in 1986 has shown that nonphysician practitioners can perform about 80 percent of the services provided by primary care physicians with comparable quality. A randomized trial of physicians and NPs providing care in ambulatory care settings who had the same authority, responsibilities, productivity, and administrative requirements were shown to have comparable patient outcomes (see pages 5 and 11 of the June 2002 MedPAC report). Nonphysician practitioners are trained with the expectation that they will exercise a certain degree of autonomy when providing patient care. About 90 percent of NPs and 50 percent of PAs provide primary care.

We believe sufficient control and oversight of these nonphysician practitioners is generated by State laws which allow independent practice authority. However, we remain concerned that, in those States without independent practice laws, we have a responsibility to continue to ensure the

² Mundinger, M.O., Kane, R.I., Lenez, E.R., et al., Primary Care Outcomes in Patients Treated by Nurse Practitioners or Physicians, A Randomized Trial, *The Journal of the American Medical Association*, January 5, 2000, Vol. 283, No. 1, pages 59–68.

³ Brown, S.A. and Grimes, D.E., Nurse Practitioners and Certified Nurse Midwives: A Meta Analysis of Studies on Nurses in Primary Care Roles, American Nurses Association, Washington, DC, March 1993.

⁴ Ryan, S.A., Nurse Practitioners: Educational Issues, Practice Styles, and Service Barriers. In Clawson, D.K., Osterweis, M., eds: *The Role of Physician Assistants and Nurse Practitioners in Primary Health Care* Association of Academic Health Centers, Washington, DC, 1993.

⁵ Office of Technology Assessment, U.S. Congress: *Nurse Practitioners, Physician Assistants, and Certified Nurse Midwives: A Policy Analysis*, Health Technology Case Study 37, Washington, DC, U.S. Government Printing Office, 1986.

safety and quality of services provided to Medicare beneficiaries.

Therefore, in the CY 2006 OPSS proposed rule (70 FR 42753), we proposed to revise the regulation at § 485.631(b)(1)(iv) and to add new paragraphs (b)(1)(v) and (b)(1)(vi) to § 485.631 to defer to State law regarding the review of records for outpatients cared for by nonphysician practitioners. We proposed that if State law allows these practitioners to practice independently, we would not require physicians to review and sign medical records of outpatients cared for by these nonphysician practitioners in CAHs. However, for those States that do not allow independent practice of nonphysician practitioners, we proposed to continue to maintain the requirement that periodic review is performed by the physician on outpatient records under the care of a nonphysician practitioner in a CAH. We believe a review at least every 2 weeks provides a sufficient time period without unduly imposing an administrative burden on the physician or the CAH. In addition, we proposed to allow the CAH to determine the sample size of the reviewed records in accordance with current standards of practice to allow the CAH flexibility in adapting the review to its particular circumstances. Specifically, we proposed that the physician periodically (that is, at least once every 2 weeks) reviews and signs a sample of the outpatient records of nonphysician practitioners according to the facility policy and current standards of practice. We proposed to still require periodic review and oversight of all inpatient records by physicians.

C. Public Comments Received on the Proposed Rule and Our Responses

We received 11 public comments concerning our proposed revision of § 485.631(b)(1)(iv) and the addition of §§ 485.631(b)(1)(v) and (b)(1)(vi).

Comment: The majority of commenters supported our proposal to defer to State law regarding the need for physicians to review and sign the medical records for outpatients cared for by nonphysician practitioners in CAHs. The commenters also stated that CMS should extend the application of this policy to physician review of inpatient records for patients cared for by nonphysician practitioners.

Response: We appreciate the commenters' support of our proposed policy change to defer to State law for physician oversight of outpatients cared for by nonphysician practitioners in CAHs. However, we believe the statute is very specific as to the oversight

requirement for inpatients treated by a nonphysician practitioner in a CAH. As we stated in the proposed rule, section 1820(c)(2)(B)(iv)(III) of the Act provides that CAH inpatient care provided by a PA, NP, or CNS is subject to the oversight of a physician. Therefore, we will still require physicians to periodically review and sign medical records of all inpatients cared for by a nonphysician practitioner.

Comment: Two commenters stated that, given the growing clinical independence of NPs, they have concern with CMS adding additional Federal requirements for patient record reviews that go beyond existing State licensure laws. Some commenters stated that most States do not use the term "independent practice," but instead define independent practice as the practitioner functioning autonomously. Another commenter stated that some States do not address independent practice and, instead, describe their oversight agreement as a "collaborative" agreement between the physician and the nonphysician practitioner.

Response: We share the commenters' concern with imposing requirements that do not increase the safety and health outcomes of patients. We proposed the new policy to eliminate the requirement for a physician to review and sign all medical records of outpatients (or a random sample of 25 percent for CAHs with a high volume of outpatients) cared for by a nonphysician practitioner to provide CAHs with the flexibility to comply with State laws for outpatient oversight. We believe that sufficient control and oversight of nonphysician practitioners are generated by State laws.

We also believe that the proposed policy on physician oversight of outpatient care provided by nonphysician practitioners allows for collaborative arrangements. Nonphysician practitioners who are required by State law to have a collaborative agreement with a physician would be expected to follow any State law, current standards of practice, and the CAH's policies concerning physicians collaborating with nonphysician practitioners who provide care for outpatients. We further understand that, in many instances, the terms "autonomous" and "independent" are synonymous. Although PAs are not considered independent practitioners because they always work under physician supervision, PAs perform their duties with a high degree of autonomy in providing patient care and making medical decisions. Based on these comments, and to provide clarity, we

are removing the word "independently" from the final regulation at § 485.631(b)(1)(v) and (vi) and further revising the regulation to state that, where State law requires record reviews or co-signatures, or both, by a collaborating physician, physicians must periodically, but not less than every 2 weeks, review and sign a sample of outpatient records of patients who were cared for by nonphysician practitioners in accordance with the policies of the CAH and current standards of practice. In addition, where State law does not require record reviews or co-signatures, or both, by a collaborating physician, physicians are not required to review and sign outpatient records of patients who were cared for by nonphysician practitioners.

D. Final Policy

After carefully considering the public comments received, we are adopting the proposed policy changes as final with the following modifications: We are revising the regulation at § 485.631(b)(1)(v) and (vi) by removing references to independent practice. We are further providing that physicians must review and sign a sample of outpatient records periodically, but not less than every 2 weeks, only if State law requires such record reviews or co-signatures, or both, by a collaborating physician.

XVII. Files Available to the Public Via the Internet

Addenda A and B to this final rule with comment period provide various data pertaining to CY 2006 payment for services under the OPSS. In previous years, we have listed in Addendum B hundreds of HCPCS codes describing services that are not paid under the hospital OPSS. To conserve resources and to make Addendum B more relevant to the OPSS, in this final rule with comment period that updates the OPSS for CY 2006, we are including in Addendum B only the HCPCS codes for services that are paid under the OPSS, as well as HCPCS codes that will be discontinued in CY 2006. The HCPCS codes published in Addendum B to this final rule with comment period, as well as HCPCS codes for items or services furnished in a hospital outpatient setting that are paid under a fee schedule or payment methodology other than the OPSS, and HCPCS codes for items or services not recognized or covered by Medicare, are available to the public on the CMS Web site at: <http://www.cms.hhs.gov/providers/hopps>.

For the convenience of the public, we are also including on this same CMS

Web site, in a format that can be readily downloaded and manipulated, a table that displays the HCPCS data in Addendum B sorted by APC assignment, which is identified on the Web site as Addendum C. In addition, we are including on the CMS Web site, in a format that can be easily downloaded and manipulated, Addendum A.

We note that in the CY 2006 OPSS proposed rule, we included, as Addenda H, I, J, K, L, M, N, and O, reprints of wage index related tables from the IPPS that would be used for the OPSS for CY 2006. In this final rule with comment period, we are not reprinting these tables as they were issued in the final FY 2006 IPPS rule, and corrected. Rather, we are providing a link on the CMS Web site at: <http://www.cms.hhs.gov/providers/hopps> to all of the FY 2006 IPPS wage index related tables, except for the table containing the out-migration wage adjustment data referenced in section II.D. of this preamble. The out-migration table is presented as Addendum L in this final rule with comment period. For additional assistance, contact Rebecca Kane, (410) 786-0378.

XVIII. Collection of Information Requirements

In the CY 2006 OPSS proposed rule, we solicited public comments on the following information collection requirement and the associated burden that is subject to the Paperwork Reduction Act of 1995 (PRA):

Section 485.631(b)(1)(iv), (b)(1)(v), and (b)(1)(vi)—Condition of Participation: Staffing and Staff Responsibilities

In the proposed rule, we proposed to revise § 485.631(b)(1)(iv) and add new §§ 485.631(b)(v) and (vi) of the regulations to require, as a condition of participation for a CAH, that a doctor of medicine or osteopathy (1) periodically review and sign the records of all inpatients cared for by nurse practitioners, clinical nurse specialists, certified nurse midwives, or physician assistants; and (2) periodically, but not less than every 2 weeks, review and sign a sample of outpatient records of patients cared for by nurse practitioners, clinical nurse specialists, certified nurse midwives, or physician assistants according to the policy and standard practice of the CAH when State law does not allow these nonphysician practitioners to practice independently. In addition, we proposed to provide that a doctor of medicine or osteopathy is not required to review and sign outpatient records of patients cared for by nurse practitioners, clinical nurse

specialists, certified nurse midwives, or physician assistants when State law allows these nonphysician practitioners to practice independently.

Based on public comments received on the proposed policy changes in § 485.631(b)(1), in this final rule with comment period, we have revised the proposed section to remove the term “independently” and to specify that where State law requires record review or co-signatures, or both, by a collaborating physician, physicians must review and sign a sample of outpatient records of patients who were cared for by nonphysician practitioners in accordance with the policies of the CAH and current standards of practice. We refer the readers to section XVI.C. of this preamble for a fuller discussion of these final changes.

The information collection requirements associated with these provisions are subject to the PRA. However, the collection requirement is currently approved under OMB control number 0938-0328 with an expiration date of January 31, 2008.

XIX. Regulatory Impact Analysis

A. OPSS: General

We have examined the impacts of this final rule with comment period as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96-354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4), and Executive Order 13132.

1. Executive Order 12866

Executive Order 12866 (as amended by Executive Order 13258, which merely reassigns responsibility of duties) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects (\$100 million or more in any 1 year).

We estimate that the effects of the provisions that will be implemented by this final rule with comment period will result in expenditures exceeding \$100 million in any 1 year. We estimate the total increase (from changes in this final rule with comment period as well as enrollment, utilization, and case-mix changes) in expenditures under the OPSS for CY 2006 compared to CY 2005

to be approximately \$1.4 billion. Therefore, this final rule with comment period is an economically significant rule under Executive Order 12866, and a major rule under 5 U.S.C. 804(2).

2. Regulatory Flexibility Act (RFA)

The RFA requires agencies to determine whether a rule would have a significant economic impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of \$6 million to \$29 million in any 1 year (65 FR 69432).

For purposes of the RFA, we have determined that approximately 37 percent of hospitals would be considered small entities according to the Small Business Administration (SBA) size standards. We do not have data available to calculate the percentages of entities in the pharmaceutical preparation manufacturing, biological products, or medical instrument industries that would be considered to be small entities according to the SBA size standards. For the pharmaceutical preparation manufacturing industry (NAICS 325412), the size standard is 750 or fewer employees and \$67.6 billion in annual sales (1997 business census). For biological products (except diagnostic) (NAICS 325414), with \$5.7 billion in annual sales, and medical instruments (NAICS 339112), with \$18.5 billion in annual sales, the standard is 50 or fewer employees (see the standards Web site at <http://www.sba.gov/regulations/siccodes/>). Individuals and States are not included in the definition of a small entity.

3. Small Rural Hospitals

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we previously defined a small rural hospital as a hospital with fewer than 100 beds that is located outside of a Metropolitan Statistical Area (MSA) (or New England County Metropolitan Area (NECMA)). However, under the new labor market definitions that we adopted in the November 15, 2004 final rule with comment period, for CY 2005 (consistent with the FY

2005 IPPS final rule), we no longer employ NECMAs to define urban areas in New England. Therefore, we now define a small rural hospital as a hospital with fewer than 100 beds that is located outside of an MSA. Section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98-21) designated hospitals in certain New England counties as belonging to the adjacent NECMA. Thus, for purposes of the OPSS, we classify these hospitals as urban hospitals. We believe that the changes in this final rule with comment period will affect both a substantial number of rural hospitals as well as other classes of hospitals and that the effects on some may be significant. Therefore, we conclude that this final rule with comment period will have a significant impact on a substantial number of small entities.

4. Unfunded Mandates

Section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4) also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in a single expenditure in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of \$120 million. This final rule with comment period does not mandate any requirements for State, local, or tribal governments. This final rule with comment period also does not impose unfunded mandates on the private sector of more than \$120 million dollars.

5. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it publishes any rule (proposed or final rule) that imposes substantial direct costs on State and local governments, preempts State law, or otherwise has Federalism implications.

We have examined this final rule with comment period in accordance with Executive Order 13132, Federalism, and have determined that it will not have an impact on the rights, roles, and responsibilities of State, local or tribal governments. As reflected in Table 39, the impact analysis shows that payments to governmental hospitals (including State, local, and tribal governmental hospitals) will increase by 1.9 percent under this final rule with comment period.

Comment: Several commenters noted that OPSS is the only major Medicare payment system that does not include a teaching adjustment and urged CMS to compare the unit costs of teaching hospitals with other types of hospitals

in order to support a teaching adjustment to the OPSS. One commenter suggested that such a study was necessary in light of the lower average payment increase estimated for major teaching hospitals in the proposed rule, 0.6 percent. The commenter hypothesized that teaching hospitals are more dependent on pass-through, outlier, and device-dependent APC payments, for which payments are less stable than for other hospitals, and that this is one reason for an adjustment. Finally, the commenter cited the statement in the April 7, 2000 final rule, where CMS indicated that it would study cost and payment differentials among hospitals, including teaching facilities, once there was reliable claims data under the OPSS.

Response: We do not believe that a study of the unit costs of teaching hospitals relative to other classes of hospitals is necessary at this time. As we stated in our April 7, 2000 final rule, we believe it is important to monitor ongoing trends for specific classes of hospitals. However, we also believe that such studies are especially warranted when hospitals experience a negative increase in payments. In this specific instance, major teaching hospitals are projected to experience an overall increase in payments of 1.0 percent. This increase is lower than the market basket update to the conversion factor because it reflects extra payments for drugs authorized by Pub. L. 108-173 for 2 years that expire in CY 2006. For the past 2 years, teaching hospitals have been receiving more payment for drugs than budget neutrality would allow. The increase in total payments for teaching hospitals is less this year because the provision allowing extra drug payments expires. Without considering these expiring payments for drugs, major teaching hospitals are projected to receive a 3.5 percent increase in total payments and minor teaching hospitals are projected to experience an increase of 4.1 percent. In light of such large increases, we do not believe that a study of unit costs for teaching hospitals is necessary. In addition, we are not convinced that a reliance on pass-through, outlier, or device-dependent APCs is a reason to propose an adjustment. We believe that the source of payments is less important than total payments for each hospital.

B. Impact of Changes in This Final Rule With Comment Period

We are adopting as final several proposed changes to the OPSS that are required by the statute. We are required under section 1833(t)(3)(C)(ii) of the Act to update annually the conversion factor

used to determine the APC payment rates. We are also required under section 1833(t)(9)(A) of the Act to revise, not less often than annually, the wage index and other adjustments. In addition, we must review the clinical integrity of payment groups and weights at least annually. Accordingly, in this final rule with comment period, we are updating the conversion factor and the wage index adjustment for hospital outpatient services furnished beginning January 1, 2006, as we discuss in sections II.C. and II.D., respectively, of this preamble. We also are revising the relative APC payment weights using claims data from January 1, 2004, through December 31, 2004 and updated cost report information. In response to a provision in Pub. L. 108-173 that we analyze the cost of outpatient services in rural hospitals relative to urban hospitals, we are increasing payments to rural SCHs. Section II.G. of this preamble provides greater detail on this rural adjustment. Finally, we are removing three device categories from pass-through payment status. In particular, section IV.C.1. of this preamble discusses the expiration of pass-through status for devices.

Under this final rule with comment period, the update change to the conversion factor as provided by statute will increase total OPSS payments by 3.7 percent in CY 2006. The inclusion in CY 2006 of payment for specific covered outpatient drugs within budget neutrality, and the expiration of additional drug payment outside budget neutrality, result in a net increase of 2.2 percent. The changes to the APC weights, changes to the wage indices, and the introduction of a payment adjustment for rural SCHs will not increase OPSS payments because these changes to the OPSS are budget neutral. However, these updates do change the distribution of payments within the budget neutral system as shown in Table 39 and described in more detail in this section.

C. Alternatives Considered

Alternatives to the changes we are making and the reasons that we have chosen the options that we have are discussed throughout this final rule with comment period. Some of the major issues discussed in this final rule with comment period and the options considered are discussed below.

1. Option Considered for Payment Policy for Separately Payable Drugs and Biologicals

As discussed in detail in section V.B.3 of this preamble, section 1833(t)(14)(A)(iii) of the Act requires

that payment for specified covered outpatient drugs in CY 2006, as adjusted for pharmacy overhead costs, be equal to the average acquisition cost for the drug for that year as determined by the Secretary and taking into account the hospital acquisition cost survey data collected by the GAO in CY 2004 and CY 2005. If hospital acquisition cost data are not available, the law requires that payment be equal to payment rates established under the methodology described in section 1842(o), section 1847A, or section 1847B of the Act, as calculated and adjusted by the Secretary as necessary.

The payment policy that we are adopting for CY 2006 is to pay for the acquisition and pharmacy overhead costs of all separately payable drugs and biologicals at the payment rates effective in the physician office setting as determined using the manufacturer's average sales price (ASP) methodology. (The payment rate in the physician office setting is ASP+6 percent.) These payment rates listed in this final rule with comment period are based on ASP data from the second quarter of 2005, which were used to set payment rates for drugs and biologicals in the physician office setting effective October 1, 2005, as these are the most recent numbers available to us during the development of this final rule with comment period. For the few drugs and biologicals, other than radiopharmaceuticals as discussed earlier, where ASP data are unavailable, we used the mean costs from the CY 2004 hospital claims data to determine their packaging status and for ratesetting. We believe that the ASP-based payment rates serve as the best proxy for the average acquisition and pharmacy overhead costs for the drug or biological because the rates calculated using the ASP methodology are based on the manufacturers' sales prices from the second quarter of CY 2005 and take into consideration information on sales prices to hospitals. Furthermore, payments for drugs and biologicals using the ASP methodology will allow for consistency of drug pricing between the physician offices and hospital outpatient departments.

In the CY 2006 proposed rule, we proposed paying for acquisition costs of drugs alone at the rate of ASP+6 percent, with an additional 2 percent of ASP for the pharmacy overhead costs of drugs. At that time, we also considered paying for separately payable drugs and biologicals (before payment for pharmacy overhead) at ASP+3 percent, based on the average relationship between the GAO mean purchase prices and ASP. We also considered ASP+8

percent (again before payment for pharmacy overhead) based on the average relationship between the mean costs from hospital claims data and ASP.

In the proposed rule, we did not set payment rates for separately payable drugs and biologicals at ASP+3 percent because the GAO data reflect hospital acquisition costs from a less recent period of time, as the midpoint of the time period when the survey was conducted is January 1, 2004, and it will be difficult to update the GAO mean purchase prices during CY 2006 and in future years. Because the changes in drug payments are required to be budget neutral by law, we note that paying for separately payable drugs and biologicals at ASP+3 percent relative to ASP+6 percent would have made available approximately an additional \$60 million for other items and services paid under the OPSS.

In the proposed rule, we also did not use ASP+8 percent to set payment rates for drugs and biologicals in CY 2006. The statute specifies that CY 2006 payments for specified covered outpatient drugs are required to be equal to the "average" acquisition cost for the drug. Payment at ASP+8 percent for drugs or biologicals, which represented the average relationship between the mean cost from hospital claims data and ASP at the time of the proposed rule, would reflect the product's acquisition cost plus pharmacy overhead cost, instead of acquisition cost only. Therefore, we believed at that time that it would not be appropriate for us to use ASP+8 percent to set the payment rates for drugs and biologicals in CY 2006.

In this final rule with comment period, we have updated data on drug costs, and we have reviewed the available alternatives in the light of those data. Based on our updated data, the average relationship between the mean costs from hospital claims data and ASP is now ASP+6 percent, rather than ASP+8 percent as in the proposed rule. Therefore, in this final rule with comment period, we are adopting the policy of paying both for the acquisition and pharmacy overhead costs of separately payable drugs at a combined rate of ASP+6 percent. As in the proposed rule, we considered several alternatives. We again considered paying for separately payable drugs and biologicals at ASP+3 percent, reflecting the GAO survey data on drug costs. However, payment at this level would reflect only the acquisition costs of drugs and, therefore, would not be sufficient to pay for acquisition and overhead costs. We also considered paying for the acquisition costs of drugs

alone at the proposed rate of ASP+6 percent. A commenter from MedPAC noted that, given that ASP values have declined in recent quarters and that the GAO's data did not fully reflect rebates, the proposed drug payment rates of ASP+6 percent could be too high. In addition, our more recent claims data indicate that this rate would represent excessive payment for acquisition costs of drugs alone. Instead, the hospital claims data suggest that ASP+6 percent is an appropriate rate for the acquisition and pharmacy overhead costs of drugs because pharmacy overhead costs are already built into hospital charges for drugs. Therefore, we are adopting that policy in this final rule with comment period.

Payment for drugs and biologicals under this methodology adds approximately \$500 million to the amount of drug costs that was included in our budget neutrality calculation for the CY 2005 OPSS. The effect of the addition of this amount is offset by reductions in weights for other services that are largely a function of updated, reduced CCRs.

2. Payment Adjustment for Rural SCHs

In section II.G. of this preamble, we are finalizing a 7.1 percent payment adjustment increase for rural SCHs. Section 1833(t)(13)(A) of the Act instructs the Secretary to conduct a study to determine if rural hospital outpatient costs exceed urban hospital outpatient costs. In addition, under section 1833(t)(13)(B) of the Act, the Secretary is given authorization to provide an appropriate adjustment to rural hospitals, by January 1, 2006, if rural hospital costs are determined to be greater than urban hospital costs.

For this final rule with comment period, we conducted the same analyses that we conducted for the proposed rule with updated data, and in addition, we examined the relative costliness of several classes of hospitals identified in public comments. We used regression analysis to analyze the differences in the outpatient cost per unit between rural and urban hospitals in order to compare costs after accounting for other factors that influence unit cost, including local labor supply, and complexity and volume of services.

As in the proposed rule, our initial regression analysis found that all rural hospitals give some indication of having higher cost per unit, after controlling for labor input prices, service-mix complexity, volume, facility size, and type of hospital. In order to assess whether the small difference in costs was uniform across rural hospitals or whether all of the variation was

attributable to a specific class of rural hospitals, we included more specific categories of rural hospitals in our explanatory regression analysis. We divided rural hospitals into categories indicated by their eligibility for the expiring hold harmless provision: rural SCHs, small rural hospitals with 100 or fewer beds, and all other rural hospitals. Further analysis revealed that only rural SCHs are more costly than urban hospitals holding all other variables constant. We also examined the relative costliness of other types of hospitals suggested by public comments, including urban SCHs and MDHs. We observed no significant difference in the unit costs of small rural hospitals with 100 or fewer beds, all other rural hospitals, MDHs, urban SCHs, and all other urban hospitals. Therefore, we are adopting a 7.1 percent payment increase for rural SCHs on all services except drugs, biologicals, and those paid under pass-through for CY 2006.

3. Change in the Percentage of Total OPSS Payments Dedicated to Outlier Payments

In section II.H. of this preamble, we are changing the percentage of total OPSS payments dedicated to outlier payments to 1.0 percent in CY 2006 from the current policy of 2.0 percent. We also will continue using a fixed-dollar threshold in addition to the threshold based on a multiple of the APC amount, which we have applied since the beginning of the OPSS. In response to findings reported by the MedPAC in its March 2004 Report to Congress that the OPSS outlier policy based on a multiple threshold only targeted outlier payments to simple and low cost procedures. In the same report, MedPAC recommended eliminating the entire outlier policy from the OPSS because the OPSS pays by service rather than by case and, therefore, hospitals are already paid for every increased service associated with a costly case. In addition, cost variability is lower for expensive, complex procedures than less expensive and simpler procedures. We implemented the fixed-dollar threshold in the CY 2005 OPSS that targets outlier payments to complex and expensive procedures that ultimately could impact beneficiary access to services. Our decision to reduce the percentage of total payments dedicated to outlier payments continues to refine our outlier policy to improve its appropriateness for the OPSS. A reduction in the percentage of total payment set aside for outlier payments with the fixed-dollar threshold continues to target outlier payments to those services where one costly

occurrence could pose a financial risk for hospitals, but limits these payments to the most complex and costly services. At 1.0 percent, the OPSS outlier policy becomes catastrophic insurance against an occurrence of a very costly service. At the same time, reducing the percentage of total payments dedicated to outlier payments increases the conversion factor, redistributing 1.0 percent of total payments to almost all services.

Alternatives to this policy are either to remain at 2.0 percent or to increase the percentage of payments dedicated to outliers to the statutory limit of 3.0 percent. Increasing the percentage of payments dedicated to outliers could target more payment to outliers, but is at odds with OPSS payment by service rather than case. It is not possible to eliminate outlier payments entirely without a statutory change.

D. Limitations of Our Analysis

The distributional impacts presented here are the projected effects of the final policy changes, as well as the statutory changes that will be effective for CY 2006, on various hospital groups. We estimate the effects of individual policy changes by estimating payments per service while holding all other payment policies constant. We use the best data available but do not attempt to predict behavioral responses to our policy changes. In addition, we do not make adjustments for future changes in variables such as service volume, service-mix, or number of encounters.

E. Estimated Impacts of This Final Rule With Comment Period on Hospitals

The estimated increase in the total payments made under OPSS is limited by the increase to the conversion factor set under the methodology in the statute. The distributional impacts presented do not include assumptions about changes in volume and service-mix. The enactment of Pub. L. 108-173 on December 8, 2003, provided for the payment of additional dollars in CY 2004 and CY 2005 to providers of OPSS services outside of the budget neutrality requirement for specified covered outpatient drugs. These provisions expire in CY 2006. Pub. L. 108-173 also provided for additional payment outside of the budget neutrality requirement for wage indices for specific hospitals reclassified under section 508 through CY 2007. Table 39 shows the estimated redistribution of hospital payments among providers as a result of a new APC structure, wage indices, and adjustment for rural SCHs, which are budget neutral; the estimated distribution of increased payments in

CY 2006 resulting from the combined impact of APC recalibration, wage effects, the rural SCH adjustment, and the market basket update to the conversion factor; and, finally, estimated payments considering all payments for CY 2006 relative to all payments for CY 2005, including the expiration of extra payment for specified covered outpatient drugs outside budget neutrality and the change in the percentage of total payments dedicated to outlier payments. Because the expiring payments for drugs were not budget neutral, most classes of hospitals will experience a positive update for CY 2006 that is lower than the market basket update. In essence, the presence of extra payment in previous years makes the increase for CY 2006 look artificially low. We also estimate that a few classes of hospitals may receive less payment in CY 2006. Because updates to the conversion factor, including the update of the market basket, the removal of additional money for pass-through payments, and a change in the percentage of total payments dedicated to outlier payments are applied uniformly, observed redistributions of payments in the impact table largely depends on the mix of services furnished by a hospital (for example, how the APCs for the hospital's most frequently furnished services would change), the impact of the wage index changes on the hospital, and the impact of the payment adjustment for rural SCHs. However, total payments made under this system and the extent to which this final rule with comment period redistributes money during implementation would also depend on changes in volume, practice patterns, and the mix of services billed between CY 2005 and CY 2006, which CMS cannot forecast. Overall, the final OPSS rates for CY 2006 will have a positive effect for all hospitals paid under the OPSS. Adopted changes will result in a 2.2 percent increase in Medicare payments to all hospitals, exclusive of transitional pass-through payments. Removing cancer and children's hospitals because their payments are held harmless to the pre-BBA ratio between payment and cost, suggests that adopted changes will result in a 2.3 percent increase in Medicare payments to all other hospitals.

To illustrate the impact of the CY 2006 changes adopted in this final rule with comment period, our analysis begins with a baseline simulation model that uses the final CY 2005 weights, the FY 2005 final post-reclassification IPSS wage indices, as subsequently corrected

and without additional increases resulting from section 508 reclassifications, and the final CY 2005 conversion factor. Columns 2, 3, and 4 in Table 39 reflect the independent effects of the APC reclassification and recalibration changes, updated wage indices, and the new adjustment for rural SCHs, respectively. These effects are budget neutral, which is apparent in the overall zero impact in payment for all hospitals in the top row. Column 2 shows the independent effect of changes resulting from the reclassification of services codes among APC groups and the recalibration of APC weights based on a complete year of CY 2004 hospital OPPS claims data and more recent cost report data. This column also shows the impact of incorporating drug payment at 106 percent of ASP and, for radiopharmaceuticals, payment at cost, within budget neutrality. We modeled the independent effect of APC recalibration by varying only the weights, the final CY 2005 weights versus the final CY 2006 weights, in our baseline model, and calculating the percent difference in payments. Column 3 shows the impact of updating the wage index used to calculate payment by applying the final FY 2006 IPPS wage index, as subsequently corrected. The OPPS wage index used in Column 3 does not include changes to the wage index for hospitals reclassified under section 508 of Pub. L. 108–173. We modeled the independent effect of updating the wage index by varying only the wage index, using the final CY 2006 scaled weights, and a CY 2005 conversion factor that included a budget neutrality adjustment for changes in wage effects between CY 2005 and CY 2006. Column 4 shows the budget neutral impact of adding a 7.1 percent adjustment to payment for services other than drugs, biologicals, and those receiving pass-through payments to rural SCHs. We modeled the independent effect of the payment adjustment for rural SCHs by varying only the presence of the rural adjustment, using CY 2006 scaled weights, the FY 2006 wage indices, and a CY 2005 conversion factor with budget neutrality adjustments for the new wage index and the adjustment for rural SCHs.

Column 5 demonstrates the combined “budget neutral” impact of APC recalibration, the wage index update, and the new adjustment for rural SCHs on various classes of hospitals, as well as the impact of updating the conversion factor with the market basket update. We modeled the independent effect of budget neutrality adjustments

and the market basket update by using the weights and wage indices for each year to model CY 2006 requirements, and using a CY 2005 conversion factor that included the market basket update and budget neutrality adjustments for differences in wages and the adjustment for rural SCHs.

Finally, Column 6 depicts the full impact of the CY 2006 policy on each hospital group by including the effect of all the changes for CY 2006 and comparing them to all payments in CY 2005, including those required by Pub. L. 108–173. Column 6 shows the combined budget neutral effects of Columns 2 through 5, plus the impact of changing the percentage of total payments dedicated to outlier payments to 1.0 percent, the impact of changing the percentage of total payments dedicated to transitional pass-through payments to 0.17 percent, the impact of expiring payments for drugs added on top of OPPS payments in CY 2005 as a result of Pub. L. 108–173, and the continued presence of payment for wage index increases for hospitals reclassified under section 508 of Pub. L. 108–173.

We modeled the independent effect of all changes in Column 6 using the final weights for CY 2005 with additional money for drugs authorized by Pub. L. 108–173 and the final weights for CY 2006. The wage indices in each year include wage index increases for hospitals eligible for reclassification under section 508 of Pub. L. 108–173. We used the final conversion factor for CY 2005 of \$56.983 and the final CY 2006 conversion factor of \$59.511. Column 6 also contains simulated outlier payments for each year. We used the charge inflation factor used in the final FY 2006 IPPS rule of 7.21 percent to increase individual costs on the CY 2004 claims to reflect CY 2005 dollars, and we used the most recent overall CCR for each hospital as calculated for the APC median setting process. Using the CY 2004 claims and a 7.21 percent charge inflation factor, we currently estimate that actual outlier payments for CY 2005, using a multiple threshold of 1.75 and a fixed-dollar threshold of \$1,175 will be 1.15 percent of total payments, which is .85 percent lower than the 2.0 percent that we projected in setting outlier policies for CY 2005. Outlier payments of only 1.15 percent appear in the CY 2005 comparison in Column 6. We used the same set of claims and a charge inflation factor of 14.94 percent to model the CY 2006 outliers at 1.0 percent of total payments using a multiple threshold of 1.75 and a fixed-dollar threshold of \$1,250.

Column 1: Total Number of Hospitals

Column 1 in Table 39 shows the total number of hospital providers (4,222) for which we were able to use CY 2004 hospital outpatient claims to model CY 2005 and CY 2006 payments by classes of hospitals. We excluded all hospitals for which we could not accurately estimate CY 2005 or CY 2006 payment and entities that are not paid under the OPPS. The latter entities include CAHs, all-inclusive hospitals, and hospitals located in Guam, the U.S. Virgin Islands, and the State of Maryland. This process is discussed in greater detail in section II.A. of this preamble. At this time, we are unable to calculate a disproportionate share (DSH) variable for hospitals not participating in the IPPS. Hospitals for which we do not have a DSH variable are grouped separately and generally include psychiatric hospitals, rehabilitation hospitals, and long-term care hospitals. Finally, section 1833(t)(7)(D) of the Act permanently holds harmless cancer hospitals and children’s hospitals to the proportion of their pre-BBA payment relative to their costs. Because this final rule with comment period will not impact these hospitals negatively, we removed them from our impact analyses. We show the total number (4,162) of OPPS hospitals, excluding the hold-harmless cancer hospitals and children’s hospitals, on the second line of the table.

Column 2: APC Recalibration

The combined effect of APC reclassification and recalibration, including the payment for drugs and biologicals at 106 percent of ASP for acquisition and pharmacy overhead costs, resulted in larger changes in Column 2 than are typically observed for APC recalibration. Overall, these changes have no impact on all urban hospitals, which show no projected change in payments, although some classes of urban hospitals experience decreases in payments. However, changes to the APC structure for CY 2006 tend to favor, slightly, urban hospitals that are not located in large urban areas. We estimate that large urban hospitals will experience a decline of 0.7 percent, while “other” urban hospitals experience an increase of 0.9 percent. Urban hospitals with between 0 and 99 beds and between 100 and 199 beds experience decreases, while the largest urban hospitals, those with beds greater than 500 experience increases of 0.7 percent. With regard to volume, all urban hospitals except those with the highest volume, experience decreases in payments. The lowest

volume hospitals experience the largest decrease of 5.4 percent. Urban hospitals providing the highest volume of services demonstrate a projected increase of 0.2 percent as a result of APC recalibration. Estimated decreases in payment for urban hospitals are also concentrated in some regions, specifically, New England, Pacific, South Atlantic, and Mountain, with the first two experiencing the largest decreases of 1.0 each. On the other hand, a few regions experience moderate increases. Urban hospitals in the East South Central and West North Central regions experience increases of 1.6 and 2.3 percent, respectively.

Overall, rural hospitals show a modest 0.2 percent decrease as a result of changes to the APC structure, and this 0.2 percent decrease appears to be concentrated in rural hospitals that are not rural SCHs, which experience a 0.6 percent increase. Notwithstanding a modest overall decline in payments, there is substantial variation among classes of rural hospitals. Specifically, rural hospitals with less than 100 beds and between 150 and 199 beds experience decreases, with hospitals having less than 50 beds experiencing the largest decrease of 1.6 percent. Rural hospitals with greater than 200 beds experience the largest increase of 1.6 percent. With regard to volume, all rural hospitals, except those with the highest volume, experience decreases in payments. The lowest volume hospitals experience the largest decrease of 5.7 percent. Rural hospitals providing the highest volume of services demonstrate a projected increase of 0.8 percent as a result of APC recalibration. Decreases for rural hospitals occur in every region except West North Central and the Middle Atlantic. The largest decreases are observed in the Pacific (-1.8 percent), New England (-1.4 percent), and West South Central (-1.4 percent) regions. On the other hand, rural hospitals in the Middle Atlantic and West North Central regions experience increases of 1.8 and 3.5 percent, respectively.

Among other classes of hospitals, the largest observed impacts resulting from APC recalibration include declines of 0.6 percent for nonteaching hospitals and increases of 0.4 percent for major teaching hospitals. Hospitals treating the most low-income patients (high DSH percentage) and the least low-income patients demonstrate declines of 0.2 percent. Urban hospitals that are treating DSH patients and are also teaching hospitals experience increases of 0.5 percent. We project that hospitals for which a DSH percentage is not available, including psychiatric

hospitals, rehabilitation hospitals, and long-term care hospitals will experience decreases in payments of 4.5 percent, and for the urban subset, 5.9 percent. Classifying hospitals by type of ownership suggests that proprietary and government hospitals will lose 1.1 and 0.1 percent, respectively, while voluntary hospitals will gain 0.2 percent.

Column 3: New Wage Indices

Changes introduced by the final FY 2006 IPPS wage indices will have a modest impact in CY 2006, increasing payments to rural hospitals slightly and having no effect overall on urban hospitals. We estimate that rural SCHs will experience an increase in payments of 0.1 percent, while all other rural hospitals experience an increase of 0.2 percent. With respect to volume, rural hospitals with the least volume and rural hospitals with moderate volume experience decreases of 0.1 and 0.2 percent, respectively. For both facility size and volume, no category of rural hospitals experiences an increase greater than 0.3 percent. Examining hospitals by region reveals slightly greater variability. We estimate that rural hospitals in several regions will experience decreases in payment up to 0.3 percent due to wage changes, including the Middle Atlantic, South Atlantic, West North Central, and West South Central regions. However, rural hospitals in the remaining regions experience increases. We estimate that the New England region will see the largest increase of 2.2 percent.

Overall, urban hospitals experience no change in payments as a result of the new wage indices. With respect to facility size, we estimate that urban hospitals with between 300 and 499 beds will experience a decrease in payments of 0.2 percent. Urban hospitals with less than 99 beds experience the largest increase of 0.2 percent. When categorized by volume, urban hospitals with the largest volumes experience no change in payment as a result of changes to the wage index, and urban hospitals with the lowest volume experience a 0.4 percent increase in payment. We estimate that urban hospitals in all but the Pacific, New England and the Middle Atlantic regions will experience modest decreases due to wage changes of no more than 0.5 percent (except for urban hospitals in Puerto Rico, with a decrease of 1 percent). Urban hospitals in the Pacific and New England regions will experience an increase of 1.2, and 0.2 percent, respectively. Urban hospitals in the Middle Atlantic region will experience no change in payments.

Looking across other categories of hospitals, we estimate that updating the wage index will lead major teaching hospitals to lose 0.2 percent and hospitals without graduate medical education programs are estimated to gain 0.1 percent. Hospitals serving between 0.0 and 0.10 percent of low-income patients lose up to 0.1 percent, whereas hospitals serving other percentages of low-income patients experience no change. Government, voluntary, and proprietary hospitals as classes will experience no change in payment due to wage changes.

Column 4: New Adjustment for Rural SCHs

As discussed in section II.G. of this preamble, we have increased payments for all services except drugs and biologicals to rural SCHs by 7.1 percent. This resulted in an adjustment to the conversion factor of 0.996. Targeting payments to these rural hospitals uniformly reduces payments to all other hospitals by 0.4 percent. The uniform reduction for all urban and other rural hospitals is evident in Column 4. The periodic appearance of a -0.3 among urban classes of hospitals is due to the difference between the definition of rural used for this impact table and the broader definition of rural employed for the adjustment for rural SCHs. SCHs located in urban areas that are reclassified as rural for wage index purposes are eligible for the adjustment. The observed increase of 5.6 percent for rural SCHs is lower than 7.1 percent because drugs and biologicals do not receive the payment adjustment. The remaining classes of rural hospitals show variable increases that reflect the distribution of rural SCHs. The largest increases are observed among rural hospitals with small numbers of beds, with moderate volume, and regions in the western half of the country.

Column 5: All Budget Neutrality Changes and Market Basket Update

The addition of the market basket update alleviates any negative impacts on payments for CY 2006 created by the budget neutrality adjustments made in Columns 2, 3, and 4, with the exception of hospitals with the lowest volume of services and hospitals not paid under IPPS, including psychiatric hospitals, rehabilitation hospitals, and long-term care hospitals. In many instances, the redistribution of payments created by APC recalibration offset those introduced by updating the wage indices. However, in a few instances, negative APC recalibration changes compound a reduction in payment from updating the wage index. In addition,

all urban and rural hospitals that are not SCHs experience a decrease in payment of 0.4 percent as a result of the payment adjustment for rural SCHs.

We estimate that the cumulative impact of the budget neutrality adjustments and the addition of the market basket update will result in an increase in payments for urban hospitals of 3.3 percent, which is less than the market basket update of 3.7 percent. Large urban hospitals will experience an increase of 2.5 percent and other urban hospitals will experience an increase of 4.2 percent. Most other classes of urban hospitals experience updates lower than the market basket update. Urban hospitals with the lowest volume experience a negative market basket update, which is largely a function of the 5.4 percent decrease in payments attributable to changes to the APC structure. Urban hospitals with moderate volume will also lose the bulk of the market basket update as a result of a 2.9 percent decrease resulting from the APC recalibration and the addition of the payment adjustment for rural SCHs. The same compounding effect holds true for urban hospitals in the New England and South Atlantic regions and Puerto Rico, which experience the lowest overall increases of 2.5, 2.3, and 1.4 percent, respectively. Urban hospitals in the East South Central and West North Central regions experience increases in payment for CY 2006 above the market basket update.

We estimate that the cumulative impact of budget neutrality adjustments and the market basket update will result in an overall increase for rural hospitals of 5.7 percent, with rural SCHs experiencing an update of 10.2 percent and other rural hospitals experiencing an update of 2.9 percent. In general, rural hospitals with more than 50 beds and the highest volume rural hospitals experience increases of more than 5.3 percent, which generally results from the combined impact of increases in payment from APC recalibration, wage changes, and the new adjustment for rural SCHs. We estimate that low-volume rural hospitals will experience a decrease in payments of 1.1 percent, which results from the combined impact of decreased payments attributable to APC recalibration and wage index update that are larger than the estimated 1.2 percent increase from the adjustment for rural SCHs. Rural hospitals also demonstrate large increases by region. We estimate that all regions except East South Central will experience increases larger than the market basket update. For these regions, in aggregate, the payment adjustment for rural SCHs compensates for observed

decreases in payment due to APC recalibration or the update for the wage indices.

The changes across columns for other classes of hospitals are fairly moderate and most show updates relatively close to the market basket update with the exception of hospitals not paid under the IPPS. These hospitals show negative payment updates as a result of negative payment changes for APC recalibration and the adjustment for rural SCHs. Proprietary hospitals also show an increase much less than the market basket as a result of negative payments under APC recalibration.

Column 6: All Changes for CY 2006

Column 6 compares all changes for CY 2006 to final payment for CY 2005 and includes any additional dollars resulting from provisions in Pub. L. 108–173 in both years, changes in outlier payment percentages and thresholds, and the difference in pass-through estimates. Overall, we estimate that hospitals will gain 2.2 percent under this final rule with comment period in CY 2006 relative to total spending in CY 2005, which included Pub. L. 108–173 dollars for drugs and wage indices. When we excluded cancer and children's hospitals, which are held harmless, the gain is 2.3 percent. While hospitals receive the 3.7 percent increase due to the market basket update appearing in Column 5 and the additional 0.85 percent in outlier payments that we estimate as not being paid in CY 2005, we estimate that hospitals also experience an overall 2.25 percent loss due to the expiration of additional payment for drugs in CY 2005, as well as a 0.07 percent reduction due to the change in estimated pass-through payments for CY 2006. That is, without the net additional 0.78 (0.85–0.07) percent increase in outlier payments due to lower than expected payment for outliers in CY 2005, hospitals will receive a positive increase in payments of 1.5 percent. Paying the net additional 0.78 percent in CY 2006 increases overall gains to 2.2 (rounded 2.23) percent, which is lower than the market basket update. The change in the outlier thresholds has a small redistributive impact by class of hospital and the vast majority of redistributive impacts observed between Columns 5 and 6 can be attributed to the loss of additional payment for drugs outside budget neutrality required by Pub. L. 108–173. The redistributive impact of the change in the outlier target from 2 to 1 percent is discussed in greater detail under section XIX.F. of this preamble.

In general, urban hospitals appear to experience the largest negative impacts from the combined effects of losing additional payments for drugs, the decreases in payment from the payment adjustment for rural SCHs, and, frequently, negative changes in payments due to APC recalibration. We estimate that hospitals in large urban areas will gain 1.2 percent in CY 2006 and hospitals in other urban areas will gain 2.8 percent. We estimate that low-volume urban hospitals will experience a decrease in total payments of 1.0 percent between CY 2005 and CY 2006. This negative update includes the cumulative effect of negative payments from APC recalibration, a negative impact of the payment adjustment for rural SCHs, a loss of payments outside budget neutrality for drugs and a loss of some outlier payments. All other classes of urban hospitals show increases between 0.4 and 3.8 percent. We note that urban hospitals in the East South Central and West North Central regions are estimated to receive slightly more than the market basket in spite of expiring drug payments, the largest increases for urban hospitals.

Overall, rural hospitals experience larger increases than those observed for urban hospitals because the payment adjustment for rural SCHs tends to buffer the loss of payments for drugs from Pub. L. 108–173. However, this adjustment is only for rural SCHs. Overall, we estimate that rural hospitals will experience an increase in payments of 3.9 percent. However, we also estimate that rural SCHs will experience an increase of 7.6 percent, and that the other rural hospitals will only experience an increase of 1.5 percent. With the exception of low-volume rural hospitals, no category of rural hospitals experiences a decrease in payments between CY 2005 and CY 2006, and a few groups of rural hospitals show increases comparable to, or better than, the market basket. For example, rural hospitals with more than 100 beds experience increases of at least 4.1 percent. Rural hospitals with moderate to high volume experience increases of no less than 2.8 percent. Across the regions, all rural hospitals except those in the New England and East North Central regions experience increases in payments greater than 3.2 percent. Rural hospitals in the West North Central region experience an increase of 6.1 percent. We project that low-volume rural hospitals, like low-volume urban hospitals, will experience a decrease in payments of 2.2 percent (due to decreases in payments for mid-level and high-level emergency visits).

Among other classes of hospitals, we estimate that hospitals not paid under the IPPS (DSH Not Available) will experience decreases in payments

between CY 2005 and CY 2006 of 1.5 percent. Factoring in expiring payments for drugs through Pub. L. 108-173, we estimate that major teaching hospitals

will experience an increase of 1.0 percent.

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**Table 39.—Impact of Changes for CY 2006
Hospital Outpatient Prospective Payment System**

| | (1) | (2) | (3) | (4) | (5) | (6) |
|---|---------------------------|----------------|----------------------|--|---|----------------|
| | Number of Hospitals | APC Changes | New Wage Index | New Adjustment for Rural Sole Community Hospitals | Cumulative (cols 2,3,4) with Market Basket Update | All Changes |
| ALL HOSPITALS¹ | 4,222 | 0.0 | 0.0 | 0.0 | 3.7 | 2.2 |
| ALL HOSPITALS (excludes hospitals held harmless) | 4,162 | 0.0 | 0.0 | 0.0 | 3.7 | 2.3 |
| URBAN HOSPITALS | 2,977 | 0.0 | 0.0 | -0.4 | 3.3 | 2.0 |
| LARGE URBAN (GT 1 MILL.) | 1,619 | -0.7 | 0.0 | -0.4 | 2.5 | 1.2 |
| OTHER URBAN (LE 1 MILL.) | 1,358 | 0.9 | 0.0 | -0.4 | 4.2 | 2.8 |
| RURAL HOSPITALS | 1,185 | -0.2 | 0.2 | 2.0 | 5.7 | 3.9 |
| SOLE COMMUNITY | 455 | 0.6 | 0.1 | 5.6 | 10.2 | 7.6 |
| OTHER RURAL | 730 | -0.7 | 0.2 | -0.4 | 2.9 | 1.5 |
| BEDS (URBAN) | | | | | | |
| 0 - 99 BEDS | 972 | -0.8 | 0.2 | -0.3 | 2.8 | 2.4 |
| 100-199 BEDS | 951 | -0.6 | 0.1 | -0.4 | 2.7 | 1.7 |
| 200-299 BEDS | 486 | 0.2 | 0.0 | -0.4 | 3.6 | 2.6 |
| 300-499 BEDS | 406 | 0.2 | -0.2 | -0.4 | 3.3 | 1.9 |
| 500 + BEDS | 162 | 0.7 | -0.1 | -0.4 | 3.9 | 1.5 |
| BEDS (RURAL) | | | | | | |
| 0 - 49 BEDS | 502 | -1.6 | 0.2 | 2.3 | 4.7 | 3.1 |
| 50- 100 BEDS | 401 | -1.0 | 0.3 | 2.4 | 5.4 | 3.7 |
| 101- 149 BEDS | 173 | 0.7 | 0.0 | 1.3 | 5.9 | 4.6 |
| 150- 199 BEDS | 62 | -0.4 | 0.0 | 1.9 | 5.3 | 4.1 |
| 200 + BEDS | 47 | 1.6 | 0.2 | 1.8 | 7.5 | 4.2 |
| VOLUME (URBAN) | | | | | | |
| LT 5,000 | 590 | -5.4 | 0.4 | -0.4 | -1.9 | -1.0 |
| 5,000 - 10,999 | 170 | -2.9 | 0.1 | -0.4 | 0.5 | 0.7 |
| 11,000 - 20,999 | 304 | -1.1 | 0.3 | -0.3 | 2.5 | 2.1 |
| 21,000 - 42,999 | 557 | -0.7 | 0.0 | -0.4 | 2.6 | 2.2 |
| GT 42,999 | 1,356 | 0.2 | 0.0 | -0.4 | 3.5 | 2.0 |

| | (1) | (2) | (3) | (4) | (5) | (6) |
|---|---------------------------|----------------|----------------------|--|---|----------------|
| | Number of Hospitals | APC Changes | New Wage Index | New Adjustment for Rural Sole Community Hospitals | Cumulative (cols 2,3,4) with Market Basket Update | All Changes |
| VOLUME (RURAL) | | | | | | |
| LT 5,000 | 100 | -5.7 | -0.1 | 1.2 | -1.1 | -2.2 |
| 5,000 - 10,999 | 152 | -2.6 | 0.2 | 2.4 | 3.7 | 2.8 |
| 11,000 - 20,999 | 284 | -1.7 | -0.2 | 2.3 | 4.1 | 3.1 |
| 21,000 - 42,999 | 370 | -1.3 | 0.2 | 2.1 | 4.7 | 3.4 |
| GT 42,999 | 279 | 0.8 | 0.2 | 1.9 | 6.7 | 4.4 |
| REGION (URBAN) | | | | | | |
| NEW ENGLAND | 164 | -1.0 | 0.2 | -0.4 | 2.5 | 1.0 |
| MIDDLE ATLANTIC | 392 | 0.4 | 0.0 | -0.4 | 3.7 | 2.2 |
| SOUTH ATLANTIC | 451 | -0.5 | -0.5 | -0.4 | 2.3 | 1.2 |
| EAST NORTH CENTRAL | 469 | 0.1 | -0.2 | -0.4 | 3.2 | 1.7 |
| EAST SOUTH CENTRAL | 199 | 1.6 | -0.1 | -0.4 | 4.8 | 3.8 |
| WEST NORTH CENTRAL | 190 | 2.3 | -0.3 | -0.3 | 5.4 | 3.8 |
| WEST SOUTH CENTRAL | 469 | 0.2 | -0.1 | -0.4 | 3.3 | 2.2 |
| MOUNTAIN | 170 | -0.2 | -0.3 | -0.3 | 2.9 | 1.5 |
| PACIFIC | 422 | -1.0 | 1.2 | -0.4 | 3.4 | 2.0 |
| PUERTO RICO | 51 | -0.8 | -1.0 | -0.4 | 1.4 | 0.4 |
| REGION (RURAL) | | | | | | |
| NEW ENGLAND | 29 | -1.4 | 2.2 | 1.3 | 5.7 | 2.2 |
| MIDDLE ATLANTIC | 76 | 1.8 | -0.2 | 1.6 | 7.0 | 5.3 |
| SOUTH ATLANTIC | 181 | -0.8 | -0.3 | 1.8 | 4.4 | 3.2 |
| EAST NORTH CENTRAL | 161 | -1.0 | 0.1 | 1.7 | 4.5 | 2.6 |
| EAST SOUTH CENTRAL | 199 | -1.2 | 0.6 | 0.6 | 3.6 | 3.0 |
| WEST NORTH CENTRAL | 176 | 3.5 | -0.3 | 2.5 | 9.6 | 6.1 |
| WEST SOUTH CENTRAL | 224 | -1.4 | -0.1 | 2.5 | 4.7 | 3.8 |
| MOUNTAIN | 87 | -1.3 | 0.4 | 5.1 | 7.9 | 6.0 |
| PACIFIC | 52 | -1.8 | 1.9 | 3.0 | 6.9 | 4.8 |
| TEACHING STATUS | | | | | | |
| NON-TEACHING | 3,106 | -0.6 | 0.1 | 0.3 | 3.5 | 2.4 |
| MINOR | 768 | 0.6 | 0.0 | -0.2 | 4.1 | 2.8 |
| MAJOR | 288 | 0.4 | -0.2 | -0.4 | 3.5 | 1.0 |
| DSH PATIENT PERCENT | | | | | | |
| 0 | 8 | -0.3 | 0.7 | -0.4 | 3.7 | 9.4 |
| GT 0 - 0.10 | 441 | 0.1 | -0.1 | -0.3 | 3.4 | 2.2 |
| 0.10 - 0.16 | 555 | 0.0 | 0.0 | 0.2 | 4.0 | 3.0 |
| 0.16 - 0.23 | 798 | 0.1 | 0.0 | 0.1 | 3.9 | 2.4 |
| 0.23 - 0.35 | 951 | 0.1 | 0.0 | 0.0 | 3.8 | 2.2 |
| GE 0.35 | 769 | -0.2 | 0.0 | -0.1 | 3.4 | 1.7 |
| DSH NOT AVAILABLE ² (Not IPPS) | 640 | -4.5 | 0.3 | -0.4 | -1.1 | -1.5 |
| URBAN TEACHING/DSH | | | | | | |

| | (1) | (2) | (3) | (4) | (5) | (6) |
|---|---------------------|-------------|----------------|---|---|-------------|
| | Number of Hospitals | APC Changes | New Wage Index | New Adjustment for Rural Sole Community Hospitals | Cumulative (cols 2,3,4) with Market Basket Update | All Changes |
| TEACHING & DSH | 952 | 0.5 | -0.1 | -0.4 | 3.7 | 2.0 |
| TEACHING/NO DSH | 0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| NO TEACHING/DSH | 1,454 | -0.5 | 0.1 | -0.3 | 2.9 | 1.9 |
| NO TEACHING/NO DSH | 8 | -0.3 | 0.7 | -0.4 | 3.7 | 9.4 |
| DSH NOT AVAILABLE ² (Not IPPS) | 563 | -5.9 | 0.1 | -0.4 | -2.7 | -2.5 |
| TYPE OF OWNERSHIP | | | | | | |
| VOLUNTARY | 2,319 | 0.2 | 0.0 | 0.0 | 3.9 | 2.4 |
| PROPRIETARY | 1,158 | -1.1 | 0.0 | 0.0 | 2.6 | 1.9 |
| GOVERNMENT | 685 | -0.1 | 0.0 | 0.3 | 3.9 | 1.9 |

Column (1) shows total hospitals in CY 2006.

Column (2) shows the impact of changes resulting from the reclassification of HCPCS codes among APC groups and the recalibration of APC weights based on CY 2004 hospital claims data. Column (3) shows the impact of updating the wage index used to calculate payment by applying the FY 2006 hospital inpatient wage indices.

Column (4) shows the impact of the budget neutral rural adjustment.

Column (5) shows the impact of all budget neutrality adjustments and the addition of the market basket update.

Column (6) shows the additional adjustments to the conversion factor resulting from a change in the outlier pool and pass-through estimates, and adds outlier payments.

¹These 4,222 hospitals include children and cancer hospitals which are held harmless to pre-BBA payments

²Complete DSH numbers are not available for providers that are not paid under IPPS, including rehabilitation, psychiatric, and long-term care hospitals.

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F. Estimated Impact of the Change in Outlier Policy

As stated in section II.H. of this preamble, we are changing the percentage of payments that we have set aside for outlier payments from 2.0 percent to 1.0 percent. In order to accommodate this reduction in outlier payments, we increased the fixed-dollar threshold to \$1,250. This threshold changed from the \$1,575 in the proposed rule because we used updated claims, final rule APC payment rates, an updated charge inflation factor of 14.94 percent, and each hospital's overall CCR that we calculate as part of our APC median estimation process.

Table 40 shows the impact of reducing the amount of total aggregate OPPS payments set aside for outlier payments to 1.0 percent of CY 2006 payments. Column 2 compares estimated CY 2006 total payments with a 1.0 percent outlier policy and an additional 1.0 percent of total payments in the conversion factor with estimated

CY 2006 total payment under a 2.0 percent policy. Using updated claims data, a new charge inflation factor, new APC payment rates, and CCRs, we estimate that the fixed-dollar threshold associated with a 2.0 percent outlier policy would have been \$550. We used this fixed-dollar threshold to model the 2.0 percent outlier policy. All other components of the payment system are held constant, including the multiple threshold of 1.75 times the APC payment rate. This impact differs from any impact attributable to outlier payments in Table 40 because the comparison here is within estimates of CY 2006 and not across CY 2005 and CY 2006. We expect that this policy change would slightly redistribute payments away from hospitals receiving a lot of outlier payments to hospitals generally not receiving outlier payments. We also would expect the losses to be concentrated in a few classes of hospitals and the benefits to be diffused across all other classes of hospitals.

Table 40 depicts small changes in total payments across all classes of

hospitals from reducing the amount of total payments set aside for outlier payments from 2.0 percent to 1.0 percent. As expected, modest reductions in total payments are observed for hospitals that probably receive a larger percentage of their total payments as outlier payments, including major teaching hospitals and large urban hospitals. We estimate that major teaching hospitals will experience a decrease of 0.7 percent in total payments and that large urban hospitals will experience a decrease of 0.1 percent in total payments. These same hospitals are also responsible for the 0.4 percent decrease in total payments for urban hospitals with more than 500 beds, the 0.1 percent decrease for teaching hospitals with a disproportionate share of low-income patients, and the 0.5 percent decrease for hospitals serving a large percentage of low-income patients. Also evident are slight increases in total payments for most other hospitals arising from the increase in the conversion factor. For example, rural hospitals gain 0.2 percent overall. The

decreases in total payments for low-volume rural and low-volume urban hospitals appear to be attributable to a

concentrated loss of outlier payments for moderate cost and moderate

complexity services that fail to meet the higher fixed-dollar threshold.

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**Table 40.—Impact of Changes in Outlier Percentages for CY 2006
Hospital Outpatient Prospective Payment System**

| | (1) | (2) |
|---|---------------------|---------------------------------------|
| | Number of Hospitals | Percent Change in Total 2006 Payments |
| ALL HOSPITALS¹ | 4,222 | 0.0 |
| ALL HOSPITALS (excludes hospitals held harmless) | 4,162 | 0.0 |
| URBAN HOSPS | 2,977 | 0.0 |
| LARGE URBAN (GT 1 MILL.) | 1,619 | -0.1 |
| OTHER URBAN (LE 1 MILL.) | 1,358 | 0.2 |
| RURAL HOSPS | 1,185 | 0.2 |
| SOLE COMMUNITY | 455 | 0.2 |
| OTHER RURAL | 730 | 0.2 |
| BEDS (URBAN) | | |
| 0 - 99 BEDS | 972 | -0.1 |
| 100-199 BEDS | 951 | 0.1 |
| 200-299 BEDS | 486 | 0.2 |
| 300-499 BEDS | 406 | 0.1 |
| 500 + BEDS | 162 | -0.4 |
| BEDS (RURAL) | | |
| 0 - 49 BEDS | 502 | -0.4 |
| 50- 100 BEDS | 401 | 0.2 |
| 101- 149 BEDS | 173 | 0.5 |
| 150- 199 BEDS | 62 | 0.2 |
| 200 + BEDS | 47 | 0.5 |
| VOLUME (URBAN) | | |
| LT 5,000 | 590 | -0.3 |
| 5,000 - 10,999 | 170 | -0.5 |
| 11,000 - 20,999 | 304 | -0.3 |
| 21,000 - 42,999 | 557 | 0.1 |
| GT 42,999 | 1,356 | 0.0 |
| VOLUME (RURAL) | | |
| LT 5,000 | 100 | -0.8 |
| 5,000 - 10,999 | 152 | -0.8 |
| 11,000 - 20,999 | 284 | -0.3 |
| 21,000 - 42,999 | 370 | 0.1 |
| GT 42,999 | 279 | 0.4 |
| REGION (URBAN) | | |
| NEW ENGLAND | 164 | -0.3 |
| MIDDLE ATLANTIC | 392 | -0.4 |
| SOUTH ATLANTIC | 451 | 0.3 |
| EAST NORTH CENT. | 469 | 0.0 |
| EAST SOUTH CENT. | 199 | 0.5 |
| WEST NORTH CENT. | 190 | 0.3 |
| WEST SOUTH CENT. | 469 | 0.1 |
| MOUNTAIN | 170 | 0.1 |
| PACIFIC | 422 | -0.2 |
| PUERTO RICO | 51 | -0.3 |
| REGION (RURAL) | | |
| NEW ENGLAND | 29 | 0.1 |
| MIDDLE ATLANTIC | 76 | 0.1 |
| SOUTH ATLANTIC | 181 | 0.4 |
| EAST NORTH CENT. | 161 | 0.1 |
| EAST SOUTH CENT. | 199 | 0.5 |
| WEST NORTH CENT. | 176 | 0.2 |
| WEST SOUTH CENT. | 224 | 0.2 |
| MOUNTAIN | 87 | -0.4 |
| PACIFIC | 52 | -0.6 |
| TEACHING STATUS | | |
| NON-TEACHING | 3,106 | 0.2 |
| MINOR | 768 | 0.2 |
| MAJOR | 288 | -0.7 |
| DSH PATIENT PERCENT | | |

| | (1) | (2) |
|---|---------------------|---------------------------------------|
| | Number of Hospitals | Percent Change in Total 2006 Payments |
| 0 | 8 | -0.3 |
| GT 0 - 0.10 | 441 | 0.0 |
| 0.10 - 0.16 | 555 | 0.2 |
| 0.16 - 0.23 | 798 | 0.2 |
| 0.23 - 0.35 | 951 | 0.2 |
| GE 0.35 | 769 | -0.5 |
| DSH NOT AVAILABLE ² (Not IPPS) | 640 | -0.2 |
| URBAN TEACHING/DSH | | |
| TEACHING & DSH | 952 | -0.1 |
| TEACHING/NO DSH | 0 | 0.0 |
| NO TEACHING/DSH | 1,454 | 0.2 |
| NO TEACHING/NO DSH | 8 | -0.3 |
| DSH NOT AVAILABLE ² (Not IPPS) | 563 | 0.1 |
| TYPE OF OWNERSHIP | | |
| VOLUNTARY | 2,319 | 0.0 |
| PROPRIETARY | 1,158 | 0.4 |
| GOVERNMENT | 685 | -0.2 |

Column (1) shows total number of hospitals in CY 2006.

Column (2) shows the impact of reducing outlier payments from 2 percent to 1 percent of total OPPS payments. This column does not include payments under section 508 of Pub. L. 108-173 (MMA).

¹ The 4,222 hospitals include children's and cancer hospitals which are held harmless to pre-BBA payments.

² Complete DSH numbers are not available for providers that are not paid under the IPPS, including rehabilitation, psychiatric, and long-term care hospitals.

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G. Accounting Statement

As required by OMB Circular A-4 (available at <http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf>, in Table 41

below, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this final rule with comment period. This table provides our best estimate of the increase in

Medicare payments under the OPPS as a result of the changes presented in this final rule with comment period based on the data for 4,222 hospitals. All expenditures are classified as transfers to Medicare providers (that is, OPPS).

TABLE 41.—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES FROM CY 2005 TO CY 2006

| Category | Transfers |
|--------------------------------------|---|
| Annualized Monetized Transfers | \$660 Billion. |
| From Whom to Whom | Federal Government to OPPS Medicare Providers. |
| Category | Reduction in Costs. |
| Annualized Monetized Reduction | \$436 Million. |
| From Whom to Whom | Reduction in Payments from Beneficiaries to Federal Government. |
| Total | \$1.1 Billion. |

H. Estimated Impacts of This Final Rule With Comment Period on Beneficiaries

For services for which the beneficiary pays a copayment of 20 percent of the payment rate, the beneficiary share of payment will increase for services for

which OPPS payments will rise and will decrease for services for which OPPS payments will fall. For example, for a mid-level office visit (APC 0601), the minimum unadjusted copayment in CY 2005 was \$11.22. In this final rule with

comment period, the minimum unadjusted copayment for APC 601 is \$12.05 because the OPPS payment for the service will increase under this final rule with comment period, and there is no national unadjusted copayment. In

another example, for a Level IV Needle Biopsy (APC 0037), in the CY 2005 OPPS, the national unadjusted copayment in CY 2005 was \$234.20, and the minimum unadjusted copayment was \$106.47. In this final rule with comment period, the national unadjusted copayment for APC 0037 is \$228.76 because the national unadjusted copayment is limited to 40 percent of the APC payment rate for CY 2006, as discussed in section II. of the preamble to this final rule with comment period. The minimum unadjusted copayment for APC 0037 is \$114.38. However, in all cases, the statute limits beneficiary liability for copayment for a service to the inpatient hospital deductible for the applicable year. For 2006, the inpatient deductible is \$952.

In order to better understand the impact of changes in copayment on beneficiaries we modeled the percent change in total copayment liability using CY 2004 claims. We estimate that total beneficiary liability for copayments will decline as an overall percentage of total payments from 33 percent in CY 2005 to 29 percent in CY 2006. This represents a decline in beneficiary liability of more than \$400 million from the CY 2005 OPPS to the CY 2006 OPPS.

Conclusion

The changes in this final rule with comment period will affect all classes of hospitals. Some hospitals experience significant gains and others less significant gains, but almost all hospitals will experience positive updates in OPPS payments in CY 2006. Table 39 demonstrates the estimated distributional impact of the OPPS budget neutrality requirements and an additional 2.2 percent increase in payments for CY 2006, after considering the expiring provision for additional drug payment under Pub. L. 108-173 and a change in the percentage of total payments dedicated to outliers and transitional pass-through payments, exclusive of transitional pass-through payments, across various classes of hospitals. The accompanying discussion, in combination with the rest of this final rule with comment period constitutes a regulatory impact analysis.

In accordance with the provisions of Executive Order 12866, this final rule with comment period was reviewed by the Office of Management and Budget.

XX. Waiver of Proposed Rulemaking

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite public comment on the proposed rule. The notice of proposed rulemaking includes a

reference to the legal authority under which the rule is proposed, and the terms and substances of the proposed rule or a description of the subjects and issues involved. This procedure can be waived, however, if an agency finds good cause that a notice-and-comment procedure is impracticable, unnecessary, or contrary to the public interest and incorporates a statement of the finding and its reasons in the rule issued.

As established in regulations, HCPCS codes are used to identify services for which predetermined amounts are paid under the OPPS (42 CFR 419.2(a)). The HCPCS is a national coding system comprised of Level I (CPT) codes and Level II (HCPCS National Codes) that are intended to provide uniformity to coding procedures, services, and supplies across all types of medial providers and suppliers. Level I (CPT) codes are copyrighted by the AMA and consist of several categories, including Category I codes which are five-digit numeric codes, and Category II codes which are temporary codes to track emerging technology, services, and procedures, as we discuss elsewhere in this preamble.

AMA issues an annual update of the CPT code set each fall, with January 1 as the effective date for implementing the updated CPT codes. The HCPCS, including both Level I and Level II codes, is similarly updated annually on a calendar year basis. Annual coding changes are not available to the public until the fall immediately preceding the annual January update of the OPPS. Because of the timing of the release of these codes, it is impracticable for us to provide prior notice and solicit comment on these codes in advance of the publication of the annual final rule that implements the OPPS update. Yet it is imperative that these codes be accounted for and recognized timely under the OPPS for payment because services represented by these codes will be provided to Medicare beneficiaries by outpatient hospital departments once issued by the applicable group. Moreover, as we explain above, regulations implementing HIPAA (42 CFR parts 160 and 162) require that the HCPCS be used to report health care services, including outpatient services paid under the OPPS. Therefore, we believe it would be contrary to the public interest to delay recognition of these codes as payment could not then be made for those services provided under these codes and public access to these services would be impeded.

Therefore, for good cause, we waive notice and comment rulemaking procedures with respect to these codes

noted in Addendum B with the status indicator "NI." However, we are providing a 60-day public comment period on these codes.

List of Subjects

42 CFR Part 419

Hospitals, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 485

Grant program-health, Health facilities, Medicaid, Medicare, Reporting and recordkeeping requirements.

■ For the reasons stated in the preamble of this final rule with comment period, the Centers for Medicare & Medicaid Services is amending 42 CFR Chapter IV as set forth below:

PART 419—PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES

■ A. Part 419 is amended as follows:
 ■ 1. The authority citation for Part 419 continues to read as follows:

Authority: Secs. 1102, 1833(t), and 1871 of the Social Security Act (42 U.S.C. 1302, 1395l(t), and 1395hh).

■ 2. Section 419.43 is amended by adding a new paragraph (g) to read as follows:

§ 419.43 Adjustments to national program payment and beneficiary copayment amounts.

* * * * *

(g) *Payment adjustment for certain rural hospitals.* (1) *General rule.* CMS provides for additional payment for covered hospital outpatient services not excluded under paragraph (g)(4) of this section, furnished on or after January 1, 2006, if the hospital—

(i) Is a sole community hospital under § 412.92 of this chapter; and
 (ii) Is located in a rural area as defined in § 412.64(b) of this chapter or is treated as being located in a rural area under § 412.103 of this chapter.

(2) *Amount of adjustment.* The amount of the additional payment under paragraph (g)(1) of this section is determined by CMS and is based on the difference between costs incurred by hospitals that meet the criteria in paragraphs (g)(1)(i) and (g)(1)(ii) of this section and costs incurred by hospitals located in urban areas.

(3) *Budget neutrality.* CMS establishes the payment adjustment under paragraph (g)(2) of this section in a budget neutral manner, excluding services and groups specified in paragraph (g)(4) of this section.

(4) *Excluded services and groups.* Drugs and biologicals that are paid

under a separate APC and devices of brachytherapy consisting of a seed or seeds (including a radioactive source) are excluded from qualification for the payment adjustment in paragraph (g)(2) of this section.

(5) *Copayment.* The payment adjustment in paragraph (g)(2) of this section is applied before calculating copayment amounts.

(6) *Outliers.* The payment adjustment in paragraph (g)(2) of this section is applied before calculating outlier payments.

■ 3. Section 419.66 is amended by revising paragraph (c)(1) to read as follows:

§ 419.66 Transitional pass-through payments: Medical devices.

* * * * *

(c) *Criteria for establishing device categories.* * * *

(1) CMS determines that a device to be included in the category is not appropriately described by any of the existing categories or by any category previously in effect, and was not being paid for as an outpatient service as of December 31, 1996.

* * * * *

PART 485—CONDITIONS OF PARTICIPATION: SPECIALIZED PROVIDERS

■ B. Part 485 is amended as follows:

■ 1. The authority citation for Part 485 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

■ 2. Section 485.631 is amended by—

■ a. Republishing paragraph (b)(1) introductory text.

■ b. Revising paragraph (b)(1)(iv).

■ c. Adding new paragraphs (b)(1)(v) and (b)(1)(vi).

The revision and additions read as follows:

§ 485.631 Condition of participation: Staffing and staff responsibilities.

* * * * *

(b) *Standard: Responsibilities of the doctor of medicine or osteopathy.* (1)

The doctor of medicine or osteopathy—

* * * * *

(iv) Periodically reviews and signs the records of all inpatients cared for by nurse practitioners, clinical nurse specialists, certified nurse midwives, or physician assistants.

(v) Periodically, but not less than every 2 weeks, reviews and signs a sample of outpatient records of patients cared for by nurse practitioners, clinical

nurse specialists, certified nurse midwives, or physician assistants according to the policies of the CAH and according to current standards of practice where State law requires record reviews or co-signatures, or both, by a collaborating physician.

(vi) Is not required to review and sign outpatient records of patients cared for by nurse practitioners, clinical nurse specialists, certified nurse midwives, or physician assistants where State law does not require record reviews or co-signatures, or both, by a collaborating physician.

* * * * *

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: October 26, 2005.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

Dated: November 1, 2005.

Michael O. Leavitt,

Secretary.

Editorial Note: The following Addenda will not be published in the Code of Federal Regulations.

BILLING CODE 4120-01-P

**Addendum A.—List of Ambulatory Payment Classifications (APCs) With Status Indicators,
Relative Weights, Payment Rates, and Copayment Amounts
Calendar Year 2006**

| APC | Group Title | SI | Relative Weight | Payment Rate | National Unadjusted Copayment | Minimum Unadjusted Copayment |
|------|--|----|-----------------|--------------|-------------------------------|------------------------------|
| 0001 | Level I Photochemotherapy | S | 0.3998 | \$ 23.79 | \$ 7.00 | \$ 4.76 |
| 0002 | Level I Fine Needle Biopsy/Aspiration | T | 0.9357 | \$ 55.68 | . | \$ 11.14 |
| 0003 | Bone Marrow Biopsy/Aspiration | T | 2.6756 | \$ 159.23 | . | \$ 31.85 |
| 0004 | Level I Needle Biopsy/ Aspiration Except Bone Marrow | T | 1.7771 | \$ 105.76 | \$ 22.36 | \$ 21.15 |
| 0005 | Level II Needle Biopsy/Aspiration Except Bone Marrow | T | 3.5834 | \$ 213.25 | \$ 71.59 | \$ 42.65 |
| 0006 | Level I Incision & Drainage | T | 1.5100 | \$ 89.86 | \$ 21.76 | \$ 17.97 |
| 0007 | Level II Incision & Drainage | T | 11.6717 | \$ 694.59 | . | \$ 138.92 |
| 0008 | Level III Incision and Drainage | T | 16.2953 | \$ 969.75 | . | \$ 193.95 |
| 0009 | Nail Procedures | T | 0.7513 | \$ 44.71 | . | \$ 8.94 |
| 0010 | Level I Destruction of Lesion | T | 0.5923 | \$ 35.25 | \$ 9.65 | \$ 7.05 |
| 0011 | Level II Destruction of Lesion | T | 2.2274 | \$ 132.55 | \$ 26.98 | \$ 26.51 |
| 0012 | Level I Debridement & Destruction | T | 0.8477 | \$ 50.45 | \$ 11.18 | \$ 10.09 |
| 0013 | Level II Debridement & Destruction | T | 1.0603 | \$ 63.10 | \$ 13.07 | \$ 12.62 |
| 0015 | Level III Debridement & Destruction | T | 1.6338 | \$ 97.23 | \$ 20.13 | \$ 19.45 |
| 0016 | Level IV Debridement & Destruction | T | 2.5080 | \$ 149.25 | \$ 32.68 | \$ 29.85 |
| 0017 | Level VI Debridement & Destruction | T | 17.9937 | \$ 1,070.82 | \$ 227.84 | \$ 214.16 |
| 0018 | Biopsy of Skin/Puncture of Lesion | T | 1.1010 | \$ 65.52 | \$ 16.04 | \$ 13.10 |
| 0019 | Level I Excision/ Biopsy | T | 4.1481 | \$ 246.86 | \$ 71.87 | \$ 49.37 |
| 0020 | Level II Excision/ Biopsy | T | 6.9410 | \$ 413.07 | \$ 107.67 | \$ 82.61 |
| 0021 | Level III Excision/ Biopsy | T | 14.9984 | \$ 892.57 | \$ 219.48 | \$ 178.51 |
| 0022 | Level IV Excision/ Biopsy | T | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 0023 | Exploration Penetrating Wound | T | 4.7662 | \$ 283.64 | . | \$ 56.73 |
| 0024 | Level I Skin Repair | T | 1.5513 | \$ 92.32 | \$ 30.23 | \$ 18.46 |
| 0025 | Level II Skin Repair | T | 5.3051 | \$ 315.71 | \$ 101.85 | \$ 63.14 |
| 0027 | Level IV Skin Repair | T | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 0028 | Level I Breast Surgery | T | 19.4351 | \$ 1,156.60 | \$ 303.74 | \$ 231.32 |
| 0029 | Level II Breast Surgery | T | 31.4826 | \$ 1,873.56 | \$ 632.64 | \$ 374.71 |
| 0030 | Level III Breast Surgery | T | 39.9779 | \$ 2,379.12 | \$ 763.55 | \$ 475.82 |
| 0033 | Partial Hospitalization | P | 4.1322 | \$ 245.91 | . | \$ 49.18 |
| 0035 | Venous Cutdown | T | 0.0834 | \$ 4.96 | . | \$ 0.99 |
| 0036 | Level II Fine Needle Biopsy/Aspiration | T | 2.1838 | \$ 129.96 | . | \$ 25.99 |
| 0037 | Level IV Needle Biopsy/Aspiration Except Bone Marrow | T | 9.6103 | \$ 571.92 | \$ 228.76 | \$ 114.38 |
| 0039 | Level I Implantation of Neurostimulator | S | 194.9690 | \$11,602.80 | . | \$ 2,320.56 |

| APC | Group Title | SI | Relative Weight | Payment Rate | National Unadjusted Copayment | Minimum Unadjusted Copayment |
|------|---|----|-----------------|--------------|-------------------------------|------------------------------|
| 0040 | Percutaneous Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve | S | 50.8322 | \$ 3,025.08 | . | \$ 605.02 |
| 0041 | Level I Arthroscopy | T | 28.0686 | \$ 1,670.39 | . | \$ 334.08 |
| 0042 | Level II Arthroscopy | T | 44.2075 | \$ 2,630.83 | \$ 804.74 | \$ 526.17 |
| 0043 | Closed Treatment Fracture Finger/Toe/Trunk | T | 1.7200 | \$ 102.36 | . | \$ 20.47 |
| 0045 | Bone/Joint Manipulation Under Anesthesia | T | 14.3413 | \$ 853.47 | \$ 268.47 | \$ 170.69 |
| 0046 | Open/Percutaneous Treatment Fracture or Dislocation | T | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 0047 | Arthroplasty without Prosthesis | T | 31.2345 | \$ 1,858.80 | \$ 537.03 | \$ 371.76 |
| 0048 | Level I Arthroplasty with Prosthesis | T | 43.3955 | \$ 2,582.51 | \$ 570.30 | \$ 516.50 |
| 0049 | Level I Musculoskeletal Procedures Except Hand and Foot | T | 20.3891 | \$ 1,213.38 | . | \$ 242.68 |
| 0050 | Level II Musculoskeletal Procedures Except Hand and Foot | T | 23.9367 | \$ 1,424.50 | . | \$ 284.90 |
| 0051 | Level III Musculoskeletal Procedures Except Hand and Foot | T | 36.6106 | \$ 2,178.73 | . | \$ 435.75 |
| 0052 | Level IV Musculoskeletal Procedures Except Hand and Foot | T | 43.5555 | \$ 2,592.03 | . | \$ 518.41 |
| 0053 | Level I Hand Musculoskeletal Procedures | T | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 0054 | Level II Hand Musculoskeletal Procedures | T | 25.1321 | \$ 1,495.64 | . | \$ 299.13 |
| 0055 | Level I Foot Musculoskeletal Procedures | T | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 0056 | Level II Foot Musculoskeletal Procedures | T | 40.5436 | \$ 2,412.79 | . | \$ 482.56 |
| 0057 | Bunion Procedures | T | 27.3981 | \$ 1,630.49 | \$ 475.91 | \$ 326.10 |
| 0058 | Level I Strapping and Cast Application | S | 1.0803 | \$ 64.29 | . | \$ 12.86 |
| 0060 | Manipulation Therapy | S | 0.5011 | \$ 29.82 | . | \$ 5.96 |
| 0061 | Laminectomy or Incision for Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve | S | 93.4063 | \$ 5,558.70 | . | \$ 1,111.74 |
| 0068 | CPAP Initiation | S | 1.2435 | \$ 74.00 | \$ 29.48 | \$ 14.80 |
| 0069 | Thoracoscopy | T | 30.9541 | \$ 1,842.11 | \$ 591.64 | \$ 368.42 |
| 0070 | Thoracentesis/Lavage Procedures | T | 3.2141 | \$ 191.27 | . | \$ 38.25 |
| 0071 | Level I Endoscopy Upper Airway | T | 0.8034 | \$ 47.81 | \$ 11.31 | \$ 9.56 |
| 0072 | Level II Endoscopy Upper Airway | T | 1.4448 | \$ 85.98 | \$ 21.27 | \$ 17.20 |
| 0073 | Level III Endoscopy Upper Airway | T | 4.2171 | \$ 250.96 | \$ 73.38 | \$ 50.19 |
| 0074 | Level IV Endoscopy Upper Airway | T | 15.4603 | \$ 920.06 | \$ 295.70 | \$ 184.01 |
| 0075 | Level V Endoscopy Upper Airway | T | 21.2258 | \$ 1,263.17 | \$ 445.92 | \$ 252.63 |
| 0076 | Level I Endoscopy Lower Airway | T | 9.4030 | \$ 559.58 | \$ 189.82 | \$ 111.92 |
| 0077 | Level I Pulmonary Treatment | S | 0.3428 | \$ 20.40 | \$ 7.74 | \$ 4.08 |
| 0078 | Level II Pulmonary Treatment | S | 1.0229 | \$ 60.87 | \$ 14.55 | \$ 12.17 |
| 0079 | Ventilation Initiation and Management | S | 2.2410 | \$ 133.36 | . | \$ 26.67 |

| APC | Group Title | SI | Relative Weight | Payment Rate | National Unadjusted Copayment | Minimum Unadjusted Copayment |
|------|--|----|-----------------|--------------|-------------------------------|------------------------------|
| 0080 | Diagnostic Cardiac Catheterization | T | 36.3392 | \$ 2,162.58 | \$ 838.92 | \$ 432.52 |
| 0081 | Non-Coronary Angioplasty or Atherectomy | T | 42.2664 | \$ 2,515.32 | . | \$ 503.06 |
| 0082 | Coronary Atherectomy | T | 91.3717 | \$ 5,437.62 | \$ 1,169.67 | \$ 1,087.52 |
| 0083 | Coronary Angioplasty and Percutaneous Valvuloplasty | T | 55.2741 | \$ 3,289.42 | . | \$ 657.88 |
| 0084 | Level I Electrophysiologic Evaluation | S | 9.6108 | \$ 571.95 | . | \$ 114.39 |
| 0085 | Level II Electrophysiologic Evaluation | T | 34.2055 | \$ 2,035.60 | \$ 426.25 | \$ 407.12 |
| 0086 | Ablate Heart Dysrhythm Focus | T | 42.0498 | \$ 2,502.43 | \$ 812.36 | \$ 500.49 |
| 0087 | Cardiac Electrophysiologic Recording/Mapping | T | 33.0075 | \$ 1,964.31 | . | \$ 392.86 |
| 0088 | Thrombectomy | T | 36.5126 | \$ 2,172.90 | \$ 655.22 | \$ 434.58 |
| 0089 | Insertion/Replacement of Permanent Pacemaker and Electrodes | T | 117.0463 | \$ 6,965.54 | \$ 1,682.28 | \$ 1,393.11 |
| 0090 | Insertion/Replacement of Pacemaker Pulse Generator | T | 90.2017 | \$ 5,367.99 | \$ 1,612.80 | \$ 1,073.60 |
| 0091 | Level II Vascular Ligation | T | 28.8805 | \$ 1,718.71 | \$ 348.23 | \$ 343.74 |
| 0092 | Level I Vascular Ligation | T | 26.5104 | \$ 1,577.66 | \$ 505.37 | \$ 315.53 |
| 0093 | Vascular Reconstruction/Fistula Repair without Device | T | 23.3101 | \$ 1,387.21 | . | \$ 277.44 |
| 0094 | Level I Resuscitation and Cardioversion | S | 2.4582 | \$ 146.29 | \$ 46.29 | \$ 29.26 |
| 0095 | Cardiac Rehabilitation | S | 0.5822 | \$ 34.65 | \$ 13.86 | \$ 6.93 |
| 0096 | Non-Invasive Vascular Studies | S | 1.6020 | \$ 95.34 | \$ 38.13 | \$ 19.07 |
| 0097 | Cardiac and Ambulatory Blood Pressure Monitoring | X | 1.0211 | \$ 60.77 | \$ 23.79 | \$ 12.15 |
| 0098 | Injection of Sclerosing Solution | T | 1.1444 | \$ 68.10 | . | \$ 13.62 |
| 0099 | Electrocardiograms | S | 0.3769 | \$ 22.43 | . | \$ 4.49 |
| 0100 | Cardiac Stress Tests | X | 2.4833 | \$ 147.78 | \$ 41.44 | \$ 29.56 |
| 0101 | Tilt Table Evaluation | S | 4.2112 | \$ 250.61 | \$ 100.24 | \$ 50.12 |
| 0103 | Miscellaneous Vascular Procedures | T | 15.0428 | \$ 895.21 | \$ 223.63 | \$ 179.04 |
| 0104 | Transcatheter Placement of Intracoronary Stents | T | 80.7852 | \$ 4,807.61 | . | \$ 961.52 |
| 0105 | Revision/Removal of Pacemakers, AICD, or Vascular | T | 21.9865 | \$ 1,308.44 | \$ 370.40 | \$ 261.69 |
| 0106 | Insertion/Replacement/Repair of Pacemaker and/or Electrodes | T | 55.9362 | \$ 3,328.82 | . | \$ 665.76 |
| 0107 | Insertion of Cardioverter-Defibrillator | T | 279.4800 | \$16,632.13 | \$ 3,344.78 | \$ 3,326.43 |
| 0108 | Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads | T | 375.2863 | \$22,333.66 | . | \$ 4,466.73 |
| 0109 | Removal of Implanted Devices | T | 11.1714 | \$ 664.82 | . | \$ 132.96 |
| 0110 | Transfusion | S | 3.6419 | \$ 216.73 | . | \$ 43.35 |
| 0111 | Blood Product Exchange | S | 12.0768 | \$ 718.70 | \$ 198.40 | \$ 143.74 |
| 0112 | Apheresis, Photopheresis, and Plasmapheresis | S | 26.3750 | \$ 1,569.60 | \$ 433.29 | \$ 313.92 |
| 0113 | Excision Lymphatic System | T | 21.4112 | \$ 1,274.20 | . | \$ 254.84 |
| 0114 | Thyroid/Lymphadenectomy Procedures | T | 40.4596 | \$ 2,407.79 | \$ 485.91 | \$ 481.56 |

| APC | Group Title | SI | Relative Weight | Payment Rate | National Unadjusted Copayment | Minimum Unadjusted Copayment |
|------|--|----|-----------------|--------------|-------------------------------|------------------------------|
| 0115 | Cannula/Access Device Procedures | T | 36.9806 | \$ 2,200.75 | \$ 459.35 | \$ 440.15 |
| 0116 | Chemotherapy Administration by Other Technique Except Infusion | S | 1.1488 | \$ 68.37 | . | \$ 13.67 |
| 0117 | Chemotherapy Administration by Infusion Only | S | 3.1766 | \$ 189.04 | \$ 42.54 | \$ 37.81 |
| 0120 | Infusion Therapy Except Chemotherapy | S | 2.0293 | \$ 120.77 | \$ 28.21 | \$ 24.15 |
| 0121 | Level I Tube changes and Repositioning | T | 2.2374 | \$ 133.15 | \$ 43.80 | \$ 26.63 |
| 0122 | Level II Tube changes and Repositioning | T | 6.9179 | \$ 411.69 | \$ 84.43 | \$ 82.34 |
| 0123 | Bone Marrow Harvesting and Bone Marrow/Stem Cell Transplant | S | 24.4820 | \$ 1,456.95 | . | \$ 291.39 |
| 0125 | Refilling of Infusion Pump | T | 1.9021 | \$ 113.20 | . | \$ 22.64 |
| 0127 | Stereotactic Radiosurgery | S | 122.7483 | \$ 7,304.87 | . | \$ 1,460.97 |
| 0130 | Level I Laparoscopy | T | 31.8753 | \$ 1,896.93 | \$ 659.53 | \$ 379.39 |
| 0131 | Level II Laparoscopy | T | 43.0498 | \$ 2,561.94 | \$ 1,001.89 | \$ 512.39 |
| 0132 | Level III Laparoscopy | T | 63.6859 | \$ 3,790.01 | \$ 1,239.22 | \$ 758.00 |
| 0140 | Esophageal Dilatation without Endoscopy | T | 5.2970 | \$ 315.23 | \$ 91.40 | \$ 63.05 |
| 0141 | Level I Upper GI Procedures | T | 8.0662 | \$ 480.03 | \$ 143.38 | \$ 96.01 |
| 0142 | Small Intestine Endoscopy | T | 9.0564 | \$ 538.96 | \$ 152.78 | \$ 107.79 |
| 0143 | Lower GI Endoscopy | T | 8.5588 | \$ 509.34 | \$ 186.06 | \$ 101.87 |
| 0146 | Level I Sigmoidoscopy and Anoscopy | T | 4.7086 | \$ 280.21 | \$ 64.40 | \$ 56.04 |
| 0147 | Level II Sigmoidoscopy and Anoscopy | T | 7.9652 | \$ 474.02 | . | \$ 94.80 |
| 0148 | Level I Anal/Rectal Procedures | T | 3.5047 | \$ 208.57 | \$ 53.79 | \$ 41.71 |
| 0149 | Level III Anal/Rectal Procedures | T | 18.0878 | \$ 1,076.42 | \$ 293.06 | \$ 215.28 |
| 0150 | Level IV Anal/Rectal Procedures | T | 23.8736 | \$ 1,420.74 | \$ 437.12 | \$ 284.15 |
| 0151 | Endoscopic Retrograde Cholangio-Pancreatography (ERCP) | T | 18.6171 | \$ 1,107.92 | \$ 245.46 | \$ 221.58 |
| 0152 | Level I Percutaneous Abdominal and Biliary Procedures | T | 18.2391 | \$ 1,085.43 | . | \$ 217.09 |
| 0153 | Peritoneal and Abdominal Procedures | T | 22.4936 | \$ 1,338.62 | \$ 397.95 | \$ 267.72 |
| 0154 | Hernia/Hydrocele Procedures | T | 28.6432 | \$ 1,704.59 | \$ 464.85 | \$ 340.92 |
| 0155 | Level II Anal/Rectal Procedures | T | 15.9499 | \$ 949.19 | . | \$ 189.84 |
| 0156 | Level II Urinary and Anal Procedures | T | 2.6123 | \$ 155.46 | \$ 40.52 | \$ 31.09 |
| 0157 | Colorectal Cancer Screening: Barium Enema | S | 2.1344 | \$ 127.02 | . | \$ 25.40 |
| 0158 | Colorectal Cancer Screening: Colonoscopy | T | 7.5542 | \$ 449.56 | . | \$ 112.39 |
| 0159 | Colorectal Cancer Screening: Flexible Sigmoidoscopy | S | 3.6322 | \$ 216.16 | . | \$ 54.04 |
| 0160 | Level I Cystourethroscopy and other Genitourinary Procedures | T | 6.9387 | \$ 412.93 | \$ 105.06 | \$ 82.59 |
| 0161 | Level II Cystourethroscopy and other Genitourinary Procedures | T | 18.5804 | \$ 1,105.74 | \$ 249.36 | \$ 221.15 |
| 0162 | Level III Cystourethroscopy and other Genitourinary Procedures | T | 23.3383 | \$ 1,388.89 | . | \$ 277.78 |
| 0163 | Level IV Cystourethroscopy and other | T | 33.5963 | \$ 1,999.35 | . | \$ 399.87 |

| APC | Group Title | SI | Relative Weight | Payment Rate | National Unadjusted Copayment | Minimum Unadjusted Copayment |
|------|--|----|-----------------|--------------|-------------------------------|------------------------------|
| | Genitourinary Procedures | | | | | |
| 0164 | Level I Urinary and Anal Procedures | T | 1.1600 | \$ 69.03 | \$ 16.96 | \$ 13.81 |
| 0165 | Level III Urinary and Anal Procedures | T | 16.5343 | \$ 983.97 | . | \$ 196.79 |
| 0166 | Level I Urethral Procedures | T | 17.7635 | \$ 1,057.12 | \$ 218.73 | \$ 211.42 |
| 0168 | Level II Urethral Procedures | T | 28.1985 | \$ 1,678.12 | \$ 388.16 | \$ 335.62 |
| 0169 | Lithotripsy | T | 42.4073 | \$ 2,523.70 | \$ 1,009.47 | \$ 504.74 |
| 0170 | Dialysis | S | 5.9448 | \$ 353.78 | . | \$ 70.76 |
| 0180 | Circumcision | T | 19.7721 | \$ 1,176.66 | \$ 304.87 | \$ 235.33 |
| 0181 | Penile Procedures | T | 30.9472 | \$ 1,841.70 | \$ 621.82 | \$ 368.34 |
| 0183 | Testes/Epididymis Procedures | T | 23.3500 | \$ 1,389.58 | . | \$ 277.92 |
| 0184 | Prostate Biopsy | T | 4.4432 | \$ 264.42 | \$ 96.27 | \$ 52.88 |
| 0188 | Level II Female Reproductive Proc | T | 1.2615 | \$ 75.07 | . | \$ 15.01 |
| 0189 | Level III Female Reproductive Proc | T | 2.3805 | \$ 141.67 | . | \$ 28.33 |
| 0190 | Level I Hysteroscopy | T | 20.9198 | \$ 1,244.96 | \$ 424.28 | \$ 248.99 |
| 0191 | Level I Female Reproductive Proc | T | 0.1702 | \$ 10.13 | \$ 2.85 | \$ 2.03 |
| 0192 | Level IV Female Reproductive Proc | T | 4.1597 | \$ 247.55 | . | \$ 49.51 |
| 0193 | Level V Female Reproductive Proc | T | 14.6385 | \$ 871.15 | . | \$ 174.23 |
| 0194 | Level VIII Female Reproductive Proc | T | 20.6573 | \$ 1,229.34 | \$ 397.84 | \$ 245.87 |
| 0195 | Level IX Female Reproductive Proc | T | 26.7972 | \$ 1,594.73 | \$ 483.80 | \$ 318.95 |
| 0196 | Dilation and Curettage | T | 17.0012 | \$ 1,011.76 | \$ 338.23 | \$ 202.35 |
| 0197 | Infertility Procedures | T | 3.0721 | \$ 182.82 | . | \$ 36.56 |
| 0198 | Pregnancy and Neonatal Care Procedures | T | 1.3622 | \$ 81.07 | \$ 32.19 | \$ 16.21 |
| 0200 | Level VII Female Reproductive Proc | T | 18.9518 | \$ 1,127.84 | \$ 263.69 | \$ 225.57 |
| 0201 | Level VI Female Reproductive Proc | T | 17.4749 | \$ 1,039.95 | \$ 329.65 | \$ 207.99 |
| 0202 | Level X Female Reproductive Proc | T | 41.2319 | \$ 2,453.75 | \$ 981.50 | \$ 490.75 |
| 0203 | Level IV Nerve Injections | T | 10.0965 | \$ 600.85 | \$ 240.33 | \$ 120.17 |
| 0204 | Level I Nerve Injections | T | 2.2667 | \$ 134.89 | \$ 40.13 | \$ 26.98 |
| 0206 | Level II Nerve Injections | T | 5.4011 | \$ 321.42 | \$ 75.55 | \$ 64.28 |
| 0207 | Level III Nerve Injections | T | 6.0140 | \$ 357.90 | \$ 86.92 | \$ 71.58 |
| 0208 | Laminotomies and Laminectomies | T | 42.5200 | \$ 2,530.41 | . | \$ 506.08 |
| 0209 | Extended EEG Studies and Sleep Studies, Level II | S | 11.2895 | \$ 671.85 | \$ 268.73 | \$ 134.37 |
| 0212 | Nervous System Injections | T | 2.7712 | \$ 164.92 | \$ 65.96 | \$ 32.98 |
| 0213 | Extended EEG Studies and Sleep Studies, Level I | S | 2.2509 | \$ 133.95 | \$ 53.58 | \$ 26.79 |
| 0214 | Electroencephalogram | S | 1.1863 | \$ 70.60 | \$ 28.24 | \$ 14.12 |
| 0215 | Level I Nerve and Muscle Tests | S | 0.6025 | \$ 35.86 | \$ 14.34 | \$ 7.17 |
| 0216 | Level III Nerve and Muscle Tests | S | 2.5976 | \$ 154.59 | . | \$ 30.92 |
| 0218 | Level II Nerve and Muscle Tests | S | 1.1138 | \$ 66.28 | . | \$ 13.26 |
| 0220 | Level I Nerve Procedures | T | 17.3203 | \$ 1,030.75 | . | \$ 206.15 |
| 0221 | Level II Nerve Procedures | T | 31.0536 | \$ 1,848.03 | \$ 463.62 | \$ 369.61 |
| 0222 | Implantation of Neurological Device | T | 192.4950 | \$11,455.57 | . | \$ 2,291.11 |
| 0223 | Implantation or Revision of Pain | T | 28.5636 | \$ 1,699.85 | . | \$ 339.97 |

| APC | Group Title | SI | Relative Weight | Payment Rate | National Unadjusted Copayment | Minimum Unadjusted Copayment |
|------|---|----|-----------------|--------------|-------------------------------|------------------------------|
| | Management Catheter | | | | | |
| 0224 | Implantation of Reservoir/Pump/Shunt | T | 41.1421 | \$ 2,448.41 | . | \$ 489.68 |
| 0225 | Implantation of Neurostimulator Electrodes, Cranial Nerve | S | 250.8484 | \$14,928.24 | . | \$ 2,985.65 |
| 0226 | Implantation of Drug Infusion Reservoir | T | 72.5804 | \$ 4,319.33 | . | \$ 863.87 |
| 0227 | Implantation of Drug Infusion Device | T | 155.0431 | \$ 9,226.77 | . | \$ 1,845.35 |
| 0228 | Creation of Lumbar Subarachnoid Shunt | T | 46.4126 | \$ 2,762.06 | . | \$ 552.41 |
| 0229 | Transcatheter Placement of Intravascular Shunts | T | 66.3380 | \$ 3,947.84 | . | \$ 789.57 |
| 0230 | Level I Eye Tests & Treatments | S | 0.7902 | \$ 47.03 | \$ 14.97 | \$ 9.41 |
| 0231 | Level III Eye Tests & Treatments | S | 1.9167 | \$ 114.06 | . | \$ 22.81 |
| 0232 | Level I Anterior Segment Eye Procedures | T | 6.9204 | \$ 411.84 | \$ 103.17 | \$ 82.37 |
| 0233 | Level II Anterior Segment Eye Procedures | T | 14.6645 | \$ 872.70 | \$ 266.33 | \$ 174.54 |
| 0234 | Level III Anterior Segment Eye Procedures | T | 22.0521 | \$ 1,312.34 | \$ 511.31 | \$ 262.47 |
| 0235 | Level I Posterior Segment Eye Procedures | T | 4.7925 | \$ 285.21 | \$ 69.52 | \$ 57.04 |
| 0236 | Level II Posterior Segment Eye Procedures | T | 16.9771 | \$ 1,010.32 | . | \$ 202.06 |
| 0237 | Level III Posterior Segment Eye Procedures | T | 28.7866 | \$ 1,713.12 | . | \$ 342.62 |
| 0238 | Level I Repair and Plastic Eye Procedures | T | 2.6031 | \$ 154.91 | . | \$ 30.98 |
| 0239 | Level II Repair and Plastic Eye Procedures | T | 7.0583 | \$ 420.05 | . | \$ 84.01 |
| 0240 | Level III Repair and Plastic Eye Procedures | T | 18.0194 | \$ 1,072.35 | \$ 315.31 | \$ 214.47 |
| 0241 | Level IV Repair and Plastic Eye Procedures | T | 23.1681 | \$ 1,378.76 | \$ 384.47 | \$ 275.75 |
| 0242 | Level V Repair and Plastic Eye Procedures | T | 30.3478 | \$ 1,806.03 | \$ 597.36 | \$ 361.21 |
| 0243 | Strabismus/Muscle Procedures | T | 22.0338 | \$ 1,311.25 | \$ 431.39 | \$ 262.25 |
| 0244 | Corneal Transplant | T | 38.2309 | \$ 2,275.16 | \$ 803.26 | \$ 455.03 |
| 0245 | Level I Cataract Procedures without IOL Insert | T | 13.0344 | \$ 775.69 | \$ 217.05 | \$ 155.14 |
| 0246 | Cataract Procedures with IOL Insert | T | 23.3185 | \$ 1,387.71 | \$ 495.96 | \$ 277.54 |
| 0247 | Laser Eye Procedures Except Retinal | T | 5.0255 | \$ 299.07 | \$ 104.31 | \$ 59.81 |
| 0248 | Laser Retinal Procedures | T | 4.7199 | \$ 280.89 | \$ 95.08 | \$ 56.18 |
| 0249 | Level II Cataract Procedures without IOL Insert | T | 27.6388 | \$ 1,644.81 | \$ 524.67 | \$ 328.96 |
| 0250 | Nasal Cauterization/Packing | T | 1.2241 | \$ 72.85 | \$ 25.50 | \$ 14.57 |
| 0251 | Level I ENT Procedures | T | 2.0789 | \$ 123.72 | . | \$ 24.74 |
| 0252 | Level II ENT Procedures | T | 8.1033 | \$ 482.24 | \$ 113.41 | \$ 96.45 |
| 0253 | Level III ENT Procedures | T | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |

| APC | Group Title | SI | Relative Weight | Payment Rate | National Unadjusted Copayment | Minimum Unadjusted Copayment |
|------|--|----|-----------------|--------------|-------------------------------|------------------------------|
| 0254 | Level IV ENT Procedures | T | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 0256 | Level V ENT Procedures | T | 37.0000 | \$ 2,201.91 | . | \$ 440.38 |
| 0258 | Tonsil and Adenoid Procedures | T | 21.8761 | \$ 1,301.87 | \$ 437.25 | \$ 260.37 |
| 0259 | Level VI ENT Procedures | T | 393.7337 | \$23,431.49 | \$ 8,698.43 | \$ 4,686.30 |
| 0260 | Level I Plain Film Except Teeth | X | 0.7296 | \$ 43.42 | . | \$ 8.68 |
| 0261 | Level II Plain Film Except Teeth Including Bone Density Measurement | X | 1.2416 | \$ 73.89 | . | \$ 14.78 |
| 0262 | Plain Film of Teeth | X | 0.8019 | \$ 47.72 | . | \$ 9.54 |
| 0263 | Level I Miscellaneous Radiology Procedures | X | 1.6979 | \$ 101.04 | \$ 23.77 | \$ 20.21 |
| 0264 | Level II Miscellaneous Radiology Procedures | X | 3.4542 | \$ 205.56 | \$ 79.41 | \$ 41.11 |
| 0265 | Level I Diagnostic Ultrasound | S | 0.9930 | \$ 59.09 | \$ 23.63 | \$ 11.82 |
| 0266 | Level II Diagnostic Ultrasound | S | 1.5883 | \$ 94.52 | \$ 37.80 | \$ 18.90 |
| 0267 | Level III Diagnostic Ultrasound | S | 2.5543 | \$ 152.01 | \$ 60.80 | \$ 30.40 |
| 0268 | Ultrasound Guidance Procedures | S | 1.0460 | \$ 62.25 | . | \$ 12.45 |
| 0269 | Level III Echocardiogram Except Transesophageal | S | 3.1761 | \$ 189.01 | \$ 75.60 | \$ 37.80 |
| 0270 | Transesophageal Echocardiogram | S | 5.9369 | \$ 353.31 | \$ 141.32 | \$ 70.66 |
| 0272 | Level I Fluoroscopy | X | 1.3291 | \$ 79.10 | \$ 31.64 | \$ 15.82 |
| 0274 | Myelography | S | 2.9160 | \$ 173.53 | \$ 69.41 | \$ 34.71 |
| 0275 | Arthrography | S | 3.4927 | \$ 207.85 | \$ 69.09 | \$ 41.57 |
| 0276 | Level I Digestive Radiology | S | 1.4693 | \$ 87.44 | \$ 34.97 | \$ 17.49 |
| 0277 | Level II Digestive Radiology | S | 2.2951 | \$ 136.58 | \$ 54.63 | \$ 27.32 |
| 0278 | Diagnostic Urography | S | 2.5559 | \$ 152.10 | \$ 60.84 | \$ 30.42 |
| 0279 | Level II Angiography and Venography | S | 8.6988 | \$ 517.67 | \$ 150.03 | \$ 103.53 |
| 0280 | Level III Angiography and Venography | S | 20.4187 | \$ 1,215.14 | \$ 353.85 | \$ 243.03 |
| 0282 | Miscellaneous Computerized Axial Tomography | S | 1.5934 | \$ 94.82 | \$ 37.92 | \$ 18.96 |
| 0283 | Computerized Axial Tomography with Contrast Material | S | 4.2921 | \$ 255.43 | \$ 102.17 | \$ 51.09 |
| 0284 | Magnetic Resonance Imaging and Magnetic Resonance Angiography with Contras | S | 6.2342 | \$ 371.00 | \$ 148.40 | \$ 74.20 |
| 0288 | Bone Density:Axial Skeleton | S | 1.2216 | \$ 72.70 | . | \$ 14.54 |
| 0296 | Level I Therapeutic Radiologic Procedures | S | 2.2684 | \$ 134.99 | \$ 53.99 | \$ 27.00 |
| 0297 | Level II Therapeutic Radiologic Procedures | S | 5.0977 | \$ 303.37 | \$ 121.34 | \$ 60.67 |
| 0299 | Miscellaneous Radiation Treatment | S | 5.7678 | \$ 343.25 | . | \$ 68.65 |
| 0300 | Level I Radiation Therapy | S | 1.4660 | \$ 87.24 | . | \$ 17.45 |
| 0301 | Level II Radiation Therapy | S | 2.2056 | \$ 131.26 | . | \$ 26.25 |
| 0302 | Computer Assisted Navigational Procedures | S | 4.6992 | \$ 279.65 | \$ 105.94 | \$ 55.93 |
| 0303 | Treatment Device Construction | X | 2.8241 | \$ 168.07 | \$ 66.95 | \$ 33.61 |
| 0304 | Level I Therapeutic Radiation Treatment | X | 1.7323 | \$ 103.09 | \$ 41.23 | \$ 20.62 |

| APC | Group Title | SI | Relative Weight | Payment Rate | National Unadjusted Copayment | Minimum Unadjusted Copayment |
|------|--|----|-----------------|--------------|-------------------------------|------------------------------|
| | Preparation | | | | | |
| 0305 | Level II Therapeutic Radiation Treatment Preparation | X | 3.9335 | \$ 234.09 | \$ 91.38 | \$ 46.82 |
| 0306 | Myocardial Positron Emission Tomography (PET) imaging, single study, metabolic evaluation | S | 13.4521 | \$ 800.55 | \$ 320.21 | \$ 160.11 |
| 0307 | Myocardial Positron Emission Tomography (PET) imaging, multiple studies | S | 41.7549 | \$ 2,484.88 | \$ 993.95 | \$ 496.98 |
| 0310 | Level III Therapeutic Radiation Treatment Preparation | X | 13.8818 | \$ 826.12 | \$ 325.27 | \$ 165.22 |
| 0312 | Radioelement Applications | S | 5.5674 | \$ 331.32 | . | \$ 66.26 |
| 0313 | Brachytherapy | S | 13.0202 | \$ 774.85 | . | \$ 154.97 |
| 0314 | Hyperthermic Therapies | S | 5.5840 | \$ 332.31 | \$ 98.36 | \$ 66.46 |
| 0315 | Level II Implantation of Neurostimulator | T | 312.3876 | \$18,590.50 | . | \$ 3,718.10 |
| 0320 | Electroconvulsive Therapy | S | 5.2528 | \$ 312.60 | \$ 80.06 | \$ 62.52 |
| 0321 | Biofeedback and Other Training | S | 1.3651 | \$ 81.24 | \$ 21.72 | \$ 16.25 |
| 0322 | Brief Individual Psychotherapy | S | 1.2304 | \$ 73.22 | . | \$ 14.64 |
| 0323 | Extended Individual Psychotherapy | S | 1.6398 | \$ 97.59 | \$ 20.35 | \$ 19.52 |
| 0324 | Family Psychotherapy | S | 2.3119 | \$ 137.58 | . | \$ 27.52 |
| 0325 | Group Psychotherapy | S | 1.3434 | \$ 79.95 | \$ 17.47 | \$ 15.99 |
| 0330 | Dental Procedures | S | 9.3925 | \$ 558.96 | . | \$ 111.79 |
| 0332 | Computerized Axial Tomography and Computerized Angiography without Contras | S | 3.1608 | \$ 188.10 | \$ 75.24 | \$ 37.62 |
| 0333 | Computerized Axial Tomography and Computerized Angiography without Contrast followed by Contrast | S | 5.1053 | \$ 303.82 | \$ 121.52 | \$ 60.76 |
| 0335 | Magnetic Resonance Imaging, Miscellaneous | S | 5.0997 | \$ 303.49 | \$ 121.39 | \$ 60.70 |
| 0336 | Magnetic Resonance Imaging and Magnetic Resonance Angiography without Cont | S | 5.8678 | \$ 349.20 | \$ 139.68 | \$ 69.84 |
| 0337 | MRI and Magnetic Resonance Angiography without Contrast Material followed | S | 8.5070 | \$ 506.26 | \$ 202.50 | \$ 101.25 |
| 0339 | Observation | Q | 7.1429 | \$ 425.08 | . | \$ 85.02 |
| 0340 | Minor Ancillary Procedures | X | 0.6137 | \$ 36.52 | . | \$ 7.30 |
| 0341 | Skin Tests | X | 0.1035 | \$ 6.16 | \$ 2.46 | \$ 1.23 |
| 0342 | Level I Pathology | X | 0.1450 | \$ 8.63 | \$ 3.45 | \$ 1.73 |
| 0343 | Level III Pathology | X | 0.4553 | \$ 27.10 | \$ 10.84 | \$ 5.42 |
| 0344 | Level IV Pathology | X | 0.7584 | \$ 45.13 | \$ 15.66 | \$ 9.03 |
| 0345 | Level I Transfusion Laboratory Procedures | X | 0.2170 | \$ 12.91 | \$ 2.87 | \$ 2.58 |
| 0346 | Level II Transfusion Laboratory Procedures | X | 0.3314 | \$ 19.72 | \$ 4.39 | \$ 3.94 |

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|------|--|----|-----------------|--------------|-------------------------------|------------------------------|
| 0347 | Level III Transfusion Laboratory Procedures | X | 0.8243 | \$ 49.05 | \$ 12.11 | \$ 9.81 |
| 0348 | Fertility Laboratory Procedures | X | 0.7607 | \$ 45.27 | . | \$ 9.05 |
| 0350 | Administration of flu and PPV vaccine | X | 0.3917 | \$ 23.31 | . | \$ - |
| 0352 | Level I Injections | X | 0.1368 | \$ 8.14 | . | \$ 1.63 |
| 0353 | Level II Injections | X | 0.3917 | \$ 23.31 | . | \$ 4.66 |
| 0359 | Level III Injections | X | 0.8036 | \$ 47.82 | . | \$ 9.56 |
| 0360 | Level I Alimentary Tests | X | 1.4235 | \$ 84.71 | \$ 33.88 | \$ 16.94 |
| 0361 | Level II Alimentary Tests | X | 3.5671 | \$ 212.28 | \$ 83.23 | \$ 42.46 |
| 0362 | Contact Lens and Spectacle Services | X | 2.2654 | \$ 134.82 | . | \$ 26.96 |
| 0363 | Level I Otorhinolaryngologic Function Tests | X | 0.8707 | \$ 51.82 | \$ 17.44 | \$ 10.36 |
| 0364 | Level I Audiometry | X | 0.4548 | \$ 27.07 | \$ 7.06 | \$ 5.41 |
| 0365 | Level II Audiometry | X | 1.1928 | \$ 70.98 | \$ 18.52 | \$ 14.20 |
| 0366 | Level III Audiometry | X | 1.6829 | \$ 100.15 | \$ 26.14 | \$ 20.03 |
| 0367 | Level I Pulmonary Test | X | 0.6539 | \$ 38.91 | \$ 14.80 | \$ 7.78 |
| 0368 | Level II Pulmonary Tests | X | 0.9568 | \$ 56.94 | \$ 22.77 | \$ 11.39 |
| 0369 | Level III Pulmonary Tests | X | 2.7046 | \$ 160.95 | \$ 44.18 | \$ 32.19 |
| 0370 | Allergy Tests | X | 2.8133 | \$ 167.42 | . | \$ 33.48 |
| 0372 | Therapeutic Phlebotomy | X | 0.5580 | \$ 33.21 | \$ 10.09 | \$ 6.64 |
| 0373 | Level I Neuropsychological Testing | X | 1.2514 | \$ 74.47 | . | \$ 14.89 |
| 0374 | Monitoring Psychiatric Drugs | X | 1.1270 | \$ 67.07 | . | \$ 13.41 |
| 0375 | Ancillary Outpatient Services When Patient Expires | S | 45.7015 | \$ 2,719.74 | . | \$ 543.95 |
| 0376 | Level II Cardiac Imaging | S | 5.0315 | \$ 299.43 | \$ 119.77 | \$ 59.89 |
| 0377 | Level III Cardiac Imaging | S | 6.6729 | \$ 397.11 | \$ 158.84 | \$ 79.42 |
| 0378 | Level II Pulmonary Imaging | S | 5.4064 | \$ 321.74 | \$ 128.69 | \$ 64.35 |
| 0379 | Injection adenosine 6 MG | K | | \$ 32.63 | . | \$ 6.53 |
| 0381 | Single Allergy Tests | X | 0.1925 | \$ 11.46 | \$ 2.41 | \$ 2.29 |
| 0382 | Level II Neuropsychological Testing | X | 3.4127 | \$ 203.09 | \$ 81.23 | \$ 40.62 |
| 0384 | GI Procedures with Stents | T | 26.8955 | \$ 1,600.58 | \$ 335.19 | \$ 320.12 |
| 0385 | Level I Prosthetic Urological Procedures | S | 73.7498 | \$ 4,388.92 | . | \$ 877.78 |
| 0386 | Level II Prosthetic Urological Procedures | S | 126.9292 | \$ 7,553.68 | . | \$ 1,510.74 |
| 0387 | Level II Hysteroscopy | T | 32.3170 | \$ 1,923.22 | \$ 655.55 | \$ 384.64 |
| 0388 | Discography | S | 12.1712 | \$ 724.32 | \$ 289.72 | \$ 144.86 |
| 0389 | Level I Non-imaging Nuclear Medicine | S | 1.4276 | \$ 84.96 | \$ 33.98 | \$ 16.99 |
| 0390 | Level I Endocrine Imaging | S | 2.4663 | \$ 146.77 | \$ 58.70 | \$ 29.35 |
| 0391 | Level II Endocrine Imaging | S | 2.7803 | \$ 165.46 | \$ 66.18 | \$ 33.09 |
| 0392 | Level II Non-imaging Nuclear Medicine | S | 3.5231 | \$ 209.66 | \$ 83.86 | \$ 41.93 |
| 0393 | Red Cell/Plasma Studies | S | 3.4467 | \$ 205.12 | \$ 82.04 | \$ 41.02 |
| 0394 | Hepatobiliary Imaging | S | 4.3107 | \$ 256.53 | \$ 102.61 | \$ 51.31 |
| 0395 | GI Tract Imaging | S | 3.7696 | \$ 224.33 | \$ 89.73 | \$ 44.87 |
| 0396 | Bone Imaging | S | 3.9921 | \$ 237.57 | \$ 95.02 | \$ 47.51 |

| APC | Group Title | SI | Relative Weight | Payment Rate | National Unadjusted Copayment | Minimum Unadjusted Copayment |
|------|--|----|-----------------|--------------|-------------------------------|------------------------------|
| 0397 | Vascular Imaging | S | 2.0829 | \$ 123.96 | \$ 49.58 | \$ 24.79 |
| 0398 | Level I Cardiac Imaging | S | 4.2038 | \$ 250.17 | \$ 100.06 | \$ 50.03 |
| 0399 | Nuclear Medicine Add-on Imaging | S | 1.5039 | \$ 89.50 | \$ 35.80 | \$ 17.90 |
| 0400 | Hematopoietic Imaging | S | 3.9160 | \$ 233.05 | \$ 93.22 | \$ 46.61 |
| 0401 | Level I Pulmonary Imaging | S | 3.3166 | \$ 197.37 | \$ 78.94 | \$ 39.47 |
| 0402 | Brain Imaging | S | 5.1709 | \$ 307.73 | \$ 123.09 | \$ 61.55 |
| 0403 | CSF Imaging | S | 3.5015 | \$ 208.38 | \$ 83.35 | \$ 41.68 |
| 0404 | Renal and Genitourinary Studies Level I | S | 3.6558 | \$ 217.56 | \$ 87.02 | \$ 43.51 |
| 0405 | Renal and Genitourinary Studies Level II | S | 4.1493 | \$ 246.93 | \$ 98.77 | \$ 49.39 |
| 0406 | Tumor/Infection Imaging | S | 4.1397 | \$ 246.36 | \$ 98.54 | \$ 49.27 |
| 0407 | Radionuclide Therapy | S | 3.8758 | \$ 230.65 | \$ 92.26 | \$ 46.13 |
| 0409 | Red Blood Cell Tests | X | 0.1210 | \$ 7.20 | \$ 2.20 | \$ 1.44 |
| 0411 | Respiratory Procedures | S | 0.3922 | \$ 23.34 | . | \$ 4.67 |
| 0412 | IMRT Treatment Delivery | S | 5.3573 | \$ 318.82 | . | \$ 63.76 |
| 0415 | Level II Endoscopy Lower Airway | T | 22.0722 | \$ 1,313.54 | \$ 459.92 | \$ 262.71 |
| 0416 | Level I Intravascular and Intracardiac Ultrasound and Flow Reserve | S | 16.4464 | \$ 978.74 | . | \$ 195.75 |
| 0417 | Computerized Reconstruction | S | 3.9600 | \$ 235.66 | . | \$ 47.13 |
| 0418 | Insertion of Left Ventricular Pacing Elect. | T | 169.3514 | \$10,078.27 | . | \$ 2,015.65 |
| 0421 | Prolonged Physiologic Monitoring | X | 1.6026 | \$ 95.37 | . | \$ 19.07 |
| 0422 | Level II Upper GI Procedures | T | 24.0525 | \$ 1,431.39 | \$ 448.81 | \$ 286.28 |
| 0423 | Level II Percutaneous Abdominal and Biliary Procedures | T | 39.5881 | \$ 2,355.93 | . | \$ 471.19 |
| 0425 | Level II Arthroplasty with Prosthesis | T | 104.7352 | \$ 6,232.90 | \$ 1,378.01 | \$ 1,246.58 |
| 0426 | Level II Strapping and Cast Application | S | 2.2146 | \$ 131.79 | . | \$ 26.36 |
| 0427 | Level III Tube Changes and Repositioning | T | 10.0109 | \$ 595.76 | . | \$ 119.15 |
| 0428 | Level III Sigmoidoscopy and Anoscopy | T | 20.0871 | \$ 1,195.40 | . | \$ 239.08 |
| 0429 | Level V Cystourethroscopy and other Genitourinary Procedures | T | 42.0802 | \$ 2,504.23 | . | \$ 500.85 |
| 0430 | Level IV Nerve and Muscle Tests | T | 10.8452 | \$ 645.41 | . | \$ 129.08 |
| 0432 | Health and Behavior Services | S | 0.6396 | \$ 38.06 | . | \$ 7.61 |
| 0433 | Level II Pathology | X | 0.2493 | \$ 14.84 | \$ 5.93 | \$ 2.97 |
| 0434 | Cardiac Defect Repair | T | 86.4834 | \$ 5,146.71 | . | \$ 1,029.34 |
| 0600 | Low Level Clinic Visits | V | 0.8800 | \$ 52.37 | . | \$ 10.47 |
| 0601 | Mid Level Clinic Visits | V | 1.0125 | \$ 60.25 | . | \$ 12.05 |
| 0602 | High Level Clinic Visits | V | 1.4731 | \$ 87.67 | . | \$ 17.53 |
| 0610 | Low Level Emergency Visits | V | 1.2399 | \$ 73.79 | \$ 18.71 | \$ 14.76 |
| 0611 | Mid Level Emergency Visits | V | 2.1707 | \$ 129.18 | \$ 34.26 | \$ 25.84 |
| 0612 | High Level Emergency Visits | V | 3.7772 | \$ 224.78 | \$ 51.89 | \$ 44.96 |
| 0620 | Critical Care | S | 8.0276 | \$ 477.73 | \$ 131.61 | \$ 95.55 |
| 0621 | Level I Vascular Access Procedures | T | 8.2313 | \$ 489.85 | . | \$ 97.97 |
| 0622 | Level II Vascular Access Procedures | T | 21.2464 | \$ 1,264.39 | . | \$ 252.88 |
| 0623 | Level III Vascular Access Procedures | T | 27.1472 | \$ 1,615.56 | . | \$ 323.11 |

| APC | Group Title | SI | Relative Weight | Payment Rate | National Unadjusted Copayment | Minimum Unadjusted Copayment |
|------|--|----|-----------------|--------------|-------------------------------|------------------------------|
| 0648 | Breast Reconstruction with Prosthesis | T | 53.5307 | \$ 3,185.67 | . | \$ 637.13 |
| 0651 | Complex Interstitial Radiation Source Application | S | 11.1948 | \$ 666.21 | . | \$ 133.24 |
| 0652 | Insertion of Intraperitoneal Catheters | T | 29.3648 | \$ 1,747.53 | . | \$ 349.51 |
| 0653 | Vascular Reconstruction/Fistula Repair with Device | T | 36.9427 | \$ 2,198.50 | . | \$ 439.70 |
| 0654 | Insertion/Replacement of a permanent dual chamber pacemaker | T | 112.0279 | \$ 6,666.89 | . | \$ 1,333.38 |
| 0655 | Insertion/Replacement/Conversion of a permanent dual chamber pacemaker | T | 136.8448 | \$ 8,143.77 | . | \$ 1,628.75 |
| 0656 | Transcatheter Placement of Intracoronary Drug-Eluting Stents | T | 108.1459 | \$ 6,435.87 | . | \$ 1,287.17 |
| 0657 | Placement of Tissue Clips | S | 1.6092 | \$ 95.77 | . | \$ 19.15 |
| 0658 | Percutaneous Breast Biopsies | T | 5.9888 | \$ 356.40 | . | \$ 71.28 |
| 0659 | Hyperbaric Oxygen | S | 1.5155 | \$ 90.19 | . | \$ 18.04 |
| 0660 | Level II Otorhinolaryngologic Function Tests | X | 1.5488 | \$ 92.17 | \$ 29.07 | \$ 18.43 |
| 0661 | Level V Pathology | X | 3.1514 | \$ 187.54 | \$ 75.01 | \$ 37.51 |
| 0662 | CT Angiography | S | 4.9944 | \$ 297.22 | \$ 118.88 | \$ 59.44 |
| 0664 | Level I Proton Beam Radiation Therapy | S | 15.9286 | \$ 947.93 | . | \$ 189.59 |
| 0665 | Bone Density: Appendicular Skeleton | S | 0.6381 | \$ 37.97 | . | \$ 7.59 |
| 0667 | Level II Proton Beam Radiation Therapy | S | 19.0566 | \$ 1,134.08 | . | \$ 226.82 |
| 0668 | Level I Angiography and Venography | S | 6.3104 | \$ 375.54 | \$ 88.26 | \$ 75.11 |
| 0670 | Level II Intravascular and Intracardiac Ultrasound and Flow Reserve | S | 28.7546 | \$ 1,711.22 | \$ 536.10 | \$ 342.24 |
| 0671 | Level II Echocardiogram Except Transesophageal | S | 1.6763 | \$ 99.76 | \$ 39.90 | \$ 19.95 |
| 0672 | Level IV Posterior Segment Eye Procedures | T | 36.8773 | \$ 2,194.61 | . | \$ 438.92 |
| 0673 | Level IV Anterior Segment Eye Procedures | T | 29.0835 | \$ 1,730.79 | \$ 649.56 | \$ 346.16 |
| 0674 | Prostate Cryoablation | T | 111.3747 | \$ 6,628.02 | . | \$ 1,325.60 |
| 0675 | Prostatic Thermotherapy | T | 44.8197 | \$ 2,667.27 | . | \$ 533.45 |
| 0676 | Thrombolysis and Thrombectomy | T | 2.2742 | \$ 135.34 | . | \$ 27.07 |
| 0678 | External Counterpulsation | T | 1.7600 | \$ 104.74 | . | \$ 20.95 |
| 0679 | Level II Resuscitation and Cardioversion | S | 5.4992 | \$ 327.26 | \$ 95.30 | \$ 65.45 |
| 0680 | Insertion of Patient Activated Event Recorders | S | 74.9052 | \$ 4,457.68 | . | \$ 891.54 |
| 0681 | Knee Arthroplasty | T | 135.4643 | \$ 8,061.62 | \$ 2,081.48 | \$ 1,612.32 |
| 0682 | Level V Debridement & Destruction | T | 6.7313 | \$ 400.59 | \$ 158.65 | \$ 80.12 |
| 0683 | Level II Photochemotherapy | S | 1.9289 | \$ 114.79 | \$ 25.79 | \$ 22.96 |
| 0685 | Level III Needle Biopsy/Aspiration Except Bone Marrow | T | 6.0034 | \$ 357.27 | \$ 115.47 | \$ 71.45 |
| 0686 | Level III Skin Repair | T | 13.4973 | \$ 803.24 | . | \$ 160.65 |
| 0687 | Revision/Removal of Neurostimulator Electrodes | T | 19.1962 | \$ 1,142.39 | \$ 456.95 | \$ 228.48 |

| APC | Group Title | SI | Relative Weight | Payment Rate | National Unadjusted Copayment | Minimum Unadjusted Copayment |
|------|--|----|-----------------|--------------|-------------------------------|------------------------------|
| 0688 | Revision/Removal of Neurostimulator Pulse Generator Receiver | T | 42.8588 | \$ 2,550.57 | \$ 1,020.22 | \$ 510.11 |
| 0689 | Electronic Analysis of Cardioverter-defibrillators | S | 0.5608 | \$ 33.37 | . | \$ 6.67 |
| 0690 | Electronic Analysis of Pacemakers and other Cardiac Devices | S | 0.3645 | \$ 21.69 | \$ 8.67 | \$ 4.34 |
| 0691 | Electronic Analysis of Programmable Shunts/Pumps | S | 2.5464 | \$ 151.54 | \$ 60.61 | \$ 30.31 |
| 0692 | Electronic Analysis of Neurostimulator Pulse Generators | S | 1.9774 | \$ 117.68 | \$ 30.16 | \$ 23.54 |
| 0693 | Breast Reconstruction | T | 42.2886 | \$ 2,516.64 | \$ 798.17 | \$ 503.33 |
| 0694 | Mohs Surgery | T | 3.8832 | \$ 231.09 | \$ 62.65 | \$ 46.22 |
| 0695 | Level VII Debridement & Destruction | T | 20.2372 | \$ 1,204.34 | \$ 266.59 | \$ 240.87 |
| 0697 | Level I Echocardiogram Except Transesophageal | S | 1.5121 | \$ 89.99 | \$ 35.99 | \$ 18.00 |
| 0698 | Level II Eye Tests & Treatments | S | 1.2378 | \$ 73.66 | \$ 16.52 | \$ 14.73 |
| 0699 | Level IV Eye Tests & Treatments | T | 8.9556 | \$ 532.96 | . | \$ 106.59 |
| 0700 | Antepartum Manipulation | T | 4.1398 | \$ 246.36 | . | \$ 49.27 |
| 0701 | Sr89 strontium | H | | | . | . |
| 0702 | Sm 153 lexidronm | H | | | . | . |
| 0704 | In111 satumomab | H | | | . | . |
| 0705 | Tc99m tetrofosmin | H | | | . | . |
| 0726 | Dexrazoxane HCl injection | K | | \$ 200.08 | . | \$ 40.02 |
| 0728 | Filgrastim 300 mcg injection | K | | \$ 177.81 | . | \$ 35.56 |
| 0730 | Pamidronate disodium /30 MG | K | | \$ 40.63 | . | \$ 8.13 |
| 0731 | Sargramostim injection | K | | \$ 21.87 | . | \$ 4.37 |
| 0732 | Mesna injection | K | | \$ 10.55 | . | \$ 2.11 |
| 0735 | Ampho b cholesteryl sulfate | K | | \$ 12.00 | . | \$ 2.40 |
| 0736 | Amphotericin b liposome inj | K | | \$ 18.18 | . | \$ 3.64 |
| 0737 | Nitrogen N-13 ammonia | H | | | . | . |
| 0738 | Rasburicase | G | | \$ 111.34 | . | \$ 22.27 |
| 0750 | Dolasetron mesylate | K | | \$ 6.52 | . | \$ 1.30 |
| 0763 | Dolasetron mesylate oral | K | | \$ 48.24 | . | \$ 9.65 |
| 0764 | Granisetron HCl injection | K | | \$ 7.14 | . | \$ 1.43 |
| 0765 | Granisetron HCl 1 mg oral | K | | \$ 35.13 | . | \$ 7.03 |
| 0768 | Ondansetron hcl injection | K | | \$ 3.85 | . | \$ 0.77 |
| 0769 | Ondansetron HCl 8mg oral | K | | \$ 32.77 | . | \$ 6.55 |
| 0800 | Leuprolide acetate /3.75 MG | K | | \$ 434.89 | . | \$ 86.98 |
| 0802 | Etoposide oral 50 MG | K | | \$ 37.17 | . | \$ 7.43 |
| 0807 | Aldesleukin/single use vial | K | | \$ 724.63 | . | \$ 144.93 |
| 0809 | Bcg live intravesical vac | K | | \$ 115.78 | . | \$ 23.16 |
| 0810 | Goserelin acetate implant | K | | \$ 175.04 | . | \$ 35.01 |
| 0811 | Carboplatin injection | K | | \$ 35.25 | . | \$ 7.05 |
| 0812 | Carmus bischl nitro inj | K | | \$ 139.14 | . | \$ 27.83 |
| 0814 | Asparaginase injection | K | | \$ 54.17 | . | \$ 10.83 |

| APC | Group Title | SI | Relative Weight | Payment Rate | National Unadjusted Copayment | Minimum Unadjusted Copayment |
|------|------------------------------|----|-----------------|--------------|-------------------------------|------------------------------|
| 0819 | Dacarbazine 100 mg inj | K | | \$ 5.20 | . | \$ 1.04 |
| 0820 | Daunorubicin | K | | \$ 23.90 | . | \$ 4.78 |
| 0821 | Daunorubicin citrate liposom | K | | \$ 56.51 | . | \$ 11.30 |
| 0823 | Docetaxel | K | | \$ 293.64 | . | \$ 58.73 |
| 0827 | Floxuridine injection | K | | \$ 60.41 | . | \$ 12.08 |
| 0828 | Gemcitabine HCl | K | | \$ 115.89 | . | \$ 23.18 |
| 0830 | Irinotecan injection | K | | \$ 126.92 | . | \$ 25.38 |
| 0831 | Ifosfomide injection | K | | \$ 34.68 | . | \$ 6.94 |
| 0832 | Idarubicin hcl injection | K | | \$ 286.84 | . | \$ 57.37 |
| 0834 | Interferon alfa-2a inj | K | | \$ 32.87 | . | \$ 6.57 |
| 0835 | Inj cosyntropin per 0.25 MG | K | | \$ 67.82 | . | \$ 13.56 |
| 0836 | Interferon alfa-2b inj | K | | \$ 13.30 | . | \$ 2.66 |
| 0838 | Interferon gamma 1-b inj | K | | \$ 272.44 | . | \$ 54.49 |
| 0840 | Inj melphalan hydrochl 50 MG | K | | \$ 753.64 | . | \$ 150.73 |
| 0842 | Fludarabine phosphate inj | K | | \$ 262.87 | . | \$ 52.57 |
| 0843 | Pegaspargase/singl dose vial | K | | \$ 1,611.20 | . | \$ 322.24 |
| 0844 | Pentostatin injection | K | | \$ 1,900.52 | . | \$ 380.10 |
| 0849 | Rituximab cancer treatment | K | | \$ 455.92 | . | \$ 91.18 |
| 0850 | Streptozocin injection | K | | \$ 154.68 | . | \$ 30.94 |
| 0851 | Thiotepa injection | K | | \$ 47.96 | . | \$ 9.59 |
| 0852 | Topotecan | K | | \$ 763.80 | . | \$ 152.76 |
| 0855 | Vinorelbine tartrate/10 mg | K | | \$ 42.83 | . | \$ 8.57 |
| 0856 | Porfimer sodium | K | | \$ 2,464.57 | . | \$ 492.91 |
| 0857 | Bleomycin sulfate injection | K | | \$ 48.71 | . | \$ 9.74 |
| 0858 | Inj cladribine per 1 MG | K | | \$ 37.94 | . | \$ 7.59 |
| 0860 | Plicamycin (mithramycin) inj | K | 1.0311 | \$ 61.36 | . | \$ 12.27 |
| 0861 | Leuprolide acetate injeciton | K | | \$ 10.00 | . | \$ 2.00 |
| 0862 | Mitomycin 5 MG inj | K | | \$ 22.29 | . | \$ 4.46 |
| 0863 | Paclitaxel injection | K | | \$ 13.33 | . | \$ 2.67 |
| 0864 | Mitoxantrone hydrochl / 5 MG | K | | \$ 323.80 | . | \$ 64.76 |
| 0865 | Interferon alfa-n3 inj | K | | \$ 8.60 | . | \$ 1.72 |
| 0868 | Oral aprepitant | G | | \$ 4.64 | . | \$ 0.93 |
| 0876 | Caffeine citrate injection | K | | \$ 3.37 | . | \$ 0.67 |
| 0884 | Rho d immune globulin inj | K | | \$ 84.99 | . | \$ 17.00 |
| 0887 | Azathioprine parenteral | K | | \$ 49.96 | . | \$ 9.99 |
| 0888 | Cyclosporine oral 100 mg | K | | \$ 3.48 | . | \$ 0.70 |
| 0890 | Lymphocyte immune globulin | K | | \$ 295.72 | . | \$ 59.14 |
| 0891 | Tacrolimus oral per 1 MG | K | | \$ 3.45 | . | \$ 0.69 |
| 0892 | Edetate calcium disodium inj | K | | \$ 40.38 | . | \$ 8.08 |
| 0893 | Calcitonin salmon injection | K | | \$ 37.81 | . | \$ 7.56 |
| 0895 | Deferoxamine mesylate inj | K | | \$ 15.38 | . | \$ 3.08 |
| 0900 | Alglucerase injection | K | | \$ 39.22 | . | \$ 7.84 |
| 0901 | Alpha 1 proteinase inhibitor | K | | \$ 3.28 | . | \$ 0.66 |
| 0902 | Botulinum toxin a per unit | K | | \$ 4.91 | . | \$ 0.98 |

| APC | Group Title | SI | Relative Weight | Payment Rate | National Unadjusted Copayment | Minimum Unadjusted Copayment |
|------|-------------------------------|----|-----------------|--------------|-------------------------------|------------------------------|
| 0903 | Cytomegalovirus imm IV /vial | K | | \$ 722.68 | . | \$ 144.54 |
| 0906 | RSV-ivig | K | | \$ 16.18 | . | \$ 3.24 |
| 0910 | Interferon beta-1b / .25 MG | K | | \$ 85.95 | . | \$ 17.19 |
| 0911 | Inj streptokinase /250000 IU | K | | \$ 79.50 | . | \$ 15.90 |
| 0912 | Interferon alfacon-1 | K | | \$ 3.92 | . | \$ 0.78 |
| 0913 | Ganciclovir long act implant | K | | \$ 4,240.00 | . | \$ 848.00 |
| 0916 | Injection imiglucerase /unit | K | | \$ 3.91 | . | \$ 0.78 |
| 0917 | Adenosine injection | K | | \$ 70.27 | . | \$ 14.05 |
| 0925 | Factor viii | K | | \$ 0.65 | . | \$ 0.13 |
| 0926 | Factor VIII (porcine) | K | | \$ 1.86 | . | \$ 0.37 |
| 0927 | Factor viii recombinant | K | | \$ 1.05 | . | \$ 0.21 |
| 0928 | Factor ix complex | K | | \$ 0.66 | . | \$ 0.13 |
| 0929 | Anti-inhibitor | K | | \$ 1.30 | . | \$ 0.26 |
| 0930 | Antithrombin iii injection | K | | \$ 1.64 | . | \$ 0.33 |
| 0931 | Factor IX non-recombinant | K | | \$ 0.87 | . | \$ 0.17 |
| 0932 | Factor IX recombinant | K | | \$ 0.98 | . | \$ 0.20 |
| 0935 | Clonidine hydrochloride | K | | \$ 63.34 | . | \$ 12.67 |
| 0949 | Frozen plasma, pooled, sd | K | 1.2810 | \$ 76.23 | . | \$ 15.25 |
| 0950 | Whole blood for transfusion | K | 1.9835 | \$ 118.04 | . | \$ 23.61 |
| 0952 | Cryoprecipitate each unit | K | 0.7923 | \$ 47.15 | . | \$ 9.43 |
| 0954 | RBC leukocytes reduced | K | 2.7446 | \$ 163.33 | . | \$ 32.67 |
| 0955 | Plasma, frz between 8-24hour | K | 1.2566 | \$ 74.78 | . | \$ 14.96 |
| 0956 | Plasma protein fract,5%,50ml | K | 1.1429 | \$ 68.02 | . | \$ 13.60 |
| 0957 | Platelets, each unit | K | 0.8663 | \$ 51.55 | . | \$ 10.31 |
| 0958 | Plaelet rich plasma unit | K | 4.6668 | \$ 277.73 | . | \$ 55.55 |
| 0959 | Red blood cells unit | K | 2.0435 | \$ 121.61 | . | \$ 24.32 |
| 0960 | Washed red blood cells unit | K | 3.1830 | \$ 189.42 | . | \$ 37.88 |
| 0961 | Albumin (human),5%, 50ml | K | 0.4987 | \$ 29.68 | . | \$ 5.94 |
| 0963 | Albumin (human), 5%, 250 ml | K | 1.2907 | \$ 76.81 | . | \$ 15.36 |
| 0964 | Albumin (human), 25%, 20 ml | K | 0.4839 | \$ 28.80 | . | \$ 5.76 |
| 0965 | Albumin (human), 25%, 50ml | K | 1.0966 | \$ 65.26 | . | \$ 13.05 |
| 0966 | Plasmaprotein fract,5%,250ml | K | 5.3107 | \$ 316.05 | . | \$ 63.21 |
| 0967 | Blood split unit | K | 1.3878 | \$ 82.59 | . | \$ 16.52 |
| 0968 | Platelets leukoreduced irradi | K | 2.5330 | \$ 150.74 | . | \$ 30.15 |
| 0969 | RBC leukoreduced irradiated | K | 3.6678 | \$ 218.27 | . | \$ 43.65 |
| 1009 | Cryoprecipitatereducedplasma | K | 1.2536 | \$ 74.60 | . | \$ 14.92 |
| 1010 | Blood, l/r, cmv-neg | K | 3.4943 | \$ 207.95 | . | \$ 41.59 |
| 1011 | Platelets, hla-m, l/r, unit | K | 10.2526 | \$ 610.14 | . | \$ 122.03 |
| 1013 | Platelets leukocytes reduced | K | 1.6536 | \$ 98.41 | . | \$ 19.68 |
| 1016 | Blood, l/r, froz/degly/wash | K | 4.4061 | \$ 262.21 | . | \$ 52.44 |
| 1017 | Plt, aph/pher, l/r, cmv-neg | K | 8.8483 | \$ 526.57 | . | \$ 105.31 |
| 1018 | Blood, l/r, irradiated | K | 3.0005 | \$ 178.56 | . | \$ 35.71 |
| 1019 | Plate pheres leukoredu irradi | K | 9.7736 | \$ 581.64 | . | \$ 116.33 |
| 1020 | Plt, pher, l/r cmv-neg, irr | K | 11.0037 | \$ 654.84 | . | \$ 130.97 |

| APC | Group Title | SI | Relative Weight | Payment Rate | National Unadjusted Copayment | Minimum Unadjusted Copayment |
|------|---|----|-----------------|--------------|-------------------------------|------------------------------|
| 1021 | RBC, frz/deg/wsh, l/r, irradi | K | 5.8125 | \$ 345.91 | . | \$ 69.18 |
| 1022 | RBC, l/r, cmv-neg, irradi | K | 4.4896 | \$ 267.18 | . | \$ 53.44 |
| 1045 | I131 iodobenguane, dx | H | | | . | . |
| 1052 | Injection, voriconazole | K | | \$ 4.57 | . | \$ 0.91 |
| 1064 | Th I131 so iodide cap millic | H | | | . | . |
| 1065 | I131 iodide sol, dx | H | | | . | . |
| 1083 | Adalimumab injection | K | | \$ 293.98 | . | \$ 58.80 |
| 1084 | Denileukin diftitox, 300 mcg | K | | \$ 1,252.93 | . | \$ 250.59 |
| 1085 | Gallium nitrate injection | K | | \$ 1.25 | . | \$ 0.25 |
| 1086 | Temozolomide | K | | \$ 7.22 | . | \$ 1.44 |
| 1088 | Iodine I-131 iodide cap, dx | H | | | . | . |
| 1096 | Tc99m exametazime | H | | | . | . |
| 1150 | I131 iodide sol, rx | H | | | . | . |
| 1166 | Cytarabine liposome | K | | \$ 382.72 | . | \$ 76.54 |
| 1167 | Inj, epirubicin hcl, 2 mg | K | | \$ 24.76 | . | \$ 4.95 |
| 1178 | BUSULFAN IV, 6 Mg | K | 0.1795 | \$ 10.68 | . | \$ 2.14 |
| 1203 | Verteporfin injection | K | | \$ 8.96 | . | \$ 1.79 |
| 1207 | Octreotide injection, depot | K | | \$ 87.31 | . | \$ 17.46 |
| 1210 | Inj dihydroergotamine mesylt | K | | \$ 27.28 | . | \$ 5.46 |
| 1280 | Corticotropin injection | K | | \$ 107.18 | . | \$ 21.44 |
| 1330 | Ergonovine maleate injection | K | 0.5564 | \$ 33.11 | . | \$ 6.62 |
| 1436 | Etidronate disodium inj | K | | \$ 71.69 | . | \$ 14.34 |
| 1491 | New Technology - Level IA (\$0-\$10) | S | | \$ 5.00 | \$ 2.00 | \$ 1.00 |
| 1492 | New Technology - Level IB (\$10-\$20) | S | | \$ 15.00 | . | \$ 3.00 |
| 1493 | New Technology - Level IC (\$20-\$30) | S | | \$ 25.00 | . | \$ 5.00 |
| 1494 | New Technology - Level ID (\$30-\$40) | S | | \$ 35.00 | . | \$ 7.00 |
| 1495 | New Technology - Level IE (\$40-\$50) | S | | \$ 45.00 | . | \$ 9.00 |
| 1496 | New Technology - Level IA (\$0-\$10) | T | | \$ 5.00 | . | \$ 1.00 |
| 1497 | New Technology - Level IB(\$10-\$20) | T | | \$ 15.00 | . | \$ 3.00 |
| 1498 | New Technology - Level IC (\$20-\$30) | T | | \$ 25.00 | . | \$ 5.00 |
| 1499 | New Technology - Level ID(\$30-\$40) | T | | \$ 35.00 | . | \$ 7.00 |
| 1500 | New Technology - Level IE (\$40-\$50) | T | | \$ 45.00 | . | \$ 9.00 |
| 1502 | New Technology - Level II (\$50-\$100) | S | | \$ 75.00 | . | \$ 15.00 |
| 1503 | New Technology - Level III (\$100-\$200) | S | | \$ 150.00 | . | \$ 30.00 |
| 1504 | New Technology - Level IV (\$200-\$300) | S | | \$ 250.00 | . | \$ 50.00 |
| 1505 | New Technology - Level V (\$300-\$400) | S | | \$ 350.00 | . | \$ 70.00 |
| 1506 | New Technology - Level VI (\$400-\$500) | S | | \$ 450.00 | . | \$ 90.00 |
| 1507 | New Technology - Level VII (\$500-\$600) | S | | \$ 550.00 | . | \$ 110.00 |
| 1508 | New Technology - Level VIII (\$600-\$700) | S | | \$ 650.00 | . | \$ 130.00 |

| APC | Group Title | SI | Relative Weight | Payment Rate | National Unadjusted Copayment | Minimum Unadjusted Copayment |
|------|---|----|-----------------|--------------|-------------------------------|------------------------------|
| 1509 | New Technology - Level IX (\$700 - \$800) | S | | \$ 750.00 | . | \$ 150.00 |
| 1510 | New Technology - Level X (\$800 - \$900) | S | | \$ 850.00 | . | \$ 170.00 |
| 1511 | New Technology - Level XI (\$900 - \$1000) | S | | \$ 950.00 | . | \$ 190.00 |
| 1512 | New Technology - Level XII (\$1000 - \$1100) | S | | \$ 1,050.00 | . | \$ 210.00 |
| 1513 | New Technology - Level XIII (\$1100 - \$1200) | S | | \$ 1,150.00 | . | \$ 230.00 |
| 1514 | New Technology-Level XIV (\$1200-\$1300) | S | | \$ 1,250.00 | . | \$ 250.00 |
| 1515 | New Technology - Level XV (\$1300 - \$1400) | S | | \$ 1,350.00 | . | \$ 270.00 |
| 1516 | New Technology - Level XVI (\$1400 - \$1500) | S | | \$ 1,450.00 | . | \$ 290.00 |
| 1517 | New Technology - Level XVII (\$1500-\$1600) | S | | \$ 1,550.00 | . | \$ 310.00 |
| 1518 | New Technology - Level XVIII (\$1600-\$1700) | S | | \$ 1,650.00 | . | \$ 330.00 |
| 1519 | New Technology - Level IXX (\$1700-\$1800) | S | | \$ 1,750.00 | . | \$ 350.00 |
| 1520 | New Technology - Level XX (\$1800-\$1900) | S | | \$ 1,850.00 | . | \$ 370.00 |
| 1521 | New Technology - Level XXI (\$1900-\$2000) | S | | \$ 1,950.00 | . | \$ 390.00 |
| 1522 | New Technology - Level XXII (\$2000-\$2500) | S | | \$ 2,250.00 | . | \$ 450.00 |
| 1523 | New Technology - Level XXIII (\$2500-\$3000) | S | | \$ 2,750.00 | . | \$ 550.00 |
| 1524 | New Technology - Level XIV (\$3000-\$3500) | S | | \$ 3,250.00 | . | \$ 650.00 |
| 1525 | New Technology - Level XXV (\$3500-\$4000) | S | | \$ 3,750.00 | . | \$ 750.00 |
| 1526 | New Technology - Level XXVI (\$4000-\$4500) | S | | \$ 4,250.00 | . | \$ 850.00 |
| 1527 | New Technology - Level XXVII (\$4500-\$5000) | S | | \$ 4,750.00 | . | \$ 950.00 |
| 1528 | New Technology - Level XXVIII (\$5000-\$5500) | S | | \$ 5,250.00 | . | \$ 1,050.00 |
| 1529 | New Technology - Level XXIX (\$5500-\$6000) | S | | \$ 5,750.00 | . | \$ 1,150.00 |
| 1530 | New Technology - Level XXX (\$6000-\$6500) | S | | \$ 6,250.00 | . | \$ 1,250.00 |
| 1531 | New Technology - Level XXXI (\$6500-\$7000) | S | | \$ 6,750.00 | . | \$ 1,350.00 |
| 1532 | New Technology - Level XXXII (\$7000-\$7500) | S | | \$ 7,250.00 | . | \$ 1,450.00 |

| APC | Group Title | SI | Relative Weight | Payment Rate | National Unadjusted Copayment | Minimum Unadjusted Copayment |
|------|--|----|-----------------|--------------|-------------------------------|------------------------------|
| 1533 | New Technology - Level XXXIII (\$7500-\$8000) | S | | \$ 7,750.00 | . | \$ 1,550.00 |
| 1534 | New Technology - Level XXXIV (\$8000-\$8500) | S | | \$ 8,250.00 | . | \$ 1,650.00 |
| 1535 | New Technology - Level XXXV (\$8500-\$9000) | S | | \$ 8,750.00 | . | \$ 1,750.00 |
| 1536 | New Technology - Level XXXVI (\$9000-\$9500) | S | | \$ 9,250.00 | . | \$ 1,850.00 |
| 1537 | New Technology - Level XXXVII (\$9500-\$10000) | S | | \$ 9,750.00 | . | \$ 1,950.00 |
| 1539 | New Technology - Level II (\$50 - \$100) | T | | \$ 75.00 | . | \$ 15.00 |
| 1540 | New Technology - Level III (\$100 - \$200) | T | | \$ 150.00 | . | \$ 30.00 |
| 1541 | New Technology - Level IV (\$200 - \$300) | T | | \$ 250.00 | . | \$ 50.00 |
| 1542 | New Technology - Level V (\$300 - \$400) | T | | \$ 350.00 | . | \$ 70.00 |
| 1543 | New Technology - Level VI (\$400 - \$500) | T | | \$ 450.00 | . | \$ 90.00 |
| 1544 | New Technology - Level VII (\$500 - \$600) | T | | \$ 550.00 | . | \$ 110.00 |
| 1545 | New Technology - Level VIII (\$600 - \$700) | T | | \$ 650.00 | . | \$ 130.00 |
| 1546 | New Technology - Level IX (\$700 - \$800) | T | | \$ 750.00 | . | \$ 150.00 |
| 1547 | New Technology - Level X (\$800 - \$900) | T | | \$ 850.00 | . | \$ 170.00 |
| 1548 | New Technology - Level XI (\$900 - \$1000) | T | | \$ 950.00 | . | \$ 190.00 |
| 1549 | New Technology - Level XII (\$1000 - \$1100) | T | | \$ 1,050.00 | . | \$ 210.00 |
| 1550 | New Technology - Level XIII (\$1100 - \$1200) | T | | \$ 1,150.00 | . | \$ 230.00 |
| 1551 | New Technology-Level XIV (\$1200-\$1300) | T | | \$ 1,250.00 | . | \$ 250.00 |
| 1552 | New Technology - Level XV (\$1300 - \$1400) | T | | \$ 1,350.00 | . | \$ 270.00 |
| 1553 | New Technology - Level XVI (\$1400 - \$1500) | T | | \$ 1,450.00 | . | \$ 290.00 |
| 1554 | New Technology - Level XVII (\$1500-\$1600) | T | | \$ 1,550.00 | . | \$ 310.00 |
| 1555 | New Technology - Level XVIII (\$1600-\$1700) | T | | \$ 1,650.00 | . | \$ 330.00 |
| 1556 | New Technology - Level XIX (\$1700-\$1800) | T | | \$ 1,750.00 | . | \$ 350.00 |
| 1557 | New Technology - Level XX (\$1800-\$1900) | T | | \$ 1,850.00 | . | \$ 370.00 |

| APC | Group Title | SI | Relative Weight | Payment Rate | National Unadjusted Copayment | Minimum Unadjusted Copayment |
|------|--|----|-----------------|--------------|-------------------------------|------------------------------|
| 1558 | New Technology - Level XXI (\$1900-\$2000) | T | | \$ 1,950.00 | . | \$ 390.00 |
| 1559 | New Technology - Level XXII (\$2000-\$2500) | T | | \$ 2,250.00 | . | \$ 450.00 |
| 1560 | New Technology - Level XXIII (\$2500-\$3000) | T | | \$ 2,750.00 | . | \$ 550.00 |
| 1561 | New Technology - Level XXIV (\$3000-\$3500) | T | | \$ 3,250.00 | . | \$ 650.00 |
| 1562 | New Technology - Level XXV (\$3500-\$4000) | T | | \$ 3,750.00 | . | \$ 750.00 |
| 1563 | New Technology - Level XXVI (\$4000-\$4500) | T | | \$ 4,250.00 | . | \$ 850.00 |
| 1564 | New Technology - Level XXVII (\$4500-\$5000) | T | | \$ 4,750.00 | . | \$ 950.00 |
| 1565 | New Technology - Level XXVIII (\$5000-\$5500) | T | | \$ 5,250.00 | . | \$ 1,050.00 |
| 1566 | New Technology - Level XXIX (\$5500-\$6000) | T | | \$ 5,750.00 | . | \$ 1,150.00 |
| 1567 | New Technology - Level XXX (\$6000-\$6500) | T | | \$ 6,250.00 | . | \$ 1,250.00 |
| 1568 | New Technology - Level XXXI (\$6500-\$7000) | T | | \$ 6,750.00 | . | \$ 1,350.00 |
| 1569 | New Technology - Level XXXII (\$7000-\$7500) | T | | \$ 7,250.00 | . | \$ 1,450.00 |
| 1570 | New Technology - Level XXXIII (\$7500-\$8000) | T | | \$ 7,750.00 | . | \$ 1,550.00 |
| 1571 | New Technology - Level XXXIV (\$8000-\$8500) | T | | \$ 8,250.00 | . | \$ 1,650.00 |
| 1572 | New Technology - Level XXXV (\$8500-\$9000) | T | | \$ 8,750.00 | . | \$ 1,750.00 |
| 1573 | New Technology - Level XXXVI (\$9000-\$9500) | T | | \$ 9,250.00 | . | \$ 1,850.00 |
| 1574 | New Technology - Level XXXVII (\$9500-\$10000) | T | | \$ 9,750.00 | . | \$ 1,950.00 |
| 1600 | Tc99m sestamibi | H | | | . | . |
| 1602 | Tc99m apcptide | H | | | . | . |
| 1603 | TL201 thallium | H | | | . | . |
| 1604 | In111 capromab | H | | | . | . |
| 1605 | Abciximab injection | K | | \$ 486.98 | . | \$ 97.40 |
| 1606 | Injection anistreplase 30 u | K | | \$ 2,268.46 | . | \$ 453.69 |
| 1607 | Eptifibatide injection | K | | \$ 13.13 | . | \$ 2.63 |
| 1608 | Etanercept injection | K | | \$ 149.62 | . | \$ 29.92 |
| 1609 | Rho(D) immune globulin h, sd | K | | \$ 13.73 | . | \$ 2.75 |
| 1612 | Daclizumab, parenteral | K | | \$ 367.61 | . | \$ 73.52 |
| 1613 | Trastuzumab | K | | \$ 54.39 | . | \$ 10.88 |
| 1629 | Nonmetabolic act d/e tissue | K | | \$ 10.69 | . | \$ 2.14 |
| 1630 | Hep b ig, im | K | | \$ 122.68 | . | \$ 24.54 |

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|------|-----------------------------|----|-----------------|--------------|-------------------------------|------------------------------|
| 1631 | Baclofen intrathecal trial | K | | \$ 70.74 | . | \$ 14.15 |
| 1632 | Metabolic active D/E tissue | K | | \$ 26.91 | . | \$ 5.38 |
| 1633 | Alefacept | K | | \$ 26.56 | . | \$ 5.31 |
| 1634 | Td vaccine no prsrv >= 7 im | K | | \$ 35.00 | . | \$ 7.00 |
| 1635 | Oxacillin sodium injeciton | K | | \$ 1.70 | . | \$ 0.34 |
| 1636 | Yellow fever vaccine, sc | K | | \$ 50.74 | . | \$ 10.15 |
| 1637 | Hyaluronidase injection | K | | \$ 50.15 | . | \$ 10.03 |
| 1638 | Dimecaprol injection | K | | \$ 21.85 | . | \$ 4.37 |
| 1639 | Aurothioglucose injeciton | K | | \$ 24.50 | . | \$ 4.90 |
| 1640 | Injection, methylene blue | K | | \$ 3.05 | . | \$ 0.61 |
| 1641 | Tc99m depreotide | H | | | . | . |
| 1642 | In111 ibritumomab, dx | H | | | . | . |
| 1643 | Y90 ibritumomab, rx | H | | | . | . |
| 1644 | I131 tositumomab, dx | H | | | . | . |
| 1645 | I131 tositumomab, rx | H | | | . | . |
| 1646 | In111 oxyquinoline | H | | | . | . |
| 1647 | In111 pentetate | H | | | . | . |
| 1648 | Tc99m arcitumomab | H | | | . | . |
| 1649 | Tc99m gluceptate | H | | | . | . |
| 1650 | Tc99m succimer | H | | | . | . |
| 1651 | F18 fdg | H | | | . | . |
| 1652 | Cr51 chromate | H | | | . | . |
| 1653 | I125 iothalamate, dx | H | | | . | . |
| 1654 | Rb82 rubidium | H | | | . | . |
| 1655 | Tinzaparin sodium injection | K | | \$ 2.31 | . | \$ 0.46 |
| 1670 | Tetanus immune globulin inj | K | | \$ 85.67 | . | \$ 17.13 |
| 1671 | Ga67 gallium | H | | | . | . |
| 1672 | Tc99m bicisate | H | | | . | . |
| 1673 | Tc99m labeled rbc | H | | | . | . |
| 1674 | Tc99m mertiatide | H | | | . | . |
| 1675 | P32 Na phosphate | H | | | . | . |
| 1676 | P32 chromic phosphate | H | | | . | . |
| 1677 | In111 pentetreotide | H | | | . | . |
| 1678 | Tc99m fanolesomab | H | | | . | . |
| 1679 | Technetium TC-99m aerosol | H | | | . | . |
| 1680 | Acetylcysteine injection | K | | \$ 52.00 | . | \$ 10.40 |
| 1681 | Amikacin sulfate injection | K | | \$ 12.50 | . | \$ 2.50 |
| 1682 | Aprotonin, 10,000 kiu | K | | \$ 2.31 | . | \$ 0.46 |
| 1683 | Basiliximab | K | | \$ 1,420.76 | . | \$ 284.15 |
| 1684 | Corticoelin ovine triflural | K | | \$ 3.76 | . | \$ 0.75 |
| 1685 | Darbepoetin alfa, non-esrd | K | | \$ 3.01 | . | \$ 0.60 |
| 1686 | Epoetin alfa, non-esrd | K | | \$ 9.22 | . | \$ 1.84 |
| 1687 | Digoxin immune fab (ovine) | K | | \$ 546.93 | . | \$ 109.39 |
| 1688 | Ethanolamine oleate | K | | \$ 79.35 | . | \$ 15.87 |

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|------|-------------------------------|----|-----------------|--------------|-------------------------------|------------------------------|
| 1689 | Fomepizole | K | | \$ 11.88 | . | \$ 2.38 |
| 1690 | Hemin | K | 0.0670 | \$ 3.99 | . | \$ 0.80 |
| 1691 | Iron dextran 165 injection | K | | \$ 11.80 | . | \$ 2.36 |
| 1692 | Iron dextran 267 injection | K | | \$ 10.20 | . | \$ 2.04 |
| 1693 | Lepiridin | K | | \$ 146.92 | . | \$ 29.38 |
| 1694 | Ziconotide injection | G | | \$ 6.45 | . | \$ 1.29 |
| 1695 | Nesiritide injection | K | | \$ 29.89 | . | \$ 5.98 |
| 1696 | Palifermin injection | K | | \$ 11.00 | . | \$ 2.20 |
| 1697 | Pegaptanib sodium injection | G | | \$ 1,054.70 | . | \$ 210.94 |
| 1698 | Pentastarch 10% solution | K | | \$ 12.72 | . | \$ 2.54 |
| 1699 | Sincalide injection | K | | \$ 27.58 | . | \$ 5.52 |
| 1700 | Inj secretin synthetic human | K | | \$ 20.31 | . | \$ 4.06 |
| 1701 | Treprostinil injection | K | | \$ 54.02 | . | \$ 10.80 |
| 1702 | Ovine, up to 999 USP units | K | | \$ 129.87 | . | \$ 25.97 |
| 1703 | Ovine, 1000 USP units | K | | \$ 108.33 | . | \$ 21.67 |
| 1704 | Inj Vonwillebrand factor iu | K | | \$ 0.87 | . | \$ 0.17 |
| 1705 | Factor viia | K | | \$ 1.02 | . | \$ 0.20 |
| 1706 | Hyaluron/deriv intra-art inj | K | | \$ 7.20 | . | \$ 1.44 |
| 1707 | Non-human, metabolic tissue | K | | \$ 1.01 | . | \$ 0.20 |
| 1708 | Oral dexamethasone | K | | \$ 0.22 | . | \$ 0.04 |
| 1709 | Azacitidine injection | K | | \$ 4.04 | . | \$ 0.81 |
| 1710 | Clofarabine injection | G | | \$ 116.87 | . | \$ 23.37 |
| 1711 | Histrelin implant | K | | \$ 5,000.00 | . | \$ 1,000.00 |
| 1712 | Paclitaxel injection | G | | \$ 8.32 | . | \$ 1.66 |
| 1713 | Inj Fe-based MR contrast, ml | K | | \$ 30.41 | . | \$ 6.08 |
| 1714 | HOCM <=149 mg/ml iodine | K | | \$ 0.06 | . | \$ 0.01 |
| 1715 | HOCM 200-249mg/ml iodine | K | | \$ 0.09 | . | \$ 0.02 |
| 1716 | Brachytx source, Gold 198 | H | | | . | . |
| 1717 | Brachytx source, HDR Ir-192 | H | | | . | . |
| 1718 | Brachytx source, Iodine 125 | H | | | . | . |
| 1719 | Brachytx sour, Non-HDR Ir-192 | H | | | . | . |
| 1720 | Brachytx sour, Palladium 103 | H | | | . | . |
| 1734 | HOCM 250-299mg/ml iodine | K | | \$ 0.15 | . | \$ 0.03 |
| 1735 | HOCM 300-349mg/ml iodine | K | | \$ 0.14 | . | \$ 0.03 |
| 1736 | HOCM 350-399mg/ml iodine | K | | \$ 0.38 | . | \$ 0.08 |
| 1737 | HOCM >= 400 mg/ml iodine | K | | \$ 0.20 | . | \$ 0.04 |
| 1738 | Oxaliplatin | K | | \$ 8.53 | . | \$ 1.71 |
| 1739 | Pegademase bovine, 25 iu | K | | \$ 166.07 | . | \$ 33.21 |
| 1740 | Diazoxide injection | K | | \$ 111.70 | . | \$ 22.34 |
| 1741 | Urofollitropin, 75 iu | K | | \$ 48.45 | . | \$ 9.69 |
| 2210 | Methyldopate hcl injection | K | | \$ 9.79 | . | \$ 1.96 |
| 2616 | Brachytx source, Yttrium-90 | H | | | . | . |
| 2632 | Brachytx sol, I-125, per mCi | H | | | . | . |
| 2633 | Brachytx source, Cesium-131 | H | | | . | . |

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|------|-------------------------------|----|-----------------|--------------|-------------------------------|------------------------------|
| 2634 | Brachytx source, HA, I-125 | H | | | . | . |
| 2635 | Brachytx source, HA, P-103 | H | | | . | . |
| 2636 | Brachytx linear source, P-103 | H | | | . | . |
| 2637 | Brachytx, Ytterbium-169 | H | | | . | . |
| 2730 | Pralidoxime chloride inj | K | | \$ 91.90 | . | \$ 18.38 |
| 2731 | Immune globulin, powder | K | | \$ 21.28 | . | \$ 4.26 |
| 2732 | Immune globulin, liquid | K | | \$ 28.15 | . | \$ 5.63 |
| 2770 | Quinupristin/dalfopristin | K | | \$ 103.11 | . | \$ 20.62 |
| 2940 | Somatrem injection | K | 0.5982 | \$ 35.60 | . | \$ 7.12 |
| 3030 | Sumatriptan succinate / 6 MG | K | | \$ 50.99 | . | \$ 10.20 |
| 7000 | Amifostine | K | | \$ 439.31 | . | \$ 87.86 |
| 7005 | Gonadorelin hydroch/ 100 mcg | K | | \$ 180.30 | . | \$ 36.06 |
| 7011 | Oprelvekin injection | K | | \$ 247.77 | . | \$ 49.55 |
| 7015 | Oral busulfan | K | | \$ 1.96 | . | \$ 0.39 |
| 7028 | Fosphenytoin, 50 mg | K | | \$ 5.32 | . | \$ 1.06 |
| 7034 | Somatropin injection | K | | \$ 43.87 | . | \$ 8.77 |
| 7035 | Teniposide, 50 mg | K | | \$ 264.05 | . | \$ 52.81 |
| 7036 | Urokinase 250,000 IU inj | K | | \$ 457.73 | . | \$ 91.55 |
| 7038 | Monoclonal antibodies | K | | \$ 864.56 | . | \$ 172.91 |
| 7041 | Tirofiban HCl | K | | \$ 7.86 | . | \$ 1.57 |
| 7042 | Capecitabine, oral, 150 mg | K | | \$ 3.51 | . | \$ 0.70 |
| 7043 | Infliximab injection | K | | \$ 53.43 | . | \$ 10.69 |
| 7045 | Inj trimetrexate gluconate | K | | \$ 146.85 | . | \$ 29.37 |
| 7046 | Doxorubicin hcl liposome inj | K | | \$ 364.53 | . | \$ 72.91 |
| 7048 | Alteplase recombinant | K | | \$ 31.44 | . | \$ 6.29 |
| 7049 | Filgrastim 480 mcg injection | K | | \$ 279.57 | . | \$ 55.91 |
| 7051 | Leuprolide acetate implant | K | | \$ 2,371.75 | . | \$ 474.35 |
| 7308 | Aminolevulinic acid hcl top | K | | \$ 101.87 | . | \$ 20.37 |
| 7515 | Cyclosporine oral 25 mg | K | | \$ 0.91 | . | \$ 0.18 |
| 9001 | Linezolid injection | K | | \$ 23.72 | . | \$ 4.74 |
| 9002 | Tenecteplase injection | K | | \$ 2,064.24 | . | \$ 412.85 |
| 9003 | Palivizumab, per 50 mg | K | 4.3120 | \$ 256.61 | . | \$ 51.32 |
| 9004 | Gemtuzumab ozogamicin | K | | \$ 2,248.15 | . | \$ 449.63 |
| 9005 | Retepase injection | K | | \$ 1,278.84 | . | \$ 255.77 |
| 9006 | Tacrolimus injection | K | | \$ 136.86 | . | \$ 27.37 |
| 9012 | Arsenic trioxide | K | | \$ 33.25 | . | \$ 6.65 |
| 9015 | Mycophenolate mofetil oral | K | | \$ 2.54 | . | \$ 0.51 |
| 9018 | Botulinum toxin type B | K | | \$ 7.80 | . | \$ 1.56 |
| 9019 | Caspofungin acetate | K | | \$ 32.52 | . | \$ 6.50 |
| 9020 | Sirolimus, oral | K | | \$ 6.83 | . | \$ 1.37 |
| 9022 | IM inj interferon beta 1-a | K | | \$ 93.07 | . | \$ 18.61 |
| 9023 | Rho d immune globulin 50 mcg | K | | \$ 24.51 | . | \$ 4.90 |
| 9024 | Amphotericin b lipid complex | K | | \$ 11.24 | . | \$ 2.25 |
| 9030 | Amphotericin B | K | | \$ 22.94 | . | \$ 4.59 |

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|------|------------------------------|----|-----------------|--------------|-------------------------------|------------------------------|
| 9031 | Arbutamine HCl injection | K | | \$ 160.00 | . | \$ 32.00 |
| 9032 | Baclofen 10 MG injection | K | | \$ 190.29 | . | \$ 38.06 |
| 9033 | Cidofovir injection | K | | \$ 768.71 | . | \$ 153.74 |
| 9038 | Inj estrogen conjugate 25 MG | K | | \$ 56.71 | . | \$ 11.34 |
| 9040 | Intraocular Fomivirsen na | K | | \$ 212.00 | . | \$ 42.40 |
| 9042 | Glucagon hydrochloride/1 MG | K | | \$ 64.92 | . | \$ 12.98 |
| 9044 | Ibutilide fumarate injection | K | | \$ 249.56 | . | \$ 49.91 |
| 9046 | Iron sucrose injection | K | | \$ 0.36 | . | \$ 0.07 |
| 9047 | Itraconazole injection | K | | \$ 36.30 | . | \$ 7.26 |
| 9051 | Urea injection | K | 0.6353 | \$ 37.81 | . | \$ 7.56 |
| 9054 | Metabolically active tissue | K | | \$ 15.51 | . | \$ 3.10 |
| 9055 | Injectable human tissue | K | | \$ 5.35 | . | \$ 1.07 |
| 9100 | I131 serum albumin, dx | H | | | . | . |
| 9104 | Antithymocyte globuln rabbit | K | | \$ 312.17 | . | \$ 62.43 |
| 9108 | Thyrotropin injection | K | | \$ 699.27 | . | \$ 139.85 |
| 9110 | Alemtuzumab injection | K | | \$ 511.52 | . | \$ 102.30 |
| 9112 | Inj perflutren lip micros,ml | K | | \$ 61.88 | . | \$ 12.38 |
| 9115 | Zoledronic acid | K | | \$ 200.03 | . | \$ 40.01 |
| 9119 | Pentastarch 10% solution | K | | \$ 2,078.07 | . | \$ 415.61 |
| 9120 | Injection, Fulvestrant | K | | \$ 81.33 | . | \$ 16.27 |
| 9121 | Injection, argatroban | K | 0.2176 | \$ 12.95 | . | \$ 2.59 |
| 9122 | Triptorelin pamoate | K | | \$ 372.86 | . | \$ 74.57 |
| 9124 | Daptomycin injection | G | | \$ 0.29 | . | \$ 0.06 |
| 9125 | Risperidone, long acting | G | | \$ 4.69 | . | \$ 0.94 |
| 9126 | Injection, Natalizumab, 1 MG | G | | \$ 6.39 | . | \$ 1.28 |
| 9133 | Rabies ig, im/sc | K | | \$ 63.14 | . | \$ 12.63 |
| 9134 | Rabies ig, heat treated | K | | \$ 70.47 | . | \$ 14.09 |
| 9135 | Varicella-zoster ig, im | K | | \$ 76.19 | . | \$ 15.24 |
| 9136 | Adenovirus vaccine, type 4 | K | 0.8674 | \$ 51.62 | . | \$ 10.32 |
| 9137 | Bcg vaccine, percut | K | | \$ 116.33 | . | \$ 23.27 |
| 9138 | Hep a/hep b vacc, adult im | K | 0.9250 | \$ 55.05 | . | \$ 11.01 |
| 9139 | Rabies vaccine, im | K | | \$ 137.59 | . | \$ 27.52 |
| 9140 | Rabies vaccine, id | K | 1.5048 | \$ 89.55 | . | \$ 17.91 |
| 9141 | Measles-rubella vaccine, sc | K | 1.0220 | \$ 60.82 | . | \$ 12.16 |
| 9142 | Chicken pox vaccine, sc | K | | \$ 67.07 | . | \$ 13.41 |
| 9143 | Meningococcal vaccine, sc | K | | \$ 82.66 | . | \$ 16.53 |
| 9144 | Encephalitis vaccine, sc | K | | \$ 84.60 | . | \$ 16.92 |
| 9145 | Meningococcal vaccine, im | K | 0.9025 | \$ 53.71 | . | \$ 10.74 |
| 9146 | Tc99m disofenin | H | | | . | . |
| 9148 | I123 iodide cap, dx | H | | | . | . |
| 9149 | I131 max 100uCi | H | | | . | . |
| 9150 | I125 serum albumin, dx | H | | | . | . |
| 9156 | Nonmetabolic active tissue | K | | \$ 63.37 | . | \$ 12.67 |
| 9157 | LOCM <=149 mg/ml iodine, 1ml | K | | \$ 0.24 | . | \$ 0.05 |

| APC | Group Title | SI | Relative Weight | Payment Rate | National Unadjusted Copayment | Minimum Unadjusted Copayment |
|------|------------------------------|----|-----------------|--------------|-------------------------------|------------------------------|
| 9158 | LOCM 150-199mg/ml iodine,1ml | K | | \$ 1.79 | . | \$ 0.36 |
| 9159 | LOCM 200-249mg/ml iodine,1ml | K | | \$ 1.30 | . | \$ 0.26 |
| 9160 | LOCM 250-299mg/ml iodine,1ml | K | | \$ 0.30 | . | \$ 0.06 |
| 9161 | LOCM 300-349mg/ml iodine,1ml | K | | \$ 0.34 | . | \$ 0.07 |
| 9162 | LOCM 350-399mg/ml iodine,1ml | K | | \$ 0.23 | . | \$ 0.05 |
| 9163 | LOCM >= 400 mg/ml iodine,1ml | K | | \$ 0.19 | . | \$ 0.04 |
| 9164 | Inj Gad-base MR contrast, ml | K | | \$ 2.93 | . | \$ 0.59 |
| 9165 | Oral MR contrast, 100 ml | K | | \$ 8.97 | . | \$ 1.79 |
| 9166 | Dyphylline injection | K | | \$ 8.05 | . | \$ 1.61 |
| 9167 | Valrubicin, 200 mg | K | | \$ 369.60 | . | \$ 73.92 |
| 9169 | Anthrax vaccine, sc | K | | \$ 126.46 | . | \$ 25.29 |
| 9170 | Lyme disease vaccine, im | K | 0.9161 | \$ 54.52 | . | \$ 10.90 |
| 9202 | Inj octafluoropropane mic,ml | K | | \$ 41.43 | . | \$ 8.29 |
| 9203 | Inj perflerane lip micros,ml | K | | \$ 13.25 | . | \$ 2.65 |
| 9207 | Bortezomib injection | K | | \$ 29.02 | . | \$ 5.80 |
| 9208 | Agalsidase beta injection | K | | \$ 127.17 | . | \$ 25.43 |
| 9209 | Laronidase injection | K | | \$ 23.87 | . | \$ 4.77 |
| 9210 | Palonosetron HCl | K | | \$ 17.99 | . | \$ 3.60 |
| 9213 | Permetrexed injection | G | | \$ 40.67 | . | \$ 8.13 |
| 9214 | Bevacizumab injection | G | | \$ 57.11 | . | \$ 11.42 |
| 9215 | Cetuximab injection | G | | \$ 49.76 | . | \$ 9.95 |
| 9216 | Abarelix injection | G | | \$ 67.78 | . | \$ 13.56 |
| 9217 | Leuprolide acetate suspnsion | K | | \$ 224.42 | . | \$ 44.88 |
| 9219 | Mycophenolic acid | G | | \$ 2.16 | . | \$ 0.43 |
| 9220 | Sodium hyaluronate | G | | \$ 193.59 | . | \$ 38.72 |
| 9221 | Graftjacket Reg Matrix | G | | \$ 1,307.48 | . | \$ 261.50 |
| 9222 | Graftjacket SftTis | G | | \$ 883.21 | . | \$ 176.64 |
| 9224 | Injection, galsulfase | K | | \$ 1,522.15 | . | \$ 304.43 |
| 9225 | Fluocinolone acetonide | G | | \$19,345.00 | . | \$ 3,869.00 |
| 9300 | Omalizumab injection | G | | \$ 15.88 | . | \$ 3.18 |
| 9500 | Platelets, irradiated | K | 1.4559 | \$ 86.64 | . | \$ 17.33 |
| 9501 | Platelet pheres leukoreduced | K | 8.2952 | \$ 493.66 | . | \$ 98.73 |
| 9502 | Platelet pheresis irradiated | K | 5.4817 | \$ 326.22 | . | \$ 65.24 |
| 9503 | Fr frz plasma donor retested | K | 1.5934 | \$ 94.82 | . | \$ 18.96 |
| 9504 | RBC deglycerolized | K | 5.7773 | \$ 343.81 | . | \$ 68.76 |
| 9505 | RBC irradiated | K | 2.4807 | \$ 147.63 | . | \$ 29.53 |
| 9506 | Granulocytes, pheresis unit | K | 16.7317 | \$ 995.72 | . | \$ 199.14 |
| 9507 | Platelets, pheresis | K | 7.3009 | \$ 434.48 | . | \$ 86.90 |
| 9508 | Plasma 1 donor frz w/in 8 hr | K | 1.1842 | \$ 70.47 | . | \$ 14.09 |

Addendum B.—Payment Status by HCPCS Code and Related Information – Calendar Year 2006

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|-----|--------------------|-----------------|-------------------------------------|------------------------------------|
| 00100 | Anesth, salivary gland | | N | | | | | |
| 00102 | Anesth, repair of cleft lip | | N | | | | | |
| 00103 | Anesth, blepharoplasty | | N | | | | | |
| 00104 | Anesth, electroshock | | N | | | | | |
| 00120 | Anesth, ear surgery | | N | | | | | |
| 00124 | Anesth, ear exam | | N | | | | | |
| 00126 | Anesth, tympanotomy | | N | | | | | |
| 00140 | Anesth, procedures on eye | | N | | | | | |
| 00142 | Anesth, lens surgery | | N | | | | | |
| 00144 | Anesth, corneal transplant | | N | | | | | |
| 00145 | Anesth, vitreoretinal surg | | N | | | | | |
| 00147 | Anesth, iridectomy | | N | | | | | |
| 00148 | Anesth, eye exam | | N | | | | | |
| 00160 | Anesth, nose/sinus surgery | | N | | | | | |
| 00162 | Anesth, nose/sinus surgery | | N | | | | | |
| 00164 | Anesth, biopsy of nose | | N | | | | | |
| 00170 | Anesth, procedure on mouth | | N | | | | | |
| 00172 | Anesth, cleft palate repair | | N | | | | | |
| 00174 | Anesth, pharyngeal surgery | | N | | | | | |
| 00190 | Anesth, face/skull bone surg | | N | | | | | |
| 00210 | Anesth, open head surgery | | N | | | | | |
| 00212 | Anesth, skull drainage | | N | | | | | |
| 00216 | Anesth, head vessel surgery | | N | | | | | |
| 00218 | Anesth, special head surgery | | N | | | | | |
| 00220 | Anesth, intrcrn nerve | | N | | | | | |
| 00222 | Anesth, head nerve surgery | | N | | | | | |
| 00300 | Anesth, head/neck/ptrunk | | N | | | | | |
| 00320 | Anesth, neck organ, 1 & over | | N | | | | | |
| 00322 | Anesth, biopsy of thyroid | | N | | | | | |
| 00326 | Anesth, larynx/trach, < 1 yr | | N | | | | | |
| 00350 | Anesth, neck vessel surgery | | N | | | | | |
| 00352 | Anesth, neck vessel surgery | | N | | | | | |
| 00400 | Anesth, skin, ext/per/atrunk | | N | | | | | |
| 00402 | Anesth, surgery of breast | | N | | | | | |
| 00410 | Anesth, correct heart rhythm | | N | | | | | |
| 00450 | Anesth, surgery of shoulder | | N | | | | | |
| 00454 | Anesth, collar bone biopsy | | N | | | | | |
| 00470 | Anesth, removal of rib | | N | | | | | |
| 00472 | Anesth, chest wall repair | | N | | | | | |
| 00500 | Anesth, esophageal surgery | | N | | | | | |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|-------------------------------|----|----|-----|--------------------|-----------------|-------------------------------------|------------------------------------|
| 00520 | Anesth, chest procedure | | N | | | | | |
| 00522 | Anesth, chest lining biopsy | | N | | | | | |
| 00528 | Anesth, chest partition view | | N | | | | | |
| 00529 | Anesth, chest partition view | | N | | | | | |
| 00530 | Anesth, pacemaker insertion | | N | | | | | |
| 00532 | Anesth, vascular access | | N | | | | | |
| 00534 | Anesth, cardioverter/defib | | N | | | | | |
| 00537 | Anesth, cardiac electrophys | | N | | | | | |
| 00539 | Anesth, trach-bronch reconst | | N | | | | | |
| 00541 | Anesth, one lung ventilation | | N | | | | | |
| 00548 | Anesth, trachea, bronchi surg | | N | | | | | |
| 00550 | Anesth, sternal debridement | | N | | | | | |
| 00563 | Anesth, heart surg w/arrest | | N | | | | | |
| 00566 | Anesth, cabg w/o pump | | N | | | | | |
| 00600 | Anesth, spine, cord surgery | | N | | | | | |
| 00620 | Anesth, spine, cord surgery | | N | | | | | |
| 00630 | Anesth, spine, cord surgery | | N | | | | | |
| 00634 | Anesth for chemonucleolysis | CH | N | | | | | |
| 00635 | Anesth, lumbar puncture | | N | | | | | |
| 00640 | Anesth, spine manipulation | | N | | | | | |
| 00700 | Anesth, abdominal wall surg | | N | | | | | |
| 00702 | Anesth, for liver biopsy | | N | | | | | |
| 00730 | Anesth, abdominal wall surg | | N | | | | | |
| 00740 | Anesth, upper gi visualize | | N | | | | | |
| 00750 | Anesth, repair of hernia | | N | | | | | |
| 00752 | Anesth, repair of hernia | | N | | | | | |
| 00754 | Anesth, repair of hernia | | N | | | | | |
| 00756 | Anesth, repair of hernia | | N | | | | | |
| 00770 | Anesth, blood vessel repair | | N | | | | | |
| 00790 | Anesth, surg upper abdomen | | N | | | | | |
| 00797 | Anesth, surgery for obesity | | N | | | | | |
| 00800 | Anesth, abdominal wall surg | | N | | | | | |
| 00810 | Anesth, low intestine scope | | N | | | | | |
| 00820 | Anesth, abdominal wall surg | | N | | | | | |
| 00830 | Anesth, repair of hernia | | N | | | | | |
| 00832 | Anesth, repair of hernia | | N | | | | | |
| 00834 | Anesth, hernia repair< 1 yr | | N | | | | | |
| 00836 | Anesth hernia repair preemie | | N | | | | | |
| 00840 | Anesth, surg lower abdomen | | N | | | | | |
| 00842 | Anesth, amniocentesis | | N | | | | | |
| 00851 | Anesth, tubal ligation | | N | | | | | |
| 00860 | Anesth, surgery of abdomen | | N | | | | | |
| 00862 | Anesth, kidney/ureter surg | | N | | | | | |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|-----|--------------------|-----------------|-------------------------------------|------------------------------------|
| 00870 | Anesth, bladder stone surg | | N | | | | | |
| 00872 | Anesth kidney stone destruct | | N | | | | | |
| 00873 | Anesth kidney stone destruct | | N | | | | | |
| 00880 | Anesth, abdomen vessel surg | | N | | | | | |
| 00902 | Anesth, anorectal surgery | | N | | | | | |
| 00906 | Anesth, removal of vulva | | N | | | | | |
| 00910 | Anesth, bladder surgery | | N | | | | | |
| 00912 | Anesth, bladder tumor surg | | N | | | | | |
| 00914 | Anesth, removal of prostate | | N | | | | | |
| 00916 | Anesth, bleeding control | | N | | | | | |
| 00918 | Anesth, stone removal | | N | | | | | |
| 00920 | Anesth, genitalia surgery | | N | | | | | |
| 00921 | Anesth, vasectomy | | N | | | | | |
| 00922 | Anesth, sperm duct surgery | | N | | | | | |
| 00924 | Anesth, testis exploration | | N | | | | | |
| 00926 | Anesth, removal of testis | | N | | | | | |
| 00928 | Anesth, removal of testis | | N | | | | | |
| 00930 | Anesth, testis suspension | | N | | | | | |
| 00938 | Anesth, insert penis device | | N | | | | | |
| 00940 | Anesth, vaginal procedures | | N | | | | | |
| 00942 | Anesth, surg on vag/urethral | | N | | | | | |
| 00948 | Anesth, repair of cervix | | N | | | | | |
| 00950 | Anesth, vaginal endoscopy | | N | | | | | |
| 00952 | Anesth, hysteroscope/graph | | N | | | | | |
| 01112 | Anesth, bone aspirate/bx | | N | | | | | |
| 01120 | Anesth, pelvis surgery | | N | | | | | |
| 01130 | Anesth, body cast procedure | | N | | | | | |
| 01160 | Anesth, pelvis procedure | | N | | | | | |
| 01170 | Anesth, pelvis surgery | | N | | | | | |
| 01173 | Anesth, fx repair, pelvis | | N | | | | | |
| 01180 | Anesth, pelvis nerve removal | | N | | | | | |
| 01190 | Anesth, pelvis nerve removal | CH | N | | | | | |
| 01200 | Anesth, hip joint procedure | | N | | | | | |
| 01202 | Anesth, arthroscopy of hip | | N | | | | | |
| 01210 | Anesth, hip joint surgery | | N | | | | | |
| 01215 | Anesth, revise hip repair | | N | | | | | |
| 01220 | Anesth, procedure on femur | | N | | | | | |
| 01230 | Anesth, surgery of femur | | N | | | | | |
| 01250 | Anesth, upper leg surgery | | N | | | | | |
| 01260 | Anesth, upper leg veins surg | | N | | | | | |
| 01270 | Anesth, thigh arteries surg | | N | | | | | |
| 01320 | Anesth, knee area surgery | | N | | | | | |
| 01340 | Anesth, knee area procedure | | N | | | | | |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|-----|--------------------|-----------------|-------------------------------------|------------------------------------|
| 01360 | Anesth, knee area surgery | | N | | | | | |
| 01380 | Anesth, knee joint procedure | | N | | | | | |
| 01382 | Anesth, dx knee arthroscopy | | N | | | | | |
| 01390 | Anesth, knee area procedure | | N | | | | | |
| 01392 | Anesth, knee area surgery | | N | | | | | |
| 01400 | Anesth, knee joint surgery | | N | | | | | |
| 01420 | Anesth, knee joint casting | | N | | | | | |
| 01430 | Anesth, knee veins surgery | | N | | | | | |
| 01432 | Anesth, knee vessel surg | | N | | | | | |
| 01440 | Anesth, knee arteries surg | | N | | | | | |
| 01462 | Anesth, lower leg procedure | | N | | | | | |
| 01464 | Anesth, ankle/ft arthroscopy | | N | | | | | |
| 01470 | Anesth, lower leg surgery | | N | | | | | |
| 01472 | Anesth, achilles tendon surg | | N | | | | | |
| 01474 | Anesth, lower leg surgery | | N | | | | | |
| 01480 | Anesth, lower leg bone surg | | N | | | | | |
| 01482 | Anesth, radical leg surgery | | N | | | | | |
| 01484 | Anesth, lower leg revision | | N | | | | | |
| 01490 | Anesth, lower leg casting | | N | | | | | |
| 01500 | Anesth, leg arteries surg | | N | | | | | |
| 01520 | Anesth, lower leg vein surg | | N | | | | | |
| 01522 | Anesth, lower leg vein surg | | N | | | | | |
| 01610 | Anesth, surgery of shoulder | | N | | | | | |
| 01620 | Anesth, shoulder procedure | | N | | | | | |
| 01622 | Anes dx shoulder arthroscopy | | N | | | | | |
| 01630 | Anesth, surgery of shoulder | | N | | | | | |
| 01650 | Anesth, shoulder artery surg | | N | | | | | |
| 01670 | Anesth, shoulder vein surg | | N | | | | | |
| 01680 | Anesth, shoulder casting | | N | | | | | |
| 01682 | Anesth, airplane cast | | N | | | | | |
| 01710 | Anesth, elbow area surgery | | N | | | | | |
| 01712 | Anesth, uppr arm tendon surg | | N | | | | | |
| 01714 | Anesth, uppr arm tendon surg | | N | | | | | |
| 01716 | Anesth, biceps tendon repair | | N | | | | | |
| 01730 | Anesth, uppr arm procedure | | N | | | | | |
| 01732 | Anesth, dx elbow arthroscopy | | N | | | | | |
| 01740 | Anesth, upper arm surgery | | N | | | | | |
| 01742 | Anesth, humerus surgery | | N | | | | | |
| 01744 | Anesth, humerus repair | | N | | | | | |
| 01758 | Anesth, humeral lesion surg | | N | | | | | |
| 01760 | Anesth, elbow replacement | | N | | | | | |
| 01770 | Anesth, uppr arm artery surg | | N | | | | | |
| 01772 | Anesth, uppr arm embolectomy | | N | | | | | |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|-----|--------------------|-----------------|-------------------------------------|------------------------------------|
| 01780 | Anesth, upper arm vein surg | | N | | | | | |
| 01782 | Anesth, uppr arm vein repair | | N | | | | | |
| 01810 | Anesth, lower arm surgery | | N | | | | | |
| 01820 | Anesth, lower arm procedure | | N | | | | | |
| 01829 | Anesth, dx wrist arthroscopy | | N | | | | | |
| 01830 | Anesth, lower arm surgery | | N | | | | | |
| 01832 | Anesth, wrist replacement | | N | | | | | |
| 01840 | Anesth, lwr arm artery surg | | N | | | | | |
| 01842 | Anesth, lwr arm embolectomy | | N | | | | | |
| 01844 | Anesth, vascular shunt surg | | N | | | | | |
| 01850 | Anesth, lower arm vein surg | | N | | | | | |
| 01852 | Anesth, lwr arm vein repair | | N | | | | | |
| 01860 | Anesth, lower arm casting | | N | | | | | |
| 01905 | Anes, spine inject, x-ray/re | | N | | | | | |
| 01916 | Anesth, dx arteriography | | N | | | | | |
| 01920 | Anesth, catheterize heart | | N | | | | | |
| 01922 | Anesth, cat or MRI scan | | N | | | | | |
| 01924 | Anes, ther interven rad, art | | N | | | | | |
| 01925 | Anes, ther interven rad, car | | N | | | | | |
| 01926 | Anes, tx interv rad hrt/cran | | N | | | | | |
| 01930 | Anes, ther interven rad, vei | | N | | | | | |
| 01931 | Anes, ther interven rad, tip | | N | | | | | |
| 01932 | Anes, tx interv rad, th vein | | N | | | | | |
| 01933 | Anes, tx interv rad, cran v | | N | | | | | |
| 01951 | Anesth, burn, less 4 percent | | N | | | | | |
| 01952 | Anesth, burn, 4-9 percent | | N | | | | | |
| 01953 | Anesth, burn, each 9 percent | | N | | | | | |
| 01958 | Anesth, antepartum manipul | | N | | | | | |
| 01960 | Anesth, vaginal delivery | | N | | | | | |
| 01961 | Anesth, cs delivery | | N | | | | | |
| 01962 | Anesth, emer hysterectomy | | N | | | | | |
| 01963 | Anesth, cs hysterectomy | | N | | | | | |
| 01964 | Anesth, abortion procedures | CH | D | | | | | |
| 01965 | Anesth, inc/missed ab proc | NI | N | | | | | |
| 01966 | Anesth, induced ab procedure | NI | N | | | | | |
| 01967 | Anesth/analg, vag delivery | | N | | | | | |
| 01968 | Anes/analg cs deliver add-on | | N | | | | | |
| 01969 | Anesth/analg cs hyst add-on | | N | | | | | |
| 01991 | Anesth, nerve block/inj | | N | | | | | |
| 01992 | Anesth, n block/inj, prone | | N | | | | | |
| 01995 | Regional anesthesia limb | | N | | | | | |
| 01996 | Hosp manage cont drug admin | | N | | | | | |
| 01999 | Unlisted anesth procedure | | N | | | | | |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 10021 | Fna w/o image | | T | 0002 | 0.9357 | \$ 55.68 | | \$ 11.14 |
| 10022 | Fna w/image | | T | 0036 | 2.1838 | \$ 129.96 | | \$ 25.99 |
| 10040 | Acne surgery | | T | 0010 | 0.5923 | \$ 35.25 | \$ 9.65 | \$ 7.05 |
| 10060 | Drainage of skin abscess | | T | 0006 | 1.5100 | \$ 89.86 | \$ 21.76 | \$ 17.97 |
| 10061 | Drainage of skin abscess | | T | 0006 | 1.5100 | \$ 89.86 | \$ 21.76 | \$ 17.97 |
| 10080 | Drainage of pilonidal cyst | | T | 0006 | 1.5100 | \$ 89.86 | \$ 21.76 | \$ 17.97 |
| 10081 | Drainage of pilonidal cyst | | T | 0007 | 11.6717 | \$ 694.59 | | \$ 138.92 |
| 10120 | Remove foreign body | | T | 0006 | 1.5100 | \$ 89.86 | \$ 21.76 | \$ 17.97 |
| 10121 | Remove foreign body | | T | 0021 | 14.9984 | \$ 892.57 | \$ 219.48 | \$ 178.51 |
| 10140 | Drainage of hematoma/fluid | | T | 0007 | 11.6717 | \$ 694.59 | | \$ 138.92 |
| 10160 | Puncture drainage of lesion | | T | 0018 | 1.1010 | \$ 65.52 | \$ 16.04 | \$ 13.10 |
| 10180 | Complex drainage, wound | CH | T | 0008 | 16.2953 | \$ 969.75 | | \$ 193.95 |
| 11000 | Debride infected skin | CH | T | 0013 | 1.0603 | \$ 63.10 | \$ 13.07 | \$ 12.62 |
| 11001 | Debride infected skin add-on | | T | 0012 | 0.8477 | \$ 50.45 | \$ 11.18 | \$ 10.09 |
| 11010 | Debride skin, fx | | T | 0019 | 4.1481 | \$ 246.86 | \$ 71.87 | \$ 49.37 |
| 11011 | Debride skin/muscle, fx | | T | 0019 | 4.1481 | \$ 246.86 | \$ 71.87 | \$ 49.37 |
| 11012 | Debride skin/muscle/bone, fx | | T | 0019 | 4.1481 | \$ 246.86 | \$ 71.87 | \$ 49.37 |
| 11040 | Debride skin, partial | | T | 0015 | 1.6338 | \$ 97.23 | \$ 20.13 | \$ 19.45 |
| 11041 | Debride skin, full | | T | 0015 | 1.6338 | \$ 97.23 | \$ 20.13 | \$ 19.45 |
| 11042 | Debride skin/tissue | | T | 0016 | 2.5080 | \$ 149.25 | \$ 32.68 | \$ 29.85 |
| 11043 | Debride tissue/muscle | | T | 0016 | 2.5080 | \$ 149.25 | \$ 32.68 | \$ 29.85 |
| 11044 | Debride tissue/muscle/bone | | T | 0682 | 6.7313 | \$ 400.59 | \$ 158.65 | \$ 80.12 |
| 11055 | Trim skin lesion | | T | 0012 | 0.8477 | \$ 50.45 | \$ 11.18 | \$ 10.09 |
| 11056 | Trim skin lesions, 2 to 4 | | T | 0012 | 0.8477 | \$ 50.45 | \$ 11.18 | \$ 10.09 |
| 11057 | Trim skin lesions, over 4 | | T | 0013 | 1.0603 | \$ 63.10 | \$ 13.07 | \$ 12.62 |
| 11100 | Biopsy, skin lesion | | T | 0018 | 1.1010 | \$ 65.52 | \$ 16.04 | \$ 13.10 |
| 11101 | Biopsy, skin add-on | | T | 0018 | 1.1010 | \$ 65.52 | \$ 16.04 | \$ 13.10 |
| 11200 | Removal of skin tags | | T | 0013 | 1.0603 | \$ 63.10 | \$ 13.07 | \$ 12.62 |
| 11201 | Remove skin tags add-on | | T | 0015 | 1.6338 | \$ 97.23 | \$ 20.13 | \$ 19.45 |
| 11300 | Shave skin lesion | | T | 0012 | 0.8477 | \$ 50.45 | \$ 11.18 | \$ 10.09 |
| 11301 | Shave skin lesion | | T | 0012 | 0.8477 | \$ 50.45 | \$ 11.18 | \$ 10.09 |
| 11302 | Shave skin lesion | | T | 0013 | 1.0603 | \$ 63.10 | \$ 13.07 | \$ 12.62 |
| 11303 | Shave skin lesion | | T | 0015 | 1.6338 | \$ 97.23 | \$ 20.13 | \$ 19.45 |
| 11305 | Shave skin lesion | | T | 0013 | 1.0603 | \$ 63.10 | \$ 13.07 | \$ 12.62 |
| 11306 | Shave skin lesion | | T | 0013 | 1.0603 | \$ 63.10 | \$ 13.07 | \$ 12.62 |
| 11307 | Shave skin lesion | | T | 0013 | 1.0603 | \$ 63.10 | \$ 13.07 | \$ 12.62 |
| 11308 | Shave skin lesion | | T | 0013 | 1.0603 | \$ 63.10 | \$ 13.07 | \$ 12.62 |
| 11310 | Shave skin lesion | | T | 0013 | 1.0603 | \$ 63.10 | \$ 13.07 | \$ 12.62 |
| 11311 | Shave skin lesion | | T | 0013 | 1.0603 | \$ 63.10 | \$ 13.07 | \$ 12.62 |
| 11312 | Shave skin lesion | | T | 0013 | 1.0603 | \$ 63.10 | \$ 13.07 | \$ 12.62 |
| 11313 | Shave skin lesion | | T | 0016 | 2.5080 | \$ 149.25 | \$ 32.68 | \$ 29.85 |
| 11400 | Exc tr-ext b9+marg 0.5 < cm | | T | 0019 | 4.1481 | \$ 246.86 | \$ 71.87 | \$ 49.37 |
| 11401 | Exc tr-ext b9+marg 0.6-1 cm | | T | 0019 | 4.1481 | \$ 246.86 | \$ 71.87 | \$ 49.37 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 11402 | Exc tr-ext b9+marg 1.1-2 cm | | T | 0019 | 4.1481 | \$ 246.86 | \$ 71.87 | \$ 49.37 |
| 11403 | Exc tr-ext b9+marg 2.1-3 cm | | T | 0020 | 6.9410 | \$ 413.07 | \$ 107.67 | \$ 82.61 |
| 11404 | Exc tr-ext b9+marg 3.1-4 cm | | T | 0021 | 14.9984 | \$ 892.57 | \$ 219.48 | \$ 178.51 |
| 11406 | Exc tr-ext b9+marg > 4.0 cm | | T | 0021 | 14.9984 | \$ 892.57 | \$ 219.48 | \$ 178.51 |
| 11420 | Exc h-f-nk-sp b9+marg 0.5 < | | T | 0020 | 6.9410 | \$ 413.07 | \$ 107.67 | \$ 82.61 |
| 11421 | Exc h-f-nk-sp b9+marg 0.6-1 | | T | 0020 | 6.9410 | \$ 413.07 | \$ 107.67 | \$ 82.61 |
| 11422 | Exc h-f-nk-sp b9+marg 1.1-2 | | T | 0020 | 6.9410 | \$ 413.07 | \$ 107.67 | \$ 82.61 |
| 11423 | Exc h-f-nk-sp b9+marg 2.1-3 | CH | T | 0021 | 14.9984 | \$ 892.57 | \$ 219.48 | \$ 178.51 |
| 11424 | Exc h-f-nk-sp b9+marg 3.1-4 | | T | 0021 | 14.9984 | \$ 892.57 | \$ 219.48 | \$ 178.51 |
| 11426 | Exc h-f-nk-sp b9+marg > 4 cm | | T | 0022 | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 11440 | Exc face-mm b9+marg 0.5 < cm | | T | 0019 | 4.1481 | \$ 246.86 | \$ 71.87 | \$ 49.37 |
| 11441 | Exc face-mm b9+marg 0.6-1 cm | | T | 0019 | 4.1481 | \$ 246.86 | \$ 71.87 | \$ 49.37 |
| 11442 | Exc face-mm b9+marg 1.1-2 cm | | T | 0020 | 6.9410 | \$ 413.07 | \$ 107.67 | \$ 82.61 |
| 11443 | Exc face-mm b9+marg 2.1-3 cm | | T | 0020 | 6.9410 | \$ 413.07 | \$ 107.67 | \$ 82.61 |
| 11444 | Exc face-mm b9+marg 3.1-4 cm | | T | 0020 | 6.9410 | \$ 413.07 | \$ 107.67 | \$ 82.61 |
| 11446 | Exc face-mm b9+marg > 4 cm | | T | 0022 | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 11450 | Removal, sweat gland lesion | | T | 0022 | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 11451 | Removal, sweat gland lesion | | T | 0022 | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 11462 | Removal, sweat gland lesion | | T | 0022 | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 11463 | Removal, sweat gland lesion | | T | 0022 | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 11470 | Removal, sweat gland lesion | | T | 0022 | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 11471 | Removal, sweat gland lesion | | T | 0022 | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 11600 | Exc tr-ext mlg+marg 0.5 < cm | | T | 0019 | 4.1481 | \$ 246.86 | \$ 71.87 | \$ 49.37 |
| 11601 | Exc tr-ext mlg+marg 0.6-1 cm | | T | 0019 | 4.1481 | \$ 246.86 | \$ 71.87 | \$ 49.37 |
| 11602 | Exc tr-ext mlg+marg 1.1-2 cm | | T | 0019 | 4.1481 | \$ 246.86 | \$ 71.87 | \$ 49.37 |
| 11603 | Exc tr-ext mlg+marg 2.1-3 cm | | T | 0020 | 6.9410 | \$ 413.07 | \$ 107.67 | \$ 82.61 |
| 11604 | Exc tr-ext mlg+marg 3.1-4 cm | | T | 0020 | 6.9410 | \$ 413.07 | \$ 107.67 | \$ 82.61 |
| 11606 | Exc tr-ext mlg+marg > 4 cm | | T | 0021 | 14.9984 | \$ 892.57 | \$ 219.48 | \$ 178.51 |
| 11620 | Exc h-f-nk-sp mlg+marg 0.5 < | | T | 0020 | 6.9410 | \$ 413.07 | \$ 107.67 | \$ 82.61 |
| 11621 | Exc h-f-nk-sp mlg+marg 0.6-1 | | T | 0019 | 4.1481 | \$ 246.86 | \$ 71.87 | \$ 49.37 |
| 11622 | Exc h-f-nk-sp mlg+marg 1.1-2 | | T | 0020 | 6.9410 | \$ 413.07 | \$ 107.67 | \$ 82.61 |
| 11623 | Exc h-f-nk-sp mlg+marg 2.1-3 | | T | 0021 | 14.9984 | \$ 892.57 | \$ 219.48 | \$ 178.51 |
| 11624 | Exc h-f-nk-sp mlg+marg 3.1-4 | | T | 0021 | 14.9984 | \$ 892.57 | \$ 219.48 | \$ 178.51 |
| 11626 | Exc h-f-nk-sp mlg+mar > 4 cm | | T | 0022 | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 11640 | Exc face-mm malig+marg 0.5 < | CH | T | 0020 | 6.9410 | \$ 413.07 | \$ 107.67 | \$ 82.61 |
| 11641 | Exc face-mm malig+marg 0.6-1 | CH | T | 0020 | 6.9410 | \$ 413.07 | \$ 107.67 | \$ 82.61 |
| 11642 | Exc face-mm malig+marg 1.1-2 | | T | 0020 | 6.9410 | \$ 413.07 | \$ 107.67 | \$ 82.61 |
| 11643 | Exc face-mm malig+marg 2.1-3 | | T | 0020 | 6.9410 | \$ 413.07 | \$ 107.67 | \$ 82.61 |
| 11644 | Exc face-mm malig+marg 3.1-4 | | T | 0021 | 14.9984 | \$ 892.57 | \$ 219.48 | \$ 178.51 |
| 11646 | Exc face-mm mlg+marg > 4 cm | | T | 0022 | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 11719 | Trim nail(s) | | T | 0009 | 0.7513 | \$ 44.71 | | \$ 8.94 |
| 11720 | Debride nail, 1-5 | | T | 0009 | 0.7513 | \$ 44.71 | | \$ 8.94 |
| 11721 | Debride nail, 6 or more | | T | 0009 | 0.7513 | \$ 44.71 | | \$ 8.94 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 11730 | Removal of nail plate | | T | 0013 | 1.0603 | \$ 63.10 | \$ 13.07 | \$ 12.62 |
| 11732 | Remove nail plate, add-on | | T | 0012 | 0.8477 | \$ 50.45 | \$ 11.18 | \$ 10.09 |
| 11740 | Drain blood from under nail | | T | 0009 | 0.7513 | \$ 44.71 | | \$ 8.94 |
| 11750 | Removal of nail bed | | T | 0019 | 4.1481 | \$ 246.86 | \$ 71.87 | \$ 49.37 |
| 11752 | Remove nail bed/finger tip | | T | 0022 | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 11755 | Biopsy, nail unit | | T | 0019 | 4.1481 | \$ 246.86 | \$ 71.87 | \$ 49.37 |
| 11760 | Repair of nail bed | | T | 0024 | 1.5513 | \$ 92.32 | \$ 30.23 | \$ 18.46 |
| 11762 | Reconstruction of nail bed | | T | 0024 | 1.5513 | \$ 92.32 | \$ 30.23 | \$ 18.46 |
| 11765 | Excision of nail fold, toe | | T | 0015 | 1.6338 | \$ 97.23 | \$ 20.13 | \$ 19.45 |
| 11770 | Removal of pilonidal lesion | | T | 0022 | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 11771 | Removal of pilonidal lesion | | T | 0022 | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 11772 | Removal of pilonidal lesion | | T | 0022 | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 11900 | Injection into skin lesions | | T | 0012 | 0.8477 | \$ 50.45 | \$ 11.18 | \$ 10.09 |
| 11901 | Added skin lesions injection | | T | 0012 | 0.8477 | \$ 50.45 | \$ 11.18 | \$ 10.09 |
| 11920 | Correct skin color defects | | T | 0024 | 1.5513 | \$ 92.32 | \$ 30.23 | \$ 18.46 |
| 11921 | Correct skin color defects | | T | 0024 | 1.5513 | \$ 92.32 | \$ 30.23 | \$ 18.46 |
| 11922 | Correct skin color defects | | T | 0024 | 1.5513 | \$ 92.32 | \$ 30.23 | \$ 18.46 |
| 11950 | Therapy for contour defects | | T | 0024 | 1.5513 | \$ 92.32 | \$ 30.23 | \$ 18.46 |
| 11951 | Therapy for contour defects | | T | 0024 | 1.5513 | \$ 92.32 | \$ 30.23 | \$ 18.46 |
| 11952 | Therapy for contour defects | | T | 0024 | 1.5513 | \$ 92.32 | \$ 30.23 | \$ 18.46 |
| 11954 | Therapy for contour defects | | T | 0024 | 1.5513 | \$ 92.32 | \$ 30.23 | \$ 18.46 |
| 11960 | Insert tissue expander(s) | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 11970 | Replace tissue expander | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 11971 | Remove tissue expander(s) | | T | 0022 | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 11976 | Removal of contraceptive cap | | T | 0019 | 4.1481 | \$ 246.86 | \$ 71.87 | \$ 49.37 |
| 11980 | Implant hormone pellet(s) | | X | 0340 | 0.6137 | \$ 36.52 | | \$ 7.30 |
| 11981 | Insert drug implant device | | X | 0340 | 0.6137 | \$ 36.52 | | \$ 7.30 |
| 11982 | Remove drug implant device | | X | 0340 | 0.6137 | \$ 36.52 | | \$ 7.30 |
| 11983 | Remove/insert drug implant | | X | 0340 | 0.6137 | \$ 36.52 | | \$ 7.30 |
| 12001 | Repair superficial wound(s) | | T | 0024 | 1.5513 | \$ 92.32 | \$ 30.23 | \$ 18.46 |
| 12002 | Repair superficial wound(s) | | T | 0024 | 1.5513 | \$ 92.32 | \$ 30.23 | \$ 18.46 |
| 12004 | Repair superficial wound(s) | | T | 0024 | 1.5513 | \$ 92.32 | \$ 30.23 | \$ 18.46 |
| 12005 | Repair superficial wound(s) | | T | 0024 | 1.5513 | \$ 92.32 | \$ 30.23 | \$ 18.46 |
| 12006 | Repair superficial wound(s) | | T | 0024 | 1.5513 | \$ 92.32 | \$ 30.23 | \$ 18.46 |
| 12007 | Repair superficial wound(s) | | T | 0024 | 1.5513 | \$ 92.32 | \$ 30.23 | \$ 18.46 |
| 12011 | Repair superficial wound(s) | | T | 0024 | 1.5513 | \$ 92.32 | \$ 30.23 | \$ 18.46 |
| 12013 | Repair superficial wound(s) | | T | 0024 | 1.5513 | \$ 92.32 | \$ 30.23 | \$ 18.46 |
| 12014 | Repair superficial wound(s) | | T | 0024 | 1.5513 | \$ 92.32 | \$ 30.23 | \$ 18.46 |
| 12015 | Repair superficial wound(s) | | T | 0024 | 1.5513 | \$ 92.32 | \$ 30.23 | \$ 18.46 |
| 12016 | Repair superficial wound(s) | | T | 0024 | 1.5513 | \$ 92.32 | \$ 30.23 | \$ 18.46 |
| 12017 | Repair superficial wound(s) | | T | 0024 | 1.5513 | \$ 92.32 | \$ 30.23 | \$ 18.46 |
| 12018 | Repair superficial wound(s) | | T | 0024 | 1.5513 | \$ 92.32 | \$ 30.23 | \$ 18.46 |
| 12020 | Closure of split wound | | T | 0024 | 1.5513 | \$ 92.32 | \$ 30.23 | \$ 18.46 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|----------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 12021 | Closure of split wound | | T | 0024 | 1.5513 | \$ 92.32 | \$ 30.23 | \$ 18.46 |
| 12031 | Layer closure of wound(s) | | T | 0024 | 1.5513 | \$ 92.32 | \$ 30.23 | \$ 18.46 |
| 12032 | Layer closure of wound(s) | | T | 0024 | 1.5513 | \$ 92.32 | \$ 30.23 | \$ 18.46 |
| 12034 | Layer closure of wound(s) | | T | 0024 | 1.5513 | \$ 92.32 | \$ 30.23 | \$ 18.46 |
| 12035 | Layer closure of wound(s) | | T | 0024 | 1.5513 | \$ 92.32 | \$ 30.23 | \$ 18.46 |
| 12036 | Layer closure of wound(s) | | T | 0024 | 1.5513 | \$ 92.32 | \$ 30.23 | \$ 18.46 |
| 12037 | Layer closure of wound(s) | | T | 0025 | 5.3051 | \$ 315.71 | \$ 101.85 | \$ 63.14 |
| 12041 | Layer closure of wound(s) | | T | 0024 | 1.5513 | \$ 92.32 | \$ 30.23 | \$ 18.46 |
| 12042 | Layer closure of wound(s) | | T | 0024 | 1.5513 | \$ 92.32 | \$ 30.23 | \$ 18.46 |
| 12044 | Layer closure of wound(s) | | T | 0024 | 1.5513 | \$ 92.32 | \$ 30.23 | \$ 18.46 |
| 12045 | Layer closure of wound(s) | | T | 0024 | 1.5513 | \$ 92.32 | \$ 30.23 | \$ 18.46 |
| 12046 | Layer closure of wound(s) | | T | 0024 | 1.5513 | \$ 92.32 | \$ 30.23 | \$ 18.46 |
| 12047 | Layer closure of wound(s) | | T | 0025 | 5.3051 | \$ 315.71 | \$ 101.85 | \$ 63.14 |
| 12051 | Layer closure of wound(s) | | T | 0024 | 1.5513 | \$ 92.32 | \$ 30.23 | \$ 18.46 |
| 12052 | Layer closure of wound(s) | | T | 0024 | 1.5513 | \$ 92.32 | \$ 30.23 | \$ 18.46 |
| 12053 | Layer closure of wound(s) | | T | 0024 | 1.5513 | \$ 92.32 | \$ 30.23 | \$ 18.46 |
| 12054 | Layer closure of wound(s) | | T | 0024 | 1.5513 | \$ 92.32 | \$ 30.23 | \$ 18.46 |
| 12055 | Layer closure of wound(s) | | T | 0024 | 1.5513 | \$ 92.32 | \$ 30.23 | \$ 18.46 |
| 12056 | Layer closure of wound(s) | | T | 0024 | 1.5513 | \$ 92.32 | \$ 30.23 | \$ 18.46 |
| 12057 | Layer closure of wound(s) | | T | 0025 | 5.3051 | \$ 315.71 | \$ 101.85 | \$ 63.14 |
| 13100 | Repair of wound or lesion | | T | 0025 | 5.3051 | \$ 315.71 | \$ 101.85 | \$ 63.14 |
| 13101 | Repair of wound or lesion | | T | 0025 | 5.3051 | \$ 315.71 | \$ 101.85 | \$ 63.14 |
| 13102 | Repair wound/lesion add-on | | T | 0024 | 1.5513 | \$ 92.32 | \$ 30.23 | \$ 18.46 |
| 13120 | Repair of wound or lesion | | T | 0024 | 1.5513 | \$ 92.32 | \$ 30.23 | \$ 18.46 |
| 13121 | Repair of wound or lesion | | T | 0024 | 1.5513 | \$ 92.32 | \$ 30.23 | \$ 18.46 |
| 13122 | Repair wound/lesion add-on | | T | 0024 | 1.5513 | \$ 92.32 | \$ 30.23 | \$ 18.46 |
| 13131 | Repair of wound or lesion | | T | 0024 | 1.5513 | \$ 92.32 | \$ 30.23 | \$ 18.46 |
| 13132 | Repair of wound or lesion | | T | 0024 | 1.5513 | \$ 92.32 | \$ 30.23 | \$ 18.46 |
| 13133 | Repair wound/lesion add-on | | T | 0024 | 1.5513 | \$ 92.32 | \$ 30.23 | \$ 18.46 |
| 13150 | Repair of wound or lesion | | T | 0025 | 5.3051 | \$ 315.71 | \$ 101.85 | \$ 63.14 |
| 13151 | Repair of wound or lesion | | T | 0024 | 1.5513 | \$ 92.32 | \$ 30.23 | \$ 18.46 |
| 13152 | Repair of wound or lesion | | T | 0025 | 5.3051 | \$ 315.71 | \$ 101.85 | \$ 63.14 |
| 13153 | Repair wound/lesion add-on | | T | 0024 | 1.5513 | \$ 92.32 | \$ 30.23 | \$ 18.46 |
| 13160 | Late closure of wound | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 14000 | Skin tissue rearrangement | CH | T | 0686 | 13.4973 | \$ 803.24 | | \$ 160.65 |
| 14001 | Skin tissue rearrangement | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 14020 | Skin tissue rearrangement | CH | T | 0686 | 13.4973 | \$ 803.24 | | \$ 160.65 |
| 14021 | Skin tissue rearrangement | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 14040 | Skin tissue rearrangement | CH | T | 0686 | 13.4973 | \$ 803.24 | | \$ 160.65 |
| 14041 | Skin tissue rearrangement | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 14060 | Skin tissue rearrangement | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 14061 | Skin tissue rearrangement | CH | T | 0686 | 13.4973 | \$ 803.24 | | \$ 160.65 |
| 14300 | Skin tissue rearrangement | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|-------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 14350 | Skin tissue rearrangement | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15000 | Wound prep, 1st 100 sq cm | | T | 0025 | 5.3051 | \$ 315.71 | \$ 101.85 | \$ 63.14 |
| 15001 | Wound prep, addl 100 sq cm | | T | 0025 | 5.3051 | \$ 315.71 | \$ 101.85 | \$ 63.14 |
| 15040 | Harvest cultured skin graft | NI | T | 0024 | 1.5513 | \$ 92.32 | \$ 30.23 | \$ 18.46 |
| 15050 | Skin pinch graft | | T | 0025 | 5.3051 | \$ 315.71 | \$ 101.85 | \$ 63.14 |
| 15100 | Skin splnt grft, trnk/arm/leg | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15101 | Skin splnt grft t/a/l, add-on | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15110 | Epidrm autogrft trnk/arm/leg | NI | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15111 | Epidrm autogrft t/a/l add-on | NI | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15115 | Epidrm a-grft face/nck/hf/g | NI | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15116 | Epidrm a-grft f/n/hf/g addl | NI | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15120 | Skn splnt a-grft fac/nck/hf/g | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15121 | Skn splnt a-grft f/n/hf/g add | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15130 | Derm autograft, trnk/arm/leg | NI | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15131 | Derm autograft t/a/l add-on | NI | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15135 | Derm autograft face/nck/hf/g | NI | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15136 | Derm autograft, f/n/hf/g add | NI | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15150 | Cult epiderm grft t/arm/leg | NI | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15151 | Cult epiderm grft t/a/l addl | NI | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15152 | Cult epiderm graft t/a/l +% | NI | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15155 | Cult epiderm graft, f/n/hf/g | NI | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15156 | Cult epidrm grft f/n/hfg add | NI | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15157 | Cult epiderm grft f/n/hfg +% | NI | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15170 | Cell graft trunk/arms/legs | NI | T | 0024 | 1.5513 | \$ 92.32 | \$ 30.23 | \$ 18.46 |
| 15171 | Cell graft t/arm/leg add-on | NI | T | 0024 | 1.5513 | \$ 92.32 | \$ 30.23 | \$ 18.46 |
| 15175 | Acellular graft, f/n/hf/g | NI | T | 0024 | 1.5513 | \$ 92.32 | \$ 30.23 | \$ 18.46 |
| 15176 | Acell graft, f/n/hf/g add-on | NI | T | 0024 | 1.5513 | \$ 92.32 | \$ 30.23 | \$ 18.46 |
| 15200 | Skin full graft, trunk | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15201 | Skin full graft trunk add-on | | T | 0025 | 5.3051 | \$ 315.71 | \$ 101.85 | \$ 63.14 |
| 15220 | Skin full graft sclp/arm/leg | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15221 | Skin full graft add-on | | T | 0025 | 5.3051 | \$ 315.71 | \$ 101.85 | \$ 63.14 |
| 15240 | Skin full grft face/genit/hf | CH | T | 0686 | 13.4973 | \$ 803.24 | | \$ 160.65 |
| 15241 | Skin full graft add-on | | T | 0025 | 5.3051 | \$ 315.71 | \$ 101.85 | \$ 63.14 |
| 15260 | Skin full graft een & lips | CH | T | 0686 | 13.4973 | \$ 803.24 | | \$ 160.65 |
| 15261 | Skin full graft add-on | | T | 0025 | 5.3051 | \$ 315.71 | \$ 101.85 | \$ 63.14 |
| 15300 | Apply skinallogrft, t/arm/lg | NI | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15301 | Apply skinallogrft t/a/l addl | NI | T | 0025 | 5.3051 | \$ 315.71 | \$ 101.85 | \$ 63.14 |
| 15320 | Apply skin allogrft f/n/hf/g | NI | T | 0025 | 5.3051 | \$ 315.71 | \$ 101.85 | \$ 63.14 |
| 15321 | Aply skinallogrft f/n/hfg add | NI | T | 0025 | 5.3051 | \$ 315.71 | \$ 101.85 | \$ 63.14 |
| 15330 | Aply acell alogrft t/arm/leg | NI | T | 0025 | 5.3051 | \$ 315.71 | \$ 101.85 | \$ 63.14 |
| 15331 | Aply acell grft t/a/l add-on | NI | T | 0025 | 5.3051 | \$ 315.71 | \$ 101.85 | \$ 63.14 |
| 15335 | Apply acell graft, f/n/hf/g | NI | T | 0025 | 5.3051 | \$ 315.71 | \$ 101.85 | \$ 63.14 |
| 15336 | Aply acell grft f/n/hf/g add | NI | T | 0025 | 5.3051 | \$ 315.71 | \$ 101.85 | \$ 63.14 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 15340 | Apply cult skin substitute | NI | T | 0024 | 1.5513 | \$ 92.32 | \$ 30.23 | \$ 18.46 |
| 15341 | Apply cult skin sub add-on | NI | T | 0024 | 1.5513 | \$ 92.32 | \$ 30.23 | \$ 18.46 |
| 15342 | Cultured skin graft, 25 cm | CH | D | | | | | |
| 15343 | Culture skn graft addl 25 cm | CH | D | | | | | |
| 15350 | Skin homograft | CH | D | | | | | |
| 15351 | Skin homograft add-on | CH | D | | | | | |
| 15360 | Apply cult derm sub, t/a/l | NI | T | 0024 | 1.5513 | \$ 92.32 | \$ 30.23 | \$ 18.46 |
| 15361 | Aply cult derm sub t/a/l add | NI | T | 0024 | 1.5513 | \$ 92.32 | \$ 30.23 | \$ 18.46 |
| 15365 | Apply cult derm sub f/n/hf/g | NI | T | 0024 | 1.5513 | \$ 92.32 | \$ 30.23 | \$ 18.46 |
| 15366 | Apply cult derm f/hf/g add | NI | T | 0024 | 1.5513 | \$ 92.32 | \$ 30.23 | \$ 18.46 |
| 15400 | Apply skin xenograft, t/a/l | | T | 0025 | 5.3051 | \$ 315.71 | \$ 101.85 | \$ 63.14 |
| 15401 | Apply skn xenogrft t/a/l add | | T | 0025 | 5.3051 | \$ 315.71 | \$ 101.85 | \$ 63.14 |
| 15420 | Apply skin xgraft, f/n/hf/g | NI | T | 0025 | 5.3051 | \$ 315.71 | \$ 101.85 | \$ 63.14 |
| 15421 | Apply skn xgrft f/n/hf/g add | NI | T | 0025 | 5.3051 | \$ 315.71 | \$ 101.85 | \$ 63.14 |
| 15430 | Apply acellular xenograft | NI | T | 0025 | 5.3051 | \$ 315.71 | \$ 101.85 | \$ 63.14 |
| 15431 | Apply acellular xgraft add | NI | T | 0025 | 5.3051 | \$ 315.71 | \$ 101.85 | \$ 63.14 |
| 15570 | Form skin pedicle flap | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15572 | Form skin pedicle flap | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15574 | Form skin pedicle flap | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15576 | Form skin pedicle flap | CH | T | 0686 | 13.4973 | \$ 803.24 | | \$ 160.65 |
| 15600 | Skin graft | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15610 | Skin graft | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15620 | Skin graft | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15630 | Skin graft | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15650 | Transfer skin pedicle flap | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15732 | Muscle-skin graft, head/neck | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15734 | Muscle-skin graft, trunk | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15736 | Muscle-skin graft, arm | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15738 | Muscle-skin graft, leg | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15740 | Island pedicle flap graft | CH | T | 0686 | 13.4973 | \$ 803.24 | | \$ 160.65 |
| 15750 | Neurovascular pedicle graft | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15760 | Composite skin graft | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15770 | Derma-fat-fascia graft | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15775 | Hair transplant punch grafts | | T | 0025 | 5.3051 | \$ 315.71 | \$ 101.85 | \$ 63.14 |
| 15776 | Hair transplant punch grafts | | T | 0025 | 5.3051 | \$ 315.71 | \$ 101.85 | \$ 63.14 |
| 15780 | Abrasion treatment of skin | | T | 0022 | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 15781 | Abrasion treatment of skin | | T | 0019 | 4.1481 | \$ 246.86 | \$ 71.87 | \$ 49.37 |
| 15782 | Abrasion treatment of skin | | T | 0019 | 4.1481 | \$ 246.86 | \$ 71.87 | \$ 49.37 |
| 15783 | Abrasion treatment of skin | | T | 0016 | 2.5080 | \$ 149.25 | \$ 32.68 | \$ 29.85 |
| 15786 | Abrasion, lesion, single | | T | 0013 | 1.0603 | \$ 63.10 | \$ 13.07 | \$ 12.62 |
| 15787 | Abrasion, lesions, add-on | | T | 0013 | 1.0603 | \$ 63.10 | \$ 13.07 | \$ 12.62 |
| 15788 | Chemical peel, face, epiderm | | T | 0012 | 0.8477 | \$ 50.45 | \$ 11.18 | \$ 10.09 |
| 15789 | Chemical peel, face, dermal | | T | 0015 | 1.6338 | \$ 97.23 | \$ 20.13 | \$ 19.45 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 15792 | Chemical peel, nonfacial | | T | 0013 | 1.0603 | \$ 63.10 | \$ 13.07 | \$ 12.62 |
| 15793 | Chemical peel, nonfacial | | T | 0012 | 0.8477 | \$ 50.45 | \$ 11.18 | \$ 10.09 |
| 15810 | Salabrasion | CH | D | | | | | |
| 15811 | Salabrasion | CH | D | | | | | |
| 15819 | Plastic surgery, neck | | T | 0025 | 5.3051 | \$ 315.71 | \$ 101.85 | \$ 63.14 |
| 15820 | Revision of lower eyelid | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15821 | Revision of lower eyelid | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15822 | Revision of upper eyelid | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15823 | Revision of upper eyelid | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15824 | Removal of forehead wrinkles | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15825 | Removal of neck wrinkles | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15826 | Removal of brow wrinkles | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15828 | Removal of face wrinkles | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15829 | Removal of skin wrinkles | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15831 | Excise excessive skin tissue | | T | 0022 | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 15832 | Excise excessive skin tissue | | T | 0022 | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 15833 | Excise excessive skin tissue | | T | 0022 | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 15834 | Excise excessive skin tissue | | T | 0022 | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 15835 | Excise excessive skin tissue | | T | 0025 | 5.3051 | \$ 315.71 | \$ 101.85 | \$ 63.14 |
| 15836 | Excise excessive skin tissue | | T | 0021 | 14.9984 | \$ 892.57 | \$ 219.48 | \$ 178.51 |
| 15837 | Excise excessive skin tissue | | T | 0021 | 14.9984 | \$ 892.57 | \$ 219.48 | \$ 178.51 |
| 15838 | Excise excessive skin tissue | | T | 0021 | 14.9984 | \$ 892.57 | \$ 219.48 | \$ 178.51 |
| 15839 | Excise excessive skin tissue | | T | 0021 | 14.9984 | \$ 892.57 | \$ 219.48 | \$ 178.51 |
| 15840 | Graft for face nerve palsy | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15841 | Graft for face nerve palsy | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15842 | Flap for face nerve palsy | CH | T | 0686 | 13.4973 | \$ 803.24 | | \$ 160.65 |
| 15845 | Skin and muscle repair, face | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15850 | Removal of sutures | | T | 0016 | 2.5080 | \$ 149.25 | \$ 32.68 | \$ 29.85 |
| 15851 | Removal of sutures | | T | 0016 | 2.5080 | \$ 149.25 | \$ 32.68 | \$ 29.85 |
| 15852 | Dressing change not for burn | | X | 0340 | 0.6137 | \$ 36.52 | | \$ 7.30 |
| 15860 | Test for blood flow in graft | | X | 0359 | 0.8036 | \$ 47.82 | | \$ 9.56 |
| 15876 | Suction assisted lipectomy | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15877 | Suction assisted lipectomy | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15878 | Suction assisted lipectomy | CH | T | 0686 | 13.4973 | \$ 803.24 | | \$ 160.65 |
| 15879 | Suction assisted lipectomy | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15920 | Removal of tail bone ulcer | | T | 0019 | 4.1481 | \$ 246.86 | \$ 71.87 | \$ 49.37 |
| 15922 | Removal of tail bone ulcer | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15931 | Remove sacrum pressure sore | | T | 0022 | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 15933 | Remove sacrum pressure sore | | T | 0022 | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 15934 | Remove sacrum pressure sore | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15935 | Remove sacrum pressure sore | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15936 | Remove sacrum pressure sore | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15937 | Remove sacrum pressure sore | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|-------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 15940 | Remove hip pressure sore | | T | 0022 | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 15941 | Remove hip pressure sore | | T | 0022 | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 15944 | Remove hip pressure sore | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15945 | Remove hip pressure sore | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15946 | Remove hip pressure sore | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15950 | Remove thigh pressure sore | | T | 0022 | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 15951 | Remove thigh pressure sore | | T | 0022 | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 15952 | Remove thigh pressure sore | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15953 | Remove thigh pressure sore | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15956 | Remove thigh pressure sore | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15958 | Remove thigh pressure sore | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 15999 | Removal of pressure sore | | T | 0019 | 4.1481 | \$ 246.86 | \$ 71.87 | \$ 49.37 |
| 16000 | Initial treatment of burn(s) | | T | 0012 | 0.8477 | \$ 50.45 | \$ 11.18 | \$ 10.09 |
| 16010 | Treatment of burn(s) | CH | D | | | | | |
| 16015 | Treatment of burn(s) | CH | D | | | | | |
| 16020 | Dress/debrid p-thick burn, s | | T | 0013 | 1.0603 | \$ 63.10 | \$ 13.07 | \$ 12.62 |
| 16025 | Dress/debrid p-thick burn, m | | T | 0013 | 1.0603 | \$ 63.10 | \$ 13.07 | \$ 12.62 |
| 16030 | Dress/debrid p-thick burn, l | | T | 0015 | 1.6338 | \$ 97.23 | \$ 20.13 | \$ 19.45 |
| 17000 | Destroy benign/premlyg lesion | | T | 0010 | 0.5923 | \$ 35.25 | \$ 9.65 | \$ 7.05 |
| 17003 | Destroy lesions, 2-14 | | T | 0010 | 0.5923 | \$ 35.25 | \$ 9.65 | \$ 7.05 |
| 17004 | Destroy lesions, 15 or more | | T | 0011 | 2.2274 | \$ 132.55 | \$ 26.98 | \$ 26.51 |
| 17106 | Destruction of skin lesions | | T | 0011 | 2.2274 | \$ 132.55 | \$ 26.98 | \$ 26.51 |
| 17107 | Destruction of skin lesions | | T | 0011 | 2.2274 | \$ 132.55 | \$ 26.98 | \$ 26.51 |
| 17108 | Destruction of skin lesions | | T | 0011 | 2.2274 | \$ 132.55 | \$ 26.98 | \$ 26.51 |
| 17110 | Destruct lesion, 1-14 | CH | T | 0013 | 1.0603 | \$ 63.10 | \$ 13.07 | \$ 12.62 |
| 17111 | Destruct lesion, 15 or more | CH | T | 0013 | 1.0603 | \$ 63.10 | \$ 13.07 | \$ 12.62 |
| 17250 | Chemical cautery, tissue | | T | 0013 | 1.0603 | \$ 63.10 | \$ 13.07 | \$ 12.62 |
| 17260 | Destruction of skin lesions | | T | 0015 | 1.6338 | \$ 97.23 | \$ 20.13 | \$ 19.45 |
| 17261 | Destruction of skin lesions | | T | 0015 | 1.6338 | \$ 97.23 | \$ 20.13 | \$ 19.45 |
| 17262 | Destruction of skin lesions | | T | 0015 | 1.6338 | \$ 97.23 | \$ 20.13 | \$ 19.45 |
| 17263 | Destruction of skin lesions | | T | 0015 | 1.6338 | \$ 97.23 | \$ 20.13 | \$ 19.45 |
| 17264 | Destruction of skin lesions | | T | 0015 | 1.6338 | \$ 97.23 | \$ 20.13 | \$ 19.45 |
| 17266 | Destruction of skin lesions | | T | 0016 | 2.5080 | \$ 149.25 | \$ 32.68 | \$ 29.85 |
| 17270 | Destruction of skin lesions | | T | 0015 | 1.6338 | \$ 97.23 | \$ 20.13 | \$ 19.45 |
| 17271 | Destruction of skin lesions | | T | 0013 | 1.0603 | \$ 63.10 | \$ 13.07 | \$ 12.62 |
| 17272 | Destruction of skin lesions | | T | 0015 | 1.6338 | \$ 97.23 | \$ 20.13 | \$ 19.45 |
| 17273 | Destruction of skin lesions | | T | 0015 | 1.6338 | \$ 97.23 | \$ 20.13 | \$ 19.45 |
| 17274 | Destruction of skin lesions | | T | 0016 | 2.5080 | \$ 149.25 | \$ 32.68 | \$ 29.85 |
| 17276 | Destruction of skin lesions | | T | 0016 | 2.5080 | \$ 149.25 | \$ 32.68 | \$ 29.85 |
| 17280 | Destruction of skin lesions | | T | 0015 | 1.6338 | \$ 97.23 | \$ 20.13 | \$ 19.45 |
| 17281 | Destruction of skin lesions | | T | 0015 | 1.6338 | \$ 97.23 | \$ 20.13 | \$ 19.45 |
| 17282 | Destruction of skin lesions | | T | 0015 | 1.6338 | \$ 97.23 | \$ 20.13 | \$ 19.45 |
| 17283 | Destruction of skin lesions | | T | 0015 | 1.6338 | \$ 97.23 | \$ 20.13 | \$ 19.45 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 17284 | Destruction of skin lesions | | T | 0016 | 2.5080 | \$ 149.25 | \$ 32.68 | \$ 29.85 |
| 17286 | Destruction of skin lesions | | T | 0015 | 1.6338 | \$ 97.23 | \$ 20.13 | \$ 19.45 |
| 17304 | 1 stage mohs, up to 5 spec | | T | 0694 | 3.8832 | \$ 231.09 | \$ 62.65 | \$ 46.22 |
| 17305 | 2 stage mohs, up to 5 spec | | T | 0694 | 3.8832 | \$ 231.09 | \$ 62.65 | \$ 46.22 |
| 17306 | 3 stage mohs, up to 5 spec | | T | 0694 | 3.8832 | \$ 231.09 | \$ 62.65 | \$ 46.22 |
| 17307 | Mohs addl stage up to 5 spec | | T | 0694 | 3.8832 | \$ 231.09 | \$ 62.65 | \$ 46.22 |
| 17310 | Mohs any stage > 5 spec each | | T | 0694 | 3.8832 | \$ 231.09 | \$ 62.65 | \$ 46.22 |
| 17340 | Cryotherapy of skin | | T | 0012 | 0.8477 | \$ 50.45 | \$ 11.18 | \$ 10.09 |
| 17360 | Skin peel therapy | | T | 0013 | 1.0603 | \$ 63.10 | \$ 13.07 | \$ 12.62 |
| 17380 | Hair removal by electrolysis | | T | 0013 | 1.0603 | \$ 63.10 | \$ 13.07 | \$ 12.62 |
| 17999 | Skin tissue procedure | | T | 0006 | 1.5100 | \$ 89.86 | \$ 21.76 | \$ 17.97 |
| 19000 | Drainage of breast lesion | | T | 0004 | 1.7771 | \$ 105.76 | \$ 22.36 | \$ 21.15 |
| 19001 | Drain breast lesion add-on | | T | 0004 | 1.7771 | \$ 105.76 | \$ 22.36 | \$ 21.15 |
| 19020 | Incision of breast lesion | CH | T | 0008 | 16.2953 | \$ 969.75 | | \$ 193.95 |
| 19030 | Injection for breast x-ray | | N | | | | | |
| 19100 | Bx breast percut w/o image | | T | 0005 | 3.5834 | \$ 213.25 | \$ 71.59 | \$ 42.65 |
| 19101 | Biopsy of breast, open | | T | 0028 | 19.4351 | \$ 1,156.60 | \$ 303.74 | \$ 231.32 |
| 19102 | Bx breast percut w/image | | T | 0005 | 3.5834 | \$ 213.25 | \$ 71.59 | \$ 42.65 |
| 19103 | Bx breast percut w/device | | T | 0658 | 5.9888 | \$ 356.40 | | \$ 71.28 |
| 19110 | Nipple exploration | | T | 0028 | 19.4351 | \$ 1,156.60 | \$ 303.74 | \$ 231.32 |
| 19112 | Excise breast duct fistula | | T | 0028 | 19.4351 | \$ 1,156.60 | \$ 303.74 | \$ 231.32 |
| 19120 | Removal of breast lesion | | T | 0028 | 19.4351 | \$ 1,156.60 | \$ 303.74 | \$ 231.32 |
| 19125 | Excision, breast lesion | | T | 0028 | 19.4351 | \$ 1,156.60 | \$ 303.74 | \$ 231.32 |
| 19126 | Excision, addl breast lesion | | T | 0028 | 19.4351 | \$ 1,156.60 | \$ 303.74 | \$ 231.32 |
| 19140 | Removal of breast tissue | | T | 0028 | 19.4351 | \$ 1,156.60 | \$ 303.74 | \$ 231.32 |
| 19160 | Partial mastectomy | | T | 0028 | 19.4351 | \$ 1,156.60 | \$ 303.74 | \$ 231.32 |
| 19162 | P-mastectomy w/lv removal | | T | 0693 | 42.2886 | \$ 2,516.64 | \$ 798.17 | \$ 503.33 |
| 19180 | Removal of breast | | T | 0029 | 31.4826 | \$ 1,873.56 | \$ 632.64 | \$ 374.71 |
| 19182 | Removal of breast | | T | 0029 | 31.4826 | \$ 1,873.56 | \$ 632.64 | \$ 374.71 |
| 19240 | Removal of breast | | T | 0030 | 39.9779 | \$ 2,379.12 | \$ 763.55 | \$ 475.82 |
| 19260 | Removal of chest wall lesion | | T | 0021 | 14.9984 | \$ 892.57 | \$ 219.48 | \$ 178.51 |
| 19290 | Place needle wire, breast | | N | | | | | |
| 19291 | Place needle wire, breast | | N | | | | | |
| 19295 | Place breast clip, percut | | S | 0657 | 1.6092 | \$ 95.77 | | \$ 19.15 |
| 19296 | Place po breast cath for rad | | S | 1524 | | \$ 3,250.00 | | \$ 650.00 |
| 19297 | Place breast cath for rad | | S | 1523 | | \$ 2,750.00 | | \$ 550.00 |
| 19298 | Place breast rad tube/caths | | S | 1524 | | \$ 3,250.00 | | \$ 650.00 |
| 19316 | Suspension of breast | | T | 0029 | 31.4826 | \$ 1,873.56 | \$ 632.64 | \$ 374.71 |
| 19318 | Reduction of large breast | | T | 0693 | 42.2886 | \$ 2,516.64 | \$ 798.17 | \$ 503.33 |
| 19324 | Enlarge breast | | T | 0693 | 42.2886 | \$ 2,516.64 | \$ 798.17 | \$ 503.33 |
| 19325 | Enlarge breast with implant | | T | 0648 | 53.5307 | \$ 3,185.67 | | \$ 637.13 |
| 19328 | Removal of breast implant | | T | 0029 | 31.4826 | \$ 1,873.56 | \$ 632.64 | \$ 374.71 |
| 19330 | Removal of implant material | | T | 0029 | 31.4826 | \$ 1,873.56 | \$ 632.64 | \$ 374.71 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 19340 | Immediate breast prosthesis | | T | 0030 | 39.9779 | \$ 2,379.12 | \$ 763.55 | \$ 475.82 |
| 19342 | Delayed breast prosthesis | | T | 0648 | 53.5307 | \$ 3,185.67 | | \$ 637.13 |
| 19350 | Breast reconstruction | | T | 0028 | 19.4351 | \$ 1,156.60 | \$ 303.74 | \$ 231.32 |
| 19355 | Correct inverted nipple(s) | | T | 0029 | 31.4826 | \$ 1,873.56 | \$ 632.64 | \$ 374.71 |
| 19357 | Breast reconstruction | | T | 0648 | 53.5307 | \$ 3,185.67 | | \$ 637.13 |
| 19366 | Breast reconstruction | | T | 0029 | 31.4826 | \$ 1,873.56 | \$ 632.64 | \$ 374.71 |
| 19370 | Surgery of breast capsule | | T | 0029 | 31.4826 | \$ 1,873.56 | \$ 632.64 | \$ 374.71 |
| 19371 | Removal of breast capsule | | T | 0029 | 31.4826 | \$ 1,873.56 | \$ 632.64 | \$ 374.71 |
| 19380 | Revise breast reconstruction | | T | 0030 | 39.9779 | \$ 2,379.12 | \$ 763.55 | \$ 475.82 |
| 19396 | Design custom breast implant | | T | 0029 | 31.4826 | \$ 1,873.56 | \$ 632.64 | \$ 374.71 |
| 19499 | Breast surgery procedure | | T | 0028 | 19.4351 | \$ 1,156.60 | \$ 303.74 | \$ 231.32 |
| 20000 | Incision of abscess | | T | 0006 | 1.5100 | \$ 89.86 | \$ 21.76 | \$ 17.97 |
| 20005 | Incision of deep abscess | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 20100 | Explore wound, neck | | T | 0023 | 4.7662 | \$ 283.64 | | \$ 56.73 |
| 20101 | Explore wound, chest | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 20102 | Explore wound, abdomen | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 20103 | Explore wound, extremity | | T | 0023 | 4.7662 | \$ 283.64 | | \$ 56.73 |
| 20150 | Excise epiphyseal bar | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 20200 | Muscle biopsy | | T | 0021 | 14.9984 | \$ 892.57 | \$ 219.48 | \$ 178.51 |
| 20205 | Deep muscle biopsy | | T | 0021 | 14.9984 | \$ 892.57 | \$ 219.48 | \$ 178.51 |
| 20206 | Needle biopsy, muscle | | T | 0005 | 3.5834 | \$ 213.25 | \$ 71.59 | \$ 42.65 |
| 20220 | Bone biopsy, trocar/needle | | T | 0019 | 4.1481 | \$ 246.86 | \$ 71.87 | \$ 49.37 |
| 20225 | Bone biopsy, trocar/needle | | T | 0020 | 6.9410 | \$ 413.07 | \$ 107.67 | \$ 82.61 |
| 20240 | Bone biopsy, excisional | | T | 0022 | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 20245 | Bone biopsy, excisional | | T | 0022 | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 20250 | Open bone biopsy | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 20251 | Open bone biopsy | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 20500 | Injection of sinus tract | | T | 0251 | 2.0789 | \$ 123.72 | | \$ 24.74 |
| 20501 | Inject sinus tract for x-ray | | N | | | | | |
| 20520 | Removal of foreign body | | T | 0019 | 4.1481 | \$ 246.86 | \$ 71.87 | \$ 49.37 |
| 20525 | Removal of foreign body | | T | 0022 | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 20526 | Ther injection, carp tunnel | | T | 0204 | 2.2667 | \$ 134.89 | \$ 40.13 | \$ 26.98 |
| 20550 | Inj tendon sheath/ligament | | T | 0204 | 2.2667 | \$ 134.89 | \$ 40.13 | \$ 26.98 |
| 20551 | Inj tendon origin/insertion | | T | 0204 | 2.2667 | \$ 134.89 | \$ 40.13 | \$ 26.98 |
| 20552 | Inj trigger point, 1/2 muscl | | T | 0204 | 2.2667 | \$ 134.89 | \$ 40.13 | \$ 26.98 |
| 20553 | Inject trigger points, => 3 | | T | 0204 | 2.2667 | \$ 134.89 | \$ 40.13 | \$ 26.98 |
| 20600 | Drain/inject, joint/bursa | | T | 0204 | 2.2667 | \$ 134.89 | \$ 40.13 | \$ 26.98 |
| 20605 | Drain/inject, joint/bursa | | T | 0204 | 2.2667 | \$ 134.89 | \$ 40.13 | \$ 26.98 |
| 20610 | Drain/inject, joint/bursa | | T | 0204 | 2.2667 | \$ 134.89 | \$ 40.13 | \$ 26.98 |
| 20612 | Aspirate/inj ganglion cyst | | T | 0204 | 2.2667 | \$ 134.89 | \$ 40.13 | \$ 26.98 |
| 20615 | Treatment of bone cyst | | T | 0004 | 1.7771 | \$ 105.76 | \$ 22.36 | \$ 21.15 |
| 20650 | Insert and remove bone pin | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 20662 | Application of pelvis brace | CH | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 20663 | Application of thigh brace | CH | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 20665 | Removal of fixation device | | X | 0340 | 0.6137 | \$ 36.52 | | \$ 7.30 |
| 20670 | Removal of support implant | | T | 0021 | 14.9984 | \$ 892.57 | \$ 219.48 | \$ 178.51 |
| 20680 | Removal of support implant | | T | 0022 | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 20690 | Apply bone fixation device | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 20692 | Apply bone fixation device | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 20693 | Adjust bone fixation device | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 20694 | Remove bone fixation device | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 20822 | Replantation digit, complete | CH | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 20900 | Removal of bone for graft | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 20902 | Removal of bone for graft | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 20910 | Remove cartilage for graft | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 20912 | Remove cartilage for graft | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 20920 | Removal of fascia for graft | CH | T | 0686 | 13.4973 | \$ 803.24 | | \$ 160.65 |
| 20922 | Removal of fascia for graft | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 20924 | Removal of tendon for graft | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 20926 | Removal of tissue for graft | CH | T | 0686 | 13.4973 | \$ 803.24 | | \$ 160.65 |
| 20950 | Fluid pressure, muscle | | T | 0006 | 1.5100 | \$ 89.86 | \$ 21.76 | \$ 17.97 |
| 20972 | Bone/skin graft, metatarsal | CH | T | 0056 | 40.5436 | \$ 2,412.79 | | \$ 482.56 |
| 20973 | Bone/skin graft, great toe | CH | T | 0056 | 40.5436 | \$ 2,412.79 | | \$ 482.56 |
| 20975 | Electrical bone stimulation | | X | 0340 | 0.6137 | \$ 36.52 | | \$ 7.30 |
| 20982 | Ablate, bone tumor(s) perq | | T | 1557 | | \$ 1,850.00 | | \$ 370.00 |
| 20999 | Musculoskeletal surgery | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 21010 | Incision of jaw joint | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 21015 | Resection of facial tumor | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 21025 | Excision of bone, lower jaw | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 21026 | Excision of facial bone(s) | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 21029 | Contour of face bone lesion | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 21030 | Excise max/zygoma b9 tumor | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 21031 | Remove exostosis, mandible | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 21032 | Remove exostosis, maxilla | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 21034 | Excise max/zygoma mlg tumor | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 21040 | Excise mandible lesion | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 21044 | Removal of jaw bone lesion | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 21046 | Remove mandible cyst complex | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 21047 | Excise lwr jaw cyst w/repair | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 21048 | Remove maxilla cyst complex | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 21049 | Excis uppr jaw cyst w/repair | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 21050 | Removal of jaw joint | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 21060 | Remove jaw joint cartilage | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 21070 | Remove coronoid process | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 21076 | Prepare face/oral prosthesis | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 21077 | Prepare face/oral prosthesis | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 21079 | Prepare face/oral prosthesis | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 21080 | Prepare face/oral prosthesis | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 21081 | Prepare face/oral prosthesis | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 21082 | Prepare face/oral prosthesis | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 21083 | Prepare face/oral prosthesis | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 21084 | Prepare face/oral prosthesis | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 21085 | Prepare face/oral prosthesis | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 21086 | Prepare face/oral prosthesis | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 21087 | Prepare face/oral prosthesis | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 21088 | Prepare face/oral prosthesis | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 21089 | Prepare face/oral prosthesis | | T | 0251 | 2.0789 | \$ 123.72 | | \$ 24.74 |
| 21100 | Maxillofacial fixation | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 21110 | Interdental fixation | | T | 0252 | 8.1033 | \$ 482.24 | \$ 113.41 | \$ 96.45 |
| 21116 | Injection, jaw joint x-ray | | N | | | | | |
| 21120 | Reconstruction of chin | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 21121 | Reconstruction of chin | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 21122 | Reconstruction of chin | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 21123 | Reconstruction of chin | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 21125 | Augmentation, lower jaw bone | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 21127 | Augmentation, lower jaw bone | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 21137 | Reduction of forehead | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 21138 | Reduction of forehead | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 21139 | Reduction of forehead | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 21150 | Reconstruct midface, lefort | CH | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 21175 | Reconstruct orbit/forehead | CH | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 21181 | Contour cranial bone lesion | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 21195 | Reconst lwr jaw w/o fixation | CH | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 21198 | Reconstr lwr jaw segment | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 21199 | Reconstr lwr jaw w/advance | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 21206 | Reconstruct upper jaw bone | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 21208 | Augmentation of facial bones | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 21209 | Reduction of facial bones | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 21210 | Face bone graft | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 21215 | Lower jaw bone graft | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 21230 | Rib cartilage graft | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 21235 | Ear cartilage graft | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 21240 | Reconstruction of jaw joint | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 21242 | Reconstruction of jaw joint | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 21243 | Reconstruction of jaw joint | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 21244 | Reconstruction of lower jaw | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 21245 | Reconstruction of jaw | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 21246 | Reconstruction of jaw | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 21248 | Reconstruction of jaw | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 21249 | Reconstruction of jaw | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 21260 | Revise eye sockets | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 21261 | Revise eye sockets | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 21263 | Revise eye sockets | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 21267 | Revise eye sockets | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 21270 | Augmentation, cheek bone | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 21275 | Revision, orbitofacial bones | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 21280 | Revision of eyelid | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 21282 | Revision of eyelid | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 21295 | Revision of jaw muscle/bone | | T | 0252 | 8.1033 | \$ 482.24 | \$ 113.41 | \$ 96.45 |
| 21296 | Revision of jaw muscle/bone | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 21299 | Cranio/maxillofacial surgery | | T | 0251 | 2.0789 | \$ 123.72 | | \$ 24.74 |
| 21300 | Treatment of skull fracture | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 21310 | Treatment of nose fracture | | T | 0251 | 2.0789 | \$ 123.72 | | \$ 24.74 |
| 21315 | Treatment of nose fracture | | T | 0251 | 2.0789 | \$ 123.72 | | \$ 24.74 |
| 21320 | Treatment of nose fracture | | T | 0252 | 8.1033 | \$ 482.24 | \$ 113.41 | \$ 96.45 |
| 21325 | Treatment of nose fracture | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 21330 | Treatment of nose fracture | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 21335 | Treatment of nose fracture | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 21336 | Treat nasal septal fracture | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 21337 | Treat nasal septal fracture | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 21338 | Treat nasoethmoid fracture | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 21339 | Treat nasoethmoid fracture | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 21340 | Treatment of nose fracture | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 21345 | Treat nose/jaw fracture | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 21355 | Treat cheek bone fracture | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 21356 | Treat cheek bone fracture | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 21390 | Treat eye socket fracture | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 21400 | Treat eye socket fracture | | T | 0252 | 8.1033 | \$ 482.24 | \$ 113.41 | \$ 96.45 |
| 21401 | Treat eye socket fracture | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 21406 | Treat eye socket fracture | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 21407 | Treat eye socket fracture | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 21408 | Treat eye socket fracture | CH | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 21421 | Treat mouth roof fracture | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 21440 | Treat dental ridge fracture | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 21445 | Treat dental ridge fracture | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 21450 | Treat lower jaw fracture | | T | 0251 | 2.0789 | \$ 123.72 | | \$ 24.74 |
| 21451 | Treat lower jaw fracture | | T | 0252 | 8.1033 | \$ 482.24 | \$ 113.41 | \$ 96.45 |
| 21452 | Treat lower jaw fracture | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 21453 | Treat lower jaw fracture | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 21454 | Treat lower jaw fracture | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 21461 | Treat lower jaw fracture | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 21462 | Treat lower jaw fracture | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 21465 | Treat lower jaw fracture | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 21470 | Treat lower jaw fracture | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 21480 | Reset dislocated jaw | | T | 0251 | 2.0789 | \$ 123.72 | | \$ 24.74 |
| 21485 | Reset dislocated jaw | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 21490 | Repair dislocated jaw | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 21493 | Treat hyoid bone fracture | CH | D | | | | | |
| 21494 | Treat hyoid bone fracture | CH | D | | | | | |
| 21495 | Treat hyoid bone fracture | CH | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 21497 | Interdental wiring | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 21499 | Head surgery procedure | | T | 0251 | 2.0789 | \$ 123.72 | | \$ 24.74 |
| 21501 | Drain neck/chest lesion | | T | 0008 | 16.2953 | \$ 969.75 | | \$ 193.95 |
| 21502 | Drain chest lesion | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 21550 | Biopsy of neck/chest | | T | 0021 | 14.9984 | \$ 892.57 | \$ 219.48 | \$ 178.51 |
| 21555 | Remove lesion, neck/chest | | T | 0022 | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 21556 | Remove lesion, neck/chest | | T | 0022 | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 21557 | Remove tumor, neck/chest | | T | 0022 | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 21600 | Partial removal of rib | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 21610 | Partial removal of rib | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 21685 | Hyoid myotomy & suspension | | T | 0252 | 8.1033 | \$ 482.24 | \$ 113.41 | \$ 96.45 |
| 21700 | Revision of neck muscle | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 21720 | Revision of neck muscle | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 21725 | Revision of neck muscle | | T | 0006 | 1.5100 | \$ 89.86 | \$ 21.76 | \$ 17.97 |
| 21742 | Repair stern/nuss w/o scope | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 21743 | Repair sternum/nuss w/scope | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 21800 | Treatment of rib fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 21805 | Treatment of rib fracture | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 21820 | Treat sternum fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 21899 | Neck/chest surgery procedure | | T | 0251 | 2.0789 | \$ 123.72 | | \$ 24.74 |
| 21920 | Biopsy soft tissue of back | | T | 0020 | 6.9410 | \$ 413.07 | \$ 107.67 | \$ 82.61 |
| 21925 | Biopsy soft tissue of back | | T | 0022 | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 21930 | Remove lesion, back or flank | | T | 0022 | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 21935 | Remove tumor, back | | T | 0022 | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 22100 | Remove part of neck vertebra | | T | 0208 | 42.5200 | \$ 2,530.41 | | \$ 506.08 |
| 22101 | Remove part, thorax vertebra | | T | 0208 | 42.5200 | \$ 2,530.41 | | \$ 506.08 |
| 22102 | Remove part, lumbar vertebra | | T | 0208 | 42.5200 | \$ 2,530.41 | | \$ 506.08 |
| 22103 | Remove extra spine segment | | T | 0208 | 42.5200 | \$ 2,530.41 | | \$ 506.08 |
| 22222 | Revision of thorax spine | | T | 0208 | 42.5200 | \$ 2,530.41 | | \$ 506.08 |
| 22305 | Treat spine process fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 22310 | Treat spine fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 22315 | Treat spine fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 22505 | Manipulation of spine | | T | 0045 | 14.3413 | \$ 853.47 | \$ 268.47 | \$ 170.69 |
| 22520 | Percut vertebroplasty thor | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 22521 | Percut vertebroplasty lumb | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 22522 | Percut vertebroplasty add'l | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 22523 | Percut kyphoplasty, thor | NI | T | 0052 | 43.5555 | \$ 2,592.03 | | \$ 518.41 |
| 22524 | Percut kyphoplasty, lumbar | NI | T | 0052 | 43.5555 | \$ 2,592.03 | | \$ 518.41 |
| 22525 | Percut kyphoplasty, add-on | NI | T | 0052 | 43.5555 | \$ 2,592.03 | | \$ 518.41 |
| 22612 | Lumbar spine fusion | | T | 0208 | 42.5200 | \$ 2,530.41 | | \$ 506.08 |
| 22614 | Spine fusion, extra segment | | T | 0208 | 42.5200 | \$ 2,530.41 | | \$ 506.08 |
| 22899 | Spine surgery procedure | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 22900 | Remove abdominal wall lesion | | T | 0022 | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 22999 | Abdomen surgery procedure | | T | 0019 | 4.1481 | \$ 246.86 | \$ 71.87 | \$ 49.37 |
| 23000 | Removal of calcium deposits | | T | 0021 | 14.9984 | \$ 892.57 | \$ 219.48 | \$ 178.51 |
| 23020 | Release shoulder joint | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 23030 | Drain shoulder lesion | | T | 0008 | 16.2953 | \$ 969.75 | | \$ 193.95 |
| 23031 | Drain shoulder bursa | | T | 0008 | 16.2953 | \$ 969.75 | | \$ 193.95 |
| 23035 | Drain shoulder bone lesion | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 23040 | Exploratory shoulder surgery | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 23044 | Exploratory shoulder surgery | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 23065 | Biopsy shoulder tissues | | T | 0021 | 14.9984 | \$ 892.57 | \$ 219.48 | \$ 178.51 |
| 23066 | Biopsy shoulder tissues | | T | 0022 | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 23075 | Removal of shoulder lesion | | T | 0021 | 14.9984 | \$ 892.57 | \$ 219.48 | \$ 178.51 |
| 23076 | Removal of shoulder lesion | | T | 0022 | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 23077 | Remove tumor of shoulder | | T | 0022 | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 23100 | Biopsy of shoulder joint | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 23101 | Shoulder joint surgery | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 23105 | Remove shoulder joint lining | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 23106 | Incision of collarbone joint | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 23107 | Explore treat shoulder joint | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 23120 | Partial removal, collar bone | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 23125 | Removal of collar bone | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 23130 | Remove shoulder bone, part | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 23140 | Removal of bone lesion | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 23145 | Removal of bone lesion | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 23146 | Removal of bone lesion | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 23150 | Removal of humerus lesion | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 23155 | Removal of humerus lesion | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 23156 | Removal of humerus lesion | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 23170 | Remove collar bone lesion | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 23172 | Remove shoulder blade lesion | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 23174 | Remove humerus lesion | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 23180 | Remove collar bone lesion | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 23182 | Remove shoulder blade lesion | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 23184 | Remove humerus lesion | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 23190 | Partial removal of scapula | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 23195 | Removal of head of humerus | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|-------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 23330 | Remove shoulder foreign body | | T | 0020 | 6.9410 | \$ 413.07 | \$ 107.67 | \$ 82.61 |
| 23331 | Remove shoulder foreign body | | T | 0022 | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 23350 | Injection for shoulder x-ray | | N | | | | | |
| 23395 | Muscle transfer, shoulder/arm | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 23397 | Muscle transfers | | T | 0052 | 43.5555 | \$ 2,592.03 | | \$ 518.41 |
| 23400 | Fixation of shoulder blade | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 23405 | Incision of tendon & muscle | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 23406 | Incise tendon(s) & muscle(s) | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 23410 | Repair rotator cuff, acute | | T | 0052 | 43.5555 | \$ 2,592.03 | | \$ 518.41 |
| 23412 | Repair rotator cuff, chronic | | T | 0052 | 43.5555 | \$ 2,592.03 | | \$ 518.41 |
| 23415 | Release of shoulder ligament | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 23420 | Repair of shoulder | | T | 0052 | 43.5555 | \$ 2,592.03 | | \$ 518.41 |
| 23430 | Repair biceps tendon | | T | 0052 | 43.5555 | \$ 2,592.03 | | \$ 518.41 |
| 23440 | Remove/transplant tendon | | T | 0052 | 43.5555 | \$ 2,592.03 | | \$ 518.41 |
| 23450 | Repair shoulder capsule | | T | 0052 | 43.5555 | \$ 2,592.03 | | \$ 518.41 |
| 23455 | Repair shoulder capsule | | T | 0052 | 43.5555 | \$ 2,592.03 | | \$ 518.41 |
| 23460 | Repair shoulder capsule | | T | 0052 | 43.5555 | \$ 2,592.03 | | \$ 518.41 |
| 23462 | Repair shoulder capsule | | T | 0052 | 43.5555 | \$ 2,592.03 | | \$ 518.41 |
| 23465 | Repair shoulder capsule | | T | 0052 | 43.5555 | \$ 2,592.03 | | \$ 518.41 |
| 23466 | Repair shoulder capsule | | T | 0052 | 43.5555 | \$ 2,592.03 | | \$ 518.41 |
| 23470 | Reconstruct shoulder joint | | T | 0425 | 104.7352 | \$ 6,232.90 | \$ 1,378.01 | \$ 1,246.58 |
| 23480 | Revision of collar bone | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 23485 | Revision of collar bone | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 23490 | Reinforce clavicle | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 23491 | Reinforce shoulder bones | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 23500 | Treat clavicle fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 23505 | Treat clavicle fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 23515 | Treat clavicle fracture | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 23520 | Treat clavicle dislocation | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 23525 | Treat clavicle dislocation | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 23530 | Treat clavicle dislocation | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 23532 | Treat clavicle dislocation | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 23540 | Treat clavicle dislocation | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 23545 | Treat clavicle dislocation | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 23550 | Treat clavicle dislocation | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 23552 | Treat clavicle dislocation | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 23570 | Treat shoulder blade fx | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 23575 | Treat shoulder blade fx | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 23585 | Treat scapula fracture | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 23600 | Treat humerus fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 23605 | Treat humerus fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 23615 | Treat humerus fracture | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 23616 | Treat humerus fracture | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 23620 | Treat humerus fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 23625 | Treat humerus fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 23630 | Treat humerus fracture | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 23650 | Treat shoulder dislocation | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 23655 | Treat shoulder dislocation | | T | 0045 | 14.3413 | \$ 853.47 | \$ 268.47 | \$ 170.69 |
| 23660 | Treat shoulder dislocation | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 23665 | Treat dislocation/fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 23670 | Treat dislocation/fracture | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 23675 | Treat dislocation/fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 23680 | Treat dislocation/fracture | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 23700 | Fixation of shoulder | | T | 0045 | 14.3413 | \$ 853.47 | \$ 268.47 | \$ 170.69 |
| 23800 | Fusion of shoulder joint | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 23802 | Fusion of shoulder joint | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 23921 | Amputation follow-up surgery | | T | 0025 | 5.3051 | \$ 315.71 | \$ 101.85 | \$ 63.14 |
| 23929 | Shoulder surgery procedure | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 23930 | Drainage of arm lesion | | T | 0008 | 16.2953 | \$ 969.75 | | \$ 193.95 |
| 23931 | Drainage of arm bursa | CH | T | 0008 | 16.2953 | \$ 969.75 | | \$ 193.95 |
| 23935 | Drain arm/elbow bone lesion | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 24000 | Exploratory elbow surgery | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 24006 | Release elbow joint | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 24065 | Biopsy arm/elbow soft tissue | | T | 0021 | 14.9984 | \$ 892.57 | \$ 219.48 | \$ 178.51 |
| 24066 | Biopsy arm/elbow soft tissue | | T | 0021 | 14.9984 | \$ 892.57 | \$ 219.48 | \$ 178.51 |
| 24075 | Remove arm/elbow lesion | | T | 0021 | 14.9984 | \$ 892.57 | \$ 219.48 | \$ 178.51 |
| 24076 | Remove arm/elbow lesion | | T | 0022 | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 24077 | Remove tumor of arm/elbow | | T | 0022 | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 24100 | Biopsy elbow joint lining | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 24101 | Explore/treat elbow joint | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 24102 | Remove elbow joint lining | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 24105 | Removal of elbow bursa | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 24110 | Remove humerus lesion | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 24115 | Remove/graft bone lesion | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 24116 | Remove/graft bone lesion | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 24120 | Remove elbow lesion | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 24125 | Remove/graft bone lesion | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 24126 | Remove/graft bone lesion | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 24130 | Removal of head of radius | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 24134 | Removal of arm bone lesion | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 24136 | Remove radius bone lesion | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 24138 | Remove elbow bone lesion | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 24140 | Partial removal of arm bone | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 24145 | Partial removal of radius | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 24147 | Partial removal of elbow | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 24149 | Radical resection of elbow | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 24150 | Extensive humerus surgery | | T | 0052 | 43.5555 | \$ 2,592.03 | | \$ 518.41 |
| 24151 | Extensive humerus surgery | | T | 0052 | 43.5555 | \$ 2,592.03 | | \$ 518.41 |
| 24152 | Extensive radius surgery | | T | 0052 | 43.5555 | \$ 2,592.03 | | \$ 518.41 |
| 24153 | Extensive radius surgery | | T | 0052 | 43.5555 | \$ 2,592.03 | | \$ 518.41 |
| 24155 | Removal of elbow joint | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 24160 | Remove elbow joint implant | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 24164 | Remove radius head implant | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 24200 | Removal of arm foreign body | | T | 0019 | 4.1481 | \$ 246.86 | \$ 71.87 | \$ 49.37 |
| 24201 | Removal of arm foreign body | | T | 0021 | 14.9984 | \$ 892.57 | \$ 219.48 | \$ 178.51 |
| 24220 | Injection for elbow x-ray | | N | | | | | |
| 24300 | Manipulate elbow w/anesth | | T | 0045 | 14.3413 | \$ 853.47 | \$ 268.47 | \$ 170.69 |
| 24301 | Muscle/tendon transfer | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 24305 | Arm tendon lengthening | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 24310 | Revision of arm tendon | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 24320 | Repair of arm tendon | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 24330 | Revision of arm muscles | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 24331 | Revision of arm muscles | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 24332 | Tenolysis, triceps | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 24340 | Repair of biceps tendon | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 24341 | Repair arm tendon/muscle | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 24342 | Repair of ruptured tendon | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 24343 | Repr elbow lat ligmnt w/tiss | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 24344 | Reconstruct elbow lat ligmnt | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 24345 | Repr elbw med ligmnt w/tissu | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 24346 | Reconstruct elbow med ligmnt | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 24350 | Repair of tennis elbow | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 24351 | Repair of tennis elbow | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 24352 | Repair of tennis elbow | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 24354 | Repair of tennis elbow | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 24356 | Revision of tennis elbow | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 24360 | Reconstruct elbow joint | | T | 0047 | 31.2345 | \$ 1,858.80 | \$ 537.03 | \$ 371.76 |
| 24361 | Reconstruct elbow joint | | T | 0425 | 104.7352 | \$ 6,232.90 | \$ 1,378.01 | \$ 1,246.58 |
| 24362 | Reconstruct elbow joint | | T | 0048 | 43.3955 | \$ 2,582.51 | \$ 570.30 | \$ 516.50 |
| 24363 | Replace elbow joint | | T | 0425 | 104.7352 | \$ 6,232.90 | \$ 1,378.01 | \$ 1,246.58 |
| 24365 | Reconstruct head of radius | | T | 0047 | 31.2345 | \$ 1,858.80 | \$ 537.03 | \$ 371.76 |
| 24366 | Reconstruct head of radius | | T | 0425 | 104.7352 | \$ 6,232.90 | \$ 1,378.01 | \$ 1,246.58 |
| 24400 | Revision of humerus | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 24410 | Revision of humerus | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 24420 | Revision of humerus | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 24430 | Repair of humerus | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 24435 | Repair humerus with graft | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 24470 | Revision of elbow joint | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 24495 | Decompression of forearm | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 24498 | Reinforce humerus | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 24500 | Treat humerus fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 24505 | Treat humerus fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 24515 | Treat humerus fracture | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 24516 | Treat humerus fracture | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 24530 | Treat humerus fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 24535 | Treat humerus fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 24538 | Treat humerus fracture | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 24545 | Treat humerus fracture | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 24546 | Treat humerus fracture | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 24560 | Treat humerus fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 24565 | Treat humerus fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 24566 | Treat humerus fracture | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 24575 | Treat humerus fracture | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 24576 | Treat humerus fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 24577 | Treat humerus fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 24579 | Treat humerus fracture | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 24582 | Treat humerus fracture | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 24586 | Treat elbow fracture | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 24587 | Treat elbow fracture | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 24600 | Treat elbow dislocation | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 24605 | Treat elbow dislocation | | T | 0045 | 14.3413 | \$ 853.47 | \$ 268.47 | \$ 170.69 |
| 24615 | Treat elbow dislocation | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 24620 | Treat elbow fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 24635 | Treat elbow fracture | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 24640 | Treat elbow dislocation | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 24650 | Treat radius fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 24655 | Treat radius fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 24665 | Treat radius fracture | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 24666 | Treat radius fracture | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 24670 | Treat ulnar fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 24675 | Treat ulnar fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 24685 | Treat ulnar fracture | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 24800 | Fusion of elbow joint | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 24802 | Fusion/graft of elbow joint | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 24925 | Amputation follow-up surgery | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 24935 | Revision of amputation | | T | 0052 | 43.5555 | \$ 2,592.03 | | \$ 518.41 |
| 24999 | Upper arm/elbow surgery | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 25000 | Incision of tendon sheath | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 25001 | Incise flexor carpi radialis | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 25020 | Decompress forearm 1 space | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 25023 | Decompress forearm 1 space | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 25024 | Decompress forearm 2 spaces | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 25025 | Decompress forearm 2 spaces | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 25028 | Drainage of forearm lesion | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 25031 | Drainage of forearm bursa | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 25035 | Treat forearm bone lesion | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 25040 | Explore/treat wrist joint | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 25065 | Biopsy forearm soft tissues | | T | 0021 | 14.9984 | \$ 892.57 | \$ 219.48 | \$ 178.51 |
| 25066 | Biopsy forearm soft tissues | | T | 0022 | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 25075 | Removal forearm lesion subcu | | T | 0021 | 14.9984 | \$ 892.57 | \$ 219.48 | \$ 178.51 |
| 25076 | Removal forearm lesion deep | | T | 0022 | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 25077 | Remove tumor, forearm/wrist | | T | 0022 | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 25085 | Incision of wrist capsule | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 25100 | Biopsy of wrist joint | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 25101 | Explore/treat wrist joint | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 25105 | Remove wrist joint lining | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 25107 | Remove wrist joint cartilage | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 25110 | Remove wrist tendon lesion | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 25111 | Remove wrist tendon lesion | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 25112 | Reremove wrist tendon lesion | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 25115 | Remove wrist/forearm lesion | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 25116 | Remove wrist/forearm lesion | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 25118 | Excise wrist tendon sheath | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 25119 | Partial removal of ulna | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 25120 | Removal of forearm lesion | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 25125 | Remove/graft forearm lesion | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 25126 | Remove/graft forearm lesion | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 25130 | Removal of wrist lesion | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 25135 | Remove & graft wrist lesion | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 25136 | Remove & graft wrist lesion | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 25145 | Remove forearm bone lesion | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 25150 | Partial removal of ulna | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 25151 | Partial removal of radius | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 25170 | Extensive forearm surgery | | T | 0052 | 43.5555 | \$ 2,592.03 | | \$ 518.41 |
| 25210 | Removal of wrist bone | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 25215 | Removal of wrist bones | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 25230 | Partial removal of radius | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 25240 | Partial removal of ulna | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 25246 | Injection for wrist x-ray | | N | | | | | |
| 25248 | Remove forearm foreign body | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 25250 | Removal of wrist prosthesis | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 25251 | Removal of wrist prosthesis | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 25259 | Manipulate wrist w/anesthes | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 25260 | Repair forearm tendon/muscle | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 25263 | Repair forearm tendon/muscle | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 25265 | Repair forearm tendon/muscle | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 25270 | Repair forearm tendon/muscle | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 25272 | Repair forearm tendon/muscle | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 25274 | Repair forearm tendon/muscle | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 25275 | Repair forearm tendon sheath | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 25280 | Revise wrist/forearm tendon | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 25290 | Incise wrist/forearm tendon | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 25295 | Release wrist/forearm tendon | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 25300 | Fusion of tendons at wrist | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 25301 | Fusion of tendons at wrist | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 25310 | Transplant forearm tendon | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 25312 | Transplant forearm tendon | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 25315 | Revise palsy hand tendon(s) | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 25316 | Revise palsy hand tendon(s) | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 25320 | Repair/revise wrist joint | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 25332 | Revise wrist joint | | T | 0047 | 31.2345 | \$ 1,858.80 | \$ 537.03 | \$ 371.76 |
| 25335 | Realignment of hand | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 25337 | Reconstruct ulna/radioulnar | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 25350 | Revision of radius | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 25355 | Revision of radius | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 25360 | Revision of ulna | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 25365 | Revise radius & ulna | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 25370 | Revise radius or ulna | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 25375 | Revise radius & ulna | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 25390 | Shorten radius or ulna | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 25391 | Lengthen radius or ulna | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 25392 | Shorten radius & ulna | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 25393 | Lengthen radius & ulna | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 25394 | Repair carpal bone, shorten | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 25400 | Repair radius or ulna | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 25405 | Repair/graft radius or ulna | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 25415 | Repair radius & ulna | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 25420 | Repair/graft radius & ulna | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 25425 | Repair/graft radius or ulna | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 25426 | Repair/graft radius & ulna | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 25430 | Vasc graft into carpal bone | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 25431 | Repair nonunion carpal bone | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 25440 | Repair/graft wrist bone | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 25441 | Reconstruct wrist joint | | T | 0425 | 104.7352 | \$ 6,232.90 | \$ 1,378.01 | \$ 1,246.58 |
| 25442 | Reconstruct wrist joint | | T | 0425 | 104.7352 | \$ 6,232.90 | \$ 1,378.01 | \$ 1,246.58 |
| 25443 | Reconstruct wrist joint | | T | 0048 | 43.3955 | \$ 2,582.51 | \$ 570.30 | \$ 516.50 |
| 25444 | Reconstruct wrist joint | | T | 0048 | 43.3955 | \$ 2,582.51 | \$ 570.30 | \$ 516.50 |
| 25445 | Reconstruct wrist joint | | T | 0048 | 43.3955 | \$ 2,582.51 | \$ 570.30 | \$ 516.50 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 25446 | Wrist replacement | | T | 0425 | 104.7352 | \$ 6,232.90 | \$ 1,378.01 | \$ 1,246.58 |
| 25447 | Repair wrist joint(s) | | T | 0047 | 31.2345 | \$ 1,858.80 | \$ 537.03 | \$ 371.76 |
| 25449 | Remove wrist joint implant | | T | 0047 | 31.2345 | \$ 1,858.80 | \$ 537.03 | \$ 371.76 |
| 25450 | Revision of wrist joint | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 25455 | Revision of wrist joint | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 25490 | Reinforce radius | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 25491 | Reinforce ulna | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 25492 | Reinforce radius and ulna | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 25500 | Treat fracture of radius | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 25505 | Treat fracture of radius | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 25515 | Treat fracture of radius | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 25520 | Treat fracture of radius | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 25525 | Treat fracture of radius | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 25526 | Treat fracture of radius | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 25530 | Treat fracture of ulna | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 25535 | Treat fracture of ulna | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 25545 | Treat fracture of ulna | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 25560 | Treat fracture radius & ulna | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 25565 | Treat fracture radius & ulna | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 25574 | Treat fracture radius & ulna | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 25575 | Treat fracture radius/ulna | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 25600 | Treat fracture radius/ulna | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 25605 | Treat fracture radius/ulna | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 25611 | Treat fracture radius/ulna | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 25620 | Treat fracture radius/ulna | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 25622 | Treat wrist bone fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 25624 | Treat wrist bone fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 25628 | Treat wrist bone fracture | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 25630 | Treat wrist bone fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 25635 | Treat wrist bone fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 25645 | Treat wrist bone fracture | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 25650 | Treat wrist bone fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 25651 | Pin ulnar styloid fracture | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 25652 | Treat fracture ulnar styloid | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 25660 | Treat wrist dislocation | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 25670 | Treat wrist dislocation | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 25671 | Pin radioulnar dislocation | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 25675 | Treat wrist dislocation | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 25676 | Treat wrist dislocation | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 25680 | Treat wrist fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 25685 | Treat wrist fracture | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 25690 | Treat wrist dislocation | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 25695 | Treat wrist dislocation | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 25800 | Fusion of wrist joint | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 25805 | Fusion/graft of wrist joint | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 25810 | Fusion/graft of wrist joint | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 25820 | Fusion of hand bones | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 25825 | Fuse hand bones with graft | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 25830 | Fusion, radioulnar jnt/ulna | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 25907 | Amputation follow-up surgery | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 25922 | Amputate hand at wrist | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 25929 | Amputation follow-up surgery | CH | T | 0686 | 13.4973 | \$ 803.24 | | \$ 160.65 |
| 25999 | Forearm or wrist surgery | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 26010 | Drainage of finger abscess | | T | 0006 | 1.5100 | \$ 89.86 | \$ 21.76 | \$ 17.97 |
| 26011 | Drainage of finger abscess | | T | 0007 | 11.6717 | \$ 694.59 | | \$ 138.92 |
| 26020 | Drain hand tendon sheath | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 26025 | Drainage of palm bursa | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 26030 | Drainage of palm bursa(s) | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 26034 | Treat hand bone lesion | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 26035 | Decompress fingers/hand | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 26037 | Decompress fingers/hand | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 26040 | Release palm contracture | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26045 | Release palm contracture | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26055 | Incise finger tendon sheath | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 26060 | Incision of finger tendon | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 26070 | Explore/treat hand joint | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 26075 | Explore/treat finger joint | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 26080 | Explore/treat finger joint | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 26100 | Biopsy hand joint lining | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 26105 | Biopsy finger joint lining | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 26110 | Biopsy finger joint lining | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 26115 | Removal hand lesion subcut | | T | 0022 | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 26116 | Removal hand lesion, deep | | T | 0022 | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 26117 | Remove tumor, hand/finger | | T | 0022 | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 26121 | Release palm contracture | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26123 | Release palm contracture | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26125 | Release palm contracture | CH | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 26130 | Remove wrist joint lining | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 26135 | Revise finger joint, each | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26140 | Revise finger joint, each | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 26145 | Tendon excision, palm/finger | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 26160 | Remove tendon sheath lesion | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 26170 | Removal of palm tendon, each | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 26180 | Removal of finger tendon | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 26185 | Remove finger bone | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 26200 | Remove hand bone lesion | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 26205 | Remove/graft bone lesion | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26210 | Removal of finger lesion | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 26215 | Remove/graft finger lesion | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 26230 | Partial removal of hand bone | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 26235 | Partial removal, finger bone | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 26236 | Partial removal, finger bone | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 26250 | Extensive hand surgery | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 26255 | Extensive hand surgery | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26260 | Extensive finger surgery | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 26261 | Extensive finger surgery | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 26262 | Partial removal of finger | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 26320 | Removal of implant from hand | | T | 0021 | 14.9984 | \$ 892.57 | \$ 219.48 | \$ 178.51 |
| 26340 | Manipulate finger w/anesth | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 26350 | Repair finger/hand tendon | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26352 | Repair/graft hand tendon | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26356 | Repair finger/hand tendon | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26357 | Repair finger/hand tendon | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26358 | Repair/graft hand tendon | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26370 | Repair finger/hand tendon | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26372 | Repair/graft hand tendon | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26373 | Repair finger/hand tendon | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26390 | Revise hand/finger tendon | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26392 | Repair/graft hand tendon | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26410 | Repair hand tendon | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 26412 | Repair/graft hand tendon | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26415 | Excision, hand/finger tendon | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26416 | Graft hand or finger tendon | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26418 | Repair finger tendon | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 26420 | Repair/graft finger tendon | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26426 | Repair finger/hand tendon | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26428 | Repair/graft finger tendon | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26432 | Repair finger tendon | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 26433 | Repair finger tendon | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 26434 | Repair/graft finger tendon | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26437 | Realignment of tendons | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 26440 | Release palm/finger tendon | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 26442 | Release palm & finger tendon | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26445 | Release hand/finger tendon | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 26449 | Release forearm/hand tendon | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26450 | Incision of palm tendon | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 26455 | Incision of finger tendon | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 26460 | Incise hand/finger tendon | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 26471 | Fusion of finger tendons | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 26474 | Fusion of finger tendons | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 26476 | Tendon lengthening | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 26477 | Tendon shortening | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 26478 | Lengthening of hand tendon | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 26479 | Shortening of hand tendon | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 26480 | Transplant hand tendon | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26483 | Transplant/graft hand tendon | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26485 | Transplant palm tendon | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26489 | Transplant/graft palm tendon | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26490 | Revise thumb tendon | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26492 | Tendon transfer with graft | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26494 | Hand tendon/muscle transfer | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26496 | Revise thumb tendon | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26497 | Finger tendon transfer | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26498 | Finger tendon transfer | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26499 | Revision of finger | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26500 | Hand tendon reconstruction | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 26502 | Hand tendon reconstruction | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26504 | Hand tendon reconstruction | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26508 | Release thumb contracture | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 26510 | Thumb tendon transfer | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26516 | Fusion of knuckle joint | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26517 | Fusion of knuckle joints | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26518 | Fusion of knuckle joints | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26520 | Release knuckle contracture | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 26525 | Release finger contracture | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 26530 | Revise knuckle joint | | T | 0047 | 31.2345 | \$ 1,858.80 | \$ 537.03 | \$ 371.76 |
| 26531 | Revise knuckle with implant | | T | 0048 | 43.3955 | \$ 2,582.51 | \$ 570.30 | \$ 516.50 |
| 26535 | Revise finger joint | | T | 0047 | 31.2345 | \$ 1,858.80 | \$ 537.03 | \$ 371.76 |
| 26536 | Revise/implant finger joint | | T | 0048 | 43.3955 | \$ 2,582.51 | \$ 570.30 | \$ 516.50 |
| 26540 | Repair hand joint | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 26541 | Repair hand joint with graft | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26542 | Repair hand joint with graft | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 26545 | Reconstruct finger joint | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26546 | Repair nonunion hand | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26548 | Reconstruct finger joint | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26550 | Construct thumb replacement | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26555 | Positional change of finger | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26560 | Repair of web finger | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 26561 | Repair of web finger | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26562 | Repair of web finger | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26565 | Correct metacarpal flaw | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26567 | Correct finger deformity | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 26568 | Lengthen metacarpal/finger | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26580 | Repair hand deformity | CH | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 26587 | Reconstruct extra finger | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 26590 | Repair finger deformity | CH | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 26591 | Repair muscles of hand | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26593 | Release muscles of hand | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 26596 | Excision constricting tissue | CH | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 26600 | Treat metacarpal fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 26605 | Treat metacarpal fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 26607 | Treat metacarpal fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 26608 | Treat metacarpal fracture | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 26615 | Treat metacarpal fracture | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 26641 | Treat thumb dislocation | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 26645 | Treat thumb fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 26650 | Treat thumb fracture | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 26665 | Treat thumb fracture | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 26670 | Treat hand dislocation | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 26675 | Treat hand dislocation | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 26676 | Pin hand dislocation | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 26685 | Treat hand dislocation | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 26686 | Treat hand dislocation | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 26700 | Treat knuckle dislocation | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 26705 | Treat knuckle dislocation | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 26706 | Pin knuckle dislocation | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 26715 | Treat knuckle dislocation | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 26720 | Treat finger fracture, each | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 26725 | Treat finger fracture, each | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 26727 | Treat finger fracture, each | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 26735 | Treat finger fracture, each | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 26740 | Treat finger fracture, each | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 26742 | Treat finger fracture, each | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 26746 | Treat finger fracture, each | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 26750 | Treat finger fracture, each | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 26755 | Treat finger fracture, each | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 26756 | Pin finger fracture, each | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 26765 | Treat finger fracture, each | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 26770 | Treat finger dislocation | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 26775 | Treat finger dislocation | | T | 0045 | 14.3413 | \$ 853.47 | \$ 268.47 | \$ 170.69 |
| 26776 | Pin finger dislocation | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 26785 | Treat finger dislocation | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 26820 | Thumb fusion with graft | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26841 | Fusion of thumb | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26842 | Thumb fusion with graft | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 26843 | Fusion of hand joint | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26844 | Fusion/graft of hand joint | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26850 | Fusion of knuckle | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26852 | Fusion of knuckle with graft | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26860 | Fusion of finger joint | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26861 | Fusion of finger jnt, add-on | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26862 | Fusion/graft of finger joint | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26863 | Fuse/graft added joint | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26910 | Amputate metacarpal bone | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 26951 | Amputation of finger/thumb | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 26952 | Amputation of finger/thumb | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 26989 | Hand/finger surgery | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 26990 | Drainage of pelvis lesion | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 26991 | Drainage of pelvis bursa | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 27000 | Incision of hip tendon | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 27001 | Incision of hip tendon | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 27003 | Incision of hip tendon | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 27033 | Exploration of hip joint | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 27035 | Denervation of hip joint | | T | 0052 | 43.5555 | \$ 2,592.03 | | \$ 518.41 |
| 27040 | Biopsy of soft tissues | | T | 0020 | 6.9410 | \$ 413.07 | \$ 107.67 | \$ 82.61 |
| 27041 | Biopsy of soft tissues | | T | 0020 | 6.9410 | \$ 413.07 | \$ 107.67 | \$ 82.61 |
| 27047 | Remove hip/pelvis lesion | | T | 0022 | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 27048 | Remove hip/pelvis lesion | | T | 0022 | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 27049 | Remove tumor, hip/pelvis | | T | 0022 | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 27050 | Biopsy of sacroiliac joint | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 27052 | Biopsy of hip joint | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 27060 | Removal of ischial bursa | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 27062 | Remove femur lesion/bursa | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 27065 | Removal of hip bone lesion | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 27066 | Removal of hip bone lesion | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 27067 | Remove/graft hip bone lesion | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 27080 | Removal of tail bone | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 27086 | Remove hip foreign body | | T | 0020 | 6.9410 | \$ 413.07 | \$ 107.67 | \$ 82.61 |
| 27087 | Remove hip foreign body | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 27093 | Injection for hip x-ray | | N | | | | | |
| 27095 | Injection for hip x-ray | | N | | | | | |
| 27097 | Revision of hip tendon | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 27098 | Transfer tendon to pelvis | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 27100 | Transfer of abdominal muscle | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 27105 | Transfer of spinal muscle | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 27110 | Transfer of iliopsoas muscle | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 27111 | Transfer of iliopsoas muscle | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 27193 | Treat pelvic ring fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 27194 | Treat pelvic ring fracture | | T | 0045 | 14.3413 | \$ 853.47 | \$ 268.47 | \$ 170.69 |
| 27200 | Treat tail bone fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 27202 | Treat tail bone fracture | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 27216 | Treat pelvic ring fracture | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 27220 | Treat hip socket fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 27230 | Treat thigh fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 27235 | Treat thigh fracture | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 27238 | Treat thigh fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 27246 | Treat thigh fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 27250 | Treat hip dislocation | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 27252 | Treat hip dislocation | | T | 0045 | 14.3413 | \$ 853.47 | \$ 268.47 | \$ 170.69 |
| 27256 | Treat hip dislocation | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 27257 | Treat hip dislocation | | T | 0045 | 14.3413 | \$ 853.47 | \$ 268.47 | \$ 170.69 |
| 27265 | Treat hip dislocation | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 27266 | Treat hip dislocation | | T | 0045 | 14.3413 | \$ 853.47 | \$ 268.47 | \$ 170.69 |
| 27275 | Manipulation of hip joint | | T | 0045 | 14.3413 | \$ 853.47 | \$ 268.47 | \$ 170.69 |
| 27299 | Pelvis/hip joint surgery | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 27301 | Drain thigh/knee lesion | | T | 0008 | 16.2953 | \$ 969.75 | | \$ 193.95 |
| 27305 | Incise thigh tendon & fascia | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 27306 | Incision of thigh tendon | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 27307 | Incision of thigh tendons | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 27310 | Exploration of knee joint | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 27315 | Partial removal, thigh nerve | | T | 0220 | 17.3203 | \$ 1,030.75 | | \$ 206.15 |
| 27320 | Partial removal, thigh nerve | | T | 0220 | 17.3203 | \$ 1,030.75 | | \$ 206.15 |
| 27323 | Biopsy, thigh soft tissues | | T | 0021 | 14.9984 | \$ 892.57 | \$ 219.48 | \$ 178.51 |
| 27324 | Biopsy, thigh soft tissues | | T | 0022 | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 27327 | Removal of thigh lesion | | T | 0022 | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 27328 | Removal of thigh lesion | | T | 0022 | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 27329 | Remove tumor, thigh/knee | | T | 0022 | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 27330 | Biopsy, knee joint lining | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 27331 | Explore/treat knee joint | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 27332 | Removal of knee cartilage | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 27333 | Removal of knee cartilage | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 27334 | Remove knee joint lining | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 27335 | Remove knee joint lining | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 27340 | Removal of kneecap bursa | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 27345 | Removal of knee cyst | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 27347 | Remove knee cyst | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 27350 | Removal of kneecap | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 27355 | Remove femur lesion | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 27356 | Remove femur lesion/graft | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 27357 | Remove femur lesion/graft | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 27358 | Remove femur lesion/fixation | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 27360 | Partial removal, leg bone(s) | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 27370 | Injection for knee x-ray | | N | | | | | |
| 27372 | Removal of foreign body | | T | 0022 | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 27380 | Repair of kneecap tendon | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 27381 | Repair/graft kneecap tendon | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 27385 | Repair of thigh muscle | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 27386 | Repair/graft of thigh muscle | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 27390 | Incision of thigh tendon | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 27391 | Incision of thigh tendons | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 27392 | Incision of thigh tendons | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 27393 | Lengthening of thigh tendon | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 27394 | Lengthening of thigh tendons | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 27395 | Lengthening of thigh tendons | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 27396 | Transplant of thigh tendon | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 27397 | Transplants of thigh tendons | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 27400 | Revise thigh muscles/tendons | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 27403 | Repair of knee cartilage | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 27405 | Repair of knee ligament | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 27407 | Repair of knee ligament | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 27409 | Repair of knee ligaments | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 27412 | Autochondrocyte implant knee | | T | 0042 | 44.2075 | \$ 2,630.83 | \$ 804.74 | \$ 526.17 |
| 27415 | Osteochondral knee allograft | | T | 0042 | 44.2075 | \$ 2,630.83 | \$ 804.74 | \$ 526.17 |
| 27418 | Repair degenerated kneecap | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 27420 | Revision of unstable kneecap | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 27422 | Revision of unstable kneecap | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 27424 | Revision/removal of kneecap | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 27425 | Lat retinacular release open | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 27427 | Reconstruction, knee | | T | 0052 | 43.5555 | \$ 2,592.03 | | \$ 518.41 |
| 27428 | Reconstruction, knee | | T | 0052 | 43.5555 | \$ 2,592.03 | | \$ 518.41 |
| 27429 | Reconstruction, knee | | T | 0052 | 43.5555 | \$ 2,592.03 | | \$ 518.41 |
| 27430 | Revision of thigh muscles | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 27435 | Incision of knee joint | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 27437 | Revise kneecap | | T | 0047 | 31.2345 | \$ 1,858.80 | \$ 537.03 | \$ 371.76 |
| 27438 | Revise kneecap with implant | | T | 0048 | 43.3955 | \$ 2,582.51 | \$ 570.30 | \$ 516.50 |
| 27440 | Revision of knee joint | | T | 0047 | 31.2345 | \$ 1,858.80 | \$ 537.03 | \$ 371.76 |
| 27441 | Revision of knee joint | | T | 0047 | 31.2345 | \$ 1,858.80 | \$ 537.03 | \$ 371.76 |
| 27442 | Revision of knee joint | | T | 0047 | 31.2345 | \$ 1,858.80 | \$ 537.03 | \$ 371.76 |
| 27443 | Revision of knee joint | | T | 0047 | 31.2345 | \$ 1,858.80 | \$ 537.03 | \$ 371.76 |
| 27446 | Revision of knee joint | | T | 0681 | 135.4643 | \$ 8,061.62 | \$ 2,081.48 | \$ 1,612.32 |
| 27475 | Surgery to stop leg growth | CH | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 27496 | Decompression of thigh/knee | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 27497 | Decompression of thigh/knee | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 27498 | Decompression of thigh/knee | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 27499 | Decompression of thigh/knee | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 27500 | Treatment of thigh fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 27501 | Treatment of thigh fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 27502 | Treatment of thigh fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 27503 | Treatment of thigh fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 27508 | Treatment of thigh fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 27509 | Treatment of thigh fracture | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 27510 | Treatment of thigh fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 27516 | Treat thigh fx growth plate | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 27517 | Treat thigh fx growth plate | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 27520 | Treat kneecap fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 27524 | Treat kneecap fracture | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 27530 | Treat knee fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 27532 | Treat knee fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 27538 | Treat knee fracture(s) | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 27550 | Treat knee dislocation | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 27552 | Treat knee dislocation | | T | 0045 | 14.3413 | \$ 853.47 | \$ 268.47 | \$ 170.69 |
| 27560 | Treat kneecap dislocation | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 27562 | Treat kneecap dislocation | | T | 0045 | 14.3413 | \$ 853.47 | \$ 268.47 | \$ 170.69 |
| 27566 | Treat kneecap dislocation | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 27570 | Fixation of knee joint | | T | 0045 | 14.3413 | \$ 853.47 | \$ 268.47 | \$ 170.69 |
| 27594 | Amputation follow-up surgery | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 27599 | Leg surgery procedure | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 27600 | Decompression of lower leg | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 27601 | Decompression of lower leg | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 27602 | Decompression of lower leg | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 27603 | Drain lower leg lesion | CH | T | 0008 | 16.2953 | \$ 969.75 | | \$ 193.95 |
| 27604 | Drain lower leg bursa | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 27605 | Incision of achilles tendon | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 27606 | Incision of achilles tendon | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 27607 | Treat lower leg bone lesion | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 27610 | Explore/treat ankle joint | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 27612 | Exploration of ankle joint | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 27613 | Biopsy lower leg soft tissue | | T | 0020 | 6.9410 | \$ 413.07 | \$ 107.67 | \$ 82.61 |
| 27614 | Biopsy lower leg soft tissue | | T | 0022 | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 27615 | Remove tumor, lower leg | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 27618 | Remove lower leg lesion | | T | 0021 | 14.9984 | \$ 892.57 | \$ 219.48 | \$ 178.51 |
| 27619 | Remove lower leg lesion | | T | 0022 | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 27620 | Explore/treat ankle joint | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 27625 | Remove ankle joint lining | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 27626 | Remove ankle joint lining | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 27630 | Removal of tendon lesion | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 27635 | Remove lower leg bone lesion | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 27637 | Remove/graft leg bone lesion | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 27638 | Remove/graft leg bone lesion | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 27640 | Partial removal of tibia | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 27641 | Partial removal of fibula | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 27647 | Extensive ankle/heel surgery | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 27648 | Injection for ankle x-ray | | N | | | | | |
| 27650 | Repair achilles tendon | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 27652 | Repair/graft achilles tendon | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 27654 | Repair of achilles tendon | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 27656 | Repair leg fascia defect | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 27658 | Repair of leg tendon, each | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 27659 | Repair of leg tendon, each | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 27664 | Repair of leg tendon, each | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 27665 | Repair of leg tendon, each | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 27675 | Repair lower leg tendons | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 27676 | Repair lower leg tendons | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 27680 | Release of lower leg tendon | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 27681 | Release of lower leg tendons | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 27685 | Revision of lower leg tendon | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 27686 | Revise lower leg tendons | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 27687 | Revision of calf tendon | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 27690 | Revise lower leg tendon | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 27691 | Revise lower leg tendon | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 27692 | Revise additional leg tendon | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 27695 | Repair of ankle ligament | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 27696 | Repair of ankle ligaments | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 27698 | Repair of ankle ligament | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 27700 | Revision of ankle joint | | T | 0047 | 31.2345 | \$ 1,858.80 | \$ 537.03 | \$ 371.76 |
| 27704 | Removal of ankle implant | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 27705 | Incision of tibia | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 27707 | Incision of fibula | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 27709 | Incision of tibia & fibula | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 27730 | Repair of tibia epiphysis | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 27732 | Repair of fibula epiphysis | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 27734 | Repair lower leg epiphyses | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 27740 | Repair of leg epiphyses | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 27742 | Repair of leg epiphyses | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 27745 | Reinforce tibia | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 27750 | Treatment of tibia fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 27752 | Treatment of tibia fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 27756 | Treatment of tibia fracture | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 27758 | Treatment of tibia fracture | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 27759 | Treatment of tibia fracture | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 27760 | Treatment of ankle fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 27762 | Treatment of ankle fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 27766 | Treatment of ankle fracture | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 27780 | Treatment of fibula fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 27781 | Treatment of fibula fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 27784 | Treatment of fibula fracture | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 27786 | Treatment of ankle fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 27788 | Treatment of ankle fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 27792 | Treatment of ankle fracture | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 27808 | Treatment of ankle fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 27810 | Treatment of ankle fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 27814 | Treatment of ankle fracture | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 27816 | Treatment of ankle fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 27818 | Treatment of ankle fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 27822 | Treatment of ankle fracture | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 27823 | Treatment of ankle fracture | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 27824 | Treat lower leg fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 27825 | Treat lower leg fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 27826 | Treat lower leg fracture | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 27827 | Treat lower leg fracture | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 27828 | Treat lower leg fracture | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 27829 | Treat lower leg joint | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 27830 | Treat lower leg dislocation | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 27831 | Treat lower leg dislocation | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 27832 | Treat lower leg dislocation | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 27840 | Treat ankle dislocation | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 27842 | Treat ankle dislocation | | T | 0045 | 14.3413 | \$ 853.47 | \$ 268.47 | \$ 170.69 |
| 27846 | Treat ankle dislocation | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 27848 | Treat ankle dislocation | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 27860 | Fixation of ankle joint | | T | 0045 | 14.3413 | \$ 853.47 | \$ 268.47 | \$ 170.69 |
| 27870 | Fusion of ankle joint, open | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 27871 | Fusion of tibiofibular joint | | T | 0051 | 36.6106 | \$ 2,178.73 | | \$ 435.75 |
| 27884 | Amputation follow-up surgery | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 27889 | Amputation of foot at ankle | | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 27892 | Decompression of leg | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 27893 | Decompression of leg | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 27894 | Decompression of leg | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 27899 | Leg/ankle surgery procedure | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 28001 | Drainage of bursa of foot | | T | 0007 | 11.6717 | \$ 694.59 | | \$ 138.92 |
| 28002 | Treatment of foot infection | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 28003 | Treatment of foot infection | | T | 0049 | 20.3891 | \$ 1,213.38 | | \$ 242.68 |
| 28005 | Treat foot bone lesion | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28008 | Incision of foot fascia | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 28010 | Incision of toe tendon | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28011 | Incision of toe tendons | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28020 | Exploration of foot joint | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28022 | Exploration of foot joint | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28024 | Exploration of toe joint | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28030 | Removal of foot nerve | | T | 0220 | 17.3203 | \$ 1,030.75 | | \$ 206.15 |
| 28035 | Decompression of tibia nerve | | T | 0220 | 17.3203 | \$ 1,030.75 | | \$ 206.15 |
| 28043 | Excision of foot lesion | | T | 0021 | 14.9984 | \$ 892.57 | \$ 219.48 | \$ 178.51 |
| 28045 | Excision of foot lesion | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28046 | Resection of tumor, foot | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28050 | Biopsy of foot joint lining | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28052 | Biopsy of foot joint lining | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28054 | Biopsy of toe joint lining | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28060 | Partial removal, foot fascia | CH | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28062 | Removal of foot fascia | CH | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28070 | Removal of foot joint lining | CH | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28072 | Removal of foot joint lining | CH | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28080 | Removal of foot lesion | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28086 | Excise foot tendon sheath | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28088 | Excise foot tendon sheath | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28090 | Removal of foot lesion | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28092 | Removal of toe lesions | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28100 | Removal of ankle/heel lesion | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28102 | Remove/graft foot lesion | | T | 0056 | 40.5436 | \$ 2,412.79 | | \$ 482.56 |
| 28103 | Remove/graft foot lesion | | T | 0056 | 40.5436 | \$ 2,412.79 | | \$ 482.56 |
| 28104 | Removal of foot lesion | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28106 | Remove/graft foot lesion | | T | 0056 | 40.5436 | \$ 2,412.79 | | \$ 482.56 |
| 28107 | Remove/graft foot lesion | | T | 0056 | 40.5436 | \$ 2,412.79 | | \$ 482.56 |
| 28108 | Removal of toe lesions | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28110 | Part removal of metatarsal | CH | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28111 | Part removal of metatarsal | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28112 | Part removal of metatarsal | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28113 | Part removal of metatarsal | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28114 | Removal of metatarsal heads | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28116 | Revision of foot | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28118 | Removal of heel bone | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28119 | Removal of heel spur | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28120 | Part removal of ankle/heel | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28122 | Partial removal of foot bone | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28124 | Partial removal of toe | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28126 | Partial removal of toe | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28130 | Removal of ankle bone | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28140 | Removal of metatarsal | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 28150 | Removal of toe | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28153 | Partial removal of toe | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28160 | Partial removal of toe | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28171 | Extensive foot surgery | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28173 | Extensive foot surgery | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28175 | Extensive foot surgery | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28190 | Removal of foot foreign body | | T | 0019 | 4.1481 | \$ 246.86 | \$ 71.87 | \$ 49.37 |
| 28192 | Removal of foot foreign body | | T | 0021 | 14.9984 | \$ 892.57 | \$ 219.48 | \$ 178.51 |
| 28193 | Removal of foot foreign body | | T | 0020 | 6.9410 | \$ 413.07 | \$ 107.67 | \$ 82.61 |
| 28200 | Repair of foot tendon | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28202 | Repair/graft of foot tendon | CH | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28208 | Repair of foot tendon | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28210 | Repair/graft of foot tendon | | T | 0056 | 40.5436 | \$ 2,412.79 | | \$ 482.56 |
| 28220 | Release of foot tendon | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28222 | Release of foot tendons | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28225 | Release of foot tendon | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28226 | Release of foot tendons | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28230 | Incision of foot tendon(s) | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28232 | Incision of toe tendon | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28234 | Incision of foot tendon | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28238 | Revision of foot tendon | | T | 0056 | 40.5436 | \$ 2,412.79 | | \$ 482.56 |
| 28240 | Release of big toe | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28250 | Revision of foot fascia | CH | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28260 | Release of midfoot joint | CH | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28261 | Revision of foot tendon | CH | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28262 | Revision of foot and ankle | CH | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28264 | Release of midfoot joint | | T | 0056 | 40.5436 | \$ 2,412.79 | | \$ 482.56 |
| 28270 | Release of foot contracture | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28272 | Release of toe joint, each | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28280 | Fusion of toes | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28285 | Repair of hammertoe | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28286 | Repair of hammertoe | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28288 | Partial removal of foot bone | CH | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28289 | Repair hallux rigidus | CH | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28290 | Correction of bunion | CH | T | 0057 | 27.3981 | \$ 1,630.49 | \$ 475.91 | \$ 326.10 |
| 28292 | Correction of bunion | | T | 0057 | 27.3981 | \$ 1,630.49 | \$ 475.91 | \$ 326.10 |
| 28293 | Correction of bunion | | T | 0057 | 27.3981 | \$ 1,630.49 | \$ 475.91 | \$ 326.10 |
| 28294 | Correction of bunion | CH | T | 0057 | 27.3981 | \$ 1,630.49 | \$ 475.91 | \$ 326.10 |
| 28296 | Correction of bunion | CH | T | 0057 | 27.3981 | \$ 1,630.49 | \$ 475.91 | \$ 326.10 |
| 28297 | Correction of bunion | | T | 0057 | 27.3981 | \$ 1,630.49 | \$ 475.91 | \$ 326.10 |
| 28298 | Correction of bunion | CH | T | 0057 | 27.3981 | \$ 1,630.49 | \$ 475.91 | \$ 326.10 |
| 28299 | Correction of bunion | | T | 0057 | 27.3981 | \$ 1,630.49 | \$ 475.91 | \$ 326.10 |
| 28300 | Incision of heel bone | | T | 0056 | 40.5436 | \$ 2,412.79 | | \$ 482.56 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 28302 | Incision of ankle bone | CH | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28304 | Incision of midfoot bones | | T | 0056 | 40.5436 | \$ 2,412.79 | | \$ 482.56 |
| 28305 | Incise/graft midfoot bones | | T | 0056 | 40.5436 | \$ 2,412.79 | | \$ 482.56 |
| 28306 | Incision of metatarsal | CH | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28307 | Incision of metatarsal | CH | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28308 | Incision of metatarsal | CH | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28309 | Incision of metatarsals | | T | 0056 | 40.5436 | \$ 2,412.79 | | \$ 482.56 |
| 28310 | Revision of big toe | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28312 | Revision of toe | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28313 | Repair deformity of toe | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28315 | Removal of sesamoid bone | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28320 | Repair of foot bones | | T | 0056 | 40.5436 | \$ 2,412.79 | | \$ 482.56 |
| 28322 | Repair of metatarsals | | T | 0056 | 40.5436 | \$ 2,412.79 | | \$ 482.56 |
| 28340 | Resect enlarged toe tissue | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28341 | Resect enlarged toe | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28344 | Repair extra toe(s) | CH | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28345 | Repair webbed toe(s) | CH | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28360 | Reconstruct cleft foot | | T | 0056 | 40.5436 | \$ 2,412.79 | | \$ 482.56 |
| 28400 | Treatment of heel fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 28405 | Treatment of heel fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 28406 | Treatment of heel fracture | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 28415 | Treat heel fracture | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 28420 | Treat/graft heel fracture | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 28430 | Treatment of ankle fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 28435 | Treatment of ankle fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 28436 | Treatment of ankle fracture | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 28445 | Treat ankle fracture | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 28450 | Treat midfoot fracture, each | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 28455 | Treat midfoot fracture, each | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 28456 | Treat midfoot fracture | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 28465 | Treat midfoot fracture, each | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 28470 | Treat metatarsal fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 28475 | Treat metatarsal fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 28476 | Treat metatarsal fracture | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 28485 | Treat metatarsal fracture | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 28490 | Treat big toe fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 28495 | Treat big toe fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 28496 | Treat big toe fracture | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 28505 | Treat big toe fracture | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 28510 | Treatment of toe fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 28515 | Treatment of toe fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 28525 | Treat toe fracture | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 28530 | Treat sesamoid bone fracture | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 28531 | Treat sesamoid bone fracture | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 28540 | Treat foot dislocation | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 28545 | Treat foot dislocation | | T | 0045 | 14.3413 | \$ 853.47 | \$ 268.47 | \$ 170.69 |
| 28546 | Treat foot dislocation | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 28555 | Repair foot dislocation | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 28570 | Treat foot dislocation | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 28575 | Treat foot dislocation | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 28576 | Treat foot dislocation | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 28585 | Repair foot dislocation | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 28600 | Treat foot dislocation | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 28605 | Treat foot dislocation | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 28606 | Treat foot dislocation | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 28615 | Repair foot dislocation | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 28630 | Treat toe dislocation | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 28635 | Treat toe dislocation | | T | 0045 | 14.3413 | \$ 853.47 | \$ 268.47 | \$ 170.69 |
| 28636 | Treat toe dislocation | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 28645 | Repair toe dislocation | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 28660 | Treat toe dislocation | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 28665 | Treat toe dislocation | | T | 0045 | 14.3413 | \$ 853.47 | \$ 268.47 | \$ 170.69 |
| 28666 | Treat toe dislocation | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 28675 | Repair of toe dislocation | | T | 0046 | 37.8852 | \$ 2,254.59 | \$ 535.76 | \$ 450.92 |
| 28705 | Fusion of foot bones | | T | 0056 | 40.5436 | \$ 2,412.79 | | \$ 482.56 |
| 28715 | Fusion of foot bones | | T | 0056 | 40.5436 | \$ 2,412.79 | | \$ 482.56 |
| 28725 | Fusion of foot bones | | T | 0056 | 40.5436 | \$ 2,412.79 | | \$ 482.56 |
| 28730 | Fusion of foot bones | | T | 0056 | 40.5436 | \$ 2,412.79 | | \$ 482.56 |
| 28735 | Fusion of foot bones | | T | 0056 | 40.5436 | \$ 2,412.79 | | \$ 482.56 |
| 28737 | Revision of foot bones | | T | 0056 | 40.5436 | \$ 2,412.79 | | \$ 482.56 |
| 28740 | Fusion of foot bones | | T | 0056 | 40.5436 | \$ 2,412.79 | | \$ 482.56 |
| 28750 | Fusion of big toe joint | | T | 0056 | 40.5436 | \$ 2,412.79 | | \$ 482.56 |
| 28755 | Fusion of big toe joint | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28760 | Fusion of big toe joint | | T | 0056 | 40.5436 | \$ 2,412.79 | | \$ 482.56 |
| 28810 | Amputation toe & metatarsal | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28820 | Amputation of toe | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28825 | Partial amputation of toe | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 28890 | High energy eswt, plantar f | NI | T | 1547 | | \$ 850.00 | | \$ 170.00 |
| 28899 | Foot/toes surgery procedure | | T | 0043 | 1.7200 | \$ 102.36 | | \$ 20.47 |
| 29000 | Application of body cast | CH | S | 0058 | 1.0803 | \$ 64.29 | | \$ 12.86 |
| 29010 | Application of body cast | | S | 0426 | 2.2146 | \$ 131.79 | | \$ 26.36 |
| 29015 | Application of body cast | | S | 0426 | 2.2146 | \$ 131.79 | | \$ 26.36 |
| 29020 | Application of body cast | | S | 0058 | 1.0803 | \$ 64.29 | | \$ 12.86 |
| 29025 | Application of body cast | CH | S | 0058 | 1.0803 | \$ 64.29 | | \$ 12.86 |
| 29035 | Application of body cast | | S | 0426 | 2.2146 | \$ 131.79 | | \$ 26.36 |
| 29040 | Application of body cast | | S | 0058 | 1.0803 | \$ 64.29 | | \$ 12.86 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 29044 | Application of body cast | | S | 0426 | 2.2146 | \$ 131.79 | | \$ 26.36 |
| 29046 | Application of body cast | | S | 0426 | 2.2146 | \$ 131.79 | | \$ 26.36 |
| 29049 | Application of figure eight | | S | 0058 | 1.0803 | \$ 64.29 | | \$ 12.86 |
| 29055 | Application of shoulder cast | | S | 0426 | 2.2146 | \$ 131.79 | | \$ 26.36 |
| 29058 | Application of shoulder cast | | S | 0058 | 1.0803 | \$ 64.29 | | \$ 12.86 |
| 29065 | Application of long arm cast | | S | 0426 | 2.2146 | \$ 131.79 | | \$ 26.36 |
| 29075 | Application of forearm cast | | S | 0426 | 2.2146 | \$ 131.79 | | \$ 26.36 |
| 29085 | Apply hand/wrist cast | CH | S | 0058 | 1.0803 | \$ 64.29 | | \$ 12.86 |
| 29086 | Apply finger cast | CH | S | 0058 | 1.0803 | \$ 64.29 | | \$ 12.86 |
| 29105 | Apply long arm splint | | S | 0058 | 1.0803 | \$ 64.29 | | \$ 12.86 |
| 29125 | Apply forearm splint | | S | 0058 | 1.0803 | \$ 64.29 | | \$ 12.86 |
| 29126 | Apply forearm splint | | S | 0058 | 1.0803 | \$ 64.29 | | \$ 12.86 |
| 29130 | Application of finger splint | | S | 0058 | 1.0803 | \$ 64.29 | | \$ 12.86 |
| 29131 | Application of finger splint | | S | 0058 | 1.0803 | \$ 64.29 | | \$ 12.86 |
| 29200 | Strapping of chest | | S | 0058 | 1.0803 | \$ 64.29 | | \$ 12.86 |
| 29220 | Strapping of low back | | S | 0058 | 1.0803 | \$ 64.29 | | \$ 12.86 |
| 29240 | Strapping of shoulder | | S | 0058 | 1.0803 | \$ 64.29 | | \$ 12.86 |
| 29260 | Strapping of elbow or wrist | | S | 0058 | 1.0803 | \$ 64.29 | | \$ 12.86 |
| 29280 | Strapping of hand or finger | | S | 0058 | 1.0803 | \$ 64.29 | | \$ 12.86 |
| 29305 | Application of hip cast | | S | 0426 | 2.2146 | \$ 131.79 | | \$ 26.36 |
| 29325 | Application of hip casts | | S | 0426 | 2.2146 | \$ 131.79 | | \$ 26.36 |
| 29345 | Application of long leg cast | | S | 0426 | 2.2146 | \$ 131.79 | | \$ 26.36 |
| 29355 | Application of long leg cast | | S | 0426 | 2.2146 | \$ 131.79 | | \$ 26.36 |
| 29358 | Apply long leg cast brace | | S | 0426 | 2.2146 | \$ 131.79 | | \$ 26.36 |
| 29365 | Application of long leg cast | | S | 0426 | 2.2146 | \$ 131.79 | | \$ 26.36 |
| 29405 | Apply short leg cast | | S | 0426 | 2.2146 | \$ 131.79 | | \$ 26.36 |
| 29425 | Apply short leg cast | | S | 0426 | 2.2146 | \$ 131.79 | | \$ 26.36 |
| 29435 | Apply short leg cast | | S | 0426 | 2.2146 | \$ 131.79 | | \$ 26.36 |
| 29440 | Addition of walker to cast | CH | S | 0058 | 1.0803 | \$ 64.29 | | \$ 12.86 |
| 29445 | Apply rigid leg cast | | S | 0426 | 2.2146 | \$ 131.79 | | \$ 26.36 |
| 29450 | Application of leg cast | | S | 0058 | 1.0803 | \$ 64.29 | | \$ 12.86 |
| 29505 | Application, long leg splint | | S | 0058 | 1.0803 | \$ 64.29 | | \$ 12.86 |
| 29515 | Application lower leg splint | | S | 0058 | 1.0803 | \$ 64.29 | | \$ 12.86 |
| 29520 | Strapping of hip | | S | 0058 | 1.0803 | \$ 64.29 | | \$ 12.86 |
| 29530 | Strapping of knee | | S | 0058 | 1.0803 | \$ 64.29 | | \$ 12.86 |
| 29540 | Strapping of ankle and/or ft | | S | 0058 | 1.0803 | \$ 64.29 | | \$ 12.86 |
| 29550 | Strapping of toes | | S | 0058 | 1.0803 | \$ 64.29 | | \$ 12.86 |
| 29580 | Application of paste boot | | S | 0058 | 1.0803 | \$ 64.29 | | \$ 12.86 |
| 29590 | Application of foot splint | | S | 0058 | 1.0803 | \$ 64.29 | | \$ 12.86 |
| 29700 | Removal/revision of cast | | S | 0058 | 1.0803 | \$ 64.29 | | \$ 12.86 |
| 29705 | Removal/revision of cast | | S | 0058 | 1.0803 | \$ 64.29 | | \$ 12.86 |
| 29710 | Removal/revision of cast | | S | 0426 | 2.2146 | \$ 131.79 | | \$ 26.36 |
| 29715 | Removal/revision of cast | | S | 0058 | 1.0803 | \$ 64.29 | | \$ 12.86 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 29720 | Repair of body cast | | S | 0058 | 1.0803 | \$ 64.29 | | \$ 12.86 |
| 29730 | Windowing of cast | | S | 0058 | 1.0803 | \$ 64.29 | | \$ 12.86 |
| 29740 | Wedging of cast | | S | 0058 | 1.0803 | \$ 64.29 | | \$ 12.86 |
| 29750 | Wedging of clubfoot cast | | S | 0058 | 1.0803 | \$ 64.29 | | \$ 12.86 |
| 29799 | CASTING/STRAPPING PROCEDURE | | S | 0058 | 1.0803 | \$ 64.29 | | \$ 12.86 |
| 29800 | Jaw arthroscopy/surgery | CH | T | 0041 | 28.0686 | \$ 1,670.39 | | \$ 334.08 |
| 29804 | Jaw arthroscopy/surgery | | T | 0041 | 28.0686 | \$ 1,670.39 | | \$ 334.08 |
| 29805 | Shoulder arthroscopy, dx | | T | 0041 | 28.0686 | \$ 1,670.39 | | \$ 334.08 |
| 29806 | Shoulder arthroscopy/surgery | | T | 0042 | 44.2075 | \$ 2,630.83 | \$ 804.74 | \$ 526.17 |
| 29807 | Shoulder arthroscopy/surgery | | T | 0042 | 44.2075 | \$ 2,630.83 | \$ 804.74 | \$ 526.17 |
| 29819 | Shoulder arthroscopy/surgery | | T | 0041 | 28.0686 | \$ 1,670.39 | | \$ 334.08 |
| 29820 | Shoulder arthroscopy/surgery | | T | 0041 | 28.0686 | \$ 1,670.39 | | \$ 334.08 |
| 29821 | Shoulder arthroscopy/surgery | | T | 0041 | 28.0686 | \$ 1,670.39 | | \$ 334.08 |
| 29822 | Shoulder arthroscopy/surgery | | T | 0041 | 28.0686 | \$ 1,670.39 | | \$ 334.08 |
| 29823 | Shoulder arthroscopy/surgery | | T | 0041 | 28.0686 | \$ 1,670.39 | | \$ 334.08 |
| 29824 | Shoulder arthroscopy/surgery | CH | T | 0041 | 28.0686 | \$ 1,670.39 | | \$ 334.08 |
| 29825 | Shoulder arthroscopy/surgery | | T | 0041 | 28.0686 | \$ 1,670.39 | | \$ 334.08 |
| 29826 | Shoulder arthroscopy/surgery | | T | 0042 | 44.2075 | \$ 2,630.83 | \$ 804.74 | \$ 526.17 |
| 29827 | Arthroscop rotator cuff repr | | T | 0042 | 44.2075 | \$ 2,630.83 | \$ 804.74 | \$ 526.17 |
| 29830 | Elbow arthroscopy | | T | 0041 | 28.0686 | \$ 1,670.39 | | \$ 334.08 |
| 29834 | Elbow arthroscopy/surgery | | T | 0041 | 28.0686 | \$ 1,670.39 | | \$ 334.08 |
| 29835 | Elbow arthroscopy/surgery | | T | 0041 | 28.0686 | \$ 1,670.39 | | \$ 334.08 |
| 29836 | Elbow arthroscopy/surgery | | T | 0041 | 28.0686 | \$ 1,670.39 | | \$ 334.08 |
| 29837 | Elbow arthroscopy/surgery | | T | 0041 | 28.0686 | \$ 1,670.39 | | \$ 334.08 |
| 29838 | Elbow arthroscopy/surgery | | T | 0041 | 28.0686 | \$ 1,670.39 | | \$ 334.08 |
| 29840 | Wrist arthroscopy | | T | 0041 | 28.0686 | \$ 1,670.39 | | \$ 334.08 |
| 29843 | Wrist arthroscopy/surgery | | T | 0041 | 28.0686 | \$ 1,670.39 | | \$ 334.08 |
| 29844 | Wrist arthroscopy/surgery | | T | 0041 | 28.0686 | \$ 1,670.39 | | \$ 334.08 |
| 29845 | Wrist arthroscopy/surgery | | T | 0041 | 28.0686 | \$ 1,670.39 | | \$ 334.08 |
| 29846 | Wrist arthroscopy/surgery | | T | 0041 | 28.0686 | \$ 1,670.39 | | \$ 334.08 |
| 29847 | Wrist arthroscopy/surgery | CH | T | 0041 | 28.0686 | \$ 1,670.39 | | \$ 334.08 |
| 29848 | Wrist endoscopy/surgery | | T | 0041 | 28.0686 | \$ 1,670.39 | | \$ 334.08 |
| 29850 | Knee arthroscopy/surgery | | T | 0041 | 28.0686 | \$ 1,670.39 | | \$ 334.08 |
| 29851 | Knee arthroscopy/surgery | | T | 0042 | 44.2075 | \$ 2,630.83 | \$ 804.74 | \$ 526.17 |
| 29855 | Tibial arthroscopy/surgery | | T | 0042 | 44.2075 | \$ 2,630.83 | \$ 804.74 | \$ 526.17 |
| 29856 | Tibial arthroscopy/surgery | CH | T | 0041 | 28.0686 | \$ 1,670.39 | | \$ 334.08 |
| 29860 | Hip arthroscopy, dx | | T | 0041 | 28.0686 | \$ 1,670.39 | | \$ 334.08 |
| 29861 | Hip arthroscopy/surgery | CH | T | 0041 | 28.0686 | \$ 1,670.39 | | \$ 334.08 |
| 29862 | Hip arthroscopy/surgery | | T | 0042 | 44.2075 | \$ 2,630.83 | \$ 804.74 | \$ 526.17 |
| 29863 | Hip arthroscopy/surgery | | T | 0042 | 44.2075 | \$ 2,630.83 | \$ 804.74 | \$ 526.17 |
| 29866 | Autgrft implnt, knee w/scope | | T | 0042 | 44.2075 | \$ 2,630.83 | \$ 804.74 | \$ 526.17 |
| 29867 | Allgrft implnt, knee w/scope | | T | 0042 | 44.2075 | \$ 2,630.83 | \$ 804.74 | \$ 526.17 |
| 29868 | Meniscal trnspl, knee w/scpe | | T | 0042 | 44.2075 | \$ 2,630.83 | \$ 804.74 | \$ 526.17 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 29870 | Knee arthroscopy, dx | | T | 0041 | 28.0686 | \$ 1,670.39 | | \$ 334.08 |
| 29871 | Knee arthroscopy/drainage | | T | 0041 | 28.0686 | \$ 1,670.39 | | \$ 334.08 |
| 29873 | Knee arthroscopy/surgery | | T | 0041 | 28.0686 | \$ 1,670.39 | | \$ 334.08 |
| 29874 | Knee arthroscopy/surgery | | T | 0041 | 28.0686 | \$ 1,670.39 | | \$ 334.08 |
| 29875 | Knee arthroscopy/surgery | | T | 0041 | 28.0686 | \$ 1,670.39 | | \$ 334.08 |
| 29876 | Knee arthroscopy/surgery | | T | 0041 | 28.0686 | \$ 1,670.39 | | \$ 334.08 |
| 29877 | Knee arthroscopy/surgery | | T | 0041 | 28.0686 | \$ 1,670.39 | | \$ 334.08 |
| 29879 | Knee arthroscopy/surgery | | T | 0041 | 28.0686 | \$ 1,670.39 | | \$ 334.08 |
| 29880 | Knee arthroscopy/surgery | | T | 0041 | 28.0686 | \$ 1,670.39 | | \$ 334.08 |
| 29881 | Knee arthroscopy/surgery | | T | 0041 | 28.0686 | \$ 1,670.39 | | \$ 334.08 |
| 29882 | Knee arthroscopy/surgery | | T | 0041 | 28.0686 | \$ 1,670.39 | | \$ 334.08 |
| 29883 | Knee arthroscopy/surgery | | T | 0041 | 28.0686 | \$ 1,670.39 | | \$ 334.08 |
| 29884 | Knee arthroscopy/surgery | | T | 0041 | 28.0686 | \$ 1,670.39 | | \$ 334.08 |
| 29885 | Knee arthroscopy/surgery | | T | 0042 | 44.2075 | \$ 2,630.83 | \$ 804.74 | \$ 526.17 |
| 29886 | Knee arthroscopy/surgery | | T | 0041 | 28.0686 | \$ 1,670.39 | | \$ 334.08 |
| 29887 | Knee arthroscopy/surgery | | T | 0041 | 28.0686 | \$ 1,670.39 | | \$ 334.08 |
| 29888 | Knee arthroscopy/surgery | | T | 0042 | 44.2075 | \$ 2,630.83 | \$ 804.74 | \$ 526.17 |
| 29889 | Knee arthroscopy/surgery | | T | 0042 | 44.2075 | \$ 2,630.83 | \$ 804.74 | \$ 526.17 |
| 29891 | Ankle arthroscopy/surgery | | T | 0041 | 28.0686 | \$ 1,670.39 | | \$ 334.08 |
| 29892 | Ankle arthroscopy/surgery | | T | 0041 | 28.0686 | \$ 1,670.39 | | \$ 334.08 |
| 29893 | Scope, plantar fasciotomy | | T | 0055 | 19.9374 | \$ 1,186.49 | \$ 355.34 | \$ 237.30 |
| 29894 | Ankle arthroscopy/surgery | | T | 0041 | 28.0686 | \$ 1,670.39 | | \$ 334.08 |
| 29895 | Ankle arthroscopy/surgery | | T | 0041 | 28.0686 | \$ 1,670.39 | | \$ 334.08 |
| 29897 | Ankle arthroscopy/surgery | | T | 0041 | 28.0686 | \$ 1,670.39 | | \$ 334.08 |
| 29898 | Ankle arthroscopy/surgery | | T | 0041 | 28.0686 | \$ 1,670.39 | | \$ 334.08 |
| 29899 | Ankle arthroscopy/surgery | | T | 0042 | 44.2075 | \$ 2,630.83 | \$ 804.74 | \$ 526.17 |
| 29900 | Mcp joint arthroscopy, dx | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 29901 | Mcp joint arthroscopy, surg | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 29902 | Mcp joint arthroscopy, surg | | T | 0053 | 15.6396 | \$ 930.73 | \$ 253.49 | \$ 186.15 |
| 29999 | Arthroscopy of joint | | T | 0041 | 28.0686 | \$ 1,670.39 | | \$ 334.08 |
| 30000 | Drainage of nose lesion | | T | 0251 | 2.0789 | \$ 123.72 | | \$ 24.74 |
| 30020 | Drainage of nose lesion | | T | 0251 | 2.0789 | \$ 123.72 | | \$ 24.74 |
| 30100 | Intranasal biopsy | | T | 0252 | 8.1033 | \$ 482.24 | \$ 113.41 | \$ 96.45 |
| 30110 | Removal of nose polyp(s) | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 30115 | Removal of nose polyp(s) | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 30117 | Removal of intranasal lesion | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 30118 | Removal of intranasal lesion | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 30120 | Revision of nose | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 30124 | Removal of nose lesion | | T | 0252 | 8.1033 | \$ 482.24 | \$ 113.41 | \$ 96.45 |
| 30125 | Removal of nose lesion | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 30130 | Excise inferior turbinate | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 30140 | Resect inferior turbinate | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 30150 | Partial removal of nose | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 30160 | Removal of nose | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 30200 | Injection treatment of nose | | T | 0252 | 8.1033 | \$ 482.24 | \$ 113.41 | \$ 96.45 |
| 30210 | Nasal sinus therapy | | T | 0252 | 8.1033 | \$ 482.24 | \$ 113.41 | \$ 96.45 |
| 30220 | Insert nasal septal button | | T | 0252 | 8.1033 | \$ 482.24 | \$ 113.41 | \$ 96.45 |
| 30300 | Remove nasal foreign body | | X | 0340 | 0.6137 | \$ 36.52 | | \$ 7.30 |
| 30310 | Remove nasal foreign body | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 30320 | Remove nasal foreign body | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 30400 | Reconstruction of nose | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 30410 | Reconstruction of nose | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 30420 | Reconstruction of nose | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 30430 | Revision of nose | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 30435 | Revision of nose | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 30450 | Revision of nose | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 30460 | Revision of nose | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 30462 | Revision of nose | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 30465 | Repair nasal stenosis | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 30520 | Repair of nasal septum | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 30540 | Repair nasal defect | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 30545 | Repair nasal defect | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 30560 | Release of nasal adhesions | | T | 0251 | 2.0789 | \$ 123.72 | | \$ 24.74 |
| 30580 | Repair upper jaw fistula | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 30600 | Repair mouth/nose fistula | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 30620 | Intranasal reconstruction | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 30630 | Repair nasal septum defect | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 30801 | Ablate inf turbinate, superf | | T | 0252 | 8.1033 | \$ 482.24 | \$ 113.41 | \$ 96.45 |
| 30802 | Cauterization, inner nose | | T | 0252 | 8.1033 | \$ 482.24 | \$ 113.41 | \$ 96.45 |
| 30901 | Control of nosebleed | | T | 0250 | 1.2241 | \$ 72.85 | \$ 25.50 | \$ 14.57 |
| 30903 | Control of nosebleed | | T | 0250 | 1.2241 | \$ 72.85 | \$ 25.50 | \$ 14.57 |
| 30905 | Control of nosebleed | | T | 0250 | 1.2241 | \$ 72.85 | \$ 25.50 | \$ 14.57 |
| 30906 | Repeat control of nosebleed | | T | 0250 | 1.2241 | \$ 72.85 | \$ 25.50 | \$ 14.57 |
| 30915 | Ligation, nasal sinus artery | | T | 0091 | 28.8805 | \$ 1,718.71 | \$ 348.23 | \$ 343.74 |
| 30920 | Ligation, upper jaw artery | | T | 0092 | 26.5104 | \$ 1,577.66 | \$ 505.37 | \$ 315.53 |
| 30930 | Ther fx, nasal inf turbinate | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 30999 | Nasal surgery procedure | | T | 0251 | 2.0789 | \$ 123.72 | | \$ 24.74 |
| 31000 | Irrigation, maxillary sinus | | T | 0251 | 2.0789 | \$ 123.72 | | \$ 24.74 |
| 31002 | Irrigation, sphenoid sinus | | T | 0252 | 8.1033 | \$ 482.24 | \$ 113.41 | \$ 96.45 |
| 31020 | Exploration, maxillary sinus | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 31030 | Exploration, maxillary sinus | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 31032 | Explore sinus, remove polyps | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 31040 | Exploration behind upper jaw | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 31050 | Exploration, sphenoid sinus | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 31051 | Sphenoid sinus surgery | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 31070 | Exploration of frontal sinus | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 31075 | Exploration of frontal sinus | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 31080 | Removal of frontal sinus | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 31081 | Removal of frontal sinus | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 31084 | Removal of frontal sinus | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 31085 | Removal of frontal sinus | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 31086 | Removal of frontal sinus | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 31087 | Removal of frontal sinus | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 31090 | Exploration of sinuses | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 31200 | Removal of ethmoid sinus | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 31201 | Removal of ethmoid sinus | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 31205 | Removal of ethmoid sinus | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 31231 | Nasal endoscopy, dx | | T | 0072 | 1.4448 | \$ 85.98 | \$ 21.27 | \$ 17.20 |
| 31233 | Nasal/sinus endoscopy, dx | | T | 0072 | 1.4448 | \$ 85.98 | \$ 21.27 | \$ 17.20 |
| 31235 | Nasal/sinus endoscopy, dx | | T | 0074 | 15.4603 | \$ 920.06 | \$ 295.70 | \$ 184.01 |
| 31237 | Nasal/sinus endoscopy, surg | | T | 0075 | 21.2258 | \$ 1,263.17 | \$ 445.92 | \$ 252.63 |
| 31238 | Nasal/sinus endoscopy, surg | | T | 0074 | 15.4603 | \$ 920.06 | \$ 295.70 | \$ 184.01 |
| 31239 | Nasal/sinus endoscopy, surg | | T | 0075 | 21.2258 | \$ 1,263.17 | \$ 445.92 | \$ 252.63 |
| 31240 | Nasal/sinus endoscopy, surg | | T | 0074 | 15.4603 | \$ 920.06 | \$ 295.70 | \$ 184.01 |
| 31254 | Revision of ethmoid sinus | | T | 0075 | 21.2258 | \$ 1,263.17 | \$ 445.92 | \$ 252.63 |
| 31255 | Removal of ethmoid sinus | | T | 0075 | 21.2258 | \$ 1,263.17 | \$ 445.92 | \$ 252.63 |
| 31256 | Exploration maxillary sinus | | T | 0075 | 21.2258 | \$ 1,263.17 | \$ 445.92 | \$ 252.63 |
| 31267 | Endoscopy, maxillary sinus | | T | 0075 | 21.2258 | \$ 1,263.17 | \$ 445.92 | \$ 252.63 |
| 31276 | Sinus endoscopy, surgical | | T | 0075 | 21.2258 | \$ 1,263.17 | \$ 445.92 | \$ 252.63 |
| 31287 | Nasal/sinus endoscopy, surg | | T | 0075 | 21.2258 | \$ 1,263.17 | \$ 445.92 | \$ 252.63 |
| 31288 | Nasal/sinus endoscopy, surg | | T | 0075 | 21.2258 | \$ 1,263.17 | \$ 445.92 | \$ 252.63 |
| 31292 | Nasal/sinus endoscopy, surg | | T | 0075 | 21.2258 | \$ 1,263.17 | \$ 445.92 | \$ 252.63 |
| 31293 | Nasal/sinus endoscopy, surg | CH | T | 0075 | 21.2258 | \$ 1,263.17 | \$ 445.92 | \$ 252.63 |
| 31294 | Nasal/sinus endoscopy, surg | CH | T | 0075 | 21.2258 | \$ 1,263.17 | \$ 445.92 | \$ 252.63 |
| 31299 | Sinus surgery procedure | | T | 0251 | 2.0789 | \$ 123.72 | | \$ 24.74 |
| 31300 | Removal of larynx lesion | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 31320 | Diagnostic incision, larynx | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 31400 | Revision of larynx | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 31420 | Removal of epiglottis | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 31500 | Insert emergency airway | | S | 0094 | 2.4582 | \$ 146.29 | \$ 46.29 | \$ 29.26 |
| 31502 | Change of windpipe airway | | T | 0121 | 2.2374 | \$ 133.15 | \$ 43.80 | \$ 26.63 |
| 31505 | Diagnostic laryngoscopy | | T | 0071 | 0.8034 | \$ 47.81 | \$ 11.31 | \$ 9.56 |
| 31510 | Laryngoscopy with biopsy | | T | 0074 | 15.4603 | \$ 920.06 | \$ 295.70 | \$ 184.01 |
| 31511 | Remove foreign body, larynx | | T | 0072 | 1.4448 | \$ 85.98 | \$ 21.27 | \$ 17.20 |
| 31512 | Removal of larynx lesion | | T | 0074 | 15.4603 | \$ 920.06 | \$ 295.70 | \$ 184.01 |
| 31513 | Injection into vocal cord | | T | 0072 | 1.4448 | \$ 85.98 | \$ 21.27 | \$ 17.20 |
| 31515 | Laryngoscopy for aspiration | | T | 0074 | 15.4603 | \$ 920.06 | \$ 295.70 | \$ 184.01 |
| 31520 | Dx laryngoscopy, newborn | | T | 0072 | 1.4448 | \$ 85.98 | \$ 21.27 | \$ 17.20 |
| 31525 | Dx laryngoscopy excl nb | | T | 0074 | 15.4603 | \$ 920.06 | \$ 295.70 | \$ 184.01 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 31526 | Dx laryngoscopy w/oper scope | | T | 0075 | 21.2258 | \$ 1,263.17 | \$ 445.92 | \$ 252.63 |
| 31527 | Laryngoscopy for treatment | | T | 0075 | 21.2258 | \$ 1,263.17 | \$ 445.92 | \$ 252.63 |
| 31528 | Laryngoscopy and dilation | | T | 0074 | 15.4603 | \$ 920.06 | \$ 295.70 | \$ 184.01 |
| 31529 | Laryngoscopy and dilation | | T | 0074 | 15.4603 | \$ 920.06 | \$ 295.70 | \$ 184.01 |
| 31530 | Laryngoscopy w/fb removal | | T | 0075 | 21.2258 | \$ 1,263.17 | \$ 445.92 | \$ 252.63 |
| 31531 | Laryngoscopy w/fb & op scope | | T | 0075 | 21.2258 | \$ 1,263.17 | \$ 445.92 | \$ 252.63 |
| 31535 | Laryngoscopy w/biopsy | | T | 0075 | 21.2258 | \$ 1,263.17 | \$ 445.92 | \$ 252.63 |
| 31536 | Laryngoscopy w/bx & op scope | | T | 0075 | 21.2258 | \$ 1,263.17 | \$ 445.92 | \$ 252.63 |
| 31540 | Laryngoscopy w/exc of tumor | | T | 0075 | 21.2258 | \$ 1,263.17 | \$ 445.92 | \$ 252.63 |
| 31541 | Larynsco w/tumr exc + scope | | T | 0075 | 21.2258 | \$ 1,263.17 | \$ 445.92 | \$ 252.63 |
| 31545 | Remove vc lesion w/scope | | T | 0075 | 21.2258 | \$ 1,263.17 | \$ 445.92 | \$ 252.63 |
| 31546 | Remove vc lesion scope/graft | | T | 0075 | 21.2258 | \$ 1,263.17 | \$ 445.92 | \$ 252.63 |
| 31560 | Laryngosco w/arytenoidectom | | T | 0075 | 21.2258 | \$ 1,263.17 | \$ 445.92 | \$ 252.63 |
| 31561 | Larynsco, remve cart + scop | | T | 0075 | 21.2258 | \$ 1,263.17 | \$ 445.92 | \$ 252.63 |
| 31570 | Laryngoscope w/vc inj | | T | 0074 | 15.4603 | \$ 920.06 | \$ 295.70 | \$ 184.01 |
| 31571 | Laryngosco w/vc inj + scope | | T | 0075 | 21.2258 | \$ 1,263.17 | \$ 445.92 | \$ 252.63 |
| 31575 | Diagnostic laryngoscopy | | T | 0072 | 1.4448 | \$ 85.98 | \$ 21.27 | \$ 17.20 |
| 31576 | Laryngoscopy with biopsy | | T | 0075 | 21.2258 | \$ 1,263.17 | \$ 445.92 | \$ 252.63 |
| 31577 | Remove foreign body, larynx | | T | 0073 | 4.2171 | \$ 250.96 | \$ 73.38 | \$ 50.19 |
| 31578 | Removal of larynx lesion | | T | 0075 | 21.2258 | \$ 1,263.17 | \$ 445.92 | \$ 252.63 |
| 31579 | Diagnostic laryngoscopy | | T | 0073 | 4.2171 | \$ 250.96 | \$ 73.38 | \$ 50.19 |
| 31580 | Revision of larynx | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 31582 | Revision of larynx | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 31585 | Treat larynx fracture | CH | D | | | | | |
| 31586 | Treat larynx fracture | CH | D | | | | | |
| 31588 | Revision of larynx | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 31590 | Reinnervate larynx | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 31595 | Larynx nerve surgery | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 31599 | Larynx surgery procedure | | T | 0251 | 2.0789 | \$ 123.72 | | \$ 24.74 |
| 31600 | Incision of windpipe | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 31601 | Incision of windpipe | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 31603 | Incision of windpipe | | T | 0252 | 8.1033 | \$ 482.24 | \$ 113.41 | \$ 96.45 |
| 31605 | Incision of windpipe | | T | 0252 | 8.1033 | \$ 482.24 | \$ 113.41 | \$ 96.45 |
| 31610 | Incision of windpipe | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 31611 | Surgery/speech prosthesis | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 31612 | Puncture/clear windpipe | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 31613 | Repair windpipe opening | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 31614 | Repair windpipe opening | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 31615 | Visualization of windpipe | | T | 0076 | 9.4030 | \$ 559.58 | \$ 189.82 | \$ 111.92 |
| 31620 | Endobronchial us add-on | | S | 0670 | 28.7546 | \$ 1,711.22 | \$ 536.10 | \$ 342.24 |
| 31622 | Dx bronchoscope/wash | | T | 0076 | 9.4030 | \$ 559.58 | \$ 189.82 | \$ 111.92 |
| 31623 | Dx bronchoscope/brush | | T | 0076 | 9.4030 | \$ 559.58 | \$ 189.82 | \$ 111.92 |
| 31624 | Dx bronchoscope/lavage | | T | 0076 | 9.4030 | \$ 559.58 | \$ 189.82 | \$ 111.92 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 31625 | Bronchoscopy w/biopsy(s) | | T | 0076 | 9.4030 | \$ 559.58 | \$ 189.82 | \$ 111.92 |
| 31628 | Bronchoscopy/lung bx, each | | T | 0076 | 9.4030 | \$ 559.58 | \$ 189.82 | \$ 111.92 |
| 31629 | Bronchoscopy/needle bx, each | | T | 0076 | 9.4030 | \$ 559.58 | \$ 189.82 | \$ 111.92 |
| 31630 | Bronchoscopy dilate/fx repr | | T | 0415 | 22.0722 | \$ 1,313.54 | \$ 459.92 | \$ 262.71 |
| 31631 | Bronchoscopy, dilate w/stent | | T | 0415 | 22.0722 | \$ 1,313.54 | \$ 459.92 | \$ 262.71 |
| 31632 | Bronchoscopy/lung bx, add'l | | T | 0076 | 9.4030 | \$ 559.58 | \$ 189.82 | \$ 111.92 |
| 31633 | Bronchoscopy/needle bx add'l | | T | 0076 | 9.4030 | \$ 559.58 | \$ 189.82 | \$ 111.92 |
| 31635 | Bronchoscopy w/fb removal | | T | 0076 | 9.4030 | \$ 559.58 | \$ 189.82 | \$ 111.92 |
| 31636 | Bronchoscopy, bronch stents | | T | 0415 | 22.0722 | \$ 1,313.54 | \$ 459.92 | \$ 262.71 |
| 31637 | Bronchoscopy, stent add-on | | T | 0076 | 9.4030 | \$ 559.58 | \$ 189.82 | \$ 111.92 |
| 31638 | Bronchoscopy, revise stent | | T | 0415 | 22.0722 | \$ 1,313.54 | \$ 459.92 | \$ 262.71 |
| 31640 | Bronchoscopy w/tumor excise | | T | 0415 | 22.0722 | \$ 1,313.54 | \$ 459.92 | \$ 262.71 |
| 31641 | Bronchoscopy, treat blockage | | T | 0415 | 22.0722 | \$ 1,313.54 | \$ 459.92 | \$ 262.71 |
| 31643 | Diag bronchoscope/catheter | | T | 0076 | 9.4030 | \$ 559.58 | \$ 189.82 | \$ 111.92 |
| 31645 | Bronchoscopy, clear airways | | T | 0076 | 9.4030 | \$ 559.58 | \$ 189.82 | \$ 111.92 |
| 31646 | Bronchoscopy, reclear airway | | T | 0076 | 9.4030 | \$ 559.58 | \$ 189.82 | \$ 111.92 |
| 31656 | Bronchoscopy, inj for x-ray | | T | 0076 | 9.4030 | \$ 559.58 | \$ 189.82 | \$ 111.92 |
| 31700 | Insertion of airway catheter | | T | 0072 | 1.4448 | \$ 85.98 | \$ 21.27 | \$ 17.20 |
| 31708 | Instill airway contrast dye | | N | | | | | |
| 31710 | Insertion of airway catheter | | N | | | | | |
| 31715 | Injection for bronchus x-ray | | N | | | | | |
| 31717 | Bronchial brush biopsy | | T | 0073 | 4.2171 | \$ 250.96 | \$ 73.38 | \$ 50.19 |
| 31720 | Clearance of airways | | T | 0071 | 0.8034 | \$ 47.81 | \$ 11.31 | \$ 9.56 |
| 31730 | Intro, windpipe wire/tube | | T | 0073 | 4.2171 | \$ 250.96 | \$ 73.38 | \$ 50.19 |
| 31750 | Repair of windpipe | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 31755 | Repair of windpipe | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 31785 | Remove windpipe lesion | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 31820 | Closure of windpipe lesion | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 31825 | Repair of windpipe defect | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 31830 | Revise windpipe scar | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 31899 | Airways surgical procedure | | T | 0076 | 9.4030 | \$ 559.58 | \$ 189.82 | \$ 111.92 |
| 32000 | Drainage of chest | | T | 0070 | 3.2141 | \$ 191.27 | | \$ 38.25 |
| 32002 | Treatment of collapsed lung | | T | 0070 | 3.2141 | \$ 191.27 | | \$ 38.25 |
| 32005 | Treat lung lining chemically | | T | 0070 | 3.2141 | \$ 191.27 | | \$ 38.25 |
| 32019 | Insert pleural catheter | CH | T | 0427 | 10.0109 | \$ 595.76 | | \$ 119.15 |
| 32020 | Insertion of chest tube | | T | 0070 | 3.2141 | \$ 191.27 | | \$ 38.25 |
| 32201 | Drain, percut, lung lesion | | T | 0070 | 3.2141 | \$ 191.27 | | \$ 38.25 |
| 32400 | Needle biopsy chest lining | | T | 0685 | 6.0034 | \$ 357.27 | \$ 115.47 | \$ 71.45 |
| 32405 | Biopsy, lung or mediastinum | | T | 0685 | 6.0034 | \$ 357.27 | \$ 115.47 | \$ 71.45 |
| 32420 | Puncture/clear lung | | T | 0070 | 3.2141 | \$ 191.27 | | \$ 38.25 |
| 32520 | Remove lung & revise chest | CH | D | | | | | |
| 32522 | Remove lung & revise chest | CH | D | | | | | |
| 32525 | Remove lung & revise chest | CH | D | | | | | |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 32601 | Thoracoscopy, diagnostic | | T | 0069 | 30.9541 | \$ 1,842.11 | \$ 591.64 | \$ 368.42 |
| 32602 | Thoracoscopy, diagnostic | | T | 0069 | 30.9541 | \$ 1,842.11 | \$ 591.64 | \$ 368.42 |
| 32603 | Thoracoscopy, diagnostic | | T | 0069 | 30.9541 | \$ 1,842.11 | \$ 591.64 | \$ 368.42 |
| 32604 | Thoracoscopy, diagnostic | | T | 0069 | 30.9541 | \$ 1,842.11 | \$ 591.64 | \$ 368.42 |
| 32605 | Thoracoscopy, diagnostic | | T | 0069 | 30.9541 | \$ 1,842.11 | \$ 591.64 | \$ 368.42 |
| 32606 | Thoracoscopy, diagnostic | | T | 0069 | 30.9541 | \$ 1,842.11 | \$ 591.64 | \$ 368.42 |
| 32960 | Therapeutic pneumothorax | | T | 0070 | 3.2141 | \$ 191.27 | | \$ 38.25 |
| 32999 | Chest surgery procedure | | T | 0070 | 3.2141 | \$ 191.27 | | \$ 38.25 |
| 33010 | Drainage of heart sac | | T | 0070 | 3.2141 | \$ 191.27 | | \$ 38.25 |
| 33011 | Repeat drainage of heart sac | | T | 0070 | 3.2141 | \$ 191.27 | | \$ 38.25 |
| 33206 | Insertion of heart pacemaker | | T | 0089 | 117.0463 | \$ 6,965.54 | \$ 1,682.28 | \$ 1,393.11 |
| 33207 | Insertion of heart pacemaker | | T | 0089 | 117.0463 | \$ 6,965.54 | \$ 1,682.28 | \$ 1,393.11 |
| 33208 | Insertion of heart pacemaker | | T | 0655 | 136.8448 | \$ 8,143.77 | | \$ 1,628.75 |
| 33210 | Insertion of heart electrode | | T | 0106 | 55.9362 | \$ 3,328.82 | | \$ 665.76 |
| 33211 | Insertion of heart electrode | | T | 0106 | 55.9362 | \$ 3,328.82 | | \$ 665.76 |
| 33212 | Insertion of pulse generator | | T | 0090 | 90.2017 | \$ 5,367.99 | \$ 1,612.80 | \$ 1,073.60 |
| 33213 | Insertion of pulse generator | | T | 0654 | 112.0279 | \$ 6,666.89 | | \$ 1,333.38 |
| 33214 | Upgrade of pacemaker system | | T | 0655 | 136.8448 | \$ 8,143.77 | | \$ 1,628.75 |
| 33215 | Reposition pacing-defib lead | | T | 0105 | 21.9865 | \$ 1,308.44 | \$ 370.40 | \$ 261.69 |
| 33216 | Insert lead pace-defib, one | | T | 0106 | 55.9362 | \$ 3,328.82 | | \$ 665.76 |
| 33217 | Insert lead pace-defib, dual | | T | 0106 | 55.9362 | \$ 3,328.82 | | \$ 665.76 |
| 33218 | Repair lead pace-defib, one | | T | 0106 | 55.9362 | \$ 3,328.82 | | \$ 665.76 |
| 33220 | Repair lead pace-defib, dual | | T | 0106 | 55.9362 | \$ 3,328.82 | | \$ 665.76 |
| 33222 | Revise pocket, pacemaker | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 33223 | Revise pocket, pacing-defib | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 33224 | Insert pacing lead & connect | | T | 0418 | 169.3514 | \$10,078.27 | | \$ 2,015.65 |
| 33225 | L ventric pacing lead add-on | CH | T | 0418 | 169.3514 | \$10,078.27 | | \$ 2,015.65 |
| 33226 | Reposition l ventric lead | | T | 0105 | 21.9865 | \$ 1,308.44 | \$ 370.40 | \$ 261.69 |
| 33233 | Removal of pacemaker system | | T | 0105 | 21.9865 | \$ 1,308.44 | \$ 370.40 | \$ 261.69 |
| 33234 | Removal of pacemaker system | | T | 0105 | 21.9865 | \$ 1,308.44 | \$ 370.40 | \$ 261.69 |
| 33235 | Removal pacemaker electrode | | T | 0105 | 21.9865 | \$ 1,308.44 | \$ 370.40 | \$ 261.69 |
| 33241 | Remove pulse generator | | T | 0105 | 21.9865 | \$ 1,308.44 | \$ 370.40 | \$ 261.69 |
| 33244 | Remove eltrd, transven | | T | 0105 | 21.9865 | \$ 1,308.44 | \$ 370.40 | \$ 261.69 |
| 33282 | Implant pat-active ht record | | S | 0680 | 74.9052 | \$ 4,457.68 | | \$ 891.54 |
| 33284 | Remove pat-active ht record | | T | 0109 | 11.1714 | \$ 664.82 | | \$ 132.96 |
| 33508 | Endoscopic vein harvest | | N | | | | | |
| 33918 | Repair pulmonary atresia | CH | D | | | | | |
| 33919 | Repair pulmonary atresia | CH | D | | | | | |
| 33999 | Cardiac surgery procedure | | T | 0070 | 3.2141 | \$ 191.27 | | \$ 38.25 |
| 34101 | Removal of artery clot | | T | 0088 | 36.5126 | \$ 2,172.90 | \$ 655.22 | \$ 434.58 |
| 34111 | Removal of arm artery clot | | T | 0088 | 36.5126 | \$ 2,172.90 | \$ 655.22 | \$ 434.58 |
| 34201 | Removal of artery clot | | T | 0088 | 36.5126 | \$ 2,172.90 | \$ 655.22 | \$ 434.58 |
| 34203 | Removal of leg artery clot | | T | 0088 | 36.5126 | \$ 2,172.90 | \$ 655.22 | \$ 434.58 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|-----------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 34421 | Removal of vein clot | | T | 0088 | 36.5126 | \$ 2,172.90 | \$ 655.22 | \$ 434.58 |
| 34471 | Removal of vein clot | | T | 0088 | 36.5126 | \$ 2,172.90 | \$ 655.22 | \$ 434.58 |
| 34490 | Removal of vein clot | | T | 0088 | 36.5126 | \$ 2,172.90 | \$ 655.22 | \$ 434.58 |
| 34501 | Repair valve, femoral vein | | T | 0088 | 36.5126 | \$ 2,172.90 | \$ 655.22 | \$ 434.58 |
| 34510 | Transposition of vein valve | | T | 0088 | 36.5126 | \$ 2,172.90 | \$ 655.22 | \$ 434.58 |
| 34520 | Cross-over vein graft | | T | 0088 | 36.5126 | \$ 2,172.90 | \$ 655.22 | \$ 434.58 |
| 34530 | Leg vein fusion | | T | 0088 | 36.5126 | \$ 2,172.90 | \$ 655.22 | \$ 434.58 |
| 35011 | Repair defect of artery | | T | 0653 | 36.9427 | \$ 2,198.50 | | \$ 439.70 |
| 35161 | Repair defect of artery | | D | | | | | |
| 35162 | Repair artery rupture | | D | | | | | |
| 35180 | Repair blood vessel lesion | | T | 0093 | 23.3101 | \$ 1,387.21 | | \$ 277.44 |
| 35184 | Repair blood vessel lesion | | T | 0093 | 23.3101 | \$ 1,387.21 | | \$ 277.44 |
| 35188 | Repair blood vessel lesion | | T | 0088 | 36.5126 | \$ 2,172.90 | \$ 655.22 | \$ 434.58 |
| 35190 | Repair blood vessel lesion | | T | 0093 | 23.3101 | \$ 1,387.21 | | \$ 277.44 |
| 35201 | Repair blood vessel lesion | | T | 0093 | 23.3101 | \$ 1,387.21 | | \$ 277.44 |
| 35206 | Repair blood vessel lesion | | T | 0093 | 23.3101 | \$ 1,387.21 | | \$ 277.44 |
| 35207 | Repair blood vessel lesion | | T | 0088 | 36.5126 | \$ 2,172.90 | \$ 655.22 | \$ 434.58 |
| 35226 | Repair blood vessel lesion | | T | 0093 | 23.3101 | \$ 1,387.21 | | \$ 277.44 |
| 35231 | Repair blood vessel lesion | | T | 0093 | 23.3101 | \$ 1,387.21 | | \$ 277.44 |
| 35236 | Repair blood vessel lesion | | T | 0093 | 23.3101 | \$ 1,387.21 | | \$ 277.44 |
| 35256 | Repair blood vessel lesion | | T | 0093 | 23.3101 | \$ 1,387.21 | | \$ 277.44 |
| 35261 | Repair blood vessel lesion | | T | 0653 | 36.9427 | \$ 2,198.50 | | \$ 439.70 |
| 35266 | Repair blood vessel lesion | | T | 0653 | 36.9427 | \$ 2,198.50 | | \$ 439.70 |
| 35286 | Repair blood vessel lesion | | T | 0653 | 36.9427 | \$ 2,198.50 | | \$ 439.70 |
| 35321 | Rechanneling of artery | | T | 0093 | 23.3101 | \$ 1,387.21 | | \$ 277.44 |
| 35458 | Repair arterial blockage | | T | 0081 | 42.2664 | \$ 2,515.32 | | \$ 503.06 |
| 35459 | Repair arterial blockage | | T | 0081 | 42.2664 | \$ 2,515.32 | | \$ 503.06 |
| 35460 | Repair venous blockage | | T | 0081 | 42.2664 | \$ 2,515.32 | | \$ 503.06 |
| 35470 | Repair arterial blockage | | T | 0081 | 42.2664 | \$ 2,515.32 | | \$ 503.06 |
| 35471 | Repair arterial blockage | | T | 0081 | 42.2664 | \$ 2,515.32 | | \$ 503.06 |
| 35472 | Repair arterial blockage | | T | 0081 | 42.2664 | \$ 2,515.32 | | \$ 503.06 |
| 35473 | Repair arterial blockage | | T | 0081 | 42.2664 | \$ 2,515.32 | | \$ 503.06 |
| 35474 | Repair arterial blockage | | T | 0081 | 42.2664 | \$ 2,515.32 | | \$ 503.06 |
| 35475 | Repair arterial blockage | | T | 0081 | 42.2664 | \$ 2,515.32 | | \$ 503.06 |
| 35476 | Repair venous blockage | | T | 0081 | 42.2664 | \$ 2,515.32 | | \$ 503.06 |
| 35484 | Atherectomy, open | | T | 0081 | 42.2664 | \$ 2,515.32 | | \$ 503.06 |
| 35485 | Atherectomy, open | | T | 0081 | 42.2664 | \$ 2,515.32 | | \$ 503.06 |
| 35490 | Atherectomy, percutaneous | | T | 0081 | 42.2664 | \$ 2,515.32 | | \$ 503.06 |
| 35491 | Atherectomy, percutaneous | | T | 0081 | 42.2664 | \$ 2,515.32 | | \$ 503.06 |
| 35492 | Atherectomy, percutaneous | | T | 0081 | 42.2664 | \$ 2,515.32 | | \$ 503.06 |
| 35493 | Atherectomy, percutaneous | | T | 0081 | 42.2664 | \$ 2,515.32 | | \$ 503.06 |
| 35494 | Atherectomy, percutaneous | | T | 0081 | 42.2664 | \$ 2,515.32 | | \$ 503.06 |
| 35495 | Atherectomy, percutaneous | | T | 0081 | 42.2664 | \$ 2,515.32 | | \$ 503.06 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 35500 | Harvest vein for bypass | CH | T | 0081 | 42.2664 | \$ 2,515.32 | | \$ 503.06 |
| 35572 | Harvest femoropopliteal vein | | N | | | | | |
| 35582 | Vein bypass graft | | D | | | | | |
| 35685 | Bypass graft patency/patch | | T | 0093 | 23.3101 | \$ 1,387.21 | | \$ 277.44 |
| 35686 | Bypass graft/av fist patency | | T | 0093 | 23.3101 | \$ 1,387.21 | | \$ 277.44 |
| 35761 | Exploration of artery/vein | | T | 0115 | 36.9806 | \$ 2,200.75 | \$ 459.35 | \$ 440.15 |
| 35860 | Explore limb vessels | | T | 0093 | 23.3101 | \$ 1,387.21 | | \$ 277.44 |
| 35875 | Removal of clot in graft | | T | 0088 | 36.5126 | \$ 2,172.90 | \$ 655.22 | \$ 434.58 |
| 35876 | Removal of clot in graft | | T | 0088 | 36.5126 | \$ 2,172.90 | \$ 655.22 | \$ 434.58 |
| 35879 | Revise graft w/vein | | T | 0088 | 36.5126 | \$ 2,172.90 | \$ 655.22 | \$ 434.58 |
| 35881 | Revise graft w/vein | | T | 0088 | 36.5126 | \$ 2,172.90 | \$ 655.22 | \$ 434.58 |
| 35903 | Excision, graft, extremity | | T | 0115 | 36.9806 | \$ 2,200.75 | \$ 459.35 | \$ 440.15 |
| 36000 | Place needle in vein | | N | | | | | |
| 36002 | Pseudoaneurysm injection trt | | S | 0267 | 2.5543 | \$ 152.01 | \$ 60.80 | \$ 30.40 |
| 36005 | Injection ext venography | | N | | | | | |
| 36010 | Place catheter in vein | | N | | | | | |
| 36011 | Place catheter in vein | | N | | | | | |
| 36012 | Place catheter in vein | | N | | | | | |
| 36013 | Place catheter in artery | | N | | | | | |
| 36014 | Place catheter in artery | | N | | | | | |
| 36015 | Place catheter in artery | | N | | | | | |
| 36100 | Establish access to artery | | N | | | | | |
| 36120 | Establish access to artery | | N | | | | | |
| 36140 | Establish access to artery | | N | | | | | |
| 36145 | Artery to vein shunt | | N | | | | | |
| 36160 | Establish access to aorta | | N | | | | | |
| 36200 | Place catheter in aorta | | N | | | | | |
| 36215 | Place catheter in artery | | N | | | | | |
| 36216 | Place catheter in artery | | N | | | | | |
| 36217 | Place catheter in artery | | N | | | | | |
| 36218 | Place catheter in artery | | N | | | | | |
| 36245 | Place catheter in artery | | N | | | | | |
| 36246 | Place catheter in artery | | N | | | | | |
| 36247 | Place catheter in artery | | N | | | | | |
| 36248 | Place catheter in artery | | N | | | | | |
| 36260 | Insertion of infusion pump | CH | T | 0623 | 27.1472 | \$ 1,615.56 | | \$ 323.11 |
| 36261 | Revision of infusion pump | CH | T | 0623 | 27.1472 | \$ 1,615.56 | | \$ 323.11 |
| 36262 | Removal of infusion pump | CH | T | 0622 | 21.2464 | \$ 1,264.39 | | \$ 252.88 |
| 36299 | Vessel injection procedure | | N | | | | | |
| 36400 | BI draw < 3 yrs fem/jugular | | N | | | | | |
| 36405 | BI draw < 3 yrs scalp vein | | N | | | | | |
| 36406 | BI draw < 3 yrs other vein | | N | | | | | |
| 36410 | Non-routine bi draw > 3 yrs | | N | | | | | |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 36416 | Capillary blood draw | | N | | | | | |
| 36420 | Vein access cutdown < 1 yr | | T | 0035 | 0.0834 | \$ 4.96 | | \$ 0.99 |
| 36425 | Vein access cutdown > 1 yr | | T | 0035 | 0.0834 | \$ 4.96 | | \$ 0.99 |
| 36430 | Blood transfusion service | | S | 0110 | 3.6419 | \$ 216.73 | | \$ 43.35 |
| 36440 | BI push transfuse, 2 yr or < | | S | 0110 | 3.6419 | \$ 216.73 | | \$ 43.35 |
| 36450 | BI exchange/transfuse, nb | | S | 0110 | 3.6419 | \$ 216.73 | | \$ 43.35 |
| 36455 | BI exchange/transfuse non-nb | | S | 0110 | 3.6419 | \$ 216.73 | | \$ 43.35 |
| 36460 | Transfusion service, fetal | | S | 0110 | 3.6419 | \$ 216.73 | | \$ 43.35 |
| 36468 | Injection(s), spider veins | | T | 0098 | 1.1444 | \$ 68.10 | | \$ 13.62 |
| 36469 | Injection(s), spider veins | | T | 0098 | 1.1444 | \$ 68.10 | | \$ 13.62 |
| 36470 | Injection therapy of vein | | T | 0098 | 1.1444 | \$ 68.10 | | \$ 13.62 |
| 36471 | Injection therapy of veins | | T | 0098 | 1.1444 | \$ 68.10 | | \$ 13.62 |
| 36475 | Endovenous rf, 1st vein | CH | T | 0091 | 28.8805 | \$ 1,718.71 | \$ 348.23 | \$ 343.74 |
| 36476 | Endovenous rf, vein add-on | CH | T | 0091 | 28.8805 | \$ 1,718.71 | \$ 348.23 | \$ 343.74 |
| 36478 | Endovenous laser, 1st vein | CH | T | 0091 | 28.8805 | \$ 1,718.71 | \$ 348.23 | \$ 343.74 |
| 36479 | Endovenous laser vein addon | CH | T | 0091 | 28.8805 | \$ 1,718.71 | \$ 348.23 | \$ 343.74 |
| 36481 | Insertion of catheter, vein | | N | | | | | |
| 36500 | Insertion of catheter, vein | | N | | | | | |
| 36510 | Insertion of catheter, vein | CH | N | | | | | |
| 36511 | Apheresis wbc | | S | 0111 | 12.0768 | \$ 718.70 | \$ 198.40 | \$ 143.74 |
| 36512 | Apheresis rbc | | S | 0111 | 12.0768 | \$ 718.70 | \$ 198.40 | \$ 143.74 |
| 36513 | Apheresis platelets | | S | 0111 | 12.0768 | \$ 718.70 | \$ 198.40 | \$ 143.74 |
| 36514 | Apheresis plasma | | S | 0111 | 12.0768 | \$ 718.70 | \$ 198.40 | \$ 143.74 |
| 36515 | Apheresis, adsorp/reinfuse | CH | S | 0112 | 26.3750 | \$ 1,569.60 | \$ 433.29 | \$ 313.92 |
| 36516 | Apheresis, selective | | S | 0112 | 26.3750 | \$ 1,569.60 | \$ 433.29 | \$ 313.92 |
| 36522 | Photopheresis | | S | 0112 | 26.3750 | \$ 1,569.60 | \$ 433.29 | \$ 313.92 |
| 36540 | Collect blood venous device | | N | | | | | |
| 36550 | Declot vascular device | CH | T | 0676 | 2.2742 | \$ 135.34 | | \$ 27.07 |
| 36555 | Insert non-tunnel cv cath | CH | T | 0621 | 8.2313 | \$ 489.85 | | \$ 97.97 |
| 36556 | Insert non-tunnel cv cath | CH | T | 0621 | 8.2313 | \$ 489.85 | | \$ 97.97 |
| 36557 | Insert tunneled cv cath | CH | T | 0622 | 21.2464 | \$ 1,264.39 | | \$ 252.88 |
| 36558 | Insert tunneled cv cath | CH | T | 0622 | 21.2464 | \$ 1,264.39 | | \$ 252.88 |
| 36560 | Insert tunneled cv cath | CH | T | 0623 | 27.1472 | \$ 1,615.56 | | \$ 323.11 |
| 36561 | Insert tunneled cv cath | CH | T | 0623 | 27.1472 | \$ 1,615.56 | | \$ 323.11 |
| 36563 | Insert tunneled cv cath | CH | T | 0623 | 27.1472 | \$ 1,615.56 | | \$ 323.11 |
| 36565 | Insert tunneled cv cath | CH | T | 0623 | 27.1472 | \$ 1,615.56 | | \$ 323.11 |
| 36566 | Insert tunneled cv cath | | T | 1564 | | \$ 4,750.00 | | \$ 950.00 |
| 36568 | Insert picc cath | CH | T | 0621 | 8.2313 | \$ 489.85 | | \$ 97.97 |
| 36569 | Insert picc cath | CH | T | 0621 | 8.2313 | \$ 489.85 | | \$ 97.97 |
| 36570 | Insert picvad cath | CH | T | 0622 | 21.2464 | \$ 1,264.39 | | \$ 252.88 |
| 36571 | Insert picvad cath | CH | T | 0622 | 21.2464 | \$ 1,264.39 | | \$ 252.88 |
| 36575 | Repair tunneled cv cath | CH | T | 0621 | 8.2313 | \$ 489.85 | | \$ 97.97 |
| 36576 | Repair tunneled cv cath | CH | T | 0621 | 8.2313 | \$ 489.85 | | \$ 97.97 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 36578 | Replace tunneled cv cath | CH | T | 0622 | 21.2464 | \$ 1,264.39 | | \$ 252.88 |
| 36580 | Replace cvad cath | CH | T | 0621 | 8.2313 | \$ 489.85 | | \$ 97.97 |
| 36581 | Replace tunneled cv cath | CH | T | 0622 | 21.2464 | \$ 1,264.39 | | \$ 252.88 |
| 36582 | Replace tunneled cv cath | CH | T | 0623 | 27.1472 | \$ 1,615.56 | | \$ 323.11 |
| 36583 | Replace tunneled cv cath | CH | T | 0623 | 27.1472 | \$ 1,615.56 | | \$ 323.11 |
| 36584 | Replace picc cath | CH | T | 0621 | 8.2313 | \$ 489.85 | | \$ 97.97 |
| 36585 | Replace picvad cath | CH | T | 0622 | 21.2464 | \$ 1,264.39 | | \$ 252.88 |
| 36589 | Removal tunneled cv cath | CH | T | 0621 | 8.2313 | \$ 489.85 | | \$ 97.97 |
| 36590 | Removal tunneled cv cath | CH | T | 0621 | 8.2313 | \$ 489.85 | | \$ 97.97 |
| 36595 | Mech remov tunneled cv cath | CH | T | 0622 | 21.2464 | \$ 1,264.39 | | \$ 252.88 |
| 36596 | Mech remov tunneled cv cath | CH | T | 0621 | 8.2313 | \$ 489.85 | | \$ 97.97 |
| 36597 | Reposition venous catheter | CH | T | 0621 | 8.2313 | \$ 489.85 | | \$ 97.97 |
| 36598 | Inj w/fluor, eval cv device | NI | X | 0340 | 0.6137 | \$ 36.52 | | \$ 7.30 |
| 36600 | Withdrawal of arterial blood | | N | | | | | |
| 36620 | Insertion catheter, artery | | N | | | | | |
| 36625 | Insertion catheter, artery | | N | | | | | |
| 36640 | Insertion catheter, artery | CH | T | 0623 | 27.1472 | \$ 1,615.56 | | \$ 323.11 |
| 36680 | Insert needle, bone cavity | | T | 0002 | 0.9357 | \$ 55.68 | | \$ 11.14 |
| 36800 | Insertion of cannula | | T | 0115 | 36.9806 | \$ 2,200.75 | \$ 459.35 | \$ 440.15 |
| 36810 | Insertion of cannula | | T | 0115 | 36.9806 | \$ 2,200.75 | \$ 459.35 | \$ 440.15 |
| 36815 | Insertion of cannula | | T | 0115 | 36.9806 | \$ 2,200.75 | \$ 459.35 | \$ 440.15 |
| 36818 | Av fuse, uppr arm, cephalic | | T | 0088 | 36.5126 | \$ 2,172.90 | \$ 655.22 | \$ 434.58 |
| 36819 | Av fuse, uppr arm, basilic | | T | 0088 | 36.5126 | \$ 2,172.90 | \$ 655.22 | \$ 434.58 |
| 36820 | Av fusion/forearm vein | | T | 0088 | 36.5126 | \$ 2,172.90 | \$ 655.22 | \$ 434.58 |
| 36821 | Av fusion direct any site | | T | 0088 | 36.5126 | \$ 2,172.90 | \$ 655.22 | \$ 434.58 |
| 36825 | Artery-vein autograft | | T | 0088 | 36.5126 | \$ 2,172.90 | \$ 655.22 | \$ 434.58 |
| 36830 | Artery-vein nonautograft | | T | 0088 | 36.5126 | \$ 2,172.90 | \$ 655.22 | \$ 434.58 |
| 36831 | Open thrombect av fistula | | T | 0088 | 36.5126 | \$ 2,172.90 | \$ 655.22 | \$ 434.58 |
| 36832 | Av fistula revision, open | | T | 0088 | 36.5126 | \$ 2,172.90 | \$ 655.22 | \$ 434.58 |
| 36833 | Av fistula revision | | T | 0088 | 36.5126 | \$ 2,172.90 | \$ 655.22 | \$ 434.58 |
| 36834 | Repair A-V aneurysm | | T | 0088 | 36.5126 | \$ 2,172.90 | \$ 655.22 | \$ 434.58 |
| 36835 | Artery to vein shunt | | T | 0115 | 36.9806 | \$ 2,200.75 | \$ 459.35 | \$ 440.15 |
| 36838 | Dist revas ligation, hemo | | T | 0088 | 36.5126 | \$ 2,172.90 | \$ 655.22 | \$ 434.58 |
| 36860 | External cannula declotting | CH | T | 0676 | 2.2742 | \$ 135.34 | | \$ 27.07 |
| 36861 | Cannula declotting | | T | 0115 | 36.9806 | \$ 2,200.75 | \$ 459.35 | \$ 440.15 |
| 36870 | Percut thrombect av fistula | | T | 0653 | 36.9427 | \$ 2,198.50 | | \$ 439.70 |
| 37183 | Remove hepatic shunt (tips) | CH | T | 0229 | 66.3380 | \$ 3,947.84 | | \$ 789.57 |
| 37184 | Prim art mech thrombectomy | NI | T | 0653 | 36.9427 | \$ 2,198.50 | | \$ 439.70 |
| 37185 | Prim art m-thrombect add-on | NI | T | 0103 | 15.0428 | \$ 895.21 | \$ 223.63 | \$ 179.04 |
| 37186 | Sec art m-thrombect add-on | NI | T | 0103 | 15.0428 | \$ 895.21 | \$ 223.63 | \$ 179.04 |
| 37187 | Venous mech thrombectomy | NI | T | 0653 | 36.9427 | \$ 2,198.50 | | \$ 439.70 |
| 37188 | Venous m-thrombectomy add-on | NI | T | 0653 | 36.9427 | \$ 2,198.50 | | \$ 439.70 |
| 37195 | Thrombolytic therapy, stroke | CH | T | 0676 | 2.2742 | \$ 135.34 | | \$ 27.07 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 37200 | Transcatheter biopsy | | T | 0685 | 6.0034 | \$ 357.27 | \$ 115.47 | \$ 71.45 |
| 37201 | Transcatheter therapy infuse | | T | 0676 | 2.2742 | \$ 135.34 | | \$ 27.07 |
| 37202 | Transcatheter therapy infuse | CH | T | 0676 | 2.2742 | \$ 135.34 | | \$ 27.07 |
| 37203 | Transcatheter retrieval | | T | 0103 | 15.0428 | \$ 895.21 | \$ 223.63 | \$ 179.04 |
| 37204 | Transcatheter occlusion | | T | 0115 | 36.9806 | \$ 2,200.75 | \$ 459.35 | \$ 440.15 |
| 37205 | Transcath iv stent, percut | | T | 0229 | 66.3380 | \$ 3,947.84 | | \$ 789.57 |
| 37206 | Transcath iv stent/perc addl | | T | 0229 | 66.3380 | \$ 3,947.84 | | \$ 789.57 |
| 37207 | Transcath iv stent, open | | T | 0229 | 66.3380 | \$ 3,947.84 | | \$ 789.57 |
| 37208 | Transcath iv stent/open addl | | T | 0229 | 66.3380 | \$ 3,947.84 | | \$ 789.57 |
| 37209 | Change iv cath at thromb tx | | T | 0103 | 15.0428 | \$ 895.21 | \$ 223.63 | \$ 179.04 |
| 37250 | Iv us first vessel add-on | | S | 0416 | 16.4464 | \$ 978.74 | | \$ 195.75 |
| 37251 | Iv us each add vessel add-on | | S | 0416 | 16.4464 | \$ 978.74 | | \$ 195.75 |
| 37500 | Endoscopy ligate perf veins | | T | 0092 | 26.5104 | \$ 1,577.66 | \$ 505.37 | \$ 315.53 |
| 37501 | Vascular endoscopy procedure | | T | 0092 | 26.5104 | \$ 1,577.66 | \$ 505.37 | \$ 315.53 |
| 37565 | Ligation of neck vein | | T | 0093 | 23.3101 | \$ 1,387.21 | | \$ 277.44 |
| 37600 | Ligation of neck artery | | T | 0093 | 23.3101 | \$ 1,387.21 | | \$ 277.44 |
| 37605 | Ligation of neck artery | | T | 0091 | 28.8805 | \$ 1,718.71 | \$ 348.23 | \$ 343.74 |
| 37606 | Ligation of neck artery | | T | 0091 | 28.8805 | \$ 1,718.71 | \$ 348.23 | \$ 343.74 |
| 37607 | Ligation of a-v fistula | | T | 0092 | 26.5104 | \$ 1,577.66 | \$ 505.37 | \$ 315.53 |
| 37609 | Temporal artery procedure | | T | 0021 | 14.9984 | \$ 892.57 | \$ 219.48 | \$ 178.51 |
| 37615 | Ligation of neck artery | | T | 0091 | 28.8805 | \$ 1,718.71 | \$ 348.23 | \$ 343.74 |
| 37620 | Revision of major vein | | T | 0091 | 28.8805 | \$ 1,718.71 | \$ 348.23 | \$ 343.74 |
| 37650 | Revision of major vein | | T | 0091 | 28.8805 | \$ 1,718.71 | \$ 348.23 | \$ 343.74 |
| 37700 | Revise leg vein | | T | 0091 | 28.8805 | \$ 1,718.71 | \$ 348.23 | \$ 343.74 |
| 37718 | Ligate/strip short leg vein | NI | T | 0092 | 26.5104 | \$ 1,577.66 | \$ 505.37 | \$ 315.53 |
| 37720 | Removal of leg vein | CH | D | | | | | |
| 37722 | Ligate/strip long leg vein | NI | T | 0092 | 26.5104 | \$ 1,577.66 | \$ 505.37 | \$ 315.53 |
| 37730 | Removal of leg veins | CH | D | | | | | |
| 37735 | Removal of leg veins/lesion | | T | 0092 | 26.5104 | \$ 1,577.66 | \$ 505.37 | \$ 315.53 |
| 37760 | Ligation, leg veins, open | | T | 0091 | 28.8805 | \$ 1,718.71 | \$ 348.23 | \$ 343.74 |
| 37765 | Phleb veins - extrem - to 20 | | T | 0091 | 28.8805 | \$ 1,718.71 | \$ 348.23 | \$ 343.74 |
| 37766 | Phleb veins - extrem 20+ | | T | 0091 | 28.8805 | \$ 1,718.71 | \$ 348.23 | \$ 343.74 |
| 37780 | Revision of leg vein | | T | 0091 | 28.8805 | \$ 1,718.71 | \$ 348.23 | \$ 343.74 |
| 37785 | Ligate/divide/excise vein | | T | 0091 | 28.8805 | \$ 1,718.71 | \$ 348.23 | \$ 343.74 |
| 37790 | Penile venous occlusion | | T | 0181 | 30.9472 | \$ 1,841.70 | \$ 621.82 | \$ 368.34 |
| 37799 | Vascular surgery procedure | CH | T | 0103 | 15.0428 | \$ 895.21 | \$ 223.63 | \$ 179.04 |
| 38120 | Laparoscopy, splenectomy | | T | 0131 | 43.0498 | \$ 2,561.94 | \$ 1,001.89 | \$ 512.39 |
| 38129 | Laparoscope proc, spleen | | T | 0130 | 31.8753 | \$ 1,896.93 | \$ 659.53 | \$ 379.39 |
| 38200 | Injection for spleen x-ray | | N | | | | | |
| 38204 | BI donor search management | | N | | | | | |
| 38205 | Harvest allogenic stem cells | | S | 0111 | 12.0768 | \$ 718.70 | \$ 198.40 | \$ 143.74 |
| 38206 | Harvest auto stem cells | | S | 0111 | 12.0768 | \$ 718.70 | \$ 198.40 | \$ 143.74 |
| 38220 | Bone marrow aspiration | | T | 0003 | 2.6756 | \$ 159.23 | | \$ 31.85 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 38221 | Bone marrow biopsy | | T | 0003 | 2.6756 | \$ 159.23 | | \$ 31.85 |
| 38230 | Bone marrow collection | CH | S | 0123 | 24.4820 | \$ 1,456.95 | | \$ 291.39 |
| 38240 | Bone marrow/stem transplant | | S | 0123 | 24.4820 | \$ 1,456.95 | | \$ 291.39 |
| 38241 | Bone marrow/stem transplant | | S | 0123 | 24.4820 | \$ 1,456.95 | | \$ 291.39 |
| 38242 | Lymphocyte infuse transplant | | S | 0111 | 12.0768 | \$ 718.70 | \$ 198.40 | \$ 143.74 |
| 38300 | Drainage, lymph node lesion | CH | T | 0007 | 11.6717 | \$ 694.59 | | \$ 138.92 |
| 38305 | Drainage, lymph node lesion | | T | 0008 | 16.2953 | \$ 969.75 | | \$ 193.95 |
| 38308 | Incision of lymph channels | | T | 0113 | 21.4112 | \$ 1,274.20 | | \$ 254.84 |
| 38500 | Biopsy/removal, lymph nodes | | T | 0113 | 21.4112 | \$ 1,274.20 | | \$ 254.84 |
| 38505 | Needle biopsy, lymph nodes | | T | 0005 | 3.5834 | \$ 213.25 | \$ 71.59 | \$ 42.65 |
| 38510 | Biopsy/removal, lymph nodes | | T | 0113 | 21.4112 | \$ 1,274.20 | | \$ 254.84 |
| 38520 | Biopsy/removal, lymph nodes | | T | 0113 | 21.4112 | \$ 1,274.20 | | \$ 254.84 |
| 38525 | Biopsy/removal, lymph nodes | | T | 0113 | 21.4112 | \$ 1,274.20 | | \$ 254.84 |
| 38530 | Biopsy/removal, lymph nodes | | T | 0113 | 21.4112 | \$ 1,274.20 | | \$ 254.84 |
| 38542 | Explore deep node(s), neck | | T | 0114 | 40.4596 | \$ 2,407.79 | \$ 485.91 | \$ 481.56 |
| 38550 | Removal, neck/armpit lesion | | T | 0113 | 21.4112 | \$ 1,274.20 | | \$ 254.84 |
| 38555 | Removal, neck/armpit lesion | | T | 0113 | 21.4112 | \$ 1,274.20 | | \$ 254.84 |
| 38570 | Laparoscopy, lymph node biop | | T | 0131 | 43.0498 | \$ 2,561.94 | \$ 1,001.89 | \$ 512.39 |
| 38571 | Laparoscopy, lymphadenectomy | | T | 0132 | 63.6859 | \$ 3,790.01 | \$ 1,239.22 | \$ 758.00 |
| 38572 | Laparoscopy, lymphadenectomy | | T | 0131 | 43.0498 | \$ 2,561.94 | \$ 1,001.89 | \$ 512.39 |
| 38589 | Laparoscope proc, lymphatic | | T | 0130 | 31.8753 | \$ 1,896.93 | \$ 659.53 | \$ 379.39 |
| 38700 | Removal of lymph nodes, neck | | T | 0113 | 21.4112 | \$ 1,274.20 | | \$ 254.84 |
| 38720 | Removal of lymph nodes, neck | | T | 0113 | 21.4112 | \$ 1,274.20 | | \$ 254.84 |
| 38740 | Remove armpit lymph nodes | | T | 0114 | 40.4596 | \$ 2,407.79 | \$ 485.91 | \$ 481.56 |
| 38745 | Remove armpit lymph nodes | | T | 0114 | 40.4596 | \$ 2,407.79 | \$ 485.91 | \$ 481.56 |
| 38760 | Remove groin lymph nodes | | T | 0113 | 21.4112 | \$ 1,274.20 | | \$ 254.84 |
| 38790 | Inject for lymphatic x-ray | | N | | | | | |
| 38792 | Identify sentinel node | | N | | | | | |
| 38794 | Access thoracic lymph duct | | N | | | | | |
| 38999 | Blood/lymph system procedure | | S | 0110 | 3.6419 | \$ 216.73 | | \$ 43.35 |
| 39400 | Visualization of chest | | T | 0069 | 30.9541 | \$ 1,842.11 | \$ 591.64 | \$ 368.42 |
| 40490 | Biopsy of lip | | T | 0251 | 2.0789 | \$ 123.72 | | \$ 24.74 |
| 40500 | Partial excision of lip | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 40510 | Partial excision of lip | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 40520 | Partial excision of lip | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 40525 | Reconstruct lip with flap | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 40527 | Reconstruct lip with flap | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 40530 | Partial removal of lip | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 40650 | Repair lip | | T | 0252 | 8.1033 | \$ 482.24 | \$ 113.41 | \$ 96.45 |
| 40652 | Repair lip | | T | 0252 | 8.1033 | \$ 482.24 | \$ 113.41 | \$ 96.45 |
| 40654 | Repair lip | | T | 0252 | 8.1033 | \$ 482.24 | \$ 113.41 | \$ 96.45 |
| 40700 | Repair cleft lip/nasal | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 40701 | Repair cleft lip/nasal | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 40702 | Repair cleft lip/nasal | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 40720 | Repair cleft lip/nasal | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 40761 | Repair cleft lip/nasal | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 40799 | Lip surgery procedure | | T | 0251 | 2.0789 | \$ 123.72 | | \$ 24.74 |
| 40800 | Drainage of mouth lesion | | T | 0251 | 2.0789 | \$ 123.72 | | \$ 24.74 |
| 40801 | Drainage of mouth lesion | | T | 0252 | 8.1033 | \$ 482.24 | \$ 113.41 | \$ 96.45 |
| 40804 | Removal, foreign body, mouth | | X | 0340 | 0.6137 | \$ 36.52 | | \$ 7.30 |
| 40805 | Removal, foreign body, mouth | | T | 0252 | 8.1033 | \$ 482.24 | \$ 113.41 | \$ 96.45 |
| 40806 | Incision of lip fold | | T | 0251 | 2.0789 | \$ 123.72 | | \$ 24.74 |
| 40808 | Biopsy of mouth lesion | | T | 0251 | 2.0789 | \$ 123.72 | | \$ 24.74 |
| 40810 | Excision of mouth lesion | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 40812 | Excise/repair mouth lesion | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 40814 | Excise/repair mouth lesion | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 40816 | Excision of mouth lesion | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 40818 | Excise oral mucosa for graft | | T | 0251 | 2.0789 | \$ 123.72 | | \$ 24.74 |
| 40819 | Excise lip or cheek fold | | T | 0252 | 8.1033 | \$ 482.24 | \$ 113.41 | \$ 96.45 |
| 40820 | Treatment of mouth lesion | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 40830 | Repair mouth laceration | | T | 0251 | 2.0789 | \$ 123.72 | | \$ 24.74 |
| 40831 | Repair mouth laceration | | T | 0252 | 8.1033 | \$ 482.24 | \$ 113.41 | \$ 96.45 |
| 40840 | Reconstruction of mouth | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 40842 | Reconstruction of mouth | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 40843 | Reconstruction of mouth | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 40844 | Reconstruction of mouth | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 40845 | Reconstruction of mouth | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 40899 | Mouth surgery procedure | | T | 0251 | 2.0789 | \$ 123.72 | | \$ 24.74 |
| 41000 | Drainage of mouth lesion | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 41005 | Drainage of mouth lesion | | T | 0251 | 2.0789 | \$ 123.72 | | \$ 24.74 |
| 41006 | Drainage of mouth lesion | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 41007 | Drainage of mouth lesion | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 41008 | Drainage of mouth lesion | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 41009 | Drainage of mouth lesion | | T | 0251 | 2.0789 | \$ 123.72 | | \$ 24.74 |
| 41010 | Incision of tongue fold | | T | 0252 | 8.1033 | \$ 482.24 | \$ 113.41 | \$ 96.45 |
| 41015 | Drainage of mouth lesion | | T | 0251 | 2.0789 | \$ 123.72 | | \$ 24.74 |
| 41016 | Drainage of mouth lesion | | T | 0252 | 8.1033 | \$ 482.24 | \$ 113.41 | \$ 96.45 |
| 41017 | Drainage of mouth lesion | | T | 0252 | 8.1033 | \$ 482.24 | \$ 113.41 | \$ 96.45 |
| 41018 | Drainage of mouth lesion | | T | 0252 | 8.1033 | \$ 482.24 | \$ 113.41 | \$ 96.45 |
| 41100 | Biopsy of tongue | | T | 0252 | 8.1033 | \$ 482.24 | \$ 113.41 | \$ 96.45 |
| 41105 | Biopsy of tongue | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 41108 | Biopsy of floor of mouth | | T | 0252 | 8.1033 | \$ 482.24 | \$ 113.41 | \$ 96.45 |
| 41110 | Excision of tongue lesion | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 41112 | Excision of tongue lesion | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 41113 | Excision of tongue lesion | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 41114 | Excision of tongue lesion | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|-------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 41115 | Excision of tongue fold | | T | 0252 | 8.1033 | \$ 482.24 | \$ 113.41 | \$ 96.45 |
| 41116 | Excision of mouth lesion | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 41120 | Partial removal of tongue | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 41250 | Repair tongue laceration | | T | 0251 | 2.0789 | \$ 123.72 | | \$ 24.74 |
| 41251 | Repair tongue laceration | | T | 0251 | 2.0789 | \$ 123.72 | | \$ 24.74 |
| 41252 | Repair tongue laceration | | T | 0252 | 8.1033 | \$ 482.24 | \$ 113.41 | \$ 96.45 |
| 41500 | Fixation of tongue | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 41510 | Tongue to lip surgery | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 41520 | Reconstruction, tongue fold | | T | 0252 | 8.1033 | \$ 482.24 | \$ 113.41 | \$ 96.45 |
| 41599 | Tongue and mouth surgery | | T | 0251 | 2.0789 | \$ 123.72 | | \$ 24.74 |
| 41800 | Drainage of gum lesion | | T | 0251 | 2.0789 | \$ 123.72 | | \$ 24.74 |
| 41805 | Removal foreign body, gum | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 41806 | Removal foreign body, jawbone | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 41820 | Excision, gum, each quadrant | | T | 0252 | 8.1033 | \$ 482.24 | \$ 113.41 | \$ 96.45 |
| 41821 | Excision of gum flap | | T | 0252 | 8.1033 | \$ 482.24 | \$ 113.41 | \$ 96.45 |
| 41822 | Excision of gum lesion | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 41823 | Excision of gum lesion | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 41825 | Excision of gum lesion | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 41826 | Excision of gum lesion | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 41827 | Excision of gum lesion | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 41828 | Excision of gum lesion | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 41830 | Removal of gum tissue | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 41850 | Treatment of gum lesion | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 41870 | Gum graft | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 41872 | Repair gum | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 41874 | Repair tooth socket | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 41899 | Dental surgery procedure | | T | 0251 | 2.0789 | \$ 123.72 | | \$ 24.74 |
| 42000 | Drainage mouth roof lesion | | T | 0251 | 2.0789 | \$ 123.72 | | \$ 24.74 |
| 42100 | Biopsy roof of mouth | | T | 0252 | 8.1033 | \$ 482.24 | \$ 113.41 | \$ 96.45 |
| 42104 | Excision lesion, mouth roof | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 42106 | Excision lesion, mouth roof | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 42107 | Excision lesion, mouth roof | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 42120 | Remove palate/lesion | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 42140 | Excision of uvula | | T | 0252 | 8.1033 | \$ 482.24 | \$ 113.41 | \$ 96.45 |
| 42145 | Repair palate, pharynx/uvula | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 42160 | Treatment mouth roof lesion | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 42180 | Repair palate | | T | 0251 | 2.0789 | \$ 123.72 | | \$ 24.74 |
| 42182 | Repair palate | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 42200 | Reconstruct cleft palate | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 42205 | Reconstruct cleft palate | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 42210 | Reconstruct cleft palate | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 42215 | Reconstruct cleft palate | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 42220 | Reconstruct cleft palate | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 42225 | Reconstruct cleft palate | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 42226 | Lengthening of palate | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 42227 | Lengthening of palate | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 42235 | Repair palate | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 42260 | Repair nose to lip fistula | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 42280 | Preparation, palate mold | | T | 0251 | 2.0789 | \$ 123.72 | | \$ 24.74 |
| 42281 | Insertion, palate prosthesis | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 42299 | Palate/uvula surgery | | T | 0251 | 2.0789 | \$ 123.72 | | \$ 24.74 |
| 42300 | Drainage of salivary gland | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 42305 | Drainage of salivary gland | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 42310 | Drainage of salivary gland | | T | 0251 | 2.0789 | \$ 123.72 | | \$ 24.74 |
| 42320 | Drainage of salivary gland | | T | 0251 | 2.0789 | \$ 123.72 | | \$ 24.74 |
| 42325 | Create salivary cyst drain | CH | D | | | | | |
| 42326 | Create salivary cyst drain | CH | D | | | | | |
| 42330 | Removal of salivary stone | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 42335 | Removal of salivary stone | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 42340 | Removal of salivary stone | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 42400 | Biopsy of salivary gland | | T | 0005 | 3.5834 | \$ 213.25 | \$ 71.59 | \$ 42.65 |
| 42405 | Biopsy of salivary gland | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 42408 | Excision of salivary cyst | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 42409 | Drainage of salivary cyst | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 42410 | Excise parotid gland/lesion | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 42415 | Excise parotid gland/lesion | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 42420 | Excise parotid gland/lesion | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 42425 | Excise parotid gland/lesion | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 42440 | Excise submaxillary gland | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 42450 | Excise sublingual gland | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 42500 | Repair salivary duct | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 42505 | Repair salivary duct | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 42507 | Parotid duct diversion | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 42508 | Parotid duct diversion | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 42509 | Parotid duct diversion | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 42510 | Parotid duct diversion | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 42550 | Injection for salivary x-ray | | N | | | | | |
| 42600 | Closure of salivary fistula | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 42650 | Dilation of salivary duct | | T | 0252 | 8.1033 | \$ 482.24 | \$ 113.41 | \$ 96.45 |
| 42660 | Dilation of salivary duct | | T | 0251 | 2.0789 | \$ 123.72 | | \$ 24.74 |
| 42665 | Ligation of salivary duct | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 42699 | Salivary surgery procedure | | T | 0251 | 2.0789 | \$ 123.72 | | \$ 24.74 |
| 42700 | Drainage of tonsil abscess | | T | 0251 | 2.0789 | \$ 123.72 | | \$ 24.74 |
| 42720 | Drainage of throat abscess | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 42725 | Drainage of throat abscess | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 42800 | Biopsy of throat | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 42802 | Biopsy of throat | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 42804 | Biopsy of upper nose/throat | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 42806 | Biopsy of upper nose/throat | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 42808 | Excise pharynx lesion | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 42809 | Remove pharynx foreign body | | X | 0340 | 0.6137 | \$ 36.52 | | \$ 7.30 |
| 42810 | Excision of neck cyst | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 42815 | Excision of neck cyst | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 42820 | Remove tonsils and adenoids | | T | 0258 | 21.8761 | \$ 1,301.87 | \$ 437.25 | \$ 260.37 |
| 42821 | Remove tonsils and adenoids | | T | 0258 | 21.8761 | \$ 1,301.87 | \$ 437.25 | \$ 260.37 |
| 42825 | Removal of tonsils | | T | 0258 | 21.8761 | \$ 1,301.87 | \$ 437.25 | \$ 260.37 |
| 42826 | Removal of tonsils | | T | 0258 | 21.8761 | \$ 1,301.87 | \$ 437.25 | \$ 260.37 |
| 42830 | Removal of adenoids | | T | 0258 | 21.8761 | \$ 1,301.87 | \$ 437.25 | \$ 260.37 |
| 42831 | Removal of adenoids | | T | 0258 | 21.8761 | \$ 1,301.87 | \$ 437.25 | \$ 260.37 |
| 42835 | Removal of adenoids | | T | 0258 | 21.8761 | \$ 1,301.87 | \$ 437.25 | \$ 260.37 |
| 42836 | Removal of adenoids | | T | 0258 | 21.8761 | \$ 1,301.87 | \$ 437.25 | \$ 260.37 |
| 42842 | Extensive surgery of throat | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 42844 | Extensive surgery of throat | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 42860 | Excision of tonsil tags | | T | 0258 | 21.8761 | \$ 1,301.87 | \$ 437.25 | \$ 260.37 |
| 42870 | Excision of lingual tonsil | | T | 0258 | 21.8761 | \$ 1,301.87 | \$ 437.25 | \$ 260.37 |
| 42890 | Partial removal of pharynx | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 42892 | Revision of pharyngeal walls | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 42900 | Repair throat wound | | T | 0252 | 8.1033 | \$ 482.24 | \$ 113.41 | \$ 96.45 |
| 42950 | Reconstruction of throat | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 42955 | Surgical opening of throat | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 42960 | Control throat bleeding | | T | 0250 | 1.2241 | \$ 72.85 | \$ 25.50 | \$ 14.57 |
| 42962 | Control throat bleeding | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 42970 | Control nose/throat bleeding | | T | 0250 | 1.2241 | \$ 72.85 | \$ 25.50 | \$ 14.57 |
| 42972 | Control nose/throat bleeding | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 42999 | Throat surgery procedure | | T | 0251 | 2.0789 | \$ 123.72 | | \$ 24.74 |
| 43020 | Incision of esophagus | | T | 0252 | 8.1033 | \$ 482.24 | \$ 113.41 | \$ 96.45 |
| 43030 | Throat muscle surgery | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 43130 | Removal of esophagus pouch | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 43200 | Esophagus endoscopy | | T | 0141 | 8.0662 | \$ 480.03 | \$ 143.38 | \$ 96.01 |
| 43201 | Esoph scope w/submucous inj | | T | 0141 | 8.0662 | \$ 480.03 | \$ 143.38 | \$ 96.01 |
| 43202 | Esophagus endoscopy, biopsy | | T | 0141 | 8.0662 | \$ 480.03 | \$ 143.38 | \$ 96.01 |
| 43204 | Esoph scope w/sclerosis inj | | T | 0141 | 8.0662 | \$ 480.03 | \$ 143.38 | \$ 96.01 |
| 43205 | Esophagus endoscopy/ligation | | T | 0141 | 8.0662 | \$ 480.03 | \$ 143.38 | \$ 96.01 |
| 43215 | Esophagus endoscopy | | T | 0141 | 8.0662 | \$ 480.03 | \$ 143.38 | \$ 96.01 |
| 43216 | Esophagus endoscopy/lesion | | T | 0141 | 8.0662 | \$ 480.03 | \$ 143.38 | \$ 96.01 |
| 43217 | Esophagus endoscopy | | T | 0141 | 8.0662 | \$ 480.03 | \$ 143.38 | \$ 96.01 |
| 43219 | Esophagus endoscopy | | T | 0384 | 26.8955 | \$ 1,600.58 | \$ 335.19 | \$ 320.12 |
| 43220 | Esoph endoscopy, dilation | | T | 0141 | 8.0662 | \$ 480.03 | \$ 143.38 | \$ 96.01 |
| 43226 | Esoph endoscopy, dilation | | T | 0141 | 8.0662 | \$ 480.03 | \$ 143.38 | \$ 96.01 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 43227 | Esoph endoscopy, repair | | T | 0141 | 8.0662 | \$ 480.03 | \$ 143.38 | \$ 96.01 |
| 43228 | Esoph endoscopy, ablation | | T | 0422 | 24.0525 | \$ 1,431.39 | \$ 448.81 | \$ 286.28 |
| 43231 | Esoph endoscopy w/us exam | | T | 0141 | 8.0662 | \$ 480.03 | \$ 143.38 | \$ 96.01 |
| 43232 | Esoph endoscopy w/us fn bx | | T | 0141 | 8.0662 | \$ 480.03 | \$ 143.38 | \$ 96.01 |
| 43234 | Upper GI endoscopy, exam | | T | 0141 | 8.0662 | \$ 480.03 | \$ 143.38 | \$ 96.01 |
| 43235 | Uppr gi endoscopy, diagnosis | | T | 0141 | 8.0662 | \$ 480.03 | \$ 143.38 | \$ 96.01 |
| 43236 | Uppr gi scope w/submuc inj | | T | 0141 | 8.0662 | \$ 480.03 | \$ 143.38 | \$ 96.01 |
| 43237 | Endoscopic us exam, esoph | | T | 0141 | 8.0662 | \$ 480.03 | \$ 143.38 | \$ 96.01 |
| 43238 | Uppr gi endoscopy w/us fn bx | | T | 0141 | 8.0662 | \$ 480.03 | \$ 143.38 | \$ 96.01 |
| 43239 | Upper GI endoscopy, biopsy | | T | 0141 | 8.0662 | \$ 480.03 | \$ 143.38 | \$ 96.01 |
| 43240 | Esoph endoscope w/drain cyst | | T | 0141 | 8.0662 | \$ 480.03 | \$ 143.38 | \$ 96.01 |
| 43241 | Upper GI endoscopy with tube | | T | 0141 | 8.0662 | \$ 480.03 | \$ 143.38 | \$ 96.01 |
| 43242 | Uppr gi endoscopy w/us fn bx | | T | 0141 | 8.0662 | \$ 480.03 | \$ 143.38 | \$ 96.01 |
| 43243 | Upper gi endoscopy & inject | | T | 0141 | 8.0662 | \$ 480.03 | \$ 143.38 | \$ 96.01 |
| 43244 | Upper GI endoscopy/ligation | | T | 0141 | 8.0662 | \$ 480.03 | \$ 143.38 | \$ 96.01 |
| 43245 | Uppr gi scope dilate strictr | | T | 0141 | 8.0662 | \$ 480.03 | \$ 143.38 | \$ 96.01 |
| 43246 | Place gastrostomy tube | | T | 0141 | 8.0662 | \$ 480.03 | \$ 143.38 | \$ 96.01 |
| 43247 | Operative upper GI endoscopy | | T | 0141 | 8.0662 | \$ 480.03 | \$ 143.38 | \$ 96.01 |
| 43248 | Uppr gi endoscopy/guide wire | | T | 0141 | 8.0662 | \$ 480.03 | \$ 143.38 | \$ 96.01 |
| 43249 | Esoph endoscopy, dilation | | T | 0141 | 8.0662 | \$ 480.03 | \$ 143.38 | \$ 96.01 |
| 43250 | Upper GI endoscopy/tumor | | T | 0141 | 8.0662 | \$ 480.03 | \$ 143.38 | \$ 96.01 |
| 43251 | Operative upper GI endoscopy | | T | 0141 | 8.0662 | \$ 480.03 | \$ 143.38 | \$ 96.01 |
| 43255 | Operative upper GI endoscopy | | T | 0141 | 8.0662 | \$ 480.03 | \$ 143.38 | \$ 96.01 |
| 43256 | Uppr gi endoscopy w/stent | | T | 0384 | 26.8955 | \$ 1,600.58 | \$ 335.19 | \$ 320.12 |
| 43257 | Uppr gi scope w/thrml txmnt | | T | 0422 | 24.0525 | \$ 1,431.39 | \$ 448.81 | \$ 286.28 |
| 43258 | Operative upper GI endoscopy | | T | 0141 | 8.0662 | \$ 480.03 | \$ 143.38 | \$ 96.01 |
| 43259 | Endoscopic ultrasound exam | | T | 0141 | 8.0662 | \$ 480.03 | \$ 143.38 | \$ 96.01 |
| 43260 | Endo cholangiopancreatograph | | T | 0151 | 18.6171 | \$ 1,107.92 | \$ 245.46 | \$ 221.58 |
| 43261 | Endo cholangiopancreatograph | | T | 0151 | 18.6171 | \$ 1,107.92 | \$ 245.46 | \$ 221.58 |
| 43262 | Endo cholangiopancreatograph | | T | 0151 | 18.6171 | \$ 1,107.92 | \$ 245.46 | \$ 221.58 |
| 43263 | Endo cholangiopancreatograph | | T | 0151 | 18.6171 | \$ 1,107.92 | \$ 245.46 | \$ 221.58 |
| 43264 | Endo cholangiopancreatograph | | T | 0151 | 18.6171 | \$ 1,107.92 | \$ 245.46 | \$ 221.58 |
| 43265 | Endo cholangiopancreatograph | | T | 0151 | 18.6171 | \$ 1,107.92 | \$ 245.46 | \$ 221.58 |
| 43267 | Endo cholangiopancreatograph | | T | 0151 | 18.6171 | \$ 1,107.92 | \$ 245.46 | \$ 221.58 |
| 43268 | Endo cholangiopancreatograph | | T | 0384 | 26.8955 | \$ 1,600.58 | \$ 335.19 | \$ 320.12 |
| 43269 | Endo cholangiopancreatograph | | T | 0384 | 26.8955 | \$ 1,600.58 | \$ 335.19 | \$ 320.12 |
| 43271 | Endo cholangiopancreatograph | | T | 0151 | 18.6171 | \$ 1,107.92 | \$ 245.46 | \$ 221.58 |
| 43272 | Endo cholangiopancreatograph | | T | 0151 | 18.6171 | \$ 1,107.92 | \$ 245.46 | \$ 221.58 |
| 43280 | Laparoscopy, fundoplasty | | T | 0132 | 63.6859 | \$ 3,790.01 | \$ 1,239.22 | \$ 758.00 |
| 43289 | Laparoscope proc, esoph | | T | 0130 | 31.8753 | \$ 1,896.93 | \$ 659.53 | \$ 379.39 |
| 43450 | Dilate esophagus | | T | 0140 | 5.2970 | \$ 315.23 | \$ 91.40 | \$ 63.05 |
| 43453 | Dilate esophagus | | T | 0140 | 5.2970 | \$ 315.23 | \$ 91.40 | \$ 63.05 |
| 43456 | Dilate esophagus | | T | 0140 | 5.2970 | \$ 315.23 | \$ 91.40 | \$ 63.05 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 43458 | Dilate esophagus | | T | 0140 | 5.2970 | \$ 315.23 | \$ 91.40 | \$ 63.05 |
| 43499 | Esophagus surgery procedure | | T | 0141 | 8.0662 | \$ 480.03 | \$ 143.38 | \$ 96.01 |
| 43510 | Surgical opening of stomach | | T | 0141 | 8.0662 | \$ 480.03 | \$ 143.38 | \$ 96.01 |
| 43600 | Biopsy of stomach | | T | 0141 | 8.0662 | \$ 480.03 | \$ 143.38 | \$ 96.01 |
| 43638 | Removal of stomach, partial | CH | D | | | | | |
| 43639 | Removal of stomach, partial | CH | D | | | | | |
| 43651 | Laparoscopy, vagus nerve | | T | 0132 | 63.6859 | \$ 3,790.01 | \$ 1,239.22 | \$ 758.00 |
| 43652 | Laparoscopy, vagus nerve | | T | 0132 | 63.6859 | \$ 3,790.01 | \$ 1,239.22 | \$ 758.00 |
| 43653 | Laparoscopy, gastrostomy | | T | 0131 | 43.0498 | \$ 2,561.94 | \$ 1,001.89 | \$ 512.39 |
| 43659 | Laparoscope proc, stom | | T | 0130 | 31.8753 | \$ 1,896.93 | \$ 659.53 | \$ 379.39 |
| 43750 | Place gastrostomy tube | | T | 0141 | 8.0662 | \$ 480.03 | \$ 143.38 | \$ 96.01 |
| 43752 | Nasal/orogastric w/stent | | X | 0272 | 1.3291 | \$ 79.10 | \$ 31.64 | \$ 15.82 |
| 43760 | Change gastrostomy tube | | T | 0121 | 2.2374 | \$ 133.15 | \$ 43.80 | \$ 26.63 |
| 43761 | Reposition gastrostomy tube | CH | T | 0122 | 6.9179 | \$ 411.69 | \$ 84.43 | \$ 82.34 |
| 43830 | Place gastrostomy tube | | T | 0422 | 24.0525 | \$ 1,431.39 | \$ 448.81 | \$ 286.28 |
| 43831 | Place gastrostomy tube | | T | 0141 | 8.0662 | \$ 480.03 | \$ 143.38 | \$ 96.01 |
| 43870 | Repair stomach opening | | T | 0141 | 8.0662 | \$ 480.03 | \$ 143.38 | \$ 96.01 |
| 43886 | Revise gastric port, open | | T | 0025 | 5.3051 | \$ 315.71 | \$ 101.85 | \$ 63.14 |
| 43887 | Remove gastric port, open | | T | 0025 | 5.3051 | \$ 315.71 | \$ 101.85 | \$ 63.14 |
| 43888 | Change gastric port, open | | T | 0686 | 13.4973 | \$ 803.24 | | \$ 160.65 |
| 43999 | Stomach surgery procedure | | T | 0141 | 8.0662 | \$ 480.03 | \$ 143.38 | \$ 96.01 |
| 44100 | Biopsy of bowel | | T | 0141 | 8.0662 | \$ 480.03 | \$ 143.38 | \$ 96.01 |
| 44180 | Lap, enterolysis | NI | T | 0131 | 43.0498 | \$ 2,561.94 | \$ 1,001.89 | \$ 512.39 |
| 44186 | Lap, jejunostomy | NI | T | 0131 | 43.0498 | \$ 2,561.94 | \$ 1,001.89 | \$ 512.39 |
| 44200 | Laparoscopy, enterolysis | CH | D | | | | | |
| 44201 | Laparoscopy, jejunostomy | CH | D | | | | | |
| 44206 | Lap part colectomy w/stoma | | T | 0132 | 63.6859 | \$ 3,790.01 | \$ 1,239.22 | \$ 758.00 |
| 44207 | L colectomy/coloproctostomy | | T | 0132 | 63.6859 | \$ 3,790.01 | \$ 1,239.22 | \$ 758.00 |
| 44208 | L colectomy/coloproctostomy | | T | 0132 | 63.6859 | \$ 3,790.01 | \$ 1,239.22 | \$ 758.00 |
| 44213 | Lap, mobil splenic fl add-on | NI | T | 0130 | 31.8753 | \$ 1,896.93 | \$ 659.53 | \$ 379.39 |
| 44238 | Laparoscope proc, intestine | | T | 0130 | 31.8753 | \$ 1,896.93 | \$ 659.53 | \$ 379.39 |
| 44239 | Laparoscope proc, rectum | CH | D | | | | | |
| 44312 | Revision of ileostomy | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 44340 | Revision of colostomy | | T | 0027 | 18.1956 | \$ 1,082.84 | \$ 329.72 | \$ 216.57 |
| 44360 | Small bowel endoscopy | | T | 0142 | 9.0564 | \$ 538.96 | \$ 152.78 | \$ 107.79 |
| 44361 | Small bowel endoscopy/biopsy | | T | 0142 | 9.0564 | \$ 538.96 | \$ 152.78 | \$ 107.79 |
| 44363 | Small bowel endoscopy | | T | 0142 | 9.0564 | \$ 538.96 | \$ 152.78 | \$ 107.79 |
| 44364 | Small bowel endoscopy | | T | 0142 | 9.0564 | \$ 538.96 | \$ 152.78 | \$ 107.79 |
| 44365 | Small bowel endoscopy | | T | 0142 | 9.0564 | \$ 538.96 | \$ 152.78 | \$ 107.79 |
| 44366 | Small bowel endoscopy | | T | 0142 | 9.0564 | \$ 538.96 | \$ 152.78 | \$ 107.79 |
| 44369 | Small bowel endoscopy | | T | 0142 | 9.0564 | \$ 538.96 | \$ 152.78 | \$ 107.79 |
| 44370 | Small bowel endoscopy/stent | | T | 0384 | 26.8955 | \$ 1,600.58 | \$ 335.19 | \$ 320.12 |
| 44372 | Small bowel endoscopy | | T | 0142 | 9.0564 | \$ 538.96 | \$ 152.78 | \$ 107.79 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 44373 | Small bowel endoscopy | | T | 0142 | 9.0564 | \$ 538.96 | \$ 152.78 | \$ 107.79 |
| 44376 | Small bowel endoscopy | | T | 0142 | 9.0564 | \$ 538.96 | \$ 152.78 | \$ 107.79 |
| 44377 | Small bowel endoscopy/biopsy | | T | 0142 | 9.0564 | \$ 538.96 | \$ 152.78 | \$ 107.79 |
| 44378 | Small bowel endoscopy | | T | 0142 | 9.0564 | \$ 538.96 | \$ 152.78 | \$ 107.79 |
| 44379 | S bowel endoscope w/stent | | T | 0384 | 26.8955 | \$ 1,600.58 | \$ 335.19 | \$ 320.12 |
| 44380 | Small bowel endoscopy | | T | 0142 | 9.0564 | \$ 538.96 | \$ 152.78 | \$ 107.79 |
| 44382 | Small bowel endoscopy | | T | 0142 | 9.0564 | \$ 538.96 | \$ 152.78 | \$ 107.79 |
| 44383 | Ileoscopy w/stent | | T | 0384 | 26.8955 | \$ 1,600.58 | \$ 335.19 | \$ 320.12 |
| 44385 | Endoscopy of bowel pouch | | T | 0143 | 8.5588 | \$ 509.34 | \$ 186.06 | \$ 101.87 |
| 44386 | Endoscopy, bowel pouch/biop | | T | 0143 | 8.5588 | \$ 509.34 | \$ 186.06 | \$ 101.87 |
| 44388 | Colonoscopy | | T | 0143 | 8.5588 | \$ 509.34 | \$ 186.06 | \$ 101.87 |
| 44389 | Colonoscopy with biopsy | | T | 0143 | 8.5588 | \$ 509.34 | \$ 186.06 | \$ 101.87 |
| 44390 | Colonoscopy for foreign body | | T | 0143 | 8.5588 | \$ 509.34 | \$ 186.06 | \$ 101.87 |
| 44391 | Colonoscopy for bleeding | | T | 0143 | 8.5588 | \$ 509.34 | \$ 186.06 | \$ 101.87 |
| 44392 | Colonoscopy & polypectomy | | T | 0143 | 8.5588 | \$ 509.34 | \$ 186.06 | \$ 101.87 |
| 44393 | Colonoscopy, lesion removal | | T | 0143 | 8.5588 | \$ 509.34 | \$ 186.06 | \$ 101.87 |
| 44394 | Colonoscopy w/snare | | T | 0143 | 8.5588 | \$ 509.34 | \$ 186.06 | \$ 101.87 |
| 44397 | Colonoscopy w/stent | | T | 0384 | 26.8955 | \$ 1,600.58 | \$ 335.19 | \$ 320.12 |
| 44500 | Intro, gastrointestinal tube | | T | 0121 | 2.2374 | \$ 133.15 | \$ 43.80 | \$ 26.63 |
| 44701 | Intraop colon lavage add-on | | N | | | | | |
| 44799 | Unlisted procedure intestine | | T | 0142 | 9.0564 | \$ 538.96 | \$ 152.78 | \$ 107.79 |
| 44901 | Drain app abscess, percut | | T | 0037 | 9.6103 | \$ 571.92 | \$ 228.76 | \$ 114.38 |
| 44970 | Laparoscopy, appendectomy | | T | 0131 | 43.0498 | \$ 2,561.94 | \$ 1,001.89 | \$ 512.39 |
| 44979 | Laparoscope proc, app | | T | 0130 | 31.8753 | \$ 1,896.93 | \$ 659.53 | \$ 379.39 |
| 45000 | Drainage of pelvic abscess | | T | 0148 | 3.5047 | \$ 208.57 | \$ 53.79 | \$ 41.71 |
| 45005 | Drainage of rectal abscess | | T | 0155 | 15.9499 | \$ 949.19 | | \$ 189.84 |
| 45020 | Drainage of rectal abscess | | T | 0155 | 15.9499 | \$ 949.19 | | \$ 189.84 |
| 45100 | Biopsy of rectum | | T | 0149 | 18.0878 | \$ 1,076.42 | \$ 293.06 | \$ 215.28 |
| 45108 | Removal of anorectal lesion | | T | 0150 | 23.8736 | \$ 1,420.74 | \$ 437.12 | \$ 284.15 |
| 45150 | Excision of rectal stricture | | T | 0149 | 18.0878 | \$ 1,076.42 | \$ 293.06 | \$ 215.28 |
| 45160 | Excision of rectal lesion | | T | 0150 | 23.8736 | \$ 1,420.74 | \$ 437.12 | \$ 284.15 |
| 45170 | Excision of rectal lesion | | T | 0150 | 23.8736 | \$ 1,420.74 | \$ 437.12 | \$ 284.15 |
| 45190 | Destruction, rectal tumor | | T | 0150 | 23.8736 | \$ 1,420.74 | \$ 437.12 | \$ 284.15 |
| 45300 | Proctosigmoidoscopy dx | | T | 0146 | 4.7086 | \$ 280.21 | \$ 64.40 | \$ 56.04 |
| 45303 | Proctosigmoidoscopy dilate | CH | T | 0147 | 7.9652 | \$ 474.02 | | \$ 94.80 |
| 45305 | Proctosigmoidoscopy w/bx | CH | T | 0147 | 7.9652 | \$ 474.02 | | \$ 94.80 |
| 45307 | Proctosigmoidoscopy fb | CH | T | 0428 | 20.0871 | \$ 1,195.40 | | \$ 239.08 |
| 45308 | Proctosigmoidoscopy removal | | T | 0147 | 7.9652 | \$ 474.02 | | \$ 94.80 |
| 45309 | Proctosigmoidoscopy removal | | T | 0147 | 7.9652 | \$ 474.02 | | \$ 94.80 |
| 45315 | Proctosigmoidoscopy removal | | T | 0147 | 7.9652 | \$ 474.02 | | \$ 94.80 |
| 45317 | Proctosigmoidoscopy bleed | | T | 0147 | 7.9652 | \$ 474.02 | | \$ 94.80 |
| 45320 | Proctosigmoidoscopy ablate | CH | T | 0428 | 20.0871 | \$ 1,195.40 | | \$ 239.08 |
| 45321 | Proctosigmoidoscopy volvul | CH | T | 0428 | 20.0871 | \$ 1,195.40 | | \$ 239.08 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 45327 | Proctosigmoidoscopy w/stent | | T | 0384 | 26.8955 | \$ 1,600.58 | \$ 335.19 | \$ 320.12 |
| 45330 | Diagnostic sigmoidoscopy | | T | 0146 | 4.7086 | \$ 280.21 | \$ 64.40 | \$ 56.04 |
| 45331 | Sigmoidoscopy and biopsy | | T | 0146 | 4.7086 | \$ 280.21 | \$ 64.40 | \$ 56.04 |
| 45332 | Sigmoidoscopy w/fb removal | | T | 0146 | 4.7086 | \$ 280.21 | \$ 64.40 | \$ 56.04 |
| 45333 | Sigmoidoscopy & polypectomy | | T | 0147 | 7.9652 | \$ 474.02 | | \$ 94.80 |
| 45334 | Sigmoidoscopy for bleeding | | T | 0147 | 7.9652 | \$ 474.02 | | \$ 94.80 |
| 45335 | Sigmoidoscopy w/submuc inj | CH | T | 0146 | 4.7086 | \$ 280.21 | \$ 64.40 | \$ 56.04 |
| 45337 | Sigmoidoscopy & decompress | CH | T | 0146 | 4.7086 | \$ 280.21 | \$ 64.40 | \$ 56.04 |
| 45338 | Sigmoidoscopy w/tumr remove | | T | 0147 | 7.9652 | \$ 474.02 | | \$ 94.80 |
| 45339 | Sigmoidoscopy w/ablate tumr | | T | 0147 | 7.9652 | \$ 474.02 | | \$ 94.80 |
| 45340 | Sig w/balloon dilation | | T | 0147 | 7.9652 | \$ 474.02 | | \$ 94.80 |
| 45341 | Sigmoidoscopy w/ultrasound | | T | 0147 | 7.9652 | \$ 474.02 | | \$ 94.80 |
| 45342 | Sigmoidoscopy w/us guide bx | | T | 0147 | 7.9652 | \$ 474.02 | | \$ 94.80 |
| 45345 | Sigmoidoscopy w/stent | | T | 0384 | 26.8955 | \$ 1,600.58 | \$ 335.19 | \$ 320.12 |
| 45355 | Surgical colonoscopy | | T | 0143 | 8.5588 | \$ 509.34 | \$ 186.06 | \$ 101.87 |
| 45378 | Diagnostic colonoscopy | | T | 0143 | 8.5588 | \$ 509.34 | \$ 186.06 | \$ 101.87 |
| 45379 | Colonoscopy w/fb removal | | T | 0143 | 8.5588 | \$ 509.34 | \$ 186.06 | \$ 101.87 |
| 45380 | Colonoscopy and biopsy | | T | 0143 | 8.5588 | \$ 509.34 | \$ 186.06 | \$ 101.87 |
| 45381 | Colonoscopy, submucous inj | | T | 0143 | 8.5588 | \$ 509.34 | \$ 186.06 | \$ 101.87 |
| 45382 | Colonoscopy/control bleeding | | T | 0143 | 8.5588 | \$ 509.34 | \$ 186.06 | \$ 101.87 |
| 45383 | Lesion removal colonoscopy | | T | 0143 | 8.5588 | \$ 509.34 | \$ 186.06 | \$ 101.87 |
| 45384 | Lesion remove colonoscopy | | T | 0143 | 8.5588 | \$ 509.34 | \$ 186.06 | \$ 101.87 |
| 45385 | Lesion removal colonoscopy | | T | 0143 | 8.5588 | \$ 509.34 | \$ 186.06 | \$ 101.87 |
| 45386 | Colonoscopy dilate stricture | | T | 0143 | 8.5588 | \$ 509.34 | \$ 186.06 | \$ 101.87 |
| 45387 | Colonoscopy w/stent | | T | 0384 | 26.8955 | \$ 1,600.58 | \$ 335.19 | \$ 320.12 |
| 45391 | Colonoscopy w/endscope us | | T | 0143 | 8.5588 | \$ 509.34 | \$ 186.06 | \$ 101.87 |
| 45392 | Colonoscopy w/endoscopic fnb | | T | 0143 | 8.5588 | \$ 509.34 | \$ 186.06 | \$ 101.87 |
| 45499 | Laparoscope proc, rectum | NI | T | 0130 | 31.8753 | \$ 1,896.93 | \$ 659.53 | \$ 379.39 |
| 45500 | Repair of rectum | | T | 0149 | 18.0878 | \$ 1,076.42 | \$ 293.06 | \$ 215.28 |
| 45505 | Repair of rectum | | T | 0150 | 23.8736 | \$ 1,420.74 | \$ 437.12 | \$ 284.15 |
| 45520 | Treatment of rectal prolapse | | T | 0098 | 1.1444 | \$ 68.10 | | \$ 13.62 |
| 45541 | Correct rectal prolapse | | T | 0150 | 23.8736 | \$ 1,420.74 | \$ 437.12 | \$ 284.15 |
| 45560 | Repair of rectocele | | T | 0150 | 23.8736 | \$ 1,420.74 | \$ 437.12 | \$ 284.15 |
| 45900 | Reduction of rectal prolapse | | T | 0148 | 3.5047 | \$ 208.57 | \$ 53.79 | \$ 41.71 |
| 45905 | Dilation of anal sphincter | | T | 0149 | 18.0878 | \$ 1,076.42 | \$ 293.06 | \$ 215.28 |
| 45910 | Dilation of rectal narrowing | | T | 0149 | 18.0878 | \$ 1,076.42 | \$ 293.06 | \$ 215.28 |
| 45915 | Remove rectal obstruction | | T | 0148 | 3.5047 | \$ 208.57 | \$ 53.79 | \$ 41.71 |
| 45990 | Surg dx exam, anorectal | NI | T | 0148 | 3.5047 | \$ 208.57 | \$ 53.79 | \$ 41.71 |
| 45999 | Rectum surgery procedure | | T | 0148 | 3.5047 | \$ 208.57 | \$ 53.79 | \$ 41.71 |
| 46020 | Placement of seton | | T | 0150 | 23.8736 | \$ 1,420.74 | \$ 437.12 | \$ 284.15 |
| 46030 | Removal of rectal marker | | T | 0148 | 3.5047 | \$ 208.57 | \$ 53.79 | \$ 41.71 |
| 46040 | Incision of rectal abscess | | T | 0149 | 18.0878 | \$ 1,076.42 | \$ 293.06 | \$ 215.28 |
| 46045 | Incision of rectal abscess | | T | 0150 | 23.8736 | \$ 1,420.74 | \$ 437.12 | \$ 284.15 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 46050 | Incision of anal abscess | | T | 0148 | 3.5047 | \$ 208.57 | \$ 53.79 | \$ 41.71 |
| 46060 | Incision of rectal abscess | | T | 0150 | 23.8736 | \$ 1,420.74 | \$ 437.12 | \$ 284.15 |
| 46070 | Incision of anal septum | | T | 0155 | 15.9499 | \$ 949.19 | | \$ 189.84 |
| 46080 | Incision of anal sphincter | | T | 0149 | 18.0878 | \$ 1,076.42 | \$ 293.06 | \$ 215.28 |
| 46083 | Incise external hemorrhoid | | T | 0148 | 3.5047 | \$ 208.57 | \$ 53.79 | \$ 41.71 |
| 46200 | Removal of anal fissure | | T | 0150 | 23.8736 | \$ 1,420.74 | \$ 437.12 | \$ 284.15 |
| 46210 | Removal of anal crypt | | T | 0149 | 18.0878 | \$ 1,076.42 | \$ 293.06 | \$ 215.28 |
| 46211 | Removal of anal crypts | | T | 0150 | 23.8736 | \$ 1,420.74 | \$ 437.12 | \$ 284.15 |
| 46220 | Removal of anal tag | | T | 0149 | 18.0878 | \$ 1,076.42 | \$ 293.06 | \$ 215.28 |
| 46221 | Ligation of hemorrhoid(s) | | T | 0148 | 3.5047 | \$ 208.57 | \$ 53.79 | \$ 41.71 |
| 46230 | Removal of anal tags | | T | 0149 | 18.0878 | \$ 1,076.42 | \$ 293.06 | \$ 215.28 |
| 46250 | Hemorrhoidectomy | | T | 0150 | 23.8736 | \$ 1,420.74 | \$ 437.12 | \$ 284.15 |
| 46255 | Hemorrhoidectomy | | T | 0150 | 23.8736 | \$ 1,420.74 | \$ 437.12 | \$ 284.15 |
| 46257 | Remove hemorrhoids & fissure | | T | 0150 | 23.8736 | \$ 1,420.74 | \$ 437.12 | \$ 284.15 |
| 46258 | Remove hemorrhoids & fistula | | T | 0150 | 23.8736 | \$ 1,420.74 | \$ 437.12 | \$ 284.15 |
| 46260 | Hemorrhoidectomy | | T | 0150 | 23.8736 | \$ 1,420.74 | \$ 437.12 | \$ 284.15 |
| 46261 | Remove hemorrhoids & fissure | | T | 0150 | 23.8736 | \$ 1,420.74 | \$ 437.12 | \$ 284.15 |
| 46262 | Remove hemorrhoids & fistula | | T | 0150 | 23.8736 | \$ 1,420.74 | \$ 437.12 | \$ 284.15 |
| 46270 | Removal of anal fistula | | T | 0150 | 23.8736 | \$ 1,420.74 | \$ 437.12 | \$ 284.15 |
| 46275 | Removal of anal fistula | | T | 0150 | 23.8736 | \$ 1,420.74 | \$ 437.12 | \$ 284.15 |
| 46280 | Removal of anal fistula | | T | 0150 | 23.8736 | \$ 1,420.74 | \$ 437.12 | \$ 284.15 |
| 46285 | Removal of anal fistula | | T | 0150 | 23.8736 | \$ 1,420.74 | \$ 437.12 | \$ 284.15 |
| 46288 | Repair anal fistula | | T | 0150 | 23.8736 | \$ 1,420.74 | \$ 437.12 | \$ 284.15 |
| 46320 | Removal of hemorrhoid clot | | T | 0148 | 3.5047 | \$ 208.57 | \$ 53.79 | \$ 41.71 |
| 46500 | Injection into hemorrhoid(s) | | T | 0155 | 15.9499 | \$ 949.19 | | \$ 189.84 |
| 46505 | Chemodenervation anal musc | NI | T | 0148 | 3.5047 | \$ 208.57 | \$ 53.79 | \$ 41.71 |
| 46600 | Diagnostic anoscopy | | X | 0340 | 0.6137 | \$ 36.52 | | \$ 7.30 |
| 46604 | Anoscopy and dilation | | T | 0147 | 7.9652 | \$ 474.02 | | \$ 94.80 |
| 46606 | Anoscopy and biopsy | CH | T | 0146 | 4.7086 | \$ 280.21 | \$ 64.40 | \$ 56.04 |
| 46608 | Anoscopy, remove for body | | T | 0147 | 7.9652 | \$ 474.02 | | \$ 94.80 |
| 46610 | Anoscopy, remove lesion | CH | T | 0428 | 20.0871 | \$ 1,195.40 | | \$ 239.08 |
| 46611 | Anoscopy | | T | 0147 | 7.9652 | \$ 474.02 | | \$ 94.80 |
| 46612 | Anoscopy, remove lesions | CH | T | 0428 | 20.0871 | \$ 1,195.40 | | \$ 239.08 |
| 46614 | Anoscopy, control bleeding | CH | T | 0146 | 4.7086 | \$ 280.21 | \$ 64.40 | \$ 56.04 |
| 46615 | Anoscopy | CH | T | 0428 | 20.0871 | \$ 1,195.40 | | \$ 239.08 |
| 46700 | Repair of anal stricture | | T | 0150 | 23.8736 | \$ 1,420.74 | \$ 437.12 | \$ 284.15 |
| 46706 | Repr of anal fistula w/glue | | T | 0150 | 23.8736 | \$ 1,420.74 | \$ 437.12 | \$ 284.15 |
| 46750 | Repair of anal sphincter | | T | 0150 | 23.8736 | \$ 1,420.74 | \$ 437.12 | \$ 284.15 |
| 46753 | Reconstruction of anus | | T | 0150 | 23.8736 | \$ 1,420.74 | \$ 437.12 | \$ 284.15 |
| 46754 | Removal of suture from anus | | T | 0149 | 18.0878 | \$ 1,076.42 | \$ 293.06 | \$ 215.28 |
| 46760 | Repair of anal sphincter | | T | 0150 | 23.8736 | \$ 1,420.74 | \$ 437.12 | \$ 284.15 |
| 46761 | Repair of anal sphincter | | T | 0150 | 23.8736 | \$ 1,420.74 | \$ 437.12 | \$ 284.15 |
| 46762 | Implant artificial sphincter | | T | 0150 | 23.8736 | \$ 1,420.74 | \$ 437.12 | \$ 284.15 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 46900 | Destruction, anal lesion(s) | | T | 0016 | 2.5080 | \$ 149.25 | \$ 32.68 | \$ 29.85 |
| 46910 | Destruction, anal lesion(s) | | T | 0017 | 17.9937 | \$ 1,070.82 | \$ 227.84 | \$ 214.16 |
| 46916 | Cryosurgery, anal lesion(s) | | T | 0013 | 1.0603 | \$ 63.10 | \$ 13.07 | \$ 12.62 |
| 46917 | Laser surgery, anal lesions | | T | 0695 | 20.2372 | \$ 1,204.34 | \$ 266.59 | \$ 240.87 |
| 46922 | Excision of anal lesion(s) | | T | 0695 | 20.2372 | \$ 1,204.34 | \$ 266.59 | \$ 240.87 |
| 46924 | Destruction, anal lesion(s) | | T | 0695 | 20.2372 | \$ 1,204.34 | \$ 266.59 | \$ 240.87 |
| 46934 | Destruction of hemorrhoids | | T | 0155 | 15.9499 | \$ 949.19 | | \$ 189.84 |
| 46935 | Destruction of hemorrhoids | | T | 0155 | 15.9499 | \$ 949.19 | | \$ 189.84 |
| 46936 | Destruction of hemorrhoids | | T | 0149 | 18.0878 | \$ 1,076.42 | \$ 293.06 | \$ 215.28 |
| 46937 | Cryotherapy of rectal lesion | | T | 0149 | 18.0878 | \$ 1,076.42 | \$ 293.06 | \$ 215.28 |
| 46938 | Cryotherapy of rectal lesion | | T | 0150 | 23.8736 | \$ 1,420.74 | \$ 437.12 | \$ 284.15 |
| 46940 | Treatment of anal fissure | | T | 0149 | 18.0878 | \$ 1,076.42 | \$ 293.06 | \$ 215.28 |
| 46942 | Treatment of anal fissure | | T | 0148 | 3.5047 | \$ 208.57 | \$ 53.79 | \$ 41.71 |
| 46945 | Ligation of hemorrhoids | | T | 0155 | 15.9499 | \$ 949.19 | | \$ 189.84 |
| 46946 | Ligation of hemorrhoids | | T | 0155 | 15.9499 | \$ 949.19 | | \$ 189.84 |
| 46947 | Hemorrhoidopexy by stapling | | T | 0150 | 23.8736 | \$ 1,420.74 | \$ 437.12 | \$ 284.15 |
| 46999 | Anus surgery procedure | | T | 0148 | 3.5047 | \$ 208.57 | \$ 53.79 | \$ 41.71 |
| 47000 | Needle biopsy of liver | | T | 0685 | 6.0034 | \$ 357.27 | \$ 115.47 | \$ 71.45 |
| 47001 | Needle biopsy, liver add-on | | N | | | | | |
| 47011 | Percut drain, liver lesion | | T | 0037 | 9.6103 | \$ 571.92 | \$ 228.76 | \$ 114.38 |
| 47370 | Laparo ablate liver tumor rf | CH | T | 0132 | 63.6859 | \$ 3,790.01 | \$ 1,239.22 | \$ 758.00 |
| 47371 | Laparo ablate liver cryosurg | | T | 0131 | 43.0498 | \$ 2,561.94 | \$ 1,001.89 | \$ 512.39 |
| 47379 | Laparoscope procedure, liver | | T | 0130 | 31.8753 | \$ 1,896.93 | \$ 659.53 | \$ 379.39 |
| 47382 | Percut ablate liver rf | | T | 0423 | 39.5881 | \$ 2,355.93 | | \$ 471.19 |
| 47399 | Liver surgery procedure | | T | 0002 | 0.9357 | \$ 55.68 | | \$ 11.14 |
| 47490 | Incision of gallbladder | | T | 0152 | 18.2391 | \$ 1,085.43 | | \$ 217.09 |
| 47500 | Injection for liver x-rays | | N | | | | | |
| 47505 | Injection for liver x-rays | | N | | | | | |
| 47510 | Insert catheter, bile duct | | T | 0152 | 18.2391 | \$ 1,085.43 | | \$ 217.09 |
| 47511 | Insert bile duct drain | | T | 0152 | 18.2391 | \$ 1,085.43 | | \$ 217.09 |
| 47525 | Change bile duct catheter | CH | T | 0427 | 10.0109 | \$ 595.76 | | \$ 119.15 |
| 47530 | Revise/reinsert bile tube | CH | T | 0427 | 10.0109 | \$ 595.76 | | \$ 119.15 |
| 47552 | Biliary endoscopy thru skin | | T | 0152 | 18.2391 | \$ 1,085.43 | | \$ 217.09 |
| 47553 | Biliary endoscopy thru skin | | T | 0152 | 18.2391 | \$ 1,085.43 | | \$ 217.09 |
| 47554 | Biliary endoscopy thru skin | | T | 0152 | 18.2391 | \$ 1,085.43 | | \$ 217.09 |
| 47555 | Biliary endoscopy thru skin | | T | 0152 | 18.2391 | \$ 1,085.43 | | \$ 217.09 |
| 47556 | Biliary endoscopy thru skin | | T | 0152 | 18.2391 | \$ 1,085.43 | | \$ 217.09 |
| 47560 | Laparoscopy w/cholangio | | T | 0130 | 31.8753 | \$ 1,896.93 | \$ 659.53 | \$ 379.39 |
| 47561 | Laparo w/cholangio/biopsy | | T | 0130 | 31.8753 | \$ 1,896.93 | \$ 659.53 | \$ 379.39 |
| 47562 | Laparoscopic cholecystectomy | | T | 0131 | 43.0498 | \$ 2,561.94 | \$ 1,001.89 | \$ 512.39 |
| 47563 | Laparo cholecystectomy/graph | | T | 0131 | 43.0498 | \$ 2,561.94 | \$ 1,001.89 | \$ 512.39 |
| 47564 | Laparo cholecystectomy/explr | | T | 0131 | 43.0498 | \$ 2,561.94 | \$ 1,001.89 | \$ 512.39 |
| 47579 | Laparoscope proc, biliary | | T | 0130 | 31.8753 | \$ 1,896.93 | \$ 659.53 | \$ 379.39 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 47630 | Remove bile duct stone | | T | 0152 | 18.2391 | \$ 1,085.43 | | \$ 217.09 |
| 47999 | Bile tract surgery procedure | | T | 0152 | 18.2391 | \$ 1,085.43 | | \$ 217.09 |
| 48102 | Needle biopsy, pancreas | | T | 0685 | 6.0034 | \$ 357.27 | \$ 115.47 | \$ 71.45 |
| 48511 | Drain pancreatic pseudocyst | | T | 0037 | 9.6103 | \$ 571.92 | \$ 228.76 | \$ 114.38 |
| 48999 | Pancreas surgery procedure | | T | 0004 | 1.7771 | \$ 105.76 | \$ 22.36 | \$ 21.15 |
| 49021 | Drain abdominal abscess | | T | 0037 | 9.6103 | \$ 571.92 | \$ 228.76 | \$ 114.38 |
| 49041 | Drain, percut, abdom abscess | | T | 0037 | 9.6103 | \$ 571.92 | \$ 228.76 | \$ 114.38 |
| 49061 | Drain, percut, retroper absc | | T | 0037 | 9.6103 | \$ 571.92 | \$ 228.76 | \$ 114.38 |
| 49080 | Puncture, peritoneal cavity | | T | 0070 | 3.2141 | \$ 191.27 | | \$ 38.25 |
| 49081 | Removal of abdominal fluid | | T | 0070 | 3.2141 | \$ 191.27 | | \$ 38.25 |
| 49085 | Remove abdomen foreign body | | T | 0153 | 22.4936 | \$ 1,338.62 | \$ 397.95 | \$ 267.72 |
| 49180 | Biopsy, abdominal mass | | T | 0685 | 6.0034 | \$ 357.27 | \$ 115.47 | \$ 71.45 |
| 49200 | Removal of abdominal lesion | | T | 0130 | 31.8753 | \$ 1,896.93 | \$ 659.53 | \$ 379.39 |
| 49250 | Excision of umbilicus | | T | 0153 | 22.4936 | \$ 1,338.62 | \$ 397.95 | \$ 267.72 |
| 49320 | Diag laparo separate proc | | T | 0130 | 31.8753 | \$ 1,896.93 | \$ 659.53 | \$ 379.39 |
| 49321 | Laparoscopy, biopsy | | T | 0130 | 31.8753 | \$ 1,896.93 | \$ 659.53 | \$ 379.39 |
| 49322 | Laparoscopy, aspiration | | T | 0130 | 31.8753 | \$ 1,896.93 | \$ 659.53 | \$ 379.39 |
| 49323 | Laparo drain lymphocele | | T | 0130 | 31.8753 | \$ 1,896.93 | \$ 659.53 | \$ 379.39 |
| 49329 | Laparo proc, abdm/per/oment | | T | 0130 | 31.8753 | \$ 1,896.93 | \$ 659.53 | \$ 379.39 |
| 49400 | Air injection into abdomen | | N | | | | | |
| 49419 | Insrt abdom cath for chemotx | | T | 0115 | 36.9806 | \$ 2,200.75 | \$ 459.35 | \$ 440.15 |
| 49420 | Insert abdom drain, temp | | T | 0652 | 29.3648 | \$ 1,747.53 | | \$ 349.51 |
| 49421 | Insert abdom drain, perm | | T | 0652 | 29.3648 | \$ 1,747.53 | | \$ 349.51 |
| 49422 | Remove perm cannula/catheter | | T | 0105 | 21.9865 | \$ 1,308.44 | \$ 370.40 | \$ 261.69 |
| 49423 | Exchange drainage catheter | CH | T | 0427 | 10.0109 | \$ 595.76 | | \$ 119.15 |
| 49424 | Assess cyst, contrast inject | | N | | | | | |
| 49426 | Revise abdomen-venous shunt | | T | 0153 | 22.4936 | \$ 1,338.62 | \$ 397.95 | \$ 267.72 |
| 49427 | Injection, abdominal shunt | | N | | | | | |
| 49429 | Removal of shunt | | T | 0105 | 21.9865 | \$ 1,308.44 | \$ 370.40 | \$ 261.69 |
| 49491 | Rpr hern preemie reduc | | T | 0154 | 28.6432 | \$ 1,704.59 | \$ 464.85 | \$ 340.92 |
| 49492 | Rpr ing hern premie, blocked | | T | 0154 | 28.6432 | \$ 1,704.59 | \$ 464.85 | \$ 340.92 |
| 49495 | Rpr ing hernia baby, reduc | | T | 0154 | 28.6432 | \$ 1,704.59 | \$ 464.85 | \$ 340.92 |
| 49496 | Rpr ing hernia baby, blocked | | T | 0154 | 28.6432 | \$ 1,704.59 | \$ 464.85 | \$ 340.92 |
| 49500 | Rpr ing hernia, init, reduce | | T | 0154 | 28.6432 | \$ 1,704.59 | \$ 464.85 | \$ 340.92 |
| 49501 | Rpr ing hernia, init blocked | | T | 0154 | 28.6432 | \$ 1,704.59 | \$ 464.85 | \$ 340.92 |
| 49505 | Prp i/hern init reduc >5 yr | | T | 0154 | 28.6432 | \$ 1,704.59 | \$ 464.85 | \$ 340.92 |
| 49507 | Prp i/hern init block >5 yr | | T | 0154 | 28.6432 | \$ 1,704.59 | \$ 464.85 | \$ 340.92 |
| 49520 | Rerepair ing hernia, reduce | | T | 0154 | 28.6432 | \$ 1,704.59 | \$ 464.85 | \$ 340.92 |
| 49521 | Rerepair ing hernia, blocked | | T | 0154 | 28.6432 | \$ 1,704.59 | \$ 464.85 | \$ 340.92 |
| 49525 | Repair ing hernia, sliding | | T | 0154 | 28.6432 | \$ 1,704.59 | \$ 464.85 | \$ 340.92 |
| 49540 | Repair lumbar hernia | | T | 0154 | 28.6432 | \$ 1,704.59 | \$ 464.85 | \$ 340.92 |
| 49550 | Rpr rem hernia, init, reduce | | T | 0154 | 28.6432 | \$ 1,704.59 | \$ 464.85 | \$ 340.92 |
| 49553 | Rpr fem hernia, init blocked | | T | 0154 | 28.6432 | \$ 1,704.59 | \$ 464.85 | \$ 340.92 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|-------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 49555 | Rerepair fem hernia, reduce | | T | 0154 | 28.6432 | \$ 1,704.59 | \$ 464.85 | \$ 340.92 |
| 49557 | Rerepair fem hernia, blocked | | T | 0154 | 28.6432 | \$ 1,704.59 | \$ 464.85 | \$ 340.92 |
| 49560 | Rpr ventral hern init, reduc | | T | 0154 | 28.6432 | \$ 1,704.59 | \$ 464.85 | \$ 340.92 |
| 49561 | Rpr ventral hern init, block | | T | 0154 | 28.6432 | \$ 1,704.59 | \$ 464.85 | \$ 340.92 |
| 49565 | Rerepair ventrl hern, reduce | | T | 0154 | 28.6432 | \$ 1,704.59 | \$ 464.85 | \$ 340.92 |
| 49566 | Rerepair ventrl hern, block | | T | 0154 | 28.6432 | \$ 1,704.59 | \$ 464.85 | \$ 340.92 |
| 49568 | Hernia repair w/mesh | | T | 0154 | 28.6432 | \$ 1,704.59 | \$ 464.85 | \$ 340.92 |
| 49570 | Rpr epigastric hern, reduce | | T | 0154 | 28.6432 | \$ 1,704.59 | \$ 464.85 | \$ 340.92 |
| 49572 | Rpr epigastric hern, blocked | | T | 0154 | 28.6432 | \$ 1,704.59 | \$ 464.85 | \$ 340.92 |
| 49580 | Rpr umbil hern, reduc < 5 yr | | T | 0154 | 28.6432 | \$ 1,704.59 | \$ 464.85 | \$ 340.92 |
| 49582 | Rpr umbil hern, block < 5 yr | | T | 0154 | 28.6432 | \$ 1,704.59 | \$ 464.85 | \$ 340.92 |
| 49585 | Rpr umbil hern, reduc > 5 yr | | T | 0154 | 28.6432 | \$ 1,704.59 | \$ 464.85 | \$ 340.92 |
| 49587 | Rpr umbil hern, block > 5 yr | | T | 0154 | 28.6432 | \$ 1,704.59 | \$ 464.85 | \$ 340.92 |
| 49590 | Repair spigelian hernia | | T | 0154 | 28.6432 | \$ 1,704.59 | \$ 464.85 | \$ 340.92 |
| 49600 | Repair umbilical lesion | | T | 0154 | 28.6432 | \$ 1,704.59 | \$ 464.85 | \$ 340.92 |
| 49650 | Laparo hernia repair initial | | T | 0131 | 43.0498 | \$ 2,561.94 | \$ 1,001.89 | \$ 512.39 |
| 49651 | Laparo hernia repair recur | | T | 0131 | 43.0498 | \$ 2,561.94 | \$ 1,001.89 | \$ 512.39 |
| 49659 | Laparo proc, hernia repair | | T | 0130 | 31.8753 | \$ 1,896.93 | \$ 659.53 | \$ 379.39 |
| 49999 | Abdomen surgery procedure | | T | 0153 | 22.4936 | \$ 1,338.62 | \$ 397.95 | \$ 267.72 |
| 50020 | Renal abscess, open drain | | T | 0162 | 23.3383 | \$ 1,388.89 | | \$ 277.78 |
| 50021 | Renal abscess, percut drain | | T | 0037 | 9.6103 | \$ 571.92 | \$ 228.76 | \$ 114.38 |
| 50080 | Removal of kidney stone | CH | T | 0429 | 42.0802 | \$ 2,504.23 | | \$ 500.85 |
| 50081 | Removal of kidney stone | CH | T | 0429 | 42.0802 | \$ 2,504.23 | | \$ 500.85 |
| 50200 | Biopsy of kidney | | T | 0685 | 6.0034 | \$ 357.27 | \$ 115.47 | \$ 71.45 |
| 50382 | Change ureter stent, percut | NI | T | 0161 | 18.5804 | \$ 1,105.74 | \$ 249.36 | \$ 221.15 |
| 50384 | Remove ureter stent, percut | NI | T | 0161 | 18.5804 | \$ 1,105.74 | \$ 249.36 | \$ 221.15 |
| 50387 | Change ext/int ureter stent | NI | T | 0122 | 6.9179 | \$ 411.69 | \$ 84.43 | \$ 82.34 |
| 50389 | Remove renal tube w/fluoro | NI | T | 0156 | 2.6123 | \$ 155.46 | \$ 40.52 | \$ 31.09 |
| 50390 | Drainage of kidney lesion | | T | 0685 | 6.0034 | \$ 357.27 | \$ 115.47 | \$ 71.45 |
| 50391 | Instll rx agnt into renal tub | | T | 0156 | 2.6123 | \$ 155.46 | \$ 40.52 | \$ 31.09 |
| 50392 | Insert kidney drain | | T | 0161 | 18.5804 | \$ 1,105.74 | \$ 249.36 | \$ 221.15 |
| 50393 | Insert ureteral tube | | T | 0161 | 18.5804 | \$ 1,105.74 | \$ 249.36 | \$ 221.15 |
| 50394 | Injection for kidney x-ray | | N | | | | | |
| 50395 | Create passage to kidney | | T | 0161 | 18.5804 | \$ 1,105.74 | \$ 249.36 | \$ 221.15 |
| 50396 | Measure kidney pressure | | T | 0164 | 1.1600 | \$ 69.03 | \$ 16.96 | \$ 13.81 |
| 50398 | Change kidney tube | | T | 0122 | 6.9179 | \$ 411.69 | \$ 84.43 | \$ 82.34 |
| 50541 | Laparo ablate renal cyst | | T | 0130 | 31.8753 | \$ 1,896.93 | \$ 659.53 | \$ 379.39 |
| 50542 | Laparo ablate renal mass | CH | T | 0132 | 63.6859 | \$ 3,790.01 | \$ 1,239.22 | \$ 758.00 |
| 50543 | Laparo partial nephrectomy | | T | 0131 | 43.0498 | \$ 2,561.94 | \$ 1,001.89 | \$ 512.39 |
| 50544 | Laparoscopy, pyeloplasty | | T | 0130 | 31.8753 | \$ 1,896.93 | \$ 659.53 | \$ 379.39 |
| 50549 | Laparoscope proc, renal | | T | 0130 | 31.8753 | \$ 1,896.93 | \$ 659.53 | \$ 379.39 |
| 50551 | Kidney endoscopy | | T | 0160 | 6.9387 | \$ 412.93 | \$ 105.06 | \$ 82.59 |
| 50553 | Kidney endoscopy | | T | 0161 | 18.5804 | \$ 1,105.74 | \$ 249.36 | \$ 221.15 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 50555 | Kidney endoscopy & biopsy | | T | 0160 | 6.9387 | \$ 412.93 | \$ 105.06 | \$ 82.59 |
| 50557 | Kidney endoscopy & treatment | | T | 0162 | 23.3383 | \$ 1,388.89 | | \$ 277.78 |
| 50559 | Renal endoscopy/radiotracer | | D | | | | | |
| 50561 | Kidney endoscopy & treatment | | T | 0161 | 18.5804 | \$ 1,105.74 | \$ 249.36 | \$ 221.15 |
| 50562 | Renal scope w/tumor resect | | T | 0160 | 6.9387 | \$ 412.93 | \$ 105.06 | \$ 82.59 |
| 50570 | Kidney endoscopy | | T | 0160 | 6.9387 | \$ 412.93 | \$ 105.06 | \$ 82.59 |
| 50572 | Kidney endoscopy | | T | 0160 | 6.9387 | \$ 412.93 | \$ 105.06 | \$ 82.59 |
| 50574 | Kidney endoscopy & biopsy | | T | 0160 | 6.9387 | \$ 412.93 | \$ 105.06 | \$ 82.59 |
| 50575 | Kidney endoscopy | | T | 0163 | 33.5963 | \$ 1,999.35 | | \$ 399.87 |
| 50576 | Kidney endoscopy & treatment | | T | 0161 | 18.5804 | \$ 1,105.74 | \$ 249.36 | \$ 221.15 |
| 50578 | Renal endoscopy/radiotracer | | D | | | | | |
| 50590 | Fragmenting of kidney stone | | T | 0169 | 42.4073 | \$ 2,523.70 | \$ 1,009.47 | \$ 504.74 |
| 50592 | Perc rf ablate renal tumor | NI | T | 0423 | 39.5881 | \$ 2,355.93 | | \$ 471.19 |
| 50684 | Injection for ureter x-ray | | N | | | | | |
| 50686 | Measure ureter pressure | | T | 0164 | 1.1600 | \$ 69.03 | \$ 16.96 | \$ 13.81 |
| 50688 | Change of ureter tube/stent | | T | 0122 | 6.9179 | \$ 411.69 | \$ 84.43 | \$ 82.34 |
| 50690 | Injection for ureter x-ray | | N | | | | | |
| 50945 | Laparoscopy ureterolithotomy | | T | 0131 | 43.0498 | \$ 2,561.94 | \$ 1,001.89 | \$ 512.39 |
| 50947 | Laparo new ureter/bladder | | T | 0131 | 43.0498 | \$ 2,561.94 | \$ 1,001.89 | \$ 512.39 |
| 50948 | Laparo new ureter/bladder | | T | 0131 | 43.0498 | \$ 2,561.94 | \$ 1,001.89 | \$ 512.39 |
| 50949 | Laparoscope proc, ureter | | T | 0130 | 31.8753 | \$ 1,896.93 | \$ 659.53 | \$ 379.39 |
| 50951 | Endoscopy of ureter | | T | 0160 | 6.9387 | \$ 412.93 | \$ 105.06 | \$ 82.59 |
| 50953 | Endoscopy of ureter | | T | 0160 | 6.9387 | \$ 412.93 | \$ 105.06 | \$ 82.59 |
| 50955 | Ureter endoscopy & biopsy | | T | 0161 | 18.5804 | \$ 1,105.74 | \$ 249.36 | \$ 221.15 |
| 50957 | Ureter endoscopy & treatment | | T | 0161 | 18.5804 | \$ 1,105.74 | \$ 249.36 | \$ 221.15 |
| 50959 | Ureter endoscopy & tracer | | D | | | | | |
| 50961 | Ureter endoscopy & treatment | | T | 0161 | 18.5804 | \$ 1,105.74 | \$ 249.36 | \$ 221.15 |
| 50970 | Ureter endoscopy | | T | 0160 | 6.9387 | \$ 412.93 | \$ 105.06 | \$ 82.59 |
| 50972 | Ureter endoscopy & catheter | | T | 0160 | 6.9387 | \$ 412.93 | \$ 105.06 | \$ 82.59 |
| 50974 | Ureter endoscopy & biopsy | | T | 0161 | 18.5804 | \$ 1,105.74 | \$ 249.36 | \$ 221.15 |
| 50976 | Ureter endoscopy & treatment | | T | 0161 | 18.5804 | \$ 1,105.74 | \$ 249.36 | \$ 221.15 |
| 50978 | Ureter endoscopy & tracer | | D | | | | | |
| 50980 | Ureter endoscopy & treatment | | T | 0161 | 18.5804 | \$ 1,105.74 | \$ 249.36 | \$ 221.15 |
| 51000 | Drainage of bladder | | T | 0164 | 1.1600 | \$ 69.03 | \$ 16.96 | \$ 13.81 |
| 51005 | Drainage of bladder | | T | 0164 | 1.1600 | \$ 69.03 | \$ 16.96 | \$ 13.81 |
| 51010 | Drainage of bladder | | T | 0165 | 16.5343 | \$ 983.97 | | \$ 196.79 |
| 51020 | Incise & treat bladder | | T | 0162 | 23.3383 | \$ 1,388.89 | | \$ 277.78 |
| 51030 | Incise & treat bladder | | T | 0162 | 23.3383 | \$ 1,388.89 | | \$ 277.78 |
| 51040 | Incise & drain bladder | | T | 0162 | 23.3383 | \$ 1,388.89 | | \$ 277.78 |
| 51045 | Incise bladder/drain ureter | | T | 0160 | 6.9387 | \$ 412.93 | \$ 105.06 | \$ 82.59 |
| 51050 | Removal of bladder stone | | T | 0162 | 23.3383 | \$ 1,388.89 | | \$ 277.78 |
| 51065 | Remove ureter calculus | | T | 0162 | 23.3383 | \$ 1,388.89 | | \$ 277.78 |
| 51080 | Drainage of bladder abscess | CH | T | 0008 | 16.2953 | \$ 969.75 | | \$ 193.95 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 51500 | Removal of bladder cyst | | T | 0154 | 28.6432 | \$ 1,704.59 | \$ 464.85 | \$ 340.92 |
| 51520 | Removal of bladder lesion | | T | 0162 | 23.3383 | \$ 1,388.89 | | \$ 277.78 |
| 51600 | Injection for bladder x-ray | | N | | | | | |
| 51605 | Preparation for bladder xray | | N | | | | | |
| 51610 | Injection for bladder x-ray | | N | | | | | |
| 51700 | Irrigation of bladder | | T | 0164 | 1.1600 | \$ 69.03 | \$ 16.96 | \$ 13.81 |
| 51701 | Insert bladder catheter | CH | X | 0340 | 0.6137 | \$ 36.52 | | \$ 7.30 |
| 51702 | Insert temp bladder cath | CH | X | 0340 | 0.6137 | \$ 36.52 | | \$ 7.30 |
| 51703 | Insert bladder cath, complex | CH | T | 0164 | 1.1600 | \$ 69.03 | \$ 16.96 | \$ 13.81 |
| 51705 | Change of bladder tube | | T | 0121 | 2.2374 | \$ 133.15 | \$ 43.80 | \$ 26.63 |
| 51710 | Change of bladder tube | | T | 0122 | 6.9179 | \$ 411.69 | \$ 84.43 | \$ 82.34 |
| 51715 | Endoscopic injection/implant | CH | T | 0168 | 28.1985 | \$ 1,678.12 | \$ 388.16 | \$ 335.62 |
| 51720 | Treatment of bladder lesion | | T | 0156 | 2.6123 | \$ 155.46 | \$ 40.52 | \$ 31.09 |
| 51725 | Simple cystometrogram | | T | 0156 | 2.6123 | \$ 155.46 | \$ 40.52 | \$ 31.09 |
| 51726 | Complex cystometrogram | | T | 0156 | 2.6123 | \$ 155.46 | \$ 40.52 | \$ 31.09 |
| 51736 | Urine flow measurement | | T | 0164 | 1.1600 | \$ 69.03 | \$ 16.96 | \$ 13.81 |
| 51741 | Electro-uroflowmetry, first | | T | 0164 | 1.1600 | \$ 69.03 | \$ 16.96 | \$ 13.81 |
| 51772 | Urethra pressure profile | CH | T | 0156 | 2.6123 | \$ 155.46 | \$ 40.52 | \$ 31.09 |
| 51784 | Anal/urinary muscle study | | T | 0164 | 1.1600 | \$ 69.03 | \$ 16.96 | \$ 13.81 |
| 51785 | Anal/urinary muscle study | | T | 0164 | 1.1600 | \$ 69.03 | \$ 16.96 | \$ 13.81 |
| 51792 | Urinary reflex study | | T | 0164 | 1.1600 | \$ 69.03 | \$ 16.96 | \$ 13.81 |
| 51795 | Urine voiding pressure study | | T | 0164 | 1.1600 | \$ 69.03 | \$ 16.96 | \$ 13.81 |
| 51797 | Intraabdominal pressure test | | T | 0164 | 1.1600 | \$ 69.03 | \$ 16.96 | \$ 13.81 |
| 51798 | Us urine capacity measure | | X | 0340 | 0.6137 | \$ 36.52 | | \$ 7.30 |
| 51880 | Repair of bladder opening | | T | 0162 | 23.3383 | \$ 1,388.89 | | \$ 277.78 |
| 51990 | Laparo urethral suspension | | T | 0131 | 43.0498 | \$ 2,561.94 | \$ 1,001.89 | \$ 512.39 |
| 51992 | Laparo sling operation | | T | 0132 | 63.6859 | \$ 3,790.01 | \$ 1,239.22 | \$ 758.00 |
| 51999 | Laparoscope proc, bladder | NI | T | 0130 | 31.8753 | \$ 1,896.93 | \$ 659.53 | \$ 379.39 |
| 52000 | Cystoscopy | | T | 0160 | 6.9387 | \$ 412.93 | \$ 105.06 | \$ 82.59 |
| 52001 | Cystoscopy, removal of clots | | T | 0160 | 6.9387 | \$ 412.93 | \$ 105.06 | \$ 82.59 |
| 52005 | Cystoscopy & ureter catheter | | T | 0161 | 18.5804 | \$ 1,105.74 | \$ 249.36 | \$ 221.15 |
| 52007 | Cystoscopy and biopsy | | T | 0161 | 18.5804 | \$ 1,105.74 | \$ 249.36 | \$ 221.15 |
| 52010 | Cystoscopy & duct catheter | | T | 0160 | 6.9387 | \$ 412.93 | \$ 105.06 | \$ 82.59 |
| 52204 | Cystoscopy | | T | 0161 | 18.5804 | \$ 1,105.74 | \$ 249.36 | \$ 221.15 |
| 52214 | Cystoscopy and treatment | | T | 0162 | 23.3383 | \$ 1,388.89 | | \$ 277.78 |
| 52224 | Cystoscopy and treatment | | T | 0162 | 23.3383 | \$ 1,388.89 | | \$ 277.78 |
| 52234 | Cystoscopy and treatment | | T | 0162 | 23.3383 | \$ 1,388.89 | | \$ 277.78 |
| 52235 | Cystoscopy and treatment | | T | 0162 | 23.3383 | \$ 1,388.89 | | \$ 277.78 |
| 52240 | Cystoscopy and treatment | | T | 0162 | 23.3383 | \$ 1,388.89 | | \$ 277.78 |
| 52250 | Cystoscopy and radiotracer | | T | 0162 | 23.3383 | \$ 1,388.89 | | \$ 277.78 |
| 52260 | Cystoscopy and treatment | | T | 0161 | 18.5804 | \$ 1,105.74 | \$ 249.36 | \$ 221.15 |
| 52265 | Cystoscopy and treatment | | T | 0160 | 6.9387 | \$ 412.93 | \$ 105.06 | \$ 82.59 |
| 52270 | Cystoscopy & revise urethra | | T | 0161 | 18.5804 | \$ 1,105.74 | \$ 249.36 | \$ 221.15 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 52275 | Cystoscopy & revise urethra | | T | 0161 | 18.5804 | \$ 1,105.74 | \$ 249.36 | \$ 221.15 |
| 52276 | Cystoscopy and treatment | | T | 0161 | 18.5804 | \$ 1,105.74 | \$ 249.36 | \$ 221.15 |
| 52277 | Cystoscopy and treatment | | T | 0162 | 23.3383 | \$ 1,388.89 | | \$ 277.78 |
| 52281 | Cystoscopy and treatment | | T | 0161 | 18.5804 | \$ 1,105.74 | \$ 249.36 | \$ 221.15 |
| 52282 | Cystoscopy, implant stent | | T | 0163 | 33.5963 | \$ 1,999.35 | | \$ 399.87 |
| 52283 | Cystoscopy and treatment | | T | 0161 | 18.5804 | \$ 1,105.74 | \$ 249.36 | \$ 221.15 |
| 52285 | Cystoscopy and treatment | | T | 0161 | 18.5804 | \$ 1,105.74 | \$ 249.36 | \$ 221.15 |
| 52290 | Cystoscopy and treatment | | T | 0161 | 18.5804 | \$ 1,105.74 | \$ 249.36 | \$ 221.15 |
| 52300 | Cystoscopy and treatment | | T | 0161 | 18.5804 | \$ 1,105.74 | \$ 249.36 | \$ 221.15 |
| 52301 | Cystoscopy and treatment | | T | 0161 | 18.5804 | \$ 1,105.74 | \$ 249.36 | \$ 221.15 |
| 52305 | Cystoscopy and treatment | | T | 0161 | 18.5804 | \$ 1,105.74 | \$ 249.36 | \$ 221.15 |
| 52310 | Cystoscopy and treatment | | T | 0160 | 6.9387 | \$ 412.93 | \$ 105.06 | \$ 82.59 |
| 52315 | Cystoscopy and treatment | | T | 0161 | 18.5804 | \$ 1,105.74 | \$ 249.36 | \$ 221.15 |
| 52317 | Remove bladder stone | | T | 0162 | 23.3383 | \$ 1,388.89 | | \$ 277.78 |
| 52318 | Remove bladder stone | | T | 0162 | 23.3383 | \$ 1,388.89 | | \$ 277.78 |
| 52320 | Cystoscopy and treatment | | T | 0162 | 23.3383 | \$ 1,388.89 | | \$ 277.78 |
| 52325 | Cystoscopy, stone removal | | T | 0162 | 23.3383 | \$ 1,388.89 | | \$ 277.78 |
| 52327 | Cystoscopy, inject material | | T | 0162 | 23.3383 | \$ 1,388.89 | | \$ 277.78 |
| 52330 | Cystoscopy and treatment | | T | 0162 | 23.3383 | \$ 1,388.89 | | \$ 277.78 |
| 52332 | Cystoscopy and treatment | | T | 0162 | 23.3383 | \$ 1,388.89 | | \$ 277.78 |
| 52334 | Create passage to kidney | | T | 0162 | 23.3383 | \$ 1,388.89 | | \$ 277.78 |
| 52341 | Cysto w/ureter stricture tx | | T | 0162 | 23.3383 | \$ 1,388.89 | | \$ 277.78 |
| 52342 | Cysto w/up stricture tx | | T | 0162 | 23.3383 | \$ 1,388.89 | | \$ 277.78 |
| 52343 | Cysto w/renal stricture tx | | T | 0162 | 23.3383 | \$ 1,388.89 | | \$ 277.78 |
| 52344 | Cysto/uretero, stricture tx | | T | 0162 | 23.3383 | \$ 1,388.89 | | \$ 277.78 |
| 52345 | Cysto/uretero w/up stricture | | T | 0162 | 23.3383 | \$ 1,388.89 | | \$ 277.78 |
| 52346 | Cystouretero w/renal strict | | T | 0162 | 23.3383 | \$ 1,388.89 | | \$ 277.78 |
| 52347 | Cystoscopy, resect ducts | | D | | | | | |
| 52351 | Cystouretero & or pyeloscope | | T | 0161 | 18.5804 | \$ 1,105.74 | \$ 249.36 | \$ 221.15 |
| 52352 | Cystouretero w/stone remove | | T | 0162 | 23.3383 | \$ 1,388.89 | | \$ 277.78 |
| 52353 | Cystouretero w/lithotripsy | | T | 0163 | 33.5963 | \$ 1,999.35 | | \$ 399.87 |
| 52354 | Cystouretero w/biopsy | | T | 0162 | 23.3383 | \$ 1,388.89 | | \$ 277.78 |
| 52355 | Cystouretero w/excise tumor | | T | 0162 | 23.3383 | \$ 1,388.89 | | \$ 277.78 |
| 52400 | Cystouretero w/congen repr | | T | 0162 | 23.3383 | \$ 1,388.89 | | \$ 277.78 |
| 52402 | Cystourethro cut ejacul duct | | T | 0162 | 23.3383 | \$ 1,388.89 | | \$ 277.78 |
| 52450 | Incision of prostate | | T | 0162 | 23.3383 | \$ 1,388.89 | | \$ 277.78 |
| 52500 | Revision of bladder neck | | T | 0162 | 23.3383 | \$ 1,388.89 | | \$ 277.78 |
| 52510 | Dilation prostatic urethra | | T | 0161 | 18.5804 | \$ 1,105.74 | \$ 249.36 | \$ 221.15 |
| 52601 | Prostatectomy (TURP) | | T | 0163 | 33.5963 | \$ 1,999.35 | | \$ 399.87 |
| 52606 | Control postop bleeding | | T | 0162 | 23.3383 | \$ 1,388.89 | | \$ 277.78 |
| 52612 | Prostatectomy, first stage | | T | 0163 | 33.5963 | \$ 1,999.35 | | \$ 399.87 |
| 52614 | Prostatectomy, second stage | | T | 0163 | 33.5963 | \$ 1,999.35 | | \$ 399.87 |
| 52620 | Remove residual prostate | | T | 0163 | 33.5963 | \$ 1,999.35 | | \$ 399.87 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|-------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 52630 | Remove prostate regrowth | | T | 0163 | 33.5963 | \$ 1,999.35 | | \$ 399.87 |
| 52640 | Relieve bladder contracture | | T | 0162 | 23.3383 | \$ 1,388.89 | | \$ 277.78 |
| 52647 | Laser surgery of prostate | CH | T | 0429 | 42.0802 | \$ 2,504.23 | | \$ 500.85 |
| 52648 | Laser surgery of prostate | CH | T | 0429 | 42.0802 | \$ 2,504.23 | | \$ 500.85 |
| 52700 | Drainage of prostate abscess | | T | 0162 | 23.3383 | \$ 1,388.89 | | \$ 277.78 |
| 53000 | Incision of urethra | | T | 0166 | 17.7635 | \$ 1,057.12 | \$ 218.73 | \$ 211.42 |
| 53010 | Incision of urethra | | T | 0166 | 17.7635 | \$ 1,057.12 | \$ 218.73 | \$ 211.42 |
| 53020 | Incision of urethra | | T | 0166 | 17.7635 | \$ 1,057.12 | \$ 218.73 | \$ 211.42 |
| 53025 | Incision of urethra | | T | 0166 | 17.7635 | \$ 1,057.12 | \$ 218.73 | \$ 211.42 |
| 53040 | Drainage of urethra abscess | CH | T | 0166 | 17.7635 | \$ 1,057.12 | \$ 218.73 | \$ 211.42 |
| 53060 | Drainage of urethra abscess | | T | 0166 | 17.7635 | \$ 1,057.12 | \$ 218.73 | \$ 211.42 |
| 53080 | Drainage of urinary leakage | | T | 0166 | 17.7635 | \$ 1,057.12 | \$ 218.73 | \$ 211.42 |
| 53085 | Drainage of urinary leakage | | T | 0166 | 17.7635 | \$ 1,057.12 | \$ 218.73 | \$ 211.42 |
| 53200 | Biopsy of urethra | | T | 0166 | 17.7635 | \$ 1,057.12 | \$ 218.73 | \$ 211.42 |
| 53210 | Removal of urethra | | T | 0168 | 28.1985 | \$ 1,678.12 | \$ 388.16 | \$ 335.62 |
| 53215 | Removal of urethra | | T | 0166 | 17.7635 | \$ 1,057.12 | \$ 218.73 | \$ 211.42 |
| 53220 | Treatment of urethra lesion | | T | 0168 | 28.1985 | \$ 1,678.12 | \$ 388.16 | \$ 335.62 |
| 53230 | Removal of urethra lesion | | T | 0168 | 28.1985 | \$ 1,678.12 | \$ 388.16 | \$ 335.62 |
| 53235 | Removal of urethra lesion | | T | 0166 | 17.7635 | \$ 1,057.12 | \$ 218.73 | \$ 211.42 |
| 53240 | Surgery for urethra pouch | | T | 0168 | 28.1985 | \$ 1,678.12 | \$ 388.16 | \$ 335.62 |
| 53250 | Removal of urethra gland | | T | 0166 | 17.7635 | \$ 1,057.12 | \$ 218.73 | \$ 211.42 |
| 53260 | Treatment of urethra lesion | | T | 0166 | 17.7635 | \$ 1,057.12 | \$ 218.73 | \$ 211.42 |
| 53265 | Treatment of urethra lesion | | T | 0166 | 17.7635 | \$ 1,057.12 | \$ 218.73 | \$ 211.42 |
| 53270 | Removal of urethra gland | CH | T | 0166 | 17.7635 | \$ 1,057.12 | \$ 218.73 | \$ 211.42 |
| 53275 | Repair of urethra defect | | T | 0166 | 17.7635 | \$ 1,057.12 | \$ 218.73 | \$ 211.42 |
| 53400 | Revise urethra, stage 1 | | T | 0168 | 28.1985 | \$ 1,678.12 | \$ 388.16 | \$ 335.62 |
| 53405 | Revise urethra, stage 2 | | T | 0168 | 28.1985 | \$ 1,678.12 | \$ 388.16 | \$ 335.62 |
| 53410 | Reconstruction of urethra | | T | 0168 | 28.1985 | \$ 1,678.12 | \$ 388.16 | \$ 335.62 |
| 53420 | Reconstruct urethra, stage 1 | | T | 0168 | 28.1985 | \$ 1,678.12 | \$ 388.16 | \$ 335.62 |
| 53425 | Reconstruct urethra, stage 2 | | T | 0168 | 28.1985 | \$ 1,678.12 | \$ 388.16 | \$ 335.62 |
| 53430 | Reconstruction of urethra | | T | 0168 | 28.1985 | \$ 1,678.12 | \$ 388.16 | \$ 335.62 |
| 53431 | Reconstruct urethra/bladder | | T | 0168 | 28.1985 | \$ 1,678.12 | \$ 388.16 | \$ 335.62 |
| 53440 | Male sling procedure | | S | 0385 | 73.7498 | \$ 4,388.92 | | \$ 877.78 |
| 53442 | Remove/revise male sling | CH | T | 0168 | 28.1985 | \$ 1,678.12 | \$ 388.16 | \$ 335.62 |
| 53444 | Insert tandem cuff | | S | 0385 | 73.7498 | \$ 4,388.92 | | \$ 877.78 |
| 53445 | Insert uro/ves nck sphincter | | S | 0386 | 126.9292 | \$ 7,553.68 | | \$ 1,510.74 |
| 53446 | Remove uro sphincter | | T | 0168 | 28.1985 | \$ 1,678.12 | \$ 388.16 | \$ 335.62 |
| 53447 | Remove/replace ur sphincter | | S | 0386 | 126.9292 | \$ 7,553.68 | | \$ 1,510.74 |
| 53449 | Repair uro sphincter | | T | 0168 | 28.1985 | \$ 1,678.12 | \$ 388.16 | \$ 335.62 |
| 53450 | Revision of urethra | | T | 0168 | 28.1985 | \$ 1,678.12 | \$ 388.16 | \$ 335.62 |
| 53460 | Revision of urethra | | T | 0166 | 17.7635 | \$ 1,057.12 | \$ 218.73 | \$ 211.42 |
| 53500 | Urethrllys, transvag w/ scope | | T | 0168 | 28.1985 | \$ 1,678.12 | \$ 388.16 | \$ 335.62 |
| 53502 | Repair of urethra injury | | T | 0166 | 17.7635 | \$ 1,057.12 | \$ 218.73 | \$ 211.42 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 53505 | Repair of urethra injury | CH | T | 0168 | 28.1985 | \$ 1,678.12 | \$ 388.16 | \$ 335.62 |
| 53510 | Repair of urethra injury | | T | 0166 | 17.7635 | \$ 1,057.12 | \$ 218.73 | \$ 211.42 |
| 53515 | Repair of urethra injury | | T | 0168 | 28.1985 | \$ 1,678.12 | \$ 388.16 | \$ 335.62 |
| 53520 | Repair of urethra defect | | T | 0168 | 28.1985 | \$ 1,678.12 | \$ 388.16 | \$ 335.62 |
| 53600 | Dilate urethra stricture | | T | 0156 | 2.6123 | \$ 155.46 | \$ 40.52 | \$ 31.09 |
| 53601 | Dilate urethra stricture | | T | 0164 | 1.1600 | \$ 69.03 | \$ 16.96 | \$ 13.81 |
| 53605 | Dilate urethra stricture | | T | 0161 | 18.5804 | \$ 1,105.74 | \$ 249.36 | \$ 221.15 |
| 53620 | Dilate urethra stricture | | T | 0165 | 16.5343 | \$ 983.97 | | \$ 196.79 |
| 53621 | Dilate urethra stricture | | T | 0164 | 1.1600 | \$ 69.03 | \$ 16.96 | \$ 13.81 |
| 53660 | Dilation of urethra | | T | 0164 | 1.1600 | \$ 69.03 | \$ 16.96 | \$ 13.81 |
| 53661 | Dilation of urethra | | T | 0164 | 1.1600 | \$ 69.03 | \$ 16.96 | \$ 13.81 |
| 53665 | Dilation of urethra | | T | 0166 | 17.7635 | \$ 1,057.12 | \$ 218.73 | \$ 211.42 |
| 53850 | Prostatic microwave thermotx | | T | 0675 | 44.8197 | \$ 2,667.27 | | \$ 533.45 |
| 53852 | Prostatic rf thermotx | | T | 0675 | 44.8197 | \$ 2,667.27 | | \$ 533.45 |
| 53853 | Prostatic water thermother | | T | 0162 | 23.3383 | \$ 1,388.89 | | \$ 277.78 |
| 53899 | Urology surgery procedure | | T | 0164 | 1.1600 | \$ 69.03 | \$ 16.96 | \$ 13.81 |
| 54000 | Slitting of prepuce | | T | 0166 | 17.7635 | \$ 1,057.12 | \$ 218.73 | \$ 211.42 |
| 54001 | Slitting of prepuce | | T | 0166 | 17.7635 | \$ 1,057.12 | \$ 218.73 | \$ 211.42 |
| 54015 | Drain penis lesion | CH | T | 0008 | 16.2953 | \$ 969.75 | | \$ 193.95 |
| 54050 | Destruction, penis lesion(s) | | T | 0013 | 1.0603 | \$ 63.10 | \$ 13.07 | \$ 12.62 |
| 54055 | Destruction, penis lesion(s) | | T | 0017 | 17.9937 | \$ 1,070.82 | \$ 227.84 | \$ 214.16 |
| 54056 | Cryosurgery, penis lesion(s) | | T | 0012 | 0.8477 | \$ 50.45 | \$ 11.18 | \$ 10.09 |
| 54057 | Laser surg, penis lesion(s) | | T | 0017 | 17.9937 | \$ 1,070.82 | \$ 227.84 | \$ 214.16 |
| 54060 | Excision of penis lesion(s) | | T | 0017 | 17.9937 | \$ 1,070.82 | \$ 227.84 | \$ 214.16 |
| 54065 | Destruction, penis lesion(s) | | T | 0695 | 20.2372 | \$ 1,204.34 | \$ 266.59 | \$ 240.87 |
| 54100 | Biopsy of penis | | T | 0021 | 14.9984 | \$ 892.57 | \$ 219.48 | \$ 178.51 |
| 54105 | Biopsy of penis | | T | 0022 | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 54110 | Treatment of penis lesion | | T | 0181 | 30.9472 | \$ 1,841.70 | \$ 621.82 | \$ 368.34 |
| 54111 | Treat penis lesion, graft | | T | 0181 | 30.9472 | \$ 1,841.70 | \$ 621.82 | \$ 368.34 |
| 54112 | Treat penis lesion, graft | | T | 0181 | 30.9472 | \$ 1,841.70 | \$ 621.82 | \$ 368.34 |
| 54115 | Treatment of penis lesion | | T | 0008 | 16.2953 | \$ 969.75 | | \$ 193.95 |
| 54120 | Partial removal of penis | | T | 0181 | 30.9472 | \$ 1,841.70 | \$ 621.82 | \$ 368.34 |
| 54150 | Circumcision | | T | 0180 | 19.7721 | \$ 1,176.66 | \$ 304.87 | \$ 235.33 |
| 54152 | Circumcision | | T | 0180 | 19.7721 | \$ 1,176.66 | \$ 304.87 | \$ 235.33 |
| 54160 | Circumcision | | T | 0180 | 19.7721 | \$ 1,176.66 | \$ 304.87 | \$ 235.33 |
| 54161 | Circumcision | | T | 0180 | 19.7721 | \$ 1,176.66 | \$ 304.87 | \$ 235.33 |
| 54162 | Lysis penil circumic lesion | | T | 0180 | 19.7721 | \$ 1,176.66 | \$ 304.87 | \$ 235.33 |
| 54163 | Repair of circumcision | | T | 0180 | 19.7721 | \$ 1,176.66 | \$ 304.87 | \$ 235.33 |
| 54164 | Frenulotomy of penis | | T | 0180 | 19.7721 | \$ 1,176.66 | \$ 304.87 | \$ 235.33 |
| 54200 | Treatment of penis lesion | | T | 0156 | 2.6123 | \$ 155.46 | \$ 40.52 | \$ 31.09 |
| 54205 | Treatment of penis lesion | | T | 0181 | 30.9472 | \$ 1,841.70 | \$ 621.82 | \$ 368.34 |
| 54220 | Treatment of penis lesion | | T | 0156 | 2.6123 | \$ 155.46 | \$ 40.52 | \$ 31.09 |
| 54230 | Prepare penis study | | N | | | | | |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 54231 | Dynamic cavernosometry | | T | 0165 | 16.5343 | \$ 983.97 | | \$ 196.79 |
| 54235 | Penile injection | | T | 0164 | 1.1600 | \$ 69.03 | \$ 16.96 | \$ 13.81 |
| 54240 | Penis study | | T | 0164 | 1.1600 | \$ 69.03 | \$ 16.96 | \$ 13.81 |
| 54250 | Penis study | | T | 0164 | 1.1600 | \$ 69.03 | \$ 16.96 | \$ 13.81 |
| 54300 | Revision of penis | | T | 0181 | 30.9472 | \$ 1,841.70 | \$ 621.82 | \$ 368.34 |
| 54304 | Revision of penis | | T | 0181 | 30.9472 | \$ 1,841.70 | \$ 621.82 | \$ 368.34 |
| 54308 | Reconstruction of urethra | | T | 0181 | 30.9472 | \$ 1,841.70 | \$ 621.82 | \$ 368.34 |
| 54312 | Reconstruction of urethra | | T | 0181 | 30.9472 | \$ 1,841.70 | \$ 621.82 | \$ 368.34 |
| 54316 | Reconstruction of urethra | | T | 0181 | 30.9472 | \$ 1,841.70 | \$ 621.82 | \$ 368.34 |
| 54318 | Reconstruction of urethra | | T | 0181 | 30.9472 | \$ 1,841.70 | \$ 621.82 | \$ 368.34 |
| 54322 | Reconstruction of urethra | | T | 0181 | 30.9472 | \$ 1,841.70 | \$ 621.82 | \$ 368.34 |
| 54324 | Reconstruction of urethra | | T | 0181 | 30.9472 | \$ 1,841.70 | \$ 621.82 | \$ 368.34 |
| 54326 | Reconstruction of urethra | | T | 0181 | 30.9472 | \$ 1,841.70 | \$ 621.82 | \$ 368.34 |
| 54328 | Revise penis/urethra | | T | 0181 | 30.9472 | \$ 1,841.70 | \$ 621.82 | \$ 368.34 |
| 54340 | Secondary urethral surgery | | T | 0181 | 30.9472 | \$ 1,841.70 | \$ 621.82 | \$ 368.34 |
| 54344 | Secondary urethral surgery | | T | 0181 | 30.9472 | \$ 1,841.70 | \$ 621.82 | \$ 368.34 |
| 54348 | Secondary urethral surgery | | T | 0181 | 30.9472 | \$ 1,841.70 | \$ 621.82 | \$ 368.34 |
| 54352 | Reconstruct urethra/penis | | T | 0181 | 30.9472 | \$ 1,841.70 | \$ 621.82 | \$ 368.34 |
| 54360 | Penis plastic surgery | | T | 0181 | 30.9472 | \$ 1,841.70 | \$ 621.82 | \$ 368.34 |
| 54380 | Repair penis | | T | 0181 | 30.9472 | \$ 1,841.70 | \$ 621.82 | \$ 368.34 |
| 54385 | Repair penis | | T | 0181 | 30.9472 | \$ 1,841.70 | \$ 621.82 | \$ 368.34 |
| 54400 | Insert semi-rigid prosthesis | | S | 0385 | 73.7498 | \$ 4,388.92 | | \$ 877.78 |
| 54401 | Insert self-contd prosthesis | | S | 0386 | 126.9292 | \$ 7,553.68 | | \$ 1,510.74 |
| 54405 | Insert multi-comp penis pros | | S | 0386 | 126.9292 | \$ 7,553.68 | | \$ 1,510.74 |
| 54406 | Remove multi-comp penis pros | | T | 0181 | 30.9472 | \$ 1,841.70 | \$ 621.82 | \$ 368.34 |
| 54408 | Repair multi-comp penis pros | | T | 0181 | 30.9472 | \$ 1,841.70 | \$ 621.82 | \$ 368.34 |
| 54410 | Remove/replace penis prosth | | S | 0386 | 126.9292 | \$ 7,553.68 | | \$ 1,510.74 |
| 54415 | Remove self-contd penis pros | | T | 0181 | 30.9472 | \$ 1,841.70 | \$ 621.82 | \$ 368.34 |
| 54416 | Remv/repl penis contain pros | | S | 0386 | 126.9292 | \$ 7,553.68 | | \$ 1,510.74 |
| 54420 | Revision of penis | | T | 0181 | 30.9472 | \$ 1,841.70 | \$ 621.82 | \$ 368.34 |
| 54435 | Revision of penis | | T | 0181 | 30.9472 | \$ 1,841.70 | \$ 621.82 | \$ 368.34 |
| 54440 | Repair of penis | | T | 0181 | 30.9472 | \$ 1,841.70 | \$ 621.82 | \$ 368.34 |
| 54450 | Preputial stretching | | T | 0156 | 2.6123 | \$ 155.46 | \$ 40.52 | \$ 31.09 |
| 54500 | Biopsy of testis | | T | 0037 | 9.6103 | \$ 571.92 | \$ 228.76 | \$ 114.38 |
| 54505 | Biopsy of testis | | T | 0183 | 23.3500 | \$ 1,389.58 | | \$ 277.92 |
| 54512 | Excise lesion testis | | T | 0183 | 23.3500 | \$ 1,389.58 | | \$ 277.92 |
| 54520 | Removal of testis | | T | 0183 | 23.3500 | \$ 1,389.58 | | \$ 277.92 |
| 54522 | Orchiectomy, partial | | T | 0183 | 23.3500 | \$ 1,389.58 | | \$ 277.92 |
| 54530 | Removal of testis | | T | 0154 | 28.6432 | \$ 1,704.59 | \$ 464.85 | \$ 340.92 |
| 54550 | Exploration for testis | | T | 0154 | 28.6432 | \$ 1,704.59 | \$ 464.85 | \$ 340.92 |
| 54560 | Exploration for testis | CH | T | 0183 | 23.3500 | \$ 1,389.58 | | \$ 277.92 |
| 54600 | Reduce testis torsion | | T | 0183 | 23.3500 | \$ 1,389.58 | | \$ 277.92 |
| 54620 | Suspension of testis | | T | 0183 | 23.3500 | \$ 1,389.58 | | \$ 277.92 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 54640 | Suspension of testis | | T | 0154 | 28.6432 | \$ 1,704.59 | \$ 464.85 | \$ 340.92 |
| 54660 | Revision of testis | | T | 0183 | 23.3500 | \$ 1,389.58 | | \$ 277.92 |
| 54670 | Repair testis injury | | T | 0183 | 23.3500 | \$ 1,389.58 | | \$ 277.92 |
| 54680 | Relocation of testis(es) | | T | 0183 | 23.3500 | \$ 1,389.58 | | \$ 277.92 |
| 54690 | Laparoscopy, orchiectomy | | T | 0131 | 43.0498 | \$ 2,561.94 | \$ 1,001.89 | \$ 512.39 |
| 54692 | Laparoscopy, orchiopexy | | T | 0132 | 63.6859 | \$ 3,790.01 | \$ 1,239.22 | \$ 758.00 |
| 54699 | Laparoscope proc, testis | | T | 0130 | 31.8753 | \$ 1,896.93 | \$ 659.53 | \$ 379.39 |
| 54700 | Drainage of scrotum | | T | 0183 | 23.3500 | \$ 1,389.58 | | \$ 277.92 |
| 54800 | Biopsy of epididymis | | T | 0004 | 1.7771 | \$ 105.76 | \$ 22.36 | \$ 21.15 |
| 54820 | Exploration of epididymis | | T | 0183 | 23.3500 | \$ 1,389.58 | | \$ 277.92 |
| 54830 | Remove epididymis lesion | | T | 0183 | 23.3500 | \$ 1,389.58 | | \$ 277.92 |
| 54840 | Remove epididymis lesion | | T | 0183 | 23.3500 | \$ 1,389.58 | | \$ 277.92 |
| 54860 | Removal of epididymis | | T | 0183 | 23.3500 | \$ 1,389.58 | | \$ 277.92 |
| 54861 | Removal of epididymis | | T | 0183 | 23.3500 | \$ 1,389.58 | | \$ 277.92 |
| 54900 | Fusion of spermatic ducts | | T | 0183 | 23.3500 | \$ 1,389.58 | | \$ 277.92 |
| 54901 | Fusion of spermatic ducts | | T | 0183 | 23.3500 | \$ 1,389.58 | | \$ 277.92 |
| 55000 | Drainage of hydrocele | | T | 0004 | 1.7771 | \$ 105.76 | \$ 22.36 | \$ 21.15 |
| 55040 | Removal of hydrocele | | T | 0154 | 28.6432 | \$ 1,704.59 | \$ 464.85 | \$ 340.92 |
| 55041 | Removal of hydroceles | | T | 0154 | 28.6432 | \$ 1,704.59 | \$ 464.85 | \$ 340.92 |
| 55060 | Repair of hydrocele | | T | 0183 | 23.3500 | \$ 1,389.58 | | \$ 277.92 |
| 55100 | Drainage of scrotum abscess | CH | T | 0008 | 16.2953 | \$ 969.75 | | \$ 193.95 |
| 55110 | Explore scrotum | | T | 0183 | 23.3500 | \$ 1,389.58 | | \$ 277.92 |
| 55120 | Removal of scrotum lesion | | T | 0183 | 23.3500 | \$ 1,389.58 | | \$ 277.92 |
| 55150 | Removal of scrotum | | T | 0183 | 23.3500 | \$ 1,389.58 | | \$ 277.92 |
| 55175 | Revision of scrotum | | T | 0183 | 23.3500 | \$ 1,389.58 | | \$ 277.92 |
| 55180 | Revision of scrotum | | T | 0183 | 23.3500 | \$ 1,389.58 | | \$ 277.92 |
| 55200 | Incision of sperm duct | | T | 0183 | 23.3500 | \$ 1,389.58 | | \$ 277.92 |
| 55250 | Removal of sperm duct(s) | | T | 0183 | 23.3500 | \$ 1,389.58 | | \$ 277.92 |
| 55300 | Prepare, sperm duct x-ray | | N | | | | | |
| 55400 | Repair of sperm duct | | T | 0183 | 23.3500 | \$ 1,389.58 | | \$ 277.92 |
| 55450 | Ligation of sperm duct | | T | 0183 | 23.3500 | \$ 1,389.58 | | \$ 277.92 |
| 55500 | Removal of hydrocele | | T | 0183 | 23.3500 | \$ 1,389.58 | | \$ 277.92 |
| 55520 | Removal of sperm cord lesion | | T | 0183 | 23.3500 | \$ 1,389.58 | | \$ 277.92 |
| 55530 | Revise spermatic cord veins | | T | 0183 | 23.3500 | \$ 1,389.58 | | \$ 277.92 |
| 55535 | Revise spermatic cord veins | | T | 0154 | 28.6432 | \$ 1,704.59 | \$ 464.85 | \$ 340.92 |
| 55540 | Revise hernia & sperm veins | | T | 0154 | 28.6432 | \$ 1,704.59 | \$ 464.85 | \$ 340.92 |
| 55550 | Laparo ligate spermatic vein | | T | 0131 | 43.0498 | \$ 2,561.94 | \$ 1,001.89 | \$ 512.39 |
| 55559 | Laparo proc, spermatic cord | | T | 0130 | 31.8753 | \$ 1,896.93 | \$ 659.53 | \$ 379.39 |
| 55600 | Incise sperm duct pouch | CH | T | 0183 | 23.3500 | \$ 1,389.58 | | \$ 277.92 |
| 55680 | Remove sperm pouch lesion | | T | 0183 | 23.3500 | \$ 1,389.58 | | \$ 277.92 |
| 55700 | Biopsy of prostate | | T | 0184 | 4.4432 | \$ 264.42 | \$ 96.27 | \$ 52.88 |
| 55705 | Biopsy of prostate | | T | 0184 | 4.4432 | \$ 264.42 | \$ 96.27 | \$ 52.88 |
| 55720 | Drainage of prostate abscess | | T | 0162 | 23.3383 | \$ 1,388.89 | | \$ 277.78 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 55725 | Drainage of prostate abscess | | T | 0162 | 23.3383 | \$ 1,388.89 | | \$ 277.78 |
| 55859 | Percut/needle insert, pros | | T | 0163 | 33.5963 | \$ 1,999.35 | | \$ 399.87 |
| 55860 | Surgical exposure, prostate | | T | 0165 | 16.5343 | \$ 983.97 | | \$ 196.79 |
| 55870 | Electroejaculation | | T | 0197 | 3.0721 | \$ 182.82 | | \$ 36.56 |
| 55873 | Cryoablate prostate | | T | 0674 | 111.3747 | \$ 6,628.02 | | \$ 1,325.60 |
| 55899 | Genital surgery procedure | | T | 0164 | 1.1600 | \$ 69.03 | \$ 16.96 | \$ 13.81 |
| 56405 | I & D of vulva/perineum | CH | T | 0189 | 2.3805 | \$ 141.67 | | \$ 28.33 |
| 56420 | Drainage of gland abscess | | T | 0189 | 2.3805 | \$ 141.67 | | \$ 28.33 |
| 56440 | Surgery for vulva lesion | | T | 0194 | 20.6573 | \$ 1,229.34 | \$ 397.84 | \$ 245.87 |
| 56441 | Lysis of labial lesion(s) | | T | 0193 | 14.6385 | \$ 871.15 | | \$ 174.23 |
| 56501 | Destroy, vulva lesions, sim | | T | 0017 | 17.9937 | \$ 1,070.82 | \$ 227.84 | \$ 214.16 |
| 56515 | Destroy vulva lesion/s compl | | T | 0695 | 20.2372 | \$ 1,204.34 | \$ 266.59 | \$ 240.87 |
| 56605 | Biopsy of vulva/perineum | | T | 0019 | 4.1481 | \$ 246.86 | \$ 71.87 | \$ 49.37 |
| 56606 | Biopsy of vulva/perineum | | T | 0019 | 4.1481 | \$ 246.86 | \$ 71.87 | \$ 49.37 |
| 56620 | Partial removal of vulva | | T | 0195 | 26.7972 | \$ 1,594.73 | \$ 483.80 | \$ 318.95 |
| 56625 | Complete removal of vulva | | T | 0195 | 26.7972 | \$ 1,594.73 | \$ 483.80 | \$ 318.95 |
| 56700 | Partial removal of hymen | | T | 0194 | 20.6573 | \$ 1,229.34 | \$ 397.84 | \$ 245.87 |
| 56720 | Incision of hymen | | T | 0193 | 14.6385 | \$ 871.15 | | \$ 174.23 |
| 56740 | Remove vagina gland lesion | | T | 0194 | 20.6573 | \$ 1,229.34 | \$ 397.84 | \$ 245.87 |
| 56800 | Repair of vagina | | T | 0194 | 20.6573 | \$ 1,229.34 | \$ 397.84 | \$ 245.87 |
| 56805 | Repair clitoris | CH | T | 0193 | 14.6385 | \$ 871.15 | | \$ 174.23 |
| 56810 | Repair of perineum | | T | 0194 | 20.6573 | \$ 1,229.34 | \$ 397.84 | \$ 245.87 |
| 56820 | Exam of vulva w/scope | | T | 0188 | 1.2615 | \$ 75.07 | | \$ 15.01 |
| 56821 | Exam/biopsy of vulva w/scope | | T | 0189 | 2.3805 | \$ 141.67 | | \$ 28.33 |
| 57000 | Exploration of vagina | CH | T | 0193 | 14.6385 | \$ 871.15 | | \$ 174.23 |
| 57010 | Drainage of pelvic abscess | CH | T | 0193 | 14.6385 | \$ 871.15 | | \$ 174.23 |
| 57020 | Drainage of pelvic fluid | | T | 0192 | 4.1597 | \$ 247.55 | | \$ 49.51 |
| 57022 | I & d vaginal hematoma, pp | | T | 0007 | 11.6717 | \$ 694.59 | | \$ 138.92 |
| 57023 | I & d vag hematoma, non-ob | CH | T | 0008 | 16.2953 | \$ 969.75 | | \$ 193.95 |
| 57061 | Destroy vag lesions, simple | | T | 0194 | 20.6573 | \$ 1,229.34 | \$ 397.84 | \$ 245.87 |
| 57065 | Destroy vag lesions, complex | | T | 0194 | 20.6573 | \$ 1,229.34 | \$ 397.84 | \$ 245.87 |
| 57100 | Biopsy of vagina | | T | 0192 | 4.1597 | \$ 247.55 | | \$ 49.51 |
| 57105 | Biopsy of vagina | | T | 0194 | 20.6573 | \$ 1,229.34 | \$ 397.84 | \$ 245.87 |
| 57106 | Remove vagina wall, partial | | T | 0194 | 20.6573 | \$ 1,229.34 | \$ 397.84 | \$ 245.87 |
| 57107 | Remove vagina tissue, part | | T | 0195 | 26.7972 | \$ 1,594.73 | \$ 483.80 | \$ 318.95 |
| 57109 | Vaginectomy partial w/nodes | | T | 0195 | 26.7972 | \$ 1,594.73 | \$ 483.80 | \$ 318.95 |
| 57120 | Closure of vagina | | T | 0195 | 26.7972 | \$ 1,594.73 | \$ 483.80 | \$ 318.95 |
| 57130 | Remove vagina lesion | | T | 0194 | 20.6573 | \$ 1,229.34 | \$ 397.84 | \$ 245.87 |
| 57135 | Remove vagina lesion | | T | 0194 | 20.6573 | \$ 1,229.34 | \$ 397.84 | \$ 245.87 |
| 57150 | Treat vagina infection | | T | 0191 | 0.1702 | \$ 10.13 | \$ 2.85 | \$ 2.03 |
| 57155 | Insert uteri tandems/ovoids | CH | T | 0192 | 4.1597 | \$ 247.55 | | \$ 49.51 |
| 57160 | Insert pessary/other device | | T | 0188 | 1.2615 | \$ 75.07 | | \$ 15.01 |
| 57170 | Fitting of diaphragm/cap | | T | 0191 | 0.1702 | \$ 10.13 | \$ 2.85 | \$ 2.03 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 57180 | Treat vaginal bleeding | | T | 0189 | 2.3805 | \$ 141.67 | | \$ 28.33 |
| 57200 | Repair of vagina | | T | 0194 | 20.6573 | \$ 1,229.34 | \$ 397.84 | \$ 245.87 |
| 57210 | Repair vagina/perineum | | T | 0194 | 20.6573 | \$ 1,229.34 | \$ 397.84 | \$ 245.87 |
| 57220 | Revision of urethra | | T | 0202 | 41.2319 | \$ 2,453.75 | \$ 981.50 | \$ 490.75 |
| 57230 | Repair of urethral lesion | | T | 0195 | 26.7972 | \$ 1,594.73 | \$ 483.80 | \$ 318.95 |
| 57240 | Repair bladder & vagina | | T | 0195 | 26.7972 | \$ 1,594.73 | \$ 483.80 | \$ 318.95 |
| 57250 | Repair rectum & vagina | | T | 0195 | 26.7972 | \$ 1,594.73 | \$ 483.80 | \$ 318.95 |
| 57260 | Repair of vagina | | T | 0195 | 26.7972 | \$ 1,594.73 | \$ 483.80 | \$ 318.95 |
| 57265 | Extensive repair of vagina | | T | 0202 | 41.2319 | \$ 2,453.75 | \$ 981.50 | \$ 490.75 |
| 57267 | Insert mesh/pelvic flr addon | | T | 0154 | 28.6432 | \$ 1,704.59 | \$ 464.85 | \$ 340.92 |
| 57268 | Repair of bowel bulge | | T | 0195 | 26.7972 | \$ 1,594.73 | \$ 483.80 | \$ 318.95 |
| 57284 | Repair paravaginal defect | | T | 0202 | 41.2319 | \$ 2,453.75 | \$ 981.50 | \$ 490.75 |
| 57287 | Revise/remove sling repair | | T | 0202 | 41.2319 | \$ 2,453.75 | \$ 981.50 | \$ 490.75 |
| 57288 | Repair bladder defect | | T | 0202 | 41.2319 | \$ 2,453.75 | \$ 981.50 | \$ 490.75 |
| 57289 | Repair bladder & vagina | | T | 0195 | 26.7972 | \$ 1,594.73 | \$ 483.80 | \$ 318.95 |
| 57291 | Construction of vagina | | T | 0195 | 26.7972 | \$ 1,594.73 | \$ 483.80 | \$ 318.95 |
| 57295 | Change vaginal graft | NI | T | 0194 | 20.6573 | \$ 1,229.34 | \$ 397.84 | \$ 245.87 |
| 57300 | Repair rectum-vagina fistula | | T | 0195 | 26.7972 | \$ 1,594.73 | \$ 483.80 | \$ 318.95 |
| 57310 | Repair urethrovaginal lesion | | T | 0202 | 41.2319 | \$ 2,453.75 | \$ 981.50 | \$ 490.75 |
| 57320 | Repair bladder-vagina lesion | | T | 0195 | 26.7972 | \$ 1,594.73 | \$ 483.80 | \$ 318.95 |
| 57330 | Repair bladder-vagina lesion | | T | 0195 | 26.7972 | \$ 1,594.73 | \$ 483.80 | \$ 318.95 |
| 57400 | Dilation of vagina | | T | 0194 | 20.6573 | \$ 1,229.34 | \$ 397.84 | \$ 245.87 |
| 57410 | Pelvic examination | CH | T | 0193 | 14.6385 | \$ 871.15 | | \$ 174.23 |
| 57415 | Remove vaginal foreign body | | T | 0194 | 20.6573 | \$ 1,229.34 | \$ 397.84 | \$ 245.87 |
| 57420 | Exam of vagina w/scope | | T | 0189 | 2.3805 | \$ 141.67 | | \$ 28.33 |
| 57421 | Exam/biopsy of vag w/scope | | T | 0189 | 2.3805 | \$ 141.67 | | \$ 28.33 |
| 57425 | Laparoscopy, surg, colpopexy | | T | 0130 | 31.8753 | \$ 1,896.93 | \$ 659.53 | \$ 379.39 |
| 57452 | Exam of cervix w/scope | | T | 0189 | 2.3805 | \$ 141.67 | | \$ 28.33 |
| 57454 | Bx/curett of cervix w/scope | | T | 0189 | 2.3805 | \$ 141.67 | | \$ 28.33 |
| 57455 | Biopsy of cervix w/scope | | T | 0189 | 2.3805 | \$ 141.67 | | \$ 28.33 |
| 57456 | Endocerv curettage w/scope | | T | 0189 | 2.3805 | \$ 141.67 | | \$ 28.33 |
| 57460 | Bx of cervix w/scope, leep | | T | 0193 | 14.6385 | \$ 871.15 | | \$ 174.23 |
| 57461 | Conz of cervix w/scope, leep | | T | 0194 | 20.6573 | \$ 1,229.34 | \$ 397.84 | \$ 245.87 |
| 57500 | Biopsy of cervix | | T | 0192 | 4.1597 | \$ 247.55 | | \$ 49.51 |
| 57505 | Endocervical curettage | | T | 0189 | 2.3805 | \$ 141.67 | | \$ 28.33 |
| 57510 | Cauterization of cervix | | T | 0193 | 14.6385 | \$ 871.15 | | \$ 174.23 |
| 57511 | Cryocautery of cervix | | T | 0189 | 2.3805 | \$ 141.67 | | \$ 28.33 |
| 57513 | Laser surgery of cervix | | T | 0193 | 14.6385 | \$ 871.15 | | \$ 174.23 |
| 57520 | Conization of cervix | | T | 0194 | 20.6573 | \$ 1,229.34 | \$ 397.84 | \$ 245.87 |
| 57522 | Conization of cervix | | T | 0195 | 26.7972 | \$ 1,594.73 | \$ 483.80 | \$ 318.95 |
| 57530 | Removal of cervix | | T | 0195 | 26.7972 | \$ 1,594.73 | \$ 483.80 | \$ 318.95 |
| 57550 | Removal of residual cervix | | T | 0195 | 26.7972 | \$ 1,594.73 | \$ 483.80 | \$ 318.95 |
| 57555 | Remove cervix/repair vagina | | T | 0195 | 26.7972 | \$ 1,594.73 | \$ 483.80 | \$ 318.95 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 57556 | Remove cervix, repair bowel | | T | 0202 | 41.2319 | \$ 2,453.75 | \$ 981.50 | \$ 490.75 |
| 57700 | Revision of cervix | | T | 0194 | 20.6573 | \$ 1,229.34 | \$ 397.84 | \$ 245.87 |
| 57720 | Revision of cervix | | T | 0194 | 20.6573 | \$ 1,229.34 | \$ 397.84 | \$ 245.87 |
| 57800 | Dilation of cervical canal | | T | 0193 | 14.6385 | \$ 871.15 | | \$ 174.23 |
| 57820 | D & c of residual cervix | | T | 0196 | 17.0012 | \$ 1,011.76 | \$ 338.23 | \$ 202.35 |
| 58100 | Biopsy of uterus lining | | T | 0188 | 1.2615 | \$ 75.07 | | \$ 15.01 |
| 58110 | Bx done w/colposcopy add-on | NI | T | 0188 | 1.2615 | \$ 75.07 | | \$ 15.01 |
| 58120 | Dilation and curettage | | T | 0196 | 17.0012 | \$ 1,011.76 | \$ 338.23 | \$ 202.35 |
| 58145 | Myomectomy vag method | | T | 0195 | 26.7972 | \$ 1,594.73 | \$ 483.80 | \$ 318.95 |
| 58301 | Remove intrauterine device | | T | 0189 | 2.3805 | \$ 141.67 | | \$ 28.33 |
| 58321 | Artificial insemination | | T | 0197 | 3.0721 | \$ 182.82 | | \$ 36.56 |
| 58322 | Artificial insemination | | T | 0197 | 3.0721 | \$ 182.82 | | \$ 36.56 |
| 58323 | Sperm washing | | T | 0197 | 3.0721 | \$ 182.82 | | \$ 36.56 |
| 58340 | Catheter for hystero-graphy | | N | | | | | |
| 58345 | Reopen fallopian tube | CH | T | 0193 | 14.6385 | \$ 871.15 | | \$ 174.23 |
| 58346 | Insert heyman uteri capsule | | T | 0193 | 14.6385 | \$ 871.15 | | \$ 174.23 |
| 58350 | Reopen fallopian tube | | T | 0195 | 26.7972 | \$ 1,594.73 | \$ 483.80 | \$ 318.95 |
| 58353 | Endometr ablate, thermal | | T | 0195 | 26.7972 | \$ 1,594.73 | \$ 483.80 | \$ 318.95 |
| 58356 | Endometrial cryoablation | | T | 0202 | 41.2319 | \$ 2,453.75 | \$ 981.50 | \$ 490.75 |
| 58545 | Laparoscopic myomectomy | | T | 0130 | 31.8753 | \$ 1,896.93 | \$ 659.53 | \$ 379.39 |
| 58546 | Laparo-myomectomy, complex | | T | 0131 | 43.0498 | \$ 2,561.94 | \$ 1,001.89 | \$ 512.39 |
| 58550 | Laparo-asst vag hysterectomy | | T | 0132 | 63.6859 | \$ 3,790.01 | \$ 1,239.22 | \$ 758.00 |
| 58552 | Laparo-vag hyst incl t/o | | T | 0131 | 43.0498 | \$ 2,561.94 | \$ 1,001.89 | \$ 512.39 |
| 58553 | Laparo-vag hyst, complex | | T | 0131 | 43.0498 | \$ 2,561.94 | \$ 1,001.89 | \$ 512.39 |
| 58554 | Laparo-vag hyst w/t/o, compl | | T | 0131 | 43.0498 | \$ 2,561.94 | \$ 1,001.89 | \$ 512.39 |
| 58555 | Hysteroscopy, dx, sep proc | | T | 0190 | 20.9198 | \$ 1,244.96 | \$ 424.28 | \$ 248.99 |
| 58558 | Hysteroscopy, biopsy | | T | 0190 | 20.9198 | \$ 1,244.96 | \$ 424.28 | \$ 248.99 |
| 58559 | Hysteroscopy, lysis | | T | 0190 | 20.9198 | \$ 1,244.96 | \$ 424.28 | \$ 248.99 |
| 58560 | Hysteroscopy, resect septum | | T | 0387 | 32.3170 | \$ 1,923.22 | \$ 655.55 | \$ 384.64 |
| 58561 | Hysteroscopy, remove myoma | | T | 0387 | 32.3170 | \$ 1,923.22 | \$ 655.55 | \$ 384.64 |
| 58562 | Hysteroscopy, remove fb | | T | 0190 | 20.9198 | \$ 1,244.96 | \$ 424.28 | \$ 248.99 |
| 58563 | Hysteroscopy, ablation | | T | 0387 | 32.3170 | \$ 1,923.22 | \$ 655.55 | \$ 384.64 |
| 58565 | Hysteroscopy, sterilization | | T | 0202 | 41.2319 | \$ 2,453.75 | \$ 981.50 | \$ 490.75 |
| 58578 | Laparo proc, uterus | | T | 0130 | 31.8753 | \$ 1,896.93 | \$ 659.53 | \$ 379.39 |
| 58579 | Hysteroscope procedure | | T | 0190 | 20.9198 | \$ 1,244.96 | \$ 424.28 | \$ 248.99 |
| 58600 | Division of fallopian tube | | T | 0195 | 26.7972 | \$ 1,594.73 | \$ 483.80 | \$ 318.95 |
| 58615 | Occlude fallopian tube(s) | | T | 0194 | 20.6573 | \$ 1,229.34 | \$ 397.84 | \$ 245.87 |
| 58660 | Laparoscopy, lysis | | T | 0131 | 43.0498 | \$ 2,561.94 | \$ 1,001.89 | \$ 512.39 |
| 58661 | Laparoscopy, remove adnexa | | T | 0131 | 43.0498 | \$ 2,561.94 | \$ 1,001.89 | \$ 512.39 |
| 58662 | Laparoscopy, excise lesions | | T | 0131 | 43.0498 | \$ 2,561.94 | \$ 1,001.89 | \$ 512.39 |
| 58670 | Laparoscopy, tubal cautery | | T | 0131 | 43.0498 | \$ 2,561.94 | \$ 1,001.89 | \$ 512.39 |
| 58671 | Laparoscopy, tubal block | | T | 0131 | 43.0498 | \$ 2,561.94 | \$ 1,001.89 | \$ 512.39 |
| 58672 | Laparoscopy, fimbrioplasty | | T | 0131 | 43.0498 | \$ 2,561.94 | \$ 1,001.89 | \$ 512.39 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 58673 | Laparoscopy, salpingostomy | | T | 0131 | 43.0498 | \$ 2,561.94 | \$ 1,001.89 | \$ 512.39 |
| 58679 | Laparo proc, oviduct-ovary | | T | 0130 | 31.8753 | \$ 1,896.93 | \$ 659.53 | \$ 379.39 |
| 58770 | Create new tubal opening | | T | 0195 | 26.7972 | \$ 1,594.73 | \$ 483.80 | \$ 318.95 |
| 58800 | Drainage of ovarian cyst(s) | | T | 0193 | 14.6385 | \$ 871.15 | | \$ 174.23 |
| 58820 | Drain ovary abscess, open | | T | 0195 | 26.7972 | \$ 1,594.73 | \$ 483.80 | \$ 318.95 |
| 58823 | Drain pelvic abscess, percut | | T | 0193 | 14.6385 | \$ 871.15 | | \$ 174.23 |
| 58900 | Biopsy of ovary(s) | | T | 0193 | 14.6385 | \$ 871.15 | | \$ 174.23 |
| 58920 | Partial removal of ovary(s) | | T | 0195 | 26.7972 | \$ 1,594.73 | \$ 483.80 | \$ 318.95 |
| 58925 | Removal of ovarian cyst(s) | | T | 0195 | 26.7972 | \$ 1,594.73 | \$ 483.80 | \$ 318.95 |
| 58970 | Retrieval of oocyte | CH | T | 0197 | 3.0721 | \$ 182.82 | | \$ 36.56 |
| 58974 | Transfer of embryo | | T | 0197 | 3.0721 | \$ 182.82 | | \$ 36.56 |
| 58976 | Transfer of embryo | | T | 0197 | 3.0721 | \$ 182.82 | | \$ 36.56 |
| 58999 | Genital surgery procedure | | T | 0191 | 0.1702 | \$ 10.13 | \$ 2.85 | \$ 2.03 |
| 59000 | Amniocentesis, diagnostic | | T | 0198 | 1.3622 | \$ 81.07 | \$ 32.19 | \$ 16.21 |
| 59001 | Amniocentesis, therapeutic | CH | T | 0192 | 4.1597 | \$ 247.55 | | \$ 49.51 |
| 59012 | Fetal cord puncture,prenatal | | T | 0198 | 1.3622 | \$ 81.07 | \$ 32.19 | \$ 16.21 |
| 59015 | Chorion biopsy | | T | 0198 | 1.3622 | \$ 81.07 | \$ 32.19 | \$ 16.21 |
| 59020 | Fetal contract stress test | CH | T | 0192 | 4.1597 | \$ 247.55 | | \$ 49.51 |
| 59025 | Fetal non-stress test | | T | 0198 | 1.3622 | \$ 81.07 | \$ 32.19 | \$ 16.21 |
| 59030 | Fetal scalp blood sample | | T | 0198 | 1.3622 | \$ 81.07 | \$ 32.19 | \$ 16.21 |
| 59070 | Transabdom amnioinfus w/us | | T | 0198 | 1.3622 | \$ 81.07 | \$ 32.19 | \$ 16.21 |
| 59072 | Umbilical cord occlud w/us | | T | 0198 | 1.3622 | \$ 81.07 | \$ 32.19 | \$ 16.21 |
| 59074 | Fetal fluid drainage w/us | | T | 0198 | 1.3622 | \$ 81.07 | \$ 32.19 | \$ 16.21 |
| 59076 | Fetal shunt placement, w/us | | T | 0198 | 1.3622 | \$ 81.07 | \$ 32.19 | \$ 16.21 |
| 59100 | Remove uterus lesion | CH | T | 0195 | 26.7972 | \$ 1,594.73 | \$ 483.80 | \$ 318.95 |
| 59150 | Treat ectopic pregnancy | | T | 0131 | 43.0498 | \$ 2,561.94 | \$ 1,001.89 | \$ 512.39 |
| 59151 | Treat ectopic pregnancy | | T | 0131 | 43.0498 | \$ 2,561.94 | \$ 1,001.89 | \$ 512.39 |
| 59160 | D & c after delivery | | T | 0196 | 17.0012 | \$ 1,011.76 | \$ 338.23 | \$ 202.35 |
| 59200 | Insert cervical dilator | | T | 0189 | 2.3805 | \$ 141.67 | | \$ 28.33 |
| 59300 | Episiotomy or vaginal repair | | T | 0193 | 14.6385 | \$ 871.15 | | \$ 174.23 |
| 59320 | Revision of cervix | | T | 0194 | 20.6573 | \$ 1,229.34 | \$ 397.84 | \$ 245.87 |
| 59409 | Obstetrical care | | T | 0194 | 20.6573 | \$ 1,229.34 | \$ 397.84 | \$ 245.87 |
| 59412 | Antepartum manipulation | | T | 0700 | 4.1398 | \$ 246.36 | | \$ 49.27 |
| 59414 | Deliver placenta | CH | T | 0193 | 14.6385 | \$ 871.15 | | \$ 174.23 |
| 59612 | Vbac delivery only | | T | 0194 | 20.6573 | \$ 1,229.34 | \$ 397.84 | \$ 245.87 |
| 59812 | Treatment of miscarriage | | T | 0201 | 17.4749 | \$ 1,039.95 | \$ 329.65 | \$ 207.99 |
| 59820 | Care of miscarriage | | T | 0201 | 17.4749 | \$ 1,039.95 | \$ 329.65 | \$ 207.99 |
| 59821 | Treatment of miscarriage | | T | 0201 | 17.4749 | \$ 1,039.95 | \$ 329.65 | \$ 207.99 |
| 59840 | Abortion | | T | 0200 | 18.9518 | \$ 1,127.84 | \$ 263.69 | \$ 225.57 |
| 59841 | Abortion | | T | 0200 | 18.9518 | \$ 1,127.84 | \$ 263.69 | \$ 225.57 |
| 59866 | Abortion (mpr) | | T | 0198 | 1.3622 | \$ 81.07 | \$ 32.19 | \$ 16.21 |
| 59870 | Evacuate mole of uterus | | T | 0201 | 17.4749 | \$ 1,039.95 | \$ 329.65 | \$ 207.99 |
| 59871 | Remove cerclage suture | | T | 0194 | 20.6573 | \$ 1,229.34 | \$ 397.84 | \$ 245.87 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 59897 | Fetal invas px w/us | | T | 0198 | 1.3622 | \$ 81.07 | \$ 32.19 | \$ 16.21 |
| 59898 | Laparo proc, ob care/deliver | | T | 0130 | 31.8753 | \$ 1,896.93 | \$ 659.53 | \$ 379.39 |
| 59899 | Maternity care procedure | | T | 0198 | 1.3622 | \$ 81.07 | \$ 32.19 | \$ 16.21 |
| 60000 | Drain thyroid/tongue cyst | | T | 0252 | 8.1033 | \$ 482.24 | \$ 113.41 | \$ 96.45 |
| 60001 | Aspirate/inject thyriod cyst | | T | 0004 | 1.7771 | \$ 105.76 | \$ 22.36 | \$ 21.15 |
| 60100 | Biopsy of thyroid | | T | 0004 | 1.7771 | \$ 105.76 | \$ 22.36 | \$ 21.15 |
| 60200 | Remove thyroid lesion | | T | 0114 | 40.4596 | \$ 2,407.79 | \$ 485.91 | \$ 481.56 |
| 60210 | Partial thyroid excision | | T | 0114 | 40.4596 | \$ 2,407.79 | \$ 485.91 | \$ 481.56 |
| 60212 | Partial thyroid excision | | T | 0114 | 40.4596 | \$ 2,407.79 | \$ 485.91 | \$ 481.56 |
| 60220 | Partial removal of thyroid | | T | 0114 | 40.4596 | \$ 2,407.79 | \$ 485.91 | \$ 481.56 |
| 60225 | Partial removal of thyroid | | T | 0114 | 40.4596 | \$ 2,407.79 | \$ 485.91 | \$ 481.56 |
| 60240 | Removal of thyroid | | T | 0114 | 40.4596 | \$ 2,407.79 | \$ 485.91 | \$ 481.56 |
| 60252 | Removal of thyroid | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 60260 | Repeat thyroid surgery | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 60280 | Remove thyroid duct lesion | | T | 0114 | 40.4596 | \$ 2,407.79 | \$ 485.91 | \$ 481.56 |
| 60281 | Remove thyroid duct lesion | | T | 0114 | 40.4596 | \$ 2,407.79 | \$ 485.91 | \$ 481.56 |
| 60500 | Explore parathyroid glands | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 60512 | Autotransplant parathyroid | | T | 0022 | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 60659 | Laparo proc, endocrine | | T | 0130 | 31.8753 | \$ 1,896.93 | \$ 659.53 | \$ 379.39 |
| 60699 | Endocrine surgery procedure | | T | 0114 | 40.4596 | \$ 2,407.79 | \$ 485.91 | \$ 481.56 |
| 61000 | Remove cranial cavity fluid | | T | 0212 | 2.7712 | \$ 164.92 | \$ 65.96 | \$ 32.98 |
| 61001 | Remove cranial cavity fluid | | T | 0212 | 2.7712 | \$ 164.92 | \$ 65.96 | \$ 32.98 |
| 61020 | Remove brain cavity fluid | | T | 0212 | 2.7712 | \$ 164.92 | \$ 65.96 | \$ 32.98 |
| 61026 | Injection into brain canal | | T | 0212 | 2.7712 | \$ 164.92 | \$ 65.96 | \$ 32.98 |
| 61050 | Remove brain canal fluid | | T | 0212 | 2.7712 | \$ 164.92 | \$ 65.96 | \$ 32.98 |
| 61055 | Injection into brain canal | | T | 0212 | 2.7712 | \$ 164.92 | \$ 65.96 | \$ 32.98 |
| 61070 | Brain canal shunt procedure | | T | 0212 | 2.7712 | \$ 164.92 | \$ 65.96 | \$ 32.98 |
| 61215 | Insert brain-fluid device | | T | 0224 | 41.1421 | \$ 2,448.41 | | \$ 489.68 |
| 61330 | Decompress eye socket | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 61334 | Explore orbit/remove object | CH | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 61623 | Endovasc tempory vessel occl | CH | T | 0081 | 42.2664 | \$ 2,515.32 | | \$ 503.06 |
| 61626 | Transcath occlusion, non-cns | | T | 0081 | 42.2664 | \$ 2,515.32 | | \$ 503.06 |
| 61790 | Treat trigeminal nerve | | T | 0220 | 17.3203 | \$ 1,030.75 | | \$ 206.15 |
| 61791 | Treat trigeminal tract | | T | 0206 | 5.4011 | \$ 321.42 | \$ 75.55 | \$ 64.28 |
| 61795 | Brain surgery using computer | | S | 0302 | 4.6992 | \$ 279.65 | \$ 105.94 | \$ 55.93 |
| 61880 | Revise/remove neuroelectrode | | T | 0687 | 19.1962 | \$ 1,142.39 | \$ 456.95 | \$ 228.48 |
| 61885 | Insrt/redo neurostim 1 array | | S | 0039 | 194.9690 | \$11,602.80 | | \$ 2,320.56 |
| 61886 | Implant neurostim arrays | | T | 0315 | 312.3876 | \$18,590.50 | | \$ 3,718.10 |
| 61888 | Revise/remove neuroreceiver | | T | 0688 | 42.8588 | \$ 2,550.57 | \$ 1,020.22 | \$ 510.11 |
| 62160 | Neuroendoscopy add-on | CH | T | 0122 | 6.9179 | \$ 411.69 | \$ 84.43 | \$ 82.34 |
| 62194 | Replace/irrigate catheter | CH | T | 0427 | 10.0109 | \$ 595.76 | | \$ 119.15 |
| 62225 | Replace/irrigate catheter | CH | T | 0427 | 10.0109 | \$ 595.76 | | \$ 119.15 |
| 62230 | Replace/revise brain shunt | | T | 0224 | 41.1421 | \$ 2,448.41 | | \$ 489.68 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 62252 | Csf shunt reprogram | | S | 0691 | 2.5464 | \$ 151.54 | \$ 60.61 | \$ 30.31 |
| 62263 | Epidural lysis mult sessions | | T | 0203 | 10.0965 | \$ 600.85 | \$ 240.33 | \$ 120.17 |
| 62264 | Epidural lysis on single day | | T | 0203 | 10.0965 | \$ 600.85 | \$ 240.33 | \$ 120.17 |
| 62268 | Drain spinal cord cyst | | T | 0212 | 2.7712 | \$ 164.92 | \$ 65.96 | \$ 32.98 |
| 62269 | Needle biopsy, spinal cord | | T | 0685 | 6.0034 | \$ 357.27 | \$ 115.47 | \$ 71.45 |
| 62270 | Spinal fluid tap, diagnostic | | T | 0204 | 2.2667 | \$ 134.89 | \$ 40.13 | \$ 26.98 |
| 62272 | Drain cerebro spinal fluid | | T | 0204 | 2.2667 | \$ 134.89 | \$ 40.13 | \$ 26.98 |
| 62273 | Inject epidural patch | | T | 0206 | 5.4011 | \$ 321.42 | \$ 75.55 | \$ 64.28 |
| 62280 | Treat spinal cord lesion | | T | 0207 | 6.0140 | \$ 357.90 | \$ 86.92 | \$ 71.58 |
| 62281 | Treat spinal cord lesion | | T | 0207 | 6.0140 | \$ 357.90 | \$ 86.92 | \$ 71.58 |
| 62282 | Treat spinal canal lesion | | T | 0207 | 6.0140 | \$ 357.90 | \$ 86.92 | \$ 71.58 |
| 62284 | Injection for myelogram | | N | | | | | |
| 62287 | Percutaneous discectomy | | T | 0221 | 31.0536 | \$ 1,848.03 | \$ 463.62 | \$ 369.61 |
| 62290 | Inject for spine disk x-ray | | N | | | | | |
| 62291 | Inject for spine disk x-ray | | N | | | | | |
| 62292 | Injection into disk lesion | | T | 0212 | 2.7712 | \$ 164.92 | \$ 65.96 | \$ 32.98 |
| 62294 | Injection into spinal artery | | T | 0212 | 2.7712 | \$ 164.92 | \$ 65.96 | \$ 32.98 |
| 62310 | Inject spine c/t | | T | 0207 | 6.0140 | \$ 357.90 | \$ 86.92 | \$ 71.58 |
| 62311 | Inject spine l/s (cd) | | T | 0207 | 6.0140 | \$ 357.90 | \$ 86.92 | \$ 71.58 |
| 62318 | Inject spine w/cath, c/t | | T | 0207 | 6.0140 | \$ 357.90 | \$ 86.92 | \$ 71.58 |
| 62319 | Inject spine w/cath l/s (cd) | | T | 0207 | 6.0140 | \$ 357.90 | \$ 86.92 | \$ 71.58 |
| 62350 | Implant spinal canal cath | | T | 0223 | 28.5636 | \$ 1,699.85 | | \$ 339.97 |
| 62351 | Implant spinal canal cath | | T | 0208 | 42.5200 | \$ 2,530.41 | | \$ 506.08 |
| 62355 | Remove spinal canal catheter | | T | 0203 | 10.0965 | \$ 600.85 | \$ 240.33 | \$ 120.17 |
| 62360 | Insert spine infusion device | | T | 0226 | 72.5804 | \$ 4,319.33 | | \$ 863.87 |
| 62361 | Implant spine infusion pump | | T | 0227 | 155.0431 | \$ 9,226.77 | | \$ 1,845.35 |
| 62362 | Implant spine infusion pump | | T | 0227 | 155.0431 | \$ 9,226.77 | | \$ 1,845.35 |
| 62365 | Remove spine infusion device | | T | 0221 | 31.0536 | \$ 1,848.03 | \$ 463.62 | \$ 369.61 |
| 62367 | Analyze spine infusion pump | | S | 0691 | 2.5464 | \$ 151.54 | \$ 60.61 | \$ 30.31 |
| 62368 | Analyze spine infusion pump | | S | 0691 | 2.5464 | \$ 151.54 | \$ 60.61 | \$ 30.31 |
| 63001 | Removal of spinal lamina | | T | 0208 | 42.5200 | \$ 2,530.41 | | \$ 506.08 |
| 63003 | Removal of spinal lamina | | T | 0208 | 42.5200 | \$ 2,530.41 | | \$ 506.08 |
| 63005 | Removal of spinal lamina | | T | 0208 | 42.5200 | \$ 2,530.41 | | \$ 506.08 |
| 63011 | Removal of spinal lamina | | T | 0208 | 42.5200 | \$ 2,530.41 | | \$ 506.08 |
| 63012 | Removal of spinal lamina | | T | 0208 | 42.5200 | \$ 2,530.41 | | \$ 506.08 |
| 63015 | Removal of spinal lamina | | T | 0208 | 42.5200 | \$ 2,530.41 | | \$ 506.08 |
| 63016 | Removal of spinal lamina | | T | 0208 | 42.5200 | \$ 2,530.41 | | \$ 506.08 |
| 63017 | Removal of spinal lamina | | T | 0208 | 42.5200 | \$ 2,530.41 | | \$ 506.08 |
| 63020 | Neck spine disk surgery | | T | 0208 | 42.5200 | \$ 2,530.41 | | \$ 506.08 |
| 63030 | Low back disk surgery | | T | 0208 | 42.5200 | \$ 2,530.41 | | \$ 506.08 |
| 63035 | Spinal disk surgery add-on | | T | 0208 | 42.5200 | \$ 2,530.41 | | \$ 506.08 |
| 63040 | Laminotomy, single cervical | | T | 0208 | 42.5200 | \$ 2,530.41 | | \$ 506.08 |
| 63042 | Laminotomy, single lumbar | | T | 0208 | 42.5200 | \$ 2,530.41 | | \$ 506.08 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 63045 | Removal of spinal lamina | | T | 0208 | 42.5200 | \$ 2,530.41 | | \$ 506.08 |
| 63046 | Removal of spinal lamina | | T | 0208 | 42.5200 | \$ 2,530.41 | | \$ 506.08 |
| 63047 | Removal of spinal lamina | | T | 0208 | 42.5200 | \$ 2,530.41 | | \$ 506.08 |
| 63048 | Remove spinal lamina add-on | | T | 0208 | 42.5200 | \$ 2,530.41 | | \$ 506.08 |
| 63055 | Decompress spinal cord | | T | 0208 | 42.5200 | \$ 2,530.41 | | \$ 506.08 |
| 63056 | Decompress spinal cord | | T | 0208 | 42.5200 | \$ 2,530.41 | | \$ 506.08 |
| 63057 | Decompress spine cord add-on | | T | 0208 | 42.5200 | \$ 2,530.41 | | \$ 506.08 |
| 63064 | Decompress spinal cord | | T | 0208 | 42.5200 | \$ 2,530.41 | | \$ 506.08 |
| 63066 | Decompress spine cord add-on | | T | 0208 | 42.5200 | \$ 2,530.41 | | \$ 506.08 |
| 63075 | Neck spine disk surgery | CH | T | 0208 | 42.5200 | \$ 2,530.41 | | \$ 506.08 |
| 63600 | Remove spinal cord lesion | | T | 0220 | 17.3203 | \$ 1,030.75 | | \$ 206.15 |
| 63610 | Stimulation of spinal cord | | T | 0220 | 17.3203 | \$ 1,030.75 | | \$ 206.15 |
| 63615 | Remove lesion of spinal cord | | T | 0220 | 17.3203 | \$ 1,030.75 | | \$ 206.15 |
| 63650 | Implant neuroelectrodes | | S | 0040 | 50.8322 | \$ 3,025.08 | | \$ 605.02 |
| 63655 | Implant neuroelectrodes | CH | S | 0061 | 93.4063 | \$ 5,558.70 | | \$ 1,111.74 |
| 63660 | Revise/remove neuroelectrode | | T | 0687 | 19.1962 | \$ 1,142.39 | \$ 456.95 | \$ 228.48 |
| 63685 | Insrt/redo spine n generator | | T | 0222 | 192.4950 | \$11,455.57 | | \$ 2,291.11 |
| 63688 | Revise/remove neuroreceiver | | T | 0688 | 42.8588 | \$ 2,550.57 | \$ 1,020.22 | \$ 510.11 |
| 63741 | Install spinal shunt | | T | 0228 | 46.4126 | \$ 2,762.06 | | \$ 552.41 |
| 63744 | Revision of spinal shunt | | T | 0228 | 46.4126 | \$ 2,762.06 | | \$ 552.41 |
| 63746 | Removal of spinal shunt | | T | 0109 | 11.1714 | \$ 664.82 | | \$ 132.96 |
| 64400 | N block inj, trigeminal | | T | 0204 | 2.2667 | \$ 134.89 | \$ 40.13 | \$ 26.98 |
| 64402 | N block inj, facial | | T | 0204 | 2.2667 | \$ 134.89 | \$ 40.13 | \$ 26.98 |
| 64405 | N block inj, occipital | | T | 0204 | 2.2667 | \$ 134.89 | \$ 40.13 | \$ 26.98 |
| 64408 | N block inj, vagus | | T | 0204 | 2.2667 | \$ 134.89 | \$ 40.13 | \$ 26.98 |
| 64410 | N block inj, phrenic | | T | 0206 | 5.4011 | \$ 321.42 | \$ 75.55 | \$ 64.28 |
| 64412 | N block inj, spinal accessor | | T | 0206 | 5.4011 | \$ 321.42 | \$ 75.55 | \$ 64.28 |
| 64413 | N block inj, cervical plexus | | T | 0204 | 2.2667 | \$ 134.89 | \$ 40.13 | \$ 26.98 |
| 64415 | N block inj, brachial plexus | | T | 0204 | 2.2667 | \$ 134.89 | \$ 40.13 | \$ 26.98 |
| 64416 | N block cont infuse, b plex | | T | 0204 | 2.2667 | \$ 134.89 | \$ 40.13 | \$ 26.98 |
| 64417 | N block inj, axillary | | T | 0204 | 2.2667 | \$ 134.89 | \$ 40.13 | \$ 26.98 |
| 64418 | N block inj, suprascapular | | T | 0204 | 2.2667 | \$ 134.89 | \$ 40.13 | \$ 26.98 |
| 64420 | N block inj, intercost, sng | | T | 0204 | 2.2667 | \$ 134.89 | \$ 40.13 | \$ 26.98 |
| 64421 | N block inj, intercost, mlt | | T | 0206 | 5.4011 | \$ 321.42 | \$ 75.55 | \$ 64.28 |
| 64425 | N block inj, ilio-ing/hypogi | | T | 0204 | 2.2667 | \$ 134.89 | \$ 40.13 | \$ 26.98 |
| 64430 | N block inj, pudendal | | T | 0204 | 2.2667 | \$ 134.89 | \$ 40.13 | \$ 26.98 |
| 64435 | N block inj, paracervical | | T | 0204 | 2.2667 | \$ 134.89 | \$ 40.13 | \$ 26.98 |
| 64445 | N block inj, sciatic, sng | | T | 0204 | 2.2667 | \$ 134.89 | \$ 40.13 | \$ 26.98 |
| 64446 | N blk inj, sciatic, cont inf | | T | 0206 | 5.4011 | \$ 321.42 | \$ 75.55 | \$ 64.28 |
| 64447 | N block inj fem, single | | T | 0204 | 2.2667 | \$ 134.89 | \$ 40.13 | \$ 26.98 |
| 64448 | N block inj fem, cont inf | | T | 0204 | 2.2667 | \$ 134.89 | \$ 40.13 | \$ 26.98 |
| 64449 | N block inj, lumbar plexus | | T | 0204 | 2.2667 | \$ 134.89 | \$ 40.13 | \$ 26.98 |
| 64450 | N block, other peripheral | | T | 0204 | 2.2667 | \$ 134.89 | \$ 40.13 | \$ 26.98 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|-------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 64470 | Inj paravertebral c/t | | T | 0207 | 6.0140 | \$ 357.90 | \$ 86.92 | \$ 71.58 |
| 64472 | Inj paravertebral c/t add-on | | T | 0206 | 5.4011 | \$ 321.42 | \$ 75.55 | \$ 64.28 |
| 64475 | Inj paravertebral l/s | | T | 0207 | 6.0140 | \$ 357.90 | \$ 86.92 | \$ 71.58 |
| 64476 | Inj paravertebral l/s add-on | | T | 0206 | 5.4011 | \$ 321.42 | \$ 75.55 | \$ 64.28 |
| 64479 | Inj foramen epidural c/t | | T | 0207 | 6.0140 | \$ 357.90 | \$ 86.92 | \$ 71.58 |
| 64480 | Inj foramen epidural add-on | | T | 0207 | 6.0140 | \$ 357.90 | \$ 86.92 | \$ 71.58 |
| 64483 | Inj foramen epidural l/s | | T | 0207 | 6.0140 | \$ 357.90 | \$ 86.92 | \$ 71.58 |
| 64484 | Inj foramen epidural add-on | | T | 0207 | 6.0140 | \$ 357.90 | \$ 86.92 | \$ 71.58 |
| 64505 | N block, sphenopalatine gangl | | T | 0204 | 2.2667 | \$ 134.89 | \$ 40.13 | \$ 26.98 |
| 64508 | N block, carotid sinus s/p | | T | 0204 | 2.2667 | \$ 134.89 | \$ 40.13 | \$ 26.98 |
| 64510 | N block, stellate ganglion | | T | 0207 | 6.0140 | \$ 357.90 | \$ 86.92 | \$ 71.58 |
| 64517 | N block inj, hypogas plxs | | T | 0204 | 2.2667 | \$ 134.89 | \$ 40.13 | \$ 26.98 |
| 64520 | N block, lumbar/thoracic | | T | 0207 | 6.0140 | \$ 357.90 | \$ 86.92 | \$ 71.58 |
| 64530 | N block inj, celiac pelus | | T | 0207 | 6.0140 | \$ 357.90 | \$ 86.92 | \$ 71.58 |
| 64553 | Implant neuroelectrodes | | S | 0225 | 250.8484 | \$14,928.24 | | \$ 2,985.65 |
| 64555 | Implant neuroelectrodes | | S | 0040 | 50.8322 | \$ 3,025.08 | | \$ 605.02 |
| 64560 | Implant neuroelectrodes | | S | 0040 | 50.8322 | \$ 3,025.08 | | \$ 605.02 |
| 64561 | Implant neuroelectrodes | | S | 0040 | 50.8322 | \$ 3,025.08 | | \$ 605.02 |
| 64565 | Implant neuroelectrodes | | S | 0040 | 50.8322 | \$ 3,025.08 | | \$ 605.02 |
| 64573 | Implant neuroelectrodes | | S | 0225 | 250.8484 | \$14,928.24 | | \$ 2,985.65 |
| 64575 | Implant neuroelectrodes | CH | S | 0061 | 93.4063 | \$ 5,558.70 | | \$ 1,111.74 |
| 64577 | Implant neuroelectrodes | CH | S | 0061 | 93.4063 | \$ 5,558.70 | | \$ 1,111.74 |
| 64580 | Implant neuroelectrodes | CH | S | 0061 | 93.4063 | \$ 5,558.70 | | \$ 1,111.74 |
| 64581 | Implant neuroelectrodes | CH | S | 0061 | 93.4063 | \$ 5,558.70 | | \$ 1,111.74 |
| 64585 | Revise/remove neuroelectrode | | T | 0687 | 19.1962 | \$ 1,142.39 | \$ 456.95 | \$ 228.48 |
| 64590 | Insrt/redo perph n generator | | T | 0222 | 192.4950 | \$11,455.57 | | \$ 2,291.11 |
| 64595 | Revise/remove neuroreceiver | | T | 0688 | 42.8588 | \$ 2,550.57 | \$ 1,020.22 | \$ 510.11 |
| 64600 | Injection treatment of nerve | | T | 0203 | 10.0965 | \$ 600.85 | \$ 240.33 | \$ 120.17 |
| 64605 | Injection treatment of nerve | | T | 0203 | 10.0965 | \$ 600.85 | \$ 240.33 | \$ 120.17 |
| 64610 | Injection treatment of nerve | | T | 0203 | 10.0965 | \$ 600.85 | \$ 240.33 | \$ 120.17 |
| 64612 | Destroy nerve, face muscle | | T | 0204 | 2.2667 | \$ 134.89 | \$ 40.13 | \$ 26.98 |
| 64613 | Destroy nerve, neck muscle | | T | 0204 | 2.2667 | \$ 134.89 | \$ 40.13 | \$ 26.98 |
| 64614 | Destroy nerve, extrem musc | | T | 0204 | 2.2667 | \$ 134.89 | \$ 40.13 | \$ 26.98 |
| 64620 | Injection treatment of nerve | | T | 0203 | 10.0965 | \$ 600.85 | \$ 240.33 | \$ 120.17 |
| 64622 | Destr paravertebrl nerve l/s | | T | 0203 | 10.0965 | \$ 600.85 | \$ 240.33 | \$ 120.17 |
| 64623 | Destr paravertebral n add-on | | T | 0207 | 6.0140 | \$ 357.90 | \$ 86.92 | \$ 71.58 |
| 64626 | Destr paravertebrl nerve c/t | | T | 0203 | 10.0965 | \$ 600.85 | \$ 240.33 | \$ 120.17 |
| 64627 | Destr paravertebral n add-on | | T | 0207 | 6.0140 | \$ 357.90 | \$ 86.92 | \$ 71.58 |
| 64630 | Injection treatment of nerve | | T | 0206 | 5.4011 | \$ 321.42 | \$ 75.55 | \$ 64.28 |
| 64640 | Injection treatment of nerve | | T | 0206 | 5.4011 | \$ 321.42 | \$ 75.55 | \$ 64.28 |
| 64650 | Chemodenerv eccrine glands | NI | T | 0204 | 2.2667 | \$ 134.89 | \$ 40.13 | \$ 26.98 |
| 64653 | Chemodenerv eccrine glands | NI | T | 0204 | 2.2667 | \$ 134.89 | \$ 40.13 | \$ 26.98 |
| 64680 | Injection treatment of nerve | | T | 0207 | 6.0140 | \$ 357.90 | \$ 86.92 | \$ 71.58 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 64681 | Injection treatment of nerve | | T | 0203 | 10.0965 | \$ 600.85 | \$ 240.33 | \$ 120.17 |
| 64702 | Revise finger/toe nerve | | T | 0220 | 17.3203 | \$ 1,030.75 | | \$ 206.15 |
| 64704 | Revise hand/foot nerve | | T | 0220 | 17.3203 | \$ 1,030.75 | | \$ 206.15 |
| 64708 | Revise arm/leg nerve | | T | 0220 | 17.3203 | \$ 1,030.75 | | \$ 206.15 |
| 64712 | Revision of sciatic nerve | | T | 0220 | 17.3203 | \$ 1,030.75 | | \$ 206.15 |
| 64713 | Revision of arm nerve(s) | | T | 0220 | 17.3203 | \$ 1,030.75 | | \$ 206.15 |
| 64714 | Revise low back nerve(s) | | T | 0220 | 17.3203 | \$ 1,030.75 | | \$ 206.15 |
| 64716 | Revision of cranial nerve | | T | 0220 | 17.3203 | \$ 1,030.75 | | \$ 206.15 |
| 64718 | Revise ulnar nerve at elbow | | T | 0220 | 17.3203 | \$ 1,030.75 | | \$ 206.15 |
| 64719 | Revise ulnar nerve at wrist | | T | 0220 | 17.3203 | \$ 1,030.75 | | \$ 206.15 |
| 64721 | Carpal tunnel surgery | | T | 0220 | 17.3203 | \$ 1,030.75 | | \$ 206.15 |
| 64722 | Relieve pressure on nerve(s) | | T | 0220 | 17.3203 | \$ 1,030.75 | | \$ 206.15 |
| 64726 | Release foot/toe nerve | | T | 0220 | 17.3203 | \$ 1,030.75 | | \$ 206.15 |
| 64727 | Internal nerve revision | | T | 0220 | 17.3203 | \$ 1,030.75 | | \$ 206.15 |
| 64732 | Incision of brow nerve | | T | 0220 | 17.3203 | \$ 1,030.75 | | \$ 206.15 |
| 64734 | Incision of cheek nerve | | T | 0220 | 17.3203 | \$ 1,030.75 | | \$ 206.15 |
| 64736 | Incision of chin nerve | | T | 0220 | 17.3203 | \$ 1,030.75 | | \$ 206.15 |
| 64738 | Incision of jaw nerve | | T | 0220 | 17.3203 | \$ 1,030.75 | | \$ 206.15 |
| 64740 | Incision of tongue nerve | | T | 0220 | 17.3203 | \$ 1,030.75 | | \$ 206.15 |
| 64742 | Incision of facial nerve | | T | 0220 | 17.3203 | \$ 1,030.75 | | \$ 206.15 |
| 64744 | Incise nerve, back of head | | T | 0220 | 17.3203 | \$ 1,030.75 | | \$ 206.15 |
| 64746 | Incise diaphragm nerve | | T | 0220 | 17.3203 | \$ 1,030.75 | | \$ 206.15 |
| 64761 | Incision of pelvis nerve | | T | 0220 | 17.3203 | \$ 1,030.75 | | \$ 206.15 |
| 64763 | Incise hip/thigh nerve | CH | T | 0220 | 17.3203 | \$ 1,030.75 | | \$ 206.15 |
| 64766 | Incise hip/thigh nerve | CH | T | 0221 | 31.0536 | \$ 1,848.03 | \$ 463.62 | \$ 369.61 |
| 64771 | Sever cranial nerve | | T | 0220 | 17.3203 | \$ 1,030.75 | | \$ 206.15 |
| 64772 | Incision of spinal nerve | | T | 0220 | 17.3203 | \$ 1,030.75 | | \$ 206.15 |
| 64774 | Remove skin nerve lesion | | T | 0220 | 17.3203 | \$ 1,030.75 | | \$ 206.15 |
| 64776 | Remove digit nerve lesion | | T | 0220 | 17.3203 | \$ 1,030.75 | | \$ 206.15 |
| 64778 | Digit nerve surgery add-on | | T | 0220 | 17.3203 | \$ 1,030.75 | | \$ 206.15 |
| 64782 | Remove limb nerve lesion | | T | 0220 | 17.3203 | \$ 1,030.75 | | \$ 206.15 |
| 64783 | Limb nerve surgery add-on | | T | 0220 | 17.3203 | \$ 1,030.75 | | \$ 206.15 |
| 64784 | Remove nerve lesion | | T | 0220 | 17.3203 | \$ 1,030.75 | | \$ 206.15 |
| 64786 | Remove sciatic nerve lesion | | T | 0221 | 31.0536 | \$ 1,848.03 | \$ 463.62 | \$ 369.61 |
| 64787 | Implant nerve end | | T | 0220 | 17.3203 | \$ 1,030.75 | | \$ 206.15 |
| 64788 | Remove skin nerve lesion | | T | 0220 | 17.3203 | \$ 1,030.75 | | \$ 206.15 |
| 64790 | Removal of nerve lesion | | T | 0220 | 17.3203 | \$ 1,030.75 | | \$ 206.15 |
| 64792 | Removal of nerve lesion | | T | 0221 | 31.0536 | \$ 1,848.03 | \$ 463.62 | \$ 369.61 |
| 64795 | Biopsy of nerve | | T | 0220 | 17.3203 | \$ 1,030.75 | | \$ 206.15 |
| 64802 | Remove sympathetic nerves | | T | 0220 | 17.3203 | \$ 1,030.75 | | \$ 206.15 |
| 64820 | Remove sympathetic nerves | | T | 0220 | 17.3203 | \$ 1,030.75 | | \$ 206.15 |
| 64821 | Remove sympathetic nerves | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 64822 | Remove sympathetic nerves | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 64823 | Remove sympathetic nerves | | T | 0054 | 25.1321 | \$ 1,495.64 | | \$ 299.13 |
| 64831 | Repair of digit nerve | | T | 0221 | 31.0536 | \$ 1,848.03 | \$ 463.62 | \$ 369.61 |
| 64832 | Repair nerve add-on | | T | 0221 | 31.0536 | \$ 1,848.03 | \$ 463.62 | \$ 369.61 |
| 64834 | Repair of hand or foot nerve | | T | 0221 | 31.0536 | \$ 1,848.03 | \$ 463.62 | \$ 369.61 |
| 64835 | Repair of hand or foot nerve | | T | 0221 | 31.0536 | \$ 1,848.03 | \$ 463.62 | \$ 369.61 |
| 64836 | Repair of hand or foot nerve | | T | 0221 | 31.0536 | \$ 1,848.03 | \$ 463.62 | \$ 369.61 |
| 64837 | Repair nerve add-on | | T | 0221 | 31.0536 | \$ 1,848.03 | \$ 463.62 | \$ 369.61 |
| 64840 | Repair of leg nerve | | T | 0221 | 31.0536 | \$ 1,848.03 | \$ 463.62 | \$ 369.61 |
| 64856 | Repair/transpose nerve | | T | 0221 | 31.0536 | \$ 1,848.03 | \$ 463.62 | \$ 369.61 |
| 64857 | Repair arm/leg nerve | | T | 0221 | 31.0536 | \$ 1,848.03 | \$ 463.62 | \$ 369.61 |
| 64858 | Repair sciatic nerve | | T | 0221 | 31.0536 | \$ 1,848.03 | \$ 463.62 | \$ 369.61 |
| 64859 | Nerve surgery | | T | 0221 | 31.0536 | \$ 1,848.03 | \$ 463.62 | \$ 369.61 |
| 64861 | Repair of arm nerves | | T | 0221 | 31.0536 | \$ 1,848.03 | \$ 463.62 | \$ 369.61 |
| 64862 | Repair of low back nerves | | T | 0221 | 31.0536 | \$ 1,848.03 | \$ 463.62 | \$ 369.61 |
| 64864 | Repair of facial nerve | | T | 0221 | 31.0536 | \$ 1,848.03 | \$ 463.62 | \$ 369.61 |
| 64865 | Repair of facial nerve | | T | 0221 | 31.0536 | \$ 1,848.03 | \$ 463.62 | \$ 369.61 |
| 64870 | Fusion of facial/other nerve | | T | 0221 | 31.0536 | \$ 1,848.03 | \$ 463.62 | \$ 369.61 |
| 64872 | Subsequent repair of nerve | | T | 0221 | 31.0536 | \$ 1,848.03 | \$ 463.62 | \$ 369.61 |
| 64874 | Repair & revise nerve add-on | | T | 0221 | 31.0536 | \$ 1,848.03 | \$ 463.62 | \$ 369.61 |
| 64876 | Repair nerve/shorten bone | | T | 0221 | 31.0536 | \$ 1,848.03 | \$ 463.62 | \$ 369.61 |
| 64885 | Nerve graft, head or neck | | T | 0221 | 31.0536 | \$ 1,848.03 | \$ 463.62 | \$ 369.61 |
| 64886 | Nerve graft, head or neck | | T | 0221 | 31.0536 | \$ 1,848.03 | \$ 463.62 | \$ 369.61 |
| 64890 | Nerve graft, hand or foot | | T | 0221 | 31.0536 | \$ 1,848.03 | \$ 463.62 | \$ 369.61 |
| 64891 | Nerve graft, hand or foot | | T | 0221 | 31.0536 | \$ 1,848.03 | \$ 463.62 | \$ 369.61 |
| 64892 | Nerve graft, arm or leg | | T | 0221 | 31.0536 | \$ 1,848.03 | \$ 463.62 | \$ 369.61 |
| 64893 | Nerve graft, arm or leg | | T | 0221 | 31.0536 | \$ 1,848.03 | \$ 463.62 | \$ 369.61 |
| 64895 | Nerve graft, hand or foot | | T | 0221 | 31.0536 | \$ 1,848.03 | \$ 463.62 | \$ 369.61 |
| 64896 | Nerve graft, hand or foot | | T | 0221 | 31.0536 | \$ 1,848.03 | \$ 463.62 | \$ 369.61 |
| 64897 | Nerve graft, arm or leg | | T | 0221 | 31.0536 | \$ 1,848.03 | \$ 463.62 | \$ 369.61 |
| 64898 | Nerve graft, arm or leg | | T | 0221 | 31.0536 | \$ 1,848.03 | \$ 463.62 | \$ 369.61 |
| 64901 | Nerve graft add-on | | T | 0221 | 31.0536 | \$ 1,848.03 | \$ 463.62 | \$ 369.61 |
| 64902 | Nerve graft add-on | | T | 0221 | 31.0536 | \$ 1,848.03 | \$ 463.62 | \$ 369.61 |
| 64905 | Nerve pedicle transfer | | T | 0221 | 31.0536 | \$ 1,848.03 | \$ 463.62 | \$ 369.61 |
| 64907 | Nerve pedicle transfer | | T | 0221 | 31.0536 | \$ 1,848.03 | \$ 463.62 | \$ 369.61 |
| 64999 | Nervous system surgery | | T | 0204 | 2.2667 | \$ 134.89 | \$ 40.13 | \$ 26.98 |
| 65091 | Revise eye | | T | 0242 | 30.3478 | \$ 1,806.03 | \$ 597.36 | \$ 361.21 |
| 65093 | Revise eye with implant | | T | 0241 | 23.1681 | \$ 1,378.76 | \$ 384.47 | \$ 275.75 |
| 65101 | Removal of eye | | T | 0242 | 30.3478 | \$ 1,806.03 | \$ 597.36 | \$ 361.21 |
| 65103 | Remove eye/insert implant | | T | 0242 | 30.3478 | \$ 1,806.03 | \$ 597.36 | \$ 361.21 |
| 65105 | Remove eye/attach implant | | T | 0242 | 30.3478 | \$ 1,806.03 | \$ 597.36 | \$ 361.21 |
| 65110 | Removal of eye | | T | 0242 | 30.3478 | \$ 1,806.03 | \$ 597.36 | \$ 361.21 |
| 65112 | Remove eye/revise socket | | T | 0242 | 30.3478 | \$ 1,806.03 | \$ 597.36 | \$ 361.21 |
| 65114 | Remove eye/revise socket | | T | 0242 | 30.3478 | \$ 1,806.03 | \$ 597.36 | \$ 361.21 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 65125 | Revise ocular implant | | T | 0240 | 18.0194 | \$ 1,072.35 | \$ 315.31 | \$ 214.47 |
| 65130 | Insert ocular implant | | T | 0241 | 23.1681 | \$ 1,378.76 | \$ 384.47 | \$ 275.75 |
| 65135 | Insert ocular implant | | T | 0241 | 23.1681 | \$ 1,378.76 | \$ 384.47 | \$ 275.75 |
| 65140 | Attach ocular implant | | T | 0242 | 30.3478 | \$ 1,806.03 | \$ 597.36 | \$ 361.21 |
| 65150 | Revise ocular implant | | T | 0241 | 23.1681 | \$ 1,378.76 | \$ 384.47 | \$ 275.75 |
| 65155 | Reinsert ocular implant | | T | 0242 | 30.3478 | \$ 1,806.03 | \$ 597.36 | \$ 361.21 |
| 65175 | Removal of ocular implant | | T | 0240 | 18.0194 | \$ 1,072.35 | \$ 315.31 | \$ 214.47 |
| 65205 | Remove foreign body from eye | | S | 0698 | 1.2378 | \$ 73.66 | \$ 16.52 | \$ 14.73 |
| 65210 | Remove foreign body from eye | | S | 0698 | 1.2378 | \$ 73.66 | \$ 16.52 | \$ 14.73 |
| 65220 | Remove foreign body from eye | | S | 0698 | 1.2378 | \$ 73.66 | \$ 16.52 | \$ 14.73 |
| 65222 | Remove foreign body from eye | | S | 0698 | 1.2378 | \$ 73.66 | \$ 16.52 | \$ 14.73 |
| 65235 | Remove foreign body from eye | | T | 0233 | 14.6645 | \$ 872.70 | \$ 266.33 | \$ 174.54 |
| 65260 | Remove foreign body from eye | | T | 0236 | 16.9771 | \$ 1,010.32 | | \$ 202.06 |
| 65265 | Remove foreign body from eye | CH | T | 0237 | 28.7866 | \$ 1,713.12 | | \$ 342.62 |
| 65270 | Repair of eye wound | | T | 0240 | 18.0194 | \$ 1,072.35 | \$ 315.31 | \$ 214.47 |
| 65272 | Repair of eye wound | | T | 0234 | 22.0521 | \$ 1,312.34 | \$ 511.31 | \$ 262.47 |
| 65275 | Repair of eye wound | | T | 0234 | 22.0521 | \$ 1,312.34 | \$ 511.31 | \$ 262.47 |
| 65280 | Repair of eye wound | | T | 0236 | 16.9771 | \$ 1,010.32 | | \$ 202.06 |
| 65285 | Repair of eye wound | CH | T | 0672 | 36.8773 | \$ 2,194.61 | | \$ 438.92 |
| 65286 | Repair of eye wound | | T | 0232 | 6.9204 | \$ 411.84 | \$ 103.17 | \$ 82.37 |
| 65290 | Repair of eye socket wound | | T | 0243 | 22.0338 | \$ 1,311.25 | \$ 431.39 | \$ 262.25 |
| 65400 | Removal of eye lesion | | T | 0233 | 14.6645 | \$ 872.70 | \$ 266.33 | \$ 174.54 |
| 65410 | Biopsy of cornea | | T | 0233 | 14.6645 | \$ 872.70 | \$ 266.33 | \$ 174.54 |
| 65420 | Removal of eye lesion | | T | 0233 | 14.6645 | \$ 872.70 | \$ 266.33 | \$ 174.54 |
| 65426 | Removal of eye lesion | | T | 0234 | 22.0521 | \$ 1,312.34 | \$ 511.31 | \$ 262.47 |
| 65430 | Corneal smear | CH | S | 0698 | 1.2378 | \$ 73.66 | \$ 16.52 | \$ 14.73 |
| 65435 | Curette/treat cornea | | T | 0239 | 7.0583 | \$ 420.05 | | \$ 84.01 |
| 65436 | Curette/treat cornea | | T | 0233 | 14.6645 | \$ 872.70 | \$ 266.33 | \$ 174.54 |
| 65450 | Treatment of corneal lesion | | S | 0231 | 1.9167 | \$ 114.06 | | \$ 22.81 |
| 65600 | Revision of cornea | | T | 0240 | 18.0194 | \$ 1,072.35 | \$ 315.31 | \$ 214.47 |
| 65710 | Corneal transplant | | T | 0244 | 38.2309 | \$ 2,275.16 | \$ 803.26 | \$ 455.03 |
| 65730 | Corneal transplant | | T | 0244 | 38.2309 | \$ 2,275.16 | \$ 803.26 | \$ 455.03 |
| 65750 | Corneal transplant | | T | 0244 | 38.2309 | \$ 2,275.16 | \$ 803.26 | \$ 455.03 |
| 65755 | Corneal transplant | | T | 0244 | 38.2309 | \$ 2,275.16 | \$ 803.26 | \$ 455.03 |
| 65770 | Revise cornea with implant | | T | 0244 | 38.2309 | \$ 2,275.16 | \$ 803.26 | \$ 455.03 |
| 65772 | Correction of astigmatism | | T | 0233 | 14.6645 | \$ 872.70 | \$ 266.33 | \$ 174.54 |
| 65775 | Correction of astigmatism | | T | 0233 | 14.6645 | \$ 872.70 | \$ 266.33 | \$ 174.54 |
| 65780 | Ocular reconst, transplant | | T | 0244 | 38.2309 | \$ 2,275.16 | \$ 803.26 | \$ 455.03 |
| 65781 | Ocular reconst, transplant | | T | 0244 | 38.2309 | \$ 2,275.16 | \$ 803.26 | \$ 455.03 |
| 65782 | Ocular reconst, transplant | | T | 0244 | 38.2309 | \$ 2,275.16 | \$ 803.26 | \$ 455.03 |
| 65800 | Drainage of eye | | T | 0233 | 14.6645 | \$ 872.70 | \$ 266.33 | \$ 174.54 |
| 65805 | Drainage of eye | | T | 0233 | 14.6645 | \$ 872.70 | \$ 266.33 | \$ 174.54 |
| 65810 | Drainage of eye | | T | 0234 | 22.0521 | \$ 1,312.34 | \$ 511.31 | \$ 262.47 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|-----------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 65815 | Drainage of eye | | T | 0234 | 22.0521 | \$ 1,312.34 | \$ 511.31 | \$ 262.47 |
| 65820 | Relieve inner eye pressure | | T | 0232 | 6.9204 | \$ 411.84 | \$ 103.17 | \$ 82.37 |
| 65850 | Incision of eye | | T | 0234 | 22.0521 | \$ 1,312.34 | \$ 511.31 | \$ 262.47 |
| 65855 | Laser surgery of eye | | T | 0247 | 5.0255 | \$ 299.07 | \$ 104.31 | \$ 59.81 |
| 65860 | Incise inner eye adhesions | | T | 0247 | 5.0255 | \$ 299.07 | \$ 104.31 | \$ 59.81 |
| 65865 | Incise inner eye adhesions | | T | 0233 | 14.6645 | \$ 872.70 | \$ 266.33 | \$ 174.54 |
| 65870 | Incise inner eye adhesions | | T | 0234 | 22.0521 | \$ 1,312.34 | \$ 511.31 | \$ 262.47 |
| 65875 | Incise inner eye adhesions | | T | 0234 | 22.0521 | \$ 1,312.34 | \$ 511.31 | \$ 262.47 |
| 65880 | Incise inner eye adhesions | | T | 0233 | 14.6645 | \$ 872.70 | \$ 266.33 | \$ 174.54 |
| 65900 | Remove eye lesion | | T | 0233 | 14.6645 | \$ 872.70 | \$ 266.33 | \$ 174.54 |
| 65920 | Remove implant of eye | | T | 0234 | 22.0521 | \$ 1,312.34 | \$ 511.31 | \$ 262.47 |
| 65930 | Remove blood clot from eye | | T | 0234 | 22.0521 | \$ 1,312.34 | \$ 511.31 | \$ 262.47 |
| 66020 | Injection treatment of eye | | T | 0233 | 14.6645 | \$ 872.70 | \$ 266.33 | \$ 174.54 |
| 66030 | Injection treatment of eye | | T | 0232 | 6.9204 | \$ 411.84 | \$ 103.17 | \$ 82.37 |
| 66130 | Remove eye lesion | | T | 0234 | 22.0521 | \$ 1,312.34 | \$ 511.31 | \$ 262.47 |
| 66150 | Glaucoma surgery | | T | 0234 | 22.0521 | \$ 1,312.34 | \$ 511.31 | \$ 262.47 |
| 66155 | Glaucoma surgery | | T | 0234 | 22.0521 | \$ 1,312.34 | \$ 511.31 | \$ 262.47 |
| 66160 | Glaucoma surgery | | T | 0234 | 22.0521 | \$ 1,312.34 | \$ 511.31 | \$ 262.47 |
| 66165 | Glaucoma surgery | | T | 0234 | 22.0521 | \$ 1,312.34 | \$ 511.31 | \$ 262.47 |
| 66170 | Glaucoma surgery | | T | 0234 | 22.0521 | \$ 1,312.34 | \$ 511.31 | \$ 262.47 |
| 66172 | Incision of eye | | T | 0673 | 29.0835 | \$ 1,730.79 | \$ 649.56 | \$ 346.16 |
| 66180 | Implant eye shunt | | T | 0673 | 29.0835 | \$ 1,730.79 | \$ 649.56 | \$ 346.16 |
| 66185 | Revise eye shunt | | T | 0673 | 29.0835 | \$ 1,730.79 | \$ 649.56 | \$ 346.16 |
| 66220 | Repair eye lesion | CH | T | 0672 | 36.8773 | \$ 2,194.61 | | \$ 438.92 |
| 66225 | Repair/graft eye lesion | | T | 0673 | 29.0835 | \$ 1,730.79 | \$ 649.56 | \$ 346.16 |
| 66250 | Follow-up surgery of eye | | T | 0233 | 14.6645 | \$ 872.70 | \$ 266.33 | \$ 174.54 |
| 66500 | Incision of iris | | T | 0232 | 6.9204 | \$ 411.84 | \$ 103.17 | \$ 82.37 |
| 66505 | Incision of iris | | T | 0232 | 6.9204 | \$ 411.84 | \$ 103.17 | \$ 82.37 |
| 66600 | Remove iris and lesion | | T | 0234 | 22.0521 | \$ 1,312.34 | \$ 511.31 | \$ 262.47 |
| 66605 | Removal of iris | | T | 0234 | 22.0521 | \$ 1,312.34 | \$ 511.31 | \$ 262.47 |
| 66625 | Removal of iris | | T | 0232 | 6.9204 | \$ 411.84 | \$ 103.17 | \$ 82.37 |
| 66630 | Removal of iris | | T | 0234 | 22.0521 | \$ 1,312.34 | \$ 511.31 | \$ 262.47 |
| 66635 | Removal of iris | | T | 0234 | 22.0521 | \$ 1,312.34 | \$ 511.31 | \$ 262.47 |
| 66680 | Repair iris & ciliary body | | T | 0234 | 22.0521 | \$ 1,312.34 | \$ 511.31 | \$ 262.47 |
| 66682 | Repair iris & ciliary body | | T | 0234 | 22.0521 | \$ 1,312.34 | \$ 511.31 | \$ 262.47 |
| 66700 | Destruction, ciliary body | | T | 0233 | 14.6645 | \$ 872.70 | \$ 266.33 | \$ 174.54 |
| 66710 | Ciliary transsleral therapy | | T | 0233 | 14.6645 | \$ 872.70 | \$ 266.33 | \$ 174.54 |
| 66711 | Ciliary endoscopic ablation | | T | 0233 | 14.6645 | \$ 872.70 | \$ 266.33 | \$ 174.54 |
| 66720 | Destruction, ciliary body | | T | 0233 | 14.6645 | \$ 872.70 | \$ 266.33 | \$ 174.54 |
| 66740 | Destruction, ciliary body | | T | 0234 | 22.0521 | \$ 1,312.34 | \$ 511.31 | \$ 262.47 |
| 66761 | Revision of iris | | T | 0247 | 5.0255 | \$ 299.07 | \$ 104.31 | \$ 59.81 |
| 66762 | Revision of iris | | T | 0247 | 5.0255 | \$ 299.07 | \$ 104.31 | \$ 59.81 |
| 66770 | Removal of inner eye lesion | | T | 0247 | 5.0255 | \$ 299.07 | \$ 104.31 | \$ 59.81 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 66820 | Incision, secondary cataract | | T | 0232 | 6.9204 | \$ 411.84 | \$ 103.17 | \$ 82.37 |
| 66821 | After cataract laser surgery | | T | 0247 | 5.0255 | \$ 299.07 | \$ 104.31 | \$ 59.81 |
| 66825 | Reposition intraocular lens | | T | 0234 | 22.0521 | \$ 1,312.34 | \$ 511.31 | \$ 262.47 |
| 66830 | Removal of lens lesion | | T | 0232 | 6.9204 | \$ 411.84 | \$ 103.17 | \$ 82.37 |
| 66840 | Removal of lens material | | T | 0245 | 13.0344 | \$ 775.69 | \$ 217.05 | \$ 155.14 |
| 66850 | Removal of lens material | | T | 0249 | 27.6388 | \$ 1,644.81 | \$ 524.67 | \$ 328.96 |
| 66852 | Removal of lens material | | T | 0249 | 27.6388 | \$ 1,644.81 | \$ 524.67 | \$ 328.96 |
| 66920 | Extraction of lens | | T | 0249 | 27.6388 | \$ 1,644.81 | \$ 524.67 | \$ 328.96 |
| 66930 | Extraction of lens | | T | 0249 | 27.6388 | \$ 1,644.81 | \$ 524.67 | \$ 328.96 |
| 66940 | Extraction of lens | | T | 0245 | 13.0344 | \$ 775.69 | \$ 217.05 | \$ 155.14 |
| 66982 | Cataract surgery, complex | | T | 0246 | 23.3185 | \$ 1,387.71 | \$ 495.96 | \$ 277.54 |
| 66983 | Cataract surg w/iol, 1 stage | | T | 0246 | 23.3185 | \$ 1,387.71 | \$ 495.96 | \$ 277.54 |
| 66984 | Cataract surg w/iol, 1 stage | | T | 0246 | 23.3185 | \$ 1,387.71 | \$ 495.96 | \$ 277.54 |
| 66985 | Insert lens prosthesis | | T | 0246 | 23.3185 | \$ 1,387.71 | \$ 495.96 | \$ 277.54 |
| 66986 | Exchange lens prosthesis | | T | 0246 | 23.3185 | \$ 1,387.71 | \$ 495.96 | \$ 277.54 |
| 66990 | Ophthalmic endoscope add-on | | N | | | | | |
| 66999 | Eye surgery procedure | | T | 0232 | 6.9204 | \$ 411.84 | \$ 103.17 | \$ 82.37 |
| 67005 | Partial removal of eye fluid | | T | 0237 | 28.7866 | \$ 1,713.12 | | \$ 342.62 |
| 67010 | Partial removal of eye fluid | | T | 0237 | 28.7866 | \$ 1,713.12 | | \$ 342.62 |
| 67015 | Release of eye fluid | | T | 0237 | 28.7866 | \$ 1,713.12 | | \$ 342.62 |
| 67025 | Replace eye fluid | CH | T | 0237 | 28.7866 | \$ 1,713.12 | | \$ 342.62 |
| 67027 | Implant eye drug system | CH | T | 0672 | 36.8773 | \$ 2,194.61 | | \$ 438.92 |
| 67028 | Injection eye drug | | T | 0235 | 4.7925 | \$ 285.21 | \$ 69.52 | \$ 57.04 |
| 67030 | Incise inner eye strands | | T | 0236 | 16.9771 | \$ 1,010.32 | | \$ 202.06 |
| 67031 | Laser surgery, eye strands | | T | 0247 | 5.0255 | \$ 299.07 | \$ 104.31 | \$ 59.81 |
| 67036 | Removal of inner eye fluid | CH | T | 0672 | 36.8773 | \$ 2,194.61 | | \$ 438.92 |
| 67038 | Strip retinal membrane | CH | T | 0672 | 36.8773 | \$ 2,194.61 | | \$ 438.92 |
| 67039 | Laser treatment of retina | CH | T | 0672 | 36.8773 | \$ 2,194.61 | | \$ 438.92 |
| 67040 | Laser treatment of retina | | T | 0672 | 36.8773 | \$ 2,194.61 | | \$ 438.92 |
| 67101 | Repair detached retina | CH | T | 0236 | 16.9771 | \$ 1,010.32 | | \$ 202.06 |
| 67105 | Repair detached retina | | T | 0248 | 4.7199 | \$ 280.89 | \$ 95.08 | \$ 56.18 |
| 67107 | Repair detached retina | | T | 0672 | 36.8773 | \$ 2,194.61 | | \$ 438.92 |
| 67108 | Repair detached retina | | T | 0672 | 36.8773 | \$ 2,194.61 | | \$ 438.92 |
| 67110 | Repair detached retina | | T | 0236 | 16.9771 | \$ 1,010.32 | | \$ 202.06 |
| 67112 | Rerepair detached retina | | T | 0672 | 36.8773 | \$ 2,194.61 | | \$ 438.92 |
| 67115 | Release encircling material | | T | 0236 | 16.9771 | \$ 1,010.32 | | \$ 202.06 |
| 67120 | Remove eye implant material | | T | 0236 | 16.9771 | \$ 1,010.32 | | \$ 202.06 |
| 67121 | Remove eye implant material | CH | T | 0237 | 28.7866 | \$ 1,713.12 | | \$ 342.62 |
| 67141 | Treatment of retina | | T | 0235 | 4.7925 | \$ 285.21 | \$ 69.52 | \$ 57.04 |
| 67145 | Treatment of retina | | T | 0248 | 4.7199 | \$ 280.89 | \$ 95.08 | \$ 56.18 |
| 67208 | Treatment of retinal lesion | CH | T | 0236 | 16.9771 | \$ 1,010.32 | | \$ 202.06 |
| 67210 | Treatment of retinal lesion | | T | 0248 | 4.7199 | \$ 280.89 | \$ 95.08 | \$ 56.18 |
| 67218 | Treatment of retinal lesion | | T | 0236 | 16.9771 | \$ 1,010.32 | | \$ 202.06 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 67220 | Treatment of choroid lesion | | T | 0235 | 4.7925 | \$ 285.21 | \$ 69.52 | \$ 57.04 |
| 67221 | Ocular photodynamic ther | | T | 0235 | 4.7925 | \$ 285.21 | \$ 69.52 | \$ 57.04 |
| 67225 | Eye photodynamic ther add-on | | T | 0235 | 4.7925 | \$ 285.21 | \$ 69.52 | \$ 57.04 |
| 67227 | Treatment of retinal lesion | CH | T | 0236 | 16.9771 | \$ 1,010.32 | | \$ 202.06 |
| 67228 | Treatment of retinal lesion | | T | 0248 | 4.7199 | \$ 280.89 | \$ 95.08 | \$ 56.18 |
| 67250 | Reinforce eye wall | | T | 0240 | 18.0194 | \$ 1,072.35 | \$ 315.31 | \$ 214.47 |
| 67255 | Reinforce/graft eye wall | | T | 0237 | 28.7866 | \$ 1,713.12 | | \$ 342.62 |
| 67299 | Eye surgery procedure | | T | 0235 | 4.7925 | \$ 285.21 | \$ 69.52 | \$ 57.04 |
| 67311 | Revise eye muscle | | T | 0243 | 22.0338 | \$ 1,311.25 | \$ 431.39 | \$ 262.25 |
| 67312 | Revise two eye muscles | | T | 0243 | 22.0338 | \$ 1,311.25 | \$ 431.39 | \$ 262.25 |
| 67314 | Revise eye muscle | | T | 0243 | 22.0338 | \$ 1,311.25 | \$ 431.39 | \$ 262.25 |
| 67316 | Revise two eye muscles | | T | 0243 | 22.0338 | \$ 1,311.25 | \$ 431.39 | \$ 262.25 |
| 67318 | Revise eye muscle(s) | | T | 0243 | 22.0338 | \$ 1,311.25 | \$ 431.39 | \$ 262.25 |
| 67320 | Revise eye muscle(s) add-on | | T | 0243 | 22.0338 | \$ 1,311.25 | \$ 431.39 | \$ 262.25 |
| 67331 | Eye surgery follow-up add-on | | T | 0243 | 22.0338 | \$ 1,311.25 | \$ 431.39 | \$ 262.25 |
| 67332 | Rerevise eye muscles add-on | | T | 0243 | 22.0338 | \$ 1,311.25 | \$ 431.39 | \$ 262.25 |
| 67334 | Revise eye muscle w/suture | | T | 0243 | 22.0338 | \$ 1,311.25 | \$ 431.39 | \$ 262.25 |
| 67335 | Eye suture during surgery | | T | 0243 | 22.0338 | \$ 1,311.25 | \$ 431.39 | \$ 262.25 |
| 67340 | Revise eye muscle add-on | | T | 0243 | 22.0338 | \$ 1,311.25 | \$ 431.39 | \$ 262.25 |
| 67343 | Release eye tissue | | T | 0243 | 22.0338 | \$ 1,311.25 | \$ 431.39 | \$ 262.25 |
| 67345 | Destroy nerve of eye muscle | | T | 0238 | 2.6031 | \$ 154.91 | | \$ 30.98 |
| 67350 | Biopsy eye muscle | | T | 0699 | 8.9556 | \$ 532.96 | | \$ 106.59 |
| 67399 | Eye muscle surgery procedure | | T | 0243 | 22.0338 | \$ 1,311.25 | \$ 431.39 | \$ 262.25 |
| 67400 | Explore/biopsy eye socket | | T | 0241 | 23.1681 | \$ 1,378.76 | \$ 384.47 | \$ 275.75 |
| 67405 | Explore/drain eye socket | | T | 0241 | 23.1681 | \$ 1,378.76 | \$ 384.47 | \$ 275.75 |
| 67412 | Explore/treat eye socket | | T | 0241 | 23.1681 | \$ 1,378.76 | \$ 384.47 | \$ 275.75 |
| 67413 | Explore/treat eye socket | | T | 0241 | 23.1681 | \$ 1,378.76 | \$ 384.47 | \$ 275.75 |
| 67414 | Explr/decompress eye socket | | T | 0242 | 30.3478 | \$ 1,806.03 | \$ 597.36 | \$ 361.21 |
| 67415 | Aspiration, orbital contents | | T | 0240 | 18.0194 | \$ 1,072.35 | \$ 315.31 | \$ 214.47 |
| 67420 | Explore/treat eye socket | | T | 0242 | 30.3478 | \$ 1,806.03 | \$ 597.36 | \$ 361.21 |
| 67430 | Explore/treat eye socket | | T | 0242 | 30.3478 | \$ 1,806.03 | \$ 597.36 | \$ 361.21 |
| 67440 | Explore/drain eye socket | | T | 0242 | 30.3478 | \$ 1,806.03 | \$ 597.36 | \$ 361.21 |
| 67445 | Explr/decompress eye socket | | T | 0242 | 30.3478 | \$ 1,806.03 | \$ 597.36 | \$ 361.21 |
| 67450 | Explore/biopsy eye socket | | T | 0242 | 30.3478 | \$ 1,806.03 | \$ 597.36 | \$ 361.21 |
| 67500 | Inject/treat eye socket | | S | 0231 | 1.9167 | \$ 114.06 | | \$ 22.81 |
| 67505 | Inject/treat eye socket | | T | 0238 | 2.6031 | \$ 154.91 | | \$ 30.98 |
| 67515 | Inject/treat eye socket | | T | 0238 | 2.6031 | \$ 154.91 | | \$ 30.98 |
| 67550 | Insert eye socket implant | | T | 0242 | 30.3478 | \$ 1,806.03 | \$ 597.36 | \$ 361.21 |
| 67560 | Revise eye socket implant | | T | 0241 | 23.1681 | \$ 1,378.76 | \$ 384.47 | \$ 275.75 |
| 67570 | Decompress optic nerve | | T | 0242 | 30.3478 | \$ 1,806.03 | \$ 597.36 | \$ 361.21 |
| 67599 | Orbit surgery procedure | | T | 0238 | 2.6031 | \$ 154.91 | | \$ 30.98 |
| 67700 | Drainage of eyelid abscess | | T | 0238 | 2.6031 | \$ 154.91 | | \$ 30.98 |
| 67710 | Incision of eyelid | | T | 0239 | 7.0583 | \$ 420.05 | | \$ 84.01 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|-----------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 67715 | Incision of eyelid fold | | T | 0240 | 18.0194 | \$ 1,072.35 | \$ 315.31 | \$ 214.47 |
| 67800 | Remove eyelid lesion | | T | 0238 | 2.6031 | \$ 154.91 | | \$ 30.98 |
| 67801 | Remove eyelid lesions | | T | 0239 | 7.0583 | \$ 420.05 | | \$ 84.01 |
| 67805 | Remove eyelid lesions | | T | 0238 | 2.6031 | \$ 154.91 | | \$ 30.98 |
| 67808 | Remove eyelid lesion(s) | | T | 0240 | 18.0194 | \$ 1,072.35 | \$ 315.31 | \$ 214.47 |
| 67810 | Biopsy of eyelid | | T | 0238 | 2.6031 | \$ 154.91 | | \$ 30.98 |
| 67820 | Revise eyelashes | | S | 0698 | 1.2378 | \$ 73.66 | \$ 16.52 | \$ 14.73 |
| 67825 | Revise eyelashes | | T | 0238 | 2.6031 | \$ 154.91 | | \$ 30.98 |
| 67830 | Revise eyelashes | | T | 0239 | 7.0583 | \$ 420.05 | | \$ 84.01 |
| 67835 | Revise eyelashes | | T | 0240 | 18.0194 | \$ 1,072.35 | \$ 315.31 | \$ 214.47 |
| 67840 | Remove eyelid lesion | | T | 0239 | 7.0583 | \$ 420.05 | | \$ 84.01 |
| 67850 | Treat eyelid lesion | | T | 0239 | 7.0583 | \$ 420.05 | | \$ 84.01 |
| 67875 | Closure of eyelid by suture | | T | 0239 | 7.0583 | \$ 420.05 | | \$ 84.01 |
| 67880 | Revision of eyelid | | T | 0233 | 14.6645 | \$ 872.70 | \$ 266.33 | \$ 174.54 |
| 67882 | Revision of eyelid | | T | 0240 | 18.0194 | \$ 1,072.35 | \$ 315.31 | \$ 214.47 |
| 67900 | Repair brow defect | | T | 0240 | 18.0194 | \$ 1,072.35 | \$ 315.31 | \$ 214.47 |
| 67901 | Repair eyelid defect | | T | 0240 | 18.0194 | \$ 1,072.35 | \$ 315.31 | \$ 214.47 |
| 67902 | Repair eyelid defect | | T | 0240 | 18.0194 | \$ 1,072.35 | \$ 315.31 | \$ 214.47 |
| 67903 | Repair eyelid defect | | T | 0240 | 18.0194 | \$ 1,072.35 | \$ 315.31 | \$ 214.47 |
| 67904 | Repair eyelid defect | | T | 0240 | 18.0194 | \$ 1,072.35 | \$ 315.31 | \$ 214.47 |
| 67906 | Repair eyelid defect | | T | 0240 | 18.0194 | \$ 1,072.35 | \$ 315.31 | \$ 214.47 |
| 67908 | Repair eyelid defect | | T | 0240 | 18.0194 | \$ 1,072.35 | \$ 315.31 | \$ 214.47 |
| 67909 | Revise eyelid defect | | T | 0240 | 18.0194 | \$ 1,072.35 | \$ 315.31 | \$ 214.47 |
| 67911 | Revise eyelid defect | | T | 0240 | 18.0194 | \$ 1,072.35 | \$ 315.31 | \$ 214.47 |
| 67912 | Correction eyelid w/implant | | T | 0240 | 18.0194 | \$ 1,072.35 | \$ 315.31 | \$ 214.47 |
| 67914 | Repair eyelid defect | | T | 0240 | 18.0194 | \$ 1,072.35 | \$ 315.31 | \$ 214.47 |
| 67915 | Repair eyelid defect | CH | T | 0240 | 18.0194 | \$ 1,072.35 | \$ 315.31 | \$ 214.47 |
| 67916 | Repair eyelid defect | | T | 0240 | 18.0194 | \$ 1,072.35 | \$ 315.31 | \$ 214.47 |
| 67917 | Repair eyelid defect | | T | 0240 | 18.0194 | \$ 1,072.35 | \$ 315.31 | \$ 214.47 |
| 67921 | Repair eyelid defect | | T | 0240 | 18.0194 | \$ 1,072.35 | \$ 315.31 | \$ 214.47 |
| 67922 | Repair eyelid defect | | T | 0240 | 18.0194 | \$ 1,072.35 | \$ 315.31 | \$ 214.47 |
| 67923 | Repair eyelid defect | | T | 0240 | 18.0194 | \$ 1,072.35 | \$ 315.31 | \$ 214.47 |
| 67924 | Repair eyelid defect | | T | 0240 | 18.0194 | \$ 1,072.35 | \$ 315.31 | \$ 214.47 |
| 67930 | Repair eyelid wound | | T | 0240 | 18.0194 | \$ 1,072.35 | \$ 315.31 | \$ 214.47 |
| 67935 | Repair eyelid wound | | T | 0240 | 18.0194 | \$ 1,072.35 | \$ 315.31 | \$ 214.47 |
| 67938 | Remove eyelid foreign body | | S | 0698 | 1.2378 | \$ 73.66 | \$ 16.52 | \$ 14.73 |
| 67950 | Revision of eyelid | | T | 0240 | 18.0194 | \$ 1,072.35 | \$ 315.31 | \$ 214.47 |
| 67961 | Revision of eyelid | | T | 0240 | 18.0194 | \$ 1,072.35 | \$ 315.31 | \$ 214.47 |
| 67966 | Revision of eyelid | | T | 0240 | 18.0194 | \$ 1,072.35 | \$ 315.31 | \$ 214.47 |
| 67971 | Reconstruction of eyelid | | T | 0241 | 23.1681 | \$ 1,378.76 | \$ 384.47 | \$ 275.75 |
| 67973 | Reconstruction of eyelid | | T | 0241 | 23.1681 | \$ 1,378.76 | \$ 384.47 | \$ 275.75 |
| 67974 | Reconstruction of eyelid | | T | 0241 | 23.1681 | \$ 1,378.76 | \$ 384.47 | \$ 275.75 |
| 67975 | Reconstruction of eyelid | | T | 0240 | 18.0194 | \$ 1,072.35 | \$ 315.31 | \$ 214.47 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 67999 | Revision of eyelid | | T | 0238 | 2.6031 | \$ 154.91 | | \$ 30.98 |
| 68020 | Incise/drain eyelid lining | | T | 0240 | 18.0194 | \$ 1,072.35 | \$ 315.31 | \$ 214.47 |
| 68040 | Treatment of eyelid lesions | | S | 0698 | 1.2378 | \$ 73.66 | \$ 16.52 | \$ 14.73 |
| 68100 | Biopsy of eyelid lining | | T | 0232 | 6.9204 | \$ 411.84 | \$ 103.17 | \$ 82.37 |
| 68110 | Remove eyelid lining lesion | | T | 0699 | 8.9556 | \$ 532.96 | | \$ 106.59 |
| 68115 | Remove eyelid lining lesion | | T | 0240 | 18.0194 | \$ 1,072.35 | \$ 315.31 | \$ 214.47 |
| 68130 | Remove eyelid lining lesion | | T | 0233 | 14.6645 | \$ 872.70 | \$ 266.33 | \$ 174.54 |
| 68135 | Remove eyelid lining lesion | | T | 0239 | 7.0583 | \$ 420.05 | | \$ 84.01 |
| 68200 | Treat eyelid by injection | | S | 0230 | 0.7902 | \$ 47.03 | \$ 14.97 | \$ 9.41 |
| 68320 | Revise/graft eyelid lining | | T | 0240 | 18.0194 | \$ 1,072.35 | \$ 315.31 | \$ 214.47 |
| 68325 | Revise/graft eyelid lining | | T | 0242 | 30.3478 | \$ 1,806.03 | \$ 597.36 | \$ 361.21 |
| 68326 | Revise/graft eyelid lining | | T | 0241 | 23.1681 | \$ 1,378.76 | \$ 384.47 | \$ 275.75 |
| 68328 | Revise/graft eyelid lining | | T | 0241 | 23.1681 | \$ 1,378.76 | \$ 384.47 | \$ 275.75 |
| 68330 | Revise eyelid lining | | T | 0234 | 22.0521 | \$ 1,312.34 | \$ 511.31 | \$ 262.47 |
| 68335 | Revise/graft eyelid lining | | T | 0241 | 23.1681 | \$ 1,378.76 | \$ 384.47 | \$ 275.75 |
| 68340 | Separate eyelid adhesions | | T | 0240 | 18.0194 | \$ 1,072.35 | \$ 315.31 | \$ 214.47 |
| 68360 | Revise eyelid lining | | T | 0234 | 22.0521 | \$ 1,312.34 | \$ 511.31 | \$ 262.47 |
| 68362 | Revise eyelid lining | | T | 0234 | 22.0521 | \$ 1,312.34 | \$ 511.31 | \$ 262.47 |
| 68371 | Harvest eye tissue, alograft | | T | 0233 | 14.6645 | \$ 872.70 | \$ 266.33 | \$ 174.54 |
| 68399 | Eyelid lining surgery | | T | 0238 | 2.6031 | \$ 154.91 | | \$ 30.98 |
| 68400 | Incise/drain tear gland | | T | 0238 | 2.6031 | \$ 154.91 | | \$ 30.98 |
| 68420 | Incise/drain tear sac | | T | 0240 | 18.0194 | \$ 1,072.35 | \$ 315.31 | \$ 214.47 |
| 68440 | Incise tear duct opening | | T | 0238 | 2.6031 | \$ 154.91 | | \$ 30.98 |
| 68500 | Removal of tear gland | | T | 0241 | 23.1681 | \$ 1,378.76 | \$ 384.47 | \$ 275.75 |
| 68505 | Partial removal, tear gland | | T | 0241 | 23.1681 | \$ 1,378.76 | \$ 384.47 | \$ 275.75 |
| 68510 | Biopsy of tear gland | | T | 0240 | 18.0194 | \$ 1,072.35 | \$ 315.31 | \$ 214.47 |
| 68520 | Removal of tear sac | | T | 0241 | 23.1681 | \$ 1,378.76 | \$ 384.47 | \$ 275.75 |
| 68525 | Biopsy of tear sac | | T | 0240 | 18.0194 | \$ 1,072.35 | \$ 315.31 | \$ 214.47 |
| 68530 | Clearance of tear duct | | T | 0240 | 18.0194 | \$ 1,072.35 | \$ 315.31 | \$ 214.47 |
| 68540 | Remove tear gland lesion | | T | 0241 | 23.1681 | \$ 1,378.76 | \$ 384.47 | \$ 275.75 |
| 68550 | Remove tear gland lesion | | T | 0242 | 30.3478 | \$ 1,806.03 | \$ 597.36 | \$ 361.21 |
| 68700 | Repair tear ducts | | T | 0241 | 23.1681 | \$ 1,378.76 | \$ 384.47 | \$ 275.75 |
| 68705 | Revise tear duct opening | | T | 0238 | 2.6031 | \$ 154.91 | | \$ 30.98 |
| 68720 | Create tear sac drain | | T | 0242 | 30.3478 | \$ 1,806.03 | \$ 597.36 | \$ 361.21 |
| 68745 | Create tear duct drain | | T | 0241 | 23.1681 | \$ 1,378.76 | \$ 384.47 | \$ 275.75 |
| 68750 | Create tear duct drain | | T | 0242 | 30.3478 | \$ 1,806.03 | \$ 597.36 | \$ 361.21 |
| 68760 | Close tear duct opening | | S | 0698 | 1.2378 | \$ 73.66 | \$ 16.52 | \$ 14.73 |
| 68761 | Close tear duct opening | | S | 0231 | 1.9167 | \$ 114.06 | | \$ 22.81 |
| 68770 | Close tear system fistula | | T | 0240 | 18.0194 | \$ 1,072.35 | \$ 315.31 | \$ 214.47 |
| 68801 | Dilate tear duct opening | | S | 0698 | 1.2378 | \$ 73.66 | \$ 16.52 | \$ 14.73 |
| 68810 | Probe nasolacrimal duct | CH | S | 0231 | 1.9167 | \$ 114.06 | | \$ 22.81 |
| 68811 | Probe nasolacrimal duct | | T | 0240 | 18.0194 | \$ 1,072.35 | \$ 315.31 | \$ 214.47 |
| 68815 | Probe nasolacrimal duct | | T | 0240 | 18.0194 | \$ 1,072.35 | \$ 315.31 | \$ 214.47 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 68840 | Explore/irrigate tear ducts | | S | 0231 | 1.9167 | \$ 114.06 | | \$ 22.81 |
| 68850 | Injection for tear sac x-ray | | N | | | | | |
| 68899 | Tear duct system surgery | | S | 0230 | 0.7902 | \$ 47.03 | \$ 14.97 | \$ 9.41 |
| 69000 | Drain external ear lesion | | T | 0006 | 1.5100 | \$ 89.86 | \$ 21.76 | \$ 17.97 |
| 69005 | Drain external ear lesion | CH | T | 0008 | 16.2953 | \$ 969.75 | | \$ 193.95 |
| 69020 | Drain outer ear canal lesion | | T | 0006 | 1.5100 | \$ 89.86 | \$ 21.76 | \$ 17.97 |
| 69100 | Biopsy of external ear | | T | 0019 | 4.1481 | \$ 246.86 | \$ 71.87 | \$ 49.37 |
| 69105 | Biopsy of external ear canal | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 69110 | Remove external ear, partial | | T | 0021 | 14.9984 | \$ 892.57 | \$ 219.48 | \$ 178.51 |
| 69120 | Removal of external ear | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 69140 | Remove ear canal lesion(s) | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 69145 | Remove ear canal lesion(s) | | T | 0021 | 14.9984 | \$ 892.57 | \$ 219.48 | \$ 178.51 |
| 69150 | Extensive ear canal surgery | | T | 0252 | 8.1033 | \$ 482.24 | \$ 113.41 | \$ 96.45 |
| 69200 | Clear outer ear canal | | X | 0340 | 0.6137 | \$ 36.52 | | \$ 7.30 |
| 69205 | Clear outer ear canal | | T | 0022 | 19.5716 | \$ 1,164.73 | \$ 354.45 | \$ 232.95 |
| 69210 | Remove impacted ear wax | | X | 0340 | 0.6137 | \$ 36.52 | | \$ 7.30 |
| 69220 | Clean out mastoid cavity | | T | 0012 | 0.8477 | \$ 50.45 | \$ 11.18 | \$ 10.09 |
| 69222 | Clean out mastoid cavity | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 69300 | Revise external ear | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 69310 | Rebuild outer ear canal | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 69320 | Rebuild outer ear canal | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 69399 | Outer ear surgery procedure | | T | 0251 | 2.0789 | \$ 123.72 | | \$ 24.74 |
| 69400 | Inflate middle ear canal | | T | 0251 | 2.0789 | \$ 123.72 | | \$ 24.74 |
| 69401 | Inflate middle ear canal | | T | 0251 | 2.0789 | \$ 123.72 | | \$ 24.74 |
| 69405 | Catheterize middle ear canal | | T | 0252 | 8.1033 | \$ 482.24 | \$ 113.41 | \$ 96.45 |
| 69410 | Inset middle ear (baffle) | CH | D | | | | | |
| 69420 | Incision of eardrum | CH | T | 0251 | 2.0789 | \$ 123.72 | | \$ 24.74 |
| 69421 | Incision of eardrum | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 69424 | Remove ventilating tube | | T | 0252 | 8.1033 | \$ 482.24 | \$ 113.41 | \$ 96.45 |
| 69433 | Create eardrum opening | | T | 0252 | 8.1033 | \$ 482.24 | \$ 113.41 | \$ 96.45 |
| 69436 | Create eardrum opening | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 69440 | Exploration of middle ear | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 69450 | Eardrum revision | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 69501 | Mastoidectomy | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 69502 | Mastoidectomy | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 69505 | Remove mastoid structures | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 69511 | Extensive mastoid surgery | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 69530 | Extensive mastoid surgery | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 69540 | Remove ear lesion | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 69550 | Remove ear lesion | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 69552 | Remove ear lesion | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 69601 | Mastoid surgery revision | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 69602 | Mastoid surgery revision | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 69603 | Mastoid surgery revision | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 69604 | Mastoid surgery revision | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 69605 | Mastoid surgery revision | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 69610 | Repair of eardrum | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 69620 | Repair of eardrum | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 69631 | Repair eardrum structures | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 69632 | Rebuild eardrum structures | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 69633 | Rebuild eardrum structures | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 69635 | Repair eardrum structures | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 69636 | Rebuild eardrum structures | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 69637 | Rebuild eardrum structures | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 69641 | Revise middle ear & mastoid | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 69642 | Revise middle ear & mastoid | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 69643 | Revise middle ear & mastoid | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 69644 | Revise middle ear & mastoid | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 69645 | Revise middle ear & mastoid | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 69646 | Revise middle ear & mastoid | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 69650 | Release middle ear bone | | T | 0254 | 23.3114 | \$ 1,387.28 | \$ 321.35 | \$ 277.46 |
| 69660 | Revise middle ear bone | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 69661 | Revise middle ear bone | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 69662 | Revise middle ear bone | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 69666 | Repair middle ear structures | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 69667 | Repair middle ear structures | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 69670 | Remove mastoid air cells | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 69676 | Remove middle ear nerve | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 69700 | Close mastoid fistula | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 69711 | Remove/repair hearing aid | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 69714 | Implant temple bone w/stimul | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 69715 | Temple bne implnt w/stimulat | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 69717 | Temple bone implant revision | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 69718 | Revise temple bone implant | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 69720 | Release facial nerve | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 69725 | Release facial nerve | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 69740 | Repair facial nerve | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 69745 | Repair facial nerve | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 69799 | Middle ear surgery procedure | | T | 0251 | 2.0789 | \$ 123.72 | | \$ 24.74 |
| 69801 | Incise inner ear | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 69802 | Incise inner ear | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 69805 | Explore inner ear | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 69806 | Explore inner ear | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 69820 | Establish inner ear window | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 69840 | Revise inner ear window | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 69905 | Remove inner ear | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 69910 | Remove inner ear & mastoid | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 69915 | Incise inner ear nerve | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 69930 | Implant cochlear device | | T | 0259 | 393.7337 | \$23,431.49 | \$ 8,698.43 | \$ 4,686.30 |
| 69949 | Inner ear surgery procedure | | T | 0251 | 2.0789 | \$ 123.72 | | \$ 24.74 |
| 69955 | Release facial nerve | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 69960 | Release inner ear canal | | T | 0256 | 37.0000 | \$ 2,201.91 | | \$ 440.38 |
| 69979 | Temporal bone surgery | | T | 0251 | 2.0789 | \$ 123.72 | | \$ 24.74 |
| 69990 | Microsurgery add-on | | N | | | | | |
| 70010 | Contrast x-ray of brain | | S | 0274 | 2.9160 | \$ 173.53 | \$ 69.41 | \$ 34.71 |
| 70015 | Contrast x-ray of brain | | S | 0274 | 2.9160 | \$ 173.53 | \$ 69.41 | \$ 34.71 |
| 70030 | X-ray eye for foreign body | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 70100 | X-ray exam of jaw | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 70110 | X-ray exam of jaw | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 70120 | X-ray exam of mastoids | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 70130 | X-ray exam of mastoids | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 70134 | X-ray exam of middle ear | | X | 0261 | 1.2416 | \$ 73.89 | | \$ 14.78 |
| 70140 | X-ray exam of facial bones | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 70150 | X-ray exam of facial bones | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 70160 | X-ray exam of nasal bones | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 70170 | X-ray exam of tear duct | | X | 0264 | 3.4542 | \$ 205.56 | \$ 79.41 | \$ 41.11 |
| 70190 | X-ray exam of eye sockets | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 70200 | X-ray exam of eye sockets | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 70210 | X-ray exam of sinuses | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 70220 | X-ray exam of sinuses | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 70240 | X-ray exam, pituitary saddle | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 70250 | X-ray exam of skull | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 70260 | X-ray exam of skull | | X | 0261 | 1.2416 | \$ 73.89 | | \$ 14.78 |
| 70300 | X-ray exam of teeth | | X | 0262 | 0.8019 | \$ 47.72 | | \$ 9.54 |
| 70310 | X-ray exam of teeth | | X | 0262 | 0.8019 | \$ 47.72 | | \$ 9.54 |
| 70320 | Full mouth x-ray of teeth | | X | 0262 | 0.8019 | \$ 47.72 | | \$ 9.54 |
| 70328 | X-ray exam of jaw joint | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 70330 | X-ray exam of jaw joints | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 70332 | X-ray exam of jaw joint | | S | 0275 | 3.4927 | \$ 207.85 | \$ 69.09 | \$ 41.57 |
| 70336 | Magnetic image, jaw joint | | S | 0335 | 5.0997 | \$ 303.49 | \$ 121.39 | \$ 60.70 |
| 70350 | X-ray head for orthodontia | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 70355 | Panoramic x-ray of jaws | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 70360 | X-ray exam of neck | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 70370 | Throat x-ray & fluoroscopy | | X | 0272 | 1.3291 | \$ 79.10 | \$ 31.64 | \$ 15.82 |
| 70371 | Speech evaluation, complex | | X | 0272 | 1.3291 | \$ 79.10 | \$ 31.64 | \$ 15.82 |
| 70373 | Contrast x-ray of larynx | | X | 0263 | 1.6979 | \$ 101.04 | \$ 23.77 | \$ 20.21 |
| 70380 | X-ray exam of salivary gland | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 70390 | X-ray exam of salivary duct | | X | 0263 | 1.6979 | \$ 101.04 | \$ 23.77 | \$ 20.21 |
| 70450 | Ct head/brain w/o dye | | S | 0332 | 3.1608 | \$ 188.10 | \$ 75.24 | \$ 37.62 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 70460 | Ct head/brain w/dye | | S | 0283 | 4.2921 | \$ 255.43 | \$ 102.17 | \$ 51.09 |
| 70470 | Ct head/brain w/o & w/dye | | S | 0333 | 5.1053 | \$ 303.82 | \$ 121.52 | \$ 60.76 |
| 70480 | Ct orbit/ear/fossa w/o dye | | S | 0332 | 3.1608 | \$ 188.10 | \$ 75.24 | \$ 37.62 |
| 70481 | Ct orbit/ear/fossa w/dye | | S | 0283 | 4.2921 | \$ 255.43 | \$ 102.17 | \$ 51.09 |
| 70482 | Ct orbit/ear/fossa w/o&w/dye | | S | 0333 | 5.1053 | \$ 303.82 | \$ 121.52 | \$ 60.76 |
| 70486 | Ct maxillofacial w/o dye | | S | 0332 | 3.1608 | \$ 188.10 | \$ 75.24 | \$ 37.62 |
| 70487 | Ct maxillofacial w/dye | | S | 0283 | 4.2921 | \$ 255.43 | \$ 102.17 | \$ 51.09 |
| 70488 | Ct maxillofacial w/o & w/dye | | S | 0333 | 5.1053 | \$ 303.82 | \$ 121.52 | \$ 60.76 |
| 70490 | Ct soft tissue neck w/o dye | | S | 0332 | 3.1608 | \$ 188.10 | \$ 75.24 | \$ 37.62 |
| 70491 | Ct soft tissue neck w/dye | | S | 0283 | 4.2921 | \$ 255.43 | \$ 102.17 | \$ 51.09 |
| 70492 | Ct sft tsue nck w/o & w/dye | | S | 0333 | 5.1053 | \$ 303.82 | \$ 121.52 | \$ 60.76 |
| 70496 | Ct angiography, head | | S | 0662 | 4.9944 | \$ 297.22 | \$ 118.88 | \$ 59.44 |
| 70498 | Ct angiography, neck | | S | 0662 | 4.9944 | \$ 297.22 | \$ 118.88 | \$ 59.44 |
| 70540 | Mri orbit/face/neck w/o dye | | S | 0336 | 5.8678 | \$ 349.20 | \$ 139.68 | \$ 69.84 |
| 70542 | Mri orbit/face/neck w/dye | | S | 0284 | 6.2342 | \$ 371.00 | \$ 148.40 | \$ 74.20 |
| 70543 | Mri orbt/fac/nck w/o & w/dye | | S | 0337 | 8.5070 | \$ 506.26 | \$ 202.50 | \$ 101.25 |
| 70544 | Mr angiography head w/o dye | | S | 0336 | 5.8678 | \$ 349.20 | \$ 139.68 | \$ 69.84 |
| 70545 | Mr angiography head w/dye | | S | 0284 | 6.2342 | \$ 371.00 | \$ 148.40 | \$ 74.20 |
| 70546 | Mr angiograph head w/o&w/dye | | S | 0337 | 8.5070 | \$ 506.26 | \$ 202.50 | \$ 101.25 |
| 70547 | Mr angiography neck w/o dye | | S | 0336 | 5.8678 | \$ 349.20 | \$ 139.68 | \$ 69.84 |
| 70548 | Mr angiography neck w/dye | | S | 0284 | 6.2342 | \$ 371.00 | \$ 148.40 | \$ 74.20 |
| 70549 | Mr angiograph neck w/o&w/dye | | S | 0337 | 8.5070 | \$ 506.26 | \$ 202.50 | \$ 101.25 |
| 70551 | Mri brain w/o dye | | S | 0336 | 5.8678 | \$ 349.20 | \$ 139.68 | \$ 69.84 |
| 70552 | Mri brain w/dye | | S | 0284 | 6.2342 | \$ 371.00 | \$ 148.40 | \$ 74.20 |
| 70553 | Mri brain w/o & w/dye | | S | 0337 | 8.5070 | \$ 506.26 | \$ 202.50 | \$ 101.25 |
| 70557 | Mri brain w/o dye | | S | 0336 | 5.8678 | \$ 349.20 | \$ 139.68 | \$ 69.84 |
| 70558 | Mri brain w/dye | | S | 0284 | 6.2342 | \$ 371.00 | \$ 148.40 | \$ 74.20 |
| 70559 | Mri brain w/o & w/dye | | S | 0337 | 8.5070 | \$ 506.26 | \$ 202.50 | \$ 101.25 |
| 71010 | Chest x-ray | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 71015 | Chest x-ray | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 71020 | Chest x-ray | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 71021 | Chest x-ray | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 71022 | Chest x-ray | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 71023 | Chest x-ray and fluoroscopy | | X | 0272 | 1.3291 | \$ 79.10 | \$ 31.64 | \$ 15.82 |
| 71030 | Chest x-ray | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 71034 | Chest x-ray and fluoroscopy | | X | 0272 | 1.3291 | \$ 79.10 | \$ 31.64 | \$ 15.82 |
| 71035 | Chest x-ray | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 71040 | Contrast x-ray of bronchi | | X | 0263 | 1.6979 | \$ 101.04 | \$ 23.77 | \$ 20.21 |
| 71060 | Contrast x-ray of bronchi | | X | 0263 | 1.6979 | \$ 101.04 | \$ 23.77 | \$ 20.21 |
| 71090 | X-ray & pacemaker insertion | | X | 0272 | 1.3291 | \$ 79.10 | \$ 31.64 | \$ 15.82 |
| 71100 | X-ray exam of ribs | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 71101 | X-ray exam of ribs/chest | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 71110 | X-ray exam of ribs | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 71111 | X-ray exam of ribs/chest | | X | 0261 | 1.2416 | \$ 73.89 | | \$ 14.78 |
| 71120 | X-ray exam of breastbone | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 71130 | X-ray exam of breastbone | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 71250 | Ct thorax w/o dye | | S | 0332 | 3.1608 | \$ 188.10 | \$ 75.24 | \$ 37.62 |
| 71260 | Ct thorax w/dye | | S | 0283 | 4.2921 | \$ 255.43 | \$ 102.17 | \$ 51.09 |
| 71270 | Ct thorax w/o & w/dye | | S | 0333 | 5.1053 | \$ 303.82 | \$ 121.52 | \$ 60.76 |
| 71275 | Ct angiography, chest | | S | 0662 | 4.9944 | \$ 297.22 | \$ 118.88 | \$ 59.44 |
| 71550 | Mri chest w/o dye | | S | 0336 | 5.8678 | \$ 349.20 | \$ 139.68 | \$ 69.84 |
| 71551 | Mri chest w/dye | | S | 0284 | 6.2342 | \$ 371.00 | \$ 148.40 | \$ 74.20 |
| 71552 | Mri chest w/o & w/dye | | S | 0337 | 8.5070 | \$ 506.26 | \$ 202.50 | \$ 101.25 |
| 72010 | X-ray exam of spine | CH | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 72020 | X-ray exam of spine | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 72040 | X-ray exam of neck spine | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 72050 | X-ray exam of neck spine | | X | 0261 | 1.2416 | \$ 73.89 | | \$ 14.78 |
| 72052 | X-ray exam of neck spine | | X | 0261 | 1.2416 | \$ 73.89 | | \$ 14.78 |
| 72069 | X-ray exam of trunk spine | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 72070 | X-ray exam of thoracic spine | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 72072 | X-ray exam of thoracic spine | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 72074 | X-ray exam of thoracic spine | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 72080 | X-ray exam of trunk spine | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 72090 | X-ray exam of trunk spine | | X | 0261 | 1.2416 | \$ 73.89 | | \$ 14.78 |
| 72100 | X-ray exam of lower spine | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 72110 | X-ray exam of lower spine | | X | 0261 | 1.2416 | \$ 73.89 | | \$ 14.78 |
| 72114 | X-ray exam of lower spine | | X | 0261 | 1.2416 | \$ 73.89 | | \$ 14.78 |
| 72120 | X-ray exam of lower spine | CH | X | 0261 | 1.2416 | \$ 73.89 | | \$ 14.78 |
| 72125 | Ct neck spine w/o dye | | S | 0332 | 3.1608 | \$ 188.10 | \$ 75.24 | \$ 37.62 |
| 72126 | Ct neck spine w/dye | | S | 0283 | 4.2921 | \$ 255.43 | \$ 102.17 | \$ 51.09 |
| 72127 | Ct neck spine w/o & w/dye | | S | 0333 | 5.1053 | \$ 303.82 | \$ 121.52 | \$ 60.76 |
| 72128 | Ct chest spine w/o dye | | S | 0332 | 3.1608 | \$ 188.10 | \$ 75.24 | \$ 37.62 |
| 72129 | Ct chest spine w/dye | | S | 0283 | 4.2921 | \$ 255.43 | \$ 102.17 | \$ 51.09 |
| 72130 | Ct chest spine w/o & w/dye | | S | 0333 | 5.1053 | \$ 303.82 | \$ 121.52 | \$ 60.76 |
| 72131 | Ct lumbar spine w/o dye | | S | 0332 | 3.1608 | \$ 188.10 | \$ 75.24 | \$ 37.62 |
| 72132 | Ct lumbar spine w/dye | | S | 0283 | 4.2921 | \$ 255.43 | \$ 102.17 | \$ 51.09 |
| 72133 | Ct lumbar spine w/o & w/dye | | S | 0333 | 5.1053 | \$ 303.82 | \$ 121.52 | \$ 60.76 |
| 72141 | Mri neck spine w/o dye | | S | 0336 | 5.8678 | \$ 349.20 | \$ 139.68 | \$ 69.84 |
| 72142 | Mri neck spine w/dye | | S | 0284 | 6.2342 | \$ 371.00 | \$ 148.40 | \$ 74.20 |
| 72146 | Mri chest spine w/o dye | | S | 0336 | 5.8678 | \$ 349.20 | \$ 139.68 | \$ 69.84 |
| 72147 | Mri chest spine w/dye | | S | 0284 | 6.2342 | \$ 371.00 | \$ 148.40 | \$ 74.20 |
| 72148 | Mri lumbar spine w/o dye | | S | 0336 | 5.8678 | \$ 349.20 | \$ 139.68 | \$ 69.84 |
| 72149 | Mri lumbar spine w/dye | | S | 0284 | 6.2342 | \$ 371.00 | \$ 148.40 | \$ 74.20 |
| 72156 | Mri neck spine w/o & w/dye | | S | 0337 | 8.5070 | \$ 506.26 | \$ 202.50 | \$ 101.25 |
| 72157 | Mri chest spine w/o & w/dye | | S | 0337 | 8.5070 | \$ 506.26 | \$ 202.50 | \$ 101.25 |
| 72158 | Mri lumbar spine w/o & w/dye | | S | 0337 | 8.5070 | \$ 506.26 | \$ 202.50 | \$ 101.25 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 72170 | X-ray exam of pelvis | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 72190 | X-ray exam of pelvis | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 72191 | Ct angiograph pelv w/o&w/dye | | S | 0662 | 4.9944 | \$ 297.22 | \$ 118.88 | \$ 59.44 |
| 72192 | Ct pelvis w/o dye | | S | 0332 | 3.1608 | \$ 188.10 | \$ 75.24 | \$ 37.62 |
| 72193 | Ct pelvis w/dye | | S | 0283 | 4.2921 | \$ 255.43 | \$ 102.17 | \$ 51.09 |
| 72194 | Ct pelvis w/o & w/dye | | S | 0333 | 5.1053 | \$ 303.82 | \$ 121.52 | \$ 60.76 |
| 72195 | Mri pelvis w/o dye | | S | 0336 | 5.8678 | \$ 349.20 | \$ 139.68 | \$ 69.84 |
| 72196 | Mri pelvis w/dye | | S | 0284 | 6.2342 | \$ 371.00 | \$ 148.40 | \$ 74.20 |
| 72197 | Mri pelvis w/o & w/dye | | S | 0337 | 8.5070 | \$ 506.26 | \$ 202.50 | \$ 101.25 |
| 72200 | X-ray exam sacroiliac joints | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 72202 | X-ray exam sacroiliac joints | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 72220 | X-ray exam of tailbone | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 72240 | Contrast x-ray of neck spine | | S | 0274 | 2.9160 | \$ 173.53 | \$ 69.41 | \$ 34.71 |
| 72255 | Contrast x-ray, thorax spine | | S | 0274 | 2.9160 | \$ 173.53 | \$ 69.41 | \$ 34.71 |
| 72265 | Contrast x-ray, lower spine | | S | 0274 | 2.9160 | \$ 173.53 | \$ 69.41 | \$ 34.71 |
| 72270 | Contrast x-ray, spine | | S | 0274 | 2.9160 | \$ 173.53 | \$ 69.41 | \$ 34.71 |
| 72275 | Epidurography | | S | 0274 | 2.9160 | \$ 173.53 | \$ 69.41 | \$ 34.71 |
| 72285 | X-ray c/t spine disk | | S | 0388 | 12.1712 | \$ 724.32 | \$ 289.72 | \$ 144.86 |
| 72295 | X-ray of lower spine disk | | S | 0388 | 12.1712 | \$ 724.32 | \$ 289.72 | \$ 144.86 |
| 73000 | X-ray exam of collar bone | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 73010 | X-ray exam of shoulder blade | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 73020 | X-ray exam of shoulder | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 73030 | X-ray exam of shoulder | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 73040 | Contrast x-ray of shoulder | | S | 0275 | 3.4927 | \$ 207.85 | \$ 69.09 | \$ 41.57 |
| 73050 | X-ray exam of shoulders | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 73060 | X-ray exam of humerus | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 73070 | X-ray exam of elbow | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 73080 | X-ray exam of elbow | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 73085 | Contrast x-ray of elbow | | S | 0275 | 3.4927 | \$ 207.85 | \$ 69.09 | \$ 41.57 |
| 73090 | X-ray exam of forearm | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 73092 | X-ray exam of arm, infant | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 73100 | X-ray exam of wrist | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 73110 | X-ray exam of wrist | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 73115 | Contrast x-ray of wrist | | S | 0275 | 3.4927 | \$ 207.85 | \$ 69.09 | \$ 41.57 |
| 73120 | X-ray exam of hand | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 73130 | X-ray exam of hand | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 73140 | X-ray exam of finger(s) | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 73200 | Ct upper extremity w/o dye | | S | 0332 | 3.1608 | \$ 188.10 | \$ 75.24 | \$ 37.62 |
| 73201 | Ct upper extremity w/dye | | S | 0283 | 4.2921 | \$ 255.43 | \$ 102.17 | \$ 51.09 |
| 73202 | Ct uppr extremity w/o&w/dye | | S | 0333 | 5.1053 | \$ 303.82 | \$ 121.52 | \$ 60.76 |
| 73206 | Ct angio upr extrm w/o&w/dye | | S | 0662 | 4.9944 | \$ 297.22 | \$ 118.88 | \$ 59.44 |
| 73218 | Mri upper extremity w/o dye | | S | 0336 | 5.8678 | \$ 349.20 | \$ 139.68 | \$ 69.84 |
| 73219 | Mri upper extremity w/dye | | S | 0284 | 6.2342 | \$ 371.00 | \$ 148.40 | \$ 74.20 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 73220 | Mri uppr extremity w/o&w/dye | | S | 0337 | 8.5070 | \$ 506.26 | \$ 202.50 | \$ 101.25 |
| 73221 | Mri joint upr extrem w/o dye | | S | 0336 | 5.8678 | \$ 349.20 | \$ 139.68 | \$ 69.84 |
| 73222 | Mri joint upr extrem w/dye | | S | 0284 | 6.2342 | \$ 371.00 | \$ 148.40 | \$ 74.20 |
| 73223 | Mri joint upr extr w/o&w/dye | | S | 0337 | 8.5070 | \$ 506.26 | \$ 202.50 | \$ 101.25 |
| 73500 | X-ray exam of hip | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 73510 | X-ray exam of hip | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 73520 | X-ray exam of hips | CH | X | 0261 | 1.2416 | \$ 73.89 | | \$ 14.78 |
| 73525 | Contrast x-ray of hip | | S | 0275 | 3.4927 | \$ 207.85 | \$ 69.09 | \$ 41.57 |
| 73530 | X-ray exam of hip | | X | 0261 | 1.2416 | \$ 73.89 | | \$ 14.78 |
| 73540 | X-ray exam of pelvis & hips | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 73542 | X-ray exam, sacroiliac joint | | S | 0275 | 3.4927 | \$ 207.85 | \$ 69.09 | \$ 41.57 |
| 73550 | X-ray exam of thigh | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 73560 | X-ray exam of knee, 1 or 2 | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 73562 | X-ray exam of knee, 3 | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 73564 | X-ray exam, knee, 4 or more | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 73565 | X-ray exam of knees | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 73580 | Contrast x-ray of knee joint | | S | 0275 | 3.4927 | \$ 207.85 | \$ 69.09 | \$ 41.57 |
| 73590 | X-ray exam of lower leg | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 73592 | X-ray exam of leg, infant | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 73600 | X-ray exam of ankle | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 73610 | X-ray exam of ankle | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 73615 | Contrast x-ray of ankle | | S | 0275 | 3.4927 | \$ 207.85 | \$ 69.09 | \$ 41.57 |
| 73620 | X-ray exam of foot | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 73630 | X-ray exam of foot | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 73650 | X-ray exam of heel | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 73660 | X-ray exam of toe(s) | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 73700 | Ct lower extremity w/o dye | | S | 0332 | 3.1608 | \$ 188.10 | \$ 75.24 | \$ 37.62 |
| 73701 | Ct lower extremity w/dye | | S | 0283 | 4.2921 | \$ 255.43 | \$ 102.17 | \$ 51.09 |
| 73702 | Ct lwr extremity w/o&w/dye | | S | 0333 | 5.1053 | \$ 303.82 | \$ 121.52 | \$ 60.76 |
| 73706 | Ct angio lwr extr w/o&w/dye | | S | 0662 | 4.9944 | \$ 297.22 | \$ 118.88 | \$ 59.44 |
| 73718 | Mri lower extremity w/o dye | | S | 0336 | 5.8678 | \$ 349.20 | \$ 139.68 | \$ 69.84 |
| 73719 | Mri lower extremity w/dye | | S | 0284 | 6.2342 | \$ 371.00 | \$ 148.40 | \$ 74.20 |
| 73720 | Mri lwr extremity w/o&w/dye | | S | 0337 | 8.5070 | \$ 506.26 | \$ 202.50 | \$ 101.25 |
| 73721 | Mri jnt of lwr extre w/o dye | | S | 0336 | 5.8678 | \$ 349.20 | \$ 139.68 | \$ 69.84 |
| 73722 | Mri joint of lwr extr w/dye | | S | 0284 | 6.2342 | \$ 371.00 | \$ 148.40 | \$ 74.20 |
| 73723 | Mri joint lwr extr w/o&w/dye | | S | 0337 | 8.5070 | \$ 506.26 | \$ 202.50 | \$ 101.25 |
| 74000 | X-ray exam of abdomen | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 74010 | X-ray exam of abdomen | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 74020 | X-ray exam of abdomen | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 74022 | X-ray exam series, abdomen | | X | 0261 | 1.2416 | \$ 73.89 | | \$ 14.78 |
| 74150 | Ct abdomen w/o dye | | S | 0332 | 3.1608 | \$ 188.10 | \$ 75.24 | \$ 37.62 |
| 74160 | Ct abdomen w/dye | | S | 0283 | 4.2921 | \$ 255.43 | \$ 102.17 | \$ 51.09 |
| 74170 | Ct abdomen w/o & w/dye | | S | 0333 | 5.1053 | \$ 303.82 | \$ 121.52 | \$ 60.76 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 74175 | Ct angio abdom w/o & w/dye | | S | 0662 | 4.9944 | \$ 297.22 | \$ 118.88 | \$ 59.44 |
| 74181 | Mri abdomen w/o dye | | S | 0336 | 5.8678 | \$ 349.20 | \$ 139.68 | \$ 69.84 |
| 74182 | Mri abdomen w/dye | | S | 0284 | 6.2342 | \$ 371.00 | \$ 148.40 | \$ 74.20 |
| 74183 | Mri abdomen w/o & w/dye | | S | 0337 | 8.5070 | \$ 506.26 | \$ 202.50 | \$ 101.25 |
| 74190 | X-ray exam of peritoneum | | X | 0264 | 3.4542 | \$ 205.56 | \$ 79.41 | \$ 41.11 |
| 74210 | Contrst x-ray exam of throat | | S | 0276 | 1.4693 | \$ 87.44 | \$ 34.97 | \$ 17.49 |
| 74220 | Contrast x-ray, esophagus | | S | 0276 | 1.4693 | \$ 87.44 | \$ 34.97 | \$ 17.49 |
| 74230 | Cine/vid x-ray, throat/esoph | | S | 0276 | 1.4693 | \$ 87.44 | \$ 34.97 | \$ 17.49 |
| 74235 | Remove esophagus obstruction | | S | 0296 | 2.2684 | \$ 134.99 | \$ 53.99 | \$ 27.00 |
| 74240 | X-ray exam, upper gi tract | | S | 0276 | 1.4693 | \$ 87.44 | \$ 34.97 | \$ 17.49 |
| 74241 | X-ray exam, upper gi tract | | S | 0276 | 1.4693 | \$ 87.44 | \$ 34.97 | \$ 17.49 |
| 74245 | X-ray exam, upper gi tract | | S | 0277 | 2.2951 | \$ 136.58 | \$ 54.63 | \$ 27.32 |
| 74246 | Contrst x-ray uppr gi tract | | S | 0276 | 1.4693 | \$ 87.44 | \$ 34.97 | \$ 17.49 |
| 74247 | Contrst x-ray uppr gi tract | | S | 0276 | 1.4693 | \$ 87.44 | \$ 34.97 | \$ 17.49 |
| 74249 | Contrst x-ray uppr gi tract | | S | 0277 | 2.2951 | \$ 136.58 | \$ 54.63 | \$ 27.32 |
| 74250 | X-ray exam of small bowel | | S | 0276 | 1.4693 | \$ 87.44 | \$ 34.97 | \$ 17.49 |
| 74251 | X-ray exam of small bowel | | S | 0277 | 2.2951 | \$ 136.58 | \$ 54.63 | \$ 27.32 |
| 74260 | X-ray exam of small bowel | | S | 0277 | 2.2951 | \$ 136.58 | \$ 54.63 | \$ 27.32 |
| 74270 | Contrast x-ray exam of colon | | S | 0276 | 1.4693 | \$ 87.44 | \$ 34.97 | \$ 17.49 |
| 74280 | Contrast x-ray exam of colon | | S | 0277 | 2.2951 | \$ 136.58 | \$ 54.63 | \$ 27.32 |
| 74283 | Contrast x-ray exam of colon | | S | 0276 | 1.4693 | \$ 87.44 | \$ 34.97 | \$ 17.49 |
| 74290 | Contrast x-ray, gallbladder | | S | 0276 | 1.4693 | \$ 87.44 | \$ 34.97 | \$ 17.49 |
| 74291 | Contrast x-rays, gallbladder | | S | 0276 | 1.4693 | \$ 87.44 | \$ 34.97 | \$ 17.49 |
| 74300 | X-ray bile ducts/pancreas | | X | 0263 | 1.6979 | \$ 101.04 | \$ 23.77 | \$ 20.21 |
| 74301 | X-rays at surgery add-on | | X | 0263 | 1.6979 | \$ 101.04 | \$ 23.77 | \$ 20.21 |
| 74305 | X-ray bile ducts/pancreas | | X | 0263 | 1.6979 | \$ 101.04 | \$ 23.77 | \$ 20.21 |
| 74320 | Contrast x-ray of bile ducts | | X | 0264 | 3.4542 | \$ 205.56 | \$ 79.41 | \$ 41.11 |
| 74327 | X-ray bile stone removal | | S | 0296 | 2.2684 | \$ 134.99 | \$ 53.99 | \$ 27.00 |
| 74328 | X-ray bile duct endoscopy | | N | | | | | |
| 74329 | X-ray for pancreas endoscopy | | N | | | | | |
| 74330 | X-ray bile/panc endoscopy | | N | | | | | |
| 74340 | X-ray guide for GI tube | | X | 0272 | 1.3291 | \$ 79.10 | \$ 31.64 | \$ 15.82 |
| 74350 | X-ray guide, stomach tube | | X | 0263 | 1.6979 | \$ 101.04 | \$ 23.77 | \$ 20.21 |
| 74355 | X-ray guide, intestinal tube | | X | 0263 | 1.6979 | \$ 101.04 | \$ 23.77 | \$ 20.21 |
| 74360 | X-ray guide, GI dilation | | S | 0296 | 2.2684 | \$ 134.99 | \$ 53.99 | \$ 27.00 |
| 74363 | X-ray, bile duct dilation | | S | 0297 | 5.0977 | \$ 303.37 | \$ 121.34 | \$ 60.67 |
| 74400 | Contrst x-ray, urinary tract | | S | 0278 | 2.5559 | \$ 152.10 | \$ 60.84 | \$ 30.42 |
| 74410 | Contrst x-ray, urinary tract | | S | 0278 | 2.5559 | \$ 152.10 | \$ 60.84 | \$ 30.42 |
| 74415 | Contrst x-ray, urinary tract | | S | 0278 | 2.5559 | \$ 152.10 | \$ 60.84 | \$ 30.42 |
| 74420 | Contrst x-ray, urinary tract | | S | 0278 | 2.5559 | \$ 152.10 | \$ 60.84 | \$ 30.42 |
| 74425 | Contrst x-ray, urinary tract | | S | 0278 | 2.5559 | \$ 152.10 | \$ 60.84 | \$ 30.42 |
| 74430 | Contrast x-ray, bladder | | S | 0278 | 2.5559 | \$ 152.10 | \$ 60.84 | \$ 30.42 |
| 74440 | X-ray, male genital tract | | S | 0278 | 2.5559 | \$ 152.10 | \$ 60.84 | \$ 30.42 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 74445 | X-ray exam of penis | | S | 0278 | 2.5559 | \$ 152.10 | \$ 60.84 | \$ 30.42 |
| 74450 | X-ray, urethra/bladder | | S | 0278 | 2.5559 | \$ 152.10 | \$ 60.84 | \$ 30.42 |
| 74455 | X-ray, urethra/bladder | | S | 0278 | 2.5559 | \$ 152.10 | \$ 60.84 | \$ 30.42 |
| 74470 | X-ray exam of kidney lesion | | X | 0263 | 1.6979 | \$ 101.04 | \$ 23.77 | \$ 20.21 |
| 74475 | X-ray control, cath insert | | S | 0297 | 5.0977 | \$ 303.37 | \$ 121.34 | \$ 60.67 |
| 74480 | X-ray control, cath insert | | S | 0296 | 2.2684 | \$ 134.99 | \$ 53.99 | \$ 27.00 |
| 74485 | X-ray guide, GU dilation | | S | 0296 | 2.2684 | \$ 134.99 | \$ 53.99 | \$ 27.00 |
| 74710 | X-ray measurement of pelvis | CH | X | 0261 | 1.2416 | \$ 73.89 | | \$ 14.78 |
| 74740 | X-ray, female genital tract | | X | 0264 | 3.4542 | \$ 205.56 | \$ 79.41 | \$ 41.11 |
| 74742 | X-ray, fallopian tube | | X | 0264 | 3.4542 | \$ 205.56 | \$ 79.41 | \$ 41.11 |
| 74775 | X-ray exam of perineum | | S | 0278 | 2.5559 | \$ 152.10 | \$ 60.84 | \$ 30.42 |
| 75552 | Heart mri for morph w/o dye | | S | 0336 | 5.8678 | \$ 349.20 | \$ 139.68 | \$ 69.84 |
| 75553 | Heart mri for morph w/dye | | S | 0284 | 6.2342 | \$ 371.00 | \$ 148.40 | \$ 74.20 |
| 75554 | Cardiac MRI/function | CH | S | 0336 | 5.8678 | \$ 349.20 | \$ 139.68 | \$ 69.84 |
| 75555 | Cardiac MRI/limited study | CH | S | 0336 | 5.8678 | \$ 349.20 | \$ 139.68 | \$ 69.84 |
| 75600 | Contrast x-ray exam of aorta | | S | 0280 | 20.4187 | \$ 1,215.14 | \$ 353.85 | \$ 243.03 |
| 75605 | Contrast x-ray exam of aorta | | S | 0280 | 20.4187 | \$ 1,215.14 | \$ 353.85 | \$ 243.03 |
| 75625 | Contrast x-ray exam of aorta | | S | 0280 | 20.4187 | \$ 1,215.14 | \$ 353.85 | \$ 243.03 |
| 75630 | X-ray aorta, leg arteries | | S | 0280 | 20.4187 | \$ 1,215.14 | \$ 353.85 | \$ 243.03 |
| 75635 | Ct angio abdominal arteries | | S | 0662 | 4.9944 | \$ 297.22 | \$ 118.88 | \$ 59.44 |
| 75650 | Artery x-rays, head & neck | | S | 0280 | 20.4187 | \$ 1,215.14 | \$ 353.85 | \$ 243.03 |
| 75658 | Artery x-rays, arm | | S | 0279 | 8.6988 | \$ 517.67 | \$ 150.03 | \$ 103.53 |
| 75660 | Artery x-rays, head & neck | | S | 0668 | 6.3104 | \$ 375.54 | \$ 88.26 | \$ 75.11 |
| 75662 | Artery x-rays, head & neck | | S | 0280 | 20.4187 | \$ 1,215.14 | \$ 353.85 | \$ 243.03 |
| 75665 | Artery x-rays, head & neck | | S | 0280 | 20.4187 | \$ 1,215.14 | \$ 353.85 | \$ 243.03 |
| 75671 | Artery x-rays, head & neck | | S | 0280 | 20.4187 | \$ 1,215.14 | \$ 353.85 | \$ 243.03 |
| 75676 | Artery x-rays, neck | | S | 0280 | 20.4187 | \$ 1,215.14 | \$ 353.85 | \$ 243.03 |
| 75680 | Artery x-rays, neck | | S | 0280 | 20.4187 | \$ 1,215.14 | \$ 353.85 | \$ 243.03 |
| 75685 | Artery x-rays, spine | | S | 0280 | 20.4187 | \$ 1,215.14 | \$ 353.85 | \$ 243.03 |
| 75705 | Artery x-rays, spine | | S | 0668 | 6.3104 | \$ 375.54 | \$ 88.26 | \$ 75.11 |
| 75710 | Artery x-rays, arm/leg | | S | 0280 | 20.4187 | \$ 1,215.14 | \$ 353.85 | \$ 243.03 |
| 75716 | Artery x-rays, arms/legs | | S | 0280 | 20.4187 | \$ 1,215.14 | \$ 353.85 | \$ 243.03 |
| 75722 | Artery x-rays, kidney | | S | 0280 | 20.4187 | \$ 1,215.14 | \$ 353.85 | \$ 243.03 |
| 75724 | Artery x-rays, kidneys | | S | 0280 | 20.4187 | \$ 1,215.14 | \$ 353.85 | \$ 243.03 |
| 75726 | Artery x-rays, abdomen | | S | 0280 | 20.4187 | \$ 1,215.14 | \$ 353.85 | \$ 243.03 |
| 75731 | Artery x-rays, adrenal gland | | S | 0280 | 20.4187 | \$ 1,215.14 | \$ 353.85 | \$ 243.03 |
| 75733 | Artery x-rays, adrenals | | S | 0668 | 6.3104 | \$ 375.54 | \$ 88.26 | \$ 75.11 |
| 75736 | Artery x-rays, pelvis | | S | 0280 | 20.4187 | \$ 1,215.14 | \$ 353.85 | \$ 243.03 |
| 75741 | Artery x-rays, lung | | S | 0279 | 8.6988 | \$ 517.67 | \$ 150.03 | \$ 103.53 |
| 75743 | Artery x-rays, lungs | | S | 0280 | 20.4187 | \$ 1,215.14 | \$ 353.85 | \$ 243.03 |
| 75746 | Artery x-rays, lung | | S | 0279 | 8.6988 | \$ 517.67 | \$ 150.03 | \$ 103.53 |
| 75756 | Artery x-rays, chest | | S | 0279 | 8.6988 | \$ 517.67 | \$ 150.03 | \$ 103.53 |
| 75774 | Artery x-ray, each vessel | | S | 0279 | 8.6988 | \$ 517.67 | \$ 150.03 | \$ 103.53 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|-------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 75790 | Visualize A-V shunt | CH | S | 0279 | 8.6988 | \$ 517.67 | \$ 150.03 | \$ 103.53 |
| 75801 | Lymph vessel x-ray, arm/leg | | X | 0264 | 3.4542 | \$ 205.56 | \$ 79.41 | \$ 41.11 |
| 75803 | Lymph vessel x-ray, arms/legs | | X | 0264 | 3.4542 | \$ 205.56 | \$ 79.41 | \$ 41.11 |
| 75805 | Lymph vessel x-ray, trunk | | X | 0264 | 3.4542 | \$ 205.56 | \$ 79.41 | \$ 41.11 |
| 75807 | Lymph vessel x-ray, trunk | | X | 0264 | 3.4542 | \$ 205.56 | \$ 79.41 | \$ 41.11 |
| 75809 | Nonvascular shunt, x-ray | | X | 0263 | 1.6979 | \$ 101.04 | \$ 23.77 | \$ 20.21 |
| 75810 | Vein x-ray, spleen/liver | | S | 0279 | 8.6988 | \$ 517.67 | \$ 150.03 | \$ 103.53 |
| 75820 | Vein x-ray, arm/leg | CH | S | 0668 | 6.3104 | \$ 375.54 | \$ 88.26 | \$ 75.11 |
| 75822 | Vein x-ray, arms/legs | CH | S | 0668 | 6.3104 | \$ 375.54 | \$ 88.26 | \$ 75.11 |
| 75825 | Vein x-ray, trunk | | S | 0279 | 8.6988 | \$ 517.67 | \$ 150.03 | \$ 103.53 |
| 75827 | Vein x-ray, chest | | S | 0279 | 8.6988 | \$ 517.67 | \$ 150.03 | \$ 103.53 |
| 75831 | Vein x-ray, kidney | CH | S | 0279 | 8.6988 | \$ 517.67 | \$ 150.03 | \$ 103.53 |
| 75833 | Vein x-ray, kidneys | | S | 0279 | 8.6988 | \$ 517.67 | \$ 150.03 | \$ 103.53 |
| 75840 | Vein x-ray, adrenal gland | CH | S | 0280 | 20.4187 | \$ 1,215.14 | \$ 353.85 | \$ 243.03 |
| 75842 | Vein x-ray, adrenal glands | CH | S | 0280 | 20.4187 | \$ 1,215.14 | \$ 353.85 | \$ 243.03 |
| 75860 | Vein x-ray, neck | CH | S | 0668 | 6.3104 | \$ 375.54 | \$ 88.26 | \$ 75.11 |
| 75870 | Vein x-ray, skull | CH | S | 0668 | 6.3104 | \$ 375.54 | \$ 88.26 | \$ 75.11 |
| 75872 | Vein x-ray, skull | CH | S | 0279 | 8.6988 | \$ 517.67 | \$ 150.03 | \$ 103.53 |
| 75880 | Vein x-ray, eye socket | CH | S | 0668 | 6.3104 | \$ 375.54 | \$ 88.26 | \$ 75.11 |
| 75885 | Vein x-ray, liver | | S | 0280 | 20.4187 | \$ 1,215.14 | \$ 353.85 | \$ 243.03 |
| 75887 | Vein x-ray, liver | | S | 0279 | 8.6988 | \$ 517.67 | \$ 150.03 | \$ 103.53 |
| 75889 | Vein x-ray, liver | | S | 0280 | 20.4187 | \$ 1,215.14 | \$ 353.85 | \$ 243.03 |
| 75891 | Vein x-ray, liver | | S | 0279 | 8.6988 | \$ 517.67 | \$ 150.03 | \$ 103.53 |
| 75893 | Venous sampling by catheter | | N | | | | | |
| 75894 | X-rays, transcath therapy | | S | 0297 | 5.0977 | \$ 303.37 | \$ 121.34 | \$ 60.67 |
| 75896 | X-rays, transcath therapy | | S | 0297 | 5.0977 | \$ 303.37 | \$ 121.34 | \$ 60.67 |
| 75898 | Follow-up angiography | | X | 0263 | 1.6979 | \$ 101.04 | \$ 23.77 | \$ 20.21 |
| 75901 | Remove cva device obstruct | | X | 0263 | 1.6979 | \$ 101.04 | \$ 23.77 | \$ 20.21 |
| 75902 | Remove cva lumen obstruct | | X | 0263 | 1.6979 | \$ 101.04 | \$ 23.77 | \$ 20.21 |
| 75940 | X-ray placement, vein filter | CH | S | 0297 | 5.0977 | \$ 303.37 | \$ 121.34 | \$ 60.67 |
| 75945 | Intravascular us | | S | 0267 | 2.5543 | \$ 152.01 | \$ 60.80 | \$ 30.40 |
| 75946 | Intravascular us add-on | CH | S | 0266 | 1.5883 | \$ 94.52 | \$ 37.80 | \$ 18.90 |
| 75960 | Transcath iv stent rs&i | | S | 0668 | 6.3104 | \$ 375.54 | \$ 88.26 | \$ 75.11 |
| 75961 | Retrieval, broken catheter | | S | 0668 | 6.3104 | \$ 375.54 | \$ 88.26 | \$ 75.11 |
| 75962 | Repair arterial blockage | | S | 0668 | 6.3104 | \$ 375.54 | \$ 88.26 | \$ 75.11 |
| 75964 | Repair artery blockage, each | | S | 0668 | 6.3104 | \$ 375.54 | \$ 88.26 | \$ 75.11 |
| 75966 | Repair arterial blockage | | S | 0668 | 6.3104 | \$ 375.54 | \$ 88.26 | \$ 75.11 |
| 75968 | Repair artery blockage, each | | S | 0668 | 6.3104 | \$ 375.54 | \$ 88.26 | \$ 75.11 |
| 75970 | Vascular biopsy | | S | 0668 | 6.3104 | \$ 375.54 | \$ 88.26 | \$ 75.11 |
| 75978 | Repair venous blockage | | S | 0668 | 6.3104 | \$ 375.54 | \$ 88.26 | \$ 75.11 |
| 75980 | Contrast xray exam bile duct | | S | 0297 | 5.0977 | \$ 303.37 | \$ 121.34 | \$ 60.67 |
| 75982 | Contrast xray exam bile duct | | S | 0297 | 5.0977 | \$ 303.37 | \$ 121.34 | \$ 60.67 |
| 75984 | Xray control catheter change | | X | 0263 | 1.6979 | \$ 101.04 | \$ 23.77 | \$ 20.21 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 75989 | Abscess drainage under x-ray | | N | | | | | |
| 75992 | Atherectomy, x-ray exam | | S | 0279 | 8.6988 | \$ 517.67 | \$ 150.03 | \$ 103.53 |
| 75993 | Atherectomy, x-ray exam | | S | 0279 | 8.6988 | \$ 517.67 | \$ 150.03 | \$ 103.53 |
| 75994 | Atherectomy, x-ray exam | | S | 0279 | 8.6988 | \$ 517.67 | \$ 150.03 | \$ 103.53 |
| 75995 | Atherectomy, x-ray exam | | S | 0279 | 8.6988 | \$ 517.67 | \$ 150.03 | \$ 103.53 |
| 75996 | Atherectomy, x-ray exam | | S | 0279 | 8.6988 | \$ 517.67 | \$ 150.03 | \$ 103.53 |
| 75998 | Fluoroguide for vein device | | N | | | | | |
| 76000 | Fluoroscope examination | | X | 0272 | 1.3291 | \$ 79.10 | \$ 31.64 | \$ 15.82 |
| 76001 | Fluoroscope exam, extensive | | N | | | | | |
| 76003 | Needle localization by x-ray | | N | | | | | |
| 76005 | Fluoroguide for spine inject | | N | | | | | |
| 76006 | X-ray stress view | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 76010 | X-ray, nose to rectum | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 76012 | Percut vertebroplasty fluor | | S | 0274 | 2.9160 | \$ 173.53 | \$ 69.41 | \$ 34.71 |
| 76013 | Percut vertebroplasty, ct | | S | 0274 | 2.9160 | \$ 173.53 | \$ 69.41 | \$ 34.71 |
| 76020 | X-rays for bone age | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 76040 | X-rays, bone evaluation | CH | X | 0261 | 1.2416 | \$ 73.89 | | \$ 14.78 |
| 76061 | X-rays, bone survey | | X | 0261 | 1.2416 | \$ 73.89 | | \$ 14.78 |
| 76062 | X-rays, bone survey | | X | 0261 | 1.2416 | \$ 73.89 | | \$ 14.78 |
| 76065 | X-rays, bone evaluation | | X | 0261 | 1.2416 | \$ 73.89 | | \$ 14.78 |
| 76066 | Joint survey, single view | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 76070 | Ct bone density, axial | | S | 0288 | 1.2216 | \$ 72.70 | | \$ 14.54 |
| 76071 | Ct bone density, peripheral | | S | 0282 | 1.5934 | \$ 94.82 | \$ 37.92 | \$ 18.96 |
| 76075 | Dxa bone density, axial | | S | 0288 | 1.2216 | \$ 72.70 | | \$ 14.54 |
| 76076 | Dxa bone density/peripheral | | S | 0665 | 0.6381 | \$ 37.97 | | \$ 7.59 |
| 76077 | Ddxa bone density/v-fracture | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 76078 | Radiographic absorptiometry | CH | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 76080 | X-ray exam of fistula | | X | 0263 | 1.6979 | \$ 101.04 | \$ 23.77 | \$ 20.21 |
| 76086 | X-ray of mammary duct | | X | 0263 | 1.6979 | \$ 101.04 | \$ 23.77 | \$ 20.21 |
| 76088 | X-ray of mammary ducts | | X | 0263 | 1.6979 | \$ 101.04 | \$ 23.77 | \$ 20.21 |
| 76095 | Stereotactic breast biopsy | CH | X | 0264 | 3.4542 | \$ 205.56 | \$ 79.41 | \$ 41.11 |
| 76096 | X-ray of needle wire, breast | CH | X | 0263 | 1.6979 | \$ 101.04 | \$ 23.77 | \$ 20.21 |
| 76098 | X-ray exam, breast specimen | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 76100 | X-ray exam of body section | | X | 0261 | 1.2416 | \$ 73.89 | | \$ 14.78 |
| 76101 | Complex body section x-ray | | X | 0263 | 1.6979 | \$ 101.04 | \$ 23.77 | \$ 20.21 |
| 76102 | Complex body section x-rays | | X | 0264 | 3.4542 | \$ 205.56 | \$ 79.41 | \$ 41.11 |
| 76120 | Cine/video x-rays | | X | 0272 | 1.3291 | \$ 79.10 | \$ 31.64 | \$ 15.82 |
| 76125 | Cine/video x-rays add-on | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 76150 | X-ray exam, dry process | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 76350 | Special x-ray contrast study | | N | | | | | |
| 76355 | Ct scan for localization | | S | 0283 | 4.2921 | \$ 255.43 | \$ 102.17 | \$ 51.09 |
| 76360 | Ct scan for needle biopsy | | S | 0283 | 4.2921 | \$ 255.43 | \$ 102.17 | \$ 51.09 |
| 76362 | Ct guide for tissue ablation | CH | S | 0333 | 5.1053 | \$ 303.82 | \$ 121.52 | \$ 60.76 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 76370 | Ct scan for therapy guide | | S | 0282 | 1.5934 | \$ 94.82 | \$ 37.92 | \$ 18.96 |
| 76375 | 3d/holograph reconstr add-on | CH | D | | | | | |
| 76376 | 3d render w/o postprocess | NI | X | 0340 | 0.6137 | \$ 36.52 | | \$ 7.30 |
| 76377 | 3d rendering w/postprocess | NI | S | 0282 | 1.5934 | \$ 94.82 | \$ 37.92 | \$ 18.96 |
| 76380 | CAT scan follow-up study | | S | 0282 | 1.5934 | \$ 94.82 | \$ 37.92 | \$ 18.96 |
| 76393 | Mr guidance for needle place | | S | 0335 | 5.0997 | \$ 303.49 | \$ 121.39 | \$ 60.70 |
| 76394 | Mri for tissue ablation | | S | 0335 | 5.0997 | \$ 303.49 | \$ 121.39 | \$ 60.70 |
| 76400 | Magnetic image, bone marrow | | S | 0335 | 5.0997 | \$ 303.49 | \$ 121.39 | \$ 60.70 |
| 76496 | Fluoroscopic procedure | | X | 0272 | 1.3291 | \$ 79.10 | \$ 31.64 | \$ 15.82 |
| 76497 | Ct procedure | | S | 0282 | 1.5934 | \$ 94.82 | \$ 37.92 | \$ 18.96 |
| 76498 | Mri procedure | | S | 0335 | 5.0997 | \$ 303.49 | \$ 121.39 | \$ 60.70 |
| 76499 | Radiographic procedure | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 76506 | Echo exam of head | CH | S | 0265 | 0.9930 | \$ 59.09 | \$ 23.63 | \$ 11.82 |
| 76510 | Ophth us, b & quant a | | S | 0266 | 1.5883 | \$ 94.52 | \$ 37.80 | \$ 18.90 |
| 76511 | Ophth us, quant a only | | S | 0266 | 1.5883 | \$ 94.52 | \$ 37.80 | \$ 18.90 |
| 76512 | Ophth us, b w/non-quant a | | S | 0266 | 1.5883 | \$ 94.52 | \$ 37.80 | \$ 18.90 |
| 76513 | Echo exam of eye, water bath | | S | 0266 | 1.5883 | \$ 94.52 | \$ 37.80 | \$ 18.90 |
| 76514 | Echo exam of eye, thickness | | X | 0340 | 0.6137 | \$ 36.52 | | \$ 7.30 |
| 76516 | Echo exam of eye | CH | S | 0265 | 0.9930 | \$ 59.09 | \$ 23.63 | \$ 11.82 |
| 76519 | Echo exam of eye | | S | 0266 | 1.5883 | \$ 94.52 | \$ 37.80 | \$ 18.90 |
| 76529 | Echo exam of eye | CH | S | 0265 | 0.9930 | \$ 59.09 | \$ 23.63 | \$ 11.82 |
| 76536 | Us exam of head and neck | | S | 0266 | 1.5883 | \$ 94.52 | \$ 37.80 | \$ 18.90 |
| 76604 | Us exam, chest, b-scan | | S | 0266 | 1.5883 | \$ 94.52 | \$ 37.80 | \$ 18.90 |
| 76645 | Us exam, breast(s) | | S | 0265 | 0.9930 | \$ 59.09 | \$ 23.63 | \$ 11.82 |
| 76700 | Us exam, abdom, complete | | S | 0266 | 1.5883 | \$ 94.52 | \$ 37.80 | \$ 18.90 |
| 76705 | Echo exam of abdomen | | S | 0266 | 1.5883 | \$ 94.52 | \$ 37.80 | \$ 18.90 |
| 76770 | Us exam abdo back wall, comp | | S | 0266 | 1.5883 | \$ 94.52 | \$ 37.80 | \$ 18.90 |
| 76775 | Us exam abdo back wall, lim | | S | 0266 | 1.5883 | \$ 94.52 | \$ 37.80 | \$ 18.90 |
| 76778 | Us exam kidney transplant | | S | 0266 | 1.5883 | \$ 94.52 | \$ 37.80 | \$ 18.90 |
| 76800 | Us exam, spinal canal | | S | 0266 | 1.5883 | \$ 94.52 | \$ 37.80 | \$ 18.90 |
| 76801 | Ob us < 14 wks, single fetus | | S | 0266 | 1.5883 | \$ 94.52 | \$ 37.80 | \$ 18.90 |
| 76802 | Ob us < 14 wks, add'l fetus | | S | 0265 | 0.9930 | \$ 59.09 | \$ 23.63 | \$ 11.82 |
| 76805 | Ob us >= 14 wks, snpl fetus | | S | 0266 | 1.5883 | \$ 94.52 | \$ 37.80 | \$ 18.90 |
| 76810 | Ob us >= 14 wks, addl fetus | | S | 0266 | 1.5883 | \$ 94.52 | \$ 37.80 | \$ 18.90 |
| 76811 | Ob us, detailed, snpl fetus | | S | 0267 | 2.5543 | \$ 152.01 | \$ 60.80 | \$ 30.40 |
| 76812 | Ob us, detailed, addl fetus | | S | 0266 | 1.5883 | \$ 94.52 | \$ 37.80 | \$ 18.90 |
| 76815 | Ob us, limited, fetus(s) | | S | 0265 | 0.9930 | \$ 59.09 | \$ 23.63 | \$ 11.82 |
| 76816 | Ob us, follow-up, per fetus | | S | 0265 | 0.9930 | \$ 59.09 | \$ 23.63 | \$ 11.82 |
| 76817 | Transvaginal us, obstetric | | S | 0266 | 1.5883 | \$ 94.52 | \$ 37.80 | \$ 18.90 |
| 76818 | Fetal biophys profile w/nst | | S | 0266 | 1.5883 | \$ 94.52 | \$ 37.80 | \$ 18.90 |
| 76819 | Fetal biophys profil w/o nst | | S | 0266 | 1.5883 | \$ 94.52 | \$ 37.80 | \$ 18.90 |
| 76820 | Umbilical artery echo | | S | 0096 | 1.6020 | \$ 95.34 | \$ 38.13 | \$ 19.07 |
| 76821 | Middle cerebral artery echo | | S | 0096 | 1.6020 | \$ 95.34 | \$ 38.13 | \$ 19.07 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 76825 | Echo exam of fetal heart | | S | 0671 | 1.6763 | \$ 99.76 | \$ 39.90 | \$ 19.95 |
| 76826 | Echo exam of fetal heart | | S | 0697 | 1.5121 | \$ 89.99 | \$ 35.99 | \$ 18.00 |
| 76827 | Echo exam of fetal heart | | S | 0671 | 1.6763 | \$ 99.76 | \$ 39.90 | \$ 19.95 |
| 76828 | Echo exam of fetal heart | | S | 0697 | 1.5121 | \$ 89.99 | \$ 35.99 | \$ 18.00 |
| 76830 | Transvaginal us, non-ob | | S | 0266 | 1.5883 | \$ 94.52 | \$ 37.80 | \$ 18.90 |
| 76831 | Echo exam, uterus | CH | S | 0267 | 2.5543 | \$ 152.01 | \$ 60.80 | \$ 30.40 |
| 76856 | Us exam, pelvic, complete | | S | 0266 | 1.5883 | \$ 94.52 | \$ 37.80 | \$ 18.90 |
| 76857 | Us exam, pelvic, limited | | S | 0265 | 0.9930 | \$ 59.09 | \$ 23.63 | \$ 11.82 |
| 76870 | Us exam, scrotum | | S | 0266 | 1.5883 | \$ 94.52 | \$ 37.80 | \$ 18.90 |
| 76872 | Us, transrectal | | S | 0266 | 1.5883 | \$ 94.52 | \$ 37.80 | \$ 18.90 |
| 76873 | Echograp trans r, pros study | | S | 0266 | 1.5883 | \$ 94.52 | \$ 37.80 | \$ 18.90 |
| 76880 | Us exam, extremity | | S | 0266 | 1.5883 | \$ 94.52 | \$ 37.80 | \$ 18.90 |
| 76885 | Us exam infant hips, dynamic | CH | S | 0265 | 0.9930 | \$ 59.09 | \$ 23.63 | \$ 11.82 |
| 76886 | Us exam infant hips, static | | S | 0266 | 1.5883 | \$ 94.52 | \$ 37.80 | \$ 18.90 |
| 76930 | Echo guide, cardiocentesis | | S | 0268 | 1.0460 | \$ 62.25 | | \$ 12.45 |
| 76932 | Echo guide for heart biopsy | | S | 0268 | 1.0460 | \$ 62.25 | | \$ 12.45 |
| 76936 | Echo guide for artery repair | | S | 0268 | 1.0460 | \$ 62.25 | | \$ 12.45 |
| 76937 | Us guide, vascular access | | N | | | | | |
| 76940 | Us guide, tissue ablation | | S | 0268 | 1.0460 | \$ 62.25 | | \$ 12.45 |
| 76941 | Echo guide for transfusion | | S | 0268 | 1.0460 | \$ 62.25 | | \$ 12.45 |
| 76942 | Echo guide for biopsy | | S | 0268 | 1.0460 | \$ 62.25 | | \$ 12.45 |
| 76945 | Echo guide, villus sampling | | S | 0268 | 1.0460 | \$ 62.25 | | \$ 12.45 |
| 76946 | Echo guide for amniocentesis | | S | 0268 | 1.0460 | \$ 62.25 | | \$ 12.45 |
| 76948 | Echo guide, ova aspiration | | S | 0268 | 1.0460 | \$ 62.25 | | \$ 12.45 |
| 76950 | Echo guidance radiotherapy | | S | 0268 | 1.0460 | \$ 62.25 | | \$ 12.45 |
| 76965 | Echo guidance radiotherapy | | S | 0268 | 1.0460 | \$ 62.25 | | \$ 12.45 |
| 76970 | Ultrasound exam follow-up | | S | 0265 | 0.9930 | \$ 59.09 | \$ 23.63 | \$ 11.82 |
| 76975 | GI endoscopic ultrasound | | S | 0266 | 1.5883 | \$ 94.52 | \$ 37.80 | \$ 18.90 |
| 76977 | Us bone density measure | | X | 0340 | 0.6137 | \$ 36.52 | | \$ 7.30 |
| 76986 | Ultrasound guide intraoper | | S | 0266 | 1.5883 | \$ 94.52 | \$ 37.80 | \$ 18.90 |
| 76999 | Echo examination procedure | | S | 0265 | 0.9930 | \$ 59.09 | \$ 23.63 | \$ 11.82 |
| 77280 | Set radiation therapy field | | X | 0304 | 1.7323 | \$ 103.09 | \$ 41.23 | \$ 20.62 |
| 77285 | Set radiation therapy field | | X | 0305 | 3.9335 | \$ 234.09 | \$ 91.38 | \$ 46.82 |
| 77290 | Set radiation therapy field | | X | 0305 | 3.9335 | \$ 234.09 | \$ 91.38 | \$ 46.82 |
| 77295 | Set radiation therapy field | | X | 0310 | 13.8818 | \$ 826.12 | \$ 325.27 | \$ 165.22 |
| 77299 | Radiation therapy planning | CH | X | 0304 | 1.7323 | \$ 103.09 | \$ 41.23 | \$ 20.62 |
| 77300 | Radiation therapy dose plan | | X | 0304 | 1.7323 | \$ 103.09 | \$ 41.23 | \$ 20.62 |
| 77301 | Radiotherapy dose plan, imrt | | X | 0310 | 13.8818 | \$ 826.12 | \$ 325.27 | \$ 165.22 |
| 77305 | Teletx isodose plan simple | | X | 0304 | 1.7323 | \$ 103.09 | \$ 41.23 | \$ 20.62 |
| 77310 | Teletx isodose plan intermed | CH | X | 0305 | 3.9335 | \$ 234.09 | \$ 91.38 | \$ 46.82 |
| 77315 | Teletx isodose plan complex | | X | 0305 | 3.9335 | \$ 234.09 | \$ 91.38 | \$ 46.82 |
| 77321 | Special teletx port plan | | X | 0305 | 3.9335 | \$ 234.09 | \$ 91.38 | \$ 46.82 |
| 77326 | Brachytx isodose calc simp | | X | 0304 | 1.7323 | \$ 103.09 | \$ 41.23 | \$ 20.62 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 77327 | Brachytx isodose calc interm | | X | 0305 | 3.9335 | \$ 234.09 | \$ 91.38 | \$ 46.82 |
| 77328 | Brachytx isodose plan compl | | X | 0305 | 3.9335 | \$ 234.09 | \$ 91.38 | \$ 46.82 |
| 77331 | Special radiation dosimetry | | X | 0304 | 1.7323 | \$ 103.09 | \$ 41.23 | \$ 20.62 |
| 77332 | Radiation treatment aid(s) | | X | 0303 | 2.8241 | \$ 168.07 | \$ 66.95 | \$ 33.61 |
| 77333 | Radiation treatment aid(s) | | X | 0303 | 2.8241 | \$ 168.07 | \$ 66.95 | \$ 33.61 |
| 77334 | Radiation treatment aid(s) | | X | 0303 | 2.8241 | \$ 168.07 | \$ 66.95 | \$ 33.61 |
| 77336 | Radiation physics consult | | X | 0304 | 1.7323 | \$ 103.09 | \$ 41.23 | \$ 20.62 |
| 77370 | Radiation physics consult | | X | 0304 | 1.7323 | \$ 103.09 | \$ 41.23 | \$ 20.62 |
| 77399 | External radiation dosimetry | | X | 0304 | 1.7323 | \$ 103.09 | \$ 41.23 | \$ 20.62 |
| 77401 | Radiation treatment delivery | | S | 0300 | 1.4660 | \$ 87.24 | | \$ 17.45 |
| 77402 | Radiation treatment delivery | | S | 0300 | 1.4660 | \$ 87.24 | | \$ 17.45 |
| 77403 | Radiation treatment delivery | | S | 0300 | 1.4660 | \$ 87.24 | | \$ 17.45 |
| 77404 | Radiation treatment delivery | | S | 0300 | 1.4660 | \$ 87.24 | | \$ 17.45 |
| 77406 | Radiation treatment delivery | | S | 0300 | 1.4660 | \$ 87.24 | | \$ 17.45 |
| 77407 | Radiation treatment delivery | | S | 0300 | 1.4660 | \$ 87.24 | | \$ 17.45 |
| 77408 | Radiation treatment delivery | | S | 0300 | 1.4660 | \$ 87.24 | | \$ 17.45 |
| 77409 | Radiation treatment delivery | | S | 0300 | 1.4660 | \$ 87.24 | | \$ 17.45 |
| 77411 | Radiation treatment delivery | CH | S | 0301 | 2.2056 | \$ 131.26 | | \$ 26.25 |
| 77412 | Radiation treatment delivery | | S | 0301 | 2.2056 | \$ 131.26 | | \$ 26.25 |
| 77413 | Radiation treatment delivery | | S | 0301 | 2.2056 | \$ 131.26 | | \$ 26.25 |
| 77414 | Radiation treatment delivery | | S | 0301 | 2.2056 | \$ 131.26 | | \$ 26.25 |
| 77416 | Radiation treatment delivery | | S | 0301 | 2.2056 | \$ 131.26 | | \$ 26.25 |
| 77417 | Radiology port film(s) | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 77418 | Radiation tx delivery, imrt | | S | 0412 | 5.3573 | \$ 318.82 | | \$ 63.76 |
| 77421 | Stereoscopic x-ray guidance | NI | S | 1502 | | \$ 75.00 | | \$ 15.00 |
| 77422 | Neutron beam tx, simple | NI | S | 0301 | 2.2056 | \$ 131.26 | | \$ 26.25 |
| 77423 | Neutron beam tx, complex | NI | S | 0301 | 2.2056 | \$ 131.26 | | \$ 26.25 |
| 77470 | Special radiation treatment | | S | 0299 | 5.7678 | \$ 343.25 | | \$ 68.65 |
| 77520 | Proton trmt, simple w/o comp | | S | 0664 | 15.9286 | \$ 947.93 | | \$ 189.59 |
| 77522 | Proton trmt, simple w/comp | | S | 0664 | 15.9286 | \$ 947.93 | | \$ 189.59 |
| 77523 | Proton trmt, intermediate | CH | S | 0667 | 19.0566 | \$ 1,134.08 | | \$ 226.82 |
| 77525 | Proton treatment, complex | CH | S | 0667 | 19.0566 | \$ 1,134.08 | | \$ 226.82 |
| 77600 | Hyperthermia treatment | | S | 0314 | 5.5840 | \$ 332.31 | \$ 98.36 | \$ 66.46 |
| 77605 | Hyperthermia treatment | | S | 0314 | 5.5840 | \$ 332.31 | \$ 98.36 | \$ 66.46 |
| 77610 | Hyperthermia treatment | | S | 0314 | 5.5840 | \$ 332.31 | \$ 98.36 | \$ 66.46 |
| 77615 | Hyperthermia treatment | | S | 0314 | 5.5840 | \$ 332.31 | \$ 98.36 | \$ 66.46 |
| 77620 | Hyperthermia treatment | | S | 0314 | 5.5840 | \$ 332.31 | \$ 98.36 | \$ 66.46 |
| 77750 | Infuse radioactive materials | CH | S | 0301 | 2.2056 | \$ 131.26 | | \$ 26.25 |
| 77761 | Apply intrcav radiat simple | | S | 0312 | 5.5674 | \$ 331.32 | | \$ 66.26 |
| 77762 | Apply intrcav radiat interm | | S | 0312 | 5.5674 | \$ 331.32 | | \$ 66.26 |
| 77763 | Apply intrcav radiat compl | | S | 0312 | 5.5674 | \$ 331.32 | | \$ 66.26 |
| 77776 | Apply interstit radiat simpl | | S | 0312 | 5.5674 | \$ 331.32 | | \$ 66.26 |
| 77777 | Apply interstit radiat inter | | S | 0312 | 5.5674 | \$ 331.32 | | \$ 66.26 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 77778 | Apply interstit radiat compl | | S | 0651 | 11.1948 | \$ 666.21 | | \$ 133.24 |
| 77781 | High intensity brachytherapy | | S | 0313 | 13.0202 | \$ 774.85 | | \$ 154.97 |
| 77782 | High intensity brachytherapy | | S | 0313 | 13.0202 | \$ 774.85 | | \$ 154.97 |
| 77783 | High intensity brachytherapy | | S | 0313 | 13.0202 | \$ 774.85 | | \$ 154.97 |
| 77784 | High intensity brachytherapy | | S | 0313 | 13.0202 | \$ 774.85 | | \$ 154.97 |
| 77789 | Apply surface radiation | | S | 0300 | 1.4660 | \$ 87.24 | | \$ 17.45 |
| 77790 | Radiation handling | | N | | | | | |
| 77799 | Radium/radioisotope therapy | | S | 0313 | 13.0202 | \$ 774.85 | | \$ 154.97 |
| 78000 | Thyroid, single uptake | | S | 0389 | 1.4276 | \$ 84.96 | \$ 33.98 | \$ 16.99 |
| 78001 | Thyroid, multiple uptakes | | S | 0389 | 1.4276 | \$ 84.96 | \$ 33.98 | \$ 16.99 |
| 78003 | Thyroid suppress/stimul | CH | S | 0392 | 3.5231 | \$ 209.66 | \$ 83.86 | \$ 41.93 |
| 78006 | Thyroid imaging with uptake | | S | 0390 | 2.4663 | \$ 146.77 | \$ 58.70 | \$ 29.35 |
| 78007 | Thyroid image, mult uptakes | | S | 0391 | 2.7803 | \$ 165.46 | \$ 66.18 | \$ 33.09 |
| 78010 | Thyroid imaging | | S | 0390 | 2.4663 | \$ 146.77 | \$ 58.70 | \$ 29.35 |
| 78011 | Thyroid imaging with flow | | S | 0390 | 2.4663 | \$ 146.77 | \$ 58.70 | \$ 29.35 |
| 78015 | Thyroid met imaging | | S | 0406 | 4.1397 | \$ 246.36 | \$ 98.54 | \$ 49.27 |
| 78016 | Thyroid met imaging/studies | | S | 0406 | 4.1397 | \$ 246.36 | \$ 98.54 | \$ 49.27 |
| 78018 | Thyroid met imaging, body | | S | 0406 | 4.1397 | \$ 246.36 | \$ 98.54 | \$ 49.27 |
| 78020 | Thyroid met uptake | | S | 0399 | 1.5039 | \$ 89.50 | \$ 35.80 | \$ 17.90 |
| 78070 | Parathyroid nuclear imaging | | S | 0391 | 2.7803 | \$ 165.46 | \$ 66.18 | \$ 33.09 |
| 78075 | Adrenal nuclear imaging | | S | 0391 | 2.7803 | \$ 165.46 | \$ 66.18 | \$ 33.09 |
| 78099 | Endocrine nuclear procedure | | S | 0390 | 2.4663 | \$ 146.77 | \$ 58.70 | \$ 29.35 |
| 78102 | Bone marrow imaging, ltd | | S | 0400 | 3.9160 | \$ 233.05 | \$ 93.22 | \$ 46.61 |
| 78103 | Bone marrow imaging, mult | | S | 0400 | 3.9160 | \$ 233.05 | \$ 93.22 | \$ 46.61 |
| 78104 | Bone marrow imaging, body | | S | 0400 | 3.9160 | \$ 233.05 | \$ 93.22 | \$ 46.61 |
| 78110 | Plasma volume, single | | S | 0393 | 3.4467 | \$ 205.12 | \$ 82.04 | \$ 41.02 |
| 78111 | Plasma volume, multiple | | S | 0393 | 3.4467 | \$ 205.12 | \$ 82.04 | \$ 41.02 |
| 78120 | Red cell mass, single | | S | 0393 | 3.4467 | \$ 205.12 | \$ 82.04 | \$ 41.02 |
| 78121 | Red cell mass, multiple | | S | 0393 | 3.4467 | \$ 205.12 | \$ 82.04 | \$ 41.02 |
| 78122 | Blood volume | | S | 0393 | 3.4467 | \$ 205.12 | \$ 82.04 | \$ 41.02 |
| 78130 | Red cell survival study | | S | 0393 | 3.4467 | \$ 205.12 | \$ 82.04 | \$ 41.02 |
| 78135 | Red cell survival kinetics | | S | 0393 | 3.4467 | \$ 205.12 | \$ 82.04 | \$ 41.02 |
| 78140 | Red cell sequestration | | S | 0393 | 3.4467 | \$ 205.12 | \$ 82.04 | \$ 41.02 |
| 78160 | Plasma iron turnover | CH | D | | | | | |
| 78162 | Radioiron absorption exam | CH | D | | | | | |
| 78170 | Red cell iron utilization | CH | D | | | | | |
| 78172 | Total body iron estimation | CH | D | | | | | |
| 78185 | Spleen imaging | | S | 0400 | 3.9160 | \$ 233.05 | \$ 93.22 | \$ 46.61 |
| 78190 | Platelet survival, kinetics | CH | S | 0392 | 3.5231 | \$ 209.66 | \$ 83.86 | \$ 41.93 |
| 78191 | Platelet survival | CH | S | 0392 | 3.5231 | \$ 209.66 | \$ 83.86 | \$ 41.93 |
| 78195 | Lymph system imaging | | S | 0400 | 3.9160 | \$ 233.05 | \$ 93.22 | \$ 46.61 |
| 78199 | Blood/lymph nuclear exam | | S | 0400 | 3.9160 | \$ 233.05 | \$ 93.22 | \$ 46.61 |
| 78201 | Liver imaging | | S | 0394 | 4.3107 | \$ 256.53 | \$ 102.61 | \$ 51.31 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 78202 | Liver imaging with flow | | S | 0394 | 4.3107 | \$ 256.53 | \$ 102.61 | \$ 51.31 |
| 78205 | Liver imaging (3D) | | S | 0394 | 4.3107 | \$ 256.53 | \$ 102.61 | \$ 51.31 |
| 78206 | Liver image (3d) with flow | | S | 0394 | 4.3107 | \$ 256.53 | \$ 102.61 | \$ 51.31 |
| 78215 | Liver and spleen imaging | | S | 0394 | 4.3107 | \$ 256.53 | \$ 102.61 | \$ 51.31 |
| 78216 | Liver & spleen image/flow | | S | 0394 | 4.3107 | \$ 256.53 | \$ 102.61 | \$ 51.31 |
| 78220 | Liver function study | | S | 0394 | 4.3107 | \$ 256.53 | \$ 102.61 | \$ 51.31 |
| 78223 | Hepatobiliary imaging | | S | 0394 | 4.3107 | \$ 256.53 | \$ 102.61 | \$ 51.31 |
| 78230 | Salivary gland imaging | | S | 0395 | 3.7696 | \$ 224.33 | \$ 89.73 | \$ 44.87 |
| 78231 | Serial salivary imaging | | S | 0395 | 3.7696 | \$ 224.33 | \$ 89.73 | \$ 44.87 |
| 78232 | Salivary gland function exam | | S | 0395 | 3.7696 | \$ 224.33 | \$ 89.73 | \$ 44.87 |
| 78258 | Esophageal motility study | | S | 0395 | 3.7696 | \$ 224.33 | \$ 89.73 | \$ 44.87 |
| 78261 | Gastric mucosa imaging | | S | 0395 | 3.7696 | \$ 224.33 | \$ 89.73 | \$ 44.87 |
| 78262 | Gastroesophageal reflux exam | | S | 0395 | 3.7696 | \$ 224.33 | \$ 89.73 | \$ 44.87 |
| 78264 | Gastric emptying study | | S | 0395 | 3.7696 | \$ 224.33 | \$ 89.73 | \$ 44.87 |
| 78270 | Vit B-12 absorption exam | CH | S | 0392 | 3.5231 | \$ 209.66 | \$ 83.86 | \$ 41.93 |
| 78271 | Vit b-12 absrp exam, int fac | CH | S | 0392 | 3.5231 | \$ 209.66 | \$ 83.86 | \$ 41.93 |
| 78272 | Vit B-12 absorp, combined | CH | S | 0392 | 3.5231 | \$ 209.66 | \$ 83.86 | \$ 41.93 |
| 78278 | Acute GI blood loss imaging | | S | 0395 | 3.7696 | \$ 224.33 | \$ 89.73 | \$ 44.87 |
| 78282 | GI protein loss exam | | S | 0395 | 3.7696 | \$ 224.33 | \$ 89.73 | \$ 44.87 |
| 78290 | Meckel's divert exam | | S | 0395 | 3.7696 | \$ 224.33 | \$ 89.73 | \$ 44.87 |
| 78291 | Leveen/shunt patency exam | | S | 0395 | 3.7696 | \$ 224.33 | \$ 89.73 | \$ 44.87 |
| 78299 | GI nuclear procedure | | S | 0395 | 3.7696 | \$ 224.33 | \$ 89.73 | \$ 44.87 |
| 78300 | Bone imaging, limited area | | S | 0396 | 3.9921 | \$ 237.57 | \$ 95.02 | \$ 47.51 |
| 78305 | Bone imaging, multiple areas | | S | 0396 | 3.9921 | \$ 237.57 | \$ 95.02 | \$ 47.51 |
| 78306 | Bone imaging, whole body | | S | 0396 | 3.9921 | \$ 237.57 | \$ 95.02 | \$ 47.51 |
| 78315 | Bone imaging, 3 phase | | S | 0396 | 3.9921 | \$ 237.57 | \$ 95.02 | \$ 47.51 |
| 78320 | Bone imaging (3D) | | S | 0396 | 3.9921 | \$ 237.57 | \$ 95.02 | \$ 47.51 |
| 78350 | Bone mineral, single photon | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| 78399 | Musculoskeletal nuclear exam | | S | 0396 | 3.9921 | \$ 237.57 | \$ 95.02 | \$ 47.51 |
| 78414 | Non-imaging heart function | | S | 0398 | 4.2038 | \$ 250.17 | \$ 100.06 | \$ 50.03 |
| 78428 | Cardiac shunt imaging | | S | 0398 | 4.2038 | \$ 250.17 | \$ 100.06 | \$ 50.03 |
| 78445 | Vascular flow imaging | | S | 0397 | 2.0829 | \$ 123.96 | \$ 49.58 | \$ 24.79 |
| 78455 | Venous thrombosis study | CH | D | | | | | |
| 78456 | Acute venous thrombus image | | S | 0397 | 2.0829 | \$ 123.96 | \$ 49.58 | \$ 24.79 |
| 78457 | Venous thrombosis imaging | | S | 0397 | 2.0829 | \$ 123.96 | \$ 49.58 | \$ 24.79 |
| 78458 | Ven thrombosis images, bilat | | S | 0397 | 2.0829 | \$ 123.96 | \$ 49.58 | \$ 24.79 |
| 78459 | Heart muscle imaging (PET) | | S | 0306 | 13.4521 | \$ 800.55 | \$ 320.21 | \$ 160.11 |
| 78460 | Heart muscle blood, single | | S | 0398 | 4.2038 | \$ 250.17 | \$ 100.06 | \$ 50.03 |
| 78461 | Heart muscle blood, multiple | | S | 0377 | 6.6729 | \$ 397.11 | \$ 158.84 | \$ 79.42 |
| 78464 | Heart image (3d), single | | S | 0398 | 4.2038 | \$ 250.17 | \$ 100.06 | \$ 50.03 |
| 78465 | Heart image (3d), multiple | | S | 0377 | 6.6729 | \$ 397.11 | \$ 158.84 | \$ 79.42 |
| 78466 | Heart infarct image | | S | 0398 | 4.2038 | \$ 250.17 | \$ 100.06 | \$ 50.03 |
| 78468 | Heart infarct image (ef) | | S | 0398 | 4.2038 | \$ 250.17 | \$ 100.06 | \$ 50.03 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 78469 | Heart infarct image (3D) | | S | 0398 | 4.2038 | \$ 250.17 | \$ 100.06 | \$ 50.03 |
| 78472 | Gated heart, planar, single | | S | 0398 | 4.2038 | \$ 250.17 | \$ 100.06 | \$ 50.03 |
| 78473 | Gated heart, multiple | | S | 0376 | 5.0315 | \$ 299.43 | \$ 119.77 | \$ 59.89 |
| 78478 | Heart wall motion add-on | | S | 0399 | 1.5039 | \$ 89.50 | \$ 35.80 | \$ 17.90 |
| 78480 | Heart function add-on | | S | 0399 | 1.5039 | \$ 89.50 | \$ 35.80 | \$ 17.90 |
| 78481 | Heart first pass, single | | S | 0398 | 4.2038 | \$ 250.17 | \$ 100.06 | \$ 50.03 |
| 78483 | Heart first pass, multiple | | S | 0376 | 5.0315 | \$ 299.43 | \$ 119.77 | \$ 59.89 |
| 78491 | Heart image (pet), single | | S | 0306 | 13.4521 | \$ 800.55 | \$ 320.21 | \$ 160.11 |
| 78492 | Heart image (pet), multiple | | S | 0307 | 41.7549 | \$ 2,484.88 | \$ 993.95 | \$ 496.98 |
| 78494 | Heart image, spect | | S | 0398 | 4.2038 | \$ 250.17 | \$ 100.06 | \$ 50.03 |
| 78496 | Heart first pass add-on | | S | 0399 | 1.5039 | \$ 89.50 | \$ 35.80 | \$ 17.90 |
| 78499 | Cardiovascular nuclear exam | | S | 0398 | 4.2038 | \$ 250.17 | \$ 100.06 | \$ 50.03 |
| 78580 | Lung perfusion imaging | | S | 0401 | 3.3166 | \$ 197.37 | \$ 78.94 | \$ 39.47 |
| 78584 | Lung V/Q image single breath | | S | 0378 | 5.4064 | \$ 321.74 | \$ 128.69 | \$ 64.35 |
| 78585 | Lung V/Q imaging | | S | 0378 | 5.4064 | \$ 321.74 | \$ 128.69 | \$ 64.35 |
| 78586 | Aerosol lung image, single | | S | 0401 | 3.3166 | \$ 197.37 | \$ 78.94 | \$ 39.47 |
| 78587 | Aerosol lung image, multiple | | S | 0401 | 3.3166 | \$ 197.37 | \$ 78.94 | \$ 39.47 |
| 78588 | Perfusion lung image | | S | 0378 | 5.4064 | \$ 321.74 | \$ 128.69 | \$ 64.35 |
| 78591 | Vent image, 1 breath, 1 proj | | S | 0401 | 3.3166 | \$ 197.37 | \$ 78.94 | \$ 39.47 |
| 78593 | Vent image, 1 proj, gas | | S | 0401 | 3.3166 | \$ 197.37 | \$ 78.94 | \$ 39.47 |
| 78594 | Vent image, mult proj, gas | | S | 0401 | 3.3166 | \$ 197.37 | \$ 78.94 | \$ 39.47 |
| 78596 | Lung differential function | | S | 0378 | 5.4064 | \$ 321.74 | \$ 128.69 | \$ 64.35 |
| 78599 | Respiratory nuclear exam | | S | 0401 | 3.3166 | \$ 197.37 | \$ 78.94 | \$ 39.47 |
| 78600 | Brain imaging, ltd static | | S | 0402 | 5.1709 | \$ 307.73 | \$ 123.09 | \$ 61.55 |
| 78601 | Brain imaging, ltd w/flow | | S | 0402 | 5.1709 | \$ 307.73 | \$ 123.09 | \$ 61.55 |
| 78605 | Brain imaging, complete | | S | 0402 | 5.1709 | \$ 307.73 | \$ 123.09 | \$ 61.55 |
| 78606 | Brain imaging, compl w/flow | | S | 0402 | 5.1709 | \$ 307.73 | \$ 123.09 | \$ 61.55 |
| 78607 | Brain imaging (3D) | | S | 0402 | 5.1709 | \$ 307.73 | \$ 123.09 | \$ 61.55 |
| 78608 | Brain imaging (PET) | | S | 1513 | | \$ 1,150.00 | | \$ 230.00 |
| 78610 | Brain flow imaging only | | S | 0402 | 5.1709 | \$ 307.73 | \$ 123.09 | \$ 61.55 |
| 78615 | Cerebral vascular flow image | | S | 0402 | 5.1709 | \$ 307.73 | \$ 123.09 | \$ 61.55 |
| 78630 | Cerebrospinal fluid scan | | S | 0403 | 3.5015 | \$ 208.38 | \$ 83.35 | \$ 41.68 |
| 78635 | CSF ventriculography | | S | 0403 | 3.5015 | \$ 208.38 | \$ 83.35 | \$ 41.68 |
| 78645 | CSF shunt evaluation | | S | 0403 | 3.5015 | \$ 208.38 | \$ 83.35 | \$ 41.68 |
| 78647 | Cerebrospinal fluid scan | | S | 0403 | 3.5015 | \$ 208.38 | \$ 83.35 | \$ 41.68 |
| 78650 | CSF leakage imaging | | S | 0403 | 3.5015 | \$ 208.38 | \$ 83.35 | \$ 41.68 |
| 78660 | Nuclear exam of tear flow | | S | 0403 | 3.5015 | \$ 208.38 | \$ 83.35 | \$ 41.68 |
| 78699 | Nervous system nuclear exam | | S | 0402 | 5.1709 | \$ 307.73 | \$ 123.09 | \$ 61.55 |
| 78700 | Kidney imaging, static | | S | 0404 | 3.6558 | \$ 217.56 | \$ 87.02 | \$ 43.51 |
| 78701 | Kidney imaging with flow | | S | 0404 | 3.6558 | \$ 217.56 | \$ 87.02 | \$ 43.51 |
| 78704 | Imaging renogram | | S | 0404 | 3.6558 | \$ 217.56 | \$ 87.02 | \$ 43.51 |
| 78707 | Kidney flow/function image | | S | 0404 | 3.6558 | \$ 217.56 | \$ 87.02 | \$ 43.51 |
| 78708 | Kidney flow/function image | | S | 0405 | 4.1493 | \$ 246.93 | \$ 98.77 | \$ 49.39 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 78709 | Kidney flow/function image | | S | 0405 | 4.1493 | \$ 246.93 | \$ 98.77 | \$ 49.39 |
| 78710 | Kidney imaging (3D) | | S | 0404 | 3.6558 | \$ 217.56 | \$ 87.02 | \$ 43.51 |
| 78715 | Renal vascular flow exam | | S | 0404 | 3.6558 | \$ 217.56 | \$ 87.02 | \$ 43.51 |
| 78725 | Kidney function study | | S | 0389 | 1.4276 | \$ 84.96 | \$ 33.98 | \$ 16.99 |
| 78730 | Urinary bladder retention | | X | 0340 | 0.6137 | \$ 36.52 | | \$ 7.30 |
| 78740 | Ureteral reflux study | | S | 0404 | 3.6558 | \$ 217.56 | \$ 87.02 | \$ 43.51 |
| 78760 | Testicular imaging | | S | 0404 | 3.6558 | \$ 217.56 | \$ 87.02 | \$ 43.51 |
| 78761 | Testicular imaging/flow | | S | 0404 | 3.6558 | \$ 217.56 | \$ 87.02 | \$ 43.51 |
| 78799 | Genitourinary nuclear exam | | S | 0404 | 3.6558 | \$ 217.56 | \$ 87.02 | \$ 43.51 |
| 78800 | Tumor imaging, limited area | | S | 0406 | 4.1397 | \$ 246.36 | \$ 98.54 | \$ 49.27 |
| 78801 | Tumor imaging, mult areas | | S | 0406 | 4.1397 | \$ 246.36 | \$ 98.54 | \$ 49.27 |
| 78802 | Tumor imaging, whole body | | S | 0406 | 4.1397 | \$ 246.36 | \$ 98.54 | \$ 49.27 |
| 78803 | Tumor imaging (3D) | | S | 0406 | 4.1397 | \$ 246.36 | \$ 98.54 | \$ 49.27 |
| 78804 | Tumor imaging, whole body | | S | 1508 | | \$ 650.00 | | \$ 130.00 |
| 78805 | Abscess imaging, ltd area | | S | 0406 | 4.1397 | \$ 246.36 | \$ 98.54 | \$ 49.27 |
| 78806 | Abscess imaging, whole body | | S | 0406 | 4.1397 | \$ 246.36 | \$ 98.54 | \$ 49.27 |
| 78807 | Nuclear localization/abscess | | S | 0406 | 4.1397 | \$ 246.36 | \$ 98.54 | \$ 49.27 |
| 78810 | Tumor imaging (PET) | | D | | | | | |
| 78811 | Tumor imaging (pet), limited | | S | 1513 | | \$ 1,150.00 | | \$ 230.00 |
| 78812 | Tumor image (pet)/skul-thigh | | S | 1513 | | \$ 1,150.00 | | \$ 230.00 |
| 78813 | Tumor image (pet) full body | | S | 1513 | | \$ 1,150.00 | | \$ 230.00 |
| 78814 | Tumor image pet/ct, limited | | S | 1514 | | \$ 1,250.00 | | \$ 250.00 |
| 78815 | Tumorimage pet/ct skul-thigh | | S | 1514 | | \$ 1,250.00 | | \$ 250.00 |
| 78816 | Tumor image pet/ct full body | | S | 1514 | | \$ 1,250.00 | | \$ 250.00 |
| 78890 | Nuclear medicine data proc | | N | | | | | |
| 78891 | Nuclear med data proc | | N | | | | | |
| 78990 | Provide diag radionuclide(s) | | D | | | | | |
| 78999 | Nuclear diagnostic exam | | S | 0389 | 1.4276 | \$ 84.96 | \$ 33.98 | \$ 16.99 |
| 79000 | Init hyperthyroid therapy | | D | | | | | |
| 79001 | Repeat hyperthyroid therapy | | D | | | | | |
| 79005 | Nuclear rx, oral admin | | S | 0407 | 3.8758 | \$ 230.65 | \$ 92.26 | \$ 46.13 |
| 79020 | Thyroid ablation | | D | | | | | |
| 79030 | Thyroid ablation, carcinoma | | D | | | | | |
| 79035 | Thyroid metastatic therapy | | D | | | | | |
| 79100 | Hematopoetic nuclear therapy | | D | | | | | |
| 79101 | Nuclear rx, iv admin | | S | 0407 | 3.8758 | \$ 230.65 | \$ 92.26 | \$ 46.13 |
| 79200 | Nuclear rx, intracav admin | | S | 0407 | 3.8758 | \$ 230.65 | \$ 92.26 | \$ 46.13 |
| 79300 | Nuclr rx, interstit colloid | | S | 0407 | 3.8758 | \$ 230.65 | \$ 92.26 | \$ 46.13 |
| 79400 | Nonhemato nuclear therapy | | D | | | | | |
| 79403 | Hematopoietic nuclear tx | | S | 1507 | | \$ 550.00 | | \$ 110.00 |
| 79420 | Intravascular nuclear ther | | D | | | | | |
| 79440 | Nuclear rx, intra-articular | | S | 0407 | 3.8758 | \$ 230.65 | \$ 92.26 | \$ 46.13 |
| 79445 | Nuclear rx, intra-arterial | | S | 0407 | 3.8758 | \$ 230.65 | \$ 92.26 | \$ 46.13 |

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|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 79900 | Provide ther radiopharm(s) | | D | | | | | |
| 79999 | Nuclear medicine therapy | | S | 0407 | 3.8758 | \$ 230.65 | \$ 92.26 | \$ 46.13 |
| 80103 | Drug analysis, tissue prep | | N | | | | | |
| 80500 | Lab pathology consultation | CH | X | 0433 | 0.2493 | \$ 14.84 | \$ 5.93 | \$ 2.97 |
| 80502 | Lab pathology consultation | | X | 0342 | 0.1450 | \$ 8.63 | \$ 3.45 | \$ 1.73 |
| 82273 | Test for blood, other source | | D | | | | | |
| 83715 | Assay of blood lipoproteins | | D | | | | | |
| 83716 | Assay of blood lipoproteins | | D | | | | | |
| 85097 | Bone marrow interpretation | | X | 0343 | 0.4553 | \$ 27.10 | \$ 10.84 | \$ 5.42 |
| 85396 | Clotting assay, whole blood | | N | | | | | |
| 86064 | B cells, total count | CH | D | | | | | |
| 86077 | Physician blood bank service | CH | X | 0433 | 0.2493 | \$ 14.84 | \$ 5.93 | \$ 2.97 |
| 86078 | Physician blood bank service | | X | 0343 | 0.4553 | \$ 27.10 | \$ 10.84 | \$ 5.42 |
| 86079 | Physician blood bank service | CH | X | 0433 | 0.2493 | \$ 14.84 | \$ 5.93 | \$ 2.97 |
| 86379 | Nk cells, total count | CH | D | | | | | |
| 86485 | Skin test, candida | | X | 0341 | 0.1035 | \$ 6.16 | \$ 2.46 | \$ 1.23 |
| 86490 | Coccidioidomycosis skin test | | X | 0341 | 0.1035 | \$ 6.16 | \$ 2.46 | \$ 1.23 |
| 86510 | Histoplasmosis skin test | | X | 0341 | 0.1035 | \$ 6.16 | \$ 2.46 | \$ 1.23 |
| 86580 | TB intradermal test | | X | 0341 | 0.1035 | \$ 6.16 | \$ 2.46 | \$ 1.23 |
| 86585 | TB tine test | CH | D | | | | | |
| 86587 | Stem cells, total count | CH | D | | | | | |
| 86850 | RBC antibody screen | | X | 0345 | 0.2170 | \$ 12.91 | \$ 2.87 | \$ 2.58 |
| 86860 | RBC antibody elution | | X | 0346 | 0.3314 | \$ 19.72 | \$ 4.39 | \$ 3.94 |
| 86870 | RBC antibody identification | | X | 0346 | 0.3314 | \$ 19.72 | \$ 4.39 | \$ 3.94 |
| 86880 | Coombs test, direct | | X | 0409 | 0.1210 | \$ 7.20 | \$ 2.20 | \$ 1.44 |
| 86885 | Coombs test, indirect, qual | | X | 0409 | 0.1210 | \$ 7.20 | \$ 2.20 | \$ 1.44 |
| 86886 | Coombs test, indirect, titer | | X | 0409 | 0.1210 | \$ 7.20 | \$ 2.20 | \$ 1.44 |
| 86890 | Autologous blood process | | X | 0347 | 0.8243 | \$ 49.05 | \$ 12.11 | \$ 9.81 |
| 86891 | Autologous blood, op salvage | CH | X | 0346 | 0.3314 | \$ 19.72 | \$ 4.39 | \$ 3.94 |
| 86900 | Blood typing, ABO | | X | 0409 | 0.1210 | \$ 7.20 | \$ 2.20 | \$ 1.44 |
| 86901 | Blood typing, Rh (D) | | X | 0409 | 0.1210 | \$ 7.20 | \$ 2.20 | \$ 1.44 |
| 86903 | Blood typing, antigen screen | | X | 0345 | 0.2170 | \$ 12.91 | \$ 2.87 | \$ 2.58 |
| 86904 | Blood typing, patient serum | CH | X | 0346 | 0.3314 | \$ 19.72 | \$ 4.39 | \$ 3.94 |
| 86905 | Blood typing, RBC antigens | | X | 0345 | 0.2170 | \$ 12.91 | \$ 2.87 | \$ 2.58 |
| 86906 | Blood typing, Rh phenotype | | X | 0345 | 0.2170 | \$ 12.91 | \$ 2.87 | \$ 2.58 |
| 86920 | Compatibility test, spin | | X | 0346 | 0.3314 | \$ 19.72 | \$ 4.39 | \$ 3.94 |
| 86921 | Compatibility test, incubate | | X | 0345 | 0.2170 | \$ 12.91 | \$ 2.87 | \$ 2.58 |
| 86922 | Compatibility test, antiglob | | X | 0346 | 0.3314 | \$ 19.72 | \$ 4.39 | \$ 3.94 |
| 86923 | Compatibility test, electric | NI | X | 0345 | 0.2170 | \$ 12.91 | \$ 2.87 | \$ 2.58 |
| 86927 | Plasma, fresh frozen | CH | X | 0345 | 0.2170 | \$ 12.91 | \$ 2.87 | \$ 2.58 |
| 86930 | Frozen blood prep | | X | 0347 | 0.8243 | \$ 49.05 | \$ 12.11 | \$ 9.81 |
| 86931 | Frozen blood thaw | | X | 0347 | 0.8243 | \$ 49.05 | \$ 12.11 | \$ 9.81 |
| 86932 | Frozen blood freeze/thaw | | X | 0347 | 0.8243 | \$ 49.05 | \$ 12.11 | \$ 9.81 |

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|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 86945 | Blood product/irradiation | CH | X | 0345 | 0.2170 | \$ 12.91 | \$ 2.87 | \$ 2.58 |
| 86950 | Leukocyte transfusion | CH | X | 0345 | 0.2170 | \$ 12.91 | \$ 2.87 | \$ 2.58 |
| 86960 | Vol reduction of blood/prod | NI | X | 0345 | 0.2170 | \$ 12.91 | \$ 2.87 | \$ 2.58 |
| 86965 | Pooling blood platelets | CH | X | 0345 | 0.2170 | \$ 12.91 | \$ 2.87 | \$ 2.58 |
| 86970 | RBC pretreatment | | X | 0345 | 0.2170 | \$ 12.91 | \$ 2.87 | \$ 2.58 |
| 86971 | RBC pretreatment | | X | 0345 | 0.2170 | \$ 12.91 | \$ 2.87 | \$ 2.58 |
| 86972 | RBC pretreatment | CH | X | 0346 | 0.3314 | \$ 19.72 | \$ 4.39 | \$ 3.94 |
| 86975 | RBC pretreatment, serum | | X | 0345 | 0.2170 | \$ 12.91 | \$ 2.87 | \$ 2.58 |
| 86976 | RBC pretreatment, serum | | X | 0345 | 0.2170 | \$ 12.91 | \$ 2.87 | \$ 2.58 |
| 86977 | RBC pretreatment, serum | | X | 0345 | 0.2170 | \$ 12.91 | \$ 2.87 | \$ 2.58 |
| 86978 | RBC pretreatment, serum | | X | 0345 | 0.2170 | \$ 12.91 | \$ 2.87 | \$ 2.58 |
| 86985 | Split blood or products | CH | X | 0345 | 0.2170 | \$ 12.91 | \$ 2.87 | \$ 2.58 |
| 86999 | Transfusion procedure | | X | 0345 | 0.2170 | \$ 12.91 | \$ 2.87 | \$ 2.58 |
| 88104 | Cytopathology, fluids | CH | X | 0433 | 0.2493 | \$ 14.84 | \$ 5.93 | \$ 2.97 |
| 88106 | Cytopathology, fluids | CH | X | 0433 | 0.2493 | \$ 14.84 | \$ 5.93 | \$ 2.97 |
| 88107 | Cytopathology, fluids | CH | X | 0433 | 0.2493 | \$ 14.84 | \$ 5.93 | \$ 2.97 |
| 88108 | Cytopath, concentrate tech | CH | X | 0433 | 0.2493 | \$ 14.84 | \$ 5.93 | \$ 2.97 |
| 88112 | Cytopath, cell enhance tech | | X | 0343 | 0.4553 | \$ 27.10 | \$ 10.84 | \$ 5.42 |
| 88125 | Forensic cytopathology | | X | 0342 | 0.1450 | \$ 8.63 | \$ 3.45 | \$ 1.73 |
| 88141 | Cytopath, c/v, interpret | | N | | | | | |
| 88160 | Cytopath smear, other source | CH | X | 0433 | 0.2493 | \$ 14.84 | \$ 5.93 | \$ 2.97 |
| 88161 | Cytopath smear, other source | CH | X | 0433 | 0.2493 | \$ 14.84 | \$ 5.93 | \$ 2.97 |
| 88162 | Cytopath smear, other source | CH | X | 0433 | 0.2493 | \$ 14.84 | \$ 5.93 | \$ 2.97 |
| 88172 | Cytopathology eval of fna | | X | 0343 | 0.4553 | \$ 27.10 | \$ 10.84 | \$ 5.42 |
| 88173 | Cytopath eval, fna, report | | X | 0343 | 0.4553 | \$ 27.10 | \$ 10.84 | \$ 5.42 |
| 88180 | Cell marker study | | D | | | | | |
| 88182 | Cell marker study | | X | 0344 | 0.7584 | \$ 45.13 | \$ 15.66 | \$ 9.03 |
| 88184 | Flowcytometry/ tc, 1 marker | | X | 0344 | 0.7584 | \$ 45.13 | \$ 15.66 | \$ 9.03 |
| 88185 | Flowcytometry/tc, add-on | | X | 0343 | 0.4553 | \$ 27.10 | \$ 10.84 | \$ 5.42 |
| 88187 | Flowcytometry/read, 2-8 | | X | 0433 | 0.2493 | \$ 14.84 | \$ 5.93 | \$ 2.97 |
| 88188 | Flowcytometry/read, 9-15 | | X | 0433 | 0.2493 | \$ 14.84 | \$ 5.93 | \$ 2.97 |
| 88189 | Flowcytometry/read, 16 & > | | X | 0343 | 0.4553 | \$ 27.10 | \$ 10.84 | \$ 5.42 |
| 88299 | Cytogenetic study | | X | 0342 | 0.1450 | \$ 8.63 | \$ 3.45 | \$ 1.73 |
| 88300 | Surgical path, gross | CH | X | 0433 | 0.2493 | \$ 14.84 | \$ 5.93 | \$ 2.97 |
| 88302 | Tissue exam by pathologist | CH | X | 0433 | 0.2493 | \$ 14.84 | \$ 5.93 | \$ 2.97 |
| 88304 | Tissue exam by pathologist | | X | 0343 | 0.4553 | \$ 27.10 | \$ 10.84 | \$ 5.42 |
| 88305 | Tissue exam by pathologist | | X | 0343 | 0.4553 | \$ 27.10 | \$ 10.84 | \$ 5.42 |
| 88307 | Tissue exam by pathologist | | X | 0344 | 0.7584 | \$ 45.13 | \$ 15.66 | \$ 9.03 |
| 88309 | Tissue exam by pathologist | | X | 0344 | 0.7584 | \$ 45.13 | \$ 15.66 | \$ 9.03 |
| 88311 | Decalcify tissue | | X | 0342 | 0.1450 | \$ 8.63 | \$ 3.45 | \$ 1.73 |
| 88312 | Special stains | CH | X | 0433 | 0.2493 | \$ 14.84 | \$ 5.93 | \$ 2.97 |
| 88313 | Special stains | CH | X | 0433 | 0.2493 | \$ 14.84 | \$ 5.93 | \$ 2.97 |
| 88314 | Histochemical stain | | X | 0342 | 0.1450 | \$ 8.63 | \$ 3.45 | \$ 1.73 |

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|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 88318 | Chemical histochemistry | CH | X | 0433 | 0.2493 | \$ 14.84 | \$ 5.93 | \$ 2.97 |
| 88319 | Enzyme histochemistry | CH | X | 0343 | 0.4553 | \$ 27.10 | \$ 10.84 | \$ 5.42 |
| 88321 | Microslide consultation | CH | X | 0433 | 0.2493 | \$ 14.84 | \$ 5.93 | \$ 2.97 |
| 88323 | Microslide consultation | CH | X | 0343 | 0.4553 | \$ 27.10 | \$ 10.84 | \$ 5.42 |
| 88325 | Comprehensive review of data | | X | 0344 | 0.7584 | \$ 45.13 | \$ 15.66 | \$ 9.03 |
| 88329 | Path consult introp | CH | X | 0433 | 0.2493 | \$ 14.84 | \$ 5.93 | \$ 2.97 |
| 88331 | Path consult intraop, 1 bloc | | X | 0343 | 0.4553 | \$ 27.10 | \$ 10.84 | \$ 5.42 |
| 88332 | Path consult intraop, add'l | CH | X | 0433 | 0.2493 | \$ 14.84 | \$ 5.93 | \$ 2.97 |
| 88333 | Intraop cyto path consult, 1 | NI | X | 0343 | 0.4553 | \$ 27.10 | \$ 10.84 | \$ 5.42 |
| 88334 | Intraop cyto path consult, 2 | NI | X | 0433 | 0.2493 | \$ 14.84 | \$ 5.93 | \$ 2.97 |
| 88342 | Immunohistochemistry | CH | X | 0343 | 0.4553 | \$ 27.10 | \$ 10.84 | \$ 5.42 |
| 88346 | Immunofluorescent study | CH | X | 0343 | 0.4553 | \$ 27.10 | \$ 10.84 | \$ 5.42 |
| 88347 | Immunofluorescent study | CH | X | 0343 | 0.4553 | \$ 27.10 | \$ 10.84 | \$ 5.42 |
| 88348 | Electron microscopy | | X | 0661 | 3.1514 | \$ 187.54 | \$ 75.01 | \$ 37.51 |
| 88349 | Scanning electron microscopy | | X | 0661 | 3.1514 | \$ 187.54 | \$ 75.01 | \$ 37.51 |
| 88355 | Analysis, skeletal muscle | CH | X | 0343 | 0.4553 | \$ 27.10 | \$ 10.84 | \$ 5.42 |
| 88356 | Analysis, nerve | | X | 0344 | 0.7584 | \$ 45.13 | \$ 15.66 | \$ 9.03 |
| 88358 | Analysis, tumor | | X | 0344 | 0.7584 | \$ 45.13 | \$ 15.66 | \$ 9.03 |
| 88360 | Tumor immunohistochem/manual | | X | 0344 | 0.7584 | \$ 45.13 | \$ 15.66 | \$ 9.03 |
| 88361 | Tumor immunohistochem/comput | | X | 0344 | 0.7584 | \$ 45.13 | \$ 15.66 | \$ 9.03 |
| 88362 | Nerve teasing preparations | | X | 0344 | 0.7584 | \$ 45.13 | \$ 15.66 | \$ 9.03 |
| 88365 | Insitu hybridization (fish) | | X | 0344 | 0.7584 | \$ 45.13 | \$ 15.66 | \$ 9.03 |
| 88367 | Insitu hybridization, auto | | X | 0344 | 0.7584 | \$ 45.13 | \$ 15.66 | \$ 9.03 |
| 88368 | Insitu hybridization, manual | | X | 0344 | 0.7584 | \$ 45.13 | \$ 15.66 | \$ 9.03 |
| 88380 | Microdissection | CH | N | | | | | |
| 88384 | Eval molecular probes, 11-50 | NI | X | 0433 | 0.2493 | \$ 14.84 | \$ 5.93 | \$ 2.97 |
| 88385 | Eval molecu probes, 51-250 | NI | X | 0343 | 0.4553 | \$ 27.10 | \$ 10.84 | \$ 5.42 |
| 88386 | Eval molecu probes, 251-500 | NI | X | 0344 | 0.7584 | \$ 45.13 | \$ 15.66 | \$ 9.03 |
| 89049 | Chct for mal hyperthermia | NI | X | 0343 | 0.4553 | \$ 27.10 | \$ 10.84 | \$ 5.42 |
| 89100 | Sample intestinal contents | | X | 0360 | 1.4235 | \$ 84.71 | \$ 33.88 | \$ 16.94 |
| 89105 | Sample intestinal contents | | X | 0360 | 1.4235 | \$ 84.71 | \$ 33.88 | \$ 16.94 |
| 89130 | Sample stomach contents | | X | 0360 | 1.4235 | \$ 84.71 | \$ 33.88 | \$ 16.94 |
| 89132 | Sample stomach contents | | X | 0360 | 1.4235 | \$ 84.71 | \$ 33.88 | \$ 16.94 |
| 89135 | Sample stomach contents | | X | 0360 | 1.4235 | \$ 84.71 | \$ 33.88 | \$ 16.94 |
| 89136 | Sample stomach contents | | X | 0360 | 1.4235 | \$ 84.71 | \$ 33.88 | \$ 16.94 |
| 89140 | Sample stomach contents | | X | 0360 | 1.4235 | \$ 84.71 | \$ 33.88 | \$ 16.94 |
| 89141 | Sample stomach contents | | X | 0360 | 1.4235 | \$ 84.71 | \$ 33.88 | \$ 16.94 |
| 89220 | Sputum specimen collection | | X | 0343 | 0.4553 | \$ 27.10 | \$ 10.84 | \$ 5.42 |
| 89230 | Collect sweat for test | CH | X | 0433 | 0.2493 | \$ 14.84 | \$ 5.93 | \$ 2.97 |
| 89250 | Cultr oocyte/embryo <4 days | | X | 0348 | 0.7607 | \$ 45.27 | | \$ 9.05 |
| 89251 | Cultr oocyte/embryo <4 days | | X | 0348 | 0.7607 | \$ 45.27 | | \$ 9.05 |
| 89253 | Embryo hatching | | X | 0348 | 0.7607 | \$ 45.27 | | \$ 9.05 |
| 89254 | Oocyte identification | | X | 0348 | 0.7607 | \$ 45.27 | | \$ 9.05 |

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|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 89255 | Prepare embryo for transfer | | X | 0348 | 0.7607 | \$ 45.27 | | \$ 9.05 |
| 89257 | Sperm identification | | X | 0348 | 0.7607 | \$ 45.27 | | \$ 9.05 |
| 89258 | Cryopreservation; embryo(s) | | X | 0348 | 0.7607 | \$ 45.27 | | \$ 9.05 |
| 89259 | Cryopreservation, sperm | | X | 0348 | 0.7607 | \$ 45.27 | | \$ 9.05 |
| 89260 | Sperm isolation, simple | | X | 0348 | 0.7607 | \$ 45.27 | | \$ 9.05 |
| 89261 | Sperm isolation, complex | | X | 0348 | 0.7607 | \$ 45.27 | | \$ 9.05 |
| 89264 | Identify sperm tissue | | X | 0348 | 0.7607 | \$ 45.27 | | \$ 9.05 |
| 89268 | Insemination of oocytes | | X | 0348 | 0.7607 | \$ 45.27 | | \$ 9.05 |
| 89272 | Extended culture of oocytes | | X | 0348 | 0.7607 | \$ 45.27 | | \$ 9.05 |
| 89280 | Assist oocyte fertilization | | X | 0348 | 0.7607 | \$ 45.27 | | \$ 9.05 |
| 89281 | Assist oocyte fertilization | | X | 0348 | 0.7607 | \$ 45.27 | | \$ 9.05 |
| 89290 | Biopsy, oocyte polar body | | X | 0348 | 0.7607 | \$ 45.27 | | \$ 9.05 |
| 89291 | Biopsy, oocyte polar body | | X | 0348 | 0.7607 | \$ 45.27 | | \$ 9.05 |
| 89335 | Cryopreserve testicular tiss | | X | 0348 | 0.7607 | \$ 45.27 | | \$ 9.05 |
| 89342 | Storage/year; embryo(s) | | X | 0348 | 0.7607 | \$ 45.27 | | \$ 9.05 |
| 89343 | Storage/year; sperm/semen | | X | 0348 | 0.7607 | \$ 45.27 | | \$ 9.05 |
| 89344 | Storage/year; reprod tissue | | X | 0348 | 0.7607 | \$ 45.27 | | \$ 9.05 |
| 89346 | Storage/year; oocyte(s) | | X | 0348 | 0.7607 | \$ 45.27 | | \$ 9.05 |
| 89352 | Thawing cryopresrvd; embryo | | X | 0348 | 0.7607 | \$ 45.27 | | \$ 9.05 |
| 89353 | Thawing cryopresrvd; sperm | | X | 0348 | 0.7607 | \$ 45.27 | | \$ 9.05 |
| 89354 | Thaw cryoprsrvd; reprod tiss | | X | 0348 | 0.7607 | \$ 45.27 | | \$ 9.05 |
| 89356 | Thawing cryopresrvd; oocyte | | X | 0348 | 0.7607 | \$ 45.27 | | \$ 9.05 |
| 90296 | Diphtheria antitoxin | | N | | | | | |
| 90371 | Hep b ig, im | CH | K | 1630 | | \$ 122.68 | | \$ 24.54 |
| 90375 | Rabies ig, im/sc | CH | K | 9133 | | \$ 63.14 | | \$ 12.63 |
| 90376 | Rabies ig, heat treated | CH | K | 9134 | | \$ 70.47 | | \$ 14.09 |
| 90385 | Rh ig, minidose, im | | N | | | | | |
| 90393 | Vaccina ig, im | CH | N | | | | | |
| 90396 | Varicella-zoster ig, im | CH | K | 9135 | | \$ 76.19 | | \$ 15.24 |
| 90471 | Immunization admin | CH | X | 0353 | 0.3917 | \$ 23.31 | | \$ 4.66 |
| 90472 | Immunization admin, each add | CH | X | 0353 | 0.3917 | \$ 23.31 | | \$ 4.66 |
| 90473 | Immune admin oral/nasal | CH | S | 1491 | | \$ 5.00 | \$ 2.00 | \$ 1.00 |
| 90474 | Immune admin oral/nasal addl | CH | S | 1491 | | \$ 5.00 | \$ 2.00 | \$ 1.00 |
| 90476 | Adenovirus vaccine, type 4 | CH | K | 9136 | 0.8674 | \$ 51.62 | | \$ 10.32 |
| 90477 | Adenovirus vaccine, type 7 | | N | | | | | |
| 90581 | Anthrax vaccine, sc | CH | K | 9169 | | \$ 126.46 | | \$ 25.29 |
| 90585 | Bcg vaccine, percut | CH | K | 9137 | | \$ 116.33 | | \$ 23.27 |
| 90632 | Hep a vaccine, adult im | | N | | | | | |
| 90633 | Hep a vacc, ped/adol, 2 dose | | N | | | | | |
| 90634 | Hep a vacc, ped/adol, 3 dose | | N | | | | | |
| 90636 | Hep a/hep b vacc, adult im | CH | K | 9138 | 0.9250 | \$ 55.05 | | \$ 11.01 |
| 90645 | Hib vaccine, hboc, im | | N | | | | | |
| 90646 | Hib vaccine, prp-d, im | | N | | | | | |

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| 90647 | Hib vaccine, prp-omp, im | | N | | | | | |
| 90648 | Hib vaccine, prp-t, im | | N | | | | | |
| 90655 | Flu vaccine no preserv 6-35m | | L | | | | | |
| 90656 | Flu vaccine no preserv 3 & > | | L | | | | | |
| 90657 | Flu vaccine, 6-35 mo, im | | L | | | | | |
| 90658 | Flu vaccine age 3 & over, im | | L | | | | | |
| 90660 | Flu vaccine, nasal | CH | L | | | | | |
| 90665 | Lyme disease vaccine, im | CH | K | 9170 | 0.9161 | \$ 54.52 | | \$ 10.90 |
| 90675 | Rabies vaccine, im | CH | K | 9139 | | \$ 137.59 | | \$ 27.52 |
| 90676 | Rabies vaccine, id | CH | K | 9140 | 1.5048 | \$ 89.55 | | \$ 17.91 |
| 90680 | Rotovirus vacc 3 dose, oral | | N | | | | | |
| 90690 | Typhoid vaccine, oral | | N | | | | | |
| 90691 | Typhoid vaccine, im | | N | | | | | |
| 90692 | Typhoid vaccine, h-p, sc/id | | N | | | | | |
| 90693 | Typhoid vaccine, akd, sc | | N | | | | | |
| 90698 | Dtap-hib-ip vaccine, im | | N | | | | | |
| 90700 | Dtap vaccine, < 7 yrs, im | | N | | | | | |
| 90701 | Dtp vaccine, im | | N | | | | | |
| 90702 | Dt vaccine < 7, im | | N | | | | | |
| 90703 | Tetanus vaccine, im | | N | | | | | |
| 90704 | Mumps vaccine, sc | | N | | | | | |
| 90705 | Measles vaccine, sc | | N | | | | | |
| 90706 | Rubella vaccine, sc | | N | | | | | |
| 90707 | Mmr vaccine, sc | | N | | | | | |
| 90708 | Measles-rubella vaccine, sc | CH | K | 9141 | 1.0220 | \$ 60.82 | | \$ 12.16 |
| 90710 | Mmrv vaccine, sc | CH | N | | | | | |
| 90712 | Oral poliovirus vaccine | | N | | | | | |
| 90713 | Poliovirus, ipv, sc/im | | N | | | | | |
| 90714 | Td vaccine no prsrv >= 7 im | NI | K | 1634 | | \$ 35.00 | | \$ 7.00 |
| 90715 | Tdap vaccine >7 im | | N | | | | | |
| 90716 | Chicken pox vaccine, sc | CH | K | 9142 | | \$ 67.07 | | \$ 13.41 |
| 90717 | Yellow fever vaccine, sc | CH | K | 1636 | | \$ 50.74 | | \$ 10.15 |
| 90718 | Td vaccine > 7, im | | N | | | | | |
| 90719 | Diphtheria vaccine, im | | N | | | | | |
| 90720 | Dtp/hib vaccine, im | | N | | | | | |
| 90721 | Dtap/hib vaccine, im | | N | | | | | |
| 90725 | Cholera vaccine, injectable | CH | N | | | | | |
| 90727 | Plague vaccine, im | | N | | | | | |
| 90732 | Pneumococcal vaccine | | L | | | | | |
| 90733 | Meningococcal vaccine, sc | CH | K | 9143 | | \$ 82.66 | | \$ 16.53 |
| 90734 | Meningococcal vaccine, im | CH | K | 9145 | 0.9025 | \$ 53.71 | | \$ 10.74 |
| 90735 | Encephalitis vaccine, sc | CH | K | 9144 | | \$ 84.60 | | \$ 16.92 |
| 90740 | Hepb vacc, ill pat 3 dose im | CH | F | | | | | |

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| 90743 | Hep b vacc, adol, 2 dose, im | CH | F | | | | | |
| 90744 | Hepb vacc ped/adol 3 dose im | CH | F | | | | | |
| 90746 | Hep b vaccine, adult, im | CH | F | | | | | |
| 90747 | Hepb vacc, ill pat 4 dose im | CH | F | | | | | |
| 90749 | Vaccine toxoid | | N | | | | | |
| 90772 | Ther/proph/diag inj, sc/im | NI | X | 0353 | 0.3917 | \$ 23.31 | | \$ 4.66 |
| 90773 | Ther/proph/diag inj, ia | NI | X | 0359 | 0.8036 | \$ 47.82 | | \$ 9.56 |
| 90779 | Ther/prop/diag inj/inf proc | NI | X | 0352 | 0.1368 | \$ 8.14 | | \$ 1.63 |
| 90780 | IV infusion therapy, 1 hour | CH | D | | | | | |
| 90781 | IV infusion, additional hour | CH | D | | | | | |
| 90782 | Injection, sc/im | CH | D | | | | | |
| 90783 | Injection, ia | CH | D | | | | | |
| 90784 | Injection, iv | CH | D | | | | | |
| 90788 | Injection of antibiotic | CH | D | | | | | |
| 90799 | Ther/prophylactic/dx inject | CH | D | | | | | |
| 90801 | Psy dx interview | | S | 0323 | 1.6398 | \$ 97.59 | \$ 20.35 | \$ 19.52 |
| 90802 | Intac psy dx interview | | S | 0323 | 1.6398 | \$ 97.59 | \$ 20.35 | \$ 19.52 |
| 90804 | Psytx, office, 20-30 min | | S | 0322 | 1.2304 | \$ 73.22 | | \$ 14.64 |
| 90805 | Psytx, off, 20-30 min w/e&m | | S | 0322 | 1.2304 | \$ 73.22 | | \$ 14.64 |
| 90806 | Psytx, off, 45-50 min | | S | 0323 | 1.6398 | \$ 97.59 | \$ 20.35 | \$ 19.52 |
| 90807 | Psytx, off, 45-50 min w/e&m | | S | 0323 | 1.6398 | \$ 97.59 | \$ 20.35 | \$ 19.52 |
| 90808 | Psytx, office, 75-80 min | | S | 0323 | 1.6398 | \$ 97.59 | \$ 20.35 | \$ 19.52 |
| 90809 | Psytx, off, 75-80, w/e&m | | S | 0323 | 1.6398 | \$ 97.59 | \$ 20.35 | \$ 19.52 |
| 90810 | Intac psytx, off, 20-30 min | | S | 0322 | 1.2304 | \$ 73.22 | | \$ 14.64 |
| 90811 | Intac psytx, 20-30, w/e&m | | S | 0322 | 1.2304 | \$ 73.22 | | \$ 14.64 |
| 90812 | Intac psytx, off, 45-50 min | | S | 0323 | 1.6398 | \$ 97.59 | \$ 20.35 | \$ 19.52 |
| 90813 | Intac psytx, 45-50 min w/e&m | | S | 0323 | 1.6398 | \$ 97.59 | \$ 20.35 | \$ 19.52 |
| 90814 | Intac psytx, off, 75-80 min | | S | 0323 | 1.6398 | \$ 97.59 | \$ 20.35 | \$ 19.52 |
| 90815 | Intac psytx, 75-80 w/e&m | | S | 0323 | 1.6398 | \$ 97.59 | \$ 20.35 | \$ 19.52 |
| 90816 | Psytx, hosp, 20-30 min | | S | 0322 | 1.2304 | \$ 73.22 | | \$ 14.64 |
| 90817 | Psytx, hosp, 20-30 min w/e&m | | S | 0322 | 1.2304 | \$ 73.22 | | \$ 14.64 |
| 90818 | Psytx, hosp, 45-50 min | | S | 0323 | 1.6398 | \$ 97.59 | \$ 20.35 | \$ 19.52 |
| 90819 | Psytx, hosp, 45-50 min w/e&m | | S | 0323 | 1.6398 | \$ 97.59 | \$ 20.35 | \$ 19.52 |
| 90821 | Psytx, hosp, 75-80 min | | S | 0323 | 1.6398 | \$ 97.59 | \$ 20.35 | \$ 19.52 |
| 90822 | Psytx, hosp, 75-80 min w/e&m | | S | 0323 | 1.6398 | \$ 97.59 | \$ 20.35 | \$ 19.52 |
| 90823 | Intac psytx, hosp, 20-30 min | | S | 0322 | 1.2304 | \$ 73.22 | | \$ 14.64 |
| 90824 | Intac psytx, hsp 20-30 w/e&m | | S | 0322 | 1.2304 | \$ 73.22 | | \$ 14.64 |
| 90826 | Intac psytx, hosp, 45-50 min | | S | 0323 | 1.6398 | \$ 97.59 | \$ 20.35 | \$ 19.52 |
| 90827 | Intac psytx, hsp 45-50 w/e&m | | S | 0323 | 1.6398 | \$ 97.59 | \$ 20.35 | \$ 19.52 |
| 90828 | Intac psytx, hosp, 75-80 min | | S | 0323 | 1.6398 | \$ 97.59 | \$ 20.35 | \$ 19.52 |
| 90829 | Intac psytx, hsp 75-80 w/e&m | | S | 0323 | 1.6398 | \$ 97.59 | \$ 20.35 | \$ 19.52 |
| 90845 | Psychoanalysis | | S | 0323 | 1.6398 | \$ 97.59 | \$ 20.35 | \$ 19.52 |
| 90846 | Family psytx w/o patient | | S | 0324 | 2.3119 | \$ 137.58 | | \$ 27.52 |

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|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 90847 | Family psytx w/patient | | S | 0324 | 2.3119 | \$ 137.58 | | \$ 27.52 |
| 90849 | Multiple family group psytx | | S | 0325 | 1.3434 | \$ 79.95 | \$ 17.47 | \$ 15.99 |
| 90853 | Group psychotherapy | | S | 0325 | 1.3434 | \$ 79.95 | \$ 17.47 | \$ 15.99 |
| 90857 | Intac group psytx | | S | 0325 | 1.3434 | \$ 79.95 | \$ 17.47 | \$ 15.99 |
| 90862 | Medication management | | X | 0374 | 1.1270 | \$ 67.07 | | \$ 13.41 |
| 90865 | Narcosynthesis | | S | 0323 | 1.6398 | \$ 97.59 | \$ 20.35 | \$ 19.52 |
| 90870 | Electroconvulsive therapy | | S | 0320 | 5.2528 | \$ 312.60 | \$ 80.06 | \$ 62.52 |
| 90871 | Electroconvulsive therapy | | D | | | | | |
| 90880 | Hypnotherapy | | S | 0323 | 1.6398 | \$ 97.59 | \$ 20.35 | \$ 19.52 |
| 90885 | Psy evaluation of records | | N | | | | | |
| 90887 | Consultation with family | | N | | | | | |
| 90889 | Preparation of report | | N | | | | | |
| 90899 | Psychiatric service/therapy | | S | 0322 | 1.2304 | \$ 73.22 | | \$ 14.64 |
| 90911 | Biofeedback peri/uro/rectal | | S | 0321 | 1.3651 | \$ 81.24 | \$ 21.72 | \$ 16.25 |
| 90935 | Hemodialysis, one evaluation | | S | 0170 | 5.9448 | \$ 353.78 | | \$ 70.76 |
| 90939 | Hemodialysis study, transcut | CH | D | | | | | |
| 90940 | Hemodialysis access study | | N | | | | | |
| 90945 | Dialysis, one evaluation | | S | 0170 | 5.9448 | \$ 353.78 | | \$ 70.76 |
| 91000 | Esophageal intubation | | X | 0361 | 3.5671 | \$ 212.28 | \$ 83.23 | \$ 42.46 |
| 91010 | Esophagus motility study | | X | 0361 | 3.5671 | \$ 212.28 | \$ 83.23 | \$ 42.46 |
| 91011 | Esophagus motility study | | X | 0361 | 3.5671 | \$ 212.28 | \$ 83.23 | \$ 42.46 |
| 91012 | Esophagus motility study | | X | 0361 | 3.5671 | \$ 212.28 | \$ 83.23 | \$ 42.46 |
| 91020 | Gastric motility studies | | X | 0361 | 3.5671 | \$ 212.28 | \$ 83.23 | \$ 42.46 |
| 91022 | Duodenal motility study | NI | X | 0361 | 3.5671 | \$ 212.28 | \$ 83.23 | \$ 42.46 |
| 91030 | Acid perfusion of esophagus | | X | 0361 | 3.5671 | \$ 212.28 | \$ 83.23 | \$ 42.46 |
| 91032 | Esophagus, acid reflux test | | D | | | | | |
| 91033 | Prolonged acid reflux test | | D | | | | | |
| 91034 | Gastroesophageal reflux test | | X | 0361 | 3.5671 | \$ 212.28 | \$ 83.23 | \$ 42.46 |
| 91035 | G-esoph reflx tst w/electrod | | S | 1506 | | \$ 450.00 | | \$ 90.00 |
| 91037 | Esoph imped function test | | X | 0361 | 3.5671 | \$ 212.28 | \$ 83.23 | \$ 42.46 |
| 91038 | Esoph imped funct test > 1h | | X | 0361 | 3.5671 | \$ 212.28 | \$ 83.23 | \$ 42.46 |
| 91040 | Esoph balloon distension tst | | X | 0360 | 1.4235 | \$ 84.71 | \$ 33.88 | \$ 16.94 |
| 91052 | Gastric analysis test | | X | 0361 | 3.5671 | \$ 212.28 | \$ 83.23 | \$ 42.46 |
| 91055 | Gastric intubation for smear | | X | 0360 | 1.4235 | \$ 84.71 | \$ 33.88 | \$ 16.94 |
| 91060 | Gastric saline load test | | X | 0360 | 1.4235 | \$ 84.71 | \$ 33.88 | \$ 16.94 |
| 91065 | Breath hydrogen test | | X | 0360 | 1.4235 | \$ 84.71 | \$ 33.88 | \$ 16.94 |
| 91100 | Pass intestine bleeding tube | | X | 0360 | 1.4235 | \$ 84.71 | \$ 33.88 | \$ 16.94 |
| 91105 | Gastric intubation treatment | | X | 0360 | 1.4235 | \$ 84.71 | \$ 33.88 | \$ 16.94 |
| 91110 | Gi tract capsule endoscopy | | T | 0142 | 9.0564 | \$ 538.96 | \$ 152.78 | \$ 107.79 |
| 91120 | Rectal sensation test | | T | 0156 | 2.6123 | \$ 155.46 | \$ 40.52 | \$ 31.09 |
| 91122 | Anal pressure record | | T | 0156 | 2.6123 | \$ 155.46 | \$ 40.52 | \$ 31.09 |
| 91123 | Irrigate fecal impaction | | N | | | | | |
| 91132 | Electrogastrography | | X | 0360 | 1.4235 | \$ 84.71 | \$ 33.88 | \$ 16.94 |

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| 91133 | Electrogastrography w/test | | X | 0360 | 1.4235 | \$ 84.71 | \$ 33.88 | \$ 16.94 |
| 91299 | Gastroenterology procedure | | X | 0360 | 1.4235 | \$ 84.71 | \$ 33.88 | \$ 16.94 |
| 92002 | Eye exam, new patient | | V | 0601 | 1.0125 | \$ 60.25 | | \$ 12.05 |
| 92004 | Eye exam, new patient | CH | V | 0602 | 1.4731 | \$ 87.67 | | \$ 17.53 |
| 92012 | Eye exam established pat | | V | 0600 | 0.8800 | \$ 52.37 | | \$ 10.47 |
| 92014 | Eye exam & treatment | CH | V | 0601 | 1.0125 | \$ 60.25 | | \$ 12.05 |
| 92018 | New eye exam & treatment | | T | 0699 | 8.9556 | \$ 532.96 | | \$ 106.59 |
| 92019 | Eye exam & treatment | | T | 0699 | 8.9556 | \$ 532.96 | | \$ 106.59 |
| 92020 | Special eye evaluation | | S | 0230 | 0.7902 | \$ 47.03 | \$ 14.97 | \$ 9.41 |
| 92060 | Special eye evaluation | | S | 0230 | 0.7902 | \$ 47.03 | \$ 14.97 | \$ 9.41 |
| 92065 | Orthoptic/pleoptic training | CH | S | 0698 | 1.2378 | \$ 73.66 | \$ 16.52 | \$ 14.73 |
| 92070 | Fitting of contact lens | | N | | | | | |
| 92081 | Visual field examination(s) | | S | 0230 | 0.7902 | \$ 47.03 | \$ 14.97 | \$ 9.41 |
| 92082 | Visual field examination(s) | | S | 0230 | 0.7902 | \$ 47.03 | \$ 14.97 | \$ 9.41 |
| 92083 | Visual field examination(s) | | S | 0230 | 0.7902 | \$ 47.03 | \$ 14.97 | \$ 9.41 |
| 92100 | Serial tonometry exam(s) | | N | | | | | |
| 92120 | Tonography & eye evaluation | | S | 0230 | 0.7902 | \$ 47.03 | \$ 14.97 | \$ 9.41 |
| 92130 | Water provocation tonography | | S | 0230 | 0.7902 | \$ 47.03 | \$ 14.97 | \$ 9.41 |
| 92135 | Ophthalmic dx imaging | | S | 0230 | 0.7902 | \$ 47.03 | \$ 14.97 | \$ 9.41 |
| 92136 | Ophthalmic biometry | CH | S | 0698 | 1.2378 | \$ 73.66 | \$ 16.52 | \$ 14.73 |
| 92140 | Glaucoma provocative tests | | S | 0698 | 1.2378 | \$ 73.66 | \$ 16.52 | \$ 14.73 |
| 92225 | Special eye exam, initial | | S | 0230 | 0.7902 | \$ 47.03 | \$ 14.97 | \$ 9.41 |
| 92226 | Special eye exam, subsequent | | S | 0230 | 0.7902 | \$ 47.03 | \$ 14.97 | \$ 9.41 |
| 92230 | Eye exam with photos | | T | 0699 | 8.9556 | \$ 532.96 | | \$ 106.59 |
| 92235 | Eye exam with photos | | S | 0231 | 1.9167 | \$ 114.06 | | \$ 22.81 |
| 92240 | Icg angiography | | S | 0231 | 1.9167 | \$ 114.06 | | \$ 22.81 |
| 92250 | Eye exam with photos | | S | 0230 | 0.7902 | \$ 47.03 | \$ 14.97 | \$ 9.41 |
| 92260 | Ophthalmoscopy/dynamometry | CH | S | 0698 | 1.2378 | \$ 73.66 | \$ 16.52 | \$ 14.73 |
| 92265 | Eye muscle evaluation | | S | 0230 | 0.7902 | \$ 47.03 | \$ 14.97 | \$ 9.41 |
| 92270 | Electro-oculography | | S | 0230 | 0.7902 | \$ 47.03 | \$ 14.97 | \$ 9.41 |
| 92275 | Electroretinography | | S | 0231 | 1.9167 | \$ 114.06 | | \$ 22.81 |
| 92283 | Color vision examination | | S | 0230 | 0.7902 | \$ 47.03 | \$ 14.97 | \$ 9.41 |
| 92284 | Dark adaptation eye exam | | S | 0698 | 1.2378 | \$ 73.66 | \$ 16.52 | \$ 14.73 |
| 92285 | Eye photography | | S | 0230 | 0.7902 | \$ 47.03 | \$ 14.97 | \$ 9.41 |
| 92286 | Internal eye photography | | S | 0698 | 1.2378 | \$ 73.66 | \$ 16.52 | \$ 14.73 |
| 92287 | Internal eye photography | | S | 0698 | 1.2378 | \$ 73.66 | \$ 16.52 | \$ 14.73 |
| 92311 | Contact lens fitting | | X | 0362 | 2.2654 | \$ 134.82 | | \$ 26.96 |
| 92312 | Contact lens fitting | | X | 0362 | 2.2654 | \$ 134.82 | | \$ 26.96 |
| 92313 | Contact lens fitting | | X | 0362 | 2.2654 | \$ 134.82 | | \$ 26.96 |
| 92315 | Prescription of contact lens | | X | 0362 | 2.2654 | \$ 134.82 | | \$ 26.96 |
| 92316 | Prescription of contact lens | | X | 0362 | 2.2654 | \$ 134.82 | | \$ 26.96 |
| 92317 | Prescription of contact lens | | X | 0362 | 2.2654 | \$ 134.82 | | \$ 26.96 |
| 92325 | Modification of contact lens | | X | 0362 | 2.2654 | \$ 134.82 | | \$ 26.96 |

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| 92326 | Replacement of contact lens | | X | 0362 | 2.2654 | \$ 134.82 | | \$ 26.96 |
| 92330 | Fitting of artificial eye | CH | D | | | | | |
| 92335 | Fitting of artificial eye | CH | D | | | | | |
| 92352 | Special spectacles fitting | | X | 0362 | 2.2654 | \$ 134.82 | | \$ 26.96 |
| 92353 | Special spectacles fitting | | X | 0362 | 2.2654 | \$ 134.82 | | \$ 26.96 |
| 92354 | Special spectacles fitting | | X | 0362 | 2.2654 | \$ 134.82 | | \$ 26.96 |
| 92355 | Special spectacles fitting | | X | 0362 | 2.2654 | \$ 134.82 | | \$ 26.96 |
| 92358 | Eye prosthesis service | | X | 0362 | 2.2654 | \$ 134.82 | | \$ 26.96 |
| 92371 | Repair & adjust spectacles | | X | 0362 | 2.2654 | \$ 134.82 | | \$ 26.96 |
| 92390 | Supply of spectacles | | D | | | | | |
| 92391 | Supply of contact lenses | | D | | | | | |
| 92392 | Supply of low vision aids | | D | | | | | |
| 92393 | Supply of artificial eye | | D | | | | | |
| 92395 | Supply of spectacles | | D | | | | | |
| 92396 | Supply of contact lenses | | D | | | | | |
| 92499 | Eye service or procedure | | S | 0230 | 0.7902 | \$ 47.03 | \$ 14.97 | \$ 9.41 |
| 92502 | Ear and throat examination | | T | 0251 | 2.0789 | \$ 123.72 | | \$ 24.74 |
| 92504 | Ear microscopy examination | | N | | | | | |
| 92510 | Rehab for ear implant | | D | | | | | |
| 92511 | Nasopharyngoscopy | | T | 0071 | 0.8034 | \$ 47.81 | \$ 11.31 | \$ 9.56 |
| 92512 | Nasal function studies | | X | 0363 | 0.8707 | \$ 51.82 | \$ 17.44 | \$ 10.36 |
| 92516 | Facial nerve function test | | X | 0660 | 1.5488 | \$ 92.17 | \$ 29.07 | \$ 18.43 |
| 92520 | Laryngeal function studies | | X | 0660 | 1.5488 | \$ 92.17 | \$ 29.07 | \$ 18.43 |
| 92531 | Spontaneous nystagmus study | | N | | | | | |
| 92532 | Positional nystagmus test | | N | | | | | |
| 92533 | Caloric vestibular test | | N | | | | | |
| 92534 | Optokinetic nystagmus test | | N | | | | | |
| 92541 | Spontaneous nystagmus test | | X | 0363 | 0.8707 | \$ 51.82 | \$ 17.44 | \$ 10.36 |
| 92542 | Positional nystagmus test | | X | 0363 | 0.8707 | \$ 51.82 | \$ 17.44 | \$ 10.36 |
| 92543 | Caloric vestibular test | | X | 0660 | 1.5488 | \$ 92.17 | \$ 29.07 | \$ 18.43 |
| 92544 | Optokinetic nystagmus test | | X | 0363 | 0.8707 | \$ 51.82 | \$ 17.44 | \$ 10.36 |
| 92545 | Oscillating tracking test | | X | 0363 | 0.8707 | \$ 51.82 | \$ 17.44 | \$ 10.36 |
| 92546 | Sinusoidal rotational test | | X | 0660 | 1.5488 | \$ 92.17 | \$ 29.07 | \$ 18.43 |
| 92547 | Supplemental electrical test | | X | 0363 | 0.8707 | \$ 51.82 | \$ 17.44 | \$ 10.36 |
| 92548 | Posturography | | X | 0660 | 1.5488 | \$ 92.17 | \$ 29.07 | \$ 18.43 |
| 92552 | Pure tone audiometry, air | | X | 0364 | 0.4548 | \$ 27.07 | \$ 7.06 | \$ 5.41 |
| 92553 | Audiometry, air & bone | CH | X | 0365 | 1.1928 | \$ 70.98 | \$ 18.52 | \$ 14.20 |
| 92555 | Speech threshold audiometry | | X | 0364 | 0.4548 | \$ 27.07 | \$ 7.06 | \$ 5.41 |
| 92556 | Speech audiometry, complete | | X | 0364 | 0.4548 | \$ 27.07 | \$ 7.06 | \$ 5.41 |
| 92557 | Comprehensive hearing test | | X | 0365 | 1.1928 | \$ 70.98 | \$ 18.52 | \$ 14.20 |
| 92561 | Bekeby audiometry, diagnosis | CH | X | 0364 | 0.4548 | \$ 27.07 | \$ 7.06 | \$ 5.41 |
| 92562 | Loudness balance test | | X | 0364 | 0.4548 | \$ 27.07 | \$ 7.06 | \$ 5.41 |
| 92563 | Tone decay hearing test | | X | 0364 | 0.4548 | \$ 27.07 | \$ 7.06 | \$ 5.41 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 92564 | Sisi hearing test | | X | 0364 | 0.4548 | \$ 27.07 | \$ 7.06 | \$ 5.41 |
| 92565 | Stenger test, pure tone | | X | 0364 | 0.4548 | \$ 27.07 | \$ 7.06 | \$ 5.41 |
| 92567 | Tympanometry | | X | 0364 | 0.4548 | \$ 27.07 | \$ 7.06 | \$ 5.41 |
| 92568 | Acoustic refl threshold tst | | X | 0364 | 0.4548 | \$ 27.07 | \$ 7.06 | \$ 5.41 |
| 92569 | Acoustic reflex decay test | | X | 0364 | 0.4548 | \$ 27.07 | \$ 7.06 | \$ 5.41 |
| 92571 | Filtered speech hearing test | | X | 0364 | 0.4548 | \$ 27.07 | \$ 7.06 | \$ 5.41 |
| 92572 | Staggered spondaic word test | CH | X | 0366 | 1.6829 | \$ 100.15 | \$ 26.14 | \$ 20.03 |
| 92573 | Lombard test | | X | 0364 | 0.4548 | \$ 27.07 | \$ 7.06 | \$ 5.41 |
| 92575 | Sensorineural acuity test | | X | 0364 | 0.4548 | \$ 27.07 | \$ 7.06 | \$ 5.41 |
| 92576 | Synthetic sentence test | | X | 0364 | 0.4548 | \$ 27.07 | \$ 7.06 | \$ 5.41 |
| 92577 | Stenger test, speech | CH | X | 0366 | 1.6829 | \$ 100.15 | \$ 26.14 | \$ 20.03 |
| 92579 | Visual audiometry (vra) | | X | 0365 | 1.1928 | \$ 70.98 | \$ 18.52 | \$ 14.20 |
| 92582 | Conditioning play audiometry | | X | 0365 | 1.1928 | \$ 70.98 | \$ 18.52 | \$ 14.20 |
| 92583 | Select picture audiometry | | X | 0364 | 0.4548 | \$ 27.07 | \$ 7.06 | \$ 5.41 |
| 92584 | Electrocochleography | | X | 0660 | 1.5488 | \$ 92.17 | \$ 29.07 | \$ 18.43 |
| 92585 | Auditor evoke potent, compre | | S | 0216 | 2.5976 | \$ 154.59 | | \$ 30.92 |
| 92586 | Auditor evoke potent, limit | | S | 0218 | 1.1138 | \$ 66.28 | | \$ 13.26 |
| 92587 | Evoked auditory test | | X | 0363 | 0.8707 | \$ 51.82 | \$ 17.44 | \$ 10.36 |
| 92588 | Evoked auditory test | CH | X | 0660 | 1.5488 | \$ 92.17 | \$ 29.07 | \$ 18.43 |
| 92589 | Auditory function test(s) | | D | | | | | |
| 92596 | Ear protector evaluation | | X | 0364 | 0.4548 | \$ 27.07 | \$ 7.06 | \$ 5.41 |
| 92601 | Cochlear implt f/up exam < 7 | | X | 0366 | 1.6829 | \$ 100.15 | \$ 26.14 | \$ 20.03 |
| 92602 | Reprogram cochlear implt < 7 | | X | 0366 | 1.6829 | \$ 100.15 | \$ 26.14 | \$ 20.03 |
| 92603 | Cochlear implt f/up exam 7 > | | X | 0366 | 1.6829 | \$ 100.15 | \$ 26.14 | \$ 20.03 |
| 92604 | Reprogram cochlear implt 7 > | | X | 0366 | 1.6829 | \$ 100.15 | \$ 26.14 | \$ 20.03 |
| 92620 | Auditory function, 60 min | CH | X | 0365 | 1.1928 | \$ 70.98 | \$ 18.52 | \$ 14.20 |
| 92621 | Auditory function, + 15 min | | N | | | | | |
| 92625 | Tinnitus assessment | CH | X | 0365 | 1.1928 | \$ 70.98 | \$ 18.52 | \$ 14.20 |
| 92626 | Eval aud rehab status | NI | X | 0365 | 1.1928 | \$ 70.98 | \$ 18.52 | \$ 14.20 |
| 92627 | Eval aud status rehab add-on | NI | N | | | | | |
| 92700 | Ent procedure/service | | X | 0364 | 0.4548 | \$ 27.07 | \$ 7.06 | \$ 5.41 |
| 92950 | Heart/lung resuscitation cpr | | S | 0094 | 2.4582 | \$ 146.29 | \$ 46.29 | \$ 29.26 |
| 92953 | Temporary external pacing | | S | 0094 | 2.4582 | \$ 146.29 | \$ 46.29 | \$ 29.26 |
| 92960 | Cardioversion electric, ext | | S | 0679 | 5.4992 | \$ 327.26 | \$ 95.30 | \$ 65.45 |
| 92961 | Cardioversion, electric, int | | S | 0679 | 5.4992 | \$ 327.26 | \$ 95.30 | \$ 65.45 |
| 92973 | Percut coronary thrombectomy | CH | T | 0088 | 36.5126 | \$ 2,172.90 | \$ 655.22 | \$ 434.58 |
| 92974 | Cath place, cardio brachytx | CH | T | 0103 | 15.0428 | \$ 895.21 | \$ 223.63 | \$ 179.04 |
| 92977 | Dissolve clot, heart vessel | CH | T | 0676 | 2.2742 | \$ 135.34 | | \$ 27.07 |
| 92978 | Intravasc us, heart add-on | | S | 0670 | 28.7546 | \$ 1,711.22 | \$ 536.10 | \$ 342.24 |
| 92979 | Intravasc us, heart add-on | | S | 0416 | 16.4464 | \$ 978.74 | | \$ 195.75 |
| 92980 | Insert intracoronary stent | | T | 0104 | 80.7852 | \$ 4,807.61 | | \$ 961.52 |
| 92981 | Insert intracoronary stent | | T | 0104 | 80.7852 | \$ 4,807.61 | | \$ 961.52 |
| 92982 | Coronary artery dilation | | T | 0083 | 55.2741 | \$ 3,289.42 | | \$ 657.88 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 92984 | Coronary artery dilation | | T | 0083 | 55.2741 | \$ 3,289.42 | | \$ 657.88 |
| 92986 | Revision of aortic valve | | T | 0083 | 55.2741 | \$ 3,289.42 | | \$ 657.88 |
| 92987 | Revision of mitral valve | | T | 0083 | 55.2741 | \$ 3,289.42 | | \$ 657.88 |
| 92990 | Revision of pulmonary valve | | T | 0083 | 55.2741 | \$ 3,289.42 | | \$ 657.88 |
| 92995 | Coronary atherectomy | | T | 0082 | 91.3717 | \$ 5,437.62 | \$ 1,169.67 | \$ 1,087.52 |
| 92996 | Coronary atherectomy add-on | | T | 0082 | 91.3717 | \$ 5,437.62 | \$ 1,169.67 | \$ 1,087.52 |
| 92997 | Pul art balloon repr, percut | | T | 0081 | 42.2664 | \$ 2,515.32 | | \$ 503.06 |
| 92998 | Pul art balloon repr, percut | | T | 0081 | 42.2664 | \$ 2,515.32 | | \$ 503.06 |
| 93005 | Electrocardiogram, tracing | | S | 0099 | 0.3769 | \$ 22.43 | | \$ 4.49 |
| 93012 | Transmission of ecg | | N | | | | | |
| 93017 | Cardiovascular stress test | | X | 0100 | 2.4833 | \$ 147.78 | \$ 41.44 | \$ 29.56 |
| 93024 | Cardiac drug stress test | | X | 0100 | 2.4833 | \$ 147.78 | \$ 41.44 | \$ 29.56 |
| 93025 | Microvolt t-wave assess | | X | 0100 | 2.4833 | \$ 147.78 | \$ 41.44 | \$ 29.56 |
| 93041 | Rhythm ECG, tracing | | S | 0099 | 0.3769 | \$ 22.43 | | \$ 4.49 |
| 93225 | ECG monitor/record, 24 hrs | | X | 0097 | 1.0211 | \$ 60.77 | \$ 23.79 | \$ 12.15 |
| 93226 | ECG monitor/report, 24 hrs | | X | 0097 | 1.0211 | \$ 60.77 | \$ 23.79 | \$ 12.15 |
| 93231 | Ecg monitor/record, 24 hrs | | X | 0097 | 1.0211 | \$ 60.77 | \$ 23.79 | \$ 12.15 |
| 93232 | ECG monitor/report, 24 hrs | | X | 0097 | 1.0211 | \$ 60.77 | \$ 23.79 | \$ 12.15 |
| 93236 | ECG monitor/report, 24 hrs | | X | 0097 | 1.0211 | \$ 60.77 | \$ 23.79 | \$ 12.15 |
| 93270 | ECG recording | | X | 0097 | 1.0211 | \$ 60.77 | \$ 23.79 | \$ 12.15 |
| 93271 | Ecg/monitoring and analysis | | X | 0097 | 1.0211 | \$ 60.77 | \$ 23.79 | \$ 12.15 |
| 93278 | ECG/signal-averaged | | S | 0099 | 0.3769 | \$ 22.43 | | \$ 4.49 |
| 93303 | Echo transthoracic | | S | 0269 | 3.1761 | \$ 189.01 | \$ 75.60 | \$ 37.80 |
| 93304 | Echo transthoracic | | S | 0697 | 1.5121 | \$ 89.99 | \$ 35.99 | \$ 18.00 |
| 93307 | Echo exam of heart | | S | 0269 | 3.1761 | \$ 189.01 | \$ 75.60 | \$ 37.80 |
| 93308 | Echo exam of heart | | S | 0697 | 1.5121 | \$ 89.99 | \$ 35.99 | \$ 18.00 |
| 93312 | Echo transesophageal | | S | 0270 | 5.9369 | \$ 353.31 | \$ 141.32 | \$ 70.66 |
| 93313 | Echo transesophageal | | S | 0270 | 5.9369 | \$ 353.31 | \$ 141.32 | \$ 70.66 |
| 93314 | Echo transesophageal | | N | | | | | |
| 93315 | Echo transesophageal | | S | 0270 | 5.9369 | \$ 353.31 | \$ 141.32 | \$ 70.66 |
| 93316 | Echo transesophageal | | S | 0270 | 5.9369 | \$ 353.31 | \$ 141.32 | \$ 70.66 |
| 93317 | Echo transesophageal | | N | | | | | |
| 93318 | Echo transesophageal intraop | | S | 0270 | 5.9369 | \$ 353.31 | \$ 141.32 | \$ 70.66 |
| 93320 | Doppler echo exam, heart | | S | 0671 | 1.6763 | \$ 99.76 | \$ 39.90 | \$ 19.95 |
| 93321 | Doppler echo exam, heart | | S | 0697 | 1.5121 | \$ 89.99 | \$ 35.99 | \$ 18.00 |
| 93325 | Doppler color flow add-on | | S | 0697 | 1.5121 | \$ 89.99 | \$ 35.99 | \$ 18.00 |
| 93350 | Echo transthoracic | | S | 0269 | 3.1761 | \$ 189.01 | \$ 75.60 | \$ 37.80 |
| 93501 | Right heart catheterization | | T | 0080 | 36.3392 | \$ 2,162.58 | \$ 838.92 | \$ 432.52 |
| 93503 | Insert/place heart catheter | | T | 0103 | 15.0428 | \$ 895.21 | \$ 223.63 | \$ 179.04 |
| 93505 | Biopsy of heart lining | | T | 0103 | 15.0428 | \$ 895.21 | \$ 223.63 | \$ 179.04 |
| 93508 | Cath placement, angiography | | T | 0080 | 36.3392 | \$ 2,162.58 | \$ 838.92 | \$ 432.52 |
| 93510 | Left heart catheterization | | T | 0080 | 36.3392 | \$ 2,162.58 | \$ 838.92 | \$ 432.52 |
| 93511 | Left heart catheterization | | T | 0080 | 36.3392 | \$ 2,162.58 | \$ 838.92 | \$ 432.52 |

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|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 93514 | Left heart catheterization | | T | 0080 | 36.3392 | \$ 2,162.58 | \$ 838.92 | \$ 432.52 |
| 93524 | Left heart catheterization | | T | 0080 | 36.3392 | \$ 2,162.58 | \$ 838.92 | \$ 432.52 |
| 93526 | Rt & Lt heart catheters | | T | 0080 | 36.3392 | \$ 2,162.58 | \$ 838.92 | \$ 432.52 |
| 93527 | Rt & Lt heart catheters | | T | 0080 | 36.3392 | \$ 2,162.58 | \$ 838.92 | \$ 432.52 |
| 93528 | Rt & Lt heart catheters | | T | 0080 | 36.3392 | \$ 2,162.58 | \$ 838.92 | \$ 432.52 |
| 93529 | Rt, lt heart catheterization | | T | 0080 | 36.3392 | \$ 2,162.58 | \$ 838.92 | \$ 432.52 |
| 93530 | Rt heart cath, congenital | | T | 0080 | 36.3392 | \$ 2,162.58 | \$ 838.92 | \$ 432.52 |
| 93531 | R & l heart cath, congenital | | T | 0080 | 36.3392 | \$ 2,162.58 | \$ 838.92 | \$ 432.52 |
| 93532 | R & l heart cath, congenital | | T | 0080 | 36.3392 | \$ 2,162.58 | \$ 838.92 | \$ 432.52 |
| 93533 | R & l heart cath, congenital | | T | 0080 | 36.3392 | \$ 2,162.58 | \$ 838.92 | \$ 432.52 |
| 93539 | Injection, cardiac cath | | N | | | | | |
| 93540 | Injection, cardiac cath | | N | | | | | |
| 93541 | Injection for lung angiogram | | N | | | | | |
| 93542 | Injection for heart x-rays | | N | | | | | |
| 93543 | Injection for heart x-rays | | N | | | | | |
| 93544 | Injection for aortography | | N | | | | | |
| 93545 | Inject for coronary x-rays | | N | | | | | |
| 93555 | Imaging, cardiac cath | | N | | | | | |
| 93556 | Imaging, cardiac cath | | N | | | | | |
| 93561 | Cardiac output measurement | | N | | | | | |
| 93562 | Cardiac output measurement | | N | | | | | |
| 93571 | Heart flow reserve measure | | S | 0670 | 28.7546 | \$ 1,711.22 | \$ 536.10 | \$ 342.24 |
| 93572 | Heart flow reserve measure | | S | 0416 | 16.4464 | \$ 978.74 | | \$ 195.75 |
| 93580 | Transcath closure of asd | CH | T | 0434 | 86.4834 | \$ 5,146.71 | | \$ 1,029.34 |
| 93581 | Transcath closure of vsd | CH | T | 0434 | 86.4834 | \$ 5,146.71 | | \$ 1,029.34 |
| 93600 | Bundle of His recording | | T | 0087 | 33.0075 | \$ 1,964.31 | | \$ 392.86 |
| 93602 | Intra-atrial recording | | T | 0087 | 33.0075 | \$ 1,964.31 | | \$ 392.86 |
| 93603 | Right ventricular recording | | T | 0087 | 33.0075 | \$ 1,964.31 | | \$ 392.86 |
| 93609 | Map tachycardia, add-on | | T | 0087 | 33.0075 | \$ 1,964.31 | | \$ 392.86 |
| 93610 | Intra-atrial pacing | | T | 0087 | 33.0075 | \$ 1,964.31 | | \$ 392.86 |
| 93612 | Intraventricular pacing | | T | 0087 | 33.0075 | \$ 1,964.31 | | \$ 392.86 |
| 93613 | Electrophys map 3d, add-on | | T | 0087 | 33.0075 | \$ 1,964.31 | | \$ 392.86 |
| 93615 | Esophageal recording | | T | 0087 | 33.0075 | \$ 1,964.31 | | \$ 392.86 |
| 93616 | Esophageal recording | | T | 0087 | 33.0075 | \$ 1,964.31 | | \$ 392.86 |
| 93618 | Heart rhythm pacing | | T | 0087 | 33.0075 | \$ 1,964.31 | | \$ 392.86 |
| 93619 | Electrophysiology evaluation | | T | 0085 | 34.2055 | \$ 2,035.60 | \$ 426.25 | \$ 407.12 |
| 93620 | Electrophysiology evaluation | | T | 0085 | 34.2055 | \$ 2,035.60 | \$ 426.25 | \$ 407.12 |
| 93621 | Electrophysiology evaluation | | T | 0085 | 34.2055 | \$ 2,035.60 | \$ 426.25 | \$ 407.12 |
| 93622 | Electrophysiology evaluation | | T | 0085 | 34.2055 | \$ 2,035.60 | \$ 426.25 | \$ 407.12 |
| 93623 | Stimulation, pacing heart | | T | 0087 | 33.0075 | \$ 1,964.31 | | \$ 392.86 |
| 93624 | Electrophysiologic study | CH | T | 0085 | 34.2055 | \$ 2,035.60 | \$ 426.25 | \$ 407.12 |
| 93631 | Heart pacing, mapping | | T | 0087 | 33.0075 | \$ 1,964.31 | | \$ 392.86 |
| 93640 | Evaluation heart device | | S | 0084 | 9.6108 | \$ 571.95 | | \$ 114.39 |

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|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 93641 | Electrophysiology evaluation | | S | 0084 | 9.6108 | \$ 571.95 | | \$ 114.39 |
| 93642 | Electrophysiology evaluation | | S | 0084 | 9.6108 | \$ 571.95 | | \$ 114.39 |
| 93650 | Ablate heart dysrhythm focus | | T | 0086 | 42.0498 | \$ 2,502.43 | \$ 812.36 | \$ 500.49 |
| 93651 | Ablate heart dysrhythm focus | | T | 0086 | 42.0498 | \$ 2,502.43 | \$ 812.36 | \$ 500.49 |
| 93652 | Ablate heart dysrhythm focus | | T | 0086 | 42.0498 | \$ 2,502.43 | \$ 812.36 | \$ 500.49 |
| 93660 | Tilt table evaluation | | S | 0101 | 4.2112 | \$ 250.61 | \$ 100.24 | \$ 50.12 |
| 93662 | Intracardiac ecg (ice) | | S | 0670 | 28.7546 | \$ 1,711.22 | \$ 536.10 | \$ 342.24 |
| 93701 | Bioimpedance, thoracic | | S | 0099 | 0.3769 | \$ 22.43 | | \$ 4.49 |
| 93721 | Plethysmography tracing | | X | 0368 | 0.9568 | \$ 56.94 | \$ 22.77 | \$ 11.39 |
| 93724 | Analyze pacemaker system | | S | 0690 | 0.3645 | \$ 21.69 | \$ 8.67 | \$ 4.34 |
| 93727 | Analyze ilr system | | S | 0690 | 0.3645 | \$ 21.69 | \$ 8.67 | \$ 4.34 |
| 93731 | Analyze pacemaker system | | S | 0690 | 0.3645 | \$ 21.69 | \$ 8.67 | \$ 4.34 |
| 93732 | Analyze pacemaker system | | S | 0690 | 0.3645 | \$ 21.69 | \$ 8.67 | \$ 4.34 |
| 93733 | Telephone analy, pacemaker | | S | 0690 | 0.3645 | \$ 21.69 | \$ 8.67 | \$ 4.34 |
| 93734 | Analyze pacemaker system | | S | 0690 | 0.3645 | \$ 21.69 | \$ 8.67 | \$ 4.34 |
| 93735 | Analyze pacemaker system | | S | 0690 | 0.3645 | \$ 21.69 | \$ 8.67 | \$ 4.34 |
| 93736 | Telephonic analy, pacemaker | | S | 0690 | 0.3645 | \$ 21.69 | \$ 8.67 | \$ 4.34 |
| 93740 | Temperature gradient studies | | X | 0368 | 0.9568 | \$ 56.94 | \$ 22.77 | \$ 11.39 |
| 93741 | Analyze ht pace device sngl | | S | 0689 | 0.5608 | \$ 33.37 | | \$ 6.67 |
| 93742 | Analyze ht pace device sngl | | S | 0689 | 0.5608 | \$ 33.37 | | \$ 6.67 |
| 93743 | Analyze ht pace device dual | | S | 0689 | 0.5608 | \$ 33.37 | | \$ 6.67 |
| 93744 | Analyze ht pace device dual | | S | 0689 | 0.5608 | \$ 33.37 | | \$ 6.67 |
| 93745 | Set-up cardiovert-defibrill | | S | 0689 | 0.5608 | \$ 33.37 | | \$ 6.67 |
| 93770 | Measure venous pressure | | N | | | | | |
| 93786 | Ambulatory BP recording | | X | 0097 | 1.0211 | \$ 60.77 | \$ 23.79 | \$ 12.15 |
| 93788 | Ambulatory BP analysis | | X | 0097 | 1.0211 | \$ 60.77 | \$ 23.79 | \$ 12.15 |
| 93797 | Cardiac rehab | | S | 0095 | 0.5822 | \$ 34.65 | \$ 13.86 | \$ 6.93 |
| 93798 | Cardiac rehab/monitor | | S | 0095 | 0.5822 | \$ 34.65 | \$ 13.86 | \$ 6.93 |
| 93799 | Cardiovascular procedure | | S | 0096 | 1.6020 | \$ 95.34 | \$ 38.13 | \$ 19.07 |
| 93875 | Extracranial study | | S | 0096 | 1.6020 | \$ 95.34 | \$ 38.13 | \$ 19.07 |
| 93880 | Extracranial study | | S | 0267 | 2.5543 | \$ 152.01 | \$ 60.80 | \$ 30.40 |
| 93882 | Extracranial study | | S | 0267 | 2.5543 | \$ 152.01 | \$ 60.80 | \$ 30.40 |
| 93886 | Intracranial study | | S | 0267 | 2.5543 | \$ 152.01 | \$ 60.80 | \$ 30.40 |
| 93888 | Intracranial study | | S | 0266 | 1.5883 | \$ 94.52 | \$ 37.80 | \$ 18.90 |
| 93890 | Tcd, vasoreactivity study | | S | 0266 | 1.5883 | \$ 94.52 | \$ 37.80 | \$ 18.90 |
| 93892 | Tcd, emboli detect w/o inj | | S | 0266 | 1.5883 | \$ 94.52 | \$ 37.80 | \$ 18.90 |
| 93893 | Tcd, emboli detect w/inj | | S | 0266 | 1.5883 | \$ 94.52 | \$ 37.80 | \$ 18.90 |
| 93922 | Extremity study | | S | 0096 | 1.6020 | \$ 95.34 | \$ 38.13 | \$ 19.07 |
| 93923 | Extremity study | | S | 0096 | 1.6020 | \$ 95.34 | \$ 38.13 | \$ 19.07 |
| 93924 | Extremity study | | S | 0096 | 1.6020 | \$ 95.34 | \$ 38.13 | \$ 19.07 |
| 93925 | Lower extremity study | | S | 0267 | 2.5543 | \$ 152.01 | \$ 60.80 | \$ 30.40 |
| 93926 | Lower extremity study | CH | S | 0266 | 1.5883 | \$ 94.52 | \$ 37.80 | \$ 18.90 |
| 93930 | Upper extremity study | | S | 0267 | 2.5543 | \$ 152.01 | \$ 60.80 | \$ 30.40 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 93931 | Upper extremity study | | S | 0266 | 1.5883 | \$ 94.52 | \$ 37.80 | \$ 18.90 |
| 93965 | Extremity study | | S | 0096 | 1.6020 | \$ 95.34 | \$ 38.13 | \$ 19.07 |
| 93970 | Extremity study | | S | 0267 | 2.5543 | \$ 152.01 | \$ 60.80 | \$ 30.40 |
| 93971 | Extremity study | CH | S | 0266 | 1.5883 | \$ 94.52 | \$ 37.80 | \$ 18.90 |
| 93975 | Vascular study | | S | 0267 | 2.5543 | \$ 152.01 | \$ 60.80 | \$ 30.40 |
| 93976 | Vascular study | | S | 0267 | 2.5543 | \$ 152.01 | \$ 60.80 | \$ 30.40 |
| 93978 | Vascular study | CH | S | 0266 | 1.5883 | \$ 94.52 | \$ 37.80 | \$ 18.90 |
| 93979 | Vascular study | CH | S | 0266 | 1.5883 | \$ 94.52 | \$ 37.80 | \$ 18.90 |
| 93980 | Penile vascular study | | S | 0267 | 2.5543 | \$ 152.01 | \$ 60.80 | \$ 30.40 |
| 93981 | Penile vascular study | CH | S | 0266 | 1.5883 | \$ 94.52 | \$ 37.80 | \$ 18.90 |
| 93990 | Doppler flow testing | CH | S | 0266 | 1.5883 | \$ 94.52 | \$ 37.80 | \$ 18.90 |
| 94010 | Breathing capacity test | | X | 0368 | 0.9568 | \$ 56.94 | \$ 22.77 | \$ 11.39 |
| 94014 | Patient recorded spirometry | CH | X | 0367 | 0.6539 | \$ 38.91 | \$ 14.80 | \$ 7.78 |
| 94015 | Patient recorded spirometry | | X | 0367 | 0.6539 | \$ 38.91 | \$ 14.80 | \$ 7.78 |
| 94060 | Evaluation of wheezing | | X | 0368 | 0.9568 | \$ 56.94 | \$ 22.77 | \$ 11.39 |
| 94070 | Evaluation of wheezing | | X | 0369 | 2.7046 | \$ 160.95 | \$ 44.18 | \$ 32.19 |
| 94150 | Vital capacity test | | X | 0367 | 0.6539 | \$ 38.91 | \$ 14.80 | \$ 7.78 |
| 94200 | Lung function test (MBC/MVV) | | X | 0367 | 0.6539 | \$ 38.91 | \$ 14.80 | \$ 7.78 |
| 94240 | Residual lung capacity | | X | 0368 | 0.9568 | \$ 56.94 | \$ 22.77 | \$ 11.39 |
| 94250 | Expired gas collection | | X | 0367 | 0.6539 | \$ 38.91 | \$ 14.80 | \$ 7.78 |
| 94260 | Thoracic gas volume | CH | X | 0367 | 0.6539 | \$ 38.91 | \$ 14.80 | \$ 7.78 |
| 94350 | Lung nitrogen washout curve | CH | X | 0367 | 0.6539 | \$ 38.91 | \$ 14.80 | \$ 7.78 |
| 94360 | Measure airflow resistance | | X | 0367 | 0.6539 | \$ 38.91 | \$ 14.80 | \$ 7.78 |
| 94370 | Breath airway closing volume | | X | 0367 | 0.6539 | \$ 38.91 | \$ 14.80 | \$ 7.78 |
| 94375 | Respiratory flow volume loop | CH | X | 0367 | 0.6539 | \$ 38.91 | \$ 14.80 | \$ 7.78 |
| 94400 | CO2 breathing response curve | | X | 0367 | 0.6539 | \$ 38.91 | \$ 14.80 | \$ 7.78 |
| 94450 | Hypoxia response curve | | X | 0368 | 0.9568 | \$ 56.94 | \$ 22.77 | \$ 11.39 |
| 94452 | Hast w/report | | X | 0368 | 0.9568 | \$ 56.94 | \$ 22.77 | \$ 11.39 |
| 94453 | Hast w/oxygen titrate | | X | 0368 | 0.9568 | \$ 56.94 | \$ 22.77 | \$ 11.39 |
| 94620 | Pulmonary stress test/simple | | X | 0368 | 0.9568 | \$ 56.94 | \$ 22.77 | \$ 11.39 |
| 94621 | Pulm stress test/complex | | X | 0369 | 2.7046 | \$ 160.95 | \$ 44.18 | \$ 32.19 |
| 94640 | Airway inhalation treatment | | S | 0077 | 0.3428 | \$ 20.40 | \$ 7.74 | \$ 4.08 |
| 94642 | Aerosol inhalation treatment | | S | 0078 | 1.0229 | \$ 60.87 | \$ 14.55 | \$ 12.17 |
| 94656 | Initial ventilator mgmt | | S | 0079 | 2.2410 | \$ 133.36 | | \$ 26.67 |
| 94657 | Continued ventilator mgmt | | S | 0079 | 2.2410 | \$ 133.36 | | \$ 26.67 |
| 94660 | Pos airway pressure, CPAP | | S | 0068 | 1.2435 | \$ 74.00 | \$ 29.48 | \$ 14.80 |
| 94662 | Neg press ventilation, cnp | | S | 0079 | 2.2410 | \$ 133.36 | | \$ 26.67 |
| 94664 | Evaluate pt use of inhaler | | S | 0077 | 0.3428 | \$ 20.40 | \$ 7.74 | \$ 4.08 |
| 94667 | Chest wall manipulation | | S | 0077 | 0.3428 | \$ 20.40 | \$ 7.74 | \$ 4.08 |
| 94668 | Chest wall manipulation | | S | 0077 | 0.3428 | \$ 20.40 | \$ 7.74 | \$ 4.08 |
| 94680 | Exhaled air analysis, o2 | | X | 0367 | 0.6539 | \$ 38.91 | \$ 14.80 | \$ 7.78 |
| 94681 | Exhaled air analysis, o2/co2 | | X | 0368 | 0.9568 | \$ 56.94 | \$ 22.77 | \$ 11.39 |
| 94690 | Exhaled air analysis | | X | 0368 | 0.9568 | \$ 56.94 | \$ 22.77 | \$ 11.39 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 94720 | Monoxide diffusing capacity | | X | 0368 | 0.9568 | \$ 56.94 | \$ 22.77 | \$ 11.39 |
| 94725 | Membrane diffusion capacity | | X | 0368 | 0.9568 | \$ 56.94 | \$ 22.77 | \$ 11.39 |
| 94750 | Pulmonary compliance study | | X | 0368 | 0.9568 | \$ 56.94 | \$ 22.77 | \$ 11.39 |
| 94760 | Measure blood oxygen level | | N | | | | | |
| 94761 | Measure blood oxygen level | | N | | | | | |
| 94762 | Measure blood oxygen level | | N | | | | | |
| 94770 | Exhaled carbon dioxide test | | X | 0367 | 0.6539 | \$ 38.91 | \$ 14.80 | \$ 7.78 |
| 94772 | Breath recording, infant | | X | 0369 | 2.7046 | \$ 160.95 | \$ 44.18 | \$ 32.19 |
| 94799 | Pulmonary service/procedure | | X | 0367 | 0.6539 | \$ 38.91 | \$ 14.80 | \$ 7.78 |
| 95004 | Percut allergy skin tests | CH | X | 0381 | 0.1925 | \$ 11.46 | \$ 2.41 | \$ 2.29 |
| 95010 | Percut allergy titrate test | CH | X | 0381 | 0.1925 | \$ 11.46 | \$ 2.41 | \$ 2.29 |
| 95015 | Id allergy titrate-drug/bug | CH | X | 0381 | 0.1925 | \$ 11.46 | \$ 2.41 | \$ 2.29 |
| 95024 | Id allergy test, drug/bug | CH | X | 0381 | 0.1925 | \$ 11.46 | \$ 2.41 | \$ 2.29 |
| 95027 | Id allergy titrate-airborne | CH | X | 0381 | 0.1925 | \$ 11.46 | \$ 2.41 | \$ 2.29 |
| 95028 | Id allergy test-delayed type | CH | X | 0381 | 0.1925 | \$ 11.46 | \$ 2.41 | \$ 2.29 |
| 95044 | Allergy patch tests | CH | X | 0381 | 0.1925 | \$ 11.46 | \$ 2.41 | \$ 2.29 |
| 95052 | Photo patch test | CH | X | 0381 | 0.1925 | \$ 11.46 | \$ 2.41 | \$ 2.29 |
| 95056 | Photosensitivity tests | | X | 0370 | 2.8133 | \$ 167.42 | | \$ 33.48 |
| 95060 | Eye allergy tests | | X | 0370 | 2.8133 | \$ 167.42 | | \$ 33.48 |
| 95065 | Nose allergy test | CH | X | 0381 | 0.1925 | \$ 11.46 | \$ 2.41 | \$ 2.29 |
| 95070 | Bronchial allergy tests | | X | 0369 | 2.7046 | \$ 160.95 | \$ 44.18 | \$ 32.19 |
| 95071 | Bronchial allergy tests | | X | 0369 | 2.7046 | \$ 160.95 | \$ 44.18 | \$ 32.19 |
| 95075 | Ingestion challenge test | | X | 0361 | 3.5671 | \$ 212.28 | \$ 83.23 | \$ 42.46 |
| 95078 | Provocative testing | | X | 0370 | 2.8133 | \$ 167.42 | | \$ 33.48 |
| 95115 | Immunotherapy, one injection | | X | 0352 | 0.1368 | \$ 8.14 | | \$ 1.63 |
| 95117 | Immunotherapy injections | | X | 0353 | 0.3917 | \$ 23.31 | | \$ 4.66 |
| 95144 | Antigen therapy services | CH | X | 0353 | 0.3917 | \$ 23.31 | | \$ 4.66 |
| 95145 | Antigen therapy services | CH | X | 0353 | 0.3917 | \$ 23.31 | | \$ 4.66 |
| 95146 | Antigen therapy services | CH | X | 0353 | 0.3917 | \$ 23.31 | | \$ 4.66 |
| 95147 | Antigen therapy services | CH | X | 0353 | 0.3917 | \$ 23.31 | | \$ 4.66 |
| 95148 | Antigen therapy services | CH | X | 0353 | 0.3917 | \$ 23.31 | | \$ 4.66 |
| 95149 | Antigen therapy services | CH | X | 0353 | 0.3917 | \$ 23.31 | | \$ 4.66 |
| 95165 | Antigen therapy services | CH | X | 0353 | 0.3917 | \$ 23.31 | | \$ 4.66 |
| 95170 | Antigen therapy services | CH | X | 0352 | 0.1368 | \$ 8.14 | | \$ 1.63 |
| 95180 | Rapid desensitization | | X | 0370 | 2.8133 | \$ 167.42 | | \$ 33.48 |
| 95199 | Allergy immunology services | | X | 0370 | 2.8133 | \$ 167.42 | | \$ 33.48 |
| 95250 | Glucose monitoring, cont | | X | 0421 | 1.6026 | \$ 95.37 | | \$ 19.07 |
| 95805 | Multiple sleep latency test | | S | 0209 | 11.2895 | \$ 671.85 | \$ 268.73 | \$ 134.37 |
| 95806 | Sleep study, unattended | | S | 0213 | 2.2509 | \$ 133.95 | \$ 53.58 | \$ 26.79 |
| 95807 | Sleep study, attended | | S | 0209 | 11.2895 | \$ 671.85 | \$ 268.73 | \$ 134.37 |
| 95808 | Polysomnography, 1-3 | | S | 0209 | 11.2895 | \$ 671.85 | \$ 268.73 | \$ 134.37 |
| 95810 | Polysomnography, 4 or more | | S | 0209 | 11.2895 | \$ 671.85 | \$ 268.73 | \$ 134.37 |
| 95811 | Polysomnography w/cpap | | S | 0209 | 11.2895 | \$ 671.85 | \$ 268.73 | \$ 134.37 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 95812 | Eeg, 41-60 minutes | | S | 0213 | 2.2509 | \$ 133.95 | \$ 53.58 | \$ 26.79 |
| 95813 | Eeg, over 1 hour | | S | 0213 | 2.2509 | \$ 133.95 | \$ 53.58 | \$ 26.79 |
| 95816 | Eeg, awake and drowsy | CH | S | 0213 | 2.2509 | \$ 133.95 | \$ 53.58 | \$ 26.79 |
| 95819 | Eeg, awake and asleep | CH | S | 0213 | 2.2509 | \$ 133.95 | \$ 53.58 | \$ 26.79 |
| 95822 | Eeg, coma or sleep only | CH | S | 0213 | 2.2509 | \$ 133.95 | \$ 53.58 | \$ 26.79 |
| 95824 | Eeg, cerebral death only | | S | 0214 | 1.1863 | \$ 70.60 | \$ 28.24 | \$ 14.12 |
| 95827 | Eeg, all night recording | | S | 0213 | 2.2509 | \$ 133.95 | \$ 53.58 | \$ 26.79 |
| 95829 | Surgery electrocorticogram | | S | 0214 | 1.1863 | \$ 70.60 | \$ 28.24 | \$ 14.12 |
| 95857 | Tensilon test | | S | 0218 | 1.1138 | \$ 66.28 | | \$ 13.26 |
| 95858 | Tensilon test & myogram | CH | D | | | | | |
| 95860 | Muscle test, one limb | | S | 0218 | 1.1138 | \$ 66.28 | | \$ 13.26 |
| 95861 | Muscle test, 2 limbs | | S | 0218 | 1.1138 | \$ 66.28 | | \$ 13.26 |
| 95863 | Muscle test, 3 limbs | | S | 0218 | 1.1138 | \$ 66.28 | | \$ 13.26 |
| 95864 | Muscle test, 4 limbs | | S | 0218 | 1.1138 | \$ 66.28 | | \$ 13.26 |
| 95865 | Muscle test, larynx | NI | S | 0218 | 1.1138 | \$ 66.28 | | \$ 13.26 |
| 95866 | Muscle test, hemidiaphragm | NI | S | 0218 | 1.1138 | \$ 66.28 | | \$ 13.26 |
| 95867 | Muscle test cran nerv unilat | | S | 0218 | 1.1138 | \$ 66.28 | | \$ 13.26 |
| 95868 | Muscle test cran nerve bilat | | S | 0218 | 1.1138 | \$ 66.28 | | \$ 13.26 |
| 95869 | Muscle test, thor paraspinal | | S | 0215 | 0.6025 | \$ 35.86 | \$ 14.34 | \$ 7.17 |
| 95870 | Muscle test, nonparaspinal | | S | 0215 | 0.6025 | \$ 35.86 | \$ 14.34 | \$ 7.17 |
| 95872 | Muscle test, one fiber | | S | 0218 | 1.1138 | \$ 66.28 | | \$ 13.26 |
| 95873 | Guide nerv destr, elec stim | NI | S | 0215 | 0.6025 | \$ 35.86 | \$ 14.34 | \$ 7.17 |
| 95874 | Guide nerv destr, needle emg | NI | S | 0215 | 0.6025 | \$ 35.86 | \$ 14.34 | \$ 7.17 |
| 95875 | Limb exercise test | | S | 0215 | 0.6025 | \$ 35.86 | \$ 14.34 | \$ 7.17 |
| 95900 | Motor nerve conduction test | | S | 0215 | 0.6025 | \$ 35.86 | \$ 14.34 | \$ 7.17 |
| 95903 | Motor nerve conduction test | | S | 0215 | 0.6025 | \$ 35.86 | \$ 14.34 | \$ 7.17 |
| 95904 | Sense nerve conduction test | | S | 0215 | 0.6025 | \$ 35.86 | \$ 14.34 | \$ 7.17 |
| 95920 | Intraop nerve test add-on | | S | 0216 | 2.5976 | \$ 154.59 | | \$ 30.92 |
| 95921 | Autonomic nerv function test | | S | 0218 | 1.1138 | \$ 66.28 | | \$ 13.26 |
| 95922 | Autonomic nerv function test | | S | 0218 | 1.1138 | \$ 66.28 | | \$ 13.26 |
| 95923 | Autonomic nerv function test | | S | 0218 | 1.1138 | \$ 66.28 | | \$ 13.26 |
| 95925 | Somatosensory testing | | S | 0216 | 2.5976 | \$ 154.59 | | \$ 30.92 |
| 95926 | Somatosensory testing | | S | 0216 | 2.5976 | \$ 154.59 | | \$ 30.92 |
| 95927 | Somatosensory testing | | S | 0216 | 2.5976 | \$ 154.59 | | \$ 30.92 |
| 95928 | C motor evoked, uppr limbs | | S | 0218 | 1.1138 | \$ 66.28 | | \$ 13.26 |
| 95929 | C motor evoked, lwr limbs | | S | 0218 | 1.1138 | \$ 66.28 | | \$ 13.26 |
| 95930 | Visual evoked potential test | | S | 0216 | 2.5976 | \$ 154.59 | | \$ 30.92 |
| 95933 | Blink reflex test | | S | 0215 | 0.6025 | \$ 35.86 | \$ 14.34 | \$ 7.17 |
| 95934 | H-reflex test | | S | 0215 | 0.6025 | \$ 35.86 | \$ 14.34 | \$ 7.17 |
| 95936 | H-reflex test | | S | 0215 | 0.6025 | \$ 35.86 | \$ 14.34 | \$ 7.17 |
| 95937 | Neuromuscular junction test | | S | 0218 | 1.1138 | \$ 66.28 | | \$ 13.26 |
| 95950 | Ambulatory eeg monitoring | | S | 0209 | 11.2895 | \$ 671.85 | \$ 268.73 | \$ 134.37 |
| 95951 | EEG monitoring/videorecord | | S | 0209 | 11.2895 | \$ 671.85 | \$ 268.73 | \$ 134.37 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|-------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 95953 | EEG monitoring/computer | | S | 0209 | 11.2895 | \$ 671.85 | \$ 268.73 | \$ 134.37 |
| 95954 | EEG monitoring/giving drugs | | S | 0214 | 1.1863 | \$ 70.60 | \$ 28.24 | \$ 14.12 |
| 95955 | EEG during surgery | | S | 0213 | 2.2509 | \$ 133.95 | \$ 53.58 | \$ 26.79 |
| 95956 | Eeg monitoring, cable/radio | | S | 0209 | 11.2895 | \$ 671.85 | \$ 268.73 | \$ 134.37 |
| 95957 | EEG digital analysis | | S | 0214 | 1.1863 | \$ 70.60 | \$ 28.24 | \$ 14.12 |
| 95958 | EEG monitoring/function test | | S | 0213 | 2.2509 | \$ 133.95 | \$ 53.58 | \$ 26.79 |
| 95961 | Electrode stimulation, brain | | S | 0216 | 2.5976 | \$ 154.59 | | \$ 30.92 |
| 95962 | Electrode stim, brain add-on | | S | 0216 | 2.5976 | \$ 154.59 | | \$ 30.92 |
| 95965 | Meg, spontaneous | CH | T | 0430 | 10.8452 | \$ 645.41 | | \$ 129.08 |
| 95966 | Meg, evoked, single | CH | T | 0430 | 10.8452 | \$ 645.41 | | \$ 129.08 |
| 95967 | Meg, evoked, each add'l | CH | T | 0430 | 10.8452 | \$ 645.41 | | \$ 129.08 |
| 95970 | Analyze neurostim, no prog | | S | 0218 | 1.1138 | \$ 66.28 | | \$ 13.26 |
| 95971 | Analyze neurostim, simple | | S | 0692 | 1.9774 | \$ 117.68 | \$ 30.16 | \$ 23.54 |
| 95972 | Analyze neurostim, complex | | S | 0692 | 1.9774 | \$ 117.68 | \$ 30.16 | \$ 23.54 |
| 95973 | Analyze neurostim, complex | | S | 0692 | 1.9774 | \$ 117.68 | \$ 30.16 | \$ 23.54 |
| 95974 | Cranial neurostim, complex | | S | 0692 | 1.9774 | \$ 117.68 | \$ 30.16 | \$ 23.54 |
| 95975 | Cranial neurostim, complex | | S | 0692 | 1.9774 | \$ 117.68 | \$ 30.16 | \$ 23.54 |
| 95978 | Analyze neurostim brain/1h | | S | 0692 | 1.9774 | \$ 117.68 | \$ 30.16 | \$ 23.54 |
| 95979 | Analyz neurostim brain addon | | S | 0692 | 1.9774 | \$ 117.68 | \$ 30.16 | \$ 23.54 |
| 95990 | Spin/brain pump refill & main | | T | 0125 | 1.9021 | \$ 113.20 | | \$ 22.64 |
| 95991 | Spin/brain pump refill & main | | T | 0125 | 1.9021 | \$ 113.20 | | \$ 22.64 |
| 95999 | Neurological procedure | | S | 0215 | 0.6025 | \$ 35.86 | \$ 14.34 | \$ 7.17 |
| 96000 | Motion analysis, video/3d | | S | 0216 | 2.5976 | \$ 154.59 | | \$ 30.92 |
| 96001 | Motion test w/ft press meas | | S | 0216 | 2.5976 | \$ 154.59 | | \$ 30.92 |
| 96002 | Dynamic surface emg | | S | 0218 | 1.1138 | \$ 66.28 | | \$ 13.26 |
| 96003 | Dynamic fine wire emg | | S | 0215 | 0.6025 | \$ 35.86 | \$ 14.34 | \$ 7.17 |
| 96100 | Psychological testing | CH | D | | | | | |
| 96101 | Psycho testing by psych/phys | NI | X | 0373 | 1.2514 | \$ 74.47 | | \$ 14.89 |
| 96102 | Psycho testing by technician | NI | X | 0382 | 3.4127 | \$ 203.09 | \$ 81.23 | \$ 40.62 |
| 96103 | Psycho testing admin by comp | NI | X | 0373 | 1.2514 | \$ 74.47 | | \$ 14.89 |
| 96110 | Developmental test, lim | | X | 0373 | 1.2514 | \$ 74.47 | | \$ 14.89 |
| 96111 | Developmental test, extend | | X | 0373 | 1.2514 | \$ 74.47 | | \$ 14.89 |
| 96115 | Neurobehavior status exam | CH | D | | | | | |
| 96116 | Neurobehavioral status exam | NI | X | 0373 | 1.2514 | \$ 74.47 | | \$ 14.89 |
| 96117 | Neuropsych test battery | CH | D | | | | | |
| 96118 | Neuropsych tst by psych/phys | NI | X | 0373 | 1.2514 | \$ 74.47 | | \$ 14.89 |
| 96119 | Neuropsych testing by tech | NI | X | 0382 | 3.4127 | \$ 203.09 | \$ 81.23 | \$ 40.62 |
| 96120 | Neuropsych tst admin w/comp | NI | X | 0373 | 1.2514 | \$ 74.47 | | \$ 14.89 |
| 96150 | Assess hlth/behave, init | CH | S | 0432 | 0.6396 | \$ 38.06 | | \$ 7.61 |
| 96151 | Assess hlth/behave, subseq | CH | S | 0432 | 0.6396 | \$ 38.06 | | \$ 7.61 |
| 96152 | Intervene hlth/behave, indiv | CH | S | 0432 | 0.6396 | \$ 38.06 | | \$ 7.61 |
| 96153 | Intervene hlth/behave, group | CH | S | 0432 | 0.6396 | \$ 38.06 | | \$ 7.61 |
| 96154 | Interv hlth/behav, fam w/pt | CH | S | 0432 | 0.6396 | \$ 38.06 | | \$ 7.61 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 96400 | Chemotherapy, sc/im | CH | D | | | | | |
| 96401 | Chemo, anti-neopl, sq/im | NI | S | 0116 | 1.1488 | \$ 68.37 | | \$ 13.67 |
| 96402 | Chemo hormon antineopl sq/im | NI | S | 0116 | 1.1488 | \$ 68.37 | | \$ 13.67 |
| 96405 | Chemo intralesional, up to 7 | | S | 0116 | 1.1488 | \$ 68.37 | | \$ 13.67 |
| 96406 | Chemo intralesional over 7 | | S | 0116 | 1.1488 | \$ 68.37 | | \$ 13.67 |
| 96408 | Chemotherapy, push technique | CH | D | | | | | |
| 96410 | Chemotherapy,infusion method | CH | D | | | | | |
| 96412 | Chemo, infuse method add-on | CH | D | | | | | |
| 96414 | Chemo, infuse method add-on | CH | D | | | | | |
| 96416 | Chemo prolong infuse w/pump | NI | S | 0117 | 3.1766 | \$ 189.04 | \$ 42.54 | \$ 37.81 |
| 96420 | Chemo, ia, push tecnica | | S | 0116 | 1.1488 | \$ 68.37 | | \$ 13.67 |
| 96422 | Chemo ia infusion up to 1 hr | | S | 0117 | 3.1766 | \$ 189.04 | \$ 42.54 | \$ 37.81 |
| 96423 | Chemo ia infuse each addl hr | | N | | | | | |
| 96425 | Chemotherapy,infusion method | | S | 0117 | 3.1766 | \$ 189.04 | \$ 42.54 | \$ 37.81 |
| 96440 | Chemotherapy, intracavitary | | S | 0116 | 1.1488 | \$ 68.37 | | \$ 13.67 |
| 96445 | Chemotherapy, intracavitary | | S | 0116 | 1.1488 | \$ 68.37 | | \$ 13.67 |
| 96450 | Chemotherapy, into CNS | | S | 0116 | 1.1488 | \$ 68.37 | | \$ 13.67 |
| 96520 | Port pump refill & main | CH | D | | | | | |
| 96521 | Refill/maint, portable pump | NI | T | 0125 | 1.9021 | \$ 113.20 | | \$ 22.64 |
| 96522 | Refill/maint pump/resvr syst | NI | T | 0125 | 1.9021 | \$ 113.20 | | \$ 22.64 |
| 96523 | Irrig drug delivery device | NI | N | | | | | |
| 96530 | Syst pump refill & main | CH | D | | | | | |
| 96542 | Chemotherapy injection | | S | 0116 | 1.1488 | \$ 68.37 | | \$ 13.67 |
| 96545 | Provide chemotherapy agent | CH | D | | | | | |
| 96549 | Chemotherapy, unspecified | | S | 0116 | 1.1488 | \$ 68.37 | | \$ 13.67 |
| 96567 | Photodynamic tx, skin | CH | T | 0016 | 2.5080 | \$ 149.25 | \$ 32.68 | \$ 29.85 |
| 96570 | Photodynamic tx, 30 min | | T | 0015 | 1.6338 | \$ 97.23 | \$ 20.13 | \$ 19.45 |
| 96571 | Photodynamic tx, addl 15 min | | T | 0015 | 1.6338 | \$ 97.23 | \$ 20.13 | \$ 19.45 |
| 96900 | Ultraviolet light therapy | | S | 0001 | 0.3998 | \$ 23.79 | \$ 7.00 | \$ 4.76 |
| 96902 | Trichogram | | N | | | | | |
| 96910 | Photochemotherapy with UV-B | | S | 0001 | 0.3998 | \$ 23.79 | \$ 7.00 | \$ 4.76 |
| 96912 | Photochemotherapy with UV-A | | S | 0001 | 0.3998 | \$ 23.79 | \$ 7.00 | \$ 4.76 |
| 96913 | Photochemotherapy, UV-A or B | | S | 0683 | 1.9289 | \$ 114.79 | \$ 25.79 | \$ 22.96 |
| 96920 | Laser tx, skin < 250 sq cm | | T | 0013 | 1.0603 | \$ 63.10 | \$ 13.07 | \$ 12.62 |
| 96921 | Laser tx, skin 250-500 sq cm | | T | 0013 | 1.0603 | \$ 63.10 | \$ 13.07 | \$ 12.62 |
| 96922 | Laser tx, skin > 500 sq cm | | T | 0013 | 1.0603 | \$ 63.10 | \$ 13.07 | \$ 12.62 |
| 96999 | Dermatological procedure | | T | 0010 | 0.5923 | \$ 35.25 | \$ 9.65 | \$ 7.05 |
| 97020 | Microwave therapy | | D | | | | | |
| 97504 | Orthotic training | | D | | | | | |
| 97520 | Prosthetic training | | D | | | | | |
| 97597 | Active wound care/20 cm or < | CH | T | 0012 | 0.8477 | \$ 50.45 | \$ 11.18 | \$ 10.09 |
| 97598 | Active wound care > 20 cm | CH | T | 0013 | 1.0603 | \$ 63.10 | \$ 13.07 | \$ 12.62 |
| 97601 | Wound(s) care, selective | | D | | | | | |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 97602 | Wound(s) care non-selective | CH | X | 0340 | 0.6137 | \$ 36.52 | | \$ 7.30 |
| 97605 | Neg press wound tx, < 50 cm | CH | T | 0012 | 0.8477 | \$ 50.45 | \$ 11.18 | \$ 10.09 |
| 97606 | Neg press wound tx, > 50 cm | CH | T | 0013 | 1.0603 | \$ 63.10 | \$ 13.07 | \$ 12.62 |
| 97703 | Prosthetic checkout | | D | | | | | |
| 97780 | Acupuncture w/o stimul | | D | | | | | |
| 97781 | Acupuncture w/stimul | | D | | | | | |
| 98925 | Osteopathic manipulation | | S | 0060 | 0.5011 | \$ 29.82 | | \$ 5.96 |
| 98926 | Osteopathic manipulation | | S | 0060 | 0.5011 | \$ 29.82 | | \$ 5.96 |
| 98927 | Osteopathic manipulation | | S | 0060 | 0.5011 | \$ 29.82 | | \$ 5.96 |
| 98928 | Osteopathic manipulation | | S | 0060 | 0.5011 | \$ 29.82 | | \$ 5.96 |
| 98929 | Osteopathic manipulation | | S | 0060 | 0.5011 | \$ 29.82 | | \$ 5.96 |
| 98940 | Chiropractic manipulation | | S | 0060 | 0.5011 | \$ 29.82 | | \$ 5.96 |
| 98941 | Chiropractic manipulation | | S | 0060 | 0.5011 | \$ 29.82 | | \$ 5.96 |
| 98942 | Chiropractic manipulation | | S | 0060 | 0.5011 | \$ 29.82 | | \$ 5.96 |
| 99052 | Medical services at night | CH | D | | | | | |
| 99054 | Medical servcs, unusual hrs | | D | | | | | |
| 99078 | Group health education | | N | | | | | |
| 99091 | Collect/review data from pt | CH | N | | | | | |
| 99141 | Sedation, iv/im or inhalant | CH | D | | | | | |
| 99142 | Sedation, oral/rectal/nasal | CH | D | | | | | |
| 99143 | Mod cs by same phys, < 5 yrs | NI | N | | | | | |
| 99144 | Mod cs by same phys, 5 yrs + | NI | N | | | | | |
| 99145 | Mod cs by same phys add-on | NI | N | | | | | |
| 99148 | Mod cs diff phys < 5 yrs | NI | N | | | | | |
| 99149 | Mod cs diff phys 5 yrs + | NI | N | | | | | |
| 99150 | Mod cs diff phys add-on | NI | N | | | | | |
| 99170 | Anogenital exam, child | | T | 0191 | 0.1702 | \$ 10.13 | \$ 2.85 | \$ 2.03 |
| 99175 | Induction of vomiting | | N | | | | | |
| 99185 | Regional hypothermia | | N | | | | | |
| 99186 | Total body hypothermia | | N | | | | | |
| 99195 | Phlebotomy | | X | 0372 | 0.5580 | \$ 33.21 | \$ 10.09 | \$ 6.64 |
| 99201 | Office/outpatient visit, new | | V | 0600 | 0.8800 | \$ 52.37 | | \$ 10.47 |
| 99202 | Office/outpatient visit, new | | V | 0600 | 0.8800 | \$ 52.37 | | \$ 10.47 |
| 99203 | Office/outpatient visit, new | | V | 0601 | 1.0125 | \$ 60.25 | | \$ 12.05 |
| 99204 | Office/outpatient visit, new | | V | 0602 | 1.4731 | \$ 87.67 | | \$ 17.53 |
| 99205 | Office/outpatient visit, new | | V | 0602 | 1.4731 | \$ 87.67 | | \$ 17.53 |
| 99211 | Office/outpatient visit, est | | V | 0600 | 0.8800 | \$ 52.37 | | \$ 10.47 |
| 99212 | Office/outpatient visit, est | | V | 0600 | 0.8800 | \$ 52.37 | | \$ 10.47 |
| 99213 | Office/outpatient visit, est | | V | 0601 | 1.0125 | \$ 60.25 | | \$ 12.05 |
| 99214 | Office/outpatient visit, est | | V | 0602 | 1.4731 | \$ 87.67 | | \$ 17.53 |
| 99215 | Office/outpatient visit, est | | V | 0602 | 1.4731 | \$ 87.67 | | \$ 17.53 |
| 99241 | Office consultation | | V | 0600 | 0.8800 | \$ 52.37 | | \$ 10.47 |
| 99242 | Office consultation | | V | 0600 | 0.8800 | \$ 52.37 | | \$ 10.47 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 99243 | Office consultation | | V | 0601 | 1.0125 | \$ 60.25 | | \$ 12.05 |
| 99244 | Office consultation | | V | 0602 | 1.4731 | \$ 87.67 | | \$ 17.53 |
| 99245 | Office consultation | | V | 0602 | 1.4731 | \$ 87.67 | | \$ 17.53 |
| 99261 | Follow-up inpatient consult | CH | D | | | | | |
| 99262 | Follow-up inpatient consult | CH | D | | | | | |
| 99263 | Follow-up inpatient consult | CH | D | | | | | |
| 99271 | Confirmatory consultation | CH | D | | | | | |
| 99272 | Confirmatory consultation | CH | D | | | | | |
| 99273 | Confirmatory consultation | CH | D | | | | | |
| 99274 | Confirmatory consultation | CH | D | | | | | |
| 99275 | Confirmatory consultation | CH | D | | | | | |
| 99281 | Emergency dept visit | | V | 0610 | 1.2399 | \$ 73.79 | \$ 18.71 | \$ 14.76 |
| 99282 | Emergency dept visit | | V | 0610 | 1.2399 | \$ 73.79 | \$ 18.71 | \$ 14.76 |
| 99283 | Emergency dept visit | | V | 0611 | 2.1707 | \$ 129.18 | \$ 34.26 | \$ 25.84 |
| 99284 | Emergency dept visit | | V | 0612 | 3.7772 | \$ 224.78 | \$ 51.89 | \$ 44.96 |
| 99285 | Emergency dept visit | | V | 0612 | 3.7772 | \$ 224.78 | \$ 51.89 | \$ 44.96 |
| 99289 | Ped crit care transport | | N | | | | | |
| 99290 | Ped crit care transport addl | | N | | | | | |
| 99291 | Critical care, first hour | | S | 0620 | 8.0276 | \$ 477.73 | \$ 131.61 | \$ 95.55 |
| 99292 | Critical care, add'l 30 min | | N | | | | | |
| 99300 | Ic, infant pbw 2501-5000 gm | NI | N | | | | | |
| 99301 | Nursing facility care | | D | | | | | |
| 99302 | Nursing facility care | | D | | | | | |
| 99303 | Nursing facility care | | D | | | | | |
| 99311 | Nursing fac care, subseq | | D | | | | | |
| 99312 | Nursing fac care, subseq | | D | | | | | |
| 99313 | Nursing fac care, subseq | | D | | | | | |
| 99321 | Rest home visit, new patient | | D | | | | | |
| 99322 | Rest home visit, new patient | | D | | | | | |
| 99323 | Rest home visit, new patient | | D | | | | | |
| 99331 | Rest home visit, est pat | | D | | | | | |
| 99332 | Rest home visit, est pat | | D | | | | | |
| 99333 | Rest home visit, est pat | | D | | | | | |
| 99354 | Prolonged service, office | | N | | | | | |
| 99355 | Prolonged service, office | | N | | | | | |
| 99358 | Prolonged serv, w/o contact | | N | | | | | |
| 99359 | Prolonged serv, w/o contact | | N | | | | | |
| 99361 | Physician/team conference | CH | N | | | | | |
| 99362 | Physician/team conference | CH | N | | | | | |
| 99431 | Initial care, normal newborn | | V | 0600 | 0.8800 | \$ 52.37 | | \$ 10.47 |
| 99432 | Newborn care, not in hosp | | N | | | | | |
| 99436 | Attendance, birth | | N | | | | | |
| 99440 | Newborn resuscitation | | S | 0094 | 2.4582 | \$ 146.29 | \$ 46.29 | \$ 29.26 |

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|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 0001F | Heart failure composite | | D | | | | | |
| 0001T | Endovas repr abdo ao aneurys | | D | | | | | |
| 0002F | Tobacco use, smoking, assess | | D | | | | | |
| 0003F | Tobacco use, non-smoking | | D | | | | | |
| 0003T | Cervicography | CH | S | 1492 | | \$ 15.00 | | \$ 3.00 |
| 0004F | Tobacco use txmnt counseling | | D | | | | | |
| 0005F | Osteoarthritis composite | | D | | | | | |
| 0005T | Perc cath stent/brain cv art | | D | | | | | |
| 0006F | Statin therapy, prescribed | | D | | | | | |
| 0006T | Perc cath stent/brain cv art | | D | | | | | |
| 0007F | Beta-blocker thx prescribed | | D | | | | | |
| 0007T | Perc cath stent/brain cv art | | D | | | | | |
| 0008F | Ace inhibitor thx prescribed | | D | | | | | |
| 0008T | Upper gi endoscopy w/suture | | T | 0422 | 24.0525 | \$ 1,431.39 | \$ 448.81 | \$ 286.28 |
| 0009F | Assess anginal symptom/level | | D | | | | | |
| 0009T | Endometrial cryoablation | | D | | | | | |
| 0010F | Assess anginal symptom/level | | D | | | | | |
| 0010T | Tb test, gamma interferon | | D | | | | | |
| 0011F | Oral antiplat thx prescribed | | D | | | | | |
| 0012T | Osteochondral knee autograft | | D | | | | | |
| 0013T | Osteochondral knee allograft | | D | | | | | |
| 0014T | Meniscal transplant, knee | | D | | | | | |
| 0016T | Thermotx choroid vasc lesion | | T | 0235 | 4.7925 | \$ 285.21 | \$ 69.52 | \$ 57.04 |
| 0017T | Photocoagulat macular drusen | | T | 0235 | 4.7925 | \$ 285.21 | \$ 69.52 | \$ 57.04 |
| 0018T | Transcranial magnetic stimul | | S | 0215 | 0.6025 | \$ 35.86 | \$ 14.34 | \$ 7.17 |
| 0020T | Extracorp shock wave tx, ft | | D | | | | | |
| 0023T | Phenotype drug test, hiv 1 | | D | | | | | |
| 0027T | Endoscopic epidural lysis | CH | T | 0220 | 17.3203 | \$ 1,030.75 | | \$ 206.15 |
| 0028T | Dexa body composition study | | N | | | | | |
| 0031T | Speculoscopy | | N | | | | | |
| 0032T | Speculoscopy w/direct sample | | N | | | | | |
| 0033T | Endovasc taa repr incl subcl | CH | D | | | | | |
| 0034T | Endovasc taa repr w/o subcl | CH | D | | | | | |
| 0035T | Insert endovasc prosth, taa | CH | D | | | | | |
| 0036T | Endovasc prosth, taa, add-on | CH | D | | | | | |
| 0037T | Artery transpose/endovas taa | CH | D | | | | | |
| 0038T | Rad endovasc taa rpr w/cover | CH | D | | | | | |
| 0039T | Rad s/i, endovasc taa repair | CH | D | | | | | |
| 0040T | Rad s/i, endovasc taa prosth | CH | D | | | | | |
| 0042T | Ct perfusion w/contrast, cbf | | N | | | | | |
| 0044T | Whole body photography | | N | | | | | |
| 0045T | Whole body photography | | N | | | | | |
| 0046T | Cath lavage, mammary duct(s) | | T | 0021 | 14.9984 | \$ 892.57 | \$ 219.48 | \$ 178.51 |

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|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 0047T | Cath lavage, mammary duct(s) | | T | 0021 | 14.9984 | \$ 892.57 | \$ 219.48 | \$ 178.51 |
| 0054T | Bone surgery using computer | CH | S | 0302 | 4.6992 | \$ 279.65 | \$ 105.94 | \$ 55.93 |
| 0055T | Bone surgery using computer | CH | S | 0302 | 4.6992 | \$ 279.65 | \$ 105.94 | \$ 55.93 |
| 0056T | Bone surgery using computer | CH | S | 0302 | 4.6992 | \$ 279.65 | \$ 105.94 | \$ 55.93 |
| 0057T | Uppr gi scope w/ thrml txmnt | | D | | | | | |
| 0058T | Cryopreservation, ovary tiss | | X | 0348 | 0.7607 | \$ 45.27 | | \$ 9.05 |
| 0059T | Cryopreservation, oocyte | | X | 0348 | 0.7607 | \$ 45.27 | | \$ 9.05 |
| 0062T | Rep intradisc annulus;1 lev | CH | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 0063T | Rep intradisc annulus;>1lev | CH | T | 0050 | 23.9367 | \$ 1,424.50 | | \$ 284.90 |
| 0064T | Spectroscop eval expired gas | | X | 0367 | 0.6539 | \$ 38.91 | \$ 14.80 | \$ 7.78 |
| 0067T | Ct colonography;dx | CH | S | 0333 | 5.1053 | \$ 303.82 | \$ 121.52 | \$ 60.76 |
| 0069T | Analysis only heart sound | | N | | | | | |
| 0070T | Interp only heart sound | | N | | | | | |
| 0071T | U/s leiomyomata ablate <200 | CH | T | 0195 | 26.7972 | \$ 1,594.73 | \$ 483.80 | \$ 318.95 |
| 0072T | U/s leiomyomata ablate >200 | CH | T | 0202 | 41.2319 | \$ 2,453.75 | \$ 981.50 | \$ 490.75 |
| 0073T | Delivery, comp imrt | | S | 0412 | 5.3573 | \$ 318.82 | | \$ 63.76 |
| 0083T | Stereotactic rad tx mngmt | | N | | | | | |
| 0084T | Temp prostate urethral stent | | T | 0164 | 1.1600 | \$ 69.03 | \$ 16.96 | \$ 13.81 |
| 0085T | Breath test heart reject | | X | 0340 | 0.6137 | \$ 36.52 | | \$ 7.30 |
| 0086T | L ventricle fill pressure | | N | | | | | |
| 0087T | Sperm eval hyaluronan | | X | 0348 | 0.7607 | \$ 45.27 | | \$ 9.05 |
| 0088T | Rf tongue base vol reduxn | | T | 0253 | 16.0740 | \$ 956.58 | \$ 282.29 | \$ 191.32 |
| 0089T | Actigraphy testing, 3-day | NI | S | 0218 | 1.1138 | \$ 66.28 | | \$ 13.26 |
| 0099T | Implant corneal ring | NI | T | 0233 | 14.6645 | \$ 872.70 | \$ 266.33 | \$ 174.54 |
| 0100T | Prosth retina receive&gen | NI | T | 0672 | 36.8773 | \$ 2,194.61 | | \$ 438.92 |
| 0101T | Extracorp shockwv tx,hi enrg | NI | T | 1547 | | \$ 850.00 | | \$ 170.00 |
| 0102T | Extracorp shockwv tx,anesth | NI | T | 1547 | | \$ 850.00 | | \$ 170.00 |
| 0106T | Touch quant sensory test | NI | X | 0341 | 0.1035 | \$ 6.16 | \$ 2.46 | \$ 1.23 |
| 0107T | Vibrate quant sensory test | NI | X | 0341 | 0.1035 | \$ 6.16 | \$ 2.46 | \$ 1.23 |
| 0108T | Cool quant sensory test | NI | X | 0341 | 0.1035 | \$ 6.16 | \$ 2.46 | \$ 1.23 |
| 0109T | Heat quant sensory test | NI | X | 0341 | 0.1035 | \$ 6.16 | \$ 2.46 | \$ 1.23 |
| 0110T | Nos quant sensory test | NI | X | 0341 | 0.1035 | \$ 6.16 | \$ 2.46 | \$ 1.23 |
| 0120T | Fibroadenoma cryoablate, ea | NI | T | 0029 | 31.4826 | \$ 1,873.56 | \$ 632.64 | \$ 374.71 |
| 0123T | Scleral fistulization | NI | T | 0234 | 22.0521 | \$ 1,312.34 | \$ 511.31 | \$ 262.47 |
| 0124T | Conjunctival drug placement | NI | T | 0232 | 6.9204 | \$ 411.84 | \$ 103.17 | \$ 82.37 |
| 0126T | Chd risk imt study | NI | N | | | | | |
| 0133T | Esophageal Implant Injexn | NI | T | 1556 | | \$ 1,750.00 | | \$ 350.00 |
| 0135T | Perq cryoablate renal tumor | NI | T | 0163 | 33.5963 | \$ 1,999.35 | | \$ 399.87 |
| 0137T | Prostate Saturation Sampling | NI | T | 0184 | 4.4432 | \$ 264.42 | \$ 96.27 | \$ 52.88 |
| 0144T | Ct Heart Wo Dye; Qual Calc | NI | S | 0398 | 4.2038 | \$ 250.17 | \$ 100.06 | \$ 50.03 |
| 0145T | Ct Heart W/Wo Dye Funct | NI | S | 0376 | 5.0315 | \$ 299.43 | \$ 119.77 | \$ 59.89 |
| 0146T | Ccta W/Wo Dye | NI | S | 0376 | 5.0315 | \$ 299.43 | \$ 119.77 | \$ 59.89 |
| 0147T | Ccta W/Wo, Quan Calcium | NI | S | 0376 | 5.0315 | \$ 299.43 | \$ 119.77 | \$ 59.89 |

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|---------------|-------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| 0148T | Ccta W/Wo, Strxr | NI | S | 0377 | 6.6729 | \$ 397.11 | \$ 158.84 | \$ 79.42 |
| 0149T | Ccta W/Wo, Strxr Quan Calc | NI | S | 0377 | 6.6729 | \$ 397.11 | \$ 158.84 | \$ 79.42 |
| 0150T | Ccta W/Wo, Disease Strxr | NI | S | 0398 | 4.2038 | \$ 250.17 | \$ 100.06 | \$ 50.03 |
| 0151T | Ct Heart Funct Add-On | NI | S | 0282 | 1.5934 | \$ 94.82 | \$ 37.92 | \$ 18.96 |
| 0152T | Computer Chest Add-On | NI | N | | | | | |
| 0154T | Implant Aneur Sensor Study | NI | X | 0097 | 1.0211 | \$ 60.77 | \$ 23.79 | \$ 12.15 |
| A4220 | Infusion pump refill kit | | N | | | | | |
| A4248 | Chlorhexidine antisept | | N | | | | | |
| A4254 | Battery for glucose monitor | | D | | | | | |
| A4260 | Levonorgestrel implant | | D | | | | | |
| A4262 | Temporary tear duct plug | | N | | | | | |
| A4263 | Permanent tear duct plug | | N | | | | | |
| A4270 | Disposable endoscope sheath | CH | N | | | | | |
| A4300 | Cath impl vasc access portal | | N | | | | | |
| A4301 | Implantable access syst perc | | N | | | | | |
| A4324 | Male ext cath w/adh coating | | D | | | | | |
| A4325 | Male ext cath w/adh strip | | D | | | | | |
| A4347 | Male external catheter | | D | | | | | |
| A4521 | Adult size diaper sm each | | D | | | | | |
| A4522 | Adult size diaper med each | | D | | | | | |
| A4523 | Adult size diaper lg each | | D | | | | | |
| A4524 | Adult size diaper xl each | | D | | | | | |
| A4525 | Adult size brief sm each | | D | | | | | |
| A4526 | Adult size brief med each | | D | | | | | |
| A4527 | Adult size brief lg each | | D | | | | | |
| A4528 | Adult size brief xl each | | D | | | | | |
| A4529 | Child size diaper sm/med ea | | D | | | | | |
| A4530 | Child size diaper lg each | | D | | | | | |
| A4531 | Child size brief sm/med each | | D | | | | | |
| A4532 | Child size brief lg each | | D | | | | | |
| A4533 | Youth size diaper each | | D | | | | | |
| A4535 | Disp incont liner/shield ea | | D | | | | | |
| A4536 | Prot underwr wshbl any sz ea | | D | | | | | |
| A4537 | Under pad reusable any sz ea | | D | | | | | |
| A4538 | Reusable diaper from dpr svc | | D | | | | | |
| A4561 | Pessary rubber, any type | | N | | | | | |
| A4562 | Pessary, non rubber, any type | | N | | | | | |
| A4609 | Trach suction cath clsed sys | | D | | | | | |
| A4610 | Trach sctn cath 72h clsedsys | | D | | | | | |
| A4641 | Radiopharm dx agent noc | | N | | | | | |
| A4642 | In111 satumomab | CH | H | 0704 | | | | |
| A4643 | High dose contrast MRI | CH | D | | | | | |
| A4644 | Contrast 100-199 MGs iodine | CH | D | | | | | |

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| A4645 | Contrast 200-299 MGs iodine | CH | D | | | | | |
| A4646 | Contrast 300-399 MGs iodine | CH | D | | | | | |
| A4647 | Supp- paramagnetic contr mat | CH | D | | | | | |
| A4656 | Needle any size | | D | | | | | |
| A5119 | Skin barrier wipes box pr 50 | | D | | | | | |
| A5509 | Direct heat form shoe insert | | D | | | | | |
| A5511 | Custom fab molded shoe inser | | D | | | | | |
| A6551 | Neg press wound ther canistr | | D | | | | | |
| A9500 | Tc99m sestamibi | CH | H | 1600 | | | | |
| A9502 | Tc99m tetrofosmin | CH | H | 0705 | | | | |
| A9503 | Tc99m medronate | | N | | | | | |
| A9504 | Tc99m apcitide | CH | H | 1602 | | | | |
| A9505 | TL201 thallium | CH | H | 1603 | | | | |
| A9507 | In111 capromab | CH | H | 1604 | | | | |
| A9508 | I131 iodobenguante, dx | CH | H | 1045 | | | | |
| A9510 | Tc99m disofenin | CH | H | 9146 | | | | |
| A9511 | Technetium TC 99m depreotide | CH | D | | | | | |
| A9512 | Tc99m pertechnetate | | N | | | | | |
| A9513 | Technetium tc-99m mebrofenin | CH | D | | | | | |
| A9514 | Technetiumtc99mpyrophosphate | CH | D | | | | | |
| A9515 | Technetium tc-99m pentetate | CH | D | | | | | |
| A9516 | I123 iodide cap, dx | CH | H | 9148 | | | | |
| A9517 | I131 iodide cap, rx | CH | H | 1064 | | | | |
| A9519 | Technetiumtc-99mmacroag albu | CH | D | | | | | |
| A9520 | Technetiumtc-99m sulfur cld | CH | D | | | | | |
| A9521 | Tc99m exametazime | CH | H | 1096 | | | | |
| A9522 | Indium111ibritumomabtiuxetan | CH | D | | | | | |
| A9523 | Yttrium90ibritumomabtiuxetan | CH | D | | | | | |
| A9524 | I131 serum albumin, dx | CH | H | 9100 | | | | |
| A9525 | Low/iso-osmolar contrast mat | | D | | | | | |
| A9526 | Nitrogen N-13 ammonia | CH | H | 0737 | | | | |
| A9528 | Iodine I-131 iodide cap, dx | CH | H | 1088 | | | | |
| A9529 | I131 iodide sol, dx | CH | H | 1065 | | | | |
| A9530 | I131 iodide sol, rx | CH | H | 1150 | | | | |
| A9531 | I131 max 100uCi | CH | H | 9149 | | | | |
| A9532 | I125 serum albumin, dx | CH | H | 9150 | | | | |
| A9533 | I-131 tositumomab diagnostic | | D | | | | | |
| A9534 | I-131 tositumomab therapeut | | D | | | | | |
| A9535 | Injection, methylene blue | NI | K | 1640 | | \$ 3.05 | | \$ 0.61 |
| A9536 | Tc99m depreotide | NI | H | 1641 | | | | |
| A9537 | Tc99m mebrofenin | NI | N | | | | | |
| A9538 | Tc99m pyrophosphate | NI | N | | | | | |
| A9539 | Tc99m pentetate | NI | N | | | | | |

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|---------------|-------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| A9540 | Tc99m MAA | NI | N | | | | | |
| A9541 | Tc99m sulfur colloid | NI | N | | | | | |
| A9542 | In111 ibritumomab, dx | NI | H | 1642 | | | | |
| A9543 | Y90 ibritumomab, rx | NI | H | 1643 | | | | |
| A9544 | I131 tositumomab, dx | NI | H | 1644 | | | | |
| A9545 | I131 tositumomab, rx | NI | H | 1645 | | | | |
| A9546 | Co57/58 | NI | N | | | | | |
| A9547 | In111 oxyquinoline | NI | H | 1646 | | | | |
| A9548 | In111 pentetate | NI | H | 1647 | | | | |
| A9549 | Tc99m arcitumomab | NI | H | 1648 | | | | |
| A9550 | Tc99m gluceptate | NI | H | 1649 | | | | |
| A9551 | Tc99m succimer | NI | H | 1650 | | | | |
| A9552 | F18 fdg | NI | H | 1651 | | | | |
| A9553 | Cr51 chromate | NI | H | 1652 | | | | |
| A9554 | I125 iothalamate, dx | NI | H | 1653 | | | | |
| A9555 | Rb82 rubidium | NI | H | 1654 | | | | |
| A9556 | Ga67 gallium | NI | H | 1671 | | | | |
| A9557 | Tc99m bismate | NI | H | 1672 | | | | |
| A9558 | Xe133 xenon 10mci | NI | N | | | | | |
| A9559 | Co57 cyano | NI | N | | | | | |
| A9560 | Tc99m labeled rbc | NI | H | 1673 | | | | |
| A9561 | Tc99m oxidronate | NI | N | | | | | |
| A9562 | Tc99m mertiatide | NI | H | 1674 | | | | |
| A9563 | P32 Na phosphate | NI | H | 1675 | | | | |
| A9564 | P32 chromic phosphate | NI | H | 1676 | | | | |
| A9565 | In111 pentetate | NI | H | 1677 | | | | |
| A9566 | Tc99m fanolesomab | NI | H | 1678 | | | | |
| A9567 | Technetium TC-99m aerosol | NI | H | 1679 | | | | |
| A9600 | Sr89 strontium | CH | H | 0701 | | | | |
| A9605 | Sm 153 lexidronm | CH | H | 0702 | | | | |
| A9698 | Non-rad contrast materialNOC | NI | N | | | | | |
| A9699 | Radiopharm rx agent noc | | N | | | | | |
| B4151 | Enteral formulae cat1 natural | | D | | | | | |
| B4156 | Enteral formulae category vi | | D | | | | | |
| B4184 | Parenteral sol lipids 10% | | D | | | | | |
| B4186 | Parenteral sol lipids 20% | | D | | | | | |
| C1079 | CO 57/58 per 0.5 uCi | CH | D | | | | | |
| C1080 | I-131 tositumomab, dx | CH | D | | | | | |
| C1081 | I-131 tositumomab, tx | CH | D | | | | | |
| C1082 | In-111 ibritumomab tiuxetan | CH | D | | | | | |
| C1083 | Yttrium 90 ibritumomab tiuxe | CH | D | | | | | |
| C1091 | IN111 oxyquinoline,per0.5mCi | CH | D | | | | | |
| C1092 | IN 111 pentetate per 0.5 mCi | CH | D | | | | | |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|--------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| C1093 | TC99M fanolesomab | CH | D | | | | | |
| C1122 | Tc 99M ARCITUMOMAB PER VIAL | CH | D | | | | | |
| C1178 | BUSULFAN IV, 6 Mg | | K | 1178 | 0.1795 | \$ 10.68 | | \$ 2.14 |
| C1200 | TC 99M Sodium Glucoheptonat | CH | D | | | | | |
| C1201 | TC 99M SUCCIMER, PER Vial | CH | D | | | | | |
| C1300 | HYPERBARIC Oxygen | | S | 0659 | 1.5155 | \$ 90.19 | | \$ 18.04 |
| C1305 | Apligraf, 44cm2 | CH | D | | | | | |
| C1713 | Anchor/screw bn/bn,tis/bn | | N | | | | | |
| C1714 | Cath, trans atherectomy, dir | | N | | | | | |
| C1715 | Brachytherapy needle | | N | | | | | |
| C1716 | Brachytx source, Gold 198 | | H | 1716 | | | | |
| C1717 | Brachytx source, HDR Ir-192 | | H | 1717 | | | | |
| C1718 | Brachytx source, Iodine 125 | | H | 1718 | | | | |
| C1719 | Brachytx sour,Non-HDR Ir-192 | | H | 1719 | | | | |
| C1720 | Brachytx sour, Palladium 103 | | H | 1720 | | | | |
| C1721 | AICD, dual chamber | | N | | | | | |
| C1722 | AICD, single chamber | | N | | | | | |
| C1724 | Cath, trans atherec,rotation | | N | | | | | |
| C1725 | Cath, translumin non-laser | | N | | | | | |
| C1726 | Cath, bal dil, non-vascular | | N | | | | | |
| C1727 | Cath, bal tis dis, non-vas | | N | | | | | |
| C1728 | Cath, brachytx seed adm | | N | | | | | |
| C1729 | Cath, drainage | | N | | | | | |
| C1730 | Cath, EP, 19 or few elect | | N | | | | | |
| C1731 | Cath, EP, 20 or more elec | | N | | | | | |
| C1732 | Cath, EP, diag/abl, 3D/vect | | N | | | | | |
| C1733 | Cath, EP, othr than cool-tip | | N | | | | | |
| C1750 | Cath, hemodialysis,long-term | | N | | | | | |
| C1751 | Cath, inf, per/cent/midline | | N | | | | | |
| C1752 | Cath,hemodialysis,short-term | | N | | | | | |
| C1753 | Cath, intravas ultrasound | | N | | | | | |
| C1754 | Catheter, intradiscal | | N | | | | | |
| C1755 | Catheter, intraspinal | | N | | | | | |
| C1756 | Cath, pacing, transesoph | | N | | | | | |
| C1757 | Cath, thrombectomy/embolect | | N | | | | | |
| C1758 | Catheter, ureteral | | N | | | | | |
| C1759 | Cath, intra echocardiography | | N | | | | | |
| C1760 | Closure dev, vasc | | N | | | | | |
| C1762 | Conn tiss, human(inc fascia) | | N | | | | | |
| C1763 | Conn tiss, non-human | | N | | | | | |
| C1764 | Event recorder, cardiac | | N | | | | | |
| C1765 | Adhesion barrier | | N | | | | | |
| C1766 | Intro/sheath, strble, non-peel | | N | | | | | |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|-----|--------------------|-----------------|-------------------------------------|------------------------------------|
| C1767 | Generator, neurostim, imp | | N | | | | | |
| C1768 | Graft, vascular | | N | | | | | |
| C1769 | Guide wire | | N | | | | | |
| C1770 | Imaging coil, MR, insertable | | N | | | | | |
| C1771 | Rep dev, urinary, w/sling | | N | | | | | |
| C1772 | Infusion pump, programmable | | N | | | | | |
| C1773 | Ret dev, insertable | | N | | | | | |
| C1775 | FDG, per dose (4-40 mCi/ml) | CH | D | | | | | |
| C1776 | Joint device (implantable) | | N | | | | | |
| C1777 | Lead, AICD, endo single coil | | N | | | | | |
| C1778 | Lead, neurostimulator | | N | | | | | |
| C1779 | Lead, pmkr, transvenous VDD | | N | | | | | |
| C1780 | Lens, intraocular (new tech) | | N | | | | | |
| C1781 | Mesh (implantable) | | N | | | | | |
| C1782 | Morcellator | | N | | | | | |
| C1783 | Ocular imp, aqueous drain de | | N | | | | | |
| C1784 | Ocular dev, intraop, det ret | | N | | | | | |
| C1785 | Pmkr, dual, rate- resp | | N | | | | | |
| C1786 | Pmkr, single, rate- resp | | N | | | | | |
| C1787 | Patient progr, neurostim | | N | | | | | |
| C1788 | Port, indwelling, imp | | N | | | | | |
| C1789 | Prosthesis, breast, imp | | N | | | | | |
| C1813 | Prosthesis, penile, inflatab | | N | | | | | |
| C1814 | Retinal tamp, silicone oil | CH | N | | | | | |
| C1815 | Pros, urinary sph, imp | | N | | | | | |
| C1816 | Receiver/transmitter, neuro | | N | | | | | |
| C1817 | Septal defect imp sys | | N | | | | | |
| C1818 | Integrated keratoprosthesis | CH | N | | | | | |
| C1819 | Tissue local excision | CH | N | | | | | |
| C1874 | Stent, coated/cov w/del sys | | N | | | | | |
| C1875 | Stent, coated/cov w/o del sy | | N | | | | | |
| C1876 | Stent, non-coa/non-cov w/del | | N | | | | | |
| C1877 | Stent, non-coat/cov w/o del | | N | | | | | |
| C1878 | Matrl for vocal cord | | N | | | | | |
| C1879 | Tissue marker, implantable | | N | | | | | |
| C1880 | Vena cava filter | | N | | | | | |
| C1881 | Dialysis access system | | N | | | | | |
| C1882 | AICD, other than sing/dual | | N | | | | | |
| C1883 | Adapt/ext, pacing/neuro lead | | N | | | | | |
| C1884 | Embolization Protect syst | | N | | | | | |
| C1885 | Cath, translumin angio laser | | N | | | | | |
| C1887 | Catheter, guiding | | N | | | | | |
| C1888 | Endovas non-cardiac abl cath | | N | | | | | |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| C1891 | Infusion pump,non-prog, perm | | N | | | | | |
| C1892 | Intro/sheath,fixed,peel-away | | N | | | | | |
| C1893 | Intro/sheath, fixed,non-peel | | N | | | | | |
| C1894 | Intro/sheath, non-laser | | N | | | | | |
| C1895 | Lead, AICD, endo dual coil | | N | | | | | |
| C1896 | Lead, AICD, non sing/dual | | N | | | | | |
| C1897 | Lead, neurostim test kit | | N | | | | | |
| C1898 | Lead, pmkr, other than trans | | N | | | | | |
| C1899 | Lead, pmkr/AICD combination | | N | | | | | |
| C1900 | Lead coronary venous | | N | | | | | |
| C2614 | Probe, perc lumb disc | | N | | | | | |
| C2615 | Sealant, pulmonary, liquid | | N | | | | | |
| C2616 | Brachytx source, Yttrium-90 | | H | 2616 | | | | |
| C2617 | Stent, non-cor, tem w/o del | | N | | | | | |
| C2618 | Probe, cryoablation | | N | | | | | |
| C2619 | Pmkr, dual, non rate-resp | | N | | | | | |
| C2620 | Pmkr, single, non rate-resp | | N | | | | | |
| C2621 | Pmkr, other than sing/dual | | N | | | | | |
| C2622 | Prosthesis, penile, non-inf | | N | | | | | |
| C2625 | Stent, non-cor, tem w/del sy | | N | | | | | |
| C2626 | Infusion pump, non-prog,temp | | N | | | | | |
| C2627 | Cath, suprapubic/cystoscopic | | N | | | | | |
| C2628 | Catheter, occlusion | | N | | | | | |
| C2629 | Intro/sheath, laser | | N | | | | | |
| C2630 | Cath, EP, cool-tip | | N | | | | | |
| C2631 | Rep dev, urinary, w/o sling | | N | | | | | |
| C2632 | Brachytx sol, I-125, per mCi | | H | 2632 | | | | |
| C2633 | Brachytx source, Cesium-131 | | H | 2633 | | | | |
| C2634 | Brachytx source, HA, I-125 | | H | 2634 | | | | |
| C2635 | Brachytx source, HA, P-103 | | H | 2635 | | | | |
| C2636 | Brachytx linear source, P-10 | | H | 2636 | | | | |
| C2637 | Brachytx, Ytterbium-169 | NF | H | 2637 | | | | |
| C8900 | MRA w/cont, abd | | S | 0284 | 6.2342 | \$ 371.00 | \$ 148.40 | \$ 74.20 |
| C8901 | MRA w/o cont, abd | | S | 0336 | 5.8678 | \$ 349.20 | \$ 139.68 | \$ 69.84 |
| C8902 | MRA w/o fol w/cont, abd | | S | 0337 | 8.5070 | \$ 506.26 | \$ 202.50 | \$ 101.25 |
| C8903 | MRI w/cont, breast, uni | | S | 0284 | 6.2342 | \$ 371.00 | \$ 148.40 | \$ 74.20 |
| C8904 | MRI w/o cont, breast, uni | | S | 0336 | 5.8678 | \$ 349.20 | \$ 139.68 | \$ 69.84 |
| C8905 | MRI w/o fol w/cont, brst, un | | S | 0337 | 8.5070 | \$ 506.26 | \$ 202.50 | \$ 101.25 |
| C8906 | MRI w/cont, breast, bi | | S | 0284 | 6.2342 | \$ 371.00 | \$ 148.40 | \$ 74.20 |
| C8907 | MRI w/o cont, breast, bi | | S | 0336 | 5.8678 | \$ 349.20 | \$ 139.68 | \$ 69.84 |
| C8908 | MRI w/o fol w/cont, breast, | | S | 0337 | 8.5070 | \$ 506.26 | \$ 202.50 | \$ 101.25 |
| C8909 | MRA w/cont, chest | | S | 0284 | 6.2342 | \$ 371.00 | \$ 148.40 | \$ 74.20 |
| C8910 | MRA w/o cont, chest | | S | 0336 | 5.8678 | \$ 349.20 | \$ 139.68 | \$ 69.84 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| C8911 | MRA w/o fol w/cont, chest | | S | 0337 | 8.5070 | \$ 506.26 | \$ 202.50 | \$ 101.25 |
| C8912 | MRA w/cont, lwr ext | | S | 0284 | 6.2342 | \$ 371.00 | \$ 148.40 | \$ 74.20 |
| C8913 | MRA w/o cont, lwr ext | | S | 0336 | 5.8678 | \$ 349.20 | \$ 139.68 | \$ 69.84 |
| C8914 | MRA w/o fol w/cont, lwr ext | | S | 0337 | 8.5070 | \$ 506.26 | \$ 202.50 | \$ 101.25 |
| C8918 | MRA w/cont, pelvis | | S | 0284 | 6.2342 | \$ 371.00 | \$ 148.40 | \$ 74.20 |
| C8919 | MRA w/o cont, pelvis | | S | 0336 | 5.8678 | \$ 349.20 | \$ 139.68 | \$ 69.84 |
| C8920 | MRA w/o fol w/cont, pelvis | | S | 0337 | 8.5070 | \$ 506.26 | \$ 202.50 | \$ 101.25 |
| C8950 | IV inf, tx/dx, up to 1 hr | NI | S | 0120 | 2.0293 | \$ 120.77 | \$ 28.21 | \$ 24.15 |
| C8951 | IV inf, tx/dx, each addl hr | NI | N | | | | | |
| C8952 | Tx, prophyl, dx IV push | NI | X | 0359 | 0.8036 | \$ 47.82 | | \$ 9.56 |
| C8953 | Chemotx adm, IV push | NI | S | 0116 | 1.1488 | \$ 68.37 | | \$ 13.67 |
| C8954 | Chemotx adm, IV inf up to 1h | NI | S | 0117 | 3.1766 | \$ 189.04 | \$ 42.54 | \$ 37.81 |
| C8955 | Chemotx adm, IV inf, addl hr | NI | N | | | | | |
| C8956 | Refill/maint port/impl pump | NI | T | 0125 | 1.9021 | \$ 113.20 | | \$ 22.64 |
| C8957 | Prolonged IV inf, req pump | NI | S | 0120 | 2.0293 | \$ 120.77 | \$ 28.21 | \$ 24.15 |
| C9000 | Na chromateCr51, per 0.25mCi | CH | D | | | | | |
| C9003 | Palivizumab, per 50 mg | | K | 9003 | 4.3120 | \$ 256.61 | | \$ 51.32 |
| C9007 | Baclofen Intrathecal kit-1am | CH | D | | | | | |
| C9008 | Baclofen Refill Kit-500mcg | CH | D | | | | | |
| C9009 | Baclofen Refill Kit-2000mcg | CH | D | | | | | |
| C9013 | Co 57 cobaltous chloride | CH | D | | | | | |
| C9102 | 51 Na Chromate, 50mCi | CH | D | | | | | |
| C9103 | Na lothalamate I-125, 10 uCi | CH | D | | | | | |
| C9105 | Hep B imm glob, per 1 ml | CH | D | | | | | |
| C9109 | Tirofiban hcl, 6.25 mg | | D | | | | | |
| C9112 | Perflutren lipid micro, 2ml | CH | D | | | | | |
| C9113 | Inj pantoprazole sodium, via | | N | | | | | |
| C9121 | Injection, argatroban | | K | 9121 | 0.2176 | \$ 12.95 | | \$ 2.59 |
| C9123 | Transcyte, 247cm2 | CH | D | | | | | |
| C9124 | Injection, daptomycin | | D | | | | | |
| C9125 | Injection, risperidone | | D | | | | | |
| C9127 | Paclitaxel protein pr | CH | D | | | | | |
| C9128 | Inj pegaptanib sodium | CH | D | | | | | |
| C9129 | Inj clofarabine | CH | D | | | | | |
| C9200 | Orcel, 36 cm2 | CH | D | | | | | |
| C9201 | Dermagraft, 37.5cm2 | CH | D | | | | | |
| C9202 | Octafluoropropane | CH | D | | | | | |
| C9203 | Perflexane lipid micro | CH | D | | | | | |
| C9205 | Oxaliplatin | CH | D | | | | | |
| C9206 | Integra, per cm2 | CH | D | | | | | |
| C9207 | Injection, bortezomib | | D | | | | | |
| C9208 | Injection, agalsidase beta | | D | | | | | |
| C9209 | Injection, laronidase | | D | | | | | |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| C9210 | Injection, palonosetron HCL | | D | | | | | |
| C9211 | Inj, alefacept, IV | CH | D | | | | | |
| C9212 | Inj, alefacept, IM | CH | D | | | | | |
| C9213 | Injection, Pemetrexed | | D | | | | | |
| C9214 | Injection, Bevacizumab | | D | | | | | |
| C9215 | Injection, Cetuximab | | D | | | | | |
| C9216 | Abarelix, Inject Suspension | | D | | | | | |
| C9217 | Injection, Omalizumab | | D | | | | | |
| C9218 | Injection, Azacitidine | CH | D | | | | | |
| C9219 | Mycophenolic Acid, Oral | | D | | | | | |
| C9220 | Sodium hyaluronate | | G | 9220 | | \$ 193.59 | | \$ 38.72 |
| C9221 | Graftjacket Reg Matrix | | G | 9221 | | \$ 1,307.48 | | \$ 261.50 |
| C9222 | Graftjacket SftTis | | G | 9222 | | \$ 883.21 | | \$ 176.64 |
| C9223 | Inj adenosine, tx dx | CH | D | | | | | |
| C9224 | Injection, galsulfase | NF | K | 9224 | | \$ 1,522.15 | | \$ 304.43 |
| C9225 | Fluocinolone acetoneide | NF | G | 9225 | | \$19,345.00 | | \$ 3,869.00 |
| C9226 | Ziconotide intrathecal inf | CH | D | | | | | |
| C9400 | Thallous chloride, brand | CH | D | | | | | |
| C9401 | Strontium-89 chloride, brand | CH | D | | | | | |
| C9402 | Th I131 so iodide cap, brand | CH | D | | | | | |
| C9403 | Dx I131 so iodide cap, brand | CH | D | | | | | |
| C9404 | Dx I131 so iodide sol, brand | CH | D | | | | | |
| C9405 | Th I131 so iodide sol, brand | CH | D | | | | | |
| C9410 | Dexrazoxane HCl inj, brand | CH | D | | | | | |
| C9411 | Pamidronate disodium, brand | CH | D | | | | | |
| C9413 | Na hyaluronate bran | CH | D | | | | | |
| C9414 | Etoposide oral, brand | CH | D | | | | | |
| C9415 | Doxorubic hcl chemo, brand | CH | D | | | | | |
| C9417 | Bleomycin sulfate inj, brand | CH | D | | | | | |
| C9418 | Cisplatin inj, brand | CH | D | | | | | |
| C9419 | Inj cladribine, brand | CH | D | | | | | |
| C9420 | Cyclophosphamide inj, brand | CH | D | | | | | |
| C9421 | Cyclophosphamide lyo, brand | CH | D | | | | | |
| C9422 | Cytarabine hcl inj, brand | CH | D | | | | | |
| C9423 | Dacarbazine inj, brand | CH | D | | | | | |
| C9424 | Daunorubicin, brand | CH | D | | | | | |
| C9425 | Etoposide inj, brand | CH | D | | | | | |
| C9426 | Floxuridine inj, brand | CH | D | | | | | |
| C9427 | Ifosfomide inj, brand | CH | D | | | | | |
| C9428 | Mesna injection, brand | CH | D | | | | | |
| C9429 | Idarubicin hcl inj, brand | CH | D | | | | | |
| C9430 | Leuprolide acetate bran | CH | D | | | | | |
| C9431 | Paclitaxel inj, brand | CH | D | | | | | |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| C9432 | Mitomycin inj, brand | CH | D | | | | | |
| C9433 | Thiotepa inj, brand | CH | D | | | | | |
| C9435 | Gonadorelin hydroch, brand | CH | D | | | | | |
| C9436 | Azathioprine parenteral,brnd | CH | D | | | | | |
| C9437 | Carmus bischl nitro inj | CH | D | | | | | |
| C9438 | Cyclosporine oral, brand | CH | D | | | | | |
| C9439 | Diethylstilbestrol injection | CH | D | | | | | |
| C9440 | Vinorelbine tar,brand | CH | D | | | | | |
| C9701 | Stretta System | | D | | | | | |
| C9703 | Bard Endoscopic Suturing Sys | | D | | | | | |
| C9704 | Inj inert subs upper GI | CH | D | | | | | |
| C9712 | Insert pH capsule, GERD | | D | | | | | |
| C9713 | Non-contact laser vap prosta | CH | D | | | | | |
| C9714 | Breast inters rad tx, immed | | D | | | | | |
| C9715 | Breast inters rad tx, delay | | D | | | | | |
| C9716 | RF Energy to Anus | | S | 1519 | | \$ 1,750.00 | | \$ 350.00 |
| C9717 | Stapled Hemorrhoidopexy | | D | | | | | |
| C9718 | Kyphoplasty, first vertebra | CH | D | | | | | |
| C9719 | Kyphoplasty, each addl | CH | D | | | | | |
| C9720 | HE ESW tx, tennis elbow | CH | D | | | | | |
| C9721 | HE ESW tx, plantar fasciitis | CH | D | | | | | |
| C9722 | KV imaging w/IR tracking | CH | D | | | | | |
| C9723 | Dyn IR Perf lmg | NF | S | 1502 | | \$ 75.00 | | \$ 15.00 |
| C9724 | EPS gast cardia plic | NF | T | 0422 | 24.0525 | \$ 1,431.39 | \$ 448.81 | \$ 286.28 |
| C9725 | Place endorectal app | NF | S | 1507 | | \$ 550.00 | | \$ 110.00 |
| D0150 | Comprehensve oral evaluation | | S | 0330 | 9.3925 | \$ 558.96 | | \$ 111.79 |
| D0240 | Intraoral occlusal film | | S | 0330 | 9.3925 | \$ 558.96 | | \$ 111.79 |
| D0250 | Extraoral first film | | S | 0330 | 9.3925 | \$ 558.96 | | \$ 111.79 |
| D0260 | Extraoral ea additional film | | S | 0330 | 9.3925 | \$ 558.96 | | \$ 111.79 |
| D0270 | Dental bitewing single film | | S | 0330 | 9.3925 | \$ 558.96 | | \$ 111.79 |
| D0272 | Dental bitewings two films | | S | 0330 | 9.3925 | \$ 558.96 | | \$ 111.79 |
| D0274 | Dental bitewings four films | | S | 0330 | 9.3925 | \$ 558.96 | | \$ 111.79 |
| D0277 | Vert bitewings-sev to eight | | S | 0330 | 9.3925 | \$ 558.96 | | \$ 111.79 |
| D0460 | Pulp vitality test | | S | 0330 | 9.3925 | \$ 558.96 | | \$ 111.79 |
| D1510 | Space maintainer fxd unilat | | S | 0330 | 9.3925 | \$ 558.96 | | \$ 111.79 |
| D1515 | Fixed bilat space maintainer | | S | 0330 | 9.3925 | \$ 558.96 | | \$ 111.79 |
| D1520 | Remove unilat space maintain | | S | 0330 | 9.3925 | \$ 558.96 | | \$ 111.79 |
| D1525 | Remove bilat space maintain | | S | 0330 | 9.3925 | \$ 558.96 | | \$ 111.79 |
| D1550 | Recement space maintainer | | S | 0330 | 9.3925 | \$ 558.96 | | \$ 111.79 |
| D2999 | Dental unspec restorative pr | | S | 0330 | 9.3925 | \$ 558.96 | | \$ 111.79 |
| D3460 | Endodontic endosseous implan | | S | 0330 | 9.3925 | \$ 558.96 | | \$ 111.79 |
| D3999 | Endodontic procedure | | S | 0330 | 9.3925 | \$ 558.96 | | \$ 111.79 |
| D4260 | Osseous surgery per quadrant | | S | 0330 | 9.3925 | \$ 558.96 | | \$ 111.79 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| D4263 | Bone replce graft first site | | S | 0330 | 9.3925 | \$ 558.96 | | \$ 111.79 |
| D4264 | Bone replce graft each add | | S | 0330 | 9.3925 | \$ 558.96 | | \$ 111.79 |
| D4268 | Surgical revision procedure | | S | 0330 | 9.3925 | \$ 558.96 | | \$ 111.79 |
| D4270 | Pedicle soft tissue graft pr | | S | 0330 | 9.3925 | \$ 558.96 | | \$ 111.79 |
| D4271 | Free soft tissue graft proc | | S | 0330 | 9.3925 | \$ 558.96 | | \$ 111.79 |
| D4273 | Subepithelial tissue graft | | S | 0330 | 9.3925 | \$ 558.96 | | \$ 111.79 |
| D4355 | Full mouth debridement | | S | 0330 | 9.3925 | \$ 558.96 | | \$ 111.79 |
| D4381 | Localized delivery antimicro | | S | 0330 | 9.3925 | \$ 558.96 | | \$ 111.79 |
| D5911 | Facial moulage sectional | | S | 0330 | 9.3925 | \$ 558.96 | | \$ 111.79 |
| D5912 | Facial moulage complete | | S | 0330 | 9.3925 | \$ 558.96 | | \$ 111.79 |
| D5983 | Radiation applicator | | S | 0330 | 9.3925 | \$ 558.96 | | \$ 111.79 |
| D5984 | Radiation shield | | S | 0330 | 9.3925 | \$ 558.96 | | \$ 111.79 |
| D5985 | Radiation cone locator | | S | 0330 | 9.3925 | \$ 558.96 | | \$ 111.79 |
| D5987 | Commissure splint | | S | 0330 | 9.3925 | \$ 558.96 | | \$ 111.79 |
| D6920 | Dental connector bar | | S | 0330 | 9.3925 | \$ 558.96 | | \$ 111.79 |
| D7111 | Extraction coronal remnants | | S | 0330 | 9.3925 | \$ 558.96 | | \$ 111.79 |
| D7140 | Extraction erupted tooth/exr | | S | 0330 | 9.3925 | \$ 558.96 | | \$ 111.79 |
| D7210 | Rem imp tooth w mucoper flap | | S | 0330 | 9.3925 | \$ 558.96 | | \$ 111.79 |
| D7220 | Impact tooth remov soft tiss | | S | 0330 | 9.3925 | \$ 558.96 | | \$ 111.79 |
| D7230 | Impact tooth remov part bony | | S | 0330 | 9.3925 | \$ 558.96 | | \$ 111.79 |
| D7240 | Impact tooth remov comp bony | | S | 0330 | 9.3925 | \$ 558.96 | | \$ 111.79 |
| D7241 | Impact tooth rem bony w/comp | | S | 0330 | 9.3925 | \$ 558.96 | | \$ 111.79 |
| D7250 | Tooth root removal | | S | 0330 | 9.3925 | \$ 558.96 | | \$ 111.79 |
| D7260 | Oral antral fistula closure | | S | 0330 | 9.3925 | \$ 558.96 | | \$ 111.79 |
| D7261 | Primary closure sinus perf | | S | 0330 | 9.3925 | \$ 558.96 | | \$ 111.79 |
| D7291 | Transseptal fiberotomy | | S | 0330 | 9.3925 | \$ 558.96 | | \$ 111.79 |
| D7940 | Reshaping bone orthognathic | | S | 0330 | 9.3925 | \$ 558.96 | | \$ 111.79 |
| D9110 | Tx dental pain minor proc | | N | | | | | |
| D9230 | Analgesia | | N | | | | | |
| D9248 | Sedation (non-iv) | | N | | | | | |
| D9630 | Other drugs/medicaments | | S | 0330 | 9.3925 | \$ 558.96 | | \$ 111.79 |
| D9930 | Treatment of complications | | S | 0330 | 9.3925 | \$ 558.96 | | \$ 111.79 |
| D9940 | Dental occlusal guard | | S | 0330 | 9.3925 | \$ 558.96 | | \$ 111.79 |
| D9950 | Occlusion analysis | | S | 0330 | 9.3925 | \$ 558.96 | | \$ 111.79 |
| D9951 | Limited occlusal adjustment | | S | 0330 | 9.3925 | \$ 558.96 | | \$ 111.79 |
| D9952 | Complete occlusal adjustment | | S | 0330 | 9.3925 | \$ 558.96 | | \$ 111.79 |
| E0169 | Seatlift incorp commodechair | | D | | | | | |
| E0176 | Air pressre pad/cushion nonp | | D | | | | | |
| E0177 | Water press pad/cushion nonp | | D | | | | | |
| E0178 | Gel pressre pad/cushion nonp | | D | | | | | |
| E0179 | Dry pressre pad/cushion nonp | | D | | | | | |
| E0192 | Pad wheelchr low press/posit | | D | | | | | |
| E0454 | Pressure ventilator | | D | | | | | |

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|---------------|-------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| E0616 | Cardiac event recorder | | N | | | | | |
| E0749 | Elec osteogen stim implanted | | N | | | | | |
| E0752 | Neurostimulator electrode | | D | | | | | |
| E0754 | Pulsegenerator pt programmer | | D | | | | | |
| E0756 | Implantable pulse generator | | D | | | | | |
| E0757 | Implantable RF receiver | | D | | | | | |
| E0758 | External RF transmitter | | D | | | | | |
| E0759 | Replace rdfrequency transmitt | | D | | | | | |
| E0782 | Non-programable infusion pump | | N | | | | | |
| E0783 | Programmable infusion pump | | N | | | | | |
| E0785 | Replacement impl pump cathet | | N | | | | | |
| E0786 | Implantable pump replacement | | N | | | | | |
| E0830 | Ambulatory traction device | | N | | | | | |
| E0953 | Pneumatic tire | | D | | | | | |
| E0954 | Wheelchair semi-pneumatic ca | | D | | | | | |
| E0962 | Wheelchair 1 inch cushion | | D | | | | | |
| E0963 | Wheelchair 2 inch cushion | | D | | | | | |
| E0964 | Wheelchair 3 inch cushion | | D | | | | | |
| E0965 | Wheelchair 4 inch cushion | | D | | | | | |
| E0972 | Transfer board or device | | D | | | | | |
| E0996 | Wheelchair tire solid | | D | | | | | |
| E1000 | Wheelchair tire pneumatic ca | | D | | | | | |
| E1001 | Wheelchair wheel | | D | | | | | |
| E1012 | Int seat sys planar ped w/c | | D | | | | | |
| E1013 | Int seat sys contour ped w/c | | D | | | | | |
| E1019 | HD feature power seat | | D | | | | | |
| E1021 | Ex hd feature power seat | | D | | | | | |
| E1025 | Pedwc lat/thor sup nocontour | | D | | | | | |
| E1026 | Pedwc contoured lat/thor sup | | D | | | | | |
| E1027 | Ped wc lat/ant support | | D | | | | | |
| E1210 | Whlchr moto ful arm leg rest | | D | | | | | |
| E1211 | Wheelchair motorized w/ det | | D | | | | | |
| E1212 | Wheelchair motorized w full | | D | | | | | |
| E1213 | Wheelchair motorized w/ det | | D | | | | | |
| E1239 | Ped power wheelchair NOS | | D | | | | | |
| E1399 | Durable medical equipment mi | | N | | | | | |
| G0001 | Drawing blood for specimen | | D | | | | | |
| G0008 | Admin influenza virus vac | CH | X | 0350 | 0.3917 | \$ 23.31 | | |
| G0009 | Admin pneumococcal vaccine | CH | X | 0350 | 0.3917 | \$ 23.31 | | |
| G0030 | PET imaging prev PET single | | D | | | | | |
| G0031 | PET imaging prev PET multiple | | D | | | | | |
| G0032 | PET follow SPECT 78464 singl | | D | | | | | |
| G0033 | PET follow SPECT 78464 mult | | D | | | | | |

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| G0034 | PET follow SPECT 76865 singl | | D | | | | | |
| G0035 | PET follow SPECT 78465 mult | | D | | | | | |
| G0036 | PET follow cornry angio sing | | D | | | | | |
| G0037 | PET follow cornry angio mult | | D | | | | | |
| G0038 | PET follow myocard perf sing | | D | | | | | |
| G0039 | PET follow myocard perf mult | | D | | | | | |
| G0040 | PET follow stress echo singl | | D | | | | | |
| G0041 | PET follow stress echo mult | | D | | | | | |
| G0042 | PET follow ventriculogm sing | | D | | | | | |
| G0043 | PET follow ventriculogm mult | | D | | | | | |
| G0044 | PET following rest ECG singl | | D | | | | | |
| G0045 | PET following rest ECG mult | | D | | | | | |
| G0046 | PET follow stress ECG singl | | D | | | | | |
| G0047 | PET follow stress ECG mult | | D | | | | | |
| G0101 | CA screen;pelvic/breast exam | | V | 0600 | 0.8800 | \$ 52.37 | | \$ 10.47 |
| G0102 | Prostate ca screening; dre | | N | | | | | |
| G0104 | CA screen;flexi sigmoidscope | | S | 0159 | 3.6322 | \$ 216.16 | | \$ 54.04 |
| G0105 | Colorectal scrn; hi risk ind | | T | 0158 | 7.5542 | \$ 449.56 | | \$ 112.39 |
| G0106 | Colon CA screen;barium enema | | S | 0157 | 2.1344 | \$ 127.02 | | \$ 25.40 |
| G0110 | Nett pulm-rehab educ; ind | | D | | | | | |
| G0111 | Nett pulm-rehab educ; group | | D | | | | | |
| G0112 | Nett;nutrition guid, initial | | D | | | | | |
| G0113 | Nett;nutrition guid,subseqnt | | D | | | | | |
| G0114 | Nett; psychosocial consult | | D | | | | | |
| G0115 | Nett; psychological testing | | D | | | | | |
| G0116 | Nett; psychosocial counsel | | D | | | | | |
| G0117 | Glaucoma scrn hgh risk direc | | S | 0230 | 0.7902 | \$ 47.03 | \$ 14.97 | \$ 9.41 |
| G0118 | Glaucoma scrn hgh risk direc | | S | 0230 | 0.7902 | \$ 47.03 | \$ 14.97 | \$ 9.41 |
| G0120 | Colon ca scrn; barium enema | | S | 0157 | 2.1344 | \$ 127.02 | | \$ 25.40 |
| G0121 | Colon ca scrn not hi rsk ind | | T | 0158 | 7.5542 | \$ 449.56 | | \$ 112.39 |
| G0125 | PET img WhBD sgl pulm ring | | D | | | | | |
| G0127 | Trim nail(s) | | T | 0009 | 0.7513 | \$ 44.71 | | \$ 8.94 |
| G0129 | Partial hosp prog service | | P | 0033 | 4.1322 | \$ 245.91 | | \$ 49.18 |
| G0130 | Single energy x-ray study | | X | 0260 | 0.7296 | \$ 43.42 | | \$ 8.68 |
| G0166 | Extrnl counterpulse, per tx | | T | 0678 | 1.7600 | \$ 104.74 | | \$ 20.95 |
| G0173 | Linear acc stereo radsur com | | S | 1528 | | \$ 5,250.00 | | \$ 1,050.00 |
| G0175 | OPPS Service,sched team conf | | V | 0602 | 1.4731 | \$ 87.67 | | \$ 17.53 |
| G0176 | OPPS/PHP;activity therapy | | P | 0033 | 4.1322 | \$ 245.91 | | \$ 49.18 |
| G0177 | OPPS/PHP train & educ serv | | P | 0033 | 4.1322 | \$ 245.91 | | \$ 49.18 |
| G0186 | Dstry eye lesn,fdr vssl tech | | T | 0235 | 4.7925 | \$ 285.21 | \$ 69.52 | \$ 57.04 |
| G0210 | PET img wholebody dxlung | | D | | | | | |
| G0211 | PET img wholbody init lung | | D | | | | | |
| G0212 | PET img wholebod restag lung | | D | | | | | |

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| G0213 | PET img wholebody dx | | D | | | | | |
| G0214 | PET img wholebod init | | D | | | | | |
| G0215 | PETimg wholebod restag | | D | | | | | |
| G0216 | PET img wholebod dx melanoma | | D | | | | | |
| G0217 | PET img wholebod init melan | | D | | | | | |
| G0218 | PET img wholebod restag mela | | D | | | | | |
| G0237 | Therapeutic procd strg endur | | S | 0411 | 0.3922 | \$ 23.34 | | \$ 4.67 |
| G0238 | Oth resp proc, indiv | | S | 0411 | 0.3922 | \$ 23.34 | | \$ 4.67 |
| G0239 | Oth resp proc, group | | S | 0411 | 0.3922 | \$ 23.34 | | \$ 4.67 |
| G0242 | Multisource photon ster plan | | D | | | | | |
| G0243 | Multisour photon stereo treat | CH | S | 0127 | 122.7483 | \$ 7,304.87 | | \$ 1,460.97 |
| G0244 | Observ care by facility topt | CH | D | | | | | |
| G0245 | Initial foot exam pt lops | | V | 0600 | 0.8800 | \$ 52.37 | | \$ 10.47 |
| G0246 | Followup eval of foot pt lop | | V | 0600 | 0.8800 | \$ 52.37 | | \$ 10.47 |
| G0247 | Routine footcare pt w lops | | T | 0009 | 0.7513 | \$ 44.71 | | \$ 8.94 |
| G0248 | Demonstrate use home inr mon | | S | 1503 | | \$ 150.00 | | \$ 30.00 |
| G0249 | Provide test material,equipm | | S | 1503 | | \$ 150.00 | | \$ 30.00 |
| G0251 | Linear acc based stereo radio | | S | 1513 | | \$ 1,150.00 | | \$ 230.00 |
| G0252 | PET imaging initial dx | | D | | | | | |
| G0253 | PET image brst dection recur | | D | | | | | |
| G0257 | Unsched dialysis ESRD pt hos | | S | 0170 | 5.9448 | \$ 353.78 | | \$ 70.76 |
| G0258 | IV infusion during obs stay | | D | | | | | |
| G0259 | Inject for sacroiliac joint | | N | | | | | |
| G0260 | Inj for sacroiliac jt anesth | | T | 0206 | 5.4011 | \$ 321.42 | \$ 75.55 | \$ 64.28 |
| G0263 | Adm with CHF, CP, asthma | CH | D | | | | | |
| G0264 | Assmt otr CHF, CP, asthma | CH | D | | | | | |
| G0267 | Bone marrow or psc harvest | | S | 0110 | 3.6419 | \$ 216.73 | | \$ 43.35 |
| G0268 | Removal of impacted wax md | | X | 0340 | 0.6137 | \$ 36.52 | | \$ 7.30 |
| G0269 | Occlusive device in vein art | | N | | | | | |
| G0275 | Renal angio, cardiac cath | | N | | | | | |
| G0278 | Iliac art angio,cardiac cath | | N | | | | | |
| G0279 | Excorp shock tx, elbow epi | | D | | | | | |
| G0280 | Excorp shock tx other than | | D | | | | | |
| G0288 | Recon, CTA for surg plan | | S | 0417 | 3.9600 | \$ 235.66 | | \$ 47.13 |
| G0289 | Arthro, loose body + chondro | | N | | | | | |
| G0290 | Drug-eluting stents, single | | T | 0656 | 108.1459 | \$ 6,435.87 | | \$ 1,287.17 |
| G0291 | Drug-eluting stents,each add | | T | 0656 | 108.1459 | \$ 6,435.87 | | \$ 1,287.17 |
| G0292 | Adm exp drugs,clinical trial | | D | | | | | |
| G0293 | Non-cov surg proc,clin trial | | S | 1505 | | \$ 350.00 | | \$ 70.00 |
| G0294 | Non-cov proc, clinical trial | | S | 1502 | | \$ 75.00 | | \$ 15.00 |
| G0297 | Insert single chamber/cd | | T | 0107 | 279.4800 | \$16,632.13 | \$ 3,344.78 | \$ 3,326.43 |
| G0298 | Insert dual chamber/cd | | T | 0107 | 279.4800 | \$16,632.13 | \$ 3,344.78 | \$ 3,326.43 |
| G0299 | Inser/repos single icd+leads | | T | 0108 | 375.2863 | \$22,333.66 | | \$ 4,466.73 |

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| G0300 | Insert reposit lead dual+gen | | T | 0108 | 375.2863 | \$22,333.66 | | \$ 4,466.73 |
| G0302 | Pre-op service LVRS complete | | S | 1509 | | \$ 750.00 | | \$ 150.00 |
| G0303 | Pre-op service LVRS 10-15dos | | S | 1507 | | \$ 550.00 | | \$ 110.00 |
| G0304 | Pre-op service LVRS 1-9 dos | | S | 1504 | | \$ 250.00 | | \$ 50.00 |
| G0305 | Post op service LVRS min 6 | | S | 1504 | | \$ 250.00 | | \$ 50.00 |
| G0332 | Preadmin IV immunoglobulin | NI | S | 1502 | | \$ 75.00 | | \$ 15.00 |
| G0338 | Linear accelerator stero pln | | D | | | | | |
| G0339 | Robot lin-radsurg com, first | | S | 1528 | | \$ 5,250.00 | | \$ 1,050.00 |
| G0340 | Robt lin-radsurg fractx 2-5 | | S | 1525 | | \$ 3,750.00 | | \$ 750.00 |
| G0344 | Initial preventive exam | | V | 0601 | 1.0125 | \$ 60.25 | | \$ 12.05 |
| G0345 | IV infuse hydration, initial | | D | | | | | |
| G0346 | Each additional infuse hour | | D | | | | | |
| G0347 | IV infusion therapy/diagnost | | D | | | | | |
| G0348 | Each additional hr up to 8hr | | D | | | | | |
| G0349 | Additional sequential infuse | | D | | | | | |
| G0350 | Concurrent infusion | | D | | | | | |
| G0351 | Therapeutic/diagnostic injec | | D | | | | | |
| G0353 | IV push,single orinitial dru | | D | | | | | |
| G0354 | Each addition sequential IV | | D | | | | | |
| G0355 | Chemo adminisrate subcut/IM | | D | | | | | |
| G0356 | Hormonal anti-neoplastic | | D | | | | | |
| G0357 | IV push single/initial subst | | D | | | | | |
| G0358 | IV push each additional drug | | D | | | | | |
| G0359 | Chemotherapy IV one hr initi | | D | | | | | |
| G0360 | Each additional hr 1-8 hrs | | D | | | | | |
| G0361 | Prolong chemo infuse>8hrs pu | | D | | | | | |
| G0362 | Each add sequential infusion | | D | | | | | |
| G0363 | Irrigate implanted venous de | | D | | | | | |
| G0364 | Bone marrow aspirate & biops | | X | 0342 | 0.1450 | \$ 8.63 | \$ 3.45 | \$ 1.73 |
| G0365 | Vessel mapping hemo access | | S | 0267 | 2.5543 | \$ 152.01 | \$ 60.80 | \$ 30.40 |
| G0367 | EKG tracing for initial prev | | S | 0099 | 0.3769 | \$ 22.43 | | \$ 4.49 |
| G0369 | Pharm fee 1st month transpla | | D | | | | | |
| G0370 | Pharmacy fee oral cancer etc | | D | | | | | |
| G0371 | Pharm dispense inhalation 30 | | D | | | | | |
| G0374 | Pharm dispense inhalation 90 | | D | | | | | |
| G0375 | Smoke/tobacco counseling 3-10 | NF | S | 1491 | | \$ 5.00 | \$ 2.00 | \$ 1.00 |
| G0376 | Smoke/tobacco counseling >10 | NF | S | 1491 | | \$ 5.00 | \$ 2.00 | \$ 1.00 |
| G0378 | Hospital observation per hr | NI | Q | 0339 | 7.1429 | \$ 425.08 | | \$ 85.02 |
| G0379 | Direct admit hospital observ | NI | Q | 0600 | 0.8800 | \$ 52.37 | | \$ 10.47 |
| G3001 | Admin + supply, tositumomab | | S | 1522 | | \$ 2,250.00 | | \$ 450.00 |
| J0120 | Tetracyclin injection | CH | N | | | | | |
| J0128 | Abarelix injection | | G | 9216 | | \$ 67.78 | | \$ 13.56 |
| J0130 | Abciximab injection | | K | 1605 | | \$ 486.98 | | \$ 97.40 |

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| J0132 | Acetylcysteine injection | NI | K | 1680 | | \$ 52.00 | | \$ 10.40 |
| J0133 | Acyclovir injection | NI | N | | | | | |
| J0135 | Adalimumab injection | | K | 1083 | | \$ 293.98 | | \$ 58.80 |
| J0150 | Injection adenosine 6 MG | CH | K | 0379 | | \$ 32.63 | | \$ 6.53 |
| J0152 | Adenosine injection | CH | K | 0917 | | \$ 70.27 | | \$ 14.05 |
| J0170 | Adrenalin epinephrin inject | | N | | | | | |
| J0180 | Agalsidase beta injection | CH | K | 9208 | | \$ 127.17 | | \$ 25.43 |
| J0190 | Inj biperiden lactate/5 mg | | N | | | | | |
| J0200 | Alatrofloxacin mesylate | | N | | | | | |
| J0205 | Alglucerase injection | | K | 0900 | | \$ 39.22 | | \$ 7.84 |
| J0207 | Amifostine | | K | 7000 | | \$ 439.31 | | \$ 87.86 |
| J0210 | Methyldopate hcl injection | CH | K | 2210 | | \$ 9.79 | | \$ 1.96 |
| J0215 | Alefacept | CH | K | 1633 | | \$ 26.56 | | \$ 5.31 |
| J0256 | Alpha 1 proteinase inhibitor | | K | 0901 | | \$ 3.28 | | \$ 0.66 |
| J0278 | Amikacin sulfate injection | NI | K | 1681 | | \$ 12.50 | | \$ 2.50 |
| J0280 | Aminophyllin 250 MG inj | | N | | | | | |
| J0282 | Amiodarone HCl | CH | N | | | | | |
| J0285 | Amphotericin B | | K | 9030 | | \$ 22.94 | | \$ 4.59 |
| J0287 | Amphotericin b lipid complex | | K | 9024 | | \$ 11.24 | | \$ 2.25 |
| J0288 | Ampho b cholesteryl sulfate | | K | 0735 | | \$ 12.00 | | \$ 2.40 |
| J0289 | Amphotericin b liposome inj | | K | 0736 | | \$ 18.18 | | \$ 3.64 |
| J0290 | Ampicillin 500 MG inj | | N | | | | | |
| J0295 | Ampicillin sodium per 1.5 gm | | N | | | | | |
| J0300 | Amobarbital 125 MG inj | | N | | | | | |
| J0330 | Succinylcholine chloride inj | | N | | | | | |
| J0350 | Injection anistreplase 30 u | CH | K | 1606 | | \$ 2,268.46 | | \$ 453.69 |
| J0360 | Hydralazine hcl injection | | N | | | | | |
| J0365 | Aprotonin, 10,000 kiu | NI | K | 1682 | | \$ 2.31 | | \$ 0.46 |
| J0380 | Inj metaraminol bitartrate | | N | | | | | |
| J0390 | Chloroquine injection | | N | | | | | |
| J0395 | Arbutamine HCl injection | | K | 9031 | | \$ 160.00 | | \$ 32.00 |
| J0456 | Azithromycin | | N | | | | | |
| J0460 | Atropine sulfate injection | | N | | | | | |
| J0470 | Dimecaprol injection | CH | K | 1638 | | \$ 21.85 | | \$ 4.37 |
| J0475 | Baclofen 10 MG injection | | K | 9032 | | \$ 190.29 | | \$ 38.06 |
| J0476 | Baclofen intrathecal trial | CH | K | 1631 | | \$ 70.74 | | \$ 14.15 |
| J0480 | Basiliximab | NI | K | 1683 | | \$ 1,420.76 | | \$ 284.15 |
| J0500 | Dicyclomine injection | | N | | | | | |
| J0515 | Inj benzotropine mesylate | | N | | | | | |
| J0520 | Bethanechol chloride inject | | N | | | | | |
| J0530 | Penicillin g benzathine inj | | N | | | | | |
| J0540 | Penicillin g benzathine inj | | N | | | | | |
| J0550 | Penicillin g benzathine inj | | N | | | | | |

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| J0560 | Penicillin g benzathine inj | | N | | | | | |
| J0570 | Penicillin g benzathine inj | | N | | | | | |
| J0580 | Penicillin g benzathine inj | CH | N | | | | | |
| J0583 | Bivalirudin | CH | N | | | | | |
| J0585 | Botulinum toxin a per unit | | K | 0902 | | \$ 4.91 | | \$ 0.98 |
| J0587 | Botulinum toxin type B | | K | 9018 | | \$ 7.80 | | \$ 1.56 |
| J0592 | Buprenorphine hydrochloride | | N | | | | | |
| J0595 | Butorphanol tartrate 1 mg | CH | N | | | | | |
| J0600 | Edetate calcium disodium inj | CH | K | 0892 | | \$ 40.38 | | \$ 8.08 |
| J0610 | Calcium gluconate injection | | N | | | | | |
| J0620 | Calcium glycer & lact/10 ML | | N | | | | | |
| J0630 | Calcitonin salmon injection | CH | K | 0893 | | \$ 37.81 | | \$ 7.56 |
| J0636 | Inj calcitriol per 0.1 mcg | | N | | | | | |
| J0637 | Caspofungin acetate | | K | 9019 | | \$ 32.52 | | \$ 6.50 |
| J0640 | Leucovorin calcium injection | | N | | | | | |
| J0670 | Inj mepivacaine HCL/10 ml | | N | | | | | |
| J0690 | Cefazolin sodium injection | | N | | | | | |
| J0692 | Cefepime HCl for injection | | N | | | | | |
| J0694 | Cefoxitin sodium injection | | N | | | | | |
| J0696 | Ceftriaxone sodium injection | | N | | | | | |
| J0697 | Sterile cefuroxime injection | | N | | | | | |
| J0698 | Cefotaxime sodium injection | | N | | | | | |
| J0702 | Betamethasone acet&sod phosp | | N | | | | | |
| J0704 | Betamethasone sod phosp/4 MG | | N | | | | | |
| J0706 | Caffeine citrate injection | CH | K | 0876 | | \$ 3.37 | | \$ 0.67 |
| J0710 | Cephapirin sodium injection | | N | | | | | |
| J0713 | Inj ceftazidime per 500 mg | | N | | | | | |
| J0715 | Ceftizoxime sodium / 500 MG | | N | | | | | |
| J0720 | Chloramphenicol sodium injec | | N | | | | | |
| J0725 | Chorionic gonadotropin/1000u | | N | | | | | |
| J0735 | Clonidine hydrochloride | CH | K | 0935 | | \$ 63.34 | | \$ 12.67 |
| J0740 | Cidofovir injection | | K | 9033 | | \$ 768.71 | | \$ 153.74 |
| J0743 | Cilastatin sodium injection | CH | N | | | | | |
| J0744 | Ciprofloxacin iv | | N | | | | | |
| J0745 | Inj codeine phosphate /30 MG | | N | | | | | |
| J0760 | Colchicine injection | | N | | | | | |
| J0770 | Colistimethate sodium inj | | N | | | | | |
| J0780 | Prochlorperazine injection | | N | | | | | |
| J0795 | Corticotropin ovine triflutal | NI | K | 1684 | | \$ 3.76 | | \$ 0.75 |
| J0800 | Corticotropin injection | CH | K | 1280 | | \$ 107.18 | | \$ 21.44 |
| J0835 | Inj cosyntropin per 0.25 MG | CH | K | 0835 | | \$ 67.82 | | \$ 13.56 |
| J0850 | Cytomegalovirus imm IV /vial | | K | 0903 | | \$ 722.68 | | \$ 144.54 |
| J0878 | Daptomycin injection | | G | 9124 | | \$ 0.29 | | \$ 0.06 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| J0880 | Darbepoetin alfa injection | | D | | | | | |
| J0881 | Darbepoetin alfa, non-esrd | NI | K | 1685 | | \$ 3.01 | | \$ 0.60 |
| J0885 | Epoetin alfa, non-esrd | NI | K | 1686 | | \$ 9.22 | | \$ 1.84 |
| J0895 | Deferoxamine mesylate inj | CH | K | 0895 | | \$ 15.38 | | \$ 3.08 |
| J0900 | Testosterone enanthate inj | CH | N | | | | | |
| J0945 | Brompheniramine maleate inj | CH | N | | | | | |
| J0970 | Estradiol valerate injection | | N | | | | | |
| J1000 | Depo-estradiol cypionate inj | | N | | | | | |
| J1020 | Methylprednisolone 20 MG inj | | N | | | | | |
| J1030 | Methylprednisolone 40 MG inj | | N | | | | | |
| J1040 | Methylprednisolone 80 MG inj | | N | | | | | |
| J1051 | Medroxyprogesterone inj | CH | N | | | | | |
| J1060 | Testosterone cypionate 1 ML | | N | | | | | |
| J1070 | Testosterone cypionat 100 MG | | N | | | | | |
| J1080 | Testosterone cypionat 200 MG | | N | | | | | |
| J1094 | Inj dexamethasone acetate | | N | | | | | |
| J1100 | Dexamethasone sodium phos | | N | | | | | |
| J1110 | Inj dihydroergotamine mesylt | CH | K | 1210 | | \$ 27.28 | | \$ 5.46 |
| J1120 | Acetazolamid sodium injectio | | N | | | | | |
| J1160 | Digoxin injection | | N | | | | | |
| J1162 | Digoxin immune fab (ovine) | NI | K | 1687 | | \$ 546.93 | | \$ 109.39 |
| J1165 | Phenytoin sodium injection | | N | | | | | |
| J1170 | Hydromorphone injection | | N | | | | | |
| J1180 | Dyphylline injection | CH | K | 9166 | | \$ 8.05 | | \$ 1.61 |
| J1190 | Dexrazoxane HCl injection | | K | 0726 | | \$ 200.08 | | \$ 40.02 |
| J1200 | Diphenhydramine hcl injectio | | N | | | | | |
| J1205 | Chlorothiazide sodium inj | | N | | | | | |
| J1212 | Dimethyl sulfoxide 50% 50 ML | CH | N | | | | | |
| J1230 | Methadone injection | CH | N | | | | | |
| J1240 | Dimenhydrinate injection | | N | | | | | |
| J1245 | Dipyridamole injection | CH | N | | | | | |
| J1250 | Inj dobutamine HCL/250 mg | | N | | | | | |
| J1260 | Dolasetron mesylate | | K | 0750 | | \$ 6.52 | | \$ 1.30 |
| J1265 | Dopamine injection | NI | N | | | | | |
| J1270 | Injection, doxercalciferol | | N | | | | | |
| J1320 | Amitriptyline injection | | N | | | | | |
| J1325 | Epoprostenol injection | CH | N | | | | | |
| J1327 | Eptifibatide injection | | K | 1607 | | \$ 13.13 | | \$ 2.63 |
| J1330 | Ergonovine maleate injection | CH | K | 1330 | 0.5564 | \$ 33.11 | | \$ 6.62 |
| J1335 | Ertapenem injection | | N | | | | | |
| J1364 | Erythro lactobionate /500 MG | | N | | | | | |
| J1380 | Estradiol valerate 10 MG inj | | N | | | | | |
| J1390 | Estradiol valerate 20 MG inj | | N | | | | | |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| J1410 | Inj estrogen conjugate 25 MG | | K | 9038 | | \$ 56.71 | | \$ 11.34 |
| J1430 | Ethanolamine oleate 100 mg | NI | K | 1688 | | \$ 79.35 | | \$ 15.87 |
| J1435 | Injection estrone per 1 MG | | N | | | | | |
| J1436 | Etidronate disodium inj | CH | K | 1436 | | \$ 71.69 | | \$ 14.34 |
| J1438 | Etanercept injection | | K | 1608 | | \$ 149.62 | | \$ 29.92 |
| J1440 | Filgrastim 300 mcg injection | | K | 0728 | | \$ 177.81 | | \$ 35.56 |
| J1441 | Filgrastim 480 mcg injection | | K | 7049 | | \$ 279.57 | | \$ 55.91 |
| J1450 | Fluconazole | | N | | | | | |
| J1451 | Fomepizole, 15 mg | NI | K | 1689 | | \$ 11.88 | | \$ 2.38 |
| J1452 | Intraocular Fomivirsen na | | K | 9040 | | \$ 212.00 | | \$ 42.40 |
| J1455 | Foscarnet sodium injection | CH | N | | | | | |
| J1457 | Gallium nitrate injection | | K | 1085 | | \$ 1.25 | | \$ 0.25 |
| J1460 | Gamma globulin 1 CC inj | CH | N | | | | | |
| J1563 | IV immune globulin | CH | D | | | | | |
| J1564 | Immune globulin 10 mg | CH | D | | | | | |
| J1565 | RSV-ivig | | K | 0906 | | \$ 16.18 | | \$ 3.24 |
| J1566 | Immune globulin, powder | NI | K | 2731 | | \$ 21.28 | | \$ 4.26 |
| J1567 | Immune globulin, liquid | NI | K | 2732 | | \$ 28.15 | | \$ 5.63 |
| J1570 | Ganciclovir sodium injection | | N | | | | | |
| J1580 | Garamycin gentamicin inj | | N | | | | | |
| J1590 | Gatifloxacin injection | | N | | | | | |
| J1595 | Injection glatiramer acetate | | N | | | | | |
| J1600 | Gold sodium thiomaleate inj | | N | | | | | |
| J1610 | Glucagon hydrochloride/1 MG | | K | 9042 | | \$ 64.92 | | \$ 12.98 |
| J1620 | Gonadorelin hydroch/ 100 mcg | | K | 7005 | | \$ 180.30 | | \$ 36.06 |
| J1626 | Granisetron HCl injection | | K | 0764 | | \$ 7.14 | | \$ 1.43 |
| J1630 | Haloperidol injection | | N | | | | | |
| J1631 | Haloperidol decanoate inj | | N | | | | | |
| J1640 | Hemin, 1 mg | NI | K | 1690 | 0.0670 | \$ 3.99 | | \$ 0.80 |
| J1642 | Inj heparin sodium per 10 u | | N | | | | | |
| J1644 | Inj heparin sodium per 1000u | | N | | | | | |
| J1645 | Dalteparin sodium | | N | | | | | |
| J1650 | Inj enoxaparin sodium | | N | | | | | |
| J1652 | Fondaparinux sodium | | N | | | | | |
| J1655 | Tinzaparin sodium injection | CH | K | 1655 | | \$ 2.31 | | \$ 0.46 |
| J1670 | Tetanus immune globulin inj | CH | K | 1670 | | \$ 85.67 | | \$ 17.13 |
| J1700 | Hydrocortisone acetate inj | | N | | | | | |
| J1710 | Hydrocortisone sodium ph inj | | N | | | | | |
| J1720 | Hydrocortisone sodium succ i | | N | | | | | |
| J1730 | Diazoxide injection | CH | K | 1740 | | \$ 111.70 | | \$ 22.34 |
| J1742 | Ibutilide fumarate injection | | K | 9044 | | \$ 249.56 | | \$ 49.91 |
| J1745 | Infliximab injection | | K | 7043 | | \$ 53.43 | | \$ 10.69 |
| J1750 | Iron dextran | CH | D | | | | | |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| J1751 | Iron dextran 165 injection | NI | K | 1691 | | \$ 11.80 | | \$ 2.36 |
| J1752 | Iron dextran 267 injection | NI | K | 1692 | | \$ 10.20 | | \$ 2.04 |
| J1756 | Iron sucrose injection | | K | 9046 | | \$ 0.36 | | \$ 0.07 |
| J1785 | Injection imiglucerase /unit | | K | 0916 | | \$ 3.91 | | \$ 0.78 |
| J1790 | Droperidol injection | | N | | | | | |
| J1800 | Propranolol injection | | N | | | | | |
| J1815 | Insulin injection | | N | | | | | |
| J1817 | Insulin for insulin pump use | | N | | | | | |
| J1830 | Interferon beta-1b / .25 MG | | K | 0910 | | \$ 85.95 | | \$ 17.19 |
| J1835 | Itraconazole injection | | K | 9047 | | \$ 36.30 | | \$ 7.26 |
| J1840 | Kanamycin sulfate 500 MG inj | | N | | | | | |
| J1850 | Kanamycin sulfate 75 MG inj | | N | | | | | |
| J1885 | Ketorolac tromethamine inj | | N | | | | | |
| J1890 | Cephalothin sodium injection | | N | | | | | |
| J1931 | Laronidase injection | CH | K | 9209 | | \$ 23.87 | | \$ 4.77 |
| J1940 | Furosemide injection | | N | | | | | |
| J1945 | Lepiridin | NI | K | 1693 | | \$ 146.92 | | \$ 29.38 |
| J1950 | Leuprolide acetate /3.75 MG | | K | 0800 | | \$ 434.89 | | \$ 86.98 |
| J1956 | Levofloxacin injection | | N | | | | | |
| J1960 | Levorphanol tartrate inj | | N | | | | | |
| J1980 | Hyoscyamine sulfate inj | | N | | | | | |
| J1990 | Chlordiazepoxide injection | | N | | | | | |
| J2001 | Lidocaine injection | | N | | | | | |
| J2010 | Lincomycin injection | | N | | | | | |
| J2020 | Linezolid injection | | K | 9001 | | \$ 23.72 | | \$ 4.74 |
| J2060 | Lorazepam injection | | N | | | | | |
| J2150 | Mannitol injection | | N | | | | | |
| J2175 | Meperidine hydrochl /100 MG | | N | | | | | |
| J2180 | Meperidine/promethazine inj | | N | | | | | |
| J2185 | Meropenem | CH | N | | | | | |
| J2210 | Methylergonovin maleate inj | | N | | | | | |
| J2250 | Inj midazolam hydrochloride | | N | | | | | |
| J2260 | Inj milrinone lactate / 5 MG | CH | N | | | | | |
| J2270 | Morphine sulfate injection | | N | | | | | |
| J2271 | Morphine so4 injection 100mg | | N | | | | | |
| J2275 | Morphine sulfate injection | | N | | | | | |
| J2278 | Ziconotide injection | NI | G | 1694 | | \$ 6.45 | | \$ 1.29 |
| J2280 | Inj, moxifloxacin 100 mg | CH | N | | | | | |
| J2300 | Inj nalbuphine hydrochloride | | N | | | | | |
| J2310 | Inj naloxone hydrochloride | | N | | | | | |
| J2320 | Nandrolone decanoate 50 MG | | N | | | | | |
| J2321 | Nandrolone decanoate 100 MG | | N | | | | | |
| J2322 | Nandrolone decanoate 200 MG | | N | | | | | |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| J2324 | Nesiritide | CH | D | | | | | |
| J2325 | Nesiritide injection | NI | K | 1695 | | \$ 29.89 | | \$ 5.98 |
| J2353 | Octreotide injection, depot | | K | 1207 | | \$ 87.31 | | \$ 17.46 |
| J2354 | Octreotide inj, non-depot | CH | N | | | | | |
| J2355 | Oprelvekin injection | | K | 7011 | | \$ 247.77 | | \$ 49.55 |
| J2357 | Omalizumab injection | | G | 9300 | | \$ 15.88 | | \$ 3.18 |
| J2360 | Orphenadrine injection | | N | | | | | |
| J2370 | Phenylephrine hcl injection | | N | | | | | |
| J2400 | Chlorprocaine hcl injection | | N | | | | | |
| J2405 | Ondansetron hcl injection | | K | 0768 | | \$ 3.85 | | \$ 0.77 |
| J2410 | Oxymorphone hcl injection | | N | | | | | |
| J2425 | Palifermin injection | NI | K | 1696 | | \$ 11.00 | | \$ 2.20 |
| J2430 | Pamidronate disodium /30 MG | | K | 0730 | | \$ 40.63 | | \$ 8.13 |
| J2440 | Papaverin hcl injection | | N | | | | | |
| J2460 | Oxytetracycline injection | | N | | | | | |
| J2469 | Palonosetron HCl | CH | K | 9210 | | \$ 17.99 | | \$ 3.60 |
| J2501 | Paricalcitol | | N | | | | | |
| J2503 | Pegaptanib sodium injection | NI | G | 1697 | | \$ 1,054.70 | | \$ 210.94 |
| J2504 | Pegademase bovine, 25 iu | NI | K | 1739 | | \$ 166.07 | | \$ 33.21 |
| J2505 | Pentastarch 10% solution | | K | 9119 | | \$ 2,078.07 | | \$ 415.61 |
| J2510 | Sincalide injection | | N | | | | | |
| J2513 | Pentastarch 10% solution | NI | K | 1698 | | \$ 12.72 | | \$ 2.54 |
| J2515 | Pentobarbital sodium inj | | N | | | | | |
| J2540 | Penicillin g potassium inj | | N | | | | | |
| J2543 | Piperacillin/tazobactam | | N | | | | | |
| J2550 | Promethazine hcl injection | | N | | | | | |
| J2560 | Phenobarbital sodium inj | | N | | | | | |
| J2590 | Oxytocin injection | | N | | | | | |
| J2597 | Inj desmopressin acetate | CH | N | | | | | |
| J2650 | Prednisolone acetate inj | | N | | | | | |
| J2670 | Totazoline hcl injection | | N | | | | | |
| J2675 | Inj progesterone per 50 MG | | N | | | | | |
| J2680 | Fluphenazine decanoate 25 MG | | N | | | | | |
| J2690 | Procainamide hcl injection | | N | | | | | |
| J2700 | Oxacillin sodium injeciton | CH | K | 1635 | | \$ 1.70 | | \$ 0.34 |
| J2710 | Neostigmine methylsifte inj | | N | | | | | |
| J2720 | Inj protamine sulfate/10 MG | | N | | | | | |
| J2725 | Inj protirelin per 250 mcg | CH | N | | | | | |
| J2730 | Pralidoxime chloride inj | CH | K | 2730 | | \$ 91.90 | | \$ 18.38 |
| J2760 | Phentolaine mesylate inj | CH | N | | | | | |
| J2765 | Metoclopramide hcl injection | | N | | | | | |
| J2770 | Quinupristin/dalfopristin | CH | K | 2770 | | \$ 103.11 | | \$ 20.62 |
| J2780 | Ranitidine hydrochloride inj | | N | | | | | |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| J2783 | Rasburicase | | G | 0738 | | \$ 111.34 | | \$ 22.27 |
| J2788 | Rho d immune globulin 50 mcg | | K | 9023 | | \$ 24.51 | | \$ 4.90 |
| J2790 | Rho d immune globulin inj | CH | K | 0884 | | \$ 84.99 | | \$ 17.00 |
| J2792 | Rho(D) immune globulin h, sd | | K | 1609 | | \$ 13.73 | | \$ 2.75 |
| J2794 | Risperidone, long acting | | G | 9125 | | \$ 4.69 | | \$ 0.94 |
| J2795 | Ropivacaine HCl injection | | N | | | | | |
| J2800 | Methocarbamol injection | | N | | | | | |
| J2805 | Sinacalide injection | NI | K | 1699 | | \$ 27.58 | | \$ 5.52 |
| J2810 | Inj theophylline per 40 MG | | N | | | | | |
| J2820 | Sargramostim injection | | K | 0731 | | \$ 21.87 | | \$ 4.37 |
| J2850 | Inj secretin synthetic human | NI | K | 1700 | | \$ 20.31 | | \$ 4.06 |
| J2910 | Aurothioglucose injeciton | CH | K | 1639 | | \$ 24.50 | | \$ 4.90 |
| J2912 | Sodium chloride injection | | N | | | | | |
| J2916 | Na ferric gluconate complex | CH | N | | | | | |
| J2920 | Methylprednisolone injection | | N | | | | | |
| J2930 | Methylprednisolone injection | | N | | | | | |
| J2940 | Somatrem injection | CH | K | 2940 | 0.5982 | \$ 35.60 | | \$ 7.12 |
| J2941 | Somatropin injection | | K | 7034 | | \$ 43.87 | | \$ 8.77 |
| J2950 | Promazine hcl injection | | N | | | | | |
| J2993 | Retepase injection | | K | 9005 | | \$ 1,278.84 | | \$ 255.77 |
| J2995 | Inj streptokinase /250000 IU | | K | 0911 | | \$ 79.50 | | \$ 15.90 |
| J2997 | Alteplase recombinant | | K | 7048 | | \$ 31.44 | | \$ 6.29 |
| J3000 | Streptomycin injection | | N | | | | | |
| J3010 | Fentanyl citrate injeciton | | N | | | | | |
| J3030 | Sumatriptan succinate / 6 MG | CH | K | 3030 | | \$ 50.99 | | \$ 10.20 |
| J3070 | Pentazocine hcl injection | | N | | | | | |
| J3100 | Tenecteplase injection | | K | 9002 | | \$ 2,064.24 | | \$ 412.85 |
| J3105 | Terbutaline sulfate inj | | N | | | | | |
| J3120 | Testosterone enanthate inj | | N | | | | | |
| J3130 | Testosterone enanthate inj | | N | | | | | |
| J3140 | Testosterone suspension inj | | N | | | | | |
| J3150 | Testosteron propionate inj | | N | | | | | |
| J3230 | Chlorpromazine hcl injection | | N | | | | | |
| J3240 | Thyrotropin injection | | K | 9108 | | \$ 699.27 | | \$ 139.85 |
| J3245 | Tirofiban hydrochloride | | D | | | | | |
| J3246 | Tirofiban HCl | | K | 7041 | | \$ 7.86 | | \$ 1.57 |
| J3250 | Trimethobenzamide hcl inj | | N | | | | | |
| J3260 | Tobramycin sulfate injection | | N | | | | | |
| J3265 | Injection torsemide 10 mg/ml | | N | | | | | |
| J3280 | Thiethylperazine maleate inj | | N | | | | | |
| J3285 | Treprostinil injection | NI | K | 1701 | | \$ 54.02 | | \$ 10.80 |
| J3301 | Triamcinolone acetonide inj | | N | | | | | |
| J3302 | Triamcinolone diacetate inj | | N | | | | | |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| J3303 | Triamcinolone hexacetonl inj | | N | | | | | |
| J3305 | Inj trimetrexate glucuronate | | K | 7045 | | \$ 146.85 | | \$ 29.37 |
| J3310 | Perphenazine injeciton | | N | | | | | |
| J3315 | Triptorelin pamoate | | K | 9122 | | \$ 372.86 | | \$ 74.57 |
| J3320 | Spectinomycn di-hcl inj | | N | | | | | |
| J3350 | Urea injection | | K | 9051 | 0.6353 | \$ 37.81 | | \$ 7.56 |
| J3355 | Urofollitropin, 75 iu | NI | K | 1741 | | \$ 48.45 | | \$ 9.69 |
| J3360 | Diazepam injection | | N | | | | | |
| J3364 | Urokinase 5000 IU injection | | N | | | | | |
| J3365 | Urokinase 250,000 IU inj | | K | 7036 | | \$ 457.73 | | \$ 91.55 |
| J3370 | Vancomycin hcl injection | | N | | | | | |
| J3395 | Verteporfin injection | | D | | | | | |
| J3396 | Verteporfin injection | | K | 1203 | | \$ 8.96 | | \$ 1.79 |
| J3400 | Triflupromazine hcl inj | | N | | | | | |
| J3410 | Hydroxyzine hcl injection | | N | | | | | |
| J3411 | Thiamine hcl 100 mg | CH | N | | | | | |
| J3415 | Pyridoxine hcl 100 mg | CH | N | | | | | |
| J3420 | Vitamin b12 injection | | N | | | | | |
| J3430 | Vitamin k phytonadione inj | | N | | | | | |
| J3465 | Injection, voriconazole | | K | 1052 | | \$ 4.57 | | \$ 0.91 |
| J3470 | Hyaluronidase injection | CH | K | 1637 | | \$ 50.15 | | \$ 10.03 |
| J3471 | Ovine, up to 999 USP units | NI | K | 1702 | | \$ 129.87 | | \$ 25.97 |
| J3472 | Ovine, 1000 USP units | NI | K | 1703 | | \$ 108.33 | | \$ 21.67 |
| J3475 | Inj magnesium sulfate | | N | | | | | |
| J3480 | Inj potassium chloride | | N | | | | | |
| J3485 | Zidovudine | | N | | | | | |
| J3486 | Ziprasidone mesylate | CH | N | | | | | |
| J3487 | Zoledronic acid | | K | 9115 | | \$ 200.03 | | \$ 40.01 |
| J3490 | Drugs unclassified injection | | N | | | | | |
| J3530 | Nasal vaccine inhalation | CH | N | | | | | |
| J3590 | Unclassified biologics | | N | | | | | |
| J7030 | Normal saline solution infus | | N | | | | | |
| J7040 | Normal saline solution infus | | N | | | | | |
| J7042 | 5% dextrose/normal saline | | N | | | | | |
| J7050 | Normal saline solution infus | | N | | | | | |
| J7051 | Sterile saline/water | CH | D | | | | | |
| J7060 | 5% dextrose/water | | N | | | | | |
| J7070 | D5w infusion | | N | | | | | |
| J7100 | Dextran 40 infusion | | N | | | | | |
| J7110 | Dextran 75 infusion | | N | | | | | |
| J7120 | Ringers lactate infusion | | N | | | | | |
| J7130 | Hypertonic saline solution | | N | | | | | |
| J7188 | Inj Vonwillebrand factor iu | NI | K | 1704 | | \$ 0.87 | | \$ 0.17 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| J7189 | Factor viia | NI | K | 1705 | | \$ 1.02 | | \$ 0.20 |
| J7190 | Factor viii | | K | 0925 | | \$ 0.65 | | \$ 0.13 |
| J7191 | Factor VIII (porcine) | | K | 0926 | | \$ 1.86 | | \$ 0.37 |
| J7192 | Factor viii recombinant | | K | 0927 | | \$ 1.05 | | \$ 0.21 |
| J7193 | Factor IX non-recombinant | | K | 0931 | | \$ 0.87 | | \$ 0.17 |
| J7194 | Factor ix complex | | K | 0928 | | \$ 0.66 | | \$ 0.13 |
| J7195 | Factor IX recombinant | | K | 0932 | | \$ 0.98 | | \$ 0.20 |
| J7197 | Antithrombin iii injection | CH | K | 0930 | | \$ 1.64 | | \$ 0.33 |
| J7198 | Anti-inhibitor | | K | 0929 | | \$ 1.30 | | \$ 0.26 |
| J7308 | Aminolevulinic acid hcl top | | K | 7308 | | \$ 101.87 | | \$ 20.37 |
| J7310 | Ganciclovir long act implant | | K | 0913 | | \$ 4,240.00 | | \$ 848.00 |
| J7317 | Sodium hyaluronate injection | CH | D | | | | | |
| J7318 | Hyaluron/deriv intra-art inj | NI | K | 1706 | | \$ 7.20 | | \$ 1.44 |
| J7320 | Hylan G-F 20 injection | CH | D | | | | | |
| J7340 | Metabolic active D/E tissue | CH | K | 1632 | | \$ 26.91 | | \$ 5.38 |
| J7341 | Non-human, metabolic tissue | NI | K | 1707 | | \$ 1.01 | | \$ 0.20 |
| J7342 | Metabolically active tissue | | K | 9054 | | \$ 15.51 | | \$ 3.10 |
| J7343 | Nonmetabolic act d/e tissue | CH | K | 1629 | | \$ 10.69 | | \$ 2.14 |
| J7344 | Nonmetabolic active tissue | | K | 9156 | | \$ 63.37 | | \$ 12.67 |
| J7350 | Injectable human tissue | | K | 9055 | | \$ 5.35 | | \$ 1.07 |
| J7500 | Azathioprine oral 50mg | | N | | | | | |
| J7501 | Azathioprine parenteral | | K | 0887 | | \$ 49.96 | | \$ 9.99 |
| J7502 | Cyclosporine oral 100 mg | | K | 0888 | | \$ 3.48 | | \$ 0.70 |
| J7504 | Lymphocyte immune globulin | | K | 0890 | | \$ 295.72 | | \$ 59.14 |
| J7505 | Monoclonal antibodies | | K | 7038 | | \$ 864.56 | | \$ 172.91 |
| J7506 | Prednisone oral | | N | | | | | |
| J7507 | Tacrolimus oral per 1 MG | | K | 0891 | | \$ 3.45 | | \$ 0.69 |
| J7509 | Methylprednisolone oral | | N | | | | | |
| J7510 | Prednisolone oral per 5 mg | | N | | | | | |
| J7511 | Antithymocyte globuln rabbit | | K | 9104 | | \$ 312.17 | | \$ 62.43 |
| J7513 | Daclizumab, parenteral | | K | 1612 | | \$ 367.61 | | \$ 73.52 |
| J7515 | Cyclosporine oral 25 mg | CH | K | 7515 | | \$ 0.91 | | \$ 0.18 |
| J7516 | Cyclosporin parenteral 250mg | | N | | | | | |
| J7517 | Mycophenolate mofetil oral | | K | 9015 | | \$ 2.54 | | \$ 0.51 |
| J7518 | Mycophenolic acid | | G | 9219 | | \$ 2.16 | | \$ 0.43 |
| J7520 | Sirolimus, oral | | K | 9020 | | \$ 6.83 | | \$ 1.37 |
| J7525 | Tacrolimus injection | CH | K | 9006 | | \$ 136.86 | | \$ 27.37 |
| J7599 | Immunosuppressive drug noc | | N | | | | | |
| J7616 | Albuterol compound solution | | D | | | | | |
| J7617 | Levalbuterol compounded sol | | D | | | | | |
| J7674 | Methacholine chloride, neb | CH | N | | | | | |
| J7799 | Non-inhalation drug for DME | CH | N | | | | | |
| J8501 | Oral aprepitant | | G | 0868 | | \$ 4.64 | | \$ 0.93 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| J8510 | Oral busulfan | | K | 7015 | | \$ 1.96 | | \$ 0.39 |
| J8520 | Capecitabine, oral, 150 mg | | K | 7042 | | \$ 3.51 | | \$ 0.70 |
| J8530 | Cyclophosphamide oral 25 MG | | N | | | | | |
| J8540 | Oral dexamethasone | NI | K | 1708 | | \$ 0.22 | | \$ 0.04 |
| J8560 | Etoposide oral 50 MG | | K | 0802 | | \$ 37.17 | | \$ 7.43 |
| J8597 | Antiemetic drug oral NOS | NI | N | | | | | |
| J8600 | Melphalan oral 2 MG | | N | | | | | |
| J8610 | Methotrexate oral 2.5 MG | | N | | | | | |
| J8700 | Temozolomide | | K | 1086 | | \$ 7.22 | | \$ 1.44 |
| J9000 | Doxorubic hcl 10 MG vl chemo | CH | N | | | | | |
| J9001 | Doxorubicin hcl liposome inj | | K | 7046 | | \$ 364.53 | | \$ 72.91 |
| J9010 | Alemtuzumab injection | | K | 9110 | | \$ 511.52 | | \$ 102.30 |
| J9015 | Aldesleukin/single use vial | | K | 0807 | | \$ 724.63 | | \$ 144.93 |
| J9017 | Arsenic trioxide | | K | 9012 | | \$ 33.25 | | \$ 6.65 |
| J9020 | Asparaginase injection | | K | 0814 | | \$ 54.17 | | \$ 10.83 |
| J9025 | Azacitidine injection | NI | K | 1709 | | \$ 4.04 | | \$ 0.81 |
| J9027 | Clofarabine injection | NI | G | 1710 | | \$ 116.87 | | \$ 23.37 |
| J9031 | Bcg live intravesical vac | | K | 0809 | | \$ 115.78 | | \$ 23.16 |
| J9035 | Bevacizumab injection | | G | 9214 | | \$ 57.11 | | \$ 11.42 |
| J9040 | Bleomycin sulfate injection | | K | 0857 | | \$ 48.71 | | \$ 9.74 |
| J9041 | Bortezomib injection | CH | K | 9207 | | \$ 29.02 | | \$ 5.80 |
| J9045 | Carboplatin injection | | K | 0811 | | \$ 35.25 | | \$ 7.05 |
| J9050 | Carmus bischl nitro inj | | K | 0812 | | \$ 139.14 | | \$ 27.83 |
| J9055 | Cetuximab injection | | G | 9215 | | \$ 49.76 | | \$ 9.95 |
| J9060 | Cisplatin 10 MG injection | CH | N | | | | | |
| J9065 | Inj cladribine per 1 MG | | K | 0858 | | \$ 37.94 | | \$ 7.59 |
| J9070 | Cyclophosphamide 100 MG inj | CH | N | | | | | |
| J9093 | Cyclophosphamide lyophilized | CH | N | | | | | |
| J9098 | Cytarabine liposome | CH | K | 1166 | | \$ 382.72 | | \$ 76.54 |
| J9100 | Cytarabine hcl 100 MG inj | CH | N | | | | | |
| J9120 | Dactinomycin actinomycin d | | N | | | | | |
| J9130 | Dacarbazine 100 mg inj | | K | 0819 | | \$ 5.20 | | \$ 1.04 |
| J9150 | Daunorubicin | | K | 0820 | | \$ 23.90 | | \$ 4.78 |
| J9151 | Daunorubicin citrate liposom | | K | 0821 | | \$ 56.51 | | \$ 11.30 |
| J9160 | Denileukin diftotox, 300 mcg | | K | 1084 | | \$ 1,252.93 | | \$ 250.59 |
| J9165 | Diethylstilbestrol injection | CH | N | | | | | |
| J9170 | Docetaxel | | K | 0823 | | \$ 293.64 | | \$ 58.73 |
| J9175 | Elliotts b solution per ml | NI | N | | | | | |
| J9178 | Inj, epirubicin hcl, 2 mg | | K | 1167 | | \$ 24.76 | | \$ 4.95 |
| J9181 | Etoposide 10 MG inj | CH | N | | | | | |
| J9185 | Fludarabine phosphate inj | | K | 0842 | | \$ 262.87 | | \$ 52.57 |
| J9190 | Fluorouracil injection | | N | | | | | |
| J9200 | Floxuridine injection | | K | 0827 | | \$ 60.41 | | \$ 12.08 |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| J9201 | Gemcitabine HCl | | K | 0828 | | \$ 115.89 | | \$ 23.18 |
| J9202 | Goserelin acetate implant | | K | 0810 | | \$ 175.04 | | \$ 35.01 |
| J9206 | Irinotecan injection | | K | 0830 | | \$ 126.92 | | \$ 25.38 |
| J9208 | Ifosfomide injection | | K | 0831 | | \$ 34.68 | | \$ 6.94 |
| J9209 | Mesna injection | | K | 0732 | | \$ 10.55 | | \$ 2.11 |
| J9211 | Idarubicin hcl injection | | K | 0832 | | \$ 286.84 | | \$ 57.37 |
| J9212 | Interferon alfacon-1 | CH | K | 0912 | | \$ 3.92 | | \$ 0.78 |
| J9213 | Interferon alfa-2a inj | | K | 0834 | | \$ 32.87 | | \$ 6.57 |
| J9214 | Interferon alfa-2b inj | | K | 0836 | | \$ 13.30 | | \$ 2.66 |
| J9215 | Interferon alfa-n3 inj | | K | 0865 | | \$ 8.60 | | \$ 1.72 |
| J9216 | Interferon gamma 1-b inj | | K | 0838 | | \$ 272.44 | | \$ 54.49 |
| J9217 | Leuprolide acetate suspnsion | | K | 9217 | | \$ 224.42 | | \$ 44.88 |
| J9218 | Leuprolide acetate injeciton | | K | 0861 | | \$ 10.00 | | \$ 2.00 |
| J9219 | Leuprolide acetate implant | | K | 7051 | | \$ 2,371.75 | | \$ 474.35 |
| J9225 | Histrelin implant | NI | K | 1711 | | \$ 5,000.00 | | \$ 1,000.00 |
| J9230 | Mechlorethamine hcl inj | | N | | | | | |
| J9245 | Inj melphalan hydrochl 50 MG | | K | 0840 | | \$ 753.64 | | \$ 150.73 |
| J9250 | Methotrexate sodium inj | | N | | | | | |
| J9263 | Oxaliplatin | CH | K | 1738 | | \$ 8.53 | | \$ 1.71 |
| J9264 | Paclitaxel injection | NI | G | 1712 | | \$ 8.32 | | \$ 1.66 |
| J9265 | Paclitaxel injection | | K | 0863 | | \$ 13.33 | | \$ 2.67 |
| J9266 | Pegaspargase/singl dose vial | | K | 0843 | | \$ 1,611.20 | | \$ 322.24 |
| J9268 | Pentostatin injection | | K | 0844 | | \$ 1,900.52 | | \$ 380.10 |
| J9270 | Plicamycin (mithramycin) inj | | K | 0860 | 1.0311 | \$ 61.36 | | \$ 12.27 |
| J9280 | Mitomycin 5 MG inj | | K | 0862 | | \$ 22.29 | | \$ 4.46 |
| J9293 | Mitoxantrone hydrochl / 5 MG | | K | 0864 | | \$ 323.80 | | \$ 64.76 |
| J9300 | Gemtuzumab ozogamicin | | K | 9004 | | \$ 2,248.15 | | \$ 449.63 |
| J9305 | Pemetrexed injection | | G | 9213 | | \$ 40.67 | | \$ 8.13 |
| J9310 | Rituximab cancer treatment | | K | 0849 | | \$ 455.92 | | \$ 91.18 |
| J9320 | Streptozocin injection | CH | K | 0850 | | \$ 154.68 | | \$ 30.94 |
| J9340 | Thiotepa injection | | K | 0851 | | \$ 47.96 | | \$ 9.59 |
| J9350 | Topotecan | | K | 0852 | | \$ 763.80 | | \$ 152.76 |
| J9355 | Trastuzumab | | K | 1613 | | \$ 54.39 | | \$ 10.88 |
| J9357 | Valrubicin, 200 mg | CH | K | 9167 | | \$ 369.60 | | \$ 73.92 |
| J9360 | Vinblastine sulfate inj | | N | | | | | |
| J9370 | Vincristine sulfate 1 MG inj | | N | | | | | |
| J9390 | Vinorelbine tartrate/10 mg | | K | 0855 | | \$ 42.83 | | \$ 8.57 |
| J9395 | Injection, Fulvestrant | | K | 9120 | | \$ 81.33 | | \$ 16.27 |
| J9600 | Porfimer sodium | | K | 0856 | | \$ 2,464.57 | | \$ 492.91 |
| J9999 | Chemotherapy drug | | N | | | | | |
| K0064 | Zero pressure tube flat free | | D | | | | | |
| K0066 | Solid tire any size each | | D | | | | | |
| K0067 | Pneumatic tire any size each | | D | | | | | |

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|---------------|------------------------------|----|----|-----|--------------------|-----------------|-------------------------------------|------------------------------------|
| K0068 | Pneumatic tire tube each | | D | | | | | |
| K0074 | Pneumatic caster tire each | | D | | | | | |
| K0075 | Semi-pneumatic caster tire | | D | | | | | |
| K0076 | Solid caster tire each | | D | | | | | |
| K0078 | Pneumatic caster tire tube | | D | | | | | |
| K0102 | Crutch and cane holder | | D | | | | | |
| K0104 | Cylinder tank carrier | | D | | | | | |
| K0105 | Iv hanger | | D | | | | | |
| K0106 | Arm trough each | | D | | | | | |
| K0415 | RX antiemetic drg, oral NOS | | D | | | | | |
| K0416 | Rx antiemetic drg,rectal NOS | | D | | | | | |
| K0452 | Wheelchair bearings | | D | | | | | |
| K0600 | Functional neuromuscularstim | | D | | | | | |
| K0618 | TLSO 2 piece rigid shell | | D | | | | | |
| K0619 | TLSO 3 piece rigid shell | | D | | | | | |
| K0620 | Tubular elastic dressing | | D | | | | | |
| K0627 | Cervical pneum trac equip | | D | | | | | |
| K0628 | Multi den insert direct form | | D | | | | | |
| K0629 | Multi den insert custom mold | | D | | | | | |
| K0630 | SIO flex pelvisacral prefab | | D | | | | | |
| K0631 | SIO flex pelvisacral custom | | D | | | | | |
| K0632 | SIO panel prefab | | D | | | | | |
| K0633 | SIO panel custom | | D | | | | | |
| K0634 | LO flexibl L1-below L5 pre | | D | | | | | |
| K0635 | LO sag stays/panels pre-fab | | D | | | | | |
| K0636 | LO sagitt rigid panel prefab | | D | | | | | |
| K0637 | LO flex w/o rigid stays pre | | D | | | | | |
| K0638 | LSO flex w/rigid stays cust | | D | | | | | |
| K0639 | LSO post rigid panel pre | | D | | | | | |
| K0640 | LSO sag-coro rigid frame pre | | D | | | | | |
| K0641 | LSO sag-cor rigid frame cust | | D | | | | | |
| K0642 | LSO flexion control prefab | | D | | | | | |
| K0643 | LSO flexion control custom | | D | | | | | |
| K0644 | LSO sagit rigid panel prefab | | D | | | | | |
| K0645 | LSO sagittal rigid panel cus | | D | | | | | |
| K0646 | LSO sag-coronal panel prefab | | D | | | | | |
| K0647 | LSO sag-coronal panel custom | | D | | | | | |
| K0648 | LSO s/c shell/panel prefab | | D | | | | | |
| K0649 | LSO s/c shell/panel custom | | D | | | | | |
| K0650 | Gen w/c cushion width < 22" | | D | | | | | |
| K0651 | Gen w/c cushion width > 22" | | D | | | | | |
| K0652 | Skin pro w/c cus wd < 22" | | D | | | | | |
| K0653 | Skin protect w/c cus wd>=22" | | D | | | | | |

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|---------------|------------------------------|----|----|-----|--------------------|-----------------|-------------------------------------|------------------------------------|
| K0654 | Position w/c cush width <22" | | D | | | | | |
| K0655 | Position w/c cush width >22" | | D | | | | | |
| K0656 | Skin pro/pos w/c cus wd <22" | | D | | | | | |
| K0657 | Skin pro/pos w/c cus wd>=22" | | D | | | | | |
| K0658 | Custom fabricate w/c cushion | | D | | | | | |
| K0659 | Powered w/c cushion | | D | | | | | |
| K0660 | Gen use back cush width <22" | | D | | | | | |
| K0661 | Gen use back cush width >22" | | D | | | | | |
| K0662 | Position back cush wdth <22" | | D | | | | | |
| K0663 | Position back cush wdth >22" | | D | | | | | |
| K0664 | Pos back post/lat width <22" | | D | | | | | |
| K0665 | Pos back post/lat width >22" | | D | | | | | |
| K0666 | Custom fab w/c back cushion | | D | | | | | |
| K0667 | Mt hardwre man/light pwr w/c | | D | | | | | |
| K0668 | Replace cover w/c seat cush | | D | | | | | |
| K0670 | Stance phase only | | D | | | | | |
| K0671 | Portable oxygen concentrator | | D | | | | | |
| K0731 | Lith ion bat CID non-ear lvl | | D | | | | | |
| K0732 | Lith ion batt CID ear level | | D | | | | | |
| L0476 | TLSO flexion compres jac pre | | D | | | | | |
| L0478 | TLSO flexion compres jac cus | | D | | | | | |
| L0500 | Lso flex surgical support | | D | | | | | |
| L0510 | Lso flexible custom fabricat | | D | | | | | |
| L0515 | Lso flex elas w/ rig post pa | | D | | | | | |
| L0520 | Lso a-p-l control with apron | | D | | | | | |
| L0530 | Lso ant-pos control w apron | | D | | | | | |
| L0540 | Lso lumbar flexion a-p-l | | D | | | | | |
| L0550 | Lso a-p-l control molded | | D | | | | | |
| L0560 | Lso a-p-l w interface | | D | | | | | |
| L0561 | Prefab lso | | D | | | | | |
| L0565 | Lso a-p-l control custom | | D | | | | | |
| L0600 | Sacroiliac flex surg support | | D | | | | | |
| L0610 | Sacroiliac flexible custm fa | | D | | | | | |
| L0620 | Sacroiliac semi-rig w apron | | D | | | | | |
| L0860 | Magnetic resonanc image comp | | D | | | | | |
| L1750 | Legg perthes sling | | D | | | | | |
| L2034 | KAFO pla sin up w/wo k/a cus | NI | | | | | | |
| L2039 | KAFO,plstic,medlat rotat con | | D | | | | | |
| L2387 | Add LE poly knee custom KAFO | NI | | | | | | |
| L2435 | Knee joint polycentric joint | | D | | | | | |
| L3963 | Molded w/ articulating elbow | | D | | | | | |
| L5674 | Bk suspension sleeve | | D | | | | | |
| L5675 | Bk heavy duty susp sleeve | | D | | | | | |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| L5846 | Knee-shin sys microprocessor | | D | | | | | |
| L5847 | Microprocessor cntrl feature | | D | | | | | |
| L5989 | Pylon w elctrc force sensor | | D | | | | | |
| L8100 | Compression stocking BK18-30 | | D | | | | | |
| L8110 | Compression stocking BK30-40 | | D | | | | | |
| L8120 | Compression stocking BK40-50 | | D | | | | | |
| L8130 | Gc stocking thighlngh 18-30 | | D | | | | | |
| L8140 | Gc stocking thighlngh 30-40 | | D | | | | | |
| L8150 | Gc stocking thighlngh 40-50 | | D | | | | | |
| L8160 | Gc stocking full lngth 18-30 | | D | | | | | |
| L8170 | Gc stocking full lngth 30-40 | | D | | | | | |
| L8180 | Gc stocking full lngth 40-50 | | D | | | | | |
| L8190 | Gc stocking waistlngh 18-30 | | D | | | | | |
| L8195 | Gc stocking waistlngh 30-40 | | D | | | | | |
| L8200 | Gc stocking waistlngh 40-50 | | D | | | | | |
| L8210 | Gc stocking custom made | | D | | | | | |
| L8220 | Gc stocking lymphedema | | D | | | | | |
| L8230 | Gc stocking garter belt | | D | | | | | |
| L8239 | G compression stocking NOS | | D | | | | | |
| L8490 | Air seal suction reten systm | | D | | | | | |
| L8600 | Implant breast silicone/eq | | N | | | | | |
| L8603 | Collagen imp urinary 2.5 ml | | N | | | | | |
| L8606 | Synthetic implnt urinary 1ml | | N | | | | | |
| L8609 | Artificial cornea | NI | N | | | | | |
| L8610 | Ocular implant | | N | | | | | |
| L8612 | Aqueous shunt prosthesis | | N | | | | | |
| L8613 | Ossicular implant | | N | | | | | |
| L8614 | Cochlear device/system | | N | | | | | |
| L8620 | Repl lithium ion battery | | D | | | | | |
| L8630 | Metacarpophalangeal implant | | N | | | | | |
| L8631 | MCP joint repl 2 pc or more | | N | | | | | |
| L8641 | Metatarsal joint implant | | N | | | | | |
| L8642 | Hallux implant | | N | | | | | |
| L8658 | Interphalangeal joint spacer | | N | | | | | |
| L8659 | Interphalangeal joint repl | | N | | | | | |
| L8670 | Vascular graft, synthetic | | N | | | | | |
| L8682 | Implt neurostim radiofq rec | NI | N | | | | | |
| L8699 | Prosthetic implant NOS | | N | | | | | |
| M0064 | Visit for drug monitoring | | X | 0374 | 1.1270 | \$ 67.07 | | \$ 13.41 |
| P9010 | Whole blood for transfusion | | K | 0950 | 1.9835 | \$ 118.04 | | \$ 23.61 |
| P9011 | Blood split unit | | K | 0967 | 1.3878 | \$ 82.59 | | \$ 16.52 |
| P9012 | Cryoprecipitate each unit | | K | 0952 | 0.7923 | \$ 47.15 | | \$ 9.43 |
| P9016 | RBC leukocytes reduced | | K | 0954 | 2.7446 | \$ 163.33 | | \$ 32.67 |

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|---------------|-----------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| P9017 | Plasma 1 donor frz w/in 8 hr | | K | 9508 | 1.1842 | \$ 70.47 | | \$ 14.09 |
| P9019 | Platelets, each unit | | K | 0957 | 0.8663 | \$ 51.55 | | \$ 10.31 |
| P9020 | Plaelet rich plasma unit | | K | 0958 | 4.6668 | \$ 277.73 | | \$ 55.55 |
| P9021 | Red blood cells unit | | K | 0959 | 2.0435 | \$ 121.61 | | \$ 24.32 |
| P9022 | Washed red blood cells unit | | K | 0960 | 3.1830 | \$ 189.42 | | \$ 37.88 |
| P9023 | Frozen plasma, pooled, sd | | K | 0949 | 1.2810 | \$ 76.23 | | \$ 15.25 |
| P9031 | Platelets leukocytes reduced | | K | 1013 | 1.6536 | \$ 98.41 | | \$ 19.68 |
| P9032 | Platelets, irradiated | | K | 9500 | 1.4559 | \$ 86.64 | | \$ 17.33 |
| P9033 | Platelets leukoreduced irradiated | | K | 0968 | 2.5330 | \$ 150.74 | | \$ 30.15 |
| P9034 | Platelets, pheresis | | K | 9507 | 7.3009 | \$ 434.48 | | \$ 86.90 |
| P9035 | Platelet pheres leukoreduced | | K | 9501 | 8.2952 | \$ 493.66 | | \$ 98.73 |
| P9036 | Platelet pheresis irradiated | | K | 9502 | 5.4817 | \$ 326.22 | | \$ 65.24 |
| P9037 | Plate pheres leukoredu irradiated | | K | 1019 | 9.7736 | \$ 581.64 | | \$ 116.33 |
| P9038 | RBC irradiated | | K | 9505 | 2.4807 | \$ 147.63 | | \$ 29.53 |
| P9039 | RBC deglycerolized | | K | 9504 | 5.7773 | \$ 343.81 | | \$ 68.76 |
| P9040 | RBC leukoreduced irradiated | | K | 0969 | 3.6678 | \$ 218.27 | | \$ 43.65 |
| P9041 | Albumin (human),5%, 50ml | | K | 0961 | 0.4987 | \$ 29.68 | | \$ 5.94 |
| P9043 | Plasma protein fract,5%,50ml | | K | 0956 | 1.1429 | \$ 68.02 | | \$ 13.60 |
| P9044 | Cryoprecipitatereducedplasma | | K | 1009 | 1.2536 | \$ 74.60 | | \$ 14.92 |
| P9045 | Albumin (human), 5%, 250 ml | | K | 0963 | 1.2907 | \$ 76.81 | | \$ 15.36 |
| P9046 | Albumin (human), 25%, 20 ml | | K | 0964 | 0.4839 | \$ 28.80 | | \$ 5.76 |
| P9047 | Albumin (human), 25%, 50ml | | K | 0965 | 1.0966 | \$ 65.26 | | \$ 13.05 |
| P9048 | Plasmaprotein fract,5%,250ml | | K | 0966 | 5.3107 | \$ 316.05 | | \$ 63.21 |
| P9050 | Granulocytes, pheresis unit | | K | 9506 | 16.7317 | \$ 995.72 | | \$ 199.14 |
| P9051 | Blood, l/r, cmv-neg | | K | 1010 | 3.4943 | \$ 207.95 | | \$ 41.59 |
| P9052 | Platelets, hla-m, l/r, unit | | K | 1011 | 10.2526 | \$ 610.14 | | \$ 122.03 |
| P9053 | Plt, pher, l/r cmv-neg, irr | | K | 1020 | 11.0037 | \$ 654.84 | | \$ 130.97 |
| P9054 | Blood, l/r, froz/degly/wash | | K | 1016 | 4.4061 | \$ 262.21 | | \$ 52.44 |
| P9055 | Plt, aph/pher, l/r, cmv-neg | | K | 1017 | 8.8483 | \$ 526.57 | | \$ 105.31 |
| P9056 | Blood, l/r, irradiated | | K | 1018 | 3.0005 | \$ 178.56 | | \$ 35.71 |
| P9057 | RBC, frz/deg/wsh, l/r, irradiated | | K | 1021 | 5.8125 | \$ 345.91 | | \$ 69.18 |
| P9058 | RBC, l/r, cmv-neg, irradiated | | K | 1022 | 4.4896 | \$ 267.18 | | \$ 53.44 |
| P9059 | Plasma, frz between 8-24hour | | K | 0955 | 1.2566 | \$ 74.78 | | \$ 14.96 |
| P9060 | Fr frz plasma donor retested | | K | 9503 | 1.5934 | \$ 94.82 | | \$ 18.96 |
| P9612 | Catheterize for urine spec | | N | | | | | |
| P9615 | Urine specimen collect mult | | N | | | | | |
| Q0035 | Cardiokymography | | X | 0100 | 2.4833 | \$ 147.78 | \$ 41.44 | \$ 29.56 |
| Q0091 | Obtaining screen pap smear | | T | 0191 | 0.1702 | \$ 10.13 | \$ 2.85 | \$ 2.03 |
| Q0092 | Set up port xray equipment | | N | | | | | |
| Q0136 | Non esrd epoetin alpha inj | CH | D | | | | | |
| Q0137 | Darbepoetin alfa, non esrd | CH | D | | | | | |
| Q0163 | Diphenhydramine HCl 50mg | | N | | | | | |
| Q0164 | Prochlorperazine maleate 5mg | | N | | | | | |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|-------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| Q0166 | Granisetron HCl 1 mg oral | | K | 0765 | | \$ 35.13 | | \$ 7.03 |
| Q0167 | Dronabinol 2.5mg oral | | N | | | | | |
| Q0169 | Promethazine HCl 12.5mg oral | | N | | | | | |
| Q0171 | Chlorpromazine HCl 10mg oral | | N | | | | | |
| Q0173 | Trimethobenzamide HCl 250mg | | N | | | | | |
| Q0174 | Thiethylperazine maleate 10mg | | N | | | | | |
| Q0175 | Perphenazine 4mg oral | | N | | | | | |
| Q0177 | Hydroxyzine pamoate 25mg | | N | | | | | |
| Q0179 | Ondansetron HCl 8mg oral | | K | 0769 | | \$ 32.77 | | \$ 6.55 |
| Q0180 | Dolasetron mesylate oral | | K | 0763 | | \$ 48.24 | | \$ 9.65 |
| Q0182 | Nonmetabolic act d/e tissue | | D | | | | | |
| Q0183 | Nonmetabolic active tissue | | D | | | | | |
| Q0187 | Factor viia recombinant | CH | D | | | | | |
| Q0515 | Sermorelin acetate injection | NI | N | | | | | |
| Q1001 | Ntiol category 1 | CH | D | | | | | |
| Q1002 | Ntiol category 2 | CH | D | | | | | |
| Q1003 | Ntiol category 3 | | N | | | | | |
| Q1004 | Ntiol category 4 | | N | | | | | |
| Q1005 | Ntiol category 5 | | N | | | | | |
| Q2001 | Oral cabergoline 0.5 mg | | D | | | | | |
| Q2002 | Elliotts b solution per ml | CH | D | | | | | |
| Q2003 | Aprotinin, 10,000 kiu | CH | D | | | | | |
| Q2004 | Bladder calculi irrig sol | | N | | | | | |
| Q2005 | Corticoreslin ovine triflutat | CH | D | | | | | |
| Q2006 | Digoxin immune fab (ovine) | CH | D | | | | | |
| Q2007 | Ethanolamine oleate 100 mg | CH | D | | | | | |
| Q2008 | Fomepizole, 15 mg | CH | D | | | | | |
| Q2009 | Fosphenytoin, 50 mg | | K | 7028 | | \$ 5.32 | | \$ 1.06 |
| Q2011 | Hemin, per 1 mg | CH | D | | | | | |
| Q2012 | Pegademase bovine, 25 iu | CH | D | | | | | |
| Q2013 | Pentastarch 10% solution | CH | D | | | | | |
| Q2014 | Sermorelin acetate, 0.5 mg | CH | D | | | | | |
| Q2017 | Teniposide, 50 mg | | K | 7035 | | \$ 264.05 | | \$ 52.81 |
| Q2018 | Urofollitropin, 75 iu | CH | D | | | | | |
| Q2019 | Basiliximab | CH | D | | | | | |
| Q2020 | Histrelin acetate | CH | D | | | | | |
| Q2021 | Lepirudin | CH | D | | | | | |
| Q2022 | VonWillebrandFactrCmplxperIU | CH | D | | | | | |
| Q3000 | Rubidium-Rb-82 | CH | D | | | | | |
| Q3002 | Gallium ga 67 | CH | D | | | | | |
| Q3003 | Technetium tc99m biccisate | CH | D | | | | | |
| Q3004 | Xenon xe 133 | CH | D | | | | | |
| Q3005 | Technetium tc99m mertiatide | CH | D | | | | | |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|-------------------------------|----|----|------|--------------------|-----------------|-------------------------------------|------------------------------------|
| Q3006 | Technetium tc99m gluceptate | CH | D | | | | | |
| Q3007 | Sodium phosphate p32 | CH | D | | | | | |
| Q3008 | Indium 111-in pentetreotide | CH | D | | | | | |
| Q3009 | Technetium tc99m oxidronate | CH | D | | | | | |
| Q3010 | Technetium tc99mlabeledrbc | CH | D | | | | | |
| Q3011 | Chromic phosphate p32 | CH | D | | | | | |
| Q3012 | Cyanocobalamin cobalt co57 | CH | D | | | | | |
| Q3025 | IM inj interferon beta 1-a | | K | 9022 | | \$ 93.07 | | \$ 18.61 |
| Q3031 | Collagen skin test | | N | | | | | |
| Q4054 | Darbepoetin alfa, esrd use | | D | | | | | |
| Q4055 | Epoetin alfa, esrd use | | D | | | | | |
| Q4075 | Acyclovir, 5 mg | CH | D | | | | | |
| Q4076 | Dopamine hcl, 40 mg | CH | D | | | | | |
| Q4077 | Treprostinil, 1 mg | CH | D | | | | | |
| Q4079 | Injection, Natalizumab, 1 MG | NF | G | 9126 | | \$ 6.39 | | \$ 1.28 |
| Q9941 | IVIG lyophil 1g | CH | D | | | | | |
| Q9942 | IVIG lyophil 10 mg | CH | D | | | | | |
| Q9943 | IVIG non-lyophil 1g | CH | D | | | | | |
| Q9944 | IVIG non-lyophil 10 mg | CH | D | | | | | |
| Q9945 | LOCM <=149 mg/ml iodine, 1ml | CH | K | 9157 | | \$ 0.24 | | \$ 0.05 |
| Q9946 | LOCM <=149 mg/ml iodine, 1ml | CH | K | 9158 | | \$ 1.79 | | \$ 0.36 |
| Q9947 | LOCM 200-249mg/ml iodine, 1ml | CH | K | 9159 | | \$ 1.30 | | \$ 0.26 |
| Q9948 | LOCM 250-299mg/ml iodine, 1ml | CH | K | 9160 | | \$ 0.30 | | \$ 0.06 |
| Q9949 | LOCM 300-349mg/ml iodine, 1ml | CH | K | 9161 | | \$ 0.34 | | \$ 0.07 |
| Q9950 | LOCM 350-399mg/ml iodine, 1ml | CH | K | 9162 | | \$ 0.23 | | \$ 0.05 |
| Q9951 | LOCM >= 400 mg/ml iodine, 1ml | CH | K | 9163 | | \$ 0.19 | | \$ 0.04 |
| Q9952 | Inj Gad-base MR contrast, ml | CH | K | 9164 | | \$ 2.93 | | \$ 0.59 |
| Q9953 | Inj Fe-based MR contrast, ml | CH | K | 1713 | | \$ 30.41 | | \$ 6.08 |
| Q9954 | Oral MR contrast, 100 ml | CH | K | 9165 | | \$ 8.97 | | \$ 1.79 |
| Q9955 | Inj perflexane lip micros,ml | CH | K | 9203 | | \$ 13.25 | | \$ 2.65 |
| Q9956 | Inj octafluoropropane mic,ml | CH | K | 9202 | | \$ 41.43 | | \$ 8.29 |
| Q9957 | Inj perflutren lip micros,ml | CH | K | 9112 | | \$ 61.88 | | \$ 12.38 |
| Q9958 | HOCM <=149 mg/ml iodine, 1ml | CH | K | 1714 | | \$ 0.06 | | \$ 0.01 |
| Q9959 | HOCM 150-199mg/ml iodine, 1ml | CH | N | | | | | |
| Q9960 | HOCM 200-249mg/ml iodine, 1ml | CH | K | 1715 | | \$ 0.09 | | \$ 0.02 |
| Q9961 | HOCM 250-299mg/ml iodine, 1ml | CH | K | 1734 | | \$ 0.15 | | \$ 0.03 |
| Q9962 | HOCM 300-349mg/ml iodine, 1ml | CH | K | 1735 | | \$ 0.14 | | \$ 0.03 |
| Q9963 | HOCM 350-399mg/ml iodine, 1ml | CH | K | 1736 | | \$ 0.38 | | \$ 0.08 |
| Q9964 | HOCM >= 400 mg/ml iodine, 1ml | CH | K | 1737 | | \$ 0.20 | | \$ 0.04 |
| V2630 | Anter chamber intraocul lens | | N | | | | | |
| V2631 | Iris support intraoculr lens | | N | | | | | |
| V2632 | Post chmbr intraocular lens | | N | | | | | |
| V2785 | Corneal tissue processing | | F | | | | | |

| CPT/ HCPCS | Description | CI | SI | APC | Relative weight | Payment rate | National unadjusted copayment | Minimum unadjusted copayment |
|---------------|-------------------|----|----|-----|--------------------|-----------------|-------------------------------------|------------------------------------|
| V2790 | Amniotic membrane | | N | | | | | |

**Addendum D1.—Payment Status Indicators for the
Hospital Outpatient Prospective Payment System**

| Indicator | Item/Code/Service | OPPS Payment Status |
|-----------|--|--|
| A | Services furnished to a hospital outpatient that are paid under a fee schedule or payment system other than OPSS, for example: | Not paid under OPSS. Paid by fiscal intermediaries under a fee schedule or payment system other than OPSS. |
| | • Ambulance Services | |
| | • Clinical Diagnostic Laboratory Services | |
| | • Non-Implantable Prosthetic and Orthotic Devices | |
| | • EPO for ESRD Patients | |
| | • Physical, Occupational, and Speech Therapy | |
| | • Routine Dialysis Services for ESRD Patients Provided in a Certified Dialysis Unit of a Hospital | |
| | • Diagnostic Mammography | |
| | • Screening Mammography | |
| B | Codes that are not recognized by OPSS when submitted on an outpatient hospital Part B bill type (12x, 13x, and 14x). | Not paid under OPSS. |
| | | <ul style="list-style-type: none"> • May be paid by intermediaries when submitted on a different bill type, for example, 75x (CORF), but not paid under OPSS. • An alternate code that is recognized by OPSS when submitted on an outpatient hospital Part B bill type (12x, 13x, and 14x) may be available. |

| Indicator | Item/Code/Service | OPPS Payment Status |
|-----------|---|---|
| C | Inpatient Procedures | Not paid under OPSS. Admit patient. Bill as inpatient. |
| D | Discontinued Codes | Not paid under OPSS. |
| E | Items, Codes, and Services: <ul style="list-style-type: none"> <li data-bbox="464 359 800 470">● That are not covered by Medicare based on statutory exclusion. <li data-bbox="464 470 800 581">● That are not covered by Medicare for reasons other than statutory exclusion. <li data-bbox="464 581 800 751">● That are not recognized by Medicare but for which an alternate code for the same item or service may be available. <li data-bbox="464 751 800 852">● For which separate payment is not provided by Medicare. | Not paid under OPSS. |
| F | Corneal Tissue Acquisition; Certain CRNA Services and Hepatitis B Vaccines | Not paid under OPSS. Paid at reasonable cost. |
| G | Pass-Through Drugs and Biologicals | Paid under OPSS; Separate APC payment includes pass-through amount. |
| H | (1) Pass-Through Device Categories | (1) Separate cost-based pass-through payment; Not subject to coinsurance. |
| | (2) Brachytherapy Sources | (2) Separate cost-based non-pass-through payment. |
| | (3) Radiopharmaceutical Agents | (3) Separate cost-based non-pass-through payment. |
| K | Non-Pass-Through Drugs and Biologicals | Paid under OPSS; Separate APC payment. |
| L | Influenza Vaccine; Pneumococcal Pneumonia Vaccine | Not paid under OPSS. Paid at reasonable cost; Not subject to deductible or coinsurance. |
| M | Items and Services Not Billable to the Fiscal Intermediary | Not paid under OPSS. |

| Indicator | Item/Code/Service | OPPS Payment Status |
|-----------|--|--|
| N | Items and Services Packaged into APC Rates | Paid under OPPS; Payment is packaged into payment for other services, including outliers. Therefore, there is no separate APC payment. |
| P | Partial Hospitalization | Paid under OPPS; Per diem APC payment. |
| Q | Packaged Services Subject to Separate Payment Under OPPS Payment Criteria. | Paid under OPPS; Addendum B displays APC assignments when services are separately payable. |
| | | (1) Separate APC payment based on OPPS payment criteria. |
| | | (2) If criteria are not met, payment is packaged into payment for other services, including outliers. Therefore, there is no separate APC payment. |
| S | Significant Procedure, Not Discounted when Multiple | Paid under OPPS; Separate APC payment. |
| T | Significant Procedure, Multiple Reduction Applies | Paid under OPPS; Separate APC payment. |
| V | Clinic or Emergency Department Visit | Paid under OPPS; Separate APC payment. |
| Y | Non-Implantable Durable Medical Equipment | Not paid under OPPS. All institutional providers other than home health agencies bill to DMERC. |
| X | Ancillary Services | Paid under OPPS; Separate APC payment. |

Addendum D2.--Comment Indicators

| Comment Indicator | Descriptor |
|--------------------------|--|
| NF | New code, final APC assignment; Comments were accepted on a proposed APC assignment in the Proposed Rule; APC assignment is no longer open to comment. |
| NI | New code, interim APC assignment; Comments will be accepted on the interim APC assignment for the new code. |
| CH | Active HCPCS codes in current year and next calendar year; status indicator and/or APC assignment have changed. |

Addendum E.—CPT Codes That Are Paid Only As Inpatient Procedures

| CPT/ HCPCS | CY 2006 Final Status Indicator | Description |
|-------------------|---------------------------------------|-------------------------------|
| 00176 | C | Anesth, pharyngeal surgery |
| 00192 | C | Anesth, facial bone surgery |
| 00214 | C | Anesth, skull drainage |
| 00215 | C | Anesth, skull repair/fract |
| 00404 | C | Anesth, surgery of breast |
| 00406 | C | Anesth, surgery of breast |
| 00452 | C | Anesth, surgery of shoulder |
| 00474 | C | Anesth, surgery of rib(s) |
| 00524 | C | Anesth, chest drainage |
| 00540 | C | Anesth, chest surgery |
| 00542 | C | Anesth, release of lung |
| 00546 | C | Anesth, lung,chest wall surg |
| 00560 | C | Anesth, heart surg w/o pump |
| 00561 | C | Anesth, heart surg < age 1 |
| 00562 | C | Anesth, heart surg w/pump |
| 00580 | C | Anesth, heart/lung transplant |
| 00604 | C | Anesth, sitting procedure |
| 00622 | C | Anesth, removal of nerves |
| 00632 | C | Anesth, removal of nerves |
| 00670 | C | Anesth, spine, cord surgery |
| 00792 | C | Anesth, hemorr/excise liver |

| CPT/ HCPCS | CY 2006 Final Status Indicator | Description |
|-----------------------|---|------------------------------|
| 00794 | C | Anesth, pancreas removal |
| 00796 | C | Anesth, for liver transplant |
| 00802 | C | Anesth, fat layer removal |
| 00844 | C | Anesth, pelvis surgery |
| 00846 | C | Anesth, hysterectomy |
| 00848 | C | Anesth, pelvic organ surg |
| 00864 | C | Anesth, removal of bladder |
| 00865 | C | Anesth, removal of prostate |
| 00866 | C | Anesth, removal of adrenal |
| 00868 | C | Anesth, kidney transplant |
| 00882 | C | Anesth, major vein ligation |
| 00904 | C | Anesth, perineal surgery |
| 00908 | C | Anesth, removal of prostate |
| 00932 | C | Anesth, amputation of penis |
| 00934 | C | Anesth, penis, nodes removal |
| 00936 | C | Anesth, penis, nodes removal |
| 00944 | C | Anesth, vaginal hysterectomy |
| 01140 | C | Anesth, amputation at pelvis |
| 01150 | C | Anesth, pelvic tumor surgery |
| 01212 | C | Anesth, hip disarticulation |
| 01214 | C | Anesth, hip arthroplasty |
| 01232 | C | Anesth, amputation of femur |
| 01234 | C | Anesth, radical femur surg |
| 01272 | C | Anesth, femoral artery surg |
| 01274 | C | Anesth, femoral embolectomy |
| 01402 | C | Anesth, knee arthroplasty |
| 01404 | C | Anesth, amputation at knee |
| 01442 | C | Anesth, knee artery surg |
| 01444 | C | Anesth, knee artery repair |
| 01486 | C | Anesth, ankle replacement |
| 01502 | C | Anesth, lwr leg embolectomy |
| 01632 | C | Anesth, surgery of shoulder |
| 01634 | C | Anesth, shoulder joint amput |
| 01636 | C | Anesth, forequarter amput |
| 01638 | C | Anesth, shoulder replacement |
| 01652 | C | Anesth, shoulder vessel surg |

| CPT/ HCPCS | CY 2006 Final Status Indicator | Description |
|-----------------------|---|------------------------------|
| 01654 | C | Anesth, shoulder vessel surg |
| 01656 | C | Anesth, arm-leg vessel surg |
| 01756 | C | Anesth, radical humerus surg |
| 01990 | C | Support for organ donor |
| 11004 | C | Debride genitalia & perineum |
| 11005 | C | Debride abdom wall |
| 11006 | C | Debride genit/per/abdom wall |
| 11008 | C | Remove mesh from abd wall |
| 15756 | C | Free myo/skin flap microvasc |
| 15757 | C | Free skin flap, microvasc |
| 15758 | C | Free fascial flap, microvasc |
| 16035 | C | Incision of burn scab, initi |
| 16036 | C | Escharotomy; add'l incision |
| 19200 | C | Removal of breast |
| 19220 | C | Removal of breast |
| 19271 | C | Revision of chest wall |
| 19272 | C | Extensive chest wall surgery |
| 19361 | C | Breast reconstruction |
| 19364 | C | Breast reconstruction |
| 19367 | C | Breast reconstruction |
| 19368 | C | Breast reconstruction |
| 19369 | C | Breast reconstruction |
| 20660 | C | Apply, rem fixation device |
| 20661 | C | Application of head brace |
| 20664 | C | Halo brace application |
| 20802 | C | Replantation, arm, complete |
| 20805 | C | Replant forearm, complete |
| 20808 | C | Replantation hand, complete |
| 20816 | C | Replantation digit, complete |
| 20824 | C | Replantation thumb, complete |
| 20827 | C | Replantation thumb, complete |
| 20838 | C | Replantation foot, complete |
| 20930 | C | Spinal bone allograft |
| 20931 | C | Spinal bone allograft |
| 20936 | C | Spinal bone autograft |
| 20937 | C | Spinal bone autograft |

| CPT/ HCPCS | CY 2006 Final Status Indicator | Description |
|-----------------------|---|------------------------------|
| 20938 | C | Spinal bone autograft |
| 20955 | C | Fibula bone graft, microvasc |
| 20956 | C | Iliac bone graft, microvasc |
| 20957 | C | Mt bone graft, microvasc |
| 20962 | C | Other bone graft, microvasc |
| 20969 | C | Bone/skin graft, microvasc |
| 20970 | C | Bone/skin graft, iliac crest |
| 21045 | C | Extensive jaw surgery |
| 21141 | C | Reconstruct midface, lefort |
| 21142 | C | Reconstruct midface, lefort |
| 21143 | C | Reconstruct midface, lefort |
| 21145 | C | Reconstruct midface, lefort |
| 21146 | C | Reconstruct midface, lefort |
| 21147 | C | Reconstruct midface, lefort |
| 21151 | C | Reconstruct midface, lefort |
| 21154 | C | Reconstruct midface, lefort |
| 21155 | C | Reconstruct midface, lefort |
| 21159 | C | Reconstruct midface, lefort |
| 21160 | C | Reconstruct midface, lefort |
| 21172 | C | Reconstruct orbit/forehead |
| 21179 | C | Reconstruct entire forehead |
| 21180 | C | Reconstruct entire forehead |
| 21182 | C | Reconstruct cranial bone |
| 21183 | C | Reconstruct cranial bone |
| 21184 | C | Reconstruct cranial bone |
| 21188 | C | Reconstruction of midface |
| 21193 | C | Reconst lwr jaw w/o graft |
| 21194 | C | Reconst lwr jaw w/graft |
| 21196 | C | Reconst lwr jaw w/fixation |
| 21247 | C | Reconstruct lower jaw bone |
| 21255 | C | Reconstruct lower jaw bone |
| 21256 | C | Reconstruction of orbit |
| 21268 | C | Revise eye sockets |
| 21343 | C | Treatment of sinus fracture |
| 21344 | C | Treatment of sinus fracture |
| 21346 | C | Treat nose/jaw fracture |

| CPT/ HCPCS | CY 2006 Final Status Indicator | Description |
|-----------------------|---|------------------------------|
| 21347 | C | Treat nose/jaw fracture |
| 21348 | C | Treat nose/jaw fracture |
| 21360 | C | Treat cheek bone fracture |
| 21365 | C | Treat cheek bone fracture |
| 21366 | C | Treat cheek bone fracture |
| 21385 | C | Treat eye socket fracture |
| 21386 | C | Treat eye socket fracture |
| 21387 | C | Treat eye socket fracture |
| 21395 | C | Treat eye socket fracture |
| 21422 | C | Treat mouth roof fracture |
| 21423 | C | Treat mouth roof fracture |
| 21431 | C | Treat craniofacial fracture |
| 21432 | C | Treat craniofacial fracture |
| 21433 | C | Treat craniofacial fracture |
| 21435 | C | Treat craniofacial fracture |
| 21436 | C | Treat craniofacial fracture |
| 21510 | C | Drainage of bone lesion |
| 21615 | C | Removal of rib |
| 21616 | C | Removal of rib and nerves |
| 21620 | C | Partial removal of sternum |
| 21627 | C | Sternal debridement |
| 21630 | C | Extensive sternum surgery |
| 21632 | C | Extensive sternum surgery |
| 21705 | C | Revision of neck muscle/rib |
| 21740 | C | Reconstruction of sternum |
| 21750 | C | Repair of sternum separation |
| 21810 | C | Treatment of rib fracture(s) |
| 21825 | C | Treat sternum fracture |
| 22010 | C | I&d, p-spine, c/t/cerv-thor |
| 22015 | C | I&d, p-spine, l/s/l |
| 22110 | C | Remove part of neck vertebra |
| 22112 | C | Remove part, thorax vertebra |
| 22114 | C | Remove part, lumbar vertebra |
| 22116 | C | Remove extra spine segment |
| 22210 | C | Revision of neck spine |
| 22212 | C | Revision of thorax spine |

| CPT/ HCPCS | CY 2006 Final Status Indicator | Description |
|-----------------------|---|------------------------------|
| 22214 | C | Revision of lumbar spine |
| 22216 | C | Revise, extra spine segment |
| 22220 | C | Revision of neck spine |
| 22224 | C | Revision of lumbar spine |
| 22226 | C | Revise, extra spine segment |
| 22318 | C | Treat odontoid fx w/o graft |
| 22319 | C | Treat odontoid fx w/graft |
| 22325 | C | Treat spine fracture |
| 22326 | C | Treat neck spine fracture |
| 22327 | C | Treat thorax spine fracture |
| 22328 | C | Treat each add spine fx |
| 22532 | C | Lat thorax spine fusion |
| 22533 | C | Lat lumbar spine fusion |
| 22534 | C | Lat thor/lumb, add'l seg |
| 22548 | C | Neck spine fusion |
| 22554 | C | Neck spine fusion |
| 22556 | C | Thorax spine fusion |
| 22558 | C | Lumbar spine fusion |
| 22585 | C | Additional spinal fusion |
| 22590 | C | Spine & skull spinal fusion |
| 22595 | C | Neck spinal fusion |
| 22600 | C | Neck spine fusion |
| 22610 | C | Thorax spine fusion |
| 22630 | C | Lumbar spine fusion |
| 22632 | C | Spine fusion, extra segment |
| 22800 | C | Fusion of spine |
| 22802 | C | Fusion of spine |
| 22804 | C | Fusion of spine |
| 22808 | C | Fusion of spine |
| 22810 | C | Fusion of spine |
| 22812 | C | Fusion of spine |
| 22818 | C | Kyphectomy, 1-2 segments |
| 22819 | C | Kyphectomy, 3 or more |
| 22830 | C | Exploration of spinal fusion |
| 22840 | C | Insert spine fixation device |
| 22841 | C | Insert spine fixation device |

| CPT/ HCPCS | CY 2006 Final Status Indicator | Description |
|-----------------------|---|------------------------------|
| 22842 | C | Insert spine fixation device |
| 22843 | C | Insert spine fixation device |
| 22844 | C | Insert spine fixation device |
| 22845 | C | Insert spine fixation device |
| 22846 | C | Insert spine fixation device |
| 22847 | C | Insert spine fixation device |
| 22848 | C | Insert pelv fixation device |
| 22849 | C | Reinsert spinal fixation |
| 22850 | C | Remove spine fixation device |
| 22851 | C | Apply spine prosth device |
| 22852 | C | Remove spine fixation device |
| 22855 | C | Remove spine fixation device |
| 23200 | C | Removal of collar bone |
| 23210 | C | Removal of shoulder blade |
| 23220 | C | Partial removal of humerus |
| 23221 | C | Partial removal of humerus |
| 23222 | C | Partial removal of humerus |
| 23332 | C | Remove shoulder foreign body |
| 23472 | C | Reconstruct shoulder joint |
| 23900 | C | Amputation of arm & girdle |
| 23920 | C | Amputation at shoulder joint |
| 24900 | C | Amputation of upper arm |
| 24920 | C | Amputation of upper arm |
| 24930 | C | Amputation follow-up surgery |
| 24931 | C | Amputate upper arm & implant |
| 24940 | C | Revision of upper arm |
| 25900 | C | Amputation of forearm |
| 25905 | C | Amputation of forearm |
| 25909 | C | Amputation follow-up surgery |
| 25915 | C | Amputation of forearm |
| 25920 | C | Amputate hand at wrist |
| 25924 | C | Amputation follow-up surgery |
| 25927 | C | Amputation of hand |
| 25931 | C | Amputation follow-up surgery |
| 26551 | C | Great toe-hand transfer |
| 26553 | C | Single transfer, toe-hand |

| CPT/ HCPCS | CY 2006 Final Status Indicator | Description |
|-----------------------|---|------------------------------|
| 26554 | C | Double transfer, toe-hand |
| 26556 | C | Toe joint transfer |
| 26992 | C | Drainage of bone lesion |
| 27005 | C | Incision of hip tendon |
| 27006 | C | Incision of hip tendons |
| 27025 | C | Incision of hip/thigh fascia |
| 27030 | C | Drainage of hip joint |
| 27036 | C | Excision of hip joint/muscle |
| 27054 | C | Removal of hip joint lining |
| 27070 | C | Partial removal of hip bone |
| 27071 | C | Partial removal of hip bone |
| 27075 | C | Extensive hip surgery |
| 27076 | C | Extensive hip surgery |
| 27077 | C | Extensive hip surgery |
| 27078 | C | Extensive hip surgery |
| 27079 | C | Extensive hip surgery |
| 27090 | C | Removal of hip prosthesis |
| 27091 | C | Removal of hip prosthesis |
| 27120 | C | Reconstruction of hip socket |
| 27122 | C | Reconstruction of hip socket |
| 27125 | C | Partial hip replacement |
| 27130 | C | Total hip arthroplasty |
| 27132 | C | Total hip arthroplasty |
| 27134 | C | Revise hip joint replacement |
| 27137 | C | Revise hip joint replacement |
| 27138 | C | Revise hip joint replacement |
| 27140 | C | Transplant femur ridge |
| 27146 | C | Incision of hip bone |
| 27147 | C | Revision of hip bone |
| 27151 | C | Incision of hip bones |
| 27156 | C | Revision of hip bones |
| 27158 | C | Revision of pelvis |
| 27161 | C | Incision of neck of femur |
| 27165 | C | Incision/fixation of femur |
| 27170 | C | Repair/graft femur head/neck |
| 27175 | C | Treat slipped epiphysis |

| CPT/ HCPCS | CY 2006 Final Status Indicator | Description |
|-----------------------|---|-----------------------------|
| 27176 | C | Treat slipped epiphysis |
| 27177 | C | Treat slipped epiphysis |
| 27178 | C | Treat slipped epiphysis |
| 27179 | C | Revise head/neck of femur |
| 27181 | C | Treat slipped epiphysis |
| 27185 | C | Revision of femur epiphysis |
| 27187 | C | Reinforce hip bones |
| 27215 | C | Treat pelvic fracture(s) |
| 27217 | C | Treat pelvic ring fracture |
| 27218 | C | Treat pelvic ring fracture |
| 27222 | C | Treat hip socket fracture |
| 27226 | C | Treat hip wall fracture |
| 27227 | C | Treat hip fracture(s) |
| 27228 | C | Treat hip fracture(s) |
| 27232 | C | Treat thigh fracture |
| 27236 | C | Treat thigh fracture |
| 27240 | C | Treat thigh fracture |
| 27244 | C | Treat thigh fracture |
| 27245 | C | Treat thigh fracture |
| 27248 | C | Treat thigh fracture |
| 27253 | C | Treat hip dislocation |
| 27254 | C | Treat hip dislocation |
| 27258 | C | Treat hip dislocation |
| 27259 | C | Treat hip dislocation |
| 27280 | C | Fusion of sacroiliac joint |
| 27282 | C | Fusion of pubic bones |
| 27284 | C | Fusion of hip joint |
| 27286 | C | Fusion of hip joint |
| 27290 | C | Amputation of leg at hip |
| 27295 | C | Amputation of leg at hip |
| 27303 | C | Drainage of bone lesion |
| 27365 | C | Extensive leg surgery |
| 27445 | C | Revision of knee joint |
| 27447 | C | Total knee arthroplasty |
| 27448 | C | Incision of thigh |
| 27450 | C | Incision of thigh |

| CPT/ HCPCS | CY 2006 Final Status Indicator | Description |
|-----------------------|---|------------------------------|
| 27454 | C | Realignment of thigh bone |
| 27455 | C | Realignment of knee |
| 27457 | C | Realignment of knee |
| 27465 | C | Shortening of thigh bone |
| 27466 | C | Lengthening of thigh bone |
| 27468 | C | Shorten/lengthen thighs |
| 27470 | C | Repair of thigh |
| 27472 | C | Repair/graft of thigh |
| 27477 | C | Surgery to stop leg growth |
| 27479 | C | Surgery to stop leg growth |
| 27485 | C | Surgery to stop leg growth |
| 27486 | C | Revise/replace knee joint |
| 27487 | C | Revise/replace knee joint |
| 27488 | C | Removal of knee prosthesis |
| 27495 | C | Reinforce thigh |
| 27506 | C | Treatment of thigh fracture |
| 27507 | C | Treatment of thigh fracture |
| 27511 | C | Treatment of thigh fracture |
| 27513 | C | Treatment of thigh fracture |
| 27514 | C | Treatment of thigh fracture |
| 27519 | C | Treat thigh fx growth plate |
| 27535 | C | Treat knee fracture |
| 27536 | C | Treat knee fracture |
| 27540 | C | Treat knee fracture |
| 27556 | C | Treat knee dislocation |
| 27557 | C | Treat knee dislocation |
| 27558 | C | Treat knee dislocation |
| 27580 | C | Fusion of knee |
| 27590 | C | Amputate leg at thigh |
| 27591 | C | Amputate leg at thigh |
| 27592 | C | Amputate leg at thigh |
| 27596 | C | Amputation follow-up surgery |
| 27598 | C | Amputate lower leg at knee |
| 27645 | C | Extensive lower leg surgery |
| 27646 | C | Extensive lower leg surgery |
| 27702 | C | Reconstruct ankle joint |

| CPT/ HCPCS | CY 2006 Final Status Indicator | Description |
|-----------------------|---|------------------------------|
| 27703 | C | Reconstruction, ankle joint |
| 27712 | C | Realignment of lower leg |
| 27715 | C | Revision of lower leg |
| 27720 | C | Repair of tibia |
| 27722 | C | Repair/graft of tibia |
| 27724 | C | Repair/graft of tibia |
| 27725 | C | Repair of lower leg |
| 27727 | C | Repair of lower leg |
| 27880 | C | Amputation of lower leg |
| 27881 | C | Amputation of lower leg |
| 27882 | C | Amputation of lower leg |
| 27886 | C | Amputation follow-up surgery |
| 27888 | C | Amputation of foot at ankle |
| 28800 | C | Amputation of midfoot |
| 28805 | C | Amputation thru metatarsal |
| 31225 | C | Removal of upper jaw |
| 31230 | C | Removal of upper jaw |
| 31290 | C | Nasal/sinus endoscopy, surg |
| 31291 | C | Nasal/sinus endoscopy, surg |
| 31360 | C | Removal of larynx |
| 31365 | C | Removal of larynx |
| 31367 | C | Partial removal of larynx |
| 31368 | C | Partial removal of larynx |
| 31370 | C | Partial removal of larynx |
| 31375 | C | Partial removal of larynx |
| 31380 | C | Partial removal of larynx |
| 31382 | C | Partial removal of larynx |
| 31390 | C | Removal of larynx & pharynx |
| 31395 | C | Reconstruct larynx & pharynx |
| 31584 | C | Treat larynx fracture |
| 31587 | C | Revision of larynx |
| 31725 | C | Clearance of airways |
| 31760 | C | Repair of windpipe |
| 31766 | C | Reconstruction of windpipe |
| 31770 | C | Repair/graft of bronchus |
| 31775 | C | Reconstruct bronchus |

| CPT/ HCPCS | CY 2006 Final Status Indicator | Description |
|-----------------------|---|------------------------------|
| 31780 | C | Reconstruct windpipe |
| 31781 | C | Reconstruct windpipe |
| 31786 | C | Remove windpipe lesion |
| 31800 | C | Repair of windpipe injury |
| 31805 | C | Repair of windpipe injury |
| 32035 | C | Exploration of chest |
| 32036 | C | Exploration of chest |
| 32095 | C | Biopsy through chest wall |
| 32100 | C | Exploration/biopsy of chest |
| 32110 | C | Explore/repair chest |
| 32120 | C | Re-exploration of chest |
| 32124 | C | Explore chest free adhesions |
| 32140 | C | Removal of lung lesion(s) |
| 32141 | C | Remove/treat lung lesions |
| 32150 | C | Removal of lung lesion(s) |
| 32151 | C | Remove lung foreign body |
| 32160 | C | Open chest heart massage |
| 32200 | C | Drain, open, lung lesion |
| 32215 | C | Treat chest lining |
| 32220 | C | Release of lung |
| 32225 | C | Partial release of lung |
| 32310 | C | Removal of chest lining |
| 32320 | C | Free/remove chest lining |
| 32402 | C | Open biopsy chest lining |
| 32440 | C | Removal of lung |
| 32442 | C | Sleeve pneumonectomy |
| 32445 | C | Removal of lung |
| 32480 | C | Partial removal of lung |
| 32482 | C | Bilobectomy |
| 32484 | C | Segmentectomy |
| 32486 | C | Sleeve lobectomy |
| 32488 | C | Completion pneumonectomy |
| 32491 | C | Lung volume reduction |
| 32500 | C | Partial removal of lung |
| 32501 | C | Repair bronchus add-on |
| 32503 | C | Resect apical lung tumor |

| CPT/ HCPCS | CY 2006 Final Status Indicator | Description |
|-----------------------|---|------------------------------|
| 32504 | C | Resect apical lung tum/chest |
| 32540 | C | Removal of lung lesion |
| 32650 | C | Thoracoscopy, surgical |
| 32651 | C | Thoracoscopy, surgical |
| 32652 | C | Thoracoscopy, surgical |
| 32653 | C | Thoracoscopy, surgical |
| 32654 | C | Thoracoscopy, surgical |
| 32655 | C | Thoracoscopy, surgical |
| 32656 | C | Thoracoscopy, surgical |
| 32657 | C | Thoracoscopy, surgical |
| 32658 | C | Thoracoscopy, surgical |
| 32659 | C | Thoracoscopy, surgical |
| 32660 | C | Thoracoscopy, surgical |
| 32661 | C | Thoracoscopy, surgical |
| 32662 | C | Thoracoscopy, surgical |
| 32663 | C | Thoracoscopy, surgical |
| 32664 | C | Thoracoscopy, surgical |
| 32665 | C | Thoracoscopy, surgical |
| 32800 | C | Repair lung hernia |
| 32810 | C | Close chest after drainage |
| 32815 | C | Close bronchial fistula |
| 32820 | C | Reconstruct injured chest |
| 32850 | C | Donor pneumonectomy |
| 32851 | C | Lung transplant, single |
| 32852 | C | Lung transplant with bypass |
| 32853 | C | Lung transplant, double |
| 32854 | C | Lung transplant with bypass |
| 32855 | C | Prepare donor lung, single |
| 32856 | C | Prepare donor lung, double |
| 32900 | C | Removal of rib(s) |
| 32905 | C | Revise & repair chest wall |
| 32906 | C | Revise & repair chest wall |
| 32940 | C | Revision of lung |
| 32997 | C | Total lung lavage |
| 33015 | C | Incision of heart sac |
| 33020 | C | Incision of heart sac |

| CPT/ HCPCS | CY 2006 Final Status Indicator | Description |
|-----------------------|---|------------------------------|
| 33025 | C | Incision of heart sac |
| 33030 | C | Partial removal of heart sac |
| 33031 | C | Partial removal of heart sac |
| 33050 | C | Removal of heart sac lesion |
| 33120 | C | Removal of heart lesion |
| 33130 | C | Removal of heart lesion |
| 33140 | C | Heart revascularize (tmr) |
| 33141 | C | Heart tmr w/other procedure |
| 33200 | C | Insertion of heart pacemaker |
| 33201 | C | Insertion of heart pacemaker |
| 33236 | C | Remove electrode/thoracotomy |
| 33237 | C | Remove electrode/thoracotomy |
| 33238 | C | Remove electrode/thoracotomy |
| 33243 | C | Remove eltrd/thoracotomy |
| 33245 | C | Insert epic eltrd pace-defib |
| 33246 | C | Insert epic eltrd/generator |
| 33250 | C | Ablate heart dysrhythm focus |
| 33251 | C | Ablate heart dysrhythm focus |
| 33253 | C | Reconstruct atria |
| 33261 | C | Ablate heart dysrhythm focus |
| 33300 | C | Repair of heart wound |
| 33305 | C | Repair of heart wound |
| 33310 | C | Exploratory heart surgery |
| 33315 | C | Exploratory heart surgery |
| 33320 | C | Repair major blood vessel(s) |
| 33321 | C | Repair major vessel |
| 33322 | C | Repair major blood vessel(s) |
| 33330 | C | Insert major vessel graft |
| 33332 | C | Insert major vessel graft |
| 33335 | C | Insert major vessel graft |
| 33400 | C | Repair of aortic valve |
| 33401 | C | Valvuloplasty, open |
| 33403 | C | Valvuloplasty, w/cp bypass |
| 33404 | C | Prepare heart-aorta conduit |
| 33405 | C | Replacement of aortic valve |
| 33406 | C | Replacement of aortic valve |

| CPT/ HCPCS | CY 2006 Final Status Indicator | Description |
|-----------------------|---|------------------------------|
| 33410 | C | Replacement of aortic valve |
| 33411 | C | Replacement of aortic valve |
| 33412 | C | Replacement of aortic valve |
| 33413 | C | Replacement of aortic valve |
| 33414 | C | Repair of aortic valve |
| 33415 | C | Revision, subvalvular tissue |
| 33416 | C | Revise ventricle muscle |
| 33417 | C | Repair of aortic valve |
| 33420 | C | Revision of mitral valve |
| 33422 | C | Revision of mitral valve |
| 33425 | C | Repair of mitral valve |
| 33426 | C | Repair of mitral valve |
| 33427 | C | Repair of mitral valve |
| 33430 | C | Replacement of mitral valve |
| 33460 | C | Revision of tricuspid valve |
| 33463 | C | Valvuloplasty, tricuspid |
| 33464 | C | Valvuloplasty, tricuspid |
| 33465 | C | Replace tricuspid valve |
| 33468 | C | Revision of tricuspid valve |
| 33470 | C | Revision of pulmonary valve |
| 33471 | C | Valvotomy, pulmonary valve |
| 33472 | C | Revision of pulmonary valve |
| 33474 | C | Revision of pulmonary valve |
| 33475 | C | Replacement, pulmonary valve |
| 33476 | C | Revision of heart chamber |
| 33478 | C | Revision of heart chamber |
| 33496 | C | Repair, prosth valve clot |
| 33500 | C | Repair heart vessel fistula |
| 33501 | C | Repair heart vessel fistula |
| 33502 | C | Coronary artery correction |
| 33503 | C | Coronary artery graft |
| 33504 | C | Coronary artery graft |
| 33505 | C | Repair artery w/tunnel |
| 33506 | C | Repair artery, translocation |
| 33507 | C | Repair art, intramural |
| 33510 | C | CABG, vein, single |

| CPT/ HCPCS | CY 2006 Final Status Indicator | Description |
|-----------------------|---|------------------------------|
| 33511 | C | CABG, vein, two |
| 33512 | C | CABG, vein, three |
| 33513 | C | CABG, vein, four |
| 33514 | C | CABG, vein, five |
| 33516 | C | Cabg, vein, six or more |
| 33517 | C | CABG, artery-vein, single |
| 33518 | C | CABG, artery-vein, two |
| 33519 | C | CABG, artery-vein, three |
| 33521 | C | CABG, artery-vein, four |
| 33522 | C | CABG, artery-vein, five |
| 33523 | C | Cabg, art-vein, six or more |
| 33530 | C | Coronary artery, bypass/reop |
| 33533 | C | CABG, arterial, single |
| 33534 | C | CABG, arterial, two |
| 33535 | C | CABG, arterial, three |
| 33536 | C | Cabg, arterial, four or more |
| 33542 | C | Removal of heart lesion |
| 33545 | C | Repair of heart damage |
| 33548 | C | Restore/remodel, ventricle |
| 33572 | C | Open coronary endarterectomy |
| 33600 | C | Closure of valve |
| 33602 | C | Closure of valve |
| 33606 | C | Anastomosis/artery-aorta |
| 33608 | C | Repair anomaly w/conduit |
| 33610 | C | Repair by enlargement |
| 33611 | C | Repair double ventricle |
| 33612 | C | Repair double ventricle |
| 33615 | C | Repair, modified fontan |
| 33617 | C | Repair single ventricle |
| 33619 | C | Repair single ventricle |
| 33641 | C | Repair heart septum defect |
| 33645 | C | Revision of heart veins |
| 33647 | C | Repair heart septum defects |
| 33660 | C | Repair of heart defects |
| 33665 | C | Repair of heart defects |
| 33670 | C | Repair of heart chambers |

| CPT/ HCPCS | CY 2006 Final Status Indicator | Description |
|-----------------------|---|------------------------------|
| 33681 | C | Repair heart septum defect |
| 33684 | C | Repair heart septum defect |
| 33688 | C | Repair heart septum defect |
| 33690 | C | Reinforce pulmonary artery |
| 33692 | C | Repair of heart defects |
| 33694 | C | Repair of heart defects |
| 33697 | C | Repair of heart defects |
| 33702 | C | Repair of heart defects |
| 33710 | C | Repair of heart defects |
| 33720 | C | Repair of heart defect |
| 33722 | C | Repair of heart defect |
| 33730 | C | Repair heart-vein defect(s) |
| 33732 | C | Repair heart-vein defect |
| 33735 | C | Revision of heart chamber |
| 33736 | C | Revision of heart chamber |
| 33737 | C | Revision of heart chamber |
| 33750 | C | Major vessel shunt |
| 33755 | C | Major vessel shunt |
| 33762 | C | Major vessel shunt |
| 33764 | C | Major vessel shunt & graft |
| 33766 | C | Major vessel shunt |
| 33767 | C | Major vessel shunt |
| 33768 | C | Cavopulmonary Shunting |
| 33770 | C | Repair great vessels defect |
| 33771 | C | Repair great vessels defect |
| 33774 | C | Repair great vessels defect |
| 33775 | C | Repair great vessels defect |
| 33776 | C | Repair great vessels defect |
| 33777 | C | Repair great vessels defect |
| 33778 | C | Repair great vessels defect |
| 33779 | C | Repair great vessels defect |
| 33780 | C | Repair great vessels defect |
| 33781 | C | Repair great vessels defect |
| 33786 | C | Repair arterial trunk |
| 33788 | C | Revision of pulmonary artery |
| 33800 | C | Aortic suspension |

| CPT/ HCPCS | CY 2006 Final Status Indicator | Description |
|-----------------------|---|------------------------------|
| 33802 | C | Repair vessel defect |
| 33803 | C | Repair vessel defect |
| 33813 | C | Repair septal defect |
| 33814 | C | Repair septal defect |
| 33820 | C | Revise major vessel |
| 33822 | C | Revise major vessel |
| 33824 | C | Revise major vessel |
| 33840 | C | Remove aorta constriction |
| 33845 | C | Remove aorta constriction |
| 33851 | C | Remove aorta constriction |
| 33852 | C | Repair septal defect |
| 33853 | C | Repair septal defect |
| 33860 | C | Ascending aortic graft |
| 33861 | C | Ascending aortic graft |
| 33863 | C | Ascending aortic graft |
| 33870 | C | Transverse aortic arch graft |
| 33875 | C | Thoracic aortic graft |
| 33877 | C | Thoracoabdominal graft |
| 33880 | C | Endovasc taa repr incl subcl |
| 33881 | C | Endovasc taa repr w/o subcl |
| 33883 | C | Insert endovasc prosth, taa |
| 33884 | C | Endovasc prosth, taa, add-on |
| 33886 | C | Endovasc prosth, delayed |
| 33889 | C | Artery transpose/endovas taa |
| 33891 | C | Car-car bp grft/endovas taa |
| 33910 | C | Remove lung artery emboli |
| 33915 | C | Remove lung artery emboli |
| 33916 | C | Surgery of great vessel |
| 33917 | C | Repair pulmonary artery |
| 33920 | C | Repair pulmonary atresia |
| 33922 | C | Transect pulmonary artery |
| 33924 | C | Remove pulmonary shunt |
| 33925 | C | Rpr pul art unifocal w/o cpb |
| 33926 | C | Repr pul art, unifocal w/cpb |
| 33930 | C | Removal of donor heart/lung |
| 33933 | C | Prepare donor heart/lung |

| CPT/ HCPCS | CY 2006 Final Status Indicator | Description |
|-----------------------|---|------------------------------|
| 33935 | C | Transplantation, heart/lung |
| 33940 | C | Removal of donor heart |
| 33944 | C | Prepare donor heart |
| 33945 | C | Transplantation of heart |
| 33960 | C | External circulation assist |
| 33961 | C | External circulation assist |
| 33967 | C | Insert ia percut device |
| 33968 | C | Remove aortic assist device |
| 33970 | C | Aortic circulation assist |
| 33971 | C | Aortic circulation assist |
| 33973 | C | Insert balloon device |
| 33974 | C | Remove intra-aortic balloon |
| 33975 | C | Implant ventricular device |
| 33976 | C | Implant ventricular device |
| 33977 | C | Remove ventricular device |
| 33978 | C | Remove ventricular device |
| 33979 | C | Insert intracorporeal device |
| 33980 | C | Remove intracorporeal device |
| 34001 | C | Removal of artery clot |
| 34051 | C | Removal of artery clot |
| 34151 | C | Removal of artery clot |
| 34401 | C | Removal of vein clot |
| 34451 | C | Removal of vein clot |
| 34502 | C | Reconstruct vena cava |
| 34800 | C | Endovas aaa repr w/sm tube |
| 34802 | C | Endovas aaa repr w/2-p part |
| 34803 | C | Endovas aaa repr w/3-p part |
| 34804 | C | Endovas aaa repr w/1-p part |
| 34805 | C | Endovas aaa repr w/long tube |
| 34808 | C | Endovas iliac a device addon |
| 34812 | C | Xpose for endoprosth, femorl |
| 34813 | C | Femoral endovas graft add-on |
| 34820 | C | Xpose for endoprosth, iliac |
| 34825 | C | Endovasc extend prosth, init |
| 34826 | C | Endovasc exten prosth, add'l |
| 34830 | C | Open aortic tube prosth repr |

| CPT/ HCPCS | CY 2006 Final Status Indicator | Description |
|-----------------------|---|------------------------------|
| 34831 | C | Open aortoiliac prosth repr |
| 34832 | C | Open aortofemor prosth repr |
| 34833 | C | Xpose for endoprosth, iliac |
| 34834 | C | Xpose, endoprosth, brachial |
| 34900 | C | Endovasc iliac repr w/graft |
| 35001 | C | Repair defect of artery |
| 35002 | C | Repair artery rupture, neck |
| 35005 | C | Repair defect of artery |
| 35013 | C | Repair artery rupture, arm |
| 35021 | C | Repair defect of artery |
| 35022 | C | Repair artery rupture, chest |
| 35045 | C | Repair defect of arm artery |
| 35081 | C | Repair defect of artery |
| 35082 | C | Repair artery rupture, aorta |
| 35091 | C | Repair defect of artery |
| 35092 | C | Repair artery rupture, aorta |
| 35102 | C | Repair defect of artery |
| 35103 | C | Repair artery rupture, groin |
| 35111 | C | Repair defect of artery |
| 35112 | C | Repair artery rupture,spleen |
| 35121 | C | Repair defect of artery |
| 35122 | C | Repair artery rupture, belly |
| 35131 | C | Repair defect of artery |
| 35132 | C | Repair artery rupture, groin |
| 35141 | C | Repair defect of artery |
| 35142 | C | Repair artery rupture, thigh |
| 35151 | C | Repair defect of artery |
| 35152 | C | Repair artery rupture, knee |
| 35182 | C | Repair blood vessel lesion |
| 35189 | C | Repair blood vessel lesion |
| 35211 | C | Repair blood vessel lesion |
| 35216 | C | Repair blood vessel lesion |
| 35221 | C | Repair blood vessel lesion |
| 35241 | C | Repair blood vessel lesion |
| 35246 | C | Repair blood vessel lesion |
| 35251 | C | Repair blood vessel lesion |

| CPT/ HCPCS | CY 2006 Final Status Indicator | Description |
|-----------------------|---|-----------------------------|
| 35271 | C | Repair blood vessel lesion |
| 35276 | C | Repair blood vessel lesion |
| 35281 | C | Repair blood vessel lesion |
| 35301 | C | Rechanneling of artery |
| 35311 | C | Rechanneling of artery |
| 35331 | C | Rechanneling of artery |
| 35341 | C | Rechanneling of artery |
| 35351 | C | Rechanneling of artery |
| 35355 | C | Rechanneling of artery |
| 35361 | C | Rechanneling of artery |
| 35363 | C | Rechanneling of artery |
| 35371 | C | Rechanneling of artery |
| 35372 | C | Rechanneling of artery |
| 35381 | C | Rechanneling of artery |
| 35390 | C | Reoperation, carotid add-on |
| 35400 | C | Angioscopy |
| 35450 | C | Repair arterial blockage |
| 35452 | C | Repair arterial blockage |
| 35454 | C | Repair arterial blockage |
| 35456 | C | Repair arterial blockage |
| 35480 | C | Atherectomy, open |
| 35481 | C | Atherectomy, open |
| 35482 | C | Atherectomy, open |
| 35483 | C | Atherectomy, open |
| 35501 | C | Artery bypass graft |
| 35506 | C | Artery bypass graft |
| 35507 | C | Artery bypass graft |
| 35508 | C | Artery bypass graft |
| 35509 | C | Artery bypass graft |
| 35510 | C | Artery bypass graft |
| 35511 | C | Artery bypass graft |
| 35512 | C | Artery bypass graft |
| 35515 | C | Artery bypass graft |
| 35516 | C | Artery bypass graft |
| 35518 | C | Artery bypass graft |
| 35521 | C | Artery bypass graft |

| CPT/ HCPCS | CY 2006 Final Status Indicator | Description |
|-----------------------|---|-------------------------|
| 35522 | C | Artery bypass graft |
| 35525 | C | Artery bypass graft |
| 35526 | C | Artery bypass graft |
| 35531 | C | Artery bypass graft |
| 35533 | C | Artery bypass graft |
| 35536 | C | Artery bypass graft |
| 35541 | C | Artery bypass graft |
| 35546 | C | Artery bypass graft |
| 35548 | C | Artery bypass graft |
| 35549 | C | Artery bypass graft |
| 35551 | C | Artery bypass graft |
| 35556 | C | Artery bypass graft |
| 35558 | C | Artery bypass graft |
| 35560 | C | Artery bypass graft |
| 35563 | C | Artery bypass graft |
| 35565 | C | Artery bypass graft |
| 35566 | C | Artery bypass graft |
| 35571 | C | Artery bypass graft |
| 35583 | C | Vein bypass graft |
| 35585 | C | Vein bypass graft |
| 35587 | C | Vein bypass graft |
| 35600 | C | Harvest artery for cabg |
| 35601 | C | Artery bypass graft |
| 35606 | C | Artery bypass graft |
| 35612 | C | Artery bypass graft |
| 35616 | C | Artery bypass graft |
| 35621 | C | Artery bypass graft |
| 35623 | C | Bypass graft, not vein |
| 35626 | C | Artery bypass graft |
| 35631 | C | Artery bypass graft |
| 35636 | C | Artery bypass graft |
| 35641 | C | Artery bypass graft |
| 35642 | C | Artery bypass graft |
| 35645 | C | Artery bypass graft |
| 35646 | C | Artery bypass graft |
| 35647 | C | Artery bypass graft |

| CPT/ HCPCS | CY 2006 Final Status Indicator | Description |
|-----------------------|---|------------------------------|
| 35650 | C | Artery bypass graft |
| 35651 | C | Artery bypass graft |
| 35654 | C | Artery bypass graft |
| 35656 | C | Artery bypass graft |
| 35661 | C | Artery bypass graft |
| 35663 | C | Artery bypass graft |
| 35665 | C | Artery bypass graft |
| 35666 | C | Artery bypass graft |
| 35671 | C | Artery bypass graft |
| 35681 | C | Composite bypass graft |
| 35682 | C | Composite bypass graft |
| 35683 | C | Composite bypass graft |
| 35691 | C | Arterial transposition |
| 35693 | C | Arterial transposition |
| 35694 | C | Arterial transposition |
| 35695 | C | Arterial transposition |
| 35697 | C | Reimplant artery each |
| 35700 | C | Reoperation, bypass graft |
| 35701 | C | Exploration, carotid artery |
| 35721 | C | Exploration, femoral artery |
| 35741 | C | Exploration popliteal artery |
| 35800 | C | Explore neck vessels |
| 35820 | C | Explore chest vessels |
| 35840 | C | Explore abdominal vessels |
| 35870 | C | Repair vessel graft defect |
| 35901 | C | Excision, graft, neck |
| 35905 | C | Excision, graft, thorax |
| 35907 | C | Excision, graft, abdomen |
| 36660 | C | Insertion catheter, artery |
| 36822 | C | Insertion of cannula(s) |
| 36823 | C | Insertion of cannula(s) |
| 37140 | C | Revision of circulation |
| 37145 | C | Revision of circulation |
| 37160 | C | Revision of circulation |
| 37180 | C | Revision of circulation |
| 37181 | C | Splice spleen/kidney veins |

| CPT/ HCPCS | CY 2006 Final Status Indicator | Description |
|-----------------------|---|------------------------------|
| 37182 | C | Insert hepatic shunt (tips) |
| 37215 | C | Transcath stent, cca w/eps |
| 37216 | C | Transcath stent, cca w/o eps |
| 37616 | C | Ligation of chest artery |
| 37617 | C | Ligation of abdomen artery |
| 37618 | C | Ligation of extremity artery |
| 37660 | C | Revision of major vein |
| 37788 | C | Revascularization, penis |
| 38100 | C | Removal of spleen, total |
| 38101 | C | Removal of spleen, partial |
| 38102 | C | Removal of spleen, total |
| 38115 | C | Repair of ruptured spleen |
| 38380 | C | Thoracic duct procedure |
| 38381 | C | Thoracic duct procedure |
| 38382 | C | Thoracic duct procedure |
| 38562 | C | Removal, pelvic lymph nodes |
| 38564 | C | Removal, abdomen lymph nodes |
| 38724 | C | Removal of lymph nodes, neck |
| 38746 | C | Remove thoracic lymph nodes |
| 38747 | C | Remove abdominal lymph nodes |
| 38765 | C | Remove groin lymph nodes |
| 38770 | C | Remove pelvis lymph nodes |
| 38780 | C | Remove abdomen lymph nodes |
| 39000 | C | Exploration of chest |
| 39010 | C | Exploration of chest |
| 39200 | C | Removal chest lesion |
| 39220 | C | Removal chest lesion |
| 39499 | C | Chest procedure |
| 39501 | C | Repair diaphragm laceration |
| 39502 | C | Repair paraesophageal hernia |
| 39503 | C | Repair of diaphragm hernia |
| 39520 | C | Repair of diaphragm hernia |
| 39530 | C | Repair of diaphragm hernia |
| 39531 | C | Repair of diaphragm hernia |
| 39540 | C | Repair of diaphragm hernia |
| 39541 | C | Repair of diaphragm hernia |

| CPT/ HCPCS | CY 2006 Final Status Indicator | Description |
|-----------------------|---|------------------------------|
| 39545 | C | Revision of diaphragm |
| 39560 | C | Resect diaphragm, simple |
| 39561 | C | Resect diaphragm, complex |
| 39599 | C | Diaphragm surgery procedure |
| 41130 | C | Partial removal of tongue |
| 41135 | C | Tongue and neck surgery |
| 41140 | C | Removal of tongue |
| 41145 | C | Tongue removal, neck surgery |
| 41150 | C | Tongue, mouth, jaw surgery |
| 41153 | C | Tongue, mouth, neck surgery |
| 41155 | C | Tongue, jaw, & neck surgery |
| 42426 | C | Excise parotid gland/lesion |
| 42845 | C | Extensive surgery of throat |
| 42894 | C | Revision of pharyngeal walls |
| 42953 | C | Repair throat, esophagus |
| 42961 | C | Control throat bleeding |
| 42971 | C | Control nose/throat bleeding |
| 43045 | C | Incision of esophagus |
| 43100 | C | Excision of esophagus lesion |
| 43101 | C | Excision of esophagus lesion |
| 43107 | C | Removal of esophagus |
| 43108 | C | Removal of esophagus |
| 43112 | C | Removal of esophagus |
| 43113 | C | Removal of esophagus |
| 43116 | C | Partial removal of esophagus |
| 43117 | C | Partial removal of esophagus |
| 43118 | C | Partial removal of esophagus |
| 43121 | C | Partial removal of esophagus |
| 43122 | C | Partial removal of esophagus |
| 43123 | C | Partial removal of esophagus |
| 43124 | C | Removal of esophagus |
| 43135 | C | Removal of esophagus pouch |
| 43300 | C | Repair of esophagus |
| 43305 | C | Repair esophagus and fistula |
| 43310 | C | Repair of esophagus |
| 43312 | C | Repair esophagus and fistula |

| CPT/ HCPCS | CY 2006 Final Status Indicator | Description |
|-----------------------|---|------------------------------|
| 43313 | C | Esophagoplasty congenital |
| 43314 | C | Tracheo-esophagoplasty cong |
| 43320 | C | Fuse esophagus & stomach |
| 43324 | C | Revise esophagus & stomach |
| 43325 | C | Revise esophagus & stomach |
| 43326 | C | Revise esophagus & stomach |
| 43330 | C | Repair of esophagus |
| 43331 | C | Repair of esophagus |
| 43340 | C | Fuse esophagus & intestine |
| 43341 | C | Fuse esophagus & intestine |
| 43350 | C | Surgical opening, esophagus |
| 43351 | C | Surgical opening, esophagus |
| 43352 | C | Surgical opening, esophagus |
| 43360 | C | Gastrointestinal repair |
| 43361 | C | Gastrointestinal repair |
| 43400 | C | Ligate esophagus veins |
| 43401 | C | Esophagus surgery for veins |
| 43405 | C | Ligate/staple esophagus |
| 43410 | C | Repair esophagus wound |
| 43415 | C | Repair esophagus wound |
| 43420 | C | Repair esophagus opening |
| 43425 | C | Repair esophagus opening |
| 43460 | C | Pressure treatment esophagus |
| 43496 | C | Free jejunum flap, microvasc |
| 43500 | C | Surgical opening of stomach |
| 43501 | C | Surgical repair of stomach |
| 43502 | C | Surgical repair of stomach |
| 43520 | C | Incision of pyloric muscle |
| 43605 | C | Biopsy of stomach |
| 43610 | C | Excision of stomach lesion |
| 43611 | C | Excision of stomach lesion |
| 43620 | C | Removal of stomach |
| 43621 | C | Removal of stomach |
| 43622 | C | Removal of stomach |
| 43631 | C | Removal of stomach, partial |
| 43632 | C | Removal of stomach, partial |

| CPT/ HCPCS | CY 2006 Final Status Indicator | Description |
|-----------------------|---|-------------------------------|
| 43633 | C | Removal of stomach, partial |
| 43634 | C | Removal of stomach, partial |
| 43635 | C | Removal of stomach, partial |
| 43640 | C | Vagotomy & pylorus repair |
| 43641 | C | Vagotomy & pylorus repair |
| 43644 | C | Lap gastric bypass/roux-en-y |
| 43645 | C | Lap gastr bypass incl small i |
| 43770 | C | Lap, place gastr adjust band |
| 43771 | C | Lap, revise adjust gast band |
| 43772 | C | Lap, remove adjust gast band |
| 43773 | C | Lap, change adjust gast band |
| 43774 | C | Lap remov adj gast band/port |
| 43800 | C | Reconstruction of pylorus |
| 43810 | C | Fusion of stomach and bowel |
| 43820 | C | Fusion of stomach and bowel |
| 43825 | C | Fusion of stomach and bowel |
| 43832 | C | Place gastrostomy tube |
| 43840 | C | Repair of stomach lesion |
| 43842 | C | V-band gastroplasty |
| 43843 | C | Gastroplasty w/o v-band |
| 43845 | C | Gastroplasty duodenal switch |
| 43846 | C | Gastric bypass for obesity |
| 43847 | C | Gastric bypass incl small i |
| 43848 | C | Revision gastroplasty |
| 43850 | C | Revise stomach-bowel fusion |
| 43855 | C | Revise stomach-bowel fusion |
| 43860 | C | Revise stomach-bowel fusion |
| 43865 | C | Revise stomach-bowel fusion |
| 43880 | C | Repair stomach-bowel fistula |
| 44005 | C | Freeing of bowel adhesion |
| 44010 | C | Incision of small bowel |
| 44015 | C | Insert needle cath bowel |
| 44020 | C | Explore small intestine |
| 44021 | C | Decompress small bowel |
| 44025 | C | Incision of large bowel |
| 44050 | C | Reduce bowel obstruction |

| CPT/ HCPCS | CY 2006 Final Status Indicator | Description |
|-----------------------|---|------------------------------|
| 44055 | C | Correct malrotation of bowel |
| 44110 | C | Excise intestine lesion(s) |
| 44111 | C | Excision of bowel lesion(s) |
| 44120 | C | Removal of small intestine |
| 44121 | C | Removal of small intestine |
| 44125 | C | Removal of small intestine |
| 44126 | C | Enterectomy w/o taper, cong |
| 44127 | C | Enterectomy w/taper, cong |
| 44128 | C | Enterectomy cong, add-on |
| 44130 | C | Bowel to bowel fusion |
| 44132 | C | Enterectomy, cadaver donor |
| 44133 | C | Enterectomy, live donor |
| 44135 | C | Intestine transplnt, cadaver |
| 44136 | C | Intestine transplant, live |
| 44137 | C | Remove intestinal allograft |
| 44139 | C | Mobilization of colon |
| 44140 | C | Partial removal of colon |
| 44141 | C | Partial removal of colon |
| 44143 | C | Partial removal of colon |
| 44144 | C | Partial removal of colon |
| 44145 | C | Partial removal of colon |
| 44146 | C | Partial removal of colon |
| 44147 | C | Partial removal of colon |
| 44150 | C | Removal of colon |
| 44151 | C | Removal of colon/ileostomy |
| 44152 | C | Removal of colon/ileostomy |
| 44153 | C | Removal of colon/ileostomy |
| 44155 | C | Removal of colon/ileostomy |
| 44156 | C | Removal of colon/ileostomy |
| 44160 | C | Removal of colon |
| 44187 | C | Lap, ileo/jejuno-stomy |
| 44188 | C | Lap, colostomy |
| 44202 | C | Lap, enterectomy |
| 44203 | C | Lap resect s/intestine, addl |
| 44204 | C | Laparo partial colectomy |
| 44205 | C | Lap colectomy part w/ileum |

| CPT/ HCPCS | CY 2006 Final Status Indicator | Description |
|-----------------------|---|------------------------------|
| 44210 | C | Laparo total proctocolectomy |
| 44211 | C | Laparo total proctocolectomy |
| 44212 | C | Laparo total proctocolectomy |
| 44227 | C | Lap, close enterostomy |
| 44300 | C | Open bowel to skin |
| 44310 | C | Ileostomy/jejunostomy |
| 44314 | C | Revision of ileostomy |
| 44316 | C | Devise bowel pouch |
| 44320 | C | Colostomy |
| 44322 | C | Colostomy with biopsies |
| 44345 | C | Revision of colostomy |
| 44346 | C | Revision of colostomy |
| 44602 | C | Suture, small intestine |
| 44603 | C | Suture, small intestine |
| 44604 | C | Suture, large intestine |
| 44605 | C | Repair of bowel lesion |
| 44615 | C | Intestinal stricturoplasty |
| 44620 | C | Repair bowel opening |
| 44625 | C | Repair bowel opening |
| 44626 | C | Repair bowel opening |
| 44640 | C | Repair bowel-skin fistula |
| 44650 | C | Repair bowel fistula |
| 44660 | C | Repair bowel-bladder fistula |
| 44661 | C | Repair bowel-bladder fistula |
| 44680 | C | Surgical revision, intestine |
| 44700 | C | Suspend bowel w/prosthesis |
| 44715 | C | Prepare donor intestine |
| 44720 | C | Prep donor intestine/venous |
| 44721 | C | Prep donor intestine/artery |
| 44800 | C | Excision of bowel pouch |
| 44820 | C | Excision of mesentery lesion |
| 44850 | C | Repair of mesentery |
| 44899 | C | Bowel surgery procedure |
| 44900 | C | Drain app abscess, open |
| 44950 | C | Appendectomy |
| 44955 | C | Appendectomy add-on |

| CPT/ HCPCS | CY 2006 Final Status Indicator | Description |
|-----------------------|---|------------------------------|
| 44960 | C | Appendectomy |
| 45110 | C | Removal of rectum |
| 45111 | C | Partial removal of rectum |
| 45112 | C | Removal of rectum |
| 45113 | C | Partial proctectomy |
| 45114 | C | Partial removal of rectum |
| 45116 | C | Partial removal of rectum |
| 45119 | C | Remove rectum w/reservoir |
| 45120 | C | Removal of rectum |
| 45121 | C | Removal of rectum and colon |
| 45123 | C | Partial proctectomy |
| 45126 | C | Pelvic exenteration |
| 45130 | C | Excision of rectal prolapse |
| 45135 | C | Excision of rectal prolapse |
| 45136 | C | Excise ileoanal reservoir |
| 45395 | C | Lap, removal of rectum |
| 45397 | C | Lap, remove rectum w/pouch |
| 45400 | C | Laparoscopic proctopexy |
| 45402 | C | Lap proctopexy w/sig resect |
| 45540 | C | Correct rectal prolapse |
| 45550 | C | Repair rectum/remove sigmoid |
| 45562 | C | Exploration/repair of rectum |
| 45563 | C | Exploration/repair of rectum |
| 45800 | C | Repair rect/bladder fistula |
| 45805 | C | Repair fistula w/colostomy |
| 45820 | C | Repair rectourethral fistula |
| 45825 | C | Repair fistula w/colostomy |
| 46705 | C | Repair of anal stricture |
| 46710 | C | Repr per/vag pouch snl proc |
| 46712 | C | Repr per/vag pouch dbl proc |
| 46715 | C | Rep perf anoper fistu |
| 46716 | C | Rep perf anoper/vestib fistu |
| 46730 | C | Construction of absent anus |
| 46735 | C | Construction of absent anus |
| 46740 | C | Construction of absent anus |
| 46742 | C | Repair of imperforated anus |

| CPT/ HCPCS | CY 2006 Final Status Indicator | Description |
|-----------------------|---|------------------------------|
| 46744 | C | Repair of cloacal anomaly |
| 46746 | C | Repair of cloacal anomaly |
| 46748 | C | Repair of cloacal anomaly |
| 46751 | C | Repair of anal sphincter |
| 47010 | C | Open drainage, liver lesion |
| 47015 | C | Inject/aspirate liver cyst |
| 47100 | C | Wedge biopsy of liver |
| 47120 | C | Partial removal of liver |
| 47122 | C | Extensive removal of liver |
| 47125 | C | Partial removal of liver |
| 47130 | C | Partial removal of liver |
| 47133 | C | Removal of donor liver |
| 47135 | C | Transplantation of liver |
| 47136 | C | Transplantation of liver |
| 47140 | C | Partial removal, donor liver |
| 47141 | C | Partial removal, donor liver |
| 47142 | C | Partial removal, donor liver |
| 47143 | C | Prep donor liver, whole |
| 47144 | C | Prep donor liver, 3-segment |
| 47145 | C | Prep donor liver, lobe split |
| 47146 | C | Prep donor liver/venous |
| 47147 | C | Prep donor liver/arterial |
| 47300 | C | Surgery for liver lesion |
| 47350 | C | Repair liver wound |
| 47360 | C | Repair liver wound |
| 47361 | C | Repair liver wound |
| 47362 | C | Repair liver wound |
| 47380 | C | Open ablate liver tumor rf |
| 47381 | C | Open ablate liver tumor cryo |
| 47400 | C | Incision of liver duct |
| 47420 | C | Incision of bile duct |
| 47425 | C | Incision of bile duct |
| 47460 | C | Incise bile duct sphincter |
| 47480 | C | Incision of gallbladder |
| 47550 | C | Bile duct endoscopy add-on |
| 47570 | C | Laparo cholecystoenterostomy |

| CPT/ HCPCS | CY 2006 Final Status Indicator | Description |
|-----------------------|---|------------------------------|
| 47600 | C | Removal of gallbladder |
| 47605 | C | Removal of gallbladder |
| 47610 | C | Removal of gallbladder |
| 47612 | C | Removal of gallbladder |
| 47620 | C | Removal of gallbladder |
| 47700 | C | Exploration of bile ducts |
| 47701 | C | Bile duct revision |
| 47711 | C | Excision of bile duct tumor |
| 47712 | C | Excision of bile duct tumor |
| 47715 | C | Excision of bile duct cyst |
| 47716 | C | Fusion of bile duct cyst |
| 47720 | C | Fuse gallbladder & bowel |
| 47721 | C | Fuse upper gi structures |
| 47740 | C | Fuse gallbladder & bowel |
| 47741 | C | Fuse gallbladder & bowel |
| 47760 | C | Fuse bile ducts and bowel |
| 47765 | C | Fuse liver ducts & bowel |
| 47780 | C | Fuse bile ducts and bowel |
| 47785 | C | Fuse bile ducts and bowel |
| 47800 | C | Reconstruction of bile ducts |
| 47801 | C | Placement, bile duct support |
| 47802 | C | Fuse liver duct & intestine |
| 47900 | C | Suture bile duct injury |
| 48000 | C | Drainage of abdomen |
| 48001 | C | Placement of drain, pancreas |
| 48005 | C | Resect/debride pancreas |
| 48020 | C | Removal of pancreatic stone |
| 48100 | C | Biopsy of pancreas, open |
| 48120 | C | Removal of pancreas lesion |
| 48140 | C | Partial removal of pancreas |
| 48145 | C | Partial removal of pancreas |
| 48146 | C | Pancreatectomy |
| 48148 | C | Removal of pancreatic duct |
| 48150 | C | Partial removal of pancreas |
| 48152 | C | Pancreatectomy |
| 48153 | C | Pancreatectomy |

| CPT/ HCPCS | CY 2006 Final Status Indicator | Description |
|-----------------------|---|------------------------------|
| 48154 | C | Pancreatectomy |
| 48155 | C | Removal of pancreas |
| 48180 | C | Fuse pancreas and bowel |
| 48400 | C | Injection, intraop add-on |
| 48500 | C | Surgery of pancreatic cyst |
| 48510 | C | Drain pancreatic pseudocyst |
| 48520 | C | Fuse pancreas cyst and bowel |
| 48540 | C | Fuse pancreas cyst and bowel |
| 48545 | C | Pancreatorrhaphy |
| 48547 | C | Duodenal exclusion |
| 48551 | C | Prep donor pancreas |
| 48552 | C | Prep donor pancreas/venous |
| 48554 | C | Transpl allograft pancreas |
| 48556 | C | Removal, allograft pancreas |
| 49000 | C | Exploration of abdomen |
| 49002 | C | Reopening of abdomen |
| 49010 | C | Exploration behind abdomen |
| 49020 | C | Drain abdominal abscess |
| 49040 | C | Drain, open, abdom abscess |
| 49060 | C | Drain, open, retrop abscess |
| 49062 | C | Drain to peritoneal cavity |
| 49201 | C | Remove abdom lesion, complex |
| 49215 | C | Excise sacral spine tumor |
| 49220 | C | Multiple surgery, abdomen |
| 49255 | C | Removal of omentum |
| 49425 | C | Insert abdomen-venous drain |
| 49428 | C | Ligation of shunt |
| 49605 | C | Repair umbilical lesion |
| 49606 | C | Repair umbilical lesion |
| 49610 | C | Repair umbilical lesion |
| 49611 | C | Repair umbilical lesion |
| 49900 | C | Repair of abdominal wall |
| 49904 | C | Omental flap, extra-abdom |
| 49905 | C | Omental flap, intra-abdom |
| 49906 | C | Free omental flap, microvasc |
| 50010 | C | Exploration of kidney |

| CPT/ HCPCS | CY 2006 Final Status Indicator | Description |
|-----------------------|---|------------------------------|
| 50040 | C | Drainage of kidney |
| 50045 | C | Exploration of kidney |
| 50060 | C | Removal of kidney stone |
| 50065 | C | Incision of kidney |
| 50070 | C | Incision of kidney |
| 50075 | C | Removal of kidney stone |
| 50100 | C | Revise kidney blood vessels |
| 50120 | C | Exploration of kidney |
| 50125 | C | Explore and drain kidney |
| 50130 | C | Removal of kidney stone |
| 50135 | C | Exploration of kidney |
| 50205 | C | Biopsy of kidney |
| 50220 | C | Remove kidney, open |
| 50225 | C | Removal kidney open, complex |
| 50230 | C | Removal kidney open, radical |
| 50234 | C | Removal of kidney & ureter |
| 50236 | C | Removal of kidney & ureter |
| 50240 | C | Partial removal of kidney |
| 50250 | C | Cryoablate renal mass open |
| 50280 | C | Removal of kidney lesion |
| 50290 | C | Removal of kidney lesion |
| 50300 | C | Remove cadaver donor kidney |
| 50320 | C | Remove kidney, living donor |
| 50323 | C | Prep cadaver renal allograft |
| 50325 | C | Prep donor renal graft |
| 50327 | C | Prep renal graft/venous |
| 50328 | C | Prep renal graft/arterial |
| 50329 | C | Prep renal graft/ureteral |
| 50340 | C | Removal of kidney |
| 50360 | C | Transplantation of kidney |
| 50365 | C | Transplantation of kidney |
| 50370 | C | Remove transplanted kidney |
| 50380 | C | Reimplantation of kidney |
| 50400 | C | Revision of kidney/ureter |
| 50405 | C | Revision of kidney/ureter |
| 50500 | C | Repair of kidney wound |

| CPT/ HCPCS | CY 2006 Final Status Indicator | Description |
|-----------------------|---|------------------------------|
| 50520 | C | Close kidney-skin fistula |
| 50525 | C | Repair renal-abdomen fistula |
| 50526 | C | Repair renal-abdomen fistula |
| 50540 | C | Revision of horseshoe kidney |
| 50545 | C | Laparo radical nephrectomy |
| 50546 | C | Laparoscopic nephrectomy |
| 50547 | C | Laparo removal donor kidney |
| 50548 | C | Laparo remove w/ureter |
| 50580 | C | Kidney endoscopy & treatment |
| 50600 | C | Exploration of ureter |
| 50605 | C | Insert ureteral support |
| 50610 | C | Removal of ureter stone |
| 50620 | C | Removal of ureter stone |
| 50630 | C | Removal of ureter stone |
| 50650 | C | Removal of ureter |
| 50660 | C | Removal of ureter |
| 50700 | C | Revision of ureter |
| 50715 | C | Release of ureter |
| 50722 | C | Release of ureter |
| 50725 | C | Release/revise ureter |
| 50727 | C | Revise ureter |
| 50728 | C | Revise ureter |
| 50740 | C | Fusion of ureter & kidney |
| 50750 | C | Fusion of ureter & kidney |
| 50760 | C | Fusion of ureters |
| 50770 | C | Splicing of ureters |
| 50780 | C | Reimplant ureter in bladder |
| 50782 | C | Reimplant ureter in bladder |
| 50783 | C | Reimplant ureter in bladder |
| 50785 | C | Reimplant ureter in bladder |
| 50800 | C | Implant ureter in bowel |
| 50810 | C | Fusion of ureter & bowel |
| 50815 | C | Urine shunt to intestine |
| 50820 | C | Construct bowel bladder |
| 50825 | C | Construct bowel bladder |
| 50830 | C | Revise urine flow |

| CPT/ HCPCS | CY 2006 Final Status Indicator | Description |
|-----------------------|---|------------------------------|
| 50840 | C | Replace ureter by bowel |
| 50845 | C | Appendico-vesicostomy |
| 50860 | C | Transplant ureter to skin |
| 50900 | C | Repair of ureter |
| 50920 | C | Closure ureter/skin fistula |
| 50930 | C | Closure ureter/bowel fistula |
| 50940 | C | Release of ureter |
| 51060 | C | Removal of ureter stone |
| 51525 | C | Removal of bladder lesion |
| 51530 | C | Removal of bladder lesion |
| 51535 | C | Repair of ureter lesion |
| 51550 | C | Partial removal of bladder |
| 51555 | C | Partial removal of bladder |
| 51565 | C | Revise bladder & ureter(s) |
| 51570 | C | Removal of bladder |
| 51575 | C | Removal of bladder & nodes |
| 51580 | C | Remove bladder/revise tract |
| 51585 | C | Removal of bladder & nodes |
| 51590 | C | Remove bladder/revise tract |
| 51595 | C | Remove bladder/revise tract |
| 51596 | C | Remove bladder/create pouch |
| 51597 | C | Removal of pelvic structures |
| 51800 | C | Revision of bladder/urethra |
| 51820 | C | Revision of urinary tract |
| 51840 | C | Attach bladder/urethra |
| 51841 | C | Attach bladder/urethra |
| 51845 | C | Repair bladder neck |
| 51860 | C | Repair of bladder wound |
| 51865 | C | Repair of bladder wound |
| 51900 | C | Repair bladder/vagina lesion |
| 51920 | C | Close bladder-uterus fistula |
| 51925 | C | Hysterectomy/bladder repair |
| 51940 | C | Correction of bladder defect |
| 51960 | C | Revision of bladder & bowel |
| 51980 | C | Construct bladder opening |
| 53415 | C | Reconstruction of urethra |

| CPT/ HCPCS | CY 2006 Final Status Indicator | Description |
|-----------------------|---|------------------------------|
| 53448 | C | Remov/replc ur sphinctr comp |
| 54125 | C | Removal of penis |
| 54130 | C | Remove penis & nodes |
| 54135 | C | Remove penis & nodes |
| 54332 | C | Revise penis/urethra |
| 54336 | C | Revise penis/urethra |
| 54390 | C | Repair penis and bladder |
| 54411 | C | Remov/replc penis pros, comp |
| 54417 | C | Remv/replc penis pros, compl |
| 54430 | C | Revision of penis |
| 54535 | C | Extensive testis surgery |
| 54650 | C | Orchiopexy (Fowler-Stephens) |
| 55605 | C | Incise sperm duct pouch |
| 55650 | C | Remove sperm duct pouch |
| 55801 | C | Removal of prostate |
| 55810 | C | Extensive prostate surgery |
| 55812 | C | Extensive prostate surgery |
| 55815 | C | Extensive prostate surgery |
| 55821 | C | Removal of prostate |
| 55831 | C | Removal of prostate |
| 55840 | C | Extensive prostate surgery |
| 55842 | C | Extensive prostate surgery |
| 55845 | C | Extensive prostate surgery |
| 55862 | C | Extensive prostate surgery |
| 55865 | C | Extensive prostate surgery |
| 55866 | C | Laparo radical prostatectomy |
| 56630 | C | Extensive vulva surgery |
| 56631 | C | Extensive vulva surgery |
| 56632 | C | Extensive vulva surgery |
| 56633 | C | Extensive vulva surgery |
| 56634 | C | Extensive vulva surgery |
| 56637 | C | Extensive vulva surgery |
| 56640 | C | Extensive vulva surgery |
| 57110 | C | Remove vagina wall, complete |
| 57111 | C | Remove vagina tissue, compl |
| 57112 | C | Vaginectomy w/nodes, compl |

| CPT/ HCPCS | CY 2006 Final Status Indicator | Description |
|-----------------------|---|------------------------------|
| 57270 | C | Repair of bowel pouch |
| 57280 | C | Suspension of vagina |
| 57282 | C | Colpopexy, extraperitoneal |
| 57283 | C | Colpopexy, intraperitoneal |
| 57292 | C | Construct vagina with graft |
| 57305 | C | Repair rectum-vagina fistula |
| 57307 | C | Fistula repair & colostomy |
| 57308 | C | Fistula repair, transperine |
| 57311 | C | Repair urethrovaginal lesion |
| 57335 | C | Repair vagina |
| 57531 | C | Removal of cervix, radical |
| 57540 | C | Removal of residual cervix |
| 57545 | C | Remove cervix/repair pelvis |
| 58140 | C | Myomectomy abdom method |
| 58146 | C | Myomectomy abdom complex |
| 58150 | C | Total hysterectomy |
| 58152 | C | Total hysterectomy |
| 58180 | C | Partial hysterectomy |
| 58200 | C | Extensive hysterectomy |
| 58210 | C | Extensive hysterectomy |
| 58240 | C | Removal of pelvis contents |
| 58260 | C | Vaginal hysterectomy |
| 58262 | C | Vag hyst including t/o |
| 58263 | C | Vag hyst w/t/o & vag repair |
| 58267 | C | Vag hyst w/urinary repair |
| 58270 | C | Vag hyst w/enterocele repair |
| 58275 | C | Hysterectomy/revise vagina |
| 58280 | C | Hysterectomy/revise vagina |
| 58285 | C | Extensive hysterectomy |
| 58290 | C | Vag hyst complex |
| 58291 | C | Vag hyst incl t/o, complex |
| 58292 | C | Vag hyst t/o & repair, compl |
| 58293 | C | Vag hyst w/uro repair, compl |
| 58294 | C | Vag hyst w/enterocele, compl |
| 58400 | C | Suspension of uterus |
| 58410 | C | Suspension of uterus |

| CPT/ HCPCS | CY 2006 Final Status Indicator | Description |
|-----------------------|---|------------------------------|
| 58520 | C | Repair of ruptured uterus |
| 58540 | C | Revision of uterus |
| 58605 | C | Division of fallopian tube |
| 58611 | C | Ligate oviduct(s) add-on |
| 58700 | C | Removal of fallopian tube |
| 58720 | C | Removal of ovary/tube(s) |
| 58740 | C | Revise fallopian tube(s) |
| 58750 | C | Repair oviduct |
| 58752 | C | Revise ovarian tube(s) |
| 58760 | C | Remove tubal obstruction |
| 58805 | C | Drainage of ovarian cyst(s) |
| 58822 | C | Drain ovary abscess, percut |
| 58825 | C | Transposition, ovary(s) |
| 58940 | C | Removal of ovary(s) |
| 58943 | C | Removal of ovary(s) |
| 58950 | C | Resect ovarian malignancy |
| 58951 | C | Resect ovarian malignancy |
| 58952 | C | Resect ovarian malignancy |
| 58953 | C | Tah, rad dissect for debulk |
| 58954 | C | Tah rad debulk/lymph remove |
| 58956 | C | Bso, omentectomy w/tah |
| 58960 | C | Exploration of abdomen |
| 59120 | C | Treat ectopic pregnancy |
| 59121 | C | Treat ectopic pregnancy |
| 59130 | C | Treat ectopic pregnancy |
| 59135 | C | Treat ectopic pregnancy |
| 59136 | C | Treat ectopic pregnancy |
| 59140 | C | Treat ectopic pregnancy |
| 59325 | C | Revision of cervix |
| 59350 | C | Repair of uterus |
| 59514 | C | Cesarean delivery only |
| 59525 | C | Remove uterus after cesarean |
| 59620 | C | Attempted vbac delivery only |
| 59830 | C | Treat uterus infection |
| 59850 | C | Abortion |
| 59851 | C | Abortion |

| CPT/ HCPCS | CY 2006 Final Status Indicator | Description |
|-----------------------|---|------------------------------|
| 59852 | C | Abortion |
| 59855 | C | Abortion |
| 59856 | C | Abortion |
| 59857 | C | Abortion |
| 60254 | C | Extensive thyroid surgery |
| 60270 | C | Removal of thyroid |
| 60271 | C | Removal of thyroid |
| 60502 | C | Re-explore parathyroids |
| 60505 | C | Explore parathyroid glands |
| 60520 | C | Removal of thymus gland |
| 60521 | C | Removal of thymus gland |
| 60522 | C | Removal of thymus gland |
| 60540 | C | Explore adrenal gland |
| 60545 | C | Explore adrenal gland |
| 60600 | C | Remove carotid body lesion |
| 60605 | C | Remove carotid body lesion |
| 60650 | C | Laparoscopy adrenalectomy |
| 61105 | C | Twist drill hole |
| 61107 | C | Drill skull for implantation |
| 61108 | C | Drill skull for drainage |
| 61120 | C | Burr hole for puncture |
| 61140 | C | Pierce skull for biopsy |
| 61150 | C | Pierce skull for drainage |
| 61151 | C | Pierce skull for drainage |
| 61154 | C | Pierce skull & remove clot |
| 61156 | C | Pierce skull for drainage |
| 61210 | C | Pierce skull, implant device |
| 61250 | C | Pierce skull & explore |
| 61253 | C | Pierce skull & explore |
| 61304 | C | Open skull for exploration |
| 61305 | C | Open skull for exploration |
| 61312 | C | Open skull for drainage |
| 61313 | C | Open skull for drainage |
| 61314 | C | Open skull for drainage |
| 61315 | C | Open skull for drainage |
| 61316 | C | Implt cran bone flap to abdo |

| CPT/ HCPCS | CY 2006 Final Status Indicator | Description |
|-----------------------|---|------------------------------|
| 61320 | C | Open skull for drainage |
| 61321 | C | Open skull for drainage |
| 61322 | C | Decompressive craniotomy |
| 61323 | C | Decompressive lobectomy |
| 61332 | C | Explore/biopsy eye socket |
| 61333 | C | Explore orbit/remove lesion |
| 61340 | C | Subtemporal decompression |
| 61343 | C | Incise skull (press relief) |
| 61345 | C | Relieve cranial pressure |
| 61440 | C | Incise skull for surgery |
| 61450 | C | Incise skull for surgery |
| 61458 | C | Incise skull for brain wound |
| 61460 | C | Incise skull for surgery |
| 61470 | C | Incise skull for surgery |
| 61480 | C | Incise skull for surgery |
| 61490 | C | Incise skull for surgery |
| 61500 | C | Removal of skull lesion |
| 61501 | C | Remove infected skull bone |
| 61510 | C | Removal of brain lesion |
| 61512 | C | Remove brain lining lesion |
| 61514 | C | Removal of brain abscess |
| 61516 | C | Removal of brain lesion |
| 61517 | C | Implt brain chemotx add-on |
| 61518 | C | Removal of brain lesion |
| 61519 | C | Remove brain lining lesion |
| 61520 | C | Removal of brain lesion |
| 61521 | C | Removal of brain lesion |
| 61522 | C | Removal of brain abscess |
| 61524 | C | Removal of brain lesion |
| 61526 | C | Removal of brain lesion |
| 61530 | C | Removal of brain lesion |
| 61531 | C | Implant brain electrodes |
| 61533 | C | Implant brain electrodes |
| 61534 | C | Removal of brain lesion |
| 61535 | C | Remove brain electrodes |
| 61536 | C | Removal of brain lesion |

| CPT/ HCPCS | CY 2006 Final Status Indicator | Description |
|-----------------------|---|------------------------------|
| 61537 | C | Removal of brain tissue |
| 61538 | C | Removal of brain tissue |
| 61539 | C | Removal of brain tissue |
| 61540 | C | Removal of brain tissue |
| 61541 | C | Incision of brain tissue |
| 61542 | C | Removal of brain tissue |
| 61543 | C | Removal of brain tissue |
| 61544 | C | Remove & treat brain lesion |
| 61545 | C | Excision of brain tumor |
| 61546 | C | Removal of pituitary gland |
| 61548 | C | Removal of pituitary gland |
| 61550 | C | Release of skull seams |
| 61552 | C | Release of skull seams |
| 61556 | C | Incise skull/sutures |
| 61557 | C | Incise skull/sutures |
| 61558 | C | Excision of skull/sutures |
| 61559 | C | Excision of skull/sutures |
| 61563 | C | Excision of skull tumor |
| 61564 | C | Excision of skull tumor |
| 61566 | C | Removal of brain tissue |
| 61567 | C | Incision of brain tissue |
| 61570 | C | Remove foreign body, brain |
| 61571 | C | Incise skull for brain wound |
| 61575 | C | Skull base/brainstem surgery |
| 61576 | C | Skull base/brainstem surgery |
| 61580 | C | Craniofacial approach, skull |
| 61581 | C | Craniofacial approach, skull |
| 61582 | C | Craniofacial approach, skull |
| 61583 | C | Craniofacial approach, skull |
| 61584 | C | Orbitocranial approach/skull |
| 61585 | C | Orbitocranial approach/skull |
| 61586 | C | Resect nasopharynx, skull |
| 61590 | C | Infratemporal approach/skull |
| 61591 | C | Infratemporal approach/skull |
| 61592 | C | Orbitocranial approach/skull |
| 61595 | C | Transtemporal approach/skull |

| CPT/ HCPCS | CY 2006 Final Status Indicator | Description |
|-----------------------|---|------------------------------|
| 61596 | C | Transcochlear approach/skull |
| 61597 | C | Transcondylar approach/skull |
| 61598 | C | Transpetrosal approach/skull |
| 61600 | C | Resect/excise cranial lesion |
| 61601 | C | Resect/excise cranial lesion |
| 61605 | C | Resect/excise cranial lesion |
| 61606 | C | Resect/excise cranial lesion |
| 61607 | C | Resect/excise cranial lesion |
| 61608 | C | Resect/excise cranial lesion |
| 61609 | C | Transect artery, sinus |
| 61610 | C | Transect artery, sinus |
| 61611 | C | Transect artery, sinus |
| 61612 | C | Transect artery, sinus |
| 61613 | C | Remove aneurysm, sinus |
| 61615 | C | Resect/excise lesion, skull |
| 61616 | C | Resect/excise lesion, skull |
| 61618 | C | Repair dura |
| 61619 | C | Repair dura |
| 61624 | C | Transcath occlusion, cns |
| 61680 | C | Intracranial vessel surgery |
| 61682 | C | Intracranial vessel surgery |
| 61684 | C | Intracranial vessel surgery |
| 61686 | C | Intracranial vessel surgery |
| 61690 | C | Intracranial vessel surgery |
| 61692 | C | Intracranial vessel surgery |
| 61697 | C | Brain aneurysm repr, complx |
| 61698 | C | Brain aneurysm repr, complx |
| 61700 | C | Brain aneurysm repr, simple |
| 61702 | C | Inner skull vessel surgery |
| 61703 | C | Clamp neck artery |
| 61705 | C | Revise circulation to head |
| 61708 | C | Revise circulation to head |
| 61710 | C | Revise circulation to head |
| 61711 | C | Fusion of skull arteries |
| 61720 | C | Incise skull/brain surgery |
| 61735 | C | Incise skull/brain surgery |

| CPT/ HCPCS | CY 2006 Final Status Indicator | Description |
|-----------------------|---|------------------------------|
| 61750 | C | Incise skull/brain biopsy |
| 61751 | C | Brain biopsy w/ct/mr guide |
| 61760 | C | Implant brain electrodes |
| 61770 | C | Incise skull for treatment |
| 61850 | C | Implant neuroelectrodes |
| 61860 | C | Implant neuroelectrodes |
| 61863 | C | Implant neuroelectrode |
| 61864 | C | Implant neuroelectrde, add'l |
| 61867 | C | Implant neuroelectrode |
| 61868 | C | Implant neuroelectrde, add'l |
| 61870 | C | Implant neuroelectrodes |
| 61875 | C | Implant neuroelectrodes |
| 62000 | C | Treat skull fracture |
| 62005 | C | Treat skull fracture |
| 62010 | C | Treatment of head injury |
| 62100 | C | Repair brain fluid leakage |
| 62115 | C | Reduction of skull defect |
| 62116 | C | Reduction of skull defect |
| 62117 | C | Reduction of skull defect |
| 62120 | C | Repair skull cavity lesion |
| 62121 | C | Incise skull repair |
| 62140 | C | Repair of skull defect |
| 62141 | C | Repair of skull defect |
| 62142 | C | Remove skull plate/flap |
| 62143 | C | Replace skull plate/flap |
| 62145 | C | Repair of skull & brain |
| 62146 | C | Repair of skull with graft |
| 62147 | C | Repair of skull with graft |
| 62148 | C | Retr bone flap to fix skull |
| 62161 | C | Dissect brain w/scope |
| 62162 | C | Remove colloid cyst w/scope |
| 62163 | C | Neuroendoscopy w/fb removal |
| 62164 | C | Remove brain tumor w/scope |
| 62165 | C | Remove pituit tumor w/scope |
| 62180 | C | Establish brain cavity shunt |
| 62190 | C | Establish brain cavity shunt |

| CPT/ HCPCS | CY 2006 Final Status Indicator | Description |
|-----------------------|---|------------------------------|
| 62192 | C | Establish brain cavity shunt |
| 62200 | C | Establish brain cavity shunt |
| 62201 | C | Brain cavity shunt w/scope |
| 62220 | C | Establish brain cavity shunt |
| 62223 | C | Establish brain cavity shunt |
| 62256 | C | Remove brain cavity shunt |
| 62258 | C | Replace brain cavity shunt |
| 63043 | C | Laminotomy, add'l cervical |
| 63044 | C | Laminotomy, add'l lumbar |
| 63050 | C | Cervical laminoplasty |
| 63051 | C | C-laminoplasty w/graft/plate |
| 63076 | C | Neck spine disk surgery |
| 63077 | C | Spine disk surgery, thorax |
| 63078 | C | Spine disk surgery, thorax |
| 63081 | C | Removal of vertebral body |
| 63082 | C | Remove vertebral body add-on |
| 63085 | C | Removal of vertebral body |
| 63086 | C | Remove vertebral body add-on |
| 63087 | C | Removal of vertebral body |
| 63088 | C | Remove vertebral body add-on |
| 63090 | C | Removal of vertebral body |
| 63091 | C | Remove vertebral body add-on |
| 63101 | C | Removal of vertebral body |
| 63102 | C | Removal of vertebral body |
| 63103 | C | Remove vertebral body add-on |
| 63170 | C | Incise spinal cord tract(s) |
| 63172 | C | Drainage of spinal cyst |
| 63173 | C | Drainage of spinal cyst |
| 63180 | C | Revise spinal cord ligaments |
| 63182 | C | Revise spinal cord ligaments |
| 63185 | C | Incise spinal column/nerves |
| 63190 | C | Incise spinal column/nerves |
| 63191 | C | Incise spinal column/nerves |
| 63194 | C | Incise spinal column & cord |
| 63195 | C | Incise spinal column & cord |
| 63196 | C | Incise spinal column & cord |

| CPT/ HCPCS | CY 2006 Final Status Indicator | Description |
|-----------------------|---|------------------------------|
| 63197 | C | Incise spinal column & cord |
| 63198 | C | Incise spinal column & cord |
| 63199 | C | Incise spinal column & cord |
| 63200 | C | Release of spinal cord |
| 63250 | C | Revise spinal cord vessels |
| 63251 | C | Revise spinal cord vessels |
| 63252 | C | Revise spinal cord vessels |
| 63265 | C | Excise intraspinal lesion |
| 63266 | C | Excise intraspinal lesion |
| 63267 | C | Excise intraspinal lesion |
| 63268 | C | Excise intraspinal lesion |
| 63270 | C | Excise intraspinal lesion |
| 63271 | C | Excise intraspinal lesion |
| 63272 | C | Excise intraspinal lesion |
| 63273 | C | Excise intraspinal lesion |
| 63275 | C | Biopsy/excise spinal tumor |
| 63276 | C | Biopsy/excise spinal tumor |
| 63277 | C | Biopsy/excise spinal tumor |
| 63278 | C | Biopsy/excise spinal tumor |
| 63280 | C | Biopsy/excise spinal tumor |
| 63281 | C | Biopsy/excise spinal tumor |
| 63282 | C | Biopsy/excise spinal tumor |
| 63283 | C | Biopsy/excise spinal tumor |
| 63285 | C | Biopsy/excise spinal tumor |
| 63286 | C | Biopsy/excise spinal tumor |
| 63287 | C | Biopsy/excise spinal tumor |
| 63290 | C | Biopsy/excise spinal tumor |
| 63295 | C | Repair of laminectomy defect |
| 63300 | C | Removal of vertebral body |
| 63301 | C | Removal of vertebral body |
| 63302 | C | Removal of vertebral body |
| 63303 | C | Removal of vertebral body |
| 63304 | C | Removal of vertebral body |
| 63305 | C | Removal of vertebral body |
| 63306 | C | Removal of vertebral body |
| 63307 | C | Removal of vertebral body |

| CPT/ HCPCS | CY 2006 Final Status Indicator | Description |
|-----------------------|---|------------------------------|
| 63308 | C | Remove vertebral body add-on |
| 63700 | C | Repair of spinal herniation |
| 63702 | C | Repair of spinal herniation |
| 63704 | C | Repair of spinal herniation |
| 63706 | C | Repair of spinal herniation |
| 63707 | C | Repair spinal fluid leakage |
| 63709 | C | Repair spinal fluid leakage |
| 63710 | C | Graft repair of spine defect |
| 63740 | C | Install spinal shunt |
| 64752 | C | Incision of vagus nerve |
| 64755 | C | Incision of stomach nerves |
| 64760 | C | Incision of vagus nerve |
| 64804 | C | Remove sympathetic nerves |
| 64809 | C | Remove sympathetic nerves |
| 64818 | C | Remove sympathetic nerves |
| 64866 | C | Fusion of facial/other nerve |
| 64868 | C | Fusion of facial/other nerve |
| 65273 | C | Repair of eye wound |
| 69155 | C | Extensive ear/neck surgery |
| 69535 | C | Remove part of temporal bone |
| 69554 | C | Remove ear lesion |
| 69950 | C | Incise inner ear nerve |
| 69970 | C | Remove inner ear lesion |
| 75900 | C | Intravascular cath exchange |
| 75952 | C | Endovasc repair abdom aorta |
| 75953 | C | Abdom aneurysm endovas rpr |
| 75954 | C | Iliac aneurysm endovas rpr |
| 75956 | C | Xray, endovasc thor ao repr |
| 75957 | C | Xray, endovasc thor ao repr |
| 75958 | C | Xray, place prox ext thor ao |
| 75959 | C | Xray, place dist ext thor ao |
| 92970 | C | Cardioassist, internal |
| 92971 | C | Cardioassist, external |
| 92975 | C | Dissolve clot, heart vessel |
| 92992 | C | Revision of heart chamber |
| 92993 | C | Revision of heart chamber |

| CPT/ HCPCS | CY 2006 Final Status Indicator | Description |
|-----------------------|---|------------------------------|
| 99190 | C | Special pump services |
| 99191 | C | Special pump services |
| 99192 | C | Special pump services |
| 99251 | C | Initial inpatient consult |
| 99252 | C | Initial inpatient consult |
| 99253 | C | Initial inpatient consult |
| 99254 | C | Initial inpatient consult |
| 99255 | C | Initial inpatient consult |
| 99293 | C | Ped critical care, initial |
| 99294 | C | Ped critical care, subseq |
| 99295 | C | Neonate crit care, initial |
| 99296 | C | Neonate critical care subseq |
| 99298 | C | Ic for lbw infant < 1500 gm |
| 99299 | C | Ic, lbw infant 1500-2500 gm |
| 99356 | C | Prolonged service, inpatient |
| 99357 | C | Prolonged service, inpatient |
| 99433 | C | Normal newborn care/hospital |
| 0021T | C | Fetal oximetry, trnsvag/cerv |
| 0024T | C | Transcath cardiac reduction |
| 0048T | C | Implant ventricular device |
| 0049T | C | External circulation assist |
| 0050T | C | Removal circulation assist |
| 0051T | C | Implant total heart system |
| 0052T | C | Replace component heart syst |
| 0053T | C | Replace component heart syst |
| 0075T | C | Perq stent/chest vert art |
| 0076T | C | S&i stent/chest vert art |
| 0077T | C | Cereb therm perfusion probe |
| 0078T | C | Endovasc aort repr w/device |
| 0079T | C | Endovasc visc extnsn repr |
| 0080T | C | Endovasc aort repr rad s&i |
| 0081T | C | Endovasc visc extnsn s&i |
| 0090T | C | Cervical artific disc |
| 0091T | C | Lumbar artific disc |
| 0092T | C | Artific disc addl |
| 0093T | C | Cervical artific disectomy |

| CPT/ HCPCS | CY 2006 Final Status Indicator | Description |
|---------------|--------------------------------------|------------------------------|
| 0094T | C | Lumbar artifice discectomy |
| 0095T | C | Artifice discectomy addl |
| 0096T | C | Rev cervical artifice disc |
| 0097T | C | Rev lumbar artifice disc |
| 0098T | C | Rev artifice disc addl |
| 0153T | C | Implant Aneur Sensor Add-On |
| G0341 | C | Percutaneous islet celltrans |
| G0342 | C | Laparoscopy islet cell trans |
| G0343 | C | Laparotomy islet cell transp |

**Addendum L.—Out-Migration Wage Adjustment¹
CY 2006**

| Provider Number | | Out-Migration Adjustment | Qualifying County Name |
|--------------------|---|-----------------------------|---------------------------|
| 010005 | | 0.0259 | MARSHALL |
| 010008 | * | 0.0212 | CRENSHAW |
| 010009 | | 0.0092 | MORGAN |
| 010010 | | 0.0259 | MARSHALL |
| 010012 | * | 0.0205 | DE KALB |
| 010022 | * | 0.0714 | CHEROKEE |
| 010025 | * | 0.0235 | CHAMBERS |
| 010029 | * | 0.0107 | LEE |
| 010035 | * | 0.0375 | CULLMAN |
| 010038 | | 0.0062 | CALHOUN |
| 010045 | * | 0.0160 | FAYETTE |
| 010047 | | 0.0155 | BUTLER |
| 010054 | | 0.0092 | MORGAN |
| 010061 | | 0.0506 | JACKSON |
| 010072 | * | 0.0310 | TALLADEGA |
| 010078 | | 0.0062 | CALHOUN |
| 010083 | * | 0.0121 | BALDWIN |
| 010085 | | 0.0092 | MORGAN |
| 010100 | * | 0.0121 | BALDWIN |
| 010101 | * | 0.0310 | TALLADEGA |
| 010109 | | 0.0451 | PICKENS |
| 010115 | | 0.0093 | FRANKLIN |
| 010129 | | 0.0121 | BALDWIN |

| Provider Number | | Out-Migration Adjustment | Qualifying County Name |
|-----------------|---|--------------------------|------------------------|
| 010143 | * | 0.0375 | CULLMAN |
| 010146 | | 0.0062 | CALHOUN |
| 010150 | * | 0.0155 | BUTLER |
| 010158 | * | 0.0093 | FRANKLIN |
| 010164 | * | 0.0310 | TALLADEGA |
| 013027 | | 0.0121 | BALDWIN |
| 040014 | * | 0.0159 | WHITE |
| 040019 | * | 0.0697 | ST. FRANCIS |
| 040047 | * | 0.0090 | RANDOLPH |
| 040069 | * | 0.0140 | MISSISSIPPI |
| 040071 | | 0.0026 | JEFFERSON |
| 040076 | * | 0.1075 | HOT SPRING |
| 040100 | * | 0.0159 | WHITE |
| 050008 | | 0.0026 | SAN FRANCISCO |
| 050009 | * | 0.0478 | NAPA |
| 050013 | * | 0.0478 | NAPA |
| 050014 | * | 0.0131 | AMADOR |
| 050016 | | 0.0103 | SAN LUIS OBISPO |
| 050042 | * | 0.0219 | TEHAMA |
| 050046 | | 0.0156 | VENTURA |
| 050047 | | 0.0026 | SAN FRANCISCO |
| 050055 | | 0.0026 | SAN FRANCISCO |
| 050065 | * | 0.0029 | ORANGE |
| 050069 | * | 0.0029 | ORANGE |
| 050073 | * | 0.0269 | SOLANO |
| 050076 | * | 0.0026 | SAN FRANCISCO |
| 050082 | | 0.0156 | VENTURA |
| 050084 | | 0.0555 | SAN JOAQUIN |
| 050089 | * | 0.0152 | SAN BERNARDINO |
| 050090 | * | 0.0308 | SONOMA |
| 050099 | * | 0.0152 | SAN BERNARDINO |
| 050101 | | 0.0269 | SOLANO |
| 050117 | | 0.0463 | MERCED |
| 050118 | * | 0.0555 | SAN JOAQUIN |
| 050122 | | 0.0555 | SAN JOAQUIN |
| 050129 | * | 0.0152 | SAN BERNARDINO |
| 050133 | | 0.0170 | YUBA |
| 050136 | * | 0.0308 | SONOMA |
| 050140 | * | 0.0152 | SAN BERNARDINO |
| 050150 | * | 0.0316 | NEVADA |

| Provider Number | | Out-Migration Adjustment | Qualifying County Name |
|------------------------|---|---------------------------------|-------------------------------|
| 050152 | | 0.0026 | SAN FRANCISCO |
| 050159 | | 0.0156 | VENTURA |
| 050167 | | 0.0555 | SAN JOAQUIN |
| 050168 | * | 0.0029 | ORANGE |
| 050173 | * | 0.0029 | ORANGE |
| 050174 | * | 0.0308 | SONOMA |
| 050177 | | 0.0156 | VENTURA |
| 050193 | * | 0.0029 | ORANGE |
| 050224 | * | 0.0029 | ORANGE |
| 050226 | * | 0.0029 | ORANGE |
| 050228 | * | 0.0026 | SAN FRANCISCO |
| 050230 | * | 0.0029 | ORANGE |
| 050232 | | 0.0103 | SAN LUIS OBISPO |
| 050236 | | 0.0156 | VENTURA |
| 050245 | * | 0.0152 | SAN BERNARDINO |
| 050272 | * | 0.0152 | SAN BERNARDINO |
| 050279 | * | 0.0152 | SAN BERNARDINO |
| 050291 | * | 0.0308 | SONOMA |
| 050298 | * | 0.0152 | SAN BERNARDINO |
| 050300 | * | 0.0152 | SAN BERNARDINO |
| 050313 | | 0.0555 | SAN JOAQUIN |
| 050325 | | 0.0176 | TUOLUMNE |
| 050327 | * | 0.0152 | SAN BERNARDINO |
| 050331 | * | 0.0308 | SONOMA |
| 050335 | | 0.0176 | TUOLUMNE |
| 050336 | | 0.0555 | SAN JOAQUIN |
| 050348 | * | 0.0029 | ORANGE |
| 050367 | | 0.0269 | SOLANO |
| 050377 | | 0.0062 | MADERA |
| 050385 | * | 0.0308 | SONOMA |
| 050394 | | 0.0156 | VENTURA |
| 050407 | | 0.0026 | SAN FRANCISCO |
| 050426 | * | 0.0029 | ORANGE |
| 050444 | | 0.0463 | MERCED |
| 050454 | | 0.0026 | SAN FRANCISCO |
| 050457 | | 0.0026 | SAN FRANCISCO |
| 050469 | * | 0.0152 | SAN BERNARDINO |

| Provider Number | | Out-Migration Adjustment | Qualifying County Name |
|------------------------|---|---------------------------------|-------------------------------|
| 050476 | | 0.0257 | LAKE |
| 050494 | * | 0.0316 | NEVADA |
| 050506 | | 0.0103 | SAN LUIS OBISPO |
| 050517 | * | 0.0152 | SAN BERNARDINO |
| 050526 | * | 0.0029 | ORANGE |
| 050528 | * | 0.0463 | MERCED |
| 050535 | * | 0.0029 | ORANGE |
| 050539 | | 0.0257 | LAKE |
| 050539 | | 0.0257 | LAKE |
| 050543 | * | 0.0029 | ORANGE |
| 050547 | * | 0.0308 | SONOMA |
| 050548 | * | 0.0029 | ORANGE |
| 050549 | * | 0.0156 | VENTURA |
| 050550 | * | 0.0029 | ORANGE |
| 050551 | * | 0.0029 | ORANGE |
| 050567 | * | 0.0029 | ORANGE |
| 050568 | | 0.0062 | MADERA |
| 050570 | * | 0.0029 | ORANGE |
| 050580 | * | 0.0029 | ORANGE |
| 050584 | * | 0.0152 | SAN BERNARDINO |
| 050585 | * | 0.0029 | ORANGE |
| 050586 | * | 0.0152 | SAN BERNARDINO |
| 050589 | * | 0.0029 | ORANGE |
| 050592 | * | 0.0029 | ORANGE |
| 050594 | * | 0.0029 | ORANGE |
| 050603 | * | 0.0029 | ORANGE |
| 050609 | * | 0.0029 | ORANGE |
| 050616 | | 0.0156 | VENTURA |
| 050618 | * | 0.0152 | SAN BERNARDINO |
| 050633 | | 0.0103 | SAN LUIS OBISPO |
| 050667 | * | 0.0478 | NAPA |
| 050668 | * | 0.0026 | SAN FRANCISCO |
| 050678 | * | 0.0029 | ORANGE |
| 050680 | | 0.0269 | SOLANO |
| 050690 | * | 0.0308 | SONOMA |
| 050693 | * | 0.0029 | ORANGE |
| 050695 | | 0.0555 | SAN JOAQUIN |
| 050720 | * | 0.0029 | ORANGE |
| 050728 | * | 0.0308 | SONOMA |

| Provider Number | | Out-Migration Adjustment | Qualifying County Name |
|-----------------|---|--------------------------|------------------------|
| 050731 | | 0.0152 | SAN BERNARDINO |
| 052035 | | 0.0029 | ORANGE |
| 052037 | | 0.0152 | SAN BERNARDINO |
| 052039 | | 0.0029 | ORANGE |
| 053034 | | 0.0029 | ORANGE |
| 053037 | | 0.0152 | SAN BERNARDINO |
| 053304 | | 0.0029 | ORANGE |
| 054074 | | 0.0269 | SOLANO |
| 054077 | | 0.0156 | VENTURA |
| 054093 | | 0.0152 | SAN BERNARDINO |
| 054111 | | 0.0152 | SAN BERNARDINO |
| 054122 | | 0.0478 | NAPA |
| 054141 | | 0.0269 | SOLANO |
| 060001 | * | 0.0294 | WELD |
| 060003 | * | 0.0203 | BOULDER |
| 060027 | * | 0.0203 | BOULDER |
| 060103 | * | 0.0203 | BOULDER |
| 064007 | | 0.0203 | BOULDER |
| 070003 | * | 0.0009 | WINDHAM |
| 070006 | * | 0.0047 | FAIRFIELD |
| 070010 | * | 0.0047 | FAIRFIELD |
| 070018 | * | 0.0047 | FAIRFIELD |
| 070020 | | 0.0073 | MIDDLESEX |
| 070021 | * | 0.0009 | WINDHAM |
| 070028 | * | 0.0047 | FAIRFIELD |
| 070033 | * | 0.0047 | FAIRFIELD |
| 070034 | * | 0.0047 | FAIRFIELD |
| 074000 | | 0.0047 | FAIRFIELD |
| 074008 | | 0.0009 | WINDHAM |
| 074014 | | 0.0047 | FAIRFIELD |
| 080001 | | 0.0063 | NEW CASTLE |
| 080003 | | 0.0063 | NEW CASTLE |
| 082000 | | 0.0063 | NEW CASTLE |
| 083300 | | 0.0063 | NEW CASTLE |
| 084002 | | 0.0063 | NEW CASTLE |
| 100014 | | 0.0118 | VOLUSIA |
| 100017 | | 0.0118 | VOLUSIA |
| 100045 | * | 0.0118 | VOLUSIA |
| 100047 | | 0.0021 | CHARLOTTE |
| 100062 | | 0.0060 | MARION |

| Provider Number | | Out-Migration Adjustment | Qualifying County Name |
|------------------------|---|---------------------------------|-------------------------------|
| 100068 | | 0.0118 | VOLUSIA |
| 100072 | | 0.0118 | VOLUSIA |
| 100077 | | 0.0021 | CHARLOTTE |
| 100102 | | 0.0125 | COLUMBIA |
| 100118 | * | 0.0398 | FLAGLER |
| 100156 | | 0.0125 | COLUMBIA |
| 100175 | | 0.0231 | DE SOTO |
| 100212 | | 0.0060 | MARION |
| 100232 | | 0.0347 | PUTNAM |
| 100236 | | 0.0021 | CHARLOTTE |
| 100252 | * | 0.0233 | OKEECHOBEE |
| 100290 | | 0.0582 | SUMTER |
| 110023 | * | 0.0500 | GORDON |
| 110027 | | 0.0387 | FRANKLIN |
| 110029 | * | 0.0063 | HALL |
| 110041 | * | 0.0777 | HABERSHAM |
| 110069 | * | 0.0474 | HOUSTON |
| 110124 | | 0.0428 | WAYNE |
| 110136 | | 0.0261 | BALDWIN |
| 110150 | * | 0.0261 | BALDWIN |
| 110153 | * | 0.0474 | HOUSTON |
| 110187 | * | 0.1172 | LUMPKIN |
| 110189 | * | 0.0031 | FANNIN |
| 110190 | | 0.0182 | MACON |
| 110205 | * | 0.0779 | GILMER |
| 130003 | * | 0.0095 | NEZ PERCE |
| 130024 | | 0.0275 | BONNER |
| 130049 | * | 0.0349 | KOOTENAI |
| 130066 | | 0.0349 | KOOTENAI |
| 140012 | * | 0.0220 | LEE |
| 140026 | | 0.0346 | LA SALLE |
| 140033 | | 0.0147 | LAKE |
| 140043 | * | 0.0046 | WHITESIDE |
| 140058 | * | 0.0081 | MORGAN |
| 140084 | | 0.0147 | LAKE |
| 140100 | | 0.0147 | LAKE |
| 140110 | * | 0.0346 | LA SALLE |
| 140130 | | 0.0147 | LAKE |
| 140155 | | 0.0027 | KANKAKEE |
| 140160 | * | 0.0286 | STEPHENSON |
| 140161 | * | 0.0138 | LIVINGSTON |
| 140186 | | 0.0027 | KANKAKEE |
| 140202 | | 0.0147 | LAKE |

| Provider Number | | Out-Migration Adjustment | Qualifying County Name |
|------------------------|---|---------------------------------|-------------------------------|
| 140205 | | 0.0163 | BOONE |
| 140234 | * | 0.0346 | LA SALLE |
| 140291 | * | 0.0147 | LAKE |
| 150022 | | 0.0249 | MONTGOMERY |
| 150030 | * | 0.0201 | HENRY |
| 150035 | | 0.0083 | PORTER |
| 150045 | | 0.0416 | DE KALB |
| 150060 | | 0.0051 | VERMILLION |
| 150060 | | 0.0051 | VERMILLION |
| 150062 | | 0.0153 | DECATUR |
| 150065 | * | 0.0139 | JACKSON |
| 150076 | * | 0.0189 | MARSHALL |
| 150088 | * | 0.0196 | MADISON |
| 150091 | | 0.0573 | HUNTINGTON |
| 150102 | * | 0.0160 | STARKE |
| 150113 | * | 0.0196 | MADISON |
| 150122 | | 0.0199 | RIPLEY |
| 154047 | | 0.0189 | MARSHALL |
| 160013 | | 0.0218 | MUSCATINE |
| 160026 | * | 0.0496 | BOONE |
| 160030 | | 0.0040 | STORY |
| 160032 | | 0.0272 | JASPER |
| 160080 | * | 0.0049 | CLINTON |
| 160140 | | 0.0364 | PLYMOUTH |
| 170137 | * | 0.0336 | DOUGLAS |
| 180012 | * | 0.0083 | HARDIN |
| 180066 | * | 0.0567 | LOGAN |
| 180127 | * | 0.0352 | FRANKLIN |
| 180128 | | 0.0282 | LAWRENCE |
| 183028 | | 0.0083 | HARDIN |
| 190001 | * | 0.0645 | WASHINGTON |
| 190003 | * | 0.0107 | IBERIA |
| 190010 | | 0.0401 | TANGIPAHOA |
| 190015 | * | 0.0401 | TANGIPAHOA |
| 190017 | | 0.0235 | ST. LANDRY |
| 190054 | | 0.0107 | IBERIA |
| 190078 | | 0.0235 | ST. LANDRY |
| 190088 | | 0.0705 | WEBSTER |
| 190099 | * | 0.0390 | AVOUELLES |
| 190106 | * | 0.0238 | ALLEN |
| 190133 | | 0.0238 | ALLEN |
| 190144 | | 0.0705 | WEBSTER |
| 190184 | | 0.0161 | CALDWELL |

| Provider Number | | Out-Migration Adjustment | Qualifying County Name |
|------------------------|---|---------------------------------|-------------------------------|
| 190190 | | 0.0161 | CALDWELL |
| 190191 | * | 0.0235 | ST. LANDRY |
| 190246 | | 0.0161 | CALDWELL |
| 192040 | | 0.0401 | TANGIPAHOA |
| 193044 | | 0.0401 | TANGIPAHOA |
| 200002 | * | 0.0129 | LINCOLN |
| 200013 | | 0.0186 | WALDO |
| 200024 | * | 0.0071 | ANDROSCOGGIN |
| 200032 | | 0.0466 | OXFORD |
| 200034 | * | 0.0071 | ANDROSCOGGIN |
| 200050 | * | 0.0140 | HANCOCK |
| 210001 | | 0.0129 | WASHINGTON |
| 210004 | | 0.0040 | MONTGOMERY |
| 210016 | | 0.0040 | MONTGOMERY |
| 210018 | | 0.0040 | MONTGOMERY |
| 210022 | | 0.0040 | MONTGOMERY |
| 210023 | | 0.0209 | ANNE ARUNDEL |
| 210043 | | 0.0209 | ANNE ARUNDEL |
| 210048 | | 0.0287 | HOWARD |
| 210057 | | 0.0040 | MONTGOMERY |
| 220001 | * | 0.0056 | WORCESTER |
| 220002 | | 0.0249 | MIDDLESEX |
| 220003 | * | 0.0056 | WORCESTER |
| 220006 | | 0.0306 | ESSEX |
| 220010 | * | 0.0306 | ESSEX |
| 220011 | | 0.0249 | MIDDLESEX |
| 220019 | * | 0.0056 | WORCESTER |
| 220025 | * | 0.0056 | WORCESTER |
| 220028 | * | 0.0056 | WORCESTER |
| 220029 | * | 0.0306 | ESSEX |
| 220033 | * | 0.0306 | ESSEX |
| 220035 | * | 0.0306 | ESSEX |
| 220049 | | 0.0249 | MIDDLESEX |
| 220058 | * | 0.0056 | WORCESTER |
| 220062 | * | 0.0056 | WORCESTER |
| 220063 | | 0.0249 | MIDDLESEX |
| 220070 | | 0.0249 | MIDDLESEX |
| 220080 | * | 0.0306 | ESSEX |
| 220082 | | 0.0249 | MIDDLESEX |
| 220084 | | 0.0249 | MIDDLESEX |
| 220089 | | 0.0249 | MIDDLESEX |
| 220090 | * | 0.0056 | WORCESTER |
| 220095 | * | 0.0056 | WORCESTER |

| Provider Number | | Out-Migration Adjustment | Qualifying County Name |
|------------------------|---|---------------------------------|-------------------------------|
| 220098 | | 0.0249 | MIDDLESEX |
| 220101 | | 0.0249 | MIDDLESEX |
| 220105 | | 0.0249 | MIDDLESEX |
| 220163 | * | 0.0056 | WORCESTER |
| 220171 | | 0.0249 | MIDDLESEX |
| 220174 | * | 0.0306 | ESSEX |
| 222000 | | 0.0249 | MIDDLESEX |
| 222026 | | 0.0306 | ESSEX |
| 222044 | | 0.0306 | ESSEX |
| 223026 | | 0.0249 | MIDDLESEX |
| 223028 | | 0.0306 | ESSEX |
| 223029 | | 0.0056 | WORCESTER |
| 223033 | | 0.0056 | WORCESTER |
| 224007 | | 0.0249 | MIDDLESEX |
| 224022 | | 0.0249 | MIDDLESEX |
| 230003 | * | 0.0035 | OTTAWA |
| 230013 | * | 0.0091 | OAKLAND |
| 230015 | | 0.0359 | ST. JOSEPH |
| 230019 | * | 0.0091 | OAKLAND |
| 230021 | | 0.0136 | BERRIEN |
| 230022 | * | 0.0113 | BRANCH |
| 230029 | * | 0.0091 | OAKLAND |
| 230037 | * | 0.0178 | HILLSDALE |
| 230041 | | 0.0099 | BAY |
| 230042 | * | 0.0685 | ALLEGAN |
| 230047 | * | 0.0082 | MACOMB |
| 230069 | * | 0.0487 | LIVINGSTON |
| 230071 | * | 0.0091 | OAKLAND |
| 230072 | * | 0.0035 | OTTAWA |
| 230075 | | 0.0145 | CALHOUN |
| 230078 | * | 0.0136 | BERRIEN |
| 230092 | | 0.0389 | JACKSON |
| 230093 | * | 0.0079 | MECOSTA |
| 230096 | * | 0.0359 | ST. JOSEPH |
| 230099 | * | 0.0339 | MONROE |
| 230106 | * | 0.0030 | NEWAYGO |
| 230121 | * | 0.0691 | SHIAWASSEE |
| 230130 | * | 0.0091 | OAKLAND |
| 230151 | * | 0.0091 | OAKLAND |
| 230174 | * | 0.0035 | OTTAWA |
| 230184 | | 0.0389 | JACKSON |
| 230195 | * | 0.0082 | MACOMB |
| 230204 | * | 0.0082 | MACOMB |

| Provider Number | | Out-Migration Adjustment | Qualifying County Name |
|------------------------|---|---------------------------------|-------------------------------|
| 230207 | * | 0.0091 | OAKLAND |
| 230217 | * | 0.0145 | CALHOUN |
| 230222 | | 0.0228 | MIDLAND |
| 230223 | * | 0.0091 | OAKLAND |
| 230227 | * | 0.0082 | MACOMB |
| 230254 | * | 0.0091 | OAKLAND |
| 230257 | * | 0.0082 | MACOMB |
| 230264 | * | 0.0082 | MACOMB |
| 230269 | * | 0.0091 | OAKLAND |
| 230277 | * | 0.0091 | OAKLAND |
| 230279 | * | 0.0487 | LIVINGSTON |
| 232023 | | 0.0082 | MACOMB |
| 232025 | | 0.0136 | BERRIEN |
| 232028 | | 0.0145 | CALHOUN |
| 232034 | | 0.0685 | ALLEGAN |
| 233025 | | 0.0145 | CALHOUN |
| 233028 | | 0.0091 | OAKLAND |
| 234011 | | 0.0091 | OAKLAND |
| 234021 | | 0.0082 | MACOMB |
| 234023 | | 0.0091 | OAKLAND |
| 240013 | * | 0.0226 | MORRISON |
| 240018 | * | 0.1196 | GOODHUE |
| 240021 | | 0.0920 | LE SUEUR |
| 240044 | | 0.0868 | WINONA |
| 240064 | * | 0.0138 | ITASCA |
| 240069 | * | 0.0419 | STEELE |
| 240071 | * | 0.0454 | RICE |
| 240133 | | 0.0319 | MEEKER |
| 240152 | * | 0.0735 | KANABEC |
| 240152 | | 0.0735 | KANABEC |
| 240154 | | 0.0138 | ITASCA |
| 240187 | * | 0.0506 | MC LEOD |
| 240211 | * | 0.0705 | PINE |
| 250040 | * | 0.0294 | JACKSON |
| 250045 | | 0.0042 | HANCOCK |
| 260011 | | 0.0007 | COLE |
| 260025 | * | 0.0078 | MARION |
| 260047 | * | 0.0007 | COLE |
| 260074 | * | 0.0158 | RANDOLPH |
| 260097 | | 0.0425 | JOHNSON |
| 260127 | | 0.0158 | PIKE |
| 280054 | | 0.0137 | GAGE |
| 280077 | * | 0.0089 | DODGE |

| Provider Number | | Out-Migration Adjustment | Qualifying County Name |
|------------------------|---|---------------------------------|-------------------------------|
| 280123 | | 0.0137 | GAGE |
| 290019 | * | 0.0026 | CARSON CITY |
| 290049 | | 0.0026 | CARSON CITY |
| 293029 | | 0.0026 | CARSON CITY |
| 300011 | * | 0.0069 | HILLSBOROUGH |
| 300012 | * | 0.0069 | HILLSBOROUGH |
| 300017 | | 0.0361 | ROCKINGHAM |
| 300020 | * | 0.0069 | HILLSBOROUGH |
| 300023 | | 0.0361 | ROCKINGHAM |
| 300029 | | 0.0361 | ROCKINGHAM |
| 300034 | * | 0.0069 | HILLSBOROUGH |
| 303026 | | 0.0361 | ROCKINGHAM |
| 304001 | | 0.0361 | ROCKINGHAM |
| 310002 | * | 0.0351 | ESSEX |
| 310009 | * | 0.0351 | ESSEX |
| 310010 | | 0.0092 | MERCER |
| 310011 | | 0.0115 | CAPE MAY |
| 310013 | * | 0.0351 | ESSEX |
| 310018 | * | 0.0351 | ESSEX |
| 310021 | * | 0.0092 | MERCER |
| 310038 | * | 0.0350 | MIDDLESEX |
| 310039 | | 0.0350 | MIDDLESEX |
| 310044 | | 0.0092 | MERCER |
| 310054 | * | 0.0351 | ESSEX |
| 310070 | * | 0.0350 | MIDDLESEX |
| 310076 | * | 0.0351 | ESSEX |
| 310078 | * | 0.0351 | ESSEX |
| 310083 | * | 0.0351 | ESSEX |
| 310092 | | 0.0092 | MERCER |
| 310093 | * | 0.0351 | ESSEX |
| 310096 | * | 0.0351 | ESSEX |
| 310108 | | 0.0350 | MIDDLESEX |
| 310110 | | 0.0092 | MERCER |
| 310119 | * | 0.0351 | ESSEX |
| 310123 | | 0.0351 | ESSEX |
| 310124 | | 0.0350 | MIDDLESEX |
| 313025 | | 0.0351 | ESSEX |
| 313027 | | 0.0092 | MERCER |
| 314011 | | 0.0350 | MIDDLESEX |
| 320003 | | 0.0629 | SAN MIGUEL |
| 320011 | | 0.0442 | RIO ARRIBA |
| 320018 | | 0.0063 | DONA ANA |
| 320085 | | 0.0063 | DONA ANA |

| Provider Number | | Out-Migration Adjustment | Qualifying County Name |
|------------------------|---|---------------------------------|-------------------------------|
| 330004 | * | 0.0959 | ULSTER |
| 330008 | * | 0.0470 | WYOMING |
| 330027 | * | 0.0137 | NASSAU |
| 330094 | * | 0.0778 | COLUMBIA |
| 330106 | * | 0.0137 | NASSAU |
| 330126 | * | 0.0560 | ORANGE |
| 330135 | * | 0.0560 | ORANGE |
| 330167 | | 0.0137 | NASSAU |
| 330181 | * | 0.0137 | NASSAU |
| 330182 | * | 0.0137 | NASSAU |
| 330191 | * | 0.0026 | WARREN |
| 330198 | | 0.0137 | NASSAU |
| 330205 | * | 0.0560 | ORANGE |
| 330209 | * | 0.0560 | ORANGE |
| 330224 | | 0.0959 | ULSTER |
| 330225 | | 0.0137 | NASSAU |
| 330235 | * | 0.0270 | CAYUGA |
| 330259 | | 0.0137 | NASSAU |
| 330264 | * | 0.0560 | ORANGE |
| 330276 | | 0.0063 | FULTON |
| 330331 | | 0.0137 | NASSAU |
| 330332 | | 0.0137 | NASSAU |
| 330372 | | 0.0137 | NASSAU |
| 330386 | * | 0.1139 | SULLIVAN |
| 340015 | | 0.0267 | ROWAN |
| 340020 | | 0.0207 | LEE |
| 340021 | * | 0.0216 | CLEVELAND |
| 340037 | | 0.0216 | CLEVELAND |
| 340039 | * | 0.0144 | IREDELL |
| 340069 | * | 0.0053 | WAKE |
| 340070 | | 0.0448 | ALAMANCE |
| 340073 | * | 0.0053 | WAKE |
| 340085 | | 0.0377 | DAVIDSON |
| 340096 | | 0.0377 | DAVIDSON |
| 340104 | | 0.0216 | CLEVELAND |
| 340114 | * | 0.0053 | WAKE |
| 340126 | * | 0.0161 | WILSON |
| 340127 | * | 0.0961 | GRANVILLE |
| 340129 | * | 0.0144 | IREDELL |
| 340133 | | 0.0308 | MARTIN |
| 340138 | * | 0.0053 | WAKE |
| 340144 | * | 0.0144 | IREDELL |
| 340145 | * | 0.0563 | LINCOLN |

| Provider Number | | Out-Migration Adjustment | Qualifying County Name |
|------------------------|---|---------------------------------|-------------------------------|
| 340173 | * | 0.0053 | WAKE |
| 344014 | | 0.0053 | WAKE |
| 360013 | * | 0.0166 | SHELBY |
| 360025 | * | 0.0087 | ERIE |
| 360036 | * | 0.0263 | WAYNE |
| 360065 | * | 0.0141 | HURON |
| 360070 | | 0.0028 | STARK |
| 360078 | * | 0.0159 | PORTAGE |
| 360084 | | 0.0028 | STARK |
| 360086 | * | 0.0168 | CLARK |
| 360093 | | 0.0120 | DEFIANCE |
| 360095 | * | 0.0087 | HANCOCK |
| 360100 | | 0.0028 | STARK |
| 360107 | * | 0.0213 | SANDUSKY |
| 360131 | | 0.0028 | STARK |
| 360151 | | 0.0028 | STARK |
| 360156 | | 0.0213 | SANDUSKY |
| 360175 | * | 0.0159 | CLINTON |
| 360187 | * | 0.0168 | CLARK |
| 360197 | * | 0.0092 | LOGAN |
| 360267 | | 0.0028 | STARK |
| 362007 | | 0.0213 | SANDUSKY |
| 370004 | * | 0.0193 | OTTAWA |
| 370014 | * | 0.0831 | BRYAN |
| 370015 | * | 0.0463 | MAYES |
| 370023 | | 0.0084 | STEPHENS |
| 370065 | | 0.0121 | CRAIG |
| 370113 | * | 0.0205 | DELAWARE |
| 370149 | | 0.0356 | POTTAWATOMIE |
| 370179 | * | 0.0314 | OKFUSKEE |
| 380002 | | 0.0130 | JOSEPHINE |
| 380008 | * | 0.0201 | LINN |
| 380022 | | 0.0201 | LINN |
| 380029 | | 0.0075 | MARION |
| 380051 | | 0.0075 | MARION |
| 380056 | | 0.0075 | MARION |
| 390011 | | 0.0012 | CAMBRIA |
| 390044 | | 0.0200 | BERKS |
| 390046 | | 0.0098 | YORK |
| 390056 | | 0.0042 | HUNTINGDON |
| 390065 | * | 0.0501 | ADAMS |
| 390066 | * | 0.0259 | LEBANON |
| 390096 | | 0.0200 | BERKS |

| Provider Number | | Out-Migration Adjustment | Qualifying County Name |
|------------------------|---|---------------------------------|-------------------------------|
| 390101 | | 0.0098 | YORK |
| 390110 | * | 0.0012 | CAMBRIA |
| 390130 | | 0.0012 | CAMBRIA |
| 390138 | * | 0.0325 | FRANKLIN |
| 390146 | | 0.0053 | WARREN |
| 390150 | * | 0.0206 | GREENE |
| 390151 | * | 0.0325 | FRANKLIN |
| 390162 | | 0.0200 | NORTHAMPTON |
| 390201 | | 0.1127 | MONROE |
| 390233 | | 0.0098 | YORK |
| 392030 | | 0.0501 | ADAMS |
| 392034 | | 0.0200 | NORTHAMPTON |
| 393026 | | 0.0200 | BERKS |
| 393037 | | 0.0098 | YORK |
| 393050 | | 0.0200 | NORTHAMPTON |
| 394020 | | 0.0259 | LEBANON |
| 420007 | | 0.0001 | SPARTANBURG |
| 420020 | * | 0.0035 | GEORGETOWN |
| 420027 | | 0.0210 | ANDERSON |
| 420030 | * | 0.0103 | COLLETON |
| 420039 | * | 0.0153 | UNION |
| 420043 | | 0.0177 | CHEROKEE |
| 420068 | * | 0.0097 | ORANGEBURG |
| 420070 | * | 0.0101 | SUMTER |
| 420083 | | 0.0001 | SPARTANBURG |
| 420093 | | 0.0001 | SPARTANBURG |
| 420098 | | 0.0035 | GEORGETOWN |
| 423029 | | 0.0210 | ANDERSON |
| 440008 | * | 0.0663 | HENDERSON |
| 440024 | | 0.0387 | BRADLEY |
| 440030 | | 0.0056 | HAMBLEN |
| 440035 | * | 0.0441 | MONTGOMERY |
| 440047 | | 0.0499 | GIBSON |
| 440056 | | 0.0321 | JEFFERSON |
| 440060 | * | 0.0499 | GIBSON |
| 440063 | | 0.0011 | WASHINGTON |
| 440067 | * | 0.0056 | HAMBLEN |
| 440073 | * | 0.0513 | MAURY |
| 440105 | | 0.0011 | WASHINGTON |
| 440114 | | 0.0523 | LAUDERDALE |
| 440115 | | 0.0499 | GIBSON |
| 440143 | | 0.0448 | MARSHALL |
| 440148 | * | 0.0568 | DE KALB |

| Provider Number | | Out-Migration Adjustment | Qualifying County Name |
|------------------------|---|---------------------------------|-------------------------------|
| 440153 | | 0.0007 | COCKE |
| 440174 | | 0.0372 | HAYWOOD |
| 440181 | | 0.0407 | HARDEMAN |
| 440184 | | 0.0011 | WASHINGTON |
| 440185 | * | 0.0387 | BRADLEY |
| 444006 | | 0.0011 | WASHINGTON |
| 450032 | * | 0.0416 | HARRISON |
| 450039 | * | 0.0097 | TARRANT |
| 450050 | | 0.0750 | WARD |
| 450059 | * | 0.0073 | COMAL |
| 450064 | * | 0.0097 | TARRANT |
| 450087 | * | 0.0097 | TARRANT |
| 450099 | * | 0.0180 | GRAY |
| 450121 | * | 0.0097 | TARRANT |
| 450135 | * | 0.0097 | TARRANT |
| 450137 | * | 0.0097 | TARRANT |
| 450144 | * | 0.0573 | ANDREWS |
| 450163 | | 0.0134 | KLEBERG |
| 450187 | * | 0.0264 | WASHINGTON |
| 450194 | * | 0.0328 | CHEROKEE |
| 450214 | * | 0.0368 | WHARTON |
| 450224 | * | 0.0411 | WOOD |
| 450347 | * | 0.0427 | WALKER |
| 450362 | | 0.0486 | BURNET |
| 450370 | | 0.0258 | COLORADO |
| 450389 | * | 0.0881 | HENDERSON |
| 450395 | | 0.0484 | POLK |
| 450419 | * | 0.0097 | TARRANT |
| 450438 | * | 0.0258 | COLORADO |
| 450447 | * | 0.0358 | NAVARRO |
| 450451 | * | 0.0551 | SOMERVELL |
| 450465 | | 0.0435 | MATAGORDA |
| 450547 | * | 0.0411 | WOOD |
| 450563 | * | 0.0097 | TARRANT |
| 450565 | | 0.0486 | PALO PINTO |
| 450596 | | 0.0808 | HOOD |
| 450597 | | 0.0077 | DE WITT |
| 450623 | * | 0.0492 | FANNIN |
| 450626 | | 0.0294 | JACKSON |
| 450626 | | 0.0294 | JACKSON |
| 450639 | * | 0.0097 | TARRANT |
| 450672 | * | 0.0097 | TARRANT |
| 450675 | * | 0.0097 | TARRANT |

| Provider Number | | Out-Migration Adjustment | Qualifying County Name |
|------------------------|---|---------------------------------|-------------------------------|
| 450677 | * | 0.0097 | TARRANT |
| 450694 | * | 0.0368 | WHARTON |
| 450747 | * | 0.0195 | ANDERSON |
| 450755 | * | 0.0484 | HOCKLEY |
| 450763 | | 0.0236 | HUTCHINSON |
| 450779 | * | 0.0097 | TARRANT |
| 450813 | | 0.0195 | ANDERSON |
| 450858 | * | 0.0097 | TARRANT |
| 450872 | * | 0.0097 | TARRANT |
| 450880 | * | 0.0097 | TARRANT |
| 452019 | | 0.0097 | TARRANT |
| 452028 | | 0.0097 | TARRANT |
| 453040 | | 0.0097 | TARRANT |
| 453041 | | 0.0097 | TARRANT |
| 453042 | | 0.0097 | TARRANT |
| 453089 | | 0.0195 | ANDERSON |
| 453300 | | 0.0097 | TARRANT |
| 454012 | | 0.0097 | TARRANT |
| 460017 | | 0.0392 | BOX ELDER |
| 460036 | * | 0.0700 | WASATCH |
| 460039 | * | 0.0392 | BOX ELDER |
| 470018 | | 0.0287 | WINDSOR |
| 490019 | | 0.1240 | CULPEPER |
| 490038 | | 0.0022 | SMYTH |
| 490047 | * | 0.0198 | PAGE |
| 490084 | | 0.0167 | ESSEX |
| 490105 | * | 0.0022 | SMYTH |
| 490110 | | 0.0082 | MONTGOMERY |
| 500003 | * | 0.0208 | SKAGIT |
| 500007 | | 0.0208 | SKAGIT |
| 500019 | | 0.0213 | LEWIS |
| 500021 | | 0.0055 | PIERCE |
| 500024 | | 0.0023 | THURSTON |
| 500039 | * | 0.0174 | KITSAP |
| 500041 | * | 0.0118 | COWLITZ |
| 500079 | | 0.0055 | PIERCE |
| 500108 | | 0.0055 | PIERCE |
| 500118 | | 0.0548 | MASON |
| 500122 | * | 0.0459 | ISLAND |
| 500129 | | 0.0055 | PIERCE |
| 500139 | | 0.0023 | THURSTON |
| 500143 | | 0.0023 | THURSTON |
| 503301 | | 0.0055 | PIERCE |

| Provider Number | | Out-Migration Adjustment | Qualifying County Name |
|-----------------|---|--------------------------|------------------------|
| 504010 | | 0.0055 | PIERCE |
| 510018 | * | 0.0209 | JACKSON |
| 510028 | * | 0.0141 | FAYETTE |
| 510028 | | 0.0141 | FAYETTE |
| 510039 | | 0.0112 | OHIO |
| 510047 | * | 0.0275 | MARION |
| 510050 | | 0.0112 | OHIO |
| 510077 | * | 0.0021 | MINGO |
| 520028 | * | 0.0157 | GREEN |
| 520035 | | 0.0077 | SHEBOYGAN |
| 520042 | | 0.0118 | SAUK |
| 520044 | | 0.0077 | SHEBOYGAN |
| 520057 | | 0.0118 | SAUK |
| 520059 | * | 0.0200 | RACINE |
| 520071 | * | 0.0239 | JEFFERSON |
| 520095 | * | 0.0118 | SAUK |
| 520096 | * | 0.0200 | RACINE |
| 520102 | * | 0.0298 | WALWORTH |
| 520116 | * | 0.0239 | JEFFERSON |
| 520132 | | 0.0077 | SHEBOYGAN |
| 522005 | | 0.0200 | RACINE |

¹ Addendum L lists all hospitals that are eligible to have their wage index increased by the out-migration adjustment listed in this table. This list includes hospitals designated in Table 4J of the FY 2006 hospital IPPS final rule (August 12, 2005). Hospitals cannot receive the out-migration adjustment if they are reclassified under section 1886(d)(10) of the Act, reclassified under section 508 of Pub. L. 108-173, or redesignated under section 1886(d)(8) of the Act. Hospitals were given 45 days from the date of publication of the FY 2006 IPPS proposed rule to review their individual situations to determine whether to submit a request to withdraw their reclassification/redesignation and receive the out-migration adjustment instead. For purposes of wage index adjustments under the OPPI, we have adopted any changes in eligibility for the out-migration adjustment resulting from requests to waive reclassification. Hospitals that have already been reclassified under section 1886(d)(10) of the Act, reclassified under section 508 of Pub. L. 108-173, or redesignated under section 1886(d)(8) of the Act and did not withdraw their reclassification/redesignation for FY 2006 are designated with an asterisk. This list also includes TEFRA hospitals falling in a designated out-migration county.